CONCEPTUALIZING THE HARM DONE BY RAPE

Applications of Trauma Theory to Experiences of Sexual Assault

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Based on a review of theory and evidence, this article highlights the limitations of trauma response models and applications of posttraumatic stress to characterize the experiences of women who are raped. There are two primary problems with trauma response theories. First, traditional notions of trauma are likely too narrow to accurately capture the complexities of women's experiences of sexual violence in a gendered society. Second, the symptoms emphasized by clinical applications of the trauma model may legitimate one sociocultural manifestation of distress while excluding others. Alternative conceptualizations are presented to stimulate more ecologically grounded and culturally inclusive study of sexual violence. Using the rape of women as an example, this article illustrates the limitations of Western views of trauma and encourages researchers and practitioners to expand notions of survivors' responses to painful events.

Key words: *posttraumatic stress, trauma, rape*

OVER THE YEARS, RESEARCHERS have noted that trauma response models and notions of posttraumatic stress fall short in understanding the full range of experiences of abused women (e.g., Brown, 1991; Gilfus, 1999; Harvey, 1996; Woods & Campbell, 1993). Critics of contemporary trauma frameworks suggest that these paradigms can be exclusionary and tend to decontextualize acts of violence against women.[1] This article highlights the ways that the trauma response paradigm and the diagnostic classification of posttraumatic stress disorder (PTSD), when used as a lens for viewing sexual violence, may restrict our understanding of survivors' experiences. Concepts and theory that promote a fuller picture of postassault reactions and recov-

AUTHOR'S NOTE: The original version of this article was an analytic deconstruction of the diagnostic guidelines and published theory related to posttraumatic stress disorder, but I never thought of it as a critique of the way that researchers, theorists, and practitioners apply or use such theoretical or diagnostic heuristics. Unlike the process of writing this article, professionals in this field do not have the luxury of operating within a theoretical vacuum. Indeed, many who work with trauma victims intuitively contextualize clients' experiences or research findings in many of the ways suggested in this article.

What started as an analytic exercise in integrating a vast literature has evolved into a reflection of where the field has been, and where it should go. My deepest appreciation to Rebecca Campbell, Mary P. Koss, Stephanie Riger, the editor, and two anonymous reviewers for their contributions in the evolution of these ideas. Correspondence should be addressed to Sharon M. Wasco, University of Illinois at Chicago, 1007 West Harrison Street (M/C 285), Chicago, IL 60607-7134; e-mail: swasco@uic.edu.

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KEY POINTS OF THE RESEARCH REVIEW

- Posttraumatic stress disorder's criteria for trauma focus on threat to life and experiences of horror and intense fear, thereby de-emphasizing the social and cultural norms that encourage women to blame themselves and excuse perpetrators, which may compound the harm done by rape.
- We may hinder our understanding of rape by viewing it as a single event. Subjective experiences of rape often extend beyond the act of assault itself.
- Symptoms of posttraumatic stress reflect an ethnocentric standard of distress. Cross-cultural research suggests that intrusive thoughts and memories of the rape may be commonly experienced among different cultural groups, whereas symptoms of avoidance and hyperarousal may not.
- Because their worldviews are different from women with class or skin privilege, women of color or poor women may react to rape and other life events in unique ways; for example, gender, class, ethnicity, and previous victimization experiences may influence whether sexual violence—or other stressful life events—shatters survivors' assumptions of a just world or reinforce other beliefs about the world.

ery are also summarized. The specific aims of this article are (a) to consolidate a feminist critique of the posttraumatic stress model from contemporary theory and empirical research and (b) to summarize theory and research that supports more inclusive and contextualized understandings of rape harm. Although these arguments use rape as an example, they may have broader value in understanding many types of interpersonal violence and stressful life events.

The first critiques of trauma response theory and PTSD were published in the early 1990s; therefore, to limit the vast literature on this topic, the current review focuses primarily on journal articles and book chapters published since 1990. Two primary questions guide the review and discussion presented here: Are women's experiences of sexual assault adequately characterized by contemporary definitions of trauma and symptoms of posttraumatic stress? How can we build upon the posttraumatic stress framework to improve our understanding of postassault experiences such as distress and recovery?

THE UTILITY OF THE POSTTRAUMATIC STRESS FRAMEWORK

The trauma response model and the clinical diagnosis of PTSD have been useful in understanding rape victims' reactions and experiences in several ways. First, the PTSD diagnosis helped to reframe clinical and empirical explanations for women's reactions after assault. Prior conceptualizations of masochism or "hysteria" tended to blame victims by focusing on characteristics of individual women. By acknowledging the significance of the sexual violation, PTSD offers a scientific explanation for distress that does not blame the victim for bringing it on herself (Gilfus, 1999).

Also, the use of a posttraumatic stress framework connects rape victimologists to a large research community (Goodman, Koss, Fitzgerald, Russo, & Keita, 1993). The PTSD framework has been used to understand a wide variety of traumatic events, including combat, criminal assault, rape, accidental injury, industrial accidents, automobile accidents, being held hostage or as a prisoner of war, natural disasters, witnessing homicide, witnessing sexual assault, suffering sudden illness, or severe burns (March, 1993). The resulting body of research has allowed the development of treatments that alleviate symptoms of PTSD. Some of these treatments, such as exposure therapy, cognitive-behavioral procedures, or systematic desensitization have helped provide relief to rape survivors (Foa, Molnar, & Cahman, 1995; Foa, Rothbaum, Riggs, & Murdock, 1991; Frank et al., 1988; Resick & Schnicke, 1992). For rape survivors who suffer from chronic and severe distress, such treatment options are extremely valuable.

The PTSD diagnosis has also been exceptionally useful in generating research that scientifically analyzes predictors and outcomes of sexual assault. The detailed specifications in the

Diagnostic and Statistical Manual of Mental Disorders (*DSM*) diagnosis lend themselves well to measurement development; and researchers and clinicians have developed many reliable and valid measures by operationalizing criteria of PTSD. Empirically supported measures are extremely useful; uniform conceptualization and reliable measurement tools facilitate the ability of both practitioners and researchers to assess and document a psychological phenomenon (in this case, the harm of rape). Posttraumatic stress measures have also been used to demonstrate related traumatic injury to women, including domestic violence (Walker, 1993), antichoice protest attacks (Fitzpatrick & Wilson, 1999), and sexual harassment (Koss et al., 1994), strengthening the evidence that violence against women is pervasive and has widespread public health effects.

Third, the clinical diagnosis is critical in the American health care system. Given that rape has substantial impact on victims' psychological well-being (Hanson, 1990) and physical health (Golding, 1994; Waigandt, Wallace, Phelps, & Miller, 1990), access to mental and physical health care is essential to the recovery of many rape survivors. In fact, rape victims have been found to use both mental and physical health care services at far greater rates than nonvictimized women (Koss, Woodruff, & Koss, 1991). However, many rape victims cannot afford to pay for health services without the assistance of third-party payers who require a diagnosis for insurance reimbursement. Thus, the PTSD diagnosis offers a way for rape victims to obtain needed services (Root, 1992).

THE EMERGING CONCERNS ABOUT THE POSTTRAUMATIC STRESS FRAMEWORK

More than 20 years of research and practice have demonstrated that the concept of posttraumatic stress is a useful framework for understanding and documenting the aftermath of sexual violence as well as a practical tool for helping survivors obtain services. Furthermore, the cause-and-effect linearity of the trauma response framework is logically appealing: a particular *action*, like experiencing a traumatic event (criterion A in the PTSD diagnosis), leads to various clusters of *reactions* (symptoms specified by criteria B, C, and D in the PTSD diagnosis). However, a critical examination of each side of this trauma response "equation" highlights when practitioners and researchers should supplement the posttraumatic stress framework with more contextual understandings of actions and reactions related to sexual violence. Although this article is written with sexual violence against women in mind, these critiques may be relevant to other types of stressful life events.

The Traumatic Event: What's the Cause or Source of Harm?

The trauma response model has been effective in shifting researcher and practitioner focus off of the pathology of "hysterical" individuals, and onto the traumatic event as the source of victims' distress. In this framework, traumatic events are conceptualized as experiences that provoke feelings of fear, horror, and threat to life or integrity. The problem with this approach is that such conceptualizations highlight the extreme (violent) aspect of a sexual assault and does not necessarily address the specific cultural, social, and relational context in which sexual violence usually occurs. Those

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who adopt trauma models in their work with rape victims must not overlook cultural or societal influences, which may, for example, facilitate opportunities for men to rape women and/or encourage women to excuse the rapists' behavior in order to maintain or restore a relationship (Saxe & Wolfe, 1999).

The Traumatic Event Is Not the Only Source of Harm to Victims

Trauma researchers have worked hard to identify which specific characteristics of traumatic events are most likely to lead to the development of PTSD. A very robust finding in the trauma literature, consistent across studies examining different kinds of stressful events (e.g., interpersonal violence, accidents, natural disasters), is that the likelihood that victims will experience PTSD after surviving the event is increased by presence of injury, risk of death, or extreme violence (March, 1993). In their research on effects of violent and nonviolent crime, Kilpatrick and his colleagues (1989) found that crime victims most likely to develop PTSD were more likely to have sustained injury, to have perceived life threat, and to have experienced at least one completed rape.

The reality of rape is more complicated. Although many sexual assaults may include hallmark characteristics of trauma such as violence, injury, and fear of death, not all rapes do. For example, the *National Violence Against Women Survey* found that up to 69% of rapes do not result in physical injury (Tjaden & Thoennes, 2000). In general, research that has focused on various rape characteristics (i.e., relationship between victim and perpetrator, use of weapon) as predictors of the development of, or severity of, posttraumatic stress symptomatology has produced mixed results. Several researchers have found higher rates of PTSD among victims of "blitz rape," or sexual assaults involving strangers, weapons, or a great deal of force and/or physical injury (Bowie, Silverman, Kalick, & Edbril, 1990; Bownes, O'Gorman, & Sayers, 1991; Epstein, Saunders, & Kilpatrick, 1997; Weaver & Clum, 1995). Other research suggests that use of weapon and relationship between perpetrator and victim has no effect on psychological distress following sexual assault (Kilpatrick, Best, Saunders, & Veronen, 1988; Kilpatrick et al., 1989; Riggs, Kilpatrick, & Resnick, 1992).

Limited conceptualizations of trauma may contribute to these mixed findings. In other words, using details of the rape itself, without accounting for broader social context of survivors' lives, may be too narrow a research approach to accurately predict postassault reactions such as posttraumatic stress. Many trauma frameworks and societal responses treat incidents of interpersonal violence as single events (*a* trauma, *a* crime) (S. Jenkins, 1997). However, a more phenomenological approach to violence against women suggests that this social problem starts well before, and may continue long after, the assault itself. In their work on the measurement of intimate partner abuse, Smith, Smith, and Earp (1999) have argued for an alternative conceptualization of domestic violence that decreases scientific "bounding of battering in time and space" (p. 192). Similarly, S. Jenkins (1997) noted that we may hinder our understanding by viewing rape experiences as an event.

S. Jenkins' (1997) research on perpetrators of sexual violence suggests that rape, too, may be better conceptualized as a process. She noted that sexual violence starts with perpetrators' advance planning of their sexual assaults in advance of the actual act (S. Jenkins, 1997; see also Cleveland, M. P. Koss, & Lyons (1999) for a description of perpetrators' tactics based on analyses of survivors' narratives). A broad understanding of the "process" of rape would include victims' strategies to survive the assault, their strategies (e.g., coping, disclosure, and help-seeking) to negotiate their postassault experiences (e.g., Konradi, 1996), and society's responses to the assault, which often absolve the perpetrator of blame.

Rape May Not Always Shatter Assumptions About the World

Key tenets of trauma theory may not apply to ethnic minority and other marginalized groups in the United States. Gilfus (1999) has critiqued "shattered assumptions" theories of trauma. These theories operate on the assumption that all nontraumatized people believe that the world is basically a safe, just, and predictable

place and that trauma disrupts victims' assumptions about themselves, others, and the world (Janoff-Bulman, 1992; McCann & Pearlman, 1990). A hallmark of a traumatic event, according to these types of theories, is that the experience shatters such notions of a just world and forces victims to reorganize their cognitive schema (Janoff-Bulman, 1995).

However, racism and a history of oppression (i.e., enslavement of African Americans, genocide of Native Americans, World War II internment of Asian Americans) may preclude some racial and ethnic minorities in the United States from forming illusions of a safe, just world (Root, 1992, 1996). Likewise, poor and working class people, immigrant and refugee populations, victims of child sexual abuse, or women exposed to family or partner violence may never develop notions of a safe home or a just world (Gilfus, 1999). Thus, the shattered assumptions trauma paradigm reflects a "White, middle-class, never-victimized worldview" (Gilfus, 1999, p. 1251) and excludes people whose worldviews, at young ages, are formed by knowledge that the world is not necessarily just or safe. For some victims, rape may confirm assumptions that violence is a routine part of life or that they do not have sexual control over their bodies. The damage to these survivors may be more pervasive than a single act of rape, and the intersection of factors such as gender, class, ethnicity, and previous victimization history may generate a pattern of harm and recovery that is more intricate than what has been accounted for in most published literature on trauma.

The Symptom Clusters: What's the Effect or Manifestation of Harm?

There are three limitations of the PTSD symptom clusters that have been noted in the literature. First, the symptoms included in the PTSD diagnosis may capture just a small portion of rape-related distress. Second, this specific combination of symptoms documents an ethnocentric concept of distress and legitimizes one cultural expression of pain, which may not apply to all women. Similarly, effects of trauma characterized by a shattered assumptions trauma model overlook the various ways that gender, race, ability, and class form victims' worldviews, experiences of trauma, and manifestations of hurt. For these reasons, practitioners and researchers who work with rape survivors must continue to assess reactions to rape besides intrusion, hyperarousal, and avoidance.

PTSD Symptoms Are Only a Fraction of the Harm Done by Rape

It is difficult to determine how many rape survivors actually experience PTSD. Although some researchers have found that the majority (anywhere from 73% to 94%) of rape victims meet symptomatic criteria for PTSD shortly after the rape (Kramer & Green, 1991; Rothbaum, Foa, Riggs, Murdock, & Walsh, 1992); other findings suggest that far fewer (about one third) of female rape victims experience significant levels of PTSD (Kilpatrick, Seymour, & Edmunds, 1992). Regardless of how many survivors experience posttraumatic stress immediately after the assault, this type of distress is (a) likely to decrease over time (Rothbaum et al., 1992) and (b) not the only type of distress that victims experience.

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Woods and Campbell (1993) pointed out that "the most prominent and consistently found responses to battering—depression, low self-esteem, self-blame, and stress-related physical symptoms—are not the hallmark symptoms of PTSD, nor are they best explained by the original PTSD theoretical framework" (p. 180). Research and clinical practice suggest that this may be true in the case of rape as well. Victims of rape (and other injuries) experience a great deal of (non-posttraumatic stress) psychological distress including: damaged sense of worth, feelings of objectification, and self-blame (Good-

man, M. P. Koss, & Russo, 1993; Herman, 1992; Kimmerling & Calhoun, 1994; Rothbaum et al., 1992). Shame and self-blame can discourage survivors from seeking help (George, Winfield, & Blazer, 1992; Neville & Pugh, 1997; Ogletree, 1993; Ullman, 1996a), which in turn can hinder recovery (Orbuch, Harvey, Davis, & Merbach, 1994).

In addition to psychological and emotional aspects of distress and shame, the physical nature of rape may cause damage to physical and sexual health (Campbell, Sefl, & Ahrens, 2003a, 2003b; Golding, 1994, 1996). Golding (1994) found that rape victims were twice as likely as nonvictims to report medically explained health problems, including chronic diseases such as diabetes, arthritis, and asthma. Rape has also been related to a number of problems with sexual health, such as sexually transmitted diseases, abortions and unwanted pregnancies, sexual dysfunction, promiscuity, prostitution, sexual revictimization and/or abusive partnerships, and reproductive problems (Baker, Burgess, Brickman, & Davis, 1990; McCloskey, 1997; Roth, Wayland, & Woolsey, 1990; Shapiro & Chwarz, 1997; Waigandt et al., 1990; Zierler, Witbeck, & Mayer, 1996). Researchers and practitioners should supplement their attention given to trauma symptoms with further exploration of these physical and sexual effects of rape.

PTSD Symptoms Reflect an Ethnocentric Concept of Distress

Cross-cultural researchers contend that symptoms of the PTSD diagnosis may not apply uniformly to all cultural groups' experiences of trauma. A recent review of ethnocultural research suggests that although intrusive thoughts and memories of the traumatic event may be commonly experienced in many cultural groups, symptoms of avoidance/numbing and hyperarousal may differ according to one's ethnocultural affiliation (Marsella, Friedman, & Spain, 1999). Ethnocultural factors are also thought to determine early childhood experiences, personal and social resources for dealing with trauma, treatment options, and sources of strength and resiliency—all of which contribute to a person's vulnerability to traumas (Marsella et al., 1999).

Anthropologist J. H. Jenkins has examined the ways that culture can affect the subjective experience and expression of trauma. In her work with Salvadoran refugee women, J. H. Jenkins (1991) found that effects of trauma include dysphoric affects (anxiety, fear, and anger) and somatic complaints (shaking, trembling) that are similar to symptoms classified by PTSD. She also described reports of *calor* (heat) and *nervios* (worries), which are unique and culturally specific responses to trauma. *Calor*, for example, is a manifestation of intense heat that spreads rapidly throughout the entire body. *Calor* may be momentary or last multiple days and occurs in response to threats to one's physical integrity, serious family conflict, or life-threatening illness among some Latinas (J. H. Jenkins, 1999). J. H. Jenkins (1999) found that Salvadoran women refugees commonly reported intrusive reexperiencing of the events, especially in the form of nightmares, and increased arousal as marked by irritability and difficulty concentrating. However, numbness and avoidance were rarely observed in these women. The phenomenological experiences of women from El Salvador offer anthropological evidence that the pattern of distress specified by the PTSD diagnosis does not pertain to certain cultural groups. Also, the framework might miss aspects of harm (e.g., *calor*, *nervios*) among certain cultural groups.

Commonly Accepted Effects of Trauma May Not Apply to All Ethnocultural Groups in the U.S.

As described earlier, rape victims who hold worldviews that differ from the dominant class may endure a subjective experience of rape that is barely understood by social scientists. The harm done to minority groups may manifest, or be expressed, in ways that research has not yet captured. Fine's (1992) description of a poor African American woman's postrape trip to an emergency room provides an example of how limited frameworks of postrape reactions—whether they model distress or coping—can obscure the reality of the lives of women of color. Fine argued that traditional theories of coping

tend to be individualistic and most effective for privileged members of society. Given her social status, Altamese's decisions not to prosecute the perpetrators of the gang rape she endured, not to use her social support network for instrumental help, and not to talk to social workers were not signs of giving up, helplessness, or laziness but rather assertions of control (Fine, 1992). In a similar way, traditional notions of harm that emphasize posttraumatic stress reactions may ignore distress reactions among rape victims, especially ethnocultural minorities, that do not fit neatly into one of three cluster criteria.

IMPLICATIONS FOR RESEARCH AND PRACTICE

The evidence presented in this review does not support the replacement of the posttraumatic stress model with "better," more inclusive diagnostic criteria for rape harm. Indeed, some would argue that such attempts would be misguided:

> Given our passion for scientific inquiry, it is tempting to quantify and categorize various types of assault experience by frequency, progression of sexual contact, presence of violence, and then to equate such factors with specific treatment regimens or interventions. With few exceptions, such an approach creates a misleading linear perspective that diminishes the capacity of mental health systems to respond adequately to individuals with critical needs. (Palmer, 1991, p. 67)

Rather, these findings suggest that we may improve our understanding of a broad range of postassault experiences including, but not limited to, posttraumatic stress by explicitly considering the social context of sexual violence in our approaches to working with survivors.

Consider Broadly-Defined Sources of Harm

Feminist researchers and practitioners have broadened conventional ideas about trauma by placing rape within frameworks that acknowledge the influence of U.S. institutions (e.g., the nuclear family, criminal justice system) and culture (e.g., religion, mass media) on sexual violence against women. Some of these approaches are summarized below. This work highlights why researchers and practitioners should look beyond the act(s) of sexual violence to the cultural messages, relationship role expectations, and social norms that influence not only survivors' prerape worldviews but also their post-aassault disclosure experiences and reactions from friends, family, and service providers. These too may be sources of distress.

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Insidious Trauma

Trauma theorists working with different ethnic groups have articulated the importance of understanding disadvantaged peoples' collective trauma as the context for individual trauma. Root (1992) proposed the concept of insidious trauma, which is usually associated with the devaluing of an individual's social status because of a characteristic of their identity (e.g., gender, race/ethnicity, sexual orientation, physical ability). Insidious trauma may start as early as birth, in some cases, and may persist throughout a lifetime. For example, a child may be told that he or she is not capable of achieving or not the right kind of person to play with (e.g., too poor, wrong skin color) which over time can threaten the child's psychological sense of safety or security (Root, 1992). Insidious trauma can lead to symptoms of anxiety, depression, paranoia, and substance abuse (Root, 1992).

Exposure to insidious trauma may lead individuals to conclude that an unchangeable aspect of their identity justifies their unequal worth and lack of protection from danger (Root, 1996). Gender-based discrimination, harassment, and violence may act as insidious traumas to females, manifesting an ongoing fear of being raped and structuring of daily activities to

avoid danger at the hands of men (Gordon & Riger, 1989; Riger & Gordon, 1988). For some survivors, a sexual assault may be one part of a pattern of insidious trauma, which must be uncovered using expanded notions of rape trauma.

Ecological Models of Psychological Trauma and Sexual Assault Recovery

Some researchers have suggested that the scientific literature on psychological trauma underemphasizes environmental factors, which contribute to individual differences in posttraumatic response and recovery. Harvey (1996) delineated an ecological model of psychological trauma and provided the experiences of two rape survivors as examples of varying responses to rape as a function of "person by event by environment" influences such as class, education, and social support (Harvey, 1996). Similarly, Neville and Heppner (1999) proposed a culturally inclusive ecological model of sexual assault recovery (CIEMSAR), which is a set of individual and extra-individual level factors associated with victims' subjective experiences of rape and, subsequently, their differing patterns of responses following rape (Neville & Heppner, 1999). The CIEMSAR framework can be used to explain, for example, why one survivor may experience prototypical posttraumatic stress, whereas another might suffer decreased sense of worth or increased dependence on other people in her social support system.

Ecological frameworks integrate several variables that have long been the focus of rape research, such as assault characteristics (e.g., Riggs et al., 1992), coping response (e.g., Frazier & Burnett, 1994), and person variables (e.g., Karp, Silber, Holmstrom, & Stock, 1995) while also accounting for more recent constructs of interest such as social networks and sociocultural context (see Davis, Brickman, & Baker, 1991; George et al., 1992; Moss, Frank, & Anderson, 1990; Scott, Lefley, & Hicks, 1993; Sorenson & Siegel, 1992; Wyatt, 1992). These theories support the possibility that PTSD is one of many constellations of symptoms that rape survivors might experience and may improve our ability to account for varying reactions to rape.

The Community Response to Rape

Many researchers are examining the role of various extra-individual factors included in ecological frameworks to explain a range of postassault reactions and life changes. For survivors who disclose their experiences to others, negative reactions from friends (Davis & Brickman, 1996; Davis et al., 1991; Ullman 1996a, 1996b, 1999) and blaming or doubting responses from formal support providers such as police officers, physicians, or attorneys (Campbell, 1998; Campbell et al., 1999; Campbell, Wasco, Ahrens, Sefl, & Barnes, 2001; Ullman, 1996c) may compound the harm of the assault itself. Social stigma bestowed on rape victims makes an already degrading experience even more shameful and humiliating. These types of negative community responses to rape victims have been called secondary victimization, the second rape, or the second injury (Madigan & Gamble, 1991; Martin & Powell, 1994).

There is evidence that social reactions or secondary victimization at the hands of service providers may moderate or mediate the effect of a sexual assault on survivors' pain and/or recovery. For example, Campbell and her colleagues (1999) recently documented the interaction of type of rape, reactions from medical and legal systems, and counseling services on rape survivors' manifestation of posttraumatic stress symptoms. In this diverse sample of victims, rape survivors who were assaulted by someone they knew; subsequently received few services, but high levels of negative reactions, from medical and legal personnel; and received little to no counseling services reported the highest levels of posttraumatic stress (Campbell et al., 1999). This work documents the importance of broad conceptualization of the various sources of harm to survivors.

Address a Wide Range of Post-Rape Responses

Even though the field has long acknowledged that psychological trauma following rape (or other stressful events) can last a lifetime, current concepts of trauma have been shaped by ideas of acuteness, or urgency, that are inherent

in the term. In medical settings, emergency rooms, trauma centers, and acute care centers are places where people go to get immediate help when they present with severe symptoms. We can expand our understanding of how sexual violence impacts lives by also considering the less visible and urgent, more hidden and chronic effects of rape, such as problems related to physical and sexual health, self-blame, and interpersonal functioning. Researchers and practitioners might also shift their views to acknowledge positive responses to rape such as activism, coping and survival strategies, and efforts to help others.

Effects of Rape on Physical and Sexual Health

Research suggests that rape is a major public health issue, as sexual violence has been related to problems across almost all body systems (e.g., gastrointestinal, cardiopulmonary) as well as negative sexuality issues among survivors. Women with a history of sexual victimization perceive their health less favorably and use more health services than nonvictims (Koss, Koss, & Woodruff, 1991). In a study of female members of a health maintenance organization, Koss et al. (1991) found that the number of visits to physicians by rape victims increased 56% in the year after the crime, compared to a 2% increase by nonvictims. Thus, sexual violence taxes our medical system, not only in terms of short-term emergency care and forensic evidence collection costs immediately following rape but also long-term costs associated with primary care provision among women with a history of sexual victimization.

The relationship between sexual assault and health problems is probably complex. Sexual assault may indirectly affect physical health status through infliction of injuries, pregnancy, or communicable disease. The relationship between sexual assault and physical and sexual health outcomes may also be mediated by psychological distress, as psychological symptoms (e.g., anxiety, depression) have been linked to poor physical health status. There may even be a direct link between rape and physical and sexual health. For example, regardless of whether injury, pregnancy, or illness was sustained, rape victims report significantly more gastrointestinal problems, muscular problems (e.g., back pain), headaches, cardiopulmonary symptoms, and gynecological problems than women who have not been raped (Eby, Campbell, Sullivan, & Davidson, 1995; Golding, 1994; M. P. Koss & Heslet, 1992). Physical and sexual health outcomes may be more common among certain subgroups of rape survivors. Rape has been more strongly related to poor sexual or gynecological/urinary health among women of color (Campbell et al., 2003b; Golding, 1996) and women of low socioeconomic status (Golding, 1996). Ecologically and contextually grounded research can be used to further explore these trends and identify the physical and sexual health problems associated with sexual violence. Clinical and therapeutic interventions that focused specifically on sexual and physical health complaints among survivors can help to develop effective treatment strategies for these issues.

Chronic Shock and the Interpersonal Effects of Rape

Palmer (1991) proposed "chronic shock" as a way to understand the long-term interpersonal effects of rape. Unlike trauma models, which focus on horror and fear associated with the physical violation, this approach makes the violation of trust that accompanies sexual assault, whether through blatant violent attack or subtle coercion, primary. Chronic shock is the result of an experience of real or threatened force accompanied by an internalization of worthlessness and is experienced by the victim as feelings of intense shame or even as a distortion of reality (Palmer, 1991). This model supports the work of other theorists and poses that some of the most significant harm of rape is manifested as disconnection from others, reduced capacity for intimacy, inability to comfort oneself, and distorted loyalty in friendships, marriages, and/or living arrangements (Brown, 1994; Herman, 1992; Palmer, 1991).

An important conceptual element of chronic shock is based on the assumption that, given social and cultural norms, the world offers few safe places for rape survivors. Chronic shock occurs when "there is no safe place to work out powerful and frightening emotions" (Palmer,

1991, p. 72). Obviously, some survivors are able to avoid chronic shock by finding safe places such as rape crisis centers, close family or friend networks, and faith-based organizations. For others, though, this type of distress results from not only the terrifying experience of rape but also from living in a sociopolitical culture that does not provide many safe settings, or emotional "spaces," for women to recover from rape.

Survivor-Centered Epistemology

Gilfus (1999) denounced trauma theory altogether and proposed an epistemological shift in the way that we understand rape victims' experiences. She described a feminist, survivor-centered epistemology that legitimates survivors' knowledge of their world and their experiences. Gilfus argued that by socially constructing trauma as psychopathology, victims are restricted to individualistic solutions for extra-individual (i.e., collective and political) problems. Instead, she suggested reframing pathology (such as posttraumatic stress symptoms) into strengths, survival, and resistance strategies of women.

Exclusive reliance on posttraumatic stress responses may obscure a full picture of the cumulative harm of rape and unwittingly neglect the broader implications of rape for both research and treatment. Without recognizing a larger range of rape harm and a wider array of manifestations of that harm, it is easy to ignore society's role in maintaining the victim-blaming attitudes, inadequate treatment from social systems, and social reactions that further the harm done to women by rape.

Some recent empirical work highlights this epistemological shift in the victimology literature. In a qualitative study, Regehr, Marzali, and Jansen (1999) viewed participants as experts in their own lives and their reactions as strengths and vulnerabilities acquired through life experiences. Qualitative analyses identified a number of strengths and weaknesses of participants as "factors influencing recovery." By deemphasizing information typically collected about rape survivors (i.e., amount of psychological distress, depression), this study was able to uncover other facets of harm done by rape, including low feelings of self-worth, feelings that one's life was ruined, belief that the assault was deserved, and distrust and fear of relationships (Regehr et al., 1999). Other researchers have found that high levels of arousal, previously viewed as pathological symptoms of PTSD, may serve a buffering effect among sexually revictimized women. Wilson, Calhoun, and Bernat (1999) found that women with worse PTSD symptoms were more sensitive to threat cues in an experimentally manipulated situation and more quickly able to detect a sexually coercive interaction. These studies help readers to reframe "symptoms" as victims' strengths or survival strategies.

CONCLUSION

Exclusive reliance on posttraumatic stress responses may obscure a full picture of the cumulative harm of rape and unwittingly neglect the broader implications of rape for both research and treatment. Without recognizing a larger range of rape harm and a wider array of manifestations of that harm, it is easy to ignore society's role in maintaining the victim-blaming attitudes, inadequate treatment from social systems, and social reactions that further the harm done to women by rape. Alternative conceptualizations frame sexual violence as one form of violence against women (Gilfus, 1999), a pervasive aspect of a toxic culture (Buchwald, Fletcher, & Roth, 1993), as point(s) on a continuum of harm to girls and women across the life span (McCloskey, 1997), or as a process engaging both perpetrators and victims (S. Jenkins, 1997). Such broad conceptualizations of rape and the harm it causes may lead to clinical and community interventions that address a wider range of injury to victims. Framing rape in these ways can also highlight the importance of prevention, including efforts to reduce future cases of rape as well as negative reactions from support providers and community systems.

Meeting challenges laid out here may require innovative research and treatment approaches. Researchers will have to think about creative sampling techniques to find hidden rape victims, consider contextual variables, and combine qualitative and quantitative methodolo-

gies to generate fuller pictures of rape harm (see Lira, M. P. Koss, & Russo, 1999 for use of focus group methodology to understand Mexican American women's understanding of rape). Practitioners will have to think about goals beyond eliminating posttraumatic stress symptoms and bringing clients "back to baseline" functioning. The result, hopefully, will be social science knowledge and prevention and treatment practices that are inclusive of historically understudied or underserved rape victims, whose experiences have been overlooked by virtue of their social status or because existing research methods have not yet uncovered them. Furthermore, although this article has focused on the case of rape, in part because of the large body of feminist and cross-cultural theory and empirical work on this topic, it is likely that the ideas presented here can be used to expand understandings of other traumas as well.

IMPLICATIONS FOR PRACTICE, POLICY, AND RESEARCH

- Research and practice with victims of sexual violence can benefit from conceptualizations that broaden traditional frameworks of sexual assault as a psychological or physical trauma.
- We must continue to account for the entire *process* of rape including men's use of coercion and/or force, women's strategies for enduring sexual assault, reactions from social networks, and treatment from community service providers; these preassault and postassault events may moderate or mediate the effects of sexual violence.
- Ecological models that consider the interactions between individual factors, assault characteristics, and extra-individual factors may improve our ability to account for varying reactions to rape.
- To elucidate patterns of responses to rape that are different than the posttraumatic stress pattern, future work should focus on documenting the experiences of under-researched groups (women of color, immigrant communities, women with varying victimization histories).

NOTE

1. A national study of violence found lifetime prevalence rates for completed or attempted rape to be: 1 of 6 U.S. women and 1 of 33 U.S. men (Tjaden & Thoennes, 2000). This article focuses on the rape of females by males because it is the most common, and most thoroughly researched, type of sexual assault. In addition, the terms "rape" and "sexual assault," as well as "victim" and "survivor," are used interchangeably.

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