Chapter 1

RAPE: HISTORY, MYTHS, AND REALITY

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INTRODUCTION

Rape and sexual assault are common crimes in our society. While few would disagree that the aftermath of sexual assault is traumatic for the individual, it has only been in the past two decades that any systematic description of any psychological consequences has occurred. The advent of feminism in the 1970s led to an increasing focus on the legal, medical, and psychosocial needs of survivors, but, as recently as 1992, the American Medical Association acknowledged the large impact that sexual violence against women has on health care and admits that departments are poorly prepared and researched to deal with this problem (Council on Scientific Affairs, 1992).

Research into sexual assault largely originates from the USA and the applicability of these studies to other populations is not known. However, at least one UK study echoes the above concern and makes clear recommendations for an improvement in medical and psychological services for women, arguing that more specialized support services are needed than what is currently on offer (Lees and Gregory, 1993). The literature on and services for male rape are even more limited. This may be due to the fact that it has only recently been criminalized in the UK (Home Office, 1994) and those rates of reporting are low.

This book will attempt to open the debate on sexual assault by bringing together existing research findings and theoretical perspectives on female and male rape and sexual assault and consider the implications for future practice and policy. Different aspects of male and female sexual assault

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will be highlighted throughout, but, since the majority of data available is on women (and it is among women that the majority of those who have been raped are found), the focus will naturally bias towards women. It might, however, be the case that much of the information provided will be applicable to the male survivor. The terms 'sexual assault' and 'rape' are often used interchangeably in the literature. In this text, 'rape' will be used to describe acts meeting the legal definition, and 'sexual assault' to refer to the wide spectrum of assault behaviours (difficulties with these definitions will be discussed on p. 8). The term 'survivor' or 'complainant' will be the preferred terms used, rather than 'victim', to place the individual as having an active role in the experience of survival and recovery from rape and sexual assault. However, it is acknowledged that various debates about nomenclature exist in this area (see Chapter 3) and that much of the available research refers to the 'victim' of sexual assault. The aims of this chapter are to provide a brief overview of how rape has been defined, viewed, and managed over time.

HISTORICAL AND CULTURAL PERSPECTIVES ON RAPE AND SEXUAL ASSAULT

The silence surrounding rape prior to the 1970s has often been commented upon perhaps most notably by Susan Brownmiller, whose classic book *Against Our Will* (Brownmiller, 1975) contributed an analysis of rape which, along with feminist consciousness raising, became a turning point for improvements in social policy and legal and medical care for survivors. Brownmiller (1975) describes how rape and sexual victimization have been part of the subordination of women dating from prehistoric times to present. She cites an example from the Bible with the story of Potiphar's wife (which is an important morality lesson in Hebrew, Christian and Moslem folklore), illustrating what can happen to an upstanding man if a vengeful female cries rape. Judging from recent press coverage of 'date rape' trials in the UK, the impression is given that men continue to be unfairly accused of rape.

Brownmiller (1975) also critiques the beginning of law stating: 'concepts of rape and punishment in early English law are a wondrous maze of contradictory approaches reflecting a gradual humanisation of jurisprudence in general, and in particular, man's eternal confusion, never quite resolved, as to whether the crime was a crime against a woman's body or a crime against his estate.' She was also one of the first commentators on differences in how rape is managed based on social class and race. This work is as relevant today and should continue to be on the 'essential reading' list of those who work with survivors.

In many societies, rape in war became one of the prerogatives of the victor in battle (and news reports from current sites of conflict such as Bosnia and Rwanda suggest this continues to be the case), indicating the totality of defeat and ultimate humiliation of the defeated. This was the case certainly for women but also to some extent for men. In modern times, male rape was considered rare outside the context of incarceration (and this is the only context in which Brownmiller [1975] mentions men being raped). Nevertheless, even in ancient times, there are descriptions of men who, having been raped, 'lose their manhood' and ability to be an effective soldier. A more latter day description of this is found in T.E. Lawrence's *Lawrence of Arabia* who was raped by his Turkish captors during World War I causing much subsequent disruption to his life. Despite the passage of time, myths around loss of masculinity following rape continue to be pervasive.

The origins of research into the social and psychological impact of rape and sexual assault, the Rape Crisis movement, and improvements in care for survivors are found within the social change emanating from the feminist movement in the 1970s. Prior to the 1970s, there was little available information about individuals who had been raped, due to the focus on victimology and characterizing of the offenders often as aberrant and subject to uncontrollable sexual urges. According to Roberts (1989), this focus led to 'the victim' being to some extent irrelevant because the choice of her as victim would be unconnected with her as an individual. She continues 'one fundamental reason why the feminist anti-rape campaigns created such a change in thinking about rape was that they gave space and voice to those who had been silenced' (Roberts, 1989). Accordingly, the first Rape Crisis Centre was set up in the USA in 1970 and in the UK in 1976.

Empirical studies characterizing women's responses to rape also started to appear in the USA around this time. These were essentially descriptive studies conducted without controls and on groups who were seeking help following rape (e.g. Sutherland and Scherl, 1970; Burgess and Holmstrom, 1974; Symonds, 1975). Such studies were nevertheless instrumental in prompting subsequent research and towards improving medical services for survivors of sexual assault. The most well known of these early studies was by Burgess and Holmstrom (1974) who termed the acute traumatic reaction of sexual victimization as the 'Rape Trauma Syndrome'. This syndrome was described based on similarities of response observed in 109 child, adolescent, and adult females who had been subjected to forced sexual penetration presenting to an emergency hospital department. Burgess and Holmstrom (1974, 1979) followed this group longitudinally and noted that approximately one-quarter of women continued to have difficulties consequent on the rape 6 years later. This was one of the

few longitudinal studies in this area. Burgess and Holmstrom (1974) emphasized that this syndrome is an acute reaction to an externally imposed situational crisis.

Thus, this early conceptualization of the stress response to sexual assault closely resembles the diagnostic criteria of post-traumatic stress disorder (PTSD; DSM-III-R, APA, 1987; DSM-IV, APA, 1994). Post-traumatic reactions were described for a number of years under various names such as shell shock and combat fatigue, associated with war veterans (Breslau and Davis, 1987), and PTSD did not appear as a diagnostic category within the DSM-III of the American Psychiatric Association (APA) until 1980. PTSD has now largely subsumed the concept of 'rape trauma syndrome' and will be the focus of several chapters in this book. However, studies from the USA suggest that survivors of rape from the largest group of victims of crime affected by PTSD (Steketee and Foa, 1987).

Similar to elsewhere, the way that rape and sexual assault are managed in the UK has been slow to change. Attempts at legal reform began in the 1970s due to the sustained campaigning of groups such as Rights of Women, Women Against Rape, and Rape Crisis. One such legal reform was the amendment to the Sexual Offences Act (1976) which required that the defence should apply for permission from the judge, prior to cross-examining a complainant regarding her sexual history or sexual character. Unfortunately, this seems to continue to have little impact on how rape cases are managed by the legal system in the UK (Lees, 1996). Further notable, early work arising out of the Women Against Rape movement in London was the Women's Safety Survey published as *Ask any woman: A London inquiry into rape and sexual assault* (Hall, 1985). This was the first large-scale UK study providing information about the prevalence and characteristics of sexual offences and the experience of women who reported rape to the police and the legal systems. This study was important in lobbying for social and political reform and increasing sensitivity towards those who had experienced rape. There continues, however, to be a paucity of specialist sexual assault services for women in the UK and funding for Rape Crisis centres has been cut over the years. One pioneering model in the UK has been the Manchester Sexual Assault Referral Centre, which was set up as recently as 1986. There are few other existing specialist services in the UK, although genitourinary medicine clinics are increasingly becoming involved in the care of the sexually assaulted (Bottomley, Sadler, and Welch, 1999). Where the diverse range of legal, medical, and psychological needs that a survivor may present with are best met, however, remains a matter for debate.

While the above has primarily focused on work originating from the UK and USA, it is, however, important to note that prevalence studies suggest

that rape and sexual assault are widespread and cut across all socio-economic, ethnic, and cultural groups. That rape, and any other acts of gender-based violence against women including domestic violence, mutilation, and sexual abuse, are a public health issue deserving of international concern and action has in the last decade been adopted by the United Nations Commission on the Status of Women (Heise, Pitanguy, and Germain, 1994) and the World Health Organization (WHO, 1996). The UN Declaration against Violence against Women was stated in 1993 and provided a definition of violence against women which included recognition of both the physical and psychological harm, in both public and private spheres, caused by rape, sexual assault, and a range of other abuses. Increasingly, the very high impact that this abuse has on health is being recognized, and, in industrialized countries, it is reported that rape and domestic violence account for one in every five healthy years of life lost to women aged 15–44 (Heise *et al.*, 1994). It is hoped that by emphasizing that any form of violence against women, including rape, is a violation of basic human rights, pressure can be put on all governments to take action across relevant sectors such as the media, health, education, the legislative, and judiciary system.

Despite these worthwhile efforts, it seems the social change required to end these human rights violations is some way off. Thus, for example, on a more local level, we have had much recent media coverage of the high-profile rape trial of Mike Tyson in the USA and the acquittal of several male university students in the UK for 'date rape'. The impression given in coverage of these trials has often been that men were being unfairly accused of rape as a result of feminist political correctness (Lees, 1996). The media coverage may have contributed to an increase in the number of women reporting to the police and led some to argue that more false allegations are being reported. There is, however, no evidence to support the latter. Public disbelief in the wide prevalence of abuse and sexual stereotypes continue to contribute to the view that spurious complainants are common.

RAPE MYTHS AND STEREOTYPES

There are many rape myths, misconceptions, and stereotypes that impact on how society, and the legal and medical system, approaches the management of sexual assault. Rape myths will also affect the perceptions of the survivor, the availability of social support, and, inevitably, how an individual copes with the emotional and psychological consequences. Attention to rape myths and stereotypes originated in the feminist literature of the 1970s. Susan Brownmiller (1975) identified four fundamental

misconceptions (the 'deadly male myths of rape') that *all women want to be raped, no woman can be raped against her will, she was asking for it*, and *if you are going to be raped you might as well enjoy it*.

While virtually every common stereotype existing about rape has been discredited by accumulated knowledge over the past 20 years, there continues to be a persisting image that *rape is a physically violent assault carried out by a psychotic stranger in a dark alleyway at night*. Although this is the reality for some, most rapists do not fit criteria for psychiatric diagnosis, and the majority of rapes take place indoors and by someone known to the survivor (Dunn and Gilchrist, 1993). Terms such as acquaintance or date rape are used to describe the latter which may account for up to 80% of sexual assault reported to rape crisis centres (Warshaw, 1988). Acquaintance rape has been a largely hidden phenomena until recently, but a recent increase in publicity has arisen in the UK due to the finding that such cases are more likely to be dropped and less likely to achieve conviction by the judiciary system (Harris and Grace, 1999). This has led the Home Office to consider the idea of 'grading' the seriousness of sentences attached to rape charges (i.e. less severe sentences for acquaintance or date rape compared with stranger rape) to improve conviction rates. Clearly, there are other routes towards improving conviction rates, but this recent debate is demonstrative of how rape stereotypes are upheld in the law. There is also evidence to suggest that women who are raped by acquaintances are also less likely to report to the police (Lees and Gregory, 1993), are less likely to access medical and psychological care (Koss, Gidycz, and Wisniewski, 1988), and may be seen as more culpable and thereby less deserving of support from partners, family, and friends (Baker, Sholnik, Davis, and Brickman, 1991) than those who are raped by strangers.

Another linked rape stereotype is that *husbands cannot rape their wives*. In fact, marital rape is very common and occurs throughout most cultures (Hall, 1985; Heise *et al.*, 1994). Rape by intimates may also be secondary to other types of ongoing physical abuse. It has, however, been a stereotype upheld in law, and rape within marriage only became a crime as recently as 1992 in the UK (Home Office, 1994). The extent of the problem becomes apparent in a recent review in which it is observed that 'women in the United States are more likely to be assaulted and injured, raped, or killed by a current or ex-male partner than by all other types of assailants combined' (Council on Scientific Affairs, 1992). A further prevalent stereotype is that *woman who are raped must have done something to cause it to happen*. This judgement may be based on behaviour or dress or sexual history (i.e. *nice girls don't get raped*). The idea that someone might choose to be raped is connected to other prevalent myths including the assumption that *rape is motivated by uncontrollable male sexual desire* and accompanying this that *most women secretly desire and enjoy being raped*. Despite

accumulated evidence to debunk such myths, this is a prevalent view in the media and literature. Theories of sexual aggression, including those that support rape as a biologically and sexually motivated act, abound and will be discussed in more detail in Chapter 13. However, the argument that sexual urges are the motive are not supported by the fact that most rapists have access to consenting sexual relations at the time of the assault (Dunn and Gilchrist, 1993). Furthermore, the very high level of trauma found post-rape suggests rape is most often a terrorizing, aggressive act, which is carried out with the purpose of controlling, humiliating, and degrading the survivor.

A number of specific stereotypes affect the management of male sexual assault. First, the idea that *a real man cannot be raped* (Groth and Burgess, 1980) has until recently been upheld in the legal system in the UK where 'rape' was specified as forcible vaginal penetration (i.e. only women could be raped). This stereotype also links in with traditional views of masculinity where the expectation is that men should be able to fight back. However, in the few studies which have been carried out in this area, men have reported high levels of shock and fear during these attacks engendering feelings of helplessness and inability to respond (Mezey and King, 1989; Frazier, 1993). Another common myth affecting men is *the presence of erection or ejaculation implies consent on behalf on the survivor*. While this has been disproved in a number of human and animal studies, where it is clear that high levels of physiological arousal can lead to genital response, this myth continues to be used as a legal defence and can also be distressing for survivors (Coxell and King, 1996).

Further myths concern the confusion that a sexual act between two people of the same sex is a homosexual act: *men who rape other men must be gay* and *a man who is raped by another man must be gay or have been acting in a gay manner* (Coxell and King, 1996). Men may be less likely to report sexual assault because they fear being labelled as homosexual, and, for some men, rape may lead to acute confusion over sexuality and sexual roles. Confusion over sexuality may affect men regardless of their sexual orientation (King, 1995). The impact of rape myths on gender and sexuality are elaborated upon in Chapter 3. The above stereotypes also emphasize the sexual component of the assault whereas, similar to studies of female rape, it seems more likely that degradation and domination motivate the crime. These stereotypes have undoubtedly contributed to low reporting of male rape, and it may be particularly difficult for a man to acknowledge his victimization to family or friends, let alone the police. Consequently treatment programmes for men who have been raped are rare.

The pervasive nature of the above stereotypes are upheld in a number of studies of the rape attitudes of various professional groups including

lawyers, police, doctors, nurses, and mental health professionals (for a review see Ward, 1995). In general, it seems health care professionals respond more positively to those individuals who fit a stereotypical pattern of sexual violence (Best, Dansky, and Kilpatrick, 1992). Furthermore, these studies often find gender differences such that men tend to be more accepting of rape myths, less supportive of survivors, more tolerant of sexual violence, and more blaming of survivors, compared with women (Ward, 1995).

The above stereotypes are often internalized for survivors and give rise to high levels of self-blame. The negative impact of self-blame (and the blame of others) on post-rape functioning has been demonstrated (Wyatt, Newcomb, and Notgrass, 1991). Although attitude change towards rape has been demonstrated in a limited number of studies primarily in US college settings (Ward, 1995), there are no broader rape prevention strategies incorporating attitude change available to date. It is essential for those working with rape and sexual assault to examine our own attitudes, and misconceptions of this area as summed up in the following saying: 'Judgements are for courtrooms, not consulting and clinic rooms'. The pervasive nature of these stereotypes and their negative impact on survivors suggest a continuing need to educate the public, legal, and medical care system.

DEFINITIONS OF SEXUAL ASSAULT AND RAPE

The terms 'rape' and 'sexual assault' are often used interchangeably in the literature and are synonymous in legal usage (Koss and Harvey, 1991). However, many studies refer to a variety of forms of sexual coercion which may not constitute a legal definition of rape. In addition, legal definitions of rape and sexual assault have also been subject to extensive reform over the past two decades. Definitions of rape and sexual assault, legal or otherwise, reflect wider social movements and cultural practices. It is thus worth reviewing some of these past and present definitions both towards understanding the terminology used in the literature and also towards the complex issue of understanding how sexual assault is socially construed.

In traditional definitions, rape was defined as 'carnal knowledge of a female forcibly and against her will', and was generally restricted to vaginal–penile penetration with a woman who was not the man's wife (Bienen, 1980). Such definitions were criticised as being too narrow and contributing towards prejudicial criminal justice practices in handling rape cases (Berger, Searles, and Neuman, 1995). The feminist movement

was instrumental in achieving legal reform and argued traditional rape law regulated women's sexuality and protected male rights to possess women as sexual objects. There is considerable diversity in the reforms that were achieved in rape law. In the USA, some states redefined rape as sexual assault in an attempt to broaden the crime beyond its traditional meaning, vaginal- penile intercourse, to include oral and anal penetration as well as vaginal penetration, sexual penetration with objects, and touching of intimate body parts. Other reforms redefined the crime in gender-neutral terms in order to include male rape and some statutes removed or modified the spousal exemption which has given husbands immunity for rape of their wives (Berger *et al.*, 1995).

Others have sought to provide alternative definitions (e.g., 'non-consenting sexual relations with another person, obtained through physical force, threat or intimidation': Groth and Burgess, 1977) in an attempt to counter earlier definitions which suggested the victim should have been subjected to violence for rape to have happened and to counter the narrowness of definitions based on penile–vaginal penetration only. Many statutes in the USA define rape as the 'nonconsensual sexual penetration of an adolescent or adult obtained by physical force, by threat of bodily harm, or when the victim is incapable of giving consent by virtue of mental illness, mental retardation, or intoxication' (Searles and Berger, 1987). Clearly, this definition is an improvement in broadening the scope for conviction of rape by acknowledging the contribution of vulnerability.

In the UK, rape law reforms resembling some of the above changes have been fairly recent. Rape within marriage was legally recognized as a crime when the law was changed in a House of Lords ruling in 1992. The present legal definition of rape in the UK is presented in Table 1.1. This is the first legal recognition of male rape in the UK. While this law specifies both vaginal or anal penetration where the person does not consent to it as rape, other forms of sexual coercion including attempted rape, oral sex, and penetration by instruments continue to be crimed as 'indecent assault' (Home Office, 1994).

Legal definitions of rape and sexual assault continue to be controversial and subject to criticism due to their narrowness and consequent difficulty in achieving convictions (Lees, 1996).

Rape laws that are prejudicial, particularly against women, are universal. In many countries, the judicial system often treats rape as a crime against public morality, family honour, or 'property' (e.g. African customary law), as opposed to a crime against the individual (Heise *et al.*, 1994). In some countries, laws make it almost impossible to prosecute rape. In Pakistan, for example, the Law of Evidence considers women 'incompetent' as witnesses in cases of rape and would require four male Muslim witnesses

Table 1.1 Sexual offences in the UK: definition of rape (adapted from *Criminal Justice and Public Order Act*, Home Office, 1994)

1. It is an offence for a man to rape a woman or another man.
2. A man commits rape if –
   (a) he has sexual intercourse with a person (whether vaginal or anal) who at the time of the intercourse does not consent to it; and
   (b) at the time he knows that the person does not consent to the intercourse or is reckless as to whether that person consents to it.

   A man also commits rape if he induces a married woman to have sexual intercourse with him by impersonating her husband.

to provide corroborative evidence. In several Latin American countries, rape is only defined as a crime if it is committed against 'honest' (e.g. virginal) girls or women, while laws in Chile and Guatemala specifically dismiss the charge if a man agrees to marry the girl or woman he has raped (Heise *et al.*, 1994).

While definitions of rape and sexual assault and accompanying laws have to some extent been reformed over the years in a number of countries, Heise *et al.* (1994) point out that 'such laws are only as good as their enforcement', and it is, unfortunately, in the latter where legal responses to rape and other abuse notably fail. This is not a problem confined to developing countries; recent work in the UK suggests that only 6% of cases of rape being reported to the police actually result in a conviction, which is a decline from 24% in 1985 (Harris and Grace, 1999). Given the difficulty in reaching a consensus in defining rape and sexual assault and the inherent prejudice in many existing definitions and legal systems, it is probably not surprising that incidence and prevalence figures vary widely as described below.

THE INCIDENCE AND PREVALENCE OF SEXUAL ASSAULT

In 1983, Andrea Dworkin wrote: 'we use statistics not to try to quantify the injuries, but to convince the world that those injuries exist.' This statement exemplifies the motivation of researchers who continue to attempt to quantify the scope of rape and sexual assault in our society beyond that reported in crime statistics. The incidence of rape as reported by crime statistics refers to the number of separate criminal incidents that occurred over a fixed time period, usually a 1-year period. Reporting of rape by this method would suggest that it is a relatively infrequent crime,

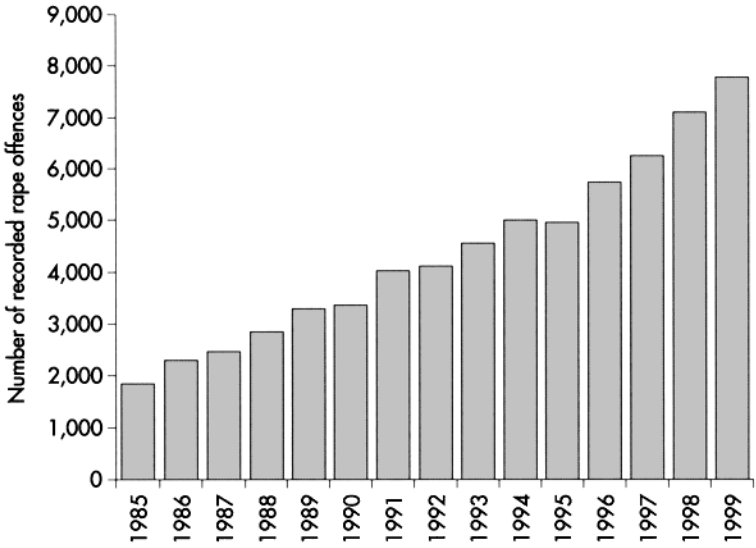

Figure 1.1 Home Office recorded rape offences (female) in the UK 1985–1999 (adapted from Harris and Grace, 1999; and *Crime and Criminal Justice Unit*, Home Office, 2000).

for example, rape represented just 3% of the violent crimes reported to National Crime Statistics (NCS) in the USA in 1985. In contrast to community surveys, according to the NCS, women are more likely to be raped by strangers than by someone they know and weapons are used in a third of rapes reported (Koss and Harvey, 1991).

Figures in the UK also suggest a low (but increasing) incidence of rape. The data available relates to rape of females. Thus, the number of rape offences recorded in England and Wales in 1992 was 4,100 which is over three times the number recorded in 1982. This is explained by both increases in reporting by the public and changes in police practice towards a greater number of cases being recorded as offences. Similarly, there is again an increase in 1994 figures where 5,082 cases of rape were recorded (Home Office, 1993, 1994). The changing incidence of recorded rape offences is shown in Figure 1.1.

Data on the number of cases of rape in men are only just starting to become available in the UK, and, in 1995, 3,142 indecent assaults and 227 rapes were recorded (*Criminal Statistics*, Home Office, 1996). In the USA, crime statistics on male rape are also limited due to the fact that the Federal Bureau of Investigation do not report men as being raped in their crime statistics because of defining rape as something that can only be committed against a woman (Isely, 1998).

The omission of male rape from recorded crime statistics is only one of the problems in this area and, in general, there is agreement in the literature that recorded offences grossly underestimate the incidence of rape and sexual assault in the population. Thus, the NCS method of collecting has been criticised due to the use of questions which require respondents to answer questions which use the term 'rape' and conceptualize it as a violent crime (Koss, 1995). Studies both in the USA and the UK have estimated that only somewhere between 7 and 25% of rape and sexual assault offences are reported to the police (Hall, 1985; Koss *et al.*, 1987; Koss, 1995). This figure may be even lower in cases involving marital rape and where the assailant is known to the survivor (Hall, 1985). In addition, a large problem, identified in a number of studies, is that complaints of rape are not always recorded by the police and if 'crimed' they were more likely to fit the classic stranger rape (Lees and Gregory, 1993). Lees and Gregory (1993) argue that the high rate of complaints of rape which are classified as 'no crime' continue to reflect a strong belief by police that women make false allegations. They cite a study carried out by the New York Crimes Analysis Unit which found that the rate of false allegations for rape and sexual offences was only around 2% (Adler, 1987).

Koss *et al.* (1987) suggest that prevalence data reflecting the cumulative number of women who have been sexually victimized are more relevant to mental health research because of the long-term medical and psychological after-effects of sexual assault. However, prevalence studies are also subject to methodological difficulties, in particular, variability in the definition of sexual assault used (which may be used as a generic term that includes rape as well as other degrees of unwanted and pressured sexual contacts not involving penetration, and incest and child sexual abuse) and the use of select populations. Koss and Harvey (1991) review a number of prevalence studies of sexual assault in the USA and, selecting those using probability sampling methods and a definition of rape resembling legal standards, suggest a 20% rape prevalence for adult women (Kilpatrick, Saunders, Veronen, Best, and Von, 1987; Koss *et al.*, 1987). In the UK, similar figures have been found; a survey questionnaire distributed to 2,000 women in London found that 17% reported completed rape (60% of these were marital rape) and a further 20% had been victims of attempted rape (Hall, 1985). Within genitourinary settings in the UK, prevalence studies of outpatient attendees suggest 28 to 35% of women report a lifetime history of sexual assault (Petrak, Skinner, and Claydon, 1995; Keane, Young, and Boyle, 1996).

Prevalence surveys on rape have typically excluded adult males until more recently (Coxell, King, Mezey, and Gordon, 1999). Early prevalence data on male rape and sexual assault have been of small and atypical samples from, for example, incarcerated populations or from

men presenting to medical and psychiatric clinics. In the USA, up to 10% of individuals reporting to treatment centres for rape are men (Kaufman, DiVasto, Kackson, Voorhees, and Christy, 1980). A more recent study in a US prison population reports that up to 22% of men may have had non-consensual sexual contact, of which over half involved anal sex (Struckman-Johnson and Struckman-Johnson, 1994). However, all prevalence figures in such studies are thought to reflect underreporting. One of the main US prevalence studies of male sexual assault carried out in the general community found that 7% of a sample of 1,480 men in Los Angeles had been sexually assaulted since the age of 16 (Sorenson, Stein, Siegel, Golding, and Burnham, 1987). Touching on an area which has received very little attention over the years, due to the assumption that perpetrators are almost always male, this study also reported a higher rate of female perpetrators compared with male perpetrators. This finding has been attributed to how forced sexual contact was defined in the study (i.e., 'In your lifetime, has anyone ever tried to pressure or force you to have sexual contact? By sexual contact I mean their touching your sexual parts, you touching their sexual parts, or sexual intercourse?') leading to respondents precluding anal penetration (Coxell and King, 1996).

In the UK, there has been one large survey reporting the lifetime prevalence of non-consensual sex in men (Coxell *et al.*, 1999). Of 2,474 men recruited through general practices, 71 (3%) reported non-consensual sexual experiences as adults (and 5% of men reported sexual abuse as children). Similar to surveys of women, having a history of child sexual abuse was predictive of non-consensual sexual experiences as an adult (Coxell *et al.*, 1999). Further data is provided in studies detailing prevalence rates of male sexual assault in specific populations. In a sample of 930 homosexual men, Hickson *et al.* (1994) found that 27.6% had been sexually assaulted at some point in their lives, and that 99 of these men had been raped. In genitourinary medicine settings in the UK, two anonymous surveys report rates of 11 and 14% of male attendees providing histories of sexual assault (Petrak *et al.*, 1995; Keane *et al.*, 1995).

Prevalence data of rape and sexual assault in women (but not men) have now been reported from many other countries; for example, Shim (1992) reports, from a sample of 2,270 women in Korea, a prevalence rate of completed rape of 8% and completed and attempted rape of 22%. In South Africa, it has been reported that a woman is raped every minute and a half, totalling approximately 386,000 women raped each year (Bindel, 1996).

Brutal rapes as part of war have occurred throughout history and are not exclusive to developing countries. The high prevalence of these crimes has

only just begun to be recorded and receive wide media coverage; for example, since fighting in Bosnia began in 1992, it is estimated that more than 20,000 Muslim women have been raped. There are reports that women have been held in 'rape camps' where they are raped repeatedly and forced to bear Serbian children as tools of 'ethnic cleansing' (Post, 1993 cited in Heise *et al.*, 1994). A study from the civil war in Liberia reported that 49% of a random sample of 205 girls and women experienced at least one act of sexual or physical violence from soldiers (15% had been raped or subjected to attempted rape) (Swiss *et al.*, 1998). Much less is known about the prevalence of sexual assault on men in war and Carlson (1997) argues this relates to wider social stereotypes denying the possibility of male rape and, perhaps, particularly in military contexts. While beyond the scope of this text, readers are referred to Swiss and Giller (1993) for a recent review of the impact of rape in war.

Precise figures of the incidence and prevalence of rape and sexual assault will remain difficult to assess. All data from which these figures arise are dependent on information given from survivors themselves. Concepts of what constitutes rape vary across cultures and there is no widely accepted universal classification system. There is evidence in the UK to suggest that, in both, women and men, reporting to the police is very low (Lees, 1996). There are no certainties that legal authorities will take appropriate action. In addition, the assaulted person may feel revictimized by the police and judiciary process (Lees, 1996). Disclosure remains problematic due to pervasive negative attitudes towards survivors who may, by acknowledging his or her rape, incur further devaluation and stigmatization.

THE CARE OF SURVIVORS OF RAPE AND SEXUAL ASSAULT

The focus of this book is to bring together much of what is known from existing research findings and theoretical perspectives from clinicians and academics in the field about the mental health care which can be provided for survivors of rape and sexual assault. In doing this, there will always be omissions, and there will always be inherent difficulties in tackling a topic that is infused with social and political values. The above discussion provides a backdrop for some of these difficulties. In attempting to provide care for the survivor, it is, however, important to gain an understanding of the context of rape and sexual assault. It is within this social and political context that the psychological responses of survivors are framed.

Rape and sexual assault are risk factors for physical and mental health

difficulties. Not all individuals will need medical and psychological care following rape. For those who do, there is no one established way in which such care should be provided. In many countries, there will not be a health infrastructure to implement rape interventions, and innovative culture specific community based programmes will be needed. It has been argued that the involvement of mental health professionals, with their tendency towards disease models and diagnoses, places emphasis on the pathology of the woman (or man) and diverts attention away from the responsibilities of the perpetrators of rape (usually men). It is also argued that, used with responsibility, diagnoses such as PTSD can be a tool to help individuals understand their behaviour and feelings as long as the underlying violence is acknowledged (WHO, 1996). Thus, this is the challenge to every mental health clinician, counsellor, and researcher who may read this book. As our knowledge expands regarding the impact of rape and sexual assault, we must assume the responsibility of how this knowledge is applied to the lives of individuals affected. As socially ingrained as rape and sexual assault may seem to be, there is evidence from anthropological research that it is not inevitable in all societies (e.g. Levinson, 1989) and evidence that strategic rape prevention interventions can be effective (Hanson and Gidycz, 1993). Our responsibility will also inevitably be to contribute towards the elimination of these crimes from our lives.

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