Wiley Series in Clinical Psychology

The Trauma of Sexual Assault

Treatment, Prevention and Practice

Edited by
Jenny Petrak and
Barbara Hedge

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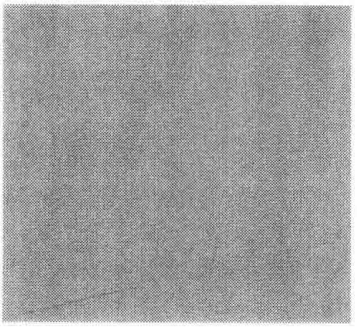

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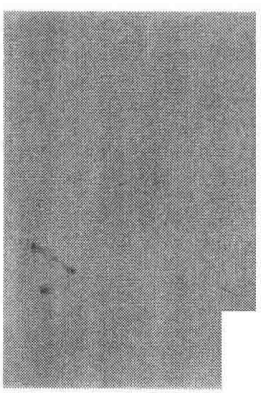

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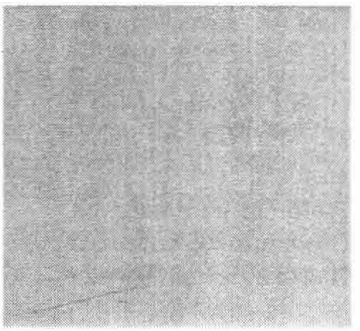

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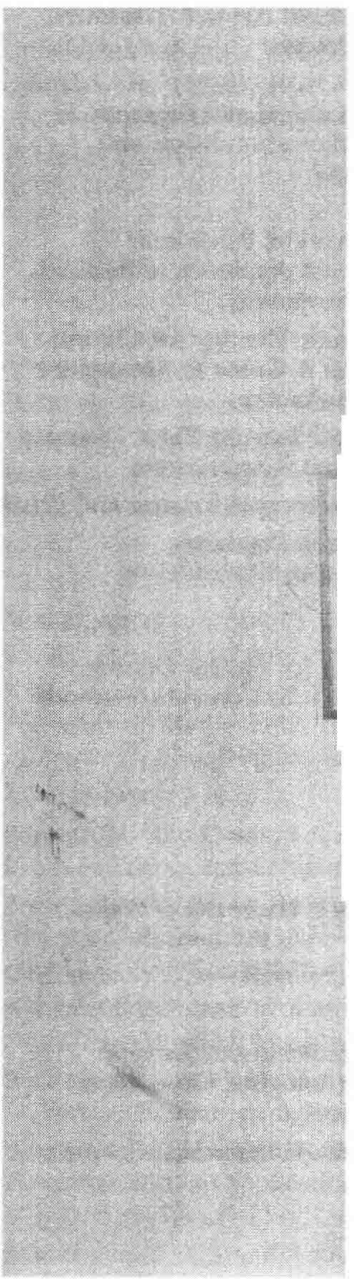

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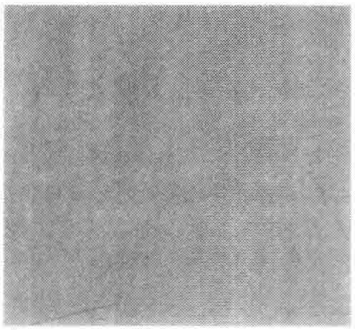

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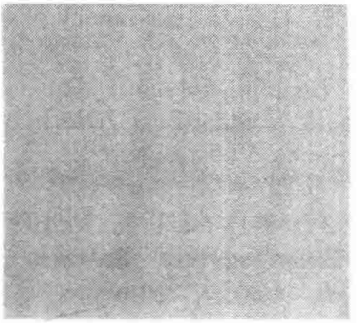

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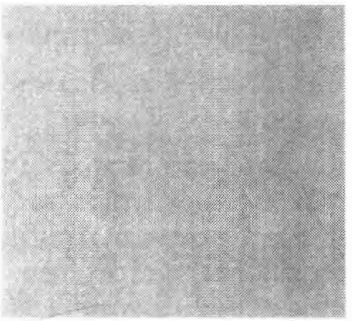


PREFACE

Why another book about rape and sexual assault? As clinical psychologists working in medical and sexual health settings, we found ourselves seeing both men and women who had experienced rape and sexual assault. While we found many interesting books from the 1970s onwards that addressed rape from the feminist, social, and political perspective, we found few texts that addressed the wide-ranging problems we encountered in the clinical setting.

Our motivation in compiling this text is to draw together current theories, research, and clinical practice relating to the management of sexual assault. This is primarily a book for clinical psychologists, psychiatrists, counsellors, support workers, therapists, and clinicians working in settings that provide for sexual assault or who are thinking of setting up such services. It will also prove useful to primary care workers and physicians working in a wider field as well as to voluntary sector agencies. Police, legal, and judicial professionals may also find an understanding of the psychological impact of sexual assault useful in improving the management of complainants.

We deliberated over how to refer to the person who has experienced sexual assault. Many texts use the terms 'victim' or 'survivor' and legal texts frequently refer to the 'complainant'. Each of these terms provides a different insight into the experience of the assaulted person. At different times, any of these terms might be appropriate. We, therefore, decided not to impose any specific terminology on the authors. As a consequence, these terms are used interchangeably throughout the book. Many case examples are used in this book. Each is based on fact but each has been significantly altered in order to protect the identity of the person involved. Cases have also been simplified in order to demonstrate salient points.

Chapter 1 begins with an overview of how rape and sexual assault has been defined in legal and clinical settings. It also introduces readers to background information, epidemiology, and a brief résumé of the way

rape and sexual assault has been viewed and managed over time. Chapter 2 reviews common affective, cognitive, and behavioural responses to sexual assault. It also considers factors that affect post-sexual assault trauma. Many texts on sexual assault only consider rape of women. In Chapter 3, Coxell and King familiarize the reader with the differential effects of gender and sexuality on the psychological effects of sexual assault.

Recently, much progress has been made in the development of therapies to address trauma. In Chapter 4, Bennice and Resick critically review a number of models and treatment studies in the field of sexual assault. Doyle and Thornton, in Chapter 5, then provide a basis that should enable the reader to carry out an initial sexual assault interview and psychological assessment. In Chapters 6–8, Naugle *et al.*, Kennerley, and Webster address psychological therapy for different aspects of the outcome of sexual assault. Chapter 9 considers the wide range of medical and physical concerns that may affect adjustment and coping in the aftermath of sexual assault.

A neglected area in the literature has been the evaluation of programmes designed to prevent rape and sexual assault. In Chapter 10, Gidycz *et al.* review the efficacy of single sex and mixed sex prevention programmes.

The first professional contacts that a person encounters after reporting a sexual assault are the police and forensic medical examiner. In Chapter 11, Rogers familiarizes the reader with details of the legal and forensic process. The preceding chapters clearly demonstrate the traumatic impact of sexual assault on the victim. The effects of working with persons who have been sexually assaulted are beginning to be recognized. Chapter 12 considers the impact of working in this area upon health-care workers.

For every person who is raped, there is a rapist. In clinical practice, people who have been assaulted frequently question the motivations of their assailant. In Chapter 13, Houston introduces the reader to theories of rape and the clinical practice of working with offenders.

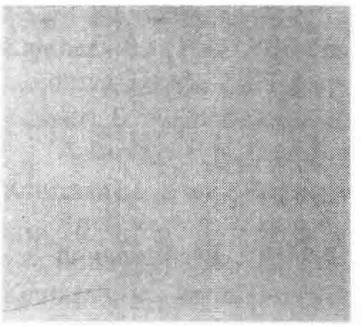
In conclusion, Chapter 14 draws together relevant themes from previous chapters and highlights the urgent need for an evidence-based health care approach to sexual assault policy, practice, and research.

Finally, we would like to thank the many people whose encouragement and support made this book possible. In particular, we thank the person, who wishes to remain anonymous, who kindly provided her story and illustrations in Chapter 2. We thank the staff and patients of the sexual assault services of Barts and the London NHS Trust who provided us with

the inspiration for this text. We are also grateful to our partners and cats who waited patiently for our attention during the preparation of this text.

May 2001

Jenny Petrak
Barbara Hedge



CONTENTS

Chapter 1

RAPE: HISTORY, MYTHS, AND REALITY

Jenny Petrak

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