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Developing a Logotherapeutic Model for understanding Victims of Sexual Assault

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Presently, there is no available logotherapeutic model for understanding the experiences of persons in crises, specifically the victims of sexual assault in Nigeria. The paper first reviewed the literature on some of the available models: equilibrium, cognitive and psychosocial transition. The author has added the existential/logotherapeutic model to literature and based on this model subsequently developed a technique in order to better identify the condition of victims of sexual assault to quickly pave the way for suitable therapy. The paper concluded that when compared with other models, the logotherapeutic model is effective for better understanding and as an intervention strategy in practice for logotherapists and non-logotherapists.

Key Words: Logotherapy, logotherapeutic model, victims, sexual assault

Generally crisis is defined by many authors in different ways but the definition by Caplan, a pioneer in the field of preventive psychiatry, would be considered in this paper: *"Crisis is not an illness. Instead, it can be defined as a time limited period of psychological disequilibrium which is precipitated by a sudden and significant change in an individual's environment. The change demands an internal and external adjustment and expression. During the adjustment, the person is often rendered incapable of self- mobilization"* (Caplan, 1964).

Sexual assault can therefore be viewed as a situational crisis that reflects the above definition. The person in such a crisis is overwhelmingly experiencing a terrible condition and finds it difficult to utilize his present resources and normal coping mechanisms. This is the reason why some scholars such as Aguilera and Messiik (1982), viewed crisis as encompassing both negative and positive situations. From the negative side, it can lead not only to terrible disease but also to homicide and suicide. On the positive side, crisis can be viewed as an opportunity because the pain or the suffering that it produces could make the individuals seek help. In this view, Brummer (1985) made it clear that when individuals use the opportunity to look for help that they would be able to *"plant the seed of self-growth and self-realization"*, while James and Gilliland (2005) posited that the reaction to crisis can be in three different ways:

1. The ideal case, in which people are able to cope superbly well with crisis themselves and they gather all available resources and coping mechanism with some experience. They bounce back to their normal self by coming out with more strength and become more confident than before the crisis. This occurs in most cases.
2. Some individuals use the available resources and coping mechanisms and survive the crisis by repressing it from their awareness. The crisis however comes back to haunt them at some point in and sometimes lasts throughout their lifetime.
3. Some others might use all the available resources and coping mechanisms to no avail. They plunge further into deeper crisis unless there is an effective intervention. Such an individual could suffer from a serious illness, suicide or homicide.

It is for persons experiencing a crisis situation due to sexual assault that are stuck in the last two situations that effective interventions must be provided. The question now is: "what is effective intervention?" James and Gilliland (2005)

Leitner (1974) and Belkin (1984) gave three intervention models which lay the foundation work for most crisis interventions strategies and methodologies. They are as follows: The Equilibrium model, (2) Cognitive Model (3) Psychosocial Transition Model. Asagba (2013) added the Existential/Logotherapeutic model to these three models, making four crisis interventional models.

The Equilibrium Model

The Equilibrium Model is based on the homeostatic sttes theory. An individual is in a normal condition or "state of equilibrium" when their emotions are well-balanced. As a result, the person is known to be psychologically or emotionally healthy. The other side of the coin is the "disequilibrium state", when the person is not psychologically or emotionally balanced and not in a good mental health state. As a result, all his or her available resources as well as coping mechanisms are no longer effective. The individual in this state is not in control, because he or she is disoriented and confused and would not be able to make the right choices at this level. It is believed by many clinicians or counselors/therapists that there is no amount of therapy or counseling that would work when the client is in the state of disequilibrium. The person must be physiologically and psychologically or emotionally balanced and stable for progress to be made in counseling seesions. This is the reason many scholars such as Caplan (1961) Lindenann (1944) and Leitner (1974) believed the equilibrium model to be the best model to be used during the early part of any crisis intervention.

In many literature reviews, it has been found that the equilibrium model is useful because evidence derived from many studies show that an array of emotional reactions were exhibited by many patients after the sexual assault. For instance, Burgess and Holmstrom (1973) and (1974) published their findings from their work with 92 women and 37 children during emergency calls made during the period. They described response patterns *as "Rape Trauma Syndrome" and found "the post-rage responses" to be "two stages, an acute, disorganization phase with behavioral, somatic and psychological manifestations, and a long-term reorganization phase in which there may be considerable individual variation, depending on ego strengths, social networks, and specific experience of the victim, especially those whom she must deal with after the rape. In the immediate or acute phase, the victim's emotion may be expressed (as in crying, sobbing, or displaying shock, disbelief anger, fear anxiety and expressing guilt and self blame) or may be controlled (composed or subdued demeanor, suggesting that the victim wants to stay in control or quickly reestablish normality)"*

Furthermore, Burgess and Holmstrom (1974) "*noted the physical reactions victims reported during the acute phase (physical pain in the area that received the brunt of the assailant's force, sleep disturbances, loss of appetite, stomach pains, nausea and those that persisted (like some gynecological and menstrual problem, aches and pains, sleep pattern disturbances)".*

According to the AVID`S Manual, (2012) the above findings were used throughout the century by both practitioners and policy makers in USA. In fact, the American Psychological Association recognizes the Rape Trauma Response known as RR-PTSD (Rape Related Post Traumatic Stress Disorder and this has been discussed in the Diagnostic and Statistical Manual (DSM IV). In other words, the survivors of rape are found to be at the highest risk of developing PSTD. Recently many scholars such as such as Leiner ,Jackson, Kearns, Astin and Rothbaum (2012) have been using the term "RR-PSTD" to describe rape response in their respective works.

The Cognitive Model

The cognitive model of crisis intervention came into being from the cognitive theory. The person in crisis is said to engage in unrealistic thinking. This kind of thinking could be due to the internal or external events that surround the person in crisis. The focus of the cognitive model is to change these unrealistic views to realistic views, using different techniques including disputing their thinking. At the end of

therapy, the client is now able to *"rationally think"* about the event or situation which was formerly considered to be negative and made them feel hopeless and sick. The client has to practice most of the techniques used in cognitive therapy.

It is generally believed that a person in crisis has to be stabilized first before the cognitive model would be most effective. When the patient in crisis is confused or disoriented, there is no need to start therapy because they would not be able to follow the instructions from the various techniques of the model.

The Psychosocial Transition Model

The Psychosocial Transition Model is based on the social learning theory, which is based on the interaction between a person's own genetic make-up and the environment that one is born into. The focus of the psychosocial transition model therefore, is to look for both the internal and external factors that are causing the crisis, in order to assist the individual to get rid of the crisis in an effective way. This is done by using both internal and external environmental coping resources such as social support (either building upon old coping mechanism or making new ones with the client) and other environmental resources that would be more suitable for the person in crisis in order to control their lives more effectively.

The psychosocial model goes beyond the person in crisis by not focusing on only the internal but also on the external factors. These external factors could include the individuals around him or her such as significant others, family, peers, jobs, religions or people in the neighborhood where the person resides. All these need to be taken into cognizance in the therapy, as they can either help promote the recovery process or hinder it. The psychosocial transaction model does not only deal with individual but with all the systems that surround the person in crisis.

As in the cognitive model, the psychosocial transition model can only be effective after the person has come out of the state of disequilibrium state.

The Existential/ Logotherapeutic Model

The existential/Logotherapeutic model is based on the existential/logotherapeutic theory, which is about the totality of the person in crisis. It is believed that the person in crisis, for example, a victim of sexual assault might not be able to actualize his or her meaning potential, and thus plunge into an unhealthy physiological and psychological state. In this state however, the spiritual dimension remains intact, in spite of the fact that they may not see much meaning in life and lack purposeful direction because of the existential vacuum they are experiencing. The existential/logotherapeutic model, therefore is not only aware of the person's physiological and psychological aspects, but also deals with the spiritual dimension (neotic dimension).

In contrast to both the cognitive and psychosocial transition models, which have to be applied after the person in crisis might have been stabilized or reached the equilibrium state, the existential/logotherapeutic model can be used regardless of the state. It is useful both in states of "disequilibrium" and "equilibrium". The techniques of the existential/ logotherapeutic model can also help to speed up the patient's healing process to normal and even beyond the state of pre-crisis.

The existential/ logotherapeutic model believes that man's physiological, psychological and spiritual dimensions are interwoven and cannot be separated. While the homeostatic theory is tenable with two dimensions (physiological and psychological) it is not tenable with the spiritual dimension, where there is always tension between what man is at present and what he or she is going to become. Frankl, the father of Logotherapy, termed this *"Noodynamics" [within individuals either unhealthy or healthy]* [Frankl (2006) and Lukas (1986).

Two important aspects of the existential/logotherapeutic model are identifed: (1) It can be used as an adjunct to the equilibrium model, whose goal is to stabilize the patient. (2) Logohints or logohooks or logotherapy techniques can help to bring the person in crisis back on track and even make them function better

than their pre-crisis state. In addition to the general goal of crisis intervention, which is to bring the patient to pre-crisis state only (termed "the new normal"), logotherapy also aims to "empower the client to attain a higher level of functioning". For instance, one can use Long's (1997) seven stages of Logotherapeutic transcendence in crisis intervention [see the sketch in the appendix]. His sketch illustrates through the stages, just how the existential/logotherapeutic model operates.

From this sketch, Long believed that stage one shows the zigzag of a normal life that is stable, but sometimes up and sometimes down, varying from one individual to another one. According to Long the zigzag lines also indicate "the fact that most people leave untapped their "meanings of the moment*" and "meanings universal (i.e. values)". It could be recalled here that the distance learning* course`s materials that Frankl(1997) Fabry (1994) and Guttman 1996 discussed on 'noetic unconscious which house the "voice of meaning" and "the noetic dimension is the *"medicine chest that contain the resources of the spirit:- our will to meaning, our goals and purposes in life; our creativity; our love (beyond the physical; conscious (beyond the superego); our sense of humor; our commitment to tasks; our ideas and ideas; our imagination; our responsibility and response-ability; our self-awareness; our compassion and forgiveness; our awareness of mortality"* (p. 5). All these are what are considered unconscious and remain to be tapped by the person in stage one.

Stage two is *"the onset of the crisis"*, where the patient is disoriented and confused and in a stage of disequilibrium from the physiological and psychological aspects but his spirit is not in disequilibrium. The individual does not utilize his "defiant power of the human spirit" and Long (1997) indicated that the *"typical symptoms include nihilistic thinking, increasing emotional or proximal isolation from others, sleep disturbance, deterioration of personal hygiene, change in eating habits and substance abuse to "numb" the pain. A powerful sense of worthlessness and suicidal ideation often begins or is exacerbated. It vicious cycle emerges- hopelessness leads to fear, which increases the hopelessness which becomes clinical depression". (p. 78)*

Stage three occurs when the person goes further down into crisis. It is noted that this stage is where suicidal intention can be put into action if care is not taken. This occurs because the person thinks that suicide is the only option available for him or her

In stage four, the person in crisis moves to "bottoming out". The person is unable to make meaningful choices because he or she cannot connect to or activate *"the defiant power of human spirit" to be able to identify available meaningful choices.*

Stage five occurs in the line of the sketch when the patient is no longer suicidal but still needs further empowerment with logotherapy techniques in order to make use of his "defiant power of human spirit". The totality of the patient must be taken into consideration.

In stage six, the patient is back into the pre-crisis state. The empowerment is mostly based on preventive skills to disable future occurrences and the ability to use his or her *"defiant power of human spirit"* to continue to improve upon the quality of life.

Stage seven moves beyond the pre-crisis state and is termed *"transcending the trauma"* Long, [1997]). The goal here is a lifelong one that goes beyond pre-crisis. *"The client becomes increasingly independent and resourceful. This result in better managing daily life and living a more self- transcend lifestyle. Their quality of life is enhanced, relationships improve, attitudes change for the better, behavior exudes optimism, energy level skyrockets and giving of self to others and to causes is manifest. The client may truly achieve essence as a human being".* P80

Conclusion

It can be concluded that the goal of therapy during logotherapy intervention is to eliminate or reduce the client's symptoms of existential vacuum and frustration by allowing him or her to make meaningful choices by activating his or her "defiant powered human spirit". Therefore, the focus of treatment is based on here and now, and therapy does not only restore his or her

level of functioning to the pre-crisis (like other therapies aim to do), but also to the higher functioning throughout his life. The roles of the logotherapist are both participant observer and active participant with Socratic dialogue as a way of communication. This makes logotherapeutic model to be viewed as an effective model not only to understand sexual assault but to be used as an intervention strategies in practice by both logotherapists and non-logotherapists.

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