OTHER CONCERNS FOR SEXUAL ASSAULT SURVIVORS

- Spiritual Issues
- Confrontational Advice
- Polygraph
- Civil Suits
- Pregnancy/Aids/ STI's/Hepatitis

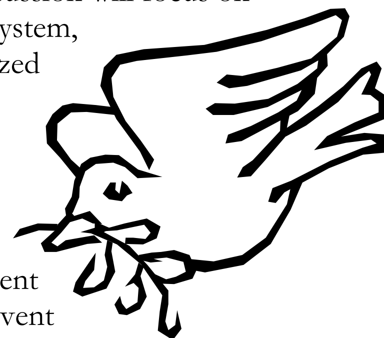
Section 8

OTHER CONCERNS FOR SEXUAL ASSAULSSURVIVORS

Successfully surviving sexual assault involves handling many issues after the attack.

Spiritual Issues for Survivors

In recent years, research has yielded much new information about the impact of traumatic events on survivors' lives. For example, in addition to whatever physical injuries a survivor might sustain, a variety of emotional and psychological after-effects also arise. Trauma as intimate as a sexual assault has an impact on every aspect of a survivor's being. Spiritual/ religious beliefs may provide comfort and strength to a survivor. But, individual belief systems can vary widely, even among adherents of one religion. This discussion will focus on potentially problematic ways that coping with assault can affect a belief system, and vice versa. Whether or not the survivor was a member of any organized religion, becoming the victim of a violent act can raise questions: "Why did this happen to me? Did I do something to deserve this? If such evil exists, how can one ever feel safe in the world? Is there a God? If so, where was He/She when this happened?"



Being the victim of violence shatters any illusion that we have an agreement with an omnipotent force guaranteeing our invulnerability. A traumatic event can disrupt our sense of connection with that higher power and create a "deeper feeling of a broken covenant" (Decker, Larry, National Center for Post-Traumatic Stress Disorder's Clinical Quarterly, vol. 5,1, Winter, 1995 1-3). At an even deeper level, all human beings nurture a hope that there is purpose and meaning to life, regardless of what tragedies occur. But it may take a survivor some time to reconnect with faith in that belief.

In the broadest sense, spirituality is a search for transcendent meaning and purpose to existence beyond the merely physical or psychological, whereas religion can be thought of as an "organized attempt to facilitate and interpret that search" (Ibid.) Spiritual themes and questions have been expressed throughout the history of mankind in various ways such as art, music and literature. Some people have pursued these questions by subscribing to specific religious beliefs; others have pursued them in other ways. Whether or not one is a member of any organized religion, a sexual assault may injure the survivor's sense of spirituality. An assault often leads survivors to wonder if a Supreme Being is intimately involved in the affairs of humans and, if so, how was such evil allowed to happen?

While it is not necessary for the advocate to function as a spiritual counselor, it is important for the advocate to recognize and be open to addressing spiritual concerns the survivor expresses, even if they are raised indirectly. Concerns may differ, depending upon the survivor's prior spiritual beliefs or religious practice. Although one may place emphasis on the Passover in Egypt, the birth of the Buddha, the life of Jesus, the vision of Mohammed, the manifestations of Shiva, the ceremonies of American Indians, the universality of the Goddess or another philosophy, a survivor may be seriously challenged to find a way to incorporate being the victim of a violent event without it affecting the person's sense of meaning and purpose.

Problems may arise if a female survivor from the Judeo-Christian tradition strictly understands God as an omnipotent father, who decrees the proper relationship between men and women is one in which men have authority and women are subservient. A survivor from this spiritual perspective may find that anger toward the perpetrator cannot be separated from anger toward a God who seemingly failed to protect her. Similarly, a male survivor from the same tradition may judge himself by those patriarchal traditions and have difficulty reconciling the Biblical image of authoritative masculinity and his own experience of becoming a victim. Both may find it difficult to experience the nurturing, forgiving, compassionate, merciful qualities also attributed to the Judeo-Christian God.

A Muslim woman victimized by sexual assault may feel terrified of possible condemnation by Allah as well as alienation or ostracism by her family, because being the victim of a sexual assault is tantamount to violating the commandants of the Prophet. Although Islam requires male and female adherents to avoid illicit (unmarried) sexual relations at all costs, it emphasizes the responsibility of women to practice modesty requiring, for example, traditional women of Islam wear the hijab or veil so as not to tempt a man who may have difficulty "suppressing his natural urges completely" (Doi, Abdur Rahman, Women in Society, Center for Islamic Legal Studies, Ahmadu Bello University, Zaira, Nigeria, 1997). An Islamic woman in the process of trying to adapt to Western society may experience a deep spiritual conflict between her traditional beliefs and the more liberal lifestyle she encounters in Western society. Although it is common for many survivors to feel they, rather than the perpetrators, are responsible for assault, this tendency may be significantly magnified if the woman and her family subscribe to religious beliefs which reinforce the idea that women are responsible if men cannot control their impulses.

Nevertheless, incorporating a spiritual awareness into work with survivors can be extremely helpful to the survivor, providing the advocate facilitates rather than directs the spiritual aspect. For instance, while it is helpful for survivors to remember that everything physical is temporary and they are more than their physical bodies, introducing abstract metaphysical concepts may not help and, in fact, may lead to more confusion if the advocate randomly initiates such discussion. If addressing spiritual issues, it is important for the advocate to avoid appearing in any way to blame the victim including or implying:

- The victim consciously or unconsciously allowed the assault;
- The survivor is morally deficient because he/she experiences emotional difficulties;
- The assault is the result of some behavior on the part of the survivor, in this or a past life;

- An omnipotent being caused or allowed the assault in order to promote the survivor's spiritual development (Adapted from King, H.M., CNYNet: Health and Environment, 6/95).

The possibility of forgiving the offender may not occur. But for some, survivors especially those reared in a religious tradition, the belief that he/she must forgive the perpetrator may present additional blocks to resolving the abuse. It is important to allow the survivor to raise this issue, when and if he/she is ready. An attempt by the advocate to introduce the subject of forgiveness before the survivor is ready may prevent the survivor from expressing natural and appropriate anger or hatred toward the perpetrator and delay recovery from the trauma. If forgiveness is an issue, it is important to help the survivor distinguish between forgiving the person and condoning or excusing the offender's behavior. For even the most spiritual, forgiveness cannot be accomplished by willpower. It is a process that evolves over time and can occur only when the survivor is ready to let go of the anger and to no longer allow the experience to dominate life. The survivor should be given permission not to forgive the perpetrator until he/she is ready, if ever. It is a process that may take years and for some, may never happen.

Probably the most important spiritual thing an advocate can do is to offer hope to the survivor. Yvonne Dolan, author of Resolving Sexual Abuse, writing about her own struggle with faith after sexual abuse, says:

> Hope was not initially available to me from within, at least not in the sense of a strong belief that I was going to have a positive future. This initial difficulty in believing in a positive future is one of the most common symptoms of sexual abuse. But while hope was not initially accessible, endurance was available. By endurance, I am talking about the simple act of willing oneself to act "as if" you believe a positive future is possible, a message to the self that sounds something like, "I will stay alive; I WILL get through this somehow, even if I don't know how right now." It is perhaps more an act of will than a belief. Fortunately, endurance can lead eventually to hope, as it did for me. But the survivor has to endure long enough to find that hope.

Some survivors have described the work required to overcome the effects of sexual abuse/assault as a kind of Shamanic Journey. "In the Shamanic tradition, a person suffers a terrible trauma and survives it, although inevitably the process of survival requires every ounce of inner strength he or she can summon. Once the trauma is over, the act of moving beyond the trauma, coming to terms with it, healing from it, is the vehicle for becoming personally gifted and exceptional—in this case resulting in the role of …Healer. Sexual abuse survivors are healers, too, initially of themselves, by necessity, and later, sometimes of others too" (Ibid.).

Rape: The Dangers of Providing Confrontational Advice

Recently, while addressing an audience on the topic of rape, one of the authors was asked what advice he would offer to a woman confronted with a rape situation. All too familiar with this question, he replied that he could recommend a course of action only if the person

asking the question would describe to him: first, the location of the confrontation; second, the personality of the hypothetical victim; and third, the type and motivation of the particular rapist.1

This conditional response certainly disappointed the audience, for they wanted an all-purpose answer that could be easily remembered and serve all situations. Unfortunately, our research and experience indicate strongly that no one piece of advice will prove valid in all or even a majority of sexual assault situations.

As faculty members of the Behavioral Science Unit (BSU) at the FBI Academy, we are experienced in the study of sexual violence and have worked with investigators from law enforcement communities throughout the nation on over 1,000 rape cases. We have had the rare opportunity of personally interviewing serial rapists, and we have worked closely with professionals widely recognized for their research in, and their investigative and academic contributions to, the study of sexual violence—Dr. Ann Wolbert Burgess, University of Pennsylvania, who pioneered the identification of Rape Trauma Syndrome; Dr. Fred Berlin, Johns Hopkins Medical Center, who has led the field in treating sexual offenders with Depo-Provera; Dr. Park Elliott Dietz, University of Virginia, a recognized expert in forensic psychiatry; and Dr. A Nicholas Groth, former director of the sex offenders' treatment program in Somers, CT, among others.

Our research and experience indicate that there is no one specific way to deal with a rape situation. Groth and Birnbaum speak for the rapists themselves when they say, "Different motives operate in different offenders and, therefore, what might be successful in dissuading one type of assailant might, in fact, only aggravate the situation with a different type of offender."2

Consequently, we wish to first highlight the dangers of giving confrontational advice. To do so, we will report the highly conflicting advice offered by professed experts in the field and by convicted rapists, and we will analyze specific cases that demonstrate the predictability of sexual assault behavior. Second, we wish to discuss the three parameters of the sexual assault situation that might assist the potential victim in determining a reasonable course of action: 1) the confrontation environment, 2) the personality of the victim and 3) the type and motivation of the rapist. We understand that reason is necessarily clouded in unexpected confrontational situations, but we believe that consideration of these factors will yield better results for the victim than if she trusts one arbitrary response that might work or that might goad the assailant to further violence.

R.R. Hazelwood and A.W. Burgess, eds. Practical Aspects of Rape Investigation: A Multidisciplinary Approach (New York, NY; Elsevier Science Publishing Co., Inc., CRC Press).

A. Nicholas Groth and H. Jean Birnbaum, Men Who Rape (New York, NY: Plenum Publishing Corporation, 1979).

ADVICE FROM RAPISTS

Occasionally, one reads an article or observes a television program in which an individual interviews one or more rapists about what a potential victim should do when confronted with a rape situation. Such a representation has great impact on its audience because the advisors are real rapists! Who should know better than the offender what would deter his attack? To believe the advice, however, the audience must assume that all rapists are behaviorally like the one presented to it.

As part of an ongoing research project, members of the BSU ask this same question of men who have raped 10 or more victims. The men have given widely divergent answers as to what would have successfully deterred each one. Some say, "Tell them to scream, fight, claw like hell." Some, "Tell them to give in because the guy is going to rape her regardless of what he has to do." Some, "Tell her to pretend that she wants him so he will finish and leave." And others, "Tell her to bribe him with money." Which rapists should the potential victim listen to? The individual who presents rapists (and their advice) to an audience has an obligation to explain that the information provided is relevant only to the rapist providing it and should not be generalized to all rape situations.

EXPERTS IN THE FIELD

Over the years, programs and techniques have mushroomed that profess to provide potential victims with the key to deterring the rapist. These programs and techniques have grown out of a variety of professions, including law enforcement, criminology, sociology, mental health and crisis intervention.

They usually advocate one or some combination of the following methods of resistance:

Physical Resistance: Training the individual in self-defense tactics, including knowledge of various pressure points that are sensitive to attack.

Verbal Resistance: Sensitizing potential victims to the effects of their tone of voice, manner and attitude, and training them to scream, negotiate, or assertively respond to the attacker's demands.

Noisemaking Devices: Acquainting and equipping individuals with whistles, miniature sirens, or other such devices.

Use of Chemicals: Providing individuals with containers of disabling gases, such as mace, or with repugnant odor devices.

Use of Weapons: Training individuals in the use of guns, keys, clubs, or stickpins in the hostile situation.

Pretext of Pregnancy or Venereal Disease: Advising individuals to claim pregnancy or disease to the attacker in hopes that it will appeal to his sense of humanity or to his fears.

Vomiting, Urinating, Defecating: Advising the individual to repel the attacker by performing disgusting physical actions.

All of these techniques certainly have their place and can be highly effective in a particular situation. But they could also be worthless or even dangerous in particular situations.

CASE STUDIES

We are certain that individuals who advocate the various methods of resistance presented above formulated them because they were employed successfully in one or more situations and present them as viable techniques with the very best of intentions. However, we are also certain that to generalize the success of one or more instances to all rape situations is not only potentially dangerous to the victim but is also irresponsible and unprofessional. The following four cases serve to illustrate the futility of providing potential victims with just one technique to deal with all rapists.

Case NO. 1

One summer evening, a 20-year-old female was walking home after attending a movie when she noticed a car with four males inside following her. She became nervous and walked to a pay phone to call her parents. As she was explaining her fears, two of the males pulled her from the phone booth and forcibly placed her in the back seat of their car. She involuntarily defecated and urinated out of fear. This so enraged her captors that they began pummeling her and forced her to consume her own waste material. Following this, the four took turns assaulting her sexually. Finally, they tied her to the rear bumper of the car and dragged her behind the automobile before releasing her. As a result, she suffered numerous fractures and required extensive medical treatment and mental health care.

Case NO. 2

The rapist, a white male in his late twenties or early thirties, entered the residence of a family of four. The husband and wife were out for the evening and had hired a 13 year old girl to baby sit. Brandishing a handgun, he subdued the baby-sitter and her young charges and forced the young girl to perform fellatio and to masturbate him. When the parents arrived home, he handcuffed the husband, forced the wife to disrobe, bound her hands behind her back and vaginally assaulted her in the husband's presence. Up to this point, the rapist had not struck or physically harmed anyone in the home and had been emotionally calm. As the rape was occurring, the husband asked his wife if she was all right, and the wife replied. "Yes, he's being a gentleman." At this point, the rapist's attitude changed dramatically. He so brutally attacked the victim's chest with his hands that she later had to undergo a radical mastectomy of both of her breasts. He was later asked why he had reacted so violently to such an innocuous statement. He answered, "Who was she to tell me that I was being a gentleman? I wanted to show her who was in charge, and she found out."

Case NO. 3

A serial murderer sexually assaulted and killed 17 women over a number of years. He had also raped and released several women during that same period of time. One of the released victims reported the assault to the local police department. Because she was a prostitute, little attention was given to her complaint. Two years later, a state police agency located and interviewed the victim, and subsequently, the offender was identified, arrested and convic-

ted. He made a full confession, startling his interrogators when answering questions about why he did not kill all his victims. He told them that, before he would kill a victim, three criteria had to be met. First, the victim must have approached him sexually (he frequented areas known for prostitutes). Second, the victim must exhibit some reluctance in performing various sexual acts, and third, the victim must make some attempt to escape. The prostitute victim mentioned earlier had met the first two criteria for death, but had made no attempt to escape even though the offender had tried twice to give her his weapon (unloaded). The victim had declined the weapon and stated that she did not want to shoot anybody, she just wanted to go home.

Case NO. 4

A 39-year-old white male sexually mistreated his wife over a number of years, even binding her and assaulting her with a hairbrush. Additionally, he had raped several women and molested his two daughters, two nieces and the daughter of a female acquaintance. During an interview about one of the rapes, he was asked what his reaction would have been had the victim resisted him either physically or verbally. He thought for several moments and replied, "I don't know. I might have left, but then again, I might have killed her. I just don't know."

These four case illustrations demonstrate dramatically that any one program on confrontation techniques would not have helped all the victims. In Case No. 4, not even the rapist was prepared to state what his reaction to resistance would have been.

THREE CRITICAL VARIABLES IN CONFRONTATIONS

This article opened with a statement that we would offer confrontational advice only if we had specific information about three critical variables: 1) the environment of the assault, 2) an understanding of certain personality characteristics of the victim and 3) the type and motivation of the rapist involved. We believe that these three variables dictate the shape a confrontation will take, and we advise police, field experts and potential victims themselves not to give or act on advice that does not take these factors into account. Below, we describe these three critical factors.

- **Location of Assault**—The advice one would provide to a victim encountering a rapist in a shopping mall parking lot at 4:00 p.m. would certainly differ from the advice for an encounter occurring at 4:00 a.m. on a deserted roadway. Use of a noisemaker would be futile in the latter situation, but may be successful in the former. To advise a person to fight, scream, defecate, or use disabling chemicals or gases is insufficient in itself. **Victims must tailor their type of resistance to the environment in which the attack is occurring**. Above all, potential victims should not be lulled into a false sense of security because they have a whistle or can of mace in their pocket. Such confidence may actually increase their chance of becoming a victim.

- **Victim Personality**—The personality of the victim strongly impacts on how she will react in a confrontation. A passive and dependent personality will have extreme difficulty implementing advice to be assertive and physically aggressive in a confrontation where a physically larger male has awakened her from sleep. Conversely, an

independent and assertive individual will be hard pressed to submit to a violation of her body without a struggle, even if she has been advised that passivity is her best course.

Anyone providing advice to an audience must remember that there are as many different personalities present, as there are audience members. To influence effectively the decision-making process of an audience, one must consider these variations and must stress that **the success of resistance behavior depends largely on the victim's ability to apply it**.

- **Type and Motivation of Rapist**—In our opinion, the most important unknown variable to consider when giving advice to potential victims is the type of rapist they may confront and the motivation that underlies his sexual attack. Is the victim being confronted by an inadequate male who has fantasized a mutually acceptable relationship? By a sexual sadist who delights in the victim's response to physical or emotional pain? Or by an offender who desires to punish or degrade women? In each case, the motivation is different, and the rapist's reaction to the victim's resistance is correspondingly different.

The spectrum of advice offered by serial rapists earlier in this chapter underlines how strongly the type and motivation of the rapist colors the dynamics of the confrontation. To assume that all rapists are alike in type and motivation demonstrates a lack of knowledge and experience. As Groth and Birnbaum note, "Physical resistance will discourage one type of rapist but excite another. If his victim screams, one assailant will flee, but another will cut her throat."

To give advice to potential victims without consideration of these critical variables can be compared to a physician who would prescribe medication or recommend surgery without the patient's medical history and documenting the signs and symptoms that would warrant such medication or surgery. Individuals who profess to have expertise in criminal sexuality have an obligation similar to a physician—to advise on a case-by-case basis, and only with complete knowledge.

The following case ironically illustrates the importance of recognizing and considering the different types of rapists.

Case NO. 5

In a large metropolitan area, a series of rapes had plagued the police over a period of months. In each instance, the rapist controlled his victim through threats and intimidation. One evening, a hospital orderly went off duty at midnight and happened upon a male beating a nurse in an attempt to rape her. The orderly went to her rescue and subdued the attacker until the police arrived. Shortly thereafter, the orderly was arrested for the series of rapes mentioned earlier. During the interrogation, he was asked why he had rescued the nurse when he was guilty of similar offenses. He became indignant and advised that they were wrong. He would never hurt a woman.

This offender did not, clearly, consider the two offenses as similar. He equated hurt with nonsexual trauma and either failed to consider, or ignored, emotional sexual trauma.4 His

willingness to turn in another rapist shows how powerfully the motivations of a rapist affect his way of seeing and behaving in a confrontation.

A BEHAVIORALLY ORIENTED APPROACH

Experts in the field take pains to broadcast valid crime prevention measures which individuals can take to minimize opportunities for the confrontation. They should also educate these same individuals in the variables involved in a rape confrontation so that they can prepare themselves in advance to handle the unexpected. While it may seem to be a cumbersome concept for one faced suddenly with a frightening situation, it removes the emphasis from one-dimensional techniques that may backfire and puts it where it should be-in advance preparation and training. In sports, athletes are trained to know their own strengths and weakness and to accustom themselves to different playing areas. On the day of their sports event, they are prepared to assess their competitors on the spot and adjust their final strategy accordingly. The same process holds true in many areas of life: to survive one must prepare himself for the unexpected. Similarly, potential victims have an excellent chance of surviving a rape confrontation if they are prepared in advance. They should be trained in assessing their personal strengths and weaknesses. They should be taught techniques of manipulating the environment to the disadvantage of the assailant, and they should be educated about the various types of rapists, their motivations, and assaultive behavioral patterns.

To date, we know of no such comprehensive training program, but we know that one is possible and must involve the cooperative participation of law enforcement, mental health, and crisis intervention professionals. The more thoroughly researched the variables are, the better they will be understood and the more effectively they could be taught and manipulated to the victim's advantage.

CONCLUSION

Field experts in the area of criminal sexuality have an enormous responsibility to the people they advise in rape resistance. Individuals tend to be fascinated by discussions of criminal sexuality, but they are almost always exceptionably naïve and uninformed. Usually they are looking for an easy solution to a difficult problem and will accept at face value whatever piece of advice is offered.

Advocates who speak at workshops or seminars on rape confrontation techniques have an obligation to refuse to provide an easy solution. They have a further obligation to keep current with the research and to provide information that will help deter rapists. Confrontational advice which considers the three-variables' approach may lack the simplicity and comfort that providing a whistle may offer, but it is a realistic approach to a complex situation that may help a victim understand more appropriate options in dealing with such an encounter. In light of new research, advocates who publicly advise one all-purpose solution to a rape confrontation may well be increasing the risk of injury to potential victims.

Interdisciplinary research is necessary to develop a viable training program for victims confronted by a rapist. Such a program would provide potential victims with information about the various types of rapists and their underlying motivations, would teach potential

victims to assess their abilities to resist and would train them to control the environment to their advantage.

Those who speak publicly on the subject should avoid offering single solutions to their audiences and should start laying the groundwork for a truly effective training program.5

REFERENCES:

A. Nicholas Groth and H. Jean Birnbaum, Men Who Rape (New York, NY: Plenum Publishing Corporation, 1979).

Federal Bureau of Investigation, U.S. Department of Justice; Reprinted from FBI Law Enforcement Bulletin, June, 1986, verbal permission of R.R. Hazelwood, March 9, 1994.

R.R. Hazelwood and A.W. Burgess, eds. Practical Aspects of Rape Investigation: A Multidisciplinary Approach (New York, NY; Elsevier Science Publishing Co., Inc., CRC Press).

R.R. Hazelwood. The Behavioral-oriented Interview of Rape Victims: The Key to Profiling. FBI Law Enforcement Bulletin, vol. 52, No. 9, September 1983, pp. 8-15.

Polygraph As A Supervision Tool

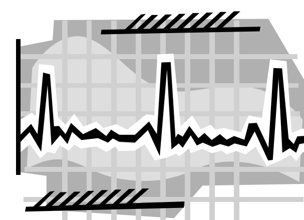
In recent years the use of polygraph to monitor probated and paroled sex offenders has increased due to new techniques and better equipment. The introduction of standardized testing formats and computerized polygraph instruments has brought polygraph out of the dark ages and into the courts.

There have been several testing formats designed specifically for use in the monitoring of convicted sex offenders. These testing formats and procedures were reviewed and approved by the Joint Polygraph Committee on Offender Testing (JPCOT). Below is a listing of the testing formats used to monitor sexual predators.

THE DISCLOSURE TEST ON THE INSTANT OFFENSE

This test is used to break denial. In some cases the convicted sex offender enters group treatment in denial of the offense for which he was convicted. The offender may state that his lawyer told him he better take a plea in his case and avoid a trial that could convict him and place him in prison. The offender states that he did not commit the offense but pled guilty to the case to avoid going to prison. The treatment process is not effective when the offender denies he has a problem. The polygraph test is administered to break denial and prepare the offender for effective counseling and treatment.

SPECIFIC ISSUE EXAMINATION



This test is used to test over a specific issue or event for which the offender has been accused since his release. If the offender is accused of an illegal act or specific re-offense, an investigation is conducted and the information uncovered is used to administer a polygraph examination.

THE DISCLOSURE TEST OVER THE SEXUAL HISTORY

This test is administered early in treatment to obtain an accurate picture of the offender's sexual history. This examination requires the offender to document every sexual episode he has experienced in his life. It covers offense issues as well as personal sexual habits and paraphilias. This information gives the treatment provider a baseline for which to begin treatment with each individual offender.

MONITORING TEST

This test is used to ascertain whether the offender has re-offended since his release. This test covers issues concerning being alone with minors, hanging out at school yards or play-grounds, exposing himself, or actually touching a minor's privates. The offender is given this test on a bi-annual basis to make sure he is complying with treatment.

MAINTENANCE TEST

This test is used to ascertain whether the offender is complying with the conditions of his parole or probation. Parole and probation carry restrictions making it a violation for the offender to consume alcohol or illegal drugs, access the internet, look at pornography or visit sexually oriented businesses. The test is also used to determine if the offender is being honest with his treatment provider and parole or probation officer.

The use of polygraph in these situations requires complete cooperation from the treatment provider and parole or probation officers. If no action is taken by these treatment or super-vision officials when an offender is shown to be deceptive, the polygraph examinations become ineffective. The individual being tested must fear detection before the test is effective. If violations are uncovered and no action is taken, the examinee no longer fears detection and the examination is moot.

The members of the JPCOT feel that it is important to recognize that with any powerful treatment tool there exists a potential for misuse. A critical point of understanding concern-ing the clinical polygraph is that it is a diagnostic tool. The polygraph examination's utility, i.e., its ability to obtain information, is a separate issue from forming diagnostic opinions that are scientifically valid, reliable and defensible. By emphasizing the use of methods with established validity and reliability, the JPCOT guidelines seek to protect examinees, regis-tered sex offender treatment providers, supervision specialists and polygraph examiners.

Civil Suit Remedies

A person who has been harmed by the wrongful conduct of another can bring a lawsuit in the civil court system for a remedy. In most cases, that remedy is monetary damages (e.g., compensation for losses and pain and suffering, reimbursement of medical bills, etc.) In other civil cases, the legal remedy being sought is an order of protection or other type of restraining order.

The most distinctive characteristic of a civil lawsuit is the control the plaintiff has over the action. The plaintiff decides whether or not to bring the lawsuit whereas in a criminal case,

the police can arrest someone for the crime whether the victim wishes the arrest to happen or not. The plaintiff chooses the attorney who will prosecute the case. In most cases, if the plaintiff is unhappy with the attorney representing him or her, the plaintiff can hire another attorney.

For some victims, the civil lawsuit is the only method of obtaining any remedy because the government does not prosecute the case or the defendant is acquitted in the criminal action. Sometimes, the defendant is acquitted in the criminal trial because the higher standard of proof (beyond a reasonable doubt) cannot be met, although the civil standard of proof (preponderance of the evidence) could be met. Sometimes, the government does not do a good job of prosecuting the offender and the victim brings a civil lawsuit in order to have an attorney chosen by the victim prosecute the case. For some victims, the goal is to establish the truth of what happened even if the defendant has no income or assets from which the judgment could be collected.

DECIDING TO FILE A CIVIL CLAIM

Whether or not to commence a civil lawsuit is an important decision for the victim. The process can invade the victim's privacy, cost money for lost time from work, attorneys' fees and litigation costs, force the victim to relive the painful memories repeatedly, and otherwise be painful and inconvenient for the victim. What many victims do not realize is that, during the discovery phase of civil litigation, the plaintiff and defendant are both entitled to compel the other to produce documents, evidence, answer questions, testify at pre-trial proceedings, etc. In some cases, confidential counseling records may become available to the offender and his or her attorney which is a horrifying prospect for most victims.

Any survivor who wishes to institute a civil claim should be well-established in supportive therapy before starting the action. It is not a good idea to start a lawsuit shortly after recovering memories of abuse or acknowledging the issue of abuse in your life.

Cases that are based solely upon her word against his are difficult. Cases with some outside corroboration are more feasible. Outside corroboration can consist of other victim evidence and also corroboration by expert mental health professionals. Expert psychologists and psychiatrists are qualified to evaluate a victim and her history in order to identify patterns of behavior and psychological and somatic (physical) complaints that are typical of victims of sexual assault.

No case can be feasible unless the perpetrator is lawsuit worthy. Theoretical cases with no hope of collecting damages are not handled well by our judicial system and only serve to further disappoint, invalidate and frustrate victims. Cases can be lost for legal reasons that have no bearing on the truth of the allegations or the merits of the claim. Lost cases only serve to further damage victims. Lost cases also send the wrong message to perpetrators. For these reasons most lawyers carefully screen victim recourse cases and only accept those with a good chance of success. When those cases are identified and successful claims are brought, victims can benefit from making their perpetrators financially and morally accountable.

ABUSE BY PROFESSIONALS

Adult victims who have been exploited by medical professionals (i.e., doctors, therapists and psychiatrists) also have a civil remedy. It is fairly well-established that mishandling of the transference/counter-transference phenomenon that arises in therapy is malpractice that is covered by insurance. (St. Paul Fire & Marine Ins. Co. v. Shernow, 222 Conn. 823 (1992).

SECURITY CASES

In some settings, adult victims may have remedies against property owners for failure to provide adequate security. For example, successful suits have been brought against parking lot and garage owners, hotels/motels, private owners of buildings open to the public and apartment building owners.

REFERENCES:

Author unknown. Abuse/Incest Support-Civil Lawsuits Against Offenders. (September 29, 1997). http://www.abuse/library/weekly/aa092997.htm?terms=abuse/incest+support+ civil=lawsuits+pm=112_300_t (November 8, 1999)

Smith, Susan K. (1999) Civil Remedies for Connecticut Victims of Sexual Abuse <http://www.smith-lawfirm.com/RemediesCT.html> (November 8, 1999).

Sexual Assault and Communicable Diseases

Sexual assault survivors are likely to have many health concerns following their assault. One common fear is of contracting a disease from their assailant. The risk of contracting a disease from a single sexual episode is relatively low, however, this does little to alleviate the fear of the survivor and realistically the chance of getting a sexually transmitted disease is always a clear possibility.

THE FACTS ABOUT SEXUALLY TRANSMITTED INFECTIONS (STIS)

STDs are diseases that are passed during sexual contact. Some of the most common STIs include: chlamydia, syphilis, genital herpes, genital warts, gonorrhea, HIV/AIDS and hepatitis B. Hepatitis and HIV/AIDS will be discussed in detail, apart from the other diseases listed above.

Some STIs can make you seriously ill or even kill you. Women are more likely than men to contract many of the STIs because it is easier for germs to get inside a woman's body during sex. Some special health problems for women caused by STIs include: problem pregnancies, pelvic inflammatory disease and a higher risk for cervical cancer.

Some women exhibit physical symptoms of an STI such as: pain during sex, spotting between periods, unusual discharge or vaginal odor, burning during urination, or sores or bumps around the vagina or inner thighs. Unfortunately, many women do not show any sign

of a STI and are therefore left untreated and likely to spread the disease to other partners. The Center for Disease Control (CDC) concludes that more than 12 million cases of sexually transmitted diseases are reported in the United States every year. The CDC offers the following summaries of various STIs.

CHLAMYDIA

Chlamydia is the most common bacterial sexually transmitted disease in the United States. It causes an estimated 4 million infections annually, primarily among adolescents and young adults. In women, untreated infections can progress to involve the upper reproductive tract and may result in serious complications. About 75 percent of women infected with chlamydia have few or no symptoms, and the infection may persist for as long as 15 months without testing and treatment. Without treatment, 20 percent to 40 percent of women with chlamydia may develop pelvic inflammatory disease (PID). An estimated 1 in 10 adolescent girls and 1 in 20 women of reproductive age are infected.

GONORRHEA

Gonorrhea is a common bacterial STI that can be treated with antibiotics. Adolescent females aged 15 to 19 have the highest rates of gonorrhea. An estimated 50 percent of women with gonorrhea have no symptoms. Without early screening and treatment, 10 to 40 percent of women with gonorrhea will develop PID.

PELVIC INFLAMMATORY DISEASE (PID)

PID refers to upper reproductive tract infections in women, which often develop when STIs go untreated or are inadequately treated. Each year, PID and its complications affect more than 750,000 women. PID can cause chronic pelvic pain or harm to the reproductive organs. Permanent damage to the fallopian tubes can result from a single episode of PID and is even more common after a second or third episode. As much as 30 percent of infertility in women may be related to preventable complications of past STIs. One potentially fatal complication of PID is ectopic pregnancy, an abnormal condition that occurs when a fertilized egg implants in a location other than inside a women's uterus—often in a fallopian tube.

HERPES SIMPLEX VIRUS (HSV)

Genital herpes is a disease caused by herpes simplex virus (HSV). The disease may recur periodically and has no cure. Scientists have estimated that about 30 million persons in the United States may have genital HSV infection. Most infected persons never recognize the symptoms of genital herpes; some will have symptoms shortly after infection and never again. A minority of those infected will have recurrent episodes of genital sores. Many cases of genital herpes are acquired from people who do not know they are infected or who had no symptoms at the time of sexual contact.

HUMAN PAPILLOMAVIRUS (HPV)

HPV is a virus that sometimes causes genital warts but in many causes infects people without causing noticeable symptoms. Concern about HPV has increased in recent years

after several studies showed that HPV infection is associated with the development of cervical cancer. Approximately 25 types of HPV can infect the genital area. These types are divided into high risk and low risk groups based on whether they are associated with cancer. Infection with a high risk type of HPV is one risk factor for cervical cancer, which causes 4,500 deaths among women each year. No cure for HPV infection exists.

SYPHILIS

Syphilis is a bacterial infection that can be cured with antibiotics. Syphilis cases increased dramatically from 1985 to 1990 among women of all ages. Rates among females were more than twice as high as rates among males in the 15 to 19 age group. African-American women have syphilis rates that are 7 times greater than the female population as a whole. More than 3000 cases of congenial syphilis were reported in 1993. Death of the fetus or newborn infant occurs in up to 40 percent of pregnant women who have untreated syphilis.

STI	WHAT TO WATCH FOR	HOW DO YOU GET THIS STI?	WHAT HAPPENS IF YOU DO NOT GET TREATED?
CHLAMYDIA OR NGU	Symptoms show up 7-21 days after having sex. Most women and some men have no symptoms. **Women:** Discharge from the vagina. Bleeding from the vagina. Burning or pain when you urinate. Pain in abdomen, some-times with fever and nausea. **Men:** Watery, white or yellow drip from penis. Burning or pain when you urinate.	Spread during vaginal, anal and oral sex with someone who has chlamydia or NGU.	You can give chlamydia or NGU to your sexual partner(s). Can lead to more serious infection. Reproductive organs can be damaged. Both men and women may no longer be able to have children. A mother with chlamydia can give it to her baby during childbirth.

GENITAL WARTS	Symptoms show up 1-8 months after contact with HPV, the virus that causes genital warts. Small, bumpy warts on the sex organs and anus. Itching or burning around the sex organs. After warts go away, the virus stays in the body. The warts can come back.	Spread during vaginal, anal and oral sex with someone who has genital warts.	You can give genital warts to your sexual partner(s). Warts may go away on their own, remain unchanged, or grow and spread. A mother with warts can give them to her baby during childbirth.
GONORRHEA	Symptoms show up 2-21 days after having sex. Most women and some men have no symptoms. **Women:** Thick yellow or white discharge from the vagina. Burning or pain when you urinate or have a bowel movement. Abnormal periods or bleeding between periods. Cramps and pain in the lower abdomen (belly). **Men:** Thick yellow or white drip from the penis. Burning or pain when you urinate or have a bowel movement. Need to urinate more often.	Spread during vaginal, anal and oral sex with someone who has gonorrhea.	You can give gonorrhea to your sexual partner(s). Can lead to more serious infection. Reproductive organs can be damaged. Both men and women may no longer be able to have children. A mother with gonorrhea can give it to her baby during childbirth. Can cause heart trouble, skin disease, arthritis and blindness.

HERPES	Symptoms show up 1 to 30 days after having sex. Some people have no symptoms. Flu-like feelings. Small, painful blisters on the sex organs or mouth. Itching or burning before the blisters appear. Blisters last 1 to 3 weeks. Blisters go away, but the disease remains. Blisters can come back.	Spread during vaginal, anal and oral sex with someone who has herpes.	You can give herpes to your sexual partner(s). Herpes cannot be cured. A mother with herpes can give it to her baby during childbirth.
SYPHILIS	**1st Stage:** Symptoms show up 3 to 12 weeks after having sex. A painless, reddish-brown sore or sores on the mouth, sex organs, breasts or fingers. Sores last 1-5 weeks. Sores go away, but remains syphilis. **2nd Stage:** Symptoms show up 1 week to 6 months after sore heals. A rash anywhere on the body. Flu-like feelings. Rash and flu-like feelings go away, but you still have syphilis.	Spread during vaginal, anal and oral sex with someone who has syphilis.	You can give syphilis to your sexual partner(s). A mother with syphilis can give it to her baby during pregnancy or have a miscarriage. Can cause heart disease, brain damage, blindness and death.

VAGINITIS	Some women have no symptoms. Itching, burning or pain in the vagina. More discharge from the vagina than normal. Discharge smells and/or looks different.	Can be spread during vaginal, anal and oral sex. Men can carry vaginitis infections without symptoms.	You can give vaginitis infections to your sexual partner(s). Uncomfortable symptoms will continue. Men can get infections in the penis, prostate gland or urethra.

HEPATITIS

Hepatitis is generally identified as A, B, or C. Hepatitis B (HBV) is the most likely strain to be spread through sexual contact. Hepatitis B is one of the most common, serious infectious diseases in the world, however, it can be prevented with a safe and effective vaccine. Hepatitis B is 100 times more infectious than the AIDS virus. One out of 20 people in the United States has been infected with Hepatitis B. Each year 300,000 new people will become infected with HBV.

HBV is found in body fluids such as blood, semen and vaginal secretions. Hepatitis B is known as the "Silent Infection" because carriers of HBV may not become noticeably sick and may not realize they have the disease. Whether they have symptoms or not, they can pass the virus onto others. Hepatitis B is so contagious that it is advised that you do not share personal items such as toothbrushes, nail clippers, pierced earrings, or razor with a carrier. **The ABCs of Viral HEPATITIS**

	HEPATITIS A (HAV)	**HEPATITIS B (HBV)**	**HEPATITIS C (HCV)**
What is it?	HAV is a virus that causes inflammation of the liver. It does not lead to chronic diseases.	HBV is a virus that causes inflammation of the liver. The virus can cause liver cell damage, leading to cirrhosis and cancer.	HCV is a virus that causes inflammation of the liver. This infection can lead to cirrhosis and cancer.
Incubation period (time from exposure to illness)	15 to 50 days. Average 30 days.	4 to 25 weeks. Average 8 to 12 weeks.	2 to 25 weeks. Average 7 to 9 weeks.

How is it spread?	Transmitted by fecal/oral route, through close person to person contact (changing diapers with-out good handwashing), anal-oral sex, or ingestion of contam-inated food and water.	Contact with infected blood, seminal fluid, vaginal secretions, contaminated needles, including tattoo/body-piercing tools, infected mother to newborn, human bite, sexual contact.	Contact with infected blood, contaminated IV needles, razors and tattoo/body piercing tools, infected mother to newborn. NOT easily spread through sex.
Symptoms	May have none, espec-ially young children. Symptoms may include light stools, dark urine, fatigue, fever and jaundice (yellow skin). Jaundice by age group < 6 yrs.: < 10% 6-14 yrs.: 40-50% > 14 yrs.: 70-80%	May have none, especially young children. Some persons have mild flu-like symptoms, dark urine, light stools, jaundice, fatigue and fever. Jaundice by age groups: < 5 yrs.: < 10% > 5 yrs.: 30-50%	It has symptoms, similar as with HBV. Between 30% with acute HCV develop symptoms and 20 to 30% develop jaundice.
Percent who develop chronic disease	None	Varies by age of onset of infection. < 5 yrs.: 30-90% > 5 yrs.: 2-10%	75%-85%

HIV/AIDS ?

Over the past ten years, the human immunodeficiency virus, the causative agent of AIDS, has reached epidemic proportions in America and around the world. It is estimated that, in the near future, everyone in America will have been touched by the AIDS epidemic in some form or fashion.

One of the most frightening and life threatening problems associated with the epidemic is the possibility that the virus can be transmitted to a victim during an act of sexual assault. Victims of sexual assault often spend many years, or even a lifetime, trying to recover from such physical and psychological traumatization. Moreover, the trauma is magnified and prolonged by the fear of contracting AIDS as a result of the attack.

HIV TESTING FOR DEFENDANTS:

Over the past several years an increasing number of sexual assault survivors are requesting that perpetrators be tested for HIV/AIDS. Texas law allows for testing of adult defendants and juvenile respondents.

Article 21.31 of the Texas Code of Criminal Procedure grants the court the power to order, either on its own motion or on the request of the victim of the alleged offense, that an adult defendant, who has been indicted under Texas Penal Code §22.11(a)(1) indecency with a child (by sexual contact), §22.0112 sexual assault, or §22.021 aggravated sexual assault, undergo a medical procedure or test to show or help show whether the defendant has a sexually transmitted diseases or has HIV or AIDS. The Texas Family Code §54.033 gives the court the same power with a juvenile who has been adjudicated and found to have committed an offense under the same Penal Code statutes. The test results may be disclosed to the survivor and the defendant or juvenile.

HIV POSTEXPOSURE PREVENTION

Post exposure prevention (PEP) is the use of antiretroviral medications as a prophylaxis in reducing a person's risk for acquiring HIV infection after exposure, unlike a vaccine, which prevents future exposures.

It is perceived that there is a window of opportunity where the HIV virus can be killed before the immune system carries the virus to the lymph nodes, where it starts to multiply. Viral replication is believed to occur within 3 to 5 days after exposure.

PEP must start before a person tests positive and before HIV is detected on a blood viral load test. The term viral load is usually used to describe the amount of HIV in a sample of blood. This is measured using tests called quantitative PCR or branched chain DNA. There are now several different tests or assays, some made commercially and others prepared by local laboratories.

CENTERS FOR DISEASE CONTROL AND PREVENTION (CDC) RECOMMENDED USE OF PEP:

- Occupational exposures of health care workers
- One isolated study states that using PEP was 81 percent effective in preventing HIV infection in health care workers.
- Perinatal transmission
- HIV antiretroviral treatment with pregnant HIV positive women and newborns has over a 68 percent success rate in preventing perinatal transmission.
- Unanticipated sexual or drug injection-related exposures to HIV

WHAT IS THE PROBABILITY OF HIV TRANSMISSION FROM ONE EXPOSURE?

- Blood transfusions-95%
- Intravenous needle exposure-67%

- Needlestick 4%
- Receptive penile-anal sexual exposure 1%–3%
- Receptive vaginal exposure 1%–2%
- Receptive oral sex- statistics are not available

PEP Treatment Protocol:

- AZT (Zidovudine) 200 mg t.i.d. for four weeks
- 3TC (Combivir) 150 mg b.i.d. for four weeks
- Optional additional treatment IDV (Indinavir) 800 mg every eight hours

Side Effects:

- Anemia, nausea, fatigue, malaise, headache, insomnia, asthenia, abdominal pain, diarrhea, pancreatitis, elevated liver function, hyperglycemia and diabetes. Most side effects are reversed when PEP is discontinued.
- Some drugs used may inhibit the metabolism of other drugs clients are taking and may make their use ineffective such as oral contraceptives.
- Due to side effects statistics for health care workers who start PEP treatment show that 30 to 50 percent discontinue treatment.
- Rates of effectiveness based on the number of hours PEP is started after possible HIV exposure: within one hour, 24 hours, or 72 hours. **Beyond 72 hours PEP is not considered as a preventive treatment.**

Follow-up should include:

- Counseling
- Medical evaluation
- Postexposure HIV antibody testing—baseline, 6 weeks, 12 weeks, and 6 months
- Post exposure prophylaxis toxicity monitoring should include a complete blood count, renal & hepatic chemical function tests, and monitoring for anemia and hepatitis before initial treatment and 2 weeks later.

Cost of Medication & Treatment: $1300 to $1700

- Who is going to provide and pay for treatment and follow up?
- How many victims have a primary care physician?
- If the victim has medical insurance, will the insurance cover HIV postexposure treatment?

What is the medical status of the rape victim when he/she arrives in the emergency room and requests a rape exam?

- When was the rape reported?
- HIV status of the perpetrator?
- Number of exposures? Were there multiple exposures over an extended period of time?