MICHIGAN STATE UNIVERSITY LIBRARIES
3 1293 10686 0871

LIBRARY
Michigan State
University

This is to certify that the

dissertation entitled

Psychological Features of Rape Victims:
Trauma, Counseling, and Recovery

presented by

Judith A. Smith

has been accepted towards fulfillment
of the requirements for

Ph.D. degree in Psychology

Major professor

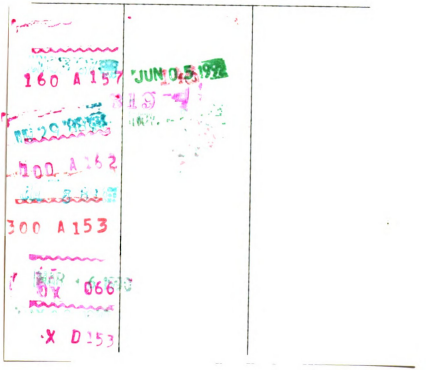
Date 10/15/82

MSU is an Affirmative Action/Equal Opportunity Institution

O-12771

MSU
LIBRARIES

RETURNING MATERIALS:
Place in book drop to remove this checkout from your record. FINES will be charged if book is returned after the date stamped below.



PSYCHOLOGICAL FEATURES OF RAPE VICTIMS: TRAUMA, COUNSELING, AND RECOVERY

By

Judith Anne Smith

A DISSERTATION

Submitted to
Michigan State University
in partial fulfillment of the requirements
for the degree of

DOCTOR OF PHILOSOPHY

Department of Clinical Psychology

1982

ABSTRACT

PSYCHOLOGICAL FEATURES OF RAPE VICTIMS:
TRAUMA, COUNSELING, AND RECOVERY

By

Judith Anne Smith

Three groups of rape victims were studied to identify variables associated with the frequency and/or intensity of adolescents' and adults' postassault symptoms. These included 20 Incoming Victims at Erie, Pennsylvania's Rape Crisis Center assaulted during the period of this research, 38 Previously Counseled victims raped from about three months to three years earlier, and 13 Uncounseled rape victims recruited through media advertisements and local womens' "grapevines". During the 90-days following rape, Incoming Victims were interviewed at nine standard intervals. Thirteen completed a series of sixteen psychological questionnaires, including the Tennessee Self-Concept Scale, the Profile of Mood States, Bem's Sex-Role Inventory, and Levenson's Locus of Control Scales. Their responses were compared with a demographically matched control group. Measures of anger, guilt, Rosenberg's Self-Esteem Scale, Assault-Related Symptom Interviews, and a Degree of Violence questionnaire were completed by all three victim groups.

Among 33 variables investigated, the severity of

postassault symptoms linked most strongly to the rapist's violence (Victim-Reported) and to being physically struck during rape. Arrested rapists' victims consistently reported lesser postassault symptoms than other victims. Other statistically significant findings included lower self-esteem, greater guilt, and more symptoms among those victims who subsequently sought professional counseling and lower self-esteem among victim's of interracial rape. The Previously Counseled reported lesser present-day symptoms, while Incoming and Uncounseled victims reported such symptoms equally often. Prior sexual assaults were reported by 20 to 25 percent of rape victims and by other women surveyed as potential demographic controls.

These findings seem especially important for counselors and therapists of rape victims, but also deserving of attention from social service administrators and policy makers. These exploratory findings merit early verification.

Copyright by
JUDITH ANNE SMITH
1982

TO MY PARENTS

for their

LOVE, GUIDANCE, and SUPPORT

ACKNOWLEDGEMENTS

I would like to extend a sincere word of thanks to the following individuals and agencies:

The 71 rape victims discussed in this study--without their courage and openness this project could not have been done. Their desire to help others at a time when they had just been harmed was truly admirable.

Mrs. Joan Martin, Director of Erie County Rape Crisis Center, and all her staff--their friendship, humor, belief in the project, and support of my efforts was invaluable. Their instruction consistently resulted in new professional growth for me.

Dr. John Hurley, chairperson of my doctoral committee, whose patience, encouragement, and advice was instrumental in the completion of this project. His feedback consistently provided a sense of clarity and direction in the often bewildering process of analyzing and writing the project's results.

Dr. Al Aniskiewicz, Dr. Elaine Donelson, and Dr. Dozier Thornton, doctoral committee members who were readily available to provide support and direction throughout the project.

Dr. John Gamble and the psychology faculty of Behrend Campus of Pennsylvania State University for allowing the use

of their computer facilities. Particular thanks goes to Dr. John Alessio and Dr. Stephen Knouse for their statistical and computer advice.

The staff and students of Opportunities Industrialization Center in Erie for their cooperation with the collection of control group data, and to the media representatives in Erie County who publicized the project.

Ms. Sharon Phelps, dissertation typist, whose confidence, patience, and reliability were greatly appreciated. Sharon's skill in rendering a presentable typed draft from the maze of my writing was truly remarkable.

Ms. Paula Freeman, Mr. Jeffrey Smith, Ms. Linda Williams, Mrs. Susan Reeder, and Mr. Russell Smith for their assistance in the coding and scoring of data. Their humor, energy, and accuracy turned often tedious work into fun. Additional thanks goes to Jeffrey for his professional drafting assistance.

My family and friends whose affection, support, and camaraderie could always be relied upon.

Jessica Marie Smith, who accepted the dissertation's demands on her mother's time as patiently as any thirteen-year-old could, and whose love and excitement made this project just a little easier to complete.

TABLE OF CONTENTS

Page

LIST OF TABLES ix

INTRODUCTION 1

The Historical Development of Interest in the Postassault Reactions of Rape Victims 2

Rape: An Overview of the Crime 7

Incidence 8
Setting 9
Profile of the victim 9
Profile of the assailant 11
Victim-offender interaction 13
Legal proceedings 15

A Review of the Literature Regarding Rape Victims Reactions 16

Demographic profiles: Amir and MacDonald 17
Questionnaire surveys 18
Clinical/empirical studies 21
Dynamics suggested by the literature 33
Methodological problems of the studies of rape 41

METHOD 44

Purpose and Procedures 44

Statement of purpose 44
Location 47
The victims 48
Research procedures with the incoming group 49
Research procedures with control group 53
Research procedures with previously counseled ECRCC victims 54
Research procedures with previous victims without counseling 56

Measures 57

Assault-Related Symptom Interview (ARSI) 57
Bem Sex Role Inventory 60
Body Cathexis Scale 63

Degree of Violence....64
Demographic Data....66
Fear Survey Schedule III (FSS III)....67
Guilt Index....69
Inventory of Psychosocial Development....71
Levenson's Internal-External Locus of Control Scale....73
Life Experiences Survey (LES)....75
Profile of Moods State (POMS)....77
Religiousity Scales....80
Rosenberg's Self-Esteem Scale....81
Support System Rating....82
Tennessee Self-Concept Scale (TSCS)....83
Thematic Apperception Test (TAT)....85

RESULTS....88

Final subject pool....88
Control group....91
Group differences on demographic variables....92
Missing data....93

Demographic Features....95

Sex....96
Age....96
Marital status....96
Socioeconomic status....96
Educational level....96
Occupation....96
Religious Identification....97
Importance of religion....97
Prior mental health counseling....97
Prior sexual assaults....98
Sexual experience....98
Race of assailant....98
Degree of relationship with assailant....99
Location of the rape....99
Presence of threats....99
Presence of weapons....99
Use of restraints....100
Striking the victim....100
Injuries....100
Feelings towards the assailant....100
Criminal justice system involvement....101
Support systems....102
Counseling systems....103
Reasons for research participation....105
Factors germane to recovery....105

Analyses of Measures Common to All Victim Groups....106

Questionnaire results....107
Intercorrelation matrix of questionnaires....109

ARSI-W results for the four time periods sampled.....109
Intercorrelation matrix of ARSI-W totals.....112
Areas of assault-related disturbance.....113
A comparison of ECRCC-affiliated and nonaffiliated uncounseled group members.....117

Effects of Demographic Variables on Measures Common to all Groups.....119

Sex.....120
Age.....120
Education.....120
Socioeconomic level.....121
Religious identification.....122
Marital status.....122
Race of the victim.....122
Occupation.....122
Prior mental health counseling.....123
Virgin at time of rape.....124
Quality of previous sexual experiences.....124
Length of time since the assault.....124
Location of the rape.....125
Previous history of sexual assaults.....125
Race of assailant.....125
Number of assailants.....126
People told during the first 7-10 days.....127
If the victims knew the assailant.....127
Presence of threats.....128
Presence of weapons.....128
Use of restraints.....128
Sexual events during the rape.....128
Victims struck.....129
Injury.....129
The arrest of the assailant.....131
If the case went to court.....131
Court verdict.....132
Contacted professional counselors for rape-related reasons.....132

Analyses of Data From the Incoming Group.....132

Comparison of control and incoming groups.....133
ARSI-O results: Means and correlations.....135
Questionnaire results: Multiple administrations.....138
Questionnaire results: Single administrations.....138
Correlation matrices for all questionnaires.....138

Summary of the Results Regarding Each Hypothesis.....147

DISCUSSION.....156

Reaction patterns.....156
Primary finding: The impact of violence.....164

Present day symptoms in the uncounseled group.....167
Previous sexual assaults.....167
The assailant's race.....169
Findings not consistent with previous literature.....171

Limitations of the Present Study and the Issue of Generalization.....173

Implications for future research.....176

Summary.....178

APPENDIX A: Questionnaires Used In The Study.....180

APPENDIX B: The DOV-O Scoring System.....218

APPENDIX C: ARSI-O Scoring Guidelines.....220

APPENDIX D: Correlation Matrices of Single and Multiple Administration Questionnaires Used with the Incoming Group.....227

APPENDIX E: Summary on Questionnaire and ARSI-W Scores Affected by Demographic Variables.....230

APPENDIX F: Independent Effects of Demographic Variables on Questionnaire and ARSI-O Scores.....235

BIBLIOGRAPHY.....243

LIST OF TABLES

Page

Table 1: Incoming Group Symptom Interview Schedule.....51

Table 2: Incoming Group Questionnaire Administration Schedule.....52

Table 3: Number of Incoming Victims Who Completed Forms...94

Table 4: Time and Percentages of ARSI-O Completions.....95

Table 5: Questionnaires Common to All Victim Groups; Means with (N's).....107

Table 6: Analysis of Variance Results from Comparisons of Questionnaire Scores by Victim Groups.....108

Table 7: Questionnaire Measures Common to All Victim Groups.....109

Table 8: Total Victims' ARSI-W Means, Variances, and Ranges.....110

Table 9: Group's ARSI-W Means at Each Time Period.....111

Table 10: Intercorrelations of ARSI-W Totals for Each Time Period.....113

Table 11: Correlations of ARSI-W and Questionnaire Scores.....114

Table 12: ARSI-W Group Means, Ranges, and Variances for Symptom Areas.....115

Table 13: Group Differences on ARSI-W Symptom Areas (ANOVA).....115

Table 14: Intercorrelation Matrix of ARSI-W Symptom Area Scores.....116

Table 15: Correlations of ARSI-W Symptom Areas with Questionnaires.....117

Table 16: Uncounseled Victim Subgroup Comparisons (ARSI-W).....119

Table 17: Mean Scores of Victims Assaulted at Home vs. Elsewhere.....126

Table 18: Comparison of Victims of Single Versus Multiple Assailants.....127

Table 19: Comparisons of Struck vs. Unstruck Victims.....130

Table 20: Comparisons of Injured vs. Noninjured Victims..130

Table 21: Mean Scores on Variables Pertinent to Professional Counseling.....133

Table 22: Means of the Control vs. Incoming Groups.....134

Table 23: ARSI-O and Subscale Means, Variances, and Ranges.....136

Table 24: Intercorrelations of ARSI-O Symptom Areas.....137

Table 25: ARSI-O Severity Indices Intercorrelated.....137

Table 26: Mean Anger, Guilt, and TSCS Scores of Incoming Members.....139

Table 27: Incoming Victim Scores on Single-Administration Questionnaires.....140

Table 28: Correlations of Self-Esteem Measures with ARSI-O Symptom Profiles.....142

Table 29: Correlation of Measures of Mood with ARSI-O Symptom Profiles.....143

Table 30: Questionnaires Correlations with ARSI-O Symptom Profiles.....145

Table 31: Correlation of Self-Esteem with ARSI-O Symptom Areas.....146

Table 32: Correlations of Mood Measures with ARSI-O Symptom Areas.....147

Table 33: Correlations of Support System Measures with ARSI-O Symptom Areas.....147

Table 34: Correlations of Questionnaires with ARSI-O Symptom Areas.....148

Table 35: Correlations of TSCS with Guilt for Incoming Victims.....152

Table 36: Intercorrelation Matrix of Single Administration Questionnaires Among Incoming Victims.....228

Table 37: Correlation of Single with Multiple Administration Questionnaires.....229

Introduction

Rape is a crime that affects tens of thousands of women each year. Forcible rape is distinguishable from other criminally violent acts such as assault, murder, and armed robbery in two primary ways: its victims are overwhelmingly female, and the violence is expressed sexually--that is, there is forcible sexual penetration of the woman's body against her will. In our culture, sex is an issue invested with highly charged emotions and beliefs. It can be anticipated that the rape victim will manifest a series of psychological reactions, both to the act of violence, and to the sexual component as well.

Investigation into the area of rape victim reactions began in the late 1960's. Although the field is still young, and characterized by a limited number of empirical studies with many methodological problems, significant knowledge about the behavioral and affective changes typically occurring in the rape victim has been gained. This information has been immediately applied towards the construction of more effective treatment programs for the victims of rape and other forms of sexual assault.

It is the author's hope that the present study will add significantly to ongoing efforts to understand the impact of rape on a victim's life, and the factors germane to recovery.

Specifically, this study will examine how demographic variables, affective states, and victim perceptions influence the pattern of recovery in adult and adolescent victims of forcible rape.

The Historical Development of Interest in the Postassault Reactions of Rape Victims.

During the 1960's behavioral science investigations of reactions to crises precipitated by death, war, natural disasters, and other such traumas began to flourish. Curiously lacking, however, was interest in empirically defining the psychological reactions of victims of another type of crisis, that of sexual assault. This omission was consistent with a broader inattention to the psychological aftereffects of any violent crime. However, as crime rates began to soar in the late 60's, victims of violent crime increasingly became a focus of national attention. For the first time, behavioral scientists began to conceptualize victims of violent crimes as individuals worthy of study.

The psychological consequences of rape on its victims has been a silent area throughout the centuries. Only infrequently are references heard regarding the plight of the victim and those close to her. One such reference was found in Greek mythology. This was the Greek myth of Demeter, goddess of life, who upon discovering that Hades, (god of death) had raped and abducted her daughter, Persephone, ordered that all earth become barren and cropless and carried out this threat until her daughter was indeed returned (Graves, 1957). In The Rape of Lucrece, Shakespeare

documented the tale of Lucretia, a Roman matron, who was raped by one of her inlaws and who killed herself given the sense of shame that followed. With the exception of these occasional literary references, however, the idea that a woman who had been raped had just experienced a very personal and damaging assault seemed to be outside people's awareness. A fact which explained how this could be so emerged as the literature was reviewed. Rape was not defined as a crime against a person, so there was no "real victim" to consider. Rather, the early laws against rape defined this assault as a criminal act by one man against the property of another man, violating the property owner's rights and damaging his goods (Clark & Lewis, 1977). This definition was possible given that the status of women, particularly in the Judeo-Christian cultures, was that of a possession owned first by the father and later by the husband. Women's sexual and reproductive value was always of prime importance, this ability to reproduce and provide her mate with heirs and status made her a valuable property. Thus, once married, the marriage contract awarded her owner-husband total and exclusive rights of sexual access to the wife.

Six hundred years ago, Anglo-Saxon law, the foundation of our contemporary legal codes, punished rapists by ordering them to pay compensation and reparation fees to the father or husband of the woman raped (Clark & Lewis, 1977). This fee was paid directly to the male having ownership of

the woman at that time as he was considered the person who had been wronged, i.e., his property had been stolen and damaged. The amount of the compensation was dependent upon the woman's economic position and how her market value had been changed by the rape. For example, the rape of a virgin daughter of a wealthy landowner would be a serious matter, as it would have seriously damaged the father's chances of extending his wealth by arranging an advantageous match for his chaste daughter. However, the rape of a daughter of an innkeeper perhaps rumored to already have lost her virginity would generally not be considered seriously as the woman had little property value to start with.

The definition of rape as a property crime, rather than a personal crime, endured to varying degrees over the years. An article from the 1952-1953 Yale Law Journal (cited in Griffin, 1971) described the rationale for present laws against rape, by noting:

> The consent standard in our society does more than protect a significant item of social currency for women (i.e., her power to withhold or grant sexual access): it fosters, and is in turn bolstered by, a masculine pride in the exclusive possession of a sexual object...A... reason for the man's condemnation of rape may be found in the threat to his status from a decrease in the "value" of his sexual possession which would result from forcible violation. The man responds to this undercutting of his status as possessor of the girl with hostility toward the rapist: no other restitution device is available. The law of rape provides an orderly outlet for his vengeance.

The lay definition of rape often was that rape was a crime of passion (not aggression) that could not occur in a truly unwilling victim. The economic and sexual status of

the victims continued to play an important role in whether the victim was viewed as credible, or not.

Given the influence of early legal definitions of rape and the folklore accompanying lay understandings of the crime, it is less surprising that the personal reactions of rape victims has received so little concern.

Early authors in psychology were not immune to lay views on sexual assault, and psychoanalytic writings initially seemed to illustrate this. Thus, Deutsch (1944) wrote that women, as the naturally more passive and masochistic of the sexes, needed stronger, more violent fantasies to stimulate them. Consequently the postassault distress of the rape victim was often viewed (Hilberman, 1976) simply as an expression of guilt arising from previous unconscious desires for such an assault to have occurred.

Society had to redefine rape as a personal crime which directly harmed its victims before serious attention could be given to the rape victim. The Women's Movement that developed in the United States in the late 1960's spearheaded the redefinition process. Gager and Schurr (1976) noted that within the feminist perspective, rape was not viewed as "an isolated phenomena of sick males," but rather as an inevitable part of a social matrix based upon sexual inequality. The issue of forcible rape served to focus attention on many aspects of women's position in modern American society, as it symbolized the damaging effects of sexual exploitation and male dominance (Geis, 1977). More

radical feminists viewed society's traditional lack of belief in the victim, and low rate of convictions of rapists, as due to the need of a patriarchal society to keep such tools as rape operable to enforce female timidity and submissiveness. Griffin (1971) wrote:

> Fear of rape keeps women off the streets at nights. Keeps women at home. Keeps women passive and modest for fear that they be thought provocative...Finally, rape is a form of mass terrorism for the victims of rape are chosen indiscriminately, but the propogandists for male supremacy broadcast that it is women who cause rape by being unchaste or in the wrong place at the wrong time — in essence, by behaving as though they were free.

Although one may agree or disagree with the theoretical perspective on rape taken by feminist authors, it was through the interest, controversy, and debate stirred by the Women's Movement that national attention became focused on reconsidering the definition of rape and the treatment of rape's victims. Demographic studies such as those conducted by criminologist Menachim Amir (1971) and MacDonald (1971) began to appear, and presented major statistical profiles of rapists and their victims as reflected in police records. Questionnaire surveys, case studies, and, finally, empirical research focused on rape victim reactions began to appear. These studies found immediate applicability and use by those counselors working with forcible rape victims. Before considering these findings, further attention will be given to the legal definition of rape and to statistics regarding the the crime, the victims, and the offenders.

Rape: An Overview of the Crime.

There are two classifications of rape: forcible rape and statutory rape. Statutory rape defines the event where a victim consents to sexual intercourse, but is legally considered incapable of such consent by virtue of age or mental impairment (e.g. retardation). Forcible rape, the topic of this study, is defined somewhat differently from state to state. However, most legal codes for forcible rape are generally consistent with Pennsylvania's codes which define rape as penetration of the vaginal area, however slight, without the victim's consent, and under force or threat of force. Erection and/or ejaculation need not occur for a charge of rape to be filed. One further stipulation is that a spouse cannot be charged with rape unless the couple is in fact separated, divorced, or living in separate residences.

This matter of definition frequently arises in comparing studies of rape victims, as different researchers have frequently relied on different definitions. Peters (1975), a Philadelphian psychiatrist, only investigated those victims meeting the criteria of vaginal penetration. Other studies have included victims of attempted rapes as well as of actual rapes. More frequently, authors (Burgess & Holmstrom, 1974; Medea & Thompson, 1974) have concurred with Hursch and Selkin's (1974) definition of rape as involving "any one or more of the following - intercourse, fellatio, cunnilingus, anal sex, or penetration of the genital area by

any part of the assailant or a foreign object as reported by the victim or determined by medical examination" when the woman does not consent, and force or threat of force is used. This definition has been particularly useful given that vaginal penetration is often not the rapist's sole intent. In fact, Selkin (1975) found that less than one-half of the rape victims at Denver Hospital Emergency Room had been simply assaulted vaginally. Similarly, Amir (1971) and Peters (1975) both reported that approximately twenty-one percent of their rape cases involved other forms of sexual practice than vaginal intercourse.

Incidence. The F.B.I. Uniform Crime Reports provide information on the number of attempted and/or successful rapes reported to the police in the United States. (They define rape as vaginal penetration only). Between 1960 and 1970 the Report showed a one hundred-twenty-one percent increase in reports of forcible rape, so that by the early 1970's about fifty thousand cases were reported a year. This rate of increase was significantly higher than that seen for other violent crimes.

It was difficult to know whether figures such as these reflected an actual increase in the crime, or merely an increased willingness to report it. It is likely that both factors were involved. These figures, of course, did not convey how many rapes occurred each year that were never brought to the police's attention. In an effort to approximate that figure, the United States Presidential Commission

on Law Enforcement and Administration of Justice (1967) sent a national survey to a randomly selected sample. Their results suggested that the true incidence of rape was at least three-and-a-half times that reported to the police. This suggested a ratio of one hundred-sixty-five rape victims per every one hundred thousand women.

Setting. Although rape may occur at any time or place, like other violent crimes it has been found to have its highest incidence on week-end nights in urban areas (Katz & Mazur, 1979). The summer months also seem to have a slightly higher incidence than the winter.

MacDonald (1971) in Denver, and Amir (1971) in Philadelphia found that about forty-eight percent of rape victims they studied were apprehended on the street, the majority of which were then taken to some indoor location where the actual rape occurred. Their statistics also showed that one-third of the victims were initially contacted and assaulted within their own homes. The third most frequent initial meeting place was in a tavern, accounting for approximately eight percent of the assaults.

Profile of the victim. There are no sure rules about who will become a victim of rape, it is a crime that can occur to anyone. However, there are certain groups and subgroups of individuals who are found to be more at risk than others. For example, women remain the prime candidates for rape, although men are by no means totally excluded. Hursch and Selkin (1974) and Massey, Garcia, and Emich (1972) each

reported that ninety-six percent of their sample was female, while four percent was male. Rape victims were generally young, with seventy-five percent of forcible rape victims used in research studies up to 1978 falling in the thirteen to thirty age range (Katz & Mazur, 1979). This figure appeared fairly uniform across the country. However, no age group was really immune; in fact, the youngest victim reported in the literature was five months (Massey, et. al., 1972); while the oldest was ninety-one years old.

Even when victims under sixteen years old were excluded from consideration, it was the woman who was single that had the highest rate of rape. The percent of single victims in existing studies ranged from sixty-two percent (Burgess & Holmstrom, 1974) to seventy-five percent (MacDonald, 1971). Single individuals were more vulnerable to other violent crimes as well.

It is of note that in all violent crimes, including rape, the percentage of minority victims was higher than would be expected given general population figures (Katz & Mazur, 1979). Also, the highest rates of reported rape and other crimes of violence came from lower socioeconomic groups, perhaps largely because it was the lower socioeconomic neighborhoods that also spawned most of the assailants (National Crime Panel Survey Report, 1975).

A frequently raised question is whether victims of rape have a greater incidence of pathological families and psychiatric disturbances than nonvictims do which may

predispose them to the assault. Research done in this area appeared very sparse and inconclusive overall (Katz & Mazur, 1979). Peters (1975) had found that ninety-two percent of the adult victims treated at the Philadelphia General Hospital Rape Center, were reported by themselves and their families as functioning well previous to the assault. Further study revealed that approximately one-third of these adults had received individual psychological counseling for personal concerns at some time in their life prior to the rape. However, as there was no control group, the question that remained unanswered was whether this was a higher figure than for the population as a whole, or for the victim's particular socioeconomic group.

Schuker (1979), a psychiatrist at Columbia University, presented some preliminary statistics that suggested that victims of a previous sexual assault were slightly more at risk for a second assault, than were women without such life histories. Possible reasons suggested for such "recidivism" were that some of Schuker's sample lived in neighborhoods that were typically quite violent, and that some of the women were rather "fearful, dependent individuals who appear more vulnerable to a successful attack." (Schuker, 1979)

Profile of the assailant. A review of the literature regarding the offender revealed that the rapist, like the victim, was most often young (ages fifteen to twenty-four), single, and from a low socioeconomic group (Katz & Mazur, 1979). Statistics from the early 1970's stated that about

ninety percent of the reported rape cases occurred between members of the same race (Amir, 1971; Eisenhower, 1969). Certain urban areas have since reported an increased rate of reported interracial rapes (Hursch & Selkin, 1974; Peters, 1975), although it was not clear if the incidence of such assaults was increasing, or merely the tendency to report them.

Approximately sixty-seven to eighty-two percent of rapes involved a lone assailant (National Crime Panel Survey, 1975). Most rapes involved some degree of planning, and thirty-six to fifty-one percent of the rapists carried a weapon (National Crime Panel Survey, 1975). More than one-third of the apprehended rapists were married, and the majority of the offenders had regular sexual contacts available to them that didn't require force to obtain (Groth & Burgess, 1977). Approximately one-third of the rapists studied were sexually dysfunctional during the rape, so it was not uncommon that ejaculation did not occur. For many rapists, there was a repetitive, compulsive quality to their committing of the crime. For example, "first offenders" frequently reported many previous assaults for which they were never caught, and the recidivism rate for rapists following release from prison was high (Enterlin, 1978; Groth & Burgess, 1977).

Those researchers studying the assailant maintained that both sexual and aggressive components were involved as motivations in every rape, although the relative

contribution of each varied from individual to individual (Cohen, Garofalo, Boucher, & Seghorn, 1971). Rape was the only illegal activity of some. For others, rape was simply one of their many antisocial behaviors. Some offenders appeared to rape primarily for the sexual stimulation, using just enough aggression to secure a victim's cooperation; while others were primarily focused on displaying aggressive and/or sadistic behavior towards the victim, with the sexual act being rather incidental. Thus, what actually occurred to the victim during the assault was somewhat dependent on the type of rapist.

Victim-offender interaction. Familiar questions asked when a woman is raped are: did she know her assailant, did she somehow bring the rape on herself, had she fought back, and was she injured. In reviewing the literature it was noted that the National Crime Panel Survey (1975) had found that the percentage of rapes of women age twelve and over in which the assailant was a stranger ranged from seventy-two to ninety-one percent. Thus, while children under twelve usually knew their assailants, such was not the case in the majority of adolescent and adult rape victims.

One percentage that crime surveys also attempted to calculate was how frequently a victim of a violent crime seemed to engage in some behavior that may have precipitated the crime. Interestingly, despite the persistent folklore of "the woman who is raped, asks to be raped", the empirical findings from the National Commission on the Causes and

Prevention of Violence (Eisenhower, 1969), which conducted a seventeen-city survey, revealed only four percent of the rape victims "assisted" in the precipitation of the crime. The two criteria by which victim precipitation of rape was said to occur were: 1) the victim agreed to sexual relations, but retracted her consent before the actual act occurred, and 2) the victim clearly invited sexual relations through language or gestures. The Federal Commission on Crimes of Violence (Russell, 1975) also independently arrived at a four percent victim-precipitation figure for rape. This was significantly lower than the victim-precipitation rate for any other violent crime, including homicide which had a twenty-two percent rate, or assault with a fourteen percent rate (Eisenhower, 1969).

Surveys also examined what percentage of the victims took some measures to defend or protect themselves. In the National Crime Panel Survey (1975), self-protection was defined as engaging in any of the following behaviors: "hitting, kicking, or scratching the offender; screaming, or yelling for help; fleeing from the offender, and using or brandishing a weapon." The crimes of rape, assault, and burglary in five large American cities were surveyed. In all five, rape was more likely than robbery to provoke self-protective behavior, and in two cities, rape was also more likely than assault to provoke self-protection. In sum, the percentage of rape victims who make some attempt to protect themselves ranged from sixty-seven to ninety percent

(National Crime Panel Survey, 1975).

In most cases, the rape victim did not receive obvious physical injury, as defined in terms of lacerations, fractures, or concussions. Only a very small percentage of victims required overnight hospital care following the assault (National Crime Panel Survey, 1975).

Legal proceedings. No overview of the crime of rape would be complete without some discussion of the legal process presently available to rape victims. For those rape victims who choose to report their rape to the police, and who press charges if their assailant is apprehended, a set sequence of legal proceedings will follow. These proceedings vary somewhat from state to state. In Pennsylvania, the police will require that the victim receive a documented medical examination and give a statement to their detectives as soon after the crime as possible. Once the assailant is apprehended, the victim will attend a preliminary hearing before a district magistrate seven to ten days after the arrest. If the magistrate believes there is enough evidence to warrant taking the case before a criminal court judge, the case will be "bound over", which means that a criminal court trial, generally before a jury, will take place within the next one-hundred-eighty-days. If the assailant is found guilty, a separate hearing may be held for sentencing. Unlike the rulings in many other states, in Pennsylvania the victim cannot be questioned in court regarding any past sexual behavior unless she has had prior consentual

intercourse with the defendant, in which case that information can be brought forward.

In examining the statistics regarding the legal consequences for rape, the arrest and conviction rates in rape cases has risen since the 1960's, although national figures indicate that the present rate continues to be lower than that of other violent crimes. One reason for this may be that in rape, more often than in other crimes, the assailant is a stranger and therefore more difficult to identify to the police. Another may be that victims of rape still remain somewhat less likely to report the crime for fear of embarrassment or blame, than do victims of other crimes.

A Review of the Literature Regarding Rape Victim Reactions.

The literature from the behavioral sciences regarding individuals who have been raped may be conveniently grouped into one of four categories. First, demographic profiles of the victims and offenders have been constructed and have yielded many of the statistics referred to in the preceding section. This demographic information was generally secured from surveying police and/or medical records, but it included little or no information regarding the victim's psychological reaction. Second, questionnaire surveys were conducted in various sections of the country that asked victims not only for demographic data, but also inquired about their feelings and reactions following the assault. Third, clincial studies documented postassault reactions as observed or discussed during counseling sessions. More

recently, some authors have begun to study postassault reactions in a more empirical fashion, using large representative samples, careful documentation of incidence and duration of postassault symptoms, and objective psychological measures to discern rape's impact. In this section of the paper, selected studies from each of the four areas will be reviewed. Those studies falling in the clinical and empirical groups will be considered jointly for clarity and readability.

Demographic profiles: Amir and MacDonald. In 1971, Menachim Amir, an Israeli sociologist who had studied under the leading criminologist Marvin Wolfgang, examined six hundred and forty-six Philadelphia police records on rapes reported between 1958-1960. From this, he published the first major statistical profile of rapists and their victims including as variables sex, age, socioeconomic class, prior victim-assailant relationship, interracial factors, etc. While Patterns in Forcible Rape (Amir, 1971) was a landmark publication presenting a composite picture of the victim, assailant, and their interaction during the assault, reactions of the victims following the assault were largely unaddressed.

MacDonald (1971) conducted a similar study examining two hundred rape cases on record with the Denver City Police. His book, Rape Offenders and Their Victims considered the same variables addressed by Amir, and included only a two-page section on the victim's reaction to rape. He noted

here that the victim's reaction during and immediately following the assault was related to such variables as threats of violence, age of victim, cultural background, personality, and prior sexual experience. The specific postrape reactions noted in the Denver Police records ranged from true or apparent lack of concern, to major emotional upheaval leading to suicidal attempts. MacDonald cited five illustrations of these reactions. Four exemplified lack-of-concern attitudes, and one was an instance of a fatalistic attitude of acceptance displayed by a middle-aged woman while no anecdote related strong emotional reactions to the rape. However, MacDonald followed this section with a five-page excerpt of a study just completed by Sutherland and Scherl (1970) that investigated the pattern of reactions to rape. The results of that study are detailed later in this section.

The method of using police, court, or hospital records to increase the understanding of the victim, assailant, and crime itself has also been used by Svalastoga (1962) in Denmark; Hursch and Selkin (1974) in Denver; and Chappell, Geis, Schafer, and Siegel (1977) in Boston and Los Angeles. While some variations exist from city to city, the demographic information has merely extended, rather than changed, the early findings of Amir and MacDonald.

Questionnaire surveys. Another means of studying the psychological and behavioral reactions of rape victims has been to encourage victims to respond to an anonymous

questionnaire. Bart (1975) published such a form in VIVA magazine and received 1070 completed responses. The occurrence of the rapes ranged from one to three years before the questionnaire was completed. Symptoms that were reported included: nightmares, postrape sexual problems, and suicidal ideation. Intrapersonally, a loss of self-respect, confidence, and sense of independence occurred. Interpersonally hostility towards men, and decreased trust in male/female relationships was noted. Twenty-two percent of the victims reported seeking psychological counseling although only thirty-five percent of these reported it as helpful. Of the sixty-five percent of the victims who sought professional help and did not find it useful, thirty-nine percent subsequently reported going to women's groups for help. It is interesting that only nine percent of the victims raped a year or less before the study reported seeking help, while the figure doubled for the two subsequent years. This suggested that some victims experienced long-term difficulties directly related to the rape.

In 1975, the Queen's Bench Foundation in San Francisco solicited a total of eighty victims from media advertisements and professional referrals to come in for one-to-two hours of structured interviewing. These interviews were similar to Bart's questionnaire, and their findings on symptoms and reactions were essentially the same. Among their conclusions were: 1) Stranger rapes seemed to effect the sense of personal safety, while familiar rapes effected

self-concept and social relationships. 2) Ventilation of the victim's feelings was reported as important for recovery to prerape levels of functioning. 3) The rape was experienced as a life-threatening event; during which the woman may have felt afraid, angry, or detached. Her concern at that time was usually less with the sexual aspect, and more with concern for physical well-being. 4) Shame, guilt, and concern over what occurred sexually followed the assault, probably reflecting the internalization of societal views. 5) The intensity of symptoms was greatly influenced by how others responded to the victims.

The final questionnaire study considered was published by Medea and Thompson in 1974. Their questionnaire, published in underground newspapers and at rape conferences, elicited sixty replies from rape victims. The majority of these women were fifteen to twenty-one years old (the total age range was seven to thirty-nine years). Eighty-eight percent were single and fifty-seven percent were students suggesting this sample was representative of the national figures on victims in several aspects. Two problems with the sample were selection biases, given how the form was published, and the high (ninety-five percent) number of Caucasian victims. A summary of the psychological reactions their victims reported is as follows:

42% felt more afraid of men
28% said it affected their lives sexually
29% were more afraid of being on their own
23% reported damaged trust in male-female relationships
17% were more hostile to men

7% had suicidal impulses following and related to the rape
5% reported nightmares

When asked who they sought for help in dealing with their psychological reactions, fifty percent of their respondents stated "no one". Twenty-five percent relied on friends, twelve percent on women's groups, and eight percent on professional counselors. Medea and Thompson did not examine the time lapse between the rape and these responses, so it was unclear which symptoms were short-term, and which were long-term difficulties.

Clinical/empirical studies. The questionnaire studies identified data about the symptoms that follow the rape and estimated their frequency. To discover what phases of recovery victims typically go through, what symptoms are predominate during each phase, and how the postassault responses resolve themselves over a period of time, required clinical studies.

One of the earliest clinical studies of the reactions of rape victims was published in 1970 by Sutherland and Scherl. Their sample consisted of thirteen young (ages eighteen to twenty-four), middle-class, Caucasian women who moved into a lower class housing area to "do something real" in today's society, and were subsequently raped. Sutherland and Scherl interviewed them in the weeks following the assault and described their reaction pattern as having three phases. Phase 1 was the Acute Reaction, lasting from a few days to a few weeks. It was characterized by intense

affect, disturbed sleep, and maximum disruption of functioning at work or in the home. Phase 2, the Outward Adjustment phase, was a period in which the woman's energies were directed at regaining control of her daily functioning. She was attempting to make her life like it was before the rape. To do this, she temporarily suppressed her feelings about the assault. Denial of the impact of the crime and rationalizations regarding the rapist were common at this time. This appeared to be a normal phase, with the denial and suppression becoming impairments only if the woman remained in this phase. Phase 3 involved Integration and Resolution. The woman began to reexperience some depression and found herself beginning to think about the rape again. She often had a need to talk about the event. During this "working through" period the woman had to resolve her feelings towards the rapist, and her feelings about herself. She had to define how much guilt she should bear and integrate the fact that she could not always be guaranteed safety in her world. The main design problems of Sutherland and Scherl's study were the small sample size and the homogeneity of their sample. The average length of time spent in Phase 2 or 3 was unspecified, apparently due to sizeable individual differences.

The most definitive and well-constructed clinical studies to date of rape victim reactions and long-term effects were those of Ann Burgess and Lynda Holmstrom (1974) at Boston City Hospital. A psychiatric nurse and

sociologist, respectively, Burgess and Holmstrom worked for the Victim Counseling Program that provided twenty-four-hour crisis intervention to the victims of sexual assault who had been brought to the hospital's emergency room. During the pilot year, 1972-1973, ninety-two adult victims were seen. The sample was heterogenous for race, age, marital status, socieconomic status and occupation. Seventy-four of the ninety-two were under age thirty, and fifty-four were single. Either Burgess or Holmstrom interviewed the victim within thirty minutes of her arrival, and conducted followup interviews via telephone or home visits weekly for the first three months, and then at six-month, nine-month, and one-year intervals. Long-term followup was accomplished by re-interviewing eighty-one of the original sample four to six years after the rape.

Burgess and Holmstrom (1974) learned enough about these victim's initial reaction patterns to delineate what they termed the "rape trauma syndrome." The syndrome was defined as an acute stress reaction to a life-endangering situation. It consisted of two phases, the acute and the long-term re-organizational. The acute phase was marked by disorganization, and typically persisted for two to three weeks. The primary initial affect of the incoming victim was not guilt or shame, as the authors had presupposed, but fear of physical injury, mutilation, or death. In the few hours immediately following the crime the victim's reactions were almost evenly divided between the expressed style, characterized by

sobbing, restlessness, and intense affect; and the controlled style, manifested by subdued or hidden affect. Those utilizing the controlled style often experienced somatic reactions such as vomiting, choking, or gagging. Beyond recovering from whatever physical trauma was incurred during the rape, the woman commonly experienced sleep and appetite disturbances, stomach pains, fatigue, headaches, anxiety and tension. Sexual functioning was commonly disturbed. Affectively, this period was characterized by feelings of shame, embarrassment, anger, revenge, fear of retaliation, and self-blame.

The long-term reorganization process began two-to-three-weeks after the assault, and its expression was again dependent on such independent variables as ego-strength and the reactions of significant others. Approximately one-third of the sample experienced nightmares at this time. Traumatophobic reactions, or phobic reactions to circumstances surrounding the rape were common. Women attacked in their own beds might develop a phobia of the indoors, while women attacked outdoors tended to develop fears of being outside. The woman might still approach such situations, or could actually avoid such places all together.

Almost all victims were increasingly fearful of being alone, and experienced varying degrees of tension, anxiety, or panic when alone. Other traumatophobic reactions were a fear of crowds, fear of people behind them, and sexual fears. The disruption of normal sexual style initiated in

the acute phase might continue during the second phase. One victim, assaulted five months before this interview, expressed her difficulty as: "There are times I get hysterical with my boyfriend. I don't want him near me; I get panicked. Sex is O.K., but I still feel like screaming."

Another common symptom of the phase was increased mobility--forty-four of the ninety-two victims changed residences shortly after the rape. Of the forty-five who had been employed, nineteen had changed or quit their job within six weeks. The portions of this mobility that were planned before the assault, and that occurred as a result of it, were unclear. Of the symptoms discussed, thirty-one of the ninety-two experienced mild versions, that is, they could discuss their symptoms and still feel they had some control over them. Twenty-one of the victims experienced moderate to severe versions, including clear lifestyle disturbances.

Burgess and Holmstrom did not initially indicate the length of this second phase. They implied that its effects gradually faded as the woman began to integrate the rape experience. In victims who had previous psychiatric disorders, or substance abuse problems, integrating the experience was more difficult. These victims showed what was termed compounded reactions, symptomatized by depression, psychotic behavior, substance abuse, suicidal behavior, and other serious problems. Eighteen of the ninety-two women experienced this type of reaction. Other categories of victims listed in the literature as sustaining more

psychological damage and/or needing more intervention included victims of multiple-offender rapes (MacDonald, 1971; Amir, 1971); physically brutal rapes; rapes where the assailant was a formerly trusted acquaintance (Bart, 1970); and rape where the assault is the woman's first sexual experience (Burgess & Holmstrom, 1974).

The majority of victims successfully maintained some psychological equilibrium throughout their reactions. No ego disintegration or self-destructive behavior occurred in any of the ninety-two during the acute phase, and the eighteen "compounded reactions" occurred in the four-to-six-week period following the crime. Those who quit jobs during the first six-weeks quickly reentered the job markets.

This early study had notable strengths including the heterogeneity of the population, thorough interviews, a substantial sample, and attention to the victim's perception as well as the clinician's. These findings have been widely published, and their book, Rape: Victims of Crisis, is a handbook used by many rape crisis centers nationwide.

In 1979, Burgess and Holmstrom reinterviewed eighty-one of the original ninety-two victims. They asked each victim whether she felt back to normal yet, whether any aftereffects of the rape remained, and if so, what they were. Seventy-four percent of the victims felt fully recovered and the remainder did not feel that way. Of the fully recovered, half stated they had recovered within months, and the other half stated that this had taken years.

The majority of those who reported full recovery also reported using a variety of conscious coping strategies with the rape aftereffects. The four most common defenses Burgess and Holmstrom found were explanation (e.g., "he must be sick"), minimization (e.g., "It could have been worse - I'm still alive"), suppression (e.g., "I don't want to talk about it anymore"), or dramatization, so defined to closely resemble catharsis. Interestingly, only five of the twenty-one unrecovered victims made any use of these four strategies.

Burgess and Holmstrom also noted that victims who presently defined themselves positively were all recovered. Victims having stable partners at the time of rape seemed to recover faster. Those who remained unrecovered more often had poor social networks, and poor occupational histories. Victims who relied on drug or alcohol, suicidal behavior, or serious withdrawal in the early months of recovery were usually among those whom took longer to recover. The authors suggested that additional factors that affected a recovery from rape included the style of attack, relationship of victim and offender, number of assailants, language of assailant, type of sexual acts, amount of violence, social network, and institutional (hospital, police) response.

One difference between Burgess and Holmstrom's findings (1974) and those of Sutherland and Scherl (1970) is that the former did not address the issue of middle, pseudo-adjustment, or recoil phase occurring during recovery. Some

authors believed that not all victims went through it, and stated that it might be common only to those victims who typically rely on control and suppression of affect, or in those whose environmental situation would not support continued overt processing of the rape (Schuker, 1979).

Peters (1975) also conducted a large, thorough clinical study of rape victims. A psychiatrist at the Philadelphia General Hospital Rape Center, Peters and his colleagues clinically interviewed three hundred and sixty-nine victims of sexual assault, ninety-eight percent of whom were reporting forcible rape. They received a standard psychiatric interview and evaluation from one to two weeks following the assault, often by home visits. Common psychiatric symptoms noted were again fears, phobias, anxiety, increased motor activity, obsessions, depressive symptoms, somatic symptoms, and suicidal ideation. Peters' evaluations at the one-to-two-week point revealed that seventy-three percent of the victims had one or more of these postrape symptoms.

Sixty-five percent of Peters' sample experienced nightmares whose frequency seemed to increase for the first few weeks or months. Seventy percent of the adults were more afraid of strangers, and thirty-seven percent were aware of more negative feelings towards men. Thirty-one percent reported decreased libido, stating they were too tense or felt too "dirty" to engage in sex. This was often compounded by the mate's reaction to the victim. Many women refused to return to their homes for several days following the

assault, and seventy-six percent permanently changed their residences. Ten percent of the victims were judged clinically depressed at the one-to-two-week postrape interview.

The literature on rape victims included such additional symptoms as compulsive washing or vomiting, inability to leave the home, panic at darkness, and pathological shyness (Greer, 1975). Price (1975) noted that some women neglected their appearance, dressed sloppily, or gained weight, as though to become less attractive to men. An additional trauma the victim often encountered, as suggested by the demographic and clinical studies, was financial loss (National Crime Panel Survey Report, 1975). Often the victim had to pay for her emergency room medical expenses. Burglary may have accompanied the rape. The assault may point out a need for additional costly security precautions (e.g., security locks, sturdier window screens). Some victims did not return to work for two weeks or more resulting in some loss of pay. If the victim also had to attend preliminary hearings or court trials, more income was lost (Katz & Mazur, 1979).

Saturnansky (1976) used projective techniques (Thematic Apperception Test and Machover Figure Drawings) along with a standard clinical interview in a research project comparing nine women who had been raped from four months to seven years before her study with a control group of five women who had never been raped but had experienced some traumatic accident earlier in their lives. She found that those raped

told significantly more TAT themes of suicide, negative evaluations of men, and stories of romance and love. From these data, Saturnansky inferred greater depression and difficulty in male-female interpersonal relationships among her rape victims, but given this small sample, it was unclear whether these qualities antedated or followed the rape.

Kilpatrick, Veronen and Resick (1979) investigated the effects of rape on forty-six victims from a period soon after the rape to six months past it. They used standardized psychometric instruments, rather than clinical interviews, to assess the effects. Specifically, they administered the Derogatis Symptom Check List, Modified Fear Survey, Profile of Mood States Scale and State Trait Anxiety Interview at the following time points: (a) six to ten days, (b) one month, (c) three months, and (d) six months postassault. A control group of thirty-five nonvictims was also used. Of the twenty-eight variables generated by their measures, victims scored higher than nonvictims on twenty-five during both periods (a) and (b), indicating a very high level of internal and behavioral distress. This finding seems to coroborate Burgess and Holmstrom's (1974) acute phase. This level of distress had greatly decreased at three months postrape with the exception of a continued increase of anxiety and phobic anxiety items, with similar findings six-months postrape. The use of standardized questionnaires with a sizeable homogenous group of subjects, and a control group, seems unique to this study. Its

results correspond closely with the clinical findings of Burgess and Holmstrom (1974), and Peters (1975). The authors' interpret their results as consistent with their learning theory model of the rape experience that predicted that fear and anxiety would be classically conditioned by the rape and generalized to similar stimuli in the victim's life. As the victim would often avoid these newly anxiety-timed objects, her general anxiety would not be readily extinguished, and might persist over time longer than other symptoms. Kilpatrick et al. (1979) also maintained that the greater the intensity of fear induced by the assault, the greater would be the number of conditioned stimuli.

Increased attention has recently been directed to clearly defining the impact of rape upon future sexual functioning. Burgess and Holmstrom (1979) investigated this topic among the eighty-one victims from their original study whom they were still following four-to-six-years postassault. Of the seventy-eight percent of their group who had been sexually active before the rape, sixty-six percent reported decreased frequency of sexual activity at six months postrape and only nineteen percent reported no change. Approximately ten percent of the sample reported increased postrape sexual activity, a phenomena that Schuker (1979) viewed as one means that some victims might use to assure themselves that their bodies are normal, or that might reflect unresolved feelings of degradation in other cases. Burgess and Holmstrom (1979) noted that some victims seemed

to sexually "act out" postassault as an expression of anger and proof that they could maintain control over a man.

Of those victims who reported increased sexual dysfunction following the rape, the nature of the dysfunctions ranged from vaginismus and loss of orgastic ability, to aversion for sexual acts specifically associated with the assailant (thirty-three percent reported this) and varying degrees of "flashbacks" of the rape scene while making love with a current partner (fifty percent reported this).

Feldman-Summers, Gordon, and Meagher (1979) had fifteen rape victims and controls retrospectively rate their satisfaction with twenty-three sex-related activities before and after the rape. They found that the victims reported their current satisfaction with sex was significantly less than that of the controls, and generally less than the victim's recall of their preassault experience. Overall, however, both the controls and the victims reported their present sexual contacts were more satisfactory than unsatisfactory. Two areas of sexual behavior that appeared unchanged after the rape were satisfaction with autoerotic practices and primarily affectional responses (i.e., being hugged, or held without erotic intent).

The impact of rape on adult and adolescent male victims is another new topic of study. Groth and Burgess (1979) studied twenty-two male rapes in a New England community. They concluded that males were less likely to report the crime, although the biopsychological impact of the rape

seemed similar to women. Kaufman (1980) compared the reactions of fourteen male victims treated in a County Hospital emergency room to those seen in one-hundred female victims treated concurrently. The male victims evidenced more denial and less overt emotional reactions than the women victims. Men were also reputed to be more likely to have had multiple assailants, been held captive longer, and have sustained more physical injury. The findings from these two studies are quite preliminary, and much further research is needed before these claims can be evaluated. In Kaufman's (1980) study a factor that was not well considered was that if male victims were less likely to report the assault than females, it may only have been those male victims of more extreme rapes (e.g., multiple assailants) that presented themselves for medical attention. In this case, the features of Kaufman's sample might not generalize to male victims in general.

Dynamics suggested by the literature. The dynamics undergirding the rape victim responses are important to understand for providing effective research or treatment designs to this population. These dynamics have been discussed from two perspectives. First, the victim's responses have been examined in terms of a crisis-theory model. Second, the sociocultural context of rape, and how this was internalized by the victim, has been examined.

When considering the crisis model, an initial understanding of what was implied by the word "crisis" was first

needed. Bard and Ellison (1974) defined a crisis as a subjective reaction to a stressful life experience that so affected the individual's stability that her ability to cope or function became seriously damaged. Stressful situations which resulted in crisis reactions have as criteria "suddenness so that there is no preparation time, arbitrariness in that the event is perceived as unfair and capricious, and unpredictability which stands in contrast to the normal developmental or anticipated life crisis" (Hilberman, 1976). The crisis typically disrupted the victim's level of functioning in the physical, emotional, social, and sexual areas. Its degree of impact depended on such variables as the victim's ego-strength and outside support system. Fairly predictable responses, however, included:

> 1) disruption of normal patterns of adaptations with disturbances in eating and sleeping, diminished functioning, and attention and concentration span 2) regression to a more helpless and dependent state in which support nurturance are sought outside of the self and 3) increased openness and accessibility to outside intervention, which presents a unique opportunity to affect the long-term outcome of the crisis. (Hilberman, 1976)

This crisis model clearly represented what was known regarding the rape victim's reaction to the assault. In terms of the criteria for a stressful life experience that could instigate a crisis, the rapist's assault was usually totally unsuspected and unprepared for. Selkin (1978) interviewed thirty-two rape victims who had been assaulted anywhere from a few days to several years before his interview. When questioned as to the emotional responses

experienced during the rape, the four adjectives selected most frequently by the victims were frightened (ninety-four percent), startled (eighty-four percent), shocked (seventy-eight percent), and terrified (seventy-six percent). While forty-four percent noted they were also angry, many other felt panicked (fifty percent) and frozen (forty percent). Clearly, the victims had not had time to assess or prepare for the assault before its occurrence.

Schuker (1979) elaborated on the view of the rape victim as a victim of crisis by comparing the process of recovery as somewhat akin to the grief work that occurred following a death. She noted that the rape victim had suffered a loss, or a "narcissistic injury to the self" that had to be resolved. In doing this, the victim in essence had to grieve for her lost sense of herself and worldview. Schuker noted that Lindemann's (1944) study of the grief process suggested that it was often two years before the whole process was complete, and observed that it may take a similar period of time for the rape victim to fully resolve her loss.

Sharon McCombie, Director of the Rape Crisis Intervention Program at Boston's Beth Israel Hospital, and author of The Rape Crisis Intervention Handbook (McCombie, 1980) maintained that while the rape victim was typical of any victim of crisis in many ways, there were three universal factors specific to the rape that comprised the "rape work" the victim must consider to resolve the assault. These

factors were derived from her program's experiences working with six hundred victims of rape over a five-year period. The first factor was to resolve how vulnerable she was during the assault. The second was to deal with any child Oedipal concerns, anxieties regarding sexual acts of the rape, and the sense of being invaded and/or defiled that could be precipitated by the loss of body boundaries during rape. Finally, McCombie maintained that the victim must deal with what the rape implied to her about the power relations between men and women in society. Individually, this would mean coming to terms with relationships to men.

Psychiatrists Notmann and Nadelson (1976) noted that it was often the capriciousness and unpredictability of the assault that was most difficult for the victim to resolve. They stated that for victims of all ages, the rape acted as a proof of a woman's vulnerability, challenging her belief in her ability to be independent and competent. This seemed particularly the case in women attacked in "safe" territory (their home) or by someone they once trusted (Bart, 1970; Brodsky, 1976). The woman attacked while in her own bed had no similar recourse, and typically showed more life-style disruptions.

Not only was the victim's view of her world as predictable and relatively safe often severely shaken, but her culturally-taught view of men as protectors was disrupted as well. Notman and Nadelson (1976) expressed this when they stated that:

> "Women expect men to be their protectors and providers, as well as relating to them sexually...The betrayal by the supposed protector who turns aggressor has a profound effect. Almost all rape victims say they trust men less after the rape. All men may be suspect, and all are potentially on trial. Uncertainty about one's ability to control the environment reverberates with concerns about the ability to control and care for oneself."

The victim's affective response to the unpredictability of the assault might be anger, terror at it reoccurring, disillusionment, loss of self-worth or guilt. The guilt could in part be a defense during the assault. That is, by assuming the blame, a victim could deny the reality of how truly helpless and vulnerable she was at the time of the assault.

Guilt could also be seen as reflecting the victim's discomfort with how she behaved during the assault. Symonds (1975), a psychoanalyst who had done research on victim reactions in general, noted that often the victims of violent assault evidenced a frozen fright response. That is, some victims initially became so shocked and then terrified that they became temporarily immobilized. All their thoughts became directed towards self-preservation. Given this terror, their perceptions and judgements often were unclear. They might display submissive and even cooperative behavior towards the assailant. Symonds likened this to the submissive response of an animal that offers its most vulnerable spot to its attacker. This response in the animal kingdom has a biological component, and the dominant animal in

nature usually ceases its aggressive attack once the submissive gesture is offered. Suarez and Gallup (1979) echoed Symond's position stating that the rape-induced paralysis often described by victims was essentially identical to the tonic immobility, or animal hypnosis, seen in the animal kingdom.

Another response to terror victim's evidenced was to regress. Some victims displayed clinging behavior to the assailant, similar to the identification with the aggressor seen in concentration camps (Symonds, 1975).

During the assault, many women automatically and often unconsciously displayed the behavior they felt was most likely to ensure that no permanent physical harm would occur to them. In the days following the assault, those women might review their behavior, and frequently would repetitively rethink the assault situation and alternative behaviors they might have used. If a woman had "froze", or displayed submission and/or cooperation during the assault, she would often feel considerable guilt and shame, even in those situations where the assailant had had a knife or gun (Burgess & Holmstrom, 1974).

In summary, the rape victim was often conceptualized as a person in crisis who would display the life-style disruption and regression characteristic of other crisis victims. Long-term dysfunctions seemed best prevented by immediate interventions (Hilberman, 1976). It was noted that the desire to avoid settings associated with the rape trauma was

frequently present, and could become generalized to less clearly related phenomena such as fear of crowds. Just as victims of a tornado might later experience feelings ranging from mild anxiety to terror at the approach of a rain storm, so did the victim of rape often develop varying degrees of fear and distrust in regards to what she perceived as the source of her hurt. If the victim generalized the source of trauma to include all men, or if she attributed the trauma to her own lack of strength and ability, serious implications for future interpersonal relationships and autonomous functioning were often raised.

Criminology researchers, Weis and Borges (1973), discussed how the sociocultural context of rape influenced victim reactions. They maintained that society had a "need" to have deserving victims, and that rape was the most extreme exemplification of this. That is, they viewed the traditional sex roles as creating and facilitating an environment in which rape could occur. They discussed the traditional socialization of women, whereby girls have been taught to view themselves as weak, dependent, passive, and needy of male protection. Little self-defense instruction has been given. Furthermore, girls have been taught that being attractive was very important, so that much of her self-esteem would be related to her body and how favorably she could get men to view it. At the same time that she was being instructed to be desirable, she was also being taught to be unavailable. Traditional dating rules assigned the

woman the responsibility of setting the limit to how much sexual contact was permissible, and also assigned her the blame when she "failed" to set appropriate limits.

When faced with a physical attack, women trained in this fashion were generally unprepared physically or psychologically to defend themselves, and often became paralyzed with fear. Following the report of the assault, however, society would ask for proof that they resisted. Trained not to resist, and to believe themselves incapable of successful self-defense, victims would often lack such proof. The folklore that no healthy, unwilling woman could be raped by one man persisted and often inhibited or prevented legal recourse. Even more damaging was the woman's internalization of this lore, an internalization that generally resulted in feelings of worthlessness, guilt, and occasionally suicidal ideation. Weis and Borges concluded their analysis by stating:

> "We have demonstrated that socialization and especially sex-role learning exploit both males and females and produce both victims and offenders... If these processes of victimization are successful with regard to rape, the raped woman is a 'legitimate' or 'safe' victim who will not be dangerous to the rapist, since she is unable to relate her experience to others or to effectively direct blame and accusation against the person who raped her."

Notman and Nadelson (1976) further noted that despite the wide variety in types, locations, and violence of sexual assaults, the woman's reaction of guilt and shame appeared universal. Like Weis and Borges they attributed this to the victim's internalization of societal norms which

misdefined the rape as a sexual event, and assigned the woman the blame for not somehow assuming her role of setting sexual limits. These authors suggested that if previous erotic fantasies of rape were entertained before the assault, they might be remembered by the victim with shame, and with a sense that the fantasy somehow had caused the act to occur.

The authors also noted that since the expression of anger was such a conflictual area for many women (given cultural restrictions against women feeling and expressing it), anger often was transformed into self-blame. Other defenses against expressing anger were seen as attempts to identify with the assailant through efforts to understand or pity him. Thus, while most authors in the field agreed that an individual who had been raped was a victim of crisis, the emotional meaning of the assault, and the affective response, appeared heavily influenced by sociocultural instructions regarding sexuality and the woman's role.

Methodological problems of the studies on rape. The study of rape victims from a demographic and/or psychological perspective is barely over ten years-old. Not surprisingly, methodological problems abound, particularly in the initial studies.

Katz and Mazur (1979), authors of Understanding the Rape Victim: A Synthesis of Research Findings, noted that it was still difficult to determine the "true" facts regarding victims due to disparities in the data presently

available. They identified five major methodological problems. First, studies have varied as to whether they focus entirely upon rape victims, or victims of other sexual assaults. This has been particularly true of some of the demographic studies. Second, studies have differed notably in age groups included, especially the youthfulness of victims. Third, initial studies differed in their definition of rape. Fourth, the way the samples were collected were quite different. Hospital studies were used by Burgess and Holmstrom (1974) and Peters (1975), while others recruited from the community or even through the Women's Movement (Saturnansky, 1976; Medea & Thompson, 1974). These first four problems have made comparisons of their findings difficult. A fifth problem is that practically all reviewed clinical studies were essentially studying the reactions of women who had reported rape, at least to the hospital or rape crisis center, so that it remained unknown how well their findings would generalize to nonreporting victims.

At the 1979 time of Katz and Mazur's book, only sixteen empirical studies regarding rape victims were reviewed. Most had serious methodological problems, including lack of control groups, lack of a systematic followup procedure, and too little direct interview contact with the victim. Only four empirical studies specifically addressed to adolescent and adult rape victims were found. These were the studies by Burgess and Holmstrom (1974), Peters (1973, 1975), and Medea and Thompson (1974). The number of empirical studies

in this area has increased in number and quality since 1979, although more high quality research is clearly needed. An additional consideration is that all of the clinical/empirical studies mentioned that have directly interviewed victims have obtained their data through some type of counseling and/or support agency or institution. This may bias the results. Not only are the findings limited to self-reporters of rape, but also to those rape victims who have received some degree of crisis intervention and/or supportive counseling. The amount, quality, and timing of the counseling has, of course, varied from victim to victim and from agency to agency. It seems important to recall this final factor when discussing what professionals now know regarding rape victims reactions, for in essence, this data has primarily reflected data from counseled victims.

Method

Purpose and Procedures

Statement of purpose. The main goal of this project was to examine relationships between the rape victim's affective states, perception of the crime, and demographic variables to determine if certain variables exerted an independent effect on the recovery pattern. Especially sought were those variables that best differentiated between protracted or difficult recoveries versus more rapid returns to preassault status. The primary sample was adolescent and adult victims of forcible rape who received crisis intervention counseling at Erie County Rape Crisis Center (ECRCC) in Pennsylvania immediately following their assault, subsequently referred to as the "incoming" group. A matched control group was also studied. A subphase involved obtaining retrospective, self-report data on the long-term effects of rape using two sources: (1) the accounts of women previously treated at ECRCC whose rapes had occurred three months to two years earlier and (2) information from other Erie County women raped at least six months before this study who had received no formal crisis intervention counseling. It was anticipated that obtaining representatives of these latter groups would be difficult, but even a small

amount of data seemed potentially useful given the sparse empirical data on the long-term affects of rape and on differences between the reaction patterns of women who did or did not receive counseling.

Several methods were used to obtain information regarding the impact of rape on the victim. Standard clinical interviews were administered at different time points to examine changes in the incoming group's symptom profiles. Traditional demographic data were gathered on each victim or victim group, including previous psychiatric history, the preassault life-stress level, and a detailed account of the assault's features. Paper-and-pencil measures of anger, guilt, self-esteem, mood state, locus of control, adherence to sex role characteristics, and level of interpersonal trust were obtained to provide data regarding each victim's affective state and personality. The victim's perception of the degree of violence involved in her assault, the extent and quality of her present support system, and her religious commitment and affiliation were also systematically recorded. The study was primarily exploratory, but a review of the literature had suggested the following hypotheses as well:

1. The incoming group would describe more severe symptoms at the time of the research participation than would members of the other victim groups.

2. Individuals raped in their own home would describe more severe symptoms overall, particularly in the area of rape-related fears, than would victims assaulted elsewhere.

3. More severe symptoms would be described by persons having a previous history of psychological problems.

4. Victim's across all groups would evidence lower self-esteem if their assailant was a known other, rather than a stranger.

5. The incoming group would report higher self-esteem at three months postassault than during the first few days following the assault.

6. The incoming group would evidence lower self-esteem at three months postassault than would members of the control and other victim groups.

7. Victims adhering to traditional sex-role stereotypes would report less anger and more guilt than those whose sex-role identification was more androgynous.

8. Those individuals expressing high amounts of guilt would evidence lower self-esteem than those expressing relatively little guilt.

9. Incoming victims would manifest greater heterosexual anxiety and more isolation than the controls.

10. Individuals who perceived their rape as particularly violent would report greater fear of heterosexual situations, less interpersonal trust, and a higher incidence of sexual difficulty than would individuals who perceived their assault as relatively less violent.

11. Incoming group members whose assailants had not yet been apprehended would report less anger the first week postrape than victims whose assailants had been quickly apprehended.

12. The amount of negative life changes in the year preceding the assault and the intensity of guilt would correlate positively with the amount of mood disturbance reported at seven to ten days postassault. The degree of religious commitment, the helpfulness of the individual's support system, and a positive self-concept would correlate negatively with mood disturbance.

Location. The study was conducted at ECRCC, a model rape crisis center that since 1973 has served Erie, Pennsylvania, its suburbs, and the rural surrounds that constitute Erie County. It has provided direct service to over 1200 victims of sexual assault and their families. Licensed by the Commonwealth of Pennsylvania as a Mental Health Emergency Service Provider, the Center also provides public education services, operates a hotline, and acts as a referral agent.

During the time this project was conducted, the ECRCC counselors were largely community volunteers who had been screened before their acceptance by the agency's director and consulting clinical psychologist. These counselors ranged in age from twenty-one to forty, and their level of formal education ranged from high school diplomas to post graduate degrees. Volunteers had completed a one-hundred-hour training program during their initial months at the Center that involved learning crisis intervention techniques and the legal and medical procedures pertinent to sexual assault victims. They accompanied senior counselors on visits to victims, first as observers, and later as assistants.

Typically, emergency room staff or area police would be the first to notify the Center that a rape had occurred after receiving the victim's consent to contact Rape Crisis. ECRCC counselors then went out to the victim, accompanied her through the medical and legal systems, and provided crisis intervention services to her and her significant

others. If a victim called in on her own, the procedure was the same. Counselors did not attempt to convince victims to press criminal charges, rather they presented the legal options and attempted to help the victim to reach her own decision. All victims were encouraged to seek medical attention. Male counselors did not make initial calls, but were readily available to work with male victims or male significant others as needed.

The initial counseling contact was usually between four and six hours. The client and her family were regularly contacted by home visits and telephone interviews for follow-up care over the next six to nine months. Each counseling contact with the victim was documented, and ongoing cases were reviewed at least once a month by the agency's staff supervisors and/or consulting psychologist. Treatment plans were written for each victim and were formally updated every three months by the psychologist. Counseling was generally terminated when the victim felt ready to close contact with the Center.

The victims. Three groups were studied. The first was composed of women who requested ECRCC's services for a rape that occurred between January 15 and August 15, 1980. The second consisted of earlier ECRCC clients who had been raped three or more months before this study began. The third was composed of individuals in Erie County who had been raped at some time previous to the research period, but who had never received any crisis intervention counseling.

Only victims of forcible rape, as defined by Hursch and Selkin (1974), who were thirteen years-old and older were studied. Data on male and female victims was collected. If the assailant was a member of the immediate nuclear family (e.g., uncle, father), or a spouse not in fact separated from the victim, the case was excluded from this study as the assault was not legally termed a rape because dynamics appeared somewhat different than those of forcible rape victims (Katz & Mazur, 1979). Also excluded were: (a) mentally retarded individuals who appeared to be functioning at a mental age younger than thirteen, (b) court-adjudicated adolescents for whom obtaining permission to interview them was a complex and lengthy process, and (c) previous clients in such psychiatric disarray (usually from causes not directly attributable to the rape) that the ECRCC director and the author believed that participation in the research was contraindicated.

Research procedures with the incoming group. When the proposal for this project was written, it had been planned to have the Center's counselors conduct the standard symptom interviews on each victim to minimize research intrusions into the counselor-client relationship. The author was to directly contact the victims only during the time periods that questionnaires were to be completed. However, given widely varying schedules and styles of interviewing, this plan's impracticality became apparent when it was discussed with the ECRCC staff. Instead, the author conducted all

research interviews. Therefore, within forty-eight hours of receiving a new forcible rape case, the ECRCC counselor asked the client's permission to be contacted by the author. In cases where the counselor firmly believed that requesting the client's participation in the research project during the first few days was contraindicated, the counselor waited until what seemed the first appropriate day to ask. It was explained that the author was conducting a research project regarding the impact of rape, and would like to determine if the victim was interested in participating. The client was assured that her confidentiality would be protected, and that she had a right to refuse the research project without affecting the counseling services she was receiving. If the victim agreed to meet the author, I accompanied the counselor to the next session. At that time the research procedures and guarantee of confidentiality was explained. If willing to participate in the projects, the victim signed a consent form, and was then administered the first symptom interview and packet of questionnaires. In the case of victims under the age of eighteen, parental permission was also documented on the consent form. Following the initial contact, the author independently met with each victim at set time points. Interview sessions were typically conducted in the victim's home in a room where other family members would not intrude. It was not always possible to keep this location standard, and victims were sometimes interviewed at the Center, in the hospital, or by telephone if the victim's

commitments precluded face-to-face contact during the period when the interview was scheduled.

Standard symptom interviews were conducted with each victim at nine time points during the first three months postassault. These were designed to measure the victim's behavioral symptoms and affective responses to the rape. The interview schedule, where Day 1 equaled the day of the assault, is shown in Table 1. Asterisks identify occasions when questionnaire packets were administered along with the interview.

Table 1

Incoming Group Symptom Interview Schedule

Time Period	Days Following Assault
First few days *	2 - 5
Week 1 *	7 - 10
Week 2	14 - 17
Week 3 *	21 - 24
Week 4	28 - 31
Week 6	42 - 45
Week 8	56 - 59
Week 10	70 - 75
Week 12 *	83 - 88

If the victim was absolutely unavailable during one or more of these time periods, during her next interview she was asked to try to remember that period as clearly as possible, and to also recall assault-related thoughts, feelings, and behaviors from the missed time period in addition to the present one. When a questionnaire packet was given, it was administered prior to the symptom interview. The sequence of questionnaires and directions was the same for each victim. Adolescents who had difficulty in either reading or

comprehending questionnaire elements were assisted. Following administration of the packet and symptom interview, time was taken to discuss all concerns that the research questions raised for the victim. A copy of each questionnaire form is given in Appendix A (p. 180). The time sequence and order in which the forms were administered is listed in Table 2.

Table 2

Incoming Group Questionnaire Administration Schedule

Time Period	Questionnaires
2 - 5 days	Tennessee Self-Concept Scale Anger Subscale Guilt Index Degree of Violence
7 - 10 days	Support System Rating Profile of Moods State (POMS) Life Experience Survey Religious Commitment Measure
3 weeks	Thematic Apperception Test (selected cards) Tennessee Self-Concept Scale Anger Subscale Guilt Index Inventory of Personality Development Fear Survey Schedule III (modified) Bem's Sex Role Inventory Levenson's Locus of Control Scale Body Cathexis Scale (modified)
12 weeks	Rosenberg Self-Esteem Scale Tennessee Self-Concept Scale Anger Subscale Guilt Index Assault-Related Symptom Interview

The author terminated contact with each client following the final research session at the twelve-week period. Each individual was informed that she could call the author in the

future if any questions or concerns regarding the research arose.

Research procedures with control group. Women students from Opportunities Industrialization Center (OIC), a vocational training center in Erie, and teenage volunteers were the controls for members of the incoming group. OIC allowed the author to attend four core classes during August 1980. This vocational school serviced a broad range of people from many age groups and socioeducational backgrounds, and was seen as a likely source of matches for members of the experimental group. The course instructors arranged for male students to be in another classroom, while the author requested the participation of the remaining (female) students in completing a questionnaire packet. Participation was voluntary and confidentiality was assured. Directions for the questionnaires were explained. Definitions of sexual assault were provided, and students were asked to note in their questionnaire packet if they had ever been a victim of sexual assault, and, if so, the type of assault and when it had occurred. Seating was sufficiently spaced to ensure privacy while forms were being completed. Each individual signed a consent form and completed the following forms in the listed order: a demographic data form, Rosenberg Self-Esteem Scale, Anger Subscale, Guilt Index, Constantinople's Inventory of Personality Development, Wolpe-Lang Fear Survey Schedule III (modified), Bem's Sex-Role Inventory, Levenson's Locus of Control Scale, and the Body Cathexis

Scale. Control group members who had never been assaulted were then matched with incoming victims as closely as possible on the following variables: age, race, socioeconomic background, educations, previous mental health history, and religious identification and commitment.

In an attempt to obtain controls for rape victims younger than seventeen, I approached two schools, a Girl Scout Troop, and the YWCA for possible assistance. Given the topic of this paper the officials of these organizations did not feel comfortable approaching parents for permission. Colleagues of the author were then provided with control group packets and instructions in the hope that the parents of adolescents they knew might be willing to allow their daughters to complete a packet. Initial responses to this strategy were poor, but by December 1981 enough packets had been received to complete the control group.

Research procedures with previously counseled ECRCC victims. All client case folders from 1978 to 1980 were reviewed by the author to compile a list of forcible rape victims whose assaults had occurred three months or more before the research period. I telephoned each individual to request her or his participation in completing a research packet. The following standard phone conversation was used with each individual:

> This is Judy Smith, a counselor from Erie Rape Crisis. Did I catch you at a good time to talk for a few minutes? A while back you were a client at the Center. I am doing a research project there to see how clients of ours, whose rapes occurred three months to a few years ago, are doing now. I wondered

> if you would be willing to complete a questionnaire packet I'd send you through the mail. It asks questions about how you are feeling now, how you feel you reacted to the assault at first, and how you felt later as you began recovering from it. Your responses are completely anonymous and confidential.
>
> I am using the results in a couple of ways. First, it will let us hear how you're doing, and how much our Center helped or didn't help you. This lets us know how we're doing. Second, I'll be using the results as part of a research project I'm doing for my doctoral degree in psychology. My project's purpose is to help educate counselors who may work with rape victims to the reactions women who've been raped have, and how counselors can be most helpful. What are your feelings about completing a packet for us?
>
> (If agrees). I'll mail the packet to you within the next few days. The first page on it will be a consent form which must be signed by you for us to use your paper. This packet will take about thirty minutes to complete. We ask that if at all possible you complete it during the first week you receive it. There will be a postage-paid envelope with the packet that you can use to return the packet to us. If you have any questions about anything on it, or if it stirs up any bad feelings, please give me a call. (Author gives Center's phone number to victim). Do you have any questions for me now? Thank you very much.....goodbye.

If the victim had no telephone, her ECRCC counselor would speak to her about the project. Victims were informed that their packets would not be viewed by any ECRCC staff unless express permission was given. This was done in an attempt to reduce possible distortions of self-reports in order to "please" the counselor. If the individual kept the packet for longer than ten to fourteen days without returning it, a reminder phone call was made. If the individual still did not return the packet following this call, no further contact was made. Thank-you letters were mailed out to victim's who returned completed packets. The

questionnaire packets sent these victims contained the following forms: a consent form, demographic sheet, Rosenberg Self-Esteem Scale, Anger Subscale, Guilt Index, Degree of Violence, and Symptom Review questionnaire.

Research procedures with previous victims without counseling. To recruit participants, the author relied on television appearances, radio announcements, and local newspaper articles to publicize the project to the Erie County community. Between late Spring and August 1980, city, county, and area college papers ran ads at different times regarding the research; the author taped four radio interviews, and appeared on three area television shows asking forcible rape victims who had never received any crisis intervention counseling from the Rape Crisis Center or any other agency, to call the Center for a research packet. Individuals were given the choice of leaving their address so a packet could be mailed, or appearing anonymously at the Center to receive one. This publicity also elicited responses among a "grapevine" of friends and colleagues who asked for packets to complete personally, or to give to rape victims known to them. In each case, the packets were number-coded, the name removed, and the address cards destroyed to fully protect the identity of these individuals. These packets were identical to those mailed to previously counseled victims.

Measures

Assault-Related Symptom Interview (ARSI). A standard symptom interview was necessary to measure the wide variety of symptoms which often follow a rape. Based on a thorough survey of the literature in the field, the author constructed a forty-four item interview sampling assault-related behavioral changes in the following areas of functioning: sleep, appetite, heterosexual relationships, sexual expression, occupation, somatic distress, assault-related fears, and changes in affect and mood. The respondent was instructed to describe only those symptoms that she believed to be directly assault-related. Two forms of the interview, a written (ARSI-W) and an oral (ARSI-O), were used. Occupation items in the oral version were devised so that students and homemakers could be rated on them as well as employees. For example, questions focused on the individual's ability to concentrate while completing a work task, be it studying, cleaning the home, or operating a machine. ARSI-W occupation questions were pertinent only for employees and students. Two sets of questions were also available in the areas of heterosexual relationships and sexual expressiveness to accommodate persons with and without partners. The ARSI-W's construction was such that participants having partners were asked five questions on the sexual expression subscale, while single persons were only asked three. As a correction, two items for single individuals were weighted to count twice to facilitate comparisons between single and partnered

victims. These two items were: "are you as comfortable with physical contact?" and "are you as comfortable with sexual contact?" The ARSI-O contained an equal number of questions for partnered and single victims.

The ARSI-W was mailed to members of the previously counseled and uncounseled groups, and administered to members of the incoming group at the twelve-week point. Respondents were asked to place a checkmark next to a particular symptom if it occurred during any of the following time periods: one week, one month, three months, or presently. Each symptom was scored as "1" (occurring), or "0" (not occurring), and all "1"'s were tallied for each symptom area, and also for a total interview score. Total scores were obtained for each time period as well as for all time periods combined.

The ARSI-O was administered to members of the incoming group on nine separate occasions over a twelve week period. The author inquired about each item within the context of a general interview. If a respondent noted she was having a particular symptom, details were sought (duration, severity, etc.). This procedure was seen as preferable to administering the written form each time as it appeared to allow for more flexibility, the acquisition of clinically richer material, and provided for greater rapport and good-will between the researcher and victims. Although the interviewer occasionally took notes during the interview, the results were generally written out immediately following the session. To reduce ARSI-O data into manipulable numerical form and to

minimize the loss of detail, a three-point rating system was devised. Each symptom was rated "1", "2", or "3", indicating that the severity of the symptom was mild, moderate, or severe, respectively. Severity was defined according to the frequency and/or intensity of symptoms. For example, a respondent having one assault-related nightmare during a set time period received a "1", whereas a victim reporting four such dreams in one time period was assigned a "3". Similarly, a victim who felt more frightened of being alone, but did not let this fear alter her behavior received a "1", while a victim responding to the same fear by literally avoiding being alone at all received a "3". The scoring criteria used for each item can be found in Appendix C (p. 220). Item scores were tallied to form a subscale score for each symptom area. These subscores were tallied to form a total score of assault-related symptom severity for a given time period, and for a global total over all time periods. To ascertain the reliability of this rating system for oral interviews, three independent judges, selected on the basis of their experience in working with victims of rape, were instructed in the system and asked to score ten randomly selected interviews from the total pool of 150. Each judge's total score per interviews was correlated with those of the author and yielded interrater reliability coefficients of .76, .76, and .82. An interrater reliability index was also calculated for each subscale area, yielding median correlation coefficients of .65 (Sleep), .61 (Appetite), .72

(Somatic), and .77 (Mood), .53 (Assault-related Fears), .56 (Heterosexual Functioning), .76 (Sexual Expression), and .63 (Occupation).

Bem Sex Role Inventory (BSRI). The BSRI (Bem, 1974) was constructed using sixty adjectives arranged in a seven-step Likert format divided into three subscales of twenty items each: masculinity (M), femininity (F), and social desirability (SD). Bem treated masculinity and femininity as separate dimensions represented by positive behaviors, rather than as opposite points. To develop these scales, 100 student judges were asked to rate 400 personality characteristics as to their appropriateness for men or women. An item was judged masculine (M) or feminine (F) if both male and female judges independently voted that the characteristic was significantly more desirable for one sex than the other. Ten positive and ten negative sex-role personality characteristics were selected as neutral, that is, they were not judged to be more desirable for one sex than the other. These items comprised the measure of social desirability (SD). Four final scores resulted: M, F, SD, and androgyny (A). The first three were obtained by finding the mean rating of the items representing that characteristic. A difference score was found by subtracting the mean feminine score from the mean masculine score. Multiplying this figure by the standard score of 2.322 yielded a t-ratio. The androgynous score was determined by examining how nearly equal the M and F scores were, for Bem had maintained that persons attributing a

nearly equal amount of masculine and feminine qualities to themselves were androgynous. Bem used a normative sample of 2000 undergraduates and found test-retest reliability coefficients for a four-week interval of .89 to .93. Negri (1978) and Sommers (1980) also found comparable figures. Bem's t-ratio for the BSRI appeared internally consistent (average alpha coefficient was .86), and the M and F scales were found to be empirically independent (Bem, 1974; Bernard, 1980). Low positive correlations were found between the BSRI and the Masculine-Feminine scale on the Guilford-Zimmerman Temperment Survey suggesting the BSRI tapped somewhat different aspects of sex-roles. Criticism's of Bem's subtractive method of defining androgyny led Bem to adopt Spence's (1975) scoring method. Spence had maintained that the truly androgynous individual would score relatively high on both M and F scales or that they would describe themselves as possessing the most desirable qualities of both dimensions. She used a median-split method of categorizing subjects into high masculine, low masculine, high feminine, and low feminine categories. Androgynous individuals were those scoring above the median on M and F whereas those scoring below it on both dimensions were considered undifferentiated in terms of sex role. Those scoring above the median on M, and below it on F, were considered masculine, and the reverse pattern was considered feminine. Bernard (1980) evaluated the impact of various BSRI scoring procedures, including the t-ratio and the median-split method, and

concluded that for research purposes the median-split procedure was best. It was used in the present project.

Bem (1974) had maintained that androgynous individuals would have more positive characteristics than sex-typed individuals. In subsequent research, androgynous persons were found to be more flexible (Bem & Lenny, 1976) and better adjusted (Cristall & Dean, 1976; Nevill, 1977). More recent findings, however, suggest that masculine-typed men and women manifested better personal adjustment in some sectors than did androgynous persons (Erdwins, Small, & Gross, 1980; Jones, Chernovetz, & Hansson, 1978). Erdwins et al. administered the Tennessee Self-Concept Scale (TSCS), BSRI, and Manifest Anxiety Scale (MAS) to one-hundred-thirty-six subjects and found that is was the masculine, rather than the androgynous, persons who reported the lower levels of anxiety, although these groups did not differ significantly in self-concept. Results of a factor analytic study conducted by Gross, Batlis, Small, and Erdwins (1979) suggested that the Masculinity items had greater connotations of adaptive functioning, while the Femininity scale contained at least five items reflecting attributes that were clearly undesirable.

Therefore, these authors predicted that individuals who attributed many feminine qualities to themselves were particularly likely to be at a disadvantage on measures of adjustment, while individuals attributing more positively valued adjectives (i.e., high Masculinity scorers) to themselves would be at an advantage. In summary, the significant

amount of debate regarding the validity of Bem's definition of, and predictions for, androgyny appear inconclusive and Bernard's (1980) critical review of the BSRI literature stated that Bem's original idea regarding androgyny has yet to be conclusively contradicted.

Body Cathexis Scale. The Body Cathexis Scale (Secord & Jourard, 1953) was designed to measure facets of self-esteem related to satisfaction with body features. Forty physical characteristics were listed and respondents were asked to rate their satisfaction with each on a five-point Likert Scale. These ratings were summed to create a total score. The higher the score, the greater the degree of negative feelings indicated. Eleven items were taken from the original scale for use in the present study. This abbreviated scale included items related to sexuality, strength, and pain tolerance, as well as some general body features. Secord and Jourard's (1953) normative sample contained only 45 male and 43 female college students. The corrected split-half reliability for their body esteem scores ranged from .78 to .83, depending on the sex of the respondent. No test-retest data were reported. A positive correlation of .66 was obtained between physical self-esteem and general esteem. This last finding was replicated by Weinberg (1960). A moderate correlation of .62 was also found between self-esteem and satisfaction with physical characteristics when only those characteristics rated important by the respondent were used (Rosen & Rosen, 1968; Watkins & Park, 1972).

Finally, Johnson (1956) reported a correlation of .79 between physical esteem and anxiety among female respondents. This significantly exceeded the comparable male correlations, perhaps reflecting the cultural training that emphasizes the importance of physical appearance for females.

Degree of Violence. The Degree of Violence (DOV) scale was created by the author to provide both a measure of how violent a rape might "objectively" appear and to assess the degree of violence perceived by the victim. As it seemed doubtful that these two facets would be identical, the DOV was divided into three subscales, each of which could be scored separately or combined into a total scale score. Webster (1977) defined violence as the "exertion of physical force so as to injure or abuse". In an attempt to provide some measure of how violent the assault might appear to individuals examining only the "objective" facts of the crime, a six-item measure of the objective degree of violence (DOV-O) was constructed. These items asked the respondent for the following information: whether the assailant was a known and trusted other; whether threats, weapons, physical restraint (tying or gagging), or physical blows were used against her; and whether the assault left her with any physical injuries. For each question answered affirmatively by the respondents, one point was assigned and further information requested. Additional half-credits (0.5) were added to the score dependent on what this new data revealed. For example, if the assailant made a threat (scored 1.0), the

victim was asked to describe it. If it was either to kill her, or to kill or maim a loved one, such as her husband or child, an additional half-credit was assigned, resulting in a total item score of 1.5. If the threat was relatively milder in nature (e.g., "Move and I'll kick you."), the total item score remained 1.0. Criteria for each item were defined to determine when to assign additional increments (see Appendix B, p. 218). Depending on the question, possible total scores of each item ranged from 1.0 to 2.0. These item scores were summed to provide a total index of the objective degree of violence. To determine how reliable this rating system was, three independent judges, again selected on the basis of their experience in working with rape victims, rated 13 of the 66 DOV-O forms collected in the present study. These 13 were selected on the basis of belonging to victims who had never been clients of the judges, thus controlling for any prior knowledge that judges might have about the assault. The judges' ratings were then compared with the author's. Interrater reliability indices ranged only from $\underline{r}$ = .92 to $\underline{r}$ = .96 (median $\underline{r}$ = .93).

The DOV's second subscale consisted of fourteen questions arranged in a five-step Likert format designed to measure the victim's perception of the violence of the assault. Summing these scores yielded a measure of the subjective degree of violence (DOV-S). Item three ("The rapist's voice was soft, 'polite'.") was the only item scored inversely. DOV-S items considered factors related to physical force

(e.g., "The rapist handled me roughly.") and also to the victim's psychological state (e.g., "I felt invaded and taken over.").

Section three consisted of one item which asked the respondents to rate how violent their attack seemed to them overall on a scale of 1 (minimally violent) to 10 (very violent). It was anticipated that in assigning this rating the victim would probably consider both her subjective response to the attack as well as her view of its "objective" features.

This rating could be considered independently, or added into a total degree of violence score (DOV-T) obtained by simply summing all subscale scores.

Demographic Data. The demographic information generally included the following: present data (age, sex, level of education, occupation, marital status, and socioeconomic group), past data (history of previous sexual assaults, preexisting mental health problems, quality of previous sexual experiences), and assault data (location, length of assault, sexual events, use of threats, assailant's voice tone, presence of weapons, degree of relationship between the assailant and victim, and amount of physical force). For control group members, the demographic data form also included a section to describe one's religious background, and asked a brief series of questions regarding major life changes occurring in the past year.

Fear Survey Schedule III (FSS-III). Wolpe and Lang (1964) designed the FSS-III to use in assessing the effect of desensitization on phobic and anxious clients. Derived from Lang and Lazovik's (1963) earlier Fear Schedule Survey, it contained 72 anxiety-engendering stimuli, each rated by the respondent for the degree of fear evoked. Five choices, ranging from no fear elicited to a high intensity of fear, were offered. The authors did not develop a formal scoring system for the inventory, but simply observed how the frequency and intensity of reported fears changed as a client participated in behavior therapy. In the present study, however, the five choices were assigned numerical weights of one to five, with one signifying "no fear elicited." These ratings were summed to provide a total score.

Several factor analytic studies of the FSS have used student (Geer, 1965; Lang and Lazovik, 1963) and clinical populations (Bates, 1971; Dixon, DeMonchaux and Sandler, 1957; Rothstein, Holmes and Boblitt, 1972). Both populations have yeilded four major factors: fears about interpersonal events (Social Anxiety), fears related to small animals (Small Animal Fears), and fears associated with death, pain, or surgery (Fears Related to Bodily Injury, Death, and Illness). An additional component, termed the Agoraphobia factor, has recently been identified (Arrindell, 1980; Hallam & Hafner, 1978). These factors corresponded closely to Wolpe and Lang's (1964) original subclassification of items into animal; tissue damage, illness, death or associated stimuli;

classical phobias; social stimuli; noise; and miscellaneous categories.

Arrindell (1980) studied the FSS-III's reliability and validity using a sample of 703 noninstitutionalized members of a society for phobic patients. Subjects were administered the FSS-III, the Symptom Checklist (Derogatis, 1977), and Zung's Self-Rating Scale for Depression (Zung, 1965). A principal components factor analysis with varimax rotation was performed. Six factors emerged, with the Social Anxiety Component accounting for most of the variance. This factor described a form of interpersonal anxiety that involved such elements as the fear of negative evaluation, concerns regarding criticism, and lack of competence. While female subjects endorsed significantly more of these items as fear-arousing than male-subjects, this sex difference did not hold for all factors. Statistically significant correlations were found between Arrindell's factors although these were only low to moderate in size. Cronbach's alpha was calculated as a reliability index for each component and the resulting coefficients ranged from .79 to .91, and .95 for the FSS-III total score. The Social Anxiety coefficient (.91) reflected high interitem consistency. Internal validity studies indicated that each FSS-III item correlated positively and significantly with the total scale score. As anticipated, the FSS-III total score correlated rather highly with the global index of psychopathology of the Symptom Checklist. The Social Anxiety factor correlated substantially ($\underline{r}$ = .61)

with the same Symptom Checklist (SC) index as well as the SC's Inadequacy Scale (r = .65).

The present study employed only the 17 FSS-III items classified as interpersonal stimuli by Wolpe and Lang (1964). Eleven of these items were contained in Arrindell's Social Anxiety factor, as discussed above. As heterosexual anxiety was what was of particular interest, each interpersonal item was rewritten to identify the stimuli as involving males, rather than people in general. For example, "speaking before a group" was changed to "speaking before a group of men". Similarly, the item "angry people" was rewritten as "angry men". The ratings of each item were summed to provide a measure of the subject's anxiety regarding interpersonal situations involving the opposite sex.

Guilt Index (GI). The GI is an eight-item, five-step Likert format scale devised by the author to assess feelings of guilt. Items #3, #5, and #6 were taken from the Guilt subscale of the Buss-Durkee Hostility Inventory (BDHI) and five new items were constructed. The BDHI (Buss & Durkee, 1957) consisted of 75 true-false items, each representing one of eight subtypes of hostility. Factor analytic studies revealed two main factors: an attitudinal component (represented by Resentment and Suspicion subscales), and a "motor" component indicating how hostility was directed (represented by Assault and remaining subscales). The seven subscales directly dealing with aggression yielded a Total Hostility Score (THS), while the eighth subscale (Guilt) was a

nine-item global index of guilt independent of the THS. A test-retest reliability coefficient of .72 for this scale was found using a college-aged sample (Biaggio, Supplee, & Curtis, 1981). The latter study found no significant differences between male and female respondents on the Guilt scale, although Sarason (1961) had earlier observed significantly higher scores among females. This Guilt subscale correlated significantly with the Guilt subscale of the Anger Self-Report, a 64-item Likert-type questionnaire also purporting to measure various aspects of hostility and its expression (Zelin, Alder, & Myerson, 1972). Both guilt measures correlated negatively with measures of constructive action, contributing to an inference that persons high on the measure of guilt were less likely than others to involve themselves in constructive action when provoked (Biaggio et al., 1981). Researchers who have employed the Buss-Durkee Hostility Inventory have encountered problems related to the dubious reliability of some subscales and their fairly high correlations with social desirability (Biaggio, 1980; Buss & Durkee, 1957). The GI was administered to a normative sample of 20 male and 11 female undergraduate students enrolled in an Introduction to Psychology course at Behrend College of Pennsylvania State University. A corrected split-half reliability coefficient of .77 was found indicating moderate internal consistency. A test-retest reliability coefficient of .92 ($p < .01$) obtained over a two-week interval, yielded evidence of its stability. To provide some estimate of

concurrent validity the BDHI Guilt subscale was also administered to these students. Only a moderate correlation coefficient (r = .68, $p < .01$) was obtained between these guilt measures despite the three overlapping items. This suggests that the GI may assess a different facet of guilt than does the BDHI.

Inventory of Psychosocial Development (IPD). Constantinople (1969) designed the IPD to operationalize and validate the first six stages of ego development proposed by Erikson (1959), namely: trust versus mistrust, autonomy versus shame, initiative versus guilt, industry versus inferiority, identity versus identity diffusion, and intimacy versus isolation. Her inventory was based on Wessman and Ricks' (1966) 60-item Q-sort. Each of Erikson's stages was represented by ten items, half of which reflected successful resolution, and half of which signified unsuccessful resolution, of a stage. Constantinople substituted a seven-point Likert scale for each of the sixty words or phrases and directed the respondent to rate how characteristic each item was of her/him. The ratings in each subscale were summed, yielding twelve subscale scores. High scores on the positive scales (e.g. trust, industry), if accompanied by low scores of the negative scale, were said to indicate successful resolution of a particular stage. Goldman and Olczak (1980) offered a somewhat different scoring procedure for the IPD, summing the ratings of the five positive subscale items and adding them to the reversed scores for the five

negative items. That is, a rating of "7" on an item reflecting unsuccessful resolution would be changed to a "1", and added in to the total score. Constantinople's scoring system was used in the present study, which employed only the Trust-Mistrust and Intimacy-Isolation subscales of the IPD. These two stages were selected as they seemed particularly likely to be vulnerable to the impact of a rape. To increase clarity, Somer's (1979) reworded items were used.

Constantinople's normative sample consisted of 925 undergraduate students. She characterized the psychometric properties of these scales as "adequate but not impressive". Test-retest reliability coefficients over a six-week interval ranged from .45 to .81 with a median correlation of .71. Somers (1979) obtained somewhat lower reliability figures with a sample of 106 college women. Constantinople acknowledged that no validity data was available on Wessman and Rick's Q-sort format, although she maintained that these authors had found an "encouraging" relationship between their scales and other clinical rating forms. Social desirability response sets appeared to influence these subscale scores, although not to an overwhelming degree. Constantinople's analysis of the IPD indicated that clear bipolar factors existed for only 3 of the stages, with the stage of autonomy vs. shame appearing particularly weak. The two subscales selected for the present studies were found to have clear bipolar construction. Some evidence for IPD's construct validity was cited, as college students appeared to achieve

more successful resolution on specific subscales (e.g., industry vs. inferiority) as they aged. This was consistent with Constantinople's expectations, as was the finding that seniors typically evidenced greater resolution than freshman. Constantinople noted that one weakness of her scale was that the utility of items appeared to vary by sex. Somer's (1979) report of significant correlations between the Eriksonian scales and Bem's M and F scales seems a related finding. Specifically, Trust, Mistrust, Autonomy, Industry, and Inferiority correlated with Bem's M scale, while Intimacy was correlated with her F scale.

Levenson's Internal-External Locus of Control Scales. For several years Rotter's Internal-External Locus of Control Scale (Rotter, 1966) was the predominant locus of control measure. Rotter had explained the difference between internal and external attributions of control as follows:

> When an event is interpreted as the result of luck, chance, or fate..by an individual, we have labeled this a belief in external control. If the person perceives that the event is contingent upon his own behavior or his own relatively permanent characteristics, we have termed this a belief in internal control.

Subsequent factor-analytic studies revealed that more than the two factors originally proposed by Rotter accounted for portions of the variance. In an attempt to obtain a conceptually cleaner measure, and to delineate the apparent third factor in Rotter's scale, Levenson (1974) devised an IE scale which retained several original items while adding some new ones. Levenson's IE scale consisted of 24 items

arranged in a Likert six-point format. These were divided into three 8-item subscales: Internal (corresponding to an internal locus of control), Chance (representing an external framework in which events occur by chance), and Powerful Others (representing a belief that the world is ordered but under the control of powerful others). Levenson (1974) administered the scale to a normative sample of 329 male college students and processed their responses by a prinicipal component factor analysis with varimax rotation which yielded the three predicted factors of the Internal (I), Chance (C), and Powerful Others (P) scales. This result was replicated by Lindbloom and Faw (1982) using a sample of 175 college students. Each subscale was found to be statistically independent (Levenson, 1974). The I-scale's high mean was consistent with Rotter's finding that most subjects were primarily internally-oriented. P- and C-scale scores were moderately correlated ($r = .59$, $p < .01$) as anticipated, given their shared belief in an external locus of control. These two scales correlated negatively with the I-scale. Levenson also normed her measure on a sample of 96 adults and found that test-retest reliabilities for a one-week interval ranged from .64 to .78. Although internal consistency estimates yielded only moderately high correlations, Levenson concluded that these were appropriate given the variety of situations sampled by the items. Negligible correlations between the IE scale and Marlowe-Crowne Social Desirability scale were found. Correlations between the

three IE subscales and demographic factors, such as age or education, were also insignificant. In examining the validity of these scales, Levenson found that the more externally-oriented patients in a hospital sample were, the lower they scored in objective information about their illness. This was seen as supportive of the hypothesis that internally-oriented persons would attempt to control their environment through knowledge. Lefcourt (1976) reported that internals were better able to delay gratification than externals, and that they also explored more effective cognitive strategies. Molinari and Khanna (1981) explored the relationships of locus of control to depression and anxiety. Both of the latter linked inversely with internality, while externality had opposite bonds. High C-scale scorers showed the most debilitating anxiety.

Life Experiences Survey (LES). Life stress, operationally defined as self-reported life changes, has been found linked to many other measures, including physical illnesses, academic performance, and psychiatric symptoms. One early life stress measure was Holmes and Rahe's (1967) Schedule of Recent Experiences (SRE), a self-administered questionnaire of 43 life changes. Items were checked off by subjects if the event had occurred to them within the past 12 months. The SRE was based on the assumption that any life change, positive or negative, was stressful in and of itself. This assumption was challenged, however, and Sarason, Johnson, and Siegel's (1978) Life Experience Survey (LES) was

designed as an improved life stress measure in which positive and negative changes could be handled separately. The LES consisted of 57 life change items which subjects rated as occurring 0 to 6 months, or 7 to 12 months ago. Respondents also rated whether the event's impact was positive or negative at the time it occurred, using a seven-point scale ranging from extremely negative (-3) to extremely positive (+3). The LES's last 10 events concerned academic life change events for use only with student populations. Responses were scored for mean positive, mean negative, and total change scores. A normative sample of 345 undergraduate students was used. Test-retest correlations for the positive change scores over a 5 to 6 week time interval ranged from .19 to .53 (Sarason et al., 1978). Reliability coefficients for negative change and total change scores ranged from .56 to .88, and .63 to .64 respectively. No change score correlated significantly with either social desirability bias or sex. Negative change scores were found to link positively with anxiety measures, but to associate inversely with grade point averages. Students at the university counseling center displayed significantly higher negative change scores than students who had not sought such services. Positive change scores showed fewer linkages to selected dependent variables. This last finding was viewed as supporting the belief that life stress is better conceptualized in terms of negative change, rather than change in general.

Johnson and Sarason (1977) noted that although

statistically significant correlations were obtained between negative change scores and dependent measures, these correlations were relatively small. They attributed this to the tremendous variability in how individual's handle negative life changes and suggested that life stress measures alone might be unable to yield strong results. They hypothesized that moderating variables helped to determine the individual's response to a high level of negative change. Nuckolls, Cassell, and Kaplan (1972) had found that women with high Schedule of Recent Experiences scores and low levels of social support systems in their environment evidenced more birth complications than women with greater social supports. Johnson and Sarason (1977) also found a significant correlation between high negative change scores (LES) and dependent measures of depression and anxiety when the individual indicated an external locus of control (Rotter, 1966). This correlation did not exist when the locus of control was internal, suggesting that locus of control operated as a moderating variable in determining the individual impact of high life stress.

Profile of Moods State (POMS). The POMS, a rating scale composed of 65 adjective items, was designed to measure fluctuations in 6 factor-analytically derived dimensions of subjective mood states: tension-anxiety, depression-dejection, anger-hostility, vigor-activity, fatigue-inertia and confusion-bewilderment (McNair, Lorr, & Droppleman, 1971). The respondent was directed to rate each adjective on a

five-point scale according to how closely it described the subject's mood during the past week, including the present day. A Total Mood Disturbance score (TMD) was obtained by summing the scores across all six factors after inversely weighting Vigor. Two normative samples were used: the first consisted of 1000 psychiatric outpatients, and the second of 856 college students. The respondent's sex accounted for little variance. Internal consistency reliability indices for the subscales ranged from .87 to .95 (McNair, et al., 1971). Test-retest reliability coefficients were obtained from outpatients immediately before and after beginning treatment, also following 6 weeks of therapy. These coefficients were somewhat low, ranging from .65 to .74 for the first interval and .43 to .53 for the second. However, the authors maintained that these were adequate for their purposes as mood would be expected to fluctuate by definition, particularly given the circumstance of initiating psychological treatment.

Six independent factor analytic studies were conducted in the validation of the POMS, with a correlation of .30 or higher required for a factor to be considered significant (McNair et al., 1971). Each study indicated that the same set of 6 mood factors could be identified, measured, and replicated--even when the population was varied.

Four areas of research offered validational evidence for the POMS. The first involved short-term psychotherapy studies in which at least some of the POMS factor scores

appeared sensitive to the changes associated with treatment (Lorr, McNair, & Weinstein, 1964; Pugatch, Haskell, & McNair, 1969). The POMS factors also appeared sensitive to the short-term changes associated with some tranquilizers as evidenced by the results of different controlled outpatient drug trials (McNair, Fisher, Sussman, Droppleman, & Kahn, 1970; McNair, Kahn, Droppleman, & Fisher, 1967, 1968). POMS factor scores have often been sensitive in studies (Fisher, Pillard, & Yamada, 1968; Pillard & Fisher, 1967) in which an emotion-inducing condition (e.g., viewing an autopsy film) was introduced. In a similar vein, Kilpatrick, Veronen, and Resick (1979) administered the POMS to 46 recent rape victims and 35 nonvictims at four time intervals and found, that at one-month postrape these groups differed significantly on all factor scores except Vigor-Activity. Finally, some evidence for concurrent validity has been found. Patients in the original normative sample completed the Hopkin's Symptom Distress Scale (Parloff, Kelman, & Frank, 1954) which yielded 3 distress scores: Somatization, Anxiety, and Depression. These three scores correlated moderately to highly with nearly all POMS factors. High correlations between POMS Tension-Anxiety and the Taylor Manifest Anxiety Scale, and moderate correlations between POMS Depression and the MMPI Depression scale, have also been found.

The POMS Anger scale was used separately in the present study to provide a measure of the fluctuations in subjectively experienced anger. The 12 items comprising this factor

had yielded an internal consistency reliability coefficient of .92, and test-retest reliability indices of .53 to .71 (McNair et al., 1971).

Religiousity Scales. Measures of religious commitment and affiliation was derived from Faulkner and DeJong's (1965) Religiousity Scales. These were designed to measure Glock and Stark's (1965) five dimensions of religiousity: ideology, ritualism, experiential, consequential, and intellectual. Each was represented by a scale containing four or five multiple-choice items that met Guttman's criteria for unidimensionality. Each subscale was scored separately with one point assigned to selected multiple-choice responses. After analysis of the 23-item measure, an eight-item composite scale of religiousity was formed. The normative sample consisted of 372 college students. The reproducibility coefficients for the subscales ranged from .90 to .94. No test-retest data were reported. The original authors cited no validational evidence other than the construct validity claimed for the Guttman procedure. The five dimensions proved moderately intercorrelated, although no two dimensions appeared identical. The belief or ideological dimension correlated most highly with the others. This was interpreted as appropriate given that belief was thought to be the central component of religiousness (Glock & Stark, 1965). Although reliability and validity data for the measure appeared sparse, it offered some access to differences between subjects in terms of religious commitment and affiliation. Six items of

the original 23 were chosen for the present study, with four selected from the ritualistic scale and the remaining two drawn from the experiential subscale. Items from the experiential scale were reworded into simpler language to improve readability for the younger adolescents of this sample.

Rosenberg's Self-Esteem Scale. Crandall (1973) cited Rosenberg's Self-Esteem Scale (1965) as one of the eight best measures of self-esteem in the sense of self-acceptance. Originally designed as a Guttman scale, the Rosenberg has been most frequently used as a ten-item Likert scale (Jacques & Chason, 1977; Marsland & Perry, 1973). This was also true in the present study where each item was scored using a four-step Likert framework such that the higher the score, the lower the self-esteem. Rosenberg's normative sample consisted of 5024 high school juniors and seniors. The scale was found to have relatively high reliability despite its brevity. Silber and Tippett (1965) found a test-retest correlation over a two-week interval of .85. The high convergent validities found between the Rosenberg and other self-esteem measures, and its inverse correlations with measures of anxiety, interpersonal insecurity, and depressive affect, have supported this scale's construct validity (Silber & Tippett, 1965).

Some authors have maintained that the Rosenberg scale is not unidimensional. Kaplan and Pokorny (1969) subjected the responses obtained by an adult sample of all ages to a factor analysis with varimax rotation and reported two independent

factors. Dobson, Goudy, Keith, and Powers (1979) used a similar procedure with a sample of 1332 adults of at least 60 years of age, and again found a two-factor solution. Among samples of adolescents and young adults (the age group the measure was originally designed for), however, others have continued to find support for the Rosenberg's unidimensional claim. For example, Hensley and Roberts (1976) used the Rosenberg with an undergraduate sample and again subjected the responses to a factor analysis with a varimax rotation. Although two factors were found, they concerned response sets. The five factor one items were exclusively positive self-acceptance statements, while only negatively worded items constituted factor two.

Hensley's (1977) factor analytic study of the scale with a college-aged sample also yielded a one-factor solution. Furthermore, no significant differences were found between the scores of male and female respondents. Dobson, Goudy, Keith, and Powers (1979) concluded that age appears to have some as yet not clearly defined influence on the structure of Rosenberg, with the unidimensionality evidence strongest among younger samples.

Support System Rating. An author-constructed checklist was used as a brief measure of a person's support system. Respondents were asked to list the people currently in their lives who were most important to them. They then indicated which of these people they wanted to tell about the assault; and how many they actually did tell. The victims rated the

helpfulness of each person's response on a five-point scale ranging from low (1) to high (5) support. An average score was then obtained. Respondents also were asked why they chose not to tell some people about the rape despite an initial desire to.

Tennessee Self-Concept Scale (TSCS). The TSCS, developed by Fitts (1965) was designed to measure self-esteem using a facet design that provided for a multidimensional description of the self. This 100-item scale consisted of two main dimensions, the internal modality of the self, and the self as an external referent. The first was composed of three scales, identity (how a person sees herself), behavior (how she acts), and self-satisfaction (self-acceptance). The second dimension consisted of five scales; physical self, moral-ethical self, personal self, social self, and family self. Ninety of the scale's 100 items were involved in these eight subscales, with the ten remaining items (taken from the MMPI's Lie scale) comprising a self-criticism score. The 90 items were equally divided into positive and negative subsets and could be responded to on a five-point scale. The TSCS thus yielded eight subscale scores reflecting different aspects of self-esteem, one measure of social desirability, and a total self-esteem score (derived by summing the eight subscales). All items had been selected by seven clinical psychologists from an item-pool composed of statements from other self-concept measures as well as from written self-descriptions of patients and nonpatients. The test was

designed for use with individuals aged twelve and over who had at least a sixth grade education. Test-retest reliabilities ranged from .67 to .92 for the various subscales (Fitts, 1965). Construct validation for the hypothesized two-dimensional grid of the TSCS was offered by Levin, Karni, and Frankel (1978). They conducted a smallest space analysis of the TSCS using eight replications, each of which confirmed that the scale tapped the two basic facets it claimed to. Vacchiano and Strauss (1968) conducted a principal components factor analysis on the responses of 260 college students to the TSCS, and found that 20 factors accounted for 66% of the variance. Boulton (1979) examined the interrelationship among the TSCS scales with the Sixteen Personality Factor Questionnaire (16PF). He concluded that the main dimension underlying the TSCS was positive self-evaluation, also characterized by good adjustment, the absence of anxiety, or the freedom from neurotic symptoms. This central dimension correlated highly with the 16 PF's secondary Anxiety vs. Adjustment measure but was essentially independent of the other dimensions of the personality sphere tapped by the 16PF. Fitts (1965) had constructed four scales of TSCS items which had best identified particular samples of psychiatric patients. Boulton (1979) examined these and found that three of these scales (Maladjustment, Personality Disorder, and Neurosis) had very high negative correlations with Total Self-Esteem. Validational evidence was also offered by LaVoie (1976) who found that adolescents scoring

high on ego-identity (a stage characterized by strong, positive commitment to beliefs and occupation) also scored higher on TSCS subscales of physical self-esteem, family self, and social self than did adolescents having lower ego-identity scores.

Thematic Apperception Test (TAT). The TAT was designed by Murray (1955) as a projective test measuring preconscious themes, conflicts, and concerns. It consists of 20 cards depicting black-and-white pictures of individuals in various environmental settings with the visual stimuli highly variable in terms of its clarity and structure. The test was presented as assessing imagination and subjects were asked to make up a story about each picture which contained a beginning, middle, and end and to provide information about what the characters were thinking or feeling. The particular identities, motives, and patterns that each subject assigned to the cards were used in interpreting the results. Generally, results were interpreted on the basis of clinical expertise. However, various authors have devised formal scoring systems, such as Pine's (1960) system for rating drive content. Smyth (1979) used Pine's approach to devise a system from which he could measure the amount of hostility or aggression in a TAT story, the amount of paramnesia material projected, the degree to which projected material was integrated in the story, and how distorted and disguised the projected material was. He used this rating system in an experiment in which he selected two groups of subjects, each

noted for obtaining a high score on a measure of hypnotic suggestibility. Each group was hypnotized and read a story. The experimental group heard a story designed to arouse their anger and a desire for revenge. The control group heard the same story minus all the portions designed to induce aggression. Smyth then administered five TAT cards (3BM, 6GF, 8BM, 13MF, and 4) selected as being particularly likely to elicit aggressive or sexual themes to each subject. Each protocol was independently rated by three judges trained in Smyth's rating system. The results indicated that the experimental group told significantly shorter stories and, after correcting for this factor, this group expressed more blatant anger than did the control group. Interrater correlations were satisfactory, and reliability coefficients were in the mid-nineties. The present study utilized Smyth's three-point scoring system for measuring the degree to which aggressive material was disguised. That is, a rating of 1 was assigned when instruments or states of being suggestive of aggression were reported in the story (e.g., "gun", "death"). A score of 2 was used when behaviors more directly implying aggression were used (e.g., "fighting", "wounding", "arguing"). A rating of 3 was assigned when anger was explicitly stated (e.g., "angry", "mad"). As the present author was interested only in the degree to which anger was disguised (and therefore theoretically less accessible on a conscious level), the ratings on this portion of the system were summed to provide a total score. To conserve time, only four TAT

cards (3BM, 4, 3GF, and 10) were administered to members of the incoming group at three weeks postassault. Because it required individual administration, the TAT was not administered to the control group.

Results

Final subject pool. Between January and August of 1980, 37 forcible rape cases involving victims 13 or older were reported. Of twenty-four asked to participate in this research, 22 agreed. Refusals were given by a young adolescent who did not want to tell her parents of her rape, and, therefore, could not provide a valid research consent form, and a young adult whose mother discouraged her participation. Of the 37 forcible rapes reported, 13 victims, or about one-third, were not invited to participate in this project. These included two retarded persons, one victim whose mother refused to allow her participation, two individuals who notified ECRCC of a rape but who refused counseling services, three adolescents whose accounts of the assault eventually revealed that no legally defined rape had occurred (they were describing, instead, a sex stress incident), and another adolescent who later acknowledged having purposely made a false rape claim. The remaining three cases included an alcoholic woman who did not follow through with counseling, one mental health system client who periodically called claiming to have been group raped, and one prostitute, believed to have been raped and badly beaten by her pimp and associates, who did not follow through with counseling. Of the 22 incoming group women, two withdrew from the research project

and ECRCC at one week postassault, two others at four weeks, and two more at six weeks postassault. The two one-week withdrawees were in their early 20's. After initially agreeing to participate, they avoided and/or refused further ECRCC contact. One stated this was because she did not want her boyfriend upset by being reminded of the assault each time that counselors contacted her. Of the four-week withdrawees, one was an 18 year-old who had experienced severe mood disturbance during her first two postassault weeks. Her rape had revived painful memories of prior incestuous experiences with her father and she terminated ECRCC contact, stating that further meetings would remind her of the incest that she wished to forget. The second woman, a 33 year-old, had only allowed phone contact with ECRCC since that assault. At about four weeks postassault she changed her phone number and did not respond to a letter requesting her new number if she desired further ECRCC contact. Of the six-week withdrawees, one was a 33 year-old partner in a dysfunctional marriage who terminated contact for unknown reasons; the other was a 21 year-old college student who was also a previous sexual assault victim. She experienced severe mood disturbances that seriously jeopardized her academic standing during the initial postassault month. To help restore her school functioning she sought professional counseling and, once focused on this, she seemed to choose to suppress further thoughts or discussion of the assault. Except for the two earliest withdrawees, the other victims contributed

sufficient data to permit some data analyses from 20 incoming victims. Nineteen of these were Caucasians and ranged in age from 13 to 33 years. The author initially interviewed 11 of these victims within 72 hours of their assault and 16 (80%) within their first postassault week.

ECRCC case records from 1978 and 1979 were examined and yielded a list of 110 previously counseled rape victims who met this project's criteria. Current addresses and/or phone numbers could be located for only 61 and all but one agreed to participate. The sole refusal was by a mother who prefered that her young daughter (the victim) not be reminded of the assault. Thirty-eight (63%) of the others completed and returned questionnaire packets. These previously counseled victims included 36 women and 2 men. They ranged in age from 14 to 61 and all but two (94.7%) were Caucasian. The time since their assault varied from six years to three months prior to this project. Sixty-five percent (23) had been raped less than 18 months before this research project and half (19) within 12 months.

Fourteen additional rape victims who had received no crisis intervention counseling voluntarily contacted the Center and completed the research data packets. Six had learned of this project via media advertisements, while three more were friends or relatives of ECRCC staff members, and four others were introduced to this project by community members unaffiliated with ECRCC. Of these 14, 13 completed research packets. They were all Caucasian females who

ranged in age from 19 to 54. Eight had been raped more than six years before this project started and four had been assaulted from between four and six years earlier. The remaining woman had been raped only three to four months before her participation.

Control group. Thirteen incoming rape victims completed all interview-based measures at three-weeks postassault. This created a need for 13 matched controls to provide an appropriate data base for comparisons. Thirty-seven women volunteered to participate in this control group. Twenty-seven were female OIC students, seven of whom were excluded because their questionnaire responses disclosed that they had also previously experienced rape or incest. The remaining 20 OIC students consisted of 11 Caucasian and nine Black women ranging in age from 17 to 49 years. Four of these were selected as controls. Ten other adolescents and adults learned of the need for this control group through a grapevine of the author's colleagues and friends. All were Caucasian females ranging in age from 15 to 27 years. Nine were chosen as controls. The selection criterion was the degree of match between potential control group members with a member of the incoming group on the following variables: age, marital status, educational level, socioeconomic group, history of prior mental health counseling, religious identification, and the present importance religion had in their life. These matched groups did not differ significantly on any of these variables by the Chi-square test.

Group differences on demographic variables. In summary, a total pool of 71 rape victims was generated: 20 incoming, 38 previously counseled, and 13 uncounseled. Chi-square was used to test for significant difference between these groups on each demographic and assault feature variable. The chi-square results were reported only when a difference significant at least at the $p < .05$ level was found. The two-tailed test of significance was exclusively used as there were no assumptions about how the groups might differ on these variables. Only variables that revealed statistically significant intergroup differences received comment. Incoming victims were found to be more likely than previously counseled victims to have experienced a prior sexual assault (χ^2 (1) = 5.98, $p < .05$), been struck during this assault (χ^2 (1) = 5.98, $p < .05$) and been injured (χ^2 (1) = 8.12, $p < .01$). The uncounseled victim group was less likely than the incoming to have been a victim of previous sexual assaults (χ^2 (1) = 3.96, $p < .05$) and more likely to have been virgins when assaulted (χ^2 (1) = 4.16, $p < .05$). This group was also significantly older, (χ^2 (3) = 10.18, $p < .05$), and better educated (χ^2 (5) = 16.25, $p < .01$) than the incoming group. In comparing the uncounseled group to the previously counseled victims, uncounseled members were more educated than previously counseled victims (χ^2 (5) = 16.90, $p < .01$), more likely to have been acquainted (usually only slightly) with their assailant (χ^2 = 6.38 (1), $p < .05$), more likely to have been injured (χ^2 (1) = 8.12, $p < .01$), and more likely

to have been virgins when assaulted (χ^2 (1) = 9.37, $p < .01$). Uncounseled group members also had been raped significantly longer ago than previously counseled clients (χ^2 (7) = 39.34, $p < .001$).

Missing data. Little missing data was found in the research packets completed by members of the previously counseled, uncounseled, or control groups. All had completed Rosenberg's Self-Esteem scale and the Anger and Guilt scales. Only one previously counseled subject omitted portions of the DOV and all the ARSI-W. Quite substantial amounts of data were missing from the questionnaires completed by the 20 incoming victims (see Table 3, p. 94).

Several factors contributed to these omissions. Although they generally remained willing to be interviewed by the author, six women refused to complete most questionnaires. Their reasons varied. One woman declined all face-to-face contact with the author/researcher and was also unwilling to have the questionnaires mailed to her home. Three claimed to not comprehend the research questionnaires. The author attempted to read the questions aloud to them while explaining the vocabulary. They quickly became frustrated, however, and declined further questionnaires. Two of these three completed the DOV before giving up. A fifth person completed the questionnaire packets administered at both a few days and one week postassault, but then refused to complete subsequent forms stating that doing so made her feel "like a guinea pig". The sixth woman completed most of the

Table 3

Number of Incoming Victims Who Completed Forms

Postassault Questionnaires	Number Completed of 20 Possible
2 - 5 Days	
TSCS I	14
Anger I	11
Guilt I	11
DOV	16
7 - 10 Days	
Support System	15
POMS	13
LES	15
Religious Commitment	15
3 Weeks	
TAT	11
TSCS II	13
Anger II	11
Guilt II	13
IPD	9
FSS	12
Bem SRI	9
Locus of Control	11
Body Cathexis	11
12 Weeks	
Rosenberg Self-Esteem	11
TSCS III	10
Anger III	11
Guilt III	11
ARSI-W	13

early questionnaires, but refused to complete more, maintaining that they seemed "stupid and meaningless". She later agreed, however, to complete the ARSI-W at 12-weeks postassault. The remaining 14 participants who were willing to complete most questionnaires varied in their refusals. Adolescents frequently rejected Bem's SRI as "too difficult", and persons in a hurry or "not feeling up to it" on a

particular day could often be encouraged to complete only what they felt "able to", typically considerable less than the whole data packet. Those who could not be interviewed until well after the initial few days were not then administered the Guilt or Anger measures.

Incoming victims did maintain a high rate of interview contacts with the author. All 20 victims completed each of the first three interviews and 18 completed the next two. By the sixth week's interview, this number declined to 17, to 16 at eight weeks, and only 14 completed the two later interviews. All interviews were completed by only 10 victims. Table 4 shows the percentage of on-time interviews and also those completed later. Most interviews occurred on time, and the vast majority (75% to 94.1%) occurred no more than one week late.

Table 4

Time and Percentages of ARSI-O Completions

Interview Period	On Time	Late 1 day to 1 week	Late 8 days to 2 weeks	Late over 14 days
few days	55	25	10	10
week 1	65	20	-	15
week 2	65	10	20	5
week 3	50	38.9	11.1	-
week 4	44.4	38.9	16.7	-
week 6	82.4	11.8	5.9	-
week 8	75	18.8	6.3	-
week 10	64.3	14.3	21.4	-
week 12	85.7	7.1	7.1	-

Demographic Features

The final pool of 71 rape victims (20 Incoming, 38 Previously Counseled, and 13 Uncounseled) was used in tabulating the demographic variable totals discussed below.

In some instances tabulations totaled less than 71 as victims occasionally neglected to complete certain items. Significant group differences on these variables were discussed on page 92.

Sex. Nearly all victims were female; only two were male. Aged 15 and 27, both were among the previously counseled.

Age. Victims ranged from 13 to 61 years, while most (73%) were 25 years-old or younger. Specifically, 12 were between 13 and 17, 40 between 18 and 25, 14 between 26 and 35, and only five were over 35 years of age. Only the uncounseled group contained no adolescents.

Marital status. The majority (43) were single, 14 were married, three were divorced, nine were separated, and one was widowed.

Socioeconomic status. The majority defined themselves as either lower middle-class (28) or middle-class (27), while smaller percentages labeled their socioeconomic status as at poverty (9) or upper middle-class (6) levels.

Educational level. The majority had a high school education (32), and seven were college graduates. Nine were currently enrolled in college. Ten victims had dropped-out of high school, and four had left college after one to three years.

Occupation. A wide range of occupations was noted, including students (18), homemakers (7), semiskilled and unskilled laborers (28), professional or technical employees

(7), and the unemployed or welfare recipients (10).

Religious identification. Thirty-two were from Protestant backgrounds, 30 from Catholic backgrounds, and two were Jewish. The two remaining people listed themselves as agnostic or "other".

Importance of religion. Respondents were asked to choose one of four phrases that best described how important religion presently was to them. Fourteen stated that religion was "very important", twenty-two defined it as "somewhat important", eleven termed it "not very important" and four viewed it as "not important".

Prior mental health counseling. When asked: "Do you have any problem with drug or alcohol abuse, severe depression, or other psychological problems?", 22 acknowledged having received some variety of mental health counseling. Among previously counseled and uncounseled victims, this may have preceded or followed their assault. Thirty-one victims (44%) acknowledged some type of mental health concern, whether or not they specified having received counseling for it. Of these, eleven (36%) stated they had periods of depression, although these were not defined as severe. Ten (36%) had been hospitalized for psychiatric reasons (primarily for depression) or for drug or alcohol abuse treatment. Three complained of substance abuse, two described severe depression, two described a combination of depression and substance abuse, two complained of anxiety, and one described sexual dysfunction.

Prior sexual assaults. Of the 69 victims responding to this question, 54 reported to have never been sexually assaulted before the time of the rape. However, 15 acknowledged prior sexual assaults of either forcible rape (9), incest (3), attempted rape (2), or indecent assault (1). Incoming group members were significantly more likely to have been previously assaulted than members of the previously counseled group (χ^2 (1) = 3.95: $p < .05$). This distinction may be artifactual, however, given that when the nine prior incoming victims were first asked whether they had been previous victims, five denied it. The assaults were not acknowledged until later interviews when the women apparently were more comfortable about sharing this information. Previously counseled and uncounseled groups did not have an opportunity to develop this relationship, so that their statistics were based only on initial replies.

Sexual experience. Forty-nine participants (70%) identified themselves as nonvirgins when assaulted and 26 of these characterized their earlier sexual experiences as primarily negative, and seven labeled them as a mixture of positive and negative experiences.

Race of assailant. Of the 57 victims describing the race of the assailant, 14 cases involved an assailant of a different race. Eleven involved Caucasian victims and Black assailants, and one case each was reported of a Caucasian victim and a Chicano assailant, a Black victim and a Caucasian assailant, and a Chicano woman and a Black assailant.

Degree of relationship with assailant. Victims were asked whether they had previously known the offender and 29 responded affirmatively, while for 40 (58%) the assailant was a total stranger. Of those acquainted with assailants, 15 defined him as a "formerly highly trusted other", 10 stated he was "only a slight acquaintance", two had first met him the day of the assault, and two did not describe the extent of the relationship.

Location of the rape. Twenty-two (31%) of the rapes occurred in the victim's home, 20 (28.2%) happened in the streets or the woods, 14 (19.7%) took place in buildings other than the victim's or assailant's home, 10 (14.1%) occurred in the assailant's home, and five (7.0%) happened in cars.

Presence of threats. Their assailants verbally threatened 46 victims (64%) in an attempt to prevent her from struggling during the assault and/or to discourage her from telling anyone about the rape. In these cases, 21 involved a threat to kill the victim, 17 threatened to physically harm her without specific mention of killing, four involved a threat to kill a victim's loved one (most frequently her child), one was intimidated with threats of telling others, and three of the threatened victims did not describe the nature of that threat.

Presence of weapons. Sixty-seven victims responded to the question of whether a weapon were present. In 22 (33%) of these cases weapons were involved, and 21 of these

concerned guns or knives.

Use of restraints. No restraints, such as gags, ropes, or blindfolds were used by offenders in most cases according to the 68 victims responding to this item. In four cases, the victim's hands and/or feet were tied, gags were reported in four others, and four additional cases involved blindfolds.

Striking the victim. Seventy victims responded to the question of whether they were struck during the assault. Twenty-five (36%) had been struck and 11 of these victims were slapped repeatedly, eight were slapped once, five were kicked or punched repeatedly, and one was struck with another object.

Injuries. Of the 70 victims responding to this question, 30 (42%) reported no physical injury; sixteen (22.5%) sustained minor scrapes or brushburns not directly inflicted by the assailant's blows; fifteen (22%) reported minor injuries caused by being struck (e.g., bruises around the throat, arms, or face), and 9 (13%) sustained major injuries, such as extensive contusions, lacerations, or concussion.

Feelings towards the assailant. Presented at the end of the ARSI-W, series of open-ended questions asked victims to describe their feelings toward their assailant, both soon after the assault and at present. They were asked to describe how they thought their spouse or boyfriend had felt about the assailant. Several victims listed more than one feeling, so multiple categories were used. The most common

feelings reported immediately following the assault were hatred (58%), fear (29%), anger (21%), and a desire for revenge (13%). Smaller numbers reported pity, confusion, self-blame, or a refusal to let themselves think about the assailant. Their present day feelings still included hatred (52%) and anger (16%), although fear appeared greatly reduced (7%). Other feelings described were a desire for revenge (10%), pity (10%), and a refusal to let themselves think about the assault or the assailant (7%). Victim's most commonly described their spouse's or boyfriend's feelings toward the assailant as a desire for revenge (39%), hatred (35%), or anger (23%), while less than 10% reported such feelings as disgust, lack of any feeling, or feeling betrayed by the assailant. The latter feelings occurred in partners who had previously considered the assailant a trusted other.

Criminal justice system involvement. Seventy victims responded to a question asking if their assailant had been arrested. Most (45 or 64.3%) were unarrested by the time of this project. In some instances this was because legal charges had either not been pressed or had been dropped, while many other assailants had simply never been found. Of 25 arrested, 21 had been bound over at the preliminary hearing and ten of these were still awaiting criminal court trials. Of the 11 cases already tried, ten "guilty" and one "not guilty" verdicts had been returned. Of the "guilty" ten, four had yet to be sentenced and two had been sentenced

but the victims could not recall what the sentence was. Of the four sentences known, one entailed only probation, two had received between one and three years imprisonment, and one received over 15 years.

Support systems. During their first 7 to 10 postassault days, 41 (57.7%) of the victims reported telling at least one significant other (friend, relative, or spouse) about the assault. Six (8%) had notified only medical or counseling personnel while nine (13%) had told no one. Five of these latter were members of the uncounseled group. Of the subjects having a boyfriend or spouse at the time of the assault, 90% informed their partner and 64% of these described their boyfriend or spouse's reaction to them as supportive and understanding, 14% described it as angry and blaming, and 9% stated that it alternated between understanding and blame. These victims said that their partners did not seem to know what to say or how to act, and three others could not discern how he felt towards her. On a Support System questionnaire, the Incoming victims identified an average of 7.5 supporters. The mean number of the latter that the victim wished to tell of her assault was 4.0 and the mean number of individuals they reported telling was 4.2. Victims rated the helpfulness of the significant other's response on a scale from "not helpful" (1) through "highly helpful" (5). The mean rating obtained was 4.2. Forty-four victims responded to questions asking whether or not they had told their "bosses or teachers" about the assault. Twenty-four (55%)

responded affirmatively and, of these, fourteen were glad that they had done so while ten were not. Twenty-six assaultees responded to questions asking how they felt about co-workers or fellow students knowing of their rape (including cases in which the victim told peers, and where peers found out through others). Fourteen (54%) of them felt glad that co-workers knew of the assault while five (19%) had mixed feelings, and six (27%) wished to not inform their peers. Eighteen of these 26 victims stated that there was at least one peer whom they wished to not know about their assault.

Counseling systems. Sixty-eight victims answered whether they had ever sought out a professional counselor for assistance with personal problems resulting from the rape. Eighteen (26.5%) responded affirmatively. In some cases, this occurred before the client began seeing an ECRCC counselor and, in other instances, it was concurrent with or had followed ECRCC involvement. Of those who went to professional counselors, eleven were still working with that counselor when they participated in this research. Nine had attended a total of four or fewer sessions, three had attended 5-12 times, three had attended 13-24 sessions, one had attended for over six months, and two did not describe the length of treatment. A variety of assault-related symptoms had prompted victims to contact professional counselors. The cited symptoms included: depression (8), sexual dysfunction (2), disruption of heterosexual relationships (2), and one each

for increased fearfulness, increased substance abuse, and suicidal impulses. Victims were asked to rate how helpful they had found professional counseling, using a scale of not helpful (1) to very helpful (10). Thirteen of these 18 completed this section, yielding a mean rating of 4.92.

Fifty-eight subjects were ECRCC clients, 46 (79%) of whom first began seeing an ECRCC counselor within 24 hours of the assault. Forty-four of these 58 completed ratings of the helpfulness of their ECRCC counselor(s). Using the same rating scale employed for professional counselors, their mean rating was 8.61. No significant difference was found between the ECRCC ratings assigned by previously counseled versus incoming clients. In examining the nine victims who assigned ratings to both professional and ECRCC counselors, quite similar ratings were observed such that the mean rating of professional counselors was 6.44 versus 7.66 for ECRCC counselors. Forty-two (72%) of the ECRCC clients wished to have some type of continued ECRCC contact, whether in the form of continued ongoing counseling or periodic phone calls from the counselor. Of 43 respondents, 26 (60%) felt they had met with their counselor as often as they wished, while 16 (37%) felt they had seen too little of their counselor, and one felt she had received too much contact. Of the 16 who felt they saw too little of the counselor, two included a written comment that they had been responsible for decreased contact, but now regretted that choice. The 13 uncounseled victims were asked why they had not contacted ECRCC, or a

similar agency, for services following the rape. Five (39%) replied that there either was no such facility at the time of their assault, or that they were unaware of the availability of such services. Five others responded that they felt too embarrassed and/or guilty, while two stated they felt they should have been able to handle their feelings regarding the assault on their own.

Reasons for research participation. The victims who completed research packets were asked why they had chosen to participate. Thirty-four responded to this question, and their responses fell into four general categories. Twenty said that they participated to help other victims, seven "to help ECRCC", four thought that the general public needed to have more information of this type, and three thought that it would help them better understand their own continued feelings about the assault.

Factors germane to recovery. After completing the ARSI-W participants were asked "What has helped you the most in putting your life back to normal since the rape? (Please be specific)". Fifty-eight victim's cited one or more important factors. Most frequently cited were counseling (20 or 34%), the victim's own attitude (17 or 29%), her family (13 or 22%), husbands or boyfriends (13 or 22%), friends (11 or 19%), and staying busy (11 or 19%). Five (3%) stated that changing their location or jobs helped, four (7%) stated that their religion had been important, and two noted that the passing of time was helpful. Five others responded that

nothing had helped, and that their lives were not yet back to normal. Of the 20 that cited counseling as beneficial, 16 referred to ECRCC's assistance, while four were receiving counseling from both ECRCC and a professional counselor. It was unclear whether these four references included both counselors, or primarily referred to only one. Examples of responses in which the victim attributed her own attitude as being important in the recovery process included references to "my logic", "my self-confidence", and "my stubbornness", as well as statements such as "I decided I was not going to let it get to me", and "I decided I had to pull myself together and I did".

Analyses of Measures Common to All Victim Groups

The data analyses of measures common to the total victim pool are organized in the following fashion. The results of standardized questionnaires will be presented in terms of mean scores and group differences. A correlation matrix examining relationships among these measures will next be developed with all statistically significant relationships identified by the following superscripts: a for $p < .001$; b for $p < .01$; and c for $p < .05$. All decimal points will be omitted in the correlation matrices. The ARSI-W scores for each of the four time periods sampled will next be similarly reported followed by a consideration of the ARSI-W symptom area scores. Finally a comparison of the ECRCC-affiliated members of the uncounseled group with the unaffiliated members will be documented to justify the use of the uncounseled

group as one group rather than two smaller ones.

Questionnaire results. The scores on the Rosenberg Self-Esteem scale, Anger scale, Guilt, DOV-T, and DOV subscales were calculated and compared for all three victim groups. Table 5 shows each groups' mean scores and number of victims (in parenthesis) that completed each measure.

Table 5

Questionnaires Common to All Victim Groups; Means with (N's)

Group	Rosenberg	Anger	Guilt	DOV-T	DOV-O	DOV-S	DOV-R
Incoming	19.82 (11)	16.82 (11)	21.73 (11)	65.39 (16)	3.56 (18)	53.88 (16)	7.29 (17)
Previously Counseled	19.84 (38)	13.00 (38)	23.37 (38)	58.44 (37)	2.99 (37)	49.65 (37)	5.62 (37)
Uncounseled	20.23 (13)	16.62 (13)	20.39 (13)	64.58 (13)	3.39 (13)	54.15 (13)	7.08 (13)

A one-way analysis of variance was calculated to determine whether the three groups differed significantly in their responses on these measures. The two posthoc procedures used to analyze significant differences were the LSD procedure, essentially a Student's t-test (Nie, Hull, Jenkins, Steinbrenner, & Bent, 1975), at probability level $p < .05$, and the Scheffe procedure at a probability level of $p < .10$. This latter probability level was recommended by Scheffe (1959), given the relative rigor of his procedure. The LSD procedure was used as it was exact for unequal group sizes. A disadvantage is that the LSD's error rate increases with the number of groups compared. However, the number of present groups was generally small, so the procedure seemed appropriate.

Statistically significant between-group differences were found on the DOV-T, DOV-R, and DOV-S. The results of the LSD and the Scheffe ($p < .05$) procedure indicated that the previously counseled group scored significantly lower on the DOV-T ($\bar{M} = 58.44$) than did members of the incoming group ($\bar{M} = 64.58$). Post-hoc analyses of the DOV-R and DOV-S by both the LSD and Scheffe indicated that the previously counseled group also rated their assault as significantly less violent ($\bar{M} = 5.62$, $\bar{M} = 49.65$) than did the incoming group's members ($\bar{M} = 7.29$, $\bar{M} = 53.88$). Hypothesis 6 stated that the incoming group would evidence lower self-esteem than the others, but this was not supported by Rosenberg's Self-Esteem index, F (2,58) = 0.05, $p = .96$. Nor were significant group differences found for either Anger or Guilt (see Table 6).

Table 6

Analysis of Variance Results from Comparisons of Questionnaire Scores by Victim Groups

Questionnaire	F Value and (df)	Probability
Rosenberg	0.05 (2,59)	.96
Anger	0.79 (2,58)	.46
Guilt	0.84 (2,58)	.44
DOV: T	5.09 (2,57)	.01
DOV: O	1.03 (2,58)	.36
DOV: S	3.84 (2,57)	.03
DOV: R	3.15 (2,58)	.04

Intercorrelation matrix of questionnaires. Hypothesis 8 had predicted that victims scoring high on the Rosenberg would also score high on Guilt. An intercorrelation matrix depicted the associations among these and other measures, and the hypothesis was supported. (see Table 7). Negative self-esteem, anger, and guilt were found to be significantly intercorrelated ($p < .001$). The DOV subscales each correlated significantly with DOV-T, however DOV-S was most strongly related. DOV subscales also correlated significantly with one another with the exception of the DOV-O/DOV-R comparison where $r = .05$.

Table 7

Questionnaire Measures Common to All Victim Groups

	Questionnaires						
				Degree of Violence (DOV)			
	Rosenberg	Anger	Guilt	O	S	R	T
Rosenberg	—	56[a]	67[a]	-08	17	15	17
Anger	56[a]	—	45[a]	-01	20	-07	15
Guilt	67[a]	45[a]	—	-02	11	-02	08
DOV: O	-08	-01	02	—	31[c]	05	46[a]
DOV: S	17	20	11	31[c]	—	27[c]	95[a]
DOV: R	15	-07	-02	05	27[c]	—	51[a]
DOV: T	17	15	08	46[a]	95[a]	51[a]	—

ARSI-W results for the four time periods sampled. A total of 62 victims completed the ARSI-W. The means, variances, and ranges for each of the four sampled time periods are listed in Table 8, p. 110.

Table 8

Total Victims' ARSI-W Means, Variances, and Ranges

Statistic	one week	one month	three months	now
Mean	19.82	15.16	10.76	8.32
Variance	61.33	76.00	55.17	43.37
Range	1-34	2-34	0-27	0.23

These figures were derived by aggregating the number of symptoms that occurred throughout the ARSI-W subscale areas on each occasion. Occupation was the only subscale omitted as some (N = 11) victims were not employees or students at the time soon after they were assaulted and, therefore, had no opportunity to obtain a score on any of the four occupation questions asked at each time period. In computing ARSI-W scores for the "now" time period, Incoming victim scores were also the scores for their three months postassault period as this group's "present day" report was done at three months postassault.

As the incoming group completed the ARSI-W closer in time to their actual assault than did the other groups, it seemed possible that the previously counseled and uncounseled group's report of symptoms during the first three time periods might differ significantly from the incoming's, given the effect of retrospective error. A oneway analysis of variance was performed comparing incoming member's scores for each of the first three time periods with all other group members. No significant differences were found, however. The relevant F-values were: one week, F (2,59) = 0.81

(p = .45); one month, F (2,59) = .30 (p = .74) and three months, F (2,59) = 2.90 (p = .06). Differences were not apparent in the "now" category either, such that F (2,59) = 2.64 (p = .08). Thus, these groups did not differ in the number of symptoms reported at any one time period, and Hypothesis 1, which had stated that incoming group members would evidence more symptoms in the "now" category than would members of the other groups, was unsupported. The data trends suggested, however, that at present the previously counseled victims reported the fewest symptoms, while uncounseled victims were still reporting essentially the same amount as incoming victims who had been assaulted only three months ago (see Table 9).

Table 9

Group's ARSI-W Means at Each Time Period

Group	N	one week	one month	three months	now
Incoming	12	22.00	16.92	10.67	10.67
Previously Counseled	37	19.76	14.65	9.32	6.78
Uncounseled	13	18.00	15.00	14.92	10.54

Another question was whether the number of reported symptoms decreased as the time since the assault increased. A repeated measures analysis of variance was calculated to test whether the victim groups as a whole reported fewer symptoms across the first three time-periods. The results were highly significant, F (2,59) = 46.32, p <.001. Post-hoc analysis using the Scheffe procedure indicated that a significant decline had occurred between one week and one

month postassault ($p < .05$), and between one and three months ($p < .01$). The "now" category was excluded from this analysis, as the incoming group's scores were not free to vary.

Additional repeated measures analysis of variance were made to determine whether each victim group evidenced a pattern of symptom decline. Incoming group members evidenced a significant difference, F (2,9) = 8.92 ($p < .001$). However, a post-hoc Scheffe analyses ($p < .10$) revealed no significant differences between any single pair of means. The previously counseled group also evidenced a significant change, F (3,33) = 42.49 ($p < .001$). Post-hoc analysis with the Scheffe procedure indicated a significant difference in the number of symptoms reported at one week and three months ($p < .05$), and one week and now ($p < .01$). The uncounseled victims also evidenced a significant difference in the number of symptoms reported over time, F (3,9) = 3.36 ($p < 0.05$). A post-hoc analysis using the Scheffe ($p < .10$) failed, however, to reveal significant differences between any single pair of means.

Intercorrelation matrix of ARSI-W totals. The intercorrelation matrix, depicted in Table 10, p. 113, gives Pearson correlation coefficients between ARSI-W totals for each time period. Positive and significant correlations existed between every combination of scores, except for scores at one week postassault versus present day.

Table 11, p. 114, shows the product-moment correlations between the number of reported symptoms (ARSI-W) on the four

Table 10

Intercorrelations of ARSI-W Totals for Each Time Period

	one week	one month	three months	now
one week:	—	76[a]	30[b]	00
one month:	76[a]	—	63[a]	24[c]
three months:	30[b]	63[a]	—	60[a]
now:	-00	24[c]	60[a]	—

occasions with the questionnaire data for participants who completed all of these measures. Present symptoms ("now") correlated significantly with most questionnaire measures and 25 of the 28 linkages overall were positive. Total degree of violence correlated positively and significantly with ARSI-W at all four time periods, a pattern closely approached by DOV-S. Only DOV-O showed no statistically significant bonds to ARSI-W. The correlations of ARSI-W with Anger steadily shifted from -.10 at one week postrape to .55 ($p < .001$) "now". This interesting pattern was closely parallel by the Rosenberg versus ARSI-W associations. Guilt was linked with the number of reported symptoms one week postassault and during the present-day period, but not during the intervening periods.

Areas of assault-related disturbance. ARSI-W scores were also aggregated over time periods, yielding a subscale total for each symptom area for the combined four periods. The Occupation subscale was computed only for the 51 victims who were employees or students when assaulted. Table 12, p. 115, depicts the mean subscale scores, ranges, and

Table 11

Correlations of ARSI-W and Questionnaire Scores

Questionnaires	N	one week	one month	three months	now
Rosenberg	61	-03	06	18	45[a]
Anger	61	-10	-06	28[c]	55[a]
Guilt	61	23[c]	14	13	36[b]
DOV: O	61	13	15	09	-04
DOV: S	60	22[c]	24[c]	21	43[a]
DOV: R	61	05	24[c]	25[c]	20
DOV: T	60	21[c]	29[c]	27[c]	36[b]

variances for the total victim group as well as the mean subscale scores for subgroups.

A one-way analysis of variance was used to determine whether the three victim groups differed significantly from each other on each ARSI-W subscale. The only statistically significant difference was for somatic disturbance: F (2,59) = 3.52 (p = .04). Post-hoc LSD and Scheffe analyses procedures ($p < .05$) revealed that previously counseled victims ($\bar{M}$ = 4.22) obtained significantly lower scores in this area than incoming group members ($\bar{M}$ = 5.62). However, the previously counseled group generally had the lowest means, and the uncounseled group generally had the highest.

The following abbreviations for each symptom area were used in Table 12, p. 115, and subsequent tables: Sleep (SLP), Appetite (APP), Somatic (SOM), Assault-related Fears (ARF), Heterosexual Relationships (HXL), Sexual Expression (SXL), and Occupation (OCC).

Table 12

ARSI-W Group Means, Ranges, and Variances for Symptom Areas

	Total Group			Subgroup		
	Mean	Variance	Range	Incoming	Previously Counseled	Uncounseled
SLP	9.08	23.55	1-19	9.17	8.57: L	10.47: H
APP	3.15	5.01	0-8	4.00: H	2.70: L	3.62
SOM	5.16	16.30	0-18	7.58: H	4.22: L	5.62
MOOD	2.92	6.96	0-8	2.50: L	2.97	3.15: H
ARF	10.42	36.84	1-24	12.50: H	10.05	9.54: L
HXL	9.27	29.42	0-20	9.42	8.38: L	11.69: H
SXL	8.34	34.42	0-20	8.83	7.57: L	10.08: H
OCC	3.88	13.19	0-12	4.00	3.80	4.00

Note. H indicates the highest group score and L indicates the lowest.

Table 13

Group Differences on ARSI-W Symptom Areas (ANOVA)

	df	F	p
SLP	2,59	0.73	.49
APP	2,59	1.94	.15
SOM	2,59	3.52	.04[c]
MOOD	2,59	0.21	.82
ARF	2,59	0.91	.41
HXL	2,59	1.85	.17
SXL	2,59	0.93	.40
OCC	2,48	0.02	.98

An intercorrelation matrix of the ARSI-W symptom area scores for all groups (N = 62) revealed positive, significant, and low to moderate correlations between each subscale (see Table 14). The strongest linkages were obtained between Appetite and Somatic symptoms (.70) and between Heterosexual Relationship and Sexual Expression (.67). Also, both Appetite and Somatic disturbance correlated appreciably with Occupation (r's = .65 and .62, respectively). The most central symptom average was Sleep disturbance, which correlated at least moderately with every other symptom.

Table 14

Intercorrelation Matrix of ARSI-W Symptom Area Scores

		Symptom Areas							
Symptom Area	N	SLP	APP	SOM	MOOD	ARF	HSX	SXL	OCC
SLP	62	—	56[a]	54[a]	42[a]	41[b]	42[a]	37[b]	49[a]
APP	62	56[a]	—	70[a]	19	30[c]	16	17	65[a]
SOM	62	54[a]	70[a]	—	29[c]	31[b]	26[c]	27[c]	62[a]
MOOD	62	42[a]	19	29[c]	—	37[b]	43[a]	22[c]	36[c]
ARF	62	41[b]	30[c]	31[b]	37[b]	—	37[a]	21	41[b]
HXL	62	42[a]	16	26[c]	43[a]	37[a]	—	67[a]	37[b]
SXL	62	37[b]	17	27[c]	22[c]	21	67[a]	—	33[c]
OCC	45	49[a]	65[a]	62[a]	36[c]	41[b]	37[b]	33[c]	—

Pearson correlations were also calculated between all questionnaire scores and postassault symptoms (as shown in Table 15, p. 117). Nearly all (51 of 56) were positive, showing general linkages of postassault symptoms with less

favorable questionnaire responses. Total violence (DOV-T) linked to symptoms most consistently. Disturbances of both Mood and Heterosexual Relationships linked most strongly and diversely to these questionnaires. The weakest bonds were obtained for DOV-O and also for the Sleep, Appetite, Occupation, and Assault-Related Fears areas of symptoms, closely trailed by Sexual Expressiveness. The DOV-S and DOV-T yielded low but positive and significant correlations with Sexual Expression and Heterosexual Relationships. These supported Hypotheses 10 which predicted that the more violent the assault, the more disturbed would be postassault male-female relationships.

Table 15

Correlations of ARSI-W Symptom Areas with Questionnaires

Symptom Area	Rosenberg	Anger	Guilt	DOV: O	DOV: S	DOV: R	DOV: T
SLP	13	13	20	09	15	19	19
APP	05	-00	03	11	18	11	21
SOM	11	08	13	02	35[b]	20	34[b]
MOOD	47[a]	43[a]	35[b]	-11	20	23[c]	22[c]
ARF	05	14	17	13	21	20	25[c]
HXL	24[c]	17	30[b]	05	31[b]	17	31[c]
SXL	10	10	13	16	24[c]	05	24[c]
OCC	-07	-10	07	07	16	18	18

A comparison of ECRCC-affiliated and nonaffiliated uncounseled group members. As three of the 13 uncounseled victims had preexisting affiliations (e.g., as friends or

relatives) with at least one ECRCC staff member, it seemed possible that this association might have unique effects. If this preexisting ECRCC association was linked with significantly different scores on questionnaire and interview measures, it would seem unfeasible to consider them as representing the same set of victims. Both uncounseled subgroups were compared for questionnaire responses using a one-tailed t-test with a probability level of $p < .05$ (i.e., it was assumed that if the three ECRCC-affiliated victims responded differentially, it would be in the direction of evidencing less disturbance). Significant differences were found on Rosenberg's Self-Esteem scale, the Anger scale, and Guilt. In each instance the three affiliated persons obtained more favorable scores, indicating higher self-esteem (t (11) = 3.21; $p < .01$), less anger (t (11) = 3.15; $p < .01$), and less guilt (t (11) = 2.49; $p < .05$).

The ARSI-W scores of the ECRCC-affiliated uncounseled group members were also compared to those of the ten remaining uncounseled victims for each of the four time periods. No significant differences were found, however, and the following F-ratios were obtained: one week, F (1.11) = .81 ($p = .39$); one month, F (1,11) = .58 ($p = .46$); three months, F (1,11) = .61 ($p = .45$); and now, F (1,11) = .59 ($p = .45$).

Finally, the ARSI-W symptom scores of the ECRCC-affiliated uncounseled victims were compared to those of their unaffiliated peers. No significant differences were found for any symptom areas (see Table 16, p. 119).

Table 16

Uncounseled Victim Subgroup Comparisons (ARSI-W)

Symptom Areas	t	df	p
SLP	0.05	11	.96
APP	0.26	11	.79
SOM	1.06	11	.31
MOOD	1.11	11	.29
ARF	0.37	11	.72
HXL	0.01	11	1.00
SXL	0.14	11	.89
OCC	0.52	8	.61

Given the relative lack of differences on dependent measures, particularly on the symptom profiles, all uncounseled victims were treated as one group during the comparisons of measures common to each victim group.

Effects of Demographic Variables on Measures Common to all Groups.

Each demographic variable was tested to determine if it exerted an independent influence on the scores from ARSI-W, Rosenberg's Self-Esteem scale, the Anger scale, Guilt, DOV-T, or DOV subscales. The pertinent victims were the 62 who had completed the ARSI-W and related measures. t-tests were used in the comparisons when the independent variable was composed of two categories. Only when a hypothesis was tested was the single-tailed t-test used. Statistical significance was set at the $p < .05$ level. When the dependent variable was repeated a measure, as was the case

with the ARSI-W scores for the four time periods, a oneway analysis of variance was used. The oneway was also used in all instances when the independent variable consisted of more than two groups. A probability level of $p < .05$ was necessary for the results to be reported as significant. Two posthoc analysis for significant results were used as previously discussed (pages 107 and 108).

Sex. No significant differences were found between the two males and 60 females on any measure.

Age. The variable of age was measured in two fashions. First, adolescents ($N = 9$) were compared to all adults age 18 and older ($N = 53$). The adolescents reported significantly more anger (t (59) = 2.24; $p < .05$), less Appetite disturbance (t (60) = 2.03; $p < .05$), and less Occupational disturbance (t (60) = 2.36, $p < .05$). They also reported significantly fewer symptoms at the one month postassault period (F (1,60) = 4.04, $p < .05$). Victims were further divided into the following three age categories: adolescents ($N = 9$), adults age 18-29 ($N = 45$), and older adults above 30 years ($N = 8$). The only significant difference occurred for Anger (F (2.58) = 4.31; $p < .05$). The LSD and Scheffe procedures ($p < .05$) indicated that adults age 30 and older reported significantly less anger ($\bar{M} = 7.5$) than the adolescents ($\bar{M} = 21.56$).

Education. Individuals were classified into four categories of education: eight high school dropouts, seven high school students, 28 high school graduates, and 19 with

college backgrounds or degrees. Significant differences were found in the amount of sexual disturbance that was reported, F (3,58) = 3.10, $p < .05$. Posthoc analysis indicated that victims having college backgrounds reported more sexual disturbances ($\bar{M}$ = 10.95) than did high school dropouts ($\bar{M}$ = 4.88).

Victims were also classified into a high school background (N = 49) and college background (N = 19) group. Those with only high school background evidenced lower self-esteem (t (59) = 2.22; $p < .05$), more anger (t (59) = 2.01; $p < .05$), and more guilt (t (59) = 2.24; $p < .05$) than those with some college training. It should be noted that the "some high school background" group included dropouts, present students, and high school graduates.

Socioeconomic level. Individuals socioeconomic status was categorized as poverty (P) level (N = 7), lower middle-class (LMC) (N = 23), middle-class (MC) (N = 25), and upper middle-class (UMC) or wealthy (N = 7). A significant difference was found in the number of symptoms reported at three months postassault (F (3,58) = 5.73; $p < .01$), with the Scheffe's indicating that P's reported significantly more symptoms ($\bar{M}$ = 18.43), than did LMC individuals ($\bar{M}$ = 7.43). Posthoc analysis using the LSD yielded the same results, but also indicated that P victims reported more symptoms than MC's ($\bar{M}$ = 12.36). Significant differences between the groups were also indicated in the symptom areas of Mood, (F (3,58) = 7.17, $p < .001$), Assault-Related Fears (F (3,58) = 4.86,

$p < .01$), and Heterosexual Relationships (F (3,58) = 2.82, $p < .05$). Posthoc analysis indicated P victims reported more Mood disturbance ($\bar{M}$ = 5.57) than LMC's ($\bar{M}$ = 1.65) and UMC's ($\bar{M}$ = 1.57), and that they also reported much more Assault-Related Fears ($\bar{M}$ = 17.51) than any other socioeconomic group, (mean scores were: LMC = 8.52, MC = 10.52, and UMC = 9.14). Posthoc analysis using the Scheffe disclosed no significant difference between any pair of categories in Heterosexual disturbance. However, the LSD procedure indicated that P victims reported more heterosexual disturbance ($\bar{M}$ = 12.14) than LMC's ($\bar{M}$ = 6.91).

Religious identification. Respondents were classified into persons of Catholic (N = 28), Protestant (N = 28), Jewish (N = 2) and other (N = 4) religious background. No significant differences were found on any measures.

Marital status. Individuals were categorized as single (N = 38), married (N = 14), separated or divorced (N = 9), and widowed (N = 1). No significant differences were found between these groups. This also held when victims were simply categorized as single or married and compared.

Race of the victim. Participants were classified as Caucasian (N = 58) or a minority group members (N = 3). Again no significant differences were found.

Occupation. Victims were first classified as employed (N = 53), a category which also included homemakers, and unemployed (N = 6). These groups differed only on the DOV-S (t (57) = 2.46; $p < .05$), such that unemployed individuals

obtained significantly higher scores ($\bar{M}$ = 59.00) as compared to the others ($\bar{M}$ = 51.09). The victims were then classified into the following occupational groups: students (N = 14), semiskilled and unskilled laborers and homemakers (N = 34), professional/technical employees (N = 7), and the unemployed (N = 6). Significantly different scores on Guilt were indicated (F (3,56) = 3.08; $p < .05$), and posthoc LSD analyses revealed that the professional/technical employees showed less guilt ($\bar{M}$ = 17.29) than did semiskilled laborers ($\bar{M}$ = 24.09) or the unemployed ($\bar{M}$ = 24.00). The Scheffe procedure yielded no significant differences between pairs of groups.

Prior mental health counseling. Individuals who had recieved previous mental health counseling (N = 17) were compared to those who had not (N = 39). Those who had received preassault counseling for a personal problem scored higher on Guilt (t (53) = 2.68; $p < .01$), reported greater postassault Mood disturbance (t (54) = 2.24; $p < .05$), greater Assault-Related Fears (t (54) = 2.35; $p < .05$), and greater disturbance in Heterosexual Relationships (t (54) = 1.75; $p < .05$). Those having preassault counseling also reported significantly more present day symptoms ($\bar{M}$ = 11.06) than did the others ($\bar{M}$ = 6.80), F (1,54) = 5.34; $p < .05$. The one-tailed t-test was used in the comparison of Heterosexual functioning, for Hypothesis 3 had predicted that individuals with previous histories of counseling would evidence more disturbance in male-female relationships and sexuality. The first part of this hypothesis appeared supported by data.

These groups did not differ significantly, however, in the area of Sexual Expression (t (54) = .36; p = .72).

Virgin at time of rape. Victims were classified into virgins (N = 19) and nonvirgins (N = 42) at the time of the assault. No significant differences were obtained.

Quality of previous sexual experiences. Participants were classified into those who described earlier sexual experiences (ESE) as all or mostly positive (N = 23), those who described ESE's as largely negative (N = 4), and those who described ESE's as a mixture of positive and negative (N = 10). Significant differences between these groups were found on the Anger (F (2,34) = 4.17, $p < .05$) and Guilt (F (2,34) = 3.66, $p < .05$) scales. Posthoc analysis using the LSD and Scheffe ($p < .05$) procedures indicated that those having mixed ESE's scored significantly higher on Anger ($\overline{M}$ = 11.30) than those reporting primarily negative ESE's ($\overline{M}$ = 6.00). Similarly, those with primarily mixed experiences scored higher on the Guilt ($\overline{M}$ = 25.60) than those with primarily negative experiences ($\overline{M}$ = 17.00).

Length of time since the assault. Individuals were categorized according to the length of time since the assault as follows: 0 - 3 months (N = 14), 4 - 12 months (N = 24), 13 - 24 months (N = 7), or 25 months to six years ago (N = 17). A significant difference on the DOV-S (F (3,56) = 5.32, $p < .01$) and DOV-T (F (3.56) = 5.34, $p < .01$) was found. Posthoc analysis indicated that those assaulted 13 - 24 months ago (all 24 of these individuals were members of the

previously counseled group) scored higher on the DOV-S and DOV-T than did members of all other groups.

Location of the rape. Hypothesis 2 had predicted that those assaulted in their own home (N = 19) would evidence more severe symptoms than those assaulted elsewhere (N = 43). The results generally conflicted with this prediction. Victims assaulted in their own home evidenced less disturbance in Mood and in Heterosexual Relationships (see Table 17, p. 126). They also evidenced higher self-esteem, less anger, and lower DOV-S and DOV-T scores. These victims did not differ significantly from those assaulted elsewhere in the number of symptoms reported at any time period, or in any other symptom area except for Occupation, although they did report significantly more Occupation-linked symptoms.

Previous history of sexual assaults. Individuals were categorized into those who had been previously sexually assaulted (N = 10), and those who had not (N = 51). The previously assaulted obtained significantly higher Anger scores ($\bar{M}$ = 23.70) than the others ($\bar{M}$ = 12.74), t (58) = 3.26, $p < .01$.

Race of assailant. Victims were classified into those raped by an assailant of the same race (N = 37), and those assaulted by any offender of a different race (N = 11). Those raped by an assailant of a different race scored significantly lower in self-esteem on the Rosenberg ($\bar{M}$ = 21.82) than for those raped by same-race assailants ($\bar{M}$ = 18.35), t (46) = 2.11, $p < .05$.

Table 17

Mean Scores of Victims Assaulted at Home vs. Elsewhere

Measure	Home	Elsewhere	t or F	df	p (one-tailed)
Rosenberg	17.32	20.95	2.44	59	.01[b]
Anger	9.89	16.76	2.49	59	.01[b]
Guilt	20.95	22.88	1.05	59	.15
DOV: O	3.58	3.11	0.90	59	.19
DOV: S	48.77	53.07	2.00	58	.03[c]
DOV: R	5.56	6.72	1.56	59	.06
DOV: T	57.65	62.83	1.95	58	.03[c]
ARSI-W:					
one week	20.58	19.49	0.25	1,60	.62
one month	15.95	14.81	0.22	1,60	.64
three months	9.53	11.30	0.75	1,60	.39
now	6.90	8.95	1.29	1,60	.26
SLP	9.42	8.93	0.36	60	.35
APP	3.42	3.02	0.64	60	.26
SOM	5.74	4.91	0.74	60	.23
MOOD	2.05	3.30	1.75	60	.04[c]
ARF	11.16	10.09	0.63	60	.26
HXL	7.53	10.05	1.71	60	.46[c]
SXL	7.68	8.63	0.58	60	.28
OCC	5.38	3.20	2.05	49	.02[b]

Number of assailants. Individuals were classified into those attacked by a single (N = 52) versus multiple assailants (N = 7). Those having multiple assailants obtained

significantly higher scores on the DOV-S ($\bar{M}$ = 58.29) and DOV-T ($\bar{M}$ = 69.86) than those with single assailants ($\bar{M}$ = 51.02 and $\bar{M}$ = 60.24, respectively). They also indicated significantly more Assault-Related Fears ($\bar{M}$ = 15.86) than others ($\bar{M}$ = 2.93). Finally, multiple assailant victims reported more symptoms at one month postassault ($\bar{M}$ = 21.57) than those with single assailants ($\bar{M}$ = 13.60), F (1.57) = 5.98; $p < .05$. T-test values are given in Table 18.

Table 18

Comparisons of Victims of Single Versus Multiple Assailants

Measure	t	df	p
DOV: S	2.41	57	.02
DOV: T	2.62	57	.01
ARSI-W: ARF	2.95	57	.01

People told during the first 7-10 days. Fifty-three of the individuals who completed the ARSI-W and related measures told at least one other person about the rape within 7-10 days of its occurrence, while nine individuals told no one. No significant differences were found between these groups, however.

If the victim knew the assailant. A DOV-O item asking whether the victim knew the assailant was responded to affirmatively by 26 individuals completing the ARSI-W, and negatively by 34 people. Hypothesis four predicted that individuals knowing their assailant would have more difficulty recovering than if he were a stranger. The sole statistically significant difference was in the opposite direction.

Thus, those raped by strangers reported significantly more disturbance in Assault-Related Fears (t (59) = 2.05, $p < .05$) than did others. The pertinent mean scores were 8.50 versus 11.63.

Presence of threats. Those reporting verbal threats during their assault (N = 40) were compared to those who did not (N = 19). This classification was based on responses to DOV-O item and these groups differed significantly on the DOV-O (t (57) = 7.11; $p < .001$), DOV-S (t (57) = 2.02; $p < .05$), and DOV-T (t (57) = 2.84; $p < .01$).

Presence of weapons. Victims were also grouped into those who reported that their assailants had a weapon (N = 21) and those who did not (N = 37). These data were also obtained from a weapon-inquiring DOV-O item and the only significant difference found between these two groups was on that scale (t (56) = 4.84; $p < .001$).

Use of restraints. Ten victims who reported that their assailants had used restraints such as rope, gag, or blindfold were compared to 45 victims reporting no such restraints. The information for this classification was derived from a DOV-O item, and these groups differed significantly only on this scale, (t (58) = 2.16; $p < .05$).

Sexual events during the rape. Victims were also classified into those whose rape reportedly involved vaginal penetration alone (N = 36) versus those reporting fellatio, cunnilingus, or sodomy (N = 26). These latter cases may have occurred singlely or been combined with vaginal penetration.

Those whose rapes involved vaginal penetration alone were found to rate the degree of violence (DOV-R) as significantly less ($\bar{M}$ = 5.78) than those whose assaults involved Involuntary Deviate Sexual Intercourse (IDSI) ($\bar{M}$ = 7.24), t (59) = 2.14, $p < .05$).

Victims struck. Participants were classified into those reportedly struck by assailants (N = 19) and those not struck (N = 42). The information for this classification was taken from the DOV-O, and the groups differed significantly on both this scale (t (59) = 4.60; $p < .001$) and on the DOV-T (t (58) = 2.87; $p < .01$). Those struck showed greater disturbance evident in several symptom areas, including: Sleep (t (60) = 2.09; $p < .05$), Appetite (t (60) = 2.83; $p < .05$), Somatic disturbance (t (60) = 2.83; $p < .05$), and Heterosexual Relationships (t (60) = 2.65; $p < .05$). The struck group's mean scores on these symptom areas were, 10.90, 4.25, 7.15, and 11.80, respectively, versus 8.21, 2.62, 4.21, and 8.07 means for the nonstruck. Struck victims also reported more symptoms during each time period (see Table 19, p. 130).

Injury. Victims were classified into those having severe (N = 10), mild (N = 26), or no injury (N = 26) following the assault. This information was derived from a DOV-O item. The relevant data analyses are listed in Table 20, p. 130. Significant linkages between the severity of the injury and how violent the assault seemed (DOV-R and DOV-T) were apparent, with the affected DOV scores steadily increasing with the severity of injury. A similar pattern held for the

linkage between the number of present day symptoms and the amount of Appetite disturbance during the three month recovery period.

Table 19

Comparisons of Struck vs. Unstruck Victims

	Means				
ARSI-W	Struck	Not Struck	F-Ratio	df	p
one week	23.20	18.21	5.94	1,60	.02
one month	19.15	13.26	6.77	1,60	.01
three months	13.60	9.41	4.58	1,60	.04
now	10.90	7.10	4.81	1,60	.03

Table 20

Comparisons of Injured vs. Noninjured Victims

	None	Mild	Moderate to severe	F	df	p
DOV: R	5.46	6.60	8.20	4.29	2,58	.02
DOV: T	57.40	63.16	67.78	5.52	2,57	.01
ARSI-W:						
Symptoms now	5.96	10.39	9.10	3.24	2,59	.05
APP	2.54	2.92	5.30	6.80	2,59	.00

Posthoc analysis indicated that the more severely injured obtained higher scores on the DOV-R ($\bar{M}$ = 8.20) and DOV-T ($\bar{M}$ = 5.46 and $\bar{M}$ = 57.41, respectively). The LSD procedure indicated that the mildly injured reported more symptoms at present ($\bar{M}$ = 10.39) than the noninjured ($\bar{M}$ = 5.96), while the Scheffe did not identify any difference between these pairs of groups. Finally, posthoc analysis indicated

that those with moderate to severe injuries evidenced more Appetite disturbance ($\bar{M}$ = 5.30) than those mildly injured ($\bar{M}$ = 2.92) or noninjured ($\bar{M}$ = 2.54).

The arrest of the assailant. The assailants of 24 victims were reportedly arrested while 37 victims reported no arrests as yet. Arrested assailants' victims reported significant fewer symptoms during the three months postassault period (F (1,59) = 10.68; $p < .01$) and at the present day (F (1,59) = 7.60; $p < .01$). Their mean scores at these two time periods were 7.33 and 5.71, respectively, as compared to the substantially larger means of 13.22 and 10.22 for victims of unapprehended rapists. Victim's whose assailants were arrested also evidenced fewer symptoms in several sectors, including Mood (t (59) = 2.29; $p < .05$), Heterosexual Relationships (t (59) = 2.10; $p < .05$), and Sexual Expression (t (59) = 2.82; $p < .01$). Their mean scores on these measures were 2.04, 7.50, and 5.96, respectively, as compared to 3.57, 10.43, and 10.05.

If the case went to court. Victims were further classified into those whose cases had gone to court (N = 16) and those whose cases had not gone to court because charges were not pressed or the trial had not yet been scheduled (N = 15). A significant difference was found in the amount of reported postassault disturbance in Heterosexual Relationships (t (29) = 2.50, $p < .05$), with those whose case had gone to court indicating fewer symptoms ($\bar{M}$ = 6.63) than those whose cases had not ($\bar{M}$ = 10.93).

Court verdict. Only 11 individuals reported court verdicts. In 10 instances the assailant was found guilty, and one "not guilty" verdict had been made. Despite the small size of this sample, comparisons were run between these two groups. However, no significant differences were found.

Contacted professional counselors for rape-related reasons. Fourteen individuals who reported seeking a professional counselor for personal problems due to their assault were compared to 46 who did not. The professional counselor contactors evidenced lower Rosenberg self-esteem (t (57) = 3.67; $p < .001$) and higher Guilt (t (57) = 2.45; $p < .05$) scores. They also reported a significantly greater number of ARSI-W symptoms at one month (F (1,58) = 4.02; $p < .05$), and three months (F (1,58) = 8.84; $p < .01$) postassault, as well as in the present day (F (1,58) = 4.28; $p < .05$). Victims who contacted professional counselors also reported more disturbance in the symptom areas of: Sleep (t (58) = 2.71; $p < .01$), Mood (t (58) = 3.03; $p < .01$), Heterosexual Relationships (t (58) = 2.58; $p < .05$), and Sexual Expression (t (58) = 2.36; $p < .05$). The mean scores on each of these measures were listed in Table 21, p. 133.

Analyses of Data From the Incoming Group

The analyses of measures pertinent to the incoming group alone began with a comparison of the scores obtained from these victims and their matched controls. The remaining data were organized in a manner similar to the format for the data obtained from all victim groups. The independent effect of

each demographic variable on individual responses was assessed. However, given the very small sample size the significant results yielded by this analysis were simply listed in Appendix F (p. 235), and only those findings pertinent to the hypothesis were discussed in the text.

Table 21

Mean Scores on Variables Pertinent to Professional Counseling

	Seekers	Nonseekers
Rosenberg	11.43	7.35
Guilt	11.57	16.60
SLP	12.07	8.22
MOOD	4.71	2.41
HXL	12.43	8.37
SXL	11.43	7.35
One Month	19.07	13.98
Three Months	15.36	9.26
Now	11.65	7.61

Comparison of Control and Incoming Groups. Thirteen incoming members completed all or part of the packet of three week postassault questionnaires. Their scores were compared to those of the 13 matched controls using the one-directional *t*-test, as shown in Table 22, p. 134. Hypothesis 6 had predicted that incoming members would evidence significantly lower self-esteem than the controls, but this was not supported by either of two self-esteem (Rosenberg and Body Cathexis) measures. Hypothesis 9 had predicted that incoming members would show greater heterosexual anxiety and more

isolation than controls. The FSS and Constantinople's Isolation scale scores were used to test this, but no significant differences were obtained. Although Hypothesis 9 was not directly supported, these groups differed significantly on Constantinople's Mistrust and Intimacy scales, with the incoming group members evidencing greater Mistrust and lower Intimacy. Futhermore, the control group members consistently scored in the "healthier" direction on virtually all measures.

Table 22

Means of the Control vs. Incoming Groups

Measure	Incoming	Control	Pairs	t-test	(df)	p
Constantinople						
Trust	22.73	22.73	11	0.00	(20)	.50
Mistrust	18.09	11.82	11	2.21	(20)	.02[b]
Intimacy	25.09	29.37	11	2.79	(20)	.00[a]
Isolation	17.09	14.10	11	1.24	(20)	.12
FSS	52.83	50.42	12	0.47	(22)	.32
Bem's SRI	+0.84	1.82	9	1.44	(16)	.09
Levenson's						
I	33.11	35.89	9	1.09	(16)	.15
C	29.00	24.11	9	1.42	(16)	.09
P	23.22	22.78	9	0.10	(16)	.46
Body Cathexis	29.09	25.82	11	1.25	(20)	.12
Rosenberg	19.82	18.82	11	0.51	(20)	.31
Anger	16.82	12.18	11	1.00	(20)	.16
Guilt	21.73	19.46	11	1.20	(20)	.12

ARSI-O results: Means and correlations. ARSI-O symptom interviews were scored so that each of the nine interviews generated both subscale scores and a total score for that time period. Subscale areas were also totalled over time periods for those respondents who had completed at least five interviews. Each victim's aggregated total across the time periods was divided by the total number of completed interviews. This made it possible to compare symptom area totals across individuals. This selection and compilation procedure yielded data from 18 of the 20 available victims. Only the two who dropped-out of the research project at four weeks were excluded. Table 23, (p. 136) lists these ARSI-O mean scores, variances, and ranges; also the subscale totals. Table 24, (p. 137) shows the intercorrelation matrix of the ARSI-O symptom areas.

The Appetite and Somatic disturbance subscales were found to have strong positive relationships ($p < .01$ and $p < .001$) with Mood and Assault-Related Fears. The subscales of Heterosexual Relationships and Sexual Expression were also significantly and positively correlated ($p < .05$). Interestingly, the central symptom areas on the ARSI-O (Appetite and Mood) were different than those on ARSI-W (Sleep and Occupation). This is probably due to the different systems of scoring for the two symptom area forms. The intercorrelation matrix given in Table 25 (p. 137) displays the linkages between the ARSI-O symptom severity indices over the nine time periods.

Table 23

ARSI-O and Subscale Means, Variance, and Ranges

ARSI-O	Mean	Variance	Ranges
Time periods			
few days	29.90	152.73	0 - 59
one week	24.90	210.10	0 - 52
two weeks	18.05	101.73	1 - 38
three weeks	13.88	103.61	2 - 35
four weeks	15.53	180.77	0 - 50
six weeks	14.82	243.03	0 - 49
eight weeks	7.81	49.90	0 - 22
ten weeks	6.50	22.82	0 - 17
twelve weeks	9.13	85.55	1 - 38
Symptom Areas			
SLP	1.93	1.59	0 - 4.29
APP	0.93	0.59	0 - 3
SOM	1.23	0.98	0 - 3.11
MOOD	3.45	2.97	.50 - 6.50
ARF	4.02	5.30	0 - 8.71
HXL	2.15	2.57	0 - 5.75
SXL	1.22	2.96	0 - 6.63
OCC	1.27	1.22	0 - 4.00

A repeated measures analysis of variance was used to determine whether reported symptoms declined over the nine time periods, and, if so, when the significant changes occurred. A significant difference was evident overall, F (8,1) = 8.51, $p < .0001$, and posthoc analysis with the Scheffe ($p < .10$)

Table 24

Intercorrelations of ARSI-O Symptom Areas

Symptom Areas	SLP	APP	SOM	MOOD	ARF	HXL	SXL	OCC
SLP	—	36	54[c]	63[b]	65[b]	15	26	44[c]
APP	36	—	47[c]	60[b]	76[a]	52[c]	61[b]	12
SOM	54[c]	47[c]	—	65[b]	65[b]	-01	-05	25
MOOD	63[b]	60[b]	65[b]	—	79[a]	26	42	46[c]
ARF	65[b]	76[a]	65[b]	79[a]	—	38	31	33
HXL	15	52[c]	-01	26	38	—	53[c]	08
SXL	26	61[b]	-05	42	31	53[c]	—	10
OCC	44[c]	12	25	46	33	08	10	—

Table 25

ARSI-O Severity Indices Intercorrelated

	FD	1	2	3	4	6	8	10	12
Few Days	—	89[a]	66[b]	29	51[c]	59[c]	40	07	08
Week 1	89[a]	—	66[b]	27	30	40	27	08	51[c]
Week 2	66[b]	66[b]	—	59[b]	48[c]	36	59[b]	75[b]	25
Week 3	29	27	59[b]	—	47[c]	29	52[c]	88[a]	12
Week 4	51[c]	30	48[c]	47[c]	—	83[a]	54[c]	36	11
Week 6	59[c]	40	36	29	83[a]	—	66[b]	-07	-02
Week 8	40	27	59[b]	52[c]	54[c]	66[b]	—	56[c]	09
Week 10	07	08	75[b]	88[a]	36	-07	56[c]	—	18
Week 12	08	51[c]	25	12	11	-02	09	18	—

indicated that symptom severity declined significantly from a few days to eight weeks postassault, and remained low at ten ($p < .10$) and twelve ($p < .05$) weeks. Although the mean symptoms declined rather consistently between a few days

postassault and six weeks, these differences were not statistically significant.

Questionnaire results: Multiple administrations. Incoming members completed the Anger, Guilt, and TSCS measures at three different time periods. The relevant means are listed in Table 26 (p. 139). A repeated measures analysis of variance was made on the scores from individuals completing all three administrations of a given measure to determine if any score changed with amount of postassault time. The Anger scale yielded an F (2,5) = 1.32; p = .30; the Guilt F (2,6) = 0.75; p = .49, and the TSCS F (2,6) = 0.90, p = .43. Thus, no significant changes occurred over time on any specific scale, but their consistently positive trend was impressive and probably statistically significant.

Questionnaire results: Single administrations. Several measures were administered only once to incoming victims. Of these, the DOV, Rosenberg, and ARSI-W have been previously discussed. The remaining one-time measures, their means, and the number of incoming members completing them are listed in Table 27 (p. 140).

Correlation matrices for all questionnaires. Pearson correlations were calculated between each of the major single-administration measures (see Table 36, Appendix D) and also between these and the multiple administration measures (see Table 37, Appendix D). Hypothesis ten had predicted that the more violent the perceived rape experience, the more heterosexual anxiety and mistrust, and the less trust would

be evidenced. The FSS and Constantinople's Trust and Mistrust subscales were correlated with the DOV subscales and total score but the DOV-S, DOV-R, and DOV-T did not correlate significantly with any of the expected measures (see Appendix D). The DOV-O, which was least expected to exert an effect, as it tapped objective rather than subjective impressions, correlated negatively and significantly with the FSS (r = -.67, $p < .05$). Twelve or fewer victims provided data for each of these correlations.

Table 26

Mean Anger, Guilt, and TSCS Scores of Incoming Members

Measure	Members completing all three administrations	(N)	Members completing any administration	(N)
Anger				
few days	26.63	(8)	29.64	(11)
three weeks	21.25	(8)	19.55	(11)
twelve weeks	16.75	(8)	16.82	(11)
Guilt				
few days	24.78	(9)	25.44	(16)
three weeks	24.44	(9)	23.62	(13)
twelve weeks	22.56	(9)	21.73	(11)
TSCS				
few days	313.33	(9)	318.36	(14)
three weeks	315.11	(9)	322.39	(13)
twelve	323.89	(9)	327.80	(10)

Note. Only those who completed all three administrations of Anger (8), Guilt (9), and TSCS (9) were used in subsequent analysis.

Table 27

Incoming Victims Scores on Single-Administration Questionnaires

Questionnaire	Mean	N (Of 20 Maximum)
Constantinople		
Trust	22.73	11
Mistrust	22.73	11
Intimacy	18.09	11
Isolation	25.09	11
Bem Sex Role Inventory	0.68	9
Levenson		
Internal	33.11	9
Control	29.00	9
Powerful Other	23.22	9
Body Cathexis Scale	29.09	11
Fear Schedule Survey	52.83	12
Thematic Apperception Test	4.55	11
Profile of Moods State	95.46	13
Religious Commitment	3.27	15
Life Experience Survey		
Negative Change	3.88	15
Positive Change	1.97	15
Total Change	2.21	15
Support System		
Number of People Listed	7.47	15
People That Wanted To Tell	4.00	14
People Told About the Rape	4.20	15
Level of Helpfulness	4.21	14

Hypothesis 12 had predicted that the greater the reported Mood disturbance (POMS and TMD scores) at 7 to 10 days postassault, the more guilt and negative life change in the year preceding the assault would be reported. Conversely, it was assumed that high religious commitment, positive self-esteem, and a support system rated high in helpfulness would correlate negatively with this score. Pearson correlations were determined between these measures (see Appendix D, pp. 227-229). Measures of self-esteem included the Rosenberg, TSCS, and the Body Cathexis Scale. The POMS-TMD evidenced a positive, significant relationship with the Body Cathexis Scale (higher BSC scores denoted more negative body stature self-esteem). This finding partially supported the hypothesis. However, the POMS yielded no other significant linkages with self-esteem measures. POMS-TMD correlated only -.03 with LES negative although total LES total changes scores linked positively (.57) and significantly to total Mood Disorder (POMS). At two to five days postassault the Guilt measures nearly linked (r = .50) to POMS-TMD, but subsequent Guilt scores correlated more weakly.

Pearson correlations were also calculated between each questionnaire completed by incoming group members and their ARSI-O score for each of the nine time periods. Although the number of victims completing many of the questionnaires was small, these linkages proved interesting. Correlations between the ARSI-O and self-esteem (e.g., the Rosenberg, TSCS, and Body Cathexis Scale) yielded statistically significant

linkages between the Rosenberg and symptom severity at four weeks postassault; also between the Body Cathexis Scale and symptom ratings on several occasions, (see Table 28).

Table 28

Correlations of Self-Esteem Measures With ARSI-O Symptom Profiles

	Postassault Times							
	Few Days	W-1	W-2	W-3	W-4	W-6	W-8	W-10	W-12
Rosenberg	20	09	12	-08	59[c]	38	54	-20	49
Body Cathexis	69[b]	79[b]	33	29	26	57[c]	73[c]	-39	23
TSCS - 1	05	10	-21	08	-29	-46	-51	-35	32
TSCS - 2	-27	-24	-03	22	-14	-42	-03	-35	-16
TSCS - 3	42	32	66[c]	49	-02	02	03	31	-09

Over these time periods low self-esteem and a negative body image tended to link with the amount of general postassault disturbance. The TSCS linked more erratically to disturbance, yielding 15 negative and 12 positive correlations, including solo positive and negative values that reached significance.

ARSI-O disturbance generally correlated positively with the several mood measures, including the POMS, Anger, Guilt, and TAT rating of Anger (see Table 29, p. 143). The POMS, administered seven to ten days postassault, rather consistently linked positively and significantly to symptom severity. The scores from Anger's first administration correlated positively and significantly with symptom severity at two and eight weeks postassault, while Anger's final administration at twelve weeks linked oppositely to early postassault symptom severity ratings.

Table 29

Correlation of Measures of Mood with ARSI-O Symptom Profiles

		Time							
Measures	FD	1	2	3	4	6	8	10	12
POMS	48[c]	63[c]	67[b]	72[b]	49	49	72[b]	84[b]	45
Anger: 1	48	52	71[b]	77[b]	38	42	44	80[c]	16
: 2	41	41	53[c]	72	04	35	61[c]	36	38
: 3	-68[c]	-65[c]	-38	11	-36	-52	-23	37	09
Guilt: 1	02	05	21	29	47	52[c]	67[b]	50	-27
: 2	30	23	43	11	39	46	64[c]	65[c]	80[b]
: 3	29	01	46	12	38	31	30	02	19
TAT	20	33	54	14	65[c]	59[c]	63[c]	15	12

Guilt scores had somewhat fewer significant bonds (5 of 27) to ARSI-O symptom profiles. However, initial Guilt (1) scores correlated positively with symptom severity indices at six and eight weeks postassault and Guilt 2 scores similarly linked with symptom severity at eight, ten, and twelve weeks postassault. Representing disguised anger, the TAT index yielded positive and significant correlations with symptom severity at four, six, and eight weeks postassault despite its very weak linkage (r = .14) at three weeks postassault. The various support system measures (i.e., the number of people in it, the number she wished to tell about the rape, the number finally told, the average level of helpfulness), failed to yield any significant correlation with the symptom severity at any of the nine time periods. Although not attaining statistical significance, eight of the nine

correlations between the helpfulness of ECRCC counselors and symptoms were positive in direction. Of the remaining questionnaires, only Constantinople's Trust and Mistrust subscales, Bem's SRI t-ratio, and LES negative and total change scores yielded any significant correlations with symptom severity indices (see Table 30 on p. 145). The Trust scale correlated negatively with indices at the four and twelve week postassault points, while the Mistrust subscale correlated positively with the disturbance at a few days postassault. Levenson's Control scale correlated negatively with severity indices at two, eight, ten, and twelve weeks postassault. Bem's t-ratio scores correlated positively with symptom severity scores at a few days postassault. LES total change scores obtained significant, positive correlations with symptom severity at two weeks postassault, while LES negative change scores correlated positively with those at four to six weeks postassault. Overall, however, few statistically significant correlations were found between the number of reported symptoms and the questionnaires cited in Table 30. Two factors to be considered for their influence was the small number of respondents, and the decreasing number of victims completing symptom interviews as the time postassault progressed.

Pearson correlations calculated between each questionnaire index and ARSI-O symptom areas are depicted in Tables 31 through 34. Among the self-esteem measures, the Rosenberg correlated positively and significantly with the amount of

Table 30

Questionnaires Correlations With ARSI-O Symptom Profiles

	Time in Weeks Postassault								
Measures	FD	1	2	3	4	6	8	10	12
C: T	-38	-02	-11	-16	-60[c]	-34	-49	-57	-83[b]
: MT	60[c]	22	39	25	52	48	17	32	35
: IN	-26	-21	10	39	16	-27	28	38	08
: IS	41	18	06	-27	12	34	-16	-26	12
L: I	-31	-19	-51	-25	-14	-12	-39	-85	-65
: C	-36	-48	-67[c]	-13	-04	-22	-76[c]	-96[c]	-67[c]
: P	-27	-51	-51	-37	21	09	-32	-20	-53
FSS	31	22	45	12	36	25	48	-18	38
SRI	59[a]	26	21	03	33	40	12	11	56
Religion	33	14	27	43	27	23	03	39	19
LES: N	18	-14	-29	-20	68[b]	61	-12	-14	-21
: P	33	31	20	22	22	40	20	04	00
: T	48	44	56[c]	39	30	40	11	31	-07
DOV: O	01	-01	22	26	20	-01	08	44	21
: S	13	01	-11	30	32	12	-17	26	08
: R	00	01	-10	30	-10	-27	-28	35	08
: T	19	07	-06	36	36	18	-10	30	15

disturbance rated in Heterosexual Relationships (see Table 31, p. 146). The TSCS yielded no significant correlations, while the Body Cathexis scale was positively and significantly correlated with disturbances in Sleep, Mood, Sexual, and Occupational areas. It should again be noted that high scores on the Rosenberg and Body Cathexis indicated low

self-esteem, while the opposite was true for the Tennessee.

Table 31

Correlation of Self-Esteem With ARSI-O Symptom Areas

	Symptom Area							
Measures	SLP	APP	SOM	MOOD	ARF	HXL	SXL	OCC
Rosenberg	01	28	-08	15	-01	67[c]	43	17
BSC	65[c]	32	20	78[b]	29	21	59[c]	69[c]
TSCS: 1	-37	-50	-29	-25	-15	-34	-28	19
TSCS: 2	04	-31	-29	04	-13	-35	-07	-16
TSCS: 3	32	38	-20	20	33	-19	48	16

The POMS Mood measure correlated positively and significantly with disturbances in Sleep, Appetite, Mood, Assault-Related Fears, and Occupation (see Table 32, p. 147). The TAT score correlated positively and significantly with disturbance in Appetite, Heterosexual Relationships, and Sexual Expression. The Anger and Guilt scales correlated with several symptom areas, as depicted in Table 32, (p. 147). Support system measures again failed to correlate significantly with ARSI-O symptom area scores (see Table 33, p. 147). LES total change scores correlated positively with the areas of Appetite disturbance and Assault-Related Fears, while other LES scores obtained no significant correlations (see Table 34, p. 148). The DOV-O correlated significantly with Somatic disturbance and Assault-Related Fears, while the DOV-S and DOV-T correlated significantly with Sleep disturbance.

Table 32

Correlations of Mood Measures With ARSI-O Symptom Areas

	SLP	APP	SOM	MOOD	ARF	HXL	SXL	OCC
POMS	53[c]	65[c]	34	83[b]	76[b]	39	39	65[c]
Anger: 1	20	77[b]	05	56	78[b]	58	44	14
: 2	-08	72[b]	14	72[b]	70[c]	37	54	05
: 3	-53[c]	-20	-10	-38	-13	-33	-43	-91[a]
Guilt: 1	49[c]	46	33	46[c]	33	41	13	-10
: 2	18	65[c]	49	40	61[c]	48	22	-13
: 3	08	48	-16	-07	15	59[c]	57[c]	37
TAT	26	64[c]	-25	39	44	83[b]	73[b]	46

Table 33

Correlations of Support System Measures With ARSI-O Symptom Areas

Measures	SLP	APP	SOM	MOOD	ARF	HXL	SXL	OCC
# Supports	-22	-28	-13	-11	-33	-03	02	-22
# Wanted to tell	00	-14	21	39	03	-10	05	08
# Told	22	-10	07	36	-05	-15	25	26
Helpfulness	22	24	36	17	43	21	-36	-20
ECRCC Helpfulness	00	21	-29	-05	38	27	-01	-01

Summary of the Results Regarding Each Hypothesis

Before concluding this chapter on data analysis, the evidence supporting each hypothesis will be reviewed and summarized.

Hypothesis one stated that the incoming group would describe more severe symptoms at the time of the research

Table 34

Correlations of Questionnaires With ARSI-O Symptom Areas

	Symptom Areas							
Measures	SLP	APP	SOM	MOOD	ARF	HXL	SXL	OCC
C: T	17	-69[a]	-02	-11	-55	-51	-48	32
: MT	29	78[b]	23	09	63[a]	30	51	14
: IN	18	-09	-29	15	02	-09	12	-02
: IS	05	39	22	-22	15	15	17	04
FSS	-08	63[a]	-36	10	27	64[a]	67[a]	10
SRI	-30	78[a]	-15	05	61	43	42	-20
Religion	59[b]	30	57[a]	26	44	-29	09	30
Levenson: I	30	-62	-09	-22	-73[a]	-01	-36	-55
: C	-09	-24	-21	-54	-10	-20	-66[a]	-39
: P	-16	-27	-21	-66[a]	-40	36	-30	-14
LES: N	28	04	25	-26	04	44	-04	18
: P	40	44	21	24	35	20	26	43
: T	27	49[a]	31	34	52[a]	09	31	30
DOV: O	29	21	67[b]	34	43[a]	-22	-27	17
: S	43[a]	-09	15	17	12	37	00	22
: R	21	-24	-19	15	-06	18	03	08
: T	47[a]	-01	28	26	22	34	01	25

Note. The following abbreviations were used: Trust (T), Mistrust (MT), Intimacy (IN), Isolation (IS), Internal (I), Control (C), Powerful Others (P), LES negative change scores (LES: N), LES positive change scores (LES: P), and LES-total change scores (LES: T).

participation than would the other victim groups. Data analyses revealed that incoming members did not report significantly more symptoms during the "present day" ARSI-W category nor, in fact, at any time periods. Of the eight sampled areas of Assault-Related disturbance, incoming members significantly exceeded the others only for Somatic disturbances. Self-esteem (Rosenberg), Anger, and Guilt were also examined. The incoming victim's scores did not significantly differ on these measures from the other two victim groups. Overall, this hypothesis was very weakly supported.

Hypothesis two stated that persons raped in their own home would have more severe symptoms, particularly in the area of rape-related fears, than would victims assaulted elsewhere. The total victim group was considered in its initial test and yielded no support. The home-assaulted did not differ significantly on the ARSI-W from the others at any of the four time periods. In fact, the home-assaulted showed significantly fewer symptoms (Heterosexual Relationships and Sexual Expression) in two of the ARSI-W's eight symptom areas. Only for Occupation did the home-assaulted evidence more severe disturbance than others. Also examined were data that assessed the amount of Assault-Related disturbance less directly. The home-assaulted evidenced significantly more positive self-esteem on the Rosenberg, less Anger, and lower degree of violence (DOV-S and DOV-T) than victims assaulted elsewhere.

The three home-assaulted incoming victims evidenced

significantly lower self-esteem only on the TSCS's second administration (of three) than did the ten assaulted elsewhere (see Appendix D, p. 227). No other self-esteem measure supported this difference. The same victims also scored lower on Constantinople's Intimacy scale, but higher on Levenson's Internal locus of control. On the ARSI-O's direct measures of symptoms, however, no significant differences were obtained. Overall, the ARSI-W and ARSI-O yielded little support for hypothesis two and some evidence was contrary. Other measures provided no substantial support.

Hypothesis three stated that victims having a previous history of psychological problems would have more severe postassault symptoms than others. The total victim group yielded some support. Those having preassault mental health counseling evidenced more severe symptoms on the ARSI-W's "now" category and more distress in three of eight sectors: (Mood; Assault-Related Fears; and Heterosexual Relationships). Precounseled victims also scored higher on the Guilt index.

Hypothesis four held that victims assaulted by a trusted other would have lower self-esteem than those raped by strangers. Although the Rosenberg self-esteem measure was administered to all victims, it failed to differentiate among those raped by strangers and acquaintances. A significant related difference was found only on the ARSI-W index of Assault-Related Fears where stranger-assaulted victims showed more fears. Hypothesis four was rejected.

Hypothesis five stated that the self-esteem of incoming

victims rise from their first few postassault days to three months postassault. A repeated-measures analysis of variance failed to reveal any differences between the TSCS self-esteem scores collected at three different postassault times nor was the trend of these means in the hypothesized direction.

Hypothesis six held that the group of incoming victims would show lower self-esteem at three months postassault than would controls and other victims. Rosenberg scores failed to differentiate between these groups. Comparisons of their scores on the Rosenberg and Body Cathexis scale also yielded no important differences. Thus, hypothesis six was rejected.

Hypothesis seven stated that victims adhering to the traditional stereotyped female sex-role would report less anger and more guilt than those having a more androgynous sex-role identification. Of the nine victims who completed the Bem Sex-role inventory, only one fit the feminine role criterion, and only three could be classified as androgynous. One of the latter dropped-out of the research at six weeks postassault when she had completed only one administration of the Guilt index and Anger measure. Further data analysis seemed inappropriate. Thus, hypothesis seven was untested and informal clinical impressions did not support it. The sole feminine-identified victim reported strong anger and guilt feelings to her interviewer (the author) during her initial postassault weeks. This was also true for one androgynous victim who reported strong feelings of guilt but minimal anger until several weeks postassault.

Hypothesis eight stated that victims who expressed high amounts of guilt would show lower self-esteem than those who expressed relatively little guilt. Analyses of their Rosenberg and Guilt scores for the total victim group supported this hypothesis. These measures correlated positively and significantly, indicating that as self-esteem increased, Guilt decreased. The Body Cathexis Scale also correlated significantly and positively with first administration Guilt scores for the ten victims who completed both measures. Additional supportive findings were yielded by the significant correlations, depicted in Table 35, between the postassault on TSCS self-esteem measure and Guilt. Thus, hypothesis eight was strongly supported.

Table 35

Correlations of TSCS With Guilt for Incoming Victims

	Guilt		
	1	2	3
TSCS 1:	-68[b] (N = 14)	-66[c] (N = 11)	-53
2:	-18	-65[c] (N = 12)	-43
3:	54	-42	03

Hypothesis nine stated that incoming victims would show greater heterosexual anxiety and more isolation than the other victims. This hypothesis was tested by the Fear Survey Schedule (FSS) and Constantinople's Isolation scale, but no significant differences were found. An examination of secondary measures disclosed that the incoming victims had scored significantly lower than others on Intimacy, the

Isolation scale's polar opposite. The incoming victims also scored significantly higher on Mistrust than did the controls. Thus, although Hypothesis nine was not directly supported, the Isolation and Mistrust measures yielded significant differencs in the predicted direction.

Hypothesis ten stated that victims who perceived their rape as particularly violent would manifest greater heterosexual fears, lesser interpersonal trust, and a higher incidence of sexual difficulties than those who perceived their assault as relatively less violent. The DOV-S and DOV-T were used to assess the perceived violence. The total victim pool provided data for correlations of ARSI-W total scores with DOV-S and DOV-T in the sectors of Heterosexual Relationships and Sexual Expression. Significant correlations were obtained between each DOV index and the two pertinent ARSI-W symptom disturbance sectors (see Table 16, p. 119). Incoming victim's data were further examined to determine whether the predicted linkages also held between the ARSI-O totals in the Heterosexual Relationships and Sexual Expression sectors with the FSS and Trust measures. DOV-O correlated significantly but inversely (-.67, $p < .05$) with FSS, and the Trust and DOV measures yielded no other significant correlations. Overall, this hypothesis was only modestly supported.

Hypothesis eleven stated that incoming victims of assailants not yet apprehended would report less anger their first postassault week than victims of nonarrested assailants. It was supported by the comparisons of initial Anger

scores of the two incoming victims whose assailants had been arrested were compared with the nine others. Significant differences were not found between these two groups on Anger scores administered at seven to ten days postassault as part of the POMS (t (11) = .80, $p < .44$), nor at any subsequent time period. Thus, this difference was obtained only during the initial two to five postassault days. Similarly, no significant Anger differences were found between victims whose assailants had been arrested and those whose assailant were not yet apprehended among the total victim group.

Hypothesis twelve held that both the amount of negative life changes in the year preceding the assault and the intensity of guilt would correlate positively with the amount of mood disturbance reported at seven to ten days postassault. The degree of religious commitment, the helpfulness of support systems, and positiveness of the self-concept were also predicted to correlate negatively with postrape mood disturbance. Incoming victims' POMS scores were correlated with the LES negative change score and also with the three administrations of the Guilt index. No significant relationships were found, although the POMS and LES total change scores did link positively. Similarly, correlations were calculated between the POMS and religious commitment, the average level of helpfulness of the support system, and self-esteem measures provided by Rosenberg, TSCS, and the Body Cathexis indices. The only significant linkage found was between the POMS and low self-esteem about bodily features on

the BCS. Thus, this hypothesis received only minimal support.

Overall, only Hypotheses two, eight, nine, and ten received moderate to strong support. Hypotheses one and twelve received very weak support, and Hypothesis seven could not be tested.

Discussion

The present study attempted to increase the amount of empirical information available on rape victims reactions while avoiding many of the earlier research design problems criticized by Katz and Mazur (1979). To this end, the present definition of rape and the criteria for selecting victims were clearly defined. Interviews were standardized and supplemented with personality inventories. The length of time postassault was carefully considered and reported. A control group was also employed. To the author's knowledge, this was the first study to recruit a sample of uncounseled rape victims, to design and utilize a measure tapping the victim's perception of the degree of violence, and to rigorously explore the independent effect of demographic variables on victim symptom profiles. The typical reaction patterns of victims is first discussed in this chapter, followed by a consideration of several specific findings.

Reaction patterns. The pattern of symptoms observed among the present adult and adolescent victims were found to be quite consistent with the pattern of results described by other investigators of the rape trauma syndrome (Peters, 1975; Burgess & Holmstrom, 1979). Acute life disruption was followed by a gradual reduction in symtomatology.

Pseudoadjustment periods were common although victims differed dramatically in the length of time spent in this phase ranging from a few days to a few months. The adolescents seemed particularly likely to remain in a lengthy pseudoadjustment period and reported fewer symptoms at one month postassault. Even when symptoms were present and clearly assault-related, some of the teenage victims continued to insist they were no longer effected in any way by the rape. This period of denial usually faded as the length of time postassault increased.

Sleep disturbances were common in victims of all ages particularly the first week postassault or preceding preliminary hearings and other court actions. For example, several victims noted they had trouble falling asleep, for each time they closed their eyes they would see the assailant's face or hear noises in the house that alarmed them. Three victims slept in their clothes for several nights to reduce feelings of vulnerability. Nightmares were common with many individual differences noted in whether the assault was directly portrayed, or veiled in symbols. An example of the first concerned a woman who could not consciously recall the assault or assailant as she had been knocked unconscious during the rape. However, she had repetitive nightmares in which the assailant's hands could be seen striking her and she would awake screaming and retching. Eventually the dreams expanded to include the assailant's face, and this shift elicited a less intense reaction. More veiled content occurred in a

woman brutally beaten and raped in her own car. She dreamed that she was also in a car and was suddenly attacked by a skunk that seized her arm with its teeth and would not let go despite her struggle. This dream terrified her, but she had not recognized it as assault-related until it was discussed in counseling.

Appetite disturbances were also common, particularly the first few weeks. The most common symptoms were weight losses of three to five pounds, stomach cramps, reduced appetite, feelings of nausea, and occasional vomiting. These symptoms generally disappeared quickly, although several individuals complained of a persistent "queasy" or "tight" feeling in their stomachs for some weeks after the assault. One adult described this as "it feels like something is kicking and wants out." An adolescent evidenced anorexic-like symptoms during the first and second postassault month which appeared resolved by the third. Other Somatic symptoms included headaches, fatigue, diarrhea, and stomach cramps.

The report of crying jags, trembling, or, conversely, feeling in a daze was common the first several days. Increased feelings of depression, anger, guilt, and anxiety in the weeks that followed were frequent, and three of the incoming victims attempted to self-medicate their emotional discomfort with alcohol and/or minor tranquilizers. A tremendous range of individual differences was seen in the intensity of emotional upheaval and the manner in which it was manifested and coped with. Vague suicidal ideation was present

in a few victims (e.g., "I'd like to go to sleep and not wake up"), but only one incoming rape victim actually attempted it. She was a 15 year-old adolescent who had preassault problems stemming from a dysfunctional family, but no previous history of suicide attempts or mental health counseling. She had been sexually assaulted by a stepfather over a two-year period as a child, an event she had never told anyone about. This experience was not revealed to Rape Crisis personnel (despite direct questioning) until she was hospitalized following her attempt on her life. Before the attempt, the victim was denying any assault-related aftereffects although increased acting out at home and with friends was noted. She cited her taking of 30 muscle relaxant pills before notifying the parent of a friend as primarily due to feelings from both sexual assaults combined with her distress over her family situation. She continued to threaten suicide during her week of medical hospitalization and refused psychiatric aftercare. Within a week of release, it was necessary to involuntarily commit her to an inpatient psychiatric unit as she remained suicidal and evidenced early anorexic symptoms. She "fell in love" with a 44 year-old patient on the Unit who treated her "like a father". Following the inevitable posthospitalization end to this romance, the victim's recovery from the assaults remained slow and protracted, although she stopped reporting suicidal ideation.

Several women found the intensity of postassault emotion frightening and expressed fears that they were "going

crazy". Victims with prior histories of mental health problems frequently feared the present upheaval would precipitate relapses. Again, victims who had characteristically handled strong affect by repression and denial applied these coping stategies to the rape as well. Handling anger was often particularly problematic, and most victims reported greater irritability toward others. Several of the adolescents reported uncharacteristically angry outbursts at school. Several women described feeling frustrated and confused regarding how to direct and manage their rage and the desire for revenge that they felt toward the often unapprehended assailant. This issue seemed more quickly resolved by victims whose assailant had been arrested, perhaps as these women could hope for some revenge or vindication through the criminal justice system. Statistically, this seemed supported as victims whose assailants were arrested reported fewer symptoms in the areas of mood, heterosexual, and sexual disturbance by the three month postassault period. Interestingly, at this point few of those cases had actually yet reached criminal court, rather the women typically were still waiting for the trial to be scheduled. However, knowing the assailant was arrested, and feeling that detectives and the district magistrate had believed her story, seemed to lead to an earlier sense of closure than if the assailant was still at large. It also may have been easier to reduce generalizing feelings about the assailant and his actions to other men and life situations, as the specific offender was caught and the

victims therefore did not feel quite as "on guard" against a possible reoccurrence.

Victims often expressed anger about their own symptoms. One woman who had previously prided herself on her self-confidence and independence found her intense postrape fear of leaving her home and consequent lifestyle changes infuriating. Another described how angry she felt to think that "he (the rapist) is out there walking around scot-free while here I sit with my life twisted all around."

Assault-related fears appeared universal and, as per Kilpatrick, Veronen, and Resick's (1979) findings, also appeared to be among the most persistent of symptoms. Fear of the dark or being alone appeared common no matter where the assault had occurred. Objects or situations reminiscent of the assault also often elicited strong fear and avoidance responses. For example, an adolescent whose assailant had grabbed her from behind attempted to go rollerskating one week postassault but became so unnerved by hearing other skaters come up behind her that she fled in tears to the ladies room. Typically, fears were of sufficient intensity the first few weeks that victims changed their lifestyle to some degree to accomodate them. Examples of this included refusing to be alone, crossing the street whenever an unknown male approached, and moving back in with parents. Gradually, the victims began to tentatively approach fearful situations, testing their ability to resume their lifestyle without incurring another assault. With increasing success,

their fears lessened. By twelve weeks postassault specific fears were often greatly reduced or absent, although wariness or anxiety in those situations was still common. This reaction pattern appeared to follow a classical conditioning paradigm, such that events paired with the aversive stimuli (the rape) obtained the ability to independently stimulate similar feelings of fear, flight responses, and anger. As the victims were encouraged to reapproach these objects through counseling, and no aversive results occurred, the conditioned fear responses began to extinguish. Kilpatrick, Veronen, and Resick (1979) attributed the increased fear and anger with men, and the victim's frequently reported sexual dysfunction as also due to this paradigm. The present findings seem congruent. The presence of a supportive male, either boyfriend or husband, with whom the victim could "test out" her fears, was often later defined by the victims as a strong positive factor in recovery. The fear that the assault might adversely affect future sexual functioning was a common initial concern among both adult and adolescent victims. Women in positive relationships with a male were able to test out this concern, discover whether any sexual difficulties existed, and, if so, discuss them in counseling. Adolescents and individuals not involved in a significant heterosexual relationship did not seem to be able to allay their anxiety as quickly, and often avoided dating early in the postassault period. Dating-avoiders often noted their primary reason was a concern that their date might also assault them. One

observed that as she walked around her college town she found herself preoccupied by the thought that some of the men probably were, or could be, assailants, and that she had no way of distinguishing them from the others. A fourteen year-old victim described similar fears, and further stated she also feared she would kick or punch any date that tried to kiss her. Conversely, one adolescent responded to her anxiety by deciding to engineer her first affair to ascertain if she was "sexually normal". Thus, great individual differences existed in how victims dealt with heterosexual and sexual concerns.

It also was notable that three women in the incoming sample (about 11%) were involved in marriages or relationships in which they had been abused by mates during an earlier time period. In each instance, this problem had been addressed and no battering had occurred for six months or longer before the assault. However, two of these women were again beaten by their mates during the first three weeks postassault, and identified the rape as the cause. Interestingly, both men involved had initially verbalized support and understanding when interviewed in the emergency room. This phenomena seemed to reflect the general clinical finding that rape victims involved in dysfunctional male-female relationships often experienced a dual crisis: (1) the rape, and (2) the crisis precipitated by their mate's response to it which frequently led to deterioration of their relationship.

Finally, problems at work during the acute phase of disruption were common with lack of concentration, absenteeism,

social withdrawal, and decreased efficiency the most frequent symptoms. Co-workers and supervisors frequently noticed and inquired about these changes. The adolescents in the sample frequently had told a friend of the rape who told another friend who told another, etcetera, and they then had to deal with the discomfort of entering school having more peers aware of their assault then they initially wished. Adolescents were less likely to confide in teachers and principals than were adults to their supervisors. Concentration in the classroom frequently suffered, and grades often dropped.

Primary finding: The impact of violence. The two factors which were most strongly related to a more difficult recovery (as defined by more symptoms over several ARSI symptom areas and times) were the degree of violence present in the assault, and whether the victim was struck or not. The DOV-T scores correlated significantly and positively with five of the eight ARSI-W symptom areas, and with the number of symptoms reported at each time period. That is, the number of symptoms often linked directly to how much violence had been experienced. The subscale eliciting the victim's perception of this (DOV-S and DOV-R) were more closely related to symptom profiles than was the DOV-O. In fact, the DOV-O did not correlate significantly with any symptom area, nor with the number of symptoms reported at any given time.

Being struck during the rape appeared to be the demographic variable which exerted the strongest independent effect on recovery. Thus, the 19 victims who had been struck,

once or repeatedly, reported more symptoms at every sampled postassault period and evidenced greater disturbance in four of the eight symptom areas than did the 42 nonstruck victims. The most severe and dramatic postassault symptoms, i.e., anxiety attacks, amnesia, and a suicide attempt all occurred in victims who had been struck although this certainly was not the only influential factor.

These findings are consistent with the recent literature in rape victimology which has emphasized that rape must be understood primarily as an act of violence and power, rather than as an act of passion or sex. Burgess and Holmstrom (1976) noted that the most predominant affective response of victims immediately following a rape was not guilt or shame, but relief at being alive and unmutilated. Veronen and Kilpatrick (1981) administered a Modified Fear Survey to 20 rape victims and their content analysis indicated it was the violent, rather than the sexual, aspects which victims viewed as most fear-engendering. Thus, whether the motive of the assailant was for sexual pleasure, power, degradation, or combination of these, the victim primarily experienced and responded to the violence.

Becker, Abel, and Skinner (1979) expressed concern that the recent literature overlooked the sexual component of the assault. They stated that:

> "The most common conceptualizations of rape are those of a crime of aggression, power, degradation and anger. We agree with this conceptualization in part but feel as do other researchers in the rape field that the sexual component of a rape should

> not be overlooked because: (a) of the negative effect that the sexual component may have on a victim's sexual attitudes, behaviors and feelings after assault and (b) there is data available that indicates that the rapist is motivated not only by anger and aggression but is also sexually motivated."

While the sexual aspects of the assault frequently concerned and distressed victims, and therefore were addressed in counseling, the sexual components of the rape per se exerted little significant effect on the recovery pattern in the present study. That is, whether the victim was a virgin or not, whether previous sexual experiences were positive or negative, or whether vaginal rape alone or a mixture of sexual acts had occurred, the effects on the recovery pattern of the victims were minimal. What did seem to negatively influence the woman's subsequent sexual expression was the physical violence within which the genital contact was couched. This violence again seemed to serve as the unconditioned stimuli effecting a panoply of objects, situations, and events associated with the assault including sexuality. Sexual aspects of the rape which particularly disturbed the present victims were the presence of oral or anal sex, degrading comments made regarding the victim's body, and the rupturing of the hymen if the victim was a virgin. In regards to the last item, some of the adolescents had highly valued their virginity, regarding it as evidence of their ability to stand by their values and convictions. In defining the rape as, in part, a loss of virginity, one teen noted "when he took my virginity it was like he took my pride..... what made me different than the other girls."

Present day symptoms in the uncounseled group. Another major finding was that uncounseled victims, the majority of whom had been raped an average of six or more years before the research, reported essentially an identical mean number of present day symptoms as did incoming victims raped only three months before the survey. The uncounseled group mean score of ten symptoms suggested that most of these victims were still experiencing significant distress rather than a mild residual effect. This interpretation appeared supported by Burgess and Holmstrom's (1979) four to six year followup study of the women from their initial survey (all of whom had received some degree of crisis intervention treatment) in which 74% of their sample described themselves as fully recovered within the first five postassault years. It appears that the uncounseled victims, as a group, experience greater difficulty resolving the assault than do counseled victims, and that the former experience assault-related distress over a longer period of time. If confirmed in a larger scale study this would emphasize the importance of crisis intervention and advocacy services for rape victims. Followup studies comparing the pattern of symptoms evidenced by counseled and uncounseled victims also appear essential to determine whether they experience differential symptom patterns.

Previous sexual assaults. A third finding was that an unexpectedly high percentage of the control and incoming group members acknowledged a previous history of sexual assault involving either rape, attempted rape, child

molestation, or incest. National Crime statisticians have long been aware that many sexual assaults were unreported, and that the percentage of sexual assault victims among the general population was probably significantly higher than present statistics reflected. What the percentage would be, however, has remained unknown.

In the present study 21% of the total victim group, and 25% of the group initially surveyed to act as controls, had been victims. Shuker (1979) had noted similar percentages among her rape victim clients and accounted for this "recidivism" by noting that such victims often lived in unsafe neighborhoods or appeared more vulnerable than other women. In the present sample, a higher percentage of women from lower socioeconomic groups was represented than would be present in a random sample of the general population and national surveys on crime have noted that violent crimes of all types occur at higher frequencies among this group. Although this percentage of previous sexual assault might be lower if more equal sampling of socioeconomic groups existed, it still seemed startling high. When combined with the statistics on battered wives (Walker, 1979), and sexual coercion and force within a marriage (Russell, 1982), the question of what sociocultural factors allow such violence against women remains.

That question is beyond this paper's scope, although Diana Russell's recent study of rape in marriage provided some insight. Russell, backed by NIMH, had retained the Field Research Corporation to survey a large number of San

Francisco women to determine the prevalence of marital rape and other sexual assault. The sample was carefully balanced to be representative of the U.S. population at large. Fourteen percent of the 930 women sampled reported they had been raped by their husband with rape defined in a traditional legal sense. Russell maintained that such rape was "a consequence of the abuse of power husbands have over their wives in the patriarchal family". That is, that the men involved frequently viewed their wives as property which was there to obey and accomodate. Certainly, this depersonalization of the female, such that she was viewed as a subordinate object, helps make it permissible to act out one's frustrations, desires, and violence upon her. This phenomena has been found to be a prominent feature in discussions with convicted rapists as well (Groth, 1977).

It should be emphasized that the present study did not establish that rape victims were more likely than other women to have been previous sexual assault victims. Instead, the percentages for the victim (21%) and initial control (25%) samples were remarkably similar. Incoming victims were often initially reluctant to reveal this history, perhaps for fear of how they would be viewed in the perspective of this additional assault. Clearly counselors need to be sensitive to the possibility of previous assaults even if such a history is initially denied.

The assailant's race. The present findings revealed that the assailant's race had some differential impact such

that poorer self-esteem was noted at three months postassault and the trend of the total victim group means also suggested greater anger, guilt, and higher DOV-T scores for the eleven interracial victims. Additionally, incoming group interracial victims reported more guilt and anger at three weeks postassault, and noted that significant others responded to them in a more helpful manner. If a larger study supports these trends as representative, the reasons for the findings may be rooted in the degree of racial prejudice and the amount of familiarity with members of another race that existed before the assault. The three incoming interracial rape victims were studied along these lines. The woman with the least exposure to integration and Black friends reacted most strongly to the racial aspect, while another Caucasian victim who had spent the last several years in integrated neighborhoods and who dated interracially reported no particular reaction to her assailant's race. The most common adverse reactions to the interracial aspect were a generalization of the fear and anger toward the assailant onto Black co-workers, peers, and students but not onto Caucasian peers, and the victim reported that she was making more racial slurs than normal for her. The victims often verbalized discomfort with these changes. The finding that significant others had responded more helpfully to these victims than to same-race victims may reflect the influence of the significant other's existing negative view of members of that race. That is, in interracial rape, racial prejudice may allow the victim to more readily blame

the assailant.

Findings not consistent with previous literature. Three findings did not appear consistent with what has been found in previous research studies, or with what has been described in anecdotal writeups. These areas were: the influence of the assault location, the effect of knowing the assailant, and the differences between the control and incoming groups.

Previous authors (Notman & Nadelson, 1976) had suggested that victims assaulted in their own home would experience greater disruption in self-confidence and their sense of autonomy, and therefore greater difficulty in resolving the assault. The present study predicted that the victims raped in their own homes would evidence more severe symptom profiles. However, the 19 victims raped at home did not evidence more symptoms than the 43 raped elsewhere. In fact, they exhibited higher self-esteem, less anger, perceived the rape as less violent, and displayed fewer symptoms in the areas of mood and heterosexual relationship. A possible explanation of these surprising results emerged from their case records. This group, besides being assaulted at home, also appeared as a group to be of a higher socioeconomic status than victims raped elsewhere. Socioeconomic status was found to be a moderately strong independent variable. Poverty-level victims (which were more prevalent in the raped-elsewhere category) reported more symptoms in the areas of mood, assault-related fears, and heterosexual relationships, as well as more symptoms at three months postassault, than did many of

the other groups. Thus, the attempt to measure the impact of the location of the rape may have been confounded by socio-economic differences between the groups. Similarly, when only the incoming group was surveyed, the finding that the three victims assaulted at home reported more negative life stresses in the preceding year may account for why they also evidenced lower self-esteem and intimacy scores than the eight victims raped elsewhere.

The present study had also predicted that individuals knowing their assailant would have more difficulty in recovering than if the assailant were a stranger. Implicit in this hypothesis was that those knowing their assailant would also have some trust for them which would then be betrayed by the assault. However, of the 29 raped by "a known other" only 15 described this other as a formerly "well-known" person. Furthermore, it was not uncommon for these victims to note on the DOV-S that their preassault level of trust for this person was rather low. Thus, it is not that surprising that knowing the assailant did not directly equate to experiencing more postassault distress. Similarly, the finding that the 40 victims of strangers experienced more assault-related fears may be due to these victim's inability to predict their assailant's personality, location, or emotional stability. Victims well-acquainted with the rapist had a greater capacity to realistically decide whether a reoccurrence or a retaliation for reporting the crime was likely.

Finally, incoming members had been expected to manifest

poorer self-esteem, greater heterosexual anxiety, and stronger feelings of isolation than control group members. This seemed reasonable as previous research had revealed significant differences between victims and controls on such measures as the Derogatis Symptom Checklist, POMS, Modified Fear Survey, the State-Trait Anxiety Inventory (Kilpatrick, Veronen, and Resick, 1979), and the Social Adjustment Scale-Self Report (Resick, Calhoun, Atkeson, & Ellis, 1981). However, the present study displayed only significant differences on Constantinople's scales of Mistrust and Intimacy, although the incoming victims scored higher than did the controls on all dependent measures with the exception of Trust, and Levenson's Internal scale. As most of these comparisons involved ten or fewer victims per group, the small sample size may have importantly limited these findings, and accounted for the relative lack of significant differences.

Limitations of the Present Study and the Issue of Generalization.

Although the previous chapter reported various interesting and statistically significant findings, only four of the hypotheses received strong support. Due to certain limitations of this study, even these findings must be considered as tentative and the lack of support for other hypothesis cannot be considered conclusive. The small numbers of uncounseled (N = 13) and incoming (N = 8) victims who were willing to fully complete questionnaires was a major limitation. The uncounseled group was not randomly selected and its inclusion of peers of counselors biased this subsample

toward being older and better-educated than the other victims. In examining the independent effect of demographic variables, some classifications (e.g., the victim's race) pertained to few victims, yielding very small N's for some statistical comparisons. Another difficulty stemmed from the author's attempt to include as many measures of personality and life functioning as possible. Some victims apparently felt overburdened by the demands of these measures. In retrospect, a lesser number of dependent measures may well have yielded greater victim cooperation. Additionally, to utilize so many measures, some were abbreviated and the resultant effects on their reliability and validity is unclear. Finally, the ARSI-W and ARSI-O, which served as the main dependent variables, met the needs of this study but had certain limitations. The ARSI-W score, as a sample summation of the raw number of symptoms reported, simply provided a gross, global index of the victim's overall symptom profile. The intensity and duration of the symptoms were not considered, nor were the symptoms weighted in degree of severity. Future studies may find a more comprehensive and complex symptom assessment measure more sensitive to the differences between victim groups. The ARSI-O did offer the advantage of considering the frequency and intensity of symptomatology, although higher interrater reliability indices would have been preferred.

In considering the study's limitations, the question of how well the present findings could be generalized to the broader population of rape victims remained an important one.

Two questions were posed in an attempt to provide some clarification. The first question was how similar was the demographic makeup of the total victim group to the demograhic distributions found in larger studies, and secondly, was the general reaction pattern of the victims consistent with what Burgess and Holmstrom (1970) and Peters (1975) described as the rape trauma syndrome?

In answering the first question, the statistics gathered in large urban studies by Amir (1971), MacDonald (1971), the National Crime Panel Survey (1975), and Peters (1975) were compared to the present findings. Only two noteworthy differences were obtained and both concerned race. That is, the present study contained a much higher percentage of Caucasian victims, and a higher frequency of interracial rape. It was unclear whether the first factor exerted a significant effect. Victim's race did not evidence an independent effect on any of the questionnaire or symptom interview scores in this study, but only three minority victims were involved. The relatively high percentage (about 25%) of interracial rapes was consistent with Hursch and Selkin's (1974) and Peters' (1975) prediction that with increased integration and urbanization rape might more frequently cross racial lines. Overall, the demographic distributions of the present study seemed comparable to earlier studies.

The second question, that of the similarity of the reaction patterns of present victims to those described by earlier studies, was answered affirmatively earlier in this

chapter. Thus, overall it appeared that present findings could be generalized.

Implications for future research.

The literature regarding the general rape trauma syndrome has become increasingly well-documented in the last five years. Rape generally appears to precipitate a crisis in the victim's life and leaves an aftermath of feelings and behavior that may benefit from skillful counseling. Examination of the particular variables involved in such reactions could be useful in predicting which victims are at risk for more severe reactions, and for deepening counselor's understanding of the variables involved in the reaction and recovery. This area of study is new, and, to the author's knowledge, the present study represents its first systematic examination. Further research along these lines involving larger samples and more sophisticated designs and data analyses would advance the state of research on rape, and might importantly illuminate more effective interventions. Such investigation seems most relevant if the sample is actually composed of rape victims rather than relying on rape-analogues. Additional followup studies reutilizing previous research samples, such as Burgess and Holmstrom's 1979 study, seem vital if counselors are to better understand the long-term impact of rape. Comparing previously counseled and uncounseled victim's reactions has obvious importance in understanding the impact counseling can have, however, obtaining random samples of uncounseled victims is notoriously difficult. Such a

sampling could probably best be obtained in a large urban area by a social service agency well-known and well-respected in the community.

Future studies may want to further explore the impact of the perceived violence in the assault to determine if the present findings can be replicated. In regards to this, the DOV questionnaire proved to be a useful and sensitive instrument in the present study and could be adapted for future use. However, a factor analysis of the items seems called for to better define the dimensions the measure taps.

Finally, more research on the attitudes and knowlege professional counselors have regarding rape and the recovery process seems essential if professionals are to be effective with rape victims. Resick and Jackson's (1981) study of gender differences in attitudes toward rape among mental health professionals was a step in this direction. Schuker (1979) noted that:

> "all those who work with rape victims may be tempted to try to avoid identification with them. One may distance oneself obsessively (e.g., asking lots of facts) or may shun the victim emotionally. Victims of any tragedy are sometimes shunned or treated as suspect...people fear being contaminated by something very frightening...a conspiracy of silence can be set up to avoid shameful, painful, or frightening material."

Silberman (1979) further warned against countertransference issues male therapists may face in working with victims or rape. In light of the powerful emotions the topic of rape frequently stirs in individuals, and the typical lack of university coursework regarding treating the sexually

assaulted client, better knowledge of counselor attitudes could prove useful in designing training programs, manuals, and inservice programs for beginning and experienced therapists alike.

Summary. The present study systematically examined the the independent effect of demographic variables on the recovery pattern of rape victims, with this pattern primarily measured in terms of the incidence of assault-related symptoms. The victim's perception of the violence inherent in rape, and being struck during the assault appeared to be most strongly associated with a difficult recovery. Additional factors appeared to be a lack of crisis intervention counseling following the assault, a previous history of mental health counseling, and a poverty-level socioeconomic status. Victims who sought professional attention evidenced more guilt, poor self-esteem, and greater difficulty in several symptom areas than victims not seeking such assistance. A substantial percentage (over 20%) of victims and controls were previous sexual assault victims, emphasizing the need for professional counselors to be aware of the needs of such potential clients, and sensitive to the factors influencing their recovery. The small sample size of the present study made it necessary to interpret the results cautiously, and replication of the findings in future research projects was indicated. While only four of the twelve original hypotheses received significant support, the study yielded various interesting and statistically significant findings. It is the author's hope

that these results may stir interest in further research so that counselors may better understand the process of recovery, and what can be done to facilitate it.

APPENDICES

APPENDIX A

Appendix A

Questionnaires Used In The Study

Assault-Related Symptom Interview-Written

HOW DO WOMEN REACT TO A RAPE? WHAT CAN THE PEOPLE WHO CARE ABOUT HER EXPECT TO SEE HER GO THROUGH, AND HOW CAN THEY HELP? THIS FORM ASKS YOU TO HELP US IN ANSWERING THESE QUESTIONS BY REMEMBERING HOW YOU FELT AND REACTED TO YOUR RAPE AT FOUR DIFFERENT TIME POINTS. THAT IS, WHAT WERE YOU GOING THROUGH

a. ONE WEEK AFTER THE RAPE
b. ONE MONTH AFTER THE ASSAULT
c. THREE MONTHS AFTER THE RAPE
d. AND PRESENTLY, THAT IS, WHAT REACTIONS DO YOU STILL HAVE THAT YOU FEEL STEM FROM THE RAPE.

BELOW ARE SEVERAL QUESTIONS. IF YOU HAD THE REACTION THE QUESTION ASKS ABOUT, PLEASE PUT A CHECK MARK (/) IN FRONT OF THE QUESTION AND UNDER THE TIME PERIOD YOU HAD IT IN.

FOR EXAMPLE, IF YOU HAD DIFFICULTY FALLING ASLEEP FOR THE WHOLE FIRST MONTH AFTER THE RAPE, YOU WOULD CHECK THE FOLLOWING:

1 WEEK	1 MOS	3 MOS	NOW	
/_	/_	___	___	Did you have trouble falling asleep?

IF YOU HAD TROUBLE FALLING ASLEEP DURING THE FIRST WEEK AFTER THE RAPE, AND THEN AGAIN THREE MONTHS LATER (BUT AT NO TIME BETWEEN OR SINCE) YOUR ANSWER WOULD LOOK LIKE THIS:

1 WEEK	1 MOS	3 MOS	NOW	
/_	___	/_	___	Did you have trouble falling asleep?

---

1 WEEK	1 MOS	3 MOS	NOW	AFTER THE RAPE.....
___	___	___	___	Did you have trouble falling asleep?
___	___	___	___	Did you wake up more during the night?
___	___	___	___	Did you have nightmares?
___	___	___	___	Did you sleep more than usual?
___	___	___	___	Did you sleep less than usual?
___	___	___	___	Were you more tired during the day?
___	___	___	___	Were you less hungry than usual?

1 WEEK	1 MOS	3 MOS	NOW	AFTER THE RAPE.....
____	____	____	____	If you were less hungry, and lost weight because of it, put in this blank, _____, the number of pounds you lost.
____	____	____	____	Were you more hungry than usual?
				If you were more hungry, and gained weight because of it, put in this blank, _____, the number of pounds you gained.
____	____	____	____	Did you feel queasy when you tried to eat?
____	____	____	____	Did you throw up after eating (because you were still upset by the rape?)
				CHECK ANY OF THESE PHYSICAL PROBLEMS THAT YOU HAD MORE AFTER THE RAPE THAN YOU USUALLY WOULD HAVE HAD (PLACE THE CHECK UNDER THE PROPER TIME PERIODS):
____	____	____	____	Headaches?
____	____	____	____	Dizziness?
____	____	____	____	Upset stomach?
____	____	____	____	Cramps?
____	____	____	____	Fatigue (always tired)?
____	____	____	____	Diarrhea?
____	____	____	____	Constipation?
____	____	____	____	Vaginal infections?
____	____	____	____	Bladder infections?
____	____	____	____	After the rape, were you more depressed than usual?
____	____	____	____	Did you get angry with others more quickly?
____	____	____	____	Did you cry more?
____	____	____	____	Were you more withdrawn (i.e., did you keep more to yourself)?
____	____	____	____	Did you have more trouble than usual getting housework done?

WHICH OF THE FOLLOWING WERE YOU MORE AFRAID OF AFTER THE RAPE?

1 WEEK	1 MOS	3 MOS	NOW	
____	____	____	____	Being alone?
____	____	____	____	The dark?
____	____	____	____	Male strangers?
____	____	____	____	Leaving the house?
____	____	____	____	Staying in the house?
____	____	____	____	Going to work or school?
____	____	____	____	Did you feel less trusting of men in general?
____	____	____	____	Were you more afraid of men in general?

IF AT THE TIME OF THE RAPE YOU HAD A HUSBAND/BOYFRIEND/OR LOVER, FILL OUT THESE NEXT QUESTIONS. IF YOU DID NOT, GO ON TO THE NEXT SECTION YOU SEE IN LARGE LETTERS.

1 WEEK	1 MOS	3 MOS	NOW	AFTER THE RAPE.....
____	____	____	____	Did you and your partner argue more after the rape?
____	____	____	____	Did you feel less close to each other?
____	____	____	____	Did your relationship end because of problems related to the rape?
____	____	____	____	Did you feel any differently when your partner held you?
____	____	____	____	Did you have intercourse (i.e., did you make love) as often as you would have before the rape?
____	____	____	____	Did you find yourself responding differently during lovemaking than you did before?
____	____	____	____	Did you think about the rape when you were making love?

1 WEEK	1 MOS	3 MOS	NOW	
____	___	___	___	Did you enjoy sex as much as you would have before the rape?
				IF AT THE TIME OF THE RAPE YOU DID NOT HAVE A HUSBAND/BOYFRIEND/OR LOVER, FILL OUT THIS PART.
____	___	___	___	After the rape, were you less willing to date?
____	___	___	___	Did you wonder if the rape would make it harder for you to have a good relationship with a man?
____	___	___	___	Did you find yourself spending less time with men than usual?
____	___	___	___	Were you as comfortable with physical contact (hugs, kisses, etc.) from male friends and dates as you would have been before the rape?
____	___	___	___	Were you as comfortable with sexual contact (petting, propositions, etc.) as you would have been before the rape?
____	___	___	___	Were you more worried about how you would perform sexually in the future?
				IF YOU WERE EMPLOYED OR A STUDENT AT THE TIME OF THE RAPE, COMPLETE THE NEXT SECTION. IF YOU WERE NOT, PLEASE GO ON TO THE FINAL SECTION.
____	___	___	___	Did you miss any days of work or school because of the rape? If so, please put in this blank, _____, about how many days, and place checkmarks in the proper time periods.
____	___	___	___	Did you have a harder time concentrating at school or work?
____	___	___	___	Did you think of quitting work or school for reasons related to the rape?

1 WEEK	1 MOS	3 MOS	NOW	AFTER THE RAPE.....
____	____	____	____	Did you quit work or school because of the rape?
____	____	____	____	If you did quit, did you get a new job or enter a new school within a month of quitting? _____
____	____	____	____	Did your boss or teachers know about the rape?
				Did you tell them? _____ Where you glad they knew? _____
____	____	____	____	Did you tell any of your co-workers or fellow students about the rape?
				Were you glad they knew? _____ Were there any you wished did not know about the rape? _____

PLEASE ANSWER THE FOLLOWING QUESTIONS IN YOUR OWN WORDS. THIS IS THE FINAL SECTION OF THE FORM.

1. What were your feelings toward the man who raped you during the first week after the rape?

2. What are your feelings about him now?

3. If you had a husband/boyfriend/or lover at the time of the rape, how do you think he felt about your rapists?

4. How do you think your husband/boyfriend/or lover felt about you?

5. What has helped you the most in putting your life back to normal since the rape? (Please be specific)

6. Have you received any counseling from Rape Crisis counselors since your rape?

7. If you answered #6 "yes", please answer the following questions. If you answered #6 "no", please skip these questions and go on to #8.

   a. How long after the rape was it before you met with a Rape Crisis counselor (or spoke to one on the phone)?

   b. On a scale from 1 to 10 (where 1 = not helpful and 10 = very helpful), how helpful has the counseling you have received from rape crisis counselors been to you. (Circle the number that best describes your answer).

   1 2 3 4 5 6 7 8 9 10
   Not helpful Very helpful

   c. During the time you have been involved with Rape Crisis, have you met with or spoke to your counselor as often as you would have liked, less than you would have liked, or more than you would have liked?

   d. Do you still wish to continue to meet with the rape crisis counselor?

8. If you did not receive any counseling from Rape Crisis, please answer the following questions:

   a. I did not call Rape Crisis after I was raped because:

   _____ I did not know there was such a Center

   _____ At the time I was raped, there was no Center in my city

   _____ I was too embarrassed to call

   _____ I felt too guilty to call

   _____ I felt I should be able to handle things on my own

   _____ Other reasons (please explain): _____

   b. I wanted to fill out this questionnaire because _____

   _____

   c. Would you like to have a Rape Crisis Counselor get in touch with you now to arrange a time to sit down and talk about some of your feelings about the rape?

9. Today, in my present day life, the rape effects the way I feel and act towards men:

___ not at all ___ very little ___ some ___ a great deal

10. Today, in my present day life, the rape effects the way I feel about and respond towards sex:

___ not at all ___ very little ___ some ___ a great deal

11. Today the rape effects the way I feel about myself:

___ not at all ___ very little ___ some ___ a great deal

12. Today the rape effects the way I act, i.e., the things I feel free to do or not to do:

___ not at all ___ very little ___ some ___ a great deal

THANK YOU FOR TAKING TIME TO THINK BACK OVER WHAT I KNOW WAS A PAINFUL EXPERIENCE, AND TO SHARE WITH ME YOUR ANSWERS. YOU HAVE HELPED US BETTER UNDERSTAND HOW WE CAN BE MOST HELPFUL TO OTHER VICTIMS OF RAPE. TAKE CARE!

Bem's Sex Role Inventory

DIRECTIONS: Please indicate on a seven point scale how well each of the characteristics describes you. Write the number appropriate for your answer beside each item on the answer sheet.

/ 1 / 2 / 3 / 4 / 5 / 6 / 7 /

Never or almost never true of me — Always or almost always true of me

___1. Self-reliant
___2. Yielding
___3. Helpful
___4. Defends own beliefs
___5. Cheerful
___6. Moody
___7. Independent
___8. Shy
___9. Conscientious
___10. Athletic
___11. Affectionate
___12. Theatrical
___13. Assertive
___14. Flatterable
___15. Happy
___16. Strong personality
___17. Loyal
___18. Unpredictable
___19. Forceful
___20. Feminine
___21. Reliable
___22. Analytical
___23. Sympathetic
___24. Jealous
___25. Has leadership ability
___26. Sensitive to the needs of others
___27. Truthful
___28. Willing to take risks
___29. Understanding
___30. Secretive
___31. Makes decisions easily
___32. Compassionate
___33. Sincere
___34. Self-sufficient
___35. Eager to soothe hurt feelings
___36. Conceited
___37. Dominant
___38. Soft spoken
___39. Likeable
___40. Masculine
___41. Warm
___42. Solemn
___43. Willing to take a stand
___44. Tender
___45. Friendly
___46. Aggressive
___47. Gullible
___48. Inefficient
___49. Acts as a leader
___50. Childlike
___51. Adaptable
___52. Individualistic
___53. Does not use harsh language
___54. Unsystematic

___55. Competitive
___56. Loves children
___57. Tactful
___58. Ambitious
___59. Gentle
___60. Conventional

Body Cathexis Scale

Think about each of the following items, and circle the number that best shows your feelings for the item according to the following scale:

1. Have strong positive feelings
2. Have moderate positive feelings
3. Have no feeling one way or the other
4. Have moderate negative feelings
5. Have strong negative feelings

1.	hair	1	2	3	4	5
2.	energy level	1	2	3	4	5
3.	weight	1	2	3	4	5
4.	sex organs	1	2	3	4	5
5.	muscular strength	1	2	3	4	5
6.	chest (or breasts)	1	2	3	4	5
7.	sex drive	1	2	3	4	5
8.	tolerance for pain	1	2	3	4	5
9.	physical stamina	1	2	3	4	5
10.	sex activities	1	2	3	4	5
11.	face	1	2	3	4	5

Degree of Violence

PLEASE ANSWER EACH OF THE FOLLOWING QUESTIONS BY CIRCLING YES OR NO, AND COMPLETING THE BLANKS.

1. Did you know your attacker? yes no

   a. If so, what was his relationship to you: _____

2. Did your attacker make any threats? yes no

   b. What were they?

3. Did your attacker say he had a weapon? yes no

   a. If so, what kind _____

   b. Did you see the weapon? yes no

4. Did the rapist tie your hands? yes no
   tie your feet? yes no
   gag you? yes no
   blindfold you? yes no

5. Did your attacker strike you? yes no

   a. If so, what did he use (ex. hands, stick, etc.): _____

   b. About how many times did he hit you? _____

6. Did you have any physical injuries after the attack? yes no

   a. If so, describe what they were: _____

   _____

PLEASE ANSWER EACH OF THE FOLLOWING QUESTIONS BY CIRCLING THE NUMBER THAT SHOWS HOW MUCH YOU AGREE WITH EACH STATEMENT WHEN:

1 = strongly disagree
2 = disagree
3 = sentence is somewhat true, and somewhat false
4 = agree, sentence is basically true
5 = strongly agree

STRONGLY DISAGREE				STRONGLY AGREE	
1	2	3	4	5	1. The assault took me totally by surprise.
1	2	3	4	5	2. The attacker was someone I knew and trusted.

STRONGLY DISAGREE				STRONGLY AGREE		
1	2	3	4	5	3.	The rapist's voice was soft, "polite".
1	2	3	4	5	4.	The rapist handled me roughly.
1	2	3	4	5	5.	My attacker treatened to kill me if I did not do what he wanted.
1	2	3	4	5	6.	I believed the rapist would kill or seriously injure me even if I did what he wanted.
1	2	3	4	5	7.	The sexual acts the rapist ordered me to do humiliated me.
1	2	3	4	5	8.	The comments my attacker made during the rape were degrading.
1	2	3	4	5	9.	I felt invaded and taken over.
1	2	3	4	5	10.	I felt helpless during the attack.
1	2	3	4	5	11.	The rape was physically painful.
1	2	3	4	5	12.	I felt powerless during the rape, the rapist had all the power.
1	2	3	4	5	13.	My attacker threatened to return if I told anyone about the rape.
1	2	3	4	5	14.	I believe my attacker might return.

RAPE IS A VIOLENT CRIME. SOME RAPES INVOLVE MORE VIOLENCE THAN OTHERS. ON A SCALE OF 1 TO 10, RATE HOW VIOLENT YOUR ATTACK SEEMED TO YOU. PLACE THE NUMBER HERE _____.

SCALE

MINIMALLY VIOLENT				MODERATELY VIOLENT					VERY VIOLENT
1	2	3	4	5	6	7	8	9	10

Demographic Data

BASIC INFORMATION

PLEASE FILL IN THE FOLLOWING INFORMATION:

ID no. ____ Age ____ Highest year of school completed _____

Marital status: single __ married __ separated __ divorced __

widowed __

Present occupation _____ Race _____

Which category best describes your economic level:

poverty level _____
lower middle class _____
middle class _____
upper middle class _____
wealthy _____

What is your religious background (e.g. Protestant, Catholic, etc.) _____

How important is religion in your life at present (CIRCLE ONE):

very important somewhat important not very important

not important

Do you have any problems with drug or alcohol abuse, severe depression, or other psychological problems? (If so, please describe):

Were you ever commited to a hospital for psychiatric (i.e. mental health) reasons?

Information on the rape

How long ago did the rape occur?

How old were you at the time of the rape?

Where was the location of the rape? (i.e. your house, the street, etc.)

Were you a virgin at the time of the rape?

If you were not a virgin, would you say the other sexual experiences you had had before the rape were:

CHECK ONE

all positive experiences _____
mostly positive experiences _____
some positive experiences _____
mostly negative experiences _____
all negative experiences _____

Was this rape the first time you had ever been raped?
(If not, please explain)

Tell, in your own words, what sexual acts were forced on you during the rape:

In the first week to ten days following the rape, who did you tell about it? Check the answers that apply:

_____ police
_____ doctor, or emergency room staff
_____ rape crisis center
_____ parent(s)
_____ husband or boyfriend
_____ sisters or brothers
_____ friends
_____ boss
_____ minister
_____ psychologist or counselor
_____ other: _____

Have you ever contacted a psychologist or mental health counselor (other than a rape crisis counselor) for any personal problems you felt were due to being raped?

If so, describe the problem briefly:

About how many times did you see the counselor? _____

On a scale from 1 to 10 where 1 = not at all helpful and 10 = very helpful, how helpful do you think your counselor was?
Place the number here _____

Was the man who raped you ever arrested by the police? yes no

Did you take the case to criminal court? yes no

What was the verdict? (i.e. was he found guilty, or not) _____

If he was found guilty, what was the sentence? _____

Fear Survey Schedule (III)

DIRECTIONS: The items in this questionnaire refer to experiences with male figures that may cause fear or other unpleasant feelings. Write the number of each item in the column that describes how much you are disturbed by it nowadays.

NOT AT ALL	A LITTLE	A FAIR AMOUNT	MUCH	VERY MUCH

1. Speaking before a group of men
2. Being teased by men
3. Entering a room where some men are already seated
4. Male strangers
5. Men in authority
6. Crowds of men
7. Tough looking men
8. Being watched working by a man
9. Ugly men
10. Being criticized by a man
11. Angry men
12. Parting from male friends
13. Feeling rejected by men
14. Feeling disapproved of by a man
15. Being ignored by men
16. Nude men
17. Looking foolish in front of a man

Guilt Index

PLEASE ANSWER EACH OF THE FOLLOWING QUESTIONS BY CIRCLING THE NUMBER THAT BEST SHOWS HOW TRUE OR FALSE EACH STATEMENT IS OF YOU. CIRCLING THE NUMBER 1 MEANS YOU FEEL THE STATEMENT IS TOTALLY FALSE, CIRCLING A 5 MEANS YOU FEEL THE STATEMENT IS TOTALLY TRUE. THERE ARE NUMBERS IN BETWEEN THESE THAT CAN BE CIRCLED AS WELL. FOR INSTANCE, CIRCLING A 2 MEANS YOU FEEL THE STATEMENT IS MOSTLY FALSE, CIRCLING A 4 MEANS IT IS MOSTLY TRUE, AND SO ON.

TOTALLY FALSE				TOTALLY TRUE		
1	2	3	4	5	1.	If something goes wrong, I usually feel I am to blame.
1	2	3	4	5	2.	Lately, I feel guilty all the time.
1	2	3	4	5	3.	I am concerned about being forgiven for my sins.
1	2	3	4	5	4.	I often feel that I have not lived the right kind of life.
1	2	3	4	5	5.	When I do wrong, my conscience punishes me severely.
1	2	3	4	5	6.	I sometimes have bad thoughts which make me feel ashamed of myself.
1	2	3	4	5	7.	When a friend is upset with me, I feel that it is my fault.
1	2	3	4	5	8.	When something bad happens to me, I feel like I deserved it.

Inventory of Psychosocial Development

DIRECTIONS: Rate the following on a 7 point scale according to the degree to which they do or do not apply to you; please rate them according to how you really are, not how you would like to be. A 1 means that the statement very much does not apply to you; a 7 means that the statement very much does apply to you. The numbers between 1 and 7 represent different degrees that the statements do or do not apply. Please circle the number which represents the degree to which the statement applies to you.

		does not apply			applies somewhat			applies very much
1.	calm and untroubled.....	1	2	3	4	5	6	7
2.	little concern for the rest of the world.....	1	2	3	4	5	6	7
3.	not able to stand frustration and everything frustrates her.....	1	2	3	4	5	6	7
4.	honest, not afraid to show herself.....	1	2	3	4	5	6	7
5.	open to new ideas.....	1	2	3	4	5	6	7
6.	overly concerned with herself.....	1	2	3	4	5	6	7
7.	can't share things with anybody.....	1	2	3	4	5	6	7
8.	warm and friendly.....	1	2	3	4	5	6	7
9.	always an optimist.....	1	2	3	4	5	6	7
10.	very lonely.....	1	2	3	4	5	6	7
11.	pessimistic, little hope..	1	2	3	4	5	6	7
12.	has sympathetic concern for others.....	1	2	3	4	5	6	7
13.	able to take things as they come.....	1	2	3	4	5	6	7
14.	cold and distant.....	1	2	3	4	5	6	7
15.	longs for lost paradise...	1	2	3	4	5	6	7
16.	tactful in personal relations.....	1	2	3	4	5	6	7

		does not apply						applies very much
					applies somewhat			
17.	deep, unshakable faith in herself.....	1	2	3	4	5	6	7
18.	secretly doesn't pay attention to the opinion of others.....	1	2	3	4	5	6	7
19.	never gets what he really wants.....	1	2	3	4	5	6	7
20.	comfortable in close relationships.....	1	2	3	4	5	6	7

Levenson's Internal-External Locus of Control Scale

DIRECTIONS:

Below there is a list of statements about yourself or your beliefs. For each statement indicate the degree to which you personally agree with the statement. Read each item carefully. On the line next to the number of the statement place the number that indicates your agreement in the following way:

1 = disagree strongly 2 = disagree moderately 3 = disagree slightly 4 = agree strongly 5 = agree moderately 6 = agree slightly

___ 1. Whether or not I get to be a leader depends mostly on my ability.

___ 2. To a great extent my life is controlled by accidental happenings.

___ 3. I feel like what happens in my life is mostly determined by powerful people.

___ 4. Whether or not I get into a car accident depends mostly on how good a driver I am.

___ 5. When I make plans, I am almost certain to make them work.

___ 6. Often there is no chance of protecting my personal interest from bad luck happenings.

___ 7. When I get what I want, it's usually because I'm lucky.

___ 8. Although I might have good ability, I will not be given leadership responsibility without appealing to those in positions of power.

___ 9. How many friends I have depends on how nice a person I am.

___10. I have often found that what is going to happen will happen.

___11. My life is chiefly controlled by powerful others.

___12. Whether or not I get into a car accident is mostly a matter of luck.

___13. People like myself have very little chance of protecting our personal interests when they conflict with those of strong pressure groups.

___14. It's not always wise for me to plan too far ahead because many things turn out to be a matter of good or bad fortune.

___15. Getting what I want requires pleasing those people above me.

___16. Whether or not I get to be a leader depends on whether I'm lucky enough to be in the right place at the right time.

___17. If important people were to decide they didn't like me, I probably wouldn't make many friends.

___18. I can pretty much determine what will happen in my life.

___19. I am usually able to protect my personal interests.

___20. Whether or not I get into a car accident depends mostly on the other driver.

___21. When I get what I want, it's usually because I worked hard for it.

___22. In order to have my plans work, I make sure that they fit in with the desires of people who have power over me.

___23. My life is determined by my own actions.

___24. It's chiefly a matter of fate whether or not I have a few friends or many friends.

Life Experience Survey

Listed below are a number of events which sometimes bring about change in the lives of those who experience them. The researcher will read each item aloud. Check those items that you have experienced in the last twelve months. When you check them, indicate whether they occurred 0 to 6 months ago, or 7 months to 1 year ago. Be sure that all check marks are directly across from the items they correspond to.

Also, for each item checked below, please write in the type and degree of impact the event had. To do this use the following rating scale:

-3 = extremely negative	+3 = extremely positive
-2 = moderately negative	+2 = moderately positive
-1 = somewhat negative	+1 = slightly positive
0 = no impact	

Thus, if an event seemed extremely negative to you, you would place a -3 next to it under the Rating column.

Event	6 mos	7 mos to 1 yr	Rating
1. Marriage			
2. Detention in jail or comparable institution			
3. Death of spouse			
4. Major change in sleeping habits			
5. Death of close family member: Who: _____			
6. Major change in eating habits			
7. Foreclosure on mortgage or loan			
8. Death of close friend			
9. Outstanding personal achievement			
10. Minor law violations (traffic tickets, etc.)			

-3 = extremely negative
-2 = moderately negative
-1 = somewhat negative
0 = no impact
+3 = extremely positive
+2 = moderately positive
+1 = slightly positive

Event	0 to 6 mos	7 mos to 1 yr	Rating
11. Male: Wife/girlfriend's pregnancy			
12. Female: Pregnancy			
13. Changed work situation (different hours, etc.)			
14. New job			
15. Serious illness or injury of close family member: Who: _____			
16. Sexual difficulties			
17. Trouble with employer			
18. Trouble with in-laws			
19. Major change in financial status			
20. Major change in closeness of family members			
21. Gaining a new family member			
22. Change of residence			
23. Marital separation from mate (due to conflict)			
24. Major change in church activities			
25. Marital reconciliation with mate			
26. Major change in number of arguments with spouse			
27. Married male: Change in wife's work outside the home			

-3 = extremely negative
-2 = moderately negative
-1 = somewhat negative
0 = no impact
+3 = extremely positive
+2 = moderately positive
+1 = slightly positive

Event	0 to 6 mos	7 mos to 1 yr	Rating
28. Married female: Change in husband's work			
29. Major change in usual type and/or amount of recreation			
30. Borrowing more than $10,000			
31. Borrowing less than $10,000			
32. Being fired from job			
33. Male: Wife/girlfriend having abortion			
34. Female: Having abortion			
35. Major personal illness or injury			
36. Major change in social activities			
37. Major change in living conditions of family			
38. Divorce			
39. Serious injury or illness of close friend			
40. Retirement from work			
41. Son or daughter leaving home			
42. Ending of formal schooling			
43. Separation from spouse			
44. Engagement			
45. Breaking up with boyfriend/girlfriend			

-3 = extremely negative
-2 = moderately negative
-1 = somewhat negative
0 = no impact
+3 = extremely positive
+2 = moderately positive
+1 = slightly positive

Event	0 to 6 mos	7 mos to 1 yr	Rating
46. Leaving home for the first time			
47. Reconciliation with boyfriend/girlfriend			
Other recent experiences which have had an impact on your life. List and rate.			
48. _____			
49. _____			
50. _____			
51. Beginning a new school experience at a higher academic level			
52. Changing to a new school at same academic level			
53. Academic probation			
54. Being dismissed from dormitory or other residence			
55. Failing an important exam			
56. Changing a major or career plans			
57. Failing a course			
58. Dropping a course			
59. Joining a fraternity/ sorority			
60. Financial problems concerning school			

Profile of Moods State

DIRECTIONS: Below is a list of words that describe feelings people have. Please read each one carefully. Then fill in the blank to the left of each word with the number which best describes HOW YOU HAVE BEEN FEELING DURING THE PAST WEEK INCLUDING TODAY. The numbers refer to the following descriptive phrases.

0 = Not at all
1 = A little
2 = Moderately
3 = Quite a bit
4 = Extremely

___ 1. Friendly	___21. Hopeless	___41. Anxious
___ 2. Tense	___22. Relaxed	___42. Ready to fight
___ 3. Angry	___23. Unworthy	___43. Goodna-tured
___ 4. Worn out	___24. Spiteful	
___ 5. Unhappy	___25. Sympathetic	___44. Gloomy
___ 6. Clear-headed	___26. Uneasy	___45. Desparate
___ 7. Lively	___27. Restless	___46. Sluggish
___ 8. Confused	___28. Unable to concentrate	___47. Rebel-lious
___ 9. Sorry for things done	___29. Fatigued	___48. Helpless
___10. Shaky	___30. Helpful	___49. Weary
___11. Listless	___31. Annoyed	___50. Bewildered
___12. Peeved	___32. Discouraged	___51. Alert
___13. Considerate	___33. Resentful	___52. Deceived
___14. Sad	___34. Nervous	___53. Furious
___15. Active	___35. Lonely	___54. Efficient
___16. On edge	___36. Miserable	___55. Trusting
___17. Grouchy	___37. Muddled	___56. Full of pep
___18. Blue	___38. Cheerful	___57. Bad-tempered
___19. Energetic	___39. Bitter	
___20. Panicky	___40. Exhausted	___58. Worthless

0 = Not at all
1 = A little
2 = Moderately
3 = Quite a bit
4 = Extremely

___59. Forgetful

___60. Carefree

___61. Terrified

___62. Guilty

___63. Vigorous

___64. Uncertain about things

___65. Bushed

Religiousity Scale

1. My religious background is:

___ Catholic
___ Protestant
denomination _____
___ Jewish
type _____
___ Moslem
___ Athiest, agnostic
___ Other _____

2. Do you feel it is possible for an individual to have a well-rounded religious life apart from the church?

a. No
b. Uncertain
c. Yes

3. How much time during the average week do you spend reading the Bible and other religious literature?

a. One hour or more
b. One-half hour
c. None

4. Which of the following best describes your participation in the act of prayer?

a. Prayer is a regular part of my behavior
b. I pray in times of stress and/or need, but not much otherwise
c. I usually only pray during formal worship services
d. Prayer is of little importance in my life
e. I never pray

5. How many of the past four Sabbath worship services have you attended?

a. Three or more
b. Two
c. One
d. None

6. Do you believe that your marriage ceremony should be performed by:

a. A religious official (minister, priest, or rabbi)
b. A religious official or a justice of the peace
c. A justice of the peace, or other civil authority

7. Are there times when you feel "close" to the divine (God)?

   a. Frequently b. Occasionally c. Rarely d. Never

8. Would you say your religious beliefs give your life a sense of purpose it would not have otherwise?

   a. Strongly agree b. Agree c. Disagree

Rosenberg Self-Esteem Scale

Using the following scale, place in each blank the number which best represents your feelings about each of the following statements:

1	2	3	4
Strongly Agree	Agree	Disagree	Strongly Disagree

___ 1. I feel that I'm a person of worth, at least on an equal basis with others.

___ 2. I feel that I have a number of good qualities.

___ 3. All in all, I am inclined to feel that I am a failure.

___ 4. I am able to do things as well as most other people.

___ 5. I feel I do not have much to be proud of.

___ 6. I take a positive attitude toward myself.

___ 7. On the whole, I am satisfied with myself.

___ 8. I wish I could have more respect for myself.

___ 9. I certainly feel useless at times.

___ 10. At times I think I am no good at all.

Support System Rating

1. List below the people currently in your life who are most important to you. You may write in as few or as many people as you choose. Be sure to write in their relationship to you. For example:

   Mary, my best friend
   Mr. Townsend, my boss
   Mrs. Brown, the gym teacher

   Enter this information in the column labeled Name and Relationship. If you need additional room, use the back of this paper.

	Name and Relationship	W	T	H Rating
1.	_____	_	_	LOW 1 2 3 4 5 HIGH
2.	_____	_	_	LOW 1 2 3 4 5 HIGH
3.	_____	_	_	LOW 1 2 3 4 5 HIGH
4.	_____	_	_	LOW 1 2 3 4 5 HIGH
5.	_____	_	_	LOW 1 2 3 4 5 HIGH
6.	_____	_	_	LOW 1 2 3 4 5 HIGH
7.	_____	_	_	LOW 1 2 3 4 5 HIGH
8.	_____	_	_	LOW 1 2 3 4 5 HIGH
9.	_____	_	_	LOW 1 2 3 4 5 HIGH
10.	_____	_	_	LOW 1 2 3 4 5 HIGH
11.	_____	_	_	LOW 1 2 3 4 5 HIGH
12.	_____	_	_	LOW 1 2 3 4 5 HIGH
13.	_____	_	_	LOW 1 2 3 4 5 HIGH
14.	_____	_	_	LOW 1 2 3 4 5 HIGH

2. Who on this list have you wanted to talk with about the rape? Place a checkmark (/) under the column "W" next to the name of each of the people on your list that you did want to discuss the assault with.

3. Which of the people on your list in Question 1 did you actually talk with about the rape? Place a checkmark (/) under the column "T" for talked to next to the name of these people.

4. The people that you did discuss the assault with may have responded to you in a way that felt helpful, or they may not have. Please rate how helpful you felt each person was according to the scale given below. Select the number from 1 to 5 that best selects how helpful the person you talked with seemed, and circle this number next to their name under the column "H Rating".

Helpfulness Scale

1	2	3	4	5
NOT HELPFUL (LOW)		MODERATELY HELPFUL		VERY HELPFUL (HIGH)

5. There may be people from your list that you've wanted to talk to about the rape, but have not. Some possible reasons for this are listed below. Please check as many as apply to you, and write in any other reasons you may have had for not speaking with them.

___ I am too embarrassed.

___ I am afraid the news would upset them.

___ I am afraid they would think less of me.

___ I feel too guilty.

___ I am afraid they would be hurt.

___ I am afraid they would blame me.

___ They might try to catch or hurt the rapist themselves.

___ Other: (EXPLAIN) _____

_____

_____

Tennessee Self-Concept Scale

ANSWERS:	Completely false	Mostly false	Partly false and partly true	Mostly true	Completely true
	1	2	3	4	5

PLACE YOUR ANSWER IN THE BLANK NEXT TO THE SENTENCE.

___ 1. I have a healthy body

___ 3. I am an attractive person

___ 5. I consider myself a sloppy person

___ 19. I am a decent sort of person

___ 21. I am an honest person

___ 23. I am a bad person

___ 37. I am a cheerful person

___ 39. I am a calm and easy going person

___ 41. I am a nobody

___ 55. I have a family that would always help me in any kind of trouble

___ 57. I am a member of a happy family

___ 59. My friends have no confidence in me

___ 73. I am a friendly person

___ 75. I am popular with men

___ 77. I am not interested in what other people do

___ 91. I do not always tell the truth

___ 93. I get angry sometimes

___ 2. I like to look nice and neat all the time

___ 4. I am full of aches and pains

___ 6. I am a sick person

___ 20. I am a religious person

___ 22. I am a moral failure

___ 24. I am a morally weak person

ANSWERS:	Completely false	Mostly false	Partly false and partly true	Mostly true	Completely true
	1	2	3	4	5

___ 38. I have a lot of self-control

___ 40. I am a hateful person

___ 42. I am losing my mind

___ 56. I am an important person to my friends and family

___ 58. I am not loved by my family

___ 60. I feel that my family doesn't trust me

___ 74. I am popular with women

___ 76. I am mad at the whole world

___ 78. I am hard to be friendly with

___ 92. Once in a while I think of things too bad to talk about

___ 94. Sometimes, when I am not feeling well, I am cross

___ 7. I am neither too fat nor too thin

___ 9. I like my looks just the way they are

___ 11. I would like to change some parts of my body

___ 25. I am satisfied with my moral behavior

___ 27. I am satisfied with my relationship to God

___ 29. I ought to go to church more

___ 43. I am satisfied to be just what I am

___ 45. I am just as nice as I should be

___ 47. I despise myself

___ 61. I am satisfied with my family relationships

___ 63. I understand my family as well as I should

___ 65. I should trust my family more

___ 79. I am as sociable as I want to be

___ 81. I try to please others, but I don't overdo it

ANSWERS:	Completely false	Mostly false	Partly false and partly true	Mostly true	Completely true
	1	2	3	4	5

___ 83. I am no good at all from a social standpoint

___ 95. I do not like everyone I know

___ 97. Once in a while, I laugh at a dirty joke

___ 8. I am neither too tall nor too short

___ 10. I don't feel as well as I should

___ 12. I should have more sex appeal

___ 26. I am as religious as I want to be

___ 28. I wish I could be more trustworthy

___ 30. I shouldn't tell so many lies

___ 44. I am as smart as I want to be

___ 46. I am not the person I would like to be

___ 48. I wish I didn't give up as easily as I do

___ 62. I treat my parents as well as I should (Use past tense if parents are not alive)

___ 64. I am too sensitive to things my family say

___ 66. I should love my family more

___ 80. I am satisfied with the way I treat other people

___ 82. I should be more polite to others

___ 84. I ought to get along better with other people

___ 96. I gossip a little at times

___ 98. At times I feel like swearing

___ 13. I take good care of myself physically

___ 15. I try to be careful about my appearance

___ 17. I often act like I am "all thumbs"

___ 31. I am true to my religion in my everyday life

ANSWERS:	Completely false	Mostly false	Partly false and partly true	Mostly true	Completely true
	1	2	3	4	5

___ 33. I try to change when I know I'm doing things that are wrong

___ 35. I sometimes do very bad things

___ 49. I can always take care of myself in any situation

___ 51. I take the blame for things without getting mad

___ 53. I do things without thinking about them first

___ 67. I try to play fair with my friends and family

___ 69. I take a real interest in my family

___ 71. I give in to my parents. (Use past tense if parents are not living)

___ 85. I try to understand the other fellow's point of view

___ 87. I get along well with other people

___ 89. I do not forgive others easily

___ 99. I would rather win than lose in a game

___ 14. I feel good most of the time

___ 16. I do poorly in sports and games

___ 18. I am a poor sleeper

___ 32. I do what is right most of the time

___ 34. I sometimes use unfair means to get ahead

___ 36. I have trouble doing the things that are right

___ 50. I solve my problems quite easily

___ 52. I change my mind a lot

___ 54. I try to run away from my problems

___ 68. I do my share of work at home

___ 70. I quarrel with my family

___ 72. I do not act like my family thinks I should

ANSWERS:	Completely false	Mostly false	Partly false and partly true	Mostly true	Completely true
	1	2	3	4	5

___ 86. I see good points in all the people I meet

___ 88. I do not feel at ease with other people

___ 90. I find it hard to talk with strangers

___100. Once in a while I put off until tomorrow what I ought to do today

APPENDIX B

Appendix B

The DOV-O Scoring System

Question 1: Assign +1 if victim stated she knew the attacker, except if victim stated she never met him but had seen him around.

Question 2: Assign +1 if assailant made any threats, even if victim does not describe them.

Add +.5 to the above score if the threat was to kill the victim, kill victim's loved one(s), or harm the victim's child.

Question 3: Assign +1 if assailant said he had a weapon.

Add an additional +.5 if he said he had a knife or gun. Add another +.5 if victim actually saw or felt weapon.

Question 4: Assign +1 if 1st, 2nd, or 3rd choice circled.

(Note: even if all 3 are circled, the score still is just "1").

Assign +1 if 4th choice is circled.

(Note: if 4th choice is circled, plus any of the others, final item score is "2").

Question 5: Assign +1 if victim says she was struck. Add +.5 to this if victim was struck more than one time. Add +.5 if victim was struck with an object other than a hand (example: stick, rock, gun, etc.).

Question 6: Assign "0" if victim says she has injuries but they were only brush burns, or small marks not directly or

The DOV-0 Scoring System

Question 6: purposely inflicted by assailant (example: a brush burn from falling on the ground).

Assign +1 if victim stated she had any physical injuries after the assault; and if the injuries were mild and directly placed on victim by assailant. Examples of mild injuries include: minor cuts, sprains, black eye, or a few small bruises.

Assign +2 for major injuries inflicted by assailant. Examples include: fractures, vaginal cuts, wounds requiring stitching or surgery, concussions, aftereffects of near strangulation, extensive bruising and swelling due to severe beating.

Note: Assign +1 if victim said she had injuries after the assault but did not describe their nature.

Note: DOV-0 score equals the sum of scores for questions one through six.

APPENDIX C

Appendix C

ARSI-O Scoring Guidelines

General guidelines:	0 = symptom didn't occur (Note: if a symptom is not mentioned, score it 0). 1 = mild occurrence 2 = moderate occurrence 3 = severe occurrence
<u>Sleep</u>	
Difficulty falling asleep:	1 = taking up to 1 more hour 2 = taking 1-2 more hours a night to fall asleep 3 = more than 2 hours a night on an average
Nightmares:	1 = 1 a week 2 = 2 a week 3 = 3 a week
Sleeping more:	1 = 1-2 more hours a day on an average 2 = 2-3 more hours 3 = 3+ hours more
Sleeping less:	Same as above
Waking more:	1 = 1-2 times that week 2 = once or twice a night for 2 or 3 nights that week 3 = waking once or twice a night for the majority of the week

TOTAL = Sum of score on the above questions.

ARSI-O Scoring Guidelines

Appetite

Less hungry:	1 = yes, but no weight loss beyond 3 pounds 2 = yes and has lost 4-6 pounds 3 = yes and lost 7-10 pounds
More hungry:	Same as above, except indicating weight gain
Queasy:	1 = yes, but infrequent and no vomiting 2 = yes, feels that way most of the week but not vomiting or losing weight because of it 3 = yes, has been queasy to point of vomiting at least one time that week
Threw up:	1 = once that week 2 = 2-3 times that week 3 = 3+ times that week

TOTAL = Sum up all points on appetite.

Somatic

Headaches:	1 = a few mild ones, didn't interfere with functioning 2 = several times that week — when it happens, it's a long, nagging headache, it may distract her from usual schedule 3 = headaches all week long — or very severe headache or migraines on occasion that disrupted functioning
Upset stomach or cramps: (If only in association with food, don't rate.)	1 = infrequent, didn't interfere 2 = majority of week, some interference 3 = severe, majority of week and/or so severe on occasion that functioning is disrupted (e.g. misses work, loss of appetite)

ARSI-O Scoring Guidelines

Somatic

Diarrhea/Constipation:
- 1 = 1 time that week
- 2 = 2 times or more but not going on majority of week
- 3 = went on most of the week

More tired:
- 1 = yes, but didn't interfere
- 2 = yes, mild interference
- 3 = yes, interferes a great deal with functioning that week

Somatic symptoms related to anxiety (e.g. trembling, cold sweats, heart palpitation):
- 1 = occasional, but not the rule for the week
- 2 = happens several times that week
- 3 = going on most of the week, or severe interference such as sporadic panic attacks

TOTAL = Total somatic points.

Affective

Depressed:
- 1 = occasional low moods, but no real interference
- 2 = more frequent low moods, mild interference with functioning
- 3 = depressed most of week and/or severe interference with functioning. Suicidal ideation during time period also give a "3" here.

Angry:
- 1 = feels more irritable/angry but no acting out
- 2 = more outbursts or arguments than usual with friends or family
- 3 = major explosions of temper, "telling off" strangers or authorities, fists in wall, etc.

ARSI-O Scoring Guidelines

Affective

Fearful: (To rate, look at average intensity of rape-related fears client reports.)	1 = startles more easily, but not avoiding anything 2 = some avoidance of feared objects 3 = near total avoidance of feared object if on own
More withdrawn:	1 = feels that way, but no observable change in her behavior 2 = yes, is decreasing social outings and socializing 3 = very intense avoidance of usual amount of socialization
Anxiety tension:	1 = off and on feeling, no somatic symptoms 2 = feels that way most the week, but no real interference with functioning 3 = feels most of the week and is interfering

TOTAL = Sum up all points on affective.

Rape-related Fears

For each fear use the following scoring system:	1 = mild, more afraid than usual but behaving the same 2 = moderate, some avoidance or change of behavior 3 = severe, near total avoidance of through most of time period — ex., won't stay in house alone, must be driven to work each day

Heterosexual

Less trusting of men:	1 = feels, but doesn't act on 2 = moderate change in behavior 3 = dramatic change in behavior around men
More afraid of men:	Same as above

ARSI-O Scoring Guidelines

If Has Partner

Less close:
1 = yes, but acting same
2 = yes, and either she or partner have shown mild behavior change
3 = major behavior change

Increase in arguments:
1 = mild increase
2 = moderate increase
3 = severe, with new threats of leaving or relationship actually disrupted

With No Partner

Less willing to date:
1 = feels less like dating, but still is
2 = moderate change in dating behavior
3 = major change in dating behavior

Spending less time with male friends:
Same as above

TOTAL

Sexual Concerns

No Partner

As comfortable with physical contact:
1 = no, but no behavior change
2 = no, and some behavior change
3 = no, and major behavior change

As comfortable with sexual contact:
1 = no, but no behavior change
2 = no, and some behavior change
3 = no, and major behavior change

Anxious re: future relationships:
1 = no, but no behavior change
2 = no, and some behavior change
3 = no, and major behavior change

ARSI-O Scoring Guidelines

Partner

Change in frequency of intercourse:

1 = yes, mild or sporadic change
2 = moderate decrease
3 = total decrease

Change in sexual satisfaction:

1 = a bit more tense, so a little less
2 = moderate change
3 = major loss of satisfaction — for example: not orgastic, refusing any sexual contact

Flashbacks while making love:

1 = yes, but doesn't interfere
2 = yes, and some interference
3 = yes, and major interference example: refusal of certain sexual practices, avoiding making love

School/Home/Work

Miss days:

1 = 1-2 days 1st 2 weeks, or much debate about going but finally went
2 = 0-2 days after 1st 2 weeks, or 3 or more days missed 1st 2 weeks
3 = 5 or more days 1st 2 weeks or still sporadically missing after 5-6 weeks.

Concentration:

1 = mild
2 = moderate
3 = severe

Quitting:

1 = occasional thoughts but doesn't
2 = constantly debating
3 = actually quits due to rape

If a housewife or unemployed, on this question give:

1 = if thinking of moving into more dependent situation (i.e., back to family) but doesn't
2 = moves into friends or family for a few days
3 = moving in with plans to stay more than a few days

ARSI-O Scoring Guidelines

School/Home/Work

Decline in performance, production, on-job:

1 = feels it has but no objective measure
2 = some drop noted (ex.: lower grades, people at work asking what's wrong)
3 = flunks course(s), fired from job due to rape-related behaviors

APPENDIX D

Appendix D

Correlation Matrices of Single and Multiple Administration Questionnaires Used with the Incoming Group

Table 36

Intercorrelation Matrix of Single Administration Questionnaires Among Incoming Victims

	Constantinople						Levenson								LES		
Measures	T	MT	IN	IS	FSS	BSRI	I	C	P	BSC	TAT	POMS	SAH	REL	N	P	T
C: T	—	-59[c]	12	-25	-18	-91[a]	50	-11	05	-17	49	02	04	-23	-15	24	14
C: MT	-59[c]	—	-32	73[b]	33	77[b]	-40	24	04	03	-23	17	-12	73	32	47	50
C: IN	12	32	—	-77[b]	24	-47	-11	-11	-26	09	39	29	-28	-20	-26	-11	-26
C: IS	-25	73[b]	-77	—	22	55	-05	24	24	-17	-27	-25	06	46	31	48	31
FSS	-18	33	24	22	—	05	-09	-20	07	15	50	31	-16	-28	-12	55	00
SRI	-91[a]	77[b]	-47	55	05	—	-44	24	-18	18	-62	-07	06	53	11	-25	24
L: I	50	-40	-11	-05	-09	-44	—	12	57	17	-02	-10	-18	-14	27	46	-60
L: C	-11	24	-11	24	-20	24	12	—	35	-50	-67[c]	-43	34	30	17	09	-38
L: P	05	04	-26	24	07	-18	57	35	—	-36	-13	-27	01	-21	57	42	-07
BACS	-17	03	09	-17	15	18	17	-50	-36	—	22	58[c]	-03	01	00	13	-14
TAT	49	-23	39	-27	50	-62	-02	-67[c]	-13	22	—	65[c]	12	41	05	30	25
POMS	02	17	29	-25	31	-07	-10	-43	-27	58[c]	65[c]	—	19	21	-03	44	57[a]
SAH	04	-12	-28	06	-16	06	-18	34	01	-03	12	19	—	-12	30	03	00
REL	-23	73[b]	-20	46	-28	53	-14	30	-21	01	41	21	-12	—	21	74	51[a]
LES: N	-15	32	-26	31	-12	11	27	17	57	00	05	-03	30	21	—	17	10
LES: P	24	47	-11	48	55	-25	46	09	42	13	30	44	03	24	17	—	49[a]
LES: T	14	50	-26	31	00	24	-60	-38	-07	-14	25	57[c]	00	51[c]	10	49[c]	—

Note. The following abbreviations were used: Trust (T), Mistrust (MT), Intimacy (IN), Isolation (IS), Levenson (L), Internal (I), Control (C), Powerful Others (P), Body Cathexis (BCS), Support System Rating - Average Level of Helpfulness (SAH), and on the LES, negative (N), positive (P), and total (T) change scores.

Table 37

Correlations of Single With Multiple Administration Questionnaires

Multiple Administrations

	TSCS			Anger			Guilt		
Measures	1	2	3	1	2	3	1	2	3
C: T	-41	-03	-07	-08	-35	-07	12	-71[c]	-15
C: MT	-08	-36	44	35	40	-10	-21	48	54
C: IN	57	81[b]	34	20	-22	26	20	-64[c]	-10
C: IS	-56	-82	00	-08	26	-05	-24	62[c]	48
FSS	-40	-33	02	48	63[c]	11	32	47	74[b]
SRI	24	-22	37	12	45	-17	-23	82[b]	04
L: I	-66[c]	-27	-77[c]	-67	-47	-25	50	-31	32
L: C	29	15	06	-06	-08	61	09	-07	-24
L: P	-11	-30	-73[c]	-12	-19	15	25	07	50
BCS	-46	01	08	06	25	-76[b]	59[c]	17	03
TAT	-42	-12	19	51	12	-53	40	-19	52
POMS	04	06	30	96[a]	59[c]	-66[c]	50	12	27
SAH	-24	-29	-34	30	-02	-06	54[c]	27	-47
REL	06	-03	58[c]	-12	-05	-15	-10	13	08
LES: N	-07	-28	-26	-08	-35	-40	16	-02	22
LES: P	-37	-50[c]	02	44	51	-03	35	10	65[c]
LES: T	03	-24	46	71[b]	44	-27	-08	01	31

APPENDIX E

Appendix E

Summary on Questionnaire and ARSI-W Scores Affected by Demographic Variables

Rosenberg self-esteem Scale. Four demographic variables linked significantly to Self-Esteem scores. Lower self-esteem was displayed by victims whose educational background was limited to high school (versus college), by victims of different race (rather than same-race) rapists, and by seekers of professional postassault counseling (versus those who did not). Contrary to expectations, those assaulted in their own home evidenced higher self-esteem than those assaulted elsewhere.

Anger. Adolescents reported significantly more anger than did adults. When the adult sample was broken into two age categories, ages 18-29, and ages 30 and older, the adolescents reported more anger. Victims with high school backgrounds also evidenced more anger than those with college backgrounds. More anger was also expressed by victims assaulted in their home and individuals who had been previously assaulted sexually. Those who described their preassault sexual experience as mixed (positive and negative) also obtained higher Anger scores than did those whose previous experiences were primarily negative.

Guilt. Individuals with a history of prerape counseling

and those who contacted professional counselors for rape-precipitated problems obtained higher Guilt scores than those without a history of counseling or who did not seek postassault professional counselors. Victims having only high school educations obtained higher Guilt scores than did those with some college. Posthoc analysis with the LSD, but not the Scheffe's, indicated that individuals employed as semi-skilled/unskilled laborers or homemakers also obtained higher Guilt scores than did professional technical employees. Those with mixed positive and negative previous sexual history obtained higher Guilt scores than individuals reporting a history of negative sexual experiences.

DOV-O. Significantly higher DOV-O scores characterized victims who reported receiving verbal threats during the assault, being physically restrained, struck, or threatened with a weapon.

DOV-S. Victims of multiple assailants, or those receiving verbal threats during the assault obtained higher scores. Those assaulted 13-24 months ago obtained higher scores than those assaulted 0-3, 4-12, or 25 months. Home-assaulted victims and those employed (versus unemployed) obtained significantly lower DOV-S scores.

DOV-R. Three groups of victims scored significantly higher than the others: (a) those injured by rapists; (b) those receiving severe to moderate injuries as opposed to milder injury; and (c) those whose assaults involved deviant sexual acts alone or in combination with vaginal penetration.

DOV-T. Victims who reported having been threatened, struck, and moderately or severely injured obtained higher DOV-T scores than those less threatened or injured. If the assault involved multiple assailants, or if the victim was assaulted in any location but her home, DOV-T scores were significantly higher. Victims who were assaulted 13-24 months ago also scored significantly higher than those raped 0-3, 4-12, or 25-plus months ago.

ARSI-W: one week postassault: Only struck victims evidenced more symptoms.

ARSI-W: one month postassault: Struck victims continued to evidence more symptoms than nonstruck. Adults also evidenced more symptoms than adolescents. Victims of multiple assailants, and those who contacted professional counselors after the rape, also reported more symptoms.

ARSI-W: three months postassault: Victims whose assailant had been arrested evidenced fewer symptoms than victims of nonapprehended assailants. If a victim had been struck, or had a history of receiving personal counseling before the assault, more symptoms were reported. Similarly, those contacting a professional counselor for postassault difficulties evidenced more symptoms than those who didn't. Finally, posthoc analysis with the LSD procedure indicated that victims receiving mild injuries reported more symptoms than did the noninjured. The Scheffe confirmed no differences between these two groups.

ARSI-W: Sleep. Two victim categories evidenced more

assault-related sleep disturbances: those who had been struck, and those who had sought professional counseling for postassault difficulties.

ARSI-W: Appetite. Adolescents evidenced significantly less disturbance than adults. Greater disturbances were reported by struck victims and by those who had been injured moderately to severely.

ARSI-W: Somatic. Struck victims evidenced more disturbance than others.

ARSI-W: Mood. Victims assaulted in their own home, and those whose assailants had been arrested, evidenced less mood disturbance than those who were assaulted elsewhere or whose assailants were unapprehended. Victims with a prior history of counseling for personal problems, those from poverty-level backgrounds, and those contacting professional counselors for postassault difficulties evidenced more disturbance than others.

ARSI-W: Assault-Related Fears. Victims who did not know their assailant, had multiple assailants, or had a previous history of receiving personal counseling, or had poverty-level backgrounds reported more disturbance than their counterparts.

ARSI-W: Heterosexual Relationships. Posthoc analysis with the LSD procedure indicated that poverty-level individuals also evidenced more postassault disruption in heterosexual relationships than did lower middle-class victims, but the Scheffe procedure did not confirm this finding. Victims

assaulted at home evidenced less disturbance than those assaulted elsewhere. Struck victims, those who had previous professional counseling, or who had contacted a professional counselor postassault evidenced greater disturbance. Posthoc analysis indicated that poverty-level individuals had more difficulty in this area than the lower-middle class. However, the Scheffe did not confirm this finding.

ARSI-W: Sexual Relationships. Those having college backgrounds reported more difficulty in this area than high school dropouts, and those who had contacted a professional counselor postassault evidenced more disturbance than those who had not. Finally, individuals whose assailants were arrested evidenced less disturbance than did victims of unapprehended assailants.

ARSI-W: Occupation. Adolescents reported less disturbance than adults, while those assaulted in their own home evidenced more disturbance than those assaulted elsewhere.

APPENDIX F

Appendix F

Independent Effects of Demographic Variables on Questionnaire and ARSI-O Scores

Several demographic variables were examined for any independent effect they might exert on the dependent measures of incoming group members. These demographic variables included: age (adolescents vs. adults), educational level (high school vs. college), socioeconomic status (below middle class vs. middle class and above), religious identification (Catholic vs. Protestant), previous history of mental health counseling, marital status (single, married, and either separated, widowed, or divorced), occupation (employed vs. unemployed), location of the rape (at home vs. elsewhere), virgins vs. nonvirgins, the quality of previous sexual experiences (generally positive vs. generally negative), those assaulted before vs. those never assaulted before the present rape, sexual events during the assault (vaginal penetration alone vs. IDSI), race of the assailant, the number of assailants (single vs. multiple), those whose assailants were arrested vs. those whose were not, those who knew their attacker vs. those who did not, the presence of threats or weapons during the assault or not, and victims who were struck and/or injured vs. those who were not. As could be seen from this listing, the variables (with the exception of marital status)

were classified into two groups alone. Finer discriminations could not be calculated given the small number of victims and the correspondingly empty cells that resulted when more than two classifications per variable were used. As was the case when similar comparisons were made using the total victim pool, t-test comparisons were used unless the dependent measure was a multiple administration measure. In this event a oneway analysis of variance was employed. In each case, a probability level of $p < .05$ was required for a result to be considered significant. When a hypothesis was being tested a one-tailed t-test was used, otherwise nondirectional t-test were employed.

Age. Seventeen individuals had completed the ARSI-O at six weeks postassault and the item about age. The six adolescent victims obtained significantly lower scores at this time period ($\bar{M} = 3.67$) than adults ($\bar{M} = 20.91$), $F(1,15) = 6.33$, $p < .05$.

Arrest of assailant. Eleven victims completed the first administration of the Anger scale and the item regarding the assailant's arrest. The two victims of arrested assailants reported more anger ($\bar{M} = 46.50$) than the nine victims whose assailant was not apprehended ($\bar{M} = 25.89$). This difference was significant ($F(1,9) = 5.43$, $p < .05$) and supported Hypothesis eleven which predicted that victim's whose assailant was not arrested would report less anger at one week postassault than victim's whose assailant was "safely behind bars".

Educational level. Ten victims completed the third administration of the TSCS and the item regarding educational level. The eight individuals of high school backgrounds obtained a mean score of 335.38 while the two victims with a college background obtained a lower mean score of 297.50. This difference was significant with F (1,8) = 6.61, $p < .05$.

Nine victims completed Levenson's Internal scale and the item regarding educational level. The six individuals of high school background obtained a mean score of 29.67 while the three victims with a college background obtained a significantly higher mean score of 40.00 (t (7) = -3.51, p = .01).

Fifteen victims completed the LES and the item regarding educational level. The twelve individuals with a high school background obtained a mean score on the negative change items of 2.03, while the three victims with college background obtained a significantly higher score of 11.29 (t (13) = -2.27, $p < .05$).

Injury. Of the 11 victims completing the four TAT cards scored for disguised anger, the two uninjured persons obtained significantly higher scores ($\bar{M}$ = 10.50) than the injured ($\bar{M}$ = 3.22). Fifteen individuals completed the support system form and item about assault-related injuries. The two noninjured reported telling significantly more people about the assault ($\bar{M}$ = 7.50) than did the thirteen injured ($\bar{M}$ = 3.69).

Location of assault. Of the eleven individuals completing Constantinople's Intimacy scale, the three victims assaulted at home evidenced lower scores on this scale than the

eight victims assaulted elsewhere (t (9) = 3.68, $p < .01$). Those assaulted at home obtained mean scores of 21.33 versus 26.50 for those assaulted elsewhere.

Those victims raped at home reported significantly more negative life change on the LES in the year preceding the assault ($\bar{M}$ = 9.34) than those raped elsewhere ($\bar{M}$ = 1.89) t (13) = 1.94, $p < .05$. A one-directional t-test was used as Hypothesis two had predicted that those assaulted at home would evidence more disturbance than those assaulted elsewhere. Fifteen individuals had completed the LES and location of the assault items with four having been assaulted at home, and eleven assaulted elsewhere.

Thirteen individuals completed the second administration of the TSCS and the location of the assault item. The three victims assaulted at home reported significantly lower self-esteem ($\bar{M}$ = 289.00) than the ten raped elsewhere ($\bar{M}$ = 332.40), F (1,11) = 8.00, $p < .05$. This supported Hypothesis two which had predicted that those raped at home would evidence lower self-esteem than those assaulted elsewhere.

Marital status. Seventeen individuals completed the ARSI-O at four weeks postassault as well as the marital status item. Three classifications of marital status were considered for comparison: single (N = 12), married (N = 2), and separated, divorced, or widowed (N = 3). The groups differed significantly on the ARSI-O score for this time period such that F (2,14) = 5.18, $p < .05$. Posthoc analysis with the Scheffe indicated that the single victims ($\bar{M}$ = 15.42) and

married individuals ($\bar{M}$ = 35.00) were significantly different ($p < .10$), and that married individuals also obtained significantly higher scores than those separated, divorced, or widowed ($\bar{M}$ = 3.00) with $p < .05$.

Number of assailants. Seventeen victims completed this administration of the ARSI-O and the number of assailants item. The four victims assaulted by multiple assailants obtained significantly higher scores ($\bar{M}$ = 37.50) than those assaulted by single assailants ($\bar{M}$ = 16.39). This difference was significant (F (1,15) = 4.87, $p < .05$.

Previous mental health counseling. Individuals with a history of receiving mental health counseling for some personal problem before the assault obtained significantly lower scores on the Body Cathexis scale than those without such a history (t (9) = -2.03, $p < .036$). Of the 11 members completing the Body Cathexis scale, four individuals had a history of counseling and obtained a mean score of 25.75, while seven individuals had no such history and obtained a mean score of 31.00.

Of the nine victims completing Levenson's locus of control measure, the victims with a history of preassault counseling obtained higher scores on the Internal scale than those without prior counseling (t (7) = 2.53, $p < .05$). The two precounseled victims obtained a mean score of 41.00, versus 30.86 for the seven others.

Fifteen victims completed the Support System Rating and the previous mental health counseling item. The five victims

having prior counseling histories reported a significantly greater number of significant others ($\bar{M}$ = 9.80) than the ten nonprecounseled victims ($\bar{M}$ = 6.30), t (13) = 2.21, $p < .05$.

Previous sexual assaults. Fourteen individuals completed the LES and history of previous sexual assault items. The seven victims with a previous history of assault reported significantly more positive life changes in the year preceding the assault ($\bar{M}$ = 2.59) than those seven never before assaulted ($\bar{M}$ = 1.35), t (12) = 2.48, $p < .05$.

Race of assailant. Twelve individuals completed both the Support System Rating and the item regarding assailant's race. Those raped by different race assailants rated the level of helpfulness of significant others told about the assault significantly higher ($\bar{M}$ = 4.74) than those victimized by same-race assailants.

Ten individuals completed the second administration of the Guilt and the race of assailant item. The seven individuals assaulted by same-race assailants reported less guilt ($\bar{M}$ = 19.71) than the four different-race victims ($\bar{M}$ = 31.75). This difference was statistically significant (F (1,9) = 7.86, $p < .05$).

Ten individuals also completed the second administration of the Anger scale and the race of assailant item. The seven victims raped by a member of the same race reported less anger ($\bar{M}$ = 19.71) than those raped by different-race assailants ($\bar{M}$ = 31.75). This difference was significant (F (1,9) = 7.86, $p < .05$).

Fifteen individuals completed the ARSI-O at six weeks postassault and the race of the assailant item. The nine individuals raped by a member of the same race obtained a lower mean score ($\bar{M}$ = 7.00) than those six assaulted by an assailant of a different race ($\bar{M}$ = 21.17). This difference was significant with F (1,13) = 4.88, $p < .05$.

Sexual events during the assault. Of the eleven who both completed the POMS and responded to a question asking about the sexual events occurring during the assault, the seven who experienced IDSI assaults obtained mean scores of 125.86, much greater than the 60.00 mean of the six victims of vaginal penetration alone. This difference was significant at a $p < .05$ level (t (11) = -2.99, p = .012.

Seventeen individuals also completed the ARSI-O at four weeks postassault and information regarding the sexual events during the rape. In eight instances, vaginal penetration alone was involved, whereas nine cases involved IDSI in combination with vaginal penetration or alone. Individuals whose assaults involved IDSI obtained higher ARSI-O scores at this time ($\bar{M}$ = 21.67) than those whose assault did not involve this ($\bar{M}$ = 8.63). This difference was significant with F (1,15) = 4.98, $p < .05$.

Threats. Ten individuals completed the first administration of the Anger scale and the assailant's threats item. Individuals who had been verbally threatened (N = 7) obtained a mean score of 24.14 versus 44.33 mean for those not verbally threatened, (N = 3). This difference was significant,

F (1,8) = 7.17, $p < .05$. Similarly, verbally threatened victims reported significantly less anger on the second administration of the Anger scale ($\bar{M}$ = 15.13) than the three not threatened ($\bar{M}$ = 41.00). This difference was statistically significant (F (1,8) = 21.13, $p < .01$).

Virginity. Seventeen victims completed the ARSI-O at six weeks postassault and the item regarding virginity. The four victims who were virgins before the assault reported no symptoms at this time period ($\bar{M}$ = 0.00) while the 13 nonvirgins obtained a mean score of 19.39. This difference was significant (F (1,15) = 6.29, $p < .05$).

BIBLIOGRAPHY

Bibliography

Amir, M. Patterns in forcible rape. Chicago: University of Chicago Press, 1971.

Arrindell, W.A. Dimensional structure and psychopathology correlates of the Fear Survey Schedule (FSS-III) in a phobic population: A factorial definition of agoraphobia. Behaviour Research and Therapy, 1980, 18, 229-242.

Bard, M., & Ellison, K. Crisis intervention and investigation of forcible rape. Police Chief, 1974, 41, 68-73.

Bart, P. Rape doesn't end with a kiss. Viva, 1975 (June).

Bates, H.D. (1971) Factorial structures and MMPI correlates of Fear Survey Schedule in a clinical population. Behaviour Research and Therapy, 1971, 9, 355-360.

Becker, J.V., Abel, G.G., & Skinner, L.J. The impact of a sexual assault on the victim's sexual life. Victimology: An International Journal, 1979, 4, 229-235.

Bem, S.L. The measurement of psychological androgyny. Journal of Consulting and Clinical Psychology, 1974, 42, 155-162.

Bem, S.L., & Lenney, E. Sex typing and the avoidance of cross-sex behavior. Journal of Personality and Social Psychology, 1976, 33, 48-54.

Bernard, L.C. Multivariate analysis of new sex-role formalations and personality. Journal of Personality and Social Psychology, 1980, 38, 323-331.

Biaggio, M.K. Assessment of anger arousal. Journal of Personality Assessment, 1980, 44, 289-298.

Biaggio, M.K., Supplee, K. & Curtis, N. Reliability and validity of four anger scales. Journal of Personality Assessment, 1981, 45, 639-648.

Boulton, B. The Tennessee Self-Concept Scale and the normal Personality Sphere (16 PF). Journal of Personality Assessment, 1979, 43, 608-613.

Brodsky, C.M. Rape at work. In M.J. Walker & S.L. Brodsky's Sexual Assault. Lexington: Lexington Books, 1976.

Burgess, A.W. & Holmstrom, L.L. Rape trauma syndrome. American Journal of Psychiatry, 1974, 131, 981-985.

Burgess, A.W. & Holmstrom, L.L. Rape: Sexual disruption and recovery. American Journal of Orthopsychiatry, 1979, 49, 648-657.

Buss & Durkee. Journal of Consulting Psychology, 1957, 21, 343-349.

Chappell, D., Geis, R. & Geis, G. (Eds.) Forcible rape: The crime, the victim, and the offender. New York: Columbia University Press; 1977.

Chappell, D., Geis, G., Schafer, S., & Siegel, L. Forcible rape: a comparative study of offenses known to the police in Boston and Los Angeles. In J. Henslin's Studies in Sociology of Sex. New York: Meredith Corporation, 1971.

Clark, L. & Lewis, D. Rape: The price of coercive sexuality. Toronto: Women's Educational Press, 1977.

Cohen, M.L., Garofalo, R., Boucher, R.B., & Seghorn, T. The psychology of rapists. In D. Chappell, R. Geis, & G. Geis (Eds.), Forcible rape: The crime, the victim, and the offender. New York: Columbia University Press, 1977.

Constantinople, A. An Eriksonian measure of personality development in college students. Developmental Psychology, 1969, 4, 357-372.

Crandall, R. The measurement of self-esteem and related constructs. In J.P. Robinson & P.R. Shaver (Eds.), Measures of Social Psychological Attitudes. (Rev. ed.) Ann Arbor: Survey Research Center, Institute for Social Research, 1973.

Cristall, L., & Dean, R. Relationship of sex-role stereotypes and self-actualization. Psychological Reports, 1976, 39, 842.

Derogatis, L.R. SCL-90: Administration, Scoring and Procedures Manual-I for the Revised version. Johns Hopkins University School of Medicine. Clinical Psychometrics Research Unit, Baltimore, 1977.

Deutsch, H. Psychology of Women (Vol. 1). New York: Grune & Stratton, 1944.

Dixon, J.J., De Monchaux, C. & Sandler, J. (1957) Patterns of anxiety: The phobias. British Journal of Medical Psychology, 1957, 30, 34-40.

Dobson, C., Goudy, W.J., Keith, P.M., & Powers, E. Further analysis of Rosenberg's self-esteem scale. Psychological Reports, 1979, 44, 639-641.

Eisenhower, M.S. To establish justice, to insure domestic tranquility. Final Report of the National Commission on Causes and Prevention of Violence. Washington, D.C.: U.S. Government Printing Office, May, 1967.

Ellis, M.E., Atkeson, B.M., & Calhoun, K.S. An assessment of long-term reaction to rape. Journal of Abnormal Psychology, 1981, 90, 263-266.

Enterlin, M. Sex Crimes Unit, personal communication with E. Schuker; 1978.

Erdwins, C., Small, A., & Gross, R. The relationship of sex role to self-concept. Journal of Clinical Psychology, 1980, 36, 111-115.

Erikson, E.H. Identity and the life cycle: Selected papers. Psychological Issues, 1959, 1, 1-171.

Faulkner & DeJong. Religiosity Scales. In Glock, C. & Stark, R. Religion and Society in Tension. Chicago: Rand McNally, 1965.

Federal Bureau of Investigation, L. Patrick Gray III, Director. Crime in the United States. Uniform Crime Reports, 1971. Washington, D.C.: U.S. Government Printing Office, August 29, 1972.

Federal Bureau of Investigation, L. Patrick Gray III, Director. Crime in the United States. Uniform Crime Reports, 1973. Washington, D.C.: U.S. Government Printing Office, November 17, 1975.

Feldman-Summers, S., Gordon, P.E., Meagher, J.R. The impact of rape on sexual satisfaction. Journal of Abnormal Psychology, 1979, 88, 101-105.

Fisher, S., Pillard, R.C., & Yamada, L. Hard-core anxiety in dental patients: Implications for drug screening. Neuropsychopharmacology, 1968, 6, 381-382.

Fitts, W.H. Manual for the Tennessee Self-Concept Scale. Nashville: Counselor Recordings and Tests, 1965.

Gager, Nancy and Schurr, Cathleen. Sexual assault: Confronting rape in America. New York: Grosset and Dunlap, 1976.

Geer, J.H. The development of a scale to measure fear. Behaviour Research and Therapy, 1965, 3, 45-53.

Geis, G. Forcible rape: an introduction. In D. Chappell, R. Geis, & G. Geis (Eds.), Forcible rape: The crime, the victim, and the offender. New York: Columbia University Press, 1977.

Glock, C. & Stark, R. Religion and Society in Tension. Chicago: Rand McNally, 1965.

Goldman, J.A. & Olczak, P.V. Effect of an innovative educational program upon self-actualization and psychosocial maturity: a replication and following. Social Behavior and Personality, 1980, 8, 41-47.

Graves, R. The Greek Myths, Volume 1. New York: Braziller, 1957.

Greer, G. Seduction is a four-letter word. In L.G. Schultz's Rape Victimology. Springfield, Ill.: Thomas, 1975.

Griffin, Susan. Rape: The all-American Crime. Ramparts, 1971, 10, 26-36.

Gross, R., Batlis, N., Small, A. & Erdwins, C. Factor structure of the Bem Sex-role Inventory and the Personal Attributes Questionnaire. Journal of Consulting and Clinical Psychology, 1979, 47, 1122-1124.

Groth, A.N. & Burgess, A. Rape: power, anger & sexuality. American Journal of Psychiatry, 1977, 134, 1239-1243.

Groth, A.N. & Burgess, A. Rape: a sexual deviation. American Journal of Orthopsychiatry, 1979, 47, 400-406.

Hallam, R.S. & Hafner, R.J. Fears of phobic patients: Factor analyses of self-report data. Behaviour Research and Therapy, 1978, 16, 1-6.

Hensley, W.E. Differences between males and females on Rosenberg scale of self-esteem. Psychological Reports, 1977, 41, 829-830.

Hensley, W.E. & Roberts, M.K. Dimensions of Rosenberg's scale of self-esteem. Psychological Reports, 1976, 38, 583-584.

Hilberman, E. The Rape Victim. New York: Basic Books, 1976.

Holmes, T.H. & Rahe, R.H. The social readjustment scale. Journal of Psychosomatic Research, 1976, 11, 213-218.

Hursch, C.J., & Selkin, J. Rape Prevention Research Project. Mimeographed Annual Report of the Violence Research Unit, Division of Psychiatric Service, Department of Health and Hospitals, Denver, 1974.

Jacques, J.M., & Chason, K.J. Self-esteem and low status groups: a changing scene? Sociological Quarterly, 1977, 18, 399-412.

Johnson, J.H., & Sarason, I.G. Life stress, depression and anxiety: Internal-external control as a moderator variable. Journal of Psychosomatic Research, 1978, 22, 205-208.

Johnson, L. Body cathexis as a factor in somatic complaints. Journal of Consulting Psychology, 1956, 20, 145-149.

Jones, W.H., Chernovetz, M.E., & Hansson, R.O. The enigma of androgyny: Differential implications for males and females? Journal of Consulting and Clinical Psychology, 1978, 46, 298-313.

Kaplan, J.B., & Pokorny, A. D. Self-derogation and psychosocial adjustment. Journal of Nervous and Mental Disease, 1969, 149, 421-434.

Katz, S., & Mazur, M. Understanding the Rape Victim: A Synthesis of Research Findings. New York: John Wiley, 1979.

Kaufman, A. Male rape victims: noninstitutionalized assault. American Journal of Psychiatry, 1980, 137, 221-223.

Kilpatrick, D.G., Veronen, L.J., & Resick, P.A. The aftermath of rape: Recent empirical findings. American Journal of Orthopsychiatry, 1979, 49, 658-669.

Lang, P.J., & Lazovik, A.D. The experimental desensitization of an animal phobia. Journal of Abnormal Social Psychology, 1963, 66, 519-525.

LaVoie, J.C. Ego identity formation in middle adolescence. Journal of Youth and Adolescence, 1976, 5, 371-385.

Lefcourt, H. Locus of Control: Current Trends in Theory and Research. Hillside, N.J.: Lawrence Erlbaum Associates, 1976.

Levenson, H. Activism and powerful others: Distinctions within the concept of internal-external control. Journal of Personality Assessment, 1974, 38, 377-382.

Levin, J., Karni, J., Frankel, Y. Analysis of the Tennessee Self-Concept Scale as a Faceted Instrument. Psychological Reports, 1978, 43, 619-623.

Lindbloom, G., & Faw, T.T. Three measures of locus of control: what do they measure. Journal of Personality Assessment, 1982, 46, 70-71.

Lindemann, E. Symtomatology & Management of Acute Grief. American Journal of Psychiatry, 1944, 101, 141-148.

Lorr, M., McNair, D.M., & Weinstein, G.J. Early effects of chlordiazepoxide (Librium) used with psychotherapy. Journal of Psychiatric Research, 1964, 1, 257-270.

MacDonald, J.M. Rape Offenders and Their Victims. Springfield: Thomas, 1971.

Marsland, D., & Perry, M. Variations in "adolescent societies," exploratory analysis of the orientations of young people. Youth and Society, 1973, 5, 61-83.

Massey, J.B., Garcia, C.R., & Emich, J.P. Management of sexually assaulted females. Obstetrics and Gynecology, 1971, 38, 29-36.

McCombie, Sharon L. The Rape Crisis Intervention Handbook: A Guide for Victim Care. Plenum Press: New York, 1980.

McNair, D.M., Lorr, M., & Droppleman, L.F. Manual: Profile of Moods States. San Diego: Educational and Industrial Testing Services, 1971.

McNair, D.M., Fisher, S., Sussman, C., Droppleman, L.F., & Kahn, R.J. Persistence of a drug-personality interaction in psychiatric outpatients. Journal of Psychiatric Research, 1970, 7, 299-205.

McNair, D.M., Kahn, R.J., Droppleman, L.F., & Fisher, S. Compatibility, acquiescence and drug effects. Neuropsychopharmacology, 1967, 5, 536-542.

McNair, D.M., Kahn, R.J., Droppleman, L.F., & Fisher, S. Patient acquiescence and drug effects. In Rickels, K. (Ed.) Non-specific factors in drug therapy. Springfield, Ill.: C.C. Thomas, 1968.

Medea, A., & Thompson, K. Against Rape: A Survival Manual for Women: How to Cope with Rape Physically and Emotionally. New York: Farrar, Straus and Giraux, 1974.

Molinari, V., & Khanna, P. Locus of control and its relationship to anxiety and depression. Journal of Personality Assessment, 1981, 45, 314-319.

Murray, H.A. Thematic Apperception Test. Pictures and manual. Cambridge: Harvard University Press, 1943.

Natioanl Crime Panel Survey Report. Criminal Victimization Surveys in the Nation's Five Largest Cities. U.S. Department of Justice, Law Enforcement Assistance Administration, National Criminal Justice Information and Statistics Service. Washington, D.C.: U.S. Government Printing Office, April, 1975.

Negri, T.F. Shame and guilt in relation to other aspects of personality. Unpublished doctoral dissertation, Michigan State University, 1978.

Nevill, D.D. Sex roles and personality correlates. Human Relations, 1977, 30, 751-759.

Nie, N.H., Hull, C.H., Jenkins, J.G., Steinbrenner, K., & Bent, D.H. SPSS. Statistical Package for the Social Sciences. New York: McGraw-Hill, 1975.

Notman, M.T., & Nadelson, C.C. The rape victim: psychodynamic considerations. American Journal of Psychiatry, 1976, 133, 408-413.

Nuckolls, K.B., Cassel, J., & Kaplan, B.H. Psychosocial assets, life crisis and the prognosis of pregnancy. American Journal of Epidemiology, 1972, 95, 431-441.

Parloff, M.B., Kelman, H.C., & Frank, J.D. Comfort, effectiveness and self-awareness as criteria of improvement in psychotherapy. American Journal of Psychiatry, 1954, 111, 343-351.

Peters, J.J. The Philadelphia Rape Victim Study. A report presented at the First International Symposium on Victimology, Jerusalem, Israel. September, 1973. Mimeographed copy from The Center for Rape Concern, Philadelphia General Hospital, 1973.

Peter, J.J. Social psychiatric study of victims reporting rape. Mimeographed copy from the Philadelphia Center for Rape Concern, Philadelphia General Hospital, 1975.

Pillard, R.C., & Fisher, S. Effects of chlordiazepoxide and secobarbital on film-induced anxiety. Psychopharmacologia, 1967, 12, 18-23.

Pine, F.A. Manual for rating drive content in the Thematic Apperception Test. Journal of Projective Techniques, 1960, 24, 32-45.

Price, V. Rape victims: The invisible patients. The Canadian Nurse, 1975, 71, 29-34.

Pugatch, D., Haskell, D., & McNair, D.M. Predictors and patterns of change associated with the course of time limited psychotherapy. Mimeo Report, 1969.

Queens Bench Foundation: Rape Victimization Study. State of California Office of Criminal Justice Planning, project number 1895, June, 1975.

Resick, P.A., Calhoun, K.I., Atkeson, B.M., & Ellis, E.M. Social adjustment in victims of sexual assault. Journal of Consulting and Clinical Psychology, 1981, 49, 705-712.

Resick, P.A., & Jackson, T.L. Attitudes toward rape among mental health professionals. American Journal of Community Psychology, 1981, 9, 481-490.

Rosen, G., & Ross, A. Relationship of body image to self-concept. Journal of Consulting and Clinical Psychology, 1968, 32, 100.

Rosenberg, M. Society and the Adolescent Self-Image. Princeton, N.J.: Princeton University Press, 1965.

Rothstein, W., Holmes, G.R., & Boblitt, W.E. A factor analysis of the Fear Survey Schedule with a psychiatric population. Journal of Clinical Psychology, 1972, 28, 78-80.

Rotter, J. Generalized expectancies for internal versus external control of reinforcement. Monograph, 1966, 80, 609.

Rotter, J. External and internal control. Psychology Today, 1971, 5, 37-42.

Russell, D.E. The Politics of Rape. New York: Stein and Day, 1975.

Russell, D.E. Rape in Marriage. New York: MacMillan, 1982.

Sarason, I.G. Intercorrelations among measures of hostility. Journal of Clinical Psychology, 1961, 17, 192-195.

Sarason, I.G., Johnson, J.H., & Siegel, J.M. Assessing the impact of life changes: Development of the Life Experiences Survey. Journal of Consulting and Clinical Psychology, 1978, 46, 932-946.

Saturnansky. A clinical study of rape victims: An analysis of the effects of rape experiences on personality dynamics and life styles. Unpublished doctoral dissertation, Michigan State University, 1976.

Scheffe, H. A method for judging all contrasts in the analysis of variance. Biometrika, 1953, 40, 87-104.

Schuker, E. Psychodynamics and treatment of sexual assault victims. Journal of the American Academy of Psychoanalysis, 1979, 7, 553-573.

Secord, P. & Jourard, S. The appraisal of body-cathexis; body cathexis and the self. Journal of Consulting Psychology, 1953, 17, 343-347.

Shakespeare, W. The rape of Lucrece. In the complete works of Shakespeare (Vol. 3). New York: Walter J. Black, Inc., 1937.

Silber, E., & Tippett, J. Self-esteem: Clinical assessment and measurement validation. Psychological Reports, 1965, 16, 1017-1071.

Silverman, D. First do no more harm: Female rape victims and the male counselor. American Journal of Orthopsychiatry, 1977, 47, 91-96.

Smyth, L. The relationship between attention and hypnosis with implications for the roles of anxiety and brain asymmetry. Unpublished doctoral dissertation, Michigan State University, 1977.

Sommers, S. College women and identity. Unpublished doctoral dissertation, Michigan State University, 1979.

Spence, J.T., Helmreich, R., & Stapp, J. Ratings of self and peers on sex role attributes and their relation to self-esteem and conceptions of masculinity and femininity. Journal of Personality and Social Psychology, 1975, 32, 29-39.

Suarez, S.D., & Gallup, G.G. Tonic immobility as a response to rape in humans: A theoretical note. Psychological Record, 1979, 29, 315-320.

Sutherland, S., & Scherl, D.J. Patterns of response among victims of rape. American Journal of Orthopsychiatry, 1970, 40, 503-511.

Svalastoga, K. Rape and social structure. Pacific Sociological Review, 1962, 5, 48-53.

Symonds, M. The psychological patterns of response of victims to rape. Mimeographed copy from Martin Symonds, Director of Victimology Program, Karen Horney Clinic, New York, New York, 1975.

United States Presidential Commission on Law Enforcement and the Administration of Justice. Washington, D.C.: U.S. Government Printing Office, 1967.

Vacchiano, R.B., & Strauss, P.S. The construct validity of the Tennessee Self-Concept Scale. Journal of Clinical Psychology, 1968, 24, 323-326.

Veronen, L.J., & Kilpatrick, D.G. Self-reported fears of rape victims: a preliminary investigation. Behavior Modification, 1980, 4, 383-396.

Walker, L.E. The battered woman. New York: Harper and Row, 1979.

Watkens, D., & Park, J. The role of subjective importance in self evaluation. Australian Journal of Psychology, 1972, 24, 209-210.

Webster's New Collegiate Dictionary. Springfield: G. & C. Merriam Company, 1977.

Weis, K., & Borges, S.S. Victimology and rape: the case of the legitimate victim. Issues in Criminology, 1973, 8, 71-115.

Wessman, A.E., & Ricks, D.F. Mood and personality. New York: Holt, Rinehart, & Winston, 1966.

Wolpe, J. & Lang, P.J. A fear survey schedule for use in behavior therapy. Behaviour Research and Therapy, 1964, 2, 27-30.

Zelin, M.L., Adler, G., & Myerson, P.G. Anger self-report: An objective questionnaire for the measurement of aggression. Journal of Consulting and Clinical Psychology, 1972, 39, 340.

Zung, W.W.K. A self-rating depression scale. Archives of General Psychiatry, 1965, 12, 63-70.