

# Summary of the History of Rape Crisis Centers

(including the pros and cons of using  
volunteer advocates)

## History of Rape Crisis Centers

### *History of Rape Crisis Advocacy*

Although rape has likely occurred for as long as humanity has existed (Brownmiller, 1975), only since the early 1970s has there been a concerted effort to better understand the issue and meet the needs of survivors. The women's movement of the 1970s created the first groundswell of information on sexual abuse and brought the extent of the problem to the forefront of public awareness. Feminists across the country organized and sought to make social changes to improve women's individual and collective status, living conditions, opportunities, power, and self-esteem (Martin, 1990).

Radical feminists in New York organized the first public speak-out on rape in 1971 (Herman, 1992). These feminists recognized rape as much more than the result of the uncontrollable sexual drive of oversexed men. Sex was recognized as a weapon that men used against women. Feminists emphasized that the wish to control women was a central factor in men's attitudes toward rape. For example, the exclusion of women from traditional male establishments such as bars usually had been seen as a way to protect women from sexual assault but may actually have been a way to control women and keep them dependent on men for protection (Brownmiller, 1975). In her landmark book on sexual assault, *Against Our Will: Men, Women, and Rape* (1975), Susan Brownmiller traced the origin of rape laws as a means for men, not women to obtain restitution for damage to their property (their women). Tracing the history of rape laws, she found that the term "rape" comes from "raptus," a Latin term that refers to the theft of property.

During the 1960s, definitions of rape became more gender neutral, and rape was recognized as a violent crime. Despite this progress, many states' sexual assault laws at that time still contained the marital exception clauses, and the victim's past sexual history was admissible into court under rules of discovery. This was traumatic to victims, who were forced to defend their sexual pasts in public courtrooms (Dupre et al., 1993).

During the mid-1970s, the National Organization for Women (NOW) initiated legislative reform in the United States. Within a decade, all 50 states changed laws to facilitate prosecution and encourage women who had been silenced for generations to come forward and report the crime of rape. As Dupre and colleagues report, as a result of pressure from feminist organizations, most states by 1980 had revised their rape laws to

- Remove the spousal exceptions, dating back to the 17th-century British "doctrine of irreversible consent," where Lord Hale proclaimed a man cannot be guilty of rape committed on his lawful wife because by their mutual matrimonial consent, the wife had given herself to her husband and was thus his possession.

- Restrict, through the implementation of “Rape Shield Laws,” the use of the victim’s previous sexual history to discredit her in court. (While this is indeed a major improvement—one that significantly limits the content of the victim’s sexual history now admissible into court—it has not totally eliminated it. For example, if sperm from another person is present in the evidentiary exam findings, that is admissible, as is any past consensual sexual contact with the accused).
- Change the definition of consent to recognize the difference between consent and submission (when, on account of fear, the victim does not physically resist); and to recognize the difference between consent and lack of consent (when the victim has fallen asleep or passed out). The use of force or coercion now also was considered in the definition of consent.
- Exclude the need for there to be a witness to the rape.
- Increase the age of statutory rape from 10 to 12 years of age in most states. (The 1990s brought an even more aggressive prosecution of statutory rape as an attempt to reduce teenage pregnancy.)

In 1976, the Pennsylvania Coalition Against Rape (PCAR), founded just one year earlier, secured passage of the first recodification of that state’s rape laws since 1939. In addition to many of the above changes, they eliminated the 90-day statute of limitations and the judicial instructions that the jury bear in mind a victim’s emotional involvement and credibility in a rape trial (Horn, 1999).

Also in 1975, the creation of the National Center for the Prevention and Control of Rape at the National Institute of Mental Health resulted in an explosion of research on the previously ignored topic of sexual assault. Millions of dollars were made available not only for studies on the impact of sexual assault, but also for the development of demonstration treatment projects to provide improved medical and psychosocial care to sexual assault survivors. Women were sought out as the agents of inquiry, not just as its objects, and as a result, most of the principal investigators on studies funded by this new center were women (Herman, 1992).

### ***History of Rape Crisis Centers***

In response to an increased awareness of rape, women worked in small, grassroots feminist collectives to develop the first rape crisis centers (RCCs) (Koss and Harvey, 1991). Nearly all the first RCCs were staffed on a volunteer basis by dedicated individuals who took the lead in developing these centers (Collins and Whalen, 1989; Edlis, 1993). In the early 1970s, many RCCs were radical feminist organizations, considered as such because, as Collins and Whalen recognized, the goal initially was not reform, but a total transformation of ideologies, power relationships, and the existing social structure. They were feminist because they were organized by women seeking to overhaul the existing power structure with its “male voices being heard

first and more often than female voices” (Fried, 1994: 573). They also recognized that their first goal had to be to establish a female-based power structure within their own organizations, because if they could not effect a power change within the RCCs, they would not be able to stop rape in society (Fried, 1994).

In these early years, organizational conflict within RCCs sometimes interfered with their ability to work in a unified way toward social change. This conflict often was the result of group members’ differing goals. RCCs needed to learn to help these subgroups negotiate more effectively and with less confrontation to establish shared goals and to work cooperatively. Or, as an alternative, RCCs had to accommodate this diversity by forming subgroups that could work independently to achieve their own goals (Fried, 1994).

Some RCCs were formed by both men and women who organized to meet a community need. In 1972, men and women in Boulder, Colorado founded Humans Against Rape and Molestation. Outrage at a rape/homicide in the community initially brought them together. Their primary goals were to assist victims and to make their community safer through crime prevention. The Boulder RCC still is an active community agency.

As more RCCs developed, representatives came together to form state coalitions. As previously mentioned, 10 RCCs in Pennsylvania joined forces in 1975 to form PCAR. They immediately began to make dramatic changes in their state’s social and legal institutions and laws. PCAR worked collaboratively with local hospitals in 1978 to develop a treatment protocol for rape victims seen at local emergency rooms, and they developed a police training manual in 1980. PCAR continues to serve as a national role model for RCCs and state coalitions. One major contribution was their effort to help establish the National Coalition Against Sexual Assault (NCASA) in 1976. All of this was accomplished by a volunteer staff working out of donated office space. The first paid positions at PCAR were not funded until 1978.

By 1979, more than 1,000 RCCs had been established across the United States. As the activities of PCAR demonstrated, RCCs already were beginning to shift from a radical feminist ideology to more liberal, reformism beliefs and an emphasis on cooperative working relationships with established social agencies (Edlis, 1993).

Thanks to both organizational evolution and the availability of funding to hire staff, the rape crisis movement has become professionalized and institutionalized. Between 1979 and the mid-1980s, significant change in existing RCCs reinforced this move away from radicalism. This included obtaining state and federal funding to hire professional and paraprofessional staff, some of whom were selected for their expertise in administration or lobbying. These RCCs recognized that, to continue receiving funding for salaries, the goals of the RCCs would need to appeal to legislators.

Wanting to be recognized for their expertise in providing counseling for sexual assault survivors, RCCs also began to stress credentials and to certify volunteers. Traditional funding sources also required RCCs to adopt traditional hierarchical organizational structures with advisory boards who hired executive directors (Collins and Whalen 1989). Most RCCs now are funded by traditional sources such as the state, the U.S. Department of Health and Human Services, and the United Way (Black and DiNitto, 1994).

Throughout the 1980s, RCCs gradually evolved from a helping model dependent on volunteer staff to a stratified, counselor-client model with paid professional and paraprofessional staff. As state and federal money became available for direct services for other crime victims, RCCs across the country capitalized on this funding by expanding their victim populations to include families of homicide victims and victims of physical assault and robbery. The emphasis moved from reform to service delivery, and the complexion of the staff changed to include more white, middle-class women (Collins and Whalen, 1989).

The next step was to understand better the impact of sexual assault and the treatment needs of rape victims. Scientific research on this impact and on evaluation of sexual assault programs was undertaken to meet this need (Burgess and Holmstrom, 1974; Ledray and Chaignot, 1981). While early feminist organizations initially stressed the “controlling” aspects of rape—the assertion of power and the experience of humiliation—and minimized the sexual dimension, researchers and women working in RCCs have since acknowledged that rape is also sexual. While the penis is certainly used as a weapon, and gaining dominance and control over the woman is often a goal (Brownmiller, 1975), if a man did not want sex, he could just beat up a woman. Rape is about sex too (Fried, 1994).

RCCs also recognized the value of legislation as a means of addressing many victim concerns, rectifying the imbalance of power, and implementing social change from the top down. During the late 1970s and into the 1980s, RCC staff and volunteers focused on changing the laws pertaining to violence against women. It was RCCs working with legislators to remove the marital exclusion clause that resulted in the ability to prosecute abusive spouses and challenged traditional ideas about the institution of marriage and a woman’s role in it (Collins and Whalen, 1989). Passage of rape counselor confidentiality statutes in the early 1980s granted privileged communication status to certified rape-crisis counselors in their contact with sexual-assault victims. They no longer needed to fear being called into court to testify, with their statements possibly used against the victims they were there to serve. This privilege was not easily won, however. In 1980, Anne Pride, then director of Pittsburgh Action Against Rape (PAAR), was held in contempt of court after refusing to give a client’s RCC record to the defense attorney in a rape trial. A mistrial was declared, and the issue of the confidentiality of RCC counseling records went to the Pennsylvania Supreme Court. In

1981, the Court ruled on *Commonwealth v. PAAR* limiting the release of victim-related counseling information to the defense. In 1983, Women Organized Against Rape (WOAR) continued the legal battle against the confidentiality statute and won (Horn, 1999).

Sen. Joseph Biden, D-DE, has been a strong, effective leader in legislating change. The Privacy Protection Act of 1978 attempted to focus the attention in the courtroom on the defendant's conduct (the rape) by excluding the victim's past sexual history from the courtroom (Biden, 1993). The Violence Prevention Service Act of 1984 created a special restitution fund, with criminals paying fines to compensate victims. Rape and domestic-abuse victims received priority for compensation (Biden, 1993). Sen. Biden first introduced the Violence Against Women Act (VAWA) in 1990, and it was signed into law September 13, 1994, as Title IV of the Violent Crime Control and Law Enforcement Act of 1994. This bill made \$800 million available for training and program development over a 6-year period, with \$26 million earmarked for the first year. The aim of VAWA was to address the problem of violence against women by

- Rectifying imbalances.
- Helping survivors by funding services.
- Providing resources and grants for education and training for police, prosecutors, judges, and victim advocates.
- Requiring treatment equal to that of men under the law by strengthening old laws and creating new ones (Biden, 1993).

The impact of VAWA and other funding sources was widely felt by RCCs across the country. For the first time, funding was readily available for expenses and honorariums, which allowed communities to bring in experts to train paraprofessionals and professionals in their area, improving local victim care. RCCs also used this newly available funding to hire staff and introduce sexual assault advocates into county attorneys' offices and police departments (Fried, 1994). Some RCCs remain social-movement organizations dedicated to broad social change from outside the existing social structure; others are working to effect change from within. Transforming gender roles is a long-term process, and the institutional development of RCCs is an important part of this social evolution (Fried, 1994).

Once RCCs were established to provide support to rape victims, attention shifted to injustices—including a tendency to blame the victim—still present in the criminal justice system and at hospitals. Rape crisis advocates, concerned about the way victims were treated by police and hospital personnel, went to police stations to support victims during interrogations (Edlis, 1993) and to hospitals during the rape exam. In many communities, this led at times to conflict between strongly feminist rape crisis advocates and the “establishment,” as represented by the police, medical personnel,

and states' attorneys. This was counterproductive to communication and education, and hampered the progress of cases through the criminal justice system. In some communities the situation still has not been rectified, especially in the relationship between the police and rape crisis advocates.

The emphasis in most RCCs today is on collaboration and cooperation rather than confrontation with other community agencies (Collins and Whalen, 1989). This move to a collegial position within the existing social service structure has made RCCs more accepted and effective in providing training to other community organizations, such as the police, prosecutors, medical facilities, and schools. Most RCC staff today cooperate effectively with these organizations as a member of the SART. Many state RCC coalitions are even taking the lead in obtaining funding to provide training and consultation to medical personnel to develop and implement SANE programs (Ledray, 1999), much as the RCCs took a leadership role in the 1970s and 1980s in sensitization training and protocol development (Horn, 1999). Their motivation comes from the recognition that the SANE model is an effective way to bridge the remaining gap in services for rape victims by providing comprehensive medical care and forensic evidence collection.

### ***When Advocacy Programs Rely on Volunteers***

Throughout the Nation, advocacy programs have traditionally relied on volunteers to staff crisis lines and ensure round-the-clock service. This has many advantages. In general, using volunteers saves money. In addition, educating civilians about sexual violence and crisis intervention provides communities with more individuals who are educated to help friends and family who have been sexually assaulted. They also are in a position to dispel myths and prejudice through their knowledge and understanding of the dynamics of sexual violence. The influence of such individuals persists even when they are no longer advocates, and can result in positive social change over the long term.

Arguably, however, volunteer advocacy programs are becoming dinosaurs among the ever-improving crisis-response models. As SART teams have become increasingly professional, the training and status of volunteer advocates has not kept pace.

Volunteers cannot be expected to have the same level of reliability and proficiency as paid professionals. Nor can they share the same level of collegiality. Compared to the proficiency, reliability, and collegiality shared by SANEs and law-enforcement professionals, advocates are in danger of becoming the weakest link.

Relying on volunteer advocates also creates a gap in the continuum of care.

Volunteers cannot guarantee off-shift availability and may not be able to do thorough followup contact, short-term case management, or legal advocacy. Because volunteer advocates are prohibited from giving out their personal phone numbers, contacting survivors becomes difficult, with most advocates unable to perform the aggressive

followup many survivors need to receive counseling immediately post-trauma, the most promising period for preventing dysfunctional coping mechanisms. If this responsibility then falls on the program coordinator, survivors have to reconnect all over again with a new person. Not surprisingly, many survivors “fall through the cracks.” This situation could be prevented if advocates were paid and had an expanded job description that included thorough followup for all recent survivors, short-term case management and counseling, ongoing medical and legal advocacy, regular office hours, and frequent on-call shifts to guarantee proficiency and consistent interaction with other first responders.

Many aspects of rape crisis advocacy nationwide still need to be elucidated. For example, what percentage of survivors receive ongoing counseling immediately post-trauma? Is the prognosis of these clients more promising than for those who do not receive such counseling? What factors make it more likely that recent survivors will use support services? How can advocates make such utilization more likely? Which crisis-counseling models used by advocates are most effective to prevent PTSD? Do regular check-in calls help survivors feel more supported? What training components are essential for advocates to feel competent in their role?

Because advocacy coordinators usually are busy training and supervising volunteers and advocacy does not have the professional cachet and credentials of other disciplines, research in this area is notably lacking. This is reflected in the fact that the field does not have a professional journal that reports on innovations, research, and successes in the rape crisis advocacy movement.

Since their inception, RCCs have relied on volunteers. Such grassroots energy is typically generated and harnessed to effect positive social change. In the rape-crisis movement, it instead is used to maintain an institutionalized status quo. This is a systemic problem because many agencies have no choice but to do so for financial reasons. Relying on volunteers, however, may jeopardize the existence of advocacy altogether. And the absence of advocates to provide agenda-free, nonjudgmental emotional support and followup case management for survivors and their families would be a tragic loss.

### ***What You Can Do***

The reality is that everything is changing except the advocates themselves. Most SANE programs provide 24-hour coverage with a small number of proficient, paid personnel; advocacy programs are challenged to do the same. Advocates need to compile examples of programs around the country that rely on paid staff and find the funding to do so. Any information evaluating the effectiveness of such programs is invaluable.

Together, advocates can make systemic changes to ensure that our crucial services remain available for survivors in need of our long-term compassion, presence, assistance, and support.

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