

**RESEARCH INTO VIOLENT BEHAVIOR:
OVERVIEW AND SEXUAL ASSAULTS**

HEARINGS

BEFORE THE

**SUBCOMMITTEE ON
DOMESTIC AND INTERNATIONAL SCIENTIFIC
PLANNING, ANALYSIS AND COOPERATION**

OF THE

COMMITTEE ON

SCIENCE AND TECHNOLOGY

U.S. HOUSE OF REPRESENTATIVES

NINETY-FIFTH CONGRESS

SECOND SESSION

JANUARY 10, 11, 12, 1978

[No. 64]

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(II)

CONTENTS

WITNESSES

	Page
January 10, 1978	7
Opening statement of Congressman James Scheuer	7
Hon. Nicholas Scopetta, deputy mayor for criminal justice of the city of New York, accompanied by Stewart Holzer	17
Hon. Stanley Fink, majority leader, New York State Assembly	32
Dr. Marvin Wolfgang, director of criminology, Center for Studies in Criminology and Criminal Law, University of Pennsylvania	83
Dr. Lynn Curtis, Special Assistant to the Secretary of the Department of Housing and Urban Development	134
Dr. Alfred Blumstein, director, Urban Systems Institute, Carnegie-Mellon University	155
Dr. John Monahan, assistant professor, Department of Psychiatry and Human Behavior and Program in Social Ecology, University of California at Irvine	264
January 11, 1978:	
Dr. Martha R. Burt, Minnesota Center for Social Research, Minneapolis, Minnesota	305
Dr. Carolyn Swift, director of training, Wyandot Mental Health Center, Lawrence, Kans.	351
Dr. Anne Wolbert Burgess, professor nursing, Boston College; and chairperson, Department of Health, Education and Welfare's Rape Prevention and Control Advisory Committee	376
Nancy McDonald, Center for Urban Ethnic Affairs, Washington, D.C.	409
Jan BenDor, C.S.W., Ypsilanti, Mich.	426
January 12, 1978:	
Dr. Nicholas Groth, director, Forensic Mental Health Department, Harrington Memorial Hospital, Southbridge, Mass.	452
David Rothenberg, executive director, The Fortune Society, New York, N.Y.; accompanied by Sergio Torres, staff counsel, The Fortune Society	475
Mary Ann Largen, former coordinator, National Organization for Women's Task Force on Rape	499
Elizabeth Kutzke, Chief, National Center for the Prevention and Control of Rape, Department of Health, Education and Welfare, accompanied by Dr. Gloria Levin, Deputy Chief, National Center for the Prevention and Control of Rape	530
Dr. Gene Abel, professor psychiatry, University of Tennessee Center for the Health Sciences, Memphis, Tenn.	605
Yolanda Bako, National Organization for Women, Rape Prevention Committee, New York, N.Y.; Caroline H. Sparks, Women's Action Collective, Columbus, Ohio, Dr. James Selkin, psychiatrist and team leader of the Department of Psychiatry, Denver General Hospital	650
APPENDIX	
Additional submissions for the record:	
Fuller, William, incarcerated prisoner at Lorton Prison, Lorton, Va.; organizer, Prisoners Against Rape	675
Kriesberg, Lois Ablin, associate professor anthropology and sociology, College of Health Related Professions, Syracuse University, "On Supporting Women's Successful Efforts Against Violence"	681
Supplemental Material:	
Abel, Gene, M.D.	746
Bako, Yolanda	741
Burgess, Ann Wolbert, R.N., D.N.Sc.	691
Groth, A. Nicholas, Ph. D.	715

(III)

55736

X
VICTIMOLOGY OF SEXUAL ASSAULT

It has only been recently that rape has become a serious focus for study. In 1972 when I started doing rape research with my Boston College colleague, Lynda Lytle Holmstrom, almost nothing was being said or done about rape as a problem. Little existed either in the scholarly or clinical literature, especially from the point of view of the victim. It has been interesting to watch this field expand as an area of study in such a short time period. I believe the latest literature search, directed by Stanley Brodsky, identifies over 3,000 citations on various areas of rape research.

In 1972, Dr. Holmstrom and I had great difficulty finding people who were receptive to the idea of rape research. We had no success in locating rape victims through the courts, police, criminologists, medical or psychiatry branches of the health delivery system in the Boston area. No one refused to talk with us, but no one really offered to help us. Impatient with delays, we tried a fifth approach--enlisting the aid of the nursing hierarchy at a large city urban hospital where many rape victims in Boston were taken--the Boston City Hospital. This proved successful with the Executive Director of Nursing Services and Education putting us directly in touch with the nursing administrator of the Emergency Services. We agreed to be available to provide 24-hour counseling services to all victims who came into the Emergency Service Department.

Two important points need to be made regarding the way we began our rape research. First; of all the disciplines we appealed to, nursing was the only one which responded to our request. Nursing additionally has continued to show its initiative and social response to this subspecialty health care area by developing protocol for delivery of services to victims

and offering continuing educational programs for updating nursing staff on the subject. Second; we found that the style of research we proposed doing was rewarding not only to us as researchers but to the victims we counseled. We developed a style that was mutually beneficial. The general public, we believe, has become much more sophisticated regarding the process researchers use. They do not willingly tolerate the older model of research where an investigator collects data and publishes findings without giving anything back to the people who were studied. We wished to depart from this method and thus with victims we exchanged counseling for information. With the hospital we exchanged our consulting services for permission to work on the emergency ward. All of our research has been of a service exchange and not a monetary exchange.

In the one year period that we were on-call to Boston City Hospital, we saw 146 people--109 adult women, 34 females under age 17 and 3 males under age 14. We had a preference for seeing things firsthand and thus used participant-observation as one main source of gathering data. We did a joint initial interview at the hospital and then telephone follow-up. With those victims who entered the criminal justice system, we accompanied the victims to the courthouse and observed hearings and trials. We have recently completed a 4-year follow-up and talked with over 80% of the rape victims. Our major findings specific to the victimology of sexual assault are summarized as follows. A set of the published articles is included for additional information.

1. Sexual assault includes three categories of victimization.

Rape is forced, violent sexual penetration against the victim's will and without the victim's consent. The trauma syndrome which develops from this attack or attempted attack includes an acute period of disruption of the victim's lifestyle followed by a longer process of reorganization of lifestyle. Accessory-to-sex reaction involves a pressured sexual situation. The offender stands in a relationship of power to the victim because of being older, being an authority figure, or for some other reason. Victims are incapable of consenting to the sexual activity because of stage of personality or cognitive development. The majority of victims are children or adolescents. Sex-stress situation is an anxiety reaction that results from the circumstances surrounding sexual activity to which both parties initially consented. The person for whom the sexual situation produces the most anxiety usually brings the matter to the attention of a professional, such as a police officer or hospital staff member.

2. Sexual assault cuts across all ages (16 months to 86 years) as can be seen from the five year statistics from Boston City Hospital.

TABLE 1

SEXUAL ASSAULT VICTIMS SEEN
AT BOSTON CITY HOSPITAL¹

	1972-1973	1973-1974	1974-1975	1975-1976	1976-1977	Totals
Older Adult	21	19	21	30	31	122 = 12%
Young Adult	88	99	105	151	123	566 = 58%
Pre-Adult	37*	76	68	51	59	291 = 30%
Total	146	194	194	232	213	979

* Victims under age 17 were only seen for the last six months of the first year study.

The five year statistics from Boston City Hospital indicate a gradual increase in sexual assault victims. This hospital is one of several in the greater Boston area that treats victims.

¹ Statistics tabulated by A.W. Burgess and M.P. McCausland

3. Coping behavior of the rape victim. The coping behavior of rape victims can be analyzed in three distinct phases--the threat of attack, the attack itself, and the period immediately thereafter. Most rape victims use verbal, physical or cognitive coping strategies when threatened with attack. During the actual rape, the coping strategy changes to trying to survive. Victims used cognitive, verbal and physical action as well as psychological defenses and physiological response. After the rape, the victim's task is escaping from the assailant and this is accomplished by trying to alert others, bargaining for freedom and/or freeing oneself. In counseling the rape victim, it is important to understand her or his individual style of coping, to be supportive of it, and to suggest alternatives for future stressful situations.

4. Crisis dimensions of the rape attack. A rape attack creates an external crisis situation for the victim. In the acute phase following the attack the victim may experience many physical symptoms, especially gastrointestinal irritability, muscular tension, sleep-pattern disturbance, genito-urinary discomfort, and a wide range of emotional reactions. The long-term process includes changes in lifestyle such as changing residence, seeking family and social network support, and dealing with repetitive nightmares and phobias.

5. Crisis and Counseling Requests of Victims. Victims' requests for assistance can be categorized into two areas: immediate crisis requests and follow-up counseling requests. Immediate crisis requests were for medical, police or psychological intervention, control and uncertain. The counseling requests were: confirmation of concern, ventilation, clarification, advice, and wants nothing.

Co-joint Research on Victim and Offender

At a regional conference in 1973, Dr. Holmstrom and I had the opportunity to listen to Dr. A. Nicholas Groth present his work with aggressive sexual offenders. It then became quite clear that we could gain additional insights into rape behavior by more closely reviewing our respective victim and offender samples. Thus, a major effort over the past two years has been made in this direction. Summaries of our principle findings are included with reprints.

6. Rape as a sexual deviation. Clinical work with offenders and victims is cited to support the concept of rape as a sexual deviation as well as a sexual offense. It is suggested that rape is directed toward the sexual expression and gratification of needs that are not basically sexual, and that it represents a developmental crisis for the offender, which in turn triggers a situational crisis for the victim.

7. Motivational intent in the sexual assault of children. Two types of child assault can be identified: sex-pressure, which is achieved by offender enticement and/or entrapment of the child into sexual activity; and sex-force, where the victim was forced to submit to the assault through exploitation, intimidation, and/or aggression. Life issues of dominance, power, authority, control, aggression, and sadism are present in varying degrees of intensity in the assault.

8. Sexual dysfunction during rape. In the investigation and prosecution of rape cases, the victim's credibility often becomes suspect when she reports numerous and ongoing sex acts by her assailant and when medical examination reports no evidence of sperm. The study of biophysiological functioning of the rapist reveals that a rapist may well experience sexual dysfunction during rape which may explain a lack of clinical evidence that sexual intercourse occurred.

9. Power, anger and sexuality. Accounts from both offenders and victims of what occurs during a rape suggest that issues of power, anger, and sexuality are important in understanding the rapist's behavior. All three issues seem to operate in every rape, but the proportion varies and one issue seems to dominate in each instance. There were no rapes in which sex was the dominant issue; sexuality was always in the service of other, nonsexual needs.

Target Concerns for Victims

Victimology research cites three main areas that relate to target concerns for victims: special victim issues, specific offender groups, and future efforts to deal with victimization.

Multiple victimization. Victimization does not necessarily end with the departure of the assailant. The institutional processing that occurs can be as devastating as the rape itself. That is, victims may be additional victimized by the manner in which people deal with them after the rape. This applies not only to those institutions that deal with rape victims (hospital, police and courts) but employers, peers, and family.

Handicapped victims. There are some people who have a physical, emotional, mental or social condition that places them at a disadvantage in being able to manage not only the sexual assault but the various people they must encounter following the assault.

Child victimization. Clinical researchers of both victims and offenders are studying the impact of early sexual victimization on subsequent lifestyle and behavior of individuals. Thus, careful attention should be paid to the potential influence that situation has on the young person.

Incest is a topic that is appearing more and more as a target concern for many communities. The state of California is pioneering in its self-help model of treating incestuous families. Regularly scheduled training workshops have been established at the Sex Abuse Treatment Center in Santa Clara for agency staff to attend and then to return home to initiate this coordinated community model to deal with incest. Several additional issues may be identified besides incest in cases involving assault by a family member:

- a) In some incest situations, the offender is sexually assaulting not only his own children but other neighbor children;
- b) Incest situations may well involve more than one child in the family;
- c) Incest situations may include the child being used for photographic purposes as well as sexual purposes.

Offender retaliation. There is an underlying fear by many rape victims that the assailant will come back and harm them. Many times, in the course of the rape, victims have been threatened with harm if indeed they do tell the police. Sometimes the fear is so great that the victim moves to another town or even out of state. Victims may also fear retaliations after an offender returns to the community after serving a prison sentence. There is relatively little data available on the incidence of retaliation by ex-offenders and/or their social network and thus, counselors do not wish to give false reassurance to the victim. From a law enforcement standpoint, there is little action police or prosecutor can take without evidence of the identity of the victimizer.

Specific Offender Groups

From a clinical viewpoint, it is most difficult to provide counseling services for the victim without knowing something about the dynamics of rape

behavior. That is, to understand what the victim has been a victim of, there is a need to know what motivates a person to rape. Thus, more attention needs to be placed on identifying the offender population group and studying this type of dangerous human behavior.

Young offenders. Relatively little attention is being paid nationally to the adolescent male who commits rape or child molestation. There appears to be a reluctance on the part of the courts and other agencies to view juvenile sexual offenses as significant or serious. Sometimes the concern is voiced that such a youngster will be stigmatized and that a conviction will jeopardize his plans for enlistment in the armed services, but more often it appears that such an offense is regarded as merely sexual experimentation, situational in nature or as an expression of the normal aggressiveness of a sexually maturing male.

Recidivists. Some offenders continue to repeat their rape behavior. Measures to deal with this group include the use of a consistent person within a Rape Unit who is responsible to see all cases of sexual assault and thus collect data on offenders who repeat the crime.

Family member assailant. This offender group has already been identified. Unfortunately, few states have treatment programs such as California to treat such offenders and victims.

Efforts to Deal with Victimization

Mental health agency approach to rape victimology. The field of rape victim counseling is quite new. Prior to 1973, virtually little attention had been paid to the counseling or psychological issues involved with people who were raped. And, although the professional literature has dramatically increased on the subject, many clinicians and agency staff have not updated their own skills and knowledges of the problems of sexual assault.

Barriers to coordination and cooperation. The need for agencies to cooperate and to coordinate services has been voiced in research reports as

well as by federal directives. The major goals of a national series of workshops on Rape and its Victims, supported through LEAA funds, were to establish coordination and cooperation of services among agencies which deliver services to rape victims. Ten regions of the country participated in these workshops. A national effort was made to address the problem of agency fragmentation. However, the problem remains major: How can we get agencies and staff to cooperate and coordinate efforts to the overall purpose of aiding the victim and identifying the offender?

RECOMMENDATIONS

Based on my experience in the field of victimology of sexual assault, I want to make the following recommendations for consideration.

Victim services. It is important that funds be made available for programs that have been providing the crisis services to rape victims. In general, it has been the rape crisis centers who were first to respond to the needs of victims and who have been providing crisis counseling with the most modest of funds.

Education/Training. It is important that curriculum content be implemented into basic professional programs such as medicine, nursing, psychology, social work at the student level. Attitudes and biases are so strong on this subject that content from current research needs to go in at the basic preparation level.

Also, curriculum content needs to be provided through continuing educational courses to practicing clinicians. This content can be provided through workshops and seminars and should be interdisciplinary in presentation.

Attention needs to be paid to community education programs for the updating of the general public on current findings regarding rape behavior and victimology. School children should know the laws of the state, thus enabling them to know when someone is committing a crime against them. Also, citizens need to know how to deal with dangerous human emergencies.

Research. The study of dangerous human behavior should continue to be a priority. Early signs of rape behavior needs to be identified. Mental health professionals should consider assuming more responsibility for dealing with aggressive behaviors and determining treatment methods for offenders.

In conclusion, with the increasing reports of sexual assaults, this is not a private syndrome. It should be a societal concern, and its treatment should be a public charge.

Thank you.

END