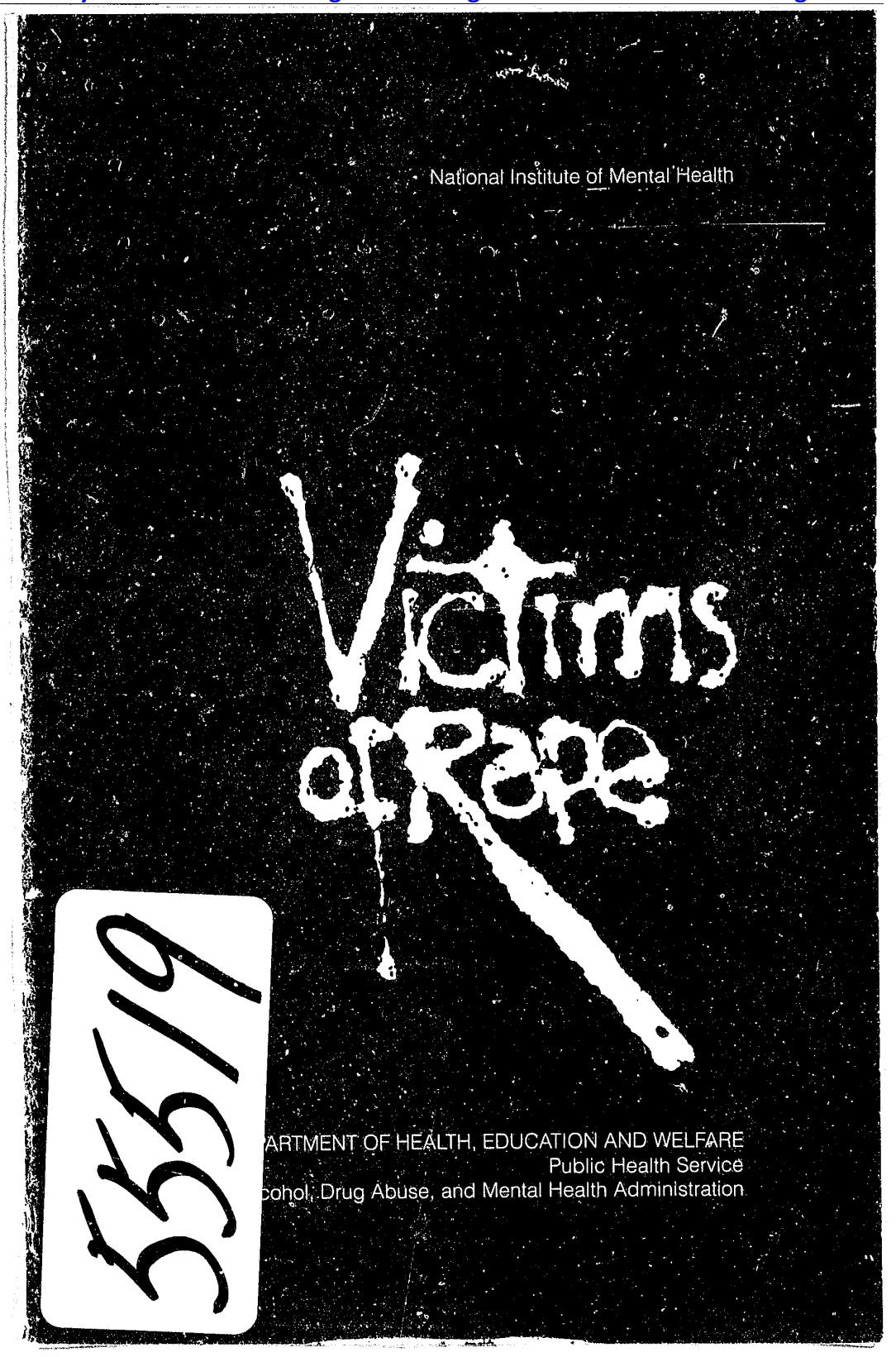

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Investigator: Joseph J. Peters, M.D.
Center for Rape Concern
Philadelphia General Hospital
Philadelphia, Pennsylvania 19104

Coinvestigators: Linda C. Meyer, M.A.
Nancy E. Carroll

Authors: William Krasner, Linda C. Meyer, and Nancy E. Carroll

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Mental Health Studies and Reports Branch
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FOREWORD

Rape is one of the commonest of crimes. It has existed throughout human history and appeared in all human societies. It has been celebrated in verse, drama, and paintings—the Sabine women, Leda and Lucrece, Blanche DuBois, Dulcinea are only a few of the famous victims. The fact that rape has engaged the attention of so many poets, novelists, dramatists, and artists attests to its intense emotional quality.

But the actual ugly, real-life fact of rape has rarely been discussed openly until recent years when rape—the unspeakable crime—has become a topic of much discussion and debate. Several books on the subject have appeared, many making the best-seller lists. Nevertheless, relatively little is known about this crime, its roots and its prevention. Rape is still surrounded by myths and misconceptions and by such contrasting emotions as terror, outrage, disgust, and even amusement. But, if rape is to be prevented and controlled and if its victims are to receive the most effective treatment, it must be brought out of the realm of emotional outcry and made the subject of dispassionate inquiry. The light of scientific research must be focused on it.

Recent Federal legislation gives explicit recognition to the need for research on rape. In 1976, Congress authorized the establishment of a National Center for Prevention and Control of Rape to be established within the National Institute of Mental Health (NIMH). Social concerns of the feminist movement and other political dynamics were the driving forces behind passage of the Act. The Center has four main areas of responsibility: research support and research-demonstration projects, information dissemination, development and distribution of training materials, and provision of technical assistance through consultation and conference. The need for services is clearly large, and beyond the resources now available to the Center.

Even before the establishment of the National Center, the NIMH supported research projects on rape. One of them—the Philadelphia Assault Victim Study—is described in this report on "Victims of Rape." The research is only one example of the beginnings of a comprehensive national program on problems associated with preventing and treating rape.

Bertram S. Brown, M.D.
Director
National Institute of Mental Health

Victims of Rape

Despite folklore, dirty jokes, and common misconceptions, rape is not an erotic sexual act. It is a brutal act of subjugation; and it is the trauma of subjugation that accounts for much of the victim's suffering. Penile-vaginal contact, accomplished by force or threat, can be just as humiliating and degrading as oral or anal intercourse accomplished by the same means.

This is a major conclusion of the 27-month Philadelphia Assault Victim Study, funded by the NIMH, and conducted by the Center for Rape Concern (CRC) at Philadelphia General Hospital (PGH). The principal investigator was the late Joseph J. Peters, M.D., a psychiatrist. Linda C. Meyer, M.A., and Nancy E. Carroll were coinvestigators. The research spans the years 1973-75.

Few of the assault victims, according to the gynecological reports, suffered much pelvic physical trauma; yet almost all of the victims were emotionally traumatized. There were two major periods of crisis: First, the rape and the events immediately following its reporting—police interrogation, medical examination, and the rest. Second, if the rapist was caught and identified, the grueling legal process, possibly leading to trial, began. Months or even years passed between the assault and the trial where the experience was discussed and relived before an audience of strangers.

These essential facts about rape and its meaning to the victim would seem, with only a little reflection, to be rather obvious. Yet they do not fit the common or even the legal stereotypes about rape and its victims. "How can you thread a moving needle?" goes the joke. The answer is quite simple:

If the "needle" is human and in threat of being beaten or maimed, it will probably stay still. "Did she enjoy it?" There are many women among rape victims who enjoy consensual intercourse, but that is not what rape is. "If she is promiscuous, one more should not matter much." A knife at the throat can be just as traumatic to an experienced prostitute as to a convent-raised virgin, and she has just as much right to treatment, justice, and protection.

Philadelphia General Hospital, where the study was conducted, is an ancient, huge, municipal hospital. (It is now closing, and the Center for Rape Concern is moving.) Public hospitals must take cases that private hospitals and physicians refuse or refer. For this reason and for legal reasons (rape is a crime, and the police are to be notified), rape cases were routinely referred to PGH. The CRC was originally formed in 1970 in response to the increased need to provide services for these victims. The research project, designed to assist in the development of a comprehensive social service model, was a direct outgrowth of this need.

Scope and Focus

Specifically, the Philadelphia Assault Victim Study at CRC was funded to study:

1. The social and psychological effects of rape upon female victims. These effects were then to be correlated with:
   (a) the circumstances that surrounded the rape
   (b) the victim's personality and social adaptation before she was raped, and
   (c) the support available from organizations and people who were important to her
2. The events as the victim passes through the criminal justice system, and the effects that they have on her mental health and adjustment.

From the beginning, the investigators realized that the study would have to be multidisciplinary. The act of rape could not be separated from its social, psychological, and legal consequences which, according to the report of the investigators, included:

> . . . social reactions and values as witnessed by the wide ranges in punishments; the anger it evokes on the part of the public; the shame, guilt and the burden of proof the victim has in some instances been forced to bear; and the stigmatizing of both offenders and occasionally victims.

However, in 1972, when this study was formulated, little research into the social and psychological effects of rape had been conducted. The psychiatric literature relied on the subjective recollections of individual victims, often long after

the fact. Other studies concentrated on police reports. To maintain a balance, the CRC sought to bring in the responses of individuals representing a wide variety of interests. In the opinion of the researchers, the study required the perspectives of psychiatrists, social workers, psychologists, sociologists, criminologists, attorneys, and physicians (most often gynecologists).

The study used a broad definition of rape that went far beyond "penetration" to emphasize the importance of force and subjugation. It included:

> . . . intercourse, cunnilingus, fellatio, anal intercourse, and any intrusion of any part of another's body or any object manipulated by the other into the genital or anal opening of the victim's body, or the intentional touching of the victim's sexual parts by another when this was accomplished by force, or threat of force, or against the victim's will.

The study included all rape victims brought to PGH by the police and all those who came on their own. Since the police were aware of almost all victims who came voluntarily to PGH, there are few unreported cases. In the years covered by the research, 3,971 victims were seen at PGH: 863 in 1972, 1,039 in 1973, 1,084 in 1974, and 985 in 1975. How many rapes were unreported, why the victims did not report them, and how they differed from those who did report are not definitively known at this time. There were and still are no reliable estimates of the total number of rapes in Philadelphia.

A survey conducted jointly by the U.S. Bureau of the Census and the Law Enforcement Assistance Administration, called *Crime in the Nation's Five Largest Cities*, gives an inkling. It estimated some 1,800 rapes of females over 12 in Philadelphia in 1972. During the period covered, 646 victims in this age group came to PGH emergency room, approximately 40 percent. In the opinion of the CRC staff, the Census and LEAA figure is not large enough. But, whatever the total, it is certain that a large number of rape victims refuse for their own varied reasons to report the matter to the authorities.

Altogether, during the period of study, 1,401 rape instances were recorded and the victims examined. The total number of persons is less because about 25 victims reported being raped on two separate occasions.

When a victim was seen at PGH, a report was forwarded within 24 hours to CRC. Medical records were also supplied. In most cases, social workers were assigned to interview the victims and to collect the data that made up much of the study.

Not all victims were interviewed. If their homes were outside of the city of Philadelphia, they were not interviewed.

Some were dropped because of a too heavy case load. There was a sizable number of unsuccessful contacts—victims who could not be reached by telephone, who did not answer their mail, who were not home whenever the social worker called, who moved and left no forwarding address, or who refused to be interviewed. Any victim or her guardian had the right to refuse to take part in the study. Eighty did refuse. Children made up a disproportionate part of the refusals.

Of the total of those who reported to PGH, 611 were unsuccessful contacts, leaving 790 actually covered who were interviewed. This figure is doubly distilled: the portion of those willing to report the rape who were also willing, and available, to be interviewed.

Some of those not contacted were not available because they feared retribution from the rapist, community censure, or more of what they might have considered trouble from the medical system or the police. Comparison of those who participated and those who did not reveals few fundamental differences in marital or socioeconomic status, in the relationship between offender and victim, in the degree of trauma, or in the presence of spermatozoa. There was a difference of a few percentage points in race. A slightly larger percent of blacks were willing to be interviewed (79 percent of those willing as compared with 75.4 percent of the total), but this difference is not great enough to keep the findings from being representative of the entire sample of 1,401.

The victims determined the content of the questionnaires. After many victims had asked questions and discussed their problems and worries, the items which seemed most important to them were included. The social workers concentrated on the details and the facts of the rape, on how the victim interacted with the medical and legal systems, and on her personal adjustment. The psychiatric research interview focused on her overall psychosexual development and her psychological response to the rape. Both types of interviews tried to assess her pre-rape orientations and adjustments as predictions of her reactions to the incident.

The Center found that victims may go through several stages of adjustment which depend not only on the individual, but on the responses of others. Thus, the Center decided to conduct four interviews during the year following the report to PGH: the first within 5 days; then at 3, 7, and 11 months.

Who Reports and Why?

Why people do not report rapes and the particulars of those rapes may never be known. Those who do not report may have similar inhibitions, but their reasons for reporting

outweigh their fears. Strongest among these reasons is the desire, and often the need, for medical treatment, comfort, and support. Of the 634 victims asked why they reported, 38 percent (241) stated that they wanted help and solace—physical, emotional, or medical. Many of those who have money sought the same help or support through private physicians or other private sources in order to avoid reporting to the police and risking embarrassment or publicity. The poor had much less choice; if they wanted help, they had to go to PGH, and that meant police attention.

Other major reasons given for reporting were associated with the desire to take the rapist off the street either to ensure punishment (23.3 percent), or to keep him from raping again (30.7 percent).

Fear of retaliation by the rapist is often publically tendered as a strong reason for not reporting. Of the 197 victims who said they had considered not reporting, less than 20 percent (39) said their primary reason was this fear. Of the 768 victims who talked to their social workers about their fear of retaliation, slightly more than 20 percent expressed strong fears and 66 percent said they had some fear. Yet these victims went ahead and reported the crime. If fear of retaliation is such a strong deterrent, why did it not deter these victims? More significant reasons for secrecy may be embarrassment, fear of what the family might say or do, fear of skepticism and suspicion, a desire not to cause trouble, and a desire for privacy.

Sometimes the victim has little choice, particularly in cases of child rape. Sometimes parents or friends will call the police, or neighbors, hearing a disturbance, will call.

The figures are skewed because certain groups such as Asians, Hispanics, Italians, and Indians in Philadelphia seem to avoid reporting. They too are raped, though perhaps at different rates. Why they do not report, and what they do about it, can only be surmised.

It is difficult to quantify something as personal and individual as rape. Each rape and each victim is different. Each incident involves a complexity of factors, feelings, actions, and reactions. There is no average rape, rapist, or rape victim. With these qualifications in mind, however, some quantification can be made that has value.

Age

The ages of the victims in the study ranged from several months to 84 years. (The CRC now reports it has worked with a 97-year-old victim.) The average age was slightly less than 20, with 15 as the most frequent. The reported

rapes, as noted, were not the majority of the rapes in Philadelphia. Still, they do indicate that the rape victims that reported to PGH were disproportionately teenagers. This may also be true of rape victims in general, although no age is safe.

This age disparity becomes dramatically evident when the rape victims are compared with the general population. Of all those reporting, 12.3 percent were 14 or 15, the ages of greatest frequency; but only 3.3 percent of all females in Philadelphia are those ages. Similarly, only 7.9 percent of the total population ranges from 16 to 20, but almost 25 percent of the reported rape victims were in this age group. On the other hand, 37 percent of all Philadelphia women are 45 or older, but represent only 4.6 percent of the reporting rape victims.

Race

Race of the victims shows an even greater disparity. Three times as many black women reported rape as white; yet there are almost twice as many white women in Philadelphia as black.

Undoubtedly figures and percentages would be altered slightly if the unreported rapes could be included. There are more white women who can afford private physicians and privacy. Nevertheless, black women are victimized disproportionately more frequently. The rape rate can be calculated at 28 victims per 10,000 black women to 4.8 victims per 10,000 white women.

Income

Determination of socioeconomic status was difficult, but, according to information on the census tracts in which victims resided, the majority of victims lived in low-income areas. This fact and the higher percentages of blacks were consistent. The poor who wanted medical attention had no option but to go to PGH. To many, reporting was unpleasant but preferable to having untreated injuries.

But, enumerating the background facts and statistics about rape victims in general is of limited usefulness. There are, however, logical age groups into which the victims fall that are distinct in several characteristics. The problems, patterns, and details of rape vary sufficiently between child, adolescent, and adult victims to justify studying them separately.

Most of the figures that follow come from a preliminary data analysis of a sample of 369 of the victims, rather than the total of 790 interviewed. These data are representative of the findings on the total sample.

The Child Victim

Background

Children, especially young children (even infants have been raped), seldom report to the police or to PGH on their own. Often they do not quite realize what has happened. When seen at PGH or interviewed by the social worker, one or more adults, usually the mother, were present. Most background and family information was supplied by an adult. If possible, the child was seen alone for a portion of the interview, particularly for the psychiatric examination.

The preliminary sample included 64 children. They ranged in age from 2 to 12; the average age was close to 8, but the most frequent age was 12. About 82 percent of the children were nonwhite, close to 18 percent were white.

Most often the child lived with the mother (84.4 percent); the father lived at the home only 36 percent of the time. In over half the cases, the family received public assistance. At the time of rape, about three-quarters of the victims attended school. The majority received average or good grades in school; most got along well in school or with friends; few had behavioral problems such as truancy or running away from home. Few belonged to organizations; generally they went to school, then came home and played with other children in the streets. There were no reasons to think of them as an abnormal group in any way.

The Rape

The brutal rape of a child can and does cause more outrage than perhaps any other crime. But brutality is not typical of child rape (unlike rapes of adolescents or adults), and, as a result, most sexual assaults of children are neglected or discounted. When the child is badly hurt, it is the "child abuse" rather than the rape that generally attracts the attention of the authorities. The sexual damage is seldom physical, seldom overtly visible.

The children do not suffer brutality in large part because they can be induced to submit to sexual advances by promises, candy, or orders from an authoritarian adult—perhaps a father figure—whose wishes they are not accustomed to refusing. The child may desire to please; she may be sworn to silence.

A favorite villain in the media, despised even by criminals, is the child molester hanging around candy stores and schoolyards. Actually, little girls are many times (80 percent of the total) more apt to be raped by people they know: 14

percent by a father or brother, 18 percent by another relative, 29 percent by friends, and 30 percent by acquaintances. Usually the rapist is 10 or more years older. Child rape is only 12.7 percent interracial.

Many of the other elements commonly associated with rape do not apply to child rape. Almost two-thirds of the time, the rape is committed during daylight or dusk, the largest percentage (56 percent) between noon and 8 p.m. Children are most often assaulted in unsupervised routine activities, such as playing outside or coming home from school. On the other hand, about a third of rapes occurred between 8 p.m. and midnight, when the child was attacked by someone supposedly caring for her, such as a babysitter.

The incidents, as the children described them, were usually of short duration, occurred mostly indoors (35 percent at home, 21.7 percent in the offender's home—which is hardly surprising, considering the degree of acquaintance).

Tempting was used in almost 25 percent of the cases. A father offered his 9-year-old daughter new clothes, for instance. "If I didn't do it, he wouldn't have bought me any!" Two adolescent boys offered a 3-year-old sunflower seeds, then attempted intercourse. In many cases, the offender simply told the little girl "I have something that is going to make you feel real good!"

Coercion was used in over 31 percent of the cases. Many victims said they were threatened with harm. Often the child was told that if she did not submit, the offender would harm younger brothers or sisters present.

Application of actual physical force was less frequent for children than for the other groups. No force at all was used in over 54 percent of the incidents. Roughness, such as pushing or shoving, was present in 30.5 percent; 16 percent of the victims were beaten by means such as slapping, but not brutally. Only 13.6 percent reported actual brutality: 8.5 percent slugging, kicking, beating, and the like, and 5.1 percent choking or gagging.

The definitions of rape are very pertinent in evaluating child molestation. Only 36.7 percent of the children were subjected to what most people, and the law, consider rape: forced penile-vaginal intercourse. (This compares with 86.4 percent of adolescent and over 95 percent of adult rapes.) According to the children, fondling or caressing occurred almost 30 percent of the time, penile-vaginal contact without penetration almost 20 percent, and oral intercourse or contact 6.6 percent. Incidence of rectal intercourse was 11.4 percent. (This was highest of any group, but could have been in error, since children have difficulty distinguishing between vaginal and rectal contact.) Other sexual acts, such as masturbation,

occurred in almost 20 percent of the cases. Repeated intercourse was least frequent as reported by children who came to PGH.

A sensitive questionnaire given to 99 of the victims refined the figures further: manual penetration in 16 children; penile-labial contact without penetration in 26; fondling *of* the child in 17; and fondling *by* the child in 3. Significantly, the child in most cases did not really know what was taking place sexually and was confused about whether or not it was wrong.

These figures are in accord with the other evidence that the child had often been molested or assaulted by someone close and well known, who had considerable authority or prestige. Except when actual intercourse occurred, physical damage was not so great as for an adult, perhaps not even measurable; but the emotional damage may be significant, especially when the assaulter was someone she respected or was supposed to respect.

What will these emotional effects be, both immediate and long-term? In large part, this will depend on the responses of those close to her, including school and neighborhood friends, but particularly her family. How the police and the criminal justice system respond may also leave scars. Usually, those responses seem to be based on misunderstandings about child rape, the victim's reactions, and confusion about whether or not the offender should be reported. Further, children have a tendency to blame themselves for things that happen to them that seem "bad," particularly when they cause strong reactions in others; this too may influence their responses, including whether or not they report the incident.

Reactions to Rape

At the turn of the 20th century, Sigmund Freud published his finding that many young children had suffered sexual molestation and that these experiences had had traumatic effects on later psychosocial development. In "The Aetiology of Hysteria" he stated that ". . . at the bottom of every case of hysteria, there are *one or more occurrences of premature sexual experiences. . . .*"

This conclusion was so unpalatable to the people then (and, for that matter, now) that it caused a considerable uproar and general rejection. Later the great pioneer himself backed away slightly from his original position, stating that many of the molestations might have been fantasied; and his followers, after 1924, put most of the emphasis on fantasy, apparently with some relief. Later, Joseph J. Peters, as a result of his private practice and his work with associates

in the CRC, was able to document the instances of reported childhood assault as too seldom, not too often, fantasied.

The CRC study is about victims, not rapists; but the characteristics of the offenders are a major determining factor in response. As Peters has written:

> In terms of a pattern, it is the same: the emotionally dependent man, the domineering or managing wife; withdrawal of the wife from an increasingly frustrating relationship. . . . The husband then begins drinking and sexually molests an accessible little girl, usually someone over whom he exercises authority, and who is unlikely to reject him.

In over half of the cases of the PGH sex offender program at CRC, the assault occurred while the offender was drinking. Over half of the child victims reported that the adult promised favors and that they thought he would not hurt them. The long-term effects, however, may be much greater than seemed probable at the time of the offense. The study at PGH, with its 3-, 7-, and 11-month followup interviews, could not measure these long-term changes. Primarily, "what was measured was the absences of response, due to the need of the mothers to minimize the severity of the sexual assault."

As a result of these factors, child victims showed fewer apparent effects of the rape than did adolescent or adult victims. Only 11 percent said they did not "feel safe" where they lived, although the families considered moving in 25 percent of the cases. Still, 31 percent had difficulty in sleeping, with nightmares in 20 percent of cases. Twenty percent ate less, a third showed negative feelings for all men, including those they knew. Almost one-half were more afraid of being out in the streets, and a full 10 percent stopped going to school altogether. The major measurable changes occurred immediately after the rape. Subsequent home visits, during the year the case was followed, showed little change unless the offender remained in the home with the child.

A much longer period of consistent observation is necessary to understand the effects of child rape and reasons for this apparent low level of immediate response. CRC staff providing services to victims of rape have found the following responses:

1. Social withdrawal
2. Self-punitive behavior, including self-reproach and guilt
3. Imagined aggression and aggressive fantasies
4. Excessive dependence, including clinging to mother
5. Projection of fear and sadness
6. Dissociative behavior and distractibility
7. Repression, denial of feeling
8. Loss of self-esteem
9. Lying and clowning

10. Worry, fear, nightmares, enuresis
11. Compulsive washing
12. Interest and fascination with—and fear of—the offender
13. Psychosexual regression

If this amount of reaction could be determined in the short period of the study and subsequent service, then the broader picture of the long-term effects of child rape surely requires—and would justify—consistent and close followup. From Freud's studies to the present, case-history material indicates that the traumatic effect of child rape extends into adulthood. These data provide a good starting point for study of long-term effects.

The Adolescent Victim

Background

The sample of adolescent girls was 121, evenly distributed throughout the age range 13 to 17. Nonwhites were overrepresented: 84.2 percent black to 15.8 percent white. More frequently than the child or adult victims, the adolescents were poor and disadvantaged: 12.7 percent came from poverty areas, compared to 6.5 percent for all other victims; 42 percent of the families received public assistance. The overwhelming majority lived with the mother (87.6 percent), and only about one-third lived with the father. Most households were large, including an average of two other siblings. Some included children from other families; eight included the victims' own children.

Adolescents had more behavior problems than the other victims. Thirty percent had been truants, 35 percent had been in fights, 23 percent had run away, 19 percent had had trouble with the police, and 7 percent had been in gangs. A large percentage had sought or received counseling or therapy services. Only about 15 percent were not going to school when the rape occurred. Most said they got along well with their classmates. Forty-one percent said they did not get along with others in the neighborhood; and 45 percent had unsatisfactory relations with their families.

This is a fairly high level of maladjustment. Of the 47 girls interviewed by psychiatrists, many had had problems with sexual relationships and with sexual adjustment prior to the rape. Only 17 percent had not had some social experience in dating and parties with boys; 55 percent had had intercourse before the rape—70 percent of these by age 14. Almost two-thirds reported little sexual satisfaction. A quarter had had previous problems in relation to males—fear of males, excessive dependence, and the like. Seventeen

percent of the victims had been sexually assaulted before the rape that brought them to CRC; in almost one-fourth of these cases, the offender was the current rapist.

The Rape

It is unfortunate that the normal and desirable developmental tendencies of adolescence—the loosening and testing of family controls, the reaching out for new identities, ideals, experiences and friends among peers, the challenge of the new, and the testing of limits—should make the teenage girl particularly vulnerable to force and assault.

Typically, the girls were raped on weekends, after dark (55 percent of the time), and away from home, often at a social affair. Moreover, the rape sequence (from first act of aggression until she left the aggressor's presence) was longer than for children or adults: Over 47 percent took longer than an hour, while less than 18 percent lasted under 15 minutes. Gang rapes were most common for this age group.

Only 15 percent were raped in their own homes, unlike other rape victims. The incident occurred in the offender's home 19.3 percent of the time and 21 percent in someone else's home. A car was the location 10 percent of the time. Abandoned buildings were used (often for gang rapes) in 8.4 percent of the incidents.

Adolescents suffered more force than children, but less than adults. Actual physical force occurred in over 80 percent: roughness (holding or pushing) in 57 percent, slapping almost 20 percent, brutal beating 16.7 percent, and choking or gagging 14 percent. Tempting was used in about 23 percent, threats in 46.3 percent, physical intimidation about 30 percent, and intimidation with a weapon 25.6 percent.

For 86.4 percent of the cases, penile-vaginal intercourse was reported, a much higher percentage than reported by children. Fellatio occurred in about 6 percent, cunnilingus about 5 percent, rectal intercourse less than 1 percent, fondling and caressing in 11 percent, and penile-vaginal contact without penetration in 4.2 percent. Reflecting the longer time and the general nature of adolescent rape, in 18.5 percent of the incidents there were repeated acts of intercourse by the same offender.

An adolescent is more likely to be victimized by more than one attacker. The average number of attackers for each rape was 2.7, as compared with 1.5 for adults; 16 percent were assaulted by 7 or more offenders; and in 28 cases, other persons who did not assault the raped girl were present.

Gangs are part of the teenage subculture in some neighborhoods; and the adolescent victims were more often in-

volved with and victimized by such gangs. Gang rapes are often part of a gang initiation rite called a "train" which is planned in advance and requires victims. Some victims are recruited by the female members of the gang and, on some false pretext, are brought to the "train"; others may be selected because, through superior achievement or outside activities, they may seem to be rising above their peers and, therefore, have to be humbled. In one particularly disturbing episode, a black teenager who had won a music scholarship that included travel abroad and attendance at a school outside her neighborhood was set up for a "train" to put her in her place. In other cases, gang rape may serve recruiting purposes; victims may join the gang to avoid other sexual assaults.

Adolescents are raped by their known peers: Over three-quarters of the sample were raped by someone within 10 years of their own age. In only 38.3 percent of the cases was the attacker a total stranger. In about half of the incidents, casual acquaintances or friends were the attackers. Family members (usually the father or stepfather) were involved in 5 percent of those reported.

Peers were generally of the same race, and only 5.8 percent of the rapes were interracial as compared with 21.4 percent for adults.

In sum, adolescent victims and offenders are usually from the same homogeneous group, from the same neighborhood, acquainted, and peers. Frequently the rape occurs in the course of accepted social interactions such as parties. The offender escalates the occasion into an attack which may be violent. Typically the girl is reaching out for friends and gets into a situation that is out of her control. For example, one girl skipped school with a few young people for what she thought would be an afternoon of talk and fun and went with them to someone's house. There the boys asked her to have sex with them. When she did not agree, she was dragged into a bedroom, and four of them raped her.

Reactions to Rape

The adolescent girls are not only vulnerable physically, but particularly vulnerable emotionally and psychologically as well. Rape, according to the researchers, can therefore have traumatic effects:

> The adolescent who is raped experiences this attack at a time when she is involved developmentally in trying to maintain a steady self-concept and to establish an independent social role of identity while undergoing substantial physiological changes and intrapsychic reorganization.

After she has been brutally subjugated, where is her independence? Where is her ability to choose and control her destiny? How can she be open and accepting? She may well ask herself these questions, as well as two final, even more damaging ones: What is love worth? What is she worth now as a marriage partner?

Her ability to cope with the impact of the rape will depend on a number of things, including maturity, earlier neurotic and developmental problems, and her ability to establish herself as a person before the rape. The help or hindrance she gets from those around her will also strongly influence her ability to adjust and to proceed to normal adulthood.

Often the early adolescent will regress, turn away from her peers—particularly the more sexually experienced friend who might have betrayed her—and retreat to the protection of her family. Not trusting herself, she may lack confidence and spontaneity; she may consider herself dirty and contaminated, a dirt that cannot be relieved by treatment or showers; and she may worry about venereal disease and pregnancy long after the danger is past.

The girl in later adolescence may have already achieved some adjustment to physical change, firmer and more rewarding relationships with boys, and more independence from her parents. She may face the rape more realistically and thus make more appropriate adjustments. She may be ready to go ahead, on a trial-and-error basis, to deal with fellow adolescents and her parents. It helps if she has good support from people who are important to her. The adolescent who is rigid or narcissistic, however, will have more self-doubts and depression and will have a more difficult post-rape adjustment.

Changes reported at the time of the first home visit emphasized increasing insecurity and distrust. Over one-quarter felt more cautious; about one-eighth felt that others blamed her for the rape. There were substantial changes in eating and sleeping habits, usually toward less of each, close to 40 percent in each category. About one-quarter had more nightmares. Fear and negative feelings showed substantial increases: Over one-third of the victims showed negative feelings toward known men, over a half toward male strangers. Over 56 percent had more fear of being alone in the streets; but home did not provide much escape either, since over one-quarter became more afraid of staying home alone. About 7 percent had dropped out of school after the rape. Over 20 percent said that family relations had worsened, but about 17 percent said that they had improved.

Over half of the victims had reduced their social activities,

with 40 percent reporting worsening heterosexual relationships. Of those who had had sexual relationships before the rape, half of the adolescents reported that these relationships had deteriorated. Of those adolescents who saw a psychiatrist, many reported that the sexual conflicts, fears, and inhibitions that they felt might interfere with their future married or sex lives had increased.

All these factors emphasize the interplay of long-term responses and effects on the victim and her lifestyle. It is much too easy and misleading to discount the effects of the rape based on first impressions, first interviews, or the report of the gynecologist or examining physician that the vagina was undamaged. In sum, long-range reactions involved:

1. More sustained unrest, leading to the desire to escape or run away
2. Increased sleep disturbances, including nightmares
3. More intense and specific fears and phobias
4. Interference with normal maturation and psychosexual development
5. Evidence, psychologically, of retreat or regression, such as avoidance of complex activities, difficulties in concentration and the use of learned skills, and dulling of creative effort

These symptoms plus repeated traumatic anxiety may recur or be reinforced by court appearances and the sight of the offender during legal proceedings and trial.

The Adult Victim

It is the adult victims that most people associate with the word "rape." The act is violent, the participants are alone, the rapist is a stranger, and penetration occurs.

Background

The age range of adult victims is very wide, 18 to 76 years in the sample of 184 in the study. The mean age, however, was 28; the median was even lower (23); and the most frequent age (15 percent) was 18. About three-quarters of the women were nonwhite.

At the time of rape, 54 percent were single, 22 percent were married, and the rest were separated, widowed, or divorced. Only 12 percent lived alone, 27 percent lived with their mothers, 10 percent with their fathers, 32 percent with at least one son, 29 percent with at least one daughter, and 7 percent lived with a roommate.

About one-third of the adults worked. Three-quarters of the married women had employed husbands. Although 41.5

percent received public assistance, adult victims were usually better off financially than the adolescent victims. About 35 percent had completed high school, 13.5 percent had had at least 1 year of college, and about 23 percent had received vocational training. Fewer than 10 percent of the women were still students.

Adult victims had fewer problems. Behavior problems were not so frequent with adults as with the adolescents and were seldom recent. Most of the CRC sample reported that they got along well or very well with friends at work or school, although 35 percent said they did not get along with neighbors very well. But they did get along with neighborhood friends, with families, husbands, and boyfriends.

About 36 percent said they had had previous contact with mental health workers before the rape; but this figure must be interpreted carefully. The adolescents also had a high rate of contact.

After the rape, 63 women received a psychiatric examination. They were comparable to the entire sample (in race and type of rape). This examination showed some past history of psychosexual trouble. In the psychiatrists' judgment, over 41 percent had had problems in heterosexual relationships before the rape. Sexual conflicts were recorded in about 43 percent: difficulty in maintaining a relationship, inhibitions, and involvement in abusive relationships. Twenty-four of the 184 had been sexually assaulted at least once before the rape; but in only one case was the offender the same. These sexual factors may play a role in the eventual readjustment of adults (and adolescents).

The Rape Incident

The mature woman was most frequently assaulted on weekends, but the rapes were more evenly distributed throughout the week than for the other ages. The great majority of assaults, more than for any other group (68.5 percent), took place after dark: 30.4 percent between 8 p.m. and midnight, 37.5 percent between midnight and 4 a.m.

Most rapes were indoors; the rapist struck quickly and was gone. Almost two-thirds took less than 45 minutes; the duration was more than an hour for 28.6 percent of the victims as compared with 47 percent for the adolescents. The woman was attacked in her own home 36 percent of the time and in an auto 12.4 percent. In less than 15 percent she had gone to or had been taken to the rapist's home. Fewer than 7 percent of the adults, in marked contrast to the adolescents, were raped in the home of a third party.

Force was not always directly physical: Almost 92 per-

cent of the victims were subjected to nonphysical force. Tempting was used in over 21 percent of the cases, verbal threats about 60 percent, and intimidation with an object such as a knife almost 45 percent of the time. A woman who has given in to threat may have no physical marks, thus creating doubts in policemen and others that she was entirely unwilling, another source of trauma for rape victims. But there was also plenty of direct force—over 89 percent. Sixty-eight percent were pushed or shoved, almost 16 percent were nonbrutally beaten, almost 28 percent were brutally beaten, and about 17 percent were choked.

In regard to sexual acts, over 95 percent of the incidents involved intercourse. Except for fondling and caressing (13 percent), other sexual acts occurred less frequently, the most common ones being fellatio in 9.3 percent, and cunnilingus in 6 percent of the cases.

Adult victims, more than any other group, were assaulted by strangers. Over 60 percent were raped by total strangers, almost 11 percent by relative strangers, about 18 percent by casual acquaintances, and only 12 percent by a friend. The extended family member, in contrast to child molestation, was the rapist in a mere 2.5 percent of the cases and was close to the victim's age. The great majority of cases (74 percent) were raped by someone within 10 years of the victim's age. Similar to the other age categories, the great majority of rapes were by members of the same race, 78 percent; but interracial rape did occur in 22 percent of the cases, usually white victims, black offenders. Only five victims had had previous consenting relations with the rapist.

Research into a social problem, particularly if it is highly charged emotionally and surrounded with legends, is valuable no matter whether the findings reinforce the stereotypes or refute them. The adult rape was close to the stereotype, but there were significant exceptions. The rapes were not primarily interracial, and they did not often occur outdoors.

Because they were more often brutalized during the attack, the adult rape victims were more likely than the others to show immediate strong emotional reactions, particularly fear. Thus, terror, backed up by force or threat, was perhaps the major factor in determining the woman's response. Twice as many adults as adolescents (35.5 percent to 71.4) reported that their major fear during the rape was of being killed. Accordingly, although most protested, few resisted physically (only 17.5 percent).

Philadelphia General Hospital collected medical evidence of force and penetration on the entire sample of 1,401 for use by the police and the courts. Although much of the infor-

mation revealed little evidence, some of the data were striking. For the majority, there was clear evidence of assault—over half showed evidence of spermatozoa. (This contrasts with the CRC's experience with the offenders which revealed several impotent rapists.) The most common injuries were facial (17.4 percent); others included scratches and bruises. Some victims required hospitalization. Still, most women who reported did not fit the picture of battered and bloody victims portrayed in the popular press.

Reactions to Rape

Almost all adult victims were adversely affected by the rape. These effects tended to vary with age.

A young adult is forming intimate, personal relationships, including sexual ones. A rape will often have a shattering effect on her personal stability and adjustment. Some women are building families, careers, or both. Demands at this stage are very great. How did the rape affect their homes, their careers, their children, their sex partners, their sex lives, and the way the neighbors and coworkers regard them? The CRC data showed that their reactions and what they perceived as the reactions of others made some of these women less effective at home or at work.

Older women were less concerned with sexual or domestic conflicts than with injury. They were more often hurt or incapacitated. Younger women might worry about the support they might get from the people with whom they lived. Older women did not always have the support of anyone to get through post-rape trauma. They were alone and they were afraid that it would happen again.

Women who had been exposed to strong force sought medical help. Only about one-fifth thought about keeping the rape a total secret, although one-half of the women wanted to keep it from someone, mostly from parents, especially mothers.

But this unwillingness to confide often had causes other than modesty or desire not to burden loved ones. This became apparent in the psychiatric examination after the rape. The sexual pattern had been affected. Two weeks after the rape, over one-third had not renewed sexual relations with their partners and were reluctant to start again. Many had less desire for intercourse and 31 percent had no interest at all. In over 44 percent of the cases, the victims reported new sexual conflicts. They had been aggressively attacked, their personal feelings of privacy, dignity, trust, and inviolability had been harshly invaded and undermined, and they would be very careful about being open and vulnerable again. (These data shed light specifically on the common stereo-

types that "she must have enjoyed it," or "most women secretly want it.")

They lived now in a world much more full of threat. Many, almost 61 percent, no longer felt safe at home; and for over three-quarters of these the feelings were a direct result of the rape. Forty-four percent intended to move, and often they moved temporarily to the home of a friend or relative.

Three-quarters feared retaliation or being raped again. The adult victims showed the most stress in describing the rape—a significant comment on the nature of adult rape.

Anger, rage, shame, and fear profoundly influenced recovery. Disturbances in eating and sleeping were immediate, but faded in time; nightmares stayed longer. Some women were still anxious about security in their own homes 1 year later. Anger was often expressed toward men in general, but it could not always find an outlet and was turned inward. What had they done to cause the rape? Shame tended to further compound distress because it often kept the woman from confiding fully with those who might have helped her.

The CRC found that the post-rape adjustments of the victims tended to fall into two groups, depending on the personalities and the degrees of maturity and adjustment of the women prior to the rape. The group that had had fairly well-integrated lifestyles and personalities beforehand required only minimal support to readjust. Those who had had trouble before found the old unresolved problems alive and active again, sometimes in aggravated form, hindering the readjustment. This group needed more indepth counseling and therapy. For some, the trauma might never end.

Social Reactions

Support System Response

We are all intimately and dependently meshed in a tight web of relationships that should support us. To a large extent, the responses of people who directly affect our lives help determine our self-images, our interpretation of events, and our abilities to face crises. This is particularly true of victims in the post-rape period. Unfortunately, family and friends tend, as do most people, to respond to the conventional concept of rape, particularly when reinforced by physicians and policemen. Women in the CRC study repeatedly reported criticism or a lack of understanding.

To children, the responses of parents, particularly the mother, are of primary importance. In fact, if a child anticipates a negative response from her mother, she may keep the rape secret, especially if she is asked to by that other

authority figure, the rapist. If the mother is confused and torn, the child is even more so. If the mother tries to protect the offender, the child may feel very isolated and vulnerable and as guilty as if the whole affair were somehow her fault. The most acute problems occurred when the rapist was the father or a close family member.

There is less confusion if the offender is outside the family and the family unites behind a common enemy. Many parents in the study decided to protect the child, and thought it would be better if she forgot all about it, did not talk about it. But the children who spoke to the social workers had not forgotten. They felt unprotected and rejected. Parents should respond to the rape as they would to any assault on their child.

What the child needed, the CRC concluded, was concern, reassurance, and steps to see that she would not be exposed again. This does not mean, however, anxiety and overprotection, which could leave her feeling guilty and confused about what she had done wrong. The little girl should, if possible, come to think that neither she nor anything important in her pre-rape world has changed. Everyday routines should be continued, except those that might leave her vulnerable to attack.

What were the actual feelings of the parents? Of 66 families examined by CRC psychiatrists, over 77 percent felt direct sympathy for the child victim, almost 82 percent felt anger toward the rapist, and 53 percent felt guilty because they had not protected her well. Yet, about 21 percent felt shame or family disgrace, and 24 percent directed their anger toward the child.

The CRC discovered that anger, properly directed, can be beneficial in post-rape adjustment of almost all the victims. With children, it should be directed by the parents at the rapist and the contributing circumstances. Directed toward the child, anger will almost always have a crippling effect, preventing her from saying what she feels and perhaps exposing her to further attack.

The child needs to speak, to tell someone who is sympathetic and supportive all about the incident and how she feels. Only if the parents give sympathy and support will she be able to bring up her questions and feelings. The parents can then discuss the event in terms she can understand and give her a perspective that will prevent repercussions. During the followup visits, CRC discovered that in almost half the cases the child had not tried to discuss the rape. Clinical experience has shown that repression can lead to later problems.

The adolescent's family faces a different set of problems.

The girl has started to assert her autonomy and is loosening the connection to her parents; relations can easily become estranged. The family is concerned with the girl's health, with the company she keeps; they are worried about embarrassment, the reactions of others, and loss of control over her. Brothers and sisters can be supportive and reassuring or can tease and shame the girl until she feels isolated.

The adolescent girls who came to the CRC were often afraid to tell the parent(s), either because of a perceived lack of understanding and communication or a fear of blame or punishment. If the victim had violated orders and gone somewhere she should not have—which was often the case—the parent(s) wanted to know why. They felt torn between anger toward, and sympathy for, the daughter; and questioning from the police usually led to more anger.

The reactions of the adolescent girl toward her family were ambivalent, sensitive, and under stress. At the first home visit, over 20 percent said that relations had worsened. In subsequent interviews, many complained that parents kept blaming them, talking about the rape, and restricting the girl's social activities. Such adolescents could easily rebel and break away, develop behavior problems, or become delinquent. On the other hand, the smothering embrace of an overprotective family, if the girl accepted it, could make it difficult for her to become independent or to establish a separate life and acquaintances outside the family.

The adolescent had a wider network of friends and peers outside the family than the child and was more sensitive to their responses. Some acquaintances might also be the offender's friends who could apply pressure on her to keep quiet. At the first visit, over 68 percent of the victims said they had not told their female friends about the rape; only 9.2 percent had told their male friends. Support cannot come from people who do not know or would be unsympathetic toward the problem, tending to intensify feelings of isolation and alienation. Over 18 percent of adolescents, in contrast to 14 percent of adults and children, reported that no one had given them support after the rape.

A particularly nasty situation developed when the victim's friends were also friends of the offender. Sometimes taunting, teasing, or threats caused her to be truant, to transfer to another school, or to drop out altogether. If she had been set up for the rape by some girlfriends, she might be confused. In desperation she might decide to become one of them, to join the gang. On the other hand, she might feel betrayed and retreat to her family. Isolation and bitterness could come to dominate and affect the rest of her life.

Adult victims were also concerned about the opinions of

others, even though they generally possess more self-assurance than adolescent victims. Adults did not want their parents to know, 28 percent because of embarrassment or shame, others to avoid upsetting them. The young adult, like the teenager, sometimes feared her parents would begin to reassert control and to threaten her independence.

Adult victims, having outgrown their childhood setting, were most affected by the responses of close friends, particularly husbands or boyfriends. Almost half told their female friends about it and over one-quarter told their male friends. Again, it was vital that friends be supportive. The CRC concluded that the presence of even one close friend who allowed the victim to pour it all out and supported her was a great help in positive adjustment. But if friends were insensitive or critical, they could aggravate her doubts and guilt about her own role in the rape and hinder her adjustments.

In sum, the importance of the reactions of those close to the victim should not be underestimated, even for adults. The most important are those with whom she was most intimate. If they changed toward her, she would have trouble overcoming her anxieties and forming new close relationships.

Medical Response

A rape victim needs good and prompt medical attention to determine injury and treatment and, if she reports the crime to police, to provide a record that can be used in legal proceedings. She faces this intimate examination and the intimate questions soon after the experience of the rape itself when she is still shaky and sensitive. The effects of this medical ordeal are very important: A good medical experience may bolster her for whatever follows.

At PGH, a regular protocol was developed to help the women through the process with less confusion and rejection than had previously occurred. After admission, the victim was taken to a cubicle to wait for examination by the nurse and the OB/GYN resident. During the waiting, either the nurse or a volunteer from Women Organized Against Rape was there to comfort her and provide information. When the resident came, he examined her for injury and venereal disease and collected evidence. The remainder of his care consisted of medication and followup. When the resident finished, he left. The nurse completed the instructions and released the patient. Except for special care for unusual cases and later GYN checkup, the medical response was finished. The medical forms served as valid medical testimony in court.

The victims generally rated the services at PGH as good. But many thought it unpleasant, the worst being the unsympathetic, overly professional doctor. The resident doctors were busy and, having found little or no obvious injury, may have resented being called. Adult victims were often withdrawn, showing little apparent emotion, and this may have reinforced this impression. Trivial things, unnoticed by the staff, matter to the victim. For instance, the victims considered the waiting time to be much longer than it actually was, indicating the stress they were under. Similarly, slights or apparent lack of support became very important, such as the resident examining her pelvic area, and not being concerned about her emotional state. Thus, of those scheduled for a followup at the clinic, only about 40 percent returned.

The children, on the other hand, had their own emergency room, in a different area away from the other emergency patients who tended to crowd in during the same evening and night hours as did the majority of rape victims. They also had pediatricians, physicians who are trained to treat the entire child and her feelings. The children and their parents gave more favorable reports about the care they received than did the rest of the victims.

The medical examination may be the simplest procedure the victim undergoes. The cost of improving facilities and staff, and providing treatment for the victim which is less stereotyped, more supporting, should not be great, especially in view of what it would mean to the victims. Treatment, however adequate medically, that does not value individuality and sensitivities may result in the victim's failure to obtain followup treatment, lowering of self-esteem, and withdrawal from society.

Criminal Justice Response

The criminal justice system is that institution in our society with which the rape victim may have the longest association, particularly if she is believed and the rapist is arrested. Months after she has finished with the medical treatment and has made adjustments in personal relationships, she may still face having her wounds reopened in a public trial. The response of the criminal justice system, and the successive crises of this long-term involvement, may determine her ultimate adjustment.

The CRC collected interview data on the victims' perceptions of the responses of the police and the courts. In addition, a Court Observer, Anne Lawrence, followed the workings of the system through trial for 25 cases, interviewed many of those involved, and described in considerable detail the interactions and the realities of what these women faced.

The police officer who responded to the call was not only the victim's first contact with the criminal justice system, but he was often the first person she saw after the rape. His attitude was therefore very important. CRC discovered that the individual policemen and detectives who became involved—their personalities and personal qualities, their philosophies about women and rape, and their competence—influenced both case outcome and personal adjustment.

The policeman called should respond quickly if he is to catch the offender and if he is to get medical help for the victim. In the study, most of them did respond quickly: Over half of 473 cases arrived in less than 6 minutes from the time of call, and 77 percent were there within 10 minutes. If the policeman delays, it may be because he knows the rapist is gone, particularly if the woman delayed calling him. This response, however, does not help her medically or emotionally, and she will be aware that her personal feelings and condition were subordinate.

When the policeman came, he collected evidence of crime, tried to catch the criminal, and took a preliminary statement. Then, instead of taking the victim directly to the hospital, in half of the instances he took her to the police station (378 of 762 victims responding). To obtain a more complete statement was the usual reason given, but apparently there were other reasons, including a police evaluation of the woman's credibility and sometimes an attempt to discourage her from pressing charges. The delays were at least as long as for those waiting for care at the PGH, often longer. Half of those taken to the police station spent 1 to 2 hours, 15 percent spent 2 to 3 hours, and over 14 percent spent over 3 hours waiting.

The continuing interest of the detective depends on whether he believes the case credible or containing enough evidence to justify apprehension and trial. This is the definition of a "founded" case. The detective brings his own attitudes and abilities to this process. For instance, Anne Lawrence concluded, "It is the opinion of the observer that the race of the victim can play an enormous role in the decision to found or to unfound cases." As one detective candidly stated, "Rape doesn't bother Negro women as much as it does white."

She also concluded that class as well as race makes a difference in that rape involving middle-class victims brings almost automatic belief and strong action on the part of the police.

About 19 percent (151) of the victims said that the police had pressured them not to press charges. In over 44 percent of these cases, the police thought the woman lied;

in over one-quarter, they said the cases would be hard to prove in court.

In the opinions of the social workers who had interviewed them, less than 1 percent of the women had made false reports.

Generally, the victims rated the officers who answered the first call very highly—3.4 on a scale of 1 to 4. (Adolescents rated them lower than the others.) The detectives who interviewed them after the medical treatment and who followed those cases that might lead to trial, however, received lower ratings—2.85.

The CRC requested further information from the police department on the disposition of each of the 1,401 rape cases. Of the 1,202 that could be located, about 27 percent were judged to be unfounded for the charge of rape (see Appendix). Thus, the police did not believe many of the women. In addition, the women were seldom told when the charges were officially "unfounded," but they knew from the expressed attitudes of the police. If women had no understanding or institutionalized outlet for distress from the lack of justice, they tended, the CRC found, to turn their anger inward as guilt and took longer to adjust.

Police response is not always negative. "In most rape cases," says Anne Lawrence, "the victim has more personal contact with the assigned detective than with any other person in the criminal justice system." If the case is "founded," the victim and her detective may become very close in the long processes leading to, and including, the trial. More than any other person, the detective begins to personify the criminal justice system; and if he gives her support, her attitudes will be quite positive. When the detectives stayed throughout the trial, the overall ratings of attitudes and treatment rose to 3.3 on a scale of 1 to 4. In one case involving five victims and a single rapist, the detective became deeply involved, stayed with the victims every day during the trial, and amused them with stories. At the end, they were so appreciative that they threw a large party for him and his partner.

The police behavior is not the only important factor determining the psychological response of the victim to the whole proceedings: The seriousness with which the case is treated at all later stages is also a significant factor. The victim will need all the support she can get during the legal process. A victim generally does not know in what she has become involved. She has the illusion that the defendant is on trial and that she will be vindicated. But the defendant has a lawyer; the victim does not. Instead she has an overworked and often underprepared assistant district attorney

who is there to prosecute the case for the State with her as a witness. She may have to sit for continuance after continuance, even at the preliminary hearing stage. The audience may contain unemployed men who are there for the show, or high school classes there to see how justice works. After being so insensitively exposed, some victims do not return to testify. Says the Court Observer, "We have also seen waiting witnesses vomit or faint while watching others being put through the ordeal of testifying."

She may not only have to go through the most intimate details of the rape in public, but be in an atmosphere full of interruptions. She must not only relive the event, but see the offender before her. She seldom understands the legal arguments, and the uneducated victim may have trouble with the questions. On the witness stand, she can easily be trapped and intimidated. In one case, two young mothers had been raped and beaten by a notorious motorcycle gang. At the preliminary hearing, two gang members sat in the audience and made obscene and threatening remarks. Other members prowled in the corridor outside. The children of one of the mothers were threatened. No wonder the victims broke down and the case had to be dismissed. Educated and determined women have a distinct advantage: They are more articulate; they are more often believed; but in the study most women victims were poor and black.

The foregoing applies mostly to adult victims. The police response to child victims was often to ignore the charge if there was no evidence of injury, particularly if the offender was a member of the family.

Since adolescent rape often takes place in social situations, or when disobeying authority, the adolescent story is frequently doubted. More pressure was put on adolescents to drop the charge than on the other groups. In general, adolescents rated their treatment by police and detectives much lower than the children or adults did. The CRC found that this treatment of adolescents at such a vulnerable time in their development resulted in estrangement from adults, feelings that no one understood them, and maladjustment that may last a lifetime.

Stereotypes of Rape

Anne Lawrence, the Court Observer, found that, during the trials, the defense attorneys often resorted to commonly held stereotypes about women and rape. "Certainly the most prevalent [myth] is the assumption that once a woman has consented to one man, she will thereafter consent to many: yes to one is yes to all."

Another myth used to discredit testimony is that women like to be raped, they find submission to a strong man exciting in their humdrum lives no matter what they may claim. Lawrence found that lawyers would ask questions like "Didn't you really like it?" "Didn't you have a climax?"

Attorneys also argued a variety of minor stereotypes: that rapists only assault pretty women, and that unattractive women having a weak self-image would be willing to concoct a rape charge to get attention. They consistently played upon middle-class conservative biases. For example, all young women during the "permissive" days of the sixties and seventies were promiscuous—ergo, rape could hardly occur among such people. They argued that women were naturally spiteful and that rape charges therefore were fabricated for revenge.

A major line of argument was that ordinary women consistently act in certain ways, and, if the victim did not, then she was either lying or had consented or was somehow abnormal. For instance, a "normal" woman would get hysterical if attacked. If she did not (and many were cowed by terror or shock), consent was implied. Yet, if she did get hysterical, then her testimony, including her identification of the rapist, could not be trusted. Says the Court Observer,

> The stereotypes which are seen in rape cases invariably portray a woman as degraded, oppressed, dependent, and victimized. They either desire assault and humiliation, are spiteful, or desperately in need of attention; they lose all control under threat and are thereby reduced to babbling idiots.

What could be more damaging to self-image and to the long slow process of rebuilding lives and attitudes? "Many women emerge from the experience of testifying with their feelings of strength and self-reliance all but eradicated."

These stereotypes are not peculiar to rape trials. Lawyers use them because they are common currency and can sometimes be exchanged with juries for verdicts of innocent. The victim confronts them especially during the first few days following the attack when she most needs help, then during the legal process, and throughout her lifetime.

Conclusion

The primary purpose of the CRC's Assault Victim Study was to study the impact of the rape and its sequelae on the victim and thereby to provide knowledge on that subject. One of its long-range, practical effects may be to counter myths and stereotypes.

Rape is assault, a form of subjecting one person to the will of another, usually through force or threat. It is not consensual. The great majority of rapes are not interracial.

Most take place indoors. No one age is inviolate. Although force is usually implied and very often used, particularly with adult women, the battered victim, beloved of tabloids, is not the norm.

Rape has different characteristics in different age groups. The child is molested in her own home by someone she knows and probably trusts. The adolescent is vulnerable to rape because of her search for new experiences and friends and the expansion of her social life; she is most often subjected to group rape. The adult also is raped in her own home, by strangers. Intercourse occurs in most cases and she is subjected to the greatest violence. None of these facts smoothly fits the stereotypes.

The CRC has considerable evidence, yet to be analyzed, from interviews and psychiatric examinations, but these data indicate that the long-term effects of the rape may be more important than the immediate ones. This is particularly significant because the victim may seem to have no reaction during the immediate post-rape period, and the impact may therefore be discounted. But she may suffer such feelings as severe anxiety, guilt, depression, inability to be independent, insecurity, and revulsion toward men. She needs a great deal of support immediately after the rape and thereafter; even one sympathetic person at a crucial time for that victim may make a sizable difference in her adjustment. Stereotype responses and shame may keep her from getting this support from family and friends. Unfortunately, the institutionalized forms of help and support, medical and legal, were usually perceived to be caught up in their own priorities and not very giving. There were exceptions, and these were important for exemplifying what could be achieved without much change. The woman should simply be regarded as a person rather than as a case or a set of organs, and it must be understood that the impact on her of the events, and her feelings, are as relevant as the objective facts. Thus the Philadelphia Assault Victim Study has started the valuable process of demystifying the meaning of rape and its multifaceted impact on the victim.

Appendix

Summary of Rape Case Disposition in Philadelphia Criminal Justice System (Estimate) [1]

Stage	*Percent of Cases Reaching Each Stage*
Report of Rape to the Emergency Room (Not all cases will be reported).	100.0 100.0
Founded Cases Labeled "Rape" or "Attempted Rape" by the Police. These are those cases which the police believe and which fit the legal definition of rape [2] or attempted rape. Those cases where the police do not believe a crime was committed or think there is not sufficient evidence to go to court are often unfounded. "Unfounded" means no further police investigation occurs. In other cases the victim may decide to retract her charge, the police may not record the complaint or they may label it as a crime other than rape (e.g., assault).	53.3
Cases Cleared by Arrest. (i.e., where one or more assailants have been arrested) (74 percent of founded cases were cleared by arrest.) [3]	39.5
Cases Prosecuted in the Adult Justice System. (Approximately 35 percent of the cases go to the Juvenile/Family Court.) [3]	25.6
Cases Completing a Preliminary Hearing and Held Over for Trial. (Some cases do not make it to preliminary hearing because charges are dropped or defendants or victims do not show up for the hearing. A case is held over for trial if there is enough evidence to support the charge and to identify the defendant.) [4] Jury trials are held for 22.3 percent of these and bench trials (Judge only) for 41.1 percent.	19.6
Cases Where the Offender Was Found Guilty on at Least One Charge. (54 percent of those held for trial.) (Cases may not make it to trial if the charges are not pressed—17.5 percent not pressed.) Of those guilty 19.1 percent are the result of guilty pleas.[4]	10.6
Cases Where the Offender Was Found Guilty of Rape. (62.6 percent of those found guilty of some charge.) [4]	6.6

Cases Where the Offender Was Found Guilty of Rape and Sentenced to Confinement in Jail or Prison. (80.9 percent of those guilty of rape.)[4]	5.4
Cases Where the Offender Was Found Guilty of Rape and Was Sentenced to More Than 2 Years of Confinement in Jail or Prison. (71.1 percent of those sentenced to jail.)[4]	3.8

[1] These statistics are based on a study of rape case disposition in Philadelphia conducted by the Center for Rape Concern. The disposition of cases for a total sample of 1,401 victims who reported rape to the police and were brought to Philadelphia General Hospital (April 1973 to June 1975) was used as a basis for these figures. This research was supported by NIMH Grant No. 21304; the PGH Research Fund; and Mr. Thomas McCahill, Research Criminologist.

[2] A person commits a felony of the first degree when he engages in sexual intercourse with another person not his spouse:
1. by forcible compulsion
2. by threat of forcible compulsion that would prevent resistance by a a person of reasonable resolution
3. who is unconscious, or
4. who is so mentally deranged or deficient that such person is incapable of consent (18 C.P.S.A. 3121)

[3] Philadelphia Police Department Statistical Report 1970, 1971, 1972, 1973.

[4] Annual Report of the Philadelphia Common Pleas and Municipal Courts, 1975.

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