# Rape Trauma Syndrome in the Military Courts

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**The military courts have developed a rich case law tradition in the area of rape trauma syndrome testimony. These cases are particularly important in the context of a military that is both increasingly female and increasingly sensitive to mixed gender relationships. This article reviews the military court's approach to rape trauma testimony over the past 15 years. The author notes that military courts have been accepting of this testimony within certain well defined limits. The author analyzes the approach to testimony at one military medical center and offers a testimony model for the forensic psychiatrist who testifies in a military setting.**

## Background

***Women in the Military*** The military has increasingly become a two-gender organization over the past 20 years, with greater and more varied opportunities for female soldiers. From 1980 to 1990 the percentage of women in the Army increased from 6.6 to 11.2 percent of the force.[1] At the end of October 1994, they comprised 12.9 percent of active duty Army soldiers.[2] More than 26,000 women were deployed to Southwest Asia during Operation Desert Storm (8.6% of all deployed Army forces), and of these 4 were killed in action, 21 wounded in action, and 2 were taken prisoner.[1] The other military services also show a significant percentage of women on active duty (Table 1).

The growing number of women in the active duty force has created a number of logistical and social changes. The military, like any other large organization, has had to deal with the many issues that arise when men and women are working closely together. Sexual relationships and roles have been a source of complex difficulties for the military law enforcement and legal establishment.[3,4] Recent U.S. Court of Appeals for the Armed Forces (USCAAF) opinions[5,6] have addressed issues of sexuality to include rape trauma syndrome (RTS)[6] and date rape.[5] In a dissenting opinion in a decision involving the importance of rehearing a case that involved an acquaintance rape (*US v. Pierce*), the court noted particular concern about the necessity of force to prove a rape and stated:

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**Table 1**
**Women Serving in the Armed Forces, by Service[a]**

| Branch of Service | Actual Number | % of Force |
|---|---|---|
| Army | 69,284 | 12.9 |
| Air Force | 65,755 | 15.6 |
| Navy | 52,317 | 11.3 |
| Marine Corps | 3,671 | 4.4 |

[a]Data provided by the Defense Manpower Data Center, Monterey, CA.[2]

> In the absence of executive or legislative clarification, the burden historically falls to the judiciary to confront important legal issues. . .in a manner which provides clear and meaningful guidance. Viewed in this light, the facts of every military rape case, particularly "acquaintance rape" cases, whose central issue is sufficiency of the evidence, become exceptionally important. They help define the permissible limits of relationships between male and female soldiers.

This article addresses the issue of RTS in the context of a military in which female soldiers are now commonplace and in which the judiciary is examining the adequacy of statutes concerning sexual behavior among soldiers.

***Statutes and Rules Regarding Rape*** Article 120 of the Uniform Code of Military Justice (UCMJ) defines rape as follows:

> (a) Any person subject to this chapter who commits an act of sexual intercourse, by force and without consent, is guilty of rape and shall be punished by death or such other punishment as a court-martial may direct.[7]

The Manual for Courts-Martial describes the role of physical force and the issue of lack of consent in some detail, stating that:

> (c)(1)(b) . . . Force and lack of consent are necessary to the offense. Thus, if the female consents to the act, it is not rape. The lack of consent required, however, is more than mere lack of acquiescence. If a woman in possession of her mental and physical faculties fails to make her lack of consent reasonably manifest by taking such measures of resistance as are called for by the circumstances, the inference may be drawn that she did consent. Consent, however, may not be inferred if resistance would have been futile, where resistance is overcome by threats of death or great bodily harm, or where the female is unable to resist because of the lack of mental or physical faculties.[8]

***Rape in the Military*** In 1992 the Orange County (California) Register obtained data on rapes in the U.S. Army via the Freedom of Information Act. Numbers widely reported at the time[9] stated that women serving in the military were 50 percent more likely to be raped than a civilian (e.g., the military rate of reported rapes was 129/100,000 compared with 81/100,000 for civilian women). Unpublished data collected from the Clerk of the Court, U.S. Army Judiciary, reveal that the number of rape charges brought for adjudication in fiscal years 1992, 1993, and 1994 were 120, 116, and 99, respectively. The conviction rate for all three years was around 40 percent. Notably, the percentage of victims who were active-duty female soldiers was nearly 37 percent.

## Rape Trauma Syndrome

RTS has been defined as "a type of posttraumatic stress disorder (PTSD) or reaction that concerns typical reactions a rape victim could exhibit due to the traumatizing impact of rape."[10] First described in 1974 by Burgess and Holmstrom,[11] RTS consists of "behavioral, somatic, and psychological reactions to

the attack."[12] The syndrome is generally described as a series of phases, beginning with an acute response to the trauma followed by stage(s) leading to eventual recovery and integration. Victims are described as initially experiencing a period of disorganization, characterized by somatic complaints (muscle tension, headaches) and fear.[11] Burgess and Holmstrom later published data that also described sleep pattern disturbances (initial and middle insomnia), eating pattern disturbances (decreased appetite), and somatic symptoms focused on the area of the body that was attacked.[13] This initial phase can last from a few days to weeks.

The reorganization phase generally occurs over the next several months to years and is characterized by victims frequently moving away from home, nightmares, various phobias (particularly of things reminiscent of the rape, e.g., being indoors and especially being alone), and sexual difficulties. The nightmares can be of both the attack itself and less specific dreams in which the victim is being chased by an unspecified assailant or is in a situation where she feels unable to act in the face of a threat. Rogers has described this quality (e.g., the varied nature of the dreams of trauma victims) as one way to distinguish between true PTSD sufferers and malingerers.[14] Sexual difficulties consist of fears of sexual activity itself, or feelings of isolation and anger in the victim's ongoing significant relationships.

One-half of the women described in the original article demonstrated a "controlled" reaction to the rape, characterized by a "calm, composed, or subdued affect."[11] These descriptors become critical when discussing the usefulness of RTS testimony in the courtroom.

The research has continued to develop over the last 20 years. Research is difficult in part because, although the original description implies an illness characterized by phases, much of the research has equated RTS to PTSD. This is a difficult comparison, because PTSD is not generally described in a phase model, but rather the diagnosis is made by the presence or absence of a complex of symptoms.

In addition, other studies have focused on other important symptoms that may be missing from both models, such as the impact of marital status[15] or specific victim vulnerability factors.[16] Studies have been consistent with the concept of a specific set of symptoms in the aftermath of assaults in general[17] and specifically after a rape.[16] Other studies have shown that these symptoms appear independent of premorbid psychiatric diagnoses.[16, 19] More recent studies have supported the idea that the most significant factor in the development of PTSD symptoms after a crime is the trauma itself[16] and that PTSD symptoms are highly prevalent in rape victims.[20] Frazier and Borgida,[21] in their review on this subject, succinctly state: "It seems most appropriate, however, to base assessments on scientific reliability on the entire, evolving body of research on rape."

## Rape Trauma Syndrome in the Courts

RTS testimony is primarily used to establish the lack of consent to a sexual act. The use of this testimony sprang from a

number of concerns about rape trials that traditionally required "corroboration of the charge, utmost resistance by the victim, a prompt complaint, cautionary jury instructions, and a 'chaste' victim."[22] The central issue that surrounds RTS testimony in the courts is admissibility. Concerns have been expressed about both the scientific basis of the testimony as well as whether or not it is too prejudicial to the accused.

***Civilian Courts*** The debate over admissibility of RTS testimony has occurred over the same period of time that the courts (both civilian and military) have redefined the admissibility standard for expert testimony in general. Prior to the changes in the Federal Rules of Evidence adopted in 1975 (and subsequently adopted in military courts in 1980), the standard for expert testimony was the Frye test, which stated that the basis of expert testimony "must be sufficiently established to have gained general acceptance in the particular field in which it belongs."[23]

Since that time the "general acceptance" standard (*Frye v. U.S.*) has been replaced by the "helpfulness" or "relevancy" standard as directed in Federal (and Military) Rule of Evidence 702, which states: "If scientific, technical, or other specialized knowledge will assist the trier of fact to understand the evidence or to determine a fact in issue, a witness qualified as an expert by knowledge, skill, experience, training, or education, may testify thereto in the form of an opinion or otherwise." This relevancy standard allows the trier of fact to weigh the evidence and generally lowers the barrier to the presentation of expert testimony. The U.S. Supreme Court, in the recent landmark decision *Daubert v. Merrell Dow Pharmaceuticals*,[24] supported this relevancy or helpfulness standard in lieu of the Frye test.

Two early RTS cases, *State v. Marks*[25] and *State v. Saldana*,[26] came to differing opinions on the admissibility of expert testimony. In *Marks*, the Kansas Supreme Court accepted the testimony based on the general acceptance standard, whereas in *Saldana* the Minnesota Supreme Court found just the opposite. The development of the civilian courts approach to RTS has been well described elsewhere[12, 22, 27]; however, 16 of 20 state supreme courts have ruled the testimony admissible, usually with limitations on how it may be used.[27]

Central to the RTS debate in all courts has been the argument over whether the testimony is more probative or predjudicial. Ideally, RTS testimony would be useful in determining whether or not the accuser has, in fact, suffered a sexual assault. Viewed in this light, the testimony is highly probative of the question at issue. However, other courts have feared that such testimony comes too close to establishing the guilt of the defendant and is thus too predjudicial. The *Saldana* court was concerned that the "aura of special reliability and trustworthiness" of the expert would be prejudicial.[26]

***Military Case Law*** Like their civilian counterparts, military courts have struggled with the psychological consequences of rape, as well as the changing rules of evidence.

In *U.S. v. Moore*,[28] published one year after *Marks* and *Saldana*, USCAAF reviewed admissibility of psychological testimony concerning the victim of a sexual assault. In *Moore*, the victim had a long history of previous sexual abuse. At the time of the offense, she was engaged to one soldier, but living in a car parked on post. The court allowed three experts, all of whom opined that the victim had a tendency to appear seductive and place herself in positions where a sexual assault might occur. Two of the three, however, stated that it was unlikely that she would engage voluntarily in sex and "later cry rape." The court found the testimony relevant to the central question of consent. They did not specifically mention RTS, but gave much credence to a psychologist's opinion about the victim's mental state at the time of the offense as probative in the question of consent:

> [Dr Randall] stated that, in his opinion, it would be consistent with Sandra's 'fear of retaliation' that, if she were struck one or more times by a male who was 'respond[ing] on a sexual basis to her' conduct, and the male 'threaten[ed] to kill her,' she would likely consent to the intercourse. This statement of opinion was comparable to the medical testimony the Court approved in *United States v. Henderson*.[28]

Notably, the testimony in *Henderson*[29] concerned the mental state of a victim who suffered from schizophrenia. In that case the court found the victim's "mental condition was such as to cause her to be overawed more easily by a demonstration of force than would be usual in a woman her age." Although there is little similarity between schizophrenia and RTS as presently conceptualized, the *Moore* court went back nearly 30 years to find a case (*Henderson*) to support the idea that the mental state of the victim did have relevance in a rape trial. The third expert accepted by the *Moore* court did not examine the victim, but rather was accepted as an expert on the "psychology of rape" and testified about a theory of rape classifications and patterns of rape victim responses.

A vigorous dissenting opinion criticized the acceptance of the testimony on the grounds that it did not meet the Frye test and that a comparison between the victims in *Henderson* and *Moore* was inappropriate. Chief Judge Everett wrote:

> this evidence invited the members—in the name of science—to speculate, disregard the evidence about what actually had occurred, ignore their own experience and common sense, and decide on the basis of sympathy for the prosecutrix.[28]

He also points out in a later footnote that "[t]his is one of several reasons why 'rape trauma syndrome' has been rejected by some courts."

Other military courts[30, 31] during the early to mid 1980s offered different opinions. In *U.S. v. Tomlinson*, the U.S. Army Court of Criminal Appeals (USACCA) (the highest Army court, but one tier below USCAAF) rejected rape trauma syndrome testimony stating that the prejudicial value outweighed the probative value. Citing *Saldana*, the court felt that the testimony had little probative value because the (jury) members were fully competent to determine the credibility of the victim and that "the danger of unfair prejudice created by such testimony is obvious."[30] The *Tomlinson* court left the door partially open, however, when they

stated that the testimony may have been allowed had it been limited to show that the "inconsistencies in [the victim's] statements were the product of emotional trauma." The implication was that limited RTS testimony might have been acceptable.

Similarly, the U.S. Air Force Court of Criminal Appeals ruled in *U.S. v. Eastman*[31] that RTS testimony was inadmissible, but noted that "our decision in this case turns on the question of the witness' qualifications and not on the admissibility or inadmissibility of evidence of Rape Trauma Syndrome."

In 1988 a lower court decision on RTS was accepted for review by USCAAF in *U.S. v. Carter*.[32] In *Carter*, a military psychiatrist specifically discussed RTS and correlated published information about the syndrome with the case at bar. The expert did not specifically give an opinion as to whether or not a rape had in fact occurred, and the military judge gave an instruction placing the testimony "in proper perspective." The USACCA upheld the conviction as did USCAAF.

The reasoning by the higher court included six parts: (1) there is sufficient data to support the existence of a rape trauma syndrome; (2) the evidence will assist the trier of fact; (3) the relevance of the testimony is "unquestionable"; (4) the matter is within the discretion of the military judge; and (5) the importance of a proper limiting instruction is "paramount." The sixth reason is unique to the military and has to do with the characteristics of military jurors, whose selection is governed "by a list of criteria that requires that only the best qualified will sit in the judgement of others. This unique method of jury selection ensures that the 'asserted vagaries of juries' found in other criminal justice systems are minimized in the military."[33]

In *U.S. v. Reynolds*[34] USCAAF again affirmed a conviction of a defendant in which the admissibility of RTS was raised on appeal. They relied on *Carter* but also reemphasized the role of the expert by citing *U.S. v. Arruza*[35] for the proposition that "the expert cannot 'opine as to the credibility or believability of' the victim." Other military cases from that period confirmed the court's position[36–38] and allowed testimony from an expert who had not evaluated the victim[39] and specifically discussed the admissibility of testimony about failure to immediately report.[36] One case was overturned because the expert used a testing instrument that had not been widely accepted and testified as to the credibility of the witness.[40]

The most recent decision involving military case law and RTS is *U.S. v. Houser*.[6] In *Houser*, USCAAF upheld the conviction of a soldier who had raped a 15-year-old, live-in babysitter while his wife was absent. In his opening statement the defense counsel raised questions concerning the victim's failure to report (she told the wife about the incident the next day) and resist. He followed this lead with a "vigorous" cross-examination of the victim in these perceived areas of inconsistency. In rebuttal, the Government offered an expert in RTS. The expert was a counseling psychologist who had worked extensively with rape victims. Notably, she had not evaluated the

victim, but rather spoke about typical RTS symptoms in a multistage model. The USCAAF opinion records a great deal of her actual testimony, making this a model case for what the court feels is appropriate testimony in this area.

In *Houser* the court specifically noted that RTS testimony need not be limited to rebuttal, was "logically relevant," and more probative than prejudicial. They also restated that the testimony was limited in that the expert could not opine as to whether or not a rape had occurred or on the credibility of the witness.

The opinion also revisited an issue addressed in *Carter*, the use of testimony from experts who have treated the victim versus testimony from experts in RTS in general. In both cases the court stated the preferred method would be to use both kinds of experts. Quoting *Carter*, in a concurring opinion, Judge Wiss writes:

> We believe the better practice would be to have the treating medical personnel testify as to the victim's emotional, physical, and mental state and have another individual, properly qualified as an expert, testify as to the various aspects of rape trauma syndrome and whether the victim's symptoms are consistent with rape trauma syndrome.
>
> Such an expert, appropriately distanced from the alleged victim, is in a position to offer truly objective assistance for the factfinders, with a substantially reduced risk of a subconscious suggestion creeping into the testimony that the expert believes the victim.[6]

## Discussion

The entire area of expert testimony has been the subject of interest in both military and civilian courts in the past 10 years. Concurrent with these changes has been the growing knowledge and understanding of rape trauma syndrome.

The military environment is a particularly difficult place to address the issue of rape, given the historically predominant male membership, the growing role of women, and the emotional and complex interpersonal issues that arise in combat. Public concern and publicity about a military unconcerned with female members has also been extremely prominent in the past several years.[4] A recent article examined rape by soldiers during wartime as a "deliberate strategy to undermine community bonds and weaken resistance to aggression."[41] Of course, a rape in the context of a plundering army is vastly different from rape at a stateside military post during peacetime. However, both situations, and the many that fall along the spectrum between these two poles, must be addressed by military law.

To a large extent, the military courts have accepted RTS testimony. Indeed, they have shown a great concern about women and men in the military environment in the above opinions on RTS as well as in other areas. Two recent cases, *U.S. v. Pierce* (quoted above) and *U.S. v. Webster*, reveal that the court is particularly sensitive to these issues. In both cases the court raised the complex issues of date and acquaintance rape in an effort to clarify military law. *Webster*[42] in particular contains a detailed and thoughtful analysis of these difficult areas. In that case the court analyzed the definition of resistance, noting that: "Such evidence of unwavering and repeated verbal protest in the context of a surprise immobilization

surely could be considered reasonable resistance . . ." The court reaffirmed the idea that "lack of consent, as well as the appropriate level or measure of resistance by the victim, is determined by the 'totality of the circumstances.'"

Despite this acceptance, problems with RTS testimony still exist. While the scientific basis for certain symptoms has continued to develop, there remains much to be done. Much of this work, like the original research, is being done to further clinical rather than forensic goals (e.g., how better to treat, not how better to correctly identify).

A complete review of the RTS literature is beyond the scope of this discussion. However, the use of experts in rape cases in the military setting will be addressed briefly.

As noted above, the courts in *Carter* and *Houser* suggested a two-witness approach to RTS (e.g., the treating professional to testify as to the actual clinical course of the victim and a separate expert to testify about RTS in general). This leaves the fact finder in the position of integrating the specific symptoms of an individual victim with the "neutral" testimony of the RTS expert. This approach theoretically reduces the "risk of a subconscious suggestion creeping into the testimony that the expert believes the victim."[6]

While this model appears logical on initial review, it is difficult to follow in practice. The risk of using two experts is that the jury will be unable to perform the necessary analysis of the clinical and research data. It is precisely this analysis that requires the expert's input. Indeed, one of the major criticisms of RTS is that it is too nonspecific, and therefore unhelpful. The properly trained expert can integrate the specific response of a victim, incorporate it into the published knowledge about the syndrome, and explain how it is or is not manifested in that victim. Simply reading the medical record or responding to hypothetical questions is not adequate. Also, this model would not apply in a situation where the victim had not sought treatment.

At the Walter Reed Army Medical Center, the victim is always interviewed by the consulting expert. In addition, investigative reports, medical records, and pertinent background information is reviewed. Neurologic and psychometric consultants are available to the evaluating psychiatrist if indicated. This is a model of an RTS expert who, while not treating the victim, has personally assessed her. The subsequent testimony integrates the victim's experience in the context of the present state of knowledge about how victims respond to rape.

Despite the natural desire to want to assist victims of a sexual assault, the military psychiatrist must keep in mind that false rapes are reported[43] and that the issue of RTS remains in dispute.[27] The courts have been clear about the limits of testimony in this area; the expert must not address whether or not they believe a rape actually occurred or comment on the credibility or believability of the victim. Our clinical experience in four recently litigated cases has been that RTS testimony can be of great assistance to the

military trier of fact in situations that are commonly confusing and emotional.

## References


1. Defense Advisory Committee on Women in the Services: Fact Sheet. Washington, DC: DACOWITS, February 1994
2. Dawson H, personal communication, December 1994
3. Jonas DS: Fraternization: time for a rational Department of Defense Standard. Mil L Rev 135:37–135, 1992
4. Chema JR: Arresting 'Tailhook': the prosecution of sexual harassment in the military. Mil L Rev 140:1–64, 1993
5. U.S. v. Pierce, 40 MJ 584 (ACMR 1994)
6. U.S. v. Houser, 36 MJ 392, 401(CMA), cert denied, 114 S Ct 182 (1993)
7. Unified Code Military Justice Art 120(a), codified as 10 USCA § 920 (West Supp 1995)
8. Manual for Courts-Martial United States 1984 (1994 ed), Pt IV, ¶ 45(c)(1)(6)
9. Army Rape Rate Tops Civilian. Chicago Tribune. December 31, 1992, p 3
10. Tetrault PA: Rape myth acceptance: a case for providing educational expert testimony in rape jury trials. Behav Sci Law 7:243–57, 1989
11. Burgess AW, Holmstrom LL: Rape trauma syndrome. Am J Psychiatry 131:980–6, 1974
12. Block AP: Rape trauma syndrome as scientific expert testimony. Arch Sex Behav 19(4): 309–23, 1990
13. Burgess AW, Holmstrom LL: Rape: Victims of Crisis. Bowie, MD: Robert J Brady, 1974, pp 38–40
14. Rogers R: Clinical Assessment of Malingering and Deception. New York: Guilford Press, 1988, p 96
15. Moss M, Frank E, Anderson B: The effects of marital status and partner support on rape trauma. Am J Orthopsychiatry 60:379–91, 1990
16. Resnick HS, Kilpatrick DG, Best CL, Kramer TL: Vulnerability stress factors in development of posttraumatic stress disorder. J Nerv Ment Dis 180:424–30, 1992
17. Modlin HC: Is there an assault syndrome? Bull Am Acad Psychiatry Law 13:139–45, 1985
18. Ellis E: A review of empirical rape research: victim reactions and response to treatment. Clin Psychol Rev 3:473–90, 1981
19. Frank E, Anderson BP: Psychiatric disorders in rape victims: past history and current symptomatology. Compr Psychiatry 28:77–82, 1987
20. Rothbaum BO, Foa EB, Riggs DS, Murdock T, Walsh W: A prospective examination of posttraumatic stress disorder in rape victims. J Traumatic Stress 5:455–75, 1992
21. Frazier PA, Borgida E: Rape trauma syndrome: a review of case law and psychological research. Law Hum Behav 16:293–311, 1992
22. Note, checking the allure of increased conviction rates: the admissibility of expert testimony on rape trauma syndrome in criminal proceedings. Va L Rev 70:1657–1705, 1984
23. Frye v. U.S., 293 F 1013, 1014 (DC Cir 1923)
24. Daubert v. Merrell Dow Pharmaceuticals, Inc, 113 S Ct 2786 (1993)
25. State v. Marks, 647 P2d 1292 (Kan 1982)
26. State v. Saldana, 324 NW2d 227, 230 (Minn 1982)
27. Stefan S: The protection racket: rape trauma syndrome, psychiatric labeling, and law. Nw U L Rev 88:1271–1345, 1994
28. U.S. v. Moore, 15 MJ 354, 374–375 (CMA 1983)
29. U.S. v. Henderson, 15 CMR 268, 272 (CMA 1954)
30. U.S. v. Tomlinson, 20 MJ 897, 901, 903 (ACMR 1985)
31. U.S. v. Eastman, 20 MJ 948, 952 (AFCMR 1985)
32. U.S. v. Carter, 22 MJ 771 (ACMR 1986), aff'd, 26 MJ 428 (CMA 1988)
33. Unified Code Military Justice Art 25(d)(2), codified as 10 USCA § 825(d)(2) (West Supp 1995)
34. U.S. v. Reynolds, 29 MJ 105 (CMA 1989)
35. U.S. v. Arruza, 26 MJ 234 (CMA 1988), cert denied, 489 US 1011 (1989)
36. U.S. v. Peel, 29 MJ 235 (CMA 1989), cert denied, 493 US 1025 (1990)
37. U.S. v. Savage, 30 MJ 863 (NMCMR 1990)
38. U.S. v. Moss, CMR 89-1152 (USNMCCCA 1990)
39. U.S. v. Leger, CMR 91-0412 (USNMCCCA 1992)
40. U.S. v. Bostick, 33 MJ 849 (ACMR 1991)
41. Swiss S, Giller JE: Rape as a crime of war: a medical perspective. JAMA 270:612–15, 1993
42. U.S. v. Webster, 40 MJ 384, 386–387 (CMA 1994)
43. Feldman MD, Ford CV, Stone T: Deceiving others/deceiving oneself: four cases of factitious rape. South Med J 87:736–8, July 1994