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WOMEN'S HEALTH

SEXUAL ASSAULT: AN EPIDEMIC HEALTH PROBLEM

by Toni Press and Zita Fearon

INTRODUCTION

Sexual assault is any sexual activity involving more than one person to which one or more of the people involved has not consented or has been coerced into consenting; it is the most rapidly increasing violent crime in the United States. According to FBI Uniform Crime Reports, the incidence of rape throughout the United States has doubled between 1968 and 1978 and this, of course, includes only those rapes reported to the police. It is widely held that sexual assault occurs 5 to 15 times as much as it is reported.[1] In a survey of Rape Crisis Centers conducted by the Consumer Health Information and Resource Center in November/December, 1980, 41 Centers, serving an aggregate population of 21.8 million people, reported having delivered rape crisis counseling and/or advocacy services to 113,093 people, 97% of whom were women. It is estimated that one woman out of 8 will be the victim of a completed rape.[2]

In New York City in 1979, 5,943 complaints for sexual assault were made to the police department; based on the above data, a minimum of 30,000 up to 150,000 incidents of sexual assault occurred in New York City in that year. These figures do not include incest, a form of sexual assault which is almost never reported to the police, and which occurs far more frequently than was commonly acknowledged until recently.[3]

HEALTH PROBLEM

These figures indicate not only an epidemic crime problem, but an epidemic health problem as well. Victims of sexual assault are unique among crime victims in that they need immediate medical care, regardless of whether there is visible physical injury, because of the possibilities of internal injury, pregnancy and venereal disease; in addition, should they want to take legal action, sexual assault victims need a medical examination to verify that a crime has taken place. The Joint Commission on the Accreditation of Hospitals acknowledges the unique position of such victims when it specifies standards for emergency protocol for rape victims and does not specify such protocol for any other crime victim, except victims of child abuse, a category that frequently overlaps with sexual assault in any case.[4]

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Aside from emergency medical intervention, experts in the fields of psychiatry, sociology and medicine, among others, agree that victims of sexual assault suffer a crisis that clearly warrants treatment specific to such victims. A rape represents a crisis, in that the victim's life-style may be disrupted physically, psychologically, socially and sexually. Postrape symptomology includes such things as shock, recurrent nightmares, developing phobias, a silent rape reaction leading to loss of confidence and self-esteem, even paranoid reaction, and a downward life course.[5] More specifically, the great majority of sociologists, psychiatrists, doctors, and others who write about the effects of sexual assault agree that "rape can be viewed as a crisis situation in which a traumatic external event breaks the balance between internal ego adaptation and the environment."[6] This experience heightens a person's sense of helplessness, intensifies conflicts about dependence and independence and generates self-criticism and guilt that devalue her/him as a person and interfere with trusting relationships, particularly with men. Other important consequences of this situation are difficulty handling anger and aggression and persistent feelings of vulnerability.[7]

TREATMENT

Treatment of sexual assault victims ideally begins with crisis intervention counseling and extends to advocacy (see below). Crisis intervention counseling is readily available and relatively brief; it reaches beyond the client to her/his family and social networks; it is focused on the client's present; it helps clients develop adoptive mechanisms for further coping; it is victim sympathetic, i.e., non-judgemental; it is non-traditional in that there is a greater degree of involvement between counselor and victim; it regards the victim as a "normal" person.[8]

In the treatment of sexual assault victims, *early crisis intervention is mandatory*, and can mean the difference between an effective resolution to the rape trauma or a lengthy, poor adjustment.[9] From time to time, and very often in the case of incest victims, referral to a more traditional psychotherapist is necessary. Although such psychotherapy is inappropriate as the initial step in the treatment process,[10] it is sometimes called for after the crisis intervention process is complete. It is imperative that rape crisis centers keep a file of therapists who work with sexual assault victims in a sympathetic, non-judgemental way. Frequently, psychotherapists are trained to deal with such victims about their sexual assault by rape crisis center staff.

ADVOCACY

It is imperative that victims of sexual assault receive services that extend beyond counseling, therapy and emergency medical services. Frequently, the institutional process through which sexual assault victims have to travel can be as devastating as the rape itself. Those institutions that are meant to help victims can at the same time further victimize them.[11] Often, in the eyes of personnel of emergency departments and police departments, the victim is to blame for the assault. Victims of sexual assault need an advocate to assist them through the medical and legal processes (indeed, sometimes to encourage them to get the medical attention they need in the first place) and to minimize the detrimental effect these processes can have on their mental health. The reasons that advocates are necessary to help victims through these processes include the fact that people in crisis historically have difficulty making decisions, the fact that victims' needs are secondary, or at least not the only, considerations of institutional personnel and the fact that, generally speaking, the groups of professionals (health workers, police, lawyers) who deal with victims do not interact with one another, and an advocate can provide a link among all the personnel with whom a victim is likely to come in contact.

Advocacy, including making sure the victim's rights are upheld during her/his medical examination, and when s/he deals with the police and the court system, making sure that the decision to press charges or not is hers/his alone, giving her/him support during the emotionally trying time when s/he is in court, is an integral part of the treatment of sexual assault victims; this is corraborated by the survey of rape crisis centers cited earlier. All of the 41 centers responding to the survey include advocacy as part of their direct services to victims.

A CASE HISTORY

As an illustration of some of the concepts discussed above, consider the case of Betty, who was raped in her car by a man who followed her there from the subway at about 10 P.M. on a summer evening. She drove herself home after the assault and, after deliberating for a couple of hours, called her police precinct to report the rape. She was told that police from the precinct in which she was raped would come to her home, but in fact police from the precinct in which she lived arrived at her apartment in 30 minutes. She was informed by these police that she had to go to the hospital and that if she didn't she could not press charges. (Incorrect: although it will make her case stronger, Betty is not legally required to seek medical treatment. Furthermore, to force Betty to seek medical treatment, instead of explaining why it would help her to do so and letting her make the decision, is to deepen her sense that she has lost control over her own life, i.e., it deepens the trauma initiated by the rapist.) In the Emergency Department of a voluntary hospital, Betty is questioned at great length about the details of the rape by an insurance clerk. Two police officers from the correct precinct (the one in which the crime occurred) and two detectives from the sex crimes unit arrive at the hospital, so that there are six police officers, an insurance clerk, a doctor and a nurse in the examining room with Betty at the same time (this is, among other things, a violation of the JCAH standard of privacy for rape victims). Each of these people questions Betty at some time; they often repeat each others' questions and often ask inappropriate questions, such as whether she had an orgasm and what she was doing out in the street at 10 P.M. in the first place. Control continues to be taken away from Betty as the doctor gives her V.D. and pregnancy tests and a large antibiotic dose without

explaining to her what the procedures are, why they are being done, or asking her whether she wants them done at all. After being at the hospital for four hours, Betty goes home in a taxi. The next evening, Betty receives a call from the rapist, who stole her pocketbook after the assault. She calls the police, who explain that they are unable to help her until they apprehend the rapist. Betty stays home from work the next two days, afraid to leave her house and be confronted by her attacker again. She sleeps badly and eats little during the three days after the attack. She is ashamed to tell anyone what has happened and finally, on the third night after the attack, she calls a rape crisis counselor. In addition to counseling Betty about her feelings and the trauma of the assault, the counselor files complaints with the head of the hospital's Emergency Department, the hospital's Community Board and the two police precincts. The counselor will go to court with Betty, will help her become involved in a group for victims of sexual assault, will go with her for her follow-up check up six weeks later, and will continue to discuss her feelings with her on a short term basis.

SERVICE DELIVERY/RAPE CRISIS CENTERS

Services to victims of sexual assault are delivered under a variety of auspices throughout the country. Examples include programs run by hospitals or attached to district attorney offices; programs designed to deliver services to people in any kind of crisis situation or people who are victims of any kind of crime. The most prevalent way in which such services are delivered and, according to the preponderance of rape literature, the most effective way, is through rape crisis centers. Rape crisis centers provide continuity if they are not affiliated with any of the other institutions involved with the victim; in addition, their services are focused only on victims of sexual assault, whose needs for treatment are different from those of either victims of other crimes or people in other crisis situations. Additionally, rape crisis centers are staffed by the very people who were the catalyst for general acknowledgement of the high incidence of sexual assault, and the needs of victims of such assault:

> *Interest in and concern about rape originated largely in the women's movement. Here, group relatedness and anger at male disinterest and often cruel treatment of raped women resulted in effective action of all kinds. It led to women's groups helping to counsel raped women, forming rape centers, effecting greater police concern and providing female officers to deal with rape victims.*[12]

Moreover, counseling through rape crisis centers relies on crisis intervention theory, rather than more traditional approaches, within a peer framework, rather than under the rubric of mental health or psychiatry.[13] A majority of services to sexual assault victims delivered outside rape crisis centers are delivered through programs attached to hospitals. Such programs are likely to be less effective than those outside hospitals, because of the conflicting roles of hospital personnel, who must collect evidence and therefore, to a certain extent, take an investigative role as well as a medical one. In addition, in counseling/advocacy programs attached to hospitals, even where they are staffed by different personnel from regular hospital personnel (e.g., emergency department staff), services are delivered only to those who are treated in the emergency department of the particular hospital where the program is housed.[14]

Overall, rape crisis centers are in the unique position of being able to deliver a wide range of services specific to sexual assault victims' needs, free from conflicts of interest.

TRAINING RAPE COUNSELOR/ADVOCATES

In his book *Rape Intervention Resource Manual*, Patrick Mills, Ed.D. compiled training standards with the help of staff at 56 rape crisis centers throughout the United States. These indicate that staff of rape crisis centers are the primary trainers of other personnel who work with sexual assault victims, including the police, psychotherapists, district attornies, emergency department volunteers and their own volunteers. The training components cited as being essential to delivering effective services to sexual assault victims are:

- *discussion of what constitutes sexual assault, and what myths about sexual assault exist;*
- *statistics on the incidence of rape, nationally, statewide and locally;*
- *socio-cultural factors contributing to the rising incidence of rape;*
- *psychology and types of rapists;*
- *psychological aspects of rape for the victim, including immediate reactions, short-term reactions, long-term reactions, in both adults and children;*
- *medical aspects of sexual assault;*
- *police procedures;*
- *procedures of the prosecuting attorney and court trial;*
- *crisis intervention techniques via telephone and face to face;*
- *handling reactions of family and friends;*
- *handling difficult calls, including silent callers, prank callers, obscene callers, chronic callers and suicidal callers;*
- *listening skills;*
- *elements of decisionmaking with regard to the medical and legal systems;*
- *rape prevention;*
- *referral systems.*

The Consumer Health Information and Resource Center has on file training manuals from rape crisis centers in Iowa City, Iowa, East Baton Rouge, Louisiana, Missoula, Montana and Madison, Wisconsin. Each of these contains in depth descriptions of the components listed above.[15] The Center also has the tabulated results of the survey of rape crisis centers referred to throughout this article.

RECOMMENDATIONS

The seriously increasing incidence of rape in the United States should be dealt with effectively in the following ways:

I) Prevention

a) Education: The problem of rape (its nature, causes

and effects), should be included in school curriculums as part of sex education and sociology courses. Young women in particular should be taught to defend themselves against rapists in grade school, high school and college physical education classes. This education should be provided in both public and private schools and most particularly in special schools for the handicapped, adapted to their needs and capabilities.

b) Research: Since rape is a behavioral and social phenomenon rather than a natural phenomenon (such as an earthquake), it can be prevented by learning what social factors contribute to its occurrence. The fact that women want and need to defend themselves against it, and that the treatment of choice is crisis intervention rather than psychotherapy, demonstrates that the cause does not lie within women themselves. The Department of Health and Human Services (DHHS) should gather and initiate research concerning the causes of rape pursuant to developing recommendations for national policy to eliminate the causes of rape. Recommendations for national policy should be made in at least the following areas:

1. Education and media: Research will probably show that some of the causes of rape lie with the view that society and men have of women and the way women are portrayed by the media as sexual objects and acceptable objects of violence.

2. Legal system: The law in the United States places the burden of proof in rape cases on the victim and has stringent requirements to establish proof of rape. The assumption which underlies the burden of proof requirement is that women themselves are the cause of rape. Recommendations for change should be made based on research and a comparison with other countries' incidence, prevention, treatment and law enforcement and legal system in rape cases.

2) Treatment

The scientific literature on rape establishes that crisis intervention and advocacy is the most effective and appropriate method of treatment for rape victims. However, Rape Crisis Centers (RCC) still report that many people are not receiving this form of treatment at hospitals and that, on the contrary, the treatment they do receive often further victimizes them. Therefore, the Federal Government should address this major public health problem by creating a regional system similar to the regional Emergency Medical Services Systems to assure that rape victims receive the treatment and services they need:

a) The DHHS should use and expand the currently existing women controlled rape crisis centers as federally designated and funded Rape Treatment Coordinating Centers (RTCCs) to co-ordinate and monitor training, treatment and advocacy. RTCCs would develop and monitor the training of all hospital, law enforcement and legal staff who come into contact with rape victims. RTCCs would themselves train and certify all instructors in rape counseling and crisis intervention. RTCCs would maintain the Rape Hotlines to counsel, advocate and refer victims, and would receive complaints against hospitals, law enforcement agencies, legal services and psychotherapists which further treated victims in judgemental, inappropriate and non-supportive ways. These agencies and services would also be monitored by RTCC advocates who would assist victims through the system.

Reports of poor treatment should not only be used to make corrections, but where such reports persist, they should be gathered and forwarded to the appropriate regulatory, educational and reimbursing agencies for further action. In the case of hospitals, persistent problems should be brought to the JCAH, state and local health department and PSRO. In turn, the JCAH, for example, should consider such persistent complaints very seriously, and as one of the factors in denying accreditation to a hospital. Other agencies should take similarly effective steps to assist in the implementation of rape treatment protocols.

PHASES OF RECOVERY FROM RAPE TRAUMA

Experts divide the recovery process of sexual assault victims into four phases:

*a) **anticipatory/threat**, during which the victim's perception of danger is drastically heightened. In this phase, a victim is typically afraid of such things as traveling on public transportation, being home alone, answering the door or even the phone, meeting new people, especially men. S/he is also prone to nightmares and a vast array of physical ailments.*

*b) **impact**, during which victims suffer varying degrees of disintegration in relationship to the external circumstances of their lives and in relationship to their feelings about and as a result of the attack. Some of the feelings typical in this phases are shame, guilt, continued and deepening fear, and anger at the attacker. Victims may also suffer an inability to communicate these (or any) feelings.*

*c) **posttraumatic recoil**, during which behavioral control increases, but so does dependency. In this phase, victims typically begin to seek to regain control of their lives often by seeking counseling or therapy. However, in this phase, the victim often relies heavily on counselors/therapists/advisors/friends.*

*d) **posttraumatic reconstitution**, during which the process of future life adjustment begins.*

FOOTNOTES

1. Connell, Noreen and Wilson, Cassandra, eds., *Rape: The First Sourcebook for Women*; New York City/Ontario: New American Library, 1974; Evans, Hannah I., Ph.D., "Psychotherapy for the Rape Victim: Some Treatment Models", *Hospital and Community Psychiatry*, 29 (5), 1978; Missoula, Montana, Rape Crisis Counseling Handbook; conversations with representatives of New York Women Against Rape and the Borough Crisis Centers in New York City.
2. Warner, Carmen Germaine, *Rape and Sexual Assault: Management and Intervention*; Germantown, MD.: Aspen Systems Corporation, 1980, p. 10.
3. Armstrong, Louise, *Kiss Daddy Good-Night*; New York City: Pocket Books, 1979, Preface.
4. Portions of the Joint Commission on the Accreditation of Hospitals Manual that are applicable, either implicitly or explicitly, to sexual assault victims are Sections 1, 2 and 3 (Standards I and V).
5. Shainess, Natalie, M.D., "Psychological Significance of Rape: Some Aspects", *New York State Journal of Medicine*, 76 (12), 1976.

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SUMMARY OF SEMINAR: "AN UPDATE AND ASSESSMENT OF CONTRACEPTIVE METHODS" MARCH 11, 1981

The growing evidence of risks involved in all the currently marketed non-barrier contraceptive methods has demonstrated the necessity for consumers of choosing a birth control method based on complete knowledge of effectiveness and risks/benefits for each method. This information is not made available to the consumer and, as a result, women's input into contraceptive research and the type of medical care they should receive has been minimal. This situation is aggravated by the lack of female physicians and researchers. The type of birth control method available for use depends upon those people who manufacture, research, fund and distribute birth control devices and chemicals and on those people who set priorities and create policy regarding research, development and use. The women's health movement is committed to having women as a group and as users replace physicians, manufacturers and politicians as decision makers in the development and use of birth control methods. An excerpt from a manual written in 1928 cites the following essential elements of an ideal contraceptive method from a consumer point of view: 1) reliability; 2) no interference with normal physiological functions; 3) no psychological disturbance; 4) controlled by the woman; 5) no bulky or elaborate apparatus to be employed; 6) simplicity; 7) moderation in price.

The first speaker, Dr. Gwen Gentile, focused her talk on the safety and effectiveness of current contraceptive methods, as well as the development and testing of new and future methods. Despite the risks involved in using the pill, which include cardiac or stroke problems, hypertension, phlebitis and clotting in the veins, Dr. Gentile considers the pill a "fine birth control method." The main criterion for this judgment was the rate of pregnancy among daily users, which is less than one per cent. She also cited certain benefits of the pill, such as less menstrual bleeding and a decreased chance of contracting benign breast cancer. While pregnancy rate serves as a valid basis for determing birth control effectiveness, this criterion fails to encompass the benefit/risk or safety factors. Dr. Gentile justified her position by stating that all methods involve some risks.

The major safety concern for IUD users is the increased risk of getting PID (pelvic inflammatory disease or infection of the tubes and ovaries resulting in sterility). Debate over the various degrees of risk attributed to this device by studies raised the important question of what constitutes a valid scientific study. The question of validity is crucial in reviewing the evidence acquired through the "Walnut Creek Contraception Drug Study," a ten-year risk/benefit study of oral contraceptive use in 16,000 women. This study utilized the following questionable ethical and scientific procedures to arrive at an improved view of the pill's safety: 1) money was provided by several pill manufacturers to replace terminated government funding; 2) the study ignored such serious side effects as sterility, diabetes, and common vaginal infections; 3) fewer than one in five of the women in the study were current users of the pill; many side effects clear up as soon as use of the pill is discontinued; 4) many of the past users had taken the pill for very brief periods of time; 5) publicity has been scant on the following results of the study: increased risk of serious eye disorders, gastro-intestinal problems, urinary tract infections, and higher rates of cervical, skin and lung cancers. Although the publicized results have not softened the FDA's concern over the morbidity and mortality caused by the pill's side effects, the study has given unwarranted support to the pill's safety. Unfortunately, both doctors and patients have been misled by the results of this study to believe that the pill is safe.

Dr. Gentile briefly discussed some of the other contraceptive methods including the diaphragm, and cream, jelly, foam and the condom. She stressed that the consumer must consider the possible long-term side effects resulting from the chemical (oxynol) in jelly or cream that is absorbed into the woman's body. The effectiveness and safety of another device, the cervical cap, remains uncertain because of insufficient data concerning the pregnancy and complication rates of use of the cap.

Some of the possibilities for future contraception that are currently being researched are the following: 1) **LHRH** — synthetic hormones similar to LHRH, which is a hormone produced by a part of the hypotholamus in the brain, have been found to have a powerful antifertility effect; 2) **HCC** — an injection for immunizing women against the pregnancy hormone; 3) **Gossipol** — a cottonseed oil extract that markedly depressed sperm production among Chinese men; 4) **Collagen sponges** — a sponge inserted into the vagina and used with various preparations; 5) **Vaginal rings** — rings smaller than a diaphragm and containing various chemicals (either a progesterone/hormone type substance or a spermicidal agent). Another alternative, **depo provera**, in use in underdeveloped countries, has not been approved by the FDA because it caused breast cancer in beagle dogs in animal studies. Another progestrogen, **norethinbrone eranthate**, has been recommended for approval by the advisory committee to the FDA and may be on the market shortly.

Dr. Louise Tyrer's talk was about the standards of practice of the American College of Obstetricians and Gynecologists (ACOG) and the regulatory process of the

FDA. The goal of ACOG is to provide the best quality gynecological and obstetrical health care to women. It seeks to attain this goal by educating and updating its membership. A public advisory committee, composed of prominent citizens, has been established for the purpose of advising ACOG on ways of providing better education and information to the public. ACOG produces several types of documents for its membership, which include policy statements, non-binding standards for ob-gyn care, opinion papers, i.e., non-policy documents which serve as technical bulletins, and ethical considerations papers, which are used as background educational material.

The FDA represents the final authority in the decision-making process pertaining to drugs and devices. The FDA utilizes expert advisory boards which provide opinions and recommendations on controversial issues. Currently, the FDA has suspended approval to market the cervical cap pending the results of further research. This delay is the result of device legislation recently passed by Congress which mandates that all devices be studied for safety and effectiveness before being marketed.

The discussion period prompted talk on many key policy issues. One of the central issues involves the need to disseminate relevant birth control information on a wider basis and at a younger age. This strategy would allow consumers to make more informed choices after an educated consideration of the cost/benefit factors of the available methods. Among the factors one should consider are: mortality, morbidity, the impact on future fertility and the failure rate.

The ultimate goal of the women's health movement is reproductive self-determination which puts birth control completely in the control of women consumers, without relieving men of their responsibility. Every woman deserves to make her own choice of birth control method, unhindered by professional bias and economic interests, which have resulted in inaccessibility and lack of awareness of acceptable, effective and risk-free methods. The urgency of this goal is made apparent by an investigation of the problems with current ob/gyn services. The following list of problems was offered by Janice Cohen, a representative of Feminist Health Works: 1) failure of the physician to provide a diagnosis where providing prescriptions or drugs; 2) the extent to which doctors are uninformed about the newest developments in their specialties; 3) inappropriate prescribing of drugs; 4) failure of physicians to screen for all relevant sexually transmitted diseases; 5) unnecessary surgery; 6) sexism; 7) inability of patients to obtain information; 8) an apparent concern among practitioners only for money.

The large, professional doctors' organizations have failed to correct this gross negligence and malpractice. One possible remedy for these practices would be a stringent policy on the part of referral agencies to recommend only doctors who follow certain practices. But this strategy may never achieve a large-scale change. This fact points to the need for a publically accountable censuring agent not under the control of physicians, as well as a clearinghouse with information about the quality of doctors' practices. The major obstacle to the attainment of these objectives is the lack of money allotted for grassroots organizing and education in the face of the tremendous financial resources of the AMA.

In considering the future direction of contraception, a great deal depends upon the positions taken by the government and the research industry. Currently, although an increased number of women prefer barrier and mechanical methods of contraception, only about 3% of world-wide contraceptive research funds are spent in that area. This issue raises the question of whether women will be able to contribute more significantly to future research decisions. The conflict between whose interests will be served in the future, the industry's or the patient's, is a pivotal one.

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The Editor Speaks

In August of this year, a march against rape took place in the streets of Manhattan. The march by itself did not represent an unusual occurance for New Yorkers. Marches have long been used as a means of bringing many kinds of issues to the attention of the public. What is significant about this particular march is its timing. It comes at a time when members of the Moral Majority are asserting their prerogative to determine what the moral values and behavioral norms of people in America should be. They would make discussion of rape or sexual assault taboo. Likewise, they would severely limit discussion of alternative contraceptive methods to physicians' offices or family planning centers. Both of these issues are highlighted in this month's journal precisely because they need to be aired. Important issues are addressed in these articles, issues which the Reagan administration and the Moral Majority would prefer to ignore.

Toni Press' study illustrates that sexual assault is not the minor problem that so many Americans are led to believe is the case. She asserts that ten to fifteen percent of the population, mainly women, are victims, a much higher figure than has been acknowledged until recently. Such figures indicate that sexual assault is a major social and health issue. More important, just as the true dimensions of the problem are being brought into focus, the Reagan administration is drastically cutting funds for these, as well as numerous other, health programs. This surely demonstrates an ostrich-burying-its-head-in-the-sand approach to a real issue that will not go away regardless of federal budgetary actions.

Yet, the real anomaly of this situation is found in the basic values advocated by the Reagan administration. Industrial capitalism is anchored strongly on a belief in the values of self-determination, self-reliance, and the unique value and dignity of the individual. Reagan, believing we have lost these values, has been advocating their resurgence as the primary ones in our society. After all, entrepreneurship and our industrial growth have been based upon them.

It so happens these are the very values that the women's movement holds to be important in the treatment of sexual assault victims. It focuses directly on the person's maintaining control over her/his life and, with appropriate assistance, returning to a normal way of life as soon as possible. The Reagan administration can play an important role in helping sexual assault victims to remain the kind of self-reliant, productive people who helped build our society, by supporting and encouraging the growth of crisis intervention centers, which have served them so well. These centers would more than repay the small costs by helping a large group of women and men to overcome the social, psychological, and economic scars produced by such assaults. The true values of the Reagan administration will be revealed by the ways in which it deals with the problems of these no longer hidden victims.

— Herbert H. Hyman

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Continued from page 4

6. Notman, Malkah T. and Nadelson, Carol C., "The Rape Victim: Psycho-Dynamic Considerations", *American Journal of Psychiatry*, 133 (4), 1977, p. 409.

7. Burgess, Ann and Lazare, Aaron, "The Sexually Abused", *Community Mental Health: Target Populations*; New York City: Prentice-Hall, 1976; Estabrook, Barbara, Fessenden, Ruth, Dumas, Mary and McBride, Thomas C., "Rape On Campus: Community Education and Services For Victims", *Journal of the American College Health Association*, 27 (2): 72-4, 1978; Ewing, Charles Patrick, *Crisis Intervention As Psychotherapy*; New York: Oxford University Press, 1978; Holmstrom, L.L. and Burgess, A.W., *The Victim of Rape: Institutional Reactions*; New York City: Wiley-Interscience, 1978; Nadelson, Carol C., "Emotional Repercussions of Rape", *Medical Aspects of Human Sexuality*, 11 (3): 16-19, 23, 27, 31, 1977; Armstrong; Connell and Wilson; Warner.

8. Burgess and Lazare, p. 245; Ewing, pp. vi-viii.

9. Evans, p. 312.

10. Armstrong, Preface and p. 16; Peters, I.J., "Children Who Are Victims of Sexual Assault and the Psychology of Offenders" in a paper to the Association for the Advancement of Psychotherapy, 1975, quoted in Armstrong, pp. 19-20; Evans, p. 310.

The issue of psychotherapy's negative impact on sexual assault victims *when it is the first treatment employed* is a complex one and not within the scope of this article. Psychiatrists, social workers, rape counselors and others who write about rape do agree, however, that crisis intervention is preferable as the initial treatment modality.

11. Holmstrom and Burgess.

12. Shainess, pp. 2046-7.

13. Evans, p. 309.

14. In addition to what I found in the literature, this was confirmed in conversations with staff of the Borough Crisis Centers in New York City, all 5 of which are attached to hospitals.

15. Mills, Patrick, *Rape Intervention Resource Manual*; Springfield, IL.: Charles C. Thomas, 1977.

A bibliography of rape literature is available through Toni Press at the Consumer Health Information and Resource Center, 377 Park Avenue South, 3rd Fl., NYC, NY 10016. This article is extrapolated from a research paper done by Ms. Press as a technical assistance project for New York Women Against Rape. Copies of the complete paper are available at the above address.

Zita Fearon and Toni Press are on the staff of the Consumer Commission on the Accreditation of Health Services. In addition, Ms. Press has worked with victims of sexual assault, primarily as a crisis intervention counselor, for several years in Madison, Wisconsin, Flagstaff, Arizona and New York City.

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