**TOPIC: Counterintuitive Behaviors in Response to Domestic Violence / Rape**

**Test of an argumentative skill deficiency model of interspousal violence.**

Infante, Dominic A., and Teresa A.

Communication Monographs, Vol 56(2), Jun, 1989. pp. 163-177.

**Abstract:**

A model of interpersonal physical violence is derived from the aggression literature and then is utilized to investigate interspousal violence. The model posits that verbal aggression is a catalyst to violence when societal, personal, and situational factors are strong enough to produce a hostile predisposition. Unless aroused by verbal aggression, a hostile disposition remains latent in the form of unexpressed anger. The framework suggests that persons in violent marriages are more verbally aggressive than other people, and also produces the counterintuitive prediction that violent spouses are less argumentative than people in nonviolent marriages. A study is reported that compared 113 clinical cases of abused wives and abusive husbands to a nonclinical population of 162 husbands and wives. Strong support for the hypothesis was observed. Implications are discussed in terms of understanding communication in violent marriages.

**Rape perceptions, gender role attitudes, and victim-perpetrator acquaintance.**

Ben-David, Sarah.

Sex Roles: A Journal of Research, Vol 53(5-6), Sep, 2005. pp. 385-399.

**Abstract:**

The connection between rape perceptions, gender role attitudes, and victim-perpetrator acquaintance was examined. One hundred fifty Israeli students rated their perceptions of the victim, the perpetrator, the situation, and the appropriate punishment, after reading scenarios in which rape was committed by a neighbor, an ex-boyfriend, and a current life partner. Significant negative correlations were found between gender-role attitudes and four measures of rape perceptions. 'Traditionals' minimized the severity of all rapes more than 'Egalitarians' did. As the acquaintance level increased, there was a greater tendency to minimize the severity of the rape, in the perceptionsof the victim, the situation, and the punishment; the situation was characterized less as rape, and was perceived as less violating of the victim's rights and less psychologically damaging. Women tended to have more egalitarian attitudes than men did, and women were less likely to minimize the severity of the rape in the measures of perceptions of the situation and the appropriate punishment.

**Rape trauma experts in the courtroom.**

Boeschen, Laura E..

Psychology, Public Policy, and Law, Vol 4(1-2), Mar-Jun, 1998. Special Issue: Sex Offenders: Scientific, Legal, and Policy Perspectives. pp. 414-432.

**Abstract:**

This article analyzes the scientific legitimacy of using expert testimony relating to psychological sequelae of rapevictimization in the courtroom and attempts to determine boundaries within which such testimony should remain to respect the limitations of current knowledge. Descriptions of the rape-related diagnoses currently used in experttestimony are followed by a discussion of the problematic issues associated with using rape trauma syndrome in the courtroom and a review of the validity and reliability issues associated with diagnosing posttraumatic stress disorder in forensic settings. The authors consider the scientific appropriateness of admitting different levels of rape experttestimony on the basis of the limitations of the scientific knowledge discussed.

**Rape trauma syndrome.**

Burgess, Ann W. and Holmstrom, Lynda L.

The American Journal of Psychiatry, Vol 131(9), Sep, 1974. pp. 981-986.

**Abstract:**

Interviewed and followed 146 patients admitted during a 1-yr period to the emergency ward of a city hospital with a presenting complaint of having been raped. Based upon an analysis of the 92 adult women rape victims in the sample, existence of a rape trauma syndrome is documented, and its symptomatology as well as that of 2 variations, compounded reaction and silent reaction, is delineated. Specific therapeutic techniques are required for each of these 3 reactions. Crisis intervention counseling is effective with typical rape trauma syndrome; additional professional help is needed in the case of compounded reaction; and the silent rape reaction means that the clinician must be alert to indications of the possibility of rape having occurred even when the patient never mentions such an attack.

**The effects of sexual assault on rape and attempted rape victims.**

Becker, Judith V.

Victimology, Vol 7(1-4), 1982. pp. 106-113.

**Abstract:**

Interviewed 20 completed rape and 20 attempted rape victims (aged 15–64 yrs) to compare and evaluate the immediate and long-term (1 yr postassault) impact of a sexual assault on these types of victims. Results indicate that attempted rape victims did not differ significantly from completed rape victims in their immediate and long-term response to a sexual assault. Both categories of victims experienced the rape trauma syndrome and had similar long-term reactions. It is concluded that attempted rape and completed rape victims have similar treatment needs and that counseling for their trauma should be available for both short- and long-term problems subsequent to a sexual assault.

**Rape trauma syndrome.**

Burgess, Ann W.

Behavioral Sciences & the Law, Vol 1(3), Sum 1983. pp. 97-113.

**Abstract:**

Discusses the relationship of rape trauma syndrome to the official diagnostic nomenclature of Post-Traumatic Stress Disorder in the DSM-III. The rape trauma syndrome is divided into 2 phases that can disrupt the physical, psychological, social, or sexual aspects of a victim's life. The acute or disruptive phase can last from days to weeks and is characterized by general stress response symptoms. During the 2nd phase—the long-term process of reorganization—the victim has the recovery task of restoring order to his/her lifestyle and reestablishing a sense of control in the world. This phase is characterized by rape-related symptoms and can last from months to years. Theoretical and practical clinical issues involved in rape trauma are reviewed as well as the early court rulings on the admissibility of rape trauma syndrome in criminal and civil cases.

**Sexual assault trauma and trauma change.**

Ruch, Libby O. and Leon, Joseph J.

Women & Health, Vol 8(4), Win 1983. pp. 5-21.

**Abstract:**

Presents an exploratory model of variables affecting level of sexual-assault trauma at given times and change in trauma levels over time. The model was tested using a sample of 166 female rape victims admitted to a treatment center over a 2-yr period. Based on a 1-way ANOVA and multiple classification analysis, findings indicate that a previous rape best explained trauma change, while victim's demographics, social supports, and other prior life stress variables were important at specific time periods during the rape trauma syndrome. Treatment-related issues are discussed. Moderately traumatized victims at intake tended to remain in the same category over time (steady-state), initially severely traumatized victims decreased with time (crisis pattern), and mildy traumatized victims became more highly traumatized by follow-up (delayed response) or stayed the same (steady-state). Contrary to predictions, Ss who had been victimized before became more severely traumatized within 2 wks.

***State v. Marks*: An analysis of expert testimony on rape trauma syndrome.**

Bristow, Ann R..

Victimology, Vol 9(2), 1984. pp. 273-281.

**Abstract:**

In 1982 the Supreme Court of Kansas handed down a decision establishing the admissibility of expert testimony on rape trauma syndrome (RTS). *State* v. *Marks* (1982) and federal guidelines for admission of expert testimony are reviewed. Judicial evaluation of the scientific respectability of research on sexual and physical trauma is addressed, and a brief review of methodologies to assess RTS is provided. Issues discussed with regard to expert testimony in RTS include (1) relevant case law of the successful/unsuccessful use of expert testimony on the battered woman syndrome, (2) aspects of the victim's history, (3) effects of repeated courtroom examination on the victim, and (4) 'clinicalization' of the problem of rape.

**The admissibility of expert testimony on rape trauma syndrome.**

Lauderdale, Helen J.

Journal of Criminal Law & Criminology, Vol 75(4), Win 1984. pp. 1366-1416.

**Abstract:**

Argues that expert testimony on rape trauma syndrome should be admissible in rape trials in which the complainant's consent is at issue. The testimony provides highly relevant information on the complainant's emotional state following the alleged rape. The experts providing information can be trained and experienced observers of postrape emotional and psychological states and, therefore, are qualified to assist jurors in understanding the significance of a rape complainant's emotional and psychological state.

**Rape trauma syndrome evidence in court.**

Frazier, Patricia and Borgida, Eugene

American Psychologist, Vol 40(9), Sep, 1985. pp. 984-993.

Abstract:

Assesses the current psycholegal status of rape trauma syndrome evidence in the context of (1) a description of the syndrome, (2) a review of pertinent case law, and (3) an examination of the evidence in light of 3 criteria for the admission of expert testimony (scientific status, helpfulness to the jury, and potential prejudicial impact). Research issues pertaining to the admissibility of rape trauma syndrome evidence are also raised. Thus far, in several decisions, the scientific reliability of the syndrome has not been challenged.

**Maladaptive responses during the reorganization phase of rape trauma syndrome.**

Waigandt, C. Alex and Miller, Deborah A.

Response to the Victimization of Women & Children, Vol 9(2), 1986. pp. 20-21.

**Abstract:**

Studied the long-term health effects of sexual assault on women via questionnaires completed by 51 victims (divided into reorganized and disorganized groups) and 74 nonvictims. Ss' responses on the Cornell Medical Index Health Questionnaire by O. Buros (1972) reveal more health problems and negative health behaviors among disorganized victims than among reorganized victims and nonvictims. Implications for health professionals working with rapevictims are discussed.

**The male rape victim.**

Calderwood, Deryck.

Medical Aspects of Human Sexuality, Vol 21(5), May, 1987. pp. 53-55.

**Abstract:**

Suggests that problems in treating the male rape victim include the reluctance of many men to report sexual assault, lack of facilities for helping men, and lack of knowledge about the phenomenon. Most male rape is by other men, and males often sustain more injuries than do females. Three phases in the rape trauma syndrome are discussed: acute, reorganization, and latent.

**Sexual abuse: Somatic and emotional reactions.**

Rimsza, Mary E.; Berg, Robert A., and Locke, Catherine

Child Abuse & Neglect, Vol 12(2), 1988. pp. 201-208.

**Abstract:**

Conducted a chart review of 72 sexual abuse (SA) victims and interviewed the mother or primary caretaker of 26 of the victims to determine if young victims of SA suffer from symptoms similar to the rape trauma syndrome reported in adults. Ss were aged 1–18 yrs. Similar symptoms were found in 48 of the 72 abused children and only 26 of a matched unabused control group. Common somatic complaints in the SA patients included dysuria, vaginal discharge, and chronic abdominal pain. Some of the emotional and behavioral problems noted during the follow-up period among the SA patients included sleep problems, runaway behavior, and suicide attempts. The duration of SA and age of the victim at the time of SA significantly affected the frequency of reported somatic symptoms, but the type of abuse and type of assailant did not significantly affect the frequency of reported somatic and emotional reactions.

**Juror common understanding and the admissibility of rape trauma syndrome evidence in court.**

Frazier, Patricia and Borgida, Eugene

**Abstract:**

Administered a sexual assault questionnaire to 22 experts on rape and posttraumatic stress disorder (PTSD) and 2 nonexpert comparison groups (87 undergraduates and 55 nonacademic university employees). Results indicate that the nonexperts were not well informed on many rape-related issues and were significantly less knowledgeable than the expert groups. Data also show consensus among the experts about the current scientific database on rapetrauma. Findings suggest that expert psychological testimony on rape trauma syndrome could be helpful in educating jurors about rape and rape victim behavior. A review of case law is included, which focuses on cases in which rape trauma syndrome evidence is used to corroborate a victim's claim that an act of intercourse was not consensual.

**Rape trauma syndrome: Is it probative of lack of consent?**

Graham, Ernest S.

Law & Psychology Review, Vol 13, Spr 1989. pp. 25-42.

**Abstract:**

Argues that research on the rape trauma syndrome is not probative of consent to prior sexual intercourse, and cannot be used in courtroom settings to corroborate an alleged victim's accusation that prior sexual intercourse with a defendant was nonconsensual. The question of the admissibility of rape trauma syndrome is discussed in terms of 3 facts examined in research (consent, prior trauma, and the cause of the alleged victim's current behavior). Analysis of these facts involves the distinction between structural and functional analyses and between experimental and correlational research designs.

**Rape trauma syndrome as scientific expert testimony.**

Block, Alan P.. Pretty, Schroeder

Archives of Sexual Behavior, Vol 19(4), Aug, 1990. pp. 309-323.

**Abstract:**

Suggests that rape trauma syndrome can help corroborate the victim's assertion of lack of consent and also help the jury understand the typical reactions of rape victims. Courts have held that expert testimony of rape trauma syndrome is admissible as evidence of lack of consent, damages in civil suits, a defense to culpable behavior, and an explanation for behavior of the victim that is inconsistent with the claim of rape. Rape trauma syndrome should be admissible if (1) the evidence presented only shows the typical reactions to rape and does not make any legal conclusions as to whether the victim was raped, (2) the expert is qualified, (3) a proper foundation is laid, (4) liberal cross-examination of the expert is allowed, and (5) the defense can introduce its own expert testimony on rapetrauma syndrome.

**Rape trauma syndrome: A review of case law and psychological research.**

Frazier, Patricia A.

Law and Human Behavior, Vol 16(3), Jun, 1992. pp. 293-311.

**Abstract:**

Reviews recent case law on the admissibility of rape trauma syndrome (RTS) evidence and psychological research relevant to concerns raised about its scientific reliability, helpfulness, and prejudicial impact. Results indicate that (1) specific concerns raised by the courts about the reliability of RTS evidence may not be warranted, (2) expert testimony on RTS could be helpful in educating jurors, and (3) expert testimony on RTS does appear to exert some influence on jury decision making in rape trials, but does not appear to unfairly prejudice the defendant.

**Immediate coping strategies among rape victims.**

Frazier, Patricia A. and Burnett, Jeffery W.

Journal of Counseling & Development, Vol 72(6), Jul-Aug, 1994. pp. 633-639.

**Abstract:**

67 rape victims (mean age 27 yrs) seen at an ER completed the Beck Depression Inventory; Symptom Checklist 90-R (SCL-90); and measures of coping strategies, social support, and positive life changes resulting from the rape. Rape trauma nurses and Ss' sisters were most supportive; male friends and boyfriends were least supportive. Coping strategies were most often behavioral. Taking precautions and thinking positively were frequent coping strategies. Expressing feelings, seeking social support, counseling, and keeping busy were most often found helpful. Staying home and withdrawing were associated with higher symptom levels; keeping busy, thinking positively, and suppressing negative thoughts were associated with lower symptom levels. Coping strategies that are emotion rather than problem focused and that are approach rather than avoidance focused appear most helpful.

**Rape trauma syndrome in the military courts.**

Young, Stephen A.

Bulletin of the American Academy of Psychiatry & the Law, Vol 23(4), 1995. pp. 563-571.

**Abstract:**

Indicates that the military courts have developed a rich case law tradition in the area of rape trauma syndrome testimony. These cases are particularly important in the context of a military that is both increasingly female and increasingly sensitive to mixed gender relationships. The military court's approach to rape trauma testimony over the past 15 yrs is reviewed. The approach to testimony at one military medical center is analyzed and a testimony model for the forensic psychiatrist who testifies in a military setting is offered.

**Rape trauma experts in the courtroom.**

Boeschen, Laura E. and Koss, Mary P.

Psychology, Public Policy, and Law, Vol 4(1-2), Mar-Jun, 1998. Special Issue: Sex Offenders: Scientific, Legal, and Policy Perspectives. pp. 414-432.

**Abstract:**

This article analyzes the scientific legitimacy of using expert testimony relating to psychological sequelae of rape victimization in the courtroom and attempts to determine boundaries within which such testimony should remain to respect the limitations of current knowledge. Descriptions of the rape-related diagnoses currently used in expert testimony are followed by a discussion of the problematic issues associated with using rape trauma syndrome in the courtroom and a review of the validity and reliability issues associated with diagnosing posttraumatic stress disorder in forensic settings. The authors consider the scientific appropriateness of admitting different levels of rape expert testimony on the basis of the limitations of the scientific knowledge discussed.

**Reactions to rape: A military forensic psychiatrist's perspective.**

Ritchie, Elspeth Cameron.

Military Medicine, Vol 163(8), Aug, 1998. pp. 505-509.

**Abstract:**

Discusses rape allegations in the military legal system from a psychiatric perspective. The original definition of 'rape trauma syndrome' and subsequent psychiatric thinking about the diagnosis are briefly outlined. Common reactions seen in military victims in this era are described. A prototypical military case is presented. An adequate evaluation of an alleged victim is outlined. Credentials and preparation of an expert witness are also briefly discussed, with cautions about the use of expert testimony in cases of alleged sexual assault and rape trauma syndrome.

**Predictors** of **PTSD** **symptom** **severity** and **social** reactions in sexual assault victims.

Ullman, Sarah E. and Filipas, Henrietta H.

Journal of Traumatic Stress, Vol 14(2), Apr, 2001. pp. 369-389.

**Abstract:**

Demographics, assault variables, and postassault responses were analyzed as correlates of posttraumatic stress disorder (PTSD) symptom severity in 323 female sexual assault victims (aged 18+ yrs). Regression analyses indicate th t less education, greater perceived life threat, and receipt of more negative social reactions upon disclosing assault were each related to greater PTSD symptom severity. Ethnic minority victims reported more negative social reactions from others. Victims of more severe sexual victimization reported fewer positive, but more negative reactions from others. Greater extent of disclosure of the assault was related to more positive and fewer negative social reactions. Telling more persons about the assault was related to more negative and positive reactions. Implications of these results for developing contextual theoretical models of rape-related PTSD are discussed.

**The utility of the expert witness in a rape case: Reconsidering rape trauma syndrome.**

McGowan, Mila Green BS Helms, Jeffrey L.

Journal of Forensic Psychology Practice, Vol 3(1), 2003. pp. 51-60.

**Abstract:**

The role of the expert witness in rape cases has been problematic for the courts and profession of psychology for some time. One of the issues that has compounded this problem is the diagnostic nomenclature regarding Rage Trauma Syndrome (RTS) and its differentiation from Post-Traumatic Stress Disorder (PTSD). This article summarizes the issues surrounding the use of RTS in expert testimony. It concludes that separating RTS diagnostically from PTSD has utility for the expert as well as for the accurate portrayal of the common sequelae of rape.

**Rape trauma syndrome: An examination of standards that determine the admissibility of expert witness testimony.**

Biggers, Jacquelyne R., and Yim, Chong I.

Journal of Forensic Psychology Practice, Vol 3(1), 2003. pp. 61-77.

Abstract:

Specialized literature on women's reactions to rape was virtually non-existent before the emergence of the women's movement in the early 1970s. By speaking out publicly, however, advocates of the civil rights reform compelled the conception of rape trauma syndrome and a proliferation of research regarding the psychological reactions of rapetrauma victims. This growth of psychological knowledge regarding the reaction of rape victims forced the courts to reexamine the standards relating to the admission of expert testimony as developed in the case Frye v. United States. As a result of this reexamination, courts have relied upon opposing standards of proof to determine the admissibility of rape trauma evidence such as those developed in section 403 and 702 of the Federal Rules of Evidence and those outlined in the case of Daubert v. Merrell Dow Pharmaceuticals, Inc. The purpose of this paper is to examine rapetrauma syndrome as it is commonly understood by both the psychological community and the judicial system and to assess its applicability to the admissibility of expert testimony.

**Was It Rape? The Function of Women's Rape Myth: Acceptance and Definitions of Sex in Labeling Their Own Experiences.**

Peterson, Zoë D., and Muehlenhard, Charlene L.

Sex Roles: A Journal of Research, Vol 51(3-4), 2004. pp. 129-144.

**Abstract:**

In a phenomenon called unacknowledged rape, many rape victims do not label their experience 'rape.' Does their level of rape myth acceptance influence this labeling process? In this study, 86 college women whose experience met the legal definition of rape described their experience, indicated how they labeled it, and completed the Illinois Rape Myth Acceptance Scale. Logistic regressions indicated that, for 2 rape myths (e.g., if women don't fight back, it's not rape), women who accepted the myth and whose experience corresponded to the myth (e.g., they did not fight back) were less likely than other women to acknowledge their experience as rape. Women were also unlikely to acknowledge rape when they did not label the nonconsensual sexual behavior 'sex.'

**Rape trauma syndrome.**

Tannura, Tammi A.

American Journal of Sexuality Education, Vol 9(2), Apr, 2014. pp. 247-256.

**Abstract:**

When the topic of sexual assault is presented in high school and college health courses, it is mostly from a prevention perspective. Rarely do such courses include the mental and emotional health issues suffered by the rape survivor. Knowledge about rape trauma syndrome helps significant people in the victim's life understand the full range of reactions to the traumatic experience of rape. This lesson describes survivors’ behaviors and reactions after a rape, otherwise known as rape trauma syndrome. Included in this lesson is the federal definition of rape, a summary of rape trauma syndrome, lyrics to a song with relevant applications to the phases of rape trauma syndrome, and a rubric for grading a reaction paper related to the lesson. Three National Health Education Standards are addressed via the lesson as well.

**Examining the scientific validity of rape trauma syndrome.**

O'Donohue, William, et. al.

Psychiatry, Psychology and Law, Vol 21(6), Nov, 2014. pp. 858-876.

Abstract:

Rape trauma syndrome (RTS) was first described by Burgess and Holmstrom (1974) who argued that there was little information that described the physical and psychological effects of rape, associated therapy and provisions for protection of the victim from further psychological harm. Since then, there have been several critiques of RTS and empirical evidence exists that RTS is not generally accepted by the relevant scientific community. Despite this, RTS is still used in courts. As such, in this article, we comprehensively evaluated RTS and determined that it is vague and imprecise, its evidential status is questionable, it is inconsistent with the most common sequelae of trauma, it ignores important mediating variables and it may not be culturally sensitive. In light of these critiques, we recommend no further use of this model in courts or in clinical practice.