Brief Report

RAPE TRAUMA SYNDROME: A RETROSPECTIVE STUDY OF POST-TRAUMATIC STRESS DISORDER AFTER SEXUAL ASSAULT AMONG INDIAN WOMEN

Udayan Bhaumik[*#]

***Consultant Psychiatrist, Antara Psychiatric Centre, Baruipur, Kolkata, India.**

Abstract

Rape is a traumatic event likely to cause post-traumatic stress disorder in at least 80% of cases. According to data released by the National Crime Records Bureau 2019 reports 93 cases of sexual assault per day, among them 118 children are also assaulted per day in India. Rape trauma syndrome is a unique variety of post-traumatic stress disorder following sexual assault. Coined by Ann Burgess and Lynda Holmstrom, it describes a phase during which the victim copes psychologically with the aftereffects of the rape. It is typically associated with the "underground" phase. *Aims and Objectives:* 1) to study post-traumatic stress disorder after sexual assault using Impact of Events Scale. 2) To study the relationship between rapes supporting myths and underground phase using Illinois rape myths acceptance scale. *Settings and Design:* A sexual assault assessment tool developed for use in the clinical settings was employed to study victims of rape. Sample size was determined by the number of women who sought help between 2018 January to 2019 November presenting to the outpatient department of M S Ramaiah Medical College, Bangalore. *Materials and Methods:* Eight women were recruited and all of them reported post-traumatic stress disorder after the event; all of them entertained rape myths and underground phase during which they behaved as though the event did not happen. *Discussion and Conclusion*: Post-traumatic stress disorder following sexual assault is unique and termed as rape trauma syndrome and rape supporting myths must be debunked to facilitate disclosure and help-seeking. *ASEAN Journal of Psychiatry, Vol. 23(3) March, 2022; 1-9.*

Keywords: Rape Trauma Syndrome, Underground Phase, Rape Supporting Myths, Post-Traumatic Stress Disorder.

Introduction

Rape is a sexual assault on a female by one or more persons without her consent. It is an act of violence and causes serious physical damage in some women and severe psychological harm and causing post-traumatic stress disorder in 80% of cases. [1,2]

In 2019, a total of 22,724 rape cases were registered in India, as per National Crime Records Bureau. Around 93 cases of sexual assault are registered every day. This amount to only 1.5% of actual cases [3].

Rape Trauma Syndrome is the gamut of reactions-emotional, physical and behavioural reported by victims of attempted or completed rape. It is a specific type or unique variety of post-traumatic stress disorder following sexual assault. Ann et al. coined this phrase to describe the series of symptoms experienced by victims. They separated the clusters of reactions into two stages: An acute, immediate phase of disruption and a long-term process of reorganization. They also reported another stage that has come to be known as the "underground" phase [4]. The impact of the incident may be so severe that the victim feels shock and disbelief. When they

begin to reduce, the primary feeling is of fear. Other feelings that may be associated are humiliation, degradation, guilt, shame, self-blame, anger and revenge.

Victims often differ in their style of expressing. Two predominant styles described are expressed style and controlled style. As in other crisis situations, victims of sexual assault may react with fear and confusion. They may have difficulty in problem solving and in mobilizing the strength to accomplish daily tasks. This usually lasts from a few days to a few weeks.

The underground stage is a period during which victims attempt to return to their lives as if nothing has happened. During this period, they may try to block thoughts of the assault from their minds. They may not want to talk about the incident and tend to avoid reminders. Some people may remain in this phase for many years [4].

The process of reorganization begins with a return to emotional turmoil. Events like seeing the assailant again, the arrival of court summons, a nightmare, or a certain sensor neural reminder may trigger this new phase. It can be extremely frightening to people in this stage to again feel emotional pain.

When the assault is committed by a stranger, fear appears to be the predominant emotion. More commonly, however, assaults are committed by a familiar face. In this kind of assault, feelings of self-blame and guilt are more common and can be overwhelming.

Rape supporting myths held as beliefs by care givers and victims themselves often cause significant secondary trauma after disclosure; it delays disclosure in many cases [5]. Rape myths are attitudes that are generally false and unscientific but are widely held; they serve to justify male sexual aggression against women [4]. Kamdar et al. studied the effects of rape myths in college students and found them to be common in the local population [6].

These phenomena, though known to occur, have not been well recognized among mental health professionals. It may be one of the reasons why victims of rape are sometimes not well understood. These factors may delay their recovery and precipitate catastrophic responses among rape survivors. The following eight case vignettes show the various stages of rape trauma syndrome, by which we have attempted to shed some light on this aspect which is a very important part to facilitate recovery in the victims.

Materials and Methods

The study was a descriptive, exploratory study involving a series of cases seen in the outpatient department in Psychiatry of a tertiary general hospital in Bangalore, Karnataka between January 2018 to November 2019.

The aims of the study were:

- To study posttraumatic stress disorder after sexual assault using impact of events scale.
- To study the relationship between rape supporting myths in the victims and delayed disclosure using Illinois rape myths acceptance scale.

Inclusion criteria

- Adult women spontaneously reporting sexual assault.
- Adult women giving informed consent.
- Women without previous history of mental illness.

Exclusion criteria

- Children aged less than 18 years.
- Males and Trans genders.

Women spontaneously reporting recent or past sexual assault as the presenting complaint and coming to the outpatient department were recruited for the study by the authors. Convenience sampling was used. Socio demographic data was used to estimate the "underground phase" unique to the post-traumatic stress disorder following sexual assault.

A semi-structured sexual assault assessment tool developed by the authors for the clinical setting was employed to establish the event. Impact of events scale to determine post-traumatic stress disorder and Illinois rape myth acceptance scale were applied. [7,8] Written consent was obtained from the clients before recruiting them. Autobiographic and demographic details have been altered to protect confidentiality. Institutional ethical clearance was taken.

Results

Case vignette 1

A 23-year-old woman was admitted with history of sexual assault 3 years back. She was accompanied by her parents who denied the event. The patient explained that she had volunteered in a Non-Governmental Organization (NGO) on wildlife conservation. She had befriended a boy who had invited her home. In his house, she had smoked cannabis for the first time. She was intoxicated when he raped her.

She had not complained to the police and leading her life as though nothing had happened. On being confronted, reported fear of contracting a sexually transmitted illness; she met another boy in her Arts School; he elicited a confession from her about rape by staging a drama to bully her. This started a process of introspection, where she began to tell her family about the rape and imagined that the boy who had tricked her into confession in public was talking to her father and family members. She had begun to imagine that news reports about rape were based on her. She avoided pursuing her hobby in wildlife conservation. She blamed herself as the cause of rape. She had confided in a dentist previously about the rape, who had avoided her thereafter. The patient's family did not believe her. She reiterated the story of rape every day to all the psychiatrists consistently.

She demanded to speak to a therapist and refused antipsychotics. She was willing to accept that she had obsessive guilt over herpes zoster. She suffered from obsessive fears of going out alone even to college, fatigue without exertion, crying spells, rage towards the abuser, and persecutory ideas towards her friend from the arts school. She would repeatedly ask her mother to reassure her that she was not guilty of enjoying rape.

After 6-7 sessions, she was finally able to accept that she was exaggerating the omnipotence of the man forcing her to disclose rape. She blamed her parents for allowing her to go to the perpetrator's house. When she visited the author, she accepted anxiolytics and anti-obsessive drugs. In the end, she refused to follow up for therapy sessions. She contacted the authors through e-mails several times using various pseudonyms. He primary fear till she dropped out was that the rapist might stalk her on social media.

Case vignette 2

An Indian woman aged 32 years presented with anger outbursts and abusive behaviour towards her husband living abroad; she had come to her parental home in India demanding divorce. She would have auditory hallucinations about her neighbours commenting about her; she had wanted to work in a school, though she was qualified as an engineer. On further clarification, she revealed that this was her second marriage.

The patient said that her paternal cousin (male) would speak to her in sexual innuendos since she was 15 years old. She had not reported this to anyone. While she was engaged to her first husband, she went out with the cousin to his quarters where she was raped under intoxication with alcohol. She had been unable to consent at the time. Later, she behaved as though nothing happened. She confided in her mother after she found herself to be pregnant and medically terminated it. A few weeks after her marriage to her first husband, she disclosed the matter to him. He felt betrayed and applied for divorce with mutual consent. Thought the patient consented to the divorce, she later felt cheated. She also faced questions and humiliations among relatives. The patient was subjected to victim blaming and shaming by her in laws prior to the divorce; her parents also disapproved of her speaking of the incident to the second husband as secondary trauma after disclosure had been significant.

The patient married the second man in the United States who accepted her past and the divorce. He did not want his family to be told. She however felt insulted by his attitude towards her skills as an engineer. She had already experienced guilt towards the medical termination of pregnancy after the sexual assault. The second husband was inclined to have a child which precipitated obsessions of guilt in the patient.

She would experience flash backs of her traumatic marriage with her first husband and all the shaming she had gone through. She demanded divorce from the second husband as her first husband demanded divorce from her and flew back to India.

The patient relocated to another city as a working woman and later decided against the second divorce after sessions of trauma focused psychotherapy, narrative therapy and anti-obsessive medicines; she gradually developed insight that her acting out/repetition compulsion with the second husband was triggered by the trauma of first divorce.

Case vignette 3

The patient was a 36-year-old, unmarried, Doctorate in computer sciences from United States. She was brought to the authors with a history of odd behaviours, social withdrawal, poor personal hygiene, decreased sleep, decreased appetite and crying spells.

She had been living alone in a village, training children in using computers. She narrated her life events where she had been bullied and sexually objectified by others to a self-proclaimed Godman in that village. Initially hesitant, she later agreed to have sexual relations with the God man, believing it to be a 'healing procedure'. The patient developed veganism's when penetration was attempted. Following the attempted rape, the patient started fearing that the Godman would harm the children whom she would teach. These obsessive fears were later replaced by fears of harm being caused to her father and sister by the Godman and his gang. The patient compulsively called the village headman and wanted to see that children were safe. She was hospitalized thrice after developing panic attacks. She was started on a Selective Serotonin Reuptake Inhibitor (SSRI) and antipsychotics for the yielding compulsions and poor insight. She recovered over a period of 3 months and resumed her research work as faculty of an institute and maintained well till dropping out.

Case vignette 4

An 18-year-old studying in her pre-university course was brought in with complaints that she was repeatedly calling and texting a male student and texting him without his approval. This led to the boy's mother complaining to the institutional authorities. The patient was judged negatively for this act both at home and outside. She was bullied at school by other students and teachers after news spread.

She would have flashbacks and anger outbursts at the recollection of the incident, causing an academic decline. She did not agree with the judgment being made that she was sexually interested in the boy with whom she was communicating.

The patient was psycho-educated about post-traumatic stress disorder. She was started on an SSRI, beta blockers, and modafinil 100mg. She also received narrative therapy. After about 1 year, during a session, she revealed that she had been raped by 3 men while she was going to her tuition in the ninth standard. She reported shame over the incident and guilt for returning late from the tuitions by a road that had less traffic. She had apparently not reported to anyone except the male student who was her friend. He had consoled and supported her at that time; hence she was texting him or calling him whenever she had a flash back.

The patient did not defend herself because of the guilt and shame she felt over the rape. She stopped texting the boy and thereafter was able to focus and complete her education. The parents were not told about the rape, as the patient had requested confidentiality.

Case vignette 5

A 34-year-old lady, director of a software company, was brought with acute loss of memory of a traumatic event that occurred the previous night. She had been assaulted by her trusted driver of four years at her house, for which she had lodged a complaint at the local police station.

When seen by the authors, she denied the sexual assault. She was able to recall the perpetrator slapping her and lying on top of her. The shock of betrayal was tremendous. She was diagnosed to have acute stress disorder with dissociative amnesia and was referred to her local psychologist. She came for several follow ups, during which she reported fear of moving out of the house; she would seldom attend her office. She improved with antidepressants and antianxiety medication, following which she was able to resume her activities of daily living.

Case vignette 6

A 24-year-old young woman was brought with complaints of anxiety, palpitations, and absenteeism during her working hours whenever she was criticized by senior colleagues. She had been seeing a psychiatrist for over six months was being treated with an SSRI and had experienced little relief. She had crying spells and death wishes.

She later revealed that she had been kidnapped at the age of 15 years by a cab driver who drove her to music classes. He had taken obscene pictures of her. The abductors were arrested and tried in court. The photographs were destroyed.

The incident received significant media coverage led to further trauma. The patient failed her 12th exams twice before clearing them. Even after joining engineering, she continued to have episodes of excess sleeping and withdrawn behaviour. She was taken to a psychiatrist who minimized the effect of her trauma; following her interactions with the psychiatrist, the patient became aggressive with parents, expecting them to have protected her. She started identifying the triggers for her flash backs-fear of taxis and fear of being close to strangers.

She told the therapist that she was raped in the car by all the assailants and had never spoken about it to parents until 9 years after the incident. She was explained about the underground phase and the time. Following treatment, the patient had fewer flash backs. Her stress-related binging also improved over time. The patient was continued on citalopram for excessive anger and pervasive sadness. With treatment, she was able to live independently and pursue her post-graduation.

Case vignette 7

A married woman aged 54 years was admitted for vaginal hysterectomy for dysfunctional uterine bleeding. She was nulliparous and a widow at the time of her index marriage. She reported being looked down upon by her husband and his family as an already married woman, who was fully experienced in matters of sex the patient felt raped by her husband. They had no children of their own. The patient did not bond with her stepchildren since her mother-in-law dominated their caregiving. She would have panic attacks at thoughts of having the uterus removed and was apprehensive about it. She later described it as a reminder of what she believed was marital rape. She was diagnosed to have delayed post-traumatic stress disorder, with obsessive fears of rape.

Case vignette 8

A 38-year-old woman was brought with a history of seizure-like episodes, for which she had been on treatment for more than a decade. Electroencephalography (EEG) was normal. The patient was an orphan living with relatives 16 years ago, when a boy from the city claimed to be in love with her and married her. She was found to be working as a commercial sex worker for 6 days before she was rescued by an accidental police raid and was sheltered by a Non-Governmental Organization (NGO) that housed children. Patient was working for this NGO when she developed these spells. During these episodes, she would repeatedly disrobe herself.

The patient recall feeling distressed when she had to work at a men's hostel. She was diagnosed with dissociative motor disorder; she improved with graded exposure to public places with a trusted person and later alone. Her dissociative episodes remitted after 1 year of narrative exposure response therapy.

The duration of the underground phase and rape myths elicited in each participant have been depicted in Table 1.

Table 1. Table depicting the durations of underground phase of subjects and various rape myths entertained by them.

Index case	Duration of underground phase	Rape myth entertained by victim
Case 1	3 years	A girl who gets intoxicated is asking for it
Case 2	10 years	As she had accepted to drinking with her cousin, she should also accept the rape as it was her fault
Case 3	1 month	Because of veganism's rape did not occur.
Case 4	2 years	Sexual contact was required to be accepted into her peer group.
Case 5	24 hours	Belief that she had done something that had attracted the rapists.
Case 6	9 years	Self-blame for trusting
Case 7	25 years	Sex is a conjugal right
Case 8	20 years	All women who are raped automatically become commercial sex workers.

Discussion

All patients were scored on Impact of events Scale and Illinois Rape myth acceptance scale. The time taken to disclose the event was recorded to determine the approximate duration of the underground phase. All cases reported underground phase and belief in rape supporting myths.

The first case had typical features of rape trauma syndrome. The underground phase had lasted for 3 years, and traumatic disclosure led to an obsessive doubt about the experience, with compulsive confiding for external validation. Patient had obsessive fears of sexually transmitted disease. Patient believed rape myths, hence blamed her though she was violated. Subsequent secondary trauma due to disclosure was significant [4,5].

Her dentist had stopped talking to her, her parents disbelieved her and brought to the psychiatrist and the classmate who had conned her into talking about it had openly blamed her for the experience. These show the acceptance of sexual aggression against women embedded in society. Rape myths continue to control the psyche of the larger society surrounding the victim and trauma of disclosure is bigger than the trauma of living with an experience [9]. Benevolent sexism, hostile sexism and belief in the just world may lead to women getting women blamed more for date rape than the perpetrator [10].

The second patient had been in underground phase for 3 years and returned to the memory of rape with an emotional turmoil. Frequent change of contact information that is described in victims was noted in her change of e-mail addresses and fear of being stalked [11]. She also avoided all reminders of the trauma by avoiding her previous areas of expertise. Due of the guilt that is predominant when the victim knows and trusts the assailant, the patient was in shock and unable to disclose due to self-blame. The victim had pre-traumatic beliefs (girls with suspect character smoked drugs and went out on dates

with boys) supporting rape myths [10]. Due to this, she would suffer from guilt and obsessive need for reassurance by her mother. It is likely that secondary trauma following disclosure caused the patient to withdraw from therapy [11].

The perpetrator had groomed the patient from childhood and abused her after she was intoxicated. The patient knew and had refused intercourse, but because she was intoxicated her resistance was inadequate according to her; she blamed herself for the situation. Even though her pregnancy was because of rape she felt guilty of terminating it [12]. Here the patient believed that she had cheated on her first husband as she was engaged to marry him and had gone drinking with another man. She also shared rape sustaining myths, hence had given mutual consent divorce to her first husband despite the victim blaming and shaming she had suffered [4,5,9]. The patient had repetition compulsions in her second marriage, when she asked for divorce from her husband and insulted him. She had flashbacks of neighbours talking about her and relatives condemning her character.

Case 3 was subjected to brainwashing and coercive thought indoctrination by the Godman [13]. She had resisted the sexual assault but developed obsessive fears. She suffered a psychotic breakdown as her ego could not come to terms with the actions; she had committed following brain washing. Thereafter, the patient had lost faith in her judgment of men. She completely denied the impact of sexual assault and vaginismus. Her avoidance of traumatic reminders included not visiting temples, pujas and chants.

Case 4 hailed from a repressive cultural background. She was blamed and character assassinated by the school authorities for texting a boy. Due to fear of victim blaming and victim shaming the patient had never spoken of assault to anyone. She disclosed the assault to the therapist after one year of the event.

Case 5 had acute stress reaction with dissociative amnesia for the traumatic event. Because she had trusted her driver, she suffered from betrayal trauma. She suffered from agoraphobia and could not talk about rape at all. She avoided transport had begun within hours after rape and was unable to travel without her husband.

Case 6 hailed from a high functioning family, hence achieved her academic goals coping with autonomic hyper arousal. The patient's parents were sensitive and defensive about the assault since they blamed themselves for the incident. Most of the conflicts were triggered by her eating; refusing to exercise as she felt autonomic hyper arousal was a reminder of the trauma. The underground phase lasted for nine years; the patient had not disclosed about the rape to family members.

Case 7 had marital rape that is not classified as an offense in India. Hence it did not receive the attention it required and even the victim afraid to even call it rape.

Case 8 was a victim of human trafficking; despite this she was blamed as much as the offender. She suffered from chronic feelings of guilt and shame. Many cases of sexual assault by persons known to the victim go unreported [14,15].

The victims here belonged to different backgrounds in terms of socioeconomic class and education. Yet all of them had and endorsed rape myths. In some of these cases, they were found to be firmly entrenched even in family members and friends. The authors also found varying durations of the underground phase. The authors were not able to find any correlation between socioeconomic class, level of education or number of rape myths endorsed. In all of them, there was significant impact of the trauma of sexual abuse on the lives of the individual and their close ones. Yet they were not recognized till confrontation.

Rape trauma syndrome and underground phase have been scarcely reported due to multiple reasons and scarcely studied. It can lead to various psychological reactions in the victim. It is not uncommon for victims of rape to develop obsessive symptoms originating from the guilt of the event. Sometimes frank depressive and

psychotic symptoms may be noted. All these symptoms can be believed to originate from post-traumatic stress in the aftermath of rape, which has been described as rape-trauma syndrome.

A significant limitation of the study is that all these individuals visited the authors at various points in their respective underground phases. This creates significant recall bias. Some of them also dropped out early, leading to a difficulty in following the course and evolution of psychiatric symptoms the underground phase and its outcome over a prolonged period.

Exclusion of men and transgender was another limitation. According to Indian law, men cannot be 'raped' whereas it is accepted in some other countries. The transgender community is also vulnerable to penetrative sexual abuse, and it is worthwhile studying the evolution and course of the underground phase and the trauma they typically encounter after rape. This is because the expression of their distress and trauma may be significantly different from women.

Conclusion

There are no rape crisis centres in India to address crimes such as committed on these women. Addressing mental health issues of rape victims also requires a multidisciplinary approach. It is not uncommon to find rape myths in the judicial system as well. This may significantly affect reporting by victims [16]. Sexual violence against women and the impact of the same on mental health of women remains largely un-researched. Debunking of rape supporting myths is required so that victims do not suffer from self-blame. It is also important for mental health professionals to recognize this phenomenon and gently encourage disclosure to help healing and recovery.

Rape trauma syndrome as a unique form of post-traumatic stress disorder with underground phase needs further research and emphasis.

Rape prevention workshops addressing rape myths can significantly improve bystander intervention and help-seeking by victims and may be crucial steps in reducing prevalence of rapes [17].

Future research can be aimed at examining the importance of previous rape education to determine how it impacts rape myth acceptance and bystander attitudes.

References

1. Roth S, Newman E, Pelcovitz D. Complex PTSD in victims exposed to sexual and physical abuse: Results from the DSM-IV field trial for posttraumatic stress disorder. Journal of Traumatic Stress 1997; 10: 539–555.
2. Kalra G, Bhugra D. Sexual violence against women: Understanding cross-cultural intersections. Indian Journal of Psychiatry 2013; 55: 244-249. [Crossref], [Google Scholar], [Indexed]
3. Burgess AM, Holmstrom LL. Rape trauma Syndrome. American Journal of Psychiatry 1974; 131: 981-986.
4. Edwards KM, Turchik JA, Dardis CM. Rape myths: History, individual and institutional-level presence and implications for change. Sex Roles 2011; 65: 176.
5. Buddie AM, Miller G. Beyond rape myths: A more complex view of perceptions of rape victims. Sex Roles 2001; 45: 139-160.
6. Kamdar ZN, Kosambiya K, Chawada BL. Rape: Is it a lifestyle or behavioural problem? Indian Journal of Psychiatry 2017; 59: 77-82.
7. Salsman JM, Schalet BD, Andrykowski MA. The impact of events scale: A comparison of frequency versus severity approaches to measuring cancer-specific distress. Psychooncology. 2015; 24: 1738-1745.
8. Payne DL, Kimberly A, Lonsway KA. Rape myth acceptance: Exploration of its structure and its measurement using the Illinois rape myth acceptance scale. Journal of Research in Personality 1999; 33: 27-68.
9. Abbey A. Acquaintance rape and alcohol consumption on college

campuses: How are they linked? American Journal of College Health 1991; 39: 165-170.
10. Chapleau KM, Oswald DL. Power, sex and rape myth acceptance: Testing two models of rape proclivity. The Journal of Sex Research 2010; 47: 66-78.
11. Koss MP, Dinero TE, Seibel CA. Stranger and acquaintance rape: Are there differences in the victim's experience?. Psychology of Women Quarterly 1988; 12: 1-24.
12. Major B, Appelbaum M, Beckman L. Abortion and mental health. Evaluating the evidence. American Psychologist 2009; 64: 863-890.
13. Ciarlante MBS. Disclosing sexual victimization. The Prevention Researcher 2007; 14: 11.
14. Pedersen SH, Strömwall LA. Victim blame, sexism and just-world beliefs: A cross-cultural comparison. Psychology Psychiatry and Law 2013; 20: 932-941.
15. Clark JNA. Crime of identity: Rape and its neglected victims. Journal of Human Rights 2014; 13: 146.
16. Safri T. Prevalence of rape myths in contemporary India. International Journal of Research 2015; 3: 147-152.
17. McMahon S. Rape myth beliefs and bystander attitudes among incoming college students. Journal of American College Health 2010; 59: 5-11.

Corresponding author: Udayan Bhaumik, Consultant Psychiatrist, Antara Psychiatric Centre, Baruipur, Kolkata, India

Email: udayan.bhaumik@gmail.com

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