Rape Trauma Syndrome

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The authors interviewed and followed 146 patients admitted during a one-year period to the emergency ward of a city hospital with a presenting complaint of having been raped. Based upon an analysis of the 92 adult women rape victims in the sample, they document the existence of a rape trauma syndrome and delineate its symptomatology as well as that of two variations, compounded reaction and silent reaction. Specific therapeutic techniques are required for each of these three reactions. Crisis intervention counseling is effective with typical rape trauma syndrome; additional professional help is needed in the case of compounded reaction; and the silent rape reaction means that the clinician must be alert to indications of the possibility of rape having occurred even when the patient never mentions such an attack.

RAPE affects the lives of thousands of women each year. The Uniform Crime Reports from the Federal Bureau of Investigation indicated a 121-percent increase in reported cases of rape between 1960 and 1970. In 1970, over 37,000 cases were reported in the United States (1). A District of Columbia task force studying the problem in the capital area stated that rape was the fastest growing crime of violence there (2).

The literature on sexual offenses, including rape, is voluminous (3–5), but it has overlooked the victim. There is little information on the physical and psychological effects of rape, the therapeutic management of the victim, and the provisions for protection of the victim from further psychological insult (6–9).

In response to the problem of rape in the greater Boston area, the Victim Counseling Program was designed as a collaborative effort between Boston College School of Nursing and Boston City Hospital to provide 24-hour crisis intervention to rape victims and to study the problems the victim experiences as a result of being sexually assaulted.

The purpose of this paper is to report the immediate and long-term effects of rape as described by the victim.

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METHOD

Study Population

The study population consisted of all persons who entered the emergency ward of Boston City Hospital during the one-year period July 20, 1972, through July 19, 1973, with the complaint of having been raped. The resulting sample was made up of 146 patients: 109 adult women, 34 female children, and 3 male children.

We divided these 146 patients into three main categories: 1) victims of forcible rape (either completed or attempted rape, usually the former); 2) victims in situations to which they were an accessory due to their inability to consent; and 3) victims of sexually stressful situations—sexual encounters to which they had initially consented but that went beyond their expectations and ability to control.

The rape trauma syndrome delineated in this paper was derived from an analysis of the symptoms of the 92 adult women in our sample who were victims of forcible rape. Future reports will analyze the problems of the other victims. Although not directly included in this paper, supplementary data were also gathered from 14 patients referred to the Victim Counseling Program by other agencies and from consultation calls from other clinicians working with rape victims.

A major research advantage in the location of the project at Boston City Hospital was the fact that it provided a heterogeneous sample of victims. Disparate social classes were included in the victim population. Ethnic groups included fairly equal numbers of black and white women, plus a smaller number of Oriental, Indian, and Spanish-speaking women. In regard to work status, the victims were career women, housewives, college students, and women on welfare. The age span was 17 to 73 years; the group included single, married, divorced, separated, and widowed women as well as women living with men by consensual agreement (see table 1). A variety of occupations were represented, such as schoolteacher, business manager, researcher, assembly line worker, secretary, housekeeper, cocktail waitress, and health worker. There were victims with no children, women pregnant up to the eighth month, postpartum mothers, and women with anywhere from 1 to 10 children. The women ranged in physical attractiveness from very pretty to very plain; they were dressed in styles ranging from high fashion to hippie clothes.

TABLE 1
Distribution of Marital Status by Age (N = 92)

Marital Status	Age (in Years)				
	17–20	21–29	30–39	40–49	50–73
Single	29	25	0	2	1
Married	2	1	2	2	0
Divorced, separated, or widowed	2	6	7	2	2
Living with a man by consensual agreement	4	5	0	0	0

Interview Method

The counselors (the coauthors of this paper) were telephoned when a rape victim was admitted to the emergency department of Boston City Hospital; we arrived at the hospital within 30 minutes. We interviewed all the victims admitted during the one-year period regardless of time of day or night. Follow-up was conducted by use of telephone counseling or home visits. This method of study provided an 85-percent rate of direct follow-up. An additional 5 percent of the victims were followed indirectly through their families or reports by the police or other service agencies who knew them. Detailed notes of the interviews, telephone calls, and visits were then analyzed in terms of the symptoms reported as well as changes in thoughts, feelings, and behavior. We accompanied those victims who pressed charges to court and took detailed notes of all court proceedings and recorded the victims' reactions to this process (10, 11). Contact with the families and other members of the victims' social network was part of the assessment and follow-up procedure.

MANIFESTATIONS OF RAPE TRAUMA SYNDROME

Rape trauma syndrome is the acute phase and long-term reorganization process that occurs as a result of forcible rape or attempted forcible rape. This syndrome of behavioral, somatic, and psychological reactions is an acute stress reaction to a life-threatening situation.

Forcible rape is defined in this paper as the carnal knowledge of a woman by an assailant by force and against her will. The important point is that rape is not primarily a sexual act. On the contrary, our data and those of researchers studying rapists suggest that rape is primarily an act of violence with sex as the weapon (5). Thus it is not surprising that the victim experiences a syndrome with specific symptomatology as a result of the attack made upon her.

The syndrome is usually a two-phase reaction. The first is the acute phase. This is the period in which there is a great deal of disorganization in the woman's lifestyle as a result of the rape. Physical symptoms are especially noticeable, and one prominent feeling noted is fear. The second phase begins when the woman begins 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. Motor activity changes and nightmares and phobias are especially likely during this phase.

The medical regimen for the rape victim involves the prescription of antipregnancy and antivenereal disease medication after the physical and gynecological examination. The procedure usually includes prescribing 25 to 50 mg. of diethylstilbestrol a day for five days to protect against pregnancy and 4.8 million units of aqueous procaine penicillin intramuscularly to protect against venereal disease. Symptoms reported by the patient need to be distinguished as either side effects of the medication or conditions resulting from the sexual assault.

THE ACUTE PHASE: DISORGANIZATION

Impact Reactions

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 feelings of shock or disbelief are expressed. When interviewed within a few hours of the rape, the women in this study mainly showed two emotional styles (12): the expressed style, in which feelings of fear, anger, and anxiety were shown through such behavior as crying, sobbing, smiling, restlessness, and tenseness; and the controlled style, in which feelings were masked or hidden and a calm, composed, or subdued affect was seen. A fairly equal number of women showed each style.

Somatic Reactions

During the first several weeks following a rape many of the acute somatic manifestations described below were evident.

1. *Physical trauma.* This included general soreness and bruising from the physical attack in various parts of the body such as the throat, neck, breasts, thighs, legs, and arms. Irritation and trauma to the throat were especially a problem for those women forced to have oral sex.
2. *Skeletal muscle tension.* Tension headaches and fatigue, as well as sleep pattern disturbances, were common symptoms. Women were either not able to sleep or would fall asleep only to wake and not be able to go back to sleep. Women who had been suddenly awakened from sleep by the assailant frequently found that they would wake each night at the time the attack had occurred. The victim might cry or scream out in her sleep. Victims also described experiencing a startle reaction—they become edgy and jumpy over minor incidents.
3. *Gastrointestinal irritability.* Women might complain of stomach pains. The appetite might be affected, and the victim might state that she did not eat, food had no taste, or she felt nauseated from the antipregnancy medication. Victims described feeling nauseated just thinking of the rape.
4. *Genitourinary disturbance.* Gynecological symptoms such as vaginal discharge, itching, a burning sensation on urination, and generalized pain were common. A

TABLE 2
*Severity of Symptoms During Reorganization Process by Age (N = 92)**

Severity of Symptoms	Age (in Years)				
	17-20	21-29	30-39	40-49	50-73
No symptoms: no symptoms reported and symptoms denied when asked about a specific area	7	4	2	0	0
Mild symptoms: minor discomfort with the symptom reported; ability to talk about discomfort and feeling of control over symptom present	12	16	0	2	1
Moderate to severe symptoms: distressing symptoms such as phobic reactions described; ability to function but disturbance in lifestyle present	12	5	1	1	2
Compounded symptoms: symptoms directly related to the rape plus reactivation of symptoms connected with a previously existing condition such as heavy drinking or drug use	7	5	3	3	0
No data available	0	5	4	0	0

*At time of telephone follow-up.

number of women developed chronic vaginal infections following the rape. Rectal bleeding and pain were reported by women who had been forced to have anal sex.

Emotional Reactions

Victims expressed a wide gamut of feelings as they began to deal with the aftereffects of the rape. These feelings ranged from fear, humiliation, and embarrassment to anger, revenge, and self-blame. Fear of physical violence and death was the primary feeling described. Victims stated that it was not the rape that was so upsetting as much as the feeling that they would be killed as a result of the assault. One woman stated: "I am really mad. My life is disrupted; every part of it upset. And I have to be grateful I wasn't killed. I thought he would murder me."

Self-blame was another reaction women described—partly because of their socialization to the attitude of "blame the victim." For example, one young woman had entered her apartment building one afternoon after shopping. As she stopped to take her keys from her purse, she was assaulted in the hallway by a man who then forced his way into her apartment. She fought against him to the point of taking his knife and using it against him and in the process was quite severely beaten, bruised, and raped. Later she said:

> I keep wondering maybe if I had done something different when I first saw him that it wouldn't have happened—neither he nor I would be in trouble. Maybe it was my fault. See, that's where I get when I think about it. My father always said whatever a man did to a woman, she provoked it.

THE LONG-TERM PROCESS: REORGANIZATION

All victims in our sample experienced disorganization in their lifestyle following the rape; their presence at the emergency ward of the hospital was testimony to that fact. Various factors affected their coping behavior regarding the trauma, i.e., ego strength, social network support, and the way people treated them as victims. This coping and reorganization process began at different times for the individual victims.

Victims did not all experience the same symptoms in the same sequence. What was consistent was that they did experience an acute phase of disorganization; many also experienced mild to moderate symptoms in the reorganization process, as table 2 indicates. Very few victims reported no symptoms. The number of victims over age 30 was small, but the data at least suggest that they might have been more prone to compounded reactions than the younger age groups.

Motor Activity

The long-term effects of the rape generally consisted of an increase in motor activity, especially through changing residence. The move, in order to ensure safety and to facilitate the victim's ability to function in a normal style, was very common. Forty-four of the 92 victims changed residences within a relatively short period of time after the rape. There was also a strong need to get away, and some women took trips to other states or countries.

Changing one's telephone number was a common reaction. It was often changed to an unlisted number. The woman might do this as a precautionary measure or as the result of threatening or obscene telephone calls. The victim was haunted by the fear that the assailant knew where she was and would come back for her.

Another common response was to turn for support to family members not normally seen daily. Forty-eight women made special trips home, which often meant traveling to another city. In most cases, the victim told her parents what had happened, but occasionally the victim contacted her parents for support and did not explain why she was suddenly interested in talking with them or being with them. Twenty-five women turned to close friends for support. Thus 73 of the 92 women had some social network support to which they turned.

Nightmares

Dreams and nightmares could be very upsetting. Twenty-nine of the victims spontaneously described frightening dreams, as illustrated in the following statement.

> I had a terrifying nightmare and shook for two days. I was at work and there was this maniac killer in the store. He killed two of the salesgirls by slitting their throats. I'd gone to set the time clock and when I came back the two girls were dead. I thought I was next. I had to go home. On the way I ran into two girls I knew. We were walking along and we ran into the maniac killer and he was the man who attacked me —he looked like the man. One of the girls held back and said, "No—I'm staying here." I said I knew him and was going to fight him. At this point I woke with the terrible fear of impending doom and fright. I knew the knife part was real because it was the same knife the man held to my throat.

Women reported two types of dreams. One is similar to the above example where the victim wishes to do something but then wakes before acting. As time progressed, the second type occurred: the dream material changed somewhat, and frequently the victim reported mastery in the dream—being able to fight off the assailant. A young woman reported the following dream one month following her rape.

> I had a knife and I was with the guy and I went to stab him and the knife bent. I did it again and he started bleeding and he died. Then I walked away laughing with the knife in my hand.

This dream woke the victim up; she was crying so hard that her mother came in to see what was wrong. The girl stated that in her waking hours she never cries.

Traumatophobia

Sandor Rado coined the term "traumatophobia" to define the phobic reaction to a traumatic situation (13). We saw this phenomenon, which Rado described in war victims, in the rape victim. The phobia develops as a defensive reaction to the circumstances of the rape. The following were the most common phobic reactions among our sample.

Fear of indoors. This occurred in women who had been attacked while sleeping in their beds. As one victim stated, "I feel better outside. I can see what is coming. I feel trapped inside. My fear is being inside, not outside."

Fear of outdoors. This occurred in women who had been attacked outside of their homes. These women felt safe inside but would walk outside only with the protection of another person or only when necessary. As one victim stated, "It is sheer terror for every step I take. I can't wait to get to the safety of my own place."

Fear of being alone. Almost all victims reported fears of being alone after the rape. Often the victim had been attacked while alone, when no one could come to her rescue. One victim said: "I can't stand being alone. I hear every little noise—the windows creaking. I am a bundle of nerves."

Fear of crowds. Many victims were quite apprehensive when they had to be in crowds or ride on public transporation. One 41-year-old victim said:

> I'm still nervous from this, when people come too close—like when I have to go through the trolley station and the crowds are bad. When I am in crowds I get the bad thoughts. I will look over at a guy and if he looks really weird, I will hope something bad will happen to him.

Fear of people behind them. Some victims reported being fearful of people walking behind them. This was often common if the woman had been approached suddenly from behind. One victim said:

> I can't stand to have someone behind me. When I feel someone is behind me, my heart starts pounding. Last week I turned on a guy that was walking in back of me and waited till he walked by. I just couldn't stand it.

Sexual fears. Many women experienced a crisis in their sexual life as a result of the rape. Their normal sexual style had been disrupted. For the women who had had no prior sexual activity, the incident was especially upsetting. For the victims who were sexually active, the fear increased when they were confronted by their husband or boyfriend with resuming sexual relations. One victim said:

> My boyfriend thought it [the rape] might give me a negative feeling to sex and he wanted to be sure it didn't. That night as soon as we were back to the apartment he wanted to make love. I didn't want sex, especially that night.... He also admitted he wanted to know if he could make love to me or if he would be repulsed by me and unable to.

This victim and her boyfriend had considerable difficulty resuming many aspects of their relationship besides the sexual part. Many women were unable to resume a normal sexual style during the acute phase and persisted with the difficulty. One victim reported, five months after the assault, "There are times I get hysterical with my boyfriend. I don't want him near me; I get panicked. Sex is OK, but I still feel like screaming."

CLINICAL IMPLICATIONS

Management of Rape Trauma Syndrome

There are several basic assumptions underlying the model of crisis intervention that we used in counseling the rape victim.

1. The rape represented a crisis in that the woman's style of life was disrupted.
2. The victim was regarded as a "normal" woman who had been functioning adequately prior to the crisis situation.
3. Crisis counseling was the treatment model of choice to return the woman to her previous level of functioning as quickly as possible. The crisis counseling was issue-oriented treatment. Previous problems were not a priority for discussion; in no way was the counseling considered

psychotherapy. When other issues of major concern that indicated another treatment model were identified by the victim, referrals were offered if the woman so requested.

4. We took an active role in initiating therapeutic contact as opposed to more traditional methods where the patient is expected to be the initiator. We went to the hospital to see the victim and then contacted her later by telephone.

Management of Compounded Reaction

There were some victims who had either a past or current history of physical, psychiatric, or social difficulties along with the rape trauma syndrome. A minority of the women in our sample were representative of this group. It became quite clear that these women needed more than crisis counseling. For this group, who were known to other therapists, physicians, or agencies, we assumed a secondary position. Support was provided for the rape incident, especially if the woman pressed charges against the assailant, but the counselor worked closely with the other agencies. It was noted that this group developed additional symptoms such as depression, psychotic behavior, psychosomatic disorders, suicidal behavior, and acting-out behavior associated with alcoholism, drug use, and sexual activity.

Management of Silent Rape Reaction

Since a significant proportion of women still do not report a rape, clinicians should be alert to a syndrome that we call the silent reaction to rape. This reaction occurs in the victim who has not told anyone of the rape, who has not settled her feelings and reactions on the issue, and who is carrying a tremendous psychological burden.

Evidence of such a syndrome became apparent to us as a result of life history data. A number of the women in our sample stated that they had been raped or molested at a previous time, often when they were children or adolescents. Often these women had not told anyone of the rape and had just kept the burden within themselves. The current rape reactivated their reaction to the prior experience. It became clear that because they had not talked about the previous rape, the syndrome had continued to develop, and these women had carried unresolved issues with them for years. They would talk as much of the previous rape as they did of the current situation.

A diagnosis of this syndrome should be considered when the clinician observes any of the following symptoms during an evaluation interview.

1. Increasing signs of anxiety as the interview progresses, such as long periods of silence, blocking of associations, minor stuttering, and physical distress.

2. The patient reports sudden marked irritability or actual avoidance of relationships with men or marked change in sexual behavior.

3. History of sudden onset of phobic reactions and fear of being alone, going outside, or being inside alone.

4. Persistent loss of self-confidence and self-esteem, an attitude of self-blame, paranoid feelings, or dreams of violence and/or nightmares.

Clinicians who suspect that the patient was raped in the past should be sure to include questions relevant to the woman's sexual behavior in the evaluation interview and to ask if anyone has ever attempted to assault her. Such questions may release considerable pent-up material relevant to forced sexual activity.

DISCUSSION

The crisis that results when a woman has been sexually assaulted is in the service of self-preservation. The victims in our sample felt that living was better than dying and that was the choice which had to be made. The victims' reactions to the impending threat to their lives is the nucleus around which an adaptive pattern may be noted.

The coping behavior of individuals to life-threatening situations has been documented in the work of such writers as Grinker and Spiegel (14), Lindemann (15), Kübler-Ross (16), and Hamburg (17). Kübler-Ross wrote of the process patients go through to come to terms with the fact of dying. Hamburg wrote of the resourcefulness of patients in facing catastrophic news and discussed a variety of implicit strategies by which patients face threats to life. This broad sequence of the acute phase, group support, and the long-run resolution described by these authors is compatible with the psychological work rape victims must do over time.

The majority of our rape victims were able to reorganize their lifestyle after the acute symptom phase, stay alert to possible threats to their lifestyle, and focus upon protecting themselves from further insult. This latter action was difficult because the world was perceived as a traumatic environment after the assault. As one victim said, "On the exterior I am OK, but inside [I feel] every man is the rapist."

The rape victim was able to maintain a certain equilibrium. In no case did the victim show ego disintegration, bizarre behavior, or self-destructive behavior during the acute phase. As indicated, there were a few victims who did regress to a previous level of impaired functioning four to six weeks following the assault.

With the increasing reports of rape, this is not a private syndrome. It should be a societal concern, and its treatment should be a public charge. Professionals will be called upon increasingly to assist the rape victim in the acute and long-term reorganization processes.

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