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The Double-Edged Sword of Diagnosis: Medical Neoliberalism in Rape Crisis Center Counseling

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THE DOUBLE-EDGED SWORD OF DIAGNOSIS:
MEDICAL NEOLIBERALISM IN RAPE CRISIS CENTER COUNSELING

A Dissertation Presented

by

SHANNON M. PETERS

Submitted to the Office of Graduate Studies,
University of Massachusetts Boston,
in partial fulfillment of the requirements for the degree of

DOCTOR OF PHILOSOPHY

August 2019

Counseling Psychology Program

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ABSTRACT

THE DOUBLE-EDGED SWORD OF DIAGNOSIS: MEDICAL NEOLIBERALISM IN RAPE CRISIS CENTER COUNSELING

August 2019

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The prevalence of sexual violence in the United States is a critical issue and the aftermath of sexual assault can have profound effects on psychological well-being. Rape Crisis Centers play a vital role in supporting sexual violence survivors. The framework through which Rape Crisis Center clinicians understand the experiences of survivors has a substantial impact on the course of counseling, how survivors interpret their own experiences, and survivors' psychological health. A neoliberal medicalized framework conceptualizes distress post-sexual assault as a disease or disorder and places the responsibility on an individual to 'fix' themselves, situating the problem within the person, rather than in a sociopolitical context. This framework has become increasingly prevalent in Western society and has permeated psychology.

The goal of the present study was to explore the impact of a neoliberal medicalized discourse on clinicians' understandings of survivor distress and provide a counter-dialogue to the often polarizing conversations as to whether medicalization is 'good' or 'bad.' This study aimed to answer: 1) How does a medicalized discourse impact how Rape Crisis Center clinicians make meaning of their clients' experiences post-sexual assault? And 2) What are the advantages and disadvantages of using a medicalized framework to understand the aftermath of sexual assault for survivors who seek services? Engaging in qualitative inquiry, a modified version of interpretative phenomenological analysis was employed.

Analysis revealed four master themes titled, *Wielding the Double-Edged Sword of the Medical Model*, *Navigating the Healing Process with Survivors*, *Stay in Your Lane: The Role of the RCC*, and *Understanding and Honoring Survivor Shame*. The themes are discussed in terms of how medical neoliberalism subtly influences clinicians' work. Implications for social justice are considered, especially as they relate to Rape Crisis Centers' aims to increase access for marginalized populations. Recommendations for researchers and clinicians working with sexual violence survivors are provided pertaining to (a) how to critically adopt a medical framework, (b) how to empower survivors with information about medication, (c) alternatives to individual counseling for survivors, and (d) future research with survivors to further explore the effects of medical neoliberalism on their conceptualizations of distress post-sexual assault.

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CHAPTER 1

INTRODUCTION

The prevalence of sexual assault in the United States is a critical issue. A national survey found that 19% of women and 2% of men reported being raped in their lifetime, and 44% of women and 23% of men reported experiencing some other form of sexual violence (Breiding et al., 2014). The aftermath of sexual assault has profound effects, including physical and psychological distress that may last for decades (Acierno et al., 2007; Black et al., 2011; Breiding et al., 2014). Additionally, the response a survivor receives after disclosing sexual assault can have a significant impact on psychological well-being, physical health, coping skills utilized, self-esteem, and the development of PTSD symptoms for many years post-disclosure (Campbell, Ahrens, Sefl, Wasco, & Barnes, 2001; Martzolf et al., 2010; Sigurvinsdottir & Ullman, 2015; Ullman & Peter-Hagene, 2014). Recent research has also found that survivors often report more negative reactions from formal supports, including counseling services, victims' rights advocates, medical professionals, and police, than informal supports, such as family members, friends, and partners (Campbell, Ahrens, et al., 2001; Campbell, Wasco, Ahrens, Sefl, & Barnes, 2001; Ullman & Filipas, 2001).

Rape Crisis Centers (RCCs) have played a vital role in supporting individuals who have experienced sexual violence since they were first established in the 1970s

(Campbell & Martin, 2001; Robinson & Hudson, 2011). RCCs are often the frontline of services for survivors, providing crisis intervention (e.g., crisis hotline), medical and legal advocacy, and counseling services (Campbell & Martin, 2001). The philosophy of treatment through which therapists in RCCs understand the experiences of sexual assault survivors has a substantial impact on the course of therapy and how survivors interpret their own experiences. The therapy process influences how survivors make meaning of their experiences and understand their sense of self post-assault, thereby having a profound effect on survivors' futures. Therefore, it is important to understand what shapes clinicians' conceptualizations of their clients' experiences post-assault. In contemporary society, distress is often conceptualized as an illness or a disorder. Not surprisingly, RCCs have come under pressure to adopt this framework. The purpose of the present study is to explore how clinicians at RCCs both utilize and move beyond the conceptualization of distress qua disorder in their psychological work with clients.

The medical model refers to a fundamental belief that the complex human experience of distress is best understood intra-individually, as a disease or disorder. Thus, this model situates the problem within the person, rather than in a sociopolitical context. Medicalization is the process of this belief becoming pervasive in current Western society (Conrad, 1992). The medicalization of post-sexual assault experiences occurs when providers, clinicians, and survivors themselves view experiences in the aftermath of sexual assault as disordered (e.g., distressing emotions and behaviors are seen as symptoms) and requiring professional or expert treatment (e.g., pharmacotherapy, psychotherapy for symptom reduction) to 'fix' the distress.

Concerns about the medicalization of normal human experiences have been raised for decades (e.g., Conrad, 1992; Finkelstein, 1990; Summerfield, 2004; Ussher, 2010), especially because dominant discourses (e.g., a biopsychiatric discourse that explains distress using a medical model) can be used to exert social control (Foucault, 1972). Because a medical model inherently focuses on the pathos and an individual's illness or deficiency, it is easy to pathologize rather than emphasize an individual's strength and resiliency. A biopsychiatric framework may also result in obscuring relational struggles or sociopolitical issues (Tiefer, 2012; Ussher, 2010). This *psychiatric imperialism* promotes the status quo by "obscur[ing] the social processes that produce and define deviance by locating problems in an individual biology" (Moncrieff, 1997, p. 63). It is important to remember, as philosopher Michel Foucault (1984) astutely noted, it is "not that everything is bad, but that everything is dangerous" (p. 343). This idea aptly applies to the partnership between medicine and psychology. The medicalization of sexual trauma has both positive and negative effects, and rather than succumbing to an unhelpful dichotomy—either one is pro or anti medicalization—it is more helpful to develop a deeper understanding of the context in which a medicalized discourse is useful or harmful.

In today's society, there is an inescapable connection between medical institutions and where survivors of sexual assault seek support; a recent study found that 21% of female survivors sought medical care post-assault (Zinzow, Resnick, Barr, Danielson, & Kilpatrick, 2012). Often, responses to survivors who disclose sexual assault are inadequate or harmful (Starzynski & Ullman, 2014). Medical and legal institutions may

respond in ways that revictimize survivors such as unnecessarily invasive evidence collection processes or through victim-blaming attitudes and practices (Durazo, 2006). Sexual assault survivors who consider reporting the assault to police often have forensic evidence collected in hospital emergency departments. As part of evidence collection, Sexual Assault Nurse Examiners (SANEs) use a black light to identify physical evidence on the survivor's body. Although this is important from a legal standpoint, Mulla (2014) noted how survivors become dehumanized and objectified in this process, with their experience reduced to what glows under the black light. This black light can serve as a metaphor: Clinicians using a medical model to understand distress post-sexual assault would be analogous to shining the black light on their clients. This light may be a helpful method to discover things that would not have been seen otherwise. However, the client is still left in the dark and the 'evidence' becomes more prominent than the person. The question then becomes, how may a biopsychiatric framework be useful and how may it be insufficient to fully illuminate the experiences of survivors post-sexual assault? The aim of this study is to better understand the ways in which RCC clinicians make sense of survivor experiences, specifically in the context of a medical model.

It is first important to understand the history of the medical model in trauma work. The inception of Posttraumatic Stress Disorder (PTSD) in the third edition of the *Diagnostic and Statistical Manual of Mental Disorders (DSM)* in 1980 was made possible due to an increasingly prevalent assumption that the aftermath of trauma would inevitably result in pathology (i.e., the medicalization of post-traumatic experiences; Stein, Seedat, Iversen, & Wessely, 2007). Many feminist activists supported the new

diagnosis for sexual assault survivors because it externalized survivors' symptoms, thereby reducing blame (Lamb, 1999; Yehuda & McFarlane, 1995). Today, PTSD—a common diagnosis for survivors of sexual assault—could be considered the epitome of the medicalization of trauma because of the focus on intra-individual symptoms (e.g., flashbacks, hyperarousal). Researchers are also increasingly focused on trauma's neurobiological effects (Miller, Wolf, & Keane, 2014) and medication is used more and more as a first line treatment, with 37% of female survivors prescribed either sedatives or antidepressants (Sturza & Campbell, 2005).

PTSD was originally conceptualized as a normal response to abnormal events (Herman, 1997). However, since the rates of sexual assault are so high—over 40% for women (Breiding et al., 2014)—these events cannot be considered abnormal. Therefore, PTSD may be better conceptualized as a normal response to normalized events. Today, women survivors of sexual assault are diagnosed with PTSD at high rates, with a lifetime prevalence of 24-58% (Walsh et al., 2012), and the high numbers alone make one wonder about the applicability this diagnosis. In fact, one danger of medicalization is *diagnostic drift* (I. B. Andersen, Sørensen, & Prener, 1991), in which an increasing number of behaviors or experiences become defined as symptoms rather than normal distress, inflating the prevalence of a disorder (Moynihan et al., 2013). In the context of *DSM* diagnoses, this phenomenon has also been termed *mission creep*, “the gradual but inevitable expansion of a mission beyond its original goals” (Paris, 2015, p. 57).

Addressing these concerns is not to suggest that the diagnosis of PTSD should never be given, as there have certainly been benefits to a biopsychiatric model of trauma.

The formation of PTSD has advanced knowledge about symptoms of post-traumatic stress and provided more access to treatments by having an alternative diagnosis to Borderline Personality Disorder or Major Depressive Disorder (both commonly assigned to individuals, and in particular, women, who have experienced trauma; Acierno et al., 2007; Black et al., 2011; Shaw, 2005; Woodward, Taft, Gordon, & Meis, 2009). Despite the focus on pathology, a medical model does not have to be disempowering; many researchers are finding ways to use neuroscience and other medical frameworks in validating and affirmative ways (e.g., scientifically authenticating the negative mental and physical effects of poverty or discrimination; Ivey & Zalaquett, 2011). A medicalized discourse of sexual trauma is a tool that can be used to frame a survivor's experience. The problem arises when it is the only tool a clinician is aware of, and is used indiscriminately, without space to accommodate alternative models that better fit an individual survivor's experiences or address the larger social structures and environment.

A clinician can never know in advance how someone will experience the assignment of a *DSM* diagnosis, whether it will be received positively or negatively. In light of the power imbalance between survivors and their providers who are diagnosing (i.e., labeling) the survivor's experiences, assigning a mental health diagnosis may undermine survivors' ability to define their own experiences. This raises the question, is this diagnosis truly honoring survivors' experiences, or is it pathologizing them in a way that fails to appreciate the complexity of their lived experience? May a diagnosis do both simultaneously? The discourse of PTSD has been called "one of the worst thieves" (Lamb, 1999, p. 111) of survivor agency and resiliency because, for some individuals,

understanding their experience qua disorder is neither accurate nor helpful. In addition, stark gender differences were found in the years following the inclusion of PTSD in the *DSM*, with women more likely than men to be assigned a diagnosis of Borderline Personality Disorder over PTSD (Becker & Lamb, 1994), although this discrepancy may be less prevalent today (Woodward et al., 2009).

Because of its limitations, many scholars have identified alternatives to the medical model. Integral to these approaches is the conceptualization of distress within a sociopolitical context (LaFrance & McKenzie-Mohr, 2013). Ecological models (Ballou, Matsumoto, & Wagner, 2002; Bronfenbrenner, 1979; Campbell, Dworkin, & Cabral, 2009; Neville & Heppner, 1999) are valuable because they provide multiple access points for intervention (e.g., microsystem, macrosystem) beyond the medical model's individual level. An understanding of the role of cultural context is essential when using these models with survivors:

Manifestations of the cultural construction of gender are present before, during and after the rape; they influence the development of female personality; they provide ways of organizing experience that women bring to the rape; and they affect the meanings that the women and other people give to the rape. (Lebowitz & Roth, 1994, p. 382)

Scholars have also found it beneficial to broaden the definitions of recovery in order to move beyond outcome measures, and include a sense of meaning and connection versus just the absence of symptoms (Slade, Williams, Bird, Leamy, & Le Boutillier, 2012).

RCCs were at the forefront of developing alternatives to the medical model; they were founded via grassroots efforts during the second wave feminist movement in order to combat an oppressive culture that facilitated sexual violence (Maier, 2011). Today, RCCs are an invaluable resource to survivors of sexual assault with almost a quarter of female survivors accessing their services (Planty, Langton, Krebs, Berzofsky, & Smiley-McDonald, 2013). RCCs commonly apply the empowerment model (Rappaport, 1984), promoting survivor agency. Research has shown that individuals who feel in control of their lives experience less distress and engage in more adaptive coping mechanisms (Frazier et al., 2011). Although there have been critiques of the ways empowerment prizes masculine characteristics of individualism, mastery, and control, and concerns that it can lead to a disregard of extra-individual factors of distress (Cosgrove & McHugh, 2000; Fine, 1992; Riger, 1993), Rappaport (1984) and many community psychologists embrace ecological definitions of empowerment. There has also been an emphasis on group empowerment that encourages community involvement and establishing support networks (Cosgrove & McHugh, 2000; Falloot & Harris, 2002; Ullman & Townsend, 2008).

Since the 1970s, RCCs have needed to adapt to an increasingly medicalized framework. This framework is congruent with a neoliberal agenda. While there are many definitions of neoliberalism (Venugopal, 2015), this study will utilize the following definition: Neoliberalism is a political economic theory “that proposes that human well-being can best be advanced by liberating individual entrepreneurial freedoms and skills within an institutional framework characterized by strong private property rights, free

markets, and free trade” (D. Harvey, 2007, p. 2). Individuals who embrace a neoliberal agenda emphasize competition, reduced state responsibility for social well-being, privatizing public assets, and corporatizing human services (Sugarman, 2015, p. 104). Medical neoliberalism turns health and wellness into a commodity, and patients into consumers who bear the responsibility of making appropriate healthcare choices (J. A. Fisher, 2007). Neoliberalism is deeply interconnected with patriarchal structures and reinforces class and gender inequalities within the current capitalist system (Hubbard, 2004).

Survivors of sexual assault are often stigmatized by their inability to meet neoliberal ideals: The value of self-responsibility can lead to victim-blaming; survivors experiencing great distress may struggle to be productive; and because of the prizing of individualism, survivors who seek out community supports may be seen as dependent. Yet, “psychology is wedded to the social, cultural, political, and economic conditions of its times” (Sugarman, 2015, p. 115), and clinicians are increasingly pressured to coach their clients to adapt to these neoliberal values under what Layton (2015) calls “a neoliberal ethic of surveillance” (para. 26) that can conflict with therapists’ desire to provide quality care. This pressure may be even more pronounced in RCCs as they are in a time of transition, becoming more reliant on grant funding, more bureaucratic, and more collaborative with other agencies, as well as engaging less in political activism (Maier, 2011). It has been questioned whether these changes are beneficial and necessary for the survival of RCCs (Campbell, Baker, & Mazurek, 1998; Maier, 2011) or damaging to the anti-rape movement (Beres, Crow, & Gotell, 2009; Maier, 2011). Additionally,

researchers have identified ways that RCCs have been able to resist a neoliberal influence by aligning with other women's organizations and internally maintaining their feminist identities (Beres et al., 2009; Knight & Rodgers, 2012; Maier, 2008). Therefore, it is important for more research to explore the impact of neoliberalism on the medicalization of post-sexual assault experiences and counseling in RCCs.

Purpose of the Study

The aftermath of sexual assault can have a profound impact on psychological well-being. RCCs have been at the forefront of supporting survivors for over four decades. Despite their feminist roots, RCCs are not immune to the push to medicalize distress. For example, administrators may be pressured by funding sources to utilize a biopsychiatric model (Maier, 2011). Using this model may pathologize survivors' experiences and make it challenging for counselors to engage their clients around social inequities because of an overemphasis on pharmacotherapy. However, RCCs have also been able to harness the benefits of a medical model that validates survivors' distress, reduces stigma, and provides easier access to services. It is important to recognize that medicalization did not gain prominence in isolation. Medicalization has been facilitated by neoliberal ideals of self-responsibility, independence, and productivity. Foucault (1976/1990) was prescient when he suggested that individualized, psychologized explanations of distress reinforce a neoliberal argument that individuals are responsible for their own recovery. Clinicians in RCCs are constantly confronted with a neoliberal medicalized discourse and must navigate if, when, and how to engage in or resist this discourse with survivors.

There is a gap in the current literature on the impact of a medical model in therapy at RCCs within the context of a neoliberal climate. The present study adds to the existing literature by specifically asking how RCC clinicians adopt, reject, and/or circumvent medical neoliberalism. Engaging in qualitative inquiry, using a modified version of interpretative phenomenological analysis (IPA), the main focus is to explore how RCC clinicians, working within a society that prizes biopsychiatric explanations for distress, understand their clients' experiences post-assault. An additional focus of this study is to investigate how clinicians' conceptualizations impact the way in which they support survivors. Specifically, this study addresses the question, how do clinicians experience their roles when survivors adopt a medicalized discourse (e.g., when survivors experience themselves as 'having' PTSD) and how do clinicians create a space for survivors whose experiences post-assault do not fit a medical model? The results of this study are used to develop recommendations for clinicians about how to identify clinical blind spots when a neoliberal medicalized discourse may be influencing their conceptualization of post-sexual assault experiences. Additionally, the results will be useful in developing an understanding of how to judiciously appropriate a medicalized discourse that is congruent with survivors' lived experience.

Social Justice Implications of the Study

Reducing the psychological impact of sexual assault is a social justice issue. Individuals of all races, genders, sexual orientations, and socioeconomic statuses have been subjected to sexual violence, but some populations experience sexual assault at higher rates than others. For example, women are raped 10 times more often than men

(Breiding et al., 2014). Women's experiences in particular have been noted for being increasingly medicalized and, by extension, regulated (see e.g., Becker, 2010, for discussion on the medicalization of stress). American Indian and Alaska Native individuals experience sexual violence at higher rates than White, Black, and Hispanic individuals (Breiding et al., 2014). In addition, lesbian and gay, and especially bisexual and transgender individuals are exposed to sexual violence at higher rates than their heterosexual and cisgender peers (Edwards et al., 2015; Walters, Chen, & Breiding, 2013).

Not only do individuals of minority populations experience sexual violence more often, they are also held to standards of coping created based upon assumptions of racial and class privilege. This can hinder recovery, as a recent study found that depression and PTSD symptomatology do not decrease as significantly during the first three years post-assault for bisexual, and especially Black bisexual women, compared to heterosexual women (Sigurvinsdottir & Ullman, 2016). Because of this, current counseling frameworks that focus on intrapsychic problems can inadvertently maintain oppressive social structures (Greenleaf & Bryant, 2012). Fine's (1992) *therapeutic hegemony paradox* helps articulate the issue: People who have little control over the root of their problems are treated with individualized psychological approaches aimed at increasing self-efficacy that ignore the oppressive systems which contributed to those problems. A traditional medical or psychological model that reduces almost all problems to within the individual does not have the complexity to address issues such as intersectionality, oppression, and power dynamics that are at the forefront of social justice discourses.

Therefore, it is crucial for research to be conducted that explores how clinicians are conceptualizing survivors' distress and using or moving beyond biopsychiatric, individualized models in order to prevent further perpetuating oppressive structures.

This project also explores how current conceptualizations of distress post-sexual assault may inhibit larger social change to end sexual violence. A “Western medical model of disease deflects political causation and individualizes the origin of the problem/illness. Likewise the medical industrial complex (MIC), yet another partnering of the state and capital, co-opts social justice issues by taking them under its jurisdiction” (Durazo, 2007, p. 120). According to Durazo (2006), the medicalization of post-sexual assault experiences ignores racial and social inequities that create an environment conducive to sexual violence, thereby preventing larger social change from occurring. Campbell et al. (1998) contended that direct service work in RCCs is itself an act of social change. However, in order for it to be effective, clinicians need to (a) recognize when a medical model may benefit survivors versus when it is not serving them, and (b) have the skills to either judiciously appropriate a medical model or to resist it and turn to an alternative. This study is a first step in providing resources for clinicians to develop these skills.

Research Questions

An interpretative phenomenological approach was chosen to guide the design and implementation of this study. The study was driven by the following research questions:

- 1) How does a medicalized discourse impact how Rape Crisis Center clinicians make meaning of their clients' experiences post-sexual assault?

- 2) What are the advantages and disadvantages of using a medicalized framework to understand the aftermath of sexual assault for survivors who seek services?

Definition of Terms

Sexual Violence/Sexual Assault is an umbrella term that includes completed and attempted rape, sexual coercion, unwanted sexual contact, and any unwanted sexual experience (Breiding et al., 2014).

Sexual Assault Survivor is used throughout the paper, recognizing that the use of the term “survivor” upholds the dichotomy of victim/survivor that imposes a certain meaning on someone’s experience, which may or may not be valid. However, working within the limitations of the current discourse, survivor is considered the more respectful and empowering label and will therefore be used in this study.

Rape Crisis Centers are non-profit organizations originally established, independent of medical institutions, during the second wave feminist movement in the 1970s as grassroots political spaces for activists to provide support for survivors as well as engage in larger social change (Maier, 2011). Their services include crisis intervention (often in the form of a hotline), medical and legal advocacy, and counseling services (Campbell & Martin, 2001).

Medical Model is a fundamental belief that the complex human experience of distress is best understood intra-individually as a disease or disorder.

Medical Neoliberalism is a political philosophy that includes a national trend toward privatizing social services and healthcare, and a culture that treats health and

wellness as commodities, influencing healthcare at policy, institutional, and cultural levels (J. A. Fisher, 2007).

Medicalization is the process of a medical model becoming pervasive in current Western society (Conrad, 1992; see Busfield, 2017, for a detailed history of the term).

Neoliberalism is a political economic theory “that proposes that human well-being can best be advanced by liberating individual entrepreneurial freedoms and skills within an institutional framework characterized by strong private property rights, free markets, and free trade” (D. Harvey, 2007, p. 2).

Neoliberal Medicalized Discourse is the language and terminology used to communicate a medicalized understanding of distress qua disorder (a.k.a. psychiatric discourse), that are reinforced and facilitated by neoliberal ideals.

CHAPTER 2

REVIEW OF THE LITERATURE

This chapter will first review the prevalence and negative effects of sexual assault and the literature regarding the impact that responses to sexual assault disclosures have on psychological well-being. Following will be a discussion of the theories and literature on the medicalization of post-sexual assault experiences and feminist critiques of the trauma model for survivors. Next there will be a review of the literature on the role of rape crisis counseling for sexual assault survivors, followed by a description of the changes in rape crisis counseling over the past four decades due to the rise of neoliberalism. This chapter concludes with a summary of the relevant theories and studies that comprise the current literature base, and a description of the gaps in the literature that will be addressed by the present study.

Prevalence and Impact of Sexual Assault

Sexual assault, or sexual violence, refers to completed and attempted rape, sexual coercion, unwanted sexual contact, and any unwanted sexual experience (Breiding et al., 2014). In the U.S., 19% of women and 2% of men are raped in their lifetime, and 44% of women and 23% of men experience some other form of sexual violence (Breiding et al., 2014). Although sexual assault affects individuals across all demographic groups, some populations are more likely to experience it, such as American Indian and Alaska Native

individuals and gender or sexual minorities, especially people who identify as bisexual or transgender (Breiding et al., 2014; Edwards et al., 2015; Walters et al., 2013). As shown in the statistics above, women experience rape almost 10 times as often as men (Breiding et al., 2014), and therefore the vast majority of research on sexual assault focuses on female survivors.

Individuals who have experienced sexual violence are more likely to report their mental health as poor compared to individuals without a history of sexual violence (Black et al., 2011). Post-sexual assault, women are more likely to face substance abuse issues, depression, symptoms of Posttraumatic Stress Disorder (PTSD), and chronic medical conditions (Acierno et al., 2007; Black et al., 2011; Ullman & Brecklin, 2003). In fact, 24-58% of women who have experienced sexual assault are diagnosed with PTSD, with higher rates for women who have experienced multiple sexual assaults (Walsh et al., 2012). Survivors are also more likely to engage in self-harm and suicidal behavior (Brooker & Tocque, 2016). Lack of social supports increases the risk of poor mental health outcomes (Rahm, Renck, & Ringsberg, 2013), which is especially important since many survivors face isolation due to the stigma and shame associated with sexual abuse.

Disclosing Sexual Assault to Formal and Informal Supports

Over 80% of female survivors disclose their assault to at least one person (Ahrens, Cabral, & Abeling, 2009). The social context and expectations of the person the survivor is disclosing to may affect how that person responds to the survivor, which in turn can impact how the survivor makes meaning of their experiences post-disclosure (M. R. Harvey, Mishler, Koenen, & Harney, 2000). A number of studies have explored the

impact of positive versus negative reactions to disclosures of sexual assault. As expected, those who had a positive experience disclosing their assault (e.g., felt believed and validated) had fewer emotional and physical health issues, more adaptive coping mechanisms, higher self-esteem, and less PTSD symptomatology; survivors who received negative responses to disclosures (e.g., blaming, patronizing, controlling) were more likely to blame themselves for the assault, engage in maladaptive coping skills such as alcohol misuse, exhibit symptoms of PTSD, and feel less in control of their recovery (Campbell, Ahrens, et al., 2001; Martsof et al., 2010; Sigurvinsdottir & Ullman, 2015; Ullman & Peter-Hagene, 2014). In addition, Campbell, Ahrens, et al. (2001) found that negative responses to sexual assault disclosures had a more profound effect on survivor distress compared to positive responses or never disclosing.

Many studies have shown that survivors who disclose their assault to informal supports (e.g., friends, family, romantic partners) have more positive experiences than those who report to formal supports (e.g., counselors, victims' rights advocates, medical professionals, police; Campbell, Ahrens, et al., 2001; Campbell, Wasco, et al., 2001; Ullman & Filipas, 2001). Medical and legal institutions may revictimize survivors via invasive evidence collection or victim-blaming such as accusing survivors of provoking the assault (Durazo, 2006). The negative experiences survivors face when they are not supported by their communities are so common and impactful that Madigan and Gamble (1991) termed this phenomenon *the second rape*.

Studies have also investigated the characteristics that facilitate or inhibit access to formal support providers. Ullman and Filipas (2001) found that survivors were more

likely to disclose to formal supports if they were assaulted by a stranger and were physically injured during the assault. But in these cases, the survivors were also more likely to have negative experiences with their disclosures. This is presumably because they were also reporting to police, who are known for often responding poorly to survivors (Starzynski & Ullman, 2014).

Patterson, Greeson, and Campbell (2009) found that personal beliefs and expectations could also be barriers to seeking out formal support. The results of their qualitative study showed that survivors who did not seek formal support often believed they were unworthy of help due to self-blame or because their assault did not match the conventional image of rape (i.e., perpetrator is a stranger and/or uses a weapon). Additionally, participants expected formal help-seeking to cause more psychological harm if service providers did not believe them. In a meta-summary of 31 qualitative studies, with data from over 1,000 male and female survivors, Martsof et al. (2010) found that regardless of the professional role, survivors had a more positive interaction when they felt believed, validated, and listened to, and when they perceived that professionals were competently using their roles to help the survivor. Therefore, the way formal supports respond to survivors will have a significant effect on reducing barriers to accessing services.

First person narratives. A small number of qualitative studies have explored how survivors understand their experiences post-assault and what they find beneficial to move forward. One theme that emerged from these studies, conducted over two decades, was that survivors' understandings are greatly impacted by the social context, and

therefore theories of trauma must have a contextual grounding (M. R. Harvey et al., 2000; Ovenden, 2012; Riessman, 1989). M. R. Harvey et al. (2000) described how survivors rely on social discourse to create personal narratives, “we may use the culture’s collective narrative as a point of departure, providing a general map of the terrain within which our story will be located” (p. 307). Using a phenomenological approach, Lebowitz and Roth (1994) explored how survivors make sense of their sociocultural context post-rape. Their findings demonstrate the critical importance of cultural values in the meaning making process. They also demonstrate that, post-assault, survivors have a new understanding for how cultural and patriarchal structures facilitate sexual violence. Lebowitz and Roth (1994) write “being raped acts as a floodlight which allows the survivor to see what was present all along but which previously was unrecognizably embedded in the social landscape” (p. 371). Female survivors of sexual assault routinely—and often unknowingly—reference sociocultural gender norms when making meaning of their experiences (Lebowitz & Roth, 1994). Treatments for survivors should support this process, rather than attempt to circumvent it with individualized models of distress.

The studies also highlighted the need for clinicians to humbly listen to survivors and understand post-assault experiences in the survivor’s own words (M. R. Harvey et al., 2000; Riessman, 1989; Sorsoli, 2010). Both Riessman (1989) and M. R. Harvey et al. (2000) explained that this is especially important when working with clients who have experienced sexual assault because survivor narratives often involve a great deal of discontinuity, which can be difficult for listeners to tolerate. Therefore, clinicians must be able to resist the urge to shape survivors’ stories into coherent narratives, and instead

hold the space for contradiction, allowing survivors the time and freedom to shape their own narratives and make meaning of the trauma (Anderson & Hiersteiner, 2008). This conclusion is supported by the work of Kallivayalil, Levitan, Brown, and Harvey (2013) who found that survivor narratives became more cohesive as survivors engaged in psychotherapy. Ovenden (2012) reviewed first-person accounts from survivors of childhood sexual abuse and highlighted that pathologizing discourses from clinicians and the greater field of psychology (e.g., diagnosing, identifying symptoms) restricted survivors' ability to take on more empowered identities. All of these explorations of survivor narratives demonstrate the diversity and complexity of post-assault experiences.

The Medicalization of Post-Sexual Assault Experiences

Medicalization. Conrad (1992) explained medicalization as the process of nonmedical problems becoming defined and treated in medical ways. The medical model has been described as a framework in which diseases are “universal and invariant to time or place” (Conrad & Barker, 2010, p. S67). For the purposes of this study, the medical model will refer to a fundamental belief that the complex human experience of distress is best understood as a disease or disorder. Medicalization will refer to the process of this belief becoming pervasive in current Western society (see Busfield, 2017, for a detailed history of the term medicalization). Although medicine is traditionally thought to address solely illness, injury or pathology, society has increasingly called on medicine to improve people's well-being and happiness (e.g., sexual function, infertility, alcoholism, old age; Finkelstein, 1990; Rose, 2007). Thus, “medicine is inextricably intertwined with the ways in which we experience and give meaning to our world” (Rose, 2007, p. 701).

For decades, scholars have critiqued the medicalization of normal human experiences (e.g., Conrad, 1992; Conrad & Schneider, 1992; Finkelstein, 1990; Summerfield, 2004; Ussher, 2010). When medical institutions have the authority to respond to normal human experiences, individuals and their providers are more likely to interpret behaviors and emotions qua symptoms due to what philosopher Michel Foucault (1973) called the *medical gaze*. This process is significant because dominant discourses (e.g., a biomedical explanation for distress) are used as vehicles for social control by labeling and othering deviance, thereby establishing norms and accepted truths within a society (Conrad & Schneider, 1992; Foucault, 1972). Through this “ethic of human accounting” (Finkelstein, 1990, p. 15) people become less tolerant of behaviors or appearances that deviate from normal.

The ways a medical model is used to exert social control may be best understood through Foucault’s (1976/1990) concept of *biopower*, which he defined as “techniques for achieving the subjugation of bodies and the control of populations” (p. 140). Biopower is how a nation state can coopt the human body and with the subtle development of social expectations, use individuals within the society to hold other individuals—and themselves—accountable to those social norms, and thereby regulate human behavior through self-surveillance, without any obvious presence of the nation state (Foucault, 1976/1990). When responding to survivors of sexual assault, a medical model may promote biopower and further scrutinize and regulate survivors’ behaviors, rather than address systemic issues.

Medicalization occurs for many deviant and normal human experiences, but women's experiences seem more susceptible than men's (Conrad, 1992). Many scholars have highlighted the disproportionate medicalization, and by extension, increased regulation of women's distress (Becker, 2010; Kruger, van Straaten, Taylor, Lourens, & Dukas, 2014; Liebert, 2010; Ussher, 2010, 2013). Many of these critiques (Liebert, 2010; Ussher, 2010, 2013) have centered on women being diagnosed with depression almost twice as frequently as men (Strine et al., 2008). Kruger et al. (2014) interviewed low-income South African mothers and found that the diagnosis of depression concealed the most common emotion expressed by the women—anger at the impossibility of meeting ideal parenting standards while living in poverty. “The gendered nature of this medicalization results in an insidious creeping of pathologization into women's lives” (Ussher, 2010, p. 14) and an incognizance of social context. Women are also disproportionately represented in the diagnosis of Borderline Personality Disorder, especially women who have experienced childhood sexual abuse (Shaw, 2005). Becker and Lamb (1994) found that clinicians provided with identical case examples were more likely to give a diagnosis of Borderline Personality Disorder if the scenario client was female, although a more recent study with a similar design did not find evidence of gender bias (Woodward et al., 2009). Because sexual assault is experienced by women at significantly higher rates than men (Breiding et al., 2014), it is important to address the ways in which medicalization is shaped by gender bias.

Psychiatric taxonomy and the aftermath of sexual assault: A feminist critique of the trauma model. *The Diagnostic and Statistical Manual of Mental Disorders*

(*DSM*), currently in its fifth edition, has been termed the ‘Bible’ of psychiatric taxonomy (i.e., the classification of mental disorders). In fact, within the psychiatric field it is described as “the cornerstone of substantial progress in reliability” (American Psychiatric Association, 2013, p. 5). However, the validity, reliability, and utility of the *DSM* have been questioned by many scholars (e.g., Burstow, 2005; Georgaca, 2013; Vanheule, 2014; Vanheule & Devisch, 2014). The *DSM* underwent substantial revisions in its third edition in 1980, when it was facing a “crisis of legitimacy” (Lafrance & McKenzie-Mohr, 2013, p. 121), and it became less aligned with psychoanalysis and more associated with biomedical explanations of distress. Summerfield (2004) argued that this substantial shift was the result of psychiatry’s desire to have more human experiences fall under its purview in order to increase the number of patients seeking psychiatric services, thereby creating a solution to the legitimacy crisis. Lafrance and McKenzie-Mohr (2013) acknowledged the appeal of a psychiatric taxonomy that could provide validation for people’s suffering. However, they contended that this validation is an illusion: “the biomedical discourse dominates, not because it reveals ‘truth’, but due to its ability to construct a particular version of reality” (Lafrance & McKenzie-Mohr, 2013, p. 120). In the following section the idea that a diagnosis of PTSD constructs a specific reality for survivors, rather than identifies a pre-existing disorder, will be explored.

The reification of posttraumatic stress disorder. PTSD first appeared in the third edition of the *DSM* in 1980, shortly after the groundbreaking study by Burgess and Holstrom (1974) substantiated the existence of a Rape Trauma Syndrome. In 1980, the use of a PTSD diagnosis for sexual assault survivors was supported by many feminist

activists because it externalized the blame of survivors' symptoms by conceptualizing them as normal responses to abnormal events (Lamb, 1999; Yehuda & McFarlane, 1995). Judith Herman (1997), a leading scholar in the field of trauma, highlighted an issue with this definition for sexual trauma: "Rape, battery, and other forms of sexual and domestic violence are so common a part of women's lives that they can hardly be described as outside the range of ordinary experience" (p. 33). In addition, some traumatic events may produce more symptoms of PTSD than others, and traumatic events where harm was intentionally inflicted by another person, such as sexual assault, tend to lead to higher rates of PTSD symptoms (Yehuda & McFarlane, 1995).

Among a number of scholars who have questioned the validity of PTSD (e.g., Becker & Lamb, 1994; Burstow, 2005; Davidson, 1994; Miller et al., 2014; Summerfield, 1999; Vanheule & Devisch, 2014; Woodward et al., 2009), Sharratt (2011) raised the issue that PTSD "homogenizes [survivors of rape] as women who must be treated as fragile and highly vulnerable" (p. 310). However, because of the significant contributions PTSD provided for survivors in the 1980s, Lafrance and McKenzie-Mohr (2013) noted that "the questioning of PTSD as a construct... can be seen to threaten the very legitimacy for which so many worked so tirelessly" (p. 128). Therefore, it is important to acknowledge the historical and present-day benefits that PTSD and medicalization have provided for survivors of trauma, and simultaneously recognize the medical model's limitations and possible harmful effects for survivors.

Benefits of medicalization for survivors of gender-based violence. Because sexual violence is disproportionately experienced by women and seen as a form of

gender-based oppression, it is often referred to as gender-based violence. The aftermath of gender-based violence was initially medicalized by emphasizing the physical (e.g., sexually transmitted diseases) and mental health problems that can result from sexual trauma as a way to decrease stigma and provide survivors with more access to services (Lamb, 1999; Ticktin, 2011). A psychiatric discourse provided a new narrative to counter the often victim blaming frameworks for women who experienced sexual and intimate partner violence (Gavey & Schmidt, 2011). In the 1980s, the new diagnosis of PTSD improved physician's abilities to respond to battered women by externalizing the cause of their symptoms (Kurz, 1987). The creation of PTSD also helped to advance research about PTSD symptoms and provided access to treatments to reduce those symptoms (Stein et al., 2007; Summerfield, 2001). However, many survivors may find a diagnosis pathologizing rather than validating, and medicalization may broaden what experiences are considered symptoms rather than normal distress after a trauma (Stein et al., 2007).

Delimiting possibilities for recovery and social change. Scholars have identified negative impacts that a medical model can have on survivors' understandings of their experiences post-assault, and their ability to move forward. Some researchers have shown that biogenetic explanations for mental illness may actually increase stigma and prejudice, especially for diagnoses that are viewed as more chronic (Read, 2007; Read, Haslam, Sayce, & Davies, 2006). A major theme in critiques of medicalization is the reductionist nature of a medical model that does not capture the complexities of human distress (e.g., Tseris, 2015; Wasco, 2003). Tseris (2015) addressed concerns about the potential harm of the trauma narrative, even one based in modern feminist theory,

because of its tendency to dichotomize women who have experienced trauma as “thriving” or “floundering” (p. 35).

As many feminist scholars have warned (e.g., LaFrance & McKenzie-Mohr, 2013; Wasco, 2003), when a psychiatric discourse is dominant, it supersedes other conceptualizations of distress. As a result, presentations of distress that fit a medical model become more valued than others, as do specific treatments. In 2017, the American Psychological Association published clinical practice guidelines for the treatment of PTSD in adults. The guideline developers emphasized evidence-based treatments and their strongest recommendations were for manualized treatments: cognitive behavior therapy, cognitive processing therapy, cognitive therapy, and prolonged exposure therapy. They also recommended the use of four antidepressant medications. The guideline developers explicitly excluded complementary or alternative treatments (e.g., yoga, acupuncture) from their systematic review of the literature, describing these as “beyond the scope” (American Psychological Association, 2017, p. 2) of the guideline.

As demonstrated in the American Psychological Association’s (2017) PTSD guideline, a biomedical discourse of distress can prime both service providers and survivors for a biological solution (e.g., psychiatric medication). Critiquing medicalization, Svenaeus (2007) stated that the increase in drug marketing by pharmaceutical companies encourages consumers to look for biological causes and to pathologize distress, rather than accept that pain is part of life. In fact, the only study found in the literature to quantitatively measure the impact of medicalization for sexual

assault survivors found that 37% of survivors were prescribed either sedatives or antidepressants (Sturza & Campbell, 2005).

Viewing sexual trauma from a medical perspective can also lead to a focus on deficits and vulnerabilities, rather than recognizing the strength and resiliency of survivors, which can result in survivors adopting an injured identity (Gilfus, 1999). In fact, Lamb (1999) called the discourse of PTSD “one of the worst thieves” (p. 111) of survivor agency and resiliency. Other scholars have used a feminist theoretical framework to address how a medical model individualizes the problem of gender-based violence, thereby ignoring racial and social inequities that contribute to such violence and obstructing social change (e.g., Durazo, 2006, 2007). Likewise, current frameworks in counseling that focus on intrapsychic problems (e.g., a medical model) can inadvertently maintain oppressive social structures (Greenleaf & Bryant, 2012).

Alternatives to the medical model. Durazo (2006) stated that medicalization silences other approaches to coping with distress, and many scholars have attempted to combat this issue by developing alternate models to counter or supplement a medical one. A fundamental aspect of these alternatives is that distress is understood within a social, historical, and political context (Lafrance & McKenzie-Mohr, 2013). Many of these models use an ecological approach (Ballou et al., 2002; Bronfenbrenner, 1979; Campbell et al., 2009; Neville & Heppner, 1999; Wasco, 2003). Ballou et al. (2002) designed an intersectional feminist ecological model based on ecological theory, feminist theory, transformative multiculturalism, and liberation psychology. Feminist ecological theory acknowledges the *reciprocal interactivity* (Ballou et al., 2002, p. 115) between

individuals and their socio-geo-political environment. Ballou et al.'s model expanded upon Bronfenbrenner's (1979) theory by (a) adding planetary/climatic context in addition to historical context, and (b) including coordinates of racial, class, gender, and age privileges that intersect with each level of the model (i.e., individual, micro, exo, macro).

Campbell et al. (2009) extended Neville and Heppner's (1999) culturally inclusive ecological model of sexual assault recovery (CIEMSAR), and concluded that "mental health consequences of rape are caused by multiple factors beyond characteristics of the victim or the assault" (Campbell et al., 2009, p. 238). Campbell et al. (2009) emphasized that their model allows for more complexity and diversity in survivor experiences post-assault, as well as provides a broader range of opportunities for intervention, because one can offer support at any level (e.g., individual, microsystem, macrosystem). For example, at the microsystem level, an intervention could involve improving responses from family members and friends to disclosures of sexual assault (e.g., Edwards & Ullman, 2016).

Other authors have called for a more radical approach. Burstow (2003) suggested that trauma therapy be grounded in the ways oppression promotes trauma via what she termed *political empathy* (p. 1310), in addition to traditional empathy. She also recommended that counseling completely separate itself from psychiatry because, by using the *DSM*, counselors extend psychiatry's power at the expense of the power of individuals to label their own experiences. Another approach is to redefine recovery from a more sociopolitical perspective. For example, Slade et al. (2012) define recovery as (a) grounded in the lived experience of the process of recovering, versus clinician driven

markers or outcomes; (b) judged based on a personal sense of empowerment and connection to others, rather than solely the absence of symptoms; and (c) not dependent upon formal treatment since mental health professionals may hinder recovery, just as they may assist in it. All of these approaches provide valuable options beyond the medical model insofar as they provide greater flexibility in interventions, create more opportunities for collaboration, and allow for the intricacy of human experience.

The Role of Rape Crisis Counseling for Sexual Assault Survivors

Rape Crisis Centers (RCCs) were established during the second wave feminist movement in the 1970s and designed as grassroots political spaces for activists to provide support for survivors as well as engage in larger social change (Campbell & Martin, 2001; Maier, 2011). A special report by the U.S. Department of Justice found that almost 1 in 4 female sexual assault survivors sought support from a victim service agency (e.g., an RCC; Planty et al., 2013). Research has shown that assistance from RCC services mitigates the often negative experiences survivors have with police, the legal system, and medical services (Campbell, 2006). Many RCCs have different programs to focus on sexual assault prevention (e.g., community outreach) and response to sexual assault (e.g., counseling services, hotline, medical and legal advocacy; Campbell & Martin, 2001). This review will focus on the role of RCCs in providing counseling services to individuals who have experienced sexual assault.

Few studies have investigated the effectiveness of counseling in RCCs, but those that have demonstrate its benefits for survivors (Byington, Martin, DiNitto, & Maxwell, 1991; Wasco et al., 2004; Westmarland & Alderson, 2013). RCC counseling is an

important service that supports survivors in regaining a sense of agency, combatting stigma, providing psychoeducation and resources, and decreasing psychological distress (Robertson, 1990; Wasco et al., 2004). In England, Westmarland and Alderson (2013) developed a tool called Taking Back Control in order to evaluate the effectiveness of rape crisis counseling for general health, mental health, and overall well-being. The researchers found that clients improved on all measures of the tool, with the largest change in the number of survivors who endorsed that they felt empowered and in control of their lives.

Empowerment model. A common approach for responding to sexual assault survivors at RCCs is the empowerment model (Ullman & Townsend, 2008). Rappaport (1984) defined empowerment as a process, enacted by an attitude or behavior, that is “the mechanism by which people, organizations, and communities gain mastery over their lives” (p. 3). Research has shown that individuals who feel in control of their current state experience less distress and utilize more adaptive coping strategies (Frazier et al., 2011). Ullman and Townsend (2008) conducted qualitative interviews with 25 rape survivor advocates to identify how the empowerment model is understood and enacted in RCCs. All participants in the study mentioned empowerment and over two thirds demonstrated using the approach in their direct work with survivors. Many of the participants understood empowerment to be synonymous with a client-centered approach.

In a seminal article, Riger (1993) provided one of the first critiques of the concept of empowerment. She warned that the focus on individualism can lead to competition between ‘empowered’ individuals, and criticized the way empowerment esteems

masculine ideals of mastery and control. Around the same time, Fine (1992) wrote about the *therapeutic hegemony paradox*, in which “those individuals with the least control over the causes of their problems, much less the means for structural resolution, are prescribed psychological models for individual efficacy” (p. 72). Although she did not name the empowerment model directly, Fine critiqued the dominant framework for coping after an assault—taking back control—for ignoring racial or social oppression that limits individuals’ capacity to exert control over their circumstances. Scholars have suggested that connection and community should be valued as much as empowerment (Cosgrove & McHugh, 2000; Riger, 1993), and over the past couple of decades, interventions have focused more on group empowerment. For example, Falot and Harris (2002) have adapted the Trauma Recovery and Empowerment Model for groups in order to foster a sense of community in addition to teaching concrete skills for recovery. Also, one of the interventions modern day rape victim advocates use to promote empowerment is to encourage community involvement and the development of support networks (Ullman & Townsend, 2008).

Changes in Rape Crisis Counseling: Causes and Effects

Neoliberalism in psychology. Many scholars have written about the impact of neoliberalism on the field of psychology. Neoliberalism is a political economic theory “that proposes that human well-being can best be advanced by liberating individual entrepreneurial freedoms and skills within an institutional framework characterized by strong private property rights, free markets, and free trade” (D. Harvey, 2007, p. 2). The main components of a neoliberal agenda are competition, reduced state responsibility for

social well-being, privatizing public assets, and corporatizing human services (Sugarman, 2015, p. 104). Neoliberalism is reinforced through what Foucault (2008) termed *governmentality*, “the way in which one conducts the conduct of men” (p. 186), or the ways sociopolitical institutions police human behavior. Scholars have begun to understand neoliberalism, not only as a political economic theory, but as a discourse (Springer, 2012) and ideology (Esposito & Perez, 2014) where the complexities of human life are reduced to economic concerns and people come to believe that this is the ‘natural’ or ‘normal’ state of being.

Many scholars have addressed the ways neoliberalism impacts therapy. Sugarman (2015) described how client-centered therapy and many other psychotherapies ascribe to neoliberal goals of autonomy, self-responsibility, and self-actualization. Rizq (2014) described the ways neoliberalism creates an *audit culture* that “is undermining our therapeutic relationships with patients... undermining the public’s trust in mental health professionals... [and] perverting the course of therapy” (p. 211). Building off of Rizq’s critiques, Layton (2015) identified “an untenable conflict between the therapists’ ethic of care and a neoliberal ethic of surveillance” (para. 26). The rise in neoliberal ideals in Western society therefore presents new challenges for clinicians, especially for those working with survivors of sexual assault. Medical neoliberalism, which makes health and wellness into a commodity, and turns patients into consumers who bear the responsibility of making appropriate healthcare choices, has also been analyzed and found to influence healthcare at policy, institutional, and cultural levels (J. A. Fisher, 2007). In medical

neoliberalism, human suffering is reframed as a disease and viewed as an economic burden (Layton, 2014), resulting in a shift from rights to risk calculations (Lorenz, 2013).

Neoliberalism and gender-based violence. Neoliberalism began impacting the women's movement in the 1970s (Knight & Rodgers, 2012). Like medicalization, neoliberalism can impede change at the societal level and hinder the movement to end sexual violence. The increase of neoliberal governance, with its "glorification of individual self-help and responsibility" (p. 142), is reprivatizing sexual assault and undoing previous feminist work to have sexual violence conceptualized as a social problem (Beres et al., 2009). In neoliberalism, people are considered fully responsible for their success and happiness (Sugarman, 2015), which also implies that people are responsible for their failures and distress; the cause of problems is not in the sociopolitical realm, but within the individual. In this way, neoliberalism perpetuates victim blaming—people are responsible for what happens in their lives and therefore survivors are partially or fully at fault for their assault. This message can have significant negative consequences, leading many survivors to feel intense shame and self-blame (Ahrens et al., 2009; Campbell, Ahrens, et al., 2001).

Not only do neoliberal ideals make it difficult to end sexual violence, they also make recovery more challenging for survivors. Productivity is highly valued in neoliberalism. In fact, Western trauma theory compares the brain after trauma to a broken machine (Summerfield, 1999), essentially reducing humans to their output ability. Yet, sexual assault survivors who are experiencing great amounts of distress often struggle to be productive. Also in a neoliberal culture, sociability, confidence, and ingenuity are

prized (Sugarman, 2015), but these traits may be very difficult for sexual assault survivors to exude, making it harder for them to be accepted and valued. In addition, neoliberalism disregards the value of interdependence and collectivism (Sugarman, 2015), and therefore survivors may try to rely solely on intra-individual resources at the expense of community or culturally-based resources.

Effects of neoliberalism on rape crisis centers. Over the last four decades, RCCs have needed to adapt to an increasingly neoliberal framework (Maier, 2011). For example, RCCs, and women's organizations as a whole, have become more reliant on government and grant funding (Maier, 2011). Durazo (2007) warned strongly against this because she believes "funding, whether government or foundation money, emerges from the deepest ravages of capitalist inequality... it will not fund the movement to end violence against women" (p. 126). RCCs have also become more bureaucratic, more collaborative with other agencies, and less engaged in political activism (Maier, 2011). RCCs have needed to partner with the very institutions they were seeking to transform, making it much harder to fight for change in direct and radical ways (Beres et al., 2009). As early as 1980, scholars were noticing changes in rape crisis counselors' perspectives of sexual assault: "Individualist accounts of rape have taken the place of those which look at the political and economic context of rape as a social problem" (M. L. Andersen & Renzetti, 1980, p. 324). Katzenstein (1990) also noticed the changing landscape of women's groups, but viewed the adjustments as positive. She developed the term *unobtrusive mobilization* to describe how women's organizations, such as RCCs, have

not lost their feminist values, but instead shifted their strategy from calling for change from outside of the system to creating change from within it.

A number of qualitative and mixed methods studies have been conducted in the U.S. and Canada to better understand the evolution of RCCs and women's organizations in general. This research has focused on RCCs from an organizational level, often interviewing members from a variety of positions (e.g., directors, staff, volunteers; Beres et al., 2009; Campbell et al., 1998; Fried, 1994; Maier, 2008, 2011; Townsend & Campbell, 2007). Through this research, some scholars have concluded that the changes were necessary and an adaptive response (Campbell et al., 1998; Maier, 2011). Campbell et al. (1998) stated that "'de-radicalizing' was the key to weathering changing political climates" (p. 477). However, other researchers have highlighted the ways changes in RCCs' structure and mission have been damaging to the anti-rape movement by depoliticizing and decontextualizing sexual violence (Beres et al., 2009; Maier, 2011). Researchers have also identified ways women's organizations have resisted transformation by maintaining their feminist identities, at least internally, and building alliances with other women's organizations (Beres et al., 2009; Katzenstein, 1990; Knight & Rodgers, 2012; Maier, 2008).

Although these studies focused on organizational-level impacts, some researchers also examined changes in counseling services due to funding. Even though there is a recent push in the field of psychology to conduct ever shorter-term therapy, RCCs have had a slightly different trajectory. RCCs used to engage in primarily short-term interventions, mainly via crisis hotlines, where counseling was done by volunteers with

no formal psychological education (Maier, 2011). However, funding agencies wanted to see counseling conducted by professionals and RCCs needed to demonstrate effectiveness of their counseling services. Therefore, as RCCs became more reliant on grant funding, they transitioned to longer-term counseling conducted by trained professionals (Maier, 2011). Wasco et al. (2004) also found an increase in longer-term counseling at RCCs, with half of the clients in their study having 10 or more counseling sessions. However, this study was conducted over 10 years ago, and it is unclear how the continued push for short-term counseling, diminishing resources, and increased demand for survivor services has impacted current RCC counseling.

Summary and Conclusions

Sexual assault—and the following responses to survivors—have profound effects on survivor psychological well-being and recovery. RCCs have taken an essential role in supporting survivors of sexual assault, but they have not escaped the pervasive medicalization of human distress that has occurred in Western society. A biopsychiatric model may undermine important conversations around social inequities, pathologize survivors' experiences, and lead to an overemphasis on medication as the dominant treatment. However, medicalization has also benefited survivors by reducing stigma and facilitating access to services, as well as providing explanations and validation for many survivors' experiences. Medicalization has not occurred in a vacuum; it has been facilitated in the U.S. by a culture that esteems neoliberal values of self-responsibility, independence, and productivity. In turn, neoliberalism is reinforced via the medical model's intra-individual, biological explanations of distress because they perpetuate the

idea that individuals are responsible for their own recovery. Because of this, Foucault (1976/1990) described biopower as “an indispensable element in the development of capitalism” (pp. 140-141). The result of this interdependency is “a subject at once required to make its own life and heavily regulated in this making—this is what biopower and discipline together accomplish, and what neoliberal governmentality achieves” (Brown, 2006, p. 705). This relationship between medicalization and neoliberalism, known as medical neoliberalism, has created a national trend toward privatizing healthcare and a culture that commodifies health and wellness (J. A. Fisher, 2007). Clinicians in RCCs are confronted with medical neoliberalism daily because of the increasing social pressure to succumb to a neoliberal agenda, and must navigate the tension between the benefits and limitations of a medical model.

Much of the relevant literature on medicalization and neoliberalism related to sexual assault and rape crisis counseling is at least a decade old and a great deal is theoretical, with few applied studies. The current literature on the impact of a changing climate in RCCs includes mainly qualitative studies that examine RCCs from an organizational level, focusing on the ways these changes may be harmful to the larger anti-rape movement (Beres et al., 2009; Campbell et al., 1998; Fried, 1994; Maier, 2008, 2011; Townsend & Campbell, 2007). However, no previous study has examined the impact of a neoliberal medicalized discourse in therapy at RCCs, explicitly asking how RCC clinicians integrate or resist a medical model that is fundamentally connected to and maintained via neoliberalism. Campbell et al. (1998) argued that direct service work, including counseling, is by itself a form of social change for RCCs. If this is true, then it

is important to more closely examine what is happening in rape crisis counseling and how clinicians comprehend the post-sexual assault experiences of their clients. Maier (2008) called for additional research within RCCs “to better understand how staff and volunteers view their work and how these views affect their ability to serve victims and engage in social change” (p. 98). The current study adds to the existing literature by doing just that. It explores (a) how clinicians in RCCs, who operate within a culture dominated by biomedical discourses for distress, make meaning of their clients’ experiences post-assault, and (b) clinician perceptions of how a medicalized lens impacts their ability to support survivors, both positively and negatively. The present study accomplishes this through qualitative inquiry, using an interpretative phenomenological approach.

CHAPTER 3

METHODS

This chapter will begin with a brief description of qualitative research.

Interpretative Phenomenological Analysis (IPA) will be reviewed, as well as the fit of a modified version of IPA for the present study. The population studied and recruitment methods will be outlined. Next will be an overview of the protocol of the study, including theme categories, research questions, and the credibility checks that were used. Lastly, how IPA was employed in data analysis will be discussed, with special attention to the context of the researcher.

Qualitative Methodology: Interpretative Phenomenological Analysis

Qualitative research within psychology aims to understand how individuals make meaning of their experiences and make sense of their world (Coyle, 2007). The focus is on the participants' perspective in order to gather rich data that reflects the complexity of human experience. Epistemology, the philosophical questioning of how knowledge becomes known, is central to qualitative inquiry. Rather than adopting a positivist empirical approach, qualitative research assumes knowledge is constructed, and the researcher's perspective has a significant impact on the results of a study (Coyle, 2007). Qualitative research is able to tolerate complexity and contradiction in data as "what may appear to be contradictions or irrevocable disagreements within a positivist/realist frame

are then transformed into different parts of the complex picture - one that only makes sense when all the different parts are considered together” (Ussher, 2000, p. 227).

Qualitative work also allows for a deconstruction of what is assumed to be ‘individuality’ and acknowledges how meaning making is inherently reliant upon available societal discourses (Henriques, Hollway, Urwin, Venn, & Walkerdine, 1984).

IPA is a qualitative research methodology aimed at understanding people’s lived experience and how they make sense of both their personal and social contexts (Smith, Flowers, & Larkin, 2009). IPA is based on three theoretical constructs: phenomenology, hermeneutics, and idiography (Smith & Eatough, 2007). Phenomenology, a concept introduced by philosopher Edmund Husserl, refers to attuning to how individuals perceive and experience a particular phenomenon, or what makes that phenomenon unique (Pietkiewicz & Smith, 2014). Therefore, by using a phenomenological approach in IPA, emergent data is rich with participant perceptions; however, although the goal of IPA is to understand the participants’ lived experiences, researchers recognize that this cannot be done without some level of researcher interpretation (Smith & Osborn, 2004). Therefore, IPA involves a double hermeneutic in which participants attempt to make their own meaning, while the researcher simultaneously interprets how participants are engaging in this meaning-making process (Smith & Eatough, 2007). The last pillar of IPA is idiography, in which the focus is on the individual experience of each participant as case studies, rather than working toward any generalizable findings (Smith & Eatough, 2007). Therefore, the findings remain close to the participants’ narratives and own words, even when developing higher order themes.

In IPA, the meaning in participant responses is more important than frequency with which certain themes arise. Rather than use pre-existing theories to guide data analysis, IPA uses an inductive approach, where meaning is generated from participants' data. IPA often collects data through semi-structured, individual interviews that allow for flexibility in the data collection process. This format also facilitates a dialogue between the researcher and participants, which enhances the information gathered and the researcher's understanding of participant experiences (Hill Collins, 1989). Typically, interviews are recorded and then transcribed. Researchers both listen to recordings and read each interview transcript multiple times to better understand the participant's perspective. Then, researchers identify meaningful units of text within the raw data. These units are then grouped together into lower order themes, which represent an overarching idea shared by the included meaning units. Lower order themes coalesce into higher order themes. Throughout the data analysis process, the idiographic emphasis of IPA is preserved, as higher order themes will reflect the lower order themes that create them, which in turn reflect the participants' own words in the meaningful units of text (Smith & Eatough, 2007; Smith & Osborn, 2004).

Interpretative Phenomenological Analysis and the Present Study

The present study used a modified version of an IPA research design, one that was informed by a material-discursive-intrapsychic approach (Ussher, 2000). Incorporating a material-discursive approach allows for a deeper appreciation of the sociopolitical context of experience. Specifically, this approach acknowledges biological and institutional factors (i.e., material); the power of language and social discourse (i.e.,

discursive); and individual, psychological factors (i.e., intrapsychic). The researcher engages in critical realism, which “can reconcile both the biomedical and psychosocial aspects of experience, as well as incorporate the cultural and historical context in which the meaning about experience is created” (Ussher, 2000, p. 221). This design is therefore fitting for a study on the interplay between biomedical and psychological factors used to understand post-sexual assault experiences. By employing a critical realist perspective, the researcher can understand “consciousness as something produced rather than the source of ideas and the social world – as constituted and not constitutive” (Henriques et al., 1984, p. 8). Experience is not something that people have, rather it is mediated, negotiated, and constructed by societal discourses (e.g., survivors of trauma can only conceptualize themselves as ‘having’ Posttraumatic Stress Disorder [PTSD] insofar as they have the discourse for psychiatric diagnoses and symptoms). At the same time, a critical realist approach still honors individual differences and the real distress that survivors experience.

A qualitative approach is appropriate when studying the experiences of clinicians in Rape Crisis Centers (RCCs) as the second wave feminist movement within which RCCs were developed was the same movement that shaped modern qualitative research. Many feminist researchers rejected the ways quantitative research tended to over-value masculine traits and evaluated individuals based on male norms, and they therefore turned to qualitative approaches (Coyle, 2007). In research and scholarly work critiquing medicalization, feminist and postmodern researchers have addressed how to transcend a psychiatric discourse when studying human distress, especially in women, by engaging in

a phenomenological approach that allows for complex understandings of experiences and acknowledges psychiatric taxonomy as a social construction with ethical and political implications (Cosgrove, 2000; Hornstein, 2013).

A qualitative approach is also fitting because of the parallel processes it creates. A medical model often follows a positivist empirical perspective, assuming there is a biological explanation to distress that can be found and treated through scientific inquiry. Rather than adopting this perspective through quantitative analysis, I sought to understand the ways a medical model both defines and limits clinicians' understandings of their clients' post-sexual assault experiences. With epistemological reflexivity, I also analyzed the way my research questions defined and limited what I learned (Pietkiewicz & Smith, 2014; for further reading on reflexivity, see Harding, 1991; Morawski, 2005). Many of the studies exploring the changing climate of RCCs have used qualitative methods (e.g., Fried, 1994; Knight & Rodgers, 2012; Maier, 2011; Townsend & Campbell, 2007). Therefore, the present study's methodology was aligned with previous research, but aimed to extend on existing literature by explicitly examining the impact of a medical model within a neoliberal climate and specifically interviewing clinicians at RCCs, rather than individuals from a broad range of roles at RCCs (e.g., directors, staff, volunteers).

Participants

IPA employs purposive sampling where, due to its idiographic focus, it is desirable for participants to be relatively homogeneous (Smith & Osborn, 2004). There is no rule on number of participants and studies often have small sample sizes, with

consensus that six to eight participants is an appropriate number (Smith & Eatough, 2007). Participants in the present study included clinicians who were currently working at an RCC or had worked at an RCC within the last year. They were recruited from RCCs that are either free-standing or are part of a larger mental health agency.

A total of six participants from three RCCs in the Northeast were included in the study. Participants ranged in age from 24-59 years old. Three participants identified as White, two as Hispanic, and one as Middle Eastern. The two Hispanic participants spoke Spanish as their first language and one identified as an immigrant. Five participants identified as female and one as male. Five participants identified as heterosexual and one as lesbian. Participants varied in how long they had been working as an RCC clinician, ranging from one to eight years.

Data Collection

Participants were recruited through an email that was sent to all clinicians currently working at participating RCCs (a total of 6 RCCs in the Northeast and Midwest were contacted during recruitment). Special attention was given during the recruitment process to ensure marginalized populations (e.g., people of color) were included in the study and snowball sampling was employed in order to ensure a more diverse sample. Recruited participants completed a demographic questionnaire (Appendix A) and engaged in face-to-face, individual, semi-structured interviews with the principal investigator (PI) that lasted about an hour to an hour and a half. Participants were given the option to interview at the RCC where they work, an office at the University of Massachusetts Boston, or a public venue that was convenient for the participant and that

provided sufficient privacy to conduct the interview, such as a reserved room in a library. Participants were asked to discuss difficult topics, as they were sharing their experiences providing counseling to sexual assault survivors. I was also asking about challenges that participants face as therapists, which they may be reluctant to share. Therefore, I approached the interviews with sensitivity and with the goal to provide a space where participants felt safe and comfortable to be honest in their responses.

In order to better understand how a medical model within a neoliberal context affects clinicians' therapeutic work, open ended interview questions were based on four overarching categories of inquiry: 1) how clinicians make sense of their clients' lived experience of the aftermath of sexual assault, 2) ways clinicians use and/or resist psychiatric discourse as codified in the *Diagnostic and Statistical Manual of Mental Disorders (DSM)*, 3) clinician perspectives of the empowerment model and trauma discourse, and 4) what clinicians find challenging and helpful about counseling people who have experienced sexual assault (see Appendix B for semi-structured interview questions).

Ethical Considerations

Institutional Review Board (IRB) approval for the study was provided through the University of Massachusetts Boston prior to recruitment. Permission to recruit participants was also obtained from the Clinical Director at each participating RCC. Participants were required to document informed consent for both the interview and having the interview recorded and transcribed. Participants were informed that transcripts would only have de-identified information and all data would be stored on password-

protected devices. Participants were also told not to provide any identifying information about their clients. Participants were informed that they could withdraw from the interview at any time without negative consequences. Participants also had access to IRB documentation and contact information for the PI and committee chair in the event that they had any concerns or questions. There was no more than minimal risk to participants given that the participants were trained clinicians who have chosen to work with survivors of sexual assault in their career. However, agency (i.e., RCC where participant works) and community resources were available to participants for support if they were requested.

Data Analysis Strategy

Using a constructivist approach, a thematic inductive analysis was used to analyze the data from the semi-structured interviews. Interviews were recorded and transcribed. I read each transcript and listened to each recording multiple times before engaging in multiple levels of analysis. I used QSR International's NVivo 11 software to conduct the coding and analysis of the data. Each transcript was broken into segments that were coded as meaningful units of text. Using constant comparison, meaning units were compared to each other and grouped into lower order themes based on commonalities. Although an effort was made to incorporate all meaning units into lower order themes, if a meaning unit did not fit with any other units, it was discarded. Continuing to engage in constant comparison, clusters of lower order themes were formed into higher order themes. Throughout the iterative process, I maintained a journal of thoughts, perceptions, and potential biases that arose during data analysis.

Credibility Checks

At the end of the interview, participants were asked two questions to check for procedural integrity: 1) Was there anything that made it difficult to answer questions openly? and 2) Do you have any recommendations for future interviews? Information gathered from these questions was incorporated into the interview process with future participants. For example, some participants requested access to the *DSM-5* diagnostic criteria for PTSD, and this was provided in later interviews.

During data analysis, the committee member providing methodological expertise and two research assistants who have experience conducting qualitative research reviewed the meaningful units of text, lower order themes, and higher order themes at each stage of analysis for consistency among patterns. If a research assistant had any discrepancies, they were discussed at the level of analysis where the disagreement existed (i.e., meaning unit, lower order, higher order), including a reflexive assessment of whether my context or biases, as noted in my journal, impacted the results. If anything could not be resolved through consensus, the discrepancy was reviewed with the committee member providing methodological expertise, who assisted in making a final decision.

In addition, member checks were conducted; participants were invited to review the preliminary results of higher order themes based on their individual interview and provide feedback. Four of the six participants submitted feedback. One participant asked for clarification on a theme and once this was provided, agreed with the theme. Another requested a small adjustment to the phrasing of a theme, which was made to better reflect

the participant's perspective. Participants agreed with all other higher order themes as written.

Context of Researcher

As the PI of this study, I am a White woman in my late twenties who is currently a fourth year doctoral candidate at the University of Massachusetts Boston. I have past experience conducting qualitative interviews and data analysis using grounded theory (Wheeler, Horne, Levitt, Peters, & Maroney, 2014). I have been working with survivors of sexual assault for the past eight years through volunteer positions on sexual assault hotlines. These volunteer positions have included over 50 hours of training on how to support survivors of sexual assault and I have taken over 350 crisis calls from survivors of sexual assault and their loved ones. I am a current volunteer at one of the RCCs where I recruited participants. However, the volunteer hotline program and counseling services do not overlap, and I have no relationship with any clinicians at participating RCCs.

Feminist qualitative scholarship, including IPA, acknowledges that the researcher's personal experiences and perspective will—and should—influence the interpretation of the data (Haraway, 1991; Harding, 1991). In addition, Black feminist scholars posit that responsible, accountable research necessitates researchers to have passion for and opinions about their work (Hill Collins, 1989). I approached this project from the perspective that medicalization of sexual trauma is pervasive and medical neoliberalism may be negatively impacting survivors' recovery and their ability to independently label and apply meaning to their experiences of sexual assault. Therefore, I came with the following assumptions: (a) survivors of sexual assault who have sought

formal help have been engaged in primarily medical models of responses and treatments and (b) the opportunity to autonomously define one's experiences and path to recovery is beneficial for survivors. However, I recognize that there have been many benefits to a medical model, as it validates many survivors' experiences and streamlines treatment. I was open to discovering what arose from the qualitative interviews. I also engaged in the practice, common in IPA, of bracketing my own biases and preconceived notions in order to allow themes to arise from the data itself (Pietkiewicz & Smith, 2014). Even with bracketing, it is important to acknowledge that objectivity or validity "is not a commodity that can be purchased with techniques... Rather, validity is like integrity, character, and quality, to be assessed relative to purpose and circumstances" (Brinberg & McGrath, 1985, p. 13).

Summary and Conclusions

The present study employed a qualitative methodology, using IPA informed by a material-discursive-intrapsychic approach, in order to investigate the impact of medical neoliberalism on RCC clinicians' conceptualizations of their clients' experiences and the therapy process. The primary focus was to understand how participants make meaning of their experiences and how contemporary discourses (e.g., trauma discourse) and practices (e.g., increase in psychotropic medications) may affect their clinical work. Data was collected via semi-structured interviews and analyzed using an inductive thematic approach, with constant comparison and iterative analysis to ensure trustworthiness, credibility, and accuracy of interpretation. The results include higher order themes across interviews, illustrated through direct quotations from participants.

CHAPTER 4

RESULTS

Analysis revealed four master themes, each of which are comprised of underlying emergent themes. Themes are presented in order of relevance to research questions, with the most applicable themes presented first. Since the participants were all Rape Crisis Center (RCC) clinicians, the themes represent clinicians' perspectives on sexual trauma counseling and survivor healing. The themes have been named *Wielding the Double-Edged Sword of the Medical Model*, *Navigating the Healing Process with Survivors*, *Stay in Your Lane: The Role of the RCC*, and *Understanding and Honoring Survivor Shame*. Supporting quotations are provided and participants are identified by number (e.g., Participant 1, Participant 2) to maintain confidentiality. Results of the analysis are summarized in Table 1.

Wielding the Double-Edged Sword of the Medical Model

All six participants identified both benefits and harms of conceptualizing post-sexual assault experiences using a medical model, with one participant describing diagnosis as a “double-edged sword” (Participant 5). Despite the drawbacks, all participants still used a medicalized conceptualization in some form. They spoke about how they are able to use a medical model to their clients' benefit by engaging with it flexibly (e.g., addressing survivors' symptoms and distress rather than focusing on

Table 1

Master Themes and Emergent Themes Across Study Participants

| |
|---|
| Wielding the Double-Edged Sword of the Medical Model |
| Harnessing the Benefits of a Medical Model |
| Mitigating the Harms of a Medical Model |
| RCC Clinicians as Medication Managers |
| Navigating the Healing Process with Survivors |
| Supporting Survivors Along the Nonlinear Journey of Healing |
| Facilitating Survivors' Understanding and Overcoming of Negative Effects of Sexual Violence |
| Managing Paradoxical Effects of the Trauma Discourse with Survivors |
| Stay in Your Lane: The Role of the RCC |
| RCCs are Designed for Short-Term Sexual Violence Work |
| Being Tripped by One's Roots: Aiming to Increase Access to Marginalized and Underserved Populations |
| RCCs are Part of a Social Movement to End Sexual Violence |
| Understanding and Honoring Survivor Shame |
| Self-Blame as a Protective Act |
| Stigma and Victim Blaming Foster Survivor Shame and Minimization of Sexual Violence |

whether diagnostic criteria were met) and prioritizing empowerment (e.g., normalizing reactions to trauma). Participants were also asked about their clients' medication use, and described ways they assist in access to medication and medication management.

Harnessing the benefits of a medical model. Although all clinicians reported that the diagnostic criteria for Posttraumatic Stress Disorder (PTSD) fits for most survivors, there was a wide range regarding how well they thought diagnosis captures survivors' experiences. Some participants found it to be a very good fit, and others identified some aspects of the survivor experience that are not completely represented (e.g., the symptom criteria are accurate but may not fully capture the quality of survivors' experiences). Participants identified numerous benefits of using a medical model to conceptualize survivor distress, especially related to framing distress in terms of

symptoms and the diagnosis of PTSD. They reported that receiving a PTSD diagnosis can normalize survivor reactions to the assault, validate their distress, and be a starting point for treatment or accessing other services (e.g., legal, disability services). One participant stated:

So on our intake we do ask about all of the PTSD symptoms and they are incredibly normalizing for people. People who come in and feel they're going crazy. And so being able to hear, or to see on a piece of paper that these are things that fit into a box and that they're actually very normal responses to a really abnormal thing that has been done to them, um, can both be unsettling and comforting at the same time. (Participant 1)

Three participants also spoke specifically about how clients respond well to biological explanations of their feelings and behaviors. Participants described that using a biological framework to explain symptoms such as triggers, flashbacks, and hypervigilance help to destigmatize survivors' reactions to trauma (e.g., "I'm not crazy") by situating the reaction within the body as an adaptive response. Participants used a similar technique when introducing certain coping strategies, explaining how the strategies impact biological processes, as illustrated in the following quote:

I also find that it helps, um, when you're doing things like, doing coping exercises with clients and things like that. For them to start with like a basic understanding of what's going on so then you can talk to them about what this what, you know, like what, what does diaphragmatic breathing do for you? Um, how does it actually help?" (Participant 5)

Participants also described how a medical model provides a shared language for professionals, streamlining clinicians' conversations about survivor experiences and plans for treatment. One participant described that being a diagnostician is part of their professional identity, even if they are not formally diagnosing in their role as an RCC

clinician. Another participant spoke in particular about how Western society orients toward a medical model, so medical frameworks would be difficult to avoid completely:

*Psychology also as a field is like so desperate to be recognized as like a very hard science and so in terms of that too. Like we want to be able to put everything into a very neat box the same way that you would with a medical diagnosis. Um, so yeah, I think I would definitely say in terms of the field and the way that we talk about it there's definitely some pressure to think about it in a certain way.
(Participant 5)*

In general, all participants indicated that a medical framework for post-sexual assault distress has many positive effects for survivors. Most notably, conceptualizing distress in terms of PTSD symptoms can be normalizing and validating. Therefore, participants continued to use these conceptualizations, despite the drawbacks of a medical model.

Mitigating the harms of a medical model. Participants also identified numerous potential harms or limitations to conceptualizing survivor distress using a medical framework. They described how this can be disempowering, deficits-based, pathologizing, reductionist (e.g., reduces someone to a label), and reinforces a power hierarchy in the client-therapist relationship. One participant described diagnosing as “a power process by itself,” elaborating, “it can be hard to diagnose a client over here because I’m telling her that I decide how is she feeling. I decide, what are the symptoms that she is having, or how is she going to fit in this book” (Participant 4).

Two participants also spoke about how a medical framework not only pathologizes survivors’ reactions to trauma, but their coping strategies as well. As the quote below illustrates, even while critiquing a medical model that emphasizes symptoms and pathology, participants still often used a biological framework to validate survivor experiences.

Those are ways that somehow your brain or your body figures out how to keep you alive. And may, and again like maybe drinking or doing drugs or self-injury or whatever the thing is, maybe that was the thing that allowed someone to not end their life. (Participant 1)

Participants also spoke of the limitations of the PTSD diagnosis to fully encapsulate survivor experiences. For example, participants described survivors who may be experiencing significant distress but whose experiences do not fit neatly into PTSD diagnostic symptoms, and therefore would not meet the criteria for PTSD. Two participants stated that for some survivors, not receiving a PTSD diagnosis despite experiencing distress can feel invalidating and minimize their suffering. On the other end of the spectrum, participants described some survivors who have a difficult time accepting a diagnosis of PTSD because it may feel like a weakness to develop a disorder, especially because of something that was done to them. One participant described what a survivor may say to a clinician in response to receiving a PTSD diagnosis: “I didn’t want this label to like be assigned to me because like of what this person did to me” (Participant 3). This quote illustrates how survivors may feel that, even though their experience is a reaction to sexual violence that someone else committed, it is their body or mind that is the problem, because they are the one receiving a diagnosis of mental illness. Relatedly, the distinction between a single event trauma and complex trauma was invoked; all participants who discussed this stated there should be a differential diagnosis for complex trauma included in the *Diagnostic and Statistical Manual of Mental Disorders (DSM)*.

Despite these limitations, all participants used a medical framework, particularly referring to PTSD diagnosis and symptoms, when speaking about survivor distress.

Participants indicated that the harms of a medical framework can be mitigated when used flexibly and in an empowering way. This may include being less strict on the diagnostic criteria when assigning a PTSD diagnosis and avoiding diagnostic terminology in session. As one participant stated, “I think, I mean, we’re given the tools to [normalize] without necessarily invoking a diagnosis to do it” (Participant 5).

One way of negotiating the potential harms of a diagnosis was to divorce symptoms from diagnosis. Participants often described that the actual diagnostic label is the most problematic and pathologizing, but that symptoms can resonate with survivor experiences and be very useful. As one participant illustrated:

A lot of times I will use the term post-traumatic stress reactions. Versus post-traumatic stress disorder... I think for me, again, eh for me it relates to the symptoms of the trauma. It relates to the symptoms, whatever the person is bringing in the room, that’s their post-traumatic stress reaction. (Participant 6)

Because of their ambivalence about assigning a diagnosis, the four participants who were designating a PTSD diagnosis in their clients’ charts may not share with their client that they are diagnosing. Overall, participants identified many problems and limitations of a medical framework. However, because of the positive effects, all participants continued to engage with a medical model in some form, while attempting to minimize the potential harms.

RCC clinicians as medication managers. Participants generally indicated that medication can be a helpful but limited tool to increase survivors’ baseline functioning. Participants stated medication should be used in conjunction with therapy and some highlighted that it is not a long-term solution. RCC clinicians aimed to engage in

empowering medication management and facilitate often challenging medication referrals. One participant described medications as “band aids,” stating:

They might help treat the symptoms of feeling down or feeling depressed but they don't relieve some of the other things, I think. Like flashbacks, um hypervigilance, feelings of mistrust or distrust in the world. And again, I think that... the way that sexual violence impacts someone's core beliefs about themselves and the world can't really be treated by a medication. (Participant 1)

Participants reported significant variety in how many clients come in or ask about medication, and how often clinicians broach the conversation about medication. One participant only had two clients on medication in the year and a half she was working at an RCC, while another participant estimated about 70% of her clients were on medication. A consistent message across participants was that there are many barriers to accessing medication, including a limited number of prescribing providers, prescribers not being versed in sexual trauma, and clients not having health insurance. One participant described, “I think [referrals to prescribing providers is] one of our biggest, one of the hardest that we do. I mean 'cause we also do see a lot of people that don't have insurance or have like really bad insurance and so that's hard” (Participant 3).

Participants saw themselves as resources who could provide information to survivors about the option of medication and prescriber referrals. They highly valued informed consent and approached medication conversations from an empowerment framework, leaving the decision whether or not to pursue medication to the survivor. One participant described that they introduce medication by saying to clients, “I want you to have the knowledge and it couldn't hurt to talk with a someone, a provider about what options might be out there. And then you can have all the information to make a decision

for yourself” (Participant 1). Participants reported that some clients are not interested in medication for a variety of reasons: they would prefer to try other coping strategies, cultural values about medication (e.g., participants reported that Hispanic clients tended to use medication less than White clients), or not wanting to require a medication because of an action someone else did to them (i.e., sexually assaulted them). When clients were not interested in medication, this was generally supported by participants; although sometimes participants described thinking medication would be a helpful choice, as in the following quote:

Like, sometimes they're like, well some people tell me about medication, what do you think? And it's like, returning it to like, what do you think? Like, I think it's a tool but it's, it's you. And some other clients, more than others you're like, well it, it's your decision but I think it could be a really good idea [laugh]. (Participant 2)

Many clinicians reported that talking about medication became central to their therapy, including promoting communication with prescribers, managing clients' expectations about medication efficacy, and validating clients' frustrations when medications are not effective or result in side effects. One participant explained it as, “a lot of times the counseling become more about the obstacles of talking to the psychiatrist and the, the side effects of the medication and how hard that is and maybe not feeling the effects, that that became the focus” (Participant 2). This participant described conversations about medication as “needed,” yet also expressed that it was not how she or the client wanted to spend the therapy time. Overall, most participants actively and routinely engaged with their clients in conversations about medication, using a medicalized framework about symptom reduction or symptom management.

Navigating the Healing Process with Survivors

All participants highlighted that the healing journey is nonlinear and different for every survivor. However, they also identified trends in the healing trajectory, often referring to stage models, and described that counseling can facilitate the healing process. Participants noted the many significant and negative effects that sexual violence can have on a person, but also held hope for their clients' ability to overcome these effects, make meaning of their experiences, and resume a sense of normalcy. When asked about the prevalence of a trauma discourse and how it may impact survivors' healing, participants noted paradoxical effects.

Supporting survivors along the nonlinear journey of healing. Participants often spoke about healing as a nonlinear journey facilitated by an empowering counseling process and clinician strategies. Participants had great faith in the power of counseling with one participant stating, "I don't think that there are emotional issues that you can't solve by or through the process of therapy" (Participant 5). Participants used varied theoretical models, both across participants and across their clients. These included Judith Herman's three stages of recovery, Carl Rogers' client-centered counseling, narrative therapy, positive psychology, strengths-based approaches, cognitive behavior therapy, and dialectical behavior therapy. Psychoeducation was identified by four participants as an important and empowering piece of counseling that can facilitate the healing process.

All participants reported that empowerment is central to their work and that it involves assisting survivors in regaining a sense of control and agency, taking a nonjudgmental stance, and believing survivors. One participant described it as "the thread

throughout” that informs her work, stating “I want my client to feel like they... are the ones in charge of their treatment and, and, and in control of their healing process” (Participant 1). Participants identified even simple ways to promote a sense of empowerment in counseling, such as allowing the client to decide where to sit and what to discuss.

Although empowerment was a pillar of all participants’ work with survivors, three participants also spoke about the limitations to an empowerment model. Two participants described that it can be off-putting or overwhelming for clients who are not used to being given many choices, or who may be seeking a counselor to fill an expert role. The other participant also identified that significant safety concerns for a client may be a time when she breaks from an empowering framework:

Yeah I think the only time that maybe things in maybe, might not feel empowering is if, if there is kind of like a containment issue or if somebody is like engaging in something that’s really unsafe and we sort of have to like, you know in an empowering way express like, we’re worried about you. (Participant 3)

Participants highlighted the importance of establishing safety and trust in counseling. This includes addressing power dynamics between the client and counselor. A major component was also believing survivors, illustrated in the following quote:

I think that our, like for me I think it’s kind of making people feel like this is a place that they can come and we’re gonna believe them and we’re gonna support them and like that that will never be questioned. Uh and that’s like really important to me. And I think that that is honestly like one of the biggest pieces of what we do is like having, having that be true and um, and I think that’s kinda the basis for people being able to like come here and feel safe and feel like they can work on what they want to work on, right? And because I think that’s just the surface, right? Like you believe me, and that’s great and now we can get into some of this deeper stuff about like what I don’t believe about myself. (Participant 3)

Even though participants stressed that healing is nonlinear and unique for each survivor, many also described that recovery occurs in general stages of early, middle, and advanced healing. Three participants referred specifically to Judith Herman's stages of healing. Participants also spoke about how different coping strategies or focuses in counseling are better suited for different stages of healing. For example, earlier stages may be more focused on coping strategies, self-care, and processing self-blame; middle stages may focus on relationships and trust; and later stages may emphasize meaning making and advocacy. One participant spoke about how deeper work in therapy is often more beneficial when some time has passed since the assault: "Yeah, it can be hard to think about, to like have to talk about something like this like right after, like before you've even really processed it" (Participant 3).

Although survivor advocacy to end sexual violence was encouraged in various forms (e.g., volunteering, fundraising, advisory board, activism), a theme that arose was that advocacy is best when done in later stages of recovery, as it may be overwhelming for a survivor to attempt early on in their healing. One participant stated:

So a lot of, I think their dream is, is that they're gonna be an advocate or they're gonna be a volunteer here, or they're gonna want big changes, or they wanna just talk more in their community. But a lot of times they are not there yet so it's like, trying to slow them down because... that seems like the end, right? The end of the healing... journey. (Participant 2)

Three participants spoke about ways survivors want to "rush" the healing process. Although participants did not believe recovery could be rushed, they indicated it could be facilitated through counseling and other supports. One participant said, "I also think that

sometimes people feel like if I just like throw a bunch of things at this problem then it'll like, then I'll quickly get better which doesn't really happen" (Participant 3).

According to participants, survivors may seek counseling at different stages of healing and in varied times since their assault. Three participants spoke about how a significant life event or transition (e.g., new relationship, end of relationship, new job, graduation, move, death of a loved one) may prompt someone to seek therapy. Others may seek RCC counseling early on if they learned about counseling through other RCC services they accessed (e.g., medical advocacy, legal advocacy).

One participant highlighted that counseling can be difficult and survivors may resist engaging in it through beliefs, behaviors, and relationships, yet this resistance is paradoxically also part of a survivor's healing process as it may serve as a protection and a way for survivors to demonstrate their control in a situation. The participant stated, "to normalize that nobody wants to come here, it's a horrible place to come. We try to make it as pretty as possible, but it's still is a horrible place" (Participant 2).

Holistic practices and self-care were encouraged by all participants including meditation, mindfulness, yoga, and art therapy. Participants highlighted holistic practices that involve physical touch or reconnecting survivors to their bodies as being especially healing for sexual violence survivors. One participant identified sexual violence as "very spiritually damaging" (Participant 5) and three participants spoke about the value of engaging in religion or spiritual practices as part of the healing process.

Participants also noted how survivors' support systems can impact the healing process positively or negatively. They described that if someone's support system is

validating, this can reduce stigma and self-blame, and facilitate healing, whereas blaming or minimizing responses from loved ones can foster more shame and hinder the healing process. Three participants also spoke about how survivors sometimes maintain relationships with their perpetrators, possibly because the perpetrator is a family member or romantic partner. These participants described how this can add barriers to healing, but also the importance of respecting survivors' decisions. One participant explained:

It's a struggle I think more on our end to kind of like be more neutral about when, or like be, like make sure we're being neutral in this... things like you know, we always want to prioritize like safety but if, I don't know, if a person is really ultimately going to return to that relationship or that person, you know, you kind of, it's hard [laugh]. (Participant 3)

Four participants also spoke about the incredible power of group counseling for survivors. They described that group counseling offers unique benefits beyond individual counseling. These include a survivor's ability to help others which fosters agency and builds a sense of community. Additionally, by seeing others who have gone through similar things and have similar reactions, survivors can move beyond intellectual knowing and develop a deeper appreciation that they are not alone in their experiences. One participant identified group therapy as especially beneficial for male survivors since sexual assault against men is uniquely stigmatized and made invisible:

Because there is the idea that men aren't raped and there is the idea that you know maybe I'm the only person that this has happened to. Um, or like men, you know this isn't supposed to happen to men. Or, um, you know things like that. And like, like I was saying earlier with the idea of like, masculinity interacting with itself. I think, it's a, it's really great to be in a room, um, with your emotional experience with your, um, you know, your life experience of of uh having gone through this and being a survivor and having other men observe that and accept you. Um, and, I think that's, uh, very like subversive to toxic masculinity. (Participant 5)

Overall, participants described the healing process as nonlinear and varied, but also identified general phases most survivors tend to move through. Participants used a number of different therapeutic strategies and frameworks to facilitate healing, prioritizing empowerment and client agency in counseling.

Facilitating survivors’ understanding and overcoming of negative effects of sexual violence. Participants identified the numerous negative effects that sexual violence can have on someone’s life. These include a sense of disempowerment or lack of control, broken trust in people and the world, a disrupted sense of self, and low self-esteem. According to participants, survivors may feel isolated, like a burden, spiritually damaged, anger toward self and others, and broken. Participants also noted that trauma can precede other mental health diagnoses and make people feel they are going “crazy.” Four participants described how experiencing sexual violence interferes with a survivor’s productivity and normal functioning in society. One participant, comparing more White or “American” clients to Hispanic clients, described that White clients “want to be very productive and sometimes, like, counseling or self-care or taking time to heal is not productive” (Participant 2).

Four participants also explicitly spoke about triggers, which are things that “stir up... [a survivor’s] history of sexual assault or sexual abuse” (Participant 1). They described a wide range of events that can be triggering for survivors such as sexual violence in a movie, a significant event in the survivor’s personal life (e.g., a break up), or more generally “what’s going on in the world” (Participant 3). Triggers can also be more specific and difficult to avoid, which, according to participants, can lead to

significant disruption in a survivor's life. One participant gave the example, "you know one woman in particular, um, the person who sexually assaulted her drove a red car. So any time she passed a red car she was triggered" (Participant 6).

One participant highlighted that sexual violence is often not the only cause of someone's distress, "the folks that we work with have um, they're not just survivors of sexual violence, they, there's so many other things that are happening in their lives" (Participant 6). Paradoxically, participants also discussed that for many survivors their assault feels like their entire identity. One participant described, "that event defines who are they, today. Even if it happened five, ten years ago. Yes. That is the power of that event, of some clients" (Participant 4).

Despite the many negative effects of sexual violence, participants also noted survivors' resilience and the ways, even if survivors felt forever changed, those changes could be adaptive and meaningful. One participant gave the example of survivors developing a more realistic view of the world and the societal factors that facilitate sexual violence:

I think like in a, like sort of adaptive like change that happens for people is that they have this sort of m- more insight into the world? And like wheth- and if it's not like a, like a paranoid kind of worry it's kinda like, I see the world as unsafe in like a realistic way? Or like, and I can, and I, and I see like the way that our culture perpetuates like this kind of stuff and, um, and they can, and I think that can... be actually really helpful. Um... like a help- like kind of like a... a way that you could use this experience as, in like, I don't know, as like a way to, as a, in a more like adaptive way rather than saying like, I'm totally broken by this, and like I'll never be the same like in a bad way. Like and I think that's true, like I think people are definitely changed? But it's not always like, in a bad way. (Participant 3)

Participants noted how sexual trauma is distinct from other traumas due to the interpersonal violation and stigma. Therefore, they promoted that clinicians should be specially trained in providing therapy for survivors of sexual trauma. One participant proposed:

When I say that I work [at an RCC] people get very quiet and very uncomfortable and I think that that speaks to the views that people still have around sexual violence. And so if you aren't aware of that and aren't recognizing what that carries for a survivor and how that's reinforced in all these different arenas on top of coming from themselves, then you're not going to effectively be able to treat it. (Participant 1)

Generally, participants discussed the numerous and substantial negative effects sexual violence can have on a survivor, but also indicated that survivors can overcome these struggles and have adaptive changes in their worldview. Participants described that the counseling process can facilitate these positive changes.

Managing paradoxical effects of the trauma discourse with survivors.

Participants were asked about their thoughts on how the discourse of 'trauma' has become more prevalent in everyday language. Five participants brought up how sexual violence is increasingly being discussed in the media and particularly in politics.

Participants identified both benefits and drawbacks of the increased discourse around trauma. As illustrated in the following quote, the benefits include that it can increase visibility of sexual violence and survivors, which can in turn facilitate access to services for survivors.

Sexual assault and sexual abuse are being talked about more and so people are thinking, recognizing maybe pieces of their histories that they were too ashamed to think about or access or talk about and are now recognizing that it, that it is okay to talk about it or even recognizing that that is what was done to them. (Participant 1)

However, there were also many negative effects identified by all participants and two participants indicated the drawbacks outweigh the benefits. Problems included that the prevalence of the trauma discourse has led to minimizing the perceived impact of sexual violence on survivors. One participant explained:

I would want to say that it's normalizing but I, I think, um, it's not in a lot of ways. Because if you think like, even if you were to think oh it's great to hear that other people are having traumatic experiences. If their traumatic experience is, you know, I broke my favorite cup or something and then like yours is having been sexually assaulted then like that's the opposite of normalizing. (Participant 5)

Another negative consequence of the prevalent trauma discourse was that it perpetuates misconceptions about healing (e.g., there is one right way to heal, healing should occur quickly), and the counseling process (e.g., survivors will be pressured to painfully retell their story in counseling). One participant illustrated:

This taboo that oh well you were raped but it has been six months, you should be fine, right, now? And that no, there's still not a lot of knowledge. That maybe they know what PTSD is, and what trauma is? But they don't know how much it takes to actually heal or cope with it. (Participant 2)

One participant spoke about how “trauma” can be used as a euphemism for sexual assault and although this may be helpful to a survivor who is overwhelmed by labeling their experience, it can also serve to minimize the experience: “Some generically call it trauma versus calling, it's like a, a, a safer term for them to use than, than using rape or sexual assault. I, I think we even sometimes buy into it” (Participant 1). Another participant found the word “trauma” to be overly clinical and therefore avoided using it. Overall, participants grappled with the paradoxical effects of the trauma discourse that both facilitate and hinder survivors’ healing processes.

Stay in Your Lane: The Role of the RCC

All participants highlighted that RCC counseling is short-term and sexual trauma focused. According to participants, it is not a place for therapy to address more complex mental health challenges (e.g., comorbid diagnoses, personality disorders). Participants also discussed ways RCCs are trying to adapt to be safe and helpful spaces for survivors with marginalized identities or identities that are not commonly associated with survivorship (e.g., men; “what it means to be a man and also, um, be a survivor of sexual violence, which a lot of people don’t think of as even being a thing,” Participant 5). Participants noted a significant barrier to accessing diverse populations is that RCCs were primarily developed by White, straight, cisgender women to serve survivors with mirroring identities. In addition to the role of counseling, clinicians also spoke about RCC’s role in the larger movement to end sexual violence, and how staff and clients can become involved in this.

RCCs are designed for short-term sexual violence work. One participant stated that her RCC has session limits, while the two other RCCs were reported to have general guides to be short-term but had more flexibility if a client needed to be seen for longer (e.g., was in the process of getting insurance or on a waitlist for a long-term therapist). According to participants, complex mental health problems or long-term therapy work is routinely referred out. Participants often prized goal-oriented and symptom-based counseling as the most helpful in an RCC setting, as discussed in the following quote:

Well I think if you go through a mental health path there has to be a diagnosis you know, someone has to diagnose you. We don’t diagnose. Um. Like I said we work with the symptoms of the trauma. What, what brought you here? Oh, you can’t sleep at night? Oh, you have nightmares. Oh, you have, um, um. You know.

You, you find yourself in situations where, um, safety might be an issue. Um, you know? You're, you find yourself in risky situations. You know. So it's okay, somebody in the mental health world has to diagnose and then has, you know, we have treatment, we develop treatment plans, but it's more goal-oriented. (Participant 6)

As illustrated in the above quote, and the one below, participants also indicated that comprehensive diagnostic assessment is less important in RCC counseling because they are doing focused trauma therapy, not mental health work where differential diagnoses may be needed. However, participants made an exception for the diagnosis of PTSD, which was given, at least informally, to almost all clients.

Here I have the, it's a luxury that, it's not a luxury but you know that most people who come to this door they're gonna have PTSD. But if I was in a mental health clinic, like, and I don't know a client and they're coming with all these symptoms I wouldn't know where to start, maybe I can start treating the symptoms but, the DSM offers you, like, maybe a guide. (Participant 2)

Two participants discussed the role of funding in determining the scope of RCCs and RCC counseling. They stated that funders desire short-term, crisis-oriented work, which makes it difficult for RCCs to provide longer-term counseling. One participant who worked at an RCC with a strict 12 session limit spoke about the limitations of short-term, crisis counseling for survivors:

I prefer to, to work with that client in a long-term. Because, um, imagine a client that after the seven or eighth week we are creating the relationship between clinician and client and the client feels really comfortable coming here, and that client never miss an appointment and then I have to refer that client. And then that client needs to disclose again and to get that confidence with that, with that clinician, with that psychologist and that is re-traumatizing by itself. So, so I agree with the long-term therapy. But you know I think it is because funding, that we need to a twelve-week program. Ehhh. So that's something that I, I can't change. I want to, but hmm. (Participant 4)

From all participants, there was a clear and resounding description of RCC counseling as short-term, sexual trauma focused worked. They identified both benefits and drawbacks of this treatment model.

Being tripped by one’s roots: Aiming to increase access to marginalized and underserved populations. Participants highlighted the importance of addressing power dynamics when aiming to improve RCC services for marginalized populations. All participants alluded to ways sexual violence is related to power and control, and that sexual violence is an act of dominating or exerting one’s power over another, rather than being solely about sex. As one participant described, “It’s always about power. About who has the power, and how much power do I have in society?” (Participant 4). Three participants explicitly discussed how, because sexual violence is about power, those with less power in society—individuals of marginalized or oppressed identities—are more vulnerable to sexual violence: “The more vulnerable and marginalized that you are the easier it is for someone to oppress you or abuse that vulnerability” (Participant 2). Participants spoke of the importance that RCC clinicians understand how being a member of a marginalized population makes someone more vulnerable to sexual violence and adds barriers to healing. As one participant stated:

So I think it has to do with a lot of, like, the resources too because the more resources you have, the most... easy to, it is to heal. Like, if you have money that means that you can actually really take away time from school or from work and, or you can actually pay counseling. Or you know that you have insurance and they’re gonna pay for this. (Participant 2)

Participants stated that marginalized populations are less likely to report assaults for fear of consequences (e.g., undocumented immigrants may fear deportation) or not

having access to information about reporting procedures. Survivors with marginalized identities may also require more assistance with case management (e.g., immigration, housing, food stamps), which is time intensive for clinicians. The below quote illustrates how participants discussed that marginalized individuals' resources are additionally taxed and sexual violence recovery may not be the priority for someone facing other stressors or oppression.

I think that there are oftentimes just, within an identity then multiple layers of trauma that don't exist for folks that maybe have one of those variables. And so the re- um... I think for some folks then the impact of the trauma can be even more so in that they, it's layered... in that the resources that they have internally and externally are more taxed. Um, internally and then limited externally. I think additionally for, but then for so oth- other folks I think that they, they're coping with so many other things that this doesn't get to be a priority for them to focus on or to work on. (Participant 1)

Participants also suggested that clinicians need to be aware of power dynamics based on counselor and client identities. Participants spoke about ways a mismatch of cultural values and expectations in counseling (e.g., cultural norm that talking about sex or personal matters are taboo) can be challenging. This can put strain on clinicians to maintain an empowering stance and validate clients' beliefs when there are cultural differences. One participant described:

So it was hard because, like, you want so say like, oh that's, they should not believe these things. But you cannot say that and so you're trying to be supportive and understanding, but also knowing that like, how these views could hurt, like they were hurting her. (Participant 2)

Three participants spoke about how RCCs were historically staffed by White, straight, cisgender women to serve a similar population. Participants reported that this is the perception most people still have about modern RCCs and is generally reflected in

current staffing, which makes it difficult for individuals from marginalized populations to feel confident their needs will be met at an RCC. One participant illustrated this, “Like what are these White, what are a bunch of White women gonna like do for, like what are they gonna know about my experience, right?” (Participant 3). All participants described ways the RCCs where they worked are trying to increase access to more diverse and underserved populations (e.g., male survivors who often experience invisibility). One participant spoke specifically about increasing access to the LGBTQ community:

Rape crisis centers historically have been places for White, heterosexual cisgendered women. Um, and then maybe have moved into accessing, you know, the... I don't want to throw even throw trans in there yet but like [laugh] the, the gay community, right? And so... it is not a space that I think has traditionally been seen as, for all. (Participant 1)

Participants also spoke about their RCC's efforts to hire more clinicians of color. One participant shared her Executive Director's goal to have an RCC fully staffed by people of color. The two Hispanic participants were hired specifically as Spanish speakers to better meet the needs of this population. These two participants discussed that speaking the same language is important but only one piece of culturally competent counseling, as it is more than just a simple translation of concepts. It is about building a relationship and shared understanding: “I need to always ask them what does sexual violence means for them, because even when we talk the same language it could be different” (Participant 4). The two Hispanic participants described that building a shared understanding is especially difficult around medicalized language. One participant described:

So having that vocabulary in Spanish, first of all, finding a good translation for it and finally we find one, but then how you explain it? And it takes a lot of time to

explain that. And explain PTSD or panic attacks or flashbacks. Flashbacks is a, so I think, it's because maybe more of the PTSD research was done in English and in this country. I don't know if other languages they have the same problem or not. But at least in Spanish there's not a lot of language and sometimes it's just literally the translation. Like flashbacks, you say that in Spanish too but they are not going to under- understand it, so you need to explain it. (Participant 2)

Overall, participants addressed how power and control relate to sexual violence, and in turn the oppression of marginalized populations. All participants voiced a desire for RCCs to be more accessible for marginalized and underserved populations, but also identified barriers to achieving this goal.

RCCs are part of a social movement to end sexual violence. Five participants identified that part of an RCC's role is to promote social change that will ultimately end sexual violence. Participants varied in their sense of personal responsibility to engage in this social change. Some stated that they were responsible solely for supporting survivors in healing, while other parts of the agency engaged in social change efforts. One participant described:

I think being part of a place like [RCC] where we aren't just doing the clinical work right? We're, we're just a small [laugh] part of a bigger team and knowing that we have folks that are engaging in prevention work and that there are folks that are working on legislation. Um, and that that is something that we're all welcome to be involved in. As something that I carry with me. (Participant 1)

Three participants stated that engaging in social change work was important not only in session, but in their personal lives. One participant stated, "I think we as clinicians also double as advocates, in most cases if we're feeling up to it, um in that like part of our, part of our role takes place outside of the, um, outside of the, the room" (Participant 5). Participants found this work personally and professionally rewarding, but also draining and frustrating at times.

Five participants spoke about ways survivors get involved in advocacy or volunteering to end sexual violence and support other survivors. They spoke about how this can be empowering and is often helpful toward the end of a survivor's healing journey. One participant discussed a new survivor board of advisors at their RCC: "I think it does amazing things. I think it, again, it works towards empowerment, and, you know their voice matters... Their voice is the only voice" (Participant 6). All participants spoke in one way or another about how RCCs as a whole, clinicians, and survivors can all play a role in the mission to end sexual violence, and that this can be empowering for both clinicians and survivors.

Understanding and Honoring Survivor Shame

One of the most salient and pervasive themes throughout all interviews was the shame and self-blame experienced by survivors. Participants spoke about how self-blame fosters a sense of control in survivors. They also discussed ways societal messages perpetuate survivor shame and minimize experiences of sexual violence.

Self-blame as a protective act. A consistent theme across all participants was understanding survivor self-blame as a protective act. Participants conceptualized that when a survivor believes the assault was their fault it gives the survivor a sense of control, because it means it had been within their power to stop the assault if they had done something differently or better. In addition, it allows participants to maintain a belief in a just and stable world. Participants discussed that this is a coping strategy that is often needed, especially early in the healing process. Part of their work as counselors is to

honor how self-blame serves survivors, while also supporting survivors to find new ways to feel empowered and safe without self-blame. As one participant said:

You know finding a way to blame oneself then gives a person a sense of control that they could potentially prevent such a thing from happening to them again and so I think that their brain finds a way to blame themselves or to look back on the situation and say that they could have done something differently um and that gives them this false sense of control either for the future and also back over the situation. (Participant 1)

For all participants, survivor shame and self-blame was a salient and prominent topic of discussion. All participants explicitly described how they understand self-blame to be a protective act, as well as a consequence of stigma and victim blaming. They described that understanding the causes of shame and self-blame reduces pathologizing or judging survivors' behavior and aids in the therapeutic process.

Stigma and victim blaming foster survivor shame and minimization of sexual violence. Another consistent theme from participants was that societal messages, often via the media, politics, or one's local community, perpetuate messages of victim blaming, which survivors then internalize. As one participant described, "I think that like no matter... kind of how they've, how a person has kind of like, um, like intellectually thought about this blame like the fact that there's always like some emotional, like some kind of like emotional blame" (Participant 3). Although the dominant narrative from participants was that society normalizes sexual violence and perpetuates victim blaming, one participant discussed how the recent movement in the media to hold perpetrators accountable (e.g., the #MeToo movement) may be the beginning of a cultural shift: "I think that we are starting to see, very recently, survivors being believed, very recently"

(Participant 6). All participants indicated that unpacking shame and its sources is an important part of counseling.

Participants spoke about how the normalization of sexual violence by society makes perpetration more likely and is connected to survivors' minimizing their experiences of sexual violence. Two participants specifically cited the example of Trump being elected president despite his remarks about "grab[bing] a woman's pussy"

(Participant 6). Four participants also identified masculine gender norms or toxic masculinity as factors that contribute to sexual violence perpetration. Participants noted that most perpetrators are male and most survivors are female, addressing the gendered power differences in society. As one participant described, "when a perpetrator is a male that this is the way that we teach men that it's okay, things that it's okay for men to do."

(Participant 1). Survivors may also be encouraged by family or their communities to consider sexual violence as normal. Three participants specifically discussed this in the context of "rape culture." Participants also spoke about how sexual violence is unique from other traumatic events due to the tendency for society to victim blame in a way it does not for people who experience other traumas (e.g., veterans). One participant used the example of a mugging:

Um, I think that our culture perpetuates it in a way that a lot, you know like people don't sit around saying like, it's okay to, you know, I don't know, mug someone, right? Like, there, there isn't a lot in our culture that makes it okay or that softens it. Whereas with rape and sexual assault I think there's still so many messages. Not to go in, you know, to politics and in, in television that rape is still joked about and it's still made to seem like it's a misunderstanding. (Participant 1)

Three participants also mentioned the additional challenges faced by male survivors of sexual violence. One participant spoke specifically about how myths that men cannot be raped lead to increased stigma, shame, and denial in male survivors:

Uh, there's definitely a lot of like, denial or minimizing in male survivors. Especially, um, like for male survivors who haven't talked about it at all and haven't like had a chance to process any of the things that, um, they experienced. Uh, I think a lot of them, a lot of the male survivors that I talked had said for a long time that they believed that they must have wanted it. Or, um you know there's there's the whole, um, biological piece with men too like where it's like if you're erect then you must have wanted it, you know. (Participant 5)

All participants, in some form, discussed societal, cultural, and family messages that normalize sexual violence and blame survivors. These messages facilitate future sexual violence and lead to internalized shame for survivors, which inhibits healing. Participants indicated that addressing blaming messages and challenging internalized shame in counseling can be a beneficial part of the healing process for survivors.

CHAPTER 5

DISCUSSION

The purpose of this chapter is to discuss the qualitative results in greater depth. This chapter will synthesize the findings in the context of previous research and explore how medicalization and a neoliberal agenda may influence participants' work as therapists. Implications of these results for research, practice, and social justice will be discussed, and recommendations for counselors working with survivors of sexual violence will be provided. Lastly, this chapter will review the study's limitations, which should be considered when interpreting the findings.

A neoliberal medicalized discourse, which treats health and wellness as commodities and places responsibility on individuals to make appropriate healthcare choices (J. A. Fisher, 2007) runs the risk of focusing on symptoms without addressing the societal context of patriarchy and intersecting forms of oppression. In this way it can inadvertently promote a capitalist patriarchal agenda. With an aim to honor the tensions inherent in a medical model, the purpose of the present study is to provide a counter-dialogue to the often polarizing conversations as to whether medicalization is 'good' or 'bad'. Rather than assume a priori that there are clear benefits or disadvantages, the goal is to explore the impact of medical neoliberalism on clinicians' understandings of survivor distress. The objectives of the present study were to (a) better understand how a

neoliberal medicalized discourse impacts how Rape Crisis Center (RCC) clinicians make meaning of their clients' experiences post-sexual assault and (b) explore the advantages and disadvantages of using a medicalized framework to conceptualize survivor distress. The themes from the present study are discussed in terms of the ways a neoliberal medicalized discourse subtly influenced participants' work as RCC clinicians.

Situating Findings within Sociopolitical and Historical Context

Medicalization. Results of the study suggest that a medical model is pervasive in modern RCCs. One example is the frequency of medication management done by modern RCC clinicians. The reliance on a medical framework stands in stark contrast to the development of RCCs in the 1970s; they were founded as a result of grassroots efforts and purposefully positioned themselves outside of the medical system (Maier, 2011). Participants were critical of the medical model to varying degrees, but many did not appear aware of how hegemonic the medicalization of distress had become. This suggests that a biopsychiatric framework has become so normalized in the field of counseling, and within RCCs, that it has become the ground on which we stand. Therefore, we often do not stop to look at it or question it. Even participants who expressed strong criticisms of the *Diagnostic and Statistical Manual of Mental Disorders (DSM)*, and of the ways diagnosis may pathologize distress, used neurobiological explanations and symptom-based language routinely in interviews. Additionally, when asked what may be missing from the diagnosis of Posttraumatic Stress Disorder (PTSD), participants' first answer was often "I don't know." Yet with time, each participant was able to identify some

problem or limitation of the diagnosis. This suggests that RCC clinicians may not routinely critically analyze the medical model on which they often rely.

Most participants said that the diagnostic criteria for PTSD are broad enough that the diagnosis generally fits for most survivors. This suggests that when using a medical framework to understand survivor experiences, the framework does a good job. However, it is because clinicians are looking through a medical lens that they arrive at a medicalized conceptualization. Thus, the method of measurement is inseparable from the measurement itself, or put more simply, what we measure for determines what we find (Bohr, 1963, 1998; see also, Cosgrove & Wheeler, 2013). Therefore, the question may not be whether PTSD fits for survivors. Rather, perhaps it would be more helpful to ask: What does this diagnosis highlight or capture and what does it obscure?

Relatedly, participants appeared to generalize their interactions with clients to all survivors. Because most or all of their clients met criteria for PTSD, they seemed to assume that the majority of survivors would also meet the criteria. Again, measurement “is a potent moment in the construction of scientific knowledge” (Barad, 2007, p. 67). Clinicians are working with a skewed sample of survivors, as these are individuals who are experiencing significant distress and sought out a Western, individual model of therapy (albeit in the feminist setting of an RCC versus being referred to therapy via a healthcare provider). One in four survivors access an RCC in some format (Planty et al., 2013), but many of those may not be engaging in counseling. That leaves more than three in four survivors who are not in RCC clinicians’ sample. The ways that distress presents in those seeking RCC counseling may not necessarily generalize to all survivors. In turn,

if the criteria for PTSD could be met by every survivor of sexual violence and is considered a normal reaction to an abnormal event (Lamb, 1999; Yehuda & McFarlane, 1995), does the diagnosis lose its meaning as a mental disorder? In this case, diagnostic drift (I. B. Andersen et al., 1991; Moynihan et al., 2013) may have occurred, as an increasing number of behaviors and experiences have been defined as symptoms rather than expected distress post-assault, inflating the prevalence of PTSD.

One of the most salient and moving emergent themes that arose from participants was “Self-Blame as a Protective Act.” Participants outlined the many ways that society’s normalization of sexual violence and victim blaming perpetuate shame and self-blame. They all also understood self-blame to be a coping strategy that is adaptive within the context of pervasive sexual violence: A survivor believing the assault was their fault gives the survivor a sense of control, because it means it had been within their power to stop the assault, and maintains their faith in a just and stable world. However, one of the diagnostic criteria for PTSD in the *DSM-5* is “persistent, distorted cognitions about the cause or consequences of the traumatic event(s) that lead the individual to blame himself/herself or others” (American Psychiatric Association, 2013, p. 272). This is perhaps one of the most striking examples of how a decontextualized, symptom-based conceptualization unnecessarily pathologizes survivor experiences and labels self-blame as a symptom, rather than a consequence of societal messages and an adaptive coping strategy, robbing survivors of their agency.

An interesting paradox that arose in the interviews was how participants described survivors’ concerns about being “crazy.” Participants reported that some survivors may

come to counseling thinking “I’m crazy.” Learning about PTSD symptoms helps some survivors feel less crazy and receiving a diagnosis may provide a sense of community with others who have been assigned the same diagnosis. In these cases, receiving a diagnosis of a mental disorder actually makes someone feel more sane, self-compassionate, and connected. This finding supports previous research that receiving a diagnosis of PTSD can reduce stigma (Kurz, 1987; Lamb 1999; Ticktin, 2011; Yehuda & McFarlane, 1995). However, participants described other survivors who interpreted a diagnosis to be synonymous with “crazy” or mentally “weak.” Bursztajn, Feinbloom, Hamm, & Brodsky’s (2001) concept of *medical uncertainty* may be helpful in understanding this phenomenon: Assigning any diagnosis always involves some level of uncertainty; clinicians should acknowledge this uncertainty and use conversations about it as an opportunity to develop or enhance rapport with clients. These findings therefore support the proposal that clinicians should never assume to know in advance how a client will experience a *DSM* diagnosis.

Medicalizing the healing journey. The majority of participants specifically identified Judith Herman’s (1997) three stages of recovery as a framework they use to understand survivor healing. Herman’s first stage is re-establishing a sense of safety. This includes safety in relationships, the world, and with oneself. Since RCCs primarily provide short-term crisis counseling, many participants described that most of their clients are working through this stage. The second stage, remembrance and mourning, is when survivors process memories of the traumatic event and grieve the person they were prior to the trauma. This stage does not necessarily involve discussing painful memories

or sharing graphic details about one's assault and some participants stated that they do not recommend this in short-term crisis counseling. Herman's third and final stage is reconnection. At this stage survivors may attempt to make meaning of their experiences and engage in personally fulfilling activities. Sometimes this stage is described as the shift from 'surviving' to 'thriving.' Although participants indicated it is rare to work with clients in the third stage at an RCC, some participants said that when clients returned to counseling after a significant amount of time since the assault had passed they may be in this stage. Two participants who worked in settings with stricter session limits and who most often worked with clients immediately following an assault said they never saw clients reach this stage in counseling at their RCC. Research suggests that growth and distress post-assault are not mutually exclusive, and survivors can experience both throughout healing (Borja, Callahan, & Long, 2006; Luthar, Cicchetti, & Becker, 2000).

Participants reported that using Herman's (1997) stage model helps to provide targeted interventions for clients based on their stage of recovery (e.g., recommending coping strategies in stage one, addressing shame and self-blame in stage two, and facilitating meaning making in stage three). Multiple participants also highlighted that the healing process cannot be "rushed" and it seemed participants did not think that stages could be skipped. However, research by Frazier, Conlon, and Glaser (2001) suggests that the greatest changes post-assault occur between 2 weeks and 2 months, "contrary to the prevailing notion that most growth occurs through a long, gradual process" (p. 1054).

At times stage frameworks appeared to result in a tension between the empowerment model and medical model. The most salient example was participants'

opinions about when survivors should engage in activism. All participants described how sexual violence activism, advocacy, or volunteering can enhance survivor agency. However, some participants had strong concerns about survivors being overwhelmed or triggered if they attempt this work too soon. One participant explicitly described advocacy as “the end of the healing journey” (Participant 2). Therefore, there was an underlying message that survivors can engage in activism as a way to foster empowerment, but only once their clinician deems them advanced enough in their healing to be able to handle it. In this framework, clinicians may become gatekeepers, deciding when a client is healed and ready for the next step. This reflects a dynamic often seen with medical providers who set limits for patients healing from physical injuries or illness. Yet, 80% of survivors report positive changes of increased empathy and concern for others in similar situations just two weeks post-assault (Frazier et al., 2001) and engaging in collective action has been linked to feeling more empowered (Drury, Cocking, Beale, Hanson, & Rapley, 2005). Therefore, survivors engaging in a collective goal to prevent others from experiencing sexual assault by providing testimonies or engaging in education and activism may be beneficial much sooner than clinicians assume.

Similar to the example above, a tension arose throughout the interviews between empowering clients to be experts in their own experiences versus the clinician as expert, again demonstrating this dialectic between an empowerment and a medical model. All participants wanted to aid clients to feel in control of their decisions and the therapeutic process. Often participants explicitly tried to avoid the expert role in sessions. At the

same time, clinicians have education and expertise about how therapy may be most effective and sometimes participants had conceptualizations about their clients that did not match their clients' self-reports. For example, a lower order theme that arose in some interviews was that if a client does not report symptoms of PTSD, it does not mean they are not having them, but the client simply may not be identifying them yet. Here, the participants' confidence in a medicalized conceptualization of survivor experiences superseded their clients' descriptions. This *epistemic injustice* (Fricker, 2007) ignores survivors' experiences as valuable forms of knowledge and undermines survivors' ability to define their own experiences. While medical and stage models of healing can provide helpful frameworks for clinicians and clients, it is important that clinicians remember healing is often not linear and that each survivor's experience will be individualized and mixed with positive (e.g., growth post-assault) and negative experiences (Borja et al., 2006).

Societal factors that influence sexual violence, trauma reactions, and healing.

Results of the present study support previous research identifying how societal factors facilitate sexual assault by normalizing gender-based violence and placing blame on survivors rather than perpetrators (Campbell, Dworkin, et al., 2009; M. R. Harvey, 1996; Heise, 1998; Muehlenhard, Humphreys, Jozkowski, & Peterson, 2016). Additionally, participants' perspectives support literature on how sexual violence is an exertion of power and control, and at a societal level is used to oppress marginalized populations (e.g., women, LGBTQ individuals, people of color, immigrants; Breiding et al., 2014; Edwards et al., 2015; Walters et al., 2013). One of the issues many participants raised

with the prevalence of the trauma discourse is that it does not always recognize the unique characteristics of sexual trauma within a society organized by rape culture.

Rape culture in particular was a lower order theme discussed by many participants as a phenomenon that perpetuates sexual violence, stigmatizes survivors, increases survivor shame, and creates barriers to healing. The umbrella term of rape culture is unified by the idea that there are attitudes and actions present in society that allow people to feel entitled to women's bodies (Buchwald, Fletcher, & Roth, 1993). This entitlement leads to women perceiving "a continuum of threatened violence that ranges from sexual remarks to sexual touching to rape itself. A rape culture condones physical and emotional terrorism against women and presents it as the norm" (Buchwald et al., 1993, p. vii). Within this continuum are a variety of concepts that psychology has studied for decades including ambivalent sexism, objectification, harassment, rape myths, victim blaming, and rape avoidance behaviors. Utilizing an ecological lens, these forces operate at every level to shape women's experiences of sexual assault; both facilitating the assault and making healing more difficult (Campbell, Dworkin, et al., 2009; M. R. Harvey, 1996; Heise, 1998).

Another lower order theme that emerged for many participants was survivor anger and displaced anger. Participants reported that most survivor anger is self-directed and some survivors direct their anger toward those who allowed sexual violence to occur (e.g., angry at their mother for allowing their father to molest them). Participants stated that it was rarer for survivors to initially direct the anger solely toward the perpetrator, and that the process of shifting blame onto the perpetrator is often healing. One

participant also stated that intense anger is rarely seen in women, but may be seen in male survivors more often. These findings support previous literature that describes how women are socialized to restrict their expressions of anger (Motz, 2001). How women and men are taught to express their emotions impacts what emotions they may gravitate to post-assault. Additionally, clinicians may be primed to see certain behaviors or emotions as matching or conflicting with stereotypes of a client's gender and racial identities, and this can impact clinicians' conceptualizations and the diagnoses they assign (e.g., Becker & Lamb, 1994). An uncritical assessment that does not take gender socialization and racial prejudice into account may lead to pathologizing emotional expressions that do not fit with socialized roles.

Important to the current study, women's anger—especially women of color's anger about their oppression (e.g., Lorde, 1984a, 1984b)—is often neglected or pathologized (see e.g., D. Fisher & Spiro, 2010; Kruger et al., 2014). However, righteous anger is a “lucid and appropriate” (McWeeny, 2010, p. 295) response to violation and oppression. Anger can also be powerful when transformed into passion for advocacy and social change work (D. Fisher & Spiro, 2010). Therefore, it is vital that clinicians are cautious not to pathologize anger in survivors of sexual violence, especially female survivors of color.

Neoliberalism. A neoliberal agenda prizes competition, reduces state responsibility for social well-being, privatizes public assets, and corporatizes human services (Sugarman, 2015). While neoliberalism has often been associated with economic policies, such as deregulation and privatization, its influence as a larger ideology

stretches far beyond political strategies. The *market rationality* (Mirowski, 2018) inherent in such policies extends into cultural beliefs, societal practices, and individual self-understandings. As a result, ways of thinking and behaving that fit the demands of the market, such as autonomy and productivity, come to be seen as normal, or even desirable and healthy, while those that fail to meet these demands may be construed as deviant or pathological. As a neoliberal market society conflates health with productivity and success, a service that increases competitiveness on the market becomes understood as a consumer good or product (Esposito & Perez, 2014). Thus, medical neoliberalism turns health and wellness into a commodity (J. A. Fisher, 2007). Foucault's (2008) concept of neoliberal governmentality reveals that the values of individualism and competition are not inherent in individuals; rather they come to be instantiated at all levels of society through social practices, programs, and techniques (Rose, 1999). This insight raises the question, in what ways are RCCs both subject to, and purveyors of, forms of discipline or control that shape them toward neoliberal ends? Governmentality refers both to the ways in which individuals are enticed to govern themselves through discourse and the ways in which organizations, like RCCs, are governed by other social institutions (Foucault, 1991). There was evidence of both forms of governmentality in the present study.

First, neoliberalism permeated the discourse used by participants. One participant specifically described that her White clients “want to be very productive” (Participant 2) and it is therefore challenging for these clients to engage in self-care because this act is not productive in a neoliberal sense. Another participant stated that survivors want to “function like a normal person in society [again]” (Participant 5). Yet another described

many survivors' goals to include things like going back to work or returning to school. Although these goals may be personally meaningful to clients, part of that meaning is often derived from being a productive, functioning, and normal member of society because a neoliberal agenda promotes these as values necessary for a good life (Esposito & Perez, 2014; Sugarman, 2015). In this way, RCC clinicians are confronted with the discourse of neoliberalism by survivors themselves, which shapes clinicians' practices.

Within this dialectic, RCC clinicians may attempt to navigate these demands while unwittingly reinforcing them. Because RCC counseling is client-centered, if achieving success in a neoliberal sense is the client's goal, it will most likely also be the focus of therapy. A tension described by many participants arose between their clinical expertise (e.g., that self-care is important) and their clients' desires to fit into a neoliberal society post-assault. Taking this one step further, the concept of self-care itself can be understood as a product of a neoliberal and individualistic society because self-care places responsibility for one's happiness and wellness on an individual, rather than the community or larger society (Layton, 2015). Sugarman (2015) connects how self-care makes "individuals fully responsible for themselves" to the way that "neoliberalism conflates economic and moral behavior" (p. 114). That is, by making successful competition on the market a personal good or virtue, neoliberal ideology encourages individuals to seek out ways of maintaining their productivity and competitiveness in isolation.

Therefore, even while clinicians may validate the belief that survivors do not always need to be productive or meet neoliberal dictates, they may inadvertently

reinforce neoliberalism in another way, by invoking the discourse of self-care. This discourse implies that individual happiness and well-being can and should be the prerogative of the individual. By describing neoliberalism as a discourse, Springer (2012) reveals how neoliberalism evades a top-down or bottom-up approach, as it circulates within the discourse it constructs. In this way, neoliberalism isolates individuals as competitive self-concerned agents, and privileges market-based assessments of human worth. As a result, the individual becomes responsible for the health consequences of this isolated existence, and as a solution, neoliberalism offers that individuals may care for themselves in isolation to facilitate their return to “ruthless competitive individualism” (Giroux, 2005, p. 8).

Survivors, operating within a neoliberal culture, are encouraged to comply with society’s values and conform to a prescribed way of living. While following such neoliberal dictates may provide meaning and a sense of place in the world, transitional and liminal periods when individuals are temporarily outside of predefined social scripts may provoke distress. This process is reflected in another lower order theme that arose: Participants discussed that survivors often seek counseling after they complete a significant life event, such as finishing school. There are many possible reasons for this trend. Transitions are opportunities for personal transformation and may be difficult; therefore they are a time when many people seek therapy (Schlossberg, 1981). However, another possible explanation is that productivity is used as an avoidant coping strategy for survivors, and in meeting their goal, they are also losing a coping mechanism, which is why they seek counseling. This possibly warrants further investigation.

The RCC and survivor movement produces a discourse of its own that interacts with wider neoliberal discourses. Participants spoke about the victim/survivor dialectic and mirrored the common practice in RCC counseling to use the word “survivor” over “victim” as it is considered the more respectful and empowering label. Although much has been written on these terms from an empowerment perspective (Hockett & Saucier, 2015; Ovenden, 2012; Young & Maguire, 2003), there has been less focus on how this dichotomy upholds a neoliberal agenda. Participants often spoke about how to help survivors “feel” more in control or have a “sense” of agency; using the language of “survivor” was one example. Addressing survivors’ sense of safety and belief in a just world is vital, as research shows these views are still negatively affected at least one year post-assault (Frazier et al., 2001). However, placing the emphasis on survivors’ felt sense of safety may displace the responsibility onto survivors without addressing larger systems that are making society unsafe for marginalized populations. Lebowitz and Roth (1994) describe how being raped awakens individuals to an oppressive social landscape in which gender-based violence is normative. In her seven stage model of the “path of *conocimiento*,” Gloria Anzaldúa (2002) writes about *arrebato*, the rupture in one’s life (e.g., sexual assault) that creates a sense of dissonance and provides the catalyst for a search for new knowledge (e.g., intellectual, emotional, spiritual) and personal transformation (Bobel, Sieber, Suyemoto, Tang, & Torke, 2006; for discussion of Heideggerian pathways to recovery from trauma see also Churchill, 2013; Ekeh, 2016). Counseling for survivors can support this process by aiding survivors to see the world as

unsafe in a “realistic way” (Participant 3) and assess where they do have control or can gain control in their lives, not only an illusion of it.

The second form of governmentality, in which organizations, like RCCs, are governed by other social institutions, was also present. Findings from the study support previous literature that examined how the spread of neoliberalism is resulting in the reprivatization of the work to end sexual violence (Beres et al., 2009). Therefore, RCCs have become more reliant on grant funding, which limits their ability to engage in social change work and political activism (Maier, 2011). RCCs’ increasing governance by funding agencies is an illustration of Foucault’s (2008) concept of *macro-technologies*: how institutions and authorities govern other organizations in a way that reflects and encourages compliance with neoliberal aims.

This example of macro-technologies can be seen in the comments of two participants who specifically spoke about how funders’ demands limit the type of counseling offered at their RCCs. As illustrated in the master theme, “Stay in Your Lane: The Role of the RCC,” participants described a tension between their RCC’s meeting funder’s expectations and the RCC’s role as a change maker. Participants dealt with this tension in a variety of ways. Some compartmentalized, focusing their work on the individual and leaving the social change work to other parts of the RCC. Others brought in more advocacy or social change conversations into their sessions, as well as engaged in advocacy on a personal level. Additionally, participants described a clear distinction between rape crisis counseling and mental health counseling. The former focuses on survivors’ reactions to trauma and coping strategies, whereas the latter was considered

more long-term and could cover a range of topics and mental health diagnoses. In contrast to previous research that suggested RCCs' reliance on grant funding was leading to a longer-term model (Wasco et al, 2004; Maier, 2011), all participants in the present study described RCC counseling as short-term, with one site having a strict 12-session limit. Clients who have more complex mental health challenges (e.g., comorbid diagnoses, personality disorders) are often referred out from RCCs. A question that needs to be examined is whether the distinction between crisis counseling and mental health counseling is helpful for survivors, or whether it is primarily a consequence of funding limitations that may create barriers to survivor healing.

Layton (2015) spoke about a similar phenomenon when managed care became prominent in the 1990s and previously psychodynamic-oriented clinicians began to see long-term therapy as “a narcissistic indulgence” (para. 5). In both instances, a neoliberal agenda resulted in shorter-term, goal-oriented therapies and therapists created a narrative to explain why this is actually better for clients. There may be ways that this form of therapy is better for survivors (e.g., providing space for focused work on trauma with clinicians who have developed an expertise in trauma therapy). However, mental health professionals cannot avoid the possible harms or limitations of short-term counseling (e.g., emotional toll of disclosing assault to a new therapist as discussed by Participant 4; short-term therapy being insufficient to resolve client's presenting problem, Brech, & Agulnik, 1998). Likewise, long-term therapy often places a significant financial burden and time commitment on clients when similar results may be achieved through other forms of community support. Therefore, it is important for clinicians to critically examine

what factors contribute to their chosen methods of therapy and how each method may impact their clients.

It is important to note that all participants expressed a genuine care for survivors and wanted to be helpful in their clients' healing process. Participants were certainly not deliberately pushing a neoliberal agenda onto their clients. Instead, the results of the study highlight the complex relationships between neoliberalism and the work of RCC clinicians. Therefore, clinicians must be willing to critically analyze how their approach to counseling may be influenced by neoliberalism, and assess the benefits and limitations of their approach through this lens (see e.g., Carr and Battle, 2015, for critique of how attachment theory may promote a neoliberal agenda to the detriment of clients).

Implications for Social Justice

The present study has a number of social justice implications. First, a significant emergent theme was that marginalized identities increase one's vulnerability to experience sexual violence, increase the likelihood that the individual rather than the perpetrator or context will be seen as responsible, and also pose more barriers to healing. As discussed in the introduction, Fine's (1992) therapeutic hegemony paradox states that those who have little control over the root of their problems are treated with individualized psychological approaches aimed at increasing self-efficacy that ignore the oppressive systems which contributed to those problems. This is a social justice issue that needs to be remedied. Acknowledging and challenging the context within which sexual violence occurs is essential to creating a safe and equitable society. Additionally, clinicians must take context into account to avoid pathologizing behaviors that can be

explained by cultural differences or the effect of oppression and marginalization. Psychology has a dark history of perpetuating racial prejudice by targeting personal deficits in people of color and obscuring institutional practices that are at the root of racial inequities (Fine & Cross, 2016; see Richards, 2012, for historical review of race and racism in psychology). As Cross (2012) powerfully described, “We pathologize and psychologize almost as a way of guarding against comprehending how predicaments excreted by social injustice, greed, and avarice can make normal people, ordinary people, seem odd” (p. 718). As modeled by participants in the present study, it is essential that clinicians continue to acknowledge how psychology has facilitated racial oppression and reflect on their own biases that may be affecting their work and inflicting harm on their clients.

The emergent theme “Being Tripped by One’s Roots: Aiming to Increase Access to Marginalized and Underserved Populations” perhaps has the most important social justice implications. All participants discussed that their RCCs are working to become more accessible to underserved and marginalized populations. Many participants acknowledged that RCCs were founded primarily by White, straight, cisgender women and served a similar population (Greensite, 2003). This has created a barrier to people with other identities feeling welcome or understood at RCCs. This finding also corroborates previous literature that the feminist movement to end sexual violence, primarily led by White cisgender women—a movement that often left out survivors of color, LGBTQ survivors, survivors with disabilities, and survivors from immigrant communities—is learning from its mistakes (Arnold & Aki, 2013). Activists from these

marginalized communities have also been engaging in a movement to end sexual violence, but their contributions have often been ignored (see e.g., INCITE!, 2001, an organization of radical feminists of color working to end violence against women, gender non-conforming individuals, and transgender people of color). In an effort to address the needs of survivors with intersecting marginalized identities, many participants expressed that more clinicians of color should be hired at RCCs. This would both provide clients with more options for who they see in counseling, as well as give more of a voice to the needs of marginalized populations as RCCs are developing mission statements and long-term goals.

Participants also spoke about the need for RCCs to go out into the community to provide information on their services, rather than waiting for communities to come to them. A delicate balance needs to be made and psychologists must try not to impose their own values about counseling onto a population that may not find it as beneficial. Participants spoke about cultural barriers to therapy or clients' resistance to therapy due to cultural factors, implying an underlying belief that counseling is an important piece of healing. It is essential that clinicians reflect on this bias and decenter their own values. Similarly, the two Hispanic participants discussed some differences between their Hispanic and White clients. One example was that fewer Hispanic clients take psychotropic medication compared to White clients. Reasons for this should be further explored and it is recommended that clients be provided with alternative options (e.g., holistic practices, spiritual or religious resources, community supports). Additionally, it is important that clinicians do not view how White clients engage in therapy or with

medication as the standard and unintentionally try to have other clients match this model (e.g., conceptualizing a culturally-based decision to decline counseling or medication as client resistance). Clinicians hold a significant amount of power in the therapeutic relationship, especially when assigning a diagnosis. Multiple participants highlighted that clinicians need to be aware of this power differential and how having a clinician with more privileged identities and a client with more marginalized identities further complicates power dynamics in counseling.

Recommendations

These findings support previous literature suggesting that there are many ways a medical model can be helpful with survivors of sexual violence. Most notably, clinicians discuss how conceptualizing distress in terms of PTSD symptoms can be normalizing and validating for survivors. Therefore, clinicians may choose to continue engaging in a medical framework to the benefit of their clients. At the same time, it is important that clinicians are interacting with this framework consciously, reflectively, and critically. Additionally, by being mindful of the potential problems of a medical frame, clinicians may be better able to identify if harms are occurring, and empower their clients to do the same. The following are specific recommendations for clinicians working with survivors of sexual assault. However, all psychologists and mental health professionals can learn from how RCC clinicians are thoughtful and reflective about the language they use with clients.

1. Adopting a medical framework intentionally and critically. The results of the present study suggest that clinicians may divorce symptoms from diagnosis in an

attempt to avoid the harms of a medical frame that pathologizes a person's experiences or reduces them to a label. While using symptom-based language without assigning diagnoses may mitigate some problems, symptoms are the legs that diagnosis stands on, and they cannot be completely separated. Therefore, if clinicians want to avoid a medical framework completely, they may benefit from using language that describes behaviors or experiences in the client's words, rather than turning to symptom-based language. As one participant identified, co-constructing narratives with clients (e.g., narrative therapy; White & Epston, 1990) may be a helpful method. Additionally, the collaborative diagnostic approach developed by Pavlo, Flanagan, Leitner, and Davidson (in press) or the case formulations approach by Johnstone (2018), which were developed as alternatives to the *DSM*, incorporate clients' strengths and future goals. Rather than a single phrase diagnosis (e.g., PTSD), case formulation approaches may be multiple paragraphs long in order to capture clients' complex experiences in their own words.

These diagnostic approaches could be a beneficial practice with survivors because they can assist the clinician and survivor to jointly make meaning of distress experienced post-assault. In addition, the collaborative process promotes survivor agency. This collaboration requires clinicians to have *epistemic humility* (Wardrope, 2015), honoring the expertise of their clients due to their lived experience. If clinicians choose to use symptom-based language, then it is important they acknowledge that they are using a medical framework and the potential harms that come with it (e.g., decontextualized approach, reductionist, pathologizing).

Similar to separating symptoms from diagnosis, participants often distinguished PTSD from other *DSM* diagnoses as a less pathologizing alternative. This perspective aligns with previous literature on why PTSD was supported as a diagnosis for survivors of sexual violence when it was first introduced in 1980 (Lamb 1999; Yehuda & McFarlane, 1995). However, it is important to recognize that PTSD is grounded in a medicalized framework, and to scrutinize the limitations and dangers that come with that framework.

Participants ranged in how much they had critically analyzed diagnosis and a medical model previously. Therefore, clinicians may need institutional support and training in order to be able to approach their work with a more intentional evaluation of the medical model. This could be done through in-services, or having space to discuss the strengths and limitations of a medical model in staff meetings, as well as brainstorm what alternative frameworks are being used by clinicians. Busfield's (2017) history of medicalization and analysis of the benefits and limitations of the concept may be helpful to clinicians aiming to have more structured conversations about a medical model in clinical settings. More trainings could also be available on conducting therapy from a feminist intersectional or contextualized perspective, and how to translate perspectives from differing theoretical frameworks for—and with—clients. It is also helpful for clinicians to remember that there may be a selection bias in those clients who are seeking counseling. Therefore, the level of distress or pathology that clinicians see in their clients may not generalize to the experience of all survivors, especially those who have chosen not to seek out formal services.

Likewise, it could be helpful if policies about whether or not clinicians are diagnosing were uniform within an RCC and clearly communicated to clients. Most participants described that they do not explicitly inform their clients when they are assigning a diagnosis of PTSD, often because they were concerned it would lead the client to feel pathologized, or take up unnecessary space in time-limited counseling. However, shying away from talking about diagnosis is not the solution: “Rather than closing psychology’s laboratory doors on the storms that rage around it, there is a greater strength to be gained through constructive dialogue” (Gergen, 2001, p. 811). Following Gergen, clinicians may benefit from trainings on how to have conversations with their clients about the diagnoses they are assigning and how to integrate into that conversation the advantages and limitations of diagnosis. In these conversations, clients would then have the ability to express how receiving the diagnosis affects them and in what ways they may or may not agree with the diagnosis. Again, Bursztajn et al.’s (2001) concept of medical uncertainty may be helpful as clinicians never know in advance how a client will respond to receiving a diagnosis. Conversations about the uncertainties and limitations of our psychiatric diagnostic system and medical framework should be embraced rather than avoided.

2. Empower clients with information about medication and increase access to quality medical providers. A striking finding from the study was how often clinicians are engaging in conversations with clients about psychotropic medication. Part of the reason for this may be that, in a neoliberal climate, prescribing providers spend very little time with patients. The majority of physicians report spending 13-24 minutes with a

patient, with only 11% reporting they spend 25 minutes or more (Kane, 2018). The result is that medical providers are not able to take the time to fully educate patients about their treatment options, and therefore *job creep* (Van Dyne & Ellis, 2004) occurs as conversations about informed consent and medication side effects get pushed onto other professionals, like therapists. Participants varied in whether it was them or their clients who raised the conversation about medication. The general goal of these conversations was to provide clients with more information and a space to process their questions, concerns, and frustrations with medication in order for clients to be more empowered in their interactions with their prescribing providers. This goal could be achieved by more consistent and robust conversations about medication. This would require clinicians to be trained in and practice having conversations about medication with clients that truly communicate to clients that clinicians are only providing information, without having an agenda one way or the other.

Additionally, it would be helpful for clinicians to be better informed about what the assessment and prescribing process may be for their clients so as not to provide misinformation. For example, one participant stated “they’re not gonna go to some, to their doctor and say that they’ve been sexually assaulted and they’re gonna write them like some tranq- like prescription for a tranquilizer, right?” However, research by Campbell and Sturza (2005) suggests this is a possibility. In their study of 102 sexual assault survivors, 38 participants received prescriptions for psychotropic medication and up to 20 received prescriptions for sedatives or tranquilizers in order to cope with symptoms related to the assault. While this could be evidence of rational prescribing (4/5

participants did not receive a sedative or tranquilizer prescription), qualitative data from the same study suggest that some prescribers may be uncomfortable with disclosures of sexual assault and may reactively write prescriptions without asking more about the survivor's experience or current symptoms (Sturza & Campbell, 2005). When clinicians are better informed about prescribing practices they can have more frank and accurate conversations with their clients about what to expect when speaking with a prescribing provider. This enables clients to be prepared and empowered to exercise truly informed consent (Berg, Appelbaum, Lidz, & Parker, 2001).

Relatedly, survivors would benefit if more healthcare settings adopted a universal design for integrated care that is person-centered, recovery-oriented, and trauma informed (see Bassuk, Latta, Sember, Raja, & Richard's, 2017, guidelines for universal design in healthcare systems). According to the Institute of Medicine (2001), patient-centered care customizes treatment based on patient needs and prizes patient agency, transparency, the relationship between providers and patients, and cooperation between providers. By engaging in patient-centered assessments (Zatzick et al., 2001), medical providers could better understand each patient's unique concerns and priorities (e.g., medical, psychological, work-related, financial, relational). Many participants also noted the dearth of trauma informed prescribing providers, which can result in providers labeling behaviors as pathological rather than adaptive responses to trauma (Elliott, Bjelajac, Falloot, Markoff, & Reed, 2005). Therefore, it would be beneficial for more trainings to be done in medical schools or as continuing education credits to increase the number of providers who are educated about the impacts of trauma, and specifically how sexual

trauma is distinct from other traumas due to increased stigma and the interpersonal violation experienced. If RCCs are able to refer clients to integrated care healthcare settings that are client-centered and trauma informed, it will most likely improve survivors' interactions with prescribing providers by de-objectifying patients, helping survivors to have more agency, and lessening the risk that they will be pathologized.

3. Alternatives to individual counseling for sexual assault survivors. The context of the present study was RCC counseling, and therefore most interventions discussed occurred within a short-term, individual counseling setting. Since the majority of participants' interactions are with survivors who have self-selected to attend individual therapy, this may skew clinicians' perspectives that individual counseling is the best approach. This is illustrated by a participant who stated, "I don't think that there are emotional issues that you can't solve by or through the process of therapy" (Participant 5). A study by Gavey & Schmidt (2011) found that the average person's perceptions of sexual assault predominantly include assumptions that it is always traumatic and that professional support is very important to recovery. Although these assumptions may reduce stigma and improve access to services, these rigid, pathologizing understandings of sexual assault could also dictate limited paths for recovery and restricted ways for survivors to describe the impact of their assault. No clinician is able to fully predict whether a survivor will develop posttraumatic stress symptoms or PTSD, or their path to recovery (Bonanno, 2004).

In addition to individual counseling, participants also spoke about many other pathways survivors may take to heal (e.g., group counseling, social supports, spiritual

healing, creative arts, holistic practices, activism). More resources could be directed to increasing survivor access to approaches beyond individual counseling (e.g., D. Fisher & Spiro's, 2010, Finding Our Voice advocacy training program). This may be especially beneficial for survivors who do not have the financial resources to pay for individual counseling, as well as survivors whose cultural values do not align with those of individual counseling.

Group counseling was praised by many participants for the unique benefits it has for survivors, beyond individual counseling. Group counseling helps members foster agency and build community, and provides a deeper demonstration that they are not alone in their experiences (Yalom, 2005), which can serve to normalize survivors' reactions to sexual violence. Additionally, group counseling allows members to teach and learn from each other, communicating that their knowledge and experience is valuable, rather than prizing the expertise of a clinician or medical provider. Therefore, survivors may benefit from more opportunities for group counseling (Castillo, Lacefield, Baca, Blankenship, & Qualls, 2014; Echeburúa, Sarasua, & Zubizarreta, 2014; Lubin, Loris, Burt, & Johnson, 1998; Resick, Jordan, Girelli, Hutter, & Marhoefer-Dvorak, 1988). One participant expressed that group therapy is especially destigmatizing for male survivors, which is supported by the literature (Hoyt, Rielage, & Williams, 2012). More groups that offer support for specific identities (e.g., gender, race) or types of assault (e.g., childhood sexual abuse) may also be helpful.

Social support may be achieved more formally or clinically in a group counseling setting. However, participants also spoke of the immense power that a survivor's support

network has to either facilitate or inhibit survivor healing. Therefore, strengthening informal supports and fostering survivor connections in their social, cultural, and spiritual communities is essential. This could be done with ecological models of intervention (e.g., Campbell et al.'s, 2009, culturally inclusive ecological model of sexual assault recovery; CIEMSAR). For example, at the microsystem level, lay people can be educated about how to compassionately respond to disclosures of sexual violence (e.g., Edwards & Ullman, 2016, Supporting Survivors and Self training for college students). Support networks will also be improved through larger social change that reduces victim blaming and increases believing and validating survivors. One participant expressed optimism that a paradigm shift is occurring in which survivors are being believed and perpetrators are being held accountable. This is reflected in how sexual assault in the U.S. has received much warranted attention in the media and policy discussions. For example, *Time* magazine's 2017 Person of the Year was awarded to The Silence Breakers who launched the #MeToo campaign to give voice to survivors of sexual violence (Zacharek, Dockterman, & Edwards, 2017).

Many participants spoke about a mind-body connection and the importance of holistic practices that reconnect survivors with their bodies or involve physical touch (e.g., yoga, massage). There is significant literature on the physical reactions to a traumatic event (see e.g., van der Kolk, 2004, 2006). Participant stated that providing psychoeducation on biophysiology often serves to normalize survivors' trauma reactions and helps explain why certain coping strategies may be beneficial. More research into the benefits of holistic practices is needed; however, it must be done in a way that does not

medicalize physiological reactions to trauma. Additionally, it is important that clinicians be informed about the variety of alternative approaches to reconnect survivors with their bodies, as many were discussed by participants (e.g., mindfulness, yoga, acupuncture, massage, being in nature). Providers of these services who are trained in trauma informed approaches are also vital (e.g., trauma informed yoga; Clark et al., 2014). The American Psychological Association could invest in research on holistic practices and include information on referrals to these treatments in their next edition of the clinical practice guideline for PTSD (see American Psychological Association, 2017, for current edition in which alternative treatments are excluded from the guideline).

4. Future research with survivors of sexual violence. The present study added to the literature by providing a better understanding of how RCC clinicians conceptualize their clients' distress. However, this does not tell us about survivors' perceptions of a medical model. More qualitative research is warranted that explores survivors' own conceptualizations of their distress and if/how those conceptualizations are influenced by a neoliberal medicalized discourse. A similar methodology to the present study could be used, with participants being sexual assault survivors who sought services at an RCC, or survivors who did not seek professional services.

Additionally, there is a burgeoning body of literature on posttraumatic growth (Frazier et al., 2001; Tedeschi & Calhoun, 2004) that relates to participants' discussions of survivor resilience. Relatedly, there has been a movement to use the term stress-related growth (Borja et al., 2006; Luthar et al., 2000) over posttraumatic growth in an attempt to depathologize stress and recognize that people who experience sexual violence vary in

how they define those experiences. More research is needed on how survivors understand growth experienced post-assault and how to foster this growth without pathologizing or labeling survivor experiences. Exploring survivor's growth process via Anzaldúa's (2002) path to *conocimiento* may also be a helpful framework, especially for survivors of color, and could provide an alternative to a more medicalized understanding of posttraumatic growth.

Limitations

The study had several limitations that should be considered when interpreting the findings. A significant limitation was related to sampling. Although sampling for diversity was attempted, four out of the six participants identified as White and no participants identified as Black or African American (two participants identified as Hispanic). This sample is representative of RCCs that have historically been predominantly White but have recently been intentionally hiring more Spanish speaking clinicians (Greensite, 2003). However, given the insight the two Hispanic participants provided about the barriers to RCC counseling for marginalized populations and the ways oppression facilitates sexual violence, it would have been beneficial to learn from more clinicians of color and immigrants in the present study. Additionally, only one participant was male, again mirroring common staffing at RCCs. This participant had unique contributions about the stigmatization and invisibility of male survivors.

Another limitation related to sampling was that all participants worked in the same geographic region in the Northeast and participants were not balanced across RCCs (i.e., four participants worked at the same RCC, the two other participants were from two

other RCCs). Although snowball sampling was used to attempt to recruit participants from other geographic regions, these recruitment procedures did not yield any additional participants. Future research that interviews RCC clinicians from different geographical areas that are diverse in culture and political values would add a great deal to the current data. Participants also varied in their roles at the RCC. Although all participants had engaged in clinical work, some participants were staff clinicians, one was an intern, and others had managerial roles (e.g., intern training program coordinator, clinical director). This variety may have made the themes more difficult to interpret, but also provided more complexity and variety to the findings because participants were speaking from different perspectives.

The semi-structured nature of the qualitative interview, while providing flexibility, also presents a limitation of less standardization across interviews. Therefore, participants may not have had an equal opportunity to address issues and themes. Because of this, the number of participants who endorsed a particular theme should not be interpreted as representing the frequency that it would be endorsed in a larger population of RCC clinicians. At times participants alluded to multiple ideas in one statement and therefore there was some overlap across themes. Thus, results were organized in a meaningful way based on what emerged and my expertise in order to best meet the study's objectives. Also, when engaging in data analysis it appeared that sometimes when I asked a question about post-sexual assault experiences, the participant responded by discussing the experience of the assault itself. This sometimes made the data difficult to interpret. Future interviews on this topic should ensure greater clarity

both via the phrasing of questions and in follow up inquiry, to ensure participants and the interviewer are discussing the same topic.

In the procedural checks at the end of each interview, one participant suggested that I have the *DSM-5* diagnostic criteria for PTSD available and other participants also reported struggling to discuss how the diagnosis of PTSD fits for clients without reviewing the criteria. I therefore provided this information at the final interview, but did not have it readily available for other interviews. This led to some participants discussing misinformation about the diagnostic criteria (e.g., that it does not include a symptom about self-blame when it does). However, most interviews were done in participants' offices where they did not appear to have easy access to the *DSM* in their daily clinical work. Therefore, not having the diagnostic criteria available at interviews may have resulted in a better representation of participants' understanding of PTSD criteria and how they use it in clinical work. Additionally, the intention of the interview questions about PTSD was not to go symptom by symptom, but to assess overall whether a medical conceptualization is sufficient to understand survivor experiences.

Summary and Conclusion

In the present qualitative study, RCC clinicians were asked about their conceptualizations of post-sexual assault experiences and opinions about symptom-based language and diagnoses. The objective was to learn from RCC clinicians in their work counseling survivors of sexual assault and identify how a neoliberal medicalized discourse may be influencing clinicians' conceptualizations and counseling. Results from the present study support previous literature suggesting that a neoliberal, biopsychiatric

model may undermine important conversations around social inequities, pathologize survivors' experiences, and lead to an overemphasis on medication as the dominant treatment. Yet, it has also benefited survivors by reducing stigma and facilitating access to services, as well as providing explanations and validation for many survivors' experiences. In order to more fully appreciate the diversity of survivors' experiences and the context within which they are reacting to sexual violence, a deconstruction of medical neoliberalism, rather than a unilateral dismissal, is essential.

This study contributed novel findings to the field, most notably bringing to light how pervasive medical neoliberalism has become in RCC counseling and identifying its advantages and disadvantages. Additionally, the study identified how a neoliberal agenda has permeated RCC counseling via funders' influence and the emphasis on returning survivors to functional and productive citizens. Recommendations were provided about how to (a) judiciously appropriate a medical model to the benefit of clients while still acknowledging and monitoring potential harms, (b) empower clients with information related to medication, (c) support survivors using methods that are alternative or complementary to individual counseling, and (d) engage in future research to better understand survivors' experiences of a medical model. It is hoped that the findings from this study can provide a counter-conversation to the often polarizing stances of whether medicalization is 'good' or 'bad' in order to explore the paradoxical impact of a neoliberal medicalized discourse on clinicians' understandings of survivor distress.

APPENDIX A

DEMOGRAPHIC QUESTIONNAIRE

Name: _____

Age: _____

Race: _____

Ethnicity: _____

Gender Identity:

- Cisgender Woman
- Cisgender Man
- Transgender Woman
- Transgender Man
- Gender Nonconforming
- Other: _____

Sexual Orientation:

- Heterosexual
- Gay
- Lesbian
- Bisexual
- Queer
- Other: _____

Post-Bachelor Degree(s) Received:

- M.S.W.
- M.A. in _____
- M.S. in _____
- PhD in _____
- PsyD in _____
- None

Professional License:

- LICSW
- LMHC
- Licensed Psychologist
- Other: _____
- None

Job Title: _____

Years working/volunteering at Rape Crisis Center: _____

Years working as Clinician: _____

Years working at Rape Crisis Center as Clinician: _____

APPENDIX B

SEMI-STRUCTURED INTERVIEW AREAS OF INQUIRY

- How did you come to work as a clinician for [RCC]?
 - *Possible Prompt:* What led you to choose working for an RCC over other agencies?
- Although experiences vary, in general, how would you describe the most common experiences of sexual assault survivors post-assault?
 - *Possible Prompt:* This may be in terms of bodily experiences, self-representations, to whom or how a survivor attributes blame (such as personal, interpersonal, societal).
 - *Reverse:* Are there any areas that may be less common that you see in terms of what people are struggling with post-assault?
- In your experience, is there any particular language or explanatory frameworks that survivors tend to use as they make meaning of their experience?
 - *Possible Prompt:* This may be in terms of to whom or how a survivor attributes blame or responsibility for the assault.
 - Is there any language/framework that you find helpful?
- What issues/experiences/struggles bring people into rape crisis counseling today?
 - Over time, have you seen any changes in how post-sexual assault experiences are understood?
- What ways of conceptualizing post-sexual assault experiences do you find helpful in therapy?
 - *Reverse:* When engaging in therapy, what do you find challenging about ways post-sexual assault experiences are commonly thought about?
- In what ways, if any, do you find the use of DSM diagnoses or symptom-based language helpful?
 - *Possible Prompt:* Can you give an example?
 - *Reverse:* In what ways, if any, do you find the use of DSM diagnoses or symptom-based language challenging or not helpful for your clients?
 - *Possible Prompt:* Can you give an example?
- In what ways, if any, do you believe that a diagnosis of PTSD captures the experience of sexual assault survivors?
 - *Reverse:* What, if anything, seems to be missing from the way PTSD describes experiences of survivors?
- Does the Rape Crisis Center where you work use mental health diagnoses? How so?
 - *Possible Prompt:* Do you diagnose your clients?
 - Do you feel any pressure to understand the aftermath of sexual assault in terms of symptoms or DSM diagnosis? If so, in what ways?
Possible Prompts:
 - Pressure may be from the survivor, agency, society, or otherwise.
 - How do you navigate that pressure?

- The language of trauma has become common in everyday conversations. What are your thoughts on this?
 - *Possible Prompt:* In what ways do you see the concept or discourse of “trauma” already present in the therapy room before you may bring it up?
 - What do you see as the possible benefits of this?
 - What do you see as the possible costs or drawbacks?
- What is your clinical opinion about how psychotropic medications are used currently with survivors?
 - *Possible Prompt:* What is your process for referring to a prescribing provider? How often to do make referrals?
 - How many of your clients enter therapy already on medication or asking about medication?
 - Was there a time when your client was on psychotropic medication and didn’t find it helpful? How did you negotiate that?
 - Do you recommend any holistic health practices?
- How does empowerment get incorporated into your work as a therapist?
- What is the mission of the RCC you work for?
 - Do you incorporate this mission into your work with clients? How so?
- How do you address issues of racial, cultural, or other diversities in your work at [RCC]?
 - How do you balance your approach of working with individuals and addressing the societal/sociopolitical issue of sexual assault?
- *Possible Prompts:*
 - Have you ever worked with somebody where you thought language or cultural differences was a barrier?
 - What is your familiarity with an intersectional perspective? Does that impact your clinical work?
- Is there anything else you would like to add, or that we did not discuss?
- *Procedural Integrity Questions:*
 - Was there anything that made it difficult to answer questions openly?
 - Do you have any recommendations for future interviews?

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