PSYCHOLOGICAL DISORDER AND MORAL HARM: CONCEPTIONS OF THE VICTIMS OF RAPE

by

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Abstract

This essay examines two perspectives from which to consider rape victims. The first perspective is adopted by psychologists and other professionals who treat rape victims. The second perspective is a moral framework that draws on fundamental Kantian insights into moral agency.

Chapter One offers the theoretical basis of the first framework. Particular attention is paid to the diagnosis of rape victims as suffering from a specific disorder, rape trauma syndrome. Chapter Two further elaborates this framework. It considers the connection between rape trauma syndrome and an official mental disorder, posttraumatic stress disorder. I note some stresses induced in the notion of disorder by this assimilation. I also offer concerns about seeing both rape victims and rapists as suffering from mental disorders.

Chapter Three draws on the philosophical literature, especially the work of Peter Strawson and other Kantian moral philosophers, as well as my own experiences as an advocate in a rape crisis center, to offer an alternative perspective. This framework asks us to see rape victims not as suffering a particular sort of mental disorder, but as needing to recover their sense of moral agency and worth in response to horrific evil.

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This essay is dedicated

to the memory of

Terence S. Shea, S.J.

Introduction

> Rape is to women as lynching was to blacks: the ultimate physical threat by which all men keep all women in a state of psychological intimidation (Susan Brownmiller found in Hilberman, 1976, p. 6).
>
> Rape is an act of aggression in which the victim is denied her self-determination. It is an act of violence which, if not actually followed by beatings or murder, nevertheless always carries with it the threat of death. And finally, rape is a form of mass terrorism, for the victims of rape are chosen indiscriminately but the propagandists for male supremacy broadcast that it is women who cause rape by being unchaste or in the wrong place at the wrong time- in essence, by behaving as though they were free (Susan Griffin found in Hilberman, 1976, p. 6, emphasis added).

When one comes across such poignant statements as these, one feels that it has finally come to be known that rape is one of the ultimate human horrors. Those who work in aid of rape victims speak eloquently and touchingly about the suffering of those they treat. The language used is often filled with terms philosophers regard as the moral notions regarding human beings and humanity in general. The papers, lectures, and books written by professionals involved in the research and treatment of rape victims use terms which are very much moral terms: trust, autonomy, dignity, self-respect, guilt, shame, anger, and degradation are among the terms used. But there is something distinctly different about these terms when one finds them in the theories used to treat rape victims. They seem to lack the thick moral content that is to be found when they are used

by moral philosophers. The difference is that they have undergone a reduction of sorts, a reduction to their usefulness for psychological purposes. The project of the first chapter is to expose the meaning behind the moral terms used by those who are treating, in one way or another, the victims of rape.

There is a great deal of ground to cover in chapter one. I have split it into three sections. I will begin the first section by explicating rape trauma syndrome. This will lead to an exploration of general crisis theory and rape crisis theory. Then, I will look at how crisis theory forms the basis for the treatment of and recovery criteria for victims of rape.

Psychology and medicine have taken on a very scientific approach to dealing with human subjects.[1] Yet the topic at hand is laden with moral issues. In the second chapter I take a step back to see a larger picture. I will demonstrate a connection between rape trauma syndrome and mental disorder. It turns out that one can draw the startling conclusion that all rape victims are bound to suffer from a diagnosable mental disorder. In order better to understand what it might mean to diagnose a rape victim with a mental disorder I then turn to look at the definitions for the terms used in making a diagnosis of this kind. Then, I will conclude chapter two by pulling together the threads of the various theories and treatments to show

the reader what psychology sees in a person and how it perceives that it can best help those in psychological distress. The case will be put forward that the standards for diagnosis, treatment and recovery may not be sufficient to help victims recover from this very particular kind of harm. In fact, the claim I make is that they may be doing further harm to rape victims.

Finally, in chapter three I propose an alternative framework for thinking about and aiding victims of rape. Rape victims turn to the moral aspects of having been raped; these are aspects that the clinical framework is ill equipped to handle. After considering the problems which come up when using a strictly clinical approach in treating rape victims I will examine alternative moral frameworks which might better accommodate the issues raised by victims of rape. Then, in the final sections of chapter three, I argue that the best moral framework to take up in aid of rape victims is a Kantian moral perspective. A robustly moral perspective is most able to help rape victims regain the sense of their own humanity which they seem to have lost.

Endnote to the Introduction

1. In this work I will be discussing the theories of social scientists of many stripes. Those that I have researched for this work are predominately North American psychologists who worked in this century. The tenor of most of what the clinicians, researchers and theorists are doing is psychologistic. Thus, I have elected to use the term "psychology" as a very general term meant to include those whom I have studied. I do not mean to include here the whole of psychology. It will be demonstrated that the choice of the term is appropriate on the following pages.

Chapter One

Rape Crisis Theory

The experience of rape and its aftermath is clearly one of the worst possible experiences any person could have.[1] The victim's life is threatened, she is degraded and violated in an exceptionally personal way. In the aftermath she must find ways of dealing with the incident, of carrying on in the face of an experience that tends to destroy one's sense of how life can and should go. The victim is subject to both physical and emotional (or psychological) harm. The long term effects of this event can reach into every aspect of her life. The event of a rape in a person's life will often alter her life permanently.

It is profoundly moving to listen to the testimonies of women who have undergone the horrific experience of being raped. Every rape is different and every victim is an individual, and yet there is a stunning similarity in the report of what they think and feel in the days, weeks, months and even years after the rape. What follows is a series of quotes which are taken from many rape victims. The time span of the quotes begins with an interview done some days after a rape and continues through to some years after a rape.

- Since the night of the rape, I haven't felt much except anxious (Koss, 1991, p.49).

- All I felt was terror and pain ... I couldn't even cry (McCombie, 1980, p. 169).
- It's the worst thing I have ever gone through. I wouldn't wish it on my worst enemy (McCombie, 1980, p.158).
- Why did this have to happen to me? (McCombie, 1980, 159).
- It takes away all security (Koss, 1991, p.42).
- Now I sleep with a hockey stick and feel as though my previous sense of confidence has been replaced with an overwhelming feeling of helplessness (Koss, 1991, p. 65).
- I [feel] different from other people (Koss, 1991, p. 68).
- I'm scared I'll never be the same (McCombie, 1980, p.159).

When reading the literature on rape and its effects on the victim it becomes clear that there is a common experience of horror and degradation. Fear, anxiety, isolation and pain (both psychological and physical) are prevalent amongst victims during and after the rape. In addition, the victims are struck by the inexplicable nature of the event. They cannot understand why it happened to them. Research reveals that victims of unexpected traumatic events (such as rape or terrorism) need to have an explanation for the occurrence, something that can justify the event. With rape victims it is often the case that they will find fault with themselves rather than leave the question unanswered.[2]

In light of the recognition of the devastating effects of rape, researchers in the social sciences, medicine, psychology and psychiatry have set out to explain rape and its effect on victims. They look at rapists and at rape victims to see why it happens, who it happens to, how it effects them, and perhaps eventually, how to prevent it from happening. As mentioned before, if the question of why it happened has an answer, then it will be possible for victims, with the help of the clinicians, to make sense of the experience. Making sense of the experience seems to mean that the victim knows and understands why it was that she was raped and that this 'knowledge' helps her to recover from the event.

Because of the criminal aspect of rape, researchers tend to have more access to the victims of rape than to the perpetrators of rape. There are very few convictions on rape charges, and even fewer charges made in relation to the number of victims claiming to have been raped. It is highly unlikely that there will ever be people coming into therapy or research labs as rapists unless they are compelled to do so by the law. Thus, a large body of information has developed about victims of rape but there is comparatively little information regarding the rapists.[3] The most influential research has been done by Ann Wolbert Burgess, a professor of nursing (and subsequently the Chairperson of the Rape Control and Advisory Committee for the U.S.

Department of Health, Education and Welfare) and Linda Lytle Holmstrom, a professor of sociology. In 1972 Burgess and Holmstrom began a victim counselling program at the Boston City Hospital in cooperation with the emergency unit staff. It was an effort to observe, describe, understand, and treat the effects of rape on the victim. Their project was to interview and offer a kind of crisis intervention to victims of sexual assault at the first possible time after a victim has been raped. This turns out, in many cases, to be the emergency room of the local hospital. Based on their research and practice in the first year they published Rape: Victims of Crisis which according to Anne Hargreaves in her preface to the book, "communicates basic principles of technique" for treating rape victims (Hargreaves in Burgess and Holmstrom, 1974, p. vii). Their work resulted in many changes for hospitals and social service agencies dealing with rape victims throughout North America. The research done at that time is the cornerstone of rape crisis theory and intervention techniques implemented today.

Before I launch into my analysis a few technical points must be made here in order for there to be clarity of reference throughout this work. For the sake of brevity and, I hope, clarity I have chosen to use the term 'clinician' to refer to the doctors, nurses, psychiatrists, psychologists and sociologists who treat rape victims. I will limit the scope of this term to the people who are

regarded in the field as professionals with a kind of expertise that is suited to the needs of the rape victim. There are also non-professional individuals trained to "stand up for" the rape victim. The term "advocate" is used to identify the individuals of this group. Standing up for the victim simply means that advocates provide support to the victim by giving her information, by telling her what to expect at different stages of her experience, and by being there as literally a shoulder to cry on if need be. An advocate is usually present at the hospital when the victim first comes in, can accompany the victim to police interviews, meetings with lawyers, court appearances, and so on. In short, whatever interaction the victim may have with others as a direct result of having been raped is an interaction that may, at the victim's discretion, be attended by the advocate. For the most part advocates are trained volunteers associated with a rape crisis center. Social workers tend to fit into their own category. This is due, at least in part, to the fact that they play a role only when the victim is in need of the particular kinds of care that a social worker has access to (i.e. welfare and other forms of public assistance). "Clinics" will designate the places where a rape victim goes for various forms of health treatment. (Treatment is yet another ambiguous term; its various meanings will be worked out in the course of this chapter.) Obviously there are some crossovers between

what treatment in hospital is and what treatment is in a clinic for psychological treatment. But there are also vast differences. The common ground is more in the conceptual framework used to treat victims of rape than it is in the details of implementation of the conceptual framework.

A very general framework is used by Burgess and Holmstrom, as well as by the larger clinical community today. Burgess and Holmstrom are said to have used a biopsychosocial approach in conducting their research.[4] The biopsychosocial approach is an attempt to overcome perceived difficulties in the dominant antecedent approach to medically treating people, the biomedical approach.[5] In Health Psychology: Biopsychosocial Interactions, Edward Sarafino explains that biomedicine bases its treatment and diagnosis schemes on the assumption that "all diseases or physical disorders can be explained by disturbances in physiological processes, which result from injury, biochemical imbalances, bacterial or viral infection and the like..." (Sarafino, 1994, p.9). It "assumes that disease is an affliction of the body and is separate from the psychological and social processes of the mind" (Sarafino, 1994, p.9). According to the proponents of the biopsychosocial model this model does not regard the subject as a person; personality and life style are not thought to be relevant to any possible line of diagnosis or treatment. For the most part the psycho-social situation of the person

is viewed as a kind of impediment to understanding what is happening to or in the body. Here we see the mind-body distinction in a very literal way. The patient is not thought to know enough to be able to contribute in a relevant way to discovering the cause or cure to his ailment. More and more often we are hearing that this is a faulty model because of its intentional neglect of the person suffering. It has come to be believed that a person's 'lifestyle', that is their "everyday pattern of behavior", plays a significant role in understanding health and illness (Sarafino, 1994, p.10). The biopsychosocial approach to health and illness takes into account "... that health and illness result from the interplay of biological, psychological and social forces" (Sarafino, 1994, p.15).

To a great extent the biopsychosocial approach to health and illness looks at each person as a system. A system is seen as a "dynamic entity consisting of components that are continuously interrelated" (Sarafino, 1994, p. 17). In this way it remains very much within the framework of medicine and mechanism. There are thought to be three basic systems to consider for each person: the biological organism including genetic makeup, cells, organs, etc.; the psychological system composed of the lifestyle and personality of the person; and the social system where one's relationships to others are considered. The psychological system is also includes behavioral and mental processes, the

last being divided into three subsystems: cognition, emotion and motivation. The social system encompasses family and friends, community, and society in general. When assessing a prospective patient for treatment needs of whatever kind, a clinician will attempt to find out how all of these factors (or systems) play into the life of that individual. By identifying which systems are 'functioning' and which are not the clinician is better able to determine the needs of her patient. For example, does a patient have headaches because she has bumped her head? Or, as is more common, is there some aspect of her "lifestyle" (stress, caffeine, lack of sleep, too much sleep, etc.) that might bring about headaches? Using the biopsychosocial approach, the patient is assessed for her level of functioning in all three of the general systems mentioned above. This is thought to be a more effective way of treating people when they are ill and especially for preventing illness in the future.

Rape Trauma Syndrome

Burgess and Holmstrom identified the cluster of "symptoms" displayed by rape victims as "Rape Trauma Syndrome". There are three sub-components of this syndrome, A) Rape trauma, B) Compounded reaction and C) Silent reaction. Rape trauma (A) has two categories; it is characterized initially by either a controlled or an

expressed emotional reaction to the event of the rape which develops into two phases -- the acute or disorganization phase and the long term, or reorganization phase. The initial categorization for victim reaction, expressed or controlled, allows for the fact that many victims appear to be very much in control of themselves. Some clinicians might go so far as to say that victims sometimes appear to be unaffected by the event; this may cast doubt for some people on whether or not a rape has occurred at all. It turns out that victims are frequently in a kind of shock or are suffering from utter exhaustion; they may not, for whatever reason, show a reaction. This by no means should be construed as evidence of an undisturbed person. The compound reaction (B) includes rape trauma and is "compounded" by factors outside of the "rape event" such as prior psychological or physical problems, alcohol or drug use, and stressors such as relationship, work, academic, or financial hardship.[6] It is not necessary to show any particular or specifiable behavior in order to be classified as suffering from compounded rape trauma.

In addition, there are women who do not report that they have been raped. It is considered to be a given by all form of research done on rape that more than half of the rapes perpetrated go unreported by the victim. Category (C), the silent reaction, is designed to capture that set of victims who undergo a rape and subsequently rape trauma

syndrome, but elect for whatever reason(s) not to tell anyone that they have been raped. Burgess and Holmstrom regard this group of women as more likely to suffer long term compounded affects of rape trauma. As a result of their silence they do not receive the kinds of attention thought by clinicians to be needed in order to foster the reorganization and recovery phases of rape trauma syndrome.

Below is a chart that briefly sets out the symptoms of a person suffering from rape trauma syndrome. This chart is taken from the previously mentioned Classification of Nursing Diagnoses (Kim, et al., 1980, p.393). In this book rape trauma syndrome is officially recognized as a diagnosis which nurses can make. Rape trauma syndrome has an official diagnostic number and even a subclassification indicating the person's potential for violence.[7]

29.148 Rape Trauma Syndrome
.149 Violence, potential for

A. Rape Trauma

Defining Characteristics of the Acute Phase:

Emotional reactions: anger, embarrassment, fear of physical violence and death, humiliation, revenge, self-blame. Multiple physical symptoms: gastrointestinal irritability, genitourinary discomfort, muscle tension, sleep pattern disturbance.

Defining Characteristics of the Long-term phase:

Changes in life style (changes in residence, dealing with repetitive nightmares and phobias; seeking family support; seeking social network support).

B. Compound Reaction

All defining characteristics listed under rape trauma. Reactivated symptoms of such previous conditions, i.e., physical illness, psychiatric illness. Reliance on alcohol and/or drugs.

C. Silent Reaction

The defining characteristics of the silent reaction:

Abrupt change in relationships with men; increase in nightmares; increasing anxiety during interview, i.e., blocking of associations, long periods of silence, minor stuttering, physical distress. Marked changes in sexual behavior; no verbalization of the occurrence of rape; sudden onset of phobic reactions (Kim, et al., 1980, p.393).

It is an interesting fact about rape trauma syndrome that every possible reaction is considered a symptom of rape trauma syndrome - including the cuts and bruises, muscle tension, and headaches which are some of the physical traumata that result from rape. A victim is likely to be anxious, angry, depressed, even shocked. Or she may not show any sense of disruption at all and may even seem quite normal. According to the diagnostic criteria, all of these things are, nevertheless, signs of the acute/disorganization phase of rape trauma syndrome setting in. What the clinicians are saying, in effect, is that if one is raped one will necessarily suffer from rape trauma syndrome. Any reaction to rape is regarded as evidence of rape trauma syndrome. Rape trauma syndrome is a diagnosable mental disorder. Thus if one is raped, then, necessarily, one will suffer from a mental disorder. Rape trauma syndrome allows

for any kind of reaction, thus one can be reacting "normally" but only from within the parameters of the syndrome.

In the face of this necessity, clinicians claim that to suffer rape trauma syndrome is to experience a kind of break down constituted by the "disorganization" or "disruption of life style" for the victim. For clinicians, organization and the resuming of one's previous lifestyle are the signs of recovery from the syndrome. In general it is thought that humans order their lives based on various events and situations that confront them. We are supposed to develop in certain ways at certain times. At any point in a person's life he or she may be confronted with any number and kinds of crises. Rape is a crisis because it seriously disorganizes and disrupts the victim's life style. The theory of crisis informs the deep background for both rape trauma syndrome itself and treatment of those suffering from rape trauma. In the next section I turn to examine the theories of human life crises. Then we can move on to consider the treatment and recovery of the rape victim in more detail.

Crisis Theory

There are several key elements of assessment for Burgess and Holmstrom. In the basic treatment, intervention

and assessment of a rape victim is concerned with her physical well being, her psychological needs and her social support system. Part of what defines the assessment is the reliance upon established crisis theory. Burgess and Holmstrom ground their treatment and research of rape victims in research done on crisis theory. At the time, the work of Erik Erikson (1950) was the primary body of research on human developmental crisis. A general theory of human crisis had not been formulated. However, much of what they took from Erikson continues to serve as the basis of crisis theory and, specifically, rape crisis theory today.

A crisis is "a crucial situation which, in turn, causes a disequilibrium to an individual's life style" (Burgess and Holmstrom, 1974, p. 300). The theory of crisis is a predictive and explanatory tool designed to allow clinicians to short circuit a crisis reaction. Crisis theory contends that there are two kinds of crises a person may have, internal or external. The response to rape is seen as a response to an identifiable externally imposed crisis in the victim's life. Rape victims are supposed to experience a crisis which causes a disintegration of life style and a potential stoppage in ego quality development.

In an effort to understand how rape victims are viewed and subsequently treated by clinicians I want to explain how rape crisis theory is constructed. It is important to see how the clinicians go about identifying what is important

for the treatment of rape victims. It will tell us about how human beings are understood today by the predominant institutions treating victims of sexual assault. As Burgess and Holmstrom are to the bedrock of the research done on rape victims, Erik Erikson is to North American human developmental psychology -- the foundation of crisis theory. I will begin by outlining the developmental crisis theory of Erik Erikson from his book Childhood and Society (Erikson, 1950, pp. 67-92 and 219-234).

According to Burgess and Holmstrom the notion of internal crises is taken from Erikson's "developmental crises of the life cycle" (Burgess and Holmstrom, 1979, p. 204). Developmental crises are considered normal and expectable, even predictable events or phases in every person's life. The way that they are described by Burgess and Holmstrom presents them as situations where there is a task that must be completed for the crisis to be overcome. There are opposing ego qualities which one must choose between. Each crisis is set within a particular age range, so that by a certain age one will normally be expected to have mastered certain tasks and incorporated them into her way of coping in life. The rape crisis, which is external, is said to "interact" with the developmental tasks that the victim is currently engaged in. This interaction of the two kinds of crises determines the meaning that the rape will have for the particular victim.

> The sexual assault takes on specific meaning to victims according to their stage of development in the life cycle. The counsellor needs to look at the developmental point of the victim and try to understand what the attack means to the victim at that age (Burgess and Holmstrom, 1974, p. 112).

There are eight developmental crises, Erikson calls them "The Eight Stages of Man" (Erikson, 1950, p.219). In these stages a crisis occurs wherein the individual must struggle to attain some ego quality necessary to getting on in life. Thus the crises are set up as contests between two or more ego qualities. Within each stage is a task that must be accomplished in order to resolve the conflict. Each phase identifies ego qualities - one of which is the sign of a successful conflict resolution. In the list below I have underlined the ego quality which is to be achieved in the crisis struggle. In parentheses next to each stage I have written the developmental "zones and modes and modalities" of the respective conflicts, and a rough estimate of the age at which each stage occurs. The "Eight Stages of Man" are, in chronological order: <u>basic trust</u> versus mistrust (oral-sensory, infancy); <u>autonomy</u> versus shame and doubt (muscular-anal, 2-3); <u>initiative</u> versus guilt (locomotor-genital, 4-7); <u>industry</u> versus inferiority (latency, 8-12); <u>identity</u> versus role confusion (puberty and adolescence, 13-19); <u>intimacy</u> versus isolation (young adulthood, 20-29); <u>generativity</u> versus stagnation (adulthood, 30-49); and <u>ego integrity</u> versus despair (maturity, 50+). According to Erikson, if one fails to integrate one infantile stage or

another it can lead to neurotic mental disorders later in life (Erikson, 1950, p. 57).

What follows is a brief explanation of the tasks involved in each of the eight stages and a brief description of how each of these corresponds to the rape crisis.[8]

Stage I Basic Trust vs. Mistrust (infancy)

Task: "To form establishment of enduring patterns for the solution of the nuclear conflict of basic trust versus basic mistrust in mere existence is the first task of the ego" (Erikson, 1950, p.226).

Rape crisis Issue: The victim may fail to acquire trust as her prevailing ego quality.[9]

Stage II Autonomy vs. Shame and Doubt (2-3)

Task: To gain control of the eliminative functions. To learn to stand on one's own feet while still under the protection of those one learned to trust in Stage I.

Stage III Initiative vs. Guilt (4-7)

Task: The child is to "gradually develop a sense of parental responsibility, where he can gain some insight into the institutions, functions and roles which will permit his responsible participation" (Erikson, 1950, p.226).

Rape crisis issue: At this stage a child is concerned with notions of right and wrong. Usually a victim at this age grasps the notion that what was done to her should not have happened, that people are not allowed to do this to children.

Stage IV Industry vs. Inferiority (8-12)

Task: "He can become an eager and absorbed unit of a productive situation" "To bring a productive situation to completion in an aim which gradually supersedes the whims and wishes of his autonomous organism ... the work principle (Ives Henrick) teaches him the pleasure of work completion by steady attention and persevering diligence" (Erikson, 1950, p. 227).

Rape crisis issue: The child begins to be aware of rape as a sexual act, and as such, it is embarrassing. It is frequently confused with any or all other intimate acts (He may wonder if rape is what his parents do or if kissing is rape.)

Stage V Identity vs. Role Diffusion (13-19)

Task: Childhood ends here, youth begins. "The sense of ego identity then, is the accrued confidence that the inner sameness and continuity are matched by the sameness and continuity of one's meaning for others, as evidenced by the tangible promise of a 'career'" (Erikson, 1950, p. 228).

Rape crisis issue: An adolescent is not inclined to talk to or confide in adults. She may be concerned about the possibility of pregnancy. It is thought that this is one of the largest groups of rape victims who do not report that they have been raped.

Stage VI Intimacy and Isolation (20-29)

Task: To "face the fear of ego loss in situations which can call for self-abandon: in orgasms and sexual unions, in close friendships and in physical combat, in experiences of inspiration by teachers and of intuition from the recesses of the self" (Erikson, 1950, p. 229).

Rape crisis issue: The young adult is concerned with the possibility of pregnancy and with maintaining her established intimate relationship. She tends to be more talkative with clinicians, perhaps seeking advice on how to tell other people and to take a course of action with regard to the potential for pregnancy and disease.

Stage VII Generativity vs. Stagnation (30-49)

Task: "Generativity is primarily the interest in establishing and guiding the next generation or whatever in a given case may become the absorbing object of parental kind of responsibility" (Erikson, 1950, p. 231).

Rape crisis issue: The adult victim is concerned with how the rape will affect others in her family or support network. She will be concerned with how this may change her life style, it may call into question issues of sexuality (a diminished desire, etc...) The adult victim is also concerned about possible pregnancy and disease.

Stage VIII Ego Integrity vs. Despair (50+)

Task: " ... [T]he ego's accrued assurance of its proclivity for order and meaning" is a sign of one's entrance into Stage VIII. "The possessor of integrity is ready to defend the dignity of his own life style against all physical and economic threats." He is the possessor of " ... emotional integration which permits participation by fellowship as well as acceptance of the responsibility of leadership" (Erikson, 1950, pp. 232-3).

Rape crisis issue: The mature or older adult is usually more concerned with her physical safety , she may be more strongly affected by a fear of having nearly died. She is also concerned with how to tell her family (her children and grandchildren).

Having detailed the general theories of internal, developmental crises which are ordinary and expected stages of a person's life I now to move on to look at what Burgess and Holmstrom define as an external crisis. Rape is a crisis which is externally imposed. This externally imposed crisis can set off a new internal crisis. (In the next section I address this issue by looking at different treatment models.) Burgess and Holmstrom consider two kinds of external crises: situational and victim crises (Burgess and Holmstrom, 1974, p. 110). Situational crises arise from events or situations that "from the point of view of the person affected" are unexpected and unpredictable (Burgess and Holmstrom, 1974, p.110). The lack of preparedness for the event can increase the potential for a crisis reaction because one is at a loss for how to handle the new and unexpected event. This in turn brings about a "psychological disequilibrium" (Burgess and Holmstrom, 1979, p.111). The following are events that might cause or at

least precede a situational crisis: death (being unexpectedly widowed), birth (a new sibling or perhaps a child born with a serious birth defect), getting married, and beginning school for the first time.

Victim crises are those where "the individual faces and overwhelmingly hazardous situation and in which the individual may be physically [and]/or psychologically injured, traumatized, destroyed or sacrificed" (Burgess and Holmstrom, 1974, p.111). The causes or precedents can be of human design or environmental. Among the human designed causal factors are war, riots, murder, rape and torture. Environmental causes are events such as earthquakes, floods, and other very dangerous, sudden and violent forms of natural disaster.

Rape, of course, constitutes a victim crisis. It has an effect on the victim that is not unlike the effect war has on soldiers. It can be utterly debilitating. Later in this chapter I will demonstrate that these two groups of people are understood to have a good deal in common.

The Needs Identified, Treatment and Recovery

In assessing the kind of treatment thought to be warranted for victims of rape we must return to the perceived needs of the victims. Then we will proceed to the way that these needs form the kind of treatment a person

might receive. From there we can take a closer look at what constitutes a recovery from the event of a rape in one's life.

The needs identified by Burgess and Holmstrom are first touched upon in the developmental crisis theory. A brief reminder of the rape crisis issues associated with each level of development may be in order here. For the very young victims (infancy to age 3) trust is the issue. For children ages 4-7, notions of right and wrong are present. For children 8-12, they perceive that the event can be construed as sexual and, as such, as embarrassing. Once the rape victim enters adolescence the concerns begin to cohere around a particular set of issues: pregnancy, sexually transmitted disease, and the stigma attached to rape victims. Within the age groups 13-19, 20-29, 30-49 and 50+ the concern is how to tell a certain group of people. For teens the concern is with talking to parents; with young adults the concern is to talk to one's significant other and family; in maturity the concern turns partially around, one must now decide whether and how to tell children and partners. Finally, in late maturity there is the concern for telling one's adult children and perhaps also one's grandchildren. Late maturity also carries an increased concern with physical harm, as one is more fragile in these years than in the teen to adulthood years. It seems to be the case that these are the concerns addressed most quickly

for victims. Most of the issues involved for teens through the oldest victims tend to be resolved within the first few days following the rape. Thus, they constitute the acute crisis intervention.

As time passes, victims suffer in the ways specified in the acute phase of rape trauma syndrome. These are less strictly physical aftereffects and tend to be more focused on the psychological and social aspects of the event. This is when the disorganization of a victim's life becomes apparent. A victim may lose her appetite, sleep badly or not at all, suffer from headaches, mood swings, anxiousness and the like for quite a long time. Most rapists threaten their victims with death or torture immediately if they do not cooperate, and later, if they tell anyone. Thus, it is not unusual for the victim to feel that she is not safe anywhere. Often she will change her phone number, stay with friends or family and/or move to a new place. These changes, brought about by the victim, are seen as a move from the acute phase to the long-term phase of rape trauma syndrome. It is thought that these changes are signs that the victim is re-establishing herself, her life-style (which, you will recall, is said to have been interrupted and disorganized); she is on the path to recovery. The way that a clinician may encourage a victim on her path to recovery is by using various psychological theories which

are thought to put to rest the issues that arise during the acute phase of rape trauma syndrome.

There are several models of treatment involved, some run concurrent with one another, others are taken up at different phases of recovery, some come up only in particular cases. I will address each as it would come up chronologically in the treatment of the victim, beginning with the medical model.

Medical treatment is very straightforward in that it is concerned primarily with the physical harm done to the victim and the possible aftereffects that this will have for the victim. The medical treatment entails gathering evidence for a possible prosecution if the assailant is caught and tried, medication for possible pregnancy and sexually transmitted diseases, and assessment of the psychological affects of the event. For the most part the medical model is concerned to ensure the physical well-being of the victim.

The social network model is the next aspect of treatment. The point here is to determine the extent to which the victim has a supportive social network. A clinician or advocate tries to assess the number and location of possible friends and family that the victim may rely upon for support in the immediate aftermath of the rape. It is thought that the stronger the social network of the victim the more likely she is to begin to recover.

Thus, the clinician or advocate tries to see that the victim is in contact with someone she can rely upon for support before she leaves the hospital. Part of the social network is the victim's work, school, and social activities. The social network model is concerned to get the victim back to living her life as it was before she was raped. It is, of course, encouraged in such a way that the victim is empowered to make her own decisions about when to do something and what to do. So long as she begins to pursue activities and interactions with other people the social network model is considered to be effectively helping the victim to recover.

The next model of treatment is called the Behavioral Model. Its primary focus is on "desensitizing the person to the behavior that results from the rape experience - specifically, the phobic reactions". The thought here is that "mental health problems or distress [are] unacceptable or noneffective behavior[s]...." Phobic reactions are seen as "behavior learned in a maladaptive way" (Burgess and Holmstrom, 1974, p.228).[10]

The implementation of this model of treatment is designed to diminish the negative reactions to the rape, such as fear, anxiety and stress. Moreover, the behavioral model seeks to

> ... inflate her [the victim's] own self-esteem and self-confidence in dealing with the world again. The victim then has the potential to reach her previous level of functioning or of strengthening

> her capabilities to feel secure again (Burgess and Holmstrom, 1974, p.228).

The process of desensitization is aimed at helping the victim gain a kind of control over her memories of the rape. The further aim is to get the victim not to feel the feelings associated with the rape. She will (it is hoped) be able to recall the event in a more dispassionate manner thus having "psychological control over the memory" which "strips it of its power to distress the victim over and over" (Burgess and Holmstrom, 1974, p.228). It seems that the goal here is to "settle the issue" so to speak. The settling seems to consist in returning to one's prior life style. If rape is considered a disruption of life style leading to disorganization of the life style, then to reorganize or at least put it back into place constitutes a recovery, or at least a settling of the event into the past that no longer confronts the victim.

The last model is called the Psychological Model. It is a model of treatment involving the belief that "...there is a reason or meaning to the problem a person experiences" (Burgess and Holmstrom, 1974, p.230). This model uses the developmental stage theory as part of its basis, and personality theory fills in the rest of the story and treatment. Under this model a clinician assesses the way that the victim "...handled maturational or developmental phases of life" (Burgess and Holmstrom, 1974, p.230). This is done because it is thought that traumas such as rape make

see, they turn out to be something that one might call basic human needs. But as further interpreted by Burgess and Holmstrom they begin to look a bit different.

The need to be cared about, when it is a strongly felt need prior to the rape, may cause the victim to suffer more acutely from the kinds of rejection that many rape victims are subjected to, too often by the people they most need to feel loved by. It is not at all unusual for family members, spouse, boyfriend or friends of a rape victim to react to the event in an unsupportive, sometimes even hostile or accusatory way. This in turn leads the victim to feel that she is somehow inferior or unworthy of the affections of those she loves and respects. She may begin to think that she could be blamed for having been raped to the degree that she actually deserved to be raped.

The need to be in control is interpreted by Burgess and Holmstrom in the following way. The person who needs to be in control needs to be in control of herself, her emotions. More specifically she is the type of person who needs to be seen as good and loving rather than angry, hateful or destructive. Being emotionally out of control is equated with being bad. Thus, when this victim becomes angry she views herself as bad and out of control; she is thus unable to feel what some construe as the appropriate emotions for the circumstances. She too is likely to fall into self-blame and self-doubt concerning the part she may have played

a person particularly vulnerable to the pitfalls of a poorly resolved ego quality. That is, if one was never able to establish the trust necessary in Erikson's stage 1, then one will be faced with many difficulties with trust now as a result of the rape.[11] Personality theory holds that one can explain aspects of the rape event in terms of the victim's personality. Her personality is thought to dictate the details of her life style in such a way that once the clinicians understand her personality they will understand her life style which is in turn supposed to inform the conditions of the rape and her reaction to it. The questions asked within this model run along the following lines: why was the victim at the particular location, what is her chosen life-style, and more generally how does her personality dictate the choices she makes?[12]

There are three "dynamic" issues in personality theory. When any one of these issues is threatened in some way "...one's self-esteem is also lowered which in turn brings on a psychological or crisis reaction" (Burgess and Holmstrom, 1974, p. 230). The three dynamic issues are articulated by Burgess and Holmstrom as they relate to the rape crisis. For us it is important to see how they make use of this theory in order better to assess the criteria for treatment and recovery of a rape victim. In a nutshell the issues are as follows: the need to be cared about; the need to be in control; and the need to achieve. As you can

in the rape -- that is, she begins to believe that it was her fault that she was raped and that she could or should have prevented it. Her positive self-evaluation depends upon her ability to deny negative emotions (i.e. anger and hate) and to believe that there was nothing she could or should have done to prevent the rape from happening.

The need to achieve is seen to be the need for superiority, strength, and security. This person will have to fight off feelings of weakness and insecurity after having been raped. The feelings elicited by the event of a rape are less centered on how this affects her relation to others or her feelings of moral integrity. She is inclined to feel a kind of defeat and powerlessness indicative of a competitive person who has lost at something -- in this case she lost her power to control and protect herself, thus lowering her perceived status as an achiever (and as a human being).

The recovery of a victim from a rape is supposed to be shown through her move back into her previous life style in such a way that it is clear to the victim and to her counsellor that she is not denying the event or its effect on her. This is demonstrated in part by the victim's testimony that the memory of the event is no longer traumatic and that she has control over when she thinks about the event. She is able to "psychologically let go of the pain, fear and memory and feels a degree of calm within

herself to go about the business of living again" (Burgess and Holmstrom, 1974, p. 234). She moves from being a victim to being a survivor.

Endnotes to Chapter One

1. In this paper I have elected to refer to rape victims in the feminine rather than the masculine. This is not to be read as claiming that males are not raped or sexually assaulted. When it will not be confusing, I will incorporate reference in the masculine in order to strike a balance of reference between male and female overall. Moreover, as an advocate I spoke to women nearly all of the time and find that it would be inappropriate to incorporate gender neutral language into a paper about rape victims. I am inclined to think that gender neutral language makes a mockery of the countless women who have been raped and assaulted.

2. Throughout this document I will return to this issue. I believe it is a very important aspect in determining what must be done to help rape victims.

3. At the end of chapter two I will briefly examine some aspects of the early research by clinical authorities on men deemed to be sexually dangerous.

4. According to the Classification of Nursing Diagnoses -- Proceedings of the Third and Fourth National Conferences by Mi Ja Kim, et al, they "collected biopsychosocial data" during the counselling sessions for rape victims (Kim et al, 1980, pp. 305-6).

5. Burgess and Holmstrom do not claim overtly that this is what they are doing. But given the kinds of things that they stress in assessing victims and seeking ways of facilitating recovery it seems both acceptable and sensible retroactively to claim that this is the approach that they took in their research of rape victims.

6. The term 'stressors' is psychological jargon for those aspects of life that can and do cause stress in one's life. They have in mind troubled relationships, tensions at work, pressure to perform at school or elsewhere, and any other thing that is likely to cause stress in an individual.

7. However, it is not found in the more widely known medical manuals such as the Diagnostic and Statistical Manuals, the Merck Manual, or the ICD-10. In section II of this chapter I will return to this in order to offer an explanation for the absence of rape trauma syndrome from these diagnostic manuals.

8. Burgess and Holmstrom think that the victim's age determines the type of crisis and concerns that she will have. One may have difficulty resolving the autonomy vs. shame and doubt conflict if one is molested or raped at the age when

this is the conflict at hand (i.e. 2-3 years of age). But that a victim, at age 23, may be troubled by the thought that the rape constitutes a violation to her autonomy is presumably not what they would identify as a crisis related issue. (That is, it is not an issue related to the crisis caused by the rape.)

9. Burgess and Holmstrom lump stage one and two together such that between infancy and age three there is a certain uniformity to the concerns and issues involved for the victim.

10. I find it necessary here to quote somewhat extensively. I want to allow Burgess and Holmstrom to speak for themselves. When I turn to the analysis of what they have said it will make more sense to the reader if he has seen what they said in the first place.

11. Of course, this makes sense on one level. But, it seems that anyone would have a difficulties with trust after having been raped. Does this entail that all rape victims who suffer a compounded crisis involving an inability to establish trusting relationships failed to resolve the stage I ego crisis?

12. The terms used by the clinicians here, especially the notion of chosen life style, intimate that they presume that how and where victims live is largely a matter of choice. This is, at best, doubtful in the case of many of the women most at risk of rape: the poor and uneducated. (This remark was prompted by comments made by Earl Winkler on a prior draft.)

Chapter Two

The Psychological Account of Rape: Elaborations and Concerns

With the framework of rape crisis theory now in place, we can now step back and look more generally at how this framework asks us to conceive rape victims. In this chapter we will look at some of the claims about both rape victims and rapists to which this framework is committed. These claims, it will be argued, both show stresses within the framework of rape crisis theory and stand rather at odds with the victims' own conceptions of themselves. This will prepare us for the alternative framework offered in Chapter Three.

Rape Trauma Syndrome and Mental Disorder

On the psychological model rape victims are considered to experience a kind of traumatic shock beginning with the realization that they are about to be deeply harmed and possibly killed for reasons they cannot discover. The trauma continues through a long process of recovering from the event.

In the Merck Manual of Diagnosis and Therapy, published by the Merck Research Laboratories, rape trauma syndrome has not been acknowledged as such but the rape victim is considered to have suffered an extremely stressful

psychological trauma (Merck, 1992, pp. 1832-30). Under the heading "Medical Examination of the Rape Victim" one finds the following instruction: "Patients should be viewed as undergoing a post traumatic stress disorder that typically has an acute phase lasting a few days to a few weeks, followed by a long-term process of reorganization and recovery" (Merck, 1992, pp. 1832-3, emphasis added). As mentioned before, rape trauma syndrome itself is not even mentioned in the diagnostic manuals, except for the Classification of Nursing Diagnoses manual. In 1980, rape trauma syndrome appears to have been completely subsumed under the larger disorder "Posttraumatic Stress Disorder" by the American Psychiatric Association in Diagnostic and Statistical Manual -- III (henceforth, DSM-III).

Posttraumatic stress disorder is most commonly thought of as the disorder suffered by war veterans. The disorder is, however, much more broadly defined than that. In accordance with the general diagnostic thrust of the American Psychiatric Association, it is characterized by certain kinds of behavior or symptoms of the group of people who are diagnosed with it. The most important factor in those who suffer from posttraumatic stress disorder is that they all undergo the experience of a "...traumatic event that is generally outside the range of usual human experience" (APA, DSM-III, 1980, p.236). It is thought that anyone in the situation would be greatly distressed and it

must be outside the range of such events as bereavement, illness, business losses and so on. The characteristic symptom for sufferers is an inability to control the recall of the traumatic event.[1]

For demonstrative purposes, I will list below the most recent criteria for the diagnosis of posttraumatic stress disorder[2]:

> Diagnostic criteria for 309.81 Post traumatic stress disorder
>
> A. 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 the physical integrity of self or others
> (2) the person's response involved intense fear, helplessness, or horror.*
>
> B. The traumatic event is persistently reexperienced in one (or more) of the following ways:
> (1) recurrent and intrusive distressing recollections of the event, including images, thoughts, or perceptions.*
> (2) recurrent distressing dreams of the event.*
> (3) acting or feeling as if the traumatic event were recurring (includes a sense of reliving the experience, illusions, hallucinations, and dissociative flashback episodes, including those that occur on awakening or when intoxicated).*
> (4) intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event.
> (5) physiological reactivity on exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event.

C. Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness (not present before the trauma), as indicated by three (or more) of the following:

(1) efforts to avoid thoughts, feelings, or conversations associated with the trauma
(2) efforts to avoid activities, places, or people that arouse recollections of the trauma
(3) inability to recall an important aspect of the trauma
(4) markedly diminished interest or participation in significant activities
(5) feeling of detachment or estrangement from others
(6) restricted range of affect (e.g. unable to have loving feelings)
(7) sense of a foreshortened future (e.g. does not expect to have a career, marriage, children, or a normal life span)

D. Persistent symptoms of increased arousal (not present before the trauma), as indicated by two (or more) of the following:

(1) difficulty falling or staying asleep
(2) irritability or outbursts of anger
(3) difficulty concentrating
(4) hypervigilance
(5) exaggerated startle response

E. Duration of the disturbance (symptoms in Criteria B, C, and D) is more than 1 month.

F. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

specify if:
Acute: if duration of symptoms is less than 3 months
Chronic: if duration of symptoms is 3 months or more

specify if:
With Delayed Onset: if onset of symptoms is at least 6 months after the stressor (APA, DSM-IV, 1994, pp. 424-9).

So, rape trauma syndrome is never acknowledged as a separate disease entity, but a direct comparison between

rape trauma syndrome and posttraumatic stress disorder makes clear that rape victims are likely candidates for this mental disorder. There is also the diagnostic category "Acute stress disorder (308.3)" for those that suffer similar symptoms for 1 month or less. It is only if one's symptoms continue for more than one month that one is upgraded to an official case of posttraumatic stress disorder.

There is, clearly, a firm connection between posttraumatic stress disorder and rape trauma syndrome even though they emerged as official diagnoses for different groups of practitioners in different publications. Though neither group mentions the other disorder, both disorders were officially acknowledged in 1980. They fit together due to the obvious similarities in the effects that war has on veterans and that rape has on victims. Posttraumatic stress disorder emphasizes the lack of control one has over one's memory recall and one's moods. Generally, those with posttraumatic stress disorder are not managing their lives according to the norms of their culture. They are disorderly in certain ways which they are not able to control (i.e. angry outbursts, joblessness, homelessness, addiction to any number of legal and illegal drugs). Rape victims exhibit similar inability to cope and to function normally.

Thus, as we have shown in Chapter One above, given the way that rape trauma syndrome is defined, one need only be raped in order to suffer from it. Therefore, since rape trauma syndrome is considered a type of posttraumatic stress disorder (or acute stress disorder), a rape victim is taken to be necessarily suffering from a mental disorder as soon as she begins to react to the traumatic event of the rape.

The notions of mental disease, illness, and disorder are a bit vague even within the language of psychiatry. It has been difficult to locate the particular meaning of these terms. However, a look at attempts to define these terms reveals that rape trauma syndrome only problematically fits within the general notion of mental disorder. This fact reveals a tension in clinical thought that proves to be instructive.

In Psychiatric Diagnosis: A Biopsychosocial Approach, Jess Amchin, quoted the DSM-III-R as defining a disorder as follows:

> In DSM-III-R each of the mental disorders is conceptualized as a clinically significant behavioral or psychological syndrome or pattern that occurs in a person and that is associated with present distress (a painful symptom) or disability (impairment in one or more important areas of functioning) or with a significantly increased risk of suffering death, pain, disability, or an important loss of freedom. In addition, this syndrome or pattern must not be merely an expectable response to a particular event, e.g. the death of a loved one. Whatever its original cause, it must currently be considered a manifestation of a behavioral, psychological, or biological dysfunction in the person. Neither deviant behavior, e.g. political,

> religious, or sexual, nor conflicts that are primarily between the individual and society are mental disorders unless the deviance or conflict is a symptom of a dysfunction in the person as described above... (Amchin, 1991, p.53, emphasis added).

The disorders we are concerned with here, posttraumatic stress disorder and rape trauma syndrome, were considered anxiety disorders in DSM-III. Quoting again from Amchin, anxiety is defined as the feeling of "apprehension, tension, [and] uneasiness that stems from the anticipation of danger, which may be internal or external" (Amchin, 1991, p. 112). Anxiety disorders, according to ICD-10 Classification of Mental and Behavioral Disorders, published by the World Health Organization (WHO), are to be regarded as "maladaptive responses to severe or continued stress, in that they interfere with successful coping mechanisms and thus lead to problems in social functioning" (WHO, 1992, pp. 145-6). In 1980 the disorders which are now regarded as anxiety disorders were regarded as "neuroses". There was, however, a conscious shift from DSM-III to DSM-III-R in the conceptual framework. The "neurotic-psychotic" distinction was dropped in favor of more phenomenologically descriptive criteria for mental disorders. (Perhaps credit can also be given to an increasing amount of political pressure from advocacy groups on the one hand and insurance companies on the other hand.) In The New Language of Psychiatry: Learning and Using DSM-III, Ronald Levy, says of posttraumatic stress disorder that it describes the

"...untoward reactions of some individuals after undergoing extreme stress" (Levy, 1982, p. 203, emphasis added).

There is a tension here in psychiatric thought about those suffering from rape trauma and posttraumatic stress. Those who suffer from these disorders have experienced something beyond the bounds of ordinary human experience that is thought likely to induce significant stress reactions. In some sense, not reacting might be considered (and is considered in the case of rape trauma syndrome and posttraumatic stress disorder) potentially more harmful to the victim than manifesting a stress or anxiety disorder right away. So, psychological reaction to the point of dysfunction is considered the norm in the case of extremely stressful events such as rape, torture, war, and some natural disasters. But, according to the definition of disorder above, the behavior of the person "...must not be merely an expectable response to a particular event..." In the case of people with rape trauma syndrome or posttraumatic stress disorder the response is, in an important sense, normal but the cause of the response is not within the bounds of ordinary human experience.

Right off the bat, then, we have a tension here. Obviously these are people in need of help. They have little if any control over their memory and for many it is as if they have no control over their own minds. The definition of posttraumatic stress disorder specifies that

the trauma cannot be an experience most of us will have undergone. Thus, there is a terrible sense of isolation for those who do have these experiences. One does not talk about such things if one feels that one will be misunderstood or if the listener might underestimate the importance and traumatic nature of the situation. Naturally, these aspects of trauma drive a person to a kind of adaptation that may not fit well with the standard expectations of the rest of society. It seems that they do become disordered in a way from the experience and perhaps from the ongoing recurrence of the trauma within them. But this seems quite different from the person who, within ordinary circumstances (i.e., circumstances not punctuated with extreme trauma), is unable to cope and becomes seriously disordered and dysfunctional. Rape trauma and posttraumatic stress both have precipitating causes, which are extreme. Most mental disorders do not. Or at least, one need not know the cause in order to diagnose a person with most official DSM mental disorders.

There is no obvious way to resolve this tension while remaining within the clinical framework. The clear place to begin would be to try to make out a distinction between expectable reactions to expectable or normal events in human life (for example, the death of a parent) and expectable reactions to abnormal and extreme events (for example, rape and war). It is not at all clear that this can be done,

however. "Abnormal" here cannot simply be understood as "unusual" or "unexpectable". It is not within the spirit of the psychological approach to claim, for example, that rape trauma syndrome would cease to exist in societies where rape was an expectable event in the life of women. Indeed, psychiatric literature (such as Folnegovic-Smalc, 1994) on the rape of women in the civil war in Bosnia-Herzegovina uses the language of posttraumatic stress disorder in a situation of widespread and systematic rape. The best attempts to understand "abnormal" in this context seem to be notions such as "horrific" or "inhuman" but these notions don't seem to be explicable in straight-forwardly psychological ways.

The fact that rape trauma syndrome fits into posttraumatic stress disorder indicates something only problematically resolvable. The inevitability of rape trauma syndrome in response to the rape event seems to indicate that the clinicians want to be able to say that rape victims are harmed severely in all cases. They want to acknowledge and emphasize the severity of these kinds of trauma. War, torture and rape must be seen in light of what they almost necessarily do to those who experience them. The horrible nature of the trauma event must be acknowledged in some way. Within the clinical framework, the way to do this is to claim that the harm done is so severe as to cause a mental disorder. This is the obvious way within the

framework to acknowledge the universally harmful nature of extreme trauma. Any reaction to horrific events can, then, be seen as normal because all who suffer such events are disordered. The pathologization of victims and, thus, normal reactions to abnormal and hideous traumatic events, is the way that clinicians typically understand the universal harm of rape and other severe traumas. The problem is that the disorders (rape trauma syndrome and posttraumatic stress syndrome), which are by definition the sum of predictable and inevitable reactions to such traumas, do not fit the definition of disorders given by the APA. Disorder seems ill-fitted to the work it is asked to do in cases of extremely traumatic events -- expected responses to unexpected events are not part of the standard definition of mental disorder.

In chapter one I mentioned that some research has been done by clinicians on rapists. Before I continue the analysis of the implications of the clinical framework I want to turn briefly to examine what the clinicians have learned about rapists.

Clinicians and the Rapist

In the same way that clinicians are regarded as having expert knowledge of rape victims, they have come to be regarded as the experts on criminal behavior.[3] They claim

to have a body of knowledge about rapists, as they do other kinds of criminals. That is, they have spent time researching, interviewing and observing rapists and from these efforts it is thought that a certain expert knowledge has come about. Although I am primarily concerned with the treatment of rape victims, it is helpful to see what the clinicians have to say about those who commit rape. As mentioned before, research subjects of this kind are hard to come by because they are criminals. Most of the research done is on the rapists who are caught and convicted of this crime; this may skew the sample quite a bit.

Before going into the results of the study of rapists I will introduce typical circumstances under which clinicians have access to them. The Massachusetts Correctional Institution at Bridgewater was founded in 1959 for the observation, evaluation, treatment and rehabilitation of "sexually dangerous" individuals. The subjects were evaluated to determine whether they should be committed to the center for treatment. If the subject was judged to be treatable he was then committed for an indefinite period of time, meaning until he was considered by the clinicians to be less likely to commit sexually dangerous acts. The following information is taken from an article about this facility, "The Psychology of Rapists", written by Murray Cohen, et al (Cohen, et al. 1971, pp. 307-27).

Studies show that there are three basic kinds of rapist, each is distinguished according to the aim the rapist seeks. These aims are a) aggressive aim, b) sexual aim, and c) aggression diffusion aim.[4] Each category is composed of descriptive qualities of character, personality, developmental abilities in behavior, relationships, work and other activities of day to day life. It is interesting to note that each kind of rapist is thought to have a defective development of one or more of the Eriksonian ego qualities. At the time that the article was published the clinicians guardedly compared each category with a particular diagnosis found in the DSM-II. The DSM disorders did not include the proclivity towards socially unacceptable sexual behavior. I suspect that if one were to consult the more recent DSM-IV one would find that there are more descriptively accurate diagnoses that assimilate both the DSM-II personality disorders and the symptomatic behavior such as sexual assault.

The aggressive aim rapist is violent and angry when he rapes, his aim is to violate and to hurt his victim severely. He rapes total strangers chosen randomly, usually after an altercation with a person he is in a relationship with. He is basically regarded as normal in his day to day life, except for his quick temper and violent outbursts. He works regularly and well, he is manly and responsible, and he hates things that affront his sense of manhood. The

problems lie in his underdeveloped ego qualities of identity and intimacy. The clinicians regard his behavior as symptomatic of poorly resolved homosexual tendencies which he represses as best he can. The opposing qualities to identity and intimacy are role diffusion and isolation. The related DSM-II disorder is the "explosive personality disorder" which fails to capture his focused aggression toward women, but holds adequately enough (Cohen, et al., 1971, p.326).

The sexual aim rapist is perhaps the most stereotypical or popularly understood kind of rapist. This rapist seeks out a woman, usually a stranger, but not at random as with the aggressive aim rapist. He is sexually aroused and thinks, or at least hopes, that his victim will find him pleasing. In general, the sexual aim rapist is not gratuitously violent; he does harm only to get what he wants. Clinicians find that the sexual aim rapist is afflicted by guilt and shame. He is said to be both socially and sexually impotent in daily life, as well as when he attacks his victims. Guilt and shame are the opposing ego qualities to autonomy and initiative. The sexual aim rapist is also thought to be struggling with homosexual impulses, but his reactions are less violent than the aggressive aim rapist. Nonetheless his raping is symptomatic of someone trying to find intimacy which he has failed to find using the socially sanctioned practices. The

DSM-II disorder most closely fitting the sexual aim rapist is "inadequate personality disorder", which fails to accommodate the extent of the perversity of this type of rapist, but overall describes his personality structure adequately (Cohen at al., 1971, p. 326).

The sex aggression-diffusion rapist is concerned to elicit aggressive behavior from his victim. There is no sexual excitation without violence for him. Clinicians observe that there is a "sadistic component" to this type of rapist. According to Burgess and Holmstrom this person will also show a history of

> nonsexual, antisocial behavior, an absence of stable relationships, [a] lack of concern for others, difficulty in tolerating frustration, poor ego controls, [and] absence of psychic discomfort over their behavior... (Burgess and Holmstrom, 1974, p.29).

His personality development "reveals an absence of the latency period" which is the stage when one is supposed to resolve the conflict between industry and inferiority. It is not entirely clear if the clinicians mean to say that the personality development arrests at this point or if it simply skipped over this stage. Given that Erikson understood each stage to be successive upon the last it is likely that the clinicians mean that the sex aggression-diffusion rapist developed the undesirable ego qualities from this point forward. This idea is supported by the symptoms that clinicians point to. His behavior is impulsive and he is cruel to those who are weaker than he

is. Clinicians are inclined to view this type of rapist as psychotic and suffering from the DSM-II "antisocial personality disorder".

There is one other category of rapist mentioned by Burgess and Holmstrom, but is not discussed in any depth by Cohen et al.. The impulse rapist does not set out to rape but will do so if the opportunity arises. According to Burgess and Holmstrom "various researchers ... consider this rape an expression of predatory disorder" (Burgess and Holmstrom, 1974, p.32). The aim of the impulse rapist is difficult to gauge, he is usually engaged in some other criminal activity first. Some compare this person to one who is with a conquering army, raping and pillaging go hand in hand.

I will not go further into this aspect of clinical study. I want merely to point out the similarity of framework used to view rapists and their victims. Both groups of people are regarded as suffering from psychological problems of one kind or another. The clinicians have found a way to say that rape is abnormal by making both rape and the reaction to it expressions of mental disorder. In laymen's terms, all of these people are sick. The rapists are sick. They express the symptoms of their sickness by raping, which in turn makes their victims sick.

Conclusion

The clinicians want to know why the victims of rape and other traumas become disordered individuals. In psychology the answers and explanations lie in the vocabulary of medicine and social science. The people who rape, murder and torment are not normal. Not being normal translates into being sick. The sickness that these deviants have is social only in so far as the expression of symptoms affect others, hence the term anti-social. The clinicians are looking for explanations that show that these people are sick in the same way that a person with cancer is sick. That is, they seek the causes which show that the deviant has little or no control over his behavior. As a consequence, when a victim needs to know why she, of all the people in the world, was chosen to be tormented, the answer is simple; "the person who did this to you is sick". Thus the victim is able to know that she <u>is</u> a victim, she had no responsibility for the perpetrators actions, she was chosen because the rapist is sick. In the same sense the rapist's "sickness" also diminishes his responsibility.

As I draw this chapter to a close, I want to direct attention to the thread that holds crisis theory and the various treatment theories together. They are used to treat people who have been raped, but are also applied to people seeking psychological treatment generally. The connecting

thread is an instrumentalist view that clinicians have of the human subject. We are, on this view, complex systems ordered toward various functions. The language of psychology and medicine is about function, order, organization, integration and productivity. Yet, as we have seen, autonomy, shame, guilt, integrity, anger, self-respect or self-esteem, victimhood, and trust are all also part of the language of psychology.

The framework of instrumentalism within psychology requires a consequentialist view of harm. An action is wrong if it causes harm. The harm of rape is apparent. Victims of rape manifest both physical and psychological traumata as a direct result of the rape. Treatment based on a diagnosis of rape trauma syndrome is designed to be helpful to all victims of rape. But once one goes beyond the 'normal' set of reactions (i.e. symptoms of rape trauma; sleep disturbance, mood swings, moving, etc.), one is then suffering a compounded reaction which puts her into a category where she is abnormal because she is reacting badly or in a maladaptive way.

The harm that clinicians see is the disordering, the disorganization, and the cessation of normal functioning in the psychological, physical and social systems. Once a rape victim is back to her previous level of functioning in these areas she is considered to be a recovered survivor of rape. The bad effects have been reversed. To be a survivor is to

able to manage both one's reactions to and memories of the rape to the point that they no longer interfere with one's life.

The instrumentalism stems from two things, the heavy and barely acknowledged reliance of much psychological theory on Erik Erikson's "Eight Stages of Man" and the deeper framework which sees human beings as mechanical, functional systems. Only when we fail to function within the norms of our society is something wrong enough to be concerned with it.

North American Psychology and medicine in general have become highly scientized. They no longer seek to work within the murky regions of the moral and humane. There are not enough 'facts' in this realm. Morality, the soul, and humanity have been exchanged for cognitive function, biochemistry, social systems and prozac. The words commonly construed as moral (or at least value laden) in the theories on the preceding pages are hollow shells by comparison to the fully moral use of these words. Autonomy has become an ego quality one acquires in the face of shame and doubt. It is the child's quest to learn to control his eliminative functions that brings up the possibility of autonomy in a person. Shame is a result of failing to live up to the expectations of those one trusts. Doubt comes with finding oneself less worthy by virtue of failure. Thus, it is

possible to be undeserving of, or even to fail to be in possession of autonomy.

The list of required ego qualities is impressive and instructive when trying to understand why clinicians might question emotional reactions to rape. If one is feeling suddenly unable to continue in her previous life due to deep fear of both the rapist and other people's reactions to her having been raped, then she is having a compounded reaction based in a poorly resolved ego conflict. Rather than a justified fear based on the cultural norms surrounding rape and the fact that many rapists are never prosecuted, she is displaying a fault in her personality structure (seen by clinicians as the source of the self and of one's positive self-evaluation).

Emotions frequently referred to as moral emotions -- anger, guilt, shame, indignation, and outrage -- are treated as further signs of a maladaptive personality on the part of the victim. She may be asked why she is angry or why she feels that she should have or could have done something to prevent the rape. The answers to these questions are thought to be found in the victim's past, that is in the personality structure and developmental stage of the person, not in the actual trauma experienced during and after the rape.

A person who has been raped has been victimized. No one wants to question this. The kind of victimhood assigned

to one who has been raped varies across the relevant fields. Legally speaking, one is a victim of a violent crime. This applies to one's legal status, the person's legal rights have been violated. Rape causes physical harm, so one is a victim of violence done to the body. Rape also causes harm to the psyche; a person who has been raped may see herself as essentially a victim. This brand of victimhood is an identity of sorts that one who has been raped may adopt. By adopting the language of disorder, disorganization, abnormality, lack of control and dysfunction, clinicians encourage a rape victim to adopt the stance of a person defined as a victim (as opposed to a person who has been victimized).

In Rewriting the Soul: Multiple Personality and the Sciences of Memory, Ian Hacking calls this the looping effect of human kinds (that is, kinds of humans we might be). He argues that we tend to behave in ways that are expected of us, especially if the expectation arises from an authority we respect such as a physician or therapist.

> People classified in a certain way tend to conform to or grow into the ways that they are described; but they also evolve in their own ways, so that the classifications and descriptions have to be constantly revised (Hacking, 1995, p.21).[5]

The treatment offered by clinicians and the framework which informs the treatment is designed to get a person to function in a certain way. In order to excuse and to alter her behavior, clinicians ask the rape victim to see herself

from within the stance of victimhood. This is true because her behavior is deviant from the norm. As deviant, it is seen as undesirable or dysfunctional. But, if the deviance is caused by a trauma such as rape, then she is a victim and, as such, her behavior is excused from some of the standards of normalcy. Thus, the rape victim takes on the identity of a victim in order to explain herself and to excuse herself from the standards applied to non-victims. But she must remain a victim for as long as she is affected by the event of the rape. Given that most rape victims do not feel that they will ever return to being their former selves, they appear to be stuck, helpless in the victim stance.

After years of feminist critique, psychology has come up with a move out of the victim stance. It is the move from victim to survivor. As a survivor she is still able to acknowledge herself, and be acknowledged as, a person who was a victim and who may not be the way she was before she was raped. But she does not remain in the state where she is unable to function in everyday life. Thus, one is still affected, and sees herself as changed permanently, but she will survive and carry on. The looping effect of human kinds results in people changing their way of being (for good or evil). As "constructed knowledge loops in upon people's moral lives, [it] changes their sense of self-worth, reorganizes and reevaluates the soul" (Hacking, 1995,

p.68). It certainly seems to be true that psychological victimhood and survival have the effect of changing the rape victim's conception of herself.[6]

The move to pathologize normal (or at least reasonable) reactions to extraordinary trauma seems like a potentially harmful move. There are details in the definitions and testimonies of the victims of posttraumatic stress disorder and rape trauma syndrome that lead me to think that these symptoms signify more than psychological dysfunction. The harm done seems to affect more than basic human functioning. It is said by all the manuals that posttraumatic stress disorder is more severe in those who suffered at the hands of other human beings - that is, if the trauma was of human design and implementation. So the question I want to ask is this, are these people sick or has their humanity been deeply injured? Either way, at this time in our society they are going to wind up seeing an expert in psychological disorders. But perhaps the approach that the clinician takes is not the one that is most beneficial to the victim of severe trauma. It will be said that the victim is mentally disordered, sick, disorganized, managing or functioning badly, all in the course of acknowledging her suffering. As a result, victims of trauma must take on a kind of responsibility that works against them. They have failed to cope with a traumatic event. The question that needs to be asked is <u>why</u> did they fail to cope? It was not

for lack of coping skills in normal life. It is more that the horror of the experience has left them without any explanation of why it happened. There are no good reasons; or, rather, there are no justifications for the hideous things that have been done to veterans of wars and to rape victims. In war and rape, the message sent is that one is not regarded as a fellow human being; one wouldn't do this to one's fellows. It is inhuman treatment aimed at destroying one's personhood or humanity. And it works, in so far as it places the person in a position where the world in which trusted falls apart.

With a medicalized framework the clinicians take the question of why a person has been victimized to be a request for an empirical explanation. In essence, it is a question of the nature of the rapist's disorder. Similarly, if the victim asks how she is to live with this event, she receives an answer that is aimed at getting her back to a certain prior level of functioning. But in my experience as an advocate these questions are asked less with a curiosity about explanations or prognoses and more with an eye toward possible justifications. When a person has been victimized by her or his fellow human beings those who try to help must be doubly careful not to revictimize the person.

In the following chapter I turn to another way of thinking about these events and the reactions of the people to whom they happen. I will begin by examining the notion

of psychological victimhood and compare it to other ways of thinking about being a victim. Then I take up the question put forward by rape victims: When a victim of rape asks why she was raped and how she ought to react, what is she asking? The psycho-social-medicalized answer has been examined in this chapter. I will propose another framework for thinking about what a victim of rape is asking.

Endnotes to Chapter Two

1. For an illuminating discussion of the relation between posttraumatic stress disorder and memory see Ian Hacking (1995).

2. In the places marked with a '*' there is a note that specifies the symptoms a child might exhibit if she is suffering from this disorder. In an attempt to be brief I have omitted these notes.

3. In the introduction to this chapter I explained the catch-all term "clinicians" to apply to the people researching, treating and (it is hoped) curing rape victims. I will now change the scope of the term slightly in order to accommodate a somewhat different group of people researching, treating and curing criminals. In this case the term is meant to refer to psychiatrists, behavioral and social scientists, sociologists, psychologists, and criminologists. I want to stress that the use of the term is in no way meant to refer to any specific person in any these fields. It is important that the scope of the term also be limited to those professionals concerned with these two groups of people. I do not wish to be seen as critiquing the whole of any of these disciplines.

4. Burgess and Holmstrom have found that these categories accurately correspond to the descriptions, given by victims, of the way they perceive the behavior and intentions of the rapist (Burgess and Holmstrom, 1974, p.22).

5. This might be why rape victims have come to be known as sufferers of posttraumatic stress syndrome rather than rape trauma syndrome.

6. I will return to this in greater detail in Chapter Three.

Chapter Three

An Alternative Framework: Rape and Moral Harm

Chapter two concluded with a preliminary examination of the position a rape victim finds herself in when she undergoes the treatment suggested via rape crisis theory. On the following pages I take up alternative frameworks for treating persons and their needs. One of the central issues, perhaps the central issue, for a rape victim is the question of why this event happened to her. Many people are unable to come to terms with an event which they cannot explain to themselves. The clinical approach can serve the purpose of providing a explanation, and, perhaps, an excuse. Rape communicates contempt, malevolence and utter disregard for the victim; these are very difficult attitudes to come to terms with. Rape is the acting out of the symptoms of a disordered individual, according to clinicians. The victim is an object of the rapist's actions. This may explain why the perpetrator allowed himself to behave in such a way: he has tendencies to behave in unsanctioned ways. Perhaps he convinces that women in short skirts want to be raped, or that drunken women deserve to be raped, or simply that women are there for whatever purposes he may have. Explanations of this sort are not intended to provide justification, but it is thought that they provide an account of the rapist's behavior. But is an explanation of this sort what a rape

victim needs? Suppose a contributing cause for the rape was some unintended cue from the victim, then the answer suggests that the victim could have done something to prevent herself from being the person the perpetrator chose to attack.

Rape victims are offered medical explanations of the rapist; they are also given medical explanations for the reactions they experience as a result of having been raped. The medical explanations start with rape crisis theory which, not unreasonably, tries to prevent rape victims from seeing themselves as responsible for causing the rape. It also attempts to keep the rape victims from developing a full blown crisis in lifestyle and functioning. Granting victim status to a rape victim may seem like the helpful thing to do given that one needs an excuse to behave in ways ordinarily considered abnormal in some way. If there is no sign of physical harm then psychological harm is the only explanation available that legitimates behavior which does not conform to the norms of our society. But by virtue of imposing this framework onto rape victims, clinicians have classified both rapists and their victims as psychologically abnormal people.

From chapter one we know that all rape victims are ipso facto thought to suffer from rape trauma syndrome. Then in chapter two rape trauma syndrome was determined to be a mental disorder by virtue of its connection to posttraumatic

stress disorder. In the conclusion to chapter two I referred to the looping effect of human kinds. Rape trauma syndrome has created a new class of people, or a new way of being a person by redescribing rape victims under the description of a mental disorder. Rape victims have become psychological victims in so far as they see themselves and are seen as victims. Basically, rape victims have become a special sub-class of a larger class of human victims.

I have misgivings about placing rape victims into a stance where they are viewed by others, and see themselves, as psychological victims. It is one thing to say that I have been the victim of a crime. In this case I mean that some harm has been done to me, some harmful event has occurred in my life. This has no extension to my identity in general. It is more a statement about my circumstances or perhaps the experiences of my life, than a statement about who I am. However, rape crisis theory asks us to consider that when a person says, "I am a victim," she is telling you something about herself; she is telling you she suffers from a mental disorder. It also asks the victim to consider herself in this way. The designation communicates something about how she may think, feel and behave, as well as how you should think, feel and behave in relation to her. The difference is that of the two stances: one is about an event that occurred which violated this person in some way, the person has been victimized -- this is victimhood per se.

The other simply, and poignantly states that the speaker is a victim, that an event has changed her status in the world from ordinary person to victim -- this is psychological victimhood.

"Victimhood" is a term, like many others in this work, which has taken on so many meanings that it is hard to know just what is implied in any one case. I have used the term repeatedly when referring to those who have been raped. In some cases it is simply a label. Certainly it makes sense to refer to those who have been raped as victims of rape. The act is harmful in so many ways that there is little if any surface ambiguity. However, when we begin to look at the connotations of the term it looks less and less like a good thing to call oneself or to use as a way of labelling for therapeutic purposes.

The kind of account and associations we have about victimhood and related moral terms can make a difference between helping a rape victim and further harming her. In this chapter I will examine this difference by looking at the alternative stances that can be taken up by clinicians, rape victims, and society in general.

First, I want to look at what happens when one adopts the psychological victim stance. In my discussion I will make use of Peter Strawson's essay "Freedom and Resentment" (1962). In this essay he gives an account of two stances people tend to take up when dealing with their fellow human

beings. Then, in the second section, I rely upon my experience as an advocate for victims of sexual assault to talk about what victims of rape are going through. I will offer an example of what helped the rape victims during the initial stages of dealing with the trauma of having been raped. It turns out that my practical experience points to the importance of a moral stance when talking to and assisting the victims of rape. I found that the harm the victims were feeling seemed to go beyond the bounds of the standard clinical framework. In the third section of this chapter I turn to examine different moral frameworks from which to view and treat those who have been raped. I suggest that, of the standard moral theories, rights based morality and Kantian morality are the most plausible theories to take up when thinking about the needs of rape victims. Ultimately, I find that Kantian morality best illuminates the issues and helps in thinking about the moral nature of rape. I put forward the claim that rape victims must first be treated as persons rather than as victims. In conclusion, I put forward a proposal to use a robustly moral stance which prevents the victim from falling prey to the typical plights and assumptions made about rape and protects her from seeing herself as a victim rather than as a moral agent who has been victimized. With the framework of moral agency in place, moral personhood ceases to be some far off abstraction and becomes something of genuine human value.

Strawson

Peter Strawson (1962) claims there are two important stances we take up in situations where moral sentiments are likely to arise. There are some people we excuse due to exceptional circumstances as not fully responsible for their actions. Though we may resent their behavior, we do not feel they deserve to be treated as having transgressed any moral boundaries. A common example is the way we regard the behavior of children. Another example is of a person who has been victimized per se. We do not hold her morally responsible for the event or for her reaction to it (within certain boundaries). We tend to excuse her odd behavior for a while and hope that this person will soon recover from the trauma. However, we do not expect to assume this stance with either children or victims permanently. These people are still members of the moral community though they receive the temporary benefits of being excused from certain, though not all, of the standards held for all members of the community. These are everyday people who find themselves in very extraordinary circumstances that are taken to be a temporary state of affairs.[1] The standard notion of victimhood per se and commonsense seem to indicate that this is the correct stance for rape victims. The victim may maintain full standing as a responsible member of the

community while being given the understanding and patience needed to come to grips with her experience.[2]

There are other people, though, who are somehow abnormal. It is not merely an event or circumstance of their lives but that they are somehow different from the rest of us; the people are extraordinary rather than the situation they are in. We do not in general hold this group responsible for their actions in spite of the fact that they may offend against the bounds of the moral community. These people are not subject to the ordinary standards of society. In some cases this may be important for the object of this stance. Perhaps she cannot measure up due to a lower intelligence or a less robust sanity than is expected of a full member of the community. This is not to say that they are not members, rather that they are not full members of the community. Nor are they ever expected to achieve this status. Strawson calls this the objective stance:

> To adopt the objective attitude to another human being is to see him, perhaps, as an object of social policy; as a subject for what, in a wide range of sense, might be called treatment; as something to be taken account, perhaps precautionary account, of; to be managed or handled or cured or trained; perhaps simply to be avoided (Strawson, 1962, p. 194).

The victim stance recommended by crisis theory and psychology in general takes up objective attitudes toward rape victims by virtue of the fact that victims are categorized as mentally disordered. The objective stance permits us to step back and in some sense withhold our moral

attitudes. This stance does not carry any of the standard attitudes towards the subject (e.g., resentment, anger, gratitude). It is a direct result of the framework that the clinicians use to evaluate and treat rape victims that makes this the stance that clinicians adopt with their subjects. Rape victims are placed into the realm of those in need of treatment and reordering to the exclusion of other human needs. In short, a psychological victim is no longer a fully fledged member of the moral community.[3]

An alternative stance is the Participant stance where we are engaged with others and able to argue, reason and negotiate with them. There is at least the presumption that we are participating in some kind of reasoned exchange with another person. In this case sympathy, empathy and other reciprocal sentiments are possible and appropriate. We view each other as equally participating in a relationship. I talked about ordinary people in extraordinary circumstances above. The participant stance includes these people by virtue of the fact that they retain the fundamental aspects of this stance even during the time when we excuse them from many the day to day standards.

There is a fundamental opposition between the stances. On one end of the spectrum we have the objective stance where we feel no moral reactive attitudes at all. At first this seems like the right stance to occupy in viewing the victim. She ought not be the recipient of any more

resentment, blame or anger. Clinicians use expert knowledge and facts as a guide to their reaction to those viewed objectively. You will recall that the Merck Manual recommends that clinicians view the rape victim as "undergoing a posttraumatic stress disorder". Any and all reactions to the trauma will prove to the clinician that the victim is in need of treatment. The clinician is there to treat and study the subject, not to pass judgment on her. But as mentioned above, the objective stance restricts our attitudes and sentiments. Fellow feeling is not appropriate when one adopts objective attitudes for another person.

At the other end of the spectrum we find that our "humanity" (participation) is what guides our reactions to the persons and situations that call forth moral reactive attitudes (Strawson, 1962, p.194).[4] The objective stance places the clinician in the position where he may not feel indignation on behalf of his client. He is to remain "objective".

To take up the objective stance is to objectify and even dehumanize the subject. What I am trying to draw out here is the distinction made when one shifts from viewing others as one of us to viewing someone as a object, for the purposes of treatment, acquisition of expert clinical knowledge, or whatever. This shift removes the subject's humanity. It is important to see the implications of turning responsible moral agents who have been victimized

more or less entirely into victims of disease and disorder. As victims they are incapable of explaining or claiming control over their behavior. Their state has control over them. This is not a helpful way to treat victims of rape.

A rape victim's sense of self and place in the community has been deeply violated. She has lost her clear sense of her human (moral) standing. By eliminating or diminishing her participatory status as a responsible member of the community, the clinicians also take away the basic ground for moral agency. Without these basic human qualities it becomes exceptionally difficult for a victim of rape to recover what she has lost in the trauma.

When a rape victim faces the utter contempt that rape expresses she may find herself feeling gravely distressed. Even in situations where some event seems utterly random we find ourselves wanting to know what the rapist meant to communicate by his action. Strawson, drawing on another commonplace, points out

> how much it matters to us, whether the actions of other people -- and particularly of <u>some</u> other people -- reflect attitudes towards us of goodwill, affection, or esteem on the one hand or contempt, indifference, or malevolence on the other (Strawson, 1962, p.191).

I think that this is the reason we are so concerned to find out why rapists rape. If we find a way to think that they have treated their victims wrongly, then we are able to compensate for the violence done to us by them by regarding their contempt and malevolence as unfounded. So, this may

explain why we must know why. The question now remains, is the answer provided by clinicians the most helpful answer?

Strawson gives an account of the attitudes we adopt with regard to people in a variety of situations (Strawson, 1962, pp. 190-99). If we believe that we are the beneficiaries of someone's kind intentions we feel gratitude. When someone does some small harm, say stepping on someone's toes, we feel resentful. If he apologizes, claiming it was an accident, we forgive and forget. However, when someone causes another person harm, for no reason other than his contempt for the other person, we rightfully feel resentment. Under this analysis, a rape victim may appropriately feel extreme resentment toward the rapist. In addition, other members of her moral community may feel indignant on the victim's behalf. The perpetrator has offended both the victim and the community with his callous attitude and hateful treatment of others. But there is a conflict here between the participant stance and the stance occupied by clinicians, the objective stance.

The participant stance reveals an unfortunate byproduct of psychological victimhood. The clinicians must hold that rape constitutes a double victimization. Someone who is raped is the victim of a mentally disordered person and this event causes her to be the victim of a mental disorder. The therapy model used employs the tactic of teaching her that she is in no way responsible for having been raped. This is

surely right. But she is also taught that the anger, shame or guilt she might feel as a result of the rape are symptoms of her disorder. Such emotions signify a flaw in her personality development (rather than understandable reactions to the harm done to the victim as seen from the participant stance). Thus, she is first a victim of a sick person toward whom resentment might be inappropriate (he, too, is to be considered from the objective stance) and then a victim because her natural reaction signifies a crisis and disorder in her personality structure. There is, in other words, <u>something wrong with her</u>. She must now come to view herself from the objective stance.

There is no question but that clinicians want to help rape victims. Certainly the work and research that has been done has had significant impact on the way we think about rape and its effects on victims. Drawing attention to the seriousness of the harm is a help. Culturally speaking, tolerance for persons who rape has gone down. People have begun to question the common assumptions about rape. The most reprehensible assumption is that if a woman is raped, then she must have done something to deserve it. This is not to say that this kind of thinking has disappeared. But the research has been able to establish that those who are raped are quite often severely harmed in one way or another and that rapists are possessed of views and personality structures which society finds intolerable.

Given the scientific/instrumental framework the harm must be empirically verifiable and clinically significant. The conception they have of persons in general forces them to see a natural reaction to a horrific event as a malfunctioning which leads to mental disorder. The clinicians have developed a method of sorts for restoring rape victims to their previous level of functioning. As a person with a disorder, a rape victim has a special status which relieves her of certain responsibilities that most of us have. Rape trauma syndrome is an explanatory tool as well as a tool for identifying victims. It explains what a victim does when she has been raped. It also tells us how to spot a rape victim. What it does not do is acknowledge the wrong of the rape itself. It seems as if one could say that rape is both a sign of and a cause of a disorder in the same way that high fat diets signify the possibility of and the cause of heart disease. The question one must ask is how is it helpful to me if I have been raped to be told that I now suffer from a mental disorder (as does the rapist)? It is as if what the clinicians are saying is that rape trauma syndrome is the one harm done by rape. Surely this can't be right.

In the next section I turn to see how these theories fit with the realities of rape and its aftereffects for victims. In my work as an advocate I have had many conversations with victims of rape. Frequently these

conversations took us beyond the framework of rape crisis theory. This happened as a result of the questions the victims were asking and the answers they were finding. It is hoped that this section will help to clarify what the rape victims think and feel as they undergo the process of adjusting to the horrors of having been raped.

An Application

The work of Burgess and Holmstrom functioned as a textbook of sorts for training advocates. Thus, I went into the work looking for the symptoms of rape trauma syndrome. But perhaps because of my lack of training as a clinician I had not lost contact with the natural disposition toward participatory interactions with the people I wanted to help. Let me begin by telling you what I found to be true as I worked with victims of rape.

It is true that rape victims are typically in shock and that they are often behaving abnormally by ordinary standards. They cry, shake, chain smoke, lash out angrily, stare at the walls, refuse to talk, or talk incessantly. This list could go on forever. When the rape victims talked, they frequently expressed concerns for their safety or the safety of their children. By the standards of Burgess and Holmstrom this was a rape crisis issue. Frequently I spent time making sure that the victim was in

fact safe. There is little else that matters to a person if she feels that she is in danger. Basic needs come first in advocacy work. Crisis intervention at this level takes very little expert knowledge. One must be sure that there is a place for her to go and that her children are safe. It helps to find out if the victim has anyone she can rely upon for support in the immediate future. All of this must come first. A person's mind must be at ease about the immediate future before she will begin to turn to thinking about what has happened and how she will be affected by it. But once this has happened, that is, once a victim begins to turn a critical eye on the event, and usually upon herself, an advocate's work really begins.

The critical eye of the victim is looking for explanations for what has happened to her. She may feel shame, doubt and guilt immediately. Her feelings are generally a sure sign that she believes that she somehow caused the rape. Perhaps she had been drinking, or perhaps she even flirted with the rapist the last time she saw him. Or maybe she is merely acquainted with him from work or school. More often than not the victim and the rapist have some minimal acquaintance. The clinician takes these thoughts and feelings of shame, doubt and guilt to be aspects of rape trauma syndrome.

As mentioned above rape victims inevitably ask why they were raped. It seems that there are many ways of

understanding and answering this question. As discussed above, the clinical framework takes the question to be one of accounting for the motives and actions of the rapist. The clinicians endeavor to explain what motivates a rapist. In part the motive can be detected in hearing the account of a rapist's behavior from the victim. In other words, if the victim perceived the attacker as angry with a violent hatred of her, then this will reveal that her attacker was an anger rapist. According to clinicians the men who rape women have strong antisocial and destructive beliefs and attitudes towards women. Most of their negative emotional reactions manifest in violence towards whatever distresses them, in this case it is women. Basically men rape women because they hate women. Clinicians then need to find out why the rapists have this attitude.

Clinicians acknowledge the undesirability of rape and of the beliefs and attitudes that contribute to the event of a man raping. However, it often seemed to be true that the rape victims were asking for more than information and explanations of the psychological makeup and health of the rapist. There are events in human life that lead us to ask how something could have happened and whether there is any way it could possibly be justified or made sense of. Rape is one of those events. The harm done to a person who is raped expands beyond the physical and the functional aspects of the individual. Rape also constitutes a moral harm, it

calls into question the victim's very humanity. When a rape victim asks why she was raped she is asking about how someone could possibly have done this to her. There are issues of desert and justifiability implied in this kind of question. Causal explanations can and do lead to victims blaming themselves for having been raped. When I took the rape victims' question to be about the moral aspects of what had been done to them it proved to be helpful in finding a way out of the victim stance for the victim.

According to clinicians, part of being in shock is a disordered thought process. One of my duties was to help a rape victim think clearly if she was willing to let me help. It is important to short circuit any tendency she might have to blame herself for the rape. I often had conversations about the thoughts and feelings of the rape victims with regard to rape in general and more specifically in relation to having been the victim of a rape. Many victims do feel that they could deserve to have been raped. I tried to examine the grounds for this belief with rape victims to see if the victim really believed that she deserved to be raped.[5]

When a rape victim blamed herself for having been raped I asked her to think about whether or not it is possible or permissible to consider someone she knows as deserving of such inhumane treatment. As the quotes in chapter one point out (pp. 4-5), this is something that most rape victims

would not wish on their worst enemy. I find that looking at the event of the rape as if it happened to someone else helps the victim to see things more clearly. She is more inclined to adopt a participatory stance when thinking about others. So, I take the victim's experience and ask her to think about it as having happened to someone else - a loved one, perhaps a sister or a friend. Once the victim has begun to think about the rape in a slightly abstracted fashion I ask her to review the event with me. Let us call this chosen person 'Jill' and the rapist 'Jack' for the sake of simplicity. Here is an example of what I might ask a victim:

> Jill met Jack at a party, just the way you did. Jill was tipsy and she did hope that Jack would ask her out for next weekend. She might have even flirted with him a bit. When Jack offered to walk Jill home, she accepted. But instead of walking Jill home, Jack raped Jill in a secluded spot along the way and then left her there. Did Jill deserve to be raped?

If the rape victim answers no I move on to check over the particular details that make the victim think that she might have done something to deserve to be raped. Thus, we will go over details about her attire, her marital status, the locks on her door, and so on until we run out of the things she may have been at "fault" over. The basic question is this, "could Jill deserve to be raped for any reason at all?" When we come to the point where the rape victim thinks that her loved one could not possible deserve to be raped under the very circumstances under which she was

raped, I change the loved one for anyone. That is, I ask if this is something that any other person could deserve? Some will say that they think rapists deserve to be raped, but rapists are the only group of people that rape victims have ever picked out in my presence as deserving of rape. Usually, the rape victim will say that she does not think that anyone else could deserve to be raped.

From this point it is a matter of pointing out that she, the victim, is a person. She is a person in the same way that all of those people undeserving of rape are persons; thus she does not deserve to be raped either. No circumstance can alter the fact that she did not and could not deserve to be raped. As a person she is deserving of a certain kind of treatment. She deserves to be treated with the respect due any person. Her humanity and dignity have been assaulted. To all of this she can now reply that the rapist is wrong and that she is a person undeserving of this kind of treatment. When she regards herself in this way she begins to see the requirements of self-respect as well. Self-respect will minimally require that she not regard herself as deserving of treatment that she would deem inhumane, and thus impermissible, for any person to receive. When this process goes well, the victim realizes that rape cannot be justified under any circumstances. She also comes to realize that the clinical explanations for the rapist's

actions, and for her feelings as well, are explanations and not justifications.

In this process, the rape victim engages in a discourse involving moral reasoning with regard to others; she takes up the participant stance. The victim shows that she cares about the issue and that she regards herself as a moral agent when thinking about others when she discusses them. This action presupposes moral agency and status and it exhibits these qualities. As the victim is able to discuss the relevant considerations for Jill, she comes to see that she too is within the group of people who must be seen as moral agents by the very fact that she is questioning and reasoning as a moral agent.

A point I must make is that what counts as success for me is quite different from the kind of success aimed at in rape crisis theory. I aim to show a rape victim that the best way out of victimhood is to reassert her moral personhood. This is not to say that I think that this will prevent the rape victim from developing a crisis of some sort. I do intend to maintain that it is only as a moral agent that the rape victim will find the most robust way of combating the harm done by the rapist. She will not be rendered merely an object of treatment and pity, and she will be bolstered by the fact that no act of contempt can take away her humanity.

Strictly speaking, the clinical framework does not accommodate the moral questions asked by rape victims. The fact that they do not address this aspect of the event with the victim leads to the continued diminution of the sense of humanity that a rape victim has. As she takes her role as a psychological victim she will be less and less able to see herself as a moral agent.

An Alternative Framework

The psychological approach leads a victim further into the victim stance in order to show her that she is not responsible for causing the rape; moreover, it renders understandable any reaction she may have. But her reaction can only be seen as a manifestation of a mental disorder. The clinicians want to restore a victim to proper functioning by moving her from victim to survivor. This is done by "inflating her self-esteem". An analogy that has always occurred to me when thinking about this is the following. When a vase is broken it can be glued together again. In its restored state it will function as before. But it will be less valuable, less attractive and more fragile than it was prior to the break. It seems to me that this is what the psychological victim to survivor strategy does with persons who have been raped. By rendering their treatment value neutral clinicians have diminished by the

ability of the rape victim to see herself as a whole person with worth regardless of what happens to her.

I have been using the term "victimhood per se" as a term that acknowledges the moral nature of victimhood. At this point I want take on more explicit terminology by adopting the term moral victimhood as a stronger version of victimhood per se. I take moral victimhood to be different from psychological victimhood in several ways. First it is different because the harm done need not be empirically verifiable by an expert in how humans work. Moral harm may be assessed by looking at what the assailant did to the victim. Rape attacks the humanity of the victim; she has been the object of contempt. Rape is said to be a crime of violence, not of sex. But there is no denying that the nature of rape lends itself to very complicated thoughts and emotions that occur with human intimacy. As Onora O'Neill (1989, p. 120) argues, intimacy is the human relationship with the greatest capacity for treating others as persons as well as the greatest capacity for violating the humanity of another person. Shame, doubt and guilt are common emotions for victims of violent crimes in general. Rape victims continue to feel these emotions long after the event, sometimes many years go by with little or no improvement in the rape victim's outlook (Koss, 1991, p. 60-70). Sometimes, as in the case of those who thoroughly adopt the psychological victim stance, these emotions become part of

their identity. Such a person feels shame and guilt for having been raped; it has changed her in some very important way. Her doubt may lie in her inability to know whether or not she behaved in the right way during the rape. A second way that moral victimhood differs from psychological victimhood is that moral victimhood acknowledges that rape attacks the victim's moral personhood. Moral personhood has to do with humanity rather than with proper function. Another important difference is that with moral victimhood one has the backing of the moral community and the assurance that rape is unjustifiable. This, of course, lends her the sense of her humanity in common with others which is a potent positive factor for those who have been treated as if they have no claims to being treated as persons.

In what follows I propose a more formalized alternative to the clinical approach based on my experience as an advocate. To see the rape victim right from the start as having been morally harmed allows her to maintain her integrity as a person. Those who are diagnosed with mental disorders lose a degree of something essential to that integrity. Depending upon the way we view human beings this is something that will vary greatly. From a moral stance those who are mentally disordered at least lose their status as fully participating members of a moral community. Part of what they lose is their voice because they have lost

their status as reasonable agents and so their deepest concerns may not be taken very seriously.

Rape confronts the victim with treatment that denies her status as a member of the moral community. It certainly does not constitute treating the victim as a human being deserving of respect. Rather she is treated as less than human and a good deal more than her rights are violated. As an advocate I found that rape victims lost sight of their moral personhood. They came into the emergency room looking for an explanation (which when going the biopsychosocial route doubles as an excuse because when rapists are viewed objectively they are excused from membership in the moral community) for what had happened to them. When faced with the senselessness of rape the victim often looks to herself to see if there is anything about her that would make a person think that this is the way she should be or wanted to be treated.

In clinical research, theory and treatment one does not see the assertion that moral harm has been done. But surely the clinicians are trying to find a way to say that rape is wrong and should not happen. By shifting to a moral framework we are able to say that rape is simply wrong in itself. There is a way to see the act as wrong regardless of its effects. That is to see it as morally wrong. To regard it as morally wrong is to say that it is impermissible in any circumstances and that there is never a

justification for the act. It is not to say that there are no explanations for why rapists rape, or why they choose the people that they do. Certainly, there do seem to be explanations of this sort. If a rape victim is offered the opportunity to see that what was done to her was wrong regardless of the circumstances, including the amount and kind of harm done, she may be able to avoid the descent into the stance of psychological victimhood. Why is that? Because to assert the absolute wrongness of rape is to say that there are certain things that people cannot ever do to each other for any reason. Thus, the rape victim maintains her status as a full moral agent in the moral community. She is able to adopt the appropriate moral attitudes to someone who morally harms another person. She is also able to receive from her fellow moral agents the benefit of their moral indignation on her behalf. This kind of community builds a bond that brings a victim into the fold of the community rather than separating her with the status of a mentally disordered person. The mentally disordered garner our pity, our fear, and our paternalistic affection.[6] They do not enjoy participant status in the moral community because they are unable (for whatever reasons) to be fully participating. When one thinks about human action without the clinical framework one is able morally to condemn the behavior of those who commit crimes against humanity.

Participant status enables a person to feel a full range of moral sentiments and attitudes which are appropriate to those who have both responsibilities and rights as moral agents. Those who are not able to adopt this stance may have these same sentiments and attitudes but these will be regarded as signs of a problem in the personality structure or coping mechanisms of the person. Morality has been cut out of psychology perhaps because clinicians take themselves to be studying how humans work, not right and wrong. But it seems that sometimes we don't 'work' because some deep moral wrong has been done to us. But this is not the issue for psychology. The issue is to get the subject to function again in a satisfactory way.

The problem of course is that a victim of rape has been treated as though she were not a person (in any morally participatory and significant sense). She will need help in restoring herself to the position of full moral agent. That is where this alternative way of helping a rape victim comes into play. We must help the victim to see that she is a human being. Humanity carries with it powerful moral status which she can rely upon as a source of strength and self-assurance at a time when she has been treated as unworthy of basic human respect and dignity. The source of this humanity is Kantian autonomy. It is frequently argued that Kantian autonomy is a metaphysical notion requiring copious amounts of complicated argument to justify. But it turns

out that this is the framework that best illuminates our moral practices, at least in cases like these.[7]

I have chosen Kantian autonomy because it is a moral stance that asserts that there are certain fundamentally valuable qualities shared by all human beings. Autonomy is the ground of our humanity. Our basic moral and legal rights as human beings stem from this autonomy.

Autonomy and Respect

I have stated above that I am sure that clinicians are trying to do something beneficial for rape victims. Although they want to say that rape should not happen, they do not want to say that it is morally wrong. They want to leave the moralizing out of their interactions with people. But it is precisely the concerns raised in chapters one and two, the profound effects of rape on the victim, which form the basis of clinical research, that show that rape is a moral issue that must be regarded as such. Rape victims continue to ask for moral reasons. Even in a disordered state a rape victim is morally reasoning and trying to understand what has happened to her.[8]

Considered from the point of view of psychology and medicine a victim's autonomy, self-respect, and integrity are matters of ego development at best. Those using personality theory and Eriksonian developmental theory will

hold that if a victim suffers from feelings of shame, guilt, and doubt she is exhibiting the signs of an internal developmental crisis. According to Erikson, a poorly developed ego quality can in fact lead to neurotic dysfunction later in life (Erikson, 1950, p. 57).

Undoubtedly the event of a rape in one's life is legitimately regarded as a crisis. The question is how we ought to regard the crisis. Is rape a precipitating event to a crisis or is it a crisis in itself? Like the notion of victimhood it is possible for crisis to be located within the person, as with psychological victimhood, or a crisis can be an event that happens to a person, as with moral victimhood. By adopting a moral stance the victim is still seen as an autonomous moral agent and the crisis is an external event. As such, the crisis may have an influence on her life but it does not render her a different kind of person.

Psychological autonomy is not something which everyone has in equal proportion. The Eriksonian autonomy is very narrow in scope; there is a more general version in use within psychology. Psychological autonomy is taken to be a kind of psychological maturity which some humans have and some do not. It is an empirically discernible quality involving a certain type of independence of judgment. For some psychologists it also involves emotional independence from others. Self-reliance and security in one's self-

esteem are some of the hallmarks of psychological autonomy. If one is willing to listen to other viewpoints, and to think carefully by weighing options before acting this too is a sign of psychological autonomy.[9]

Thomas Hill (1992) points out that this version of autonomy functions as both a descriptive category and as a normative ideal. It is a way of assessing people and of encouraging them to develop in a socially sanctioned manner. By making autonomy into an ideal of character it marks as superior those who exhibit highly developed autonomy.[10] Recall that for Erik Erikson autonomy is an ego quality to be achieved. The child is charged with the task of developing self-control in order to deflect the potential shame and doubt which might come about if he fails. The autonomy of rape crisis theory is based in Eriksonian autonomy.

On the other hand, "Kantian autonomy is treated as "an 'idea' of reason, attributed on a priori grounds to all rational wills" (Hill, 1992, pp. 78-9). This autonomy is a trait of all people and serves as the ground for the respect due to all human beings. From the moral point of view autonomy carries a great deal of significance. To be possessed of autonomy one must merely be capable of reasoning. Rape victims continue to reason. The quality or correctness of their reasoning is not strictly speaking a

consideration for exhibiting autonomy. Kantian autonomy is an a priori attribute of all rational beings.[11]

One need not behave morally in order to be autonomous. A Kantian would say that the knowingly immoral simply fail to behave in accordance with their autonomy. Perhaps a better way of putting it is to say that they fail to express their autonomy. Action according to maxims is autonomous regardless of whether the maxims are consistent with the categorical imperative. One can choose to behave in accordance with such maxims. To flout the moral law in this way is to behave immorally precisely because one could have followed it. Autonomy grants a status in the moral world that has little or nothing to do with self-control and independence per se. These are more accurately described as qualities that can develop out of one's autonomous nature.

Unlike psychological autonomy, Kantian autonomy is explicitly concerned with moral obligations and moral rights. These in turn make up the universal condition of moral agency for all human beings. Only autonomous moral agents are under moral obligations. An autonomous agent is one who exhibits "minimal rationality", i.e., can reason and be reasoned with (recall Strawson's participant stance). As such she is a member of a moral community within which she enjoys both the benefits and the responsibilities of moral agency.

Onora O'Neill writes a compelling critique of the non-Kantian autonomy in her article "Action, anthropology and autonomy":

> Autonomy as now commonly construed ... may have little of no intrinsic connection with conceptions of the good, the right or the rational. No doubt autonomy, so construed, may have instrumental importance as an efficient means to human happiness ... but this is a contingent matter. In many situations this sort of autonomy will cost rather than constitute our happiness, and its connection with morality is often obscure (O'Neill, 1989, p.75).

If autonomy is simply a matter of independence from something or self-control then our happiness may be contingent upon things we frequently have little influence over. There are many circumstances in life where we are in fact dependent upon others. If autonomy is the means to happiness but is so easily lost then we may be condemned to unhappiness rather easily. Rape is certainly an event in which the victim loses her control over her life and becomes dependent upon others for assistance and understanding. Her psychological autonomy has been lost. Strictly Kantian autonomy, on the other hand, is intrinsic to all people and constitutes at least some portion of our humanity. This autonomy is not lost by the rape victim.

Another use of the term "autonomy" comes up in talk of human rights. It is often tempting to see autonomy as a right. As a right we can demand that people not violate it. But people do violate each other's rights; thus, autonomy so construed is also something one can lose. Moreover, even

basic rights can be overruled by those who enforce the rights. Thus, if autonomy is a right and an agent behaves in opposition to the standards for the bearers of this right, she could lose her autonomy (or never gain it in the first place). On this account a person could wind up not being considered autonomous. Without autonomy she is free of responsibility and we are free of our obligations to her. If someone is undeserving of our respect then we are permitted to treat her in any way that we see fit. At first, this may seem benevolent: we may "know better" than the non-autonomous agent or determine that she is not morally fit at all. Clinicians, as experts on human functioning, are thought to be the authorities in this area. Subjects are expected to defer to the expert knowledge of the clinicians.[12]

Kantian autonomy is not something people have a right to in the same way that we have rights to liberty or suffrage. It is a property which is the basis of moral rights but is not itself a right. A right that autonomy grants is perhaps the right to self-determination. But someone who is not capable of self-determination is not, by virtue of this inability, a non-autonomous agent. For example, a slave may be unable to direct his life consistently with his choices; he is by all external standards not self-determining. But, he still has autonomy in the Kantian sense as it is a quality guaranteed a priori

of all persons. It is part of what it is to be human regardless of one's lot in life. It is of course true that one will have less opportunity to behave in accordance with this inherent quality if one is a slave, but this does not take that quality away. The same is true for a rape victim, her humanity and dignity have been assaulted but she is no less an autonomous moral agent as a result of being raped than she was before the incident.

For psychology to neglect a victim's moral agency is to grant clinicians permission to view victims merely as subjects for treatment. This is also what the rapist has done to the victim; he has denied her status as a moral agent. Their intentions are opposed, but benevolence and malevolence may both lead to domination and indifference to the persons affected. What we must do is regard the victim as possessed of autonomy, which means that we respect her as a human being rather than treat her as a victim. This is not to say that she has not been victimized, nor that she is undeserving of our sympathies for the traumatic experience she has had. Rather the point is that she is a person who has been victimized. She is not now changed into a different type of person, a victim. To treat a person who has been victimized with respect as a moral agent is quite different from the requirements of treatment for a psychological victim.

As there is a vast conceptual difference between Kantian and psychological autonomy, so to there is a difference between Kantian and psychological respect. In psychology, respect takes on a less morally robust character. To be the object of respect is to be held in esteem. The esteem is granted on the basis of certain characteristics attributed to the person. The characteristics have little if anything to do with moral personhood. They are general qualities of excellence, talents, etc. For example, we all admire and hold in high esteem a fabulous chef. She maintains standards of quality that repeatedly regale us with gastronomic delights. The esteem is based on our assessment of her qualities as a chef. Should she fail to be such a chef, we would find no basis for holding her in so high a position, unless we also felt that she had some other aspect worthy of value. As a subject of such respect, a person is judged according to what she does and how well she does it. A person's worthiness is constituted by attributes involving factors extrinsic to her. The psychological concept of self is so deeply connected to function and productivity that when there is a failure of function there may be little or nothing left that is considered valuable or worthy of respect. Victims of crisis, therefore, may have nothing left to value but their failure.[13] However, when one can conceive of oneself as intrinsically a moral agent (but, of

course, with other external attributes such as being a chef or mechanic, then one's worth is not so linked to the fluctuations and unexpected events of life. A failure at something is not a motive to cease regarding oneself as a person worthy of one's own or others' esteem. It can be a serious matter - but it should not call into question one's sense of personhood.

Autonomy and Universalizability

I have claimed that the Kantian moral perspective is the best way of thinking about rape victims and their concerns. We can also illuminate aspects of the Kantian moral philosophy by thinking about rape victims. It is frequently argued that the connection between autonomy and the categorical imperative is very difficult to see. But I have found that the principle of universalizability comes up naturally as a part of the discourse with victims of rape as they think about the implications of what has been done to them. Let me return to the conversations I had with rape victim in order to demonstrate this.

Initially I found that rape victims suffered from feelings of shame, doubt and guilt. They feared that they were somehow responsible for the rape. At the same time these women were willing and able to assert that no other person could deserve to be raped. What I found was an

instability in the victim's sense of her moral standing. She knew that it made sense to hold certain moral standards for others, but she did not firmly believe that the same standards applied to herself. In a sense she regarded herself as different from everyone else, seemingly by virtue of having been raped. Thus when I engaged a rape victim in a moral discourse about others she was quite able to see that the rape was morally wrong. But it was not until I asked her what exempted her from these standards that she began to see that she could consider herself as having been morally violated by an impermissible and inhumane act. Her sense of the humanity of others and her willingness to act as a participatory member of the community were readily accessible in conversation. So why did she think that she, but no other (potential) victim, could be deserve to be raped or be blameworthy for having been raped? The missing link was her sense of her own humanity. Thus, all I had to do was show her own place as part of the moral community to her and to engage her in thinking that her humanity was no less valuable than any other person's.

It should be made clear that I did not go into the emergency room planning to apply the universalizability principle to the situation. This is simply the kind of reasoning that proved most able to guide the rape victim back into her sense of humanity. The universal quality of the situation, that is that rape is always wrong, removed

the intrinsically personal interest of the victim. By thinking of herself in a slightly abstracted fashion she was able to generalized back to herself that which she held for all other people -- in this case that rape is wrong in and of itself; no causal story can change that.

Perhaps this is what Kant had in mind when he was thinking about the facts of moral reasoning. The process I have described was something that came about quite naturally. It seems to be true that this simply is the way that we think about certain aspects of human moral life. It certainly seems to link autonomy and the moral law in a way that is not laden with the burdens of metaphysical doubts offered constantly by those who do seem to have forgotten what it is "actually like to be involved in ordinary inter-personal relationships, ranging from the most intimate to the most casual" (Strawson, 1962, p.192).

Conclusion

I have from time to time referred to the consequentialist nature of the framework adopted in psychology; let us return to this subject. Within psychology the obvious way to say that something ought not to happen is to say that it causes either physical or psychological harm that impairs functioning. The

consequences of other's actions must not interfere with the proper functioning of human beings.

When a person is thought to be a complex ordered system which either functions properly or not, then a sign of harm is when the system is not functioning. Once one is functioning again then the harm has been removed. Life can go on as before. If one does not malfunction, one is considered to be unharmed. Human beings, however, are much more than so many systems functioning in some way or other. Functioning is a rather minimal requirement for human living; survival is an even lower standard. The notion of flourishing is absent from the psychological literature I have read.

When a person is harmed to the point where she "disorders" we must look more carefully at what is happening. Why does she suddenly feel that her whole life has just crumbled in on its foundation? As mentioned above, victims of extreme human designed and executed trauma want to know why one of their fellow human beings would try to destroy them. When someone or something is trying to destroy you, you want to know what you could have done to <u>deserve</u> destruction. The notion of desert is of course tied in with morality. I suspect that one "disorders" precisely because the harm is a moral harm that cuts to the core of a person. Someone has set out deliberately to treat you as something unworthy of basic human respect and dignity. A

consequentialist framework may, however, allow that there may be a time when harm to an individual will achieve a justified end.[14] Also, considered clinically, if a person can recover from the attempt at destruction then the harm done can be taken less seriously. But surely we want to be in a position to say that intentional destruction of human beings by other human beings is legitimately regarded as morally wrong.

The a priori autonomy of persons grounds requirements for respecting ourselves and one another. This in turn grounds the legitimacy of reactive moral attitudes in situations where this respect is violated. Once autonomy is an a priori attribute of all persons we have open to us a full range of rights and responsibilities to ourselves and others. This simply cannot happen if autonomy is something earned or learned that can be absent or taken away from some. We cannot assert moral responsibility without some ground for the rights we claim as human beings.

If we view victims in this way perhaps we can make more sense of the notion of regarding a rape victim as a moral agent. As a moral agent, a rape victim continues to be an autonomous rational being. As such she is the bearer of human dignity and moral rights. The moral rights establish that rape is wrong because as a victim of rape she has been treated as something other than a moral agent. But she is a moral agent. By virtue of her agency she is able to feel

reactive moral attitudes such as resentment for the treatment and anger she suffered at the hands of the rapist. In addition we may feel indignation on her behalf. To be sure, her grave moral situation leads to diminished capacities and she is in need of certain kinds of assistance. It does not mean that we should think of her nonmorally by adopting the objective stance. By regarding rape as a moral wrong the victim is able to maintain her agency while compensating for the harm done; she need not regard herself as a particular and disordered type of individual, a rape trauma sufferer, in order to regard herself as having been victimized.

I suggest that a rape victim needs assistance that reestablishes her sense of being a human being in the moral sense. There is no doubt that certain kinds of events -- rape and torture, for example -- call into question the victim's sense of humanity. In ordinary life we form beliefs and ideals based on notions of how human beings ought to treat each other. We are moral beings and we do organize our lives according to basic assumptions and expectations about what is and is not permissible. This is not to say that we think that horrible things will not happen. It is more accurately seen as an assumption that certain things should not happen and that when they do, some kind of moral reaction will be appropriate. We behave as if we have at least some confidence that others will not do

these things to us. When a person does suffer at the hands of a fellow human being it brings into question those basic assumptions. One asks oneself, "why me?"; we search for reasons for such horrors. Typically we can find a cause, but we should not make the mistake of equating a cause with a justification. It would make no sense to look for justification when a hurricane destroys a village. However, as human beings possessed of reason and autonomy, it is incumbent upon us to ask the question, "what could possibly make this justify this act?" If there is no justification then it is an immoral act, and hence wrong. A rapist's reasons for raping may be socially conditioned or even determined; clinicians may even find some category of person that he fits into. But they are do not assert that the rapist has committed a moral wrong. To say that it is morally wrong would necessitate the possibility of holding a rapist responsible for his actions regardless of why he behaves as he does. A current clinical trend is to argue that people who behave in anti-social ways, which tend to be criminal ways as well, are in need of psychiatric treatment (broadly construed) and not punishment. The anti-social behavior is not under the control of the person acting, thus it is thought to be cruel to hold him responsible for his actions.

I argue, however, that treating people as human beings first and subjects of psychological theory, disease,

disorder, and/or as victims second is a more helpful way to aid them. When a person is harmed in the way that rape victims are harmed she needs a robust foundation to rebuild her beliefs and ideals upon. The rape victim has been morally harmed and this is the reason she is so overcome by the "symptoms" of rape trauma syndrome. If we fail to say that the harm is moral then we are only able to establish that the event was wrong if it is physically or psychologically harmful. The verification of the harm can be asserted in various ways, if it is prosecutable (which is very rare) or if there is sufficient psychological and physical harm to sustain a claim that the victim is in fact a victim, then harm has been done. It seems to me that the last thing we want to do to a person in so fragile a state is to condemn her to view herself as a victim. This version of victimhood is more about who the person is than about what has happened to her. So, rather than being a person who has been victimized gravely, she is a victim, a disordered individual. Victims move from being victims to being survivors. But what does it mean to think of oneself as a victim or as a survivor? These terms are only helpful when they are understood to be moral concepts rather than functional or dysfunctional states of the human organism.

The move from psychological victim to survivor is not as morally helpful a move as adopting a framework that retains the rape victim's status as a moral agent throughout

her ordeal. If one is a moral agent, one has certain characteristics, rights and strengths to rely on that a psychological victim is not perceived to have. If clinicians were to reinstate a more morally robust terminology into their treatment, rape victims would not have to remain in a stance that sets them morally apart from the rest of society.

Endnotes to Chapter Three

1. Children may be regarded somewhat differently in that the circumstance is their very immaturity, but that too is regarded as temporary.

2. I have used the term "we" to refer to the general moral community. This is not a particular group, such as the clinicians of chapter one, but a group which composes a community or society in very general terms.

3. I should stress that Strawson (1962, p. 190) pointed out that he was going to be trade in certain dichotomies and generalizations, which he refers to as commonplaces, for the sake of being able to talk about how we tend to behave and feel in relation to other people in our interaction with them. I will follow him on this point. He has an eminently more graceful way of putting this than I when he says,

> the object of these commonplaces is to try to keep before our minds something it is easy to forget when we are engaged in philosophy, especially in our cool, contemporary style, viz. what it is actually like to be involved in ordinary inter-personal relationships, ranging from the most intimate to the most casual" (1962, p.192).

4. The term "humanity" in this context is taken from Strawson. Strawson is not trying to give an account of humanity outside of the terms used to describe the commonplace notion of the participant stance. The essence of his project claims that there is no account of humanity that can be given in non-moral terms. I follow him in this in as much as I find this way of thinking about humanity to agree with my experiences of both the "intimate and the casual inter-personal relationships".

5. In what follows I have been careful to generalize to the point that no individual that I ever worked with can be identified. The details that I give are merely there to help the reader to appreciate the kinds of thoughts and feelings that a rape victim might experience.

6. Which is not to say that I think that this is a good thing. At this point though, I have merely adopted Strawson's method of stating "the facts as we know them."

7. This is not to deny that there are metaphysical concerns for Kantian autonomy, it is more the case that these are not my concern in this essay.

8. Admittedly she may be reasoning badly, but from the Kantian point of view if she is capable of reasoning at all we are morally obligated to treat her as a moral agent possessed of reason and autonomy.

9. For a very thorough investigation of the many different connotations of autonomy, dignity, self-respect and so on see Dillon (1995) and also Christman (1989).

10. See Lawrence Kohlberg's work on moral development. For a contrasting view of this brand of autonomy see Gilligan (1982).

11. My ideas about Kantian ethics are informed by the scholarship of Thomas E. Hill, Jr. (1991; 1992) and Onora O'Neill (1989). This is not to say that what follows is an explication of their work. Rather, I take myself to be in agreement with them about the basic notions of Kantian autonomy and respect for persons. They may not be in agreement with me with regard to how I apply these notions in the case of rape.

12. Thinking of autonomy as a right granted or withheld also permits the institution of slavery; slaves did not count as persons at all. Thus, they were not even candidates for moral agency.

13. It's no wonder people are said to suffer identity crises. If one's worth is bound up in nothing but non-intrinsic qualities what is there that cannot be lost?

14. When there is a war on it is the custom of each country to vilify the enemy as something lower than a mere animal. The enemy is a monster that wants nothing more than your destruction, and it wants that for no good reason. But when we meet this monster, it is nothing more than another human being who is equally surprised to see that we are human beings. It is only by dehumanizing that it becomes a simple matter of destroying the enemy.

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