CHAPTER 3

Posttraumatic Stress Disorder:
Rape Trauma

Jocelyn Rowley, a 20-year-old single woman, was a sophomore at a midwestern university. She had always been a good student, but her grades had fallen recently, and she was having trouble studying. Her academic difficulties, coupled with some problems with relationships and with sleeping, had finally led Jocelyn to see a therapist for the first time. Although she was afraid of being alone, she had no interest in her current friends or boyfriend. She told the therapist that when she was doing everyday things like reading a book, she sometimes was overcome by vivid images of violent events in which she was the victim of a mugging or an assault. These symptoms had begun rather suddenly, and together they made her afraid that she was losing her mind.

Most of Jocelyn’s symptoms had begun about two months before she visited the university’s counseling service. Since then, she had been having nightmares almost every night about unfamiliar men in dark clothing trying to harm her. She was not having trouble falling asleep, but she was trying to stay awake to avoid the nightmares. During the day, if someone walked up behind her and tapped her unexpectedly on the shoulder, she would be extremely startled, to the point that her friends became offended by her reactions. When she was studying, especially if she was reading her English textbook, images of physical brutality would intrude on her thoughts and distract her. She had a great deal of difficulty concentrating on her schoolwork.

Jocelyn also reported problems with interpersonal relationships. She and her boyfriend had argued frequently in recent weeks, even though she could not identify any specific problems in their relationship. “I just get so angry at him,” she told the therapist. Her boyfriend had complained that she was not emotionally invested in the relationship. He had also accused her of cheating on him, which she denied. These problems were understandably causing her boyfriend to distance himself from her. Unfortunately, his reaction made Jocelyn feel abandoned.
Jocelyn was afraid to walk alone to the library at night. She could not bring herself to ask anyone to walk with her because she didn’t know if she could feel safe with anyone. Her inability to study in the library intensified her academic problems. Jocelyn’s roommates had begun to complain that she was unusually sensitive to their teasing. They noticed that she cried frequently and at unexpected times.

In the course of the first few therapy sessions, the psychologist asked a number of questions about Jocelyn’s life just prior to entering therapy. Because the symptoms had such a rapid onset, the therapist was looking for a specific stressful event that might have caused her symptoms. During these first few sessions, Jocelyn reported that she had begun to feel more and more dissociated from herself. She would catch a glimpse of herself in the mirror and think, “Is that me?” She would walk around in the winter weather with no gloves on and be relieved when her hands hurt from the cold, because “at least it’s an indication that I’m alive.”

After several sessions, Jocelyn mentioned to her therapist that she had been raped by the teaching assistant in her English literature course. The rape occurred 2 months before she entered therapy. Jocelyn seemed surprised when the therapist was interested in the event, saying “Oh, well, that’s already taken care of. It didn’t really affect me much at all.” The therapist explained that serious trauma such as rape is rarely resolved by itself, and especially not quickly. When it became apparent that Jocelyn had not previously reported the rape to anyone else, her therapist strongly advised her to contact the police. She refused, citing a number of reasons, ranging from her conviction that no one would believe her (especially 2 months after the incident) to the fear of facing cross-examination and further humiliation. Without Jocelyn’s consent, the therapist could not report the rape because the information she had obtained from Jocelyn was protected by confidentiality (the ethical obligation not to reveal private communications, in this case, between psychologist and client). There are some rare exceptions to this ethical principle. State laws require mental-health professionals to break confidentiality and report cases of child abuse. Psychologists are also required to report clients who are imminently dangerous to themselves or others. These exceptions did not apply to Jocelyn’s situation.

Jocelyn gradually revealed the story of the rape over the next few sessions. She had needed help writing an English paper, and her T.A. had invited her to his house one night so that he could tutor her. When she arrived at the house, which he shared with several male graduate students, he was busy working. He left her alone in his room to study her English textbook. When he returned, he approached her from behind while she was reading and grabbed her. The T.A. forced her onto his bed and raped her. Jocelyn said that she had not struggled or fought physically because she was terrified and stunned at what was happening to her. She had protested verbally, saying, “No!” and, “Don’t do this to me!” several times, but he ignored her earnest objections. She had been afraid to yell loudly because there were only other men in the house, and she was not sure whether or not they would help her.
After the rape, the T.A. walked Jocelyn back to her dorm and warned her not to tell anyone. She agreed at the time, thinking that if she never told anyone what had happened, she could effectively erase the event and prevent it from having a negative effect on her life. She went up to her dorm room and took an hour-long hot shower, trying to scrub away the effects of the rape. While describing these events to the therapist, Jocelyn shook and her voice was breathy. She kept saying, “You believe me, don’t you?”

For several days after the rape occurred, Jocelyn believed that she had been able to keep it from affecting her everyday life. The more she tried not to think about it, however, the more times it came to mind. She began to feel stupid and guilty for having gone to a T.A.’s house in the first place, and because she had not been able to anticipate the rape, Jocelyn wondered whether her own behavior had contributed to the rape: Had she dressed in some way or said something that indicated a sexual invitation to him? She was ashamed that she was not strong enough to have prevented the rape or its negative consequences.

Jocelyn had initially believed that only one aspect of her life changed after the rape; she no longer attended discussion sections for her English course. Unfortunately, several other problems soon became evident. Her exaggerated startle response became more and more of a problem because her friends were puzzled by her intense reactions to their casual, friendly gestures. Frequent nightmares prevented her from getting any real sleep, and she was having trouble functioning academically. She had no further contact with her T.A. unless she saw him while walking across campus. When that happened, she would duck into a doorway to avoid him. She also began to withdraw from relationships with other people, especially her boyfriend. He responded to this retreat by pressuring her sexually. She no longer had any interest in sex and repeatedly rejected his physical advances. All these problems finally made Jocelyn believe that she was losing control of her feelings, and she decided to seek professional help.

**Social History**

Jocelyn had grown up in a small midwestern town 100 miles away from the university. She was the oldest of three children. Both of her parents were successful in their professional occupations, and they were involved in the community and their children’s schools. Jocelyn had attended public schools and was mostly an A student. She was involved in several extracurricular activities. In high school, she had some trouble making friends, both because she was shy and because it was considered “nerdy” to be an A student. It wasn’t until she enrolled at the university that she was able to form a relatively large peer group.

Jocelyn’s parents were strict about dating and curfews. She had not been interested in attending large parties or drinking when she was in high school. She did have a boyfriend during her junior and senior years. They began dating when they were both 16 years old and became sexually involved a year...
later. That relationship had ended when they left their hometown to attend different colleges.

Jocelyn recalled that her high school boyfriend had occasionally pressured her into having sex when she thought it was too risky or when she was not interested. She denied having previously been a victim of sexual assault, although one incident she described did sound abusive to the therapist. When she was about 13 years old, Jocelyn went to a summer music camp to play the trombone, an instrument not usually played by a female. One day after rehearsal, the boys in her section ganged up on her, teasing her that “girls can’t play trombones!” One boy began to wrestle with her and, in the melee, placed a finger inside her shorts into her vagina. Jocelyn remembered yelling at him. The boy let her go, and then all the boys ran away. Jocelyn had never viewed that event as being assaultive until she thought about it in reference to being raped.

Jocelyn’s adjustment to college had been good; she made several friends, and most of her grades were good. She had never before sought psychological help. Jocelyn felt as if she had the world under control until she was raped by someone she knew.

**Conceptualization and Treatment**

As Jocelyn began to address her anxiety symptoms, additional problems were caused by other people’s reactions to the account of her rape. These difficulties kept the focus of treatment away from her primary anxiety symptoms. After telling her psychologist that she had been raped, Jocelyn began to tell other people in her life, including her boyfriend and her roommates. Her roommates were understandably frightened by what had happened to her, and they tried to divorce themselves from the possibility that it might happen to them. They did this by either accusing her of lying or pointing out differences between them: “I never would have gone to a T.A.’s house,” or, “You’ve slept with more people than me; he must have sensed that,” or, “You didn’t look beat up; you must not have fought back hard enough.” The absence of meaningful support from her friends fueled Jocelyn’s progressive withdrawal. Her anxiety symptoms became more pronounced, and she also became depressed.

Her boyfriend’s unfortunate and self-centered reaction to the description of her rape quickly led to the end of their relationship. He sought help to cope with his own feelings about her rape by talking to some mutual friends. Jocelyn had specifically asked him not to discuss the attack with other people she knew. Jocelyn’s general feelings of being out of control of her life were exacerbated by her apparent inability to contain the spread of gossip about her assault. One specific event, which would have been trivial under ordinary circumstances, led to a series of heated exchanges between Jocelyn and her boyfriend. He approached her from behind and playfully put his arms around her. When she jumped and screamed in fright, he tightened his grip, preventing her escape.
After arguing about this incident a number of times, they decided not to see each other anymore.

Jocelyn finally approached her English professor and told her that she had been sexually assaulted by the T.A. The professor’s reaction progressed from shock to outrage. She recommended that Jocelyn report the attack to the appropriate campus office. Unfortunately, Jocelyn still refused. She was not ready to report her attacker to the university or to press legal charges, in part because she felt that she could not bear being in the same room with him for any reason. The professor did assign Jocelyn to a different T.A. so that she could continue to go to discussions for the class. She also told Jocelyn that she was uncomfortable letting the matter drop. She asked whether Jocelyn would mind if she discussed the situation with the dean and with campus police. Jocelyn agreed reluctantly, only after the professor promised not to use Jocelyn’s name in any of these conversations.

Treatment during this time focused primarily on giving Jocelyn an opportunity to express her considerable anger and frustration about her situation. Jocelyn frequently railed to her therapist against the unfairness of the situation. For example, to deal with her fear of walking alone after dark, she was trying to find someone to walk with her. It seemed bitterly ironic, however, that she wanted a friend to protect her from violence from strangers. It was, after all, someone she knew rather well who had raped her.

Jocelyn also felt a great deal of guilt over not having been able to prevent her assault. Perhaps she hadn’t fought hard enough. Maybe she had unknowingly flirted with him. Did he assume that she knew he was inviting her to his house for sex? Was she a fool for not having recognized that implicit invitation? She also felt guilty about the effect of her situation on her boyfriend and roommates. Was she responsible for the fact that she had made them fearful and resentful?

In one session, the therapist pointed out that the intrusive images that Jocelyn now experienced while reading her English textbook might result from the fact that she had been reading that textbook when her attacker grabbed her from behind. Jocelyn was relieved to hear this explanation because she had worried that she really was going crazy. This insight did not immediately diminish the frequency of her intrusive images, however, and she remained frustrated and depressed.

By this time, Jocelyn’s nightmares had become increasingly severe. The content of her dreams was more and more obviously rape related. The dream would begin with Jocelyn in a crowded parking lot. Then a shadowy male in dark clothing would approach her, tell her he wanted to rape her, and proceed to attack her. She remembered trying to fight off the attack in her dream, but her limbs felt as if they were in thick glue and her struggles were ineffective. The other people in the parking lot stood watching, clapping and cheering for her assailant. Jocelyn would wake up in the middle of the room, crouched as if awaiting attack. These experiences terrified Jocelyn, and they also frightened her roommates.
The therapist’s treatment strategy moved to a focused, cognitive-behavioral intervention that had two main parts. The first part was to address the cognitive processes that prolong a maladaptive view of traumatic events. Specific procedures included self-monitoring of activities, graded task assignments (such as going out alone), and modification of maladaptive thoughts regarding the event (such as guilt and self-blame) (Yadin & Foa, 2007). This part of the treatment procedure had actually begun as soon as Jocelyn entered therapy. It was continued in parallel with the second part of the therapy, which is based on prolonged exposure.

In prolonged exposure, the victim reexperiences the original trauma in a safe situation to decrease slowly the emotional intensity associated with memory of the event. This step is based on the notion that repeated presentation of an aversive stimulus will lead to habituation (defined as the process by which a person’s response to the same stimulus lessens with repeated presentations). Jocelyn had, of course, experienced many fleeting and terrifying images of the rape during the weeks after it happened. This form of “reliving” the traumatic experience is symptomatic of the disorder. It presumably does not lead to improvement in the person’s condition because the experiences are too intensely frightening and too short-lived to allow negative emotions to be processed completely. In the therapy, Jocelyn was asked to relive the rape scene in her imagination. She described it aloud to the therapist in the present tense. The therapist helped Jocelyn repeat this sequence many times during each session. The sessions were recorded on audiotape, and Jocelyn was required to listen to the tape at least once every day.

As the end of the semester approached, Jocelyn was able to resume her studies. This was an important sign of improvement. Flunking out of school would have been the ultimate proof that the rape had permanently affected her life, and she struggled not to let that happen. She ended the semester by passing three of her four classes, including English. Therapy was terminated somewhat prematurely after 16 sessions (twice weekly for 8 weeks) because the semester was ending, and Jocelyn was going home for the summer. The psychologist could not convince her to continue therapy during the summer, although she still suffered from occasional nightmares and other symptoms. Jocelyn refused to see a therapist in the summer because she would have to tell her parents, and she was not ready to do that.

A follow-up call to Jocelyn when she returned the following spring, after having taken a semester off, revealed that Jocelyn had finally told her parents about the rape. They were much more supportive than Jocelyn had anticipated. She had continued treatment with another therapist, and her symptoms had diminished slowly over time. She now had nightmares only on rare occasions, and they were usually triggered by a specific event, such as viewing a sexually violent movie or when someone physically restrained her in a joking manner. Jocelyn decided not to return to therapy at the university’s counseling service,
saying that she was tired of being preoccupied by the rape. She believed that it was time for her to concentrate on her studies.

**Ten-Year Follow-Up**

Jocelyn performed well in school and on the job in the years following her rape. She completed college and then earned her master’s degree in library science. She enjoyed her work as a librarian at a small college in her hometown. Her social life recovered more slowly. Jocelyn experienced residual symptoms of posttraumatic stress disorder (PTSD) intermittently for several years. She no longer met the formal diagnostic criteria for PTSD, however, because her symptoms were not sufficiently frequent or severe. In the following pages, we describe her experiences during this time.

Jocelyn still suffered from occasional nightmares if she watched a movie or a TV show with a scene containing sexual violence. Rape scenes did not have to be overtly graphic to cause a nightmare. In fact, scenes in which a rape was alluded to rather than depicted on screen were just as disturbing to Jocelyn. She tried to avoid movies or TV shows with sexual violence. This decision might be interpreted as avoiding stimuli associated with her rape trauma (a symptom of PTSD). Her avoidance was also the product of Jocelyn’s conscious decision not to support the segment of the entertainment industry that profits from depicting such scenes.

Other examples of lingering mild PTSD symptoms included hypervigilance and increased startle response. Jocelyn was hypervigilant in situations that might present a threat to her own safety. For example, when speaking with a male colleague in his office, she was often concerned about the distance to the door and the proximity of assistance if she called for it. Of course, we all protect ourselves by being cautious and alert. But Jocelyn found herself worrying too much about potential threats when none existed. This hypervigilance occasionally intruded on Jocelyn’s professional career. It could make her appear unnecessarily suspicious and aloof to her coworkers, especially the men. Jocelyn also continued to be jumpy if someone touched her from behind, though the degree of her startle response had diminished greatly since college.

The residual effects of the rape trauma could also be seen in the way that Jocelyn struggled to control her temper, which had become volatile. When provoked, the intensity of her subjective response was often out of proportion to the situation. Events that would annoy or irritate most people (such as being treated rudely by a boss) would cause her to become enraged. Because she knew that the intensity of her anger was often inappropriate, she almost always suppressed it. Jocelyn was afraid of what might happen if she acted on her feelings. Suppressing her anger interfered with her ability to have discussions or arguments with other people. If Jocelyn was involved in a discussion, she would
often concede a point with which she disagreed to avoid “blowing up.” She became unnecessarily timid about stating her opinions.

Jocelyn’s relationships with men were also affected by the lingering impact of her rape. For a period of time in her early 20s (immediately following the rape), Jocelyn avoided intimate contact with men entirely. She referred to this time as her “celibacy” years. Jocelyn avoided intimacy with men to sort through her own feelings about herself, her remaining guilt surrounding her rape, and her feelings about men. Several young men found her attractive during this time (perhaps because she was uninterested in them), but she rejected their overtures. Jocelyn’s parents and friends were afraid that surviving the rape had “turned her into a lesbian” because she was not interested in dating men. Perhaps in rebellion against her parents’ concerns, Jocelyn joined a women’s poetry cooperative and a women’s music group that included women of all sexual orientations. She found this community to be warm and supportive. She made several close female friends, but she never felt any sexual attraction to them. This was a difficult time in which Jocelyn forged new friendships and also reestablished relationships with her previous social support network whenever possible.

When Jocelyn eventually began dating again, she seemed to choose relationships that allowed her to avoid emotional intimacy. She pursued men who were inappropriate for her (such as someone who lived a thousand miles away, or someone who was already married). Her affairs were brief and even exciting, but they did not result in significant, long-term relationships. At times, she could not imagine having a meaningful emotional relationship with a partner. Establishing clear consent to have intercourse prior to engaging in any type of sexual foreplay was of ultimate importance to her. Therefore, her sexual relationships tended to be “all or nothing”; she either had intercourse with the man she was dating or did not share any physical intimacy at all. Jocelyn realized later that she probably conducted her relationships in this fashion so that decisions of consent were as unambiguous and unemotional as possible.

Recognition of these ongoing difficulties led Jocelyn to decide to go back into therapy with a local psychologist. She had just met a new boyfriend and seemed to sense something special about this relationship from the beginning. Jocelyn wanted to work on issues involving intimacy, trust, and sexuality, in the hope that progress in these areas would help her forge a better relationship with her new boyfriend (who did eventually become her husband).

During this therapy, Jocelyn acknowledged that she felt very close to her boyfriend, but she had a great deal of difficulty learning to trust him. She found it hard to believe him when he said that he loved her. They were also having some trouble in their sexual relationship. Many forms of touching, if the touch was not gentle enough, were upsetting to Jocelyn. If her partner accidentally did anything that caused her discomfort during physical intimacy, Jocelyn would think to herself: “This is it. He’s been good until now, but now he’s going to hurt me.” Because of these irrational thoughts, Jocelyn frequently interrupted sexual
contact with her boyfriend abruptly. He found these reactions confusing, and their relationship was becoming strained.

Jocelyn’s therapist used cognitive therapy to address these problems. Her goal was to eliminate the systematic biases in thinking that were responsible for Jocelyn’s maladaptive feelings and behavior. She treated Jocelyn’s distorted patterns of thinking and her biased conclusions as being testable hypotheses. She used their therapy sessions as an opportunity to identify, test, and challenge these hypotheses. Several strategies were employed. Her distorted thoughts were either decatastrophized (developing what-if strategies to deal with feared consequences), reattributed (considering alternative causes of events), or redefined (changing the perspective of the problem so that the person feels some control over it). For example, Jocelyn’s reactions to painful stimuli during physical intimacy with her boyfriend were reattributed (Could your discomfort be the result of something other than his desire to hurt you?). Her fears during normal verbal arguments with men were decatastrophized (What is the worst thing that could really happen?).

Therapy also included some elements of anger-management training (Novaco & Taylor, 2006). In the initial phase of this process, Jocelyn learned to monitor her own anger and the situations that triggered it. Applied relaxation was employed to help her learn to regulate arousal in situations that were potentially provocative. The same cognitive-restructuring procedures that had been used to address her anxiety and fear were now used to help her modify distorted thoughts and misinterpretations of events that sometimes led to inappropriate anger. Finally, the therapist helped her to rehearse assertive communication skills that would allow Jocelyn to express herself clearly in situations that had previously led to withdrawal or the suppression of her true feelings.

Cognitive therapy and anger-management training helped Jocelyn improve her communication skills with others, including her boyfriend, as well as people at work. Her mood was more stable, and she felt better about herself. She also developed a deeper, more meaningful relationship with her boyfriend. They were married soon after the therapy was completed.

The fact that Jocelyn’s PTSD symptoms persisted for several years after the rape may seem discouraging. Nevertheless, beyond her subtle relationship problems, the long-term impact of the rape was not devastating. Jocelyn was able to complete school, have a successful career, regain closeness with family and friends, and (with a little additional help in therapy) form an intimate and lasting relationship with a loving partner. She occasionally mourns the loss of her 20s because her relationships were so chaotic, but she also has many important plans and hopes for the future.

**Discussion**

Rape is an alarmingly frequent problem on college campuses and in other areas of our society (Elliott, Mok, & Briere, 2004). Consider, for example, the results
of the National Health and Social Life Survey, the first large-scale examina-
tion of sexual behavior in the United States since the Kinsey reports (Laumann,
Gagnon, Michael, & Michaels, 1994). In this national probability sample of
women between the ages of 18 and 59, 22% reported that they had been forced
by a man to do something sexually that they did not want to do. Only 4% of
these coercive sexual acts were committed by a stranger.

Unfortunately, most rapes are never reported. On college campuses, less
than 5% of rapes are reported to police (Cole, 2006). Victims like Jocelyn,
whose immediate reactions to the rape included intense fear, helplessness, avoidance,
and emotional detachment, may be particularly unlikely to contact legal
authorities.

Should other people have reported Jocelyn’s rape when they heard about
it? Her therapist was clearly prevented from filing a complaint by the ethi-
cal principle of confidentiality. If her therapist had reported the rape against
Jocelyn’s objections, the therapist would have violated her trust and seriously
damaged their therapeutic relationship. Her English professor, on the other
hand, was not strictly bound by this professional obligation. Policies guiding
the behavior of faculty members in this circumstance currently vary from one
university to the next and are the topic of heated debate. Some might argue that
Jocelyn’s professor should have reported the rapist to police or campus admin-
istrators, even if it meant acting against Jocelyn’s wishes. One justification
would be to protect other students. Other people might believe that Jocelyn’s
decision not to report the rape should be respected so that she would not feel
even more helpless or out of control. Would she be exposed to further danger
if charges were filed without her knowledge? What would happen if the rap-
ist tried to retaliate, and Jocelyn did not know that he had been confronted by
authorities? What action could be taken against him without Jocelyn’s direct
testimony, and how would his right to due process be protected? These are all
difficult questions. We encourage people to seek advice on these matters from
local police officials and from sexual assault resource agencies. Just as many
state laws now require therapists to break confidentiality to warn potential vic-
tims of violence, new regulations may be passed to deal with the plight of rape
victims and the need to report this heinous crime.

One frequent outcome of rape is posttraumatic stress disorder (PTSD).
PTSD is included in the Diagnostic and Statistical Manual of Mental Disorders
(DSM-IV-TR; APA, 2000, pp. 467–468) under the general heading of Anxiety
Disorders. PTSD is defined by the following criteria:

1. The person has been exposed to a traumatic event in which both of the fol-
lowing were present:
   a. The person experienced, witnessed, or was confronted with an event or
events that involved actual or threatened death or serious injury, or a
threat to the physical integrity of self or others.
   b. The person’s response involved intense fear, helplessness, or horror.
2. The traumatic event is persistently reexperienced in one (or more) of the following ways:
   a. Recurrent and intrusive distressing recollections of the event, including images, thoughts, or perceptions
   b. Recurrent distressing dreams of the event
   c. Acting or feeling as if the traumatic event were recurring
   d. Intense psychological distress at exposure to cues that symbolize or resemble an aspect of the traumatic event
   e. Physiological reactivity on exposure to cues that symbolize or resemble an aspect of the traumatic event

3. Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness (not present before the trauma), as indicated by three (or more) of the following:
   a. Efforts to avoid thoughts, feelings, or conversation associated with the trauma
   b. Efforts to avoid activities, places, or people that arouse recollections of the trauma
   c. Inability to recall an important aspect of the trauma
   d. Markedly diminished interest or participation in significant activities
   e. Feeling of detachment or estrangement from others
   f. Restricted range of affect (such as being unable to have loving feelings)
   g. Sense of a foreshortened future (e.g., does not expect to have a career, marriage, children, or a normal life span)

4. Persistent symptoms of increased arousal (not present before the trauma), as indicated by two (or more) of the following:
   a. Difficulty falling asleep or staying asleep
   b. Irritability or outbursts of anger
   c. Difficulty concentrating
   d. Hypervigilance
   e. Exaggerated startle response

5. Duration of the disturbance is more than 1 month.

6. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

The rape and the fear surrounding it were clearly responsible for provoking the symptoms that Jocelyn experienced. One of the key elements of PTSD is the recurrence or reexperience of stimuli associated with the event. Jocelyn initially experienced this symptom in the form of intrusive, violent images that came to mind whenever she opened her English textbook. Her recurrent nightmares were another symptom linked to reexperiencing the event. Whenever one of these images or dreams occurred, Jocelyn would become extremely fearful and distract herself (escape) as quickly as possible. This type of reexperiencing of the trauma should be distinguished from the procedures used in cognitive-behavioral treatment. The latter is designed to ensure prolonged exposure in the context of
a safe and supportive environment, which allows the person’s intense emotional response to diminish gradually.

Avoidance of rape-related stimuli has been shown to differentiate rape victims with PTSD from those rape victims who did not develop PTSD. Jocelyn’s avoidance was manifested by withdrawal from her friends, her decision not to report the rape, and perhaps her reluctance to return to therapy for several years. Her feelings of dissociation, such as asking, “Is that me?” when looking in the mirror, were another sign of Jocelyn’s avoidance.

Jocelyn’s increased arousal was consistent with the DSM-IV-TR (APA, 2000) description of PTSD. Her exaggerated startle response, irritability in interpersonal relationships, difficulty studying, and sleep disturbance are all signs of the heightened arousal that is associated with this disorder. The length of time that had elapsed since the initial appearance of her symptoms and the obvious impact that these symptoms had on her adjustment also indicate that Jocelyn met the formal diagnostic criteria for PTSD.

The term posttraumatic stress disorder was introduced to the formal diagnostic manual with the publication of DSM-III in 1980 (APA, 1980). The concept of a severe and maladaptive reaction to a traumatic event was recognized many years earlier, but it was described in different terms. The disorder had been observed among soldiers returning from World War II and was known as Traumatic Neurosis of War in DSM-I (APA, 1952). The category was dropped in the next edition of the diagnostic manual, DSM-II (APA, 1968), even though the phenomenon had been well documented in combat veterans. DSM-III (APA, 1980) returned the concept to the manual and listed it with other types of anxiety disorders. This version of the manual expanded the range of possible stressors from a limited focus on combat experiences to the consideration of any traumatic event that was “outside the range of usual human experience” (APA, 1980, p. 247). In other words, people who had been victims of a crime or survivors of a natural disaster might also develop the symptoms of PTSD.

Following the publication of DSM-III, clinicians reported that many victims of rape suffered from the symptoms of PTSD. There were problems, however, with the way in which the disorder was described in the diagnostic manual. For example, epidemiological studies indicated that rape was not “outside the range of usual human experience.” Rape is not an uncommon event. The DSM-III (APA, 1980) criteria also put the therapist in the difficult position of having to make a judgment about the expected or usual impact of an environmental event. The authors of DSM-IV (APA, 1994) corrected some of these problems when they revised the criteria for PTSD. The traumatic event is now described as one in which the person experienced a threat of death or serious injury and responded with intense fear. This description clearly includes rape as a traumatic event.

The classification of PTSD has been criticized on a number of grounds (McNally, 2003). Some scientists suggest that PTSD may not be a mental disorder because it is a reaction to an event that would be distressing for almost
anyone. Thus, perhaps PTSD should be separated from anxiety disorders and placed in an etiologically based category along with other disorders that follow traumatic events. This grouping would include adjustment disorders and enduring personality changes that may follow trauma. This approach is currently used in the *International Classification of Diseases* (*ICD*; World Health Organization, 1990).

Further questions about the classification of PTSD as an anxiety disorder involve the nature of its core symptoms (Friedman, 2009; Zohar, Juven-Wetzler, Myers, & Fostick, 2008). Some symptoms in PTSD do involve anxiety, such as recurrent, intrusive images; avoidance; hypervigilance; and startle responses. These are similar to the symptoms of obsessive-compulsive disorder (OCD), phobic disorder, and generalized anxiety disorder (GAD). But PTSD also shares many symptoms with dissociative disorders such as amnesia, fugue, and multiple personality. These include flashbacks, memory impairment, and body dissociation. These classification issues will need to be addressed in future versions of the DSM.

It is difficult to estimate the true prevalence of PTSD from epidemiological studies because the disorder is precipitated by traumatic events (Keane, Marshall, & Taft, 2006). These events may be personal, affecting one person at a time, as in the case of rape, but they may also be events that affect a large number of people simultaneously, as in the case of a hurricane. How many people in the general population are exposed to traumatic events that might trigger PTSD? The National Comorbidity Study (NCS) found that 60% of men and 51% of women reported at least one such traumatic event at some time during their lives (Kessler et al., 1999). Many of these people had been exposed to more than one traumatic event. The most frequently reported traumatic events were witnessing someone being badly injured or killed, being involved in a natural disaster, being involved in a life-threatening accident, and being the victim of an assault or robbery. These alarming numbers indicate that traumatic events are unfortunately a relatively common experience in our society.

The overall rate of PTSD in the general population is higher for women (10%) than for men (5%) (Kilpatrick & Acierno, 2003). This pattern may be surprising in light of the fact that men are somewhat more likely to be exposed to traumatic events. How can it be explained? The NCS investigators suggest that, in comparison to men, women may be more likely to be exposed to traumatic events that are psychologically catastrophic. Rape is one example. Women are much more likely to be raped than men, and the rate of PTSD (for both male and female victims) is much higher following rape than following any other type of traumatic event. What are the distinguishing features of rape that account for its devastating impact? In comparison to many other traumatic events, rape involves directed, focused, intentional harm that is associated with the most intimate interpersonal act (Calhoun & Wilson, 2000).

The prevalence rate for symptoms of PTSD is highest immediately after the traumatic event. Most rape victims (95%) show symptoms of PTSD within 1 or
2 weeks of the crime (although the person cannot technically meet the DSM-IV-TR criteria until after the symptoms have been present for at least 1 month). The rate tapers off over time, with 48% of the victims meeting the criteria for PTSD 3 months after the rape. For many people, PTSD can become a chronic condition (Kuwert et al., 2010). Jocelyn certainly experienced some symptoms of PTSD for many years, even though her overall condition had improved, and she no longer met the formal criteria for the disorder.

**Etiological Considerations**

Not all victims of trauma develop PTSD. What determines whether or not a victim will develop PTSD following a traumatic event? There do not appear to be systematic differences between crime victims who develop PTSD and those who do not in terms of demographic characteristics such as race, employment, education, and income. One common line of investigation is whether or not rape victims who developed PTSD had different premorbid personality characteristics or a different pattern of adjustment that may have contributed to developing PTSD. Some evidence suggests a relationship between depression prior to the crime, the level of stress associated with the crime (e.g., an attack with life threat, actual injury, or completed rape), and the probability of developing PTSD. If the victim is depressed before the assault, and if the victim is assaulted in a particularly severe manner, then she is more likely to suffer from PTSD following the crime in comparison to victims of lower stress crimes (Bonanno, Galea, Bucciarelli, & Vlahov, 2007; Ozer & Weiss, 2004).

Cognitive factors may also influence whether a rape victim will develop PTSD. A perceived life threat may be present even in situations that are not overtly violent. In fact, the severity of perceived life threat, rather than actual life threat, may be the best predictor of whether a person will develop PTSD (Basoglu & Paker, 1995). The person’s beliefs about whether she or he can control future events are also important. Victims who perceive (perhaps with justification) that future negative events are uncontrollable are much more likely to have severe PTSD symptoms than those victims who perceive some future control (Basoglu & Mineka, 1992). This indication is particularly important when viewed in light of the fact that many women who have been raped report that they expect to be raped again.

Risk for persistent problems following a traumatic event is also increased by avoidance of emotional feelings and rumination about the traumatic event. Victims who suppress their feelings of anger may have an increased risk of developing PTSD after a rape (Foa & Riggs, 1995). Intense anger may interfere with the modification of the traumatic memory (to make it more congruent with previous feelings of safety). Anger also inhibits fear, so the victim cannot habituate to the fear response. Jocelyn’s ongoing problems with the experience of anger may have helped to prolong her other symptoms of PTSD, such as nightmares and hyperarousal.
Protective factors such as the person’s level of social support may help to prevent or limit the development of PTSD and other psychological consequences of rape (Andrews, Brewin, & Rose, 2003; Keane, Fisher, Krinsley, & Niles, 1994). Unfortunately, simply having a social support network may not be enough. The tendency of the victim to withdraw and avoid situations is an inherent part of the disorder. This avoidance may mean that victims do not take advantage of social support, even if it is available to them. In Jocelyn’s case, the reactions of her friends often led to further problems and made her feel less in control and more alienated from other people. This kind of problem may help to explain why some studies do not find that social support serves as a protective factor.

The moderating effects of social support may also be complex. Consider, for example, the evidence regarding traumatic stress responses among survivors of torture (Başoğlu et al., 1994). Those victims with extensive social support networks were less likely to be anxious or depressed, but social support did not specifically reduce the frequency or severity of PTSD symptoms. This pattern suggests that the needs of trauma survivors must be addressed broadly. In other words, factors that alleviate some of the more general consequences of exposure to trauma may not have a direct impact on the more focal symptoms of PTSD, such as avoidance and numbing, reexperiencing, and increased arousal.

Attitudes that society holds toward victims of sexual assault are also important in relation to social support (Ullman & Filipas, 2001). Some people apparently believe that certain women somehow deserved to be raped. These women undoubtedly receive less social support than other victims. People may also be more supportive after hearing the details of an assault that was clearly non-consensual—one in which the victim violently fought back when attacked by a stranger—than when the circumstances surrounding the assault were more ambiguous (the woman’s protests were verbal and not physical). Myths about rape, especially about acquaintance rape, may decrease the amount of social support received by victims of these crimes.

Jocelyn’s case also highlights another frequent consequence of rape trauma. Many victims develop sexual dysfunctions. These problems include decreased motivation for sexual activity, arousal difficulties, and inhibited orgasm (Gillock, Zayfert, Hegel, & Ferguson, 2005). Their onset is undoubtedly mediated by a complex interaction of emotional responses to the rape, including anxiety, depression, and guilt. They can be exacerbated by interpersonal difficulties with, and lack of support from, sexual partners, as illustrated by Jocelyn’s boyfriend at the time of her rape. Sexual difficulties may be an important consideration in planning treatment for some victims of sexual trauma.

**Treatment**

The most effective forms of treatment for PTSD involve the use of either cognitive-behavior therapy or antidepressant medication, alone or in combination (Foa, Keane, Friedman, & Cohen, 2009; Forbes et al., 2010). The psychological
intervention that has been used and tested most extensively is prolonged exposure. This procedure starts with initial sessions of information gathering. These are followed by several sessions devoted to reliving the rape scene in the client’s imagination. Clients are instructed to relive the assault by imagining it and describing it to the therapist, as many times as possible, during the 60-minute sessions. Sessions are recorded, and patients are instructed to listen to the tape at least once a day. Patients are also required to participate in situations outside the therapy sessions that are deemed to be safe but also elicit fear or avoidance responses. An adapted form of this treatment was used in Jocelyn’s therapy.

Cognitive therapy is another effective psychological approach to the treatment of PTSD. It can be used on its own or in combination with prolonged exposure. Perceived threat, more than actual threat, is a better predictor of many of the symptoms of PTSD. Cognitive therapy can address maladaptive ways of perceiving events in the person’s environment. It can also be used to change unrealistic assumptions and beliefs that lead to negative emotions such as guilt. For example, in Jocelyn’s case, her therapist might have used cognitive-therapy procedures to reduce her feelings of guilt about the assault and its consequences (i.e., blaming herself for the rape). Cognitive therapy and prolonged exposure are both effective and approximately equal in their effects on reducing symptoms of PTSD (Bradley, Greene, Russ, Dutra, & Westen, 2005).

Various types of antidepressant medication are also effective forms of treatment for PTSD (Osterman, Erdos, Oldham, & Ivkovic, 2011). Carefully controlled outcome studies indicate that selective serotonin reuptake inhibitors, such as sertraline (Zoloft) and paroxetine (Paxil), lead to a reduction in PTSD symptoms for many patients within a period of 6 weeks. In actual practice, cognitive-behavior therapy is often combined with the use of medication.

Final Comments

We have used the term victim rather than survivor to describe a person who experienced a traumatic event. This choice was made primarily because victim is the term used in the scientific literature on PTSD. We also want to point out, however, that many rape victims prefer to think of themselves as survivors to enhance their sense of control over events in their environments. Further information and resources are also available in Robin Warshaw’s book, I Never Called It Rape (1994). Her descriptions are less technical than this case, and they may provide additional sources of support.

Discussion Questions

1. Discuss the issues surrounding Jocelyn’s reluctance to report her rape. Should her therapist have reported it to the police without her patient’s consent? Was there a better way for the English professor to handle the situation?
2. How did Jocelyn’s friends respond to her problems? Did they help the situation or make it worse? Is there anything that they could have done that would have been more beneficial to her?

3. Do you think that a person can develop PTSD after witnessing an assault, a bad accident, or some other kind of traumatic event (that happened to someone else)? Or does PTSD only occur in people who are directly the victims of trauma? What kind of evidence would be needed to answer this question empirically?

4. Do you think that PTSD should be classified as a form of anxiety disorder? Should it be included with the dissociative disorders? Why?