Medical and Legal Aspects of Rape

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Initial management of a rape victim calls for a thorough examination, a written record of her account of the assault, proper collection of physical evidence that a rape has been committed, and sensitivity to the woman's emotions. Physician recognition of the many — and often paradoxical — signs and symptoms of the rape trauma syndrome is essential in dealing with the psychological aspects of the event.

In the United States a woman is forcibly raped every 8 minutes, so that the probability that a physician will be called on to treat a victim of rape is high. Unreported rape is estimated to occur 3 to 10 times more often than reported rape. One woman in 10 will be the victim of an attempted or actual rape during her lifetime. In 85 per cent of these assaults, the victim is beaten or intimidated with a display of life-threatening physical force. One in 4 victims, subjected to group rape, is likely to suffer more direct physical violence and extreme humiliation. Approximately one-half of all rape victims are assaulted in their homes. Contrary to popular belief, rapists pay little attention to appearance. The woman's "sexual allure" has little to do with her being chosen as a victim. Another disturbing fact: the incidence of rape in women over 60 has increased by 800 per cent during the last 15 years.

Emotional Impact of Rape

Rape is not merely a sexual assault but a violent crime directed against a woman that is capable of disrupting her physical, emotional, social, and sexual equilibrium. Because of the force, brutality, and humiliation associated with rape, the victim experiences the assault as a violation of her self and this may precipitate a personal crisis. She is left with feelings of terror, disbelief, helplessness, and loss of control over her life. Although responses vary with the victim's prior adaptive capability, coping style, and social support system, the physician must realize that there is no typical reaction to rape. Victims do, however, share certain reaction patterns.

To appreciate the emotional impact of rape, the physician must understand how people behave in a crisis. The data on emotional disorganization following any gross stress such as fire, explosion, or rape are remarkably similar and suggest that approximately one-quarter of the population behaves in a cool and reasoning fashion, while an additional quarter becomes mentally and emotionally incapacitated. The remaining 50 per cent are numbed and bewildered by the event. When stress is overwhelming, as it is in rape, increased vigilance is often followed by a diminished sense of alertness and a dulling of the senses, memory, and affective responses. Initially, some patients exhibit shock and disbelief, and may experience severe anxiety, apprehension, and fearful-

Rape Trauma Syndrome

Acute Phase of Disorganization
- Shock
- Disbelief

Expressed Affective Impact
- Anxiety
- Fearfulness
- Sobbing
- Smiling
- Shaking
- Restlessness

Controlled Affective Impact
- Calmness
- Composure
- Silence

Mood Swings
- Humiliation
- Degradation
- Guilt
- Shame
- Embarrassment
- Self-blame
- Anger
- Revenge
- Fear of another assault

Physical and Physiologic Symptoms
- Exhaustion
- Sleep disturbance
- Soreness
- Bruising
- Skeletal muscle tension
- Gastrointestinal irritability
- Appetite disturbance
- Genitourinary disturbances

Thought Processes
- Denial
- Undoing
- Obsessing

Long-Term Process of Reorganization
- Reorganization of lifestyle
- Some affective reactions
- Mood swings
- Physiologic reactions
- Dreams and nightmares
- Fears and phobias

ness, displayed in sobbing, inappropriate smiling, shaking, and restlessness. Others may appear calm, composed, silent, or withdrawn.

Initial Management

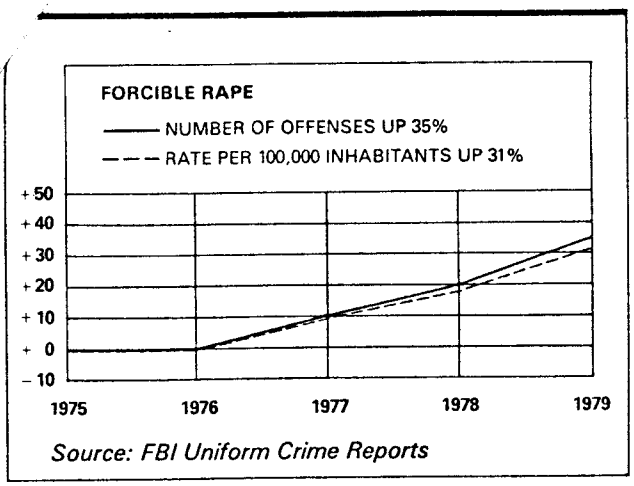
When a rape victim comes to the physician's office, she should be treated promptly. Nursing personnel should be prepared in advance to provide any victim with nonjudgmental support. The woman should be asked if she wishes to see a clergyman of her faith.

The mannner in which the initial examination is conducted is often the first step in the psychiatric management of the rape victim. Escorting her into a quiet private room where she is never left alone enhances the woman's dignity and sense of security. The physician should spend as much time as possible to evaluate and support the victim and establish rapport. A careful explanation of procedures to be performed and the reasons for them can help to allay the victim's sense of anxiety, fear, and mistrust. The patient should be allowed to talk freely about the episode if she chooses. On the other hand, the woman who remains quiet and withdrawn must not be forced to recall details that make her apprehensive.

Written consent for examination and treatment is best obtained prior to examining or treating the patient. The physician takes a detailed history, performs a careful physical, and records the victim's report of the event in as detailed a manner as time permits. Specific consent should be signed for the collection of material that may be used as evidence (e.g., x-rays, slides, smears, photographs, and pubic hair combings). If possible, sedatives should be withheld during the initial history taking and examination, since early sedation may impair the victim's ability to recount important facts and further contribute to her sense of loss of control. When sedatives are required, they should be administered sparingly.

The history should be taken to determine the medical diagnosis and treatment, not to make a legal judgment as to whether rape occurred. Such judgments are the domain of the courts. It is important that the physician use the phrase "alleged rape" or "alleged sexual assault" when making entries about the event in the patient's record. The victim should, however, be encouraged to describe in her own words the assault, the circumstances that led to the event, and the incidents that occurred afterward.

Sensitivity to the victim's subjective response and self-appraisal while she describes the assault is as important as the attention given to the external details of the assault. Knowledge of the surrounding circumstances may help predict the course the woman's emotional reactions will take in the weeks following



Source: FBI Uniform Crime Reports

the rape. Having the victim describe the event in her own words may give her an opportunity to express her feelings and thus serve as the beginning of treatment insofar as the emotional aspects of the rape are involved.

Important areas to be covered in the history are the time and place of the assault; a description of the assailant, his manner and appearance, his method of approach and assault, his use of alcohol or drugs, and his use (or nonuse) of contraceptives; the nature of the sexual assault (vaginal, oral, or anal); coercive measures used (verbal threats or the actual use of physical violence, or weapons); the actions of the victim during the assault (struggling or otherwise resisting, acquiescing, or cooperating); and the actions of the victim after the assault (bathing, douching, or attempting to obtain any other medical intervention). The victim's gynecologic history should detail existing and past problems, surgical procedures, pregnancies, method of contraception, dates of most recent menses and coitus before the assault. Information about alcohol and drug use on the part of the victim during the assault is also important in assessing the victim's general mental state and her sense of helplessness and loss of control. If the victim was under the influence of alcohol or drugs before the assault, she may be more likely to condemn herself and feel guilty on later reflection about her diminished capacity to take care of herself.

For medicolegal purposes, it is advisable to have a nurse present during the entire medical examination and to have her cosign the history and certify that it is an accurate account of what the patient said. If the patient wishes and gives written consent, and the physician concurs, a friend or relative may be permitted to remain with her during the examination. A nurse should be present if possible when the victim undresses, and be trained to note on her nursing chart the condition of the victim's clothing, making particular reference to rips, torn buttons, stains, and so on. Clothing should be carefully identified and stored in plastic bags for subsequent analysis.

The physician should perform a detailed mental status examination to document whether cognitive impairment is present during the victim's initial report. This may be helpful in explaining any subsequent discrepancies in testimony. A detailed neurologic examination for central nervous system trauma or injury that would impair mental function is also essential. If appropriate, consultation with a psychiatrist, neurologist, or pathologist should be sought and carefully recorded.

The physician should conduct the examination in a manner that will make the patient feel comfortable, secure, safe, and in control. During the physical examination, the presence of bruises, lacerations, tears, or foreign bodies should be described accurately and treated appropriately. Before any treatment is administered that will alter the physical signs of the rape, written consent should be obtained from the victim for medical photographs, which may then be taken and identified. X-rays and other laboratory work should be done as indicated.

Forensic samples to be taken, labeled, and specifically identified with an appropriate mark and placed in separate containers, include the following: a vaginal smear for acid phosphatase determination; a vaginal smear to determine the presence of semen blood antigen; cervical and rectal cultures for gonorrhea; blood samples for serologic testing; fingernail scrapings; pubic hair combings; clothing; and medical photographs of lesions or bruises.

The physician must deal with the possibility that the patient has contracted a venereal disease from the rapist. In most cases a prophylactic antibiotic is administered without waiting for the test results. If the woman is in her reproductive years and is not using an oral contraceptive or IUD, a postcoital contraceptive, usually DES, may be suggested.

Emotional Management

It is advisable to explain to rape victims the reactions they may experience as a consequence of the assault. Specifically, the physician should explain that many victims develop anxiety, insomnia, various physical complaints, and nightmares, and that these symptoms do not indicate an impending mental illness. Whenever possible, support should be offered to reinforce adaptive patterns of behavior that the victim has undertaken and to increase her self-esteem. If the victim has told friends, family, and police about the rape, the physician can explain that the first step in dealing with the assault has been taken. If the woman wishes to prosecute, she should be reassured

Assisting the Rape Victim

Case Report - *What To Do*

A 68-year-old white woman was brought to the emergency room of a university teaching hospital by city police. She was dazed, agitated, and terrified. Her face was bruised and a fracture of the left orbit was found. Before beginning the physical examination, the physician sat beside the patient, and spoke to her quietly, reassuring the woman that she was now safe. Multiple bruises were evident on her breasts, arms, and abdomen. Vaginal bleeding secondary to vaginal tear was also present. Laboratory examination of vaginal smears showed semen, and examination of pubic hair combings revealed the presence of pubic hairs different from those of the victim. Fingernail scrapings contained skin cells of a different blood type. The woman became quiet and withdrawn, and responded to any verbal contact by sobbing: "Why me? Why me?"

The victim appeared shamed and humiliated, and expressed concern about how to tell her children that she had been the victim of such a crime. The physician reassured her that she was in no way to blame and that her behavior was typical of rape victims and necessary to save her life. He made an appointment to see her in his office.

Case Report - *What* Not *To Do*

A 35-year-old, twice-divorced mother of three was beaten and raped while crossing a city park in a large metropolitan area. She submitted to her attacker without resistance. After the assault, she walked to a nearby hospital and informed the emergency room physician that she had been raped. Initially, she did not appear upset and had no significant bruises on her body. The physician examined her and recorded on her chart that she said she had been raped, but few details of the woman's report were given verbatim. Also included was the physician's suggestion that the patient notify the police after discharge from the emergency room and that a vaginal smear for semen was taken. In his notes the physician mentioned that the woman was attractively dressed, wore jewelry and makeup, and did not seem to be overly concerned about the assault. No mention was made of any formal mental status testing, nor were pubic hair combings, fingernail scrapings, medical photographs, cultures for venereal disease, or clothing obtained.

The following day the woman reported the rape to the police, and was able to identify her assailant in a police lineup approximately 10 days later. When the case went to trial, the defense attorney developed the following points: the victim had been divorced; she had an active sex life; the alleged rape took place late at night; she was attractively dressed and heavily made-up; she did not seem to be particularly concerned by the rape when seen in the emergency room; and there was no specific evidence of a physical nature to prove that a rape had occurred. The attorney also underscored discrepancies between her initial report of the rape, obtained the day after the assault, and a statement she made approximately 2 weeks later. Her assailant was found not guilty.

that this is a constructive way to deal with her anger and that her willingness to prosecute may also be helpful to other women who might be raped by the same man. If she expresses guilt or shame over having acquiesced to the rape, it is often worthwhile to acknowledge that she had no other choice but to cooperate in the face of threats of violence.

Two Phases of Rape

The physician should be aware that the rape trauma syndrome occurs in two distinct phases. The first phase represents a period of acute disorganization of personality. Most victims experience rapid mood changes and tend to harbor feelings of degradation, humiliation, guilt, shame, and embarrassment. They

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may be self-accusatory or exhibit extreme anger. The majority of individuals believe that another assault may occur, but this fear has not yet become predominant. Obsessional thinking about what they might have done to prevent or avoid the rape is often present.

During this phase, patients frequently have a sense of physical exhaustion and lassitude and begin to experience marked sleep disturbances. They complain of physical manifestations such as soreness, bruises, gastrointestinal disturbances, appetite loss, and genitourinary problems.

The physician should remember that the woman who reacts to rape with initial emotional control is just as likely to experience — at some later time — the symptoms of acute disorganization as the woman who shows early emotional disruption.

Since many victims are fearful of the consequences of reporting a rape to anyone, physicians should consider whether rape occurred in patients who show the same type of reaction listed below as women known to have been raped.

- Increasing signs of anxiety accompanied by long periods of silence, thought blocking, loosening of associations, and minor stuttering.

- Sudden, marked irritability accompanied by avoidance of relationships with men or marked changes in sexual behavior.

- A history of phobic reactions of sudden onset and fears of being alone, going outside, or being confined in small areas (e.g., elevators).

- A sudden, persistent loss of self-confidence and self-esteem associated with self-blame, paranoid feelings, dreams of violence, and recurrent nightmares.

The initial disorganization phase may last from a few days to a few weeks and usually overlaps the woman's transition into the second, or reorganization phase. Reorganization generally begins 1 week after the assault and may last for several weeks or months. During this phase the woman begins to integrate the impact and meaning of the rape. Characteristically, she reflects on how she coped with the rape and draws conclusions about herself from her behavior. She may view herself negatively and suffer a severe loss of self-esteem. Because the rape will usually alter or disrupt the woman's lifestyle, she may alter her normal routine, perhaps changing her phone number, habit patterns, residence, sphere of friends, or her job. Her dependency needs are heightened at this time, yet she may feel emotionally distant from her family and thus find it difficult to elicit their support. During the early reorganization phase, mood swings and physiologic symptoms persist. The rape victim may continually experience feelings of fear, anxiety, revenge, embarrassment, humiliation, and self-blame.

Specific consent should be signed for the collection of material that may be used as evidence (e.g., x-rays, slides, smears, photographs, and pubic hair combings).

Recurrent and violent dreams and nightmares are characteristic symptoms of the disorganization and reorganization phases. The two dream themes most commonly reported by rape victims are those of reenactment and mastery. Often, the victim is concerned about the violent nature of her dreams. Recurrent nightmares are reported by 50–70 per cent of rape victims.

Ten per cent of victims develop overwhelming fears and, eventually, phobias related specifically to the circumstances of the rape. These include fear of being in confined places or crowds and anxiety during social occasions. Such victims often report overwhelming anxiety reactions when they are left alone. Of these women, 5–15 per cent report a marked alteration in libido. Often, this has a significant impact on their marriages and tends to drive them further apart from their husbands.

A Unique Legal Problem

As the above case clearly illustrates, rape presents a unique legal problem: without physical evidence, the legal proceedings consist of one individual's testimony about another. Many women are terrified of reporting a rape because, as in the case described, they fear accusations of promiscuity and "encouraging," or provocative behavior. They are also afraid that the rapist will be freed to commit further violence without having to pay any legal consequences.

These fears should not be taken lightly, nor are they unjustified. The physician should be aware of the unique demands placed upon medical performance by rape victims and the judicial system. It is necessary to proceed slowly and systematically in examining, evaluating, and treating the victim, and in gathering forensic materials to spare the victim further humiliation and trauma in the courtroom. Proper evaluation not only comforts the rape victim but is also essential for proper functioning of the criminal justice system. □