Lisbeth Bang

Health services for rape victims

This article describes the rape trauma service in Oslo.

Until quite recently, health authorities in Europe were unaware of the mental and physical harm caused by rape, which was treated purely as a criminal offence. Victims of rape were not offered medical aid, and somatic acute medicine did not regard them as one of the multitraumatized groups of patients requiring special attention. Rape was not considered harmful to health and unless there were visible signs of physical injury requiring treatment, victims had no access to immediate aid. Today in most parts of Europe the procedures for the reception and treatment of rape victims are still based on police requirements and the demands of the legal system for proof and the securing of evidence. They are not intended to provide a medical service even in cases where an examination is carried out in a hospital gynaecological department. In Norway the conditions set for such an examination were that the rape had to be reported to the police, a copy of the report had to be submitted to the hospital, and a policeman had to accompany the victim to the examination.

During the last 20 years, research and experience have shown rape to be a trauma with serious consequences for health and society. Research has been carried out among those who have reported rape to the police or who have sought aid. Effects of rape have been seen among 80% of the people examined (1, 2), the reactions being diagnosed as post-traumatic stress disturbances. Sexual assault and violence are still criminal matters but are nowadays also recognized as a health problem. Since rape damages the victim’s health it is important to determine the extent of rape, how many victims suffer permanent harm, and how the authorities can best offer medical treatment to reduce long-term effects. One consequence of the knowledge recently gained is that it has become logical for medical and judicial bodies to cooperate in providing assistance.

Sexual assault

Rape and incest have always been taboo in the sense that it has been felt undesirable to talk about them and a matter of shame and dishonour to be a victim. Only a fraction of sexual assaults, perhaps under 1%, comes to the notice of police or health services. Little
research has been done on the extent of sexual assault or on the percentages of women and men annually subjected to it. Research in the United Kingdom and USA indicates a prevalence of one or more consummated rapes during the lifetime of 21–23% of the urban female population and an annual rape incidence of approximately 3% (3, 4). In Norway a study showed that 14% of married women and 6% of unmarried women had suffered sexual abuse on one or more occasions (5). Establishing reception and treatment facilities is a challenge to the health services. From an epidemiological point of view the problem concerns a large proportion of the population. On the organizational side the health services have to turn their attention to removing the stigma and shame attached to being a rape or incest patient.

**Acute and chronic damage to health**

The damage resulting from sexual assault can be physical, mental and social. Mental harm usually presents the greatest problem.

Acute physical harm can be seen as consequent on the violence accompanying sexual assault: the use of weapons, branding with cigarettes, striking with a clenched fist or open hand, attempted strangling, kicking, and being thrown against hard objects. Visible injuries include scratches, abrasions, swellings, extravasation, subcutaneous and surface bruising, and haematomas from torn tissues and muscle fibres. The fracturing of facial bones, ribs, hands, wrists and forearms occurs in some cases. Damage to mucous membranes can be observed in the oral and anal cavities, vulva, vagina, and in the membranes and skin of the penis and testicles.

The seriousness of injuries depends on the extent of penetration by the penis or whatever foreign body has been used in the assault. Damage to the mucous membranes consists normally of inflammation, irritation, scratches and swelling. In some cases perforation of the mucous membranes can be observed. Venereal diseases, pregnancy and infections of the urinary tract and vagina are consequences that may manifest themselves in the course of time.

Effects on health that can be observed during the weeks and months following a sexual assault include: infection and pains in the uterus; digestive problems such as lack of appetite, nausea, vomiting, stomach pains and pains resembling colic; and also loss of weight, headaches and general muscular pain. Psychosomatic symptoms include insomnia, nightmares, loss of concentration and irritability. The effects on health may be longlasting and chronic, a situation that can be prevented by therapeutic aid and support for the victim from qualified personnel as well as from family members and friends.

The psychological manifestations following rape comprise the rape trauma syndrome, which is divided into various phases. The shock phase is immediate and can last from hours to days, ending when the victim begins to understand and recognize what has happened. During the reaction phase, usually lasting four to six weeks, somatic reactions appear, as well as psychological ones such as anxiety that can develop into phobia, insomnia, nightmares, involuntary
flashbacks (traumatic reliving of the rape), mental chaos and thoughts of suicide. The recuperation and reorientation phase can take several years and is characterized by continued traumatic reliving of the rape.

A person seeking help after a rape can either notify the police or go straight to hospital.

notwithstanding the giving of treatment. Symptoms include problems with intimate relationships, loss of interest in previous activities, insomnia, nightmares, self-reproach, feelings of inferiority, self-destructive behaviour such as abuse of alcohol and drugs, contemplation of suicide and attempts to commit suicide. The rape trauma syndrome is a crisis reaction similar to that experienced by persons exposed to war, natural disasters, torture, gross violence and serious accidents. The mental symptoms can be regarded as normal reactions to abnormal occurrences and can be seen in women and men whose behaviour has shown no signs of mental disturbance prior to rape.

There may also be social manifestations by victims of sexual assault. Many victims, fearing that others will find out what has happened, tend to isolate themselves. Some are afraid of becoming victims of a similar assault again and in order to avoid this may move to another town or country, change their employment, never go out alone, and so on. These reactions lead to a reduction in social contacts.

Needs after sexual assault

In addition to accepting medical treatment and care, a victim of sexual assault may choose to notify the police. The legal system requires forensic documentation and the collection of evidence. Since rape victims are a high-risk group with regard to the development of psychological problems, it is vital that medical care and treatment be made available at the earliest possible moment. The patient must receive priority if long-term harm is to be avoided. Health services must consider cultural attitudes that inhibit or prevent patients from coping with the stress unaided.

Rape trauma service

Oslo’s rape trauma service, inaugurated in 1986, is based on an agreement between professional groups and official bodies. It forms an integral part of the health care system, not a new, special unit. The emergency section is located in Oslo’s Municipal Emergency Hospital which deals with acute health and social problems. The rape trauma service is open 24 hours a day. All treatment is given in accordance with the wishes of those seeking assistance, without charge, and regardless of whether the police have been notified. The same applies to follow-up procedures. Persons subjected to rape are classified as emergency cases, bypassing the normal queuing system and coming second only to patients whose lives are in danger. Rape victims aged under 14 years are sent to the children’s ward at Aker Hospital, where the same service is available.

The service comprises the following:
— medical examination and treatment;
— forensic examination and collection of evidence;
— crisis counselling for the patient and, where necessary, the patient’s immediate family;
— up to 24 hours’ stay for care and observation;
— contact with legal adviser and police;
— follow-up medical treatment;
— follow-up psychological assistance.

The first five of these items constitute the emergency service for victims of rape. Follow-up medical treatment is given by the Municipal Emergency Hospital. Follow-up psychological assistance is available from any of ten psychiatric outpatient departments or five family advice centres in Oslo.

A person seeking help after a rape can either notify the police or go straight to hospital. If the person chooses to go first to the police, the agreement between the police and the health service ensures that only the most necessary questions are asked. The patient is then brought directly to the rape trauma service for immediate treatment and aid. The main statement to the police is not given until after the patient has received treatment and psychosocial care; in some cases it is postponed until the following day. The police are willing to go to the hospital to take a statement if this seems to be to the patient’s benefit; the same applies to the lawyers involved in rape cases. One of the aims of the reorganized service for rape victims is that all acute help should be available at one site and that the patient should be spared the burden of travelling around in Oslo. If the raped person chooses to go direct to the hospital the first contact is made at the reception desk, where her or his name, date of birth and address are noted. Applications for treatment are sorted into the main categories of minor surgery, fractures, general medicine and social problems. When it becomes clear that medical aid is being sought in connection with a rape, the special service for such cases is set in motion and the nurse on duty in the general health section is notified.

This nurse is the practical coordinator. The patient is taken to a special room with furnishings of a comparatively domestic character: there are house plants, pictures on the walls, and a small kitchen where coffee, tea, soup and sandwiches are available. Other personnel avoid visiting the room when such a patient is present. The nurse ascertains what has happened and explains what the rape trauma service has to offer. A schedule is agreed for those parts of the service the patient decides to accept. When the nurse leaves the room to prepare the medical and forensic examination she summons a counsellor so that the patient is not left alone.

Doctors and nurses of the general health section conduct the medical and forensic examinations, obtain evidence, give medical treatment, and are responsible for the patients while they are under observation. Trained social workers and personnel from the psychiatric emergency unit give advice and arrange for follow-up psychological assistance at a psychiatric outpatient department or family advice centre. The rape trauma service has a list of lawyers ready to act as legal advisers and provide details of where they can be contacted outside office hours.

One of the preconditions for integrating the rape trauma service into the health service
was that all personnel involved in the treatment of rape victims should undergo special training. There is a 10% turnover of medical staff and training courses are therefore necessary twice a year. The hospital has developed a two-day basic course on rape. The first part deals with attitudes, myths and realities in relation to rape, the second gives a summary of the services provided for victims, and the final part offers practical instruction and training for personnel in the medical fields concerned. The various professional groups that collaborate with each other on a day-to-day basis attend the course together. Each group also receives thorough training in its special field. The advisers attend guidance sessions with a psychiatrist every two weeks. Training is also given to prepare staff for appearing as expert witnesses in the high court. The rape trauma service unit comes under the medical and administrative control of a medical supervisor acting on the authority of Oslo City Council.

Cooperation with the police

The Oslo Board of Health felt that cooperation with the police and the legal authorities would benefit the new service for rape victims. A committee consisting of representatives of police lawyers, investigators and technicians, the police school, the Institute for Forensic Medicine, the Oslo Board of Health, the Municipal Emergency Hospital and the legal profession produced a report dealing with the following matters.

- The initial phase when the victim may wish to notify the police of an assault or seeks aid from the rape trauma service but has no wish to report the matter to the police.

- Medical and gynaecological examinations.

- Procedures for recording the state of the victim's clothes, for securing evidence and for photographing injuries, bruises, and so on.

- The possibility of calling personnel from the rape trauma service to give evidence in court.

- Information for and training of police officers, public prosecutors and other members of the legal system.

- Information for the general public.

The committee recognized that a victim of rape may be in a state of shock and that lengthy questioning by the police immediately after a sexual assault is unlikely to establish details of what has happened, the symptoms of shock being limited memory, reduced perception and an inability to react. The patient's mental condition is such that her or his description of events may seem confused and unconvincing. The committee decided that if the person concerned first approached the police, the only information to be recorded would concern the nature of the assault and any details that might help to identify the attacker and indicate where the assault took place. The taking of a full statement was to be postponed until the patient had received medical aid and regained a measure of mental balance. The choice of a male or female investigator rests with the victim. If the victim sought aid from the rape trauma service first, the staff would, at some stage.
during treatment, take up the question of notifying the police. If the patient were in doubt as to what is involved a legal adviser would be called in. Should the patient decide not to notify the police an offer of forensic examination and documentation of evidence was nevertheless to be made in case he or she had a change of mind.

Partly in the light of developments in England and the USA, a six-page standard medico-legal case record and a standard selection of diagrams of the body were compiled, to assist forensic examination and the recording of evidence. Visible injuries are described in the record, illustrated on the diagrams, and photographed. A special container was designed for the equipment required to collect biological traces. Routines were laid down for the microscopic identification of spermatozoa and the detection of acid phosphatase and specific proteins of seminal fluid taken from the vagina, other body orifices and the skin. More recently, methods have been developed to identify and compare samples of DNA. It has become a matter of routine to collect other biological materials, such as hair, blood, skin and saliva. Procedures were introduced to ensure the correct securing of clothes, personal effects and foreign particles. Personnel from the Criminal Investigation Department were engaged to instruct doctors and nurses in photography and procedures for securing evidence. At the Municipal Emergency Hospital a special room was equipped to provide optimal conditions for forensic examination and a locked filing cabinet was installed for the exclusive storage of data on these cases.

The committee emphasized the need to inform the police force as a whole about the new procedures for the investigation of cases of rape. In particular, public prosecutors have to be able to evaluate the new forensic information now obtainable. The police school was encouraged to give the investigation of sexual crimes a larger share of the curriculum. With regard to information for the victims of rape, the Oslo Board of Health and the police cooperated to produce a brochure giving details of the new service, which was distributed in Oslo to all health and social centres, child welfare clinics, psychiatric outpatient departments, family advice centres, police departments, chemists and libraries.

The committee agreed to monitor the proposed procedures and to evaluate the project. A representative of the child reception ward at Aker Hospital has joined the committee since its formation.

Results

The rape trauma service accepts patients aged 14 years and upwards. In 1986, 141 patients, nine of them men, were dealt with. In the following year 168 rape victims, including four men, applied for medical aid. The number of persons in Oslo now receiving medical aid each year after rape has more than quadrupled since the opening of the rape reception centre. The service assists people who have reported rape to the police and those who are seeking only medical and psychosocial treatment; 56% of the latter have chosen to notify the police.

There are now health services for rape victims in Trondheim and Bodo as well as Oslo, and additional rape trauma services are projected for Drammen, Bergen, Hamar, Kristiansund and Tonsberg.

In the recently revised Guidelines for municipal health, published in 1990 by the Directorate of Public Health, a new section is included giving directives for the treatment of violence and sexual assault. Municipal
medical officers are responsible for ensuring that a service is available for victims of sexual violence. The essential features of such a service are outlined together with the necessary framework, including the teaching of personnel. An evaluation of requirements is recommended, possibly by means of a questionnaire to be answered anonymously by patients.

With financial backing from the government a teaching package dealing with the reception and treatment of victims of sexual assault was put together in 1988. The target group is interdisciplinary and interdepartmental, the intention being to bring together professional groups whose basic education has not covered this subject at all. The teaching aids consist of a general textbook on sexual violence, a manual dealing specifically with the medical and forensic examination of victims, a dramatized video on rape, another on incest, a series of slides illustrating the medical and forensic examination, pamphlets for course participants containing a survey of the basic themes, and a guide for course leaders to assist them in the teaching process. The rape trauma service unit in Oslo serves as a starting point. The teaching aids were evaluated during a countrywide investigation in 1989 and received favourable criticism.

References


The enormous toll of work accidents

[The International Labour Organisation estimates] that about 180,000 workers are killed and 110 million are injured in occupational accidents each year... These figures show that occupational injury is a serious national problem in terms of human suffering and social costs. The medical and societal importance of accidents is emphasized by the fact that they often involve young people and cause long periods of disability and loss of a large number of working years... The human, public health, and economic consequences of accidents make their prevention one of the most worthwhile priority areas of preventive health policy, both for public health and for occupational health and safety.