



University of Connecticut

Women's Center

Testimony of Elizabeth J. Cracco, Ph.D.

In support of SB 1343 An Act Concerning Compassionate Care for Victims of Sexual Assault

Elizabeth Cracco, Ph.D.,

Coordinator of the Violence Against Women Prevention Program

University of Connecticut Women's Center

Submitted to the Human Services Committee

Public Hearing, March 13, 2007

Senator Harris, Representative Villano, and members of the Human Service Committee, my name is Dr. Elizabeth Cracco. I coordinate the Violence Against Women Prevention Program at the University of Connecticut Women's Center, and I am a licensed psychologist in the state of Connecticut specializing in working with survivors of sexual trauma. I also have specific expertise with victims in the immediate aftermath of trauma, serving as an advocate for the Rape Crisis Center of Dane County in Madison, WI, and as a state-wide trainer of sexual assault service providers for the Wisconsin Coalition Against Sexual Assault. In all of these capacities, I have had extensive opportunities to assist survivors as they attempt to negotiate the labyrinth of post-assault decisions and systems all while experiencing the dysregulation of trauma.

As you consider what constitutes compassionate care for victims of sexual assault, I would like to provide you with critical information regarding the effects of trauma during the time immediately following assault. Rape Trauma Syndrome, first conceptualized by Burgess and Holmstrom (1974) identifies this period immediately following the assault and lasting for several days post-assault as the acute or impact phase. Symptoms characteristic of this phase are organized into two categories. The first category known as positive (in lay terms symptoms that we can "see") or expressed style can be marked by acute anxiety, hyperarousal, fear, restlessness, shaking, and crying. A second, and sometimes thought to be more common presentation, is categorized as negative or controlled style, which can include numbness, apathy, dissociation, and avoidance. Victims may also alternate between these states of hyperarousal and numbness. The important point is that in both cases, the outward presentation stems from internal experience of coping mechanisms being overwhelmed.

Clinical trauma assessment of victims seeking emergency room care within 72 hours of their assault validates and expands on Rape Trauma Syndrome, by identifying three broad categories of trauma – expressed emotional trauma, controlled emotional trauma and

An Equal Opportunity Employer

Student Union – 4th Floor
2110 Hillside Road, Unit 3118
Storrs, Connecticut 06269-3118

Telephone: (860) 486-4738
Facsimile: (860) 486-1104
e-mail: womensctr@uconn.edu
web: <http://www.womenscenter.uconn.edu>

cognitive trauma (Ruch, Gartrell, Ramelli & Coyne, 1991). In my experience it is common for victims to express confusion, fear, a sense of shock or unreality and most of all helplessness and powerlessness. Indeed, recent advances in neuroimaging technology have allowed us to understand that trauma influences the basic structure and operation of the brain and therefore the resulting patterns of cognitive, behavioral and emotional processing. By way of analogy, the brains alarm system behaves like an alarm system you may have at your home. After a violent electrical storm it can be short-circuited, the system becomes overwhelmed, such that it may react to the slightest provocation, or it may be totally unable to discriminate danger appropriately.

During this period of extreme dysregulation, how a victim copes with sexual assault can be contingent upon her interaction with service providers immediately following the trauma. Everyone the victim comes in contact with, including friends, family, police, advocates and health care providers are all crisis responders, and can and should work toward meeting the basic needs of the victim during this acute phase of trauma.

Your own reactions to trauma experiences may provide a useful reference point into the nature of these basic needs. During our shared trauma of witnessing the attacks on 9/11 many of us gravitated to the people and places that felt safest to us, physically and emotionally. Some of us wanted to talk about what we were seeing, and we all wanted more information about what was happening and what would happen. In my experience and according to the research literature, those reactions reflect the same immediate basic needs felt by survivors of sexual trauma, which are: 1) the need to feel safe, 2) the need to express emotion, and 3) the need for information about the decisions and processes one faces (Woods, 2000).

Survivors have experienced their own source of terror and are often terrified. In that state, we ask them to make complex decisions about reporting, to sit for long hours in chaotic and public waiting rooms, to undergo a long and invasive physical examination. Research shows the exam alone can last up to 8 hours, and on average is 3 hours, not including time in the waiting room, or the time spent deciding to seek treatment (Ciancone, Wilson, Collette, & Gersen, 2000). In my direct experience, survivors are scared and anxious about many things, ranging from where they will go next, and where they will be safe, to whether they will have to deal with pregnancy. Failing to provide survivors with basic information regarding emergency contraception, forcing them to go elsewhere after undergoing an exam to receive treatment, or transferring a survivor from one hospital to another reflects a standard of care that is negligent. This practice ignores those basic needs for information and safety, and fails to consider the disorganizing impact of the trauma that the victim is experiencing. Knowledge of trauma and the basic needs of survivors identified in the research should compel us to simplify victims' experience of care insofar as possible. Evidence shows that the existence of regulations and written protocols calling for emergency contraception translates to increased provision of this care for survivors (Martin, Young, Billings, & Bross, 2007). I urge you to support this important proposal that would require all hospitals across the state to meet the basic needs of survivors by providing them with the full range of information and treatment, including provision of emergency contraception.

References

Burgess, A.W. & L.L. Holmstrom (1974). Rape Trauma Syndrome, *American Journal of Psychiatry*, 131, 981-986.

Ciancone, A.C., Wilson, C., Collette, R., & Gersen, L.W. (2000). Sexual Assault Nurse Examiner programs in the United States. *Annals of Emergency Medicine*, 35(4), 353-357.

Daane, D. (2005). Victim response to sexual assault. In *Sexual Assault: The Victims, the Perpetrators, and the Criminal Justice System*, F. P. Reddington & B. W. Kreisel (eds.), pp. 77-106.

Hartman, C.R. & Burgess, A.W. (1991). Neurobiology of rape trauma, in *Rape and Sexual Assault III*, A.W. Burgess (ed.), pp 1-11.

Martin, S. L., Young, S. K., Billings, D. L., & Bross, C. C. (2007). Health care-based interventions for women who have experienced sexual violence. *Trauma, Violence, & Abuse*, (8)1, 3-18.

Ruch, L., Gartrell, J.W., Ramelli, A., & Coyne, B. J. (1991). The clinical trauma assessment: Evaluating sexual assault victims in the emergency room. *Psychological Assessment*, 3, 405-411.

Woods, T. O. (2000). *First response to victims of crime*. U.S. Department of Justice: Office of Victims of Crime. Washington, D.C..