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The Personal is Political: A Feminist and Trauma-Informed Therapeutic Approach to Working With a Survivor of Sexual Assault

Kate Richmond¹, Elizabeth Geiger², and Carly Reed¹

Abstract
The following case study highlights the application of a conceptual framework that incorporates feminist theory, trauma theory, and the importance of attending to identity development with individuals who have experienced gender-based violence. This case study illustrates the treatment of a 25-year-old female survivor of sexual assault suffering from depression, anxiety, and feelings of self-blame. Findings show a decrease in depression and anxiety, which provides support for the effectiveness of an integrated feminist and trauma-informed therapeutic approach. Because very few graduate training programs incorporate feminist theory and trauma theory in their curricula, recommendations for clinicians and students are provided.

Keywords
feminist therapy, trauma, sexual assault

1 Theoretical and Research Basis for Treatment
Feminist therapy is a theoretically driven approach that specifically acknowledges the mental health risks associated with living in a patriarchal and hegemonic environment (Maine, 2004). The historical context in which feminist therapy evolved is largely responsible for the existence of multiple feminist therapies (Marecek, 2003). Feminist therapy grew out of the feminist political movements of the 1960s and 1970s, when consciousness-raising groups emerged and provided a catalyst for women to come together to share their personal concerns about discrimination (Enns, 2004). As the benefits from consciousness-raising groups became more apparent, clinicians began to integrate feminist principles into their preferred therapeutic modalities—generating feminist therapies.

Because there is no one feminist therapeutic modality, practitioners are connected through shared values (Rederstorff & Levendosky, 2007). A common goal among feminist therapists is to encourage the development of a feminist consciousness (Brown, 2004). Clients learn to make connections between their symptoms and the social context in which they live (Enns & Sinacore, 2005), and to distinguish between internal and external sources of distress, so that they do not unnecessarily blame themselves for the cause of their presenting concerns (Worell & Remer, 2005).

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This is critical to the therapeutic process because the experience and denial of sexism has been linked to greater psychological distress (Fischer & Holz, 2010; Klonoff, Landrine, & Campbell, 2000). In addition to creating more awareness of the social environment, feminist therapists also strive to develop egalitarian relationships with their clients and explicitly value and support the client’s voice through a person-centered approach (Maine, 2004). This enables the client to feel empowered, gain insight about oppression, and collaboratively develop strategies to promote social justice within the client’s environment.

Controlled clinical trials, qualitative studies, clinical case studies, and single-participant designs support the validity of feminist therapy (Israeli & Santor, 2000). Feminist therapies have been found to reduce depression and anxiety, increase a sense of control and empowerment, promote positive identity development, help a client feel understood, and restore self-trust (Brown & Bryan, 2007; Rader & Gilbert, 2005; Rederstorff & Levendosky, 2007). Furthermore, the use of consciousness-raising in feminist therapy increases clients’ awareness of sexism and discrimination in their lives and provides support and tools to combat future discrimination (Worell & Remer, 2003). Because of this focus on consciousness-raising, some researchers have advocated for the use of feminist therapy when addressing distress related to career development, domestic violence, body shame, and eating disorders (Peterson, Tantleff-Dunn, & Bedwell, 2006). In particular, the experience of sexual assault has been conceptualized within a sociopolitical context, which has resulted in treatments that integrate feminist ideals (Brown, 2007).

Similar to feminist theory, trauma theory emerged in the 1970s and represented a major shift in thinking about the psychological effects of traumatization. Prior to the emergence of trauma theory, survivors of traumatic events were often pathologized and viewed as characterologically weak (Bloom, 2013). Contemporary trauma theory acknowledges that the experience of trauma can overwhelm internal and external coping resources, making it difficult to manage external threats (Briere & Scott, 2012). The subsequent development of trauma response symptoms (e.g., learned helplessness, affect dysregulation, hypervigilance) are dependent on the unique ways in which an individual’s mind and body respond to the experience of trauma (Bloom, 2013). According to feminist conceptualizations, trauma response symptoms are thought to serve communicative functions and reflect learned strategies to cope with environmental stressors (Brown, 2007). In addition to the experience of a traumatic incident, hegemonic norms can shape world-views and increase the likelihood of developing trauma response symptoms (Brown, 2008).

According to The National Intimate Partner and Sexual Violence Survey (2011), approximately 1 in 5 women (18.3%) and 1 in 71 men (1.4%) reported experiencing rape at some point in their lives. In addition, approximately 1 in 20 women (5.6%) and 1 in 20 men (5.3%) reported experiencing sexual assault other than rape (i.e., sexual coercion, unwanted sexual contact, or non-contact unwanted sexual experiences). Scholars conceptualize that sexual violence directed toward men and women stem from patriarchal values within a given context (Hearn, 2004; Swartout, 2013). Subsequently, feminist clinicians and scholars have played a critical role in theorizing and formulating treatment options for survivors of trauma (Brown, 2007; Freyd, 1996; Herman, 1997; Root, 1992; Walker, 1991). Because of the early influence of feminist thinking on treatment, most trauma therapies implicitly incorporate many feminist tenants (Brown, 2004). For example, a central issue in trauma treatment is the consideration of sociocultural variables (Briere & Scott, 2012). Indeed, the experience and aftermath of a traumatic event are influenced by social identity variables such as age, race, class, sexual orientation, disability, and gender (Brown, 2008; Stewart, Ouimette, & Brown, 2002). For this reason, most trauma therapies recognize that attention to a survivor’s identity and the power often denied or ascribed to a client’s social identity is critical to the healing process (Briere & Scott, 2012).

Identity development is also influenced by the experience of trauma (Briere & Scott, 2012). Thus, a trauma and feminist-informed therapeutic process actively challenges the unhealthy aspects of a hegemonic environment and helps clients redefine a more positive self-image (Enns,
Particularly in cases of sexual assault, clinicians must acknowledge and challenge the pervasive societal messages that place undue blame on victims and minimize the experience of rape/incest (Ryan, 2011). When internalized, these messages can give rise to self-denigrating thoughts that are often accompanied by powerful emotions, such as shame and guilt (Heath, Lynch, Fritch, McArthur, & Smith, 2011). These emotions frequently influence a survivor’s personal identity (Wilson, Droždek, & Turkovic, 2006). It is not uncommon for survivors of violence to describe themselves in statements of self-hatred and heightened vulnerability (Kallivayalil, Levitan, Brown, & Harvey, 2013), which in turn undermines resiliency and growth.

To facilitate positive identity development, contemporary feminist clinicians have utilized the Feminist Identity Development Scale (FIDS) model to guide therapeutic work (Downing & Roush, 1985; McNamara & Rickard, 1989; Rederstorff & Levendosky, 2007), as well as the ADDRESSING model (Brown, 2008; Hays, 2001). The FIDS model (Downing & Roush, 1985) encourages clients to progress through identity stages, leading to an affirmed feminist-informed identity. The ADDRESSING model (Hays, 2001) emphasizes how multiple social locations (age, race, class, gender, sexual orientation, etc.) might influence the way a survivor makes sense of a traumatic experience. For example, an individual may wonder if membership to a particular group (e.g., being a woman) increased the likelihood of being victimized. Likewise, the same person may also consider how their membership to another particular group (e.g., middle class) provided them with resources, such as access to treatment, to cope with the aftermath of trauma.

Feminist therapists help clients see how different social locations can provide an advantage (privileged) or a disadvantaged (oppressed) status (Worell & Remer, 2003). By identifying membership to privileged and oppressed groups, clients begin to understand that cultural norms influence how a client understands their sense of self within the context of their experience of trauma. This can illuminate conflicts between external pressures and internal desires of self-definition. Ultimately, a therapeutic goal is to have the client resolve these conflicts and develop a sense of interdependence among social identities while also incorporating feminist ideals into self-definition (Root, 1992; Rederstorff & Levendosky, 2007). Such focus on identity development promotes empowerment and subsequently reduces depression and anxiety (Worell & Remer, 2003).

The purpose of this case study is to evaluate evidence for the effectiveness of a feminist and trauma-informed therapeutic approach to working with a survivor of sexual assault. In the beginning of treatment, Jill, the client, was experiencing severe levels of anxiety and moderate-to-severe levels of depression. Using an integrative model that incorporated feminist theory, trauma theory, and attention to identity development, over the course of 1 year, Jill reported moderate levels of anxiety and mild levels of depression. For clarity, the case will be presented from the perspective of one therapist working with the client.

2 Case Introduction

Jill was a 25-year-old, heterosexual, able-bodied, White woman who, at the time of intake, was in her 1st year of law school at a large private university. Jill sought counseling at Student Counseling Services, following an emotional meeting with an academic advisor. Jill was informed, for the first time ever, that she was being placed on academic probation.

3 Presenting Complaints

At intake, Jill reported excessive worry, rumination of doubtful thoughts, and nervousness since her recent transition into law school. She reported that her symptoms, which included increased heart rate, migraines, difficulty sleeping, guilt, decreased ability to concentrate, nervousness, lack of energy, and feelings of loneliness and emptiness were impairing her academic and social life. At the time of intake, Jill reported slight suicidal ideation, but she denied an intent or plan.
4 History

Jill reported a turbulent childhood, marked by parental discord and strict family rules. She believed that her father may have suffered from depression. A successful businessman, he displayed “bad views of women” and was “demanding and overly critical” toward Jill and her mother. Jill described her relationship with her mother as “alright,” but she described feeling resentful toward her mother for “not standing up to [her] dad.” Furthermore, Jill disclosed that her mother, a nurse and homemaker, struggled with body image concerns, which further contributed to Jill’s resentment toward her mother. Jill reported that her mother placed a great deal of emphasis on physical beauty.

Jill admitted to a relatively long history of anxious and depressive symptomatology. She recalled many of her difficulties beginning in middle school, at age 10, when she entered puberty much earlier than her classmates. She became the center of her peers’ criticism and felt ashamed and embarrassed by her developing body. Jill admitted to having a poor history of maintaining friendships and disclosed a long history of low self-esteem and a fear of failure, despite being very academically successful. In high school, Jill experienced an extended episode, where she lost interest in her usual activities and became lethargic, sleeping most of the day.

Jill disclosed that her anxiety and depressive symptoms became far worse in her 2nd year of college when her then-boyfriend’s roommate raped her. At intake, Jill tearfully reported waking up in her boyfriend’s bed to find his roommate on top of her. Jill pretended she was asleep, until the perpetrator left the room. She reported having precise detailed memory of the event, despite not feeling any physical pain or fear during the actual experience. She reported, “I just couldn’t move.” Immediately after the event, she felt intense fear and had intrusive memories of the event. Jill never told her parents, boyfriend, friends, or administrators about the incident. Instead, she transferred from her small private college to a larger university and isolated herself from her social group.

She continually questioned her role in the rape, specifically because she “had decided to sleep alone” and “had passed out drunk in the bed” and because she “hadn’t stopped him when [she] had the chance.” She reported “I’m not even sure he knows he did it.” Jill reported being “very cautious of most people” and was “still pretty anxious.” Jill also reported that she could not envision herself as one day having a romantic partner or even a family, as the thought of any physical intimacy terrified her. She also admitted that she did not attend university-sponsored events because she did not want to be around peers who were drinking.

5 Assessment

Given the nature of Jill’s presenting problems, it was essential that the formal assessment process minimize possible victim blaming and reflect sensitivity. To ensure this, the therapist and the client collaboratively discussed the purpose of assessment and created strategies for collecting necessary information. Self-report measures as well as a consultation with Jill’s physician were agreed as appropriate. Jill was already taking Effexor (Venlafaxine) once a day, so a waiver was signed to allow this therapist to speak with her primary health physician. Jill was prescribed Effexor when she began Law School (9 months prior to the beginning of therapy).

Since Jill reported depressive and anxious symptoms during the initial intake and since depression and anxiety are lasting reactions to sexual assault, the Beck Depression Inventory (BDI-II; Beck, Steer, & Brown, 1996) and the Beck Anxiety Inventory (BAI; Beck & Steer, 1990) were administered. The BDI-II is a 21-item, empirically validated self-report instrument that measures levels of depressive symptomatology. Individuals scoring 0 to 13 are considered to be minimally depressed, 14 to 19 indicates mild depression, 20 to 28 indicates moderate depression, and scores 29 or above indicate severe depression. The BDI has an alpha coefficient of .81. The BAI is a
21-item, empirically validated self-report instrument, which yields an estimate of anxiety. Individuals scoring 0 to 9 are considered to have a normal level of anxiety, 10 to 18 indicate mild-to-moderate anxiety, 19 to 29 reflect moderate-to-severe anxiety, and scores of 30 and above indicate severe anxiety. The BAI has an alpha coefficient of .71. At the beginning of the therapy, Jill scored in the moderate-to-severe range for depression and the severe range for anxiety (BDI = 25 and BAI = 30).

To assess for trauma-related symptoms, Jill completed the Trauma Symptom Inventory (TSI; Briere, 1995). The TSI has an alpha coefficient ranging from .73 to .91. Jill’s profile was considered valid, with clinical elevations (T > 65) on Anxious Arousal (T = 70), Depression (T = 66), Defensive Avoidance (T = 69), and Sexual Concerns (T = 78). Jill’s TSI profile also demonstrated that several scales were approaching clinical elevations: Anger/Irritability (T = 62), Intrusive Experiences (T = 61), Impaired Self-Reference (T = 64), and Tension Reduction Behavior (TRB = 63). The Personal Progress Scale–Revised (PPS-R; Johnson, Worell, & Chandler, 2005) was also used to measure emotions, cognitions, and experiences that represent empowerment, gender role awareness, and well-being. The PPS-R has an alpha coefficient ranging from .84 to .89. Jill’s responses to the PPS-R demonstrated that she had feelings of self-blame, self-doubt, and an inability to connect external stresses to internal distress.

6 Case Conceptualization

To conceptualize Jill’s distress from a feminist and trauma-informed perspective, several factors needed to be considered, beginning with the gender role socialization that began during Jill’s childhood. Strict gender roles call for women to be submissive and self-sacrificing, which increases women’s likelihood of developing depression (Brown, 2008; Israeli & Santor, 2000). According to Jill’s reports, her mother adopted a traditional feminine role and reinforced gender-typed behaviors. Thus, Jill learned gender-role expectations through parental modeling and direct and indirect encouragement of gender-typed behavior, which lead to Jill adopting her family’s gender-related rules. These rules served as personal guidelines or ideals for Jill’s behavior as a child and created self-imposed expectations (I can, I should) and restrictions (I can’t, I shouldn’t; Worell & Remer, 2003).

Young girls learn to place priority on the needs and concerns of others and specifically learn to value men as the dominant group (Worell & Remer, 2003). Jill’s reports of her childhood depicted her father as maintaining power within the family, as he established house rules, initiated action, made family decisions, and imposed rewards and punishments. The explicit power differential between her parents coupled with her father’s critical views on women undoubtedly influenced Jill’s developing identity as a girl. This type of experience is also suggestive of insidious trauma (Root, 1992). Insidious trauma can begin early in life as a result of repetitive and enduring experiences of sexist statements and/or acts. Over time, these incidents have a cumulative effect and can activate survival mechanisms, such as heightened sensitivity, depressed mood, paranoid-like behavior, and agitation following minor stresses (Root, 1992). It is quite likely that Jill developed these coping strategies as a means to deal with her oppressive environment, a process also associated with learned helplessness (Root, 1992).

Although it is likely that Jill experienced depressive and anxious symptoms as a child, Jill recalled that her depressive symptoms began in middle school. During this time, adolescent girls can begin to hide their feelings to maintain friendships and adopt inauthentic selves to fill the stereotypical roles defined by a male-oriented society (Pipher, 1994). In addition, girls are most likely to be targeted for sexual objectification as they enter into reproductive years (Fredrickson & Roberts, 1997). Since Jill began to mature earlier than many of her peers and was ridiculed for this maturation, it is likely that she developed a keen awareness of her classmate’s observation of her body (Fredrickson & Roberts, 1997). If Jill began to internalize this objectifying gaze, she...
may have engaged in self-surveillance, which may have further disconnected herself from her internal physiological experiences (Fredrickson & Roberts, 1997). Since many girls develop a sense of self in relation to others, her social isolation could have further exacerbated her depressed mood and loneliness (Witvliet, Knoll, Hinman, & DeYoung, 2010).

Her experience in middle school was further complicated by messages from her mother that she should strive to achieve traditional standards of physical beauty. Jill received the message that she should be “sexy” without being “sexual” (Tolman, 2002). Jill’s sex education aimed to discourage sexuality, as a means to warn against pregnancy and sexually transmitted diseases. Consequently, she never received any type of modeling or discussion on healthy sexual desire or satisfaction.

These early experiences set the stage for Jill’s response to her traumatic episode. Essential to a feminist conceptualization of Jill’s trauma is the notion that her experience is highly and profoundly personal, rooted in her psychosocial context. The unique contribution of Jill’s interpersonal, biological, and sociopolitical perspectives influenced multiple factors associated with the rape, which included how Jill attributed blame, her resiliency to her experience, and the social support she received (Kirmayer, Lemelson, & Barad, 2007). For example, Jill’s history of major depression likely increased her vulnerability to the development and maintenance of anxiety symptoms following her traumatic experience (McFarlane, 2000). Given her father’s early devaluation of women, her mother’s strict adherence to gender beauty norms, and her experience of body ridicule in school, the rape was yet another gender-based violation that likely exacerbated Jill’s sense of helplessness and fear. Feminist therapists view all of these gender-based violations as manifestations of a patriarchal culture, intended to reinforce male domination (Brown, 2008).

Because of these experiences, Jill began to doubt her own perceptions, which may have decreased the likelihood to reach out to social support (Kahn, Jackson, Kully, Badger, & Halvorsen, 2003). As a teenager, Jill was socialized by the following messages: that “good women are virgins” and that “rape only occurs to promiscuous women.” Jill learned that rape could be prevented as long as she took the necessary precautions to prevent an assault. Immediately following the assault, Jill questioned her role in the rape, thinking that she “could have done more to stop it.” Such rape myths are common in American society and stem from heteronormative expectations that women are responsible for controlling men’s sexual behavior (Suarez & Gadalla, 2010). Feminist scholars demonstrate pervasive endorsement of rape myths that serve to minimize and justify male sexual aggression (Webster & Dunn, 2005). Indeed, these messages may have become so engrained in Jill’s understanding of the assault that she may not fully grasp their influences on her current psychological distress (Worell & Remer, 2003). Without identifying, critiquing, and disentangling these myths, Jill would continue to experience self-blame, shame, and guilt (Webster & Dunn, 2005). Furthermore, it is likely that the sexual assault altered Jill’s sense of personal identity. The rape may have enhanced traumatic memory in Jill’s schemata and created a reference point that influenced her new and old memories of herself. Such traumatic memories may have served as a cognitive point of reference and in turn reshaped her understanding of herself and the world around her (Berntsen & Rubin, 2007).

In addition, Jill’s experience of the rape likely had strong physiological effects. During the sexual assault, Jill reported that she was “frozen.” The freeze response, also known as tonic immobility, is common among rape victims (Rothschild, 2000). When fight or flight is not possible, tonic immobility is an instantaneous and automatic response meant to protect a victim from further harm. Another component of tonic immobility is the release of analgesia, which has a numbing effect on the mind and body (Rothschild, 2000). Survivors often experience a tremendous degree of shame and guilt following an assault because of their unawareness of this strong physiological experience. Jill was riddled with self-blame following the rape, and without an understanding of her bodily functions, she may have assumed to have more control than she did during the attack. It is likely that Jill continued to deal with chronic autonomic hyperarousal, and
without the knowledge of this, Jill could be misattributing internal arousal cues. In addition, the sexual assault may have caused disruption in Jill’s noradrenergic activation system, which would result in more pronounced response to minor stresses (Heim, & Nemeroff, 2009).

7 Course of Treatment and Assessment of Progress

Initial sessions were spent establishing rapport and trust with Jill. Unconditional positive regard, active listening, collaborative goal setting, and demystifying techniques were used to enhance the process of rapport building. An initial goal was to develop an egalitarian relationship, a key value of feminist therapy (Rader & Gilbert, 2005). To do this, the therapist initiated an honest and open discussion about the role of power in the therapeutic relationship. The therapist expressed an interest in working collaboratively, making use of the therapist’s knowledge and Jill’s expertise about knowing what was best for her life (Brown, 2007). By allowing Jill to be an active participant in the initial planning stages of therapy and by sharing primary references, Jill became an educated consumer about therapy.

In addition, the therapist facilitated a power analysis, which is a useful technique that helps the client learn about the different kinds of powers she possesses and how she uses (and misuses) power in her relationships (Worell & Remer, 2003). The power analysis revealed that Jill primarily relied on indirect forms to exert power. The therapist acknowledged that issues of assertiveness are quite common among women, because the gender role socialization process teaches women to be passive (Rudman & Glick, 2008). Together, Jill and the therapist agreed to practice power-sharing in sessions. Jill learned when and how to assert her needs with the aid of the therapist. When Jill appeared to experience a heightened state of arousal or when she became withdrawn, the therapist gently inquired about Jill’s experience in the here-and-now. During these moments, it was common for Jill to respond that she needed to take a break and/or change the subject. This process helped Jill begin to understand how her physiological experiences provide useful information about her emotions and, subsequently, her needs. By increasing Jill’s awareness about her experiences in the here-and-now, she could work to improve her relationship with her body and practice assertiveness skills in session. By responding empathetically and respectfully, the therapist reinforced Jill’s belief that she had the right and the power to slow down or change the course of therapy. Disagreement with the therapist was viewed as a positive assertion rather than as Jill’s resistance (Worell & Remer, 2003).

Jill and the therapist also agreed that constant monitoring of her depressive symptoms would be appropriate, particularly because Jill had initially expressed slight suicidal ideation. A critical component of feminist trauma therapy is creating safety (both in therapy and in Jill’s life). Monitoring suicidal thoughts was an important part of keeping Jill safe. Much of the beginning of the therapy was spent developing a strong therapeutic relationship, anchored in trust, acceptance, and flexibility, which allowed for an open and honest discussion of the potential threat of suicide and was critical in maintaining a sense of safety (Briere & Scott, 2012). Identifying Jill’s strengths also helped promote safety by supporting Jill’s resources and promoting hope and empowerment (Rothschild, 2000). Jill was motivated to be in therapy, and she was quite intelligent. Despite her current academic struggles, she had a long history of academic achievement. She also maintained a relatively structured schedule. She attended classes, study groups, and participated in weight training classes twice a week.

As therapy progressed, the therapist introduced an assessment of social locations, which is a technique used in feminist therapy that allows the client to identify how her social identities shape a particular stressor in her life (Israeli & Santor, 2000). Jill chose the competitive nature of her academic program. This was an ideal selection because it was a less emotionally laden stressor than the assault, and Jill reported that she was not quite ready to discuss the rape. An analysis of Jill’s academic environment in relation to her most salient social locations
demonstrated that, as a child, there were very few female role models for her in the legal field. The lack of female representation had further created feelings of invisibility and devaluation, which is not uncommon for women who work in non-traditional professions (Hoyt & Simon, 2011). In addition, Jill recognized that her depressed mood and anxious symptoms had prevented her from achieving at the level she desired in her present academic environment. The assessment of Jill’s social identities also allowed her to examine the privilege she held over others (Parker, 2003). This type of exploration enabled Jill to look at her intersecting identities and what it meant to be a White, heterosexual, middle-class law student. Jill and this therapist discussed how systematic power structures are arranged in the United States, and this dialogue sparked an interest in Jill’s desire to learn more about social justice and the law.

Jill also explored the ways in which her social support was limited because of her difficulties connecting with other women, particularly in her present academic program. The therapist informed Jill that a Graduate Women’s Support Group was being formed through Student Counseling Services. Feminist therapy suggests that working with women’s support groups helps develop a value for female friendship and helps women obtain a sense of connection and empowerment (Clemans, 2005). Although initially reluctant, after several encouraging sessions, Jill agreed to join the support group.

The therapist also notified Jill that a Take Back the Night (TBTN) March was scheduled to occur on campus. Some feminist therapists suggest using social activism as a way to better the client’s mental health (Israeli & Santor, 2000). Jill and this therapist discussed her potential reactions to hearing other survivors speak and also the possibility for her to share her story. Jill was enthusiastic about the TBTN March and volunteered to hang signs around her academic building to inform other community members about the event. After several honest discussions in session, Jill decided not to attend the actual event, but she nevertheless felt empowered by her ability to support the event through her outreach endeavors.

Simultaneously, Jill and the therapist began to explore the many ways in which Jill’s earlier education had taught and reinforced rape myths. Consciousness-raising is a critical component of feminist therapy. By exploring Jill’s post-assault reaction within the context of larger social attitudes, Jill was able to reduce her self-blame and begin to develop self-empathy (Moor, 2007). Jill also indicated a desire to reduce her intense anxiety reactions to traumatic stimuli, and the therapist and Jill collaboratively discussed a prolonged exposure (PE) plan, which included social support and relaxation techniques (Worell & Remer, 2003). PE involves having a client confront feared, but safe, thoughts, sensations, and memories with the goal of achieving “emotional processing,” whereby the client incorporates accurate information into the original feared structure (Foa, 2011, p. 1043). In Jill’s case, much of the processing involved recalling images of the rape, as well as experiencing intense feelings of guilt, shame, and self-blame in the sessions. The therapist and Jill agreed to focus on relaxation strategies and self-care before, during, and after direct processing of trauma material (Brown, 2004).

As exposure increased in session, Jill disclosed that she was restricting her food intake. Together, the therapist and Jill discussed Jill’s body image beliefs and her body dissatisfaction within the context of the many unrealistic expectations placed on women in contemporary American society (Evans, 2003). Jill was also able to identify that her mother’s evaluative focus on physical appearance and Jill’s experience in middle school continued to influence her body image. The therapist encouraged Jill to discuss this in the Graduate Women’s Support group, and through that process, she was able to hear how pervasive body dissatisfaction was among her peers. Collaboratively, the therapist and Jill identified ways to develop a more positive body image, including having Jill disrupt and challenge critical thoughts about her body and also develop mindfulness while engaging in activities that supported body agency (e.g., weight training classes). Jill also agreed to meet with a student health dietician to ensure that she was appropriately meeting her nutritional needs.
Past research has found that developing a feminist identity reduces body shame and negative eating attitudes (Hurt et al., 2007), so, in addition to modulating exposure, the therapist and Jill began a discussion about incorporating feminist ideals into her identity. Jill explored the ways in which her identity had been altered following the sexual assault, and she began to identify empowering ways the trauma had unintentionally prompted growth (Zoellner & Maercker, 2006). Jill acknowledged that her feminist consciousness was developed in response to her experience with sexism, and that she was able to confidently see herself as a survivor, rather than a victim. Jill’s development of a feminist consciousness allowed her to view her personal experiences through a political lens (Moane, 2010). This gave Jill insight on the societal forces affecting women’s daily lives on the micro, meso, and macro levels, and empowered her to become more involved with activities connected to social justice. Jill reported that feminist ideals were an important component of her feelings of empowerment.

Because of the Student Counseling Center’s policy of making a referral if therapy extended beyond 1 year, Jill and the therapist agreed to end individual therapy after 1 year. Jill continued to attend the Graduate Women’s Support group; she did not seek a referral for additional individual therapy.

Jill agreed to evaluate her therapeutic work via subjective appraisal and objective self-report measures. Due to the ease of the measures, the BAI and the BDI were administered every 10th session to evaluate the treatment process and to serve as self-monitoring for Jill. The results of the BDI and the BAI scores indicated that Jill’s depression and anxiety decreased over the course of therapy (see Table 1).

### Table 1. Mean Scores for the BAI and the BDI at Every 10th Session.

<table>
<thead>
<tr>
<th>Measure</th>
<th>Pre-treatment</th>
<th>Session 10</th>
<th>Session 20</th>
<th>Session 30</th>
<th>Session 40</th>
<th>Session 50</th>
<th>Follow-up</th>
</tr>
</thead>
<tbody>
<tr>
<td>BDI</td>
<td>25</td>
<td>25</td>
<td>18</td>
<td>20</td>
<td>16</td>
<td>12</td>
<td>11</td>
</tr>
<tr>
<td>BAI</td>
<td>30</td>
<td>30</td>
<td>33</td>
<td>28</td>
<td>29</td>
<td>20</td>
<td>19</td>
</tr>
</tbody>
</table>

Note. BAI = Beck Anxiety Inventory; BDI = Beck Depression Inventory.

8 Complicating Factors

After several months in therapy, Jill began to discuss a man she met in her program. At the beginning of one session, she reported being shocked and startled when he unexpectedly kissed her after a study session. As she discussed the situation in session, Jill began to cry and shake. She explained that since her assault she had been “doing something” that “she never told anyone before about.” Jill tearfully reported “cutting herself.” On inquiry, Jill disclosed that every once and awhile she used a small razor to cut the inside of her upper thigh. Jill reported wanting to stop this behavior because she would be embarrassed to have anyone discover her secret. She noticed that her urge to cut was very high following the unexpected kiss. Jill indicated a desire to begin “working through” her experience of trauma because she was sure the kiss had prompted her desire to cut.

The therapist actively listened to Jill and provided non-judgmental responses to her reports of self-inflicted violence. A feminist approach to working with women who self-harm is for the therapist to provide an understanding and empathetic response (McAndrew & Warne, 2005). Self-inflicted violence is very complex and can result from women’s experiences of feeling powerless in a patriarchal society (Brown & Bryan, 2007). Cutting is often used as a means to regulate heightened arousal, and it is not uncommon for there to be significant shame around cutting behavior (McAndrew & Warne, 2005). By sharing her experience with the therapist, Jill was taking a courageous step toward undoing shame. By offering Jill an alternative explanation for her cutting, the therapist was able to reframe Jill’s behavior and provide new meaning to her...
experience (Greenberg & Watson, 2006). Furthermore, the therapist’s non-judgmental stance modeled compassion and understanding.

In keeping with the framework of collaborative work, the therapist indicated that Jill could make the decision to continue with her behavior and/or work toward developing other ways to calm herself. Non-coercive tactics in reducing self-inflicted violence is a feminist technique aimed at affirming the client’s autonomy (Brown & Bryan, 2007). Jill indicated that she wanted to stop the behavior, but she was convinced that she would not be able to prevent it. Since Jill was unsure how often she actually cut herself, the therapist requested that she monitor her behavior patterns. Self-monitoring was introduced as a way to increase Jill’s self-awareness and thus make her mindful of her behavior choices following triggers (Worell & Remer, 2003). Collaboratively, Jill and this therapist agreed that Jill would create a journal, which would monitor the time/day of her behavior, the situation prior to the behavior, and her thoughts and feelings during that time. Jill would bring the journal to each session; however, all information would be kept in Jill’s possession and Jill could decide when and how much to disclose in a session. The therapist also suggested that Jill learn about other women’s experience with self-inflicted violence, and suggested several books for Jill to read. Bibliotherapy is a technique used in feminist and trauma-informed therapy that increases the client’s knowledge and expertise about her therapeutic process (Worell & Remer, 2003).

Over the course of several months, Jill mentioned that she read extensively about self-inflicted violence and was surprised to learn that this behavior is quite common among other women with experiences of trauma. Jill also learned important information about her behavior patterns. Her journal revealed that when she experienced desire, her anxiety increased, and she subsequently experienced a strong urge to cut (although she did not always actually do it). She was able to identify a link between her assault, triggers, and her current coping mechanism. Collaboratively, Jill and this therapist discussed alternative options to cutting, which included progressive muscle relaxation, breathing exercises, and grounding techniques (Worell & Remer, 2003). Jill also increased her participation in weight training classes, which helped her learn to control and release muscle tension (Rothschild, 2000).

9 Access and Barriers to Care

Because Jill sought treatment through the Student Counseling Center, treatment was disrupted when the college was closed for holidays and school breaks (Fall/Spring break), and termination was partially decided based on the Student Counseling Center’s policy regarding session limits. There were no other apparent access issues; services were free to all students for up to 1 year. There were no session limits on support group therapy.

10 Follow-Up

At a 1 month follow-up, Jill had a face-to-face session and reported that individual therapy and support group were helpful in the reduction of her presenting symptoms. Jill claimed to have increased empowerment and a stronger sense of her identity as a woman. She had successfully stopped cutting for 5½ weeks and had significantly less surveillance of her food intake. She was interested in dating. Although Jill stopped attending individual therapy, she continued attending the Graduate Women’s Support group.

11 Treatment Implications of the Case

Feminist therapy is one of the few approaches to psychotherapy that incorporates the feminist values of “the personal is political” (Maine, 2004). This approach focuses on the socially
constructed power arrangements in contemporary society and aims to help clients consider how these affect well-being. When integrated with trauma-informed therapeutic approaches, Jill was able to reframe her experience of trauma by connecting her understanding to its social meaning. More specifically, the therapist and Jill worked together to become aware of how her identity as a woman shaped her experience of her trauma (Worell & Remer, 2003). Bringing awareness to the power differences and expectations of women in society allowed Jill to start undoing the toxic effects of sexual assault (Moor, 2007). This approach was necessary to effectively deal with Jill’s cognitive appraisal of the sexual assault and the subsequent anxiety, self-doubt, and self-blame. Furthermore, by making use of assertiveness training and power-sharing in the here-and-now, Jill became more aware of her own personal power, leading to a sense of empowerment. Finally, modulated prolonged exposure, combined with relaxation strategies, allowed for emotional processing, which ultimately eliminated avoidant behaviors.

This therapeutic approach helped Jill cope with the harmful effects of her sexual assault, along with encouraging her to develop a social support system through the Women’s Graduate Support Group. This sense of community and individual power will help Jill to continue to develop a positive identity and self-image. By living with a feminist consciousness, Jill undermines the power of patriarchy (Maine, 2004).

12 Recommendations to Clinicians and Students

This case study supports the effectiveness of applying a feminist and trauma-informed therapeutic process in treating survivors of sexual assault. Clinicians can benefit from using this integrated approach in that it promotes exploration of the client’s identity development with a sociocultural framework (Briere & Scott, 2012; Brown, 2004). Such exploration, as demonstrated in Jill’s treatment, proves to be a crucial element in the healing process.

Although research continues to support feminist and trauma-informed theory, graduate training programs seldom utilize feminist theory and trauma theory as a primary focus (Courtois & Gold, 2009; Goodrich & Silverstein, 2005). Licensing and accreditation requirements encourage many graduate training programs to focus on traditional forms of therapy (Goodman et al., 2004). When feminist and trauma perspectives are included they are often presented as add-ons rather than central elements of training (Courtois & Gold, 2009). Therefore, students may need to look for resources outside of their training programs. Students and clinicians may find it helpful to utilize the following professional resources: American Psychological Association Division 35 and Division 51, Association for Women in Psychology, and the Feminist Therapy Institute, as well as the following journals: Women in Therapy, Psychology of Women Quarterly, Sex Roles, and Psychology of Men and Masculinity. Last, the following books may also be useful: Subversive Dialogues, Feminist Perspectives in Therapy, Feminist Therapy.

Clinicians and students can also benefit from recognizing the power of consciousness-raising peer support groups. As shown in Jill’s treatment, the use of the women’s support group was a powerful approach in addition to individual therapy. Consciousness-raising allows women to raise awareness of gender roles and oppression through peer discussion and shared experiences (Clemans, 2005). Consciousness-raising in a peer support group is especially effective at helping women gain a sense of membership with other women. Thus, it is useful to become aware of such resources that can help aid our clients in further understanding their problems through a larger social, political, and cultural context.

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