Patterns of sexual violence among men

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1. BACKGROUND

That it is possible for an adult man to be sexually assaulted has been recognised for some time, although this recognition has usually been confined to incarcerated populations. In cases outside this population, assailants have been popularly understood to be predatory homosexuals assaulting younger heterosexual men. With the advent of second wave feminism and an understanding of rape as an act of violence rather than lust (Brownmiller, 1975) these assailants are now predominantly considered to be heterosexual.

There exists a small research literature on the sexual assault of men in the UK (Mezey and King, 1989; Hillman *et al*., 1990a, 1990b, 1991; Lacey and Roberts, 1991; Hickson *et al*., 1994; Huckle, 1996) the majority of which relies on victims attending medical or social services and is predominantly quantitative.

2. OBJECTIVES

Given the low level of basic descriptive research in this area the aim of the project was to provide an overview of the sexual assault of adult males and of existing services for them. Our objectives were:

- to collect and organise accounts of sexual assaults of adult men from victims recruited through both service and non-service sources;
- to survey statutory and voluntary agencies providing legal, medical and psycho-social services to male victims of sexual assault;
- to provide a synthesis of these accounts that engages with a range of theoretical positions.

3. METHODS

3.1 Victim interviews

In the UK, sexual assault of men legally concerns only those assaults where the victim is 18 years and older. Males below that age are legally assumed incapable of consensual homosexual activity. However, we took a lower age of 16 both to recognise the inaccuracy of this assumption (see Davies *et al.*, 1993) and to make more meaningful comparisons with the sexual assault of women.

We use the term 'rape' to refer only to non-consensual anal or vaginal intercourse and 'sexual assault' to encompass both rape and other non-consensual sexual acts. The

study did not pre-define sexual assault. The sample thus consists of men who considered themselves to have been sexually assaulted.

It is difficult to sample sexual assault victims. Random techniques are inappropriate for populations which are non-denumerable, invisible and stigmatised, as is purposive sampling, which assumes prior knowledge of the spanning variables. It is not possible to rely on techniques such as snowballing and capture-recapture methods when the members of the population neither know one another nor frequent particular venues.

Given these problems, and the qualitative nature of the investigation, we sought a diverse rather than representative sample. Consequently we attempted to use diverse recruitment methods.

We had intended to recruit respondents through the Second Standing Conference on the Sexual Abuse of Men (February 1996) and the self-help group *Survivors.* We also placed recruitment posters in 166 GUM clinics throughout the UK. However, these sources actually provided very few respondents. Our predominant mode of recruitment was newspaper and magazine advertising.

Two waves of advertising ran from February 1996 until April and from August to November 1996. Given the limited budget, the advertisement was small, concise and clear. A typical advertisement, which appeared in the 'community', 'noticeboard', or 'personal health' sections of a variety of national and local newspapers is shown in Figure 1. The total cost was £1483.

ARE YOU A MAN WHO HAS BEEN SEXUALLY ASSAULTED AS AN ADULT?
Would you be willing to contribute to a national study raising awareness that this happens?
Your input will be invaluable.

Totally confidential.
To arrange an interview call Ford (male) or Laurie (female) at **Freephone 0800 *** *****

Figure 1: Typical media advertisement

Potential respondents were asked to telephone a *Freephone* number. If eligible for the study, they could choose a male or female interviewer. However, most requested the researcher who answered their call. At the start of recruitment, we encouraged respondents to come to our offices for interview to decrease costs and increase safety. However, a high proportion subsequently failed to attend and this strategy was reversed by first asking to interview them at home. Interviewers carried a mobile-phone and an office call-back safety system was employed.

Respondents had control over both the structure and the content of the interview. An extensive *aide memoire* was developed to ensure that the accounts covered comparable material, were sufficiently detailed with maximum internal consistency. Contradictions in accounts were sensitively challenged and further clarity sought.

Before the interview proper, any reservations were discussed with the respondent. He was asked permission for audio recording and confidentiality procedures were explained. Respondents could switch off the machine at any time. No respondent refused to be

recorded and none prematurely terminated an interview. At the end of interview, respondent were made aware of available services.

Alexander *et al.* (1989) observed that rape researchers may develop similar responses to their research as victims do to their assault. Both researchers had considerable experience in interviewing about sensitive and potentially distressing topics (including sexual assaults) and recognised the need for interviewer support. We took every opportunity to discuss the interviews with each other as soon as possible after completion. Whilst the research did disrupt our psychological well-being and emotional lives, this was not debilitating and neither considered discontinuing interviewing.

The tape recorded interviews were transcribed. The initial analysis extracted quantifiable variables such as current demographics, number of assaults, age at assault, number of assailants. Two researchers working independently then divided the text into six (possibly overlapping) broad sections: the assault; the victim's immediate response (next 24 hours); experiences over the next few weeks; longer-term consequences; consideration or use of police or legal services; physical injury, medical or sexual health services; consideration or use of psychological or support services. Inter-researcher agreement was high. Each section was subjected to thematic content analysis and quantifiable measures noted where appropriate.

3.2 Gay men's assault prevalence survey

In July 1995 an annual sexual behaviour survey was carried out by Sigma Research at the Lesbian and Gay Pride Festival in London. We took the opportunity to ask two questions about life time experiences of sexual assault and rape.

3.3 Service surveys and service provider interviews

We undertook three separate postal surveys of services to gauge how common male clients of sexual abuse were and how services responded.

The first survey was sent to senior health advisors in all 282 sexual health clinics and genito-urinary medicine departments in the UK. The survey covered their experience with male clients who had been sexually assaulted, referrals, availability of specific services and liaison with legal and psycho-social services. Reminders were sent after six weeks.

The second survey went out to all 43 constabularies and forces in England and Wales. A brief questionnaire covered numbers of men reporting, services and policy.

The third survey involved local Victim Support schemes. Since their addresses are not publicly available, we asked the National Office to include the questionnaire in the VS newsletter. They were initially very supportive and we dispatched 400 questionnaires to them. However, after several delays, the Assistant Director of VS demanded veto rights of any findings. As we were unable to agree, this survey did not go ahead.

In addition, we conducted exploratory interviews on the more complex issues in service provision with approximately 40 service providers (including legal, sexual health and psycho-social support services).

4. RESULTS

4.1 Victim interviews

In all, 53 men were interviewed and 46 of the tapes were usable. Considering serial assaults by the same person as one event, these 46 men described 60 separate instances of sexual assault. Of these, three featured female assailants, two of whom assaulted in conjunction with a male.

Of the 46 respondents, 36 reported one assault, seven reported two, two reported three and one man four separate assaults. This gives a repeat sexual victimisation rate of 22% for this sample.

Circumstances of assaults

Two researchers independently sorted the assaults into groups based on the relationship between the assailant(s) and victim and the circumstances of the assault. Cross-coder reliability was high and eight relationship categories emerged.

Ten assaults were serial assaults by the same assailant in which the number of assaults varied from two to over one hundred. One serial assault involved sexual blackmail by a single female assailant. The other nine serial assaults fell into three categories.

> *Abuse of authority* - these closely resemble the sexual abuse of children but with an adult victim. Assailants included relatives, carers of men with disabilities and men who had befriended much younger men. The assaults were generally coercive and manipulative rather than violent. One of these serial assaults was perpetrated by both male and female assailants.
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> *In gay partnerships* - in which one partner regularly sexually assaulted the other, often accompanied by battery. These assaults closely resembled rape in marriage.
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> *In all-male institutions* - these were repeated sexual assaults in prisons of one inmate by another and of men in the armed forces by other recruits.

There were 50 single occasion assaults. In five, the victim was a friend or acquaintance of their assailant.

> *Acquaintance assaults* - the victims were usually gay men, and known as such by their assailants, who were of various sexualities. In most cases, the assailant took advantage of the victim's incapacity through alcohol or illness.

In the remaining assaults the victims encountered their assailants only hours or minutes before the assault. Four distinct scenarios emerged:

> *Assaults on sex workers* - These were not occasions where a client refused to pay but involved physical assault and forced sexual acts. One of these assaults was perpetrated by both a male and a female.

In casual sex contexts - victims had shown interest in or had actually engaged in some consensual sex with their assailants. The assaults involved sexual acts the victim did not want, sometimes accompanied by physical violence.

Stranger assaults - victims had met their assailants only shortly before the assault in a wide variety of contexts (eg. hitchhiking, on a beach, at a party, sleeping rough, viewing a flat, selling door-to-door). These are distinguished from the previous category in that the victim had shown no sexual interest in the assailant.

Blitz assaults - these immediate assaults occur in public or semi-public places. No interaction takes place before the assaults commence.

Characteristics of Assaults

Over two-thirds of the assaults occurred when men were less than 26 years of age (range, 16 to 65). The youngest group of victims (and the narrowest age range) was those assaulted by authority figures. Whilst the range of ages in other categories is wide, victims of stranger assaults may be generally older. Assailants were usually but not always older than the victims, often considerably so.

Twenty featured two or more assailants. Multiple assailants featured in all categories except the 'abuse of authority'. However, they appear to be more common in the 'blitz attacks' than any other.

Anal penetration (rape) was by far the most common sexual act forced on victims. Of the 60 assaults, 49 were rapes and a further three attempted rapes. Rape featured in all relationship categories but was most common in 'blitz attacks'. In about a quarter of assaults, the assailant(s) attempted to arouse the victim sexually with no obvious variation between categories. In nearly all cases, the assailant(s) ejaculated and this was the most common marker for the end of an assault. In one rape the assailant used a condom.

About half of the assaults took place in the assailant's home, a quarter in the victim's home and a quarter outdoors (including semi-public locations). Almost all blitz attacks and most assaults by strangers occurred outside. The majority of assaults in casual sex contexts took place at the assailant's home.

More than a third of the assaults involved physical violence above the force used to procure sexual acts. Violence was both instrumental (to subdue to victim) and gratuitous (purely to inflict harm). Eight assaults featured weapons, all knives. The least violent assaults were those in the 'abuse of authority' category, the most violent those in male institutions. The range of violence used was greatest in assaults in casual sex contexts. Overall, assaults by multiple assailants appear more violent than those by a single assailant.

In nearly a third of the assaults the victim sustained physical injury, most commonly anal trauma. This was not confined to men who were not homosexually active. Non-anal injury was, unsurprisingly, most common in violent assaults.

Overall, almost two thirds of respondents identified as gay or bisexual. However, their sexuality was not relevant in all of their assaults. Whilst it appears that gay and bisexual men are more likely to have been assaulted than other men, they are also more willing to take part in the research of this type.

Impact of assaults

Sexual assault was experienced as traumatic by almost all the men we interviewed. In some cases the impact was profound and did not markedly differ according to type of assault or the sexuality of the victim. Gay men do not appear to 'cope better' with assault than other men. In all respects, variation in impact is greater within the eight categories than between them. Broadly, violent assaults are invariably traumatic, whereas non-violent assaults are not inevitably so.

In general, the extent of the psychological impact derives from the victim's interpretation of the event as much as from the specific features of the assault. For example, virtually all the men blamed themselves at some point for what had happened. This varied depending on the circumstances of the assault but the *extent* of self-blame was similar irrespective of circumstances. Also, those assaults that did not involve anal penetration were not necessarily experienced as less traumatic than those that did.

In the majority of assaults, the victim's immediate response was confusion and disbelief, a search for safety and an attempt at normalisation. This involved achieving physical distance from the assailant(s) and the scene of the attack and a psychological distancing from what had happened, as well as an attempt at 'washing' the experience away by bathing or scrubbing. Experiences following assault generally create silence and isolation and involve anger, shame, guilt, self-blame and fear of both people (particularly men) and homosexuality. There may also be somatic disturbances and a generalised withdrawal from everyday life.

On the whole, men did not speak to others about their assaults. When they did so, the impact of the assault was strongly mediated by others' reactions. While some men found support from significant others, more found their negative feelings compounded by dismissive or blaming attitudes.

In the longer term, the impact of assault makes itself felt as (general) distrust and difficulties with sexual and intimate relationships. The latter may be particularly problematic for gay men as their intimate partners are more likely to be men.

The victims' use and experiences of services are described in the service review below.

4.2 Sexual victimisation of gay and bisexual men prevalence survey

The prevalence survey was completed by 1137 men who were resident in the UK. All had sex with men and identified as gay or bisexual. Overall, 279 (24.5%) indicated they had been sexually assaulted or abused and 146 (12.8%) had been assaulted at age 16 or older. Of these, 98 (8.6% of the whole sample, 67.1% of those assaulted as adults) had been raped as adults.

4.3 Service reviews

4.3.1 Legal Recourse Services

The Metropolitan Police - Metropolitan Police policy on serious sexual offences does not differentiate male and female victims and states that: a senior officer must lead the investigation; a chaperon (specially trained constable of the victim's preferred sex) should provide support and assistance to the victim throughout the investigation; treatment for serious physical injuries should be given in hospital before the forensic examination; forensic examinations should be undertaken in a dedicated rape examination suite by a doctor of the victim's preferred sex; the victim's account should be believed unless there is strong contradictory evidence and even if an allegation is withdrawn, a full investigation should occur.

We interviewed six representatives of varying ranks within the Metropolitan Police. They said that, in practice, it is not always possible to find male chaperons or female doctors. They stated that convictions are particularly difficult without forensic evidence such as semen or trauma to the anal passage. They fully recognised the difficulty in bringing charges and securing convictions. In the Metropolitan area, in 1994/5 there were 30 reported sexual assaults of men and one attempted assault. In 1995/6 this rose to 45 reported sexual assaults of men. These cases represent about five percent of all sexual assaults.

Training in the medical examination of sexual assault victims provided by the Metropolitan Police's Forensic Science Laboratory does not cover male victims.

Police forces survey - Of the 43 questionnaires, 12 (28%) were returned. All the forces that responded had reports of sexual assault from adult male victims within the last year. The median number was 10.5 (range 3 to 65). About 80% were indecent assaults. On average, 50% resulted in a charge.

Nine forces gave men the choice of a male or female police chaperon(e) and seven the choice of a male or female doctor. Six had policies and procedures for sexual assault of both men and women, three for female victims only and three had no written policies for either. Six had police chaperon(e)s and 11 had special rape examination suites. All referred victims to Victim Support. Only eight referred to GUM clinics for STD testing and two to a local sexual assault centre.

Eleven provide training on sexual assault, but only five include sections on male victims. Only the three forces with the highest numbers of assaults provide training on sexual assault of men. Nearly all forces expressed a need for additional training for sexual assault in general and male victims in particular.

The Crown Prosecution Service (CPS) - We spoke with two representatives of the CPS which is responsible for criminal prosecution. The CPS uses two tests in making a decision to prosecute. First the evidence must be sufficient for a "realistic prospect of conviction" and secondly, the public interest must be served by a prosecution.

The rate of convictions for sexual assault of women is low but there are too few male cases to examine attrition rates at court level. A Home Office study (Grace, Lloyd and Smith, 1992) of attrition for female rapes and attempted rapes found that 25% resulted in conviction and more recently Lees' (1996) found an even lower proportion (8%).

Victims' use of legal resource services - Nine of the 60 assaults were reported to the police by nine different victims between 1978 and 1995, although the sexual nature of the assault was not always revealed. Only two of these nine considered their experience positively and both of these were recent reports. The remaining respondents considered their treatment to be as traumatic as the assault itself.

Four of the reported assaults were blitz attacks by multiple assailants and three of these four involved substantial injury. Two were assaults in casual sex contexts, two stranger assaults and one abuse of authority assault.

Many men simply did not think to report their assault. Among those who did, there were consistent reasons for not reporting: blaming themselves for the assault; concerns about homophobia and dismissal by the police. Whilst common for all men, these concerns were particularly prevalent among men assaulted in casual sex contexts.

4.3.2 Health services

Sexual health services survey - Of 282 questionnaires sent out, 196 (69.5%) were returned. In the last year, 57% of all clinics had male clients reporting sexual assault but only 24% of those gathered monitoring data. In these, the median number of such clients in the last year was four (mean=4.4, range=1-15).

Of clinics with sexually assaulted male clients, 51% had a designated staff member to deal with these cases (most frequently a health advisor) and 64 were always able to allow the client a choice of male or female doctor. The most common sources of referrals had been psycho-social support agencies (75%) and the police (43%).

The availability of a range of services is given in Figure 2. Of all clinics, 27% able to provide a forensic examination on site and 20% had written protocols for dealing with sexual assaults although about half of these covered female victims only.

Service	Frequency	%
HIV testing	192	98.5
STD screening	184	94.4
Counselling	168	86.2
Assistance reporting to the police	97	49.7
Support groups	67	34.4
Other	24	12.3

Figure 2: Sexual health services offered to men who have been sexually assaulted

Most (81%) indicated they would refer clients to other agencies, most commonly Victim Support (22%), Rape Crisis Centres (21%), Survivors (21%) and clinical psychology services (19%).

Victims' use of health services - The overwhelming reason for seeking health services following assault was physical injury, usually from accident and emergency departments. However, even extensive injury did not guarantee men would seek assistance.

Of the 60 assaults, 17 occurred after 1985 when HIV testing became widely available. Eight respondents attended sexual health services as a result of their assault (predominantly for HIV testing) and two disclosed their assault. Of those respondents who considered STDs but did not attend, shame and embarrassment were the primary reasons.

4.3.3 Psycho-social support services

Rape Crisis Centres and Sexual Assault Centres - RCCs have existed in the UK for 20 years. They have traditionally been provided by women for women although some claim recent funding pressure to include men in their remit and this has become a controversial issue (Gillespie, 1996). In 1996 the Rape Crisis Federation was formed whose first membership criterion excludes centres with men on the staff or management committee or who counsel or give on-going support to male victims of sexual assault.

Of the 40 RCCs we identified, six provided services to men, although two provided telephone service only. We interviewed all six RCCs concerning when male clients were first accepted, their numbers of male clients, policies and procedures, services, training, *etc*.

More of the RCCs' male clients are adult men recovering from sexual abuse as boys rather than men sexually assaulted as adults. There were 96 male callers to the largest centre in the last year and 83 in the previous year. A second service had 41 men calling their the helpline in 1995/96, eight of whom were raped as adults. The remaining two centres do not record gender of clients.

The RCC offering the most comprehensive service has the largest number of clients, suggesting that unfulfilled demand exists. All centres accepted and made referrals from and to a wide range of agencies. Unlike female clients, most male clients were referred from another agency.

Sexual assault centres (SAC), the first of which opened in 1986, are jointly funded by police and health authorities. They offer forensic examination as well as counselling and support. There is little overlap in service provision and clientele between RCCs and SACs. SAC referrals come primarily from the police and include recent victims. In contrast, RCC clients tend to self-refer some time after the assault (Foley, 1996). There are currently three SACs in England, two of which provide the same level of service to female and male victims. The third allows the police use of its examination suite for male victims and plans to extend its male service.

The centres mainly deal with heterosexual victims (although most male volunteers are gay). Male clients differed from females predominantly in being more likely to talk about the details of the assault and less likely to talk about its emotional impact.

For both RCCs and SACs the relatively low number of male clients often makes it difficult to justify separate premises for male services. Recently, one SAC in a large rural setting has pioneered a 'virtual' centre, by contracting out counselling, allowing a wider choice of counsellor. In 1995, 20 men were referred, 15% of the total.

Victim Support - The charity Victim Support (VS) has 378 schemes in the UK. In 1995 they dealt with 15,400 victims of sexual assault. A recent survey (Victim Support, 1996) found that 5.4% of sexual assault victims dealt with by VS were male, suggesting that VS assisted over 800 men. Despite this, the same report claims "few [male victims of sexual assault] come forward for support" (p.5).

Although the law on rape was changed in 1994, VS produced a training document in 1995 dealing only with female victims. Their Code of Practice does not mention male victims. Local schemes wishing to train volunteers for male victims are advised by the National Office to approach *Survivors* (see below). The National Office claimed to be planning to develop policies and procedures for dealing with male victims.

We identified two local schemes offering specific services to men who have been sexually assaulted: one a helpline, the other a rape crisis service. As with RCCs, the helpline deals predominantly with victims of childhood abuse.

Survivors - Survivors groups are local self-help groups for men who have experienced unwanted sex. The stability of these groups is low. Invariably they depend on the commitment of a small number of individuals operating without resources and groups collapse when those individuals are unable to continue. All the groups we became aware of were for adults who were sexually abused as children and for men sexually assaulted in adulthood. Groups typically offer a telephone helpline for a few hours per week. Our repeated attempts to make contact with the majority of these groups was unsuccessful.

The longest standing and most successful Survivors group in Britain is based in London, founded in 1986. Interviews were carried out with one of its founders (who currently supervises counsellors) and with the administrator. From its inception the group sought to provide help and support to all men who had experienced sexual assault or abuse, irrespective of age and sexual orientation. They currently provide a National telephone helpline and for those who can attend in London, face-to-face counselling, group discussion and support, predominantly carried out in volunteers' homes. We were unable to obtain recent monitoring data for this group. However, it appears that approximately a third of clients are men assaulted as adults, half of whom are gay. This means a larger proportion of Survivors' clients are gay men than the RCCs and SACs.

Survivors (London) currently receives no statutory funding. Despite this, the group was constantly referred to as a national resource and referral point by many of the service providers we contacted. Volunteers have many speaking engagements and are involved in training for the Metropolitan Police and other services.

Victims' use of psycho-social support services - Approximately half of the men approached some kind of psycho-social support service following assault, often some time later. Men used a diverse range of routes to services and often experienced pillar-to-post referral paths. The most common services contacted were RCCs, survivors groups and generic therapists and counsellors. Most men who contacted RCCs were refused services which compounded their feelings of isolation. Survivors groups were often difficult to contact. Very few had unproblematic access to high quality and appropriate support.

5. CONCLUSIONS

It is important to distinguish assaults from assault victims. For example, Farrell (1993) states "Most rapes of men occur in prison" (p. 244). This may well be true but it is not the same assertion as 'most men who are raped are raped in prison'. Of the 46 men only one had been assaulted in prison but during the period he was incarcerated he was probably assaulted more often than all the other assaults considered together.

Studies of sexual assaults of men (or of sexually assaulted men) often compare aggregate levels of certain characteristics (eg. the proportion of assaults featuring multiple assailants) with studies of sexual assaults of women (or sexually assaulted women). However, the heterogeneity of the circumstances of assaults described by this research demonstrates that this is problematic. Any differences found may be due to the different proportions of assaults which occur in different circumstances and not to the gender of the victim *per se.* For example, it is often claimed that men are more likely to be victims of multiple assailants, suffer more violent assaults and are less likely to report being sexually assaulted than women. Our findings suggest that any comparisons take into account (even control for) the varying circumstances of assault.

There is no simple distinction between (child) abuse and (adult) assault: abusive relationships happen to adults while minors can be assaulted. Young adult males are particularly vulnerable to sexual assault. Adult males are sexually assaulted outside (as well as inside) all-male institutions, in a variety of circumstances whose diversity reflects that of assaults of women. The overwhelming majority of sexual assaults on adult males are carried out by men, not women.

Sexual assaults of men are not a homogenous group of events: they occur in a wide variety of circumstances and contexts. The sexuality of the assailants and their motivations appear to vary enormously. However, many assaults occur in circumstances in which homosexually active men are much more likely to be found than other men. All men who are assaulted in gay partnerships and in casual sex contexts are homosexually active. In addition, many of those assaulted by friends and acquaintances appear to have been selected because they are known to be gay. Some of the blitz attacks and stranger assaults appear to have (paradoxically) homophobic overtones. However, male victims of sexual assault are by no means all homosexually active men.

A unified theory of male rape is probably unattainable. The motives and mechanisms of, say multiple assailant blitz attacks and assaults within gay partnerships are very different, although both operate along and create gradients of power.

The majority of existing services deal with male clients who have been sexually assaulted, suggesting that the sexual assault of men is not a particularly rare occurrence. All type of service provision (legal recourse, health, support, etc.) is relatively haphazard and geographically uneven. Where services exist, men contribute up to 15% of the caseload. However, most of the victims we interviewed had not sought out services, overwhelmingly due to the stigma they felt about the assault.

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