SURVIVING RAPE: PROFILE AND COPING REACTIONS OF FILIPINO RAPE SURVIVORS SEEN AT THE UP-PGH WOMEN'S DESK FROM JANUARY 1999 TO DECEMBER 2000

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ABSTRACT

This paper, a hospital-based review of sexual assault cases from 1999 to 2000, is a descriptive study of rape victims who asked for the assistance of UP-PGH Women's Desk. It focuses on the medical and behavioral aspects including the person's coping reactions before, during and after the incident. It provides a profile of the 114 survivors, legal and medical definition of terms and other data important in the understanding of rape and assault cases.

I. INTRODUCTION

Background and Statement of the Problem

To date, this is the one and only hospital-based review of sexual assault cases focusing on the medical and behavioral aspects of survivors. The reported rape cases from the National Statistical Coordination Board (NCSB) reached 3,177 in 1999 from a lower figure of 2,346 in 1995, or an increase of about 35 percent (Figure 1). This data translate, on the average, to nine women raped in the Philippines daily.

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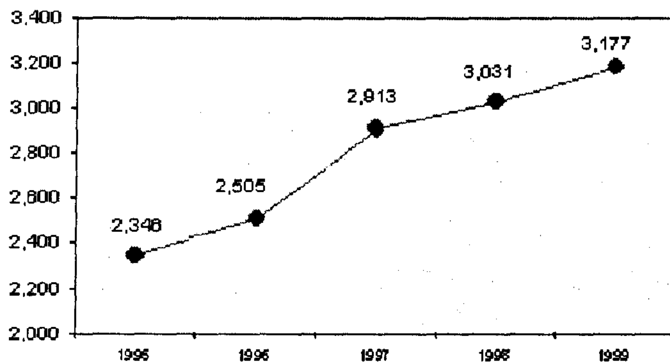
Figures gathered from the Philippine National Police revealed that reported rape cases in the country in the period 1999-2000 were about 6248 (with a steady increase of 2346 in 1995 to 3177 in 2000). Metro Manila had 334 cases in 1999 and 277 cases in 2000. Of these, 18.7% or 114 cases were seen at the UP-PGH Women's Desk.

Figure 1

Reported Rape Cases in the Philippines, 1995-1999
(Source: NCSB)



The UP-PGH is one of the first to establish a unit dedicated to assisting women victims of violence such as rape. The Women's Desk, in the course of the treatment and management of rape cases, has inevitably become involved in the judicial aspect of rape serving to provide expert witnesses in the trial. This experience brought to the fore the inadequacies of routine medical interview and examination upon which "medical experts" base their opinion when called upon to testify in court. This "medical expert's opinion" usually includes a judgment as to the appropriateness or inappropriateness of the complainant's behavior before, during and after the alleged rape. These opinions often play a very critical and influential role in the outcome of

cases. A 1996 review of convictions upheld by the Supreme Court noted that some acquittals have been based on "inappropriate" behavior during or after the rape incident. "The complainant's failure to flee and/or shout for help before the alleged rape was committed is not consistent with the normal behavior of a woman who feels her virtue is being threatened," the Court ruled. In the other case, the Supreme Court (Women's Legal Bureau, 1996) noted that the complainant's behavior immediately after the alleged rape "displayed outright inconsistencies with the natural behavior of an outraged woman disrobed of her honor." An accused was also acquitted, on the ground of reasonable doubt, because the Court said that the victim did not resist the sexual advances since the victim allegedly held the perpetrator's hands during the incident[1].

But what constitutes "normal/ natural behavior" in the case of rape? Judith Herman (Herman, 1992) notes that observers who have never experienced prolonged terror and who have no understanding of coercive methods of control presume that they would show greater courage and resistance than the victim in similar circumstances. Hence the common tendency to account for the victim's behavior by seeking flaws in her behavior, her personality or moral character.

Although rape is a daily fare in newspapers and the mainstream media, there has been no in-depth study of the crime in general (Monares, 1996), much less of the Filipino victim's reactions/coping. There is a dearth of locally developed data on the subject so that therapists, social workers and other professionals rely on Western models to understand and attend to the rape survivor. To date, this is the one and only hospital-based review of sexual assault cases focusing on its medical and behavioral aspects.

[1]Atty. Edna J. Conde of the Supreme Court, during the preliminary presentation of the study reported that, since the implementation of the new rape law of 1997, there has been active efforts to educate judges and lawyers about these misconceptions.

A. Definition of Terms

Rape — defined as the act of forced penetration of any bodily orifice accomplished by the use of force, the threat of force or without force when the survivor is unable to physically or mentally give her consent (Surratt, 1999). The Philippine Anti-Rape Law of 1997 explains:

Rape is committed—

1. By a man who shall have carnal knowledge of a woman under any of the following:
   a. Through force, threat, or intimidation;
   b. When the offended party is deprived of reason or otherwise unconscious;
   c. By means of fraudulent machination or grave abuse of authority; and
   d. When the offended party is under twelve (12) years of age or is demented, even though none of the circumstances mentioned above are present.

Coping — consciously directed behaviors intended to modify and to terminate symptoms (Comprehensive Textbook of Psychiatry, 6th edition, 1995).

Explanation — is providing some reason for the rape. It gives some understanding of the act and aids in returning some degree of control to the survivor (Burgess and Holmstrom, 1978).

Minimization — is comparing the trauma to their perception of rape, their current situation, to other victims or to a prior experience. It reduces the anxiety to a smaller, more manageable context and it decreases the terrifying aspects and allows the person to think of it in tolerable amounts (Burgess and Holmstrom, 1978).

Suppression — is when a person tries to put the memory of the rape completely out of her mind through a conscious effort. It provides cognitive control over thoughts of the rape (Burgess and Holmstrom, 1978).

Dramatization — is repeatedly overexpressing the trauma and thereby dissipating it (Burgess and Holmstrom, 1978).

Adaptive — coping behavior which restores equilibrium and/or with potentially protective results.

Maladaptive — coping behavior with potentially dangerous and destructive results.

C. Objectives

This papers aims to:

1. to describe the psychosocial profile of rape survivors seen at the UP-PGH Women's Desk in terms of the following:
    - 1.1 age
    - 1.2 civil status
    - 1.3 highest educational attainment
    - 1.4 employment
    - 1.5 history of violence
    - 1.6 physical injuries resulting from the assault
2. to identify the circumstances of the rape in terms of the following:
    - 2.1 place of occurrence
    - 2.2 type of rape
    - 2.3 use of weapon
    - 2.4 number of assailants
    - 2.5 period up to consult

3. to identify the reactions and coping styles of the Filipino rape survivors at various stages of the assault.

D. Limitations of the study

Subjects are women who come in voluntarily to report an experience of rape. These subjects may not be representative of all rape cases. Many rape cases remain unreported because of the stigma, a lack of awareness, or because of the nature of the crime.

Listening to the rape survivor recount the rape and subsequently identifying coping behavior is a difficult exercise. Doubly challenging is categorizing the coping behavior and recognizing which behavior is adaptive or maladaptive.

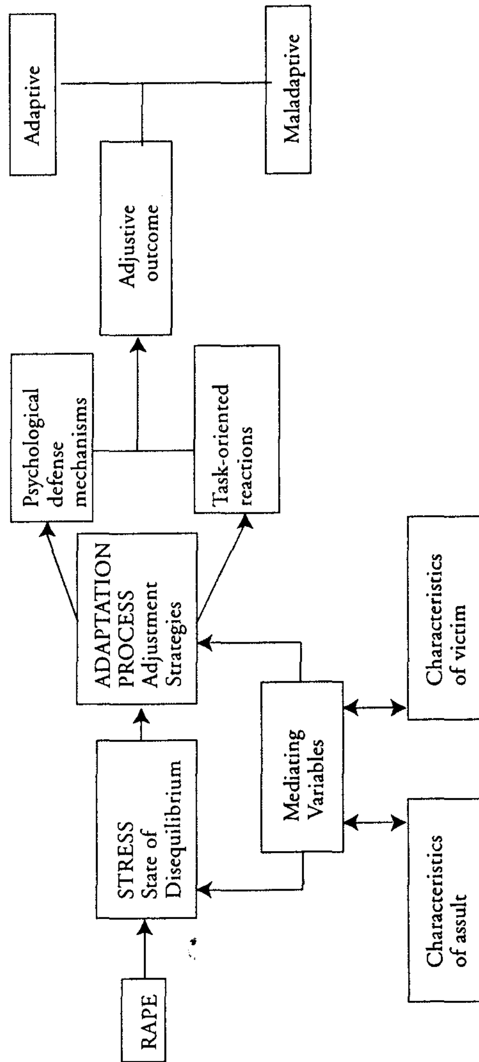
Barriers to disclosure may be present especially in the acute stage of the trauma. A survivor may not be able to disclose certain details because of a sense of guilt, shame, or a sense of disbelief that suspends thought about the incident. The interviewer, for her part, may not facilitate this disclosure by her personality, by countertransference issues, and even by the choice of techniques used during the interview. The context of the patient-physician relationship may further inhibit the sharing of feelings and thoughts as survivors respond to the traditional role of the doctor.

II. REVIEW OF LITERATURE

Sexual assault may be viewed as a traumatic life event that produces overwhelming stress and demands the extensive use of personal adjustive resources to restore a stable level of pre-crisis functioning (Ward, 1995). It may be understood and analyzed using the conceptual framework of a clinical model of stress and coping as shown in figure 2.

Several factors influence the adaptation process and the outcome of the stressful situation. Among these are the characteristics of the assault experienced and the characteristics of the

Stress and coping framework (Ward, 1988b, p167)



victim. Notman and Madelson reported that each rape victim responds to and integrates the experience differently depending on her age, life situation, the circumstances of the rape, her specific personality style and the responses of persons from whom she seeks support. Furthermore, Surratt documented that even if the situations of the rape are similar, people are individuals and respond differently to similar situations. This study specifically looked into the psychological defense mechanism and task-oriented reactions of survivors.

Burgess and Holmstrom conducted a study in 1976 on the coping behavior of 92 rape victims. They identified **coping tasks and strategies used by the rape survivors before, during and after the attack.**

Before the attack, an early awareness of danger is delineated from the definite threat of attack. Several survivors described a subjective awareness alerting them to danger. This subjective awareness may be cognitive, perceptual or affective — often the victim describes it as a "sixth sense" or a feeling of impending danger. The coping task during this phase is to react quickly to this warning.

The threat of attack is the point when the person realizes that there is definite danger to her life. The coping task identified is to attempt to avoid or escape the situation. Burgess and Holmstrom identified the basic strategies used in this phase. Survivors reported assessing the situation to determine possible alternatives like how to escape from the car or plan how to keep calm, using verbal tactics like talking one's way out of the situation, stalling for time, reasoning with the assailant to change his mind, trying to gain sympathy, using flattery or feigning illness, joking and sarcasm, or verbal aggression. Verbal tactics constitute the major coping strategy used. Physical actions aimed at preventing the attack were also documented, like fleeing or

fighting the assailant. Some survivors were unable to use any strategy to avoid the attack becoming totally paralyzed and helpless.

During the attack, the coping task identified was to survive the attack despite the many demands forced upon the victim. Among the cognitive strategies used to cope were mentally focusing and directing attention to some specific thought to keep their minds off the reality of the event and focus on survival. This includes memorizing details of the assailant, recalling advice people have given on the subject, or recalling memories of previous violent situations. Verbal tactics used were screaming and yelling which served both to relieve tension and alert people to the attack. Several survivors also talked with the assailant during the attack believing that this will help them to avoid additional violence. Survivors reported struggling and fighting with their assailants to avoid full penetration. Psychological defenses at this stage include denying the attack, experiencing dissociation, suppressing the rape and rationalizing. Physiological responses of choking, gagging, vomiting, pain, urinating, nausea, hyperventilating and losing consciousness were also reported. **After the attack,** escaping from the assailant was the identified coping task. Survivors bargained for their freedom, concentrated on how to obtain help, or resorted to cognitive strategies like keeping herself calm in order to properly appraise the situation and find avenues for escape.

Burgess and Holmstrom (1978) identified four types of defense mechanisms used by rape survivors **after the attack.** These are explanation, minimization, suppression and dramatization. **Explanation** is providing some reason for the rape. It gives some understanding of the act and aids in returning some degree of control to the survivor. **Minimization** is comparing the trauma to their perception of rape, their current situation, to other

victims or to a prior experience. It reduces the anxiety to a smaller, more manageable context and it decreases the terrifying aspects and allows the person to think of it in tolerable amounts. **Suppression** is when a person tries to put the memory of the rape completely out of her mind through a conscious effort. It provides cognitive control over thoughts of the rape. **Dramatization** is repeatedly overexpressing the trauma and thereby dissipating it.

III. METHODOLOGY

This is a cross-sectional descriptive study of the profile of Filipino rape victims. It also seeks to identify their coping reactions before, during and after the assault.

Sampling

The study population consisted of all rape survivors seen at the UP-PGH Women's Desk with the chief complaint of rape. A total of 114 survivors were seen from January 1999 to December 2000. Data were gathered from the intake form recorded by either the nurse-on-duty at the women's desk or the social worker in charge of the case. In several instances, other emergency room physicians who managed the patient added to the data in the intake form. For the reactions and coping styles portion of the research involving the psychiatrist, only 30 survivors were available for an in-depth interview.

Data Collection

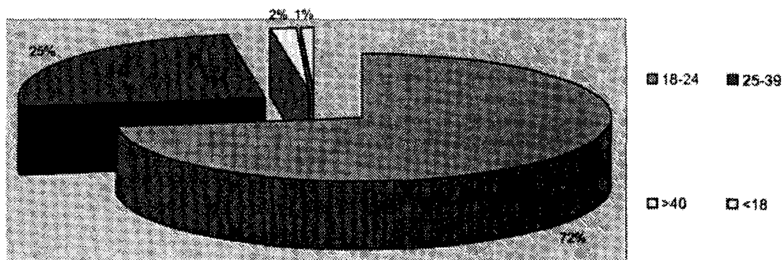
The survivors were initially interviewed by the social worker for the incident report and the socio-demographic data. They were then referred to the investigator for the interview. The survivor was made to relate the incident including her reactions

to the experience with the investigator asking open-ended questions from time to time. These questions pertained to the survivor's account of the different phases of the rape and her cognitive, behavioral, physical and emotional reactions. The questions did not follow any order but depended on the victim's account of the incident. The procedure was taped following consent from the survivor. Transcripts were available for eight survivors who consented while process notes were referred to for the rest of the survivors. Number of interviews averaged about three per survivor in the 30 cases studied for coping behavior.

IV. RESULTS

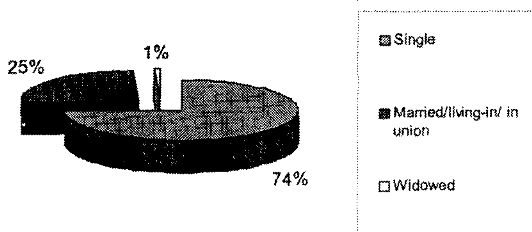
Table 1 (see appendix) shows the sociodemographic profile of rape survivors seen at the UP-PGH Women's Desk from 1999-2000. As shown in figure 3, 72% (82) belonged to the age group 18-24 years, 25% (28) belonged to the 25-39 years, 2% (3) belonged to the >40 years while 1% (1) was less than 18 years with the mean age of 21 years old. The women were from 18 to more than 50 years old.

Figure 3. Age of Rape Survivors
(Women's Desk, 1999-2000)



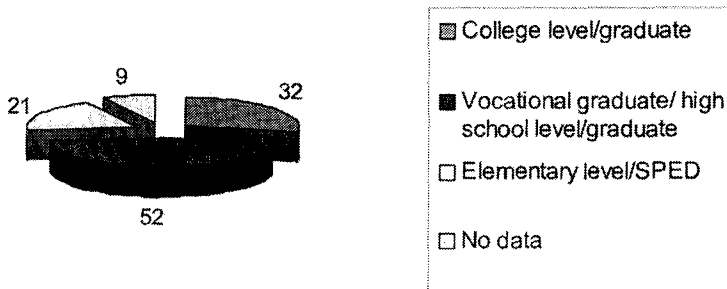
The distribution of Filipino rape survivors seen at the UP-PGH Women's Desk according to civil status revealed that 75% (85) were single, 24.5% (28) married/in-union and 0.5% (1) widowed (figure 4; figures are rounded off).

Figure 4. Civil Status of Rape Survivors (Women's Desk, 1999-2000)



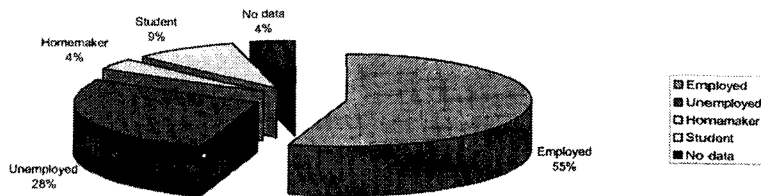
Based on the highest level of educational attainment, the survivors with vocational/high school level reached 46% (52), college level/graduates 28% (32), elementary level 18% (21) (figure 5).

Figure 5. Educational Attainment of Rape Survivors (Women's Desk 1999-2000)



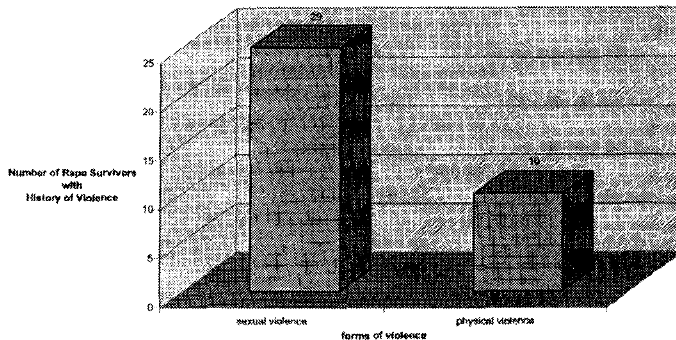
In terms of occupation 55% (63) were employed with a variety of occupations among which are domestic helper, waitress/ food server, assistant manager of a cosmetics franchise, KTV entertainer, and a student (figure 6).

Figure 6. Occupation of Rape Survivors (Women's Desk 1999-2000)



Considering that 56% do not have data on the history of violence, 34% (39) out of the 50 who disclosed, had a history of violence. Previous histories of violence include either sexual abuse by another perpetrator, incest, or physical abuse by another partner, or physical abuse as children (figure 7).

Figure 7. Thirty-nine out of the 114 Rape Survivors with History of Violence (Women's Desk 1999-2000)



Survivors with no physical injuries resulting from the rape incident numbered 80% (91) while only 20% (23) had injuries (figure 8).

Figure 8. Physical Injuries Resulting from the Abuse/Rape (Women's Desk, 1999-2000)

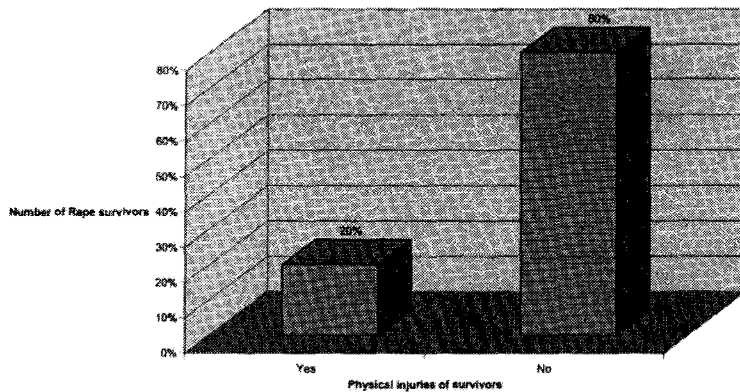
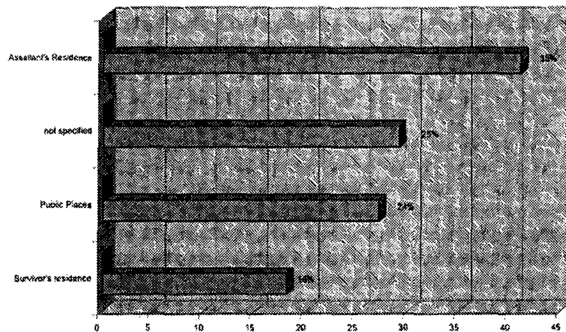


Table 2 (see appendix) shows the Circumstances of the rape as reported by the Filipino rape survivors seen at the UP-PGH Women's Desk from 1999-2000.

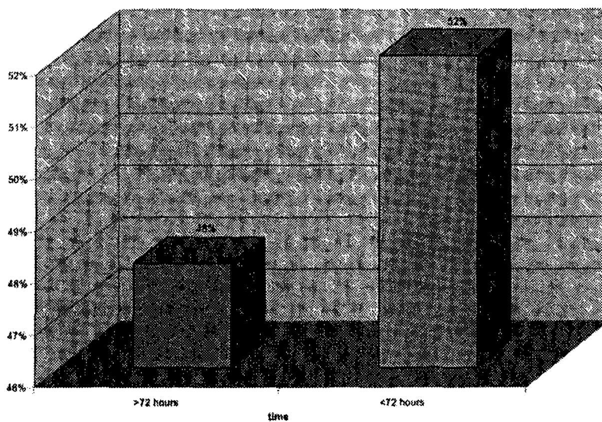
Based on place of occurrence, 35% (41) reported rape in the assailant's residence, 24% (27) reported having been raped in public places like parks, motel/hotel, public comfort rooms, while 16% (18) were raped in the survivor's residence. Unfortunately, 25% (28) have no data (figure 9).

Figure 9. Place of Occurrence of Rape



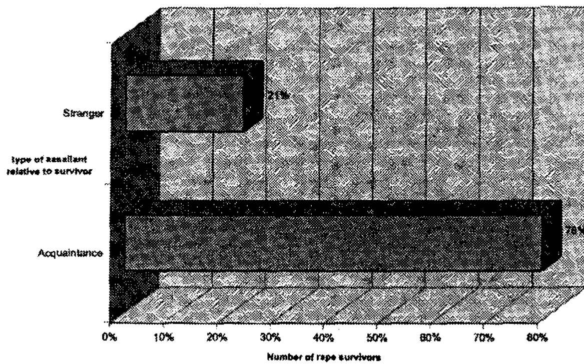
Based on the time of consult after the rape incident, 52% (59) were seen at the UP-PGH women's desk <72 hours after the rape while 48% (55) were seen after 72 hours (figure 10).

Figure 10. Period Up to Consult



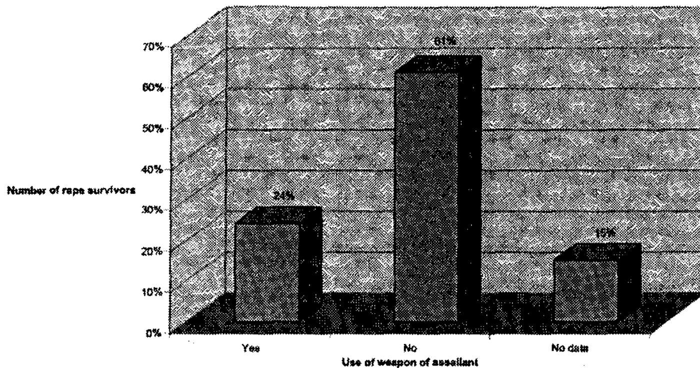
Seventy-eight percent (89) were raped by persons known to the victim (acquaintance rape, persons of authority, marital rape, incest) while 21% (24) were not known to the rape survivor (figure 11).

Figure 11. Type of Rape



Based on the presence or absence of weapons during the sexual assault, the majority (61% or 70 of the cases) used no weapon while 24% (27 of the cases) had a weapon, with no data in 15% (17) of the cases seen (figure 12).

Figure 12. Use of Weapon During the Rape (Women's Desk, 1999-2000)



Lastly, based on the number of assailants, 81% (92) reported one assailant while 14% (16) reported two or more assailants. Majority of the survivors in the in-depth interviews could not recall what they were doing before the rape. Among those who did remember, many felt a sense of danger, or "kutob", prior to the assault although many resorted to psychological mechanisms of coping rather than actively avoiding or escaping danger.

During the actual rape incident, passive reactions like "naghubad na rin ako dahil baka masaktan pa" , "sinabi ko na rin po na masarap dahil natakot ako" outnumbered the other behavioral or nonbehavioral responses including those who actively fought off the attacker.

After the rape, non-behavioral or psychologic reactions were used as coping by majority of the victims. These include physiologic responses like pain in different parts of the body and sleep disturbance, emotional reactions like self-pity, anger, suspiciousness, and the use of suppression.

V. DISCUSSION

The results of the study revealed that most of the Filipino rape survivors seen at the UP-PGH women's desk are in the age group 18-24 and 25-39; single, all of the women had some form of formal education and most are employed.

These findings are consistent with the WHO Report on Violence and Health 2001 in the following areas: young age, with some formal education, and employed.

The huge majority of the PGH cases were single. This may suggest the underreporting of marital rape due to lack of information regarding this type of rape, and perhaps the lesser stigma attached to single women reporting rape.

Based on the circumstances of the rape, most of the survivors reported rape **by one unarmed assailant known to the survivor in the assailant's residence or public places.**

Majority of the rape survivors interviewed were raped by people known to them and in familiar surroundings. The data confirms that there exists a higher danger of sexual assault in familiar surroundings and from persons with a relationship or at least familiar to the survivor. The findings are consistent with the WHO report that the greater majority of sexual violence occur in the home of the victim or abuser. The results of this study also confirm the Women's Crisis Center Report in 1998 that 7 out of 10 victims were raped by men known to them.

Physical injuries. This supports the argument that absence of signs of physical resistance such as physical injury does not rule out rape as was demonstrated by a study by Koss (Koss, 1988) of 8000 college students which showed that more than 75% of those raped by acquaintances did not sustain physical injury. Majority of the survivors seen did not sustain any physical injury as a result of the assault. Many of the assailants used no weapon to force themselves on their victims. The victims were coerced through psychological means by people they trust or at least they are familiar with. This belies the myth that rape happens to women who are bold enough to venture far from home or seek the company of strangers.

The study revealed that rape survivors reported a wide range of behavior at various stages of the rape. Some bit, kicked and punched their perpetrators while some resorted to prayers, passively cooperated or even blacked out in the face of such violence. This range of coping behavior were similar to those of Filipino disaster victims as reported in the study by Ignacio

and Perlas in 1995. They found that spirituality, creativity, humor, passivity/dependency, anger and blaming of others, denial of the pain and the gravity of the situation were among the strategies used by Filipino victims of disaster to cope with their stressful situations.

Differences in the reactions and coping styles of the rape survivors at various stages of the assault were generally comparable to findings in foreign literature. Many of the patients seen were in the acute phase of recovery so that physiological reactions and emotional responses of fear, self-blame, anger, humiliation, embarrassment and revenge were observed.

Before the rape, and even up to the point when the threat of rape is at hand, no apparent measure to fight or flee from the assault was noted even though many of the survivors who had memories of events prior to the assault had subjective feelings of danger or "kutob".

During the attack, most prominent are the survivor's apparent passivity. This is a survival tactic as most victims assume that rape can be an exchange for life, or that rape can be an exchange for a good-faith guarantee against further physical harm, disfigurement or severe damage.

Many of the survivors suppressed or denied the reality of the incident. A significant number of them attributed their loss of memory to drugs which allegedly were placed in their drinks by the assailants. *"inalok sa akin, ininom ko naman po, hindi ko po akalain na meron pong pampatulog"; "may nilagay po siyang pampatulog para di ko maramdaman"; nakipaglaban po ako sa kanila pero pinainom po nila ako ng gamot".* This form of coping may be consistent with efforts of the survivor to ward off culpability of the attack or as a form of denial.

Cognitive strategies were noted to be used by survivors during and after the rape. Several studies confirm that victims have a

fundamental need to understand their abuse and to consciously find meaning in their experience (Nadelson, Burgess, Tulipat, 1976). There is considerable evidence that cognitive elaboration of sexual violence in itself facilitates recovery.

After the rape, physiologic and emotional reactions were more prominent. Among the emotional reactions, self-blame was highly notable. Ronnie Janoff-Bulman distinguished characterological and behavioral forms of self-blame in victims of sexual assault. In characterological self-blame, victims attribute the trauma to themselves, like seeing themselves as provoking the assault, as victim-types, or worthless persons. Behavioral self-blame ascribes blame to careless behaviors like not locking the door or accepting a ride from a stranger, etc.

In this study, self-blame was observed to be more characterological with the survivors describing themselves as "*walang lakas ng loob, walang nagawa, kasi nagtiwala ako*" pointing to themselves as part of the problem.

The importance of the families' reactions and opinions were highly valued by the survivors. Many wanted to consult their families in planning their subsequent actions; quite a number were worried about their parents' reactions following their rape.

Reactions and coping styles could not be correlated with age and civil status since most of the survivors interviewed were in the 18-24 age group and single. There was no note of differences in reaction and coping styles across occupations and educational attainment. Of those who were asked about previous history of abuse, a significant number of survivors had a prior history of abuse as compared to the general population. It is unfortunate that a sizeable number of the cases reviewed were not asked this information.

VI. CONCLUSION

1. Women are not safe even in a familiar environment

The study confirmed the higher frequency of rape by persons known to the victim as opposed to rape perpetrated by strangers. The rape frequently occurred in familiar places either in the assailant's or victim's home. This has therapeutic implications since assault by persons known to the victim or survivor provokes a strong sense of betrayal which makes for deeper psychological trauma (Wyatt and Newcomb, 1990).

2. Survivors do not always present signs of physical injuries

The medical certificate, unless it confirms the presence of physical injury, has no actual value as proof or evidence that rape did not occur. The study revealed that majority of rape survivors do not have physical injuries as a result of the rape. Most of the assailants were familiar to the survivors; most used no weapon but rather used psychological coercion to force themselves on the victim. Again approach to these kind of victims have to consider the findings that women who have been sexually coerced by physical rather than psychological force have fewer post-rape adjustment problems (Mynatt and Allgeier, 1990).

3. A rape survivor may be passive or compliant and exhibit a wide range of coping behavior

The study confirmed that a woman who is raped employs a wide range of coping behavior during the various stages of the attack. Before and up to the time of rape, a woman uses both verbal tactics and physical resistance as well as non-behavioral or psychological modes of coping like the denial or suppression

of danger. During the actual rape, a woman may actually fight off her attacker but majority may seem passively compliant. Non-behavioral modes of coping may also be employed. After the rape, a woman uses mostly non-behavioral modes of coping with predominantly physiologic and emotional reactions as well as use psychologic defenses like suppression and dramatization.

4. A woman who is raped may not actively fight off the assailant

The cases studied demonstrated that physical resistance is not the most common reaction of the victim in all stages of the attack. Passive resistance, verbal tactics and psychological defense mechanisms as earlier mentioned were the more common behavior during the rape while non-behavioral modes of coping was mostly employed after the rape.

5. Women are motivated to report the rape as soon as possible

In this study, women report to the authorities in the crucial period (<72 hours) when forensic evidence can be collected to aid in the apprehension and subsequent conviction of the perpetrator. Advocacy and education campaigns are effective in encouraging women to overcome shame and fear of public scandal as a result of reporting. This forbodes well for the success of forensic intervention necessary for the prosecution of cases.

6. Rape survivors may not have accurate, complete and consistent accounts of the incident

Most survivors have poor or very inaccurate recall of the series of events. Based on the experience of interviewing these women, and the observation that psychological mechanisms like

suppression, dramatization, denial and dissociation were employed, memories of the rape may not be recounted as accurately and consistency as we expect it to be. The phenomenon of "traumatic recall" must therefore be carefully considered before judging the testimony of a survivor as inconsistent and unreliable

POLICY IMPLICATIONS AND RECOMMENDATIONS

The study provided the psychological perspective which can be integrated into the multidimensional sociological and anthropological perspectives of rape.

The study also raises the need for a rape surveillance system in UP-PGH and other hospitals. It also provides opportunity to review the adequacy of data gathering practices in the hospital and the development of a precise intake form at the UP-PGH Women's Desk. The exercise emphasizes the critical importance of a quality intake form and skilled personnel handling the interview. It also raises the need to provide and sustain psychological support for victims who seek justice in the courts. It raises the need for gender-sensitivity training among judges and lawyers as well.

The study raises the need for sexuality education and skills training in the recognition of danger/prevention of rape among students.

RESEARCH IMPLICATIONS

Further studies are recommended on the following concerns and issues:

1. Profile of rape victims who report vs. those who do not report to authorities

2. Outcome of survivors who report
3. Convictions and acquittals
4. Adaptive vs maladaptive strategies
5. Establish risk and prognostic factors

RECOMMENDATIONS

1. Educate women, including young girls, towards prevention, self-defense and the recognition of danger;
2. Educate the judiciary, police and other institutions concerned with sexually abused women regarding the facts and myths about rape;
3. Educate the police, medical and other health professionals on the importance and proper collection of forensic evidence;
4. Improve the system of evidence collection in the UP-PGH Women's Desk;
5. Train medical and other health professionals on proper documentation of medico-legal cases.

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APPENDICES

Table 1. **Distribution of Filipino Rape Survivors seen at the UP-PGH Women's Desk from 1999 -2000 according to socio-demographic profile.**

Characteristic	N=114	%
a. **Age**		
<18	1	1
18 – 24	82	72
25 – 39	28	25
>40	3	2
TOTAL	114	
b. **Civil Status**		
Single	85	75
Married/living-in/in union	28	24.5
Widowed	1	0.5
TOTAL	114	
c. **Highest Educational attainment**		
College level/graduate	32	28
Vocational graduate/high school level/graduate	52	45
Elementary level/SPED	21	18
No data	9	
TOTAL	11	
d. **Employment**		
Employed	63	55
Unemployed	32	28
Homemaker	4	4
Student	10	9
No data	5	4
TOTAL	114	
e. **History of Violence**		
Yes	39 (29 sexual violence; 10 physical violence)	34
No	11	20
No data	64	56

(Continuation table 1)

f. **Physical injuries resulting from the abuse**		
Yes	23	20
No	91	80
TOTAL	114	

Table 2. Distribution of Filipino Rape survivors according to reported Circumstances of the Rape

a. **Place of Occurrence**	N	%
Survivor's residence	18	16
Assailant's residence	40	35
Public places	27	29
No data	29	25
TOTAL	114	
b. **Period up to consult**		
Within 72H	59	52
>72 h – 2 weeks	55	48
Type of assailant		
Known	89	78
Unknown	24	21
No data	1	1
TOTAL	114	
d. **Use of Weapon**		
Yes	27	24
No	70	61
No data	17	15
TOTAL	114	
e. **Number of Assailants**		
1	92	81
2 OR MORE	16	14
No data	6	5
TOTAL	114	

Table 3: Coping mechanisms used DURING THE ATTACK

BEHAVIORAL REACTIONS	PSYCHOLOGICAL/MENTAL REACTIONS
Actively Fought off the attacker Sumisigaw ako Tinulak ko siya Pilit kong ibinalik ang damit ko Lumaban ako Sinipa ko siya **Pleaded with the rapist** Paulit-ulit kong sinasabi na "ayoko po, ayoko po" (2), Sinabi ko, Maawa na kayo Idinahilan ko na pagod na ako Sinabi ko," Kuya baka magalit si ate" Sinabi ko, "Amo kita katulong lang ako ditto" **Sinabi ko patayin mo na lang ako**	**Explanation** Iniisip kong wala naman akong kasalanan sa kanya" Iniisip kong kung may pamilya siya ba't niya ginagawa sa akin ito" Iniisip ko anong dahilan ba't tinali pa ako "wala na po akong maggawa" (2) **Suppression** "wala akong naramdaman" (2) Hindi ko po alam kung anong nangyari (6)
Passive reactions Pumayag na lang po ako kasi nag-iisa lang ako" naghubad na rin ako dahil baka masaktan pa" (2) initially resisting but later cooperating to avoid further violence (3) sinabi ko na rin po na masarap dahil natakot ako Hindi ako makagalaw Hindi makasigaw Nakatulog ako (3) "hindi na po ako lumaban dahil malakas siya" "nararamdaman ko pero di ako makagalaw" "umiyak na lang ako" (4)	**Emotional** Takot na takot ako Iniisip kong wala man lang tumulong
	Planned possible strategies Naisip kong umalis Naisip kong magsumbong.

Table 4. Coping mechanisms used AFTER THE ATTACK

BEHAVIORAL REACTIONS	PSYCHOLOGICAL/ MENTAL REACTIONS
Utilizing social support. pag-usapan ng pamilya kung ano ang gagawin (3) sineguro na palaging may kasama *(Continuation table 4)* **Actively fought-off the attacker** Tumakbo (3) nakipaglaban ako	MINIMIZATION "bahala na" **Planned possible strategies** Iniisip ko paano akong makatakas
Submissive reactions Sinabi ko, "Hindi na lang ako magsusumbong" nagsasaya na lang naligo ako umiiyak (2) gabi na bakit mo ako pauuwiin sumama pa ako sa kanya kinabukasan hindi makatayo dahil natutumba hindi makapagsalita Suicidal/homicidal ideation naiisip magpakamatay (2) nagwala gusto ko siyang patayin pagbayaran po nila yung paninira sa buhay ko gusto kong maramdaman niya yung takot at kaba na ginawa niya sa akin	EXPLANATION Iniisip ko na wala naman na akong magawa naisip ko bakit nila ginawa sa akin ito ano bang ginawa kong kasalanan hindi akalain na mangyari sa akin ito "alam ko galing ako sa ganong klaseng trabaho (referring to her job as KTV entertainer), wala po akong lakas ng loob wala po akong nagawa kasi nagtiwala ako sa kanya sumama pa kasi ako
VERBAL TACTICS Sinabi ko, "tama na" Sabi ko dapat bitayin ka Sinabi ko na hahanapin na ako ng kapatid ko	DRAMATIZATION laging naaalala ang nangyari (2) naaalala pagpumikit ng mata guni-guni na hinahawakan nila ako hinuhibaan naaalala ang pangyayai tuwing naliligo, naghuhubad parang nakikita uli ang pangyayari (2) madalas bumabalik sa isipan takot akong matulog dahil nakikita ko ang mukha niya (2) iniisip ko palagi ang ginawa niya

(Continued table 4)

	SUPPRESSION "natutulala" (7) blangko ang isip langu-lango ang utak hindi alam kung anong gagawin hindi matanggap ang nangyari di makaya ang problema nalilito Nawalan ng malay gulong-gulo and isip ko naguguluhan (3) di alam kung anong nangyayari sa akin hindi ko maalala binale-wala ko, pumasok pa ako sa trabaho (3) parang walang nangyari sa akin ayokong ipaalam sa mga magulang ko (2)
	Emotional feeling a sense of defilement (5) "binaboy" "namamaliit", "nadidiri ako sa sarili" hindi po ako makatingin sa kanya ng deretso nahihiya po ako depressed feeling (6) naiiyak, nahihirapan ako, nalulungkot (4) pain masakit fear/horror (4)
	natatakot ako dahil baka maulit pa natatakot na baka masaktan uli kinakabahan nanginiginig anger (4) specifically towards the rapist (3) palaging galit ako

(Continued table 4)

	self-blame (2) bakit di ako nakatakas akala ko mabait siya helplessness (4) wala akong mapuntakah walang matatakbuhan wala kong kalaban-laban walang pag-asa sense of being different felt suspicious of people (2) wala na akong tiwala parang inaabangan nila ako self-pity (2) awang-awa ako sa sarili naaawa ako sa sarili ko
	Physiologic responses Sleep disturbance Insomnia (5) nagigising ng madaling araw madaling magulat Physical pain/somatic complaints (15) Masakit ang katawan ko (3) Masakit ang puson ko (3) masakit ang balakang (2) Hindi makaihi May kumikirot sa ibaba (2) Nag-iba ang menstruation ko, hindi na tuloy-tuloy nanghihina (2) walang ganang kumain