Rape Trauma Syndrome

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ABSTRACT

The relationship of rape trauma syndrome to the official diagnostic nomenclature of Post-Traumatic Stress Disorder in the DSM-III is extensively discussed. The theoretical and practical clinical issues involved in rape trauma are reviewed as well as the early court rulings on the admissibility of rape trauma syndrome in criminal and civil cases.

Rape affects the lives of thousands of people each year. The FBI Uniform Crime Reports indicate over a 100% increase in reported forcible rape cases between 1970 (over 37,000 cases) and 1979 (over 75,000 cases). To truly grasp the enormity of the problem, those figures must be doubled since it is estimated that 50% of violent crimes go unreported (President's Task Force on Victims of Crime, 1982) and criminal victimization surveys estimate between 40-50% of forcible rapes are not reported (LEAA, 1975).

The legal definition of rape varies from state to state; however, the issues generally addressed include lack of consent, force or threat of force, and sexual penetration. The clinical definition of rape trauma—the focus of this paper — is the stress response pattern of the victim following forced, nonconsenting sexual activity. This rape trauma syndrome of somatic, cognitive, psychological, and behavioral symptoms is an active stress reaction to a life-threatening situation.

Parallel with the increase in rape reporting has been the positive institutional response to rape victims through the establishment of sex crime units by law enforcement agencies, victim advocates in rape crisis centers, victim specialists in prosecutor's offices and victim counselors in emergency departments of general hospitals. Rape rehabilitation services are also being covered by some

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insurance companies under its workers' compensation policies, thus placing a value on early intervention to expediate emotional and physical recovery of victims and assist in return to work.

Recognition of rape as a significant trauma and life event capable of disrupting normal life patterns is clearly being addressed by clinicians in the treatment setting. Concurrently, the admissibility of expert testimony on rape trauma syndrome is being tested both in criminal and civil litigation cases. This paper describes rape trauma syndrome within the new category of Post-Traumatic Stress Disorder of the DSM-III (American Psychiatric Association, 1980) acute, chronic and delayed. Also, this paper discusses the use of rape trauma syndrome in court.

STRESS RESPONSE PATTERNS

The human purpose of achieving a stable yet evolving state of existence has been a topic of interest in the professional literature since the mid-nineteenth century (Engel, 1953). Long before the concept of stress was formulated, Bernard (1945), a French physiologist, stated that the internal environment of all organisms must remain fairly constant despite changes in the external environment. Fifty years later Cannon(1932), an American physiologist, wrote that the coordinated physiological processes might be called equilibria, although he favored the term homeostasis. Laboratory research on the physiological mechanisms of adaptation to the stresses of life was initiated in Canada by Selye in the 1930s and the general adaptation syndrome proposed by Selye states that the biophysiological process of adaptation to stressful situations develops in three stages: first, the alarm reaction which includes initial responses of surprise and anxiety and beginning mobilization of defenses, both physiological and psychological; second, the stage of resistance in which all bodily resources are used to combat the problem; and third, the stage of exhaustion when all bodily resources have been depleted.

The psychological parallel to Selye's physiological model of stress response has been proposed by Horowtiz (1976). This model draws on the early observations of Breuer and Freud (1895) in their study of hysterical neuroses, traumatic neuroses (Fenichel, 1945), subsequent psychoanalytic studies summarized by Furst (1967), and clinical field studies of concentration camp survivors (Krystal, 1969; Niederland, 1968). Essentially two main components of stress response are summarized as: (1) an intrusive repetitive tendency, and (2) a denial-numbing tendency. The persistence of the emotionally distressing trauma related to thoughts, according to Horowitz (1976), indicates that the event has been incompletely processed cognitively and thereby remains in active memory storage as a potential influence of behavior.

In another model of human response to severe stress, Symonds (1975) describes four phases of response in victims of violence in which Phases I and II occur during the victimization and III and IV occur in the post-trauma phase. Phase I includes reactions of shock, disbelief, and denial to the occur-

ing event with temporary paralysis of action and denial of sensory impression. Phase II, or when denial is overwhelmed by reality, is termed "frozen fright" and includes terror-induced, pseudo-calm, detached behavior. In Phase III, after the criminal departs, the victim experiences circular bouts of apathy, resignation, anger, resentment, rage, insomnia, startle reactions, and a replay of the traumatic event through dreams and nightmares. The fourth phase includes restoration and resolution and integration of the experience into the victim's behavior and lifestyle.

PATTERNS OF VICTIM RESPONSE TO RAPE

Rape, until the 1970s, thrived on prudery, misunderstanding and silence. It is only in this past decade that the academic and scientific publications have multiplied on the topic. According to Chappell, Geis, and Fogarty (1974) studies performed prior to 1969 focused on the concern that individuals accused of rape should be protected and studies since 1969 have focused largely on protection and help for the victim. Midlarsky's (1977) review of articles on the psychological effects of rape, and intervention for rape victims in the post-traumatic period, located 78 references between 1965 and1976, with 36 on the effects of rape and 42 on intervention.

The early 1970s materials on victims were anecdotal in nature, written primarily by feminists and carried common themes: the sense of personal outrage over intimate violation; a lack of clarity concerning how to characterize the event even to oneself, and even how to characterize oneself following the event; the felt ineptness of systems that treat victims; the lack of consistent guidelines about the benefits of pursuing legal channels; and the lack of understanding of why the rape occurred and who the perpetrator was (Midlarsky, 1980).

In the 1970s, several publications appeared in the psychiatric literature presenting a marked departure from the traditional view of rape as victim-provoked. Rather than discussing rape so exclusively in terms of intrapsychic concepts, the contemporary view began to portray rape as an event imposed upon the victim from the outside: that is, as an external event. Sutherland and Scherl (1970), early workers in rape counseling, observed a three-phase syndrome of reaction to rape by 13 white psychiatrically healthy young women, ages 18-24, whom they treated in a public health crisis service. They defined the immediate reaction as an acute phase, characterized by shock and disbelief followed by or alternating with fear and anxiety. The second phase, called "pseudo-adjustment," included such coping mechanisms as denial, suppression of affect, and rationalization used to regain equilibrium. The victim resumes normal activities, appears to be adjusting, and shows little interest in outside help. This reaction is believed to be a healthy response, however temporary and superficial it may be. The final phase, integration, often begins with the victim's feeling depressed and wanting to talk. A specific incident may trigger this phase—pregnancy, a court summons, seeing a man who looks like

the assailant, flashbacks. During this phase, the victim must face and resolve feelings about herself and her assailant. Self-blame and a sense of defilement are common. Anger turned toward the assailant may be felt for the first time or be turned inward, intensifying the depression characteristic of early integration. Sutherland and Scherl (1970) observed that fear, anxiety and depression are within normal limits if reactive, time-limited and nonpsychotic.

Werner (1972) describes a psychotherapy case where the therapeutic process was interrupted by a rape. The patient, a graduate student in her twenties, was in the second year of therapy when the attack occurred. The situation was verified by witnesses and the police quickly caught the assailants. Werner conceptualized the attack as an external stress. He spoke of the subsequent therapy material as resulting from an "actual tragedy rather than a fantasy." He emphasized how the rape interrupted the therapy in several ways: (1) the pace and content changed in that it was no longer a leisurely exploration of relationships and fantasies; and (2) new symptoms of insomnia, appetite loss, frequent crying and fears of being alone gave a clinical picture suggestive of a severe grief reaction.

In a 1973 hospital-based study using a convenience sample of all (N = 146) persons admitted to the emergency department with the complaint of rape, Burgess, a psychiatric nurse, and Holmstrom, a sociologist, described three types of sexual victimization as: rape trauma syndrome, accessory-to-sex, and sex stress situations. They analyzed data from 109 child, adolescent and adult victims, ages 5-73, who had been subjected to forced sexual penetration. Discovering similarities in responses that seemed to qualify as a clinical entity, they termed this acute traumatic reaction the rape trauma syndrome, in which the nucleus of the anxiety was a subjective state of terror and overwhelming fear of being killed. Rape trauma triggers intrapsychic disequilibrium with a resultant crisis state for the victim.

The rape trauma syndrome (Burgess and Holmstrom, 1974) is divided into two phases which can disrupt the physical, psychological, social or sexual aspects of a victim's life. The acute or disruptive phase can last from days to weeks and is characterized by general stress response symptoms. During the second phase—the long-term process of reorganization—the victim has the recovery task of restoring order to his or her lifestyle and re-establishing a sense of control in the world. This phase is characterized by rape-related symptoms and can last from months to years.

RAPE-RELATED POST-TRAUMATIC STRESS DISORDER

The early conceptualizations of the stress response patterns of rape victims are consistent with the diagnostic criteria of Post-Traumatic Stress Disorder (PTSD) of the DSM-III within the major category of Anxiety Disorders. The four cardinal criteria will be discussed with documentation from clinical research data.

Stressor of Significant Magnitude

The primary feature of PTSD is that the stressor be of significant magnitude as to evoke distinguishable symptoms in almost everyone. PTSD is defined by symptoms which have a temporal and presumably causal relationship to a stressor beyond usual human experience (Ochburg and Fojtik-Stround, 1982). The stressor under review is rape.

The contemporary view of rape sees it as an act of violence expressing power, aggression, conquest, degradation, anger, hatred, and contempt (Bart, 1975; Brownmiller, 1975; Burgess and Holmstrom, 1974; Cohen et al., 1971; Davis, 1968; Gelles, 1977; Griffin, 1971; Metzger, 1976; Russell, 1975; Schwendinger and Schwendinger, 1974; Symonds, 1976). Bard and Ellison (1974) have emphasized the significance of the personal violation for the rape victim. Hilberman (1976) characterizes rape as the "ultimate violation of the self, short of homicide, with the invasion of one's inner and most private space, as well as loss of autonomy and contol." Hilberman argues that it is the person's self, not an orifice, that has been invaded and that the core meaning of rape is the same for a virgin, a housewife, a lesbian, and a prostitute.

Notman and Nadelson (1976) observe how a rape attack heightens a woman's sense of helplessness, intensifies conflicts about dependence and independence, generates self-criticism and guilt that devalue her as an individual, and interferes with partner relationships. Burgess and Holmstrom (1976) noted that for almost all victims, the rape was something far out of the ordinary that seriously taxed their adaptive resources.

Rape is an interactional process involving at least two persons. In assessing the magnitude of the stressor, it is important to understand the behavior of rapists (Symonds, 1976). Books have been written on psychosexual disorders starting in 1886 with Kraft-Ebing's *Psychopathia Sexualis* (1965), the psychology of sex (Ellis, 1942) and moving to the study of the sex offender (Karpman, 1954; Gebhard et al., 1965). Prior to 1970, the dominant view of offenders was derived from psychiatric theories which suggested, among others, that men raped because of mental illness (Leppman, 1941; Karpman, 1954), or because of uncontrollable urges (Karpman, 1954; Guttmacher and Weihofen, 1952) or because alcohol reduced their social constraints (Leppman, 1941; Guttmacher, 1951). Criminology theory has suggested the role of the victim in the offense of rape through the concepts of victim precipitation and victim participation (von Hentig, 1948; Mendelsohn, 1963; Wolfgang, 1966; Schafer, 1968; Amir, 1971).

Contemporary views of rapists, starting in the 1970s include the feminist perspective which views rape as serving the function of social control (Brownmiller, 1975; Griffin, 1971; Reynolds, 1974) and by keeping women in their place (Weis and Borges, 1973; Russell, 1975). The sociological perspective views rape as behavior learned socially through interactions with others (Scully and Marolla, 1982). The clinical perspective has classified the rapist by descriptive psychiatric categories (Rada, 1978) and by psychological motiva-

tion (Cohen et al, 1971; Groth, 1979). Of pragmatic assistance in assessing impact on victim has been rape conceptualized as a pseudosexual act and as an act of violence and power rather than primarily a sexual act. On the basis of clinical data on 133 convicted rapists and 92 adult victims, Groth, Burgess and Holmstrom (1978) viewed rape as complex and multidetermined and addressing issues of hostility (anger) and control (power) more than passion (sexuality). Subdivisions of these categories include the power-assertive rapist who perceives rape as a means of expressing his virility and dominance; the power reassurance rapist who uses the act of rape to resolve doubts about his sexual adequacy; the anger-retaliation rapist who seeks revenge by degrading and humiliating women; and the anger-excitation rapist who derives sexual excitement from inflicting pain and punishing his victim. In pair or group rape the motive of seeking male comraderie has been suggested (Holmstrom and Burgess, 1981) and the motive of a sense of entitlement to sexual services has been observed in data on father-daughter incest (Herman and Hirschman, 1981), wife rape (Russell, 1981) and date situations (Bart and O'Brien, forthcoming).

Analysis of the dynamics and method of operation of the rapist helps to explain what specific aspects have terrorized and/or victimized the person. Style of attack has been found to contain characteristics classified as *blitz*, where the victim is quickly subdued and propelled into the assault; *con,* where the victim is approached verbally and then betrayed and assaulted; or *surprise*, where the rapist waits and targets a victim or sneaks up on and surprises the victim (Burgess and Holstrom, 1974; Hazelwood, forthcoming). Other factors to assess include site of attack (safe vs. unsafe territory), degree of prior acquaintance between assailant and victim, amount of physical force and subsequent injury, method of control used by assailant, use of weapon, resistance by victim and assailant response, conversation and language used by the assailant, sexual demands and sexual dysfunction of the assailant.

Intrusive Imagery

The second major diagnostic criteria is re-experiencing of the trauma, which is most frequently evidenced by recurrent and intrusive recollection of the event ("It is the first thing I think of when I wake up in the morning"). Day images are common ("Something will trigger in my head and it all comes back"). The victim may feel as though the traumatic event was recurring ("I panicked at work when two people came into the store and acted suspicious"). Or the impact may be so intense that the victim will not report remembering anything initially ("I was in constant fear; crying...just had to be led around...the panic was unbelievable") and then be reminded constantly of the event. The victim may report seeing the assailant everywhere ("I see his face on every man") as well as searching him out ("I walk next to walls and look at every face and think: Is he the one?").

Dreams and Nightmares

Dreams and nightmares are common and very upsetting. Dreams include people chasing the victim and revictimizing the victim. Dreams may be of three types: (1) replication of the state of victimization and helplessness ("I use my mace and it turns to water"); (2) symbolic dreams which include a theme from the rape, as in one case in which a victim pleaded unsuccessfully her fear of pregnancy and had recurrent dreams of eggs pouring out of her and babies rolling down the hill and dying; and (3) mastery dreams in which the victim is powerful in assuming control ("I took the knife and stabbed him over and over"). Non-mastery dreams dominate until the victim is recovered. An illustration of the wide range of non-mastery dreams is provided from the dream material of three victims of the same assault. A father, mother and daughter, traveling on vacation, registered at a motel and were awakened around 1 a.m. by two armed men who broke into their room, bound the father and raped the mother and daughter. Nightmares averaged 4-5 times a week for the first year. The father's repetitive dream included faceless armed men chopping his wife and daughter into little bloody pieces. This dream would awaken the father with feelings of terror, cold and sweat. He would get up, take his gun, walk downstairs to his den, light cigarette after cigarette and sit guarding the door until morning. The mother's repetitive dream included her seeing the men chase her. She buys three guns but in her dream is unable to kill them. The daughter dreams of the men coming after her. She takes a gun, shoots at the men but is unsuccessful in killing them and they start chasing her. She starts running, gets to a tunnel which is all black inside and wakes up.

The third major diagnostic criteria is a numbing of responsiveness to or reduced involvement with the environment. Victims talk of being in a "state of shock," or "feeling numb," or state "it doesn't feel real." They say they can't believe it happened. Sometimes this phenomenon is observed through the demeanor of the victim as in an expressed style where the feelings the victim had were visible (e.g., anxiety, fear, shame, sobbing, relief, anger, paranoia) or a controlled style where the victim appeared calm and controlled externally. This latter style is more common reflecting denial, shock or exhaustion (Burgess and Holmstrom, 1974; Horowitz, 1976; Soules et al., 1978). This psychic numbing may be observed through the victim's reduced interests in former activities ("I used to enjoy sketching in the park but now am terrified of going out alone"). Victims will talk of previously taking long walks but now feel constrained in their activities; of feeling isolated and estranged from others ("Stay in my own little world by myself now"). Victims may be immobilized and refuse to venture out of their apartment except for work or, if attacked inside the home, may feel less anxious at work or outside. There may be constricted affect. People will comment on the sudden change in the victim's behavior, as one husband who said, "She used to be the spark plug in the family." Victims may become defensive and rigid in demeanor; may refuse to attend social functions; may stop work or school and withdraw from their

family ("I live by myself now and prefer that. I can retreat; I have my own loaded gun"). Victims talk of how easily one can become a victim ("He was in the door in seconds"). One 52-year-old woman became socially isolated from her friends, less patient with her grandchildren and found it exceedingly difficult to attend to the health needs of her elderly parents. The terror holds the affect of the victim ("I feel like a dead woman") and the behavior following the rape is in the service of survivial ("I sleep fully clothed so this time I can run out of the house if he comes back to get me").

Other Inclusion Criteria

The fourth criteria states that there be two of the following list of symptoms that were not present prior to the rape:

Exaggerated startle response or hyperalertness. Victims report feeling moody, irritable, experiencing crying spells, often when crying was not a common behavior. Victims report feeling paranoid ("I keep thinking I am being followed"); search their house before feeling safe; feel there are "eyes" everywhere; believe people can tell by looking that they have been raped. They may act on their hyperalertness ("I scream when I hear footsteps behind me"). Victims may change residence and telephone number in order to feel safe and anonymous.

Disturbance in sleep pattern. In the acute disruptive phase there can be a wide range of somatic complaints that frequently includes headaches as well as sleep pattern disturbance. Victims are either not able to fall asleep or fall asleep only to wake and not be able to return to sleep. Victims who have been suddenly awakened from their sleep by the assailant may find themselves waking each night at the same time the attack occurred. Partners of victims report that the victim may cry or scream out during sleep.

Guilt about surviving or behavior employed during the rape. Victims may express a self-blame reaction to the rape because of their socialization to the attitude of "blame the victim" (Ryan, 1971). Or victims may feel guilty about not reporting. In cases in which the same assailant rapes a second person, such as in the same work place or apartment complex, the first victim may feel guilty for not reporting initially. Or in cases in which a partner or parent is present, there may be guilt for not being able to prevent the rape of the partner or child.

Impairment of memory and/or power of concentration. The intrusive imagery, in part, is responsible for the victim's not being able to concentrate on school work (Schuker, 1979) or usual activities. Victims may have memory lapses ("I couldn't remember the names of my customers"); or have decreased energy levels ("I found doing the laundry was too exhausting"). Students have difficulty writing papers and examinations ("I failed my final tests").

Avoidance of activities that arouse recollection. Fears and phobias develop as a defensive reaction to the circumstances of the rape. Rado (1948), in describing war victims, used the term traumatophobia to define the phobic reaction to a traumatic situation. Some of the common phobic responses

noted in rape victims include: fears of indoors if the rape occurred inside; fears of outdoors if the rape occurred outside the home; fear of being alone ("I can't take a shower if my husband isn't home"); fear of crowds ("I panic when there are people around"); fear of elevators or stairs or people behind them ("I left my clothes in the dryer for four days because I was too scared to go to the cellar"). There are a wide variety of activities that can trigger a flashback ("My stomach gets into a big knot when anything reminds me of it"). Victims try to avoid memories by throwing out clothes they were wearing during the rape or the furniture from their room if attacked inside.

Increased symptoms to event that symbolize or resemble the event. One of the more common rape-related symptoms that resemble the rape occur when the victim is confronted with sexual activity. Many victims experienced disruption in the sexual life area and developed a wide range of symptoms including change in sexual frequency (abstention, decreased activity as well as increased); flashbacks to the rape; vaginismus; change in orgasmic response; and worries about partner reaction to the rape. Some women terminated primary relationships; there could be a change in gender preference for a sexual partner. Other symbolic events where linkage was noted between some idiosyncratic aspect of the rape included the following: difficulty swallowing, singing or speaking after forced oral sexual penetration; repetition of symptoms from a prior victimization following the second victimization; anniversary reaction due to the day or time of the month (e.g., full moon; during the victim's menstrual period; date of the month).

TREATMENT

The prototype of crisis responses is the acute grief reaction (Notman and Nadelson, 1976; Ochburg and Fojtik-Stroud, 1982; Parad, 1965; Rado, 1948; Tyhurst, 1951). Lindemann (1944) first described the grieving process after interviewing survivors and relatives of a community disaster involving fire. Response to loss was characterized by distorted, prolonged or delayed reactions.

Crisis Intervention

Crisis intervention is clearly the treatment of choice when a rape is disclosed immediately after it has occurred (Burgess and Holmstrom, 1974; Forman, 1980; Fox and Scherl, 1975; McCombie, 1980). The basic assumptions underlying this type of intervention include: (1) the rape represents a crisis in that the victim's style of life is disrupted; (2) the victim is regarded as "normal" or functioning adequately prior to the external stressor; (3) crisis intervention aims to return the victim to his or her previous level of functioning as quickly as possible. The crisis model is issue-oriented treatment designed to ameliorate the target symptom of anxiety, fear, depression, loss of control and decreased assertiveness. The most favorable prognosis for treatment of acute rape

trauma occurs if the victim is seen immediately following the rape; the speed of the intervention is crucial. The use of the term "crisis intervention" provides a non-threatening term that avoids labeling the treatment in psychiatric terms. Other crisis services to offer the victim include advocacy services, especially regarding legal matters, work with the victim's support system and victim mutual support groups.

Within the acute period, issues unique to the crisis need to be resolved and integrated or the victim will fail to return to a pre-crisis level of functioning. Rape work—the term used by Bassuk (1980)—refers to the content specific to rape which needs to be addressed. Three factors pathognomic of the crisis response to rape, and which comprise the rape work, include: (1) resolution of the threatened sense of safety in the world or confrontation with one's vulnerability and helplessness—one's potential victim status; (2) reworking of body image and body boundaries connected with self-esteem; and (3) confrontation with power relations between men and women. The aim of rape work is to regain a sense of safety and a valued sense of self and to re-establish sharing, altruistic, mutually satisfying partner relationships in a world where rape remains a threat to all women.

Treatment Models

The question of treatment models in general, as raised by Paul (1966), is not how should one best treat a patient, but which treatment model in the hands of which therapist is most appropriate for a particular type of patient as defined by a specific outcome measure. To apply this question to the rape victim, one needs to look at the assessment of efficacy of treatment. The clinician can assess whether the victim has come to terms psychologically and cognitively with the assault when there is evidence that the victim can both control the cognitions regarding the rape as to when they intrude into consciousness and discuss with equanimity the rape and its impact on his or her life. Concurrent with the cognitive integration of the rape and the victim's control over the pain, fear and memory of the event, there needs to be evidence of a return to pre-crisis level of functioning, most especially with primary relationships as well as work, family and social relationships. Working with the victim in therapy, the clinician can usually observe and evaluate the course of recovery, noting that victims follow their own pattern and proceed only with nonjudgmental support, concern and guidance. Several clinicians (Burgess and Holmstrom, 1978; Krupnick and Horowitz, 1979; Schuker, 1979) have observed that adaptive resolution of the trauma of rape can lead to a higher level of psychological functioning for the victim.

There are several treatment models available for treating the rape victim. Cognitive-behavioral models (Kilpatrick, Veronen and Resick, 1979) hypothesize that fear and anxiety responses are classically conditioned by a rape experience. Ochberg and Fojtik-Stroud propose a residential treatment setting for victims (1982). Cognitive restructuring (Hepper and Hepper, 1977) is espe-

cially useful in working on belief systems and thought patterns of victims. Sprung (1977) suggests some victims adjust by encapsulating the trauma into one area of functioning, enabling them to function adequately in others. Brief psychotherapy with hypnosis is described by Spiegel and Spiegel (1978). Other models include treating the family as a unit (Doyle and Dorlac, 1978; Ellis, 1978), and helping husbands and boyfriends of victims share the crisis of rape (Silverman, 1978). Ochberg and Spates (1981) argue for public programs and services.

It is not unusual for rape victims to resist seeking traditional psychotherapy model services provided by mental health staff. Very often victims will not seek psychiatric services for their symptoms. Of a total number of 135 referrals of victims of sexual assault, Krupnick and Horowitz (1980) saw only 10% at their clinic. Of the 13 victims seen, five did not complete therapy. It was suggested by Krupnick and Horowitz that those who did seek therapy did so because of intrusive imagery and symptomatology that were disruptive to life functioning. Soules et al. (1978) report that with vigorous rehabilitation programs, the percentage of victims seeking services can increase. The most common explanation for why victims do not seek psychological services is that, unless prior to the rape they have had psychotherapy, they are not inclined to define the rape as a psychological problem and perceive themselves as "normal" and not in need of psychiatric care. Midlarsky (1980) even warns that providing psychotherapy for rape victims may be a way of actually encouraging the internalization of blame and maintenance of a self-critical attitude.

Subtypes of Rape Trauma and Special Treatment Needs

The DSM-III lists three types of PTSD. The *acute disorder* may start immediately after the rape and continue with symptoms up to six months. Symptoms that last longer than the six month period may be aggravating other issues and concerns of the victim and a subtype of chronic post-traumatic stress disorder is usually diagnosed. A third category of delayed post-traumatic stress response is given to persons who suddenly exhibit symptoms either when there has been a quiescent period following the rape or when the rape has not been disclosed. These two additional subtypes have been discussed as compounded rape trauma and unresolved rape trauma.

Compounded reaction to rape trauma. There will be some victims who also have a history of past or current physical, psychiatric or social difficulties along with the acute rape trauma. This group may develop additional symptoms such as depression, psychotic behavior, psychosomatic disorders, suicidal behavior, and acting out behavior associated with alcoholism, drug use, and marked change in sexual activity. The victim needs to be referred back to a previous therapist or physician and negotiations initiated for treatment in addition to crisis intervention for the rape. Prognosis in such cases is guarded and contingent upon the amount of progress or regression that occurs specific to the aggravation of the previous psychiatric or social problems.

Unresolved sexual trauma. A delayed response to rape trauma, e.g., an unresolved sexual trauma, occurs in the victim who experienced the rape long before contact with the clinician. This victim has not told anyone of the rape, has not settled or integrated his or her thoughts, feelings or behaviors on the issue, and is carrying a tremendous psychological burden. Very often a second sexual trauma, crisis or flashback will reactivate the person's reaction to the prior experience. Psychotherapy is the treatment of choice. The following example illustrates one of the longest-kept sexual trauma secrets noted in the literature (Burgess and Holmstrom, 1979)—a secret kept for 50 years.

> A 72-year-old woman was being seen in a neighborhood health clinic for treatment of a terminal illness. The patient developed a therapeutic alliance with the medical resident of the clinic. During one conversation in which the woman talked of her feelings about dying, she revealed an early sexual trauma. She reported a situation in which she was returning home from school and four teenagers grabbed her, pushed her into the bushes and raped her. She went home crying as well as terrified and told her mother. The mother instructed the daughter to "get down on your knees and beg forgiveness." The woman never told another person about the trauma. She reported living a non-sexual lifestyle, never married and remained in the home until she was the last living member of the family.

When a diagnosis of unresolved sexual trauma is made, the person has three therapeutic tasks: (1) to talk of the previous assault in terms of the details, feelings, beliefs and thoughts; (2) to identify the reasons as to why the assault was never revealed; (3) to talk of the current traumatic situation in order to look at the similarities and differences. The prognosis for resolving an unresolved sexual trauma is favorable if the person is able to spend therapy sessions fully reviewing the experience and putting it into perspective with his or her current life situation.

Recovery

Longitudinal studies are beginning to address the process of recovery and the variables that exacerbate or reduce rape trauma. As noted by Ruch et al. (in press) rape trauma has been measured in diverse ways, including the nature of the stressor experienced by the victim, severity of the response, length of recovery time (Burgess and Holmstrom, 1978; Williams and Holmes, 1981), and adjustment problems (McCahill et al., 1979). Ruch and Chandler (1980) found a curvilinear relationship between life change and rape trauma—victims experiencing moderate life changes during the year before the assault reported less trauma than victims with severe changes or no changes. They suggest three patterns in trauma change responses to rape: (1) *crisis* response, where the most intense response is soon after the assault with a tendency toward decline in trauma level over time; (2) *steady-state* response, where there is a relatively even, stable level of trauma over an extended time; and (3) *delayed* response,

where the response level increases over time. Using a two week interval between initial interview and medical follow-up appointment for measurement of trauma change response, Ruch et al. (in press) suggest rape trauma is a complex phenomenon reflecting the impact of different variables at different points in time, but also that the prior stresses operating on the victim at the time of the assault (life change, earlier rapes, and mental health problems) have an important and independent effect on level of rape trauma and trauma change. In their study of 166 victims, prior rape was the most significant in explaining delayed trauma change. This factor of prior victimization along with low self-esteem, lack of social support, economic stress and prior mental health problems, were also found significant as variables affecting rate of recovery (Burgess and Holmstrom, 1978). Social adjustment and work adjustment issues were identified in Resick et al. (1981) in their controlled study of 93 victims.

RAPE TRAUMA SYNDROME AND THE COURT

Only a small minority of rape incidents result in criminal conviction of the offender. Rabkin (1979) using FBI figures notes that of every 100 reported cases, 51 arrests are made; 16 of those arrested are convicted of forcible rape and another 4 are convicted of lesser charges. Holmstrom and Burgess (1978) studied the outcome of the court process with their sample of 146 persons and found of the 109 rape cases reported to the police, only 24 made it sufficiently far through the criminal justice system to be tried or plea bargained.[1] The 18 tried cases resulted in 10 verdicts of not guilty (of any crime), one mistrial (hung jury), three convictions on lesser included charges and four convictions for rape, one for indecent assault and battery (a male child), and one for assault and battery. In one additional case, the grand jury did not return an indictment for rape and by mutual agreement the charges were simply placed on file. The conviction rate is even lower when one considers the issue of multiple assailants. Forty-three of the 115 rape victims in the Boston City Hospital sample were attacked by more than one person.

To prove rape in most jurisdictions in the United States, it is necessary to show that sexual intercourse occurred or was attempted, that the victim did not consent but submitted under force or imminent threat of force, and that the person charged is the assailant (Dworkin, 1966; LeGrand, 1973; Cobb and Schauer, 1977).

As concern is more visibly focused on the rights of the victim, legal reform is having an impact on improving the conviction rate for rapists (Borgida and White, 1978). One of the current tests in the courtroom pertains to the use of expert testimony on rape trauma syndrome. The admissibility of such expert testimony is being tested in several states and with varying outcomes. In two Minnesota cases it was ruled an error for an expert to testify concerning typical

1. A total of 24 victims had cases that led to a trial or plea bargain. One case with multiple assailants led to both a trial and a plea. Thus 18 cases were settled by trial and seven by plea.

post-rape symptoms while in Kansas a verdict was upheld stating it was permissible for expert testimony to be introduced. These three cases are briefly reviewed.

In *Minn* v. *Saldina*[2] the state presented an expert witness—the director of a victim assistance program—to rebut the defendant's claim that the sexual intercourse that occurred was consensual. The court examined each segment of the expert's testimony and on the factual question of whether the alleged criminal conduct occurred, ruled that the testimony was essentially an explanation of rape trauma syndrome, though not labeled as such, and "such testimony is of no help to the jury and produced an extreme danger of unfair prejudice." In another segment of testimony where the expert rendered an opinion as to whether the victim was raped, this testimony was ruled in error because as a legal conclusion it was of no use to the jury. A final segment of testimony, dealing with the opinion that the victim had not fantasized the rape, was ruled in error in that there were no unusual circumstances to the case to warrant admission of testimony concerning credibility of the victim and the credentials of the expert were not such that she could reach an opinion regarding whether a person was fantasizing or fabricating a story. In its decision, the court found one case that found no error in admitting similar evidence[3].

In *Minn.* v. *McGee*[4], the court followed the reasoning of *Minn.* v. *Saldina* as testimony sufficiently prejudicial as to require a new trial. Both cases were ruled on the same day. But one Justice, who took no part in *Saldina,* dissented, stating the testimony was properly admitted into evidence. The recently noted case by the Montana Supreme Court in *State* v. *Mackie*[5] was cited. The dissenting Justice wrote that the expert witness did not testify, as did the expert witness in *Saldina,* as to whether, in his opinion, the rape actually occurred. Rather, he discussed some of the complainant's psychological symptoms after the alleged rape and stated he found these symptoms to be consistent with rape trauma syndrome. Such evidence, noted the Justice, is probative on the issue of consent and thus helpful to the jury in resolving the conflicting facts of the case concerning that issue. The dissenting Justice continued to state that the probative value of expert testimony did not appear to be "substantially outweighed by the danger of unfair prejudice or to unwarranted reinforcement of complaintant's testimony and did not give a stamp of scientific legitimacy to the truth of complaintant's factual testimony concerning the rape."

The State of Kansas, in a 1982 decision, upheld the admission of expert testimony on rape trauma syndrome after the defendant raised the defense of consent in *State* v. *Marks*[6]. The State Supreme Court ruled: "The identification of rape trauma syndrome is a relatively new psychiatric development.

2. *Minn.* v. *Saldina,* August 31, 1982, 324 N.W. 2d 227
3. *State* v. *LeBrun,* 37 Or. App. 411, 414, 415, 587 P. 2d 1044, 1046, 1047 (1978) (no error in permitting "Rape Victim Advocate" to testify that victim's emotional state comported with that of most sexual abuse victims.)
4. *Minn.* v. *McGee,* 647 P. 2d 1292 (Kan. 1982)
5. *State* v. *Mackie,* 622 P. 2nd 673 (Mont. 1981)
6. *State* v. *Marks,* 647 P. 2nd 1292 (Il. at 1299)

Even so, if the presence of rape trauma syndrome is detectable and reliable as evidence that a forcible assault did take place, it is relevant when a defendant argues the victim consented to sexual intercourse. As such, an expert's opinion does not invade the province of the jury. It is merely offered as any other evidence, with the expert subject to cross-examination and the jury left to determine its weight." Reliability was there defined as "generally accepted as reliable within the expert's particular scientific field." The reviewing court cited several psychiatric treatises to support its ruling that the concept of rape trauma syndrome "is generally accepted to be a common reaction to sexual assault." The court found no hearsay problem, and it recognized the discretion accorded the trial judge to determine the admissibility of expert testimony.

Third Party Victims' Rights Litigation

The use of rape trauma syndrome in civil litigation cases is being used increasingly to testify as to psychological injuries of the rape. The theory underlying third party victims' rights litigation is that one of the reasons the criminal was able to commit a crime was that a third party negligently failed in some duty he owed the victim (Carrington, 1981). Most often negligence falls into an area of providing proper security on the premises, safe screening practices in hiring employees, and supervision of a criminal in non-incarcerated settings.

One of the well-publicized third party suits was a 2.5 million dollar suit awarded singer Connie Francis in damages against a Howard Johnson Motor Lodge in New York. The finding of liability was in the motel's neglecting to provide adequate security and room door locks. The emotional trauma was to the extent that the singer was unable to resume her singing career.

In reviewing 26 civil cases between 1979-1983 involving rape, 14 have been completed (Burgess, forthcoming). Six received jury awards ranging from $15,000 to $800,000. Of the eight settlements, three were settled after the trial began and five settled before the trial began with amounts from $37,000 to $300,000.

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