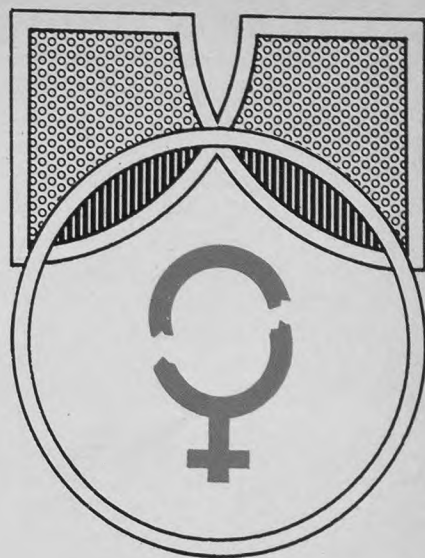


## Total Health Needs of the Rape Victim

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DR. ARTHUR KAUFMAN (*Assistant Professor of Family and Community Medicine*): Today's Family and Community Medicine Grand Rounds will address the subject of health care of the rape victim. We have selected this subject for several reasons. First, the incidence of forcible rape is on the increase nationally and more rape victims are presenting for treatment at doctors' offices and Emergency Rooms. Further, staff in our department working with rape victims have become increasingly aware that the health needs of the rape victim are complex, often requiring more comprehensive care than can be provided by either a gynecologist or a psychiatrist working alone. Accordingly, four members of our staff have established a Rape Follow-up Team which offers both crisis care to the victim of rape in the Emergency Room and broad-based follow-up care in our Family Practice Center.

To illustrate the multiplicity of problems presented by these patients, we will present a patient recently seen by our staff. Ms. Hilaski, a member of our Rape Follow-up Team, will make the case presentation.

### Case Presentation

SHERRY HILASKI (*Physician's Assistant*): The patient we are discussing today is a 20-year-old, unmarried, Caucasian woman who presented in our Emergency Room at 2 AM on a Sunday morning, alleging that she had been raped.

That evening the patient had been hitchhiking home from a movie with her 17-year-old niece when they were picked up by two men in their early 30's. Instead of driving them home, the men drove them to a deserted street and forced them out of the car at knifepoint. Both young women were ordered to undress, but the patient pleaded with the assailants to leave her niece alone because she was a virgin. The niece was left alone, but the patient was undressed and forced to commit fellatio on both assailants. Both men then proceeded to rape and sodomize her. After the attack the men drove away and the patient called the police who brought her and her niece to the Emergency Room.

In our Emergency Room the niece, who was unmolested, appeared terrified and was visibly shaking. The patient, however, appeared detached with a flattened effect. In giving a history, she related the events in a matter-of-fact manner.

She was born and raised in rural Missouri and had recently moved to Albuquerque. Her parents were divorced, and she had left both her school and home during her junior year of high school. She worked at odd jobs and had an out-of-wedlock child, now seven months old. She now subsists on a welfare check and supports her niece who is looking for a job. She has few friends, lives in a run-down area of the city, and has no means of transportation. She stated that she must hitchhike four or five times a day to buy food, take in laundry, and care for other necessities.

She related that she had been raped on five other occasions, all within the past two years. She ascribed three of these to the hazards of hitchhiking, and the other two to guests "crashing" her "pad."

When asked about her apparent casual attitude toward the attack, she stated she had been through this before. She didn't really want to be examined by the doctor ("I feel alright"), nor questioned by the police ("They never catch the guy anyway"),

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but had come to the Emergency Room solely because she wanted a "morning after" pill to prevent pregnancy. Her last menstrual period was normal and she was now at midcycle.

Positive physical findings were confined to the pelvic and rectal examinations. Pelvic exam showed a marital introitus with moderate tenderness and erythema. An aspirate from the vaginal pool showed many motile sperm. Rectal exam showed an anal abrasion and marked tenderness of the sphincter area.

Laboratory tests included cervical, rectal, and oral swabs for gonorrhea. Urine was collected for a pregnancy test and blood was collected to test for syphilis. Dry slides were made of vaginal pool material and given to the police for processing in the police criminology laboratory. A Papanicolaou smear was collected.

The patient was treated prophylactically for venereal disease with one oral dose of ampicillin 3.5 gm plus probenecid 1 gm. Diethylstilbestrol 25 mg orally twice daily for five days was prescribed to prevent pregnancy.

A follow-up clinic appointment three days later was made for the Family Practice Clinic. While in the Emergency Room the patient showed a flicker of interest in the variety of services our clinic offered, but she missed her appointment. However, one week later she appeared in the clinic without an appointment, with her seven-month-old son. She apologized for having missed her appointment but said she couldn't find a ride.

After learning that her Emergency Room tests were normal and that her repeat pelvic examination showed almost complete resolution of pelvic tenderness and anal abrasion, she related her primary interests in attending our clinic: to obtain immunizations for her infant (he had only had his first DPT and polio), and an IUD for herself. She was fitted with a Lippes Loop size "C" and her son received his second DPT and oral polio. It was incidentally noted that the infant had a severe monilial rash in the diaper area and Mycostatin cream was prescribed. Follow-up for mother and infant was arranged at this time.

Before leaving the clinic, the patient was referred to our social service department to explore possible changes in her social and economic environment.

## Medical Treatment

DR. KAUFMAN: This is a fascinating patient. Though she certainly is not typical of most victims we see, her case illustrates many problems in adequately managing the rape victim. The woman who presents in the Emergency Room reporting sexual assault confronts the staff with legal as well as medical problems. While the examining physician inherits all the medicolegal responsibility, we now know that a variety of professional and nonprofessional support services can be mobilized to best serve the rape victim. These may be local rape crisis centers, other counseling services, and other interested departments within the hospital.

The legal goals of the Emergency Room encounter include a near verbatim history, careful physical examination, and a meticulous collection of evidence (See Table). The medical goals include repair of injury, prevention of pregnancy, prevention of venereal disease, and most important, prevention of serious emotional problems.

How well were the legal and medical goals achieved in the case of this patient? I attended her in the Emergency Room and found the gynecology resident's history, physical examination, and evidence gathering exceptionally good. Most important, the resident was gentle and conveyed his sincere concern for her feelings. A patient such as this, cold and matter-of-fact, might have turned off many physicians, but I think the doctor's interest allowed her to relate her story fully.

In obtaining the history of the rape, the doctor cannot expect the victim to spontaneously relate all the events. About half of the rape victims we've seen have been forced to commit either oral or anal sex, but these are often so embarrassing to the patient that she guards their revelation. If a doctor or counselor can obtain the precise history, however, some of the guilt, disgust, and feelings of being "contaminated" can be effectively dealt with.

The medical goals of this victim's treatment were not fully achieved. Prevention of venereal disease in the rape victim is best achieved in the nonpenicillin-sensitive patient by the administration of intramuscular procaine penicillin 4.8 million units, 30 minutes after the administration of oral probenecid, 1 gm. Only this penicillin regimen

adequately treats both gonorrhea and incubating syphilis. After this treatment, if the initial serologic test for syphilis is negative, a follow-up serology in four to six weeks is unnecessary, and the patient need not have lingering doubts about being infected as a result of the assault. Of course, should the initial Emergency Room serology return positive, ie, the patient having contracted syphilis before the attack, the patient would have to be recalled to receive long-acting benzathine penicillin. This patient was treated with a single, high dose of oral ampicillin which is adequate treatment for gonorrhea, but not for incubating syphilis.

The patient was also given a prescription for diethylstilbestrol (DES) to prevent pregnancy. It is an interesting historical note that this medication, experimentally effective in preventing pregnancy in laboratory animals, received its first human trial among rape victims. Kuchera<sup>2</sup> administered DES within 72 hours of unprotected intercourse in 1,000 women at the University of Michigan Health Center. There were no pregnancies. This case illustrates the importance of disseminating health information to the public. This patient would never have come to our Emergency Room had she not been aware of the efficacy of DES.

MS. HILASKI: What are the side effects of DES and are we worried about subsequent vaginal adenocarcinoma in the victim's female offspring should the victim become pregnant?

DR. KAUFMAN: First, the term "morning after pill" is a misnomer. Actually you must take 25 mg twice daily for five days. In light of the frequent nausea, some women do not complete the course and thus do have an increased risk of pregnancy. Nausea can be treated with an antiemetic such as prochlorperazine (Compazine®). Your point about vaginal adenocarcinoma in female offspring is well taken. While recent work has linked DES with higher than expected rates of vaginal adenocarcinoma in female offspring of the recipients of the drug, its actual occurrence is rare.<sup>3</sup> Nevertheless, we customarily advise the victim that if she takes DES and becomes pregnant an abortion is indicated. DES is withheld if a menstrual history suggests the possibility of pregnancy prior to the assault, or if the victim is uncertain if she would have an abortion.



## The Rape Follow-up Team

MS. HILASKI: I would now like to turn to the last goal of medical treatment: the prevention of serious emotional problems. I will discuss this in the context of the work of our Rape Follow-up Team. In the past, when rape victims were brought in for treatment and for the gathering of legal evidence, the only uniform follow-up medical care suggested was a repeat venereal disease blood test and check-up six weeks later. Few victims kept their appointments. In the new follow-up care scheme, after initial contact between the victim and a member of the Rape Follow-up Team in the Emergency Room, an appointment is made for the Family Practice Clinic in three to four days. Here the victim receives various test results and any counseling or treatment deemed necessary.

Our team consists of four members who rotate 24-hour call one week each month. When a rape victim comes into the Emergency Room, one team member is called to attend the victim. We offer counseling, attempt to calm the patient, and explain what is going to happen in terms of police questioning, physical examination, and medical treatment. We try to demystify the experience and act as an advocate to insure that the patient receives adequate crisis care and medical treatment.

One of our key goals is to encourage the patient to return to our Family Practice Clinic where she will be seen by two members of our Rape Follow-up Team, one skilled in psychotherapy and one skilled in medical treatment. For many victims the follow-up visit serves as an entry point into the total health care system, one they may not have previously experienced. To date, 84 percent of rape victims have returned for the first follow-up appointment.

PETER DIVASTO (*MA, Consulting Psychologist*): In terms of our initial counseling there is a dual thrust. First, we talk to the victim about the incident and help her express her feelings. From crisis intervention theory we know the first contact is most important. People who are left without such early intervention often become more symptomatic earlier. The more delayed the intervention, the more difficult the problem is to deal with. Secondly, our role in explaining Emergency Room procedures is extremely im-

portant. Since many doctors fail to offer such explanations, perhaps our high rate of return visits is partly related to this early Emergency Room communication.

DR. KAUFMAN: The quality of our initial effort and subsequent high rate of return has implications for other types of health service. There is a national trend toward specialization that has led to a fragmentation of medical services. As a result, patients have lost the kind of personal contact with physicians that was once the norm. In our program, the victim is suddenly confronted with a number of professionals who arrive at the Emergency Room and express an enormous amount of concern. It is a most gratifying experience for the patients, in this case rape victims. They respond with a greater willingness to discuss problems related to the rape as well as some psychological and medical problems unrelated to the attack.

MS. HILASKI: In a sense, this experience has often been an entry point into the total health care system for many of these women. In the case presented, the patient came for a "morning after pill" and wound up feeling comfortable enough with our team to reveal a whole series of unmet family health needs.

BARBARA EPPLER (*Family Practice Staff*): What kinds of medical problems have you treated apart from counseling?

MS. HILASKI: Many medical problems relate to the assault directly. These include such problems as impetigo, perineal injury, venereal disease, and sprains. Unrelated illnesses have included such minor ailments as corns, condyloma acuminata, and upper respiratory infections. But we have also referred women for abortion and done much contraceptive counseling: placing patients on birth control pills, inserting IUD's. A few have requested health education conferences. One adolescent brought her friends for a talk on menses. Because so much of our work includes the whole family, other family members often ask us to treat their own ailments. For example, we are currently treating the mother of a rape victim for a bleeding peptic ulcer. Often, family members request sleeping pills and tranquilizers.

MS. EPPLER: Does your team deal with the courts?

MS. HILASKI: Not directly. The

gynecologist is the one who is called to testify. But our service improves the legal aspects of managing the rape victim. Some women are very upset in the Emergency Room and initially state they will not press charges, either because of fear of retaliation or lack of faith in the effectiveness of the police in catching the criminal. Counseling tends to allay their fears and lets them think more clearly about the value of giving a deposition to the police and deciding later whether to press charges.

JOSEPHINE VANDERMEER (*MA, Victim Counseling*): I see our role basically as assessing the victim's needs. During the interim between Emergency Room visit and clinic follow-up, I often maintain contact with the victim via telephone counseling. On occasion I have made house calls, particularly if the victim is a child. This enables me to assess the need for working with the family. I also find that in some cases, after the crisis has been dealt with, the victim wants to work on areas of concern that may not have been related to the rape.

DR. KAUFMAN: Concerning the reaction of families, I have found that in the instances of rape of young children the victim is often far less affected than the parents. The parents often suffer a great deal of guilt and express much anger. I sometimes worry if the long-term injury to the child won't stem more from the persistent anxiety and overprotectiveness of the parents than from the attack itself.

MS. VANDERMEER: This is also true of the adolescents with whom I have worked. One mother was actually hospitalized during the weekend after her daughter was gang raped. The daughter was far less affected by the experience. Much of the follow-up counseling I do involves both mother and daughter. Very often during the crisis period we wind up spending more time counseling the mother or other family members than we do counseling the victim.

## Rape Trauma Syndrome

MS. EPPLER: What kinds of reactions do the rape victims experience days after the assault?

MS. VANDERMEER: Burgess and Holmstrom<sup>4</sup> recently described "the rape trauma syndrome" which fits quite closely the patterns of reactions and behavior demonstrated by many

of the patients we see. Often there is an initial shock reaction during the first few days. Then the victim begins to experience fears of being alone, of going outside, etc. They have fears about reestablishment of sexual relationships with their partners. There may be recurring nightmares which often recount the actual assault. Insomnia is frequent. There are disturbances in the normal patterns of eating. Victims often change residence, often many times within a short period of time. Even those who do not move often talk about plans to move. Among adolescent victims this often takes the form of wanting to change schools.

DR. KAUFMAN: I have seen a number of child and adolescent victims express the fear that their schoolmates will find out about the assault and taunt them.

### Multiple Rape

MS. EPPLER: The patient presented was the victim of rape a number of times over several years. Is there any difference in the personalities or past histories of such victims and those who have been raped just once?

MR. DIVASTO: I saw a 14-year-old victim who was raped once before within the past year. She was very, very calm and almost indifferent, much like the case presented today.

MS. HILASKI: I have seen several victims who have been raped a number of times. Most of them were teenagers and they seemed calmer than most. Perhaps they just knew the hospital and police routine better. I sensed that some have an inkling that something in their behavior influences their being raped. Many factors may enter here, whether it be where they hang out, the crowd they run around with, or their particular kind of life-style or economic situation.

MR. DIVASTO: The patient presented this morning has a number of indices that would indicate that she had a fair amount of difficulty coping with stress in the past. We might then expect her to be upset by the rape. However, she presents herself in a blasé fashion. In an interesting study of attitudes toward rape victims, Jones and Aronson point out that the "respectability" of a victim often affects the staff's perception of her degree of participation in the assault.<sup>5</sup> This, in turn, can affect our treatment of the victim.

MS. HILASKI: I sometimes see our

role as helping the victim realize that she has some control over her situation.

MR. DIVASTO: Our attitude towards the patient in the Emergency Room is crucial. In the case presented, we could easily fall into the trap of presuming that since rape was routine for her, it's routine for us. We could thereby fail to explore the many important dimensions underlying her behavior.

MS. VANDERMEER: The same thing is true for a person who presents in the Emergency Room who has been molested sexually over a period of years. Our initial impulse might be that this is not a critical situation, but in reality it might very well be. We recently saw a family in which it had just been discovered that the natural father had been raping his 13-year-old daughter for two years. There was literally a family explosion with accusations, guilt, family breakup, loss of income, and so on. This case required more crisis intervention than any other we have seen, yet initially the Emergency Room staff failed to notify us because the Emergency Room presentation was not that of an acute rape.

MS. EPPLER: How typical is the case that was presented this morning?

MS. VANDERMEER: Not typical compared to what we have seen so far. The greater percentage of victims whom we have seen are much more distressed emotionally in the Emergency Room than this woman was. Burgess and Holmstrom describe two reactions: the composed, controlled reaction and also the hysterical one. People's ways of responding are different. This does not mean that the woman who is composed is any less distressed. Her mode of response is merely different. While most people think that rape usually occurs while someone is hitchhiking, in fact, most of the women we have seen were assaulted while walking down the street and forced into an alley or into a car. The next most common mode of attack is breaking into the victim's home at night.

### Economic Factors

DR. KAUFMAN: We should not lose sight of the fact that behavior is often related to economics. If you live on a marginal income, you may not be able to afford a car. Since there is scant public transportation in Albuquerque, many people must rely on

hitchhiking to get around. If you think of the woman discussed this morning, she has an infant and must travel several times each day for groceries, clothes, and entertainment. I almost wonder if, in some way, rape isn't an unavoidable hazard of poverty. In the same vein for a variety of reasons the poor have more medical problems. They also receive less medical treatment. Since the incidence of rape, just like other crimes, is much higher in areas of poverty, it is not surprising that we encounter a wide range of medical problems among rape victims unrelated to the assault itself.

MR. DIVASTO: Concerning the case under discussion, I am not sure how much of her behavior we could attribute to economic causes. Three of her previous rapes occurred while hitchhiking. The patient displays several of the characteristic patterns of wayward adolescence: leaving home early, out-of-wedlock pregnancy, and moving around the country. The fact that she continues to hitchhike fits in with her presentation in the Emergency Room largely unshaken, not particularly upset. Also, her contact with us after the Emergency Room experience really didn't touch on the emotional side of her life. She was desirous of obtaining treatment to prevent pregnancy, contraception, and immunization for her infant. Her style of interaction with health care providers suggests a haphazard care for herself which I don't see as necessarily rooted in economics. I see that as a psychological function.

MS. EPPLER: Has alcohol played a prominent part in the cases of rape which you have seen?

MS. VANDERMEER: Yes, particularly in the offender.

MS. HILASKI: We see many women who are later attacked by men who picked them up in bars. If the woman has been drinking before the assault, her reaction to the rape is often layered with much more guilt. She may feel, unjustifiably, that she somehow encouraged the attacker and that doctors and police will not be sympathetic to her case. For this reason, many of these victims do not press charges and do not seek medical attention.

### Implications for Family Physicians

MS. EPPLER: What are the implications of your work with rape victims for family physicians?



MR. DIVASTO: To me one of the most striking needs is for some facility in handling crisis situations. Often-times family physicians are well trained in handling medical emergencies but perhaps not as well-equipped to handle emotional crises.

MS. HILASKI: The attitude of the physician is extremely important. Just as we strive for objectivity in other aspects of health care, it is doubly important to be objective in dealing with the rape victim. An attitude of concern is shown when follow-up appointments are arranged in a matter of days rather than weeks.

DR. KAUFMAN: Along that line, I think it is very interesting and ironic that when laboratory tests come back positive for strep throat or gonorrhea we do not hesitate to pick up the phone and notify the patient of results or send out a team of individuals to bring back both patient and contacts. There is no reason why the victim of rape should not also receive immediate follow-up contact, especially since we are now cognizant of the benefit of early intervention and vigorous follow-up.

MR. DIVASTO: The family physician should also be sensitized to the fact that the child victim of rape may often present with symptoms that do not seem to be connected with the sexual assault. The ones most frequently reported are sudden onset of enuresis, abdominal pain, and sleep disorders.

DR. KAUFMAN: Another crucial point for the family physician to remember is that treatment of the rape victim need not be viewed as a crisis best treated by a gynecologist or a psychiatrist. In truth, the health needs of rape victims are so complex that they might best be met by a generalist skilled in follow-up ambulatory care provided in a compassionate atmosphere.

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### Table. Protocol Management of Alleged Sexual Assault Victims at the Bernalillo County Medical Center

#### Preexamination Considerations

1. Accord the alleged victim of sexual assault high priority in the Emergency Room or clinic.
2. Obtain routine identifying information such as name, date of birth, age, etc.
3. Have patient sign consent for physical examination, treatment, and, if she wishes, release of information to the police.
4. If the police have not been notified, they may be called at this time if the patient so desires.
5. Treat the patient sympathetically. As soon as possible, offer counseling and a clear explanation of the medico-legal procedures that will follow.

#### History

A detailed history must be obtained and recorded with liberal quotations. Rape is not a diagnosis. That is a matter for the courts to decide. If the word "rape" is used, use the preface "alleged," or "suspected." Record the time, place, and the circumstances of the assault. Other important kinds of historical data include date and character of last menses, recent drug use, and whether the patient bathed or doused after the assault.

#### Physical Examination

1. Emotional state: is the patient tearful, stoic, enebriated?
2. General appearance: are there any bruises, lacerations, torn or bloody clothing?
3. External genitalia: evidence of trauma?
4. Speculum examination: inspect cervix and vagina with nonlubricated, but water-moistened speculum.

#### Obtain the Following for Police Evidence Kit

1. Collect all clothing that may be contaminated with body secretions, hair, or other foreign matter.
2. Examine the victim's skin for blood and seminal stains. If present, obtain a specimen using a saline-moistened swab. Place swab in a clean test tube. (Both blood and semen can be typed from these specimens.)
3. Examine the pubic area for matted hair. Examine the fingernails for dried blood or skin scrapings. Clip these areas and place in small envelope. (Blood or semen may be retrieved.)
4. Comb the pubic area with a fine tooth comb. Place the comb and any removed hair in an envelope. (Male and female hair can be differentiated.)
5. Swab the vagina (mouth or anus where indicated) and prepare two dry slides of the secretions. (Using special stains and a phase contrast microscope, sperm can be detected on these dried slides.)
6. Irrigate the vagina with 5 cc of saline and collect the washing in a test tube. (The fluid is tested for acid phosphatase, an enzyme present in high titer in semen.)
7. Draw a venous blood sample into a nonclotting test tube. (This is for determination of the victim's blood type.)

#### Obtain the Following for the Hospital Laboratory

1. Examine a wet mount of vaginal contents and cervical mucus for sperm. Are sperm present? Are they motile? (This can help set time of last coitus.)
2. Culture cervix (and other penetrated areas) for N. gonorrhea.
3. Collect urine for a pregnancy test.
4. Draw clotted blood specimen for serologic test for syphilis.

#### Repair of Any Injury

Serious hemorrhage necessitates control and replacement of any volume or blood deficit. An experienced gynecological surgeon should be summoned if extensive laceration is suspected. Tetanus immunization should be considered if the skin is broken. Most minor trauma is relieved by cold compresses, elevation of hips, and mild analgesia.

#### Prevention of Pregnancy

Post-coital prevention of pregnancy should be attempted in victims of childbearing age who are likely to be fertile, who are at a vulnerable time in their menstrual cycle, and who do not have contraceptive protection. Diethylstilbestrol, 25 mg orally twice daily for five days is prescribed. Because nausea is a frequent side effect, an antiemetic is of benefit prophylactically.

#### Prevention of Venereal Disease

Adults should receive 4.8 million units of procaine penicillin intramuscularly 30 minutes after 1 gm of probenecid orally. If allergic to penicillin, a satisfactory gonorrhea prophylaxis is tetracycline 1.5 gm orally stat. followed by 0.5 gm orally q6h for 4 days. Follow-up serology in six weeks is unnecessary if penicillin is given and the initial serology is negative. But follow-up serology is necessary if tetracycline is given. The proper dosage of antibiotics for children must be calculated according to the patient's weight.

#### Prevention of Serious Emotional Sequelae

Crisis intervention counseling should be offered at the time of initial examination. Follow-up counseling at the time of the return checkup in three or four days is recommended.