

Rape

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1 Summary

- Rape and sexual assault affects adults of all ages and children, both male and female.
- Certain populations are more vulnerable to sexual assault and exploitation and are liable to develop more severe and persistent psychological reactions - in particular, people with learning disability and in institutionalised care.
- Psychiatric history taking should include questions about experiences of past sexual and physical violence as a matter of routine.
- Rape and sexual assault in adults is associated with depression, generalised and phobic anxiety and post-traumatic stress disorder in a substantial number of victims.
- Children's reactions to rape will depend on their developmental status, chronological age and the social/familial context of the abuse.
- False allegations of rape and sexual assault are rare.
- Recovered memories of child sexual abuse in child or adult survivors may be induced through suggestion or persuasion in 'therapy', but the prevalence and clinical significance remains uncertain.
- The minority of rape victims seek psychiatric help in the acute phase; more commonly, psychiatric treatment is sought after a delay, or for symptoms that may, at first, not appear to be directly connected to the pre-existing sexual trauma.
- Sexual assault survivors may require initial support and crisis intervention in the acute phase or management of chronic distress, including specific psychotherapeutic intervention for mental illness or disorder that may arise.
- Assessment of child survivors must incorporate a child protection perspective through effective multi-agency working.
- People with learning disability face particular problems in relation to disclosure and giving evidence in court, and are frequently regarded as unreliable witnesses.
- Although most initial input for adult survivors, in the acute phase, is provided through the voluntary sector and GPs there is a definite and clear role for psychiatrists providing consultation, assessment, longer-term management and preparing medico-legal reports.
- Additional training is required to enable psychiatrists to effectively assess and treat survivors of rape and sexual abuse.

- From evaluation studies, cognitive-behavioural psychotherapy appears to be a particularly effective model of intervention for adults and children.

2 Introduction

The following policy statement was commissioned following a meeting by the College's Executive and Finance Committee. The Specialist Sections of the College were each asked to nominate a representative to form a working party which could prepare a statement.

The current policy statement replaces the previous memorandum, approved by Council in 1975, and reflects the considerable advances in knowledge about rape and its effects as well as the intervening changes in the law which have affected the definition, processing and prosecution of rape claims.

Within the document we have used the term "rape" to encompass a wide range of sexual assault and adverse sexual experiences. Whilst the majority of victims are female (reflected by the use of the pronoun "she" in parts of the document), men are also sexually assaulted, a fact that has only recently been given legal recognition. Although stranger rape is a common stereotype, most women are raped by someone they know. Victims of acquaintance rape are less likely to report to the police, have less chance of the case being proceeded with and are less likely to achieve a successful conviction than women raped by strangers. It is more difficult to prove non-consent when evidence is presented of consensual sexual relations having occurred in the past. The closer the relationship between the victim and the alleged perpetrator, the more likely it is that she will be regarded as a willing participant, rather than a rape victim.

Specially vulnerable groups include victims of domestic violence (Frieze, 1983), children (Finkelhor, 1986, Hobbs and Wynne, 1995), street workers (Silbert and Pines, 1984), the learning disabled (Sinason, 1993) and psychiatric in-patients (Thomas et al, 1995).

This document will discuss the following areas:

- (i) the legal position and criminal justice procedure
- (ii) the effects of rape and any subsequent legal proceedings on victims
- (iii) support and treatment
- (iv) the role of the psychiatrist in supporting/treating rape victims.

We shall also provide a brief review of characteristics of sex offenders, only a minority of whom are likely to require or respond to treatment. This last section has been added on the basis of our belief that in attempting to understand and offer help to the victims of sexual assault, it is helpful to be informed about the other half of the offence equation.

We hope that this statement will raise awareness of rape within the College and its impact on psychological health, interpersonal and social functioning, in order to highlight the needs of rape victims and to enhance the capacity of psychiatrists to meet those needs.

3 Legal issues

Definition of rape (England and Wales)

The most recent legal definition of rape is contained in the Criminal Justice and Public Order Act 1994, and is as follows:

- It is an offence for a man to rape a woman or another man.
- A man commits rape if:
 - he has sexual intercourse with a person (whether vaginal or anal) who at the time of the intercourse does not consent to it, and
 - 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.

This new legal definition extends the range of behaviours previously described as rape by including anal as well as vaginal penetration, and by acknowledging that men as well as women can be victims of rape. Nevertheless, it is important to remember that the social definition of rape is probably broader than this, and incorporates a much wider range of unwanted and uninvited sexual experiences.

The majority of perpetrators of sexual offences against men and women are male. Sexual offences by women constitute less than 0.1% of all convictions for sexual offences (Criminal Statistics, England and Wales, 1994).

In addition, the Sexual Offences Act 1956 makes it an absolute offence for a man to have sexual intercourse with a woman who is defective. (Defective is defined as severe impairment of intelligence and social functioning, i.e. IQ less than 50.)

The same protection applied to defective males when the Sexual Offences Act 1967 legalised homosexuality. The Criminal Justice Act 1994 does not change this situation. However, ignorance of the extent of the learning disability can sometimes be used by the perpetrator as a defence.

Definition of rape (Northern Ireland, Republic of Ireland and Scotland)

The Mental Health (Northern Ireland) Order 1986 makes it an offence to have unlawful sexual intercourse with a woman suffering from severe mental handicap. The maximum penalty is two years' imprisonment. Consent is not a defence.

The Mental Health (Northern Ireland) Order 1986 also makes provision for the protection of patients with regard to unlawful sexual intercourse by persons employed by hospitals, or in a position of authority over patients.

Although there are some minor differences in the law covering rape in Scotland, the Republic of Ireland and Northern Ireland, as opposed to England and Wales, these do not substantially alter the position as outlined in the proposed policy document.

Changes in the law

The current law on rape reflects certain key developments that have taken place over the last twenty years or so. The most important of these are as follows.

Rape within marriage

Until recently, a man could not be convicted of raping his wife, unless they were legally separated. The law has now changed, so that a husband can now be convicted of raping his wife.

Anonymity for the victim

After a victim has reported a crime of sexual violence to the police, his/her identity is protected from publication. The same restrictions apply to the media reporting of any resulting court case.

There have been discussions in the past as to the desirability or otherwise of extending the protection of anonymity to the defendants acquitted of rape offences. On the one hand, arguments have been put forward about the perceived unfairness of protecting victims but not defendants in this way. Some commentators take the view that the stigma of what turns out to be unsubstantiated rape charges is so great that the defendants in these cases must be given additional protection. Others, however, argue that the parallel should not be drawn between victims and defendants in cases of sexual offences, but rather between defendants in rape cases and defendants in any other case. The stigma of being unfairly accused of murder or major fraud, for example, can be just as great for the individual concerned, yet there is no call for anonymity in those cases.

Admissibility of sexual history

Subject to the trial judge's decision, the victim of rape is protected by law from some kinds of questioning about his or her past sexual experiences, except in relation to the defendant. Nevertheless, some judges do permit this sort of questioning, if it can be argued that such information is relevant to the current proceedings.

Male rape

Section 142 of the Criminal Justice and Public Order Act redefines rape to include

non-consensual intercourse, vaginal or anal, with either a man or a woman. The mental element is unchanged - i.e. whether the alleged perpetrator recognises non-consent, or is reckless as to whether the victim consents - and the maximum penalty remains life. One effect of the amendment is to raise the maximum penalty for non-consensual buggery of a man from 10 years to life imprisonment.

Corroboration

Until 1994, judges had a legal obligation to warn jurors that it was dangerous for them to convict a defendant of a sexual crime on the word of the complainant alone. In other words, jurors were asked to look for independent evidence to support the complainant's account of events before convicting. This legal anomaly has now been abolished.

4 The criminal justice process

Under-reporting of sexual offences is a serious problem which leads to the majority of rape attacks remaining hidden (Kilpatrick et al, 1987, Stanko, 1988, Home Office, 1991, British Crime Survey, 1993). The proportion of cases reported is likely to be even smaller for the less serious sexual offences. It is possible to report to the police any time after the assault, although it is almost certain that crucial corroborative evidence will be lost if the assault is not reported within 24 hours.

After reporting, the police will attempt to get a statement from the victim within the first 24 hours, as well as carrying out a physical examination. Many forces provide an officer known as a 'chaperone' or a 'Victim Liaison Officer' who is responsible for providing the victim with information about the course and progress of the investigation and with support. The investigation may take many weeks or months. During this time, the victim may see their assailant, or may be concerned as to whether they are still in danger. Although in theory it is possible for victims to withdraw their evidence at any stage, through fear of their assailants or through anxiety about the court process, in practice, once the police have decided to go ahead, a lot of pressure may be put on the rape victim to continue to co-operate. Indeed, failure to do so may be regarded as contempt of court.

It is not uncommon for either the police or the Crown Prosecution Service to decide that they will not pursue the case: only approximately one-third of all cases of rape reported to the police are proceeded with. This may occur because of 'insufficient evidence', particularly where there has been a delay in reporting, or if prosecution is not seen to be in the public interest. It is also not uncommon for the investigation to fail to find the suspect, and therefore be closed without result.

All rape trials will be heard at a Crown Court. Very few of these will be heard in less than six months, and 9 to 12 months is more usual. A Witness Service now exists in most Crown Courts and should be established in all Crown Courts by December 1995. The Witness Service, which is run by Victim Support, provides information on court procedures, offers practical assistance and can provide pre-trial visits to familiarise witnesses with the court room. In courts without a Witness Support Scheme, the victim may be required to sit in the public area with the defendant's family, although 'designated seating' for victims or victim witnesses and their families should still be available. The victim is not represented because her role is only as a prosecution witness. The court case may go on for several days; equally, it may be postponed at very short notice, without any warning to the victim.

Even judges and juries are affected by stereotypical perceptions of rape (Adler, 1987), making conviction more likely when the facts of the case fit with the classic picture of stranger rape. Given that the majority of rapes are committed by offenders known to the victim it follows that the facts rarely fit the stereotype. However, those women who are raped by strangers are more likely to report to the police and these cases are more likely to result in a trial and conviction, thus perpetuating the stereotype.

The attrition rate from the assault taking place to a successful conviction is such that only a small minority of alleged rapists will eventually be convicted and receive a custodial sentence (Wright, 1985, Gregory & Lees, 1996). It is likely that a significant number of guilty men escape justice because of shortcomings in the criminal justice process and the extremely restricted way of conceptualising and defining rape. It is hoped that recent revisions within the Criminal Justice and Public Order Act (1994) may go some way towards rectifying this situation.

The rape victim often experiences the court proceedings as a form of secondary victimisation which leaves them feeling humiliated, fearful, angry and deeply disillusioned with the criminal justice system, particularly if she believes that her assailant is wrongly acquitted (Shapland, 1985, Maguire and Corbett, 1987, Corbett and Hobdell, 1988).

5 Reactions to rape

It is now accepted that the experience of rape and serious sexual assault is associated with severe emotional, cognitive and behavioural consequences in a significant proportion of victims (e.g. Burgess and Holmstrom, 1974, Resick et al, 1981, Maguire and Corbett, 1987, Mezey and Taylor, 1988, Kilpatrick et al, 1985, Kilpatrick et al, 1989). Victims of rape often describe feeling contaminated, unclean, almost untouchable afterwards. Whether or not the levels of distress develop into recognisable psychiatric illness, the experience may destroy the victim's assumptions about safety, trust, sexuality, intimacy and the predictability of the future. Victims of sexual assault often report a profound shift in their attitudes, values and expectations, which may lead to a sense of being fundamentally changed. The experience of rape is often associated with a sense of loss, as if a part of oneself, real or symbolic, has been destroyed.

Although most victims do not develop mental illness following rape, many survivors experience particular difficulties in coming to terms with the experience. The profound and long-term mental health consequences reflect the violent, terrifying and traumatic nature of a rape attack and parallel responses following traumatic and life-threatening events generally.

There is some evidence that rape is more pathogenic than any other form of violent crime (Kilpatrick et al, 1987), perhaps because the act perverts a normal and valued aspect of life. About one third of women who report rape develop long-term psychological and social problems, including problems in relating at an intimate or trusting level, sexual dysfunction, persisting anger and irritability, helplessness and excessive dependence, loss of confidence and self-esteem.

Predictors of such long-term disturbance include:

- the presence of prior psychological and social problems (Frank and Anderson, 1987, Atkeson et al, 1982, Streit-Forest and Goulet, 1987)
- past victimisation experiences, particularly childhood sexual abuse (Miller et al, 1978, Ellis et al, 1981, Santiago et al, 1985)
- past psychiatric illness, drug or alcohol abuse (Atkeson et al, 1982)
- the lack of a supportive social network (Hilberman, 1976).

Rape trauma syndrome was first described in the 1970s and is now regarded as a variant of post-traumatic stress disorder (PTSD). The symptoms of a post-traumatic stress reaction (intrusive recollections, avoidance and hyper-arousal) are present in the majority of rape victims for several weeks after the assault (Steketee and Foa, 1977). However, symptoms of post-traumatic stress disorder as well as other indicators of distress resolve rapidly over time, so that at three months after the assault, even in the absence of intervention, most victims no longer meet criteria for PTSD. The spontaneous resolution of generalised and

phobic anxiety and depression also occurs. The presence of the following three variables are highly predictive of the development of PTSD: completed rape (versus attempted), physical injury, and subjective perception of life threat (Kilpatrick et al, 1989). However, most victims are able to cope with or 'process' the experience without developing chronic psychiatric disorder. However, even for rape victims who appear to have recovered, future exposure to stresses (such as the trial) may cause an exacerbation of symptoms or a relapse.

Secondary victimisation

In making a decision to report an offence to the police, a victim is exposed to the risk of secondary victimisation, as a result of treatment by the police and the court process. Often, victims report that going through the criminal justice system, or being subjected to critical or unhelpful reactions, has an impact which may be as negative as the initial assault and compounds their sense of humiliation and outrage (Shapland, 1985, Maguire and Corbett, 1987, Corbett and Hobdell, 1988).

The prevalence of rape and sexual violence, in general, relates to socio-cultural factors as well as the individual characteristics of the victim or perpetrator (Sanday, 1981, Bancroft, 1991). There are numerous myths and beliefs about sexual violence, which have a negative effect on the victim, particularly in terms of how she is regarded by friends, family and the legal system. Some of the societal attitudes to sexual crime are particularly unhelpful, e.g. that nice girls don't get raped, that it is impossible to have sex with a woman unless she wants it, that women say no when they mean yes, that women require a degree of force to achieve sexual arousal, that women fantasise about rape and that women lie about rape. Such widely held myths contribute to what has been referred to as a "rape supportive culture" (Murrin and Laws, 1990, Malamuth, 1986, Darke, 1990).

The reactions of family, partners and friends also have a considerable impact on the recovery of victims of sexual crime; where members of the victim's social network hold some of the above views, they may do much to inhibit disclosure (Silverman, 1978). The prevalence of such beliefs, sometimes held by the victims themselves, may promote a climate in which the victim feels blamed, criticised and often disbelieved.

6 False allegations of rape

Rape victims are often accused of lying and attempts are made to discredit them, particularly within the court room (Adler, 1987). Assertions of deliberate and calculated deceitfulness are largely anecdotal and unsupported by research on this issue. There is no evidence to suggest that false allegations of rape and sexual assault are any more prevalent than for other criminal offences. There is little to be gained from making a false allegation and the procedures that the alleged victim has to go through, as the chief prosecution witness, are stressful and unpleasant.

The attrition rate for rape allegations is extremely high and only the minority of cases reported proceed to trial and conviction (Gregory and Lees, 1996). Some rape claims may be dismissed by the police, the Crown Prosecution Service or the jury, even though the woman continues to insist and believe that she has been subjected to unlawful non-consensual sexual intercourse.

Possible explanations of false rape claims being made include the following:

- malicious claims; although there is no systematic description of the women who make such claims, or the reasons for making them.
- allegations which are made by women who are ashamed of having had sexual intercourse, who regret it afterwards or who are frightened that others will find out, such as current partners or fathers.
- women may be pressurised by others or the opinion of others to make and pursue such allegations.
- allegations made by women out of anger, out of revenge or because of rejection.
- allegations arising out of false beliefs due to mental disorder (rare).

The belief that false allegations of rape are a significant problem is reflected in the English legal process, despite the lack of supporting evidence. Historically, rape trials have been unique in requiring judges to warn the jury of the dangers of convicting the defendant, on the word of the woman alone. An acquittal of the defendant is often misinterpreted as a false allegation.

Alternative interpretations may be that either the claimant was mistaken (as to the nature of the physical touching or to consent), or that the prosecution failed to satisfy the burden of proof required by the jury. Some commentators have suggested that a fairer verdict in rape cases might be the Scottish one 'not proven'.

False claims of sexual abuse by children are rare, when made by children alone (1-2%), but increase markedly in relation to custody cases. In such cases, allegations may be made (and sustained) by persons other than the child in question.

7 Recovered memories

False memory syndrome is perhaps more properly described as recovered memories and refers to adult recollections of childhood sexual abuse, after a delay of many years, sometimes under the influence of hypnosis or psychotherapy (Lindsay and Read, 1994). It has been argued that the act of abuse is so traumatic that memories of the abuse are repressed for many years and only reach conscious awareness when the individual seeks treatment for symptoms that, at the time, may not seem directly connected to the abuse.

Recovered memories or false memory syndrome, relates to sexually abusive experiences in childhood, rather than to adult sexual victimisation. Women who have been raped as adults do not usually banish the memory from conscious awareness: the frequent and intrusive post-traumatic memories are generally impossible for the victim to avoid. Although they may not have reported the rape or talked about the experience to anyone, they remain aware of what has happened, often in vivid detail.

A woman may only disclose what has happened if circumstances precipitate this, e.g. if she is raped again, if she encounters the perpetrator, or if events in her life, such as a first sexual experience, getting married or having children, occur which may resonate with the past abuse and reactivate former fears, anxieties and conflicts.

For a detailed and authoritative review of the scientific basis for recovered memories, we refer the reader to the recent report of the Working Party of the British Psychological Society, chaired by Professor John Morton (BPS, 1984). The executive summary of the report noted the following:

- that complete or partial memory loss is a frequently reported consequence of experiencing certain kinds of psychological traumas, including childhood sexual abuse.
- that memories may be recovered within or independent of therapy.
- that recovered memories may contain significant errors, partly dependent on the age at which the event occurred.
- that sustained pressure or persuasion by an authority figure could lead to retrieval or elaboration of 'memories' of events that never actually happened, but that there is no reliable evidence at present that this is a widespread phenomenon in the UK.

8 Treatment of adult survivors

Until the recognition of the rape trauma syndrome in the 1970s, there was little attempt to consider the treatment needs of sexual assault victims. In recent years, however, there has been an expansion of treatment programmes for this group. Not all rape survivors require or seek treatment, in any recognised sense. It is therefore important to try and identify 'vulnerability' factors that are predictors of long-term disturbance so that the treatment can be targeted towards those women who are most in need.

Treatment can be considered as follows:

- management of rape victims in the acute phase
- intervention for prolonged or delayed reactions
- specific psychotherapeutic intervention for mental disorder or illness.

Management of rape victims in the acute phase

Rape victims are rarely referred to psychiatrists in the immediate aftermath of the attack. At that point the distress experienced by most rape victims should be regarded as a variant of a normal grief reaction, rather than as an indication of mental illness. Acute management of a rape victim should include a careful history and medical examination. This should only be carried out with fully informed consent and with an explanation to the person involved of why such information is being collected. Careful clinical examination is important for legal reasons and should only be carried out by medical personnel who are experienced in cases of sexual assault. Physical examination is a particularly sensitive issue and there is a clear need to avoid secondary victimisation by insensitive examination techniques. Practical advice at this stage may involve discussion of reporting to the police if this has not already been addressed and the mechanics of what a legal process will involve. Generally, initial counselling is provided by voluntary, community organisations, such as Victims Support Schemes, as well as family and friends who may provide support and help.

In the immediate aftermath of a rape, victims need support and advice. This is available from:

- WPC 'chaperones' or Victim Liaison Officer appointed to support each rape victim
- National Association of Victims Support Schemes
- Rape Crisis Centres
- Survivors (for male victims)
- GPs
- other local services.

In all cases of rape, a female police officer is appointed to act as chaperone or Victim Liaison Officer during examinations, and advise about the investigation and procedures. Chaperones specifically do not have the training to offer counselling. In some police stations, it has proved impossible for chaperones to provide anything but the bare minimum in terms of advice or support. Recently, male chaperones have started to be trained to advise and assist male victims.

Referrals to Victims Support Schemes generally come from the police, although increasingly the schemes are willing to accept direct referrals from victims themselves, health professionals, other agencies or individuals working with victims at any time after the assault. Victim Support Schemes, which are Home Office funded, vary in the amount of specific counselling they provide. Victim Support volunteers are trained to give information, advice and emotional support to women who have been raped or sexually assaulted, as well as to victims of crime in general. They are particularly helpful in offering practical assistance, e.g. completing Criminal Injuries Compensation Board forms, accompanying the victim to identification parades, setting up appointments for STD clinics, offering short-term crisis intervention, offering general support, advice and guidance about the legal process, and accompanying the victim to court if this is requested. Victim Support Schemes do not provide the required training, nor do they have the resources to offer long-term counselling or psychiatric treatment in cases where the reactions are more prolonged and complex than anticipated. In areas with high levels of personal violence, supply may not be able to match demand.

Most people who have been sexually assaulted will benefit from support and some level of sensitive counselling soon after the event. In some cases, however, it may be inappropriate to pursue a course of counselling with a victim of sexual assault who is not yet ready or able to consider the circumstances of that assault.

Management in the acute phase is usually client-centred and non-directive. During the acute phase victims may be unable to describe much of the sexual assault in detail because of the distressing emotions that such memories evoke. Counsellors should not pressurise their clients into going further than they can reasonably manage. The victim should be given the time to discuss the assault in a sensitive and supportive environment, to be able to talk about what happened without feeling criticised or judged. He or she should not to be subjected to intrusive and persistent questioning which may be experienced as a form of re-victimisation. Some direction may be needed, however, to correct certain cognitive distortions and misunderstandings about the assault, particularly guilt, self-blame and inappropriate attributions. Victims may have ambivalent feelings towards the assailant who had both the power to harm and the power to save them during the attack.

Interventions for prolonged or delayed reactions

Psychiatric intervention may be required for patients who develop serious psychological syndromes following the assault such as unremitting post-traumatic

stress disorder or major depression. Clients who have had pre-existing psychological or personality problems may also require referral to psychiatrists.

It is probably inappropriate to offer psychotherapy in the first 4-6 months after the assault. A number of studies have shown a rapid and spontaneous resolution of symptoms of psychological distress in the first few months after rape, regardless of the treatment offered. Early psychiatric intervention may result in any improvement in symptoms being erroneously attributed to the treatment, rather than natural process of recovery. If symptoms, which may be disabling and distressing, have persisted for longer than 3-4 months no further spontaneous improvement is likely without specific psychiatric intervention. Veronen and Kilpatrick (1983) found that at one-year follow-up, only 25% of untreated women were symptom-free. Burgess and Holmstrom's five-year follow-up of women who had been raped found that 37% women took months to recover, 37% took years to recover and 26% reported themselves still unrecovered from the experience.

Persistence of rape-related PTSD beyond three months post-assault is predictive of long-term disorder and can be anticipated in victims showing high initial levels of rape-related psychopathology (Rothbaum et al, 1992).

Research evidence on the most effective method of treatment for victims of sexual assault is minimal and there is a great need for controlled assessments of the various treatment strategies. As in the acute phase, client-centred, time-limited psychotherapy may be used in which the survivor is given time to consolidate memories of the assault and to ventilate his or her distress. More directive therapies, including cognitive behavioural therapy, are often indicated for victims who have persistent and troubling assumptions about their own role in the assault, intrusive memories, marked generalised or phobic anxiety, depression, and persisting sexual dysfunction.

Evaluation of stress inoculation training for rape victims suggest that this is an effective model of intervention for rape victims with persisting psychological distress. Stress inoculation training consists of two phases: the first is an educational package in which the cognitive, emotional, physical and behavioural responses to fear are explained within a framework that is understandable and that makes sense to the victim. In the second phase, specific skills are taught for coping with fears and their physical, cognitive and behavioural expression. Such skills include relaxation, breathing control, covert modelling, role playing, thought stopping and guided self-dialogue. Throughout this process victims are encouraged to carry out homework to reinforce the learning process. They are advised to assess the probability of the feared event recurring, to resist avoidance behaviour and to check back on automatic self-criticism and devaluation. The process usually lasts over twelve sessions.

Imaginal exposure has also produced some good results, particularly in reducing persisting high levels of generalised anxiety and phobic avoidance. This process requires the victim to describe the incident in detail, as if it were currently

happening. Their account may be recorded on tape in order that the victim can repeatedly expose themselves to the trauma. In this way anxiety and fear responses can eventually be extinguished, or at least made tolerable.

Therapists require at least a minimal training in counselling techniques, cognitive-behavioural therapy or interpersonal psychotherapy. It is difficult to lay down guidelines on the length or frequency of the therapy as there is no reliable research on this. It would appear sensible, however, that counsellors understand the nature of sexual assault and the reactions of victims, and that they have some experience in psychotherapy. Sexual assault goes to the very centre of issues concerning sexuality, personal vulnerability and self-esteem, and thus specific training is likely to be necessary for most therapists. Therapists must make every effort to separate out their own attitudes and feelings about sexual assault, and avoid pre-judging the material presented by clients. They should know how to ask for information and when to respect clients' privacy, and should appreciate the confidential nature of the information shared with them.

There is no evidence that the gender of the therapist has any major effect on outcome, although survivors may express a preference. Many women who have been sexually assaulted find it too difficult to reveal the nature of the assault to a male therapist. Male victims may find it embarrassing or humiliating to describe their assault to another man. Client preferences are very personal and it is impossible to generalise.

Gender issues in the treatment of victims of sexual assault are important. Issues for male victims may include loss of a sense of masculinity and self-esteem, confusion over sexuality and sexual role, and fear or disbelief. For women victims, an inability to trust men or to establish sexual relationships may be a major and prolonged problem. Personal differences between clients are, perhaps, as important as gender differences.

The role of psychiatrists in treating rape victims

Psychiatrists, psychologists and mental health professionals play a crucial role in the assessment and management of rape-related disorder, although this role could be further enhanced with further specific training. Mental Health professionals have skills in working in multi-disciplinary settings, and in communicating with distressed people. Most psychiatrists will not be involved in the immediate aftermath of a rape. On rare occasions, the police may contact psychiatric or psychological services when a woman alleging rape is very distressed, or suicidal. Psychiatric consultation is particularly likely to relate to delayed disclosure, often associated with protracted reactions in the victim, which may emerge in the context of consultation about apparently unrelated symptoms.

In the past, the reluctance of victims to accept psychiatric help has related to certain negative perceptions of mental health professionals and a view that rape

and sexual assault were not medical problems. However, there is now much greater recognition and sensitivity by psychiatrists in dealing with associated gender, ethnic and cultural issues in the problems being presented by patients, as well as the greater availability of female psychiatrists for patients who request this. Nowadays, psychiatrists are increasingly aware of the role of external trauma in precipitating disorder and the management of such.

As well as carrying out a mental state examination (with particular focus on post-traumatic stress reactions), the psychiatrist needs to be aware of the importance of keeping clear and accurate records, which include verbatim statements by the victim, wherever possible, details of the time, place and nature of the alleged assault and identity of the perpetrator as well as the victim's immediate and longer-term emotional and behavioural reactions. Psychologists may also play an invaluable role in psychotherapeutic work, as well as offering advice to the courts on specific issues such as the victim's level of suggestibility.

Psychiatric referrals may come from community resources, in addition to lawyers, GPs, family members, and the Criminal Injuries Compensation Board (CICB) for the purposes of advice, assessment, treatment or the preparation of medico-legal reports.

Psychiatrists and psychologists may be able to assist and advise both the police and the victim in such circumstances. Psychiatrists should be able to provide information on the nature and course of normal stress reactions as such information may be helpful to all parties. The advantage of psychiatric referrals for rape victims is that psychiatric services can generally draw on a multi-disciplinary team, including CPNs and psychologists, who can help tackle multiple clinical problems within a co-ordinated treatment framework.

With further training, psychiatrists and mental health professionals represent a valuable specialist resource. There are few if any other services that have the potential to treat serious mental disorder which may arise as a direct consequence of a traumatic sexual assault. If psychiatrists are to be involved they need to be aware of potential disadvantages associated with psychiatric referral - in particular, the fact that psychiatric services and the inference of mental illness may be perceived as stigmatising. However, this needs to be set alongside the victim's right to have serious mental disorder identified and treated and for the resources to be allocated to enable this to happen

9 Training and education

Psychiatrists need to be aware of how the experience of violent crime can give rise to disabling psychopathology and psychiatric illness in a number of victims. Psychiatrists therefore need to understand the course and treatment of normal traumatic stress reactions and should be able to advise the rape victim about situations in the future when an exacerbation of symptoms might be expected, e.g. attending court.

Psychiatrists need to be aware of the high rate of sexual assault reported by their male and female patients, which may be a contributory factor to their current illness. However, survivors rarely disclose such experiences spontaneously. Psychiatric history taking should include questions about experiences of past sexual and physical violence as a matter of routine. Such enquiries must be made in a sensitive manner, with opportunities for further discussion and referral to specialist rape counselling services, if this is requested by the victim. The psychiatrist should know how to assess treatment needs for rape victims, and be informed about community resources which offer specific advice, should psychiatric treatment not be considered appropriate.

10 Medico-legal issues

Research has shown that the likelihood of obtaining a conviction for rape depends on factors unrelated to the nature of the claim, such as the personal characteristics of the woman, whether her past sexual history was made admissible during the hearing and the promptness of reporting the crime to the police (Adler, 1987).

Forensic psychiatrists and general psychiatrists may be asked to comment upon the effects of sexual assault as expert witnesses in the courtroom. The effects upon the victim may be taken into account at sentencing; therefore, psychiatrists who undertake such work need to familiarise themselves with the short and long-term effects of sexual assaults.

Psychiatrists may also be involved in preparation of reports for the Criminal Injuries Compensation Board. Such reports need to include statements about effects on work and social life, as well as psychiatric illness, and the likely prognosis. Rarely, the psychological sequelae of a rape may contribute to violent behaviour, or crime.

There are now new arrangements governing the release of prisoners serving a life sentence and those convicted of particularly sensitive or violent offences (these are not defined but are highly likely to include many sexual offenders). For cases currently coming to court, it means that, at the time of sentence, the victim should be asked whether she wishes to be kept informed of the offender's progress through the Criminal Justice System. If requested she will then be offered, by the relevant Probation Service, consultation on decisions regarding the offender's home leave and parole so that any concerns she might have about her safety can be taken into account.

11 Learning disability and sexual assault

Sexual offences against people with learning disabilities are seldom described as rape, but as sexual assault or sexual abuse. The terminology used is thought to reflect the fact that most offences against this vulnerable group of adults involves the corruption of a relationship of trust. In particular, professional sexual misconduct is a special concern for people with disabilities because they typically have a great deal of contact with and dependence on professional caregivers (Sobsey, 1994). Several studies have shown that stranger abuse or rape is rare. The commonest groups of offenders are disability service providers, family members, acquaintances and neighbours and peers with learning disabilities, many of whom have been previously abused themselves (Sobsey, 1994, Brown and Turk, 1992). Perpetrators are nearly always male and the abuse is typically chronic. Many authors report finding previously known or hidden histories of sexual abuse in people with learning disability, referred for intervention for behavioural disturbance (Ryan, 1994).

It may be very difficult to establish in people with learning disability, whether consent to intercourse was given and if so, whether this was valid consent. Poor comprehension and verbal skills may prevent the victim from expressing their wishes or understanding what is happening and increased suggestibility may elicit consent which is not informed and is therefore invalid.

It is rare to obtain a successful prosecution when a person with learning disability has been raped. The majority of cases do not even get to court, because the victims are considered by the Crown Prosecution Service (CPS), to be “unreliable witnesses” and they will not proceed without sufficient corroboration. If a case does get to court, the atmosphere and proceedings may be very intimidating to a person with learning disability and some kind of Witness Support Scheme is essential. The allowing of videotaped evidence, as in child protection cases, would help considerably.

The long-term psychological and social problems in rape victims with a learning disability are likely to be similar to those described in a non-disabled population, although with perhaps a greater emphasis on behavioural disorder, chronic psychiatric disorder and disordered functioning. Therapies which have been found to be effective in the general population, such as cognitive restructuring, are more problematic in people with poor verbal skills; non-verbal techniques, such as art therapy, may be more useful.

12 Child victims of sexual assault

The majority of sexual offences against children are not rapacious violent attacks but are the culmination of a long process of targeting vulnerable victims, grooming these children by a combination of seductive techniques, coercion and emotional blackmail and finally after months or years moving on to more serious penetrative sexual abuse. The sequelae of childhood sexual abuse have been well described (Finkelhor, 1986, Wyatt & Powell, 1988). The physical and emotional sequelae of acute rape of children are less well described as a separate entity but Hobbs & Wynne (1995) describe clearly the physical findings of sexual assault in children. Some relevant psychiatric findings in relation to child victims of rape are listed below but the point must be made that it is unwise to take one symptom or sign as diagnostic of serious sexual assault in a child and that the wider picture (including family context, behavioural disturbance, etc.) needs to be considered.

Possible psychiatric findings in child victims of rape

Child rape victims may already be victims of long-standing sexual abuse, physical abuse, emotional abuse or neglect and may therefore present a complex emotional picture onto which acute reactions to rape are superimposed. However, a very small number of child rape victims have been subjected to a once-only stranger assault. Responses to rape will vary depending on the child's developmental status and chronological age. In other words, toddlers of three or four years who have been subject to violent anal rape, for instance, may react very differently from teenagers suffering the same assault.

Very young children who are pre-verbal or not fully communicative in words may show disturbed behaviours such as sexualised behaviour, screaming attacks, clinging to a carer, acute stranger anxiety, nightmares, a regression to bed wetting (if the child is already dry), soiling, and possibly eating disturbances.

Children in the middle age group, say between ages 5-12 years may respond to a rape attack with a clear graphic verbal description of the events, by demonstrating what has occurred through play with toys or dolls, or by actually drawing the incident when asked. From an assessment and evidential point of view, the interpretation of play and drawing by emotionally disturbed rape victims should be approached with caution since a number of past events may be alluded to in the material provided.

Again within the 5-12 year age range, children may respond to acute rape with psychosomatic problems such as recurrent abdominal pain with no organic aetiology, exacerbation of existing illnesses such as asthma, regression to earlier wetting and soiling patterns, dysphagia (if there has been forced oral rape), constipation and anal retention (if there has been anal rape) dysuria and possible

urinary tract infections in girls (if there has been vaginal rape). It is possible that psychosomatic symptoms will occur in the child rape victim as well as emotional and behavioural disturbance.

In the age group 13-18 years, similar psychosomatic and emotional problems may be found. If the rape has been repeated over a period of time and become a regular process then more chronic symptomatology such as anorexia nervosa or bulimia may be anticipated. Adolescents and young people within this age group, mostly but not exclusively girl victims of rape, may show patterns of self-mutilation, cutting their arms and body (often in areas hidden by clothing) with razors or objects, repeatedly overdosing or making other attempts to commit suicide, binge drinking and drug abuse, and may present to the casualty departments of hospitals with some or all of the sequelae of this symptomatic behaviour. It is extremely unusual for a rapacious attack on a young person to result in a psychotic breakdown with florid psychotic symptoms such as delusions, hallucinations, ideas of reference etc. More commonly, acute depressive reactions and suicidal ideation with attempts at suicide may be found in the adolescent rape victim.

It should also be remembered that rape pregnancy may occur and may be a precipitant of severe emotional disturbance or adolescent breakdown.

Very rarely, and usually in the context of long-standing family violence, rape victims may make homicidal attempts upon their abusers or other adults. A thorough assessment should elicit the level of risk in any one case.

In all age groups, children and young people may present with the acute symptoms of PTSD where the presenting features may vary between a state of acute shock (as seen in victims of road traffic accidents) to more subtle manifestations of PTSD, such as increased general arousal (jumpiness) or avoidance of circumstances which bring back memories of the rape. In much younger children, post-traumatic stress symptoms may be confined to behavioural disturbances mentioned above, but children in the school age years may be able to draw vivid pictures of the rape events, flashbacks or nightmares which are part of the symptomatology.

Assessment

For a full description of assessment approaches see Bentovim, Elton, Hildebrand, Tranter & Vizard (1988), MacFarlane, Cockriel & Dugan (1990), Glaser & Frosh (1993). At all stages in the assessment of child rape victims, a child protection perspective is essential. This means working at all times with child protection agencies such as social services and the police. However, key points in relation to the assessment of child survivors of rape are as follows.

A systemic context

The systemic context around the rape assessment should be created at the outset.

In other words, all relevant agencies involved with the case should be invited to attend a preliminary professionals' meeting (if time allows) to contribute relevant background information for the assessment. Failing this, urgent telephone consultation should clarify different professional roles, before the assessment. An allocated social worker from the local authority should be involved in every case involving the rape of a child or young person under 18 years of age. The assessing psychiatrist has no mandate to deal with child protection issues and must not be put in this role during the assessment process.

Assess with a colleague if possible

The assessing psychiatrist should try to work with another colleague (preferably of the opposite sex) either in the room or observing through a video system to provide some feedback and supervision of this delicate assessment process. The presence of another colleague may also be very important at a later stage in terms of verifying evidence gathered.

Excellent written, audio or video records

A clear written, audio or possibly videotape record of the assessment should be taken since this may be required for later legal proceedings. All written documentation should have the name of the patient, the name of the assessing psychiatrist(s), the date, the venue of the assessment, the individuals seen for the assessment, the names of any other professionals present, the issues covered and discussed in the assessment, the opinion arrived at during the assessment, with the plan of action at the end of the notes. All handwritten notes should be legible, and in due course a properly constructed report should be created.

An ordered interview format

Different approaches to interviewing rape victims and sexually abused children now proliferate but good practice clearly suggests that an ordered or semi-structured approach to conducting such interviews is helpful both to the victim, the interviewer, and the subsequent evidential legal process (Bentovim et al, 1988, Home Office, 1992).

Treatment of child survivors of rape

Some child survivors of rape may show acute psychiatric disturbance, acting out behaviours, or possibly a psychotic reaction which may require admission to a children's psychiatric unit. With acute post-traumatic stress symptomatology, good practice would now suggest a debriefing process in relation to the rape event to help accelerate the working through of the trauma, and to prevent post-traumatic symptoms becoming chronic. Where the rape has been repeated or

chronic, treatment will need to deal with any residual post-traumatic effects either through an extended form of trauma debriefing, or cognitive work aimed at changing distorted thinking about the victim's culpability and coping strategies. In the medium to longer term, it is likely that most rape victims, particularly those with pre-existing vulnerabilities, will require long-term individual psychotherapy and this should be arranged. For a minority of healthier or more resilient rape victims, group work with other children or young people who have suffered similar trauma might well be helpful. Attention must also be given to the need for support and possible treatment of the rape victim's family. Even if the family was involved in the abuse, it will be necessary to provide some form of intervention to make sure that treatment for the victim carries a better chance of success. Even if the victim of rape is living separately from the family, in care for instance, other siblings with the family may need assessment and possible treatment to cope with their own distress about what has happened to their brother or sister.

In the drama and distress surrounding an incident of rape, it should not be forgotten that any assessment and treatment needs to be part of a longer-term care plan for the victim. Such a care plan should involve long-term follow-up over three to five years, with regular psychiatric review of the mental state of the rape victim. Although it is helpful and indeed essential for other disciplines to be actively involved in such a review with the assessing psychiatrist, a mental state examination appropriate to the developmental age of the child or young person should be undertaken during such review meetings.

Medico-legal issues

There are a number of medico-legal issues arising from a rape assault on a child or young person.

Criminal proceedings may be taken out against the alleged abuser, in which the child rape victim may be asked to testify. Such an experience may either be empowering for a suitably prepared rape victim or deeply distressing for someone who is already vulnerable. Appropriate counselling and support will need to be given before the child or young person appears in court.

The assessing psychiatrist's report may well be used in criminal proceedings and evidence may need to be given during the court hearing.

As a result of the rape, if it involves a family member or brings up issues of a change of placement, civil proceedings under the Children Act 1989 may occur, and the assessing psychiatrist may be required to give evidence in these proceedings.

In due course, the victim may decide to take legal action against the abuser through a civil claim for damages and in such instances the assessing psychiatrist's report may will be used, or a fresh report commissioned. In such personal injury cases much devolves around the original diagnosis given at the time of the assessment, particularly if this includes post-traumatic stress disorder when the

issue of causality may be invoked. The assessing psychiatrist will need to be able to address such medico-legal issues in a court context.

Finally, the child victim of rape may put in a claim to the Criminal Injuries Compensation Board (CICB) for government monies to compensate for the trauma, with the intention of using these monies to fund subsequent therapy or help with rehabilitation to adult life. The original psychiatric report or a subsequent report may be requested for perusal by the CICB.

13 Men who rape

Rape is a legal term referring to a narrowly defined specific sexual act. Sex offenders may have committed rape but equally they may have been convicted of lesser offences such as indecent assault because the stringent legal definition of rape frequently results in plea bargaining. This practice reduces an original charge of rape to that of a sexual offence carrying less severe penalties, so that the chances of a successful prosecution are enhanced.

Any discussion on the characteristics of rapists must recognise that many men who have committed rape are not convicted of the offence. The behavioural patterns of rapists are unlikely to be significantly different from men convicted of other forms of adult sexual assault. Throughout this section the term sex offender will be used rather than the word rapist.

Sexual offenders are rarely mentally ill, nor do they have any clearly defined biological or endocrine abnormality which would lead to an excessive libido. Amongst convicted rapists, however, there appears to be increased rates of personality disorder, particularly antisocial personality disorder, and marked disturbances in the ability to form and maintain close intimate relationships.

Psychological explanations of the motivations of offenders have emphasised the power and aggressive aspects of the behaviour. Sexual gratification must also be a motivating factor, although a number of researchers have emphasised the high rates of sexual dysfunction experienced during an assault. Aggression and violence may be integral rather than incidental to sexual arousal for sadistic rapists.

There is evidence that alcohol is implicated in up to 50% of rape assaults and may exert its influence through its permissive as well as disinhibiting effects (Christie et al, 1979, Gebhard et al, 1965, Evans, 1982).

Very few sex offenders receive any form of psychiatric assessment prior to disposal. Those who do may not represent rapists as a whole. Sex offenders receiving a prison sentence of more than four years may be offered a place on the prison-based Sex Offender Treatment Programme (currently under evaluation by the Home Office). Sex offenders receiving a sentence of less than four years are unlikely to have their sexual offending addressed in prison, unless they are transferred to HMP Grendon at some point during their sentence.

A small number of rapists are admitted to secure therapeutic settings (generally maximum or medium-secure), if their psychological 'disorder' is considered treatable. There are also very limited treatment resources in the community. The Gracewell Institute in Birmingham, which was one of the few residential facilities for treating sex offenders, closed down in 1994. Most treatment for sex offenders is provided by the probation service, sometimes in conjunction with forensic psychiatric services, either on a voluntary basis or as a probation order with a

condition of treatment. However, many treatment programmes accept child sex abusers rather than offenders against adults, because of concerns about dangerousness and treatability.

There is no evidence from evaluative research that treatment results in any long-term benefit to rapists or society in terms of decreased recidivism. Results from programmes treating child sex abusers are more encouraging. Such programmes use cognitive behavioural techniques, including relapse prevention, with the possible addition of antilibidinal drugs (e.g. cyproterone acetate), social skills training, and advice about alcohol and drug abuse. Concerns about treating rapists also relate to the possibility that any treatment regime could be undermined by sub-cultural attitudes which encourage the man to deny the unacceptability of his behaviour and the damaging consequences for the victim (see also Secondary Victimization, p. 13).

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National Association for the Protection From Sexual Abuse of Adults and Children with Learning Disabilities (NAPSAC)

Department of Mental Handicap, Queens Medical Centre, Nottingham, NG7 2UH

Contact: Mrs Pam Cooke

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VOICE UK

A support and action group for people with learning disabilities who have been abused.

PO Box 238, Derby, DE 9JN