Further Aspects of Male-on-Male Rape and Sexual Assault in Greater Manchester

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ABSTRACT
The purpose of this paper is to describe pertinent non-medical circumstances around male-on-male sexual assault, and supplements the earlier article in this journal regarding forensic medical aspects of this population. As services (medical, policing and judicial) see more males they will need to adapt themselves to their needs as well as those of their female clients. St. Mary's Sexual Assault Referral Centre (Greater Manchester, UK) opened in October 1986. Up to May 2003 it had seen 376 male (370 individual clients) and 7,789 female cases (7,403 clients). Of these, significantly fewer males reported to the police than females, although this difference has disappeared in recent years. There were also significant differences between the sexes regarding relationship, number of assailants, and assault location. There were no statistically significant differences between the sexes for age of the client, and presence in the assault of weapons or additional violence.

INTRODUCTION

This paper is a companion piece to Forensic Medical Aspects of Male-on-Male Rape and Sexual Assault in Greater Manchester previously published by the same authors in this journal (McLean et al., 2004).

St. Mary's Centre

This paper provides an epidemiological survey of certain features of cases seen at a sexual assault referral centre (SARC). Established in 1986, the St. Mary's Centre, in Manchester, was the first comprehensive forensic medical, counselling and aftercare service in the UK for people alleging rape or sexual assault. The Centre is a pioneering collaboration between Greater Manchester Police (GMP), Greater Manchester Police Authority, and Central Manchester and Manchester Children's University Hospitals NHS Trust, and it sees females and males that either live in or were assaulted in Greater Manchester. Based at dedicated accommodation in St. Mary's Hospital, counselling and other support services are provided, as well as forensic medical examinations conducted by a specially trained staff of female doctors on behalf of GMP. All of the Centre's services to eligible clients are free.

Definitions and stereotypes

Rape and sexual assault are issues surrounded by myths, stereotypes and misconceptions that affect how society considers the acts and the actors involved. It is important, then, for the term 'male-on-male rape and sexual assault' and its components to be defined. These preconceptions also affect those who work closely with these issues in that they, too, may hold an incorrect view of sexual assault, but also that their motivation to do such work may be prejudged by others. Susan Brownmiller (1975) opened her essential work *Against Our Will* by recounting how, whilst writing the book, people asked if she

had been raped. There is a suspicion that those working in such a field do so either because they were assaulted, and/or were men-haters. No doubt this suspicion would also apply to male workers in the field, and, additionally, that they are gay too.

Male

This paper concerns the rape and sexual assault of males by other males, and so the definition of terms is important. The use of the term 'male rape' to indicate male-on-male rape is commonly used with the prefix of 'male', here intended to distinguish such assaults from those experienced by females. Rape is automatically considered to involve a female victim. The term is gendered to become 'male rape', similar to phrases such as 'male nurse' or 'male model'. In repeating the separateness of male from female rape, the idea that male rape is a rarity is reinforced, males will remain less likely to report their experiences, and public services will continue to be designed just for female clients. The use of the word 'male' alone is also ambiguous, and could be taken to indicate the gender of the assailant. Therefore, male-on-male rape and sexual assault is a clearer description (Scarce, 1997).

Age

The sexual assault of boys, rather than adult males, is of course included in this description. The assault of boys is acknowledged much more widely in society than the abuse of adult males. Children can be forgiven their vulnerability, and categories of offenders such as paedophiles can be demonised and marginalized, so that the issue is distanced from the ordinary lives of most of us. A man's violent and sexual violation of another man also violates a patriarchal society's guiding principle that the individual man is the basis of that society's strength and security (Scarce, 1997).

Sexuality

Male-on-male rape has been called 'homosexual rape' (Saum et al., 1995) but unless one is specifying the rape of a homosexual by another homosexual, and perhaps even then, this may be a misleading term. For example, Harry (1992) described instances of the rape of homosexual men by heterosexual men as a punitive act of 'gay-bashing'. Gay victims and gay rapists exist (Hickson et al., 1994) but it would be an unhelpful generalisation to consider that the victims of male-on-male assaults are always homosexual since only homosexual men could find themselves in a situation where rape could arise, either by attracting the attention of the rapist or failing to resist him (Laurent, 1993).

This is particularly manifest in sexual assaults occurring within prisons. For example, anal (and vaginal) rape has been described as endemic in US prisons, yet because of the homophobic prison culture the perpetrators consider their actions to be congruent with masculine and heterosexual behaviour (Banbury, 2004). The St. Mary's Centre does not enquire about its clients' sexuality and so the relevance of that issue to sexual assault is not addressed here.

Incidence and prevalence

The idea of men raping men, indeed the possibility that men can be raped, is one that is rarely acknowledged within mainstream society and it is true that the number of reported male-on-male rapes is a fraction of the total of reported rapes; between 5% and 10% for the UK and USA (Scarce, 1997). However, for both males and females who have been raped or sexually assaulted, it is believed that most assaults are not reported; for example, the 2000 British Crime Survey (BCS) (Myhill and Allen, 2002) estimated that 61,000 females were raped in 1999, whereas the police recorded 7,707 incidents (about 12%). The foremost assessment of male-on-male sexual assault found 3% of a representative sample of 2,468 men reported having experienced such an assault since the age of 16 years (Coxell et al., 1999). Notably, such experience under the age of 16 was reported by 5% (of 2,423), which undoubtedly included cases of on-going sexual abuse. That class of assault is not the focus of this paper.

It has been argued that the social construction of masculinity, and the central role of the

male in a patriarchal society, stifles the reporting of male-on-male sexual assaults to a greater degree than male-on-female (Calderwood, 1987), although that is not to suggest that the true prevalence of male-on-male assault is not actually lesser than male-on-female sexual assault. Reported incidents of male-on-male rape are increasing, for example in England and Wales there were 10.7% more reports of male-on-male rape in the year April 2000 to March 2001 than in the previous 12 months, compared to a 1.5% increase in male-on-female rape for the same period (Povey, 2001).

Assailants, weapons and location

Kaufman et al., (1980) found that males were more likely than females to be assaulted by multiple assailants. According to Pesola et al. (1999) males were half as likely as females to be assaulted by a stranger and twice as likely to be assaulted by an acquaintance known for less than 24 hours (based on only 27 males and 198 females). The first British study of male-on-male sexual assault survivors (again based on small figures, i.e., 22) found that assaults by strangers were very rare (Mezey and King, 1989). The Haven (a SARC in London) found that a weapon was present in 11% of all cases seen there during one year, and violence in addition to the sexual assault was reported in 50% cases (Kerr et al., 2003), but separate rates for males and females were not reported in the paper. A characteristic also neglected within the literature has been the type of place where assaults occur.

Psychological impact

In his book *Male On Male Rape* – the single most important piece of work on the issue – Michael Scarce (1997) cites homophobia as the principal cause of the stigma attached to men who have been raped. As women who have been raped may be considered promiscuous (the common confusion of rape and sex), so men may be considered homosexual. As well as the imposition of stigma by society, these social constructions can foster confusion within the individual regarding his sexuality following a rape. The fact that penile erection and ejaculation by the victim during rape is possible as a physiological response may further add to such self-questioning, regardless of prior sexual orientation (King et al., 2000).

Rape Trauma Syndrome (e.g., Burgess and Holstrom, 1974) describes a form of post-traumatic stress syndrome particular to the experience of rape and other serious sexual assault. It involves four stages, defined by a range of symptoms that can include fear, shame, guilt, anger, physical repulsion, phobias, obsessive-compulsive disorders, mood swings, and relationship problems. This syndrome has been described largely with reference to females and whilst much may be transferred to males, service providers (especially counsellors) must be sensitive to that which does not (Ellis, 2002). Kaufman et al. (1980) for example, found that males were more likely than females to experience denial and to control their emotional response.

METHOD

Aim

The aim of this study was to ascertain the differences and similarities between the non-medical characteristics of male-on-male assaults and male-on-female assaults. It is intended that these findings assist sexual assault support services to develop a gender-sensitive rather than female-specific approach.

Design

This study was a retrospective epidemiological study on two cohorts of subjects, male and female. There were no hypotheses but a research question, to identify any differences between comparable aspects of sexual assault on males and females.

Participants

This survey includes clients seen at the St. Mary's Centre from its opening in October 1986 up to mid-May, 2003. The Centre mainly sees adults from Greater Manchester that have been raped or sexually assaulted by a non-family member on a single occasion, as opposed to cases of child sexual abuse.

During the survey period a total of 8,165

cases of alleged rape or sexual assault were seen at the Centre; 7,789 cases involved female clients, 376 were male, and together they comprised 7,773 individual clients. The extra 392 cases were due to 284 female and six male clients who attended the Centre on more than one occasion because of separate incidents of assault. This is why the term 'case' is mainly used here rather than 'client'. Of these 7,773 individual clients, 7,403 (95.2%) were female and 370 (4.8%) male. None of these clients were inmates at prison at the time of the assault.

Procedure

A new computer database at St Mary's Centre has been created to hold much of the information from the clients' paper records. This paper is based on reports from that database. Frequency and chi-square statistics were calculated using SPSS. Analyses were two-tailed since differences in either direction were not predicted.

RESULTS

Gender, reporting and age

Whilst the overall proportion of males in the Centre's client group is 4.8%, in recent years it has been nearer 8%. In 2001 there were 57 male cases (the most ever seen in one calendar year), forming 8.6% of all cases that year, and 50 (7.8%) in 2002 (the second highest number).

The proportion of police-referred male cases has increased, as well as the total number of male cases, to 68.4% of all male clients in 2002; female cases had also gone up to 72.5% in that year. Overall, 218 (58%) of all the male cases were police referrals; the other 158 (42%) were self-referrals. This compares to 5,213 (66.9%) police and 2,576 (33.1%) self-referrals for all female cases. The smaller proportion of male police referrals compared with female police referrals is statistically significant when analysed with a chi-square test (p=0.001, a=0.05, odds ratio=1.449, 95% CI lower=1.172, upper=1.790), although not for recent years (i.e., 2001 and 2002) when they were looked at separately.

The mean female age was 25.6 years (mode 17, median 23, standard deviation 10.6, range 2-89) and the mean male age was 25.5 years (mode 17, median 23, standard deviation 9.9, range 12-93). These figures are based on client age at the time of first attendance at the Centre for all 8,165 cases and therefore include clients who attended the Centre for counselling some time (in some cases years) after the assault. Averages of age for female clients who were examined (and therefore had been assaulted no more than a few days previously) were almost identical to those for all female clients, whereas examined males were about 18 months younger than the mean for the whole male client group. The ages of male and female clients did not show significant differences at the 0.05 level, either in the group of all cases nor the subgroup of examined cases, when tested with one-way ANOVAs.

Assailants

The relationship between the assailant and the client was specified in 83% (312/376) and 87.5% (6,812/7,789) of cases for males and females respectively. The commonest category of relationship in both male and female cases was that of stranger. However, whilst for males this represented 37.8% of cases where a relationship was defined in the records, it was notably less in female cases, at 30.9%. Other notable differences were that current and former partners were rarely cited as assailants in male cases (3.2% together), whereas they were much more commonly cited in female cases (17.2%).

There was a slightly higher incidence of male than female cases that involved an authority figure, such as care home attendant, priest, teacher, or prison officer. Since the Centre does not serve survivors of child sexual abuse (i.e., long-term abuse by a known person) the incidents of assault by a family member or authority figure are one-off events. The relationship between the assailant and the client was not known or recorded in 64 (17%) and 977 (12.5%) of cases for male and females respectively. A chi-square test found that these differences were statistically significant (p=0.000, df=8, a=0.05, two-tailed). Table I below shows this feature in more detail.

Excluding 56 and 1,074 unknowns in male

Table I. Relationship of client to alleged assailant.

Relationship	Cases			
	Male (n=312)		Female (n=6,812)	
	N	%	N	%
Stranger	118	37.8	2,105	30.9
Acquaintance time unknown	54	17.3	1,204	17.7
Acquaintance over 24 hours	54	17.3	858	12.6
Acquaintance under 24 hours	29	9.3	563	8.3
Colleague	20	6.4	456	6.7
Authority figure	19	6.1	142	2.1
Family member	8	2.6	315	4.6
Current partner	8	2.6	688	10.1
Former partner	2	0.6	481	7.1

and female cases respectively, a single assailant was involved in 252 (78.8%) of 376 male and 5,900 (87.9%) of 6,715 female cases (although others may have been complicit in its commission). Two assailants were involved in 37 (11.6%) male cases and 491 (7.3%) female cases. Three or more assailants accounted for the remainder of cases. The greater proportion of multiple-assailants in male cases was statistically significant when tested by a one-way ANOVA (p=0.00, df=7,034, a=0.05, two-tailed). Only two male cases reported the involvement of female assailants.

Location of assault

Excluding 97 (25.8%) unknowns for males and 1,375 (17.5%) for females, the commonest location for an assault on males was outside in a public place, such as the street or a park. (See Table II for details). A chi-square test found that the differences in the proportion of assaults that occurred in other locations were statistically significant (p=0.00, df=5, a=0.05, two-tailed).

Weapons and violence

The use of a weapon, or additional violence beyond the sexual assault itself, is recorded during forensic medical examinations. In these 5,359 cases a weapon was present in slightly more male cases (33, 14.5%, n=228) compared with female (588, 11.5%, n=4,543). Additional violence or force was applied in 130 (55.9%) male cases and 2,963 (57.7%) female. Looking at only those cases in which a weapon was present, additional violence was still used by

Table II. Locations where assaults were alleged to have occurred.

Location	Assaults			
	Male (n=279)		Female (n=6,414)	
	N	%	N	%
Public place	86	30.8	1,895	29.5
Assailant's home	78	28.0	1,449	22.6
Own residence	54	19.4	1,928	30.1
Pub/club	40	14.3	546	8.5
Vehicle	17	6.1	497	7.7
Another's home	4	1.4	99	1.5

the assailant in 30 (90.9%, n=33) male cases and 495 (84.2%, n=588) female. Chi-square tests found that the differences between male and female cases in these features were not statistically significant at the 0.05 level.

Counselling

One hundred and seventy-nine (47.6%) male and 4,334 (55.6%) female cases received counselling at the Centre. These include clients whose first contact with the Centre was to obtain counselling. Of the total of 4,513 cases receiving counselling, 4% and 96% were with male and female clients respectively. Of the 5,359 cases who had a forensic medical examination, 2,196 went on to take up counselling at the Centre. Sixty-three cases were male, being 27.6% of all male cases examined, and 2.9% of all examined cases. For female cases, these figures were 2,133, 41.6%, and 97.1%, respectively.

DISCUSSION

Gender, reporting and age

The significant difference between the numbers of male and female police-referred cases indicates an even greater prohibition against reporting rape and sexual assault for males. However, this ground is starting to be made up and the proportion of incidents that are being reported is growing. The notable increase in numbers of males reporting rape seen nationally is reflected in the greater proportion of males seen at the Centre overall and who come via the police. There is now no statistically significant difference between male and female police referrals, whereas previously male clients often did not want police involvement. These findings suggest the key age group for targeting awareness about the risk of sexual assault and the importance of safety behaviour is 15 to 17 years for males and females.

Assailants

Differences between the sexes in relationship to the assailant were significant. Assailants that were current or former sexual partners were about six times more common in female cases than male, which suggests that assaults on males by their female or male partners is either rare or rarely reported. The findings of Pesola et al. (1999) regarding sex differences in stranger and acquaintance assaults were not repeated. Most sexual assaults in both male and female cases were committed by sole assailants, although others may have assisted in other aspects of the offence. However, two or more assailants were significantly more common in male cases (about one fifth) than in female (about one eighth), in line with the findings over 20 years ago by Kaufman et al. (1980). This suggests a stronger 'culture' within male-on-male assailants of co-operation and shared gratification, and/or a greater amount of strength required to subdue a male, and/or a higher incidence of 'punishment' rapes.

Location of assault

Statistically significant differences between the experiences of male and female clients were again found here. Assaults occurred in public places in about 30% of both male and female cases, public places being streets, alleys, parks, other outside places, and also the workplace. In cases where the assailant was classified as a stranger and the location of the assault was known, this rose to 52.5% and 53.7% of male and female cases respectively. Second and third commonest locations in male cases were at the assailant's home and at the client's own residence. The former may have been as a result of kidnapping but was more likely due to previous good relations with the assailant, whereas the latter may have been as a result of a break-in but was more likely due to the assailant having been invited in.

The finding that these second and third places are transposed for female cases reflects the higher prevalence of assaults on females by current or former partners compared with male cases. The terms 'homes' and 'residences' include permanent or temporary abodes such as hostels, hotels, or university halls. The proportion of assaults on males in public houses or nightclubs is higher than for females, suggesting a greater risk for men whilst socialising. Assaults in vehicles, including taxis and bogus taxis, and kidnapping incidents, occurred at similar rates for males

and females. Likewise, assaults at the residence of a person other than the client or assailant, occurred most usually during or after a party.

Weapons and violence

There are no significant differences between male and female cases regarding the use by the assailant of a weapon or violence beyond that of the sexual assault itself. This contradicts the significant finding of Kaufman et al. (1980) for greater violence against males. That male cases reported no more violence by assailants than females suggests that males are not significantly harder to subdue. Looking only at those cases in which a weapon was present, the level of additional violence was even higher. This suggests that whilst people may be more acquiescent when faced with a weapon, the assailant continues to use violence. Taking or using a weapon during the assault indicates a higher propensity for violence in the assailant, and that violence is therefore part of the sexual assault and the gratification gained, not simply a means by which to subdue the subject.

Counselling

Overall numbers of males receiving counselling were similar, if a little below, those of females. However, males who had a medical examination were much less likely to take up counselling afterwards than females. Statistical tests were not possible here due to the manner in which this information had been recorded.

CONCLUSION

Despite a trend over the past decade for increasing disclosure by male sexual assault victims, including to the police, males remain a fraction of the victims known to services. Targeting awareness of the reality of male-on-male sexual assault at the key vulnerable age group of 15 to 17 year olds, may reduce the risk of assault and improve disclosure rates so that victims receive the necessary care. For males, such awareness may include the increased risk from group assaults and the high proportion of assaults that occur at home or the assailant's home, during or after a party. The resistance of males to disclosing and seeking assistance can be seen in the reduced rate at which male examination clients return for counselling. It may also be that the apparent under-representation of partner assaults (compared with female cases) is due to an even more hidden problem of domestic violence within the gay community. Further research is intended at St. Mary's Centre into the decision-making processes behind disclosure and the barriers to seeking assistance, so that male victims may be better provided for by the growing chain of UK SARCs.

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