Helping victims of rape

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Despite the frequency of the crime, victims of rape frequently prefer to remain silent and fail to take advantage of the services their communities may offer. In describing an effective rape-treatment program, the author suggests ways to overcome this reluctance.

As is true in many states, Section 261 of the California Penal Code defines rape as "an act of sexual intercourse . . . with a female . . . where she resists, but her resistance is overcome by force or violence [italics added] . . . [or] where she is prevented from resisting by threats of great and immediate bodily harm, accompanied by apparent power of execution" such as with a knife or gun. The victim also may be forced to engage in oral and anal sexual activity. In addition, she frequently suffers other abuse and physical injury. Psychologically, the victim is terrorized by her total loss of control. Rape is an assault on her integrity, sense of safety, and personal identity. It produces severe and long-lasting emotional trauma and social disruption in her own life and in that of her family.

Rape is a frequent crime. According to the Federal Bureau of Investigation, a rape is reported in the United States once every ten minutes. However, not every rape is reported; national surveys have found a ratio of 1 to 3.5 between victims who do report the crime and those who do not. Thus, with a population of over 100 million women in this country, it is reasonable to assume that at least 250,000 of them will be raped next year. If this rate were to remain constant, the chances are better than 1 in 15 that a woman will be raped sometime during her life!

Until recently, most of the literature on the topic of rape has dealt with the rapist. Criminologists and psychotherapists have tried to determine the characteristics of men who commit this crime, what makes them do it, and how they might be prevented from raping again. So far, however, no effective means of treatment, prevention, or deterrence have been developed for the rapist. Therefore, it is not surprising that the women's movement and public officials are focusing their attention on helping victims of rape.

This paper presents a response that the social work profession can make to the problem of rape. It describes the major components of an established program and presents guidelines for developing hospital-based, comprehensive rape treatment.

The initial step in developing a rape-treatment program is to identify the victim's needs. Sources of information that are helpful in this process include the views of women who have been raped, the experiences of those who provide treatment to victims, and readings in the professional literature. Together, these sources indicate that the rape victim's needs include the following:

1. Information about what to do and where to go after the rape in order to obtain medical, mental health, social, and legal services.
2. Immediate and follow-up medical care for physical trauma, collection of medicolegal evidence, prevention of venereal disease, and protection against unwanted pregnancy.
3. Immediate and follow-up professional counseling for emotional trauma and its consequent social disruption.
4. Skilled, sensitive treatment by police officers, social workers, nurses, physicians, lawyers, and others who treat or question the victim.
5. Support from significant others because talking about the experience with friends and relatives who are understanding is helpful in resolving the crisis.
6. Legal assistance including information about rights, advocacy, and representation in the criminal justice system.

PROGRAM DEVELOPMENT

Rape victims clearly require a comprehensive range of services from persons in the fields of medicine, law, and mental health. However, a woman who has been raped is in a state of extreme emotional crisis. She is not prepared to go to one place for medical care, another for counseling, and still another for information about her legal rights. Therefore, one agency must take responsibility for developing the program and for organizing and coordinating additional support services. This primary care facility must be able to treat the victim's needs for critical care and be psychologically accessible; that is, the victim must recognize it as a safe and appropriate place to go for help. Because rape frequently oc-
curs at night—well outside the normal 8:00 to 5:00 working day—this facility must be available to victims on a 24-hour basis.

The emergency department of a hospital is one resource in the community that is convenient and capable of providing the range of expertise necessary to treat the victim's immediate needs. It can mobilize in one location the diverse skills necessary for professional treatment of the medical and psychological aspects of rape trauma. The hospital staff is experienced in dealing with patients and families in crisis, in collecting and transmitting medicolegal evidence, and in coordinating community resources.

It may be neither feasible nor efficient for the hospital to support financially all the services necessary for a comprehensive rape-treatment program. There are, however, other potential sources of support, including client fees, health insurance (such as Medicaid), and law enforcement funds for medical examinations and the collection of medicolegal evidence. Many services needed by victims may be available in the community already. These resources can be incorporated into the program through the use of referral. Decisions regarding which resources to use are not purely economic; they involve an assessment of which organization can do the best job. For example, to assist the rape victim in dealing with the criminal justice system, the best approach may be to use volunteer legal advocates who have been trained by persons or agencies with special knowledge about the legal process.

The inclusion of community resources in the program is also related to their ability to respond to the unique needs of rape victims. Agencies to which victims may be referred for direct services must be assessed in terms of their eligibility requirements, methods of service delivery, and their ability to offer immediate help. Agencies with long waiting lists should be avoided.

Relevant considerations in planning care for victims of rape include space and equipment, supplies, personnel for direct services, and staff time for training. In addition, personal commitments on the part of staff to support various aspects of the program are necessary. For example, because the emotional trauma accompanying rape requires immediate counseling intervention, a social worker must be available at all times.

Most rapes are not reported. The reasons for this behavior are important because they effectively deny these victims access to services. These reasons include the following: (1) shame and guilt about acknowledging the rape, (2) lack of knowledge about what to do when rape occurs, (3) widespread publicity about the unsympathetic treatment some victims receive from hospitals, law enforcement agencies, and even their own families, and (4) lack of information about available services in the community. Access to the program is also affected by such characteristics of the community as socioeconomic status, languages spoken, and transportation services.

Rape is a crime. Because of this, there are laws that impose constraints and guidelines on a rape program. For example, California law requires that hospitals report all incidents of rape to law enforcement authorities. However, many women in need of services do not want to talk with the police. Program policies and procedures must be instituted to resolve this conflict for the benefit of the victim. For example, the hospital can inform her that although it has to disclose certain basic facts to law enforcement authorities, there is no legal requirement that she herself report or discuss the rape. Therefore, the hospital can care for the victim, protect her rights, and still fulfill its legal responsibilities.

Protocols and guidelines for treating victims have been developed by professional societies, licensing bodies, and hospital councils. These outline minimum standards and suggest procedures for supplying medical and emotional care. Implementation of these standards is not only of benefit to the victim, but may be necessary for purposes of accreditation, approval, and support.

A major issue raised by women's groups and rape victims alike has been the treatment of some victims by the police, hospitals, and lawyers. One victim called this the "continuing rape." The attitudes and behavior of everyone with whom the victim has contact, as well as the procedures to which she is exposed, have a direct impact on her emotional trauma. Therefore, education and training about rape must include the larger community in addition to the program staff.

The most important expertise for developing and directing services for rape victims is the knowledge of how to respond to emotional trauma. This trauma must be dealt with directly, by therapeutic intervention with the victim, and indirectly, through every person, policy, and procedure involved in the program. A second important skill is the ability to coordinate multiple resources. Administering a comprehensive service program to deal with rape victims and their needs involves working with individuals, groups, communities, and organizations. It requires a general understanding of social systems and social change, as well as clinical knowledge about crisis, trauma, loss, and relationships. The training and experience of the social work clinician are, therefore, particularly relevant.

MODEL PROGRAM

In view of the rape victim's needs, the Santa Monica Hospital Medical Center (SMHMC) instituted a model rape-treatment program, each component of which reflects the overall psychosocial focus of this program. The head of the hospital's department of social services, a licensed clinical social worker, is the director.

Information Dissemination The information released to the community communicates the basic premise of the rape-treatment program—that the hospital recognizes the special needs of the victim of rape and has instituted various services to meet these needs. In order to afford full access to these services and to insure their effective utilization, the hospital must give the program maximum visibility.
The information is relayed to the community in a variety of ways. These include television and radio news releases and interviews, newspaper articles, and brochures distributed to such community organizations as crisis clinics, schools, and hot lines who potentially have contact with rape victims. Use is also made of informal communication networks to spread word about the program. Talking with people about what is being done, and doing it well, encourages word-of-mouth publicity. If you help people, they will tell others.

Medical Care The medical care component provides thorough and sensitive treatment of the victim's immediate and long-term physical needs. Immediate treatment is provided at any hour of the day or night by the emergency department. This includes obtaining a brief history, diagnosing and treating general trauma, performing a gynecological examination and appropriate laboratory tests, and providing information and treatment for venereal disease and pregnancy.

The program director provides education and training for the medical and paramedical staff so that they can integrate the victim's mental health needs into medical policy and procedures. For example, rape victims are given priority for treatment, a private examining room is always used, the victim is never left alone in the room, and, before the examination, the victim is told what will be done and why. In this way, the medical care is sensitive to the victim's need for privacy. It takes into account the recent threat to her sense of safety and the importance of her being in control.

Even after the victim's emergency medical needs have been treated, follow-up medical care is often indicated. In such cases, the victim is referred to a private physician or medical clinic in the community. The social worker makes certain that the resources to which the victim is referred are financially and geographically accessible to her. To insure that the victim, who is often in a state of crisis, will remember all she is told, all instructions about follow-up care are given in writing.

Supportive Services Counseling and supportive services help the victim and others around her deal with the emotional trauma and the social problems that result from the assault. To the victim, rape involves the critical loss of cherished and significant parts of herself and her security, in addition to great disruption in feelings, relationships, and activities. The social work services focus on the meaning that the rape experience has for the victim—its immediate and long-term personal and social impact.

A unique feature of this program is that counseling is provided for all rape victims and their family and friends at whatever hour of the day or night they come to the emergency department for care. Furthermore, for four to six months following the assault, the social worker continues to provide counseling and other social services for the victim and those significant others who are key to her support. This program component is supported by the hospital, which offers these services at no cost to the victim.

Among the clinical issues with which the social worker must deal in the counseling process is one that is unique to victims of rape. A rape victim must frequently struggle with the feeling that she could have done something to prevent the assault; that somehow she allowed it to happen. She goes over and over each detail of the event, thinking of ways in which she might have been more effective in her resistance or escape. The victim wants to be in control and to undo what happened. She looks for a reason for the rape so that she can prevent any recurrence. The most commonly selected reason for its happening is that she—either by commission or omission—did something wrong.

In general clinical practice, the social worker deals with the issue of personal responsibility. The counseling process frequently involves a client's examination and acceptance of her own motivation and responsibility in a relationship or a life experience. Instilling this sense of responsibility in the client is often a therapeutic goal in the helping process. In working with a rape victim, however, the clinician must use caution to avoid this customary stance. A woman who talks about her rape needs to know that her responsibility, in this sense, is not an issue. The clinician must communicate this indirectly, by the focus of the clinical process, and directly, by saying, for example, "You were not responsible."

In addition to counseling, the social worker must also provide information to the victim about her rights and options, about rape trauma, and about the recovery processes she will experience as she moves through the medical care system and, later, through the criminal justice system. Thus, the social worker functions as an advocate or representative of the victim by giving her a professional relationship and access to information that will help her cope with the demands imposed by the experience.

Staff Training The program director orients the staff to the policy and procedures used in implementing the rape treatment program and teaches all members about rape so that they can recognize and respond to the psycho-social needs of the victim and her family. Included in staff training are social workers, orderlies, nurses, clerks, physicians—everyone who might have contact with the victim. This training also forms an important part of the regular orientation that new staff members receive.

The facts about rape, its incidence and patterns of occurrence, are useful for staff members to know, but are unsettling, especially for women. Any woman—regardless of race, age, income, marital status, living arrangements, or sexual preference—may be raped. Rape happens in places we all go and while doing all the routine
things we do in our daily lives. To improve their understanding and acceptance of the victim, it is important for staff members to know these facts.

People who work in emergency departments and hospitals see trauma and serious life crises every day. Rape is different and evokes different attitudes and feelings. Along with the clinical content of the rape experience, it is important that staff members develop this self-awareness.

Staff training is an ongoing process involving such activities as periodic in-service seminars and the circulation of articles and materials about rape. Protocols outlining policies and procedures are formulated and discussed at meetings and are then incorporated in procedure manuals where they can be referred to as needed.

The program director meets regularly with the staff to discuss issues related to the program. These meetings provide a structure by which staff members can discuss their own attitudes and feelings about rape and the treatment of victims. In addition, it gives them the opportunity to have input into the program. Since the nursing staff and other ancillary personnel have an important role in the care of rape victims, they participate in the planning as well.

A major portion of staff training is done through informal discussion. The social worker must be sensitive and responsive to comments and behavior that indicate attitudes that would be detrimental to the care of the rape victim or that reveal a troubled staff member. Another aspect of this informal training is that the social worker's recognition and responsiveness to the needs of rape victims influences the rest of the staff. When the worker comes to the hospital at 3:00 a.m. to counsel a victim and her family, staff members more fully appreciate the seriousness of a victim's needs.

Coordination with Other Agencies
This component insures that all rape victims are given access to the full range of services necessary to meet their needs. The program director establishes a current resource file of community agencies, which is available for the use of the program staff.

Not only is coordination with other agencies necessary to insure victims the comprehensive services they need, it also insures that rape victims are referred to the hospital for care. Hot lines refer rape victims to the hospital because they know that the victims' right to refuse to talk with police will be respected and that they will receive appropriate care. Law enforcement personnel provide victims with transportation to the hospital because they value the program's success in meeting the psychosocial needs of such women and because the hospital has become increasingly skilled in the procedures of collecting evidence.

Rape victims are referred to select community resources for follow-up medical care and legal advocate services not provided at the hospital. The social worker's ongoing counseling of the victim and her family provide current data regarding the value and responsiveness of these support services.

Another aspect of coordination with community agencies is the educational process of sharing skills and knowledge to improve the care of rape victims. For example, the program director gives seminars for law enforcement officers on the emotional trauma of rape and the victim's needs. In order to better understand the rape victim and prepare her for the legal process, the social worker must become knowledgeable about the criminal justice system.

Community Education
Community education enhances awareness of the significance of rape as a community problem and educates the community as a whole about rape and the needs of its victims. The primary goal is to raise the consciousness of the community so that it can deal more effectively with beliefs about rape and attitudes toward women who are raped.

The victim's trauma affects and is affected by all her relationships and experiences as well as by the attitudes and values of the community. Community education must deal with the widespread belief that rape happens only in certain places and to certain kinds of women—that is, "to those who ask for it" and "to those who let it happen." There is a self-serving comfort in promulgating this belief. Blame is a form of control—it distances and protects us, and masks our own shared vulnerability. Like attitudes about unemployment ("anyone can work who really wants to"), attitudes toward the woman who has been raped impose on the victim a further assault. Open discussion about rape reduces the stigma attached to it and, in so doing, encourages victims to seek help.

The program director gives talks and leads group discussions in such settings as schools and places of employment, at women's groups and at professional conferences. Another aspect of community education is professional consultation. Many agencies and clinicians in private practice request information about rape trauma and the work that is done with victims of rape. The program director gives seminars and training workshops to encourage the sharing of insights, procedures, and materials.

Program Evaluation
Program evaluation is necessary to modify and improve the program and to insure that it meets the needs of victims and the community. Part of the evaluation effort is devoted to an assessment of the extent to which the program components have been implemented and utilized properly, documentation of the rationale for changes in the program, and a determination of the additional steps and activities that should be initiated.

In addition, the evaluation is focused on measuring the extent to which the program achieves its objectives. Although financial resources for a true research study are not often available, partial information can be obtained by keeping records and comparing them to baseline data. For example, information can be collected on the sources of referrals and an assessment can be made as to whether these sources are directly linked to the program's components. If several women seek help on their own because they heard about the program on television, it is evident that at least one of the program's components is
having its desired impact. Similarly, as part of the routine follow-up on victims, questions are asked about the quality of care they received and whether the counseling was helpful.

CONCLUSIONS

The experience of conducting the program presented in this article has crystallized some of the major issues concerning rape treatment and the needs of victims. Perhaps the most significant issue is the pervasive impact of the unwillingness on the part of the victim to report rape. By failing to do so, she and her family deny themselves needed services and increase the risk to other women by reducing the chances of apprehending rapists.17

Reports in the public media of the cruel and judgmental treatment of rape victims by police officers, hospital personnel, and others actually deter women from reporting rape or seeking services for rape trauma. A dramatic example of this was the young woman who was brought to the emergency department having attempted suicide several days after her rape. To her, that was a better solution to the crisis than risking the harsh treatment that she was convinced she would receive.

Some reports of bad treatment are true. However, this can be changed by training all personnel who have contact with the victim, educating the community to encourage and support her to seek help, mobilizing and coordinating hospital and community resources to provide help, and publicizing the availability of effective and sensitive treatment. The experience at SMHMC corroborates that rape victims are more able and willing to provide information and to cooperate in the rapist’s prosecution when they receive support from family and friends as well as from relationships and services provided by a rape treatment program.18

It is essential that as “good” treatment is made available it is also publicized. It seems likely that as this knowledge becomes more widely disseminated, there will be an increasing demand for social workers to establish programs in their own communities to meet the needs of rape victims.

NOTES AND REFERENCES

8. The Penal Code of the State of California, Section 11160.
17. Rape Victimization Study, p. 86.
18. Olson and Stiers, op. cit., p. 18.