Understanding Rape and Sexual Assault

20 Years of Progress and Future Directions

REBECCA CAMPBELL
Michigan State University
SHARON M. WASCO
University of Massachusetts–Lowell

During the past 20 years, researchers have documented the widespread problem of rape in American society. Approximately one in four women are raped in their adult lifetime, which causes severe psychological distress and long-term physical health problems. The impact of sexual assault extends far beyond rape survivors as their family, friends, and significant others are also negatively affected. Moreover, those who help rape victims, such as rape victim advocates, therapists, as well as sexual assault researchers, can experience vicarious trauma. Future research and advocacy should focus on improving the community response to rape and the prevention of sexual assault.

Keywords: *rape; sexual assault; history of research; secondary victimization; prevention*

This year the **Journal of Interpersonal Violence** marks 20 years of publication, providing an opportunity to reflect on 2 decades of scholarship on interpersonal violence and traumatic injury. As community psychologists who study rape, our current work is guided by research that long ago identified sexual assault as a serious social problem. As we move forward to investigate complex relationships between rape survivors and their communities, it is worth reviewing the foundations on which this work is built and examine what we still need to learn about sexual violence.

In the early 1980s, very little academic research existed that documented the prevalence of sexual assault. Community-based rape crisis centers emerged in the early 1970s, and rape victim advocates knew the problem of sexual assault was rampant in American society. However, proof from academia had not yet arrived. The scholarship of Diana Russell and Mary Koss

JOURNAL OF INTERPERSONAL VIOLENCE, Vol. 20 No. 1, January 2005 127-131
DOI: 10.1177/0886260504268604

changed that, and to this day their research on the prevalence of sexual assault remains one of the most important things we have learned about interpersonal violence in general and sexual assault in particular in the past 20 years. Russell's (1983, 1984) landmark study of community women in San Francisco revealed that 24% of women had experienced a completed rape and 44% had experienced a completed or attempted rape. Koss and her colleagues conducted a national random survey of college women and found that 1 in 4 women had experienced rape or attempted rape in their lifetimes and 84% of the women knew their attacker (Koss, Gidycz, & Wisniewski, 1987). Rape was not rare, and it was not primarily a stranger-in-the-bushes phenomenon. It was a violent crime committed against millions of women by men they knew and trusted. Comparable prevalence rates have been obtained by multiple independent research teams, and 20 years later it is still clear that sexual assault is far too prevalent.

From that founding research on the prevalence of rape, other researchers began to document the widespread deleterious effects that sexual assault has on women's lives. Within the past 20 years, we have learned that the mental health effects of this crime are devastating as rape survivors are the largest group of persons with post-traumatic stress disorder (PTSD; Foa & Rothbaum, 1998). The inclusion of PTSD into the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM*) in 1980 was a major conceptual development in the study of trauma associated with sexual violence. Although this framework may be limited in its ability to capture fully the nature of sexual assault (see Wasco, 2003), it has spawned a proliferation of research documenting the psychological injury caused by rape. Beyond this focus on psychological impact, emerging research suggests that rape survivors experience more acute and chronic physical health problems than do women who are not victimized (Golding, 1994; Koss, Koss, & Woodruff, 1991). Sexual assault also affects women's sexual health risk-taking behaviors and places some at greater risk for contracting HIV (Campbell, Sefl, & Ahrens, 2004).

The radiating impact of sexual assault does not stop with the survivor's health and well-being. Research indicates that coping with the aftermath of rape can cause significant stress for the family, friends, and significant others of sexual assault survivors (Ahrens & Campbell, 2000; Burge, 1983; Remer & Elliott, 1988). Professionals who help women recover from rape are not spared its devastating effects as rape crisis center staff, rape victim advocates, and sexual assault therapists experience vicarious trauma (Schauben & Frazier, 1995; Wasco & Campbell, 2002). Even those who study rape can become emotionally affected by bearing witness to the devastating impact of this crime (Alexander et al., 1989; Campbell, 2002).

Building on the research that documented the problem of rape in American society, we now need to move from prevalence to prevention (Bachar & Koss, 2001). Prevalence studies today yield nearly the same numbers, and for all the debate over which methods are the most precise, it is essential to not lose sight of the fact that the incidence of sexual assault is not going down significantly because prevention remains elusive. Neither community-based practitioners nor academic researchers have been able to identify models of prevention effective enough to put a serious dent in incidence rates. Longer term education programs such as the one evaluated by Lonsway and her colleagues have been found to create lasting attitude change and increased assertive communication (Lonsway et al., 1998). Yet prevention programs that specifically target men are few in number and have not been able to identify the critical processes by which sustainable behavioral change can be achieved. Addressing this challenge will take time; however, within the next 10 years researchers and advocates need to work together to identify promising practices in prevention.

In addition, we need to focus on improving community-based interventions for rape survivors. Although many rape survivors do seek counseling and there are several therapeutic models that have demonstrated effectiveness (see Resick, Nishith, Weaver, Astin, & Feuer, 2002), more needs to be done to provide emotionally supportive care outside of mental health services. For example, many communities throughout the United States have created sexual assault nurse examiner (SANE) programs whereby specially trained forensic nurses provide 24-hours-a-day, first-response care to sexual assault victims in either hospital or nonhospital settings (Ahrens et al., 2000; Ledray, 1999). Preliminary evidence suggests that SANE programs may have positive effects on survivors' emotional recovery and may actually improve the prosecution rates of sexual assault (Campbell, Patterson, & Lichty, 2004; Crandall & Helitzer, 2003). Research on innovative community responses to rape, such as SANE programs, is needed to find new ways to help survivors in addition to traditional mental health services.

Understanding the prevalence, impact, and prevention of sexual assault is complicated, and we need methodological frameworks that can help researchers capture the complexity of these problems. Throughout its history, violence against women research has been primarily quantitative in nature. Given the complex nature of violence-related trauma, the development of point-and-click statistical software has been a major innovation that has allowed researchers to model complicated relationships among many variables using multivariate quantitative statistics. However, qualitative work may be equally important as it can shed new light on old problems. For

example, it has been well documented in numerous quantitative studies that most sexual assault cases are rarely prosecuted; however, it was Frohmann's (1991, 1997, 1998) qualitative ethnography of prosecutorial decision making in sexual assault cases that began to explain why this problem was occurring. Qualitative approaches may be particularly helpful when trying to answer why and how questions. Such process questions are the next step in many areas of sexual assault research, and expanding the methodological diversity of the trauma literature is needed. As the field of rape research moves forward, mixed method approaches may be able to address difficult questions regarding treatment, intervention, and prevention. Any methodological framework would also benefit from pooling the complementary expertise of researchers, practitioners, advocates, and survivors. Such collaborative research may help uncover answers to today's most elusive questions.

REFERENCES

Ahrens, C. E., & Campbell, R. (2000). Assisting rape victims as they recover from rape: The impact on friends. *Journal of Interpersonal Violence*, *15*, 959-986.

Ahrens, C. E., Campbell, R., Wasco, S. M., Aponte, G., Grubstein, L., & Davidson, W. S. (2000). Sexual assault nurse examiner (SANE) programs: An alternative approach to medical service delivery for rape victims. *Journal of Interpersonal Violence*, *15*, 921-943.

Alexander, J. G., de Chesnay, M., Marshall, E., Campbell, A. R., Johnson, S., & Wright, R. (1989). Parallel reactions in rape victims and rape researchers. *Violence and Victims*, *4*, 57-62.

Bachar, K. J., & Koss, M. P. (2001). From prevalence to prevention: Closing the gap between what we know about rape and what we do. In C. M. Renzetti, R. K. Bergen, & J. L. Edleson (Eds.), *Sourcebook on violence against women* (pp. 117-142). Thousand Oaks, CA: Sage.

Burge, S. K. (1983). Rape: Individual and family reactions. In C. Figley & H. McCubbin (Eds.), *Stress and the family: Coping with catastrophe* (pp. 103-119). New York: Brunner/Mazel.

Campbell, R. (2002). *Emotionally involved: The impact of researching rape*. New York: Routledge.

Campbell, R., Patterson, D., & Lichty, L. (2004). *Sexual assault nurse examiner (SANE) programs: A review of psychological and legal effectiveness*. Manuscript submitted for publication.

Campbell, R., Sefl, T., & Ahrens, C. E. (2004). The impact of rape on women's sexual health risk behaviors. *Health Psychology*, *23*, 67-74.

Crandall, C., & Helitzer, D. (2003). *Impact evaluation of a sexual assault nurse examiner (SANE) program* (NIJ 203276). Washington, DC: National Institute of Justice.

Foa, E. B., & Rothbaum, B. O. (1998). *Treating the trauma of rape: Cognitive behavioral therapy for PTSD*. New York: Guilford.

Frohmann, L. (1991). Discrediting victims' allegations of sexual assault: Prosecutorial accounts of case rejections. *Social Problems*, *38*, 213-226.

Frohmann, L. (1997). Convictability and discordant locales: Reproducing race, class, and gender ideologies in prosecutorial decision making. *Law and Society Review*, *31*, 531-556.

Frohmann, L. (1998). Constituting power in sexual assault cases: Prosecutorial strategies for victim management. *Social Problems*, *45*, 393-407.
Golding, J. (1994). Sexual assault history and physical health in randomly selected Los Angeles women. *Health Psychology*, *13*, 130-138.
Koss, M. P., Gidycz, C. A., & Wisniewski, N. (1987). The scope of rape: Incidence and prevalence of sexual aggression and victimization in a national sample of higher education students. *Journal of Consulting and Clinical Psychology*, *55*, 162-170.
Koss, M. P., Koss, P. G., & Woodruff, W. J. (1991). Deleterious effects of criminal victimization on women's health and medical utilization. *Archives of Internal Medicine*, *151*, 342-347.
Ledray, L. (1999). *Sexual assault nurse examiner (SANE) development and operation guide*. Washington, DC: U.S. Department of Justice, Office for Victims of Crime.
Lonsway, K. A., Klaw, E. L., Berg, D. R., Waldo, C. R., Kothari, C., Mazurek, C. J., et al. (1998). Beyond no means no. *Journal of Interpersonal Violence*, *13*, 73-92.
Remer, R., & Elliott, J. E. (1988). Characteristics of secondary victims of sexual assault. *International Journal of Family Psychiatry*, *9*, 373-387.
Resick, P. A., Nishith, P., Weaver, T. L., Astin, M. C., & Feuer, C. A. (2002). A comparison of cognitive-processing therapy with prolonged exposure and a waiting condition for the treatment of chronic post-traumatic stress disorder in female rape victims. *Journal of Consulting and Clinical Psychology*, *70*, 867-879.
Russell, D. E. H. (1983). The prevalence and incidence of forcible rape and attempted rape of females. *Victimology: An International Journal*, *7*, 1-4.
Russell, D. E. H. (1984). *Sexual exploitation: Rape, child sexual abuse, and workplace harassment*. Beverly Hills, CA: Sage.
Schauben, L. J., & Frazier, P. A. (1995). Vicarious trauma: The effects on female counselors of working with sexual violence survivors. *Psychology of Women Quarterly*, *19*, 49-64.
Wasco, S. M. (2003). Conceptualizing the harm done by rape: Applications of trauma theory to experiences of sexual assault. *Trauma, Violence, & Abuse*, *4*, 309-322.
Wasco, S. M., & Campbell, R. (2002). Emotional reactions of rape victim advocates: A multiple case study of anger and fear. *Psychology of Women Quarterly*, *26*, 120-130.

Rebecca Campbell, Ph.D., is an associate professor of quantitative and community psychology at Michigan State University. Her research examines how the legal, medical, and mental health systems respond to the needs of rape victims. She is the author of Emotionally Involved: The Impact of Researching Rape*, which won the 2002 Distinguished Publication Award from the Association for Women in Psychology.*

Sharon M. Wasco, Ph.D., is an assistant professor of psychology at the University of Massachusetts–Lowell. In her work, she applies an ecological perspective to understanding sexual violence. Her current research focuses on identifying individual, interpersonal, and sociocultural factors associated with repeated sexual victimization among young women.