2 Sexual violence: prevalence, dynamics and consequences

SUMMARY

- Sexual violence can take many different forms; it is not limited to acts of non-consensual intercourse but includes a wide range of sexual behaviours, including attempts to obtain a sexual act, sexual harassment, coercion, trafficking for sexual exploitation and female genital mutilation. These guidelines, however, deal mainly with sexual assault (rape) and child sexual abuse.
- The vast majority of victims of sexual violence are female and most perpetrators are male.
- In most cases of sexual assault, the perpetrator is someone the victim knows, and perhaps knows well, such as a current or former intimate partner, or a relative.
- Sexual assault is an aggressive act motivated by power and control.
- Sexual violence has both physical and psychological effects on health and well-being; these can be short- and/or long-term. The health consequences of, and the responses to, sexual violence vary markedly between individuals and according to the nature of the abuse (e.g. frequency, severity, perpetrator).

2.1 Definition of sexual violence

The terms "rape", "sexual assault", "sexual abuse" and "sexual violence" are generally considered to be synonymous and are often used interchangeably. However, these terms may have very different meanings (and implications) in varying situations and locations. More significantly, legal definitions of specific types of sexual violence may differ from the medical and social definitions, and furthermore, can vary between countries and even within countries. It is important, therefore, that health care professionals are aware of the legal definitions of sexual violence within their own jurisdiction, particularly as it applies to the age of consent and marriage.

Sexual violence is defined as, "any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic women's sexuality, using coercion, threats of harm or physical force, by any person regardless of relationship to the victim, in any setting, including but not limited to home and work" (*1*). According to this definition, a very wide range of behaviours, from rape at gun-point to sexual coercion under a threat of dismissal (i.e. with false agreement), would be classed as an act of sexual violence.

False agreement to sexual activity can be obtained in a variety of ways; for instance, through threats of physical violence, threats of withholding benefits (such as a promotion at work or a good grade), psychological pressure or blackmail. Agreement in such circumstances does not amount to freely given consent. The same is true in cases of sexual acts involving individuals who are

unable to give consent, that is to say, individuals who are not capable of understanding the significance of the act or of indicating their consent or refusal (e.g. those who are incapacitated due to the effects of alcohol and/or drugs, or those with a mental disability); such acts would also be described as non-consensual (*17*).

2.2 Types of sexual violence

Sexual violence can take many forms and take place under very different circumstances. A person can be sexually violated by one individual or several people (e.g. gang-rapes); the incident may be planned or a surprise attack. Although sexual violence occurs most commonly in the victim's home (or in the perpetrator's home), it also takes place in many other settings, such as the workplace, at school, in prisons, cars, the streets or open spaces (e.g. parks, farmland).

The perpetrator of a sexual assault may be a date, an acquaintance, a friend, a family member, an intimate partner or former intimate partner, or a complete stranger, but more often than not, is someone known to the victim. There is no stereotypical perpetrator; sexually violent men come from all backgrounds, rich and poor, academic and uneducated, religious and non-religious. Perpetrators may be persons in positions of authority who are respected and trusted (e.g. a doctor, teacher, tourist guide, priest, police officer) and thus less likely to be suspected of sexual violence.

Sexual violence is common in situations of war and armed conflict. Specifically, rape and sexual torture are frequently used as weapons to demoralize the enemy; women are sometimes forced into "temporary marriages" with enemy soldiers. Women who are incarcerated may be subjected to sexual violence by prison guards and police officers (*18*).

Other forms of sexual violence include, but are not limited to (*19*):

— sexual slavery;
— sexual harassment (including demands for sex in exchange for job promotion or advancement or higher school marks or grades);
— trafficking for purposes of forced prostitution;
— forced exposure to pornography;
— forced pregnancy;
— forced sterilization;
— forced abortion;
— forced marriage;
— female genital mutilation;
— virginity tests.

Some perpetrators use drugs in order to facilitate sexual assault (*20*). A woman who has been plied with drugs is easier to control, to the extent that physical force is not necessary, as the drugs will render her submissive and incapacitated and, in some cases, unconscious. In this respect, the increased use of so-called "date rape" drugs in recent years has received much attention. This and other aspects of drug-facilitated sexual violence are discussed in greater detail in Box 1.

BOX 1

Drugs and sexual violence

Alcohol has long been used to facilitate non-consensual sex and remains the most popular "drug" of choice. In recent years, however, the use of "date rape" drugs has been implicated in an increasing number of cases of sexual violence. The most commonly used drugs are flunitrazepam (Rohypnol) and other benzodiazepines, gamma-hydroxybutyrate (GHB), ketamine, cocaine, methamphetamine and marijuana (20). Victims may be unaware that they have been drugged and that they have been sexually violated.

A double standard often exists between men and women in terms of drinking alcohol or using drugs. If a woman has been drinking or using drugs she is often blamed for her victimization. On the other hand, the perpetrator's behaviour is excused or justified because he was "under the influence" and thus not expected to control his behaviour.

Health workers need to be aware of the signs that are suggestive of drug-facilitated sexual violence. If patients present with any of the following symptoms, the use of drugs or alcohol should be suspected:

- impaired conscious state, memory loss, disorientation or confusion;
- impairment of speech or coordination;
- unexplained signs of trauma, particularly genital trauma;
- apparent intoxication not corresponding to stated alcohol consumption;
- unexplained loss or rearrangement of clothing;
- talking about having an "out-of-body experience".

If drugs or alcohol are suspected, it is important to be aware of the following:

- any alteration in conscious state requires immediate access to full resuscitation facilities, such as those available in emergency departments;
- the sooner specimens are taken (e.g. blood, urine) the greater the likelihood of successfully detecting any substances not knowingly taken.

While sexual violence takes many forms, these guidelines focus on providing care for victims of sexual assault and victims of child sexual abuse. For the purposes of these guidelines, rape is defined as "physically forced or otherwise coerced penetration – even if slight – of the vulva or anus, using a penis, other body parts or an object" (*1*). This definition includes coerced sexual activity that may not be considered rape if the local legal definition of rape is narrow (e.g. confined to vaginal penetrtion with a penis).

2.3 Prevalence

Sexual violence is a reality for millions of people worldwide, and for women in particular. Research indicates that the vast majority of victims of sexual violence are female, most perpetrators are male, and that most victims know their attacker (*19, 21–23*). This does not, however, negate that fact that sexual violence against men and boys is also widespread.

While it is generally acknowledged that sexual violence against women is pervasive in all countries and in all levels of society, reliable statistics concerning the prevalence of sexual violence around the world are very limited. Population-based studies of abuse by intimate partners indicate that between 6% and

46% of women report that they have experienced attempted or completed forced sex by an intimate partner or ex-partner at some time in their lives (*1*). Rape and domestic violence account for an estimated 5–16% of healthy years of life lost to women of reproductive age (*24*).

There is significant underreporting of sexual violence. Published statistics are therefore unlikely to provide an accurate picture of the true scale of the problem. This also creates difficulties when attempting to compare studies. The reasons for non-reporting are complex and multifaceted but typically include fear of retribution or ridicule, and a lack of confidence in investigators, police and health workers. Men are even less likely than women to report being a victim of sexual violence (*25*) and for this reason information about the extent of sexual violence against males is especially limited (*26*). Sexual violence against men and its consequences are discussed in more detail later in this section (see section 2.5 Health consequences).

It is also very difficult to establish true incidence rates, and even prevalence estimates, of child sexual abuse, again largely because of problems of under-reporting. Child sexual abuse is rarely reported at the time that the abuse occurs, and in many cases is never reported, and most prevalence data come from asking adults about their past experiences (*27*). Moreover, many countries lack a reliable reporting system for child sexual abuse. The situation is compounded by the fact that definitions of child sexual abuse vary between countries, making comparisons difficult. What data are available from studies conducted in different parts of the world suggest that between 7% and 36% of girls, and between 3% and 29% of boys, have suffered from child sexual abuse. The majority of studies concluded that sexual violence against girls is 1.5–3 times more widespread than that against boys. Of the reported cases of child sexual abuse, only 10–15% involve boys, a finding which highlights the discrepancy between reporting and occurrence of sexual violence in boys (*28*).

The trafficking of women and children for prostitution is becoming one of the fastest growing areas of international criminal activity. According to official estimates, somewhere between 1 and 2 million women and children are trafficked each year worldwide for forced labour, domestic servitude or sexual exploitation (29). Generally speaking, women of lower economic status are more susceptible to sexual slavery, trafficking and sexual harassment (*29*).

2.4 Dynamics of sexual violence

The driving forces behind, and the motivations for, sexually aggressive behaviour have been analysed by several researchers and can be summarized as follows:

- Sexual violence is an aggressive act. The underlying factors in many sexually violent acts are power and control, not, as is widely perceived, a craving for sex. Rarely is it a crime of passion. It is rather a violent, aggressive and hostile act used as a means to degrade, dominate, humiliate, terrorize and control women. The hostility, aggression and/or sadism displayed by the perpetrator are intended to threaten the victim's sense of self. Sexual violence violates a victim's sense of privacy, safety and well-being (*19*, *30*).
- Work with sexual offenders has confirmed that the motivating factor for

sexual violence is not sexual desire. Although sexuality and aggression are involved in all forms of sexual violence, sex is merely the medium used to express various types of non-sexual feelings such as anger and hostility towards women, as well as a need to control, dominate and assert power over them. Not all perpetrators have the same motivations for committing sexual violence, nor are they similar in the way that they commit sexually violent acts. Anger, power and sexuality are nevertheless elements that are always present, irrespective of the reason for the sexual violence or the nature of the act committed (*31*).

- Unravelling the reasons why a given individual should choose to commit a sexually violent act is a complex matter. Some common themes have, however, emerged. According to Groth, sexual violence "serves to compensate for feelings of helplessness, to reassure the offender about his sexual adequacy, to assert his identity, to retain status among his peers, to defend against sexual anxieties, to achieve sexual gratification, and to discharge frustration" (*31*).

It is important that health workers have an understanding of the dynamics of sexual violence in order to be able to offer empathetic, objective and optimum care. For a more in-depth discussion of the dynamics of sexual violence, readers are referred to the relevant chapter of the WHO *World report on violence and health* (*1*).

2.4.1 Rape myths

The reality of sexual violence is often very different to what most people believe occurs. Some of the more popularly held misconceptions about rape are summarized in Table 1. It is often easier for us, both as individuals and as members of society, to accept the many myths that surround sexual violence rather than to challenge the religious, and socially- and culturally-accepted views of what constitutes appropriate sexual behaviour for men and women. In most societies and cultures men are seen as the sexual aggressors; women on the other hand are expected to be sexually passive and not initiate sexual activity, engage in sex only in marriage, and remain faithful to their husbands (*32*).

Prevailing myths affect the way in which society responds to rape and rape victims. When prevailing myths go unchallenged rape is supported, justified, and even condoned. Myths tend to be victim blaming; instead of holding the perpetrator responsible for his behaviour, the victim is blamed and held responsible for the assault, especially in cases where the victim knows the perpetrator. Often victims of sexual violence are simply not believed. These circumstances make it much more difficult for victims to seek help and recover from their experience.

Any person working with people who have been raped should be aware of the differences between myth and fact. Personal beliefs and attitudes toward rape need to be examined and challenged. It is essential that health workers understand the need for impartiality. It is not the role of the health worker to make judgements about the veracity of rape allegations, nor about the innocence or guilt of the alleged perpetrator; this is for the investigators and the courts to decide.

Table 1 **Common myths about rape**

MYTH	FACT
Sex is the primary motivation for rape.	Power, anger, dominance and control are the main motivating factors for rape.
Only certain types of women are raped.	Any woman can be a victim of rape. However, many people believe women who are of high moral character ("good girls") don't get raped and that females of low moral character ("bad girls") do get raped.
Women falsely report rape.	Only a very small percentage of reported rapes are thought to be false reports.
Rape is perpetrated by a stranger.	The vast majority of rapes are perpetrated by a known assailant.
Rape involves a great deal of physical violence and the use of a weapon.	Most rapes do not involve a great deal of physical force. The majority of victims report that they were afraid of receiving serious injuries or of being killed and so offered little resistance to the attack. This may also explain why little force or weapons are needed to subdue victims.
Rape leaves obvious signs of injury.	Because most rapes do not involve a significant amount of force there may be no physical injuries. Just because a person has no physical injuries does not mean they were not raped. Only approximately one-third of rape victims sustain visible physical injuries.
When women say "no" to sex, they actually mean "yes".	"No" means no; a woman's wishes in this regard should be respected at all times.
Sex workers cannot be raped.	Any man or woman, regardless of his/her involvement in the commercial sex industry, can be raped. Studies show that a significant proportion of male and female sex workers have been raped by their clients, the police or their partners.
A man cannot rape his wife.	Any forced sex or forced sexual activity constitutes rape, regardless of whether or not the woman is married to the perpetrator. Unfortunately, many jurisdictions have marital rape exemptions in their laws; although married women are subject to rape by their husbands the law does not recognize it as such.
Rape is reported immediately to the police.	The majority of rapes are never reported to the police. Of those that are reported, most are done so more than 24 hours after the incident. Victims do not report at all or delay reporting because they think nothing will be done, the perpetrator may have made threats against them or their families, they are afraid of family or community responses or they are ashamed; some victims simply feel that it is a private matter or do not know where to report the incident.

2.4.2 Risk factors

There are many factors that act to increase the risk of someone being coerced into sex or of someone forcing sex on another person. Some of these factors are related to the attitudes, beliefs and behaviours of the individuals involved, while others are deeply rooted in social conditioning and the peer, family and community environment. Such factors not only influence the likelihood of rape, but also the reaction to it (*1, 18*).

Although any person can be sexually victimized, there are some individuals

or groups of individuals who may be more vulnerable, and so appear to be "over represented" as victims of interpersonal violence, and of sexual violence in particular. These include:

— unaccompanied women;
— lone female heads of household;
— children and young adults;
— children in foster care;
— physically and mentally disabled men and women;
— individuals in prison or held in detention;
— individuals with drug or alcohol problems;
— individuals with a past history of rape or sexual abuse;
— individuals involved in prostitution;
— individuals in an abusive intimate or dependent relationship;
— victims of war or armed conflict situations;
— the homeless or impoverished.

Just as there is no typical victim, perpetrators too come from all walks of life. Table 2 lists established risk factors for perpetrating sexual violence.

2.5 Health consequences

The health consequences of sexual violence are numerous and varied, and include physical and psychological effects, both in the short-term and in the long-term. Most significantly perhaps, sexual abuse can have devastating long-term psychological effects, influencing and radically altering a person's entire life course.

2.5.1 Physical consequences

Individuals who have experienced sexual assault may suffer a range of physical injuries, genital and non-genital, or in extreme cases, death. Mortality can result either from the act of violence itself, or from acts of retribution (e.g. "honour" killings or as a punishment for reporting the crime) or from suicide. In addition, rape victims are at an increased risk from:

— unwanted pregnancy;
— unsafe abortion;
— sexually transmitted infections (STIs), including HIV/AIDS;
— sexual dysfunction;
— infertility;
— pelvic pain and pelvic inflammatory disease;
— urinary tract infections.

Genital injuries in women are most likely to be seen in the posterior fourchette, the labia minora, the hymen and/or the fossa navicularis. The most common types of genital injuries include:

— tears;
— ecchymosis (i.e. bruising);
— abrasions;
— redness and swelling.

Table 2 **Factors which increase men's risk of committing rape**

INDIVIDUAL FACTORS	RELATIONSHIP FACTORS	COMMUNITY FACTORS	SOCIETAL FACTORS
Alcohol and drug use	Associates with sexually-aggressive or delinquent peers	Poverty, mediated through forms of crisis of male identity	Societal norms supportive of sexual violence
Coercive sexual fantasies; attitudes supportive of sexual violence	Family environment is characterized by physical violence and few resources	Lack of employment opportunities	Societal norms supportive of male superiority and sexual entitlement
Impulsive and antisocial tendencies	Strongly patriarchal relationship or family environment	Lack of institutional support from police and judicial system	Weak laws and policies related to sexual violence
Preference for impersonal sex	Emotionally unsupportive family environment	General tolerance of sexual assault within the community	Weak laws and policies related to gender equality
Hostility towards women	Family honour considered more important than the health and safety of the victim	Weak community sanctions against perpetrators of sexual violence	High levels of crime and other forms of violence
History of sexual abuse as a child			
Witnessed family violence as a child			

Source: reference (*1*).

Non-genital physical injuries typically include the following:

— bruises and contusions;
— lacerations;
— ligature marks to ankles, wrists and neck;
— pattern injuries (i.e. hand prints, finger marks, belt marks, bite marks);
— anal or rectal trauma.

More detailed information about the types of physical injuries that are associated with sexual violence is given in section 4.5 (Recording and classifying injuries).

2.5.2 Psychological consequences

Just as there is no typical victim, there is no typical reaction to the experience of sexual violence; psychological effects vary considerably from person to person. Generally speaking, however, sexual abuse should be suspected in individuals who present, particularly repeatedly, with the following health problems (*19, 22, 33*):

— rape trauma syndrome (see below);
— post-traumatic stress disorder (see below);
— depression;
— social phobias (especially in marital or date rape victims);
— anxiety;

— increased substance use or abuse;
— suicidal behaviour.

In the longer-term, victims may complain of the following:

— chronic headaches;
— fatigue;
— sleep disturbances (i.e. nightmares, flashbacks);
— recurrent nausea;
— eating disorders;
— menstrual pain;
— sexual difficulties.

In adult survivors of child sexual abuse, symptoms are often an extension of those found in children, and may include:

— depression;
— anxiety;
— post-traumatic stress disorder;
— cognitive distortions;
— externalized emotional distress;
— interpersonal difficulties, including sexual problems.

Rape trauma syndrome

Many victims of sexual violence experience rape trauma syndrome (RTS) (*34*). This is defined as "…the stress response pattern of… a person who has experienced sexual violence" (*35*). RTS may be manifested in somatic, cognitive, psychological and/or behavioural symptoms and usually consists of two phases: the acute phase and the long-term phase.

The acute phase. The acute phase is a period of disorganization. It begins immediately after the rape and persists for approximately 2–3 weeks. During the acute phase, a person usually experiences strong emotional reactions and may present with physical symptoms (see section 2.5.1 Physical consequences). Emotional responses tend to be either expressed or controlled, for example:

— crying and sobbing;
— smiling and laughing;
— calm and very controlled;
— a flat affect.

Emotions may be expressed as anger, fear or anxiety. Some individuals may show feelings of shock and numbness; others may mask their feelings and act as though everything is fine.

The acute reaction is rooted in a fear of physical injury, mutilation or death. Once victims feel safe again they may begin to experience:

— mood swings;
— feelings of humiliation;
— degradation;
— shame;

— guilt;
— embarrassment;
— self-blame;
— defencelessness;
— hopelessness;
— anger;
— revenge;
— fear of another assault.

The long-term phase. The subsequent phase is one of reorganization, and ordinarily, begins approximately 2–3 weeks after the event. At this time the person starts to reorganize their lifestyle; this reorganization may be either adaptive or maladaptive. Reactions during this phase vary markedly from person to person, depending on (*34*):

— the age of the survivor;
— their life situation;
— the circumstances surrounding the rape;
— specific personality traits;
— the response of support persons.

Victims often initiate lifestyle changes, such as moving to a new residence, changing their telephone number, or obtaining an unlisted telephone number. Some individuals choose to embark on a period of travel.

Some individuals may experience difficulties in functioning at work, home or school. Phobias, such as fear of crowds or a fear of being alone, may begin to appear depending on where the rape took place.

Sexual dysfunction or changes in a person's sex life are very common. Frequently, the person may terminate an existing relationship with an intimate partner (*34*). Some of the sexual problems that women often encounter post assault include:

— sexual aversion;
— flashbacks of the rape during sex;
— vaginismus;
— orgasmic dysfunction.

RTS in men, together with some of the post-assault sexual concerns typically voiced by men, is described in Box 2. Sexual violence victims, irrespective of sex, who have an existing psycho-pathology, or past experience of sexual violence, are likely to find that any new victimization will exacerbate their trauma and may complicate their recovery (*34*).

Post-traumatic stress disorder

Victims of sexual violence frequently experience symptoms of post-traumatic stress disorder (PTSD). PTSD appears to be more common in persons who were threatened with a weapon and/or extreme physical force, in those raped by strangers, and in cases where physical injuries were inflicted.

Symptoms of PTSD may manifest as intrusions and avoidance (*32, 36*).

BOX 2

Men as victims of sexual violence

Men most commonly experience sexual violence in the form of (*32*):

— receptive anal intercourse;
— forced masturbation of the perpetrator;
— receptive oral sex;
— forced masturbation of the victim.

Sexual violence against males is underreported, far more so than in the case of women, largely because of the reluctance of men to report acts of sexual violence to the police. This in turn is likely to be due to extreme embarrassment experienced by most males at being a victim of sexual violence. There are, however, certain settings where acts of sexual violence against males may be more prevalent, for example, in prisons and the armed forces.

Generally speaking, men have the same physical and psychological responses to sexual violence as women, including:

— fear;
— depression;
— suicidal ideation;
— anger;
— sexual and relationship problems.

Men also experience RTS in much the same way as women. However, men are likely to be particularly concerned about:

— their masculinity;
— their sexuality;
— opinions of other people (i.e. afraid that others will think they are homosexual);
— the fact that they were unable to prevent the rape.

These concerns about masculinity and sexuality may stem from the misconceptions that only homosexual men are raped and that heterosexual men would never rape another heterosexual man.

Intrusions involve reliving the experience and include:

— flashbacks;
— nightmares;
— recurrent, intrusive thoughts that stay in the mind.

Avoidance symptoms include:

— feelings of numbness;
— self-imposed isolation from family, friends and peers;
— intellectualizing the incident;
— distractions;
— increased drug or alcohol use;
— engaging in high-risk behaviours;
— avoiding places, activities or people that remind them of the assault.

Other common PTSD symptoms include dissociation, hypervigilence, irritability and emotional outbursts. For more in-depth information about PTSD, please refer to the *Diagnostic and statistical manual of mental disorders*, details of which are provided in the bibliography.