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Author(s): Ann C. Burgess and Lynda Lytle Holmstrom

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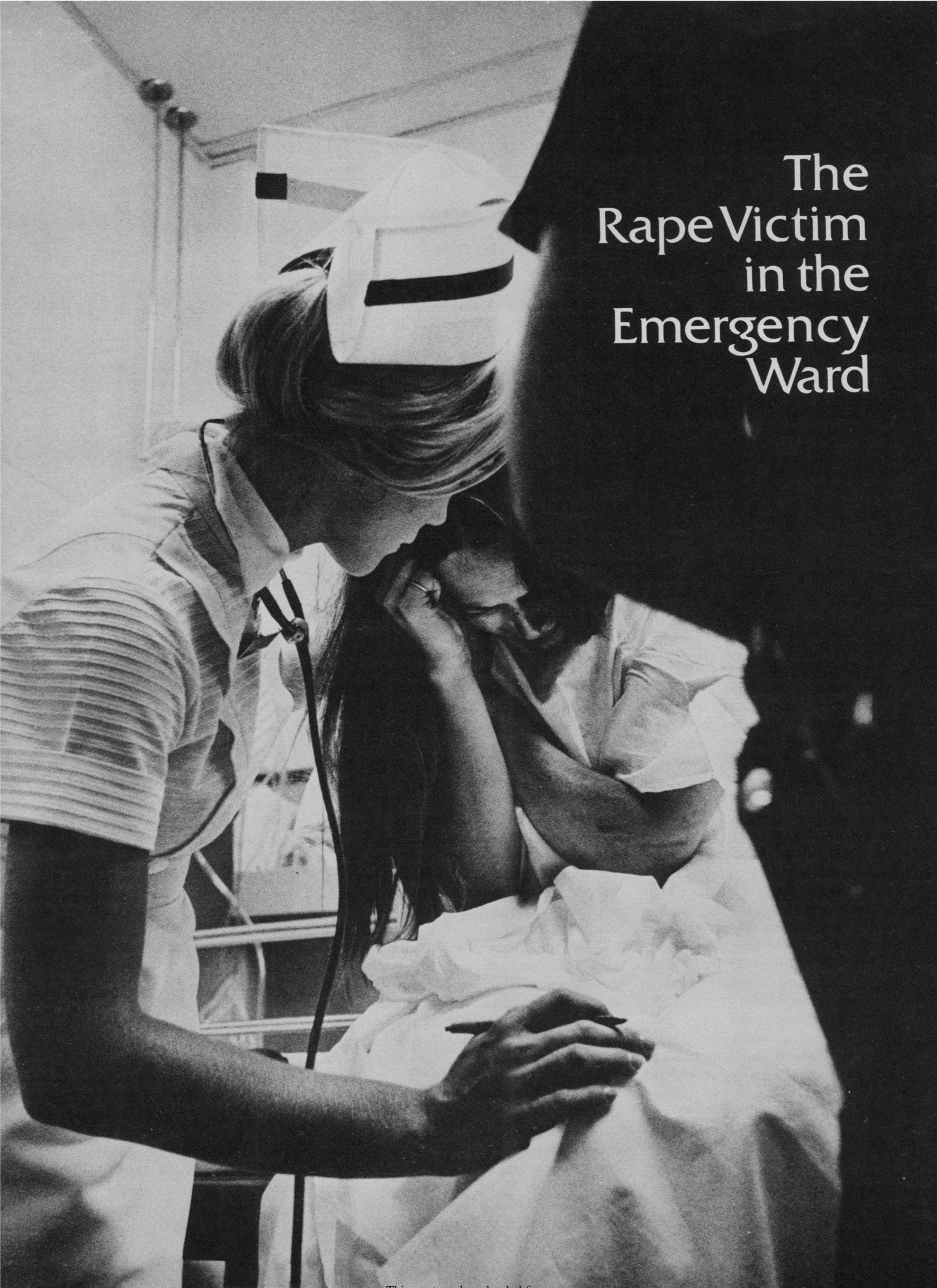
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# The Rape Victim in the Emergency Ward



***Details on injuries and care come from a psychiatric nurse and sociologist who conduct a Victim Counseling Program at Boston City Hospital.***

ANN WOLBERT BURGESS  
LYNDA LYTLE HOLMSTROM

Forcible rape is one of the four major violent crimes in the United States, and it affects the lives of thousands of women each year. FBI *Uniform Crime Reporting* indicates an 11 percent increase in the number of reported rapes in 1972. Although there has been a significant rise in the past three years in reports of forcible rape, little exists in the way of support services for rape victims. One service, a Victim Counseling Program, was begun July 20, 1972, as a voluntary collaboration between Boston College School of Nursing and the Boston City Hospital Emergency Department. The program provides 24-hour-a-day crisis intervention service for rape victims. To the best of our knowledge, it was the first such program in the Boston area and one of the first in the United States.

A psychiatric nurse and a sociologist, the co-authors of this article, staff the program. Originally, services were for adult victims. However, in December 1972, the Pediatric Walk-In Department of the

Boston City Hospital requested the staff's services and, thus, the program began to include child victims of rape, attempted rape, sexual assault, or molesting. The police, the district attorney's office in Boston, and one private hospital also began to make referrals.

The counseling program is a nurse-to-nurse referral service functioning in the following way. The rape victim comes to the Emergency Department of the Boston City Hospital and is seen by the triage nurse, who calls the gynecologist and then both counselors, who come immediately to the hospital regardless of the time.

The counselors talk with the victim, family, friends who accompanied the victim, and the police to gather as much data as possible for assessing the crisis.

The nurse-counselor makes a follow-up telephone call within 24 to 48 hours to further assess the psychological and physical state of the victim. Weekly telephone calls continue until the crisis state stabilizes. When cases become ready for court, often the crisis is reactivated and longer follow-ups are required. An evaluation and termination telephone call is made at the appropriate point, or home visits are made in selected cases where a telephone is not available.

In our early work with over 80 victims, we saw certain patterns which have major implications for nursing management.

The act of reporting a rape sets into motion a complicated process. The victim is often swept along by the day-to-day workings of the police system, the hospital system, and the legal system. She is caught up in a process which is routine to the authorities, but new to her and most often not completely understood by her. More may be done for her or to her than she expected.

Most of the rape cases we have seen at Boston City Hospital were referred by the police. The police either advised the victim to go or brought the victim to the hospital. This is important for nursing man-

agement, since it means that the woman has had to deal not only with the sexual assault, but also with the police. Even though many women are grateful for their help, talking with them is one more stressful situation for the victim.

Furthermore, in most of the cases, someone other than the victim was involved in reporting the rape to the police. Someone other than the victim made the decision to call, acted as intermediary at the request of the victim, or persuaded the victim herself to call. During the confusion which follows rape, it often is hard to determine exactly who made the decision to notify the police. It was clear, however, that in a considerable number of cases with which we were concerned, other people took it upon themselves to make the decision for the victim. In our sample, such persons included mother, father, brother, sister, grandmother, roommate, friend, fireman, and stranger. Part of the counseling process involves talking with these persons also.

**Medical Process**

Once at the emergency ward, the attention the rape victim receives depends on the protocol of the particular hospital. At Boston City Hospital, the victim is generally seen for medical and counseling services within an hour. The priority of treatment is first, medical. This includes obtaining a brief history, diagnosing general trauma, performing a gynecological examination and laboratory tests, and providing treatment for such health concerns as prevention of pregnancy and venereal disease. Second is psychological treatment, assessment and counseling. Referral—gynecological, medical, and psychological follow-up—is third.

The gynecologist examines the victim and writes the medical and gynecological report. He generally records in the patient's words a brief history of the time, place, and circumstances of the sexual assault. Statements on the patient's general appearance, physical and emotional

DR. BURGESS is associate professor of nursing, Community Health Nursing, Boston College, Chestnut Hill, Mass., where she integrates mental health and crisis concepts into the master's level course. With Dr. Holmstrom, she staffs the "Victim Counseling Program" at Boston City Hospital. She has a B.S. in nursing and D.N.Sc. from Boston University and an M.S. from the University of Maryland.

DR. HOLMSTROM is assistant professor of sociology at Boston College and is the other counselor in the "Victim Counseling Program." She teaches and researches in medical sociology, sex roles, and sociology of the professions. She has a B.A. from Stanford University, M.A. from Boston University, and Ph.D. from Brandeis University.

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*"Women have said things like, 'I will never be normal again,' and 'I wish he'd killed me.'"*

condition, bruises, lacerations, and torn or bloody clothing are recorded.

In our sample, the general physical examination of rape victims for signs of trauma indicated a significant proportion of victims suffered trauma, bruises, and lacerations, as the chart below shows.

Close to half the women were threatened with an actual weapon. Bruises to the body were from the weapon or the assailant's hands or fists. Struggles on the ground often resulted in abrasions of the legs, arms, and back.

Symptoms of trauma were reported more frequently than were found on examination. For example, many women reported that assailants put their hands around their throats and threatened to kill them if they did not do as the assailants demanded. Most of the women, fearing death, complied. Often there were no visible signs of trauma with these reports. In our sample, 21 victims reported being physically held by the assailants and 12 had verbal threats of danger without the presence of an actual weapon.

Twelve of the 80 victims required

medical, surgical, or orthopedic consultation in addition to x-ray services to confirm a diagnosis secondary to the rape diagnosis.

During the gynecological examination, a water-moistened speculum is used to preserve all evidence. The examination for trauma includes observation of the external genitalia, perineum, cervix and vaginal wall for trauma and lacerations. Specimens are obtained from the urethral orifice for bacteriological testing for venereal disease, from the cervix for cytology and Papanicolaou staining, and from the vagina and cervix for chemistry and sperm testing. The physical findings are shown in the chart below.

Eight of the 80 victims did not receive speculum/pelvic examinations. Copious vaginal bleeding required immediate vaginal packing and hospitalization of one victim. The hymen ring was intact and thus just a swab of the vaginal wall was taken from four patients. Two victims were not examined because of their pain and anxiety and one patient refused a pelvic/speculum examination.

Women were usually concerned

SIGNS OF TRAUMA IN 80 VICTIMS

	Head	Face	Throat	Chest	Abdomen	Back	Arms	Legs
Trauma	19	23	13	9	7	15	20	17
Lacerations	3	11	3	1	—	—	2	4

*While 147 marks were visible on physical examination, not all violence left visible signs.*

GYNECOLOGICAL PHYSICAL FINDINGS

	Perineum	Hymen	Vulva	Vagina	Cervix	Anus
Bruises	7	2	9	4	10	5
Lacerations	3	5	3	4	2	3

*In addition to the 147 visible signs of violence found in the general physical examination, 57 more were found by the gynecologist.*

about the possibility of pregnancy resulting from the rape but none in our sample became pregnant. To guard against pregnancy, the gynecologist prescribes diethylstilbestrol. Women have sometimes heard of the medication as the "morning-after pill" or it is explained as a "chemical D and C." This medication should be started as soon as possible and certainly within 24 to 36 hours to prevent implantation of a fertilized egg.

A variety of factors influence the physician's decision to prescribe medication of this type. Current birth control practice of the woman is one factor. Seventeen of the 80 victims were either on oral contraceptive pills (11 women), had an intrauterine device (4 women), or had had a tubal ligation (2 women).

Phase of the menstrual cycle is another factor. For women who were raped midway in their menstrual cycle, the concern about pregnancy was greatest. Even those women close to their menstrual periods were given prescriptions if they wished. Ten of the 80 victims were raped during their menstrual periods. These women had extra trauma from the tampon being pushed into the posterior cul-de-sac. The gynecologist removed the tampon on speculum examination.

Fear of exposure to venereal disease was a major concern of almost all women in our sample. Routine medical treatment was to administer procaine penicillin intramuscularly. Oral antibiotics were prescribed for those victims allergic to penicillin.

While venereal disease is a major concern at the time of the rape, a number of women will develop acute vaginal infections which may become chronic. Women need to be seen for follow-up six weeks later, and we recommend they be seen again six months after that, to be sure they have not contracted a venereal disease, especially syphilis.

#### Psychological Process

For most women in the sample, the rape represented a crisis with either psychological or social conse-

quences. This was made overwhelmingly clear both from data collected from the interview at the hospital and during follow-up telephone counseling.

The counselors were regarded by the victims as part of the emergency ward treatment team. Access to the women at this point in the crisis facilitated the therapeutic aspects of the counseling relationship. Most women responded favorably to the presence of the counselors and responded equally well on follow-up telephone calls. One victim said:

*It is easy to talk with you, a stranger. It is good the hospital has something like this. So many people might tend to blame the woman. It's good to talk to someone who doesn't.*

The ease or difficulty a woman has in talking about the rape experience may be viewed as her verbal style. The hospital system places demands on the victim to answer questions and describe the details of the rape. Victims respond to this in different ways. Some victims, because of their natural talking style or their youth, find this pressure to talk difficult and have a defensive reaction. Other victims respond to the pressure to talk with relief. It gives them a chance to ventilate some of their feelings. The verbal styles of the victims in our sample ranged from quiet to guarded to verbal to talkative. Often there were shifts from one style to another within an interview.

According to our data, one-half of the women in our sample were verbal and talkative and half were on the quiet and guarded end of the spectrum. Both styles are normal and it is important that nurses be aware of this variance.

The emotional style of the victim refers to the style that is normal for her in expressing her feelings. One's emotional style tends to become exaggerated under stress and having to talk about the rape experience to a variety of persons is one such stress for the victim.

In our sample, two styles were observed: In the *expressed* style, feelings of fear, anger, or anxiety were expressed verbally or shown through such behavior as crying, shaking, smiling, restlessness, and tenseness. In the *controlled* style, feelings were masked or hidden and a calm, composed, or subdued affect was seen.

Patients' responses ranged from fear, restlessness, tears, and anger to smiling, calmness, and composure. Some women had several of these responses during the course of one interview.

The primary reaction of almost all women to the rape was fear, that is, fear for their lives. To them the behavior of the assailants represented an act of violence.

A 35-year-old woman, who was grabbed by an assailant at four-thirty in the afternoon as she left her apartment to visit a friend, said:

*I felt terror. I was so scared I could think of nothing else but fear. There was no other feeling present. I don't know what I am going to do now (tears). I cannot even walk on the street. This is the worst experience of my 35 years. Nothing so terrible has happened before.*

In another situation, a 20-year-old, married student was waiting for a bus when a car stopped and three men pulled her into the car. This young woman said:

*I spent the whole time while I was riding in the car [blindfolded] thinking of the girl [in a recent newspaper story] locked in the closet who was murdered.*

A 23-year-old hospital employee walking home after the 3:00 to 11:00 P.M. shift was pulled into some bushes off the main sidewalk. She said:

*I tried yelling but he put his hand around my throat. I have never been strangled, but he tightened his hand so hard that it hurt so bad. I couldn't do anything. I was fright-*

*ened of dying—the thought of being killed when the rape was over.*

A significant number of women show their feelings by tears and crying as well as other signs of being visibly upset such as shaking. They find it difficult to talk about the incident and cry when describing the very painful parts. Women have said things like, "I will never be normal again," and, "I wish he'd killed me."

The expressed emotion of anger may have a variety of targets: the assailant, the act of rape, the police interrogation, the hospital system, the counseling service, the court process. All are appropriate foci for the victim's feelings.

When they expressed anger toward a procedure in the emergency ward, they generally spoke of the pelvic examination. One statement captures the distress of the woman:

*The pelvic was quite depressing at the time. To have to get undressed again and get up on that table and go through almost the same thing again of something being stuck into you was awful.*

Another victim directed her anger at the assailant. She said with bitterness:

*It is not fair that he should be running around having a good time while I have to go through this—to have to take medicine that will make me sick. Why should I have to go through this?*

This victim had been raped before. Thus she knew already one of the side effects of the medicine and talked about it at the hospital. For most women, the nausea and abdominal pains from medication to prevent pregnancy will be a new experience.

Still another woman expressing her anger at the assailant said:

*I was angry. I could have torn him apart if he had not had the knife. I was outraged that he would do such a thing, that he would have the gall.*



*"Many women complain of feeling dirty and request a place to wash. Many have been raped outdoors. Some have been urinated on."*

A certain number of women expressed feelings by smiling. Sometimes when feelings are unbearable, the victim defends psychologically or substitutes another feeling such as avoidance. As one woman who smiled occasionally during the interview said, "Laughing is better than crying." As another example, a 20-year-old woman returned to her apartment after work and was raped six times by a man wearing a ski mask and rubber gloves, who had broken into the apartment and was waiting for her. During the interview, she would cry occasionally when describing the upsetting parts. She also laughed several times. The laugh was used as a way of avoiding feelings. She would say, "Really, nothing is wrong with me," and laughed as she said it. She substituted a laugh for the painful memory of the attack.

Women who seemed calm and composed said they were controlling or hiding their feelings. They would say, "I will probably be depressed later when this really hits me." Also, many women were seen in the emergency ward in the middle of the night (between 1:00 A.M. and 5:00 A.M. was the most frequent time) and these women were often exhausted; they had not slept since the previous night. This calm exterior might have been a sign of sheer exhaustion.

A 20-year-old woman was assaulted in the hallway of her apartment building by an assailant who had followed her and her roommate home from a local college night place. The roommate was able to telephone the police, who arrived in time to apprehend the man in the act of rape. At 4:00 A.M. during the hospital interview, the victim said, "I feel so tired. I know I seem calm. The reaction may hit me later." It did.

Other victims who also presented

a controlled, calm outward appearance found it important to present a "strong" appearance and to have people think everything was fine and that there would be no problems. The woman would say, "I'll be fine; you don't have to worry." Or the woman would talk about the rape in a controlled, emotionless way. This was her style of coping.

Many women said they were "in a state of shock" and "feeling numb." They would say, "It doesn't seem real; I can't believe this happened," or "I just want to forget it; I don't want to remember."

Discussing the rape, the women often associated it with related issues. The woman's sexuality was one such issue. Some discussed previous sexual activity, forced sexual acts and/or rape, and the loss of virginity from the rape. One woman said, "I remember my first sexual experience; the guy just jumped on top of me." A 24-year-old woman said, "I have always hated men. I don't like sex. This is the last straw. I am puritanical about sex." The possibility of pregnancy was also a concern. One woman said, "I don't believe in abortion; but I wouldn't want the baby."

Losses, especially past relationships with men, are another theme in the concerns women have after being raped. Former engagements and other breakups in male-female relationships are often discussed. One woman talked of the death of her husband seven years previously. Another woman talked of her divorce three years previously. Still another talked of her suicide attempt as a response to her loneliness after her divorce.

Concern over future relationships, especially how to cope with men, was another theme. For example, a 21-year-old woman said:

*My fiancé will be enraged [at what*

*happened to me]. I feel so bad. He didn't want me to come to school here. Now he won't want me to stay and I have one semester left.*

A newly married, 20-year-old, college student said:

*It's like being unfaithful, but I couldn't help it. I'm afraid my husband will have the feeling I let him down. I had a religious upbringing; my family will overplay the idea that sex with anyone outside of marriage is worse than death. I could never tell my family that this happened to me.*

#### Nursing Implications

Three assumptions underlie the theoretical framework for counseling the rape victim: (a) the rape represents a situational crisis for the victim which is disruptive of her life-style; (b) the victim is viewed as a consumer of emergency health services—medical and psychological; and (c) crisis management of the rape victim is actually the practice of primary prevention of psychiatric disorders.

The nurse in the emergency ward is in an optimal position to have major therapeutic impact on the experience of the rape victim in the hospital system. There are ways to make the woman's hospital experience less traumatic.

Periodic interdisciplinary staff conferences should be held by the emergency ward team. Staff feelings and attitudes about rape victims as well as current research findings on rape would be important for staff education.

Time is an important factor in working with the rape victim. The police may be waiting for further questioning, and laboratory tests and treatment need to be instituted as quickly as possible for maximum effect. Delays should be avoided. The triage nurse should view the victim as high priority.

The woman should not be left alone, if at all possible. If a nurse is not available and there is to be a delay for the physician, encourage

family or friends to stay with the victim for emotional support. This is a good time for the nurse to make a psychological assessment of the rape victim.

A separate examining room is preferred to allow the woman privacy to fully describe the circumstances of the incident. The woman should not be rushed in her talk, as she may interpret this as being forced through the system. Force in any form may symbolize the rape experience.

The prevailing attitudes in society are not on the side of the victim. Many myths exist, leading people to interpret rape solely in sexual terms rather than in violence terms. Staff members may show their bias and ambivalence about rape victims through such statements as, "The woman is just faking," or, "This isn't a real rape case," or, "I don't believe half the stories I hear."

Any attitude which blames the victim will serve only to abort any therapeutic relationship before it has a chance to develop. Listen carefully to the victim as she relates her experience and leave moral and legal judgments to others. The nurse should be nonjudgmental.

The humanistic skills of the nurse will make a major difference in how the victim feels she has been treated at the hospital. The victim should be encouraged to talk. She has many feelings and thoughts about the rape and she often wants to talk if she feels someone will listen. Talking helps people to feel better and this, in turn, gives understanding of their reactions to the incident.

If the nurse also listens carefully she can understand the distress of the woman. When a person is understood, she is no longer alone and is more in control of her situation. Listening and understanding are important skills in counseling.

A special dimension of listening and understanding is to help the victim bear the feelings she is trying to express. Sharing the pain is an emotionally strengthening experience for the victim of rape.

The technical skills of the nurse are an important part of the overall nursing management of the rape victim. An important part of preparing the victim for the physical and gynecological examination is to find out if she has ever been examined.

For some women and especially child victims, this will be the first pelvic examination. The woman needs to know what is expected of her and what the physician will be doing and why. Often the gynecologist explains this, but reinforcement by the nurse will help the woman feel involved rather than being the object of things that are being done to her. She has just been through an experience where consent was not part of the procedure, and so cooperation with her in the hospital treatment is essential for therapeutic care.

The nurse can arrange for the physical comfort of the woman in the hospital. Victims in our sample have needed such items as safety pins, needle and thread to mend torn clothing, drinks of water to relieve their thirst, cigarettes to decrease their anxiety, and tissues to dry their tears.

Many women complain of feeling dirty and request a place to wash. Many have been raped outdoors. Some have been urinated on. Water and a basin would be important equipment to have available after the medical examination is complete. Mouthwash is also a helpful item to provide for those women (of whom there are many) who have been forced to have oral sex.

Health education is another service. The nurse is the appropriate person to further emphasize and elaborate on the prescribed medical treatment for the woman. She should ask if the woman understood what the physician advised for treatment, ask if the woman has other questions, be sure the woman understands the side effects of the penicillin (discomfort at the site of the injection) and the diethylstilbestrol (nausea, vomiting, vaginal spotting), and advise the woman to

come back to the gynecological clinic or see her own gynecologist for follow-up examination and culture for venereal disease and infection.

Discharge planning is needed, too. Rape victims often do not have transportation home. Their money may have been stolen, and they often leave the hospital at night. When the woman is ready for discharge from the emergency ward, the nurse should be sure the woman has transportation home or wherever she is going. Abandoning the victim is not therapeutic. The hospital might work out arrangements with appropriate community resources (such as police) for those situations where family or friends are not available to take the victim home.

#### **Crisis Center**

As rape crisis centers are developing, emergency departments might have the referral telephone number available for the woman. Ask the woman for permission to give her number to the crisis center with the understanding that the follow-up person from the center will take the initiative in contacting the victim. All women should have access to a follow-up service, if at all possible.

The therapeutic nursing management of the rape victim sets into motion a series of administrative, humanistic, and technical skills of the helper. To be a "genuine" victim in our society means that one must have people available who can accept and acknowledge that something extremely disruptive has occurred in one's life. In other words, the victim's claim to having been victimized needs to receive confirmation from others. If, however, the staff's attitude appears to be that "nothing has happened" to the woman, or if the attitude that "she asked for it" clouds the issue of physical and psychological trauma, the humanistic approach will be lost.

It does not take a psychiatric nurse or nursing clinician to talk with a rape victim. It is vital that all nurses have such counseling skills. △