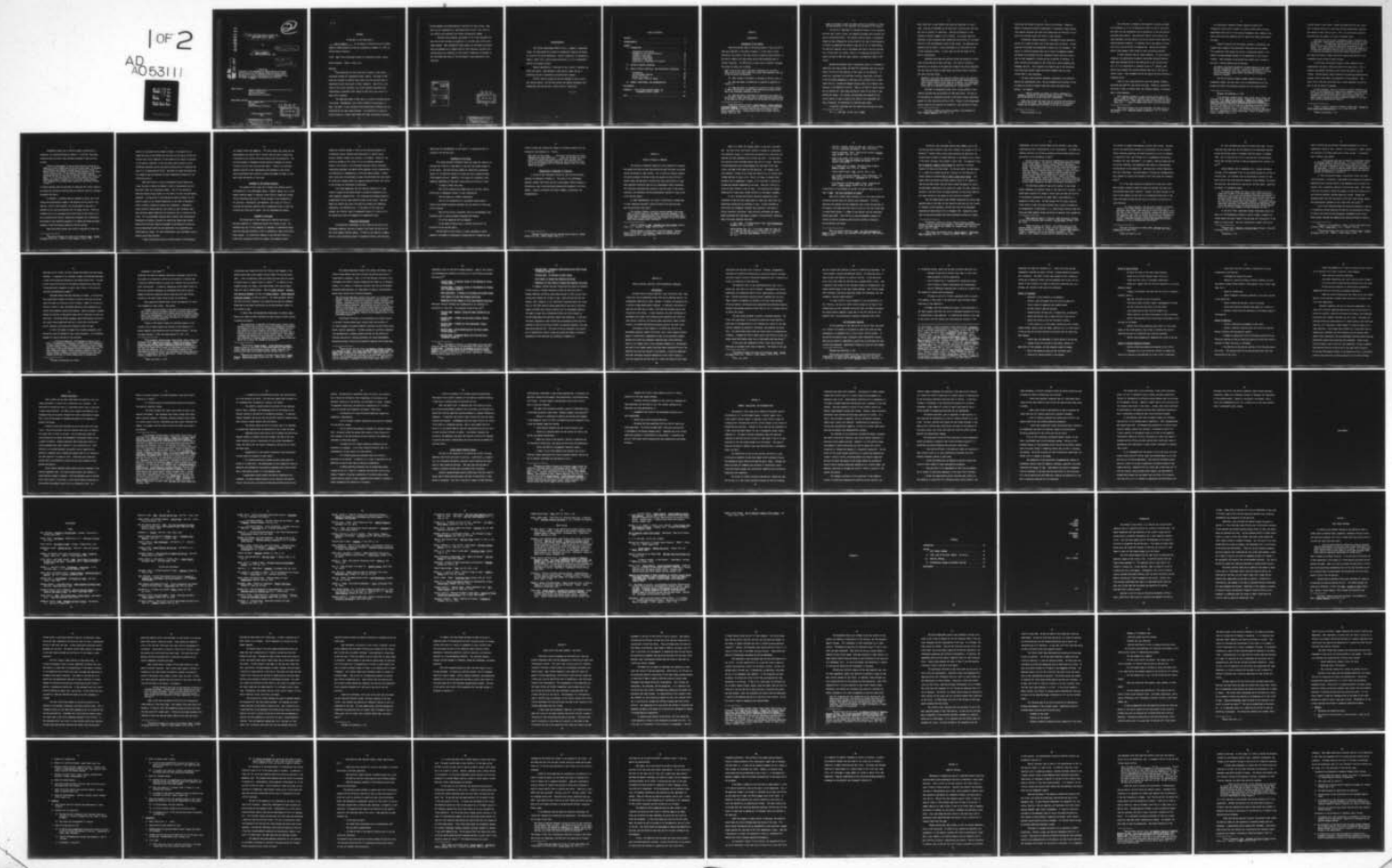
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A PRACTICUM
SUBMITTED TO THE DEPARTMENT OF ADMINISTRATION OF JUSTICE AND THE FACULTY OF THE GRADUATE SCHOOL OF WICHITA STATE UNIVERSITY IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE DEGREE OF MASTER OF ADMINISTRATION OF JUSTICE.

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ABSTRACT

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Paul C. Mouris, for the Master of Administration of Justice degree in Administration of Justice, presented on December 16, 1977, at Wichita State University.

TITLE: Rape Victim Assistance Program for Leavenworth County, Kansas

Major Professor: James A. Fagin, Ph.D.

Abstract:

The primary goal of this study was to design a rape victim assistance program for Leavenworth County, Kansas. The scope of the study was narrowed to identify those areas that the municipalities in Leavenworth County could apply to their community. Specifically, the roles of the police, hospitals, and victim referral counselors were investigated to determine their impact on the life of the victim in a rape crisis situation.

The underlying theme is that rape is a crime of violence and not a sex crime. Consequently, the victim's reaction to the assault is fear. The fear, in turn, produces strong psychological effects that are classified as the rape trauma syndrome. The recognition of rape as a violent attack on a woman necessitates that legal and medical personnel

provide empathy and understanding in working with rape victims. Rape must also be recognized as a legitimate health issue if the victim is ever going to be protected from further psychological damage.

Practices and procedures delineated in this study represent the ones this writer believes are essential to a salient rape victim assistance program. When Leavenworth County adopts and implements the manual that was prepared as an integral part of this practicum, the major end results should be a reduction in the victim's trauma and an increase in the likelihood that she will follow through in the prosecution of her assailant.

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This writer acknowledges Sheriff Terry L. Campbell, Leavenworth County, for encouraging this study and subsequently adopting the manual as a part of his police operations. Special recognition is expressed to James A. Fagin, Ph.D., Wichita State University, for his indispensable service as an expert advisor.

Special appreciation is reserved for Mrs. Evelyn F. Randolph, my editor and typist. She possesses a good sense of humor and was a continuous source of inspiration and enthusiastic support.

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P. C. M.

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CHAPTER I

INTRODUCTION

Background of the Problem

There were 56,090 rapes in the United States in 1975, and 391 of them were committed in the state of Kansas.[1] In the light of these statistics, the plight of the rape victim is receiving wide attention in the form of federal and state grants and an ever-increasing body of related literature. The definition of rape varies in specific language from state to state, but in Kansas:

> Rape is the act of sexual intercourse committed by a man with a woman not his wife, and without her consent when committed under any of the following circumstances:
>
> (a) When a woman's resistance is overcome by force or fear; or
>
> (b) When the woman is unconscious or physically powerless to resist; or
>
> (c) When the woman is incapable of giving her consent because of mental deficiency or disease, which condition was known by the man or was reasonably apparent to him; or
>
> (d) When the woman's resistance is prevented by the effect of any alcoholic liquor, narcotic, drug or other substance administered to the woman by the man or another for the purpose of preventing the

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[1] Casey Eike and Polly Pettit, Sexual Assault: Kansas Community Conference Handbook, Prepared under Grant No. 75-A-2791-1-A from Kansas Governor's Committee on Criminal Administration and Douglas County, Kansas (Lawrence, Kans.: Douglas County Rape Victim Support Service, October 1976), pp. 7-8.

> woman's resistance, unless the woman voluntarily consumes or allows the administration of the substance with knowledge of its nature.[2]

The Sheriff's Department of Leavenworth County is also concerned with the rape victim's plight, but community problems have prevented any type of coordinated effort. The criminal justice system in Leavenworth County has been unresponsive to the plight of the rape victim because of a failure to understand the crime of rape and all of its ramifications. The municipal agencies vary in the amount and type of services provided for a victim, and, as a result, there is no integrated coordination of county services to meet the legal, medical, and emotional needs of the victim.

Because the reported rape in Leavenworth County is infrequent in comparison with other crimes, the Sheriff's Department does not provide special training in the handling of rape cases for its personnel. In particular, patrolmen lack sufficient training, experience, and sensitivity to perform adequately in the rape crisis situation and a victim cannot talk to a trained policewoman because there are no female investigators in the detective division. There is no specific sexual assault unit to respond to a rape scene and special forms are not used in completing the report. As a result, the patrolman who responds to the initial report of rape is normally not familiar with department policies, procedures, and techniques for handling such events.

In addition, patrolmen who lack specialized training will more

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[2] K. S. A. 1970 Supp. 16-115, sec. 21-3502.

than likely fail to note details that would be important in a court case. Some may be impressed by the hysterical victim and may feel that the lack of hysteria is suspicious. Some may be skeptical in the absence of physical damage or torn clothing. In too many cases the patrolman is more concerned about determining the validity of the report than he is with the emotional stress of the victim. His questions and mannerism can be either a crucial detriment or an alleviation of the victim's emotional stress. In fact, they can set the stage for the entire investigation.

Unprepared patrolmen who confront crying and hysterical victims often do not know how to deal with them. This lack of training or sensitivity in relation to the emotional trauma of the victim compounds the fact that too little is known about the various kinds of injuries the rape victim may suffer.

> [Normally,] only the purely physical effects receive the attention from the investigator; yet the most severe trauma associated with a sexual assault usually is not physical in nature. It is psychological--a result of the victim's sense of having been forceably taken, freely used and completely depreciated as a human being.[3]

Patrolmen in Leavenworth County have a unique problem in that referral services are not available for the rape victim. The lack of willing medical or counseling services in the entire county complicates matters for both the police and the victim. Factors a police department usually looks for to classify an incident as a rape are proof of pene-

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[3]William H. Masters and Virginia Johnson, "The Aftermath of Rape," Redbook Magazine, June 1976, p. 74.

tration and the threat of physical force by the offender. Generally, medical corroboration cannot be determined in Leavenworth County because local medical personnel and facilities (physicians and hospitals) do not want to be involved unless the victim is their patient.

Furthermore, medical personnel in Leavenworth County apparently are not fully aware of their role in the rape crisis situation. In most cases the victim must be transported to Kansas City for treatment. This results in confusion because there are no formal arrangements between the Kansas City hospitals and the Leavenworth County municipal authorities for the treatment of victims and the collection of evidence. In short, neither the policeman nor the victim has a choice regarding the treatment facility. This situation is primarily due to the reluctance local physicians exhibit toward providing treatment that may later involve them in court testimony.

The rape victim requires immediate, sympathetic, and effective medical and psychological care. The set procedure most hospitals follow is simply an outline of medical steps the nurses and doctors must perform. For example:

> . . . Medical concerns are repair of injury, prevention of pregnancy, prevention of venereal disease and vaginal infections, and the prevention of serious emotional consequences.
>
> [They also include] the legal role of collecting the evidence of a crime for the state. Legal concerns are obtaining an historical account and the meticulous collection of any and all evidence.[4]

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[4]Eike and Pettit, p. 34.

The victim who is brought to the hospital is usually confused and frightened, so it is not emotionally useful for her if the police have been kind and considerate but her perception is that the hospital procedures were abusive. Many hospitals treat a rape victim as any other emergency, and she normally has to wait quite a while before she receives medical attention. In addition, she is the center of attraction since a police officer is guarding her. During the confusion, medical staff members often forget to treat the obvious problems.

In some instances rape can cause pregnancy. "To guard against pregnancy, the gynecologist [normally] prescribes diethylstilbestrol. Women have sometimes heard of this medication as the 'morning after pill' or it is explained as a 'chemical D and C.'"[5] However, some doctors have stopped this practice because they fear it may lead to vaginal cancer. They recommend waiting and opting for early abortion if pregnancy occurs.

There is also a good possibility that the venereal diseases, gonorrhea and syphillis, may result from rape. Generally, antibiotics are given to treat or prevent these two diseases; however, a follow-up test is also necessary.

> While venereal disease is a major concern at the time of the rape, a number of women will develop acute vaginal infections which may become chronic. Women need to be seen for follow-up six weeks later, and . . . again six months after that, to be sure they have

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[5]Ann Wolbert Burgess and Lynda Holmstrom, "The Rape Victim in the Emergency Ward," American Journal of Nursing 73, No. 10 (October 1973):1742.

not contracted a venereal disease, especially syphillis.[6] Although the rape victim is hardly in a mood to think about follow-up appointments while she is in the hospital emergency room, someone on the scene should take the responsibility for making sure these appointments are made.

Physical injuries such as bruises, abrasions, lacerations, and traumas from a weapon or the assailant's fists must also be treated. This examination often causes the victim a considerable amount of discomfort and embarrassment because of the awkwardness of the injury's location. When struggles on the ground have caused cuts or breaks in the skin, a tetanus booster may be required.

> The medical examination [normally] includes diagnosis of and treatment for any physical injuries. The part of the examination that involves evidentiary tests, both which tests and whether or not they should be performed, varies widely from [hospital] program to [hospital] program.[7]

The lack of medical evidence creates numerous problems for Leavenworth County, not only from a lack of standardization but also because the Kansas City hospitals normally will not release medical

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[6]Burgess and Holmstrom, p. 1742.

[7]Lisa Brodyaga, Margaret Gates, Susan Singer, Marna Tucker, and Richardson White, Rape and Its Victims: A Report for Citizens, Health Facilities, and Criminal Justice Agencies [Prescriptive Package], A project supported by Grants No. 74-DF-99-006 and P.O. 5-1077-J-LEAA to the Center for Women Policy Studies and subgrantees Blackstone Associates and Legal Resources, Inc., by the National Institute of Law Enforcement and Criminal Justice, Law Enforcement Assistance Administration, U.S. Department of Justice (Washington: Center for Women Policy Studies, November 1975), p. 67.

records without a court order. Kansas City physicians are also reluctant to become involved in a rape case that may necessitate a considerable amount of their time in court. This is a particularly sensitive area when they must appear in a court of another state.

> Physicians who are on duty in emergency rooms of hospitals are, in some cases, understandably reluctant to become involved in criminal cases . . . . In many cases the physician is called to testify months and even years after the date of his examination of the victim. Also, many physicians are fearful of being subjected to an intense cross-examination which may tend to impugn their efficiency or integrity and adversely affect their medical reputation.[8]

The cumulative effect of these situations creates undue delays in the Leavenworth County criminal justice process.

In most cases the physical trauma is minor compared to the psychological and social crises that befall the rape victim. This is normally the greatest challenge to the victim, her family, and her friends. Helping persons, whose intentions are good but psychologically unsound, tend to urge denial and suppression of the memories. They would like to help the victim feel that it never happened, to help her feel as she did before it happened.

> In most instances, little or no effort is made to determine the extent of the psychological trauma she has undergone or to evaluate her chances for experiencing trauma in the future. Certainly it is extremely difficult for most rape victims to evaluate their own mental turmoil objectively enough to determine whether or not they need continuing psychological support.[9]

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[8]Louis R. Vitullo, "Physical Evidence in Rape Cases," Journal of Police Science and Administration 2, No. 2 (June 1974):160.

[9]Masters and Johnson, p. 74.

Leavenworth County has no referral agency, professional or otherwise, to provide psychological support. If skilled, long-range counseling were available, many aftermath problems of rape could be avoided.

> Prevailing stereotypes of rape are that the main reactions of women are to feel ashamed and guilty after being raped. We [Burgess and Holmstrom, who operated a counseling service for victims in Boston] did not find these to be the primary reactions in the majority of victims we saw. To the contrary, the primary feeling expressed was that of fear--fear of physical injury, mutilation, and death. It is this main feeling of fear that explains why victims develop the range of symptoms we call the rape trauma syndrome. Their symptoms are an acute stress reaction to the threat of being killed.[10]

A trained counselor must be available to interpret the victim's behavior and reduce her anxiety by ensuring that she receives sensitive treatment throughout the crisis.

In addition, a counselor must be prepared to assist the victim through the psychological stages of the hospital and the judicial proceedings. While in the hospital, the victim needs to know what is expected of her, what the physician will be doing, and why. Sensitive treatment can aid in overcoming the initial shock of the attack and is key to obtaining the victim's cooperation throughout the investigation. The purpose of any counseling program is to reduce the trauma and embarrassment of rape and thereby reduce the victim's anxiety.

Under the current system, the victim is required to relate the

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[10]Ann Wolbert Burgess and Lynda Lytle Holmstrom, Rape: Victims of Crisis (Bowie, Md.: Robert J. Brady Company, 1974), p. 39.

details of the attack to any number of people. She usually has to repeat her story of the attack over and over--to the patrol officer who receives the initial complaint, to the detective (on several occasions), to the hospital personnel, to the assistant county attorney (at the preliminary hearing), and to the county attorney who will prosecute the case if it is bound over for trial. She wants to forget the attack and its trauma as soon as possible, but the investigative process will not allow her to do so.

When the victim of a rape in Leavenworth County reports the crime, she sets in motion for herself a chain of experiences that will more than likely be a painstaking ordeal. She will be required to describe personal sexual events in vivid detail for male law enforcement personnel. At some point in time she may be taken to Kansas City and asked to submit to an intimate examination of her body to determine if there is medical evidence to sustain her allegations. Leavenworth County obviously cannot make any real impact on rape incidences until each municipal agency identifies its particular role in relation to the crime. The law enforcement agencies should improve rape investigative techniques and reflect a concern for sensitivity toward rape victims. Female police officers should be assigned to the detective division so that an embarrassed victim has the opportunity to be questioned and interviewed by a woman. All rape investigators, male and female, should receive specialized training.

A rape victim should be able to receive medical and psychologi-

cal support within the community. This would reduce the trauma and the embarrassment that result from a forcible rape and would increase the likelihood of the victim's following through with the prosecution. The existing program in Leavenworth County should be expanded to provide follow-up care for the victim and her family. Finally, all municipal agencies involved in the investigation and treatment of the victim should consolidate their efforts to reduce the number of times a victim must relate the details of the crime.

Statement of the Problem Situation

The purpose of this study was to examine the uniquely specific relationship of a law enforcement agency, a medical agency, and a victim support referral agency in reducing a rape victim's trauma and increasing the likelihood that she will follow through in the prosecution of her assailant. Additionally and hopefully, this study will serve to stimulate the municipal agencies within Leavenworth County to apply the rationale set forth and to create their own comprehensive program.

Purposes of the Study

The primary goal of this study was to identify the roles of municipal agencies in a supportive service for victims of rape. The secondary goal was to bring together all agencies in Leavenworth County that have resources available to help in developing a rape victim assistance program. If a particular resource is not available locally, a professional counseling service for example, the community should

establish a network whereby a victim can be referred elsewhere for professional advice, Metropolitan Organization To Counter Sexual Assaults (MOCSA), Kansas City, Missouri, for example. Hopefully, the practical outcome of this study will be to stimulate Leavenworth County's city councils, law enforcement agencies, medical personnel, prosecuting attorneys, and mental health agencies to work cooperatively and effectively in implementing a victim assistance program. Leavenworth County must be encouraged to adopt the philosophy that rape cannot be effectively reduced unless the numerous negative factors that relate to the offense are diminished or eliminated.

This study emphasizes the fact that the reduction of a rape victim's trauma and the urging toward a successful prosecution are a total community responsibility. The investigative procedure should be accomplished with the least possible trauma to the victim. From the moment she reports the crime, she should be treated with immediate, sympathetic, and effective care. If the goals of this study are adopted, the victim of rape in Leavenworth County will receive all of her needed care within the community of Leavenworth County.

Objectives Investigated

The objectives investigated in this study are the role of law enforcement agencies, the role of medical facilities, and the role of the victim support referral agency. If there is any hope for a comprehensive victim assistance program in Leavenworth County, each and every

agency must be interdependent on the others in a concerted effort to accomplish the desired goals.

Importance of the Study

This study provides information about the range and intensity of services the victim of a rape needs to cope with the trauma brought on by the attack. Once the services needed are identified; Leavenworth County will collectively assess this study and form a community-based victim support service. Hopefully, this study will stimulate a total community commitment so that when a rape occurs the victim will know:

- To whom to report the crime.
- Her initial contact with authorities will be with a police officer who is adequately trained in rape investigation.
- She has access to a female investigator.
- She will be transported to a Leavenworth County medical facility and treated by medical personnel who are sensitive in the rape crisis situation.
- She will be told by a counselor, while at the emergency room, everything that is going to happen throughout the process.
- All of her questions will be answered.
- If she needs follow-up care, a referral service will be available for her and her family.

The end result of this study is a manual designed to insure community involvement in developing a program that will reduce the rape

victim's trauma and increase her chances of following through with the prosecution (see Appendix A). Finally:

> Each facet of the program. . . . [should be] interrelated and interdependent upon other facets and . . . [must be] designed to provide continuaing [continuing] support to other areas and most importantly, to provide continuous support for the victim while in contact with the system as well as continued support after the victim leaves the system.[11]

Organization of Remainder of Practicum

A review of the literature relating to rape victim assistance programs is presented in Chapter II. The roles of law enforcement agencies, medical facilities, and the victim support referral agency in formulating a rape victim assistance program are discussed in the third chapter. Chapter IV contains the study's summary, conclusions, and recommendations.

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[11] Metropolitan Organization To Counter Sexual Assaults, "MOCSA" (Kansas City, Mo.: MOCSA, August 1976), p. 3.

CHAPTER II

REVIEW OF RELATED LITERATURE

The review of literature compiled in this chapter will acquaint the reader with what has been done during the past few years to provide quality assistance to rape victims. Yet, in spite of numerous research and action programs initiated across the country and the printing of several books and periodical articles that focus specifically on rape, many questions concerning rape and its consequences remain unanswered. The literature discussed deals primarily with the roles of the police, hospitals, and counselors and the psychological reaction of rape on the victim and her family.

In 1965, Menachem Amir, an Israeli criminologist, claimed that "in the literature available in English there is not even one book dealing exclusively with rape."[1]

> The criminal offense of forcible rape has become, since about 1969, a rallying topic for the Women's Liberation movement in the United States, transforming what until that point had largely been a subject only of criminological and legal concern to one with considerably more extended social notoriety.[2]

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[1] John M. MacDonald, Rape: Offenders and Their Victims (Springfield, Ill.: Charles C. Thomas, 1971), p. 23.

[2] Duncan Chappell, Gilbert Geis, and Faith Fogarty, "Research Notes--Forcible Rape: Bibliography," Journal of Criminal Law and Criminology 65, No. 2 (June 1974):248.

Rape is no longer the tabooed subject it was only a few years ago. The rape victim, long either ignored or treated as a sensational and scandalous outcast, is slowly being recognized as an individual who deserves the most sympathetic help society can offer. The mass media are helping to alter attitudes toward rape and its victims. Feminists, from the beginning, have worked doggedly for the needs of the rape victim, and some of the needs are now being met. For example, until very recently, victims of sex crimes had nowhere to go to relieve their intense feelings of shock, guilt, terror, and rage, to discuss their anxieties with a sympathetic listener, or to find help in coping with strange new problems engendered by the rape. There was literally no place for most victims to turn for help. This situation has changed dramatically in many areas, thanks primarily to the women's movement.

In 1971, the New York Radical Feminists Organization held a conference in New York that urged women to "speak out" about their bad experiences concerning the aftermath of rape. Victims responded by publicizing the inadequate treatment they received at the hands of police, hospitals, and courts. Many articles challenging the common myths associated with rape began to appear in the periodical literature. Some of the most important ones were:

- A. Lake, "Rape: The Unmentionable Crime," Good Housekeeping, November 1971, pp. 104-105.
- Martha Weinman Lear, "Q: If You Rape a Woman and Steal Her T.V., What Can They Get You For in New York? A: Stealing Her T.V.," New York Times Magazine, January 30, 1972, pp. 10-11.

- Camille E. LeGrand, "Rape and Rape Laws: Sexism in Society and Law," California Law Review 61 (May 1973):919-24.
- Michelle Wasserman, "Rape: Breaking the Silence," Progressive, November 1973, pp. 19-23.
- Pamela Lakes Woods, "The Victim in a Forcible Rape Case: A Feminist View," American Criminal Law Review 11, No. 2 (Winter 1973):335-54.
- C. T. Rowan and D. M. Mazie, "Terrible Trauma of Rape," Reader's Digest, March 1974, pp. 198-204.
- "Revolt Against Rape," Time, July 22, 1974, p. 85.
- Carol Bohmer and Audrey Blumberg, "Twice Traumatized: The Rape Victim and the Court," Judicature 58, No. 8 (March 1975):391-99.
- Ellen Bernstein and Brandy Rommel, "Rape: Exploding the Myths," Today's Health, October 1975, pp. 36-39.

A description of the movement by the New York Radical Feminists may be seen in Rape: The First Sourcebook for Women.[3]

Rape crisis centers began springing up in a few large cities and university centers where sex assaults were widespread. Initially, feminists and students who were themselves rape victims started many of the centers, but women activists from all walks of life soon joined them in establishing centers. A number of the centers took the name Women Against Rape (WAR). Their aim was to provide empathetic support for victims by hotline counseling and/or escort services to hospitals, police stations, and courts.

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[3]New York Radical Feminists, Rape: The First Sourcebook for Women, ed. Noreen Connell and Cassandra Wilson (New York: New American Library, 1974).

California's Bay Area Women Against Rape (BAWAR), one of the earliest and most successful rape crisis centers, was founded in 1971 in Berkeley.[4] Another highly active group typifying the dedication and organizational talents of aroused feminists is the Women's Crisis Center of Ann Arbor, Michigan, which opened in early 1972. Its pamphlet titled How To Organize a Women's Crisis Center has served as a valuable resource for many anti-rape groups. On the east coast, the Washington, D. C., Rape Crisis Center served as a catalyst for the formation of several groups by producing How To Start a Rape Crisis Center. This manual offers guidelines and sample research forms on all aspects of rape and has been widely read and used by women throughout the nation. The Washington organization also served as a model for other centers by starting a rape task force to change conditions in the police, medical, and legal services in the region of the District of Columbia.[5]

New York Women Against Rape (NYWAR) concentrated on making legal agencies aware of the need for more sensitive dealings with the victims. In response to such awareness, the New York City Police Department organized the Rape Analysis Unit in December 1972. Recognizing that rape victims would probably feel more comfortable talking to a female

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[4]California, Office of Criminal Justice Planning, Alameda Regional Criminal Justice Planning Board, "Five-Month Interim Evaluation of Bay Area Women Against Rape (BAWAR) for Alameda County" (Oakland, Calif., April 1, 1974).

[5]Nancy Gager and Cathleen Schurr, Sexual Assault: Confronting Rape in America (New York: Grossett and Dunlap, 1976), p. 264.

investigator, this unit trained female police officers in sex crimes investigations and in psychological crisis intervention. The NYWAR also receives referrals for follow-up counseling from the Rape Analysis Unit and assists in the collection of data.[6]

> Seattle claims to have the most comprehensive anti-rape program in the United States. Its publicly financed Rape Reduction Project offers a wide range of services closely linked to the Seattle Police, the King County Prosecutor's Office, and Harborview Medical Center. The Project, a key part of the City's Plan for Criminal Justice, aims at increasing victim willingness to report and prosecute rape offenses. The two community operating agencies--the University YWCA Rape Relief Program and the Harborview Sexual Assault Center--focus on five main goals: medical and support services; information, referral and advocacy; third-party reporting of sex crimes when the victim does not want to go personally to the police; model procedures; and public information and education.[7]

The continuing growth of rape crisis centers in the United States represents an essential change in the rape crisis situation. The second major catalyst for change in recent years has been the activity of the National Organization for Women (NOW), whose membership is expanding in every state. The NOW created the first major organizational effort to deal with rape problems from a national perspective. Its headquarters, in Washington, D. C., established a National Rape Task Force and urged chapters across the nation to research local communities

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[6]Mary Keefe and Henry T. O'Reilly, "Rape Attitudinal Training for Police and Emergency Room Personnel," Police Chief, November 1975, pp. 36-37.

[7]Gager and Schurr, pp. 269-70. (For further details of the Seattle project, supported by a grant from the Law Enforcement Assistance Administration, see: K. E. Mathews, Jr., "Seattle Rape Reduction Project: Evaluation of First-Year Results, September 1, 1973 - August 31, 1974" (Seattle Law and Justice Planning Office, 1974).)

in an effort to suggest improvements to assist rape victims. The project kit the organization designed and disseminated for this research effort contained guidelines and sampling materials to aid its chapters in researching local rape problems and in recommending institutional procedures and legal improvement. For example, interview questionnaires for police, hospitals, and prosecutors were used as a consciousness-raising device in the communities. When possible, victims themselves were also interviewed. Each NOW chapter's findings and recommendations were reduced to a report and released to the local press and broadcast media.[8]

All of the above programs and methods for aiding rape victims were extremely valuable, especially when one considers the great void that existed before their inception. However, two major problems in the area of rape research are the lack of a standardized definition of the crime from state to state and the lack of validity or reliability of rape statistics.

> . . . Dr. Duncan Chappell, then Associate Professor of Criminal Justice at the State University of New York at Albany, and his assistant, Susan Singer, made comparative studies (published in 1971 and 1973) of data in Boston, Los Angeles, and New York police files. They reported a poor level in quality and quantity of information on all aspects of rape, with very little detail on either rapists or victims. Comparisons between different departments were further hampered by a lack of standardized definitions.[9]

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[8]National Organization for Women [NOW], NOW Rape Task Force Project Kit (Chicago, 1973).

[9]Gager and Schurr, p. 92.

Dr. Amir shattered many prevailing myths about rape. He surveyed 646 rape cases that the Philadelphia Police Department handled during the periods January to December 1958 and January to December 1960. Amir's study was the first to conclude with the sociological theory that the major motives of rape are aggression and violence, not sex.[10]

During 1968-69, John M. MacDonald, M.D., studied the Denver, Colorado, Police Department files on two hundred consecutive victims of forcible rape. His findings offer an authoritative analysis of rape which looks at the crime from the viewpoint of the offender, his victim, the physician, the psychiatrist, the police, and the lawyer. Referring to himself, Dr. MacDonald states:

> The author was present when many of the victims, as well as others not included in the two hundred cases, were interviewed by detectives or by a nurse from the Denver Visiting Nurse Service. In addition he interviewed some victims privately and also interviewed at length several of the men who raped victims in this study, as well as over one hundred other rape offenders. Information obtained from these interviews, from detectives and police departments, both within and beyond Colorado, and from penitentiary records contributes to the clinical examples provided throughout the book.[11]

In the early 1970s, researchers became increasingly aware that rape is a life-threatening situation in which a woman is abused in a violent manner and that a woman's life and body are involuntarily in the hands of a hostile man. They also learned that a woman's ability to

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[10]Menachem Amir, Patterns in Forcible Rape (Chicago: University of Chicago Press, 1971).

[11]MacDonald, p. 24.

cope or function may be seriously compromised momentarily or for an undetermined length of time. Sandra S. Fox and Donald J. Scherl studied the reactions of thirteen young adult victims of rape. In releasing their findings, they stated:

> . . . [T]he authors were able to identify a predictable pattern of responses common to these patients: (1) acute reaction, occurring immediately after the rape and usually lasting for several days, (2) outward adjustment, and (3) integration and resolution of the experience. A series of specific mental health interventions was then designed to help the patients work through each phase as smoothly and completely as possible.[12]

In 1972, Ann Wolbert Burgess, a psychiatric nurse, and Lynda Lytle Holmstrom, a sociologist, interviewed and followed-up 146 patients admitted during a one-year period to the emergency ward of Boston City Hospital with a presenting complaint of *having been raped*. Their objectives were to develop a counseling program, to help the victims, and to avoid serious emotional problems among the victims. Burgess and Holmstrom dealt with only one aspect of the total rape problem, namely, the psychological treatment of the victim after the assault.[13]

Prior to the research Burgess and Holmstrom conducted, a paucity of information existed regarding the physical and psychological effects of rape on the victim and the therapeutic management of the victim. These authors reported the immediate and long-term effects of rape as

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[12]Sandra S. Fox and Donald J. Scherl, "Crisis Intervention with Victims of Rape," Social Work 17, No. 1 (January 1972):37.

[13]Ann Wolbert Burgess and Lynda Lytle Holmstrom, Rape: Victims of Crisis (Bowie, Md.: Robert J. Brady Company, 1974),

described by the victims, and they labeled the effects the rape trauma syndrome. In response to the syndrome, Burgess and Holmstrom developed a rape victim counseling program for the Greater Boston Area. The most crucial result was that police and medical personnel are called upon increasingly more frequently to assist rape victims in the acute and long-term reorganization process.[14]

Attitudes toward rape were beginning to change. In particular, the accumulating evidence of society's cruelty to the rape victim was being laid open to close and critical scrutiny. Women, as victims and possible victims of rape, had become especially and increasingly concerned with pioneering studies and programs. Rape had become a frequent subject of articles in the popular press and of interviews on radio and television. The United States Congress, state legislatures, and municipal councils were questioning the way in which their institutions, police, hospitals, and courts were treating victims of rape.

In 1974, the Center for Women Policy Studies conducted a most exhaustive study of problems of rape victim assistance. Its voluminous document of results consists of four sections:

> . . . "The Police Response," "The Response of Medical Facilities," "The Response of Prosecutors' Offices," and the "Response of Citizens' Action Groups." The material presented in each is based upon the findings of national surveys conducted among each of these four groups, with special emphasis placed on agencies that have begun innovative changes in their approach to cases of rape. Each section presents findings from these nationwide surveys and then suggests guidelines for others seeking ways to improve their

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[14]Burgess and Holmstrom, pp. 37-50.

procedures in such cases.[15]

Guidelines are based on programs, techniques, procedures, and policies that appear to be especially effective and valuable in treating rape victims and therefore might be suitable for transfers and replication in other jurisdictions. In addition, appendixes contain sample forms for police and hospital procedures and information that can be used to augment discussions concerning police interviews with rape victims, counseling, and legal issues raised by rape law reformists.

Nancy Gager and Cathleen Schurr stress the necessity for sensitive treatment of rape victims. They assert:

> Foremost in police reform is the need to have the police regard the victim's physical and mental health as of primary importance. This means training the police in being sensitive, courteous, sympathetic, and nonjudgmental; in asking clear and intelligent questions and recording answers accurately; and above all in showing concern about the victim's well-being.[16]

Concern in the state of Kansas for providing support in the criminal area of sexual assault has resulted in the formation of a Kansas community rape prevention and victim support project. The project began February 1, 1976, and ended January 31, 1977. Its

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[15]Lisa Brodyaga, Margaret Gates, Susan Singer, Marna Tucker, and Richardson White, Rape and Its Victims: A Report for Citizens, Health Facilities, and Criminal Justice Agencies [Prescriptive Package], A project supported by Grants No. 74-DF-99-006 and P.O. 5-1077-J-LEAA to the Center for Women Policy Studies and subgrantees Blackstone Associates and Legal Resources, Inc., by the National Institute of Law Enforcement and Criminal Justice, Law Enforcement Assistance Administration, U.S. Department of Justice (Washington: Center for Women Policy Studies, November 1975), pp. xi-xii.

[16]Gager and Schurr, p. 102.

co-directors were "Casey Eike and Polly Pettit, staff members of the Douglas County Rape Victim Support Service [RVSS] for the past three years. Since its beginning, RVSS has worked with more than 95 victims of sexual assault or people close to victims."[17] In addition to the handbook quoted, two others, also dated October 1976, were produced under this dually funded project. They are Sexual Assault: Preventative Education Handbook, by Eike, and Sexual Assault: Kansas Community Conference Handbook, by Eike and Pettit. All three handbooks identify the roles of police, hospitals, and counseling services and recommend guidelines on how these institutions can provide emotional support to the victims of rape.

In March 1976, the Metropolitan Organization To Counter Sexual Assault was formed to offer assistance to rape victims in eight counties in Kansas and Missouri.

> The organization is dedicated to bringing about a better understanding of the crime of sexual assault and subsequently to decrease its frequency of occurrence and to promote more frequent and accurate reporting of sexual assaults, more effective and sensitive handling of the victim by both police and medical personnel, and to increase the conviction rate in sexual assault cases. While MOCSA encourages the reporting of sexual assaults to police, it also is very interested in offering supportive services to those victims who decide not to report the offense to the police.[18]

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[17] Polly Pettit, Sexual Assault: Victim Assistance Handbook, Funded by Grant No. 75-A-2791-1-A from Kansas Governor's Committee on Criminal Administration and Douglas County, Kansas (Lawrence, Kans.: Douglas County Rape Victim Support Service, October 1976), p. 3.

[18] Metropolitan Organization To Counter Sexual Assault, Sexual Assault: Meeting the Crisis [Kansas City, Mo.: MOCSA, March 1976], p. 21.

Polk County Rape/Sexual Assault Care Center, Des Moines, Iowa, offers victims medical and social services and assists the police in investigative procedures. Early in 1977 the National Institute of Law Enforcement and Criminal Justice categorized the center as an exemplary project. As a result, it received a contract from the Law Enforcement Assistance Administration, U.S. Department of Justice, and published a manual which contains the following statements:

> The Polk County Rape/Sexual Assault Care Center is a single program designed to deal with the multiple problems of rape and sexual assault. Providing victims with counseling support, reforming state statutes, coordinating with the prosecution, training and assisting police and medical personnel, and educating the public are the Center's prime objectives. Although funded primarily by the Central Iowa Area Crime Commission through the County Board of Supervisors, the Center is a truly community-oriented facility, working with and being supported by hospitals, schools, and volunteers as well as law enforcement agencies.[19]

The National Institute of Law Enforcement and Criminal Justice is currently funding another major project under the direction of Dr. Duncan Chappell of Battelle Memorial Institute Law and Justice Study Center, Seattle, Washington. Fourteen volumes will provide a comprehensive documentation of present system practices for the handling of forcible rape and will indicate directions for future developments. Nationwide surveys of police and prosecutive agencies have already been

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[19]Gerald Bryant and Paul Cirel, An Exemplary Project--A Community Response to Rape: Polk County Rape/Sexual Assault Care Center, Des Moines, Iowa, Prepared by Abt Associates, Inc., under Contract No. J-LEAA-014-74, for the National Institute of Law Enforcement and Criminal Justice, Law Enforcement Assistance Administration, U.S. Department of Justice (Washington: Government Printing Office, March 1977), p. 4.

conducted as part of this multi-faceted endeavor. Some of the findings and recommendations presently available are in the following government publications:[20]

- Forcible Rape: A National Survey of the Response by Police (Police Volume I)
- Forcible Rape: A National Survey of the Response by Prosecutors (Prosecutor Volume I)
- Rape Legislation: A Digest of Its History and Current Status
- Final Report of First Year Research Activities
- Appendices to Final Report of First Year Research Activities

Additional research findings and recommendations are scheduled for publication in late 1977. The projected volume titles are:[21]

- Forcible Rape: Medical, Police and Legal Information for Victims
- Forcible Rape: A Manual for the Patrol Officer (Police Volume II)
- Forcible Rape: A Manual for the Investigator (Police Volume III)
- Forcible Rape: Police Administrative and Policy Issues (Police Volume IV)
- Forcible Rape: Prosecutor Manual for Filing and Trial (Prosecutor Volume II)

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[20]U.S., Department of Justice, Law Enforcement Assistance Administration, National Institute of Law Enforcement and Criminal Justice, Forcible Rape: A National Survey of the Response by Police (Police Volume I), A project supported by Grant No. 75-NI-99-0015 to Battelle Memorial Institute Law and Justice Study Center (Washington: Government Printing Office, March 1977), p. ix.

[21]Ibid.

- Forcible Rape: Prosecution Administrative and Police Issues (Prosecutor Volume III)
- Forcible Rape: An Analysis of Legal Issues
- Final Report of Second Year Research Activities
- Appendices to Final Report of Second Year Research Activities

In summary, perhaps the most interesting fact about the contents of this review of related literature is that for the first time in decades questions are being raised about the way in which various institutions have treated the victims of rape. Most striking has been the absence, until recently, of any significant literature about the victim. Early in the 1970s feminist groups complained of the lack of sensitive support accorded rape victims by medical and law enforcement agencies. The women's groups set up telephone hotlines and crisis centers to provide raped women with emotional support and counseling. In the past few years, thousands of rape victims have encountered a more sensitive response on the part of police officers and hospital personnel than they might have found earlier. The roles of police, hospitals, and counselors in reducing the victim's trauma and urging her toward a successful prosecution of her assailant are discussed in Chapter III.

CHAPTER III

ROLES OF POLICE, HOSPITALS, AND PSYCHOLOGICAL COUNSELORS

Introduction

Forcible rape is without question a most terrifying crime. Many victims who survive experience fright that has an enduring quality, its consequences remaining for years, perhaps a lifetime, and accounting for a variety of deep psychological problems. In addition, convictions of rape have not been easy to obtain, even when the evidence against the accused was quite strong. In many instances, the very institutions of government which ought to be protecting and supporting the victims of rape--police, hospitals, and courts--often contribute, albeit unintentionally, to further humiliation and mental abuse of the rape victim.

The purpose of this chapter is to define the roles of law enforcement agencies, medical facilities, and a victim support referral agency in formulating a comprehensive rape victim assistance program. Because this writer has prepared a detailed rape victim assistance manual as an integral part of this practicum (Appendix A), the methodology used in this chapter merely highlights major responsibilities of key personnel who would be involved in the program. It must be recognized that each individual should be responsive to the victim's needs by providing supportive services that will lessen the impact of the trauma

associated with the rape crisis situation. Moreover, unsympathetic attitudes and insensitive questioning by police and hospital personnel can easily cause a victim to refuse the cooperation that is essential to arrest or prosecution of the assailant.

The important issue is the understanding that rape is not a sexual act, that rape is an act of violence. Consequently the victim experiences an overwhelming sense of fear, powerlessness, and helplessness. Victims consistently describe certain symptoms over and over. These clusters of symptoms are defined as the rape trauma syndrome.[1] Police and medical institutions must understand the predictable behavior patterns the syndrome produces so that they will be in a better position to assist the victim.

The rape trauma syndrome is usually a two-phase reaction. The first, the acute phase, is the period in which the victim exhibits a great deal of disorganization in her lifestyle as a result of the rape. Physical symptoms are especially noticeable, the prominent one being fear. The second phase begins when the victim starts to reorganize her lifestyle. Although the time of onset varies from victim to victim, the second phase often begins about two to three weeks after the attack.[2]

In the hours that immediately follow a rape, the victim may experience an extremely wide range of emotions. The impact of the rape

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[1] Ann Wolbert Burgess and Lynda Lytle Holmstrom, Rape: Victims of Crisis (Bowie, Md.: Robert J. Brady Company, 1974), p. 37.

[2] Ibid., pp. 37-46.

may be so severe that feelings of shock or disbelief are expressed. The victim normally displays two emotional styles. The expressed style is shown through such behavior as crying or smiling. In the controlled style, the victim hides her feelings and a subdued effect is seen. Fear is generally very strong in the long-term process of reorganization, the second reaction phase of the rape trauma syndrome. Many victims change their residence, experience unsettling dreams and nightmares, and, not uncommonly, develop severe phobias.[3]

If a rape victim is to be successful in the reorganization of her lifestyle, she must not suffer further trauma at the hands of the professionals she will encounter during the legal and medical processes. Her coping behavior depends a great deal on how well the police, the hospital staff, and psychological counselors understand their roles.

Law Enforcement Agencies

Police procedures in the rape crisis situation often contribute to a victim's willingness or reluctance to report the crime and then, subsequently, to cooperate fully in the criminal justice process. If the police are going to have a successful rape investigation program, they must be sincere in developing a sensitivity to grievances the rape victims have expressed. Researchers,[4] especially those who have engaged

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[3]Burgess and Holmstrom, p. 38.

[4]Morton Bard and Katherine Ellison, "Crisis Intervention and Investigation of Forcible Rape," Police Chief, May 1974, pp. 68-74; D. Ben-Horin, "Is Rape a Sex Crime?," Nation, August 16, 1975, pp. 112-

in victimology studies, agree that the most prevalent complaints are:

- Attitude of male police officers that rape is a sex crime.
- Debasing manner of police questioning.
- Lack of sensitivity in investigation's repetitious nature.
- Lack of access to female investigators and photographers.
- Lack of information regarding what is going on in general and the reasons for routine police procedures.
- Influence on police of victim's appearance after an assault. (For example, if the victim is not hysterical, many policemen become suspicious of the complaint.)

Policemen, the first professional group a victim encounters in the legal process, have their own set of formulated procedures to follow in investigating a rape complaint. In reporting the assault on her body to the police, the first person the victim generally contacts is the

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15; Carol Bohmer, "Judicial Attitudes Toward Rape Victims," Judicature 57, No. 7 (February 1974):303-307; W. P. Brown, "Police-Victim Relationships in Sex Crime Investigations," Police Chief, January 1970, pp. 20-24; I. Drapkin and Emilio Viano, Victimology: A New Focus, 5 vols. (Lexington, Mass.: D. C. Heath and Company, 1975); Jane S. Eyman, "Trauma of Rape," Military Police Law Enforcement Journal, Fall 1975, pp. 14-15; Nancy Gager and Cathleen Schurr, Sexual Assault: Confronting Rape in America (New York: Grossett and Dunlap, 1976); Eric Gatton, "Police Processing of Rape Complaints: A Case Study," American Journal of Criminal Law 4, No. 1 (1976):15-30; Mary Keefe and Henry T. O'Reilly, "Rape Attitudinal Training for Police and Emergency Room Personnel," Police Chief, November 1975, pp. 36-37; J. Pekkanen, Victims (New York: Dial Press, 1976); LeRoy G. Schultz, Rape Victimology (Springfield, Ill.: Charles C. Thomas, 1975); H. S. Shook, "Revitalized Methods Needed for Investigation of Rape," Police Chief, December 1975, pp. 14-15; and Louis R. Vitullo, "Physical Evidence in Rape Cases," Journal of Police Science and Administration 2, No. 2 (June 1974):160-63.

dispatcher who takes her telephone call. Others with whom she must subsequently converse are patrol officers, evidence gathering personnel, and a detective. The order in which they accomplish their respective duties may of necessity differ from the sequences that follow, but the intent of the listings is to focus on good police practices that, as a minimum, are involved in the rape crisis situation.

Duties of Dispatcher

- Determine if the situation is an emergency.
- Reflect a tone and manner that are calm and supportive.
- Voice a sense of compassion and responsiveness.
- Get the victim's name and location.
- Dispatch patrol officers and, if appropriate, an ambulance.
- Notify the hospital that a rape victim will soon arrive.
- Advise the victim to wait for the patrol officers.
- If the victim is in a safe place, instruct her not to bathe, change clothes, douche, brush her teeth, comb her hair, or clean herself in any way and not to touch articles or furniture that the rapist may have touched.
- Explain what the department is doing and who is on the way.
- Attempt to get the location of the attack, identity or description of the attacker, and the attacker's means of escape.
- Notify the detective squad and the laboratory squad.
- Issue an all points bulletin on the suspect.

Duties of Patrol Officer

- Be alert for signs of the rape trauma syndrome.
- Attend to the victim's medical needs (first aid).
- Insure that the victim is reasonably comfortable.
- Establish a rapport with the victim by behaving in a calm and objective manner.
- Conduct a preliminary interview with the victim to ascertain essential details.
- Keep the interview as brief as possible.
- Avoid being overly forceful; adopt a nonjudgmental attitude.
- Let the victim tell the story in her own words.
- Limit questioning of the victim to himself only.
- Remain impartial and record occurrences as they are related.
- Refrain from questioning the victim about minute details that she does not volunteer.
- Refrain from raising questions about details of the sexual aspect of the crime except as they relate to evidence that must be preserved and that will establish what crime was committed.
- Refrain from threatening or demeaning the victim in any way.

Duties of Evidence Gathering Personnel

- Explain evidentiary gathering procedures to the victim.
- Photograph the victim before any clothing is removed and before any cleaning or straightening up of the victim is undertaken.

- Advise the victim not to bathe or douche prior to being transported to the hospital.
- Photograph and diagram the scene.
- Recover all possible evidence (clothing, bedding, articles the suspect touched, broken objects, wiping agents, hairs, fibers, gags, tape, etc.).
- Check for fingerprints.
- Gather fingernail scrapings (preferably, this should be done by the physician).
- Secure evidence and maintain a chain of custody.
- Insure that hospital personnel have access to a "rape kit."
- Maintain liaison with the laboratory of the Kansas Bureau of Investigation.

Duties of Detective

- Explain investigative procedures to the victim.
- Conduct a detailed interview after the victim has received medical attention and psychological support.
- Attempt to combine the initial preliminary contact with the follow-up interview so that at least one occasion on which the victim is required to repeat the story is eliminated.
- Be sensitive to the physical setting of the interview room on the victim. (The setting should be private and absolutely free from distractions of any kind.)

- Permit the presence of a friend or relative of the victim if at all possible and if that is what the victim requests.
- Apply sensitive interview techniques.
- Use proper phraseology, but avoid using the term "alleged."
- Allow the victim to describe what occurred in her own words.
- Be particularly sensitive to identification processes or suggestions that the victim take a polygraph examination.
- Keep the victim informed about the status of her case (apprehension of the assailant, charges placed against him, and date of her first court appearance).

Generally speaking, the role of the police department in the rape crisis situation comprises getting the victim to the hospital as quickly as possible, gathering and preserving evidence, and conducting preliminary and in-depth interviews with the victim. The proper and thorough handling of these matters will reduce trauma to the victim and, hopefully, will encourage a larger number of victims to report valid rape complaints. Even though rape incidents in a jurisdiction may be comparatively infrequent and police agencies may be laboring under severe fiscal constraints, the law enforcement hierarchy should consider maintaining certain basic practices and procedures. These include utilizing special police forms for rape complaints, issuing a pamphlet that explains the role of the police in the rape crisis situation, hiring qualified female officers in the detective division, and holding periodic rape sensitivity training sessions for all police officers.

Medical Facilities

When a female who has been raped enters the hospital, she is no longer considered a "victim" and is referred to as a "patient." Yet, resistance to recognizing rape as a legitimate health issue is prevalent in many county hospitals. As often as not, doctors and hospitals give inadequate help and actually increase the victim's psychological trauma. This is why the attitudes of treatment personnel are as important as medical proficiency.

Society's prevailing attitudes are not on the side of the rape victim. Many existing myths view and interpret rape solely in terms of sex rather than in terms of violence. Any attitude that blames the victim serves only to thwart any therapeutic relationship before it has a chance to develop. Hospital personnel should bend every effort to reflect awareness that their function is not a moralistic one. Their function is to provide emotional and medical care as needed and to perform an important role in gathering evidence that will be required if the rape complaint is brought to trial. Physicians and nurses must protect their own professional stature and also the interests of the patient and justice.

Sexual assault patients should receive priority treatment in the hospital emergency room. This policy should prevail even though no severe physical trauma is apparent. When the emergency room is notified that a rape victim is on the way, a nurse should prepare to meet her at the entrance and promptly escort her to an examination room. As a

matter of hospital protocol, the eight procedures listed below should likewise be in effect.[5]

• All efforts should be directed toward easing and minimizing the patient's emotional trauma.

• The terms "alleged" and "rape" should never be used in the hospital environment. They represent legal terms; neither term represents a medical diagnosis. Advisedly, hospital personnel should refer to a sexual assault case by a designated code when verbal references are needed. For example, the term "Code R" would not attach any stigma to the patient.

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[5]Lisa Brodyaga, Margaret Gates, Susan Singer, Marna Tucker, and Richardson White, Rape and Its Victims: A Report for Citizens, Health Facilities, and Criminal Justice Agencies [Prescriptive Package], A project supported by Grants No. 74-DF-99-006 and P.O. 5-1077-J-LEAA to the Center for Women Policy Studies and subgrantees Blackstone Associates and Legal Resources, Inc., by the National Institute of Law Enforcement and Criminal Justice, Law Enforcement Assistance Administration, U.S. Department of Justice (Washington: Center for Women Policy Studies, November 1975); Gerald Bryant and Paul Cirel, An Exemplary Project--A Community Response to Rape: Polk County Rape/Sexual Assault Care Center, Des Moines, Iowa, Prepared by Abt Associates, Inc., under Contract No. J-LEAA-014-74, for the National Institute of Law Enforcement and Criminal Justice, Law Enforcement Assistance Administration, U.S. Department of Justice (Washington: Government Printing Office, March 1977); Burgess and Holmstrom, Rape; Ann Wolbert Burgess and Lynda Holmstrom, "The Rape Victim in the Emergency Ward," American Journal of Nursing 73, No. 10 (October 1973):1740-45; Casey Eike and Polly Pettit, Sexual Assault: Kansas Community Conference Handbook, Prepared under Grant No. 75-A-2791-1-A from Kansas Governor's Committee on Criminal Administration and Douglas County, Kansas (Lawrence, Kans.: Douglas County Rape Victim Support Service, October 1976); Arthur Frank and Stuart Frank, "Medical Aspects of Rape," Mademoiselle, February 1976, pp. 46-47; Gager and Schurr; John M. MacDonald, Rape: Offenders and Their Victims (Springfield, Ill.: Charles C. Thomas, 1971); and National Organization for Women [NOW], NOW Rape Task Force Project Kit (Chicago, 1973).

• In preparing the pre-examination workup, the history should be in the patient's own words. The chart may become legal evidence, so all statements must be objective, accurate, and legible.

• The patient's consent should be obtained for the necessary medical tests, treatment, and photographs and for the release of her hospital records to the police for evidentiary purposes. In addition, hospital personnel who do not have the patient's specific consent should never discuss a sexual assault case with anyone.

• The history should be taken in privacy, and it is important to preface each question with an explanation of why it must be asked.

• Questions should cover topics such as whether the patient has douched, bathed, or gargled since the incident, the date of her last normal menstrual period, a description of her current contraceptive usage, the time of her last sexual intercourse, and her use of alcohol and other drugs.

• Documentation of the patient's emotional state and physical injuries should be accurate in every detail.

• All records pertaining to sexual assault cases should be stored in a locked safe. The establishment of this system will serve to emphasize the confidential and sensitive atmosphere that should prevail when a rape assault patient is in the emergency room.

A gynecologist should conduct the physical examination and treatment. He should respond promptly, should ascertain the medical history from the nurse, and should corroborate pertinent data with the

patient. The physician's examination should also have a set protocol, but it should be tailored by the circumstances of the assault, the emotional condition of the patient, and the degree of trauma. However, circumstances permitting, the physician's examination will routinely cover and consider the procedures and matters listed below.

- The physician will give the patient emotional support and sympathetic understanding.
- He will perform a general examination and prescribe treatment for any physical trauma.
- He will perform the necessary treatment for venereal disease (VD). He should inform the patient that results of the VD tests will only indicate if she had VD before she was assaulted, not whether she contacted it during the assault.
- The physician will conduct necessary procedures for the prevention of pregnancy. If he offers diethylstilbestrol (DES) as a contraceptive, he must explain its after-effects.
- All evidence gathering procedures should be tactfully explained to the patient. In addition, it is just as important for the physician to explain each step of the pelvic examination.
- Evidence gathering procedures can be accomplished better through the use of a "rape kit" (combings from the pubic hair; saliva sample; fingernail scrapings; examination of the entire body; photographing obvious physical trauma; documenting the presence or absence of sperm; documenting the condition of the hymen).

• A chain of custody on all evidence should be established. Since most of the victim's clothing will be taken as possible evidence, a fresh set of clothing should be available for her.

When the medical work is completed the victim should be given her follow-up appointments (verbally and in writing), and the physician should talk with her about her possible exposure to venereal disease and pregnancy. If possible, the victim's family should also be given understanding and guidance. Arrangements should be made to escort the victim to her home or to temporary housing. What is most needed from this point on is not special medical care but understanding and caring, both of which are more difficult to obtain. The referral counselor who arrived at the emergency room about the time the victim did is prepared to provide the special understanding and caring that may be needed well into the future.

Victim Support Referral Agency

The goal of the counselor is to restore the victim's pre-rape emotional equilibrium and level of activity. Significantly, a community's law enforcement and medical personnel should recognize the importance of rape counseling services. They must know how and when to contact a counselor and what they can expect from a counselor.

Sexually assaulted women usually suffer most from fear--fear of dying, fear of being assaulted again, and fear of retaliation if they decide to prosecute. This fear, along with a number of other emotional

ramifications, constitutes a rape trauma syndrome that is treatable with emotional counseling and support from professionals, para-professionals, and friends. The main trauma is the emotional scar on the victim's daily living and lifestyle.

The rape crisis counselor performs a myriad of unheralded tasks in striving to assist a rape victim. Notably, however, the counselor:[6]

- Serves as a consultant to medical and nursing staff members in the emergency room in an effort to enhance sensitive treatment of the victim and thereby reduce her anxiety.
- Plans physical comforts for the victim's hospital stay.
- Serves as a resource center for the victim, her family, the police, and health professionals.
- Meets the victim at the hospital, assists in preparing her for the medical examination, and stays with her during the examination.
- Offers confidential nonjudgmental emotional support.
- Listens in a way that supports and validates the victim's feelings, always encouraging the victim to express whatever feeling she has in whatever legitimate way she desires to do so.

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[6]Brodyaga and others; Burgess and Holmstrom, Rape; Burgess and Holmstrom, "The Rape Victim in the Emergency Ward"; Sandra S. Fox and Donald J. Scherl, "Crisis Intervention with Victims of Rape," Social Work 17, No. 1 (January 1972):37-42; William H. Masters and Virginia Johnson, "The Aftermath of Rape," Redbook Magazine, June 1976, pp. 74 & 161; and Polly Pettit, Sexual Assault: Victim Assistance Handbook, Funded by Grant No. 75-A-2791-1-A from Kansas Governor's Committee on Criminal Administration and Douglas County, Kansas (Lawrence, Kans.: Douglas County Rape Victim Support Service, October 1976).

- Assesses the victim's coping behavior ability in facing reactions of the rape trauma syndrome.

- Provides follow-up treatment so the victim can integrate the rape experience into the whole of her life, neither repressing her experience nor being dominated by it.

- Accompanies the victim in law enforcement contacts and in court appearances.

- Assists the victim in making decisions.

- Discusses the rape experience with the victim's family and close associates. The crisis disrupts their lives also, particularly if knowledge of the assault becomes public. Sometimes the crisis brings underlying problems in relationships to the surface. A counselor can act as a facilitator during conversations when communication has become difficult.

CHAPTER IV

SUMMARY, CONCLUSIONS, AND RECOMMENDATIONS

The purpose of this study was to examine the uniquely specific relationships of a law enforcement agency, a medical agency, and a victim support referral agency in reducing a rape victim's trauma and increasing the likelihood that she will follow through in the process of prosecuting her assailant. Inherent in this study was the authorship of a rape victim assistance manual for use in Leavenworth County, Kansas (Appendix A). The manual provides information about the range and intensity of services that the victim of a rape needs if she is to cope successfully with the trauma brought on by the attack. The scope of study was narrowed to identify areas that municipalities in Leavenworth County can apply.

The problem was to look at the services available to a rape victim and to determine the services needed within Leavenworth County. The Leavenworth County Sheriff-provided the basic issues. Although the manual provides the framework and rationale in formulating a sound victim assistance program, the institutions themselves must provide the cooperation and leadership.

The review of related literature revealed that communities need the services of a rape victim assistance program and that the programs

instituted have been quite successful. The majority of recent studies stress that forcible rape is a violent crime with more emphasis on aggression than on sex. Organizations identified with or sympathetic to the women's movement generated considerable public awareness of the rape problem. They were generally critical of how criminal justice and medical establishments treated rape victims. Recently, mass circulation periodicals have featured articles about rape and its victims. As a result, the attitudes of community, police, and hospital personnel toward sexual assault are changing. Professionals are beginning to realize that psychological damage to a victim is a serious complication that must be properly and sympathetically treated.

The remainder of the practicum, including the manual, discusses the roles of the police, hospitals, and victim referral counselors in providing victim support services. Emphasis is on the positive steps that members of these institutions can take to reduce the victim's trauma and to increase her chances of a successful prosecution. The end result of this study focuses specifically on recognizing psychological trauma in assault victims, providing medical and referral supportive services to lessen the impact of the trauma, making the Leavenworth County criminal justice system more responsive to a victim's needs, and generally improving all systems the victim is likely to contact if she reports the assault.

The foremost conclusion of this practicum is that community success in maintaining cooperatively effective police, hospital, and

referral support procedures and practices in the rape crisis situation will lessen the victim's trauma and will greatly assist in returning her to her pre-assault emotional state and level of ability. A resulting increase in confidence in the institutions discussed will obviously encourage a larger number of victims to report rape assaults and to follow through in prosecuting assailants who are apprehended.

The second conclusion, just as important in some quarters, is that rape must be recognized as a crime of violence instead of as a sex crime. The basic reaction that causes the rape trauma syndrome is fear. Rape not only inflicts pain, humiliation, and fear for the duration of the actual attack, but it may also cause the victim to suffer lasting physical and psychological damage.

This practicum's third and final conclusion is that Leavenworth County can develop a successful rape victim assistance program if it establishes the basic procedures and practices listed below.

- Train police officers in the emotional needs and reactions of rape victims as well as in rape investigative procedures and offer periodic refresher courses in both areas.
- Insure that detectives are especially sensitive toward the victim in their conduct of rape investigative procedures.
- Have available in all departments at least one policewoman who is capable of performing adequately in the rape crisis situation.
- Narrow the communication gap by providing rape victims and the community at large with full information about police, medical, and

legal procedures, including information about why certain questions must be asked and certain evidence must be collected.

- Insure that hospitals recognize rape as a legitimate health issue and that they extend to rape victims the same services they extend to others.
- Take a rape victim to the hospital as soon as possible and insure that she will receive high-priority hospital treatment.
- Train all medical personnel who handle rape victims in the special sensitivity and evidence gathering procedures.
- Insure that professional and/or para-professional counselors are immediately available for emotional support and psychological follow-up counseling for the victim and also her family.

Prior to this practicum, Leavenworth County, Kansas, did not have a coordinated rape victim assistance program. The key to this proposed program is that personnel within the police and medical complex must bring about change in themselves before they can help in changing the problem. While the solutions are multi-leveled and interlocked, the bottom line is a change in attitudes.

The foundation of this-practicum's recommendations centers on Leavenworth County's need for emphasis, awareness, education, and study concerning the subject of rape. Some general and specific recommendations are advanced in the hope that the conclusions of this practicum will also be applied and that additional research and cooperation on the part of municipal agencies will be stimulated.

The primary goal of this practicum, a rape victim assistance manual for use in Leavenworth County, Kansas, has been accomplished. The goal of implementing an effective program depends upon the attitudes of the managers involved. Community leaders should not be misled by the low reported rape figure in the county. Instead, they should capitalize on the contents of the manual by pooling their respective resources to help in developing an effective rape victim assistance program.

In the meantime, each legal and medical agency can implement some portions of the proposed manual immediately. Other recommendations may require more time. The Metropolitan Organization To Counter Sexual Assaults (MOCSA), Kansas City, Missouri, is prepared to assist its "sister" agencies in Leavenworth County at no cost to the community. Incidentally, MOCSA was initially formulated by a small core group of concerned police officers who went outside their traditional roles of apprehension and investigation to seek citizen involvement in treating rape victims.

It is recommended that the sponsor of this practicum, the Leavenworth County Sheriff's Office, adopt the proposed manual as an integral part of its police operations. This positive initiative should serve as a basis for an open, cooperative, and mature system of rape support services. Responsibility for aiding rape victims does not lie with the criminal justice system alone; however, any comprehensive program should begin with the agency that the victim first contacts. From that point on it is a matter of cooperation and coordination with

and among city police, the medical community, mental health personnel, prosecutors, MOCSA, and interested citizens to implement the ingredients of the proposed manual. Hopefully, the manual's philosophy, conclusions, and recommendations will be in effect prior to the next reported rape in Leavenworth County, Kansas.

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RAPE VICTIM ASSISTANCE MANUAL

FOR

LEAVENWORTH COUNTY KANSAS

BY

PAUL C. MOURIS

1977

INTRODUCTION

The purpose of this manual is to identify the roles municipal agencies play as a supportive service for victims of forcible rape. The manual emphasizes that the reduction of the victim's trauma and the urging toward a successful prosecution are a total community responsibility. Each and every agency must be interdependent on the others in an effort to accomplish the desired goals. This manual provides information about the range and intensity of services the victim of a rape needs to cope with the trauma brought on by the attack.

The first section begins with the rape itself and describes the emotional impact on the victim's life. It explains exactly what the "Rape Trauma Syndrome" is. The important issue is that rape is not primarily a sexual act. On the contrary, rape is primarily an act of violence with sex as the weapon. Consequently, this crisis situation usually produces predictable behavior that can assist the police and the medical institution in their treatment of the victim. Finally, the first section establishes that rape is a legitimate health issue and that rape victims need the care among the repertoire of services provided within a medical center.

Sections II and III focus on the police and medical institutions, specifically their need for innovative and empathic services to

victims. These kinds of services will serve as deterrents to the crime of forcible rape by facilitating reporting procedures and, therefore, apprehension and prosecution of the assailant.

Reporting a rape initiates the complex process discussed in Section IV. The victim must cope with the usual institutional patterns of the hospital and criminal justice system, which, at best, she experiences as confusing and alien. Yet she presents herself to these authorities at a time of crisis that differs from other crises because her usual support system is probably disrupted. Her reporting of the crime establishes her as public property, and immediately she is at the mercy of the police and the hospital. These are the main reasons concerned municipal agencies must understand why the victim needs empathy, safety, and a sense of control over what has happened and what will happen in her encounters with hospital and law enforcement personnel. Any lack of sensitivity causes her reporting experience to become another assault.

The author realizes there may be community resistance to recognizing rape as a legitimate health issue that requires medical and psychological services, but this manual shows that a woman who has recently been raped takes on the label of patient. Voluntarily or involuntarily, she assumes a role that is characteristically associated with being damaged and helpless. Regardless of the presence or absence of physical injury, the emotional trauma of forced violation, which frequently is committed under the threat of death, establishes the victim's right to sensitive professional care.

SECTION I

RAPE TRAUMA SYNDROME

In spite of the attention focused on the problem of rape in recent years by numerous books, magazines, newspaper articles, movies, and television programs, too little is known about the various kinds of injuries the rape victim may suffer.

> . . . Only the purely physical effects have received attention from the investigators; yet the most severe trauma associated with a sexual assault usually is not physical in nature. It is psychological--a result of the victim's sense of having been forceably taken, freely used and completely depreciated as a human being.[1]

Rape is almost an ultimate violation. It is just short of homicide and is best understood in the context of a crime against the person and not against the hymen. Rape is an act of violence and humiliation in which the victim experiences overwhelming fear for her very existence as well as a profound sense of powerlessness and helplessness which few other events in one's life can parallel.

Forcible rape is defined as the carnal knowledge of a woman by an assailant by force and against her will. Ann Wolbert Burgess and Lynda Lytle Holmstrom, in their book Rape: Victims of Crisis (Bowie, Md.: Robert J. Brady Company, 1974), reached the conclusion that

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[1]William H. Masters and Virginia Johnson, "The Aftermath of Rape," Redbook Magazine, June 1976, p. 74.

victims suffer a significant degree of physical and emotional trauma during the rape, immediately following the rape, and over a considerable period of time after the rape. Victims consistently described certain symptoms over and over. The authors define these clusters of symptoms as the rape trauma syndrome and attribute to it two stages or phase reactions.

The first stage or phase reaction is the acute stage. It includes the moments, hours, and days immediately following the rape, when there is a great deal of disorganization in the woman's lifestyle. In the immediate hours following the rape, the woman may experience an extremely wide range of emotions. The impact of the rape may be so severe that she demonstrates feelings of shock, disbelief, or dismay. Burgess and Holmstrom conclude that victims show two main styles of emotion: expressed and controlled. In the expressed style the victim exhibits feelings of anger, fear, and anxiety. In the controlled style she masks or hides her feelings and seems to be calm, composed, or subdued.

The rape victim often appears at the police station or the hospital in an agitated, incoherent, and highly volatile state. She is frequently unable to talk about what happened to her or to describe the man who assaulted her. Sometimes the victim initially appears stable but breaks down at the first unexpected reminder of the incident. In the expressed style, the victim is often restless during the interview, becomes tense when certain questions are asked, cries and sobs when

describing specific acts of the assailant, or even smiles in an anxious manner when certain issues are stated. These mannerisms frequently occur at the time the victim must first deal with the consequences of the assault. Notification of parents is often one of the early issues that upsets the victim during the acute stage. The controlled style destroys the prevailing myth that a victim must be hysterical and tearful immediately following the rape.

Rape, forced sexual violence, elicits descriptions of a wide gamut of physical reactions. Many victims report general feelings of soreness all over their bodies and specific soreness from physical attack on the throat, neck, breasts, thighs, legs, and arms. Victims also report physical symptoms that are specific to the area of the body that was the focus of the attack. For example:

> . . . Victims forced to have oral sex may describe irritation to the mouth and throat. Victims forced to have vaginal sex may complain of vaginal discharge, itching, a burning sensation on urination, and generalized pain. Those forced to have anal sex may report rectal pain and bleeding in the days immediately following the rape.[2]

Rape victims have considerable difficulty with disorganized sleep patterns in the acute stage. They complain that they cannot fall asleep or, if they do, they find themselves waking up during the night and they cannot fall asleep again. Victims who have been attacked while sleeping in their own beds may awake nightly at the time the attack

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[2]Ann Wolbert Burgess and Lynda Lytle Holmstrom, Rape: Victims of Crisis (Bowie, Md.: Robert J. Brady Company, 1974), p. 39.

occurred and they cannot fall asleep again. Victims' screaming out in their sleep is not uncommon. Tension headaches and fatigue are also common symptoms.

The second stage of the rape trauma syndrome begins when the woman sets about reorganizing her lifestyle and dealing with after effects of the rape. Although the time of onset varies from victim to victim, the second stage usually begins about two to three weeks after the attack. Victims express a wide gamut of feelings that range from fear, humiliation, and embarrassment to anger, revenge, and self-blame. A majority of those working in the area of rape would not argue that the victim's main reactions are feelings of shame and guilt and that these feelings arise because of prevailing stereotypes and myths. For example, widely held beliefs are that rape is a sex crime, nice women do not get raped, women who are raped asked for it, and women actually enjoy rape. Nonetheless, the primary feeling victims usually express is fear, fear of physical injury, mutilation, and death.

Fear explains why victims develop the range of symptoms Burgess and Holmstrom call the rape trauma syndrome. The symptoms are acute stress reactions to the threat of being killed. Most victims are convinced they had a close encounter with death and are lucky to be alive. Seeing a car that is similar to the one in which she was abducted or seeing a man who resembles her assailant can evoke a strong emotional reaction. New and immediate symptoms may last a few days to a few weeks, but, in essence, more often than not the symptoms during the

long-term recovery process are merely reflections of symptoms during the acute stage.

Rape represents a disruption in the victim's lifestyle, not only during immediate days and weeks following the incident but well beyond. Many victims move to another residence. Some experience a strong need to get away and, if they can afford to do so, take trips to other states or countries. Others respond to the rape by staying home, by venturing out of the house only if accompanied by a friend, by being absent from work or school an unusual number of times, or by dropping work or school altogether. Still others change their telephone number or request an unlisted number. They do this as a precautionary measure or because they receive threatening calls. Rape victims fear the assailant may gain access to them through the telephone, and they are also hypersensitive to obscene telephone calls that may or may not be from the assailant.

Dreams and nightmares, which occur during both the acute phase and the long-term recovery process, are major symptoms of the rape victim. Also, phobias may develop as a defensive reaction to the circumstances of the rape. The most common phobic reactions Burgess and Holmstrom discovered were fear of indoors, fear of outdoors, fear of being alone, fear of crowds, fear of people behind them, and sexual fears.[3]

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[3]Burgess and Holmstrom, p. 45.

In summary, the rape trauma syndrome includes the acute or immediate phase of disorganization and the long-term process of reorganization that occur as a result of attempted or actual forcible rape. The acute phase consists of the immediate impact reaction (either expressed or controlled emotions), physical reactions, and emotional reaction to a life-threatening situation. The long-term recovery process involves changes in lifestyle, dreams and nightmares, and phobic reactions.

With the increasing reports of rape, the rape trauma is not a private syndrome. It should be a societal concern, and its treatment should be a public charge. Police, hospital personnel, and professional counselors will be called upon more and more to assist rape victims in the acute stage and in the long-term reorganization process. The role of the police, the victim's first encounter with the legal system, is discussed in Section II.

SECTION II

FIRST LINE OF THE LEGAL PROCESS: THE POLICE

Criticism of police procedures in the handling of rape complaints frequently stems from the atmosphere of suspicion and doubt that investigators reflect. The victim feels she must prove her innocence instead of relating a single account of circumstances surrounding the sexual attack. Rape victims frequently voice complaints about the manner of police questioning, the attitude of male officers toward the victim, and a lack of sensitivity that is emphasized in the repititious nature of the investigation. The consequences of such complaints are that many victims are further traumatized, much evidence may be lost, and victims who believe they were mistreated discourage other rape victims from going to the police. The procedures for investigating a case of forcible rape are examined in this section because the victim's initial experience with the police sets the tone of her reaction in the related experiences that will follow.

In most cases the accusatory, skeptical, and insensitive treatment the victim all too often receives from police officers is merely a reflection of the internalized attitude of most men. The belief that rape is principally a sex crime still prevails in the minds of many. This belief has led to the supposition that there may actually be some

enjoyment on the part of the victim of such an assault. Many people, including police officers, believe the victim may have consciously or unconsciously invited the attack. These attitudes about the nature of male-female relationships, about women in general, and about rape victims in particular are instrumental in determining both the qualitative and quantitative response from the police who deal with the rape victim. Moreover, many investigators believe that the crime of rape does not involve any special problems.

Policemen must be taught to understand the complexity of emotions the victim of rape may experience. Specifically, all officers on the force must develop a sensitivity to the rape trauma syndrome because at least one of them is normally with the victim at various times throughout both phases during the investigation. This includes the dispatchers, the patrolmen, and the detectives. It is important that the police gain the victim's confidence and cooperation the moment she encounters the legal process. An understanding of the traumatic shock she suffered, an overt display of concern for her, and a genuine interest in assisting her through this difficult period must take initial priority. Her cooperation will also assist the officer in obtaining the necessary evidence at the scene and in gaining her confidence to undergo a thorough physical examination.

In reporting her assault to the police, the first person the victim generally contacts is the dispatcher who answers her call. His first duty is to determine if the situation is an emergency. "Any one

of these factors places the call in that category: The victim states that she has serious injuries; she says that the event was recent; or her manner of speech indicates that she is suffering severe emotional distress."[1] However, the dispatcher must assume that the victim is in a state of crisis even if she seems calm and rational. These guidelines should be disseminated throughout the police department.

The dispatcher's tone and manner must be calm and supportive of the victim. His next responsibility is to get the victim's name and location and advise her to wait for the patrol officers. He then dispatches patrol officers and, if appropriate, an ambulance, indicating the call is an emergency rape complaint. If the dispatcher has been successful in holding the victim on the line, he reassures her that assistance is on the way. If she is in a safe place, he instructs her not to bathe, change clothes, douche, brush her teeth, comb her hair, or clean up in any way and not to touch articles or furniture the rapist may have touched. Next, the dispatcher can explain what the department is doing in the meantime and who is on the way to her location. He can also voice a sense of compassion and responsiveness.

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[1]Lisa Brodyaga, Margaret Gates, Susan Singer, Marna Tucker, and Richardson White, Rape and Its Victims: A Report for Citizens, Health Facilities, and Criminal Justice Agencies [Prescriptive Package], A project supported by Grants No. 74-DF-99-006 and P.O. 5-1077-J-LEAA to the Center for Women Policy Studies and subgrantees Blackstone Associates and Legal Resources, Inc., by the National Institute of Law Enforcement and Criminal Justice, Law Enforcement Assistance Administration, U.S. Department of Justice (Washington: Center for Women Policy Studies, November 1975), p. 31.

The dispatcher should also attempt to get the location of the attack, the identity or description of the attacker, and the attacker's means of escape. This information is then transmitted to all other patrols. The detective squad and the laboratory squad (if one is available) are then dispatched. They should be the only squads present in addition to the initial squad. Once the situation is under control, all other patrols should leave the scene to avoid confusion at the scene and at a subsequent trial. To avoid callousness from developing, a program of training and retraining for dispatchers is necessary.

Officers who initially respond to the rape complaint must realize that sympathetic support and reduction of emotional trauma are the most critical phases for the victim. In addition, those officers usually provide the bulk of the evidence for the prosecution. Their first responsibility is to give attention to the victim's medical needs. Preferably, one officer will transport the victim to a hospital for medical treatment or will make arrangements to have her taken there.

> [He] will undertake the sole responsibility for dealing with and questioning the victim. His partner [or another patrolman] will assume primary responsibility for preserving the scene, gathering evidence, and seeking assistance from detectives and the crime laboratory, instructing dispatcher to notify the hospital, a sexual assault counselor [if available] . . . .[2]

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[2]Gerald Bryant and Paul Cirel, An Exemplary Project--A Community Response to Rape: Polk County Rape/Sexual Assault Care Center, Des Moines, Iowa, Prepared by Abt Associates, Inc., under Contract No. J-LEAA-014-74, for the National Institute of Law Enforcement and Criminal Justice, Law Enforcement Assistance Administration, U.S. Department of Justice (Washington: Government Printing Office, March 1977), App. C, p. 4.

The police department should issue procedural outlines to be given to the victim to prepare her for the necessary steps in her personal treatment and the investigation of her case. As a minimum, four areas should be covered. They are the interview with the victim, the crime scene, police assistance regarding the medical examination, and information concerning the follow-up investigation. In addition, the department should utilize special complaint forms for rape investigations. Several good examples are shown in some of the bibliographic literature listed at the end of this manual.

The preliminary interview at the crime scene can be crucial for both victim and investigators. Questions clearly and sympathetically asked may elicit key information that will lead to a rapid arrest and the preservation of vital evidence. Contrarily, aside from further injury to the victim, crude and arrogant interrogators can so frighten the victim that her responses will be limited and important facts will not be reported. The officer "in charge" should answer the questions of other officers at the scene, and only he should present their questions to the victim. In other words, only one of the officers at the scene should converse with the victim.

The victim's first interview with the patrolman is one of the most important phases of the investigation. He must use his own judgment to determine if her condition warrants treatment at a hospital before she is interviewed. It is important that the officer does not prejudge the victim. He should proceed on the assumption that the

report is bona-fide. He must be aware of the trauma the victim has experienced. He must be alert that she may be in a state of confusion and disorientation and that defense mechanisms such as denial and repression may be in operation. In any case, the first interview should be short and should cover only essential points.

The initial brief interview should be carried out with as much privacy as possible. The officer must establish a rapport with the victim by behaving in a calm and objective manner. He should gain her confidence by giving the appearance that he knows what he is doing. He must avoid being forceful as he adopts a non-judgmental attitude. The important point is to let the victim tell the story in her own words, with as few interruptions as possible. The officer should not attempt to question the victim about minute details she does not volunteer. If he does, the victim is likely to "clam up" or to tell a partial story that may later cause problems in a trial. If the victim requests a female officer, the officer "in charge" should terminate the interview as soon as he has obtained enough information to fill out the incident report.

The interview must be as brief as possible for meeting the minimum requirements of the incident report. Questioning should be directed toward revealing the following points:

- Elements of the crime.
- Identity of the suspect.
- Suspect's method of operation during commission of the crime.

- Weapons or instruments used.
- Items the suspect may have touched.
- Abnormal sex acts committed.
- Injuries sustained by victim or suspect during the crime.

The following type questions will establish the elements of the crime and will assist in identifying the suspect:

- Did the suspect use a weapon?
- Did the victim resist the attack? The suspect may have blood, scratches, or injuries that may help to identify him.
- Did the suspect keep his clothes on during the sexual act? If so, semen stains are probably present on the outside of his clothing.
- Did the suspect have a car? Did the victim get the license number?
- Does the victim know the suspect's name, address, or phone number?
- Did the suspect make penetration? This question must be direct, without using offensive terms. Use proper terminology: penis, vagina, intercourse, anal intercourse, erection, fellatio, cunnilingus, sodomy, etc.

It must be emphasized that the questioning should not cover any details of the sexual aspects of the crime except as they relate to evidence that must be preserved and to establishing what crime was committed. Overzealous questioning of the victim during the initial interview could result in a great deal of harm and will likely affect

the case as much as the victim by creating in her negative attitudes that will reduce her willingness to cooperate. It is important that patrolmen remain impartial and record occurrences as related. They should not challenge the truthfulness of the victim in an attempt to clarify inconsistent and illogical statements she makes. Discrepancies revealed as a result of the interview should be conveyed to the detectives. A patrolman who is in tune with the victim's mood and reactions will adapt his questions to the circumstances and the person and will sympathetically draw from her the most pertinent information. Anyone can ask a list of questions, but the officer who understands the human dimension in a crisis situation has the power to turn a potentially difficult interview into a positive experience for both officer and victim.

Officers dealing with the victim should be honest about their feelings, and they should not make any promise they cannot keep. Before she is transported to the hospital she should be instructed not to bathe or douche. "The officer should photograph the victim before any clothing is removed or before any cleaning or straightening up of the victim is done. Close-up photographs should be taken of any injuries to the victim, no matter how minor."[3] This may be accomplished at the hospital. It is sometimes better for a female police officer to take the preliminary photographs. The officer who prepares the incident report

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[3]Bryant and Cirel, p. 5.

should be sure to include a comment regarding the victim's condition and appearance. Most importantly, he should tell her "what is going on" by tactfully and properly explaining the need for a medical examination and alerting her that specialized detectives will contact her after she has received proper medical attention.

The other officer must preserve the crime scene and notify the dispatcher to put out an all points bulletin on the suspect. The police are concerned with supporting the following legal charges:

- Sexual penetration, however slight, did occur.
- Force was used in the assault.
- The victim was forced into a sexual act against her will.

Officers at the scene have the greatest opportunity and responsibility for protecting the scene from contamination. Viewing and analyzing the crime scene while it is still fresh are challenging responsibilities. Police skills in gathering physical evidence, making technical studies, and piecing together every minute clue are extremely important in catching the assailant and proving the crime. All too often, however, sloppy and inadequate work by policemen at the scene prevents an arrest or ruins a rape case in court. Guidelines A, B, and C below represent the minimum in gathering supportive evidence.

A. <u>Interior</u>

a. Photograph and diagram the scene.

b. Note points of exit and entry, routes traveled. Check for pry marks.

c. Examine for fingerprints.

d. Recover all possible evidence: gags, knots, tape, etc.

e. Recover clothing that has evidentiary value: victim's outer clothing, ripped garments, bedding used, rugs, cushions, seat covers, articles the suspect touched.

f. Recover and submit hairs, fibers, buttons, handkerchiefs, hairpins, tissues, undergarments, etc.

g. Check for broken objects.

h. Check and collect the wash cloth and towel the victim used if she bathed after the incident.

i. Check and collect objects the assailant handled: glasses, paper, cigarette butts, etc.

j. Check for wiping agents: clothing, tissues, towels, handkerchiefs, paper, etc.

B. Exterior

a. Check escape route for possible discarded weapon or other evidence.

b. Examine area for footprints.

(1) They may provide information that indicates there was a struggle or victim was dragged and size, shape, or design of shoes.

(2) They should be photographed (if located).

c. Check for body marks on dirt.

(1) If the act was accomplished on bare soil, there is a possibility of visible disturbances in the soil: impressions of knees, feet, shoulders.

(2) Type of disturbance may indicate the presence or lack of violence.

(3) Photograph (if possible).

d. Check for matted areas in grass.

(1) If the act was accomplished on grass, the grass will be matted or depressed for a period of time, depending upon the weather.

(2) If located, note location, lighting, and general size of the matted areas and take appropriate photographs.

e. Check for vegetable matter.

(1) Whenever the act is accomplished on the ground, there is a good possibility that vegetable matter will adhere to the clothing of both victim and suspect.

(2) When such material is located, leave it where it is and preserve the clothing.

(3) A standard of the types of material should be gathered from the area of activity: grass, leaves, etc.

f. Check the presence of dirt and vegetable matter on the victim's person and clothing if the act was accomplished on the ground.

(1) If on her person, note the location.

(2) If on her clothing, preserve the clothing as found.

(3) A standard of soil in the involved area should be gathered and submitted.

C. Automobile

a. Check vehicle for fingerprints.

b. Check vehicle's door handles for hair.

c. Examine seats for blood and seminal stains (remove and submit for evidence).

d. Recover articles that may have been used as a wiping agent after an emission: handkerchiefs, rags, tissues, etc.

e. Tire tracks

(1) Most rapes that occur in vehicles take place in secluded places which are often without paved surfaces.

(2) If located, photograph the tracks and note type of tread, type of design, width of tires, width of vehicle (center of tire to center of tire), and possible length of vehicle.

The laboratory of the Kansas Bureau of Investigation can perform scientific tests on all of the above types of evidence. In addition, a "rape kit" for use by the examining physician should be available in the emergency room. The evidence thus gathered from the victim is discussed in Section III. Unfortunately, police agencies seldom employ all of the available scientific tests. While evidentiary items and traces are not conclusive in themselves, they become of great value in the prosecution when they have been accumulated and are used in conjunction with the victim's testimony.

The role of the detective is as important as any other in the rape crisis situation. During the investigation he must discover the entire story and the complete truth. Investigation is a craft that is learned through careful study and the development of skills by repeated use. This includes viewing and analyzing the crime scene and conducting a detailed interview with the victim. His role is particularly important because he will be with the victim through the entire rape trauma syndrome. The detailed interview, which should be made only after the victim has received medical attention and psychological support, must cover in further detail the same questions the patrolman covered.

The detective must make adequate preparation for the interview by thoroughly reviewing all available information about the incident. Before encountering the victim, he should:

- Know what has been reported (names, places, descriptions, etc.).
- Check the police records for victim's involvement in criminal activities or previous complaints.
- When possible, gather personal information about the victim.
- Be familiar with the crime scene and the evidence gathered.
- Know the necessary elements of the offense and what facts need to be established.

The detective should attempt to combine the initial preliminary contact with the follow-up interview so that at least one occasion on which the victim is required to repeat her story can be eliminated. Again, the atmosphere of sympathetic concern for the victim, an injured individual against whom a crime has been committed, is essential to the interview. The detective also needs to be sensitive to the physical setting of the interview room on the victim. Some questions he might consider are:

- Is the room too small?
- Are there harsh surroundings and an uncomfortable room?
- Are the chairs uncomfortable?
- Is there privacy or are people allowed to walk in and out during the interview?

The detective must avoid physical barriers between him and the victim. The interview should be held in a comfortable setting that affords privacy and freedom from distractions.

It is often desirable that a female detective conduct the interview. The major problem seen by many feminists is that most police officers are male and men look at rape as primarily sexual, while women see it as primarily violent. However, sometimes using a female officer is not possible, so the police department should consider utilizing the presence of a trained female, such as a nurse or social worker, to help ease the victim's embarrassment and anxiety.

At the onset of the interview, the detective should explain investigative procedures to the victim. Likewise, he should explain why he must ask certain questions about the rape itself and about her personal life. He may add that the same questions will be asked in court if the case results in trial. To assure the confidence of the victim, the detective should not refer to the assault as an "alleged" assault in her presence, because this would imply doubt on his part and make the victim defensive. The victim may have to repeat certain sections of her story if inconsistencies appear, but the interviewer should explain the need for such intensive questioning and should treat her with respect as an intelligent person. "The victim should never be threatened, shouted at, cursed, disparaged, teased, provoked, insulted, hounded, or treated in any other demeaning way. Police destroy their own dignity and credibility by making aspersions and innuendos against a victim, even if they genuinely doubt her report."[4] The detective should also avoid

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[4]Nancy Gager and Cathleen Schurr, Sexual Assault: Confronting Rape in America (New York: Grossett and Dunlap, 1976), p. 80.

congregating and joking with others in the presence of the victim. The policemen who deal with the rape victims during the trauma period sometimes fail to realize how hypersensitive the victims are to an action or statement.

Instead of being supported and understood by the detective at a time of trauma and shock, all too often the victim is treated with a lack of respect and is regarded scornfully. Some male investigators actually display an insensitive attitude of being more interested in explicit sexual details than in catching the rapist. "Were you a virgin before the rape occurred?" "Did you like it?" "Did you climax?" "Did his language excite you?" "How much prior sexual experience have you had?" Such questions have little to do with finding the rapist and much more to do with human curiosity or satisfying the officer's vicarious sexual urges.

If the detective applies sensitive interview techniques, the victim will respond with information and cooperation. The detective has but to keep in mind that

> the crime of rape has produced a crisis not only for the victim but for the entire family as well. The impact of the crisis, its shattering effects, the regressive tendency of all members of the family cry out for a firm, gentle but knowledgeable authority who, by his actions, can satisfy the need for support and strength.[5]

The success of the crisis intervention technique is based on the theory that police are immediately available and are authoritative figures;

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[5]Morton Bard and Katherine Ellison, "Crisis Intervention and Investigation of Forcible Rape," Police Chief, May 1974, p. 71.

thus they can be of great assistance in reducing stress if they are gentle and understanding.

Once again, the victim should be allowed to describe what occurred in her own words and without interruption. As the victim tells the story of the rape, she will also tell a great deal about herself. Her mood and general reactions, her choice of words, and her comments on unrelated matters can be useful in evaluating the facts of the case. The detective should phrase his questions in simple language, making sure that he is understood. Police phraseology can be extremely offensive, for example, referring to the assailant as the "gentleman" or asking: "What did the man say when he was making love to you?" A host of observations by an alert detective will contribute to his impression of the victim's character and her reliability as a witness.

The detective should summarize what has been covered in the interview and should ask the victim if anything needs to be added. After the interview has been completed, he should ask the victim to write her statement. If the victim does not wish to write her statement, she should be able to dictate it to the detective, who will write it for her. The victim should be encouraged to contact the detective at any time, and she should be told that she will be kept informed of any developments.

Finally, the detective must be aware that some victims experience long-range emotional problems. He must be sensitive to the process of identifying the attacker or suggesting that the victim take a

polygraph examination. The validity of the report must be based on factual evidence gathered by the investigation rather than on personal feelings about it. It must not be standard procedure to use a threat of false charges to intimidate the victim. However, on occasion false report penalties may be mentioned to the victim if, in the detective's personal judgment, there are blatant contradictions in the report and in the evidence.

A policeman is generally not qualified to judge whether a victim is in need of psychiatric care as the result of her experience. Yet, if the emotional trauma is so evident it indicates to him that such follow-up care might be in order, he should suggest such to the victim. If possible, he should explain the victim's condition to her family to avoid the possibility of upsetting her further. The family should also be advised that the victim may encounter emotional difficulties and that signs of trauma such as depression or withdrawal should be reported to her physician.

After the process of report taking is completed, the detective should keep the victim informed about the status of her case. This would include information such as apprehension of the assailant, charges placed against him, and date of her first appearance in court. Once the investigation is closed, the prosecutor's office is responsible for keeping the victim informed regarding developments.

As discussed in detail in this section, the responsibilities of the police department in the rape crisis situation are to get the victim

to a hospital for medical treatment as quickly as possible, to gather and preserve evidence from the scene of the crime, and to conduct a sensitive, in-depth interview with the victim. The proper and thorough handling of these matters will reduce trauma to the victim and, hopefully, will encourage a larger number of victims to report valid rape complaints. Physical examination of the victim and evidence gathering procedures at the hospital are discussed in Section III.

SECTION III

HOSPITAL PROTOCOL

Resistance to recognizing rape as a legitimate health issue that requires medical and psychological services is prevalent in many county hospitals. Public as well as private hospitals very often refuse to treat victims of sexual assaults. Hospitals and doctors fear becoming involved in time-consuming court cases, being attacked by defense attorneys because of negligence and incomplete evidence, and being made to look foolish. Doctors also fear becoming legally liable if they are asked to treat a victim without reporting the rape to the police. A common complaint of rape victims is that no one offers them an adequate explanation of reasons for the doctor's treatment and medication procedures. Also, many women who were virgins or had never had a pelvic examination have complained about the doctor's lack of sensitivity in treating them after the rape.

People working with rape victims, as well as victims themselves, point to one conclusion: As often as not, doctors and hospitals give inadequate help and actually increase the victim's psychological trauma. What is most needed is not special medical care but something that is more difficult to obtain, understanding and concern. Medical procedures in treating rape victims and the role of medical personnel are examined

in this section. The psychological counseling referral services are discussed in Section IV.

Medical personnel must be aware of the psychological as well as the physical needs of a rape victim. In addition, they play a very important role in gathering evidence. Hospital personnel generally see a sexual assault victim in the immediate hours following the assault. These hours, as discussed in Section I, are part of the victim's acute phase of reaction in the rape trauma syndrome. It is essential to the victim's current and future mental health that the emergency room people offer her non-judgmental support.

When the patrolman or the detective reaches the hospital with the victim, she should be placed away from the waiting area of the emergency room. So that everyone understands his responsibility, the police, hospital, referral agencies, and laboratory facilities should operate together under formal arrangements. A "rape kit" should be available at the emergency room for use by the examining physician. Even though no severe physical trauma may be present, sexual assault patients should receive priority treatment. All efforts should be made to minimize additional emotional trauma.

Attitudes of treatment personnel are as important as medical proficiency. Doctors, nurses, and hospital attendants should all be trained. They should be required to explain the need for each procedure carefully and sympathetically to the patient, and they should administer the treatment with concern for the patient's reactions. It is suggested

that emergency room staff meet the patient at the door and promptly escort her to the examination room. A statement similar to the one that follows should suffice.

> Hello, my name is Nurse _____ [or Dr. _____]. We know you've been through a very traumatic and shocking experience. It may be hard for you to talk about what just happened, but we need to ask you some questions to help you medically and legally. We need to do an examination and collect some specimens for testing. We will explain the reason for each question and test. If at any time you have a question or don't feel like talking, we understand why, but we'll try to answer any questions you ask. We want to help you the best way we know how.[1]

After the initial contact with the patient, a preexamination work-up usually involves taking her medical history. Throughout this interview it is important to preface each question with an explanation of why the information is needed. Just like the police, the doctors and nurses should avoid the designation "alleged." They have no right or need to refer to a rape as "alleged" since this is a legal term, not a medical term. Although medical evidence is used to establish whether rape has occurred, the fact of rape is entirely a question for the courts. It is advisable for hospital personnel to refer to a sexual assault by code when verbal references are needed. For example, the term "Code R" would be appropriate. The history should be in the

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[1] Gerald Bryant and Paul Cirel, An Exemplary Project--A Community Response to Rape: Polk County Rape/Sexual Assault Care Center, Des Moines, Iowa, Prepared by Abt Associates, Inc., under Contract No. J-LEAA-014-74, for the National Institute of Law Enforcement and Criminal Justice, Law Enforcement Assistance Administration, U.S. Department of Justice (Washington: Government Printing Office, March 1977), p. 31 (with minor modifications).

patient's own words. At this stage it is usual to obtain the patient's consent for the necessary medical tests, treatment, photographs, and release of her hospital records to the police for evidentiary purposes.

It might seem unnecessary to stress that the history should be obtained in privacy, but too often interviews are conducted in the emergency room within earshot of others. The history the patient gives will provide a guide to the location of bruises, scratches, or other injuries; however, her whole body should be examined.

> . . . After she has finished, direct questions may be required to clarify her account and to explore topics which have not been mentioned such as the use of alcohol or drugs, prior sexual intercourse including the date of the most recent act of intercourse prior to the rape, the date of the last menstrual period, pelvic infections or operations, the use of birth control pills or devices and prior experiences of sexual assault.[2]

It is also important to know whether the patient douched prior to the examination. Neither the physician nor the nurse should conduct an in-depth interview regarding the assault; they should only attempt to determine the nature of the assault on the patient as it relates to the examination and treatment.

Other than obvious physical injuries, the patient's most immediate physical needs are the prevention of venereal disease (VD) and pregnancy. A gynecologist should conduct this treatment. Some controversy exists over the routine use of antibiotics for venereal disease prevention and hormonal intervention (diethylstilbestrol, DES) for

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[2]John M. MacDonald, Rape: Offenders and Their Victims (Springfield, Ill.: Charles C. Thomas, 1971), p. 104.

pregnancy. Many women experience an adverse reaction to this medication in that they show symptoms similar to severe morning sickness during pregnancy. The woman should be told that if VD tests are performed during the examination they will only indicate if she had VD before she was raped, not if she contacted it when she was raped.

Procedures for prevention of venereal disease should include:

1. Cultures taken from vagina, rectum, and throat, if appropriate, for bacteriological testing for gonnorhea.
2. VDRL blood test for syphilis.
3. Determining if patient desires immediate treatment for venereal disease, and if so,
4. The administration of appropriate VD prophylaxis.
5. An explanation of the side effects of any treatment administered.
6. An explanation of the importance of obtaining VD tests at a later date to determine whether or not she has contracted any venereal disease or vaginal infection as a result of the attack.
7. Follow-up to make sure the patient receives post exam venereal disease testing.

Procedures for the prevention of pregnancy should include:

1. A pregnancy test, when appropriate, to determine if patient was pregnant prior to the assault, especially if estrogens may be used for therapy reasons.
2. An explanation to the patient that she needs another pregnancy test 6 weeks after her last period to determine whether she has become pregnant from the assault, especially if anti-pregnancy therapy is not administered.
3. A thorough oral and written explanation of possible anti-pregnancy procedures, including menstrual extraction, adoption, elective termination or abortion, or the administration of DES.

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4. Determination of the advisability of administering DES. DES should be considered only if:

   The patient is not currently using contraception.

   She is not currently pregnant.

   She has no history of cancer, diabetes, or heart disease.

   It is within 72 hours of her unprotected exposure to pregnancy.

   The facility has the ability to terminate a pregnancy if DES is administered and fails, or can make an appropriate referral.

   The patient is informed of all side effects, both short and long term.

5. Follow-up to determine reactions to any anti-pregnancy therapy administered and to make sure victim obtains a post exam pregnancy test, as needed.[3]

The patient's entire body must be examined for injuries and for foreign materials useful as evidence (fibers, lint, dirt, grease, vegetation fragments, etc.). Bite marks on the face, neck, and breasts are frequent. The thighs may show evidence of force. "Samples of the victim's pubic hair are examined in the police laboratory for foreign hairs which may reveal the sex, approximate age, and race, as well as the part of the body from which they came (although a specific individual cannot be identified)."[4]

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[3]Casey Eike and Polly Pettit, Sexual Assault: Kansas Community Conference Handbook, Prepared under Grant No. 75-A-2791-1-A from Kansas Governor's Committee on Criminal Administration and Douglas County, Kansas (Lawrence, Kans.: Douglas County Rape Victim Support Service, October 1976), pp. 36-37.

[4]Nancy Gager and Cathleen Schurr, Sexual Assault: Confronting Rape in America (New York: Grossett and Dunlap, 1976), p. 86.

There are times when a physician will be the only one who can adequately and competently examine a rape victim and properly record the data necessary for police investigative purposes. In addition to the documentation of his observations, the proper collection and preservation of whatever physical evidence the physician recovers may be most essential in the apprehension and subsequent prosecution of the person responsible for the assault. Evidence gathering procedures can be accomplished better through the use of the previously mentioned "rape kit."

Each kit should contain:

1 pair small scissors

1 disposable plastic comb

3 cotton swabs or sterile applicators

3 slides

2 double slide mailers

2 2-1/2" x 3-1/2" envelopes

1 tube for blood sample

1 culture tube (to be filled with normal saline solution for acid phosphatase)

1 dry test tube or vacutainer-evacuated glass tube

KBI [Kansas Bureau of Investigation] instruction sheet[5]

All items in the kit can be obtained through hospital supply sources.

All procedures for collecting evidence are included in the guide

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[5]Eike and Pettit, p. 38.

titled "The Kansas Bureau of Investigation's Instruction for Evidence Collection from Rape Victims" (see Form KBI-L051 in Eike and Pettit, pp. 43-44). It should be noted that pubic combing is often bewildering and obnoxious to victims and must be tactfully explained. In addition, it must be recognized that some patients may not have had a pelvic examination before. It is especially important to explain each step and how it will feel to these patients. Finally, there is no necessity for police officers to watch the victim's examination under the guise of securing the evidence.

If physical trauma is evident, a female should take the photographs. Two copies of each are needed (one for the chart and one for the police). The physician must also document the presence or absence of sperm. If an accurate, legible, and complete medical record is done, the chart and tests will speak for themselves. In some cases, the physician does not have to be present in court for certification of tests and medical records. The records custodian may appear in his behalf. A confidential, locked safe should also be established for sexual assault case files.

Procedures should also be established for a chain of custody on all evidence, i.e., body fluids, clothing. Consequently, hospitals should secure the evidence they have gathered until such time as the police or prosecutor needs it. Since most of the victim's clothing will be taken as possible evidence, she should be provided a fresh set of clothing. These clothes need not be elaborate, just comfortable

clothing to help the victim relax until she can change into her own clothes.

When the medical work is completed the victim should be given her follow-up appointments (verbally and in writing). She should already be in contact with referral counselors, whose role is discussed in Section IV. Arrangements should be made to escort the victim to her home or to temporary housing. Finally, at some point, hospitals and doctors should work out procedures for treating victims who do not wish to report the rape to the police. The task of the doctors, nurses, and therapists is to heal the afflicted and to avoid increasing the injury.

SECTION IV

PSYCHOLOGICAL COUNSELING REFERRAL SERVICES

This manual has thus far stressed the need to understand and demonstrate concern for the plight of the rape victim. Generally, every woman reacts according to her own makeup and the circumstances of the rape. Specific reactions depend on many factors: age, sexual experience, emotional integration; the sort of rape (by an acquaintance or by a stranger); the attitudes of police, medical, and legal authorities; the attitudes of the victim's family, friends, and community. Although one might expect the victim to find supportive counseling wherever she turns, such is not the case.

The final section of this manual defines the role of a victim referral support service that will provide trained rape crisis counselors. A rape crisis counselor is a consultant to medical and nursing staff members in the emergency room, and his or her interpretation of the victim's behavior, together with empathy on the part of the medical staff, can enhance sensitive treatment of the victim and thereby reduce her anxiety. In addition, the counselor will serve as a resource center for the victim, her family, and the community through consultation and educational programs for the police, educators, health professionals, and, just as importantly, the general public.

The counselor should be notified as soon as it is known that a rape victim is to be admitted to an emergency ward. The counselor must be able to understand the victim's coping behavior ability when faced with all reactions of the rape trauma syndrome. The assessment of coping behavior and strategies provides the counselor with two valuable therapeutic measures. First, such assessment can be used as a supportive measure. The second use of the assessment of coping behavior is that the counselor can determine a reference point for beginning the clinical negotiation for crisis service.

The counselor's humanistic skills will make a major difference in how the victim feels she has been treated at the hospital. The victim should be encouraged to talk. She has many feelings and thoughts about the rape and she often wants to talk if she feels someone will listen. Talking helps people to feel better and this, in turn, gives understanding of their reactions to the incident.

A counselor who listens carefully can understand the victim's distress. When a person is understood, that person is no longer alone and is more in control of a given situation. After listening to the victim recount the rape, the counselor can identify the coping behavior and impart this information to the victim. Therefore, the counselor should try to get as complete a picture as possible of the event and its aftermath. A special dimension of listening and understanding is to help the victim bear the feelings she is trying to express. Sharing the pain by verbalizing it is an emotionally strengthening experience for

the victim.

The counselor's technical skills are also an important part of the overall crisis management of the rape victim. The counselor can give the victim important information in preparing her for the physical and gynecological examinations. The victim needs to know what is expected of her and what the physician will be doing and why. The counselor can also arrange for physical comforts while the victim is in the hospital. Victims often complain of feeling dirty and request a place to wash themselves. Many have been raped outdoors. Some have been urinated on. A basin of water for the victim's use immediately after the medical examination is often overlooked by the medical staff. Since many victims are forced to perform fellatio during a rape, a mouthwash should also be made available.

Medical facilities must emphasize the need for immediate and sustained psychological counseling. As mentioned in Section I, the longest-lasting effect of rape is nearly always the psychological damage the victim suffers. A diagnosis of the rape trauma syndrome should be considered when the counselor observes any of the following symptoms during an evaluation interview:

> Increasing signs of anxiety as the interview progresses, such as long periods of silence, blocking of association, minor stuttering, and physical distress;
>
> Report by the patient of sudden marked irritability or actual avoidance in relationships with men or marked change in sexual behavior;
>
> History of sudden onset of phobic reactions and fears to [of]

being alone, going outside, or being inside;

Persistent loss of self-confidence and self-esteem, self-blame attitude, paranoid feelings, dreams of violence, and nightmares.[1]

Follow-up treatment for medical and counseling purposes is an important part of assisting rape victims. They need calm, reassuring, unwavering support. They need to know they are not crazy and the rape cannot be allowed to become a dominant factor in their lives. Every counselor must stress the victim's need for integration and adjustment and also the importance of reactions of people close to her. Husbands and boyfriends must also be counseled. They should have the counselor's name and telephone numbers. The hospital's initial support person should use follow-up telephone calls or home visits to suggest that victims take advantage of available counseling facilities.

It must be recognized that a fully functional, comprehensive rape victim services project requires constant availability of trained personnel. Since few communities can afford to pay for such services, volunteers must provide the bulk of services that are important in the rape crisis situation. In the absence of a professional rape crisis counselor, the hospital should have on hand the phone number of the nearest rape crisis center. However, the victim's number should be referred to the crisis center only with her permission and with the understanding that a follow-up person from the center will take the

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[1]Ann Wolbert Burgess and Lynda Lytle Holmstrom, Rape: Victims of Crisis (Bowie, Md.: Robert J. Brady Company, 1974), pp. 48-49.

initiative in contacting her.

There is much to be said in favor of a counseling capability that is located outside the criminal justice agencies and the hospitals. After medical and investigative procedures, the counselor can maintain telephone and personal contact with the victim throughout the lengthy prosecution process. Many believe that a counselor who can meet the victim immediately and accompany her throughout the entire legal process will provide more continuity than, for example, an emergency room nurse. The counseling goal is to minimize the possible stresses of the aftermath of the sexual assault and attempt to return the victim to her pre-assault state.

The rape crisis creates a disruption in the victim's lifestyle. The question for the counselor is how to help, to determine the needs of the victim in crisis. Appendix IV - C of the prescriptive package Rape and Its Victims offers rape victim counselors the following advice:

> As a counselor it is important to remember that you cannot separate a person's experiences, personality, and lifestyle from the crisis of rape. When we talk about counseling a rape victim, we are talking about a whole person whose momentary focus is on a specific crisis or incident and whose future life will be somehow affected by this incident. The knowledge of this fact and the ability to deal with the victim as a whole woman is what differentiates a counselor from a police officer, an examining physician, or a district attorney. All these people can be understanding and sensitive to the victim in conjunction with the performance of their responsibilities. And the performance of these duties may contribute to the well being [sic] of the victim (through rapist apprehension, proper medical treatment). The counselor goes further in providing emotional support, concrete environmental manipulation, and a potentially insightful and maturing experience. The counselor must be prepared to pick out salient concerns and deal with them initially with [when] decision-making is necessary. Concerns over family

> relationships, employment, school, and health will come up again, and the counselor can help the victim through further counseling or referral to appropriate people or agencies who can help her, if she so desires.[2]

The counselor should also talk about the experience with the victim's family and people close to the victim. The best support often comes from a friend or the husband who encourages a rape victim to express her anger, fears, or insecurity and then reassures her of her worth and the love of her friends. Counseling, whether sought or not sought, is not a replacement for warm, concerned, loving communication. The stronger the relationships between the victim and important people in her life, the greater the chance that they will support her through the crisis period and that she will need minimal counseling input.

After the rape, when the victim tries to find understanding from her loved ones, her choice depends to a large extent on the options available. While the husband seems to be the most appropriate person a married woman could or should turn to, in fact he may be the least understanding. The most frequent problem is the husband's inability to cope with the fact that his wife has been raped, especially if knowledge of the assault has become public. Without adequate counseling, the

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[2]Lisa Brodyaga, Margaret Gates, Susan Singer, Marna Tucker, and Richardson White, Rape and Its Victims: A Report for Citizens, Health Facilities, and Criminal Justice Agencies [Prescriptive Package], A project supported by Grants No. 74-DF-99-006 and P.O. 5-1077-J-LEAA to the Center for Women Policy Studies and subgrantees Blackstone Associates and Legal Resources, Inc., by the National Institute of Law Enforcement and Criminal Justice, Law Enforcement Assistance Administration, U.S. Department of Justice (Washington: Center for Women Policy Studies, November 1975), p. 290.

event may disrupt or terminate the marriage relationship. A counselor can act as a facilitator during the conversations between the two when communications may be difficult.

The friend, neighbor, co-worker, or husband's best friend turned rapist creates the most troublesome situation of all for the victim. Rape by a person she knows well provides a far more humiliating and traumatizing experience for her than rape by a stranger, because she has an emotional investment in the person. Her husband may not believe her; others, the police, for example, may express skepticism and scorn for the woman who turns in a friend and may even see her as the betrayer and the rapist as the betrayed. A counselor must be sensitive that the victim's ability to maintain old relationships or to establish new and meaningful ones may be severely damaged.

If the rapist was a stranger, the victim often fears that he was psychotic and may return to do her further harm. The victim's fear will be particularly strong if the rapist threatened to harm her again, as often happens if he suspects she will report the rape to the police. The victim needs positive assurance from those around her that life is worth living and that she needs to explore alternate ways of coping with her fear of attack.

Different rape encounters are perceived differently by different victims. Obviously there is a difference in how individual victims of any trauma react. It is common, however, for victims to ask a counselor to help them make decisions or to answer questions for them. This

happens because they are in crisis, and their normal methods of dealing with people and situations are not available to them. It must be remembered that the victim has just been through an experience in which she was stripped of all consent and control, so it is important that the counselor enable her to make her own decision. For example, the victim may ask: Do you think I should go to work tomorrow even though people will see I am all bruised? or: Do you think I should press such charges? Making her own decision can be an important step in reestablishing her self-esteem, taking control of her life again, and dispelling the feelings of helplessness. The counselor should support and stand by whatever decision the victim makes.

Whether the counselors are professionals or para-professionals, they must be aware that rape is a violent physical crime and that the aftereffects are often harrowing. A woman who has been forcibly raped cannot be expected to return to normalcy immediately. She sees the world from a perspective that is clouded by fear, guilt, embarrassment, or anger. Follow-up begins within 48 hours after the initial emergency room contact. Subsequent contacts are made at regular intervals for at least one year. The frequency and content of intervention are based on the needs of the victim and the timing of exacerbation of symptoms, such as a court appearance. As fears subside, especially if motivating factors are present, the victim will return to her pre-assault state. The counselor must continue in the meantime to meet with the victim's friends and relatives to discuss their concerns and to mobilize their

support.

Finally, a rape crisis counselor can conduct special sensitivity training sessions for police and medical personnel in regard to the emotional needs and reactions of victims of sexual assault. Training of this kind would help police and doctors to understand the actions and reactions of victims and would eliminate much of the confusion which now exists in their attitudes toward victims. An increased sensitivity and understanding on their part would do much toward increasing the victims' confidence in these institutions and, hopefully, would thereby increase the number of rape reports.

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The primary goal of this study was to design a rape victim assistance program for Leavenworth County, Kansas. The scope of the study was narrowed to identify those areas that the municipalities in Leavenworth County could apply to their community. Specifically, the roles of the police, hospitals, and victim referral counselors were investigated to determine their impact on the life of the victim in a rape crisis situation.

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Block 20 - continued:

The underlying theme is that rape is a crime of violence and not a sex crime. Consequently, the victim's reaction to the assault is fear. The fear, in turn, produces strong psychological effects that are classified as the rape trauma syndrome. The recognition of rape as a violent attack on a woman necessitates that legal and medical personnel provide empathy and understanding in working with rape victims. Rape must also be recognized as a legitimate health issue if the victim is ever going to be protected from further psychological damage.

Practices and procedures delineated in this study represent the ones this writer believes are essential to a salient rape victim assistance program. When Leavenworth County adopts and implements the manual that was prepared as an integral part of this practicum, the major end results should be a reduction in the victim's trauma and an increase in the likelihood that she will follow through in the prosecution of her assailant.