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PTSD, RTS, and Child Abuse Accommodation Syndrome: Therapeutic Tools or Fact-Finding Aids

Donna A. Gaffney, RN, DNSc, FAAN*

I know my head isn't screwed on straight. . . . I want to confess everything, hand over the guilt and mistake and anger to someone else. There is a beast in my gut, I can hear it scraping away at the inside of my ribs. Even if I dump the memory, it will stay with me, staining me. My closet is a good thing, a quiet place that helps me hold these thoughts inside my head where no one can hear them.¹

Introduction

The words of Laurie Halse Anderson, author of *Speak*, are especially appropriate for this discussion. It is the story of a ninth grader who is sexually assaulted at an underage drinking party in her community.² The author eloquently captures the psychological experience of the sexual assault survivor—the feelings of isolation, guilt, anger and pain. It is entitled *Speak* because that is what the protagonist cannot do, she cannot talk about her experience.³ Before I discuss how sexual assault traumatizes an individual, it is important to understand some basic terminology.

The terms “traumatized,” “in crisis” and “stressed” are often used interchangeably in everyday language. However trauma, stress and crisis, although related, have vastly different effects on the human experience. Researcher Rachel Yehuda describes how trauma and stress differ from each other:

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1. LAURIE HALSE ANDERSON, *SPEAK* 51 (2001).

2. *See id.* at 198.

3. *See generally id.*

- The effects of stress are alleviated when the stressor is removed.
- Traumatic events are more extreme versions of stressful events.
- The effects of the traumatic events continue well after the events have passed.
- Memory of the traumatic event lingers on, with continued arousal.⁴

Crisis is described as a threat to homeostasis, a temporary disruption of coping and problem-solving skills, but does not necessarily present a life-threatening experience.⁵ Crises very often represent a turning point, and can be developmental or situational in nature.⁶

Considering these characteristics, one can understand that sexual assault clearly falls into the category of a traumatic event rather than a crisis or stressful event. However, stress and crisis are also present. The assault itself is the life-threatening traumatic event. The consequences of that assault, going to the hospital, starting therapy or going to court, represents ongoing stressful events and crises. The emotions that are evoked by the assault, the trauma, last long after the event is over. The fear of death and the terror and helplessness experienced during the assault persist even when one is out of harm's way.⁷ The stress of going to the hospital for care may leave one frustrated, anxious or angry, but once the survivor leaves the hospital those emotions tend to subside.⁸ In other words, when a stress is eliminated, all physical and psychological reactions disappear along with it. Emotions and memories of traumatic events, by contrast, linger on. The sound of the perpetrator's voice, breaking glass or other sights and sounds accompanying the assault may intrude into daytime consciousness or night-

4. Rachel Yehuda, *Discrepancy Between Theory, Research and Practice*, Conference Presentation at the Mt. Sinai Medical Center (Sept. 1999).

5. GERALD CAPLAN, *PRINCIPLES OF PREVENTIVE PSYCHIATRY* 39 (1964).

6. *Id.* at 34-35.

7. EDNA B. FOA & BARBARA OLASOV ROTHBAUM, *TREATING THE TRAUMA OF RAPE* 72 (1998).

8. See generally Ann Wolbert Burgess & Lynda Lytle Holstrom, *Rape: Sexual Disruption and Recovery*, 49 AM. J. ORTHOPSYCHIATRY 648 (1979); Rebecca Campbell & Sheela Raja, *Secondary Victimization of Rape Victims: Insights From Mental Health Professionals Who Treat Survivors of Violence*, 14 VIOLENCE & VICTIMS 261, 262-63 (1999).

mares, unbidden but present just the same.⁹ People often continue to experience a sense of hyper-alertness similar to what was felt in those first moments after a traumatic event.¹⁰ Trauma encompasses every aspect of one's being. The physical responses persist, and in some cases, as with Posttraumatic Stress Disorder, individuals may never fully recover.

Human responses to stressful events or traumatic events can vary. There is a constellation of body and brain reactions to a traumatic event that are normal responses to threat. These are often called peri-traumatic or posttraumatic responses. However, in some situations the traumatic event and the individual's response to it cause long term dysfunction in cognition and affect. This is when Posttraumatic Stress Disorder may be identified.¹¹

One of the most important areas of ongoing research and understanding concerns the impact of trauma in general and sexual trauma in particular on brain structure and function. The next section will examine the neurophysiology of the post-traumatic response.

The Impact of Traumatic Events on the Structure and Function of the Human Brain

The seat of intellectual functioning that distinguishes human beings from all other species is the cerebral cortex. It is the largest part of the brain and possesses higher cognitive functioning; the place where information is processed with accuracy and complexity.¹² However, there are several crucial structures located deep in the center of the brain that are most important when responding to threat or danger. Among these structures are the thalamus, the hippocampus and the amygdala.¹³

9. See generally RAPE CRISIS CTR., *Rape: Medical and Legal Information*, in VIOLENCE AND VICTIMS 107 (Stefan A. Pasternack ed. 1975); FOA & ROTHBAUM, *supra* note 7, at 13.

10. FOA & ROTHBAUM, *supra* note 7, at 14.

11. See generally Rachel Yehuda, *Post-Traumatic Stress Disorder*, 346 NEW ENG. J. MED. 108 (2002).

12. DORLAND'S ILLUSTRATED MEDICAL DICTIONARY 409 (29th ed. 2000) [hereinafter DORLAND'S].

13. ROGER CICALA, THE BRAIN DISORDER SOURCEBOOK 36-37 (1999).

The thalamus is the central processor for visual and auditory stimuli. It sorts sensory cues and then sends them to the appropriate areas of the cortex.¹⁴ The amygdala is an almond shaped structure that prompts the fear response.¹⁵ The amygdala is by far the structure most involved with the emotional interpretation of incoming stimuli.¹⁶

The hippocampus is located near the amygdala and is involved in the initial consolidation and subsequent storage of memory. It processes an event and places it in time and place. In other words, it provides the context for the event. The hippocampus is especially vital to short-term memory, holding an event in place until it is either filed into long-term memory (where it lasts for a lifetime) or lost.¹⁷

The amygdala is responsible for the emotional interpretation of incoming stimuli.¹⁸ The hippocampal and amygdala memory systems work in concert with and parallel to each other. The hippocampus allows the individual to remember the actual, "real-life" context of an event—the what, who, where and when of a given event, while the amygdala indicates the emotional context of the event, initiating physiological changes associated with the trauma.¹⁹

The body responds to trauma or a threatening stimulus with a chain of events that involves two aspects of the (autonomic) nervous system. The first is the sympathetic nervous system (SNS), which regulates the smooth muscles of body organs. When the body is in a state of physical effort or stress, the SNS is in operation. The second is the parasympathetic nervous system (PNS), which is activated when the body is relaxed or in a state of rest.²⁰

When the senses receive information that signals danger, there are two pathways of response. One pathway is the passage of sensory information from the passage of sensory infor-

14. *Id.* at 36.

15. DORLAND'S, *supra* note 12, at 68; STEDMAN'S MEDICAL DICTIONARY 1816 (27th ed. 2000).

16. CICALA, *supra* note 13, at 37.

17. *Id.*

18. *Id.*

19. *Id.*

20. MIND AND BRAIN: DIALOGUES IN COGNITIVE NEUROSCIENCE 279-80 (Joseph E. LeDoux & William Hirst eds. 1986) [hereinafter MIND AND BRAIN].

mation from the sensory thalamus up into the cortex, where the stimuli are thoroughly analyzed. This is a very important step, but it has one significant disadvantage. It is relatively slow and can take a few seconds to analyze a new sensory stimulus. However, at times of threat another pathway is also used which involves the transmission of sensory information from the sensory thalamus *directly* to the amygdala. This pathway provides no opportunity for the slower analysis of the stimulus, but it does one very important thing. Within milliseconds, it fires off neurons in the amygdala that in turn trigger the body's emergency response systems. With this triggering there is a chain of neurobiological events that protects one from danger.²¹

There is a cascade of events that follows the perception of a threatening stimulus. First, the amygdala is activated. It stimulates the hypothalamus, which instructs the pituitary gland to stimulate the adrenal cortex. The adrenal glands release two steroid hormones called epinephrine and cortisol into the bloodstream. An additional hormone called norepinephrine is released from other parts of the body. Epinephrine and norepinephrine prepare the body for survival by stimulating rapid release of energy.²²

The steroid hormones also circulate back to the brain. When cortisol reaches the hippocampus it inhibits further activation. Now the body is primed for relaxation and a return to normal. However, as long as the threat is still present, the body will stay in a state of arousal. Only when the stressful event passes, does cortisol act upon the hippocampus, allowing the body to return to its non-alert state.²³

During extreme and ongoing episodes of traumatic stress, excessive neurochemicals may be released, damaging the brain and inhibiting memory functions. Yehuda found that in patients with Posttraumatic Stress Disorder (PTSD) the adrenal

21. See generally Andrew Mayes, *The Physiology of Fear and Anxiety*, in FEAR IN ANIMALS AND MAN 50-51 (W. Sluckin ed. 1979).

22. Isaac Marks, *Phobias and Obsessions: Clinical Phenomena in Search of Laboratory Models*, in PSYCHOPATHOLOGY: EXPERIMENTAL MODELS 175 (Jack D. Maser & Martin E. P. Seligman eds. 1977); see MIND AND BRAIN, *supra* note 20, at 280.

23. See generally Rachel Yehuda et al., *Predictors of Cortisol and 3-Methoxy-4-Hydroxy-phenylglycol Responses in the Acute Aftermath of Rape*, 43 BIOLOGICAL PSYCHIATRY 855 (1998) [hereinafter *Aftermath of Rape*].

glands do not produce enough cortisol to return the body to a nonstressed state.²⁴ In a more recent study Yehuda found significantly attenuated cortisol responses in female sexual assault survivors compared to women who did not have a history of sexual assault.²⁵ Other researchers have confirmed the finding that those with PTSD have lower cortisol levels than individuals without PTSD.²⁶

The expression "fight or flight" has become so commonly used that it requires further discussion in order to more fully understand it. Most people are not aware, however, that there is a preliminary response to threat that precedes fight or flight. When there is a fear stimulus, an animal or human initially responds by stopping all movement.²⁷ This state of immobility, also known as freezing, is preparatory for a fast escape when the opportunity arises or defensive aggressive behaviors, in the event that escape is not a viable option.²⁸ There is some indication that when mammals are unable to fight or flee, they continue "freezing" as a final measure when confronting a life-threatening stressor.²⁹ In the animal kingdom the rabbit "freezes" as it waits for the hunter to pass, or the mouse hangs lifeless while trapped in the cat's mouth. For a sexual assault survivor this may translate into a feeling of numbness, detach-

24. Rachel Yehuda et al., *Low Urinary Cortisol Excretion in Patients with Posttraumatic Stress Disorder*, 178 J. NERVOUS & MENTAL DISEASE 366, 368-69 (1990) [hereinafter *Low Urinary Cortisol Excretion*].

25. *Aftermath of Rape*, *supra* note 23, at 855.

26. *Id.* (citing John W. Mason et al., *Urinary Free-Cortisol Levels In Posttraumatic Stress Disorder*, 176 J. NERVOUS & MENTAL DISEASE 145 (1986); *Low Urinary Cortisol Excretion*, *supra* note 24, at 366-69; Rachel Yehuda et al., *Relationship Between Lymphocyte Glucocorticoid Receptor Number and Urinary Free Cortisol Excretion In Mood, Anxiety, and Psychotic Disorder*, 34 BIOLOGICAL PSYCHIATRY 18 (1993); Rachel Yehuda et al., *Low Urinary Cortisol Excretion in Holocaust Survivors with Posttraumatic Stress Disorder*, 152 J. AM. PSYCHIATRY 982 (1995); Rachel Yehuda et al., *Cortisol Regulation in Post-Traumatic Stress Disorder and Major Depression: A Chronobiological Analysis*, 40 BIOLOGICAL PSYCHIATRY 79 (1996)).

27. John Archer, *Behavioral Aspects of Fear*, in *FEAR IN ANIMALS AND MAN*, *supra* note 21, at 65.

28. *Id.* at 66-67.

29. Gordon G. Gallup Jr. & Jack D. Maser, *Catonia: Tonic Immobility: Evolutionary Underpinnings of Human Catalepsy and Catatonia*, in *PSYCHOPATHOLOGY: EXPERIMENTAL MODELS*, *supra* note 22, at 334-57.

ment, and/or lying motionless during an assault, or being unable to escape or scream for help.³⁰

Memory and Trauma

Memory is stored in one of two ways. Short-term memory, also called working memory, may last for only a short period, perhaps just seconds. Then, through a process called memory consolidation, information is moved to long-term storage.³¹ The way information is encoded (stored) is the way a person will remember it.³² In fact, memory is more likely to be retrieved if the individual's mood state matches that experienced at the time of the experience.³³ In other words, experiencing fear even years after an assault and for a reason unrelated to the assault can trigger the emotions of fear experienced during the assault. This concept is especially important in understanding PTSD.³⁴

The mechanisms that consolidate everyday ordinary memories are different from those responsible for handling traumatic memories.³⁵ Whether it is retained in the brain on a long-term basis depends on the role it plays in the individual's life. Memories of personal trauma are particularly durable and accurate. Lenore Terr referred to these memories as " 'burned-in' visual impressions."³⁶ They are burned into the memory of the individual and appear to remain there permanently.³⁷ These memories can leap into the individual's consciousness, unbidden, thrusting the experience before the survivor and hence can cause much disruption.³⁸ Although these recurrent memories tend to become less frequent over time, they do not disappear entirely. Moreover, their content is often more vivid, detailed

30. Grace Galliano et al., *Victim Reactions During Rape/Sexual Assault: A Preliminary Study Of The Immobility Response and Its Correlates*, 8 J. INTERPERSONAL VIOLENCE 109, 110, 114 (1993) (citing S.D. Suarez & Gordon G. Gallup Jr., *Tonic Immobility As A Response To Rape In Humans: A Theoretical Note*, 29 PSYCHOL. REC. 315 (1979)).

31. ALAN J. PARKIN, *MEMORY: A GUIDE FOR PROFESSIONALS* 7 (1996).

32. *Id.* at 19.

33. *Id.* at 27-29.

34. See DANIEL SCHACTER, *SEARCHING FOR MEMORY* 210-11, 216 (1996).

35. *Id.* at 109.

36. Lenore Terr, *What Happens To Early Memories Of Trauma?* 27 J. AM. ACAD. CHILD & ADOLESCENT PSYCHIATRY 96, 103 (1988).

37. See *id.*

38. See JUDITH HERMAN, M.D., *TRAUMA AND RECOVERY* 37 (1992).

and accurate than that of ordinary, day-to-day memories.³⁹ The factors that can distort or influence memory are developmental age, current emotional needs, time from event to recall of information, and the emotional climate of the event itself.⁴⁰ "The release of stress-related hormones, signaled by . . . the amygdala, probably accounts for some of the extraordinary power and persistence that characterize many highly emotional or traumatic experiences."⁴¹

The Risk of PTSD Following Sexual Assault

Kilpatrick, Edmunds and Seymour reported that one third of female survivors developed PTSD at some point after the assault.⁴² However, determining the factors that may put a survivor at risk for PTSD is challenging and has been the focus of a number of studies.⁴³ Rape is one of the most emotionally and physically intrusive traumatic events. The boundaries of the human body are violated in the most intimate way. The crime itself is fraught with the burden of historical myths and misconceptions, permeating every aspect of society and culture. The stigma resulting from sexual violence prevents many from seeking and receiving social support at a time when it is needed the most. In addition, it is a crime that is often blamed on the survivor. The survivor blame can be based in any number of reasons, some of which date back to biblical times. Frasier and colleagues reported that sexual assault is more likely to result in PTSD than other kinds of traumatic experiences.⁴⁴ Some au-

39. See *id.* at 37-38.

40. See generally SCHACTER, *supra* note 34.

41. *Id.* at 217.

42. Sarah E. Ullman, & Henrietta Filipas, *Predictors of PTSD Symptom Severity and Social Reactions in Sexual Assault Victims*, 14 J. TRAUMATIC STRESS 369, 369 (2001) (citing NAT'L VICTIM CTR. & THE CRIME VICTIMS RESEARCH AND TREATMENT CTR., *RAPE IN AMERICA: A REPORT TO THE NATION 7* (1992) [hereinafter *RAPE IN AMERICA*]). *RAPE IN AMERICA* was co-authored by Dr. Dean G. Kilpatrick, Director of the Crime Victims Research and Treatment Center, Christine Edmunds, The National Victim Center's Director of Program Development, and Anne Seymour, The National Victim Center's Director of Communications. *RAPE IN AMERICA*, *supra*, at 1.

43. Ullman & Filipas, *supra* note 42, at 369.

44. *Id.* at 371 (citing P. Frazier et al., *Multiple Traumas and PTSD Among Sexual Assault Survivors* (unpublished paper presented at the annual meeting of the American Psychological Association, Chicago, Ill. (1997))).

thors suggest that it is a combination of factors that make this traumatic event far more significant than other types of trauma: the physically intrusive nature of the assault, the perception that one's life is threatened and the realization that the perpetrator is another human being (one who may have been trusted and loved by the survivor) that puts the survivor at risk for PTSD. Other researchers have found that the presence of physical injury is a predictor of PTSD.⁴⁵ Campbell found that survivors, who received few services and significant secondary victimization, even when the rape characteristics were controlled, experienced more symptoms of PTSD.⁴⁶ Acierno and colleagues surveyed over 3,000 women and identified a history of depression as a risk factor for PTSD in both physical and sexual assault.⁴⁷ However, in those sexually assaulted women with a history of alcohol abuse, or physical injury sustained during the rape, their risk of developing PTSD was three times greater than women without those characteristics.⁴⁸

Prior interpersonal trauma may also contribute to PTSD symptoms in survivors of sexual assault. Nishith and colleagues found that a history of child sexual abuse seemed to increase vulnerability for adult sexual and physical assault as well as contributing to PTSD symptomatology following a recent sexual assault.⁴⁹ The researchers determined that a higher rate of childhood sexual abuse (not physical abuse) was related to higher rates of subsequent adult sexual and physical assault, which then contributed to a higher rate of PTSD symp-

45. *Id.* (citing Heidi S. Resnick et al., *Prevalence Of Civilian Trauma and PTSD In A Representative National Sample of Women*, 20 J. CONSULTING & CLINICAL PSYCHOL. 984; Dean G. Kilpatrick et al., *Victim and Crime Factors Associated with the Development of Crime-Related Post-traumatic Stress Disorder*, 20 BEHAVIOR THERAPY 199; Jeffery N. Epstein et al., *Predicting PTSD In Women With A History Of Childhood Rape*, 10 J. TRAUMATIC STRESS 573).

46. *Id.* (citing Rebecca Campbell et al., *Community Services For Rape Survivors: Enhancing Psychological Well-Being at Increasing Trauma?*, 67 J. CONSULTING & CLINICAL PSYCHOL. 847 (1999)).

47. Ron Acierno, *Risk Factors for Rape, Physical Assault, and PTSD in Women: Examination of Differential Multivariate Relationships*, 13 J. ANXIETY DISORDERS 541, 555 (1999).

48. *Id.* at 559.

49. Pallavi Nishith et al., *Prior Interpersonal Trauma: The Contribution to Current PTSD Symptoms in Female Rape Victims*, 109 J. ABNORMAL PSYCHOL. 20, 23 (2000).

toms.⁵⁰ The authors hypothesized that these data may be attributed to perceptions of trust or symptoms of unresolved traumatic stressors interfering with cognitive appraisals of risk situations.⁵¹

While there are few studies that examine the recovery environment, several studies explored negative social reactions and their impact on the survivor.⁵² It appears "that negative social reactions are related to more psychological symptoms and poorer self-rated recovery."⁵³ Ullman and Filipas examined the correlating factors of PTSD severity and both negative and positive social reactions among survivors who disclosed their assaults to social support providers (informal and formal).⁵⁴ Negative social reactions were defined as victim blame, alienating or isolating the victim and controlling responses.⁵⁵ They found a relationship between this range of negative social reactions and PTSD symptom severity.⁵⁶ In fact, stigmatizing social responses were the strongest predictor of PTSD symptoms.⁵⁷ The same study also identified race and education as predictors of PTSD symptoms, the authors suggested that women of color might be at greater risk for social reactions that stigmatize and isolate.⁵⁸

50. *Id.*

51. *Id.*

52. Ullman & Filipas, *supra* note 42, at 371.

53. *Id.* (citing Rebecca C. Campbell et al., *Community Services For Rape Survivors: Enhancing Psychological Well-being at Increasing Trauma?* 67 J. OF CONSULTING & CLINICAL PSYCHOL. 847 (1999); Robert C. Davis et al., *Supportive and Unsupportive Responses of Others to Rape Victims: Effects on Concurrent Victim Adjustment*, 19 AM. J. COMMUNITY PSYCHOL. 443 (1991); Pam McAuslan & Antonia Abbey, *Do Disclosure and the Reactions of Others Affect Mental Health, Physical Health, and Alcohol Use Following Sexual Assault?* (unpublished paper presented at the International Society for the Study of Personal Relationships, Saratoga Springs, N.Y. (1998)); Sarah E. Ullman, *Social Reactions, Coping Strategies, and Self-Blame Attributions in Adjustment to Sexual Assault*, 20 PSYCHOL. WOMEN Q. 505 (1996)).

54. *Id.* at 383.

55. *Id.*

56. *Id.*

57. *Id.*

58. Ullman & Filipas, *supra* note 42, at 384-85.

Rape Trauma and Other Syndromes in the Clinical and Legal Arenas

If one considers the use of the word "syndrome" in the context of a person's medical condition, it is a description, list or pattern of otherwise unrelated symptoms or characteristics (physical or behavioral) associated with a particular medical or behavioral state.⁵⁹ Information on various syndromes is collected through observation and anecdotal reports. Through research it is possible to identify certain patterns or constellations of symptoms or behaviors that are associated with a particular condition.

Clinical syndromes such as Rape Trauma Syndrome and Child Abuse Accommodation Syndrome are not medical diagnoses but guides to clinical practice. A syndrome does not require a set of symptoms in order to make a diagnosis. It is a set of behaviors that is associated with a condition or event that more fully described what the patient may be experiencing.⁶⁰

Burgess and Holmstrom described the psychological experiences of the sexual assault survivor in the first year after the assault.⁶¹ Although Rape Trauma Syndrome (RTS) is not included in the DSM-IV-TR, it is recognized as a nursing diagnosis and was revised and clarified by the North American Nursing Diagnosis Association in 1999.⁶² While RTS has been used in courts to explain a survivor's behavior and actions following an assault, some jurisdictions do not allow it into testimony as it would be improper to use the term "Rape Trauma Syndrome," when the legal conclusion of rape has not yet been reached.⁶³ For clinical purposes, RTS is useful in gauging the

59. RANDOM HOUSE UNABRIDGED DICTIONARY 1928 (2d ed. 1993).

60. See STATE JUDICIAL INST., A JUDGE'S DESKBOOK ON THE BASIC PHILOSOPHIES AND METHODS OF SCIENCE 184 (1999), available at <http://www.unr.edu/bench>.

61. See generally Ann Wolbert Burgess & Lynda Lytle Holmstrom, *Rape Trauma Syndrome*, 131 AM. J. PSYCHIATRY 981 (1974).

62. N. AM. NURSING DIAGNOSIS ASS'N, NURSING DIAGNOSES: DEFINITIONS AND CLASSIFICATIONS 1999-2000 131-34 (1999) [hereinafter NANDA].

63. See, e.g., *People v. Bledsoe*, 681 P.2d 291, 292, 299 (Cal. 1984) (distinguishing between the permissible use of Rape Trauma Syndrome testimony to rebut misconceptions about the behavior of rape victims and the impermissible use of rape trauma syndrome testimony to prove that a rape, in the legal sense, had occurred); *State v. McQuillen*, 689 P.2d 822, 829 (Kan. 1984) (reaffirming that expert testimony "regarding the existence of 'rape trauma syndrome' is relevant and

survivor's reactions during the first months post assault.⁶⁴ At the present time, most researchers and clinicians suggest that the behaviors associated with RTS are best characterized as Posttraumatic Stress Disorder-Rape Related Trauma.⁶⁵

Burgess and Holmstrom observed two psychological stages in the first year following the sexual assault: The Acute Stage and the Long Term Process of Re-organization.⁶⁶ The Acute Stage, primarily characterized by disorganization, consists of the *impact* reaction occurring immediately after the assault.⁶⁷ The survivor's emotional reactions may be either expressive, which includes agitation, crying and anxiety or a very controlled response.⁶⁸

Somatic and emotional reactions in the weeks that follow the sexual assault often remain hidden behind the survivor's facade of what appears to be normal from the outside. Physical complaints may include GI/GU symptoms, muscle tension, soreness, sexual problems and gastrointestinal disturbances (e.g., nausea, vomiting and compulsive eating-related to nature of assault).⁶⁹ There is also a "disruption of normal everyday routines (e.g., high absenteeism at work suddenly or, conversely, working longer than usual hours; dropping out of school; traveling different routes; going out only at certain times)."⁷⁰

The second stage, the long-term process of reorganization, is comprised of life style changes (residence, job and phone) and an attempt to re-establish family support systems.⁷¹ The intrusive symptoms noted in the Acute Stage are often present during the later months following the assault.⁷²

admissible" to rebut the defense of consent); *State v. Huey*, 699 P.2d 1290, 1294-95 (Ariz. 1985) (finding psychiatrist's testimony about the victim's mental state admissible where used to show lack of consent).

64. See generally Burgess & Holmstrom, *supra* note 61.

65. FOA & OLASOV ROTHBAUM, *supra* note 7, at 27.

66. Burgess & Holmstrom, *supra* note 61, at 982.

67. *Id.*

68. *Id.*

69. See *id.* at 982, 984.

70. See Rape Crisis Center of Catawba County, PTSD and Rape Trauma Syndrome Information Sheet, at <http://www.rapecrisiscenter.com/Rape%20Trauma%20Syndrome%20Info%20Sheet.html> (last visited Apr. 30, 2004); see also FOA & OLASOV ROTHBAUM, *supra* note 7, at 21.

71. Burgess & Holmstrom, *supra* note 61, at 983.

72. See NANDA, *supra* note 62, at 132.

The Child Sexual Abuse Accommodation Syndrome

The Child Abuse Accommodation Syndrome was first identified by Roland Summit in 1983 and is "used to explain the child's position in the dynamics of sexual victimization."⁷³ Summit "describes how child sexual abuse (CSA) occurs in families, how it requires survival strategies from victims, and how the victims face secondary trauma during disclosure."⁷⁴ "The most typical reactions of children are called the Child Sexual Abuse Accommodation Syndrome (CSAAS)."⁷⁵

Appropriate Use of Diagnoses and Syndromes

A number of authors suggest that using behavioral indicators alone to assess child sexual abuse may result in errors.⁷⁶ Besharov observed that behaviors, by themselves, are not adequate for generating opinion reports.⁷⁷ Other authors state that "none of the associated behavioral indicators, in any combination, are valid without a direct statement by the child about sexual involvement or sexual knowledge."⁷⁸ In 1994 a consensus group of experts in child sexual abuse stated:

No specific behavioral syndromes characterize victims of sexual abuse. Sexual abuse involves a wide range of possible behaviors, which appear to have widely varying effects on its victims. The absence of any sexualized behavior does not confirm that sexual abuse did not take place any more than the presence of sexualized behavior conclusively demonstrates that sexual abuse occurred; rather, both pieces of information affect the level of suspicion con-

73. See Ethel Amacher, Interviewing the Child Victim, Child Sexual Abuse Investigations: Multidisciplinary Collaborations, An Internet Resource for Forensic Investigation of Child Sexual Abuse Cases, at http://childabuse.gactr.uga.edu/both/amacher1/amacher1_print.phtml (last visited April 15, 2004); see also Roland C. Summit, *Child Abuse Accommodation Syndrome*, 7 CHILD ABUSE & NEGLECT 177 (1983).

74. Summit, *supra* note 73.

75. *Id.*

76. Ralph Underwager & Hollida Wakefield, *Special Problems with Sexual Abuse Cases*, in COPING WITH PSYCHIATRIC AND PSYCHOLOGICAL TESTIMONY 1332 (Jay Ziskin ed., 4th ed. 1995).

77. *Id.* at 1333 (citing Douglas J. Besharov, *Gaining Control Over Child Abuse Reports: Public Agencies Must Address Both Underreporting and Overreporting*, 48 PUB. WELFARE 34, 38-39 (1990)).

78. *Id.* (citing Murray Levine & Lori Battistoni, *The Corroboration Requirement in Child Sex Abuse Cases*, 9 BEHAV. SCI. & L. 3 (1991)).

cerning the child's possible experiences and should serve to promote careful and nonsuggestive investigation.⁷⁹

Research findings related to Child Abuse Accommodation Syndrome are limited and do not support sexual abuse syndrome or a CSAAS.⁸⁰ "These syndromes are [exploratory] and meet neither *Frye* nor *Daubert*."⁸¹ In fact, these syndromes are not included in the DSM-IV-TR as there is not significant evidence to support them.⁸²

However, the use of syndromes does have a place in clinical practice. They serve as guides in the care of individuals who are in treatment. These characteristic behaviors can be useful to clinicians as they determine an appropriate plan of care. The observations of associated behaviors are not meant to predict the presence of a syndrome but to inform the clinician as to behaviors observed in the presence of other indicators of sexual abuse.

Common Reactions to Traumatic Events

Physical Reactions

<i>Gastrointestinal:</i>	Nausea, Indigestion, Upset stomach
<i>Cardio-vascular:</i>	Flushing, Palpitation/Tachycardia, Sweating palms, Dry mouth, Profuse sweating, Chills and feeling cold,
<i>Respiratory:</i>	Shortness of breath, Pressure and/or tightness across the chest

79. *Id.* (quoting Michael E. Lamb, *The Investigation of Child Sexual Abuse: An International, Interdisciplinary Consensus Statement*, 28 FAM. L. Q. 151, 154 (1994)).

80. *Id.* (citing Roland Summit, *The Child Sexual Abuse Accommodation Syndrome*, 7 CHILD ABUSE & NEGLECT 177 (1983)).

81. Underwager & Wakefield, *supra* note 76, at 1333 (citing *Frye v. United States*, 293 F. 1013, 1014 (D.C. Cir. 1923) (holding that the proponents of testimony based on scientific procedures must prove that the procedure is "sufficiently established to have gained general acceptance in the particular field in which it belongs"); *Daubert v. Merrell Dow Pharm., Inc.*, 509 U.S. 579, 592-93 (1993) (holding that the proponents of testimony based on scientific procedures must prove that (1) "the reasoning or methodology underlying the testimony is scientifically valid" and (2) that the "reasoning or methodology properly can be applied to the facts at issue").

82. *Id.* (citing David L. Corwin, *Early Diagnosis of Child Sexual Abuse: Diminishing the Lasting Effects*, in LASTING EFFECTS OF CHILD ABUSE 252, 259-60 (G.E. Wyatt & G.J. Powell eds. 1988)). Child Abuse Accommodation Syndrome is not included in DSM-IV-TR either. See AM. PSYCHIATRIC ASS'N, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS: DSM-IV-TR (4th ed., text rev. 2000) [hereinafter DSM-IV-TR].

Neuromuscular: Numbness and tingling of extremities, Muscular tension, aches (Throat, Jaw), Vision Disturbances, Exhaustion/Fatigue

Emotional/Affective Responses

Fears: Separation, Safety, Abandonment

Anger/outrage

Helplessness, Hopelessness, Powerlessness

Sadness, Grief

Denial, Disbelief, Numbness

Guilt

Distrust

Cognitive Reactions

Cognitive Processing

Attention: Decreased attention span, Poor concentration, Calculation difficulties,

Orientation: Time distortion and inability to sequence events, Confusion, Disorientation

Memory: Distortions, Inability to remember crucial details or remembering details that don't necessarily have to do with the traumatic events, Flashbulb memories of event, Flashbacks (intrusive images), Nightmares

Thoughts and Statements (examples of)

Denial and disbelief: How could someone do this?
It feels so unreal; It's just like a bad dream.
I cannot talk about it.

Orientation: Time stood still
I felt so confused. I am not sure what happened.

Guilt: I wanted to get help; I should have done more.

Separation: I am all alone; No one in my family understands this.

Behavioral Responses

Immediate and Long term:

Biting lip, Clenching fists, Tapping fingers, Biting nails.

Withdrawal or Excessive silence

Exaggerated startle response to neutral cues

Episodes of panic/anxiety, Crying (episodic or precipitated by a reminder of the event)

Hypervigilance, Suspiciousness,

Excessive humor, Joking, Laughing

Irritability

Long-term:

Sleep disturbances

Alteration in risk taking (taking more risks or avoiding any risks)

Initiation/Return to drug/alcohol use

Impulsive actions

Increased/Decreased eating, Smoking

Interpersonal Reactions

Changes in interpersonal style in relationships
 Difficulty with intimacy, affection and/or sexual relationships
 Conflict and confrontation (fighting and arguing)
 Withdrawal, Isolation, Being distant from others
 Being judgmental (especially about coping and grieving styles)
 Over controlling or over-cautious to the point of limiting another's choices.

DSM-IV-TR Criteria

Acute Stress Disorder and Posttraumatic Stress Disorder

The concept of a stress response following trauma went through a series of stages and alterations in the development of the formal diagnostic criteria in the mental health community. The first Diagnostic and Statistical Manual (DSM), published in 1952, classified stress responses as "transient situational personality disturbance, gross stress reaction or adjustment reaction."⁸³ However, the second edition, published in 1968, omitted the concept of a stress reaction, including only "adjustment reactions" (of infancy, childhood, adolescence, adult or late life).⁸⁴ The DSM III, published in 1980, reincorporated the concept of a stress response by adding the first description of Posttraumatic Stress Disorder.⁸⁵ In 1994, Acute Stress Disorder was added to the DSM-IV. The criteria for both Posttraumatic Stress Disorder and Acute Stress Disorder are listed here as they appear in the DSM-IV-TR.

Acute Stress Disorder

Acute Stress Disorder develops within one month of exposure to the traumatic stressor. "The person has been exposed to a traumatic event in which both of the following were present: (1) the person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to physical integrity of self or

83. AM. PSYCHIATRIC ASS'N, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS: DSM-I (1952).

84. See AM. PSYCHIATRIC ASS'N, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS: DSM-II (1968).

85. See AM. PSYCHIATRIC ASS'N, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS: DSM-III (1980).

others”⁸⁶ and (2) “the person’s response involved intense fear, helplessness, or horror.”⁸⁷

[W]hile experiencing or after experiencing the distressing event, the individual has three (or more) of the following dissociative symptoms: [a] subjective sense of numbing, detachment, or an absence of emotional responsiveness . . . reduction of awareness of his or her surroundings (e.g., “being in a daze”), . . . derealization . . . depersonalization [or the] . . . inability to recall an important aspect of the trauma.⁸⁸

“The traumatic event is persistently re-experienced in at least one or more of the following ways: recurrent images, thoughts, dreams, illusions, flashback episodes, or a sense of re-living the experience, or distress on exposure to reminders of the traumatic event.”⁸⁹

There is “marked avoidance of stimuli that arouse recollections of the trauma.”⁹⁰ These can be “thoughts, feelings, conversations, activities, people, and places.”⁹¹

There are also clear “symptoms of anxiety or increased arousal” such as difficulty falling or staying asleep, irritability or outbursts of anger, poor concentration, hypervigilance, exaggerated startle responses and restlessness.⁹²

All of these symptoms cause “clinically significant distress or impairment in social, occupational, or other important areas of functioning or impairs the individual’s ability to pursue some necessary task, such as obtaining assistance or mobilizing personal resources by telling family members about the traumatic experience.”⁹³ The duration of the symptoms lasts for a “minimum of [two] days and a maximum of [four] weeks and occurs within four weeks of the traumatic event. . . . The disturbance is not due to the direct physiological effects of a substance . . . or general medical condition”⁹⁴

86. DSM-IV-TR, *supra* note 82, at 471.

87. *Id.*

88. *Id.*

89. *Id.* at 472.

90. *Id.*

91. DSM-IV-TR, *supra* note 82, at 472.

92. *Id.*

93. *Id.*

94. *Id.*

Posttraumatic Stress Disorder

Posttraumatic Stress Disorder can be classified as acute if symptoms last less than three months, chronic if symptoms continue for three or more months or delayed onset if symptoms begin at least six months after the stressor.⁹⁵ Like Acute Stress Disorder, PTSD occurs when a person has been “exposed to a traumatic event in which both of the following were present: (1) a person experienced, witnessed, or was confronted with an event that involved actual or threatened death or serious injury, or threat to physical integrity of self or others” and (2) “the person’s response involved intense fear, helplessness, or horror.”⁹⁶ For children fear and helplessness “may be expressed as disorganized or agitated behavior[.]”⁹⁷

Symptoms fall within three categories that seem to be contradictory in nature: symptoms in which the trauma is unwittingly re-experienced, persistent avoidance thoughts, feelings and behaviors and a state of hyper-arousal.

“The traumatic event is persistently reexperienced in one (or more) of the following ways:”⁹⁸ It is essentially re-lived through “recurrent and intrusive distressing recollections of the event, including images, thoughts or perceptions.”⁹⁹ There are also “recurrent distressing dreams of the event.”¹⁰⁰ In younger children, these dreams may be frightening but “without recognizable content.”¹⁰¹ The individual acts or feels “as if the traumatic event were recurring;” young children may reenact the event in specific detail.¹⁰² There is also the possibility of “intense psychological distress at exposure to internal or external cues [or reminders] that symbolize or resemble an aspect of the traumatic event.”¹⁰³ Finally, there may be “physiological reactivity on exposure to internal or external cues that symbolize or resemble some aspect of the traumatic event.”¹⁰⁴

95. *Id.* at 463.

96. DSM-IV-TR, *supra* note 82, at 467.

97. *Id.*

98. *Id.* at 468.

99. *Id.*

100. *Id.*

101. DSM-IV-TR, *supra* note 82, at 468.

102. *Id.*

103. *Id.*

104. *Id.*

The presence of three or more symptoms of persistent avoidance of stimuli associated with the trauma or a numbing of general responsiveness is indicative of a diagnosis of PTSD. These behaviors include purposeful "efforts to avoid thoughts, feelings or conversations associated with the trauma," avoiding "activities, places, or persons that arouse recollections of the trauma."¹⁰⁵ There may be an "inability to recall an important aspect of the trauma."¹⁰⁶ The individual may have significant "diminished interest or participation in significant activities" or a "feeling of detachment or estrangement from others."¹⁰⁷ The person may also have a "restricted range of affect," unable to [experience joy, or] have loving feelings."¹⁰⁸ Finally there may be a "sense of a foreshortened future" in which the person does not expect to have a career, significant commitment or live to see their children or siblings grow up.¹⁰⁹

Feelings of persistent increased arousal, which were not present before the trauma, are indicative of PTSD if there are two (or more) of the following: "difficulty falling or staying asleep, . . . irritability or outbursts of anger [or rage], . . . difficulty concentrating" or focusing on a task, "hypervigilance" or an "exaggerated startle response."¹¹⁰

The duration of the intrusive, avoidance or arousal symptoms is more than one month and "causes clinically significant distress or impairment in social, occupational or other important areas of functioning."¹¹¹

105. *Id.*

106. DSM-IV-TR, *supra* note 82, at 468.

107. *Id.*

108. *Id.*

109. *Id.*

110. *Id.*

111. DSM-IV-TR, *supra* note 82, at 468.

Nursing Diagnosis of Rape Trauma Syndrome¹¹²

Definition:

"Sustained maladaptive response to a forced, violent sexual penetration against the victim's will and consent."¹¹³ "This syndrome includes the following three subcomponents: Rape-Trauma [A], Compound Reaction [B], and Silent Reaction [C]."¹¹⁴

Related Factors:

Rape¹¹⁵ [actual/attempted forced sexual penetration]

Defining Characteristics:¹¹⁶

A: Rape Trauma

Subjective:

- Shock Fear Anxiety Anger
- Embarrassment
- Shame
- Guilt
- Humiliation
- Revenge
- Self-blame
- Loss of self-esteem
- Helplessness
- Powerlessness
- Nightmare and sleep disturbances
- Change in relationships
- Sexual dysfunction
- [Changes in lifestyle (change in residence; seeking family support; seeking social network support)]

Objective:

- Physical trauma (e.g., bruising, tissue irritation)
- Muscle tension and/or spasms
- Hyperalertness
- Confusion
- Disorganization
- Inability to make decisions
- Mood swings
- Vulnerability
- Depression
- Dependence
- Agitation
- Aggression
- Denial
- Phobias

112. Although attacks are most often directed toward women, men also may be victims.

113. NANDA, *supra* note 62, at 131.

114. *Id.* at 132.

115. *Id.* at 131.

116. *Id.*

- Paranoia
- Substance abuse
- Suicide attempts
- Dissociative disorders

*B: Compound Reaction*¹¹⁷

Includes all the defining characteristics listed under rape trauma, as well as the following in the Acute Phase:

- Reactivated symptoms of such previous conditions (i.e., physical/psychiatric illness)
- Reliance on alcohol and/or drugs

*C: Silent Reaction*¹¹⁸

- Abrupt changes in relationships with men
- Increase in nightmares
- Increasing anxiety during interview, that is, blocking of associations, long periods of silence, minor stuttering, physical distress
- Pronounced changes in sexual behavior
- No verbalization of the occurrence of rape
- Sudden onset of phobic reactions

*The Child Sexual Abuse Accommodation Syndrome*¹¹⁹

The most typical reactions of children are called the Child Sexual Abuse Accommodation Syndrome (CSAAS). The reactions are:

- Secrecy
- Helplessness
- Entrapment and accommodation
- Delayed, conflicted, and unconvincing disclosure
- Retraction

117. *Id.* at 132.

118. NADA, *supra* note 62, at 133.

119. Summit, *supra* note 73.