Hospital Based Rape Crisis Programmes

What can the American experience teach us?

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The importance of rape crisis programmes in the United States is that they provide *a service* for rape victims that does not exist in Britain: a hospital-based service providing physical, psychological, emotional and practical help for the rape victim and which regards this work as a crucial part of health care provision.

American rape crisis programmes have been in existence since the early 1970s and have increased in number since. There is now at least one to be found in every large city.[1] Although this report focuses on centres in Boston, these are fairly typical of all existing programmes. Boston is a young city with a large population of students, many universities and hospitals. There is currently concern about the future of rape crisis programmes, given recent funding cuts and the shifting of central funding of various health programmes to the responsibility of individual states. This means that the amount of resources made available will become dependent upon the particular sympathies and interest of individual counsellors.

Hospital rape crisis programmes form only part of the total treatment and support services provided for rape victims in the States. In Boston there are, in addition to the four hospitals, community-based rape crisis centres, run by volunteers. The first one was set up in 1972 and there are now 17 similar centres operating. Of particular interest is the difference in practice and philosophy operating in the Mount Pleasant Rape Crisis Centre and the London Rape Crisis Centre in Britain. Firstly, the Boston Rape Crisis Centre advertises its address and has an open house at all times. In contrast, the London Rape Crisis Centre does not publish its address and generally counsels over the telephone, rarely in person. Secondly, although feminist in philosophy and based in a women's centre, the Boston Group does not believe that women who come to them necessarily need or want this philosophy forced upon them. Thirdly, in Boston, these centres counsel male victims, both victims of assault and also men from the families of female rape victims. This does not occur in the London Centre. Finally, they recognise the need to maintain a close working relationship with the police and hospital services. Psychiatrists participate in the training schemes held at the rape crisis centres. In the Metropolitan area there is virtually no communication between the London Rape Crisis Centre and the police and the relationship is one of hostility. The London Rape Crisis Centre is similarly suspicious of 'professionals' who wish to get involved in this area of work, as I found when conducting research at the Institute of Psychiatry. The response was a blank refusal to give a telephone interview or to co-operate. The London Rape Crisis Centre, despite its long experience in helping victims of rape, is reticent about publicising the results of its work.

It is thought that the rape victims attending community-based rape crisis centres represent a rather different population from those who choose hospital rape programmes. In general, older non-feminist women, women with children or with perhaps a more 'traditional' view of the female role, do not go to rape crisis centres, which are felt to be too radical. In Britain, in the absence of hospital facilities dealing with rape victims, this choice is not available.

The two centres visited, the Beth Israel Royal Hospital and the Boston City Hospital, serve a very different patient population. Boston City is a state hospital, run on similar lines to the old-style charity hospitals. It is situated in the poor, deprived ghetto area of Boston, far removed from the fashionable Brookline suburb where the Beth Israel is situated. Boston City prides itself on its care for the indigent and minority groups of the City. It is well-known for its trauma care; ambulances, picking up people from accidents in the street, automatically take the patient to Boston City. However, the rape victim population differs in certain demographic details from the ordinary patient population seen at the hospital. In the general patient population 90% are black, but only about 50% of the rape victims are black and the hospital receives even fewer Hispanic women. This has led to criticisms from women's organisations who feel that the hospital is failing to meet the needs of ethnic minorities.

Because of the area it serves and also its lower status, Boston City Hospital staff are the worst paid of any other hospital in Boston and so it is difficult to attract people to work there. Ironically, it is its reputation of 'State' hospital that discourages many women from going, and also the poor ghetto area in which it is situated, even though their treatment would be free. Nonetheless Boston City Hospital estimates that it treats about 30% of rapes in the City.

In contrast to the Boston City Hospital, the Beth Israel rape crisis programme sees victims who are mostly white and middle-class. This programme started in 1974 and now treats 140–170 female rape victims per year, the number

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increasing steadily each year. The director of the programme, who trained as a sociologist, organises training of the counsellors, stimulates research, liaises with and teaches the police interviewing skills and acts as a mediator between the hospital programme and the community centres. The rape crisis team, which is co-ordinated from the emergency room, includes a psychiatrist or psychologist, a gynaecologist, a nurse and a rape crisis counsellor who is generally a trained social worker. The rape crisis service provides 24 hour a day care for rape victims and each member is called in turn to see the woman for various procedures required. She is given a completely free decision at each stage about who she wishes or does not wish to see.

Rape victims are referred by the police, rape crisis centres and universities as well as self-referrals. This centre also reports an increased number of male rape victims presenting in line with the increased number of boys amongst the child victims of sexual assault. There is a separate child sexual assault team based in the children's emergency room which treats child victims of sexual assault.

Rape victims seen at the Beth Israel are divided between acute cases and women raped years previously. The procedures, taking into account the needs of each group, are quite different. The rape victim is met by the triage nurse (the receiving nurse) to assess the urgency of the case. An acute case will take priority over other emergency patients and will be taken immediately to a private room. A nurse on the team looks after her by assessing her immediate needs, starting off a record and the inevitable checking of insurance policies. She will stay with the victim during the initial visit of two to three hours. This is much quicker than the equivalent for rape victims in Britain, who may spend from eight to nine hours giving statements and having examinations at the police station. The nurse also co-ordinates the other team members who see the victims to carry out examinations, take statements, give advice, etc.

The gynaecologists' responsibility is to collect evidence, take evidence of the assault and provide medical treatment such as contraception and prophylaxis against venereal disease. Their work with rape victims is expected to take priority over other clinical commitments. In the case of male rape victims, the gynaecologists' role is taken over by the general surgeons.

The nurse ensures that evidence is placed in the appropriate places, correctly labelled, and ensures that the patient signs the release of evidence forms which allows information and specimens to be passed to the police. There is no legal obligation on hospitals in the States to report rape to the police and the number of victims who decide to report varies from centre to centre. If a woman is unable to make up her mind immediately, specimens may be kept in the safe for up to seven days to allow the patient to make a decision about prosecution. The nurse will then check with the patient and, if she still does not wish to prosecute, the specimens are discarded. The length of time these specimens are kept varies: at Boston City the victim has six months in which to change her mind, at the Massachusetts General specimens are kept for up to seven years!.

One of the reasons the protocol guidelines are strictly adhered to is the awareness that medical and nursing records function as a legal document. Staff are advised that records must be complete, detailed, legible and free from conclusions and judgements. They are not required to comment on the veracity of the woman's claim. Staff are warned against stating whether the victim was using contraception at the time of the assault, unless specifically asked, as there are cases when this has been interpreted by the jury as a sign of promiscuity.

Following the initial visit, the woman is given information about the crime and its effects, told about local resources and given the names of emergency unit staff. She is contacted within 48 hours by the psychiatrist offering follow-up appointments and will receive a follow-up appointment from the gynaecologist after a two-week interval. The attending nurse contacts the victim within seven days to check her decision about the release of evidence and, if a police referral has been made, she will receive an appointment to see them.

One consideration governing the number of victims accepting follow-up appointments is the financial cost. At present, victims have to pay the first $100 of medical fees themselves. This is probably a deterrent for the young, poor and indigent groups. Many insurance policies do not cover rape and certain victims, particularly young students financially dependent upon their parents, are unwilling to bill their insurers as they do not wish their parents to know what has happened. Whatever the reason, the percentage of women continuing to attend is low. For most programmes 12 counselling sessions are offered with short intervals between early sessions, becoming longer towards the end of treatment. At the Beth Israel 50%–90% of women drop out between the initial visit and the first follow-up, and only 5% continue until the twelfth session. Another reason suggested for the high drop-out rate is the 'pseudo adjustment' phase. After the initial distress, most victims and their families do not wish to be reminded of the rape and stay away from the hospital. However, they may return months or years later with recurrent symptoms. The response rate for the provision of treatment for husbands and boyfriends is even more disappointing. At the Beth Israel Hospital it was found that only 1% of male relatives of victims seen agreed to be interviewed.

There has been an interesting shift in attitudes regarding the most appropriate way to treat rape victims. When the rape trauma syndrome was first described[2] the recommended way of managing was crisis intervention. This was rapidly integrated into training programmes and the therapeutic repertoire of counsellors. But initial enthusiasm for crisis intervention has given way to scepticism about its effectiveness and value in lessening the risk of long-term psychiatric sequelae.

Most research is concentrated on the acute effects of a rape attack as described in the rape trauma syndrome. More work is now being done on long-term effects and the Beth Israel Centre now sees numbers of women who remain disturbed four to five years later. This chronic reaction may

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occur in women less well-adjusted prior to the attack, and with previous histories of victimisation, psychiatric disorder, physical disorder, poor social functioning, and alcohol and drug abuse.

Perhaps the most appropriate intervention is one or two more didactic sessions, allowing the victim to anticipate the sorts of reactions she may have following the rape and to place the main emphasis on the care of victims who, six months later, remain disabled from its effects. Possibly a proportion of victims have disturbed interpersonal relationships prior to the rape and maladaptive ways of functioning. This seems to apply more to the so-called 'con' type of rape, i.e. women who are raped by acquaintances and who not only have prior histories of rape but also a two or three times increased risk of a future rape attack. Perhaps some women have difficulty in judging the appropriateness of their responses and the cues given them and this makes them more vulnerable to repeated victimisation. 'Con' victims are more likely to complete treatment and often require further, more formal, treatment in the future. In contrast, the 'blitz attack' victims—a sudden attack by a stranger—often drop out after the first counselling session because they feel they have recovered. Possibly up to 50% of rape victims need long-term help but do not receive it because psychiatrists lack the appropriate training and the motivation.

Counselling is usually on an individual basis: groups have been tried at the Beth Israel Hospital, the Boston City Hospital and the community centres but have been unsuccessful to date. This may be because women find listening to others' ordeals painful and unsupportive. However, group treatment may help women with chronic and disabling reactions who require lengthy treatment.

Currently no similar hospital-based programmes in Britain exist although a recent newspaper article reported on the first sexual assault centre run on multi-disciplinary lines to be set up in a Manchester hospital[3]. Despite the advantages and benefits for rape victims, it seems unlikely that the American system will transfer to the British Health Service.

The problem of rape in the States is more prevalent than in Britain. The main impetus for the creation of the American hospital programmes came from the feminist movement which has more financial resources than its British counterpart and also exerts considerable political pressure. Women's groups in Britain would see the medicalisation of rape as conferring a sense of anonymity and helplessness on the victim.

In the States there was a significant increase of funding in the 1970s related to rape, research and treatment. In Britain, there is no such funding for similar programmes. Rape crisis centres and other organisations, such as victims' support schemes, rely on volunteer counsellors and finance themselves through fund-raising activities and the occasional donation.

More fundamentally, the programmes described reflect the different attitude and approach in American society towards the concept of psychic trauma. Psychic trauma is rarely included in the British psychiatric repertoire or in everyday language. In the 1950s Mendelson first used the term 'victimology', referring to the study of victims of accident or crime.[4] In the States the science has grown and developed so that there is now a journal of victimology and regular victimology conferences. Events in the 1970s such as the American kidnappings in Iran and the Vietnam war and its associated trauma produced an awareness of the need for research in this area. These factors contributed to a sympathetic hearing where proposals were made to integrate the care of rape victims in the set-up of general hospitals. There was a respectable and respected body of knowledge that made the request not only reasonable but inevitable.

To set up rape programmes in hospitals in Britain would be costly and in terms which the already stretched National Health Service could barely afford, as well as the time and energy required by medical and nursing staff in casualty departments.

In the American programmes the key members find involvement in legal and Court procedures stressful and this might be a strong disincentive towards adopting a similar system in the NHS. It is likely that there would also be opposition from police surgeons who currently carry out the medical examinations on rape victims.

There is an argument that rape is not a medical issue. However, patients who have some identifiable physical disorder may in a sense see themselves as victims, if not of violence, of a system that takes away their control and creates helplessness and of illnesses that may be stigmatising, change their relationships to those around them and create uncertainty about the future. The American rape crisis programmes challenge the way in which we are currently failing to address the needs of all victims and to acknowledge their legitimate right to sensitive professional health care.

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