Is rape-related self blame distinct from other post traumatic blame attributions?

A comparison of severity and implications for treatment

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Rape treatment generally takes the form of standard trauma intervention, which may limit its ability to resolve rape-specific symptoms. For the sake of optimizing such treatment, the present study seeks to distinguish specific post-rape symptoms from those observed following other forms of trauma, particularly in respect to self-blame and related PTSD. Given typical societal victim-blaming following rape, self-blame is expected to be considerably more extreme among survivors of rape than in other victims, and predictive of relatively elevated post-trauma symptoms. Three hundred and four participants completed measures of blame attribution and PTSD, substantiating the hypotheses. Implications for rape treatment and social change are discussed.

Keywords: Rape, Rape Treatment, Self-blame, PTSD

Rape is a traumatic experience that has been shown to lead to PTSD in a high percentage of victims. According to reports, around 90% of survivors meet criteria for PTSD shortly after the assault, and 30-50% still continue to exhibit trauma symptoms months later (Kilpatrick, Edmunds, & Seymour, 1992; Rothbaum, Foa, Riggs, Murdock, & Walsh, 1992). As a result, many customary rape treatment protocols tend to focus almost exclusively on the traumatic elements of the experience, in accordance with standard trauma interventions (e.g., Foa & Rothbaum, 1998; Foa, Zoellner, Feeny, Hembree, & Alvarez-Conrad, 2002; Jaycox, Zoellner, & Foa, 2002), while overlooking important rape-specific sequelae. By not distinguishing such

particular clinical needs from those of the general post-traumatic presentation, these treatments may become limited in their ability to fully resolve all aspects of the presenting problem, to the detriment of survivors. This raises the concern that rape treatment ought to be based on an empirical distinction between the clinical aftermath of this particular trauma and that of others. The present paper seeks to address this matter by investigating some of the ways in which post-rape symptoms differ from those noted following other traumatic events. Such a classification will make it possible to match treatment to the specific needs of this population.

Currently, among the most widely used approaches to the treatment of rape survivors are Cognitive Behavioral Therapy (CBT) and its variant Prolonged Exposure (PE) (Foa & Rothbaum 1998; Foa, et al., 2002; Jaycox, Zoellner, & Foa, 2002). Although these treatment modalities are highly worthy and effective in resolving trauma symptoms, they tend to have a rather narrow focus on post-traumatic stress. Their main goal is to resolve this anxiety through habituation and desensitization. Common interventions include, in vivo exposure to trauma reminders aimed at confronting feared situations and reducing their accompanying stress, along with imaginal reliving of the rape intended to decrease the anxiety and fear associated with the traumatic memories. In addition, cognitive restructuring is employed to promote reinterpretation of anxiety provoking triggers, coupled with relaxation training, aimed at providing additional means for dealing with anxiety and fear (Foa & Rothbaum 1998).

Outcome studies have shown these modalities to be highly valuable and effective in relieving post-trauma anxiety, but also restricted in their ability to resolve other central post-rape symptoms, such as self-blame, which is noted in over 50% of survivors and linked to elevated depressive and anxiety symptoms, revictimization,

and lowered self-esteem and perceived control (Arata, 1999; Branscombe, Wohl, Owen, Allison, & N'gbala, 2003; Frazier, 1990; Littleton & Radecki Breitkopf, 2006; Miller, Markman, & Handley, 2007). For example, Meadows and Foa (1998) describe a case study of a survivor whose anxiety symptoms responded well to prolonged exposure, while her self-blame actually increased in the process. A similar account is provided by Pitman et al. (1991) who reported that while rape survivors treated with flooding showed a considerable decrease in anxiety, their self-devaluation did not respond to further exposure to the narrative. These findings emphasize the importance of distinguishing the specific needs of rape survivors from those of others, particularly in regard to self blame, which appears to be distinct, and presumably more severe, in this population. This is the focus of the present study.

There are also societal reasons to anticipate increased levels of post-rape self-blame. It is suggested that the self accusation common to rape survivors closely mirrors the specific and uniquely unfavorable social climate surrounding them. This cultural context is typified by prejudiced, victim-blaming attitudes towards rape survivors which fault and condemn them for their assault (Koss & Harvey, 1992; Lebowich & Roth, 1994; Roth & Lebowitz, 1988). This reality sets victims of rape apart from other trauma victims, as no other group of survivors is so ubiquitously blamed for causing their plight. Although social support clearly varies individually across trauma type (Holeva, Tarrier, & Wells, 2001), only rape victims face a unified accusatory social ideology, collective blaming, and a rather sweeping lack of support.

Social ideologies accusatory of rape survivors

The particular prejudiced ideology facing rape victims consists of a set of recognizable and widely shared culturally agreed upon victim-blaming attitudes (Burt, 1991; Campbell, 1998; Campbell & Raja, 1999; Campbell, Wasco, Ahrens, Sefl &

Barnes, 2001) that manifest in almost all cultural aspects, such as the media, religion, language, and literature. These stereotyped beliefs, generally subsumed in the term "rape myths" (Lonsway & Fitzgerald, 1994), revolve around the notion that rape victims somehow contributed to their own victimization and are responsible for its occurrence. Victim precipitation, which directly holds the victim responsible for the rape, is the most common and well-known rape myth. It is founded on a belief that the victim in some way provoked the rape by her behavior and/or character. Other rape myths proclaim that women can prevent rape if they truly want to, and that no woman can be forced to have sex against her will. Accordingly, if a woman is coerced into having sex she obviously did not mind it or worse yet, secretly desired it (Cowan, 2000; Koss & Harvey, 1991).

Research has documented a fairly wide acceptance of rape myths, with upward of 50% of the population endorsing some sort of belief in the attitudes they embody (Buddie & Miller, 2002). Furthermore, there are many indications that endorsement of rape myths is fairly pervasive within the legal, law enforcement, and medical establishments (Campbell et al., 2001; Ullman & Filipas, 2001). There is evidence of attributions of blame to rape victims among the clergy (Sheldon & Parent, 2002) and even within the field of mental health (Campbell, 1998; Campbell & Raja, 1999). This has been referred to as secondary victimization or second rape. Acceptance of the various rape myths has been shown to lower empathy towards rape survivors, thus decreasing the social support they receive (Smith & Frieze, 2003).

Internalized self-blame among rape survivors

Being inundated by these accusatory collective beliefs, rape survivors can hardly escape their ramifications. In fact, there is evidence that the entire experience of rape receives its fundamental meaning from this particular social context, which

essentially defines its meaning (Lebowitz & Roth, 1994). In accordance, the harsh social reactions give way to severe culturally inculcated self-blame (Frazier, 1990; Koss & Harvey, 1992; Roth & Lebowitz, 1988; Ulman,1999), across varied cultural and ethnic backgrounds (Neville et al., 2004). The internalized collective charges of victim precipitation regularly turn into self-condemnation, even though in reality they are entirely counterfactual (Arata & Burkhart, 1996; Kilpatrick and Veronen, 1983; Lebowitz & Roth, 1994; Libow & Doty, 1979; Miller, Handley, Markman, & Miller, 2010; Ulamn, 1996). Moreover, rape victims have been shown to fault themselves for not preventing their own assault in correspondence with the degree to which they perceived non-consensual sex to be viewed as legitimate in their social milieu (Miller et al., 2007). Hence, although irrational, self-blame becomes a central and relentless part of their distress, as they are besieged with ruminations of all the aspects of the event that make them culpable in their minds.

This is true even when the purpose of the self-blame is protective, as it often is, intended to give the victim some sense of control. In this process, the type of social attitudes that surround the victim can play a significant role in providing the point of reference from which she might attempt to make sense of her experience (Lebowitz & Roth, 1994; Libow & Doty, 1979). Where society is more inclined to place blame on the victim, there is a greater likelihood that this search will turn into severe self-faulting. Searching for an explanation for the unexplainable, she may turn to readily available cultural beliefs about rape victims' culpability and identify her own conduct as the cause for her victimization.

Accordingly, although some form of self-blame is common to the experience of trauma in general (Van der Kolk, 2002), it is to be expected that self-attribution of responsibility following rape will be incremental to the more customary type.

Furthermore, based on previous findings linking self-blame to post-trauma symptoms (e.g., Flannery, 1990; Holeva, et al., 2001), it is to be expected that insofar as disproportionate levels of self reproach are noted among rape survivors, they will be associated with more extreme levels of PTSD symptomatology among these victims, and that the relationship between the two manifestations will be strongest for survivors of rape. The present study seeks to determine whether this is indeed the case.

To that end, the severity of these variables in rape victims is compared to that noted among victims of other fairly prevalent types of trauma, including combat stress, traffic accidents, loss of a close person, and severe illness, all of which have been linked to some form of PTSD (Breslau et al., 1998). Although differential probability rates for developing PTSD following these traumas has been established at 49% following rape, 28% for victims of serious motor vehicle accidents, 14.3% following the sudden unexpected death of a loved one, 13% military combat related, and 4.7% of people diagnosed with severe life threatening illness, no comparison of symptom severity has been conducted to date. This study seeks to determine whether post-traumatic symptoms are likewise more severe, as they are more prevalent, following rape as compared to the others.

Clearly, we do not intend to place the suffering caused by each type of trauma in competition, but rather to deepen and fine-tune our understanding of the clinical picture following rape as it compares to those of other trauma, mainly to clarify the comparative role played by self-blame in the post-rape symptomatology. The understanding of what in the aftermath of rape is distinct from other types of trauma can guide treatment, so that it is matched specifically to the needs of this particular population.

The following hypotheses are thus tested:

1. Rape survivors will display greater self-blame than survivors of other forms of trauma.
2. Rape survivors will report higher levels of PTSD in comparison to survivors of other forms of trauma.
3. The relationship between self-blame and PTSD is strongest following rape.

Method

Sample

Three hundred and four subjects participated in the study. Two hundred and seventeen (71.6%) were women and 86 (28.4%) were men. Most of the participants (72%) were college students; the rest (28%) were community members. Participants ranged in age from 20 - 45 (mean = 26.2). Their education ranged from 8-20 (mean = 13.5) years. Sixty- nine percent were single, 28.9% were in a committed relationship or marriage, and 1.4% were divorced.

Procedure

Participants were recruited individually from the following sources: college students at Tel Hai College in northern Israel who were invited to participate in the study on a completely voluntary basis, and community members from the same part of the country who were recruited through personal contact. Participants were told that the study measured subjective wellbeing, and asked for their informed consent to partake in this study.

The test materials were handed out and collected by research assistants. The students filled out the questionnaire in a group setting during class time, whereas the community members did it at their own convenience. In both instances, participants were given verbal as well as written instructions regarding the procedure. They were

guaranteed anonymity and encouraged to respond as candidly as possible after being assured that there were no right or wrong answers to any of the items. They were also informed that they were free to discontinue their participation at any time, although very few opted to do so.

Measures

The study employed a self-report questionnaire that included measures of exposure to traumatic events, PTSD symptomatology, self-blame, and demographic questions.

Exposure to traumatic events

A scale developed specifically for this study assessed exposure to various types of traumatic events. They included: rape, defined as experiencing forced sex; sudden loss of a loved one; involvement in a serious car accident; experiencing stress during combat; and being informed of a life threatening illness. The scale listed the various traumas in the aforementioned behavioral terms and respondents were asked to indicate whether they had experienced each. Where possible, descriptions of the trauma type were adapted from separate existing measures of each trauma. For example, the item describing the event of rape was adapted from Koss & Oros (1982) Sexual Experiences Survey. Clearly this list of traumatic events is by no means exhaustive, but rather reflective of the many types of possible trauma-inducing incidents.

In addition, subjects were asked to rate their subjective experience during the event on each of the following three variables: helplessness, fear, and experiencing a threat to one's life. The ratings ranged from 1 (very low) to 6 (very high), such that high scores indicated elevated levels of the experience. At the bottom of the scale, participants who endorsed more than one trauma were asked to indicate which event

was most traumatic for them and to respond to all subsequent measures as they pertained to that particular event.

Post-Traumatic Symptoms

Post-trauma symptoms were assessed by the Post Traumatic Diagnostic Scale (PTDS) (Foa, Cashman, Jaycox, & Perry, 1997). The PTDS provides both a measure of PTSD symptom severity and a PTSD diagnosis. The PTDS corresponds to all six criteria of the DSM—IV and its psychometric properties were established in a large sample of male and female victims of diverse causes of trauma. The coefficient alpha of the scale in the present study is .89. This diagnostic scale is composed of three parts assessing symptoms of PTSD, characteristics of the trauma and duration of symptoms, and dysfunction in daily living. The present study employed only Part 1, as we were only interested in PTSD symptomatology. Seventeen items listing representative posttraumatic symptoms make up the first part. Respondents are requested to rate the number of times they have experienced each of the symptoms listed. Ratings are made on a 4-point scale-not at all (0) to all the time (3).

Self-Blame

The measure of self-blame was adapted from Meyer and Taylor's (1986) measure of attributions for rape. This scale is designed to assess rape-related self-blame, and it was employed presently for its ability to tap culturally inculcated self-blame, which is at the focus of this study. To adapt it to the investigation of self-blame across various trauma types, and to correct for any potential biases, only those questions that could reasonably apply to all types of trauma were included, while rape-specific items were omitted. For example, items such as "there is too much pornography around" were omitted as they have no relevance to any of the other events beside rape. Items that were maintained included statements such as "I got what I deserved" and "I should

have been more cautious" among other similar ones. In all, 10 items were selected. The coefficient alpha of the adapted scale within the present study is .87. Respondents rated the importance of these statements in helping them to explain why they experienced the traumatic event on a 5-point Likert scale from 1 - completely false to 5 - completely true.

Results

Characteristics of the Study Population

Of the 304 participants, 119 (39.14 %) reported experiencing at least one of the traumatic events under investigation. Fourteen (11.76%) reported having been raped, 14 (11.76%) experienced severe illness, 19 (15.96%) were in a stressful combat situation, 23 (19.32%) reported being involved in a traffic accident, 49 (41.17%) experienced the loss of a close person. Members of all groups, except for rape victims who were women only, consisted of both sexes. The mean scores and standard deviations of the main dependent variables, namely, self blame and PTSD, within each trauma type are listed in table 1.

Group comparisons

The hypothesis that rape survivors will display higher levels of self blame and trauma symptoms in comparison to survivors of other forms of trauma was tested by two sets of one way analysis of variance and post hoc comparisons. The results are displayed in Table 1. As can be seen, there were significant mean differences among the groups on both self-blame and PTSD. Tukey post hoc analyses of mean differences between rape survivors' self-blame and that of victims of other traumas were all significant ($p<.05$), with the former displaying significantly greater self-blame in comparison to each of the other groups. The same analyses for PTSD mean differences indicated that rape survivors experience significantly higher levels of

PTSD ($p<.05$) than victims of traffic accidents, severe illness, and loss of a close person. They also present with higher PTSD than do victims of combat stress, but these differences only approach statistical significance ($p<.09$).

Table 1. Symptom comparisons between rape survivors and victims of other traumas, means and standard deviations expressed as ANOVA coefficients

	Rape	Combat stress	Car accident	Severe illness	Loss	ANOVA
Self-blame	3.36 (1.15)	2.26 (.75)	2.33 (.68)	1.85 (.69)	1.73 (.60)	10.19***
PTSD	24.57 (16.2)	17.52 (9.47)	12.69 (12.42)	12.61 (10.83)	12.52 (10.18)	4.95***

* significant at the .05 level, ** significant at the .01 level, *** significant at the .00 level

Before testing the hypothesis concerning the strength of the relationship between self-blame and PTSD among the different trauma types, the simple relations between each trauma type and both variables, namely, self-blame and PTSD were assessed with regression analyses. Next, to test the hypothesis that self-blame is predictive of PTSD to a higher degree among rape survivors than among victims of other trauma, a simple regression analysis between self-blame as the independent variable and PTSD as the dependent variable was performed for each trauma type. As can be seen in Table 2, only rape and combat stress were related significantly to both types of symptom clusters, and among them, only among rape survivors was self-blame significantly predictive of PTSD levels, explaining 45% of the variance, compared to 17% among combat stress sufferers. Results further indicate that self-blame was also predictive of PTSD among participants who experienced severe illness and loss (explaining 35% and 27% of the variance in PTSD respectively), even

though these two types of events were not predictive of either symptom clusters in themselves.

Table 2. Simple relations between all types of trauma and PTSD, self-blame, and the relation between self-blame and PTSD

	Rape	Combat stress	Car accident	Severe illness	Loss
Self-blame	.23**	.21**	.007	.03	.03
PTSD	.04***	.02***	.001	.001	.004
Relation between Self-blame and PTSD	.45*	.17	.13	.35*	.27*

* significant at the .05 level, ** significant at the .01 level *** significant at the .00 level

In addition to the analysis of the central hypotheses, descriptive and comparative analyses were performed for the three subjective experience variables, namely, helplessness, fear, and experiencing a threat to one's life. Table 3 displays the means and standard deviations of these variables for each trauma, as well as one way analysis of variance coefficients and post hoc comparisons. Tukey post hoc analyses revealed that helplessness was significantly higher among rape survivors in comparison to victims of combat stress and car accidents ($p<.05$). Victims of car accidents experienced the greatest threat to life, which was significant in comparison ($p<.02$) to loss and severe illness. There were no significant group differences in the amount of fear experienced during the event.

Table 3. Comparison between subjective experience by trauma type, means and standard deviations expressed as ANOVA coefficients

	Rape	Combat stress	Car accident	Severe illness	Loss	ANOVA
Helplessness	5.7 (.61)	3.75 (2.06)	4.43 (1.66)	5.2 (.78)	5.10 (1.24)	16.31***
Fear	5.29 (.99)	4.25 (2.36)	5.00 (1.30)	4.5 (1.71)	4.40 (1.48)	1.45
Threat to life	4.07 (1.81)	4.00 (2.3)	4.44 (1.65)	2.7 (2.35)	1.75 (.80)	16.73***

* significant at the .05 level, ** significant at the .01 level, *** significant at the .00 level

Discussion

The primary purpose of this study was to further the understanding of the unique psychological consequences of rape, for the sake of optimizing its treatment. In particular, this investigation concentrated on contrasting the relative severity of post-rape self-blame and related PTSD levels to those noted in the wake of other traumatic events. As expected, rape survivors experienced self reproach and post-traumatic symptomatology at significantly higher levels than did victims of all other forms of trauma. Additionally, the relationship between these two symptoms was stronger for this population than for victims of other events. Inasmuch as rape survivors appear to suffer from much more severe self-blame and PTSD in comparison to victims of other traumas, it may be assumed that the susceptibility to developing the most extreme levels of the former may account, at least in part, for the observed elevations in the latter.

Clearly this assumption of directionality could not be determined empirically in this study due to its correlational nature. We assume a model in which differences

in PTSD levels are explained by variability in self-blame. It might, however, be argued that the elevated post-traumatic stress among rape survivors is responsible for the relatively higher levels of self reproach. Possibly, the more extreme the posttraumatic symptomatology, the greater the need to defend against the pain it entails by taking responsibility for causing the traumatic event. However, even if that were the case, the fact that the particular type of defense typical to rape survivors echoes derogatory social views about rape victims (e.g., Lebowitz & Roth, 1994; Libow & Doty, 1979) underscores the societal adversities that rape survivors must routinely deal with, unlike other trauma victims, and the added emotional burden that this entails. The causality may also be circular, such that socially inculcated self-blame contributes to PTSD exacerbation which further worsens the tendency to hold oneself responsible for the rape. In either of these interpretations, the end result is that both sets of symptoms are jointly more elevated in this population than in others and therefore in need of specific attention.

These findings, thus, have important implications for treatment. To the extent that rape-specific self-blame is incremental to the more customary self-devaluation noted in other trauma victims, it can present a serious complication to recovery. This requires special therapeutic consideration. Specifically, it implies that treatment for this population must go beyond standard trauma interventions, and focus additionally on the direct targeting of the uniquely extreme post-rape self-blame. Accordingly, there is a need to simultaneously process the self reproach alongside all other trauma symptoms throughout the treatment, as the former will likely not resolve on its own without its direct targeting. The aim is to both alleviate the pain generated by the self attribution of causality as well as to circumscribe at least some of the escalation in PTSD that appears to follow. This necessity can be overlooked, to the detriment of

rape survivors, without familiarity with the specific contributions made by self-blame to the clinical picture in the aftermath of rape, as indicated by several accounts of incomplete resolutions of these symptoms by customary trauma treatments (e.g., Meadows and Foa, 1998; Pitman et al., 1991). The present findings provide some explanation for these accounts, offering a framework that stresses the importance of supplementing customary trauma interventions with the specific processing of post-rape self-blame in order to obtain the most comprehensive and effective rape treatment.

Appreciation of the centrality of extreme self blame in the post rape clinical picture can help direct therapists towards adopting an unequivocally nonjudgmental stance towards survivors. The realization of the degree to which rape survivors internalize their social condemnation can point to the importance of avoiding re-traumatizing the victim by placing any type of blame on them. To that end, therapists must make sure that they themselves do not hold the survivor responsible for her attack in any way, irrespective of her behavior prior to, or during the rape. They must refrain from invalidating her narrative in any way. Beyond that, the therapist must actually take an active role in helping the survivor free herself of her negative self valuation by way of all suitable restructuring techniques. The survivor will not be able to fully recover until she fully believes that nothing she did makes her culpable in any way. Only then can she reclaim her life in every sense.

A few additional clinical issues are worth discussing. The finding that helplessness is most acute in the experience of rape as compared to other types of trauma may be an added factor contributing to the elevation of both self-blame and posttraumatic symptoms in this population relative to others. The experience of being rendered powerless to affect the course of events to the extent that is typical of rape,

may lead survivors to reproach themselves for supposedly not doing enough to alter the situation, which in turn might exacerbate the post-trauma agony and pain. Clearly, this finding has treatment implications as well. It denotes that rape survivors may need to be helped to process their sense of helplessness to a greater degree than other trauma victims. Treatment should facilitate establishing more realistic explanations for their inaction than culpability. Issues such as size and strength differences between the victim and the assailant, incapacitating fear and terror, and instinctual freezing are some examples.

Delving further into the pattern of results concerning the subjective aspects of the various traumatic experiences reveals that there were no significant differences between rape and combat stress victims in the degree to which they experienced a threat to their life, in spite of the fact the combat situations would appear to involve greater life threatening danger than rape. This finding resonates, however, with accounts of rape survivors who frequently report that rape is experienced as life threatening, irrespective of the presence or absence of a weapon (Koss & Harvey, 1991). Apparently, the vicious act of aggression inflicted upon their most inner body feels like an attack on their actual being, resulting in a sense of extreme fear for one's life (Herman, 1992). This too must be processed and resolved in the course of therapy.

Going beyond the implications for rape treatment, the present results also have widespread social relevance. The finding that self-blame is most extreme among rape survivors makes perfect sense in light of the distinct accusatory social milieu surrounding rape survivors, who, unlike other trauma victims, routinely endure collective victim-blaming and accusation (Arata & Burkhart, 1996; Kilpatrick and Veronen, 1983; Lebowitz, 1993; Lebowitz & Roth, 1994; Libow & Doty, 1979;

Ulamn, 1996). Insofar as this social reality is rather unique to the aftermath of rape, it is completely logical that survivors of this trauma will indeed experience self-reproach of the worst kind.

Inasmuch as the results evidence the extremely devastating emotional consequences of rape in terms of both self-blame and PTSD, they underscore the criticalness of taking social action to remedy the situation. More specifically, they call for a change in social attitude towards rape victims on both societal and interpersonal levels. That self-blame following rape was shown to be the highest among all trauma victims indicates that rape survivors are in the greatest need for social support to counteract their sense of blameworthiness and shame. Yet in the current social reality the opposite is generally the norm; they are faulted, accused and slandered. If we, as a society, are to maximize the chances for rape victims to overcome their trauma, and minimize the complications to post-rape PTSD, we must commit to replacing the widespread collective victim blaming with unconditional and unmitigated social and interpersonal support for each and every survivor.

Although there is clearly a need for future research of this kind, including larger and more diverse populations, these preliminary findings regarding some of the specific consequences of rape that set it apart from other trauma types, can, nonetheless, help tailor rape treatment to the exact needs of this particular post-traumatic presentation**.** This promises to enhance rape treatment to the benefit of survivors and the alleviation of the larger part of their presenting symptoms. It is hoped that future investigations will empirically determine the effectiveness of such treatment, and find it as useful as expected by the present results.

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