Chapter 16

Understanding and Preventing Rape

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Men rape. This is Fact One, and no discussion of sexual assault should distract us from this reality. Historically, men have always denied and evaded Fact One. That is Fact Two, and no discussion of the causes of sexual assault should deflect us from this responsibility. Recognition of reality and acknowledgment of responsibility can come with great difficulty to most men. Evasions, denials, and defensiveness, however, miss the point and simply will no longer suffice.

—Charlie Jones

Feminist scholarship and activism have transformed the way we in the Western world conceptualize the legal, social, and personal factors concerning rape. In this chapter, we explore feminist contributions to defining and assessing the prevalence of rape, describe research on societal and individual level causes of rape, provide an overview of the psychological and physical health impact of rape, critique the institutional response to rape, and examine the efficacy of prevention programs. We conclude this chapter with a series of suggestions for continuing the fight against rape started by our feminist sisters many decades ago.

DEFINITIONS AND PREVALENCE OF RAPE

Feminist thinking has resulted in a paradigmatic shift away from viewing rape as a crime against the victim's husband or father to

seeing it as a crime against the woman herself. Early 20th-century views of rape were strongly influenced by the legal backdrop of British common law that held that rape was ''an accusation easily to be made and hard to be proved, and harder to be defended by the party accused, tho [*sic*] never so innocent'' (p. 75; Hale, 1736; quoted in Garvey, 2005). Even though there was no empirical evidence to support this argument, these words held sway for two centuries. It was not until the second wave of the women's movement that conceptualizations of rape began to change.

The second wave of the women's movement in the 1970s saw the creation of consciousness raising (CR) groups as a method of creating female solidarity and political action by sharing life experiences with other women. CR groups put rape on the feminist agenda (Gavey, 2005). As a result of the knowledge gained in such groups, the prevalence of sexual victimization in women's lives led women to understand that ''the personal is political''; in other words, rape was not an individual woman's problem, but a result of structural factors that pervade society and enable rape to occur (Gavey, 2005). The antirape movement soon developed within the organized women's movement, educating the public and advocating for legislative change. Early feminists challenged the victim-blaming attitudes embedded in the legal doctrine of rape. With the establishment of rape crisis centers in the 1970s, women began to define a woman-centered view of rape, accompanied by support, counseling, and crisis intervention services.

Alongside these activist efforts, feminist social scientists and other scholars began to examine rape. Several groundbreaking feminist studies demonstrated that rape was prevalent worldwide (Brownmiller, 1975); that rape was often hidden within the guise of ''normal'' dating behavior (Koss, 1985) or marriage (Russell, 1982); and that the continued prevalence of rape was based on identifiable, generally accepted myths about rape (Burt, 1980). The potentially damaging effects of rape were first described by Burgess and Holmstrom (1974) in their pioneering work on the ''rape trauma syndrome.'' Subsequent studies have identified the clinical aspects of rape trauma syndrome and its basis in posttraumatic stress disorder discussed later in this paper.

State by state, early feminists were able to change rape laws that embodied rape myths and revictimized rape survivors. Rape activists worked to change laws that excluded rape by spouses, the so-called spousal rape exemption, but it took until 1993 before marital rape became a crime in all 50 states. Activists were also successful in broadening the definition of rape to go beyond simple penile penetration to include penetration with objects and oral and anal penetration. There have also been changes to the way that consent is assessed, removing the requirement of resistance or physical injury to prove nonconsent. For example, the U.S. Department of Justice's (2007) Office on Violence

against Women now defines sexual assault as ''any type of sexual contact or behavior that occurs without the explicit consent of the recipient of the unwanted sexual activity.'' Its definition includes vaginal or oral penetration with any object, forced oral sex, or forced masturbation.

This general definition of rape is reflected in many state laws. Although there is significant variation among state rape laws, most states include a description of physical acts such as oral, anal, and vaginal penetration. Most states also include circumstances when victims cannot consent, such as when a person is unconscious, drugged, developmentally disabled, or mentally ill.

California has a particularly detailed and inclusive definition of rape. According to a series of penal codes, rape is an act of sexual intercourse that occurs against a person's will under any of the following conditions: by means of threat or force, when a person is intoxicated and cannot resist, when a person is unconscious of the nature of the act (e.g., asleep, the act was misrepresented), through the threat of future retaliation, or through the threat of official action (e.g., incarceration, deportation) (California penal codes 261, 262). Similar codes restrict unwanted oral copulation (penal code 288a) and penetration by an object (penal code 289). In each case, any sexual act that was not fully consented to is included in the definition. According to subsection 261.6, a person must voluntarily and actively cooperate in the sexual act—if a person has not consented in word and deed, it may be considered rape.

The way rape is defined affects prevalence rates. Definitional and methodological differences may contribute to this variation (Koss, 1992). Some studies rely exclusively on legal definitions of rape, but legal definitions are relatively narrow and may not fit women's experiences (Rozee, 2005). The terminology used in prevalence surveys can also result in varying rates. Studies that define rape in behavioral terms (e.g., ''Have you ever been forced to have sex against your will?'') find higher rates than studies that use the word *rape* (Rozee & Koss, 2001). Screening criteria, too, can affect prevalence rates. Studies differ in the time frame about which they inquire. Some studies focus only on adult rapes (versus lifetime), but the way adulthood is defined still differs from study to study (e.g., 14 and over, 16 and over, 18 and over). The scope of the survey also makes a difference. Some studies focus exclusively on rape, while others combine rape, attempted rape, and sexual assault. Finally, recruitment strategies can affect prevalence rates. Rape has one of the lowest reporting rates for any violent crime (Kilpatrick, Edmunds, & Seymour, 1992; Rozee & Koss, 2001), so studies that rely exclusively on police reports have much lower estimates. As a result of these variations, there is great controversy about how to best assess prevalence (DeKeseredy & Schwartz, 2001; Kilpatrick, 2004; Koss, 1996).

To obtain an understanding of how common rape is, it is therefore necessary to look at the findings of multiple studies. Among the most

commonly cited national-level studies is the FBI's Uniform Crime Statistics (UCR). This report includes instances of forced penile–vaginal intercourse that were actually reported to the police in a given year. The most recent statistics from the UCR indicate that 93,934 women were forcibly raped in 2005. However, most researchers estimate that reported rapes comprise only a small portion of the number of actual rapes committed each year (Kilpatrick, 2004).

The Bureau of Justice Statistics's National Crime Victimization Survey (NCVS) is more comprehensive. This survey includes any form of unwanted sexual penetration against men or women through psychological or physical coercion. The most recent statistics from the NCVS indicate that 191,670 people were victims of rape, attempted rape, or sexual assault in 2005. These statistics are still considered somewhat low by most experts, however, because the methodology used to elicit rape reports from victims does not facilitate disclosure (Kilpatrick, 2004; Koss, 1996).

To remedy these methodological problems, the National Violence Against Women Survey (NVAWS) used more behaviorally based screening questions. The NVAWS found that 302,100 women were raped in the 12 months prior to the survey (Tjaden & Thoennes, 2000) and that 18 percent of women had been raped in their lifetime. Similarly, the National Women's Study used behaviorally based questions and found that 12.65 percent of women had been raped in their lifetime (Resnick, Kilpatrick, Dansky, Saunders, & Best, 1993).

Other studies have focused on more specialized populations. An early study of rape among college students found that 15 percent of college women had been raped in their lifetime (Koss, Gidycz, & Wisniewski, 1987). More recent studies with the same population have confirmed these findings. The National College Health Risk Behavior Survey found that 20 percent of college students had been raped in their lifetime and 15 percent had been raped since the age of 15 (Brener, McMahon, Warren, & Douglas, 1999), while the National Survey of Adolescents focused on youth ages 12–17 and found that 13 percent of the girls had been sexually assaulted in their lifetime (Kilpatrick, Saunders, & Smith, 2003).

Some studies have found even higher rates. A nationally representative sample of U.S. Navy recruits found that 36 percent of the women had been raped in their lifetime (Merrill et al., 1998), and a national telephone survey found that 34 percent of married women had been threatened or forced into having unwanted sex with their spouse or previous romantic partner (Basile, 2002).

After a review of these and other prevalence studies, Rozee & Koss (2001) concluded that the rate of rape in the United States has remained at a consistent 15 percent lifetime prevalence over the last quarter-century, despite various prevention efforts. Rape is common worldwide as well. It is estimated that rape occurs in 43–90 percent of nonindustrialized societies (Rozee, 1993), and one in three women

worldwide have been subjected to some form of male violence (Heise, Ellsberg, & Gottemoeller, 1999).

Rates of rape do differ by type of assailant, however. While most people envision a ''real rape'' scenario that involves a stranger with a gun who inflicts a high degree of injury to the victim (Estrich, 1987), stranger rapes are actually the least common type of rape. In fact, recent research suggests that less than a third of all sexual assaults are committed by strangers (Tjaden & Thoennes, 2000). Acquaintance, date, and marital rape, on the other hand, are far more common. According to the NVAWS, 76 percent of all rapes and physical assaults against women are committed by current or former husbands, cohabitating partners, or dates (Tjaden & Thoennes, 2000).

Rates of rape also differ by gender and age. The vast majority of rape cases involve male perpetrators and female victims. Of the rapes included in the 2005 NCVS, 98 percent of the rapists were male and 92 percent of victims were female. Rape is also more commonly perpetrated against young girls and women. According to the NVAWS, 21.6 percent of rapes were committed against children under the age of 12, 32.4 percent against teenagers between the ages of 12 and 17, 29.4 percent against young adults between the ages of 18 and 24, and 16.6 percent against adults over the age of 25 (Tjaden & Thoennes, 2000).

There is also some evidence that rape rates differ according to race/ethnicity. According to the 2005 NCVS, 46 percent of sexual assault victims were Caucasian, 27 percent were black/African American, and 19 percent were Hispanic/Latino (Tjaden & Thoennes, 2000). These rates are in contrast to a general population distribution of 75.1 percent white, 12.3 percent black, and 12.5 percent Hispanic (U.S. Census Bureau, 2000). The NVAWS also examined prevalence differences between ethnic groups and found that American Indian/Alaskan Native women had relatively higher rates of sexual and physical assault, while Asian American women had relatively lower rates (Tjaden & Thoennes, 2000). While this research suggests that racial/ethnic differences may exist, the paucity of research on different racial/ethnic groups makes it difficult to determine whether such differences are accurate or merely reflect differential rates of reporting.

Taken together, this research suggests that the crime of rape continues to victimize a wide range of women and children every year. Such high prevalence rates have prompted researchers to examine the causes of rape in an effort to identify individual, social, and cultural factors that could be changed to prevent rape.

CAUSES OF RAPE

There are several theorized explanations for why rape occurs. Feminist theories tend to focus at the macro level, examining the contribution

of social norms, gender-roles, and structural inequities that promote and enable rape. Personality and social psychological research tends to devote more effort to the micro level, examining individual-level characteristics and conditions under which rape occurs. While this literature is often overlapping and complementary, there are some distinct differences in foci. In this section, we will explore the theoretical causes of rape proposed by each of these theories, providing a critique and synthesis throughout.

Feminist Theory

Feminist theory tends to rely on sociocultural explanations of sexually aggressive behavior. It draws on the larger cultural milieu as an explanation for the behavior of individuals. In its most basic formulation, feminist theory considers rape to be an element of oppression in a male-controlled hierarchical structure (see, for example, Brownmiller, 1975; Griffin, 1979; Russell, 1984; Stanko, 1985). Bringing a critical eye to the structure of society, feminist conceptualizations examine social norms, beliefs, and practices that promote and normalize rape.

Feminist theory begins with the premise that rape is not natural or inevitable in the realm of human sexual behavior. Sanday (1981) conducted a study of a range of societies and concluded that there were cultures that were more and less rape-prone. There were even some cultures that were considered to be rape-free. If it is possible to have cultures without rape, this suggests that cultures have a role in regulating rape, and that sexual practices that support rape are learned, not simply instinctive responses.

Following from this premise, feminist scholars have focused on a number of learned cultural beliefs and practices that enable rape to occur. One such belief is that women should be passive and dependent, while men should be dominant and in control. Men learn elements of the masculine role throughout their lives in the context of social interactions and through social learning (Bandura, 1979; Bandura, Ross & Ross, 1961). The stereotypical masculine gender-role includes the qualities of being forceful, powerful, tough, callous, competitive, and dominant. Males are also discouraged from showing vulnerability. Such gender-roles often simultaneously disempower women while teaching men that the world is theirs for the taking.

These gender-roles then intersect with sexual scripts that dictate a passive sexual role for women and a dominant one for men. Women are taught to attract men; men are taught to pursue women. Such beliefs are often reinforced by peers who share similar beliefs about violence, hostility toward women, and patriarchy (Schwartz & DeKeseredy, 1997). In fact, sexual violence often becomes normalized in groups where women are viewed as objects to be sexually conquered (Koss &

Dinero, 1988; Martin & Hummer, 1989). This may be particularly likely in fraternities and athletic teams that promote hostility and degrading treatment of women (Humphrey & Kahn, 2000).

Several empirical studies have found that members of fraternities tend to have attitudes that are associated with sexual aggression. For example, they are likely to have traditional attitudes toward women, to endorse sexual promiscuity, and to believe in male dominance and in rape myths (Koss & Dinero, 1988; Martin & Hummer, 1989; Sanday, 1981). Fraternities may actively create, or simply not challenge, hostile attitudes within their membership.

In a recent study, Bleecker and Murnen (2005) surveyed men who were and men who were not affiliated with fraternities on a college campus. They also analyzed the images of women displayed in the college dormitory rooms of both groups of men. They found that fraternity men had more images of women displayed, and these images were rated by an independent group of college women as more degrading than the images of women in the rooms of nonfraternity men. Fraternity men were also more likely to endorse rape myths.

Regardless of where such scripts are learned or how they are reinforced, sexual scripts often lead men to a view of sex as a commodity that women withhold at will, leading some men to pursue sex even when a woman says no. This is particularly true when male dominance translates to a sense of male entitlement. If a man believes that sexual access to a woman's body is a right, rape is a justifiable response to a woman who is withholding what is rightfully his (Herman, 1989). Sexual scripts are also related to the belief that sex is a form of exchange between men and women (Herman, 1989). Men expect that they will receive sexual rewards for providing affection and gifts. According to this script, the man who buys dinner for his date feels he has a right to sex, even if it is by force (Goodchilds & Zellman, 1984). Such sexual scripts can easily lead to rape. They can also make it difficult for both men and women to distinguish coerced sex from noncoerced sex because our understanding of sexuality includes male dominance even in ''romantic'' interactions (Gavey, 2005).

This difficulty in identifying rape also results from prevailing rape myths that our society continues to hold about what types of assaults ''qualify'' as rape and who should be held responsible for assaults that occur. Some of these myths have to do with the narrow definition of rape. These myths suggest that rape occurs only between strangers (Ward, 1995). In fact, feminists have suggested that our society holds a script about what constitutes ''real rape'' that includes the image of a stranger conducting a surprise attack at night with a weapon (Estrich, 1987). As a culture, this image of rape is so consistently understood by both men and women that it keeps women from reporting forced sex perpetrated by someone they know since they are not sure it is ''real''

rape. This script also protects men from acknowledging that unwanted sex with an acquaintance is rape. An acquaintance rapist believes that he could not have raped since he is not a stranger to the victim (Gavey, 2005; Herman, 1989).

Other rape myths are based on inaccurate stereotypes or assumptions that allow men and women to avoid the truth that forced sex is actually rape. These myths place the responsibility for fending off assaults on the women. Rape myths dictate that all women can prevent rape by keeping away from dangerous situations. Her action or inaction has led to the rape. Observers might ask, ''Why was she out so late at night?'' or ''Why did she let him into her apartment?'' (Medea & Thompson, 1974; Ward, 1995). Essentially, the myth is that women are responsible for their own rape, since men cannot be expected to control themselves (Donat & White, 2000; Herman, 1989). Rape myths allow men to ignore their coercive behavior, and they demand that women blame themselves for their own victimization.

Burt (1980) found that men and women who believe that there is a naturally adversarial relationship between males and females are more accepting of rape myths. Importantly, males who believe in rape myths are more likely to be sexually coercive and to report that they have committed rape than men who do not believe in rape myths. Lonsway and Fitzgerald (1995) also found that men with more hostility toward women are more likely to accept rape myths.

Our culture also enables rape through the objectification of women. Women are consistently portrayed as sexual objects in the media. Such depictions dehumanize women and promote the idea that they are less intelligent and less powerful in society (MacKinnon, 1987). This is particularly likely in pornography. Many pornographic depictions portray reward or minimal punishment for engaging in sexual aggression. When exposed to these contingencies, men learn that women enjoy rape, that men will find sexual assault pleasurable, and that rape is an appropriate way to sexually relate to women. Exposure to these depictions has been found to lead to more hostile attitudes toward women, more rape myth acceptance, and more behavioral aggression in both experimental and correlational studies (Allen, Emmers, Gebhardt, & Giery, 1995; Allen, D'Alessio, & Brezgel, 1995; Linz, Donnerstein, & Penrod, 1984; Malamuth, Addison, & Koss, 2000).

These cultural supports for rape serve a political function. Ruth (1980) describes rape as ''an act of political terror'' meant to keep women in their place (p. 269). By perpetuating a system in which all men keep all women in a state of fear, rape is a tool that maintains inequality by creating fear of this specific form of assault, which influences women's mobility and freedom in daily life (Gordon & Riger, 1989; Rozee, 2003). As a result of the pernicious effects of rape fear, women seek protection from some men against the risk of abuse by other men.

Personality and Social Psychological Theories

Early theories about the causes of rape focused on psychopathology of individual convicted rapists (e.g., Groth, 1979). The emerging feminist and antirape movements of the 1970s, however, opened our eyes to the extent of rape and the ways in which rape was normalized through social norms and structures. As a result, research on the personality characteristics of rapists moved away from a pathology model and began to focus on ''unidentified'' rapists. Researchers studying this population investigated several logical personality traits. These included: low self-esteem, impulsivity, delinquency, jealousy, aggressive/hostile personality styles, poor communication/social skills, promiscuity, need for power, depression, sociopathy, anger, and hostile attitudes toward women (see White & Koss, 1991).

Several of these variables were combined by Malamuth and his colleagues (Malamuth, Linz, Heavey, Barnes, & Acker, 1995; Malamuth, Sockloskie, Koss, & Tanaka, 1991) to form the Confluence Model of sexual aggression. The model proposes two theoretically distinct paths in the statistical prediction of sexual aggression. The ''impersonal sex'' path is theorized to assess ''a noncommittal, game-playing orientation in sexual relations.'' Men identified by this path are ''willing to engage in sexual relations without closeness or commitment'' (Malmuth, p. 231). The impersonal sex path consists primarily of life experiences, such as experiencing family violence (as a victim or witness), higher levels of sexual experience (measured by the number of sexual partners), and nonconformity or delinquency (variables that measure the tendency to violate social rules).

In this model, the second, ''hostile masculinity'' path is comprised of personality and attitudinal variables. It is designed to measure ''an insecure, defensive, hypersensitive, and hostile distrustful orientation ... toward women, and gratification from controlling or dominating women'' (p. 231). Measured variables have typically included negative masculinity (a tendency to identify with the negative and power-based aspects of the male sex role), hostility toward women (a suspicious, blaming orientation toward women), adversarial sexual beliefs (a belief that the relationship between males and females is of necessity adversarial), and dominance motive (the consideration of dominance as a primary motive for engaging in sexual behavior). Attitude measures have included rape myth acceptance (the belief in various rape myths blaming women) and acceptance of interpersonal violence (the belief that some level of violence is normal in interpersonal relationships).

These paths have been considered to be theoretically independent. The hostile masculinity path is primarily reliant on personality factors or attitudes that are hostile toward women, while the impersonal sex path does not include these attitudes. However, risk analyses have

indicated that the combination of variables from both paths produces the highest risk of sexual aggression (Dean & Malamuth, 1997).

Conceptual support for the hostile masculinity path can be found in Zurbriggen's study (2000) of the cognitive associations between power and sex. In her study, men who demonstrated a strong implicit social motive toward power and who strongly associated power and sex reported a higher frequency of engaging in sexual aggression. This emphasis on power and control is consistent with feminist conceptualizations of the motives for rape. Yost and Zurbriggen (2006) also found that men who were more willing to engage in sexual activity with multiple partners and who endorsed rape myths and negative attitudes toward women were more likely to report sexual aggression. Importantly, men with an orientation toward impersonal sex who did not have coercive attitudes toward women and sexuality were not more likely to be aggressive. Such findings have been replicated in a number of studies in both the United States (e.g., Abbey & McAuslan, 2004; Dean & Malamuth, 1997; Nagayama Hall, Sue, Narang, & Lilly, 2000; Nagayama Hall, Teten, DeGarmo, Sue, & Stephens, 2005; Wheeler, George, & Dahl, 2002) and other countries (Abrams, Viki, Masser, & Bohner, 2003).

Longitudinal studies have also supported this model (Malamuth et al., 1995). Sechrist and White (2003) analyzed the predictive ability of the primarily behavioral impersonal sex path over five data collection waves. Participants completed a survey at the beginning of their college career, reporting on their experience of sexual aggression during adolescence, and again at the end of each academic year. Men's report of experiencing physical abuse as a child, promiscuity, delinquency, and previous sexual aggression perpetration reported at earlier time points predicted sexual aggression at subsequent times.

Other longitudinal studies suggest that subtypes of aggressive men may exist, however. Abbey and McAuslan (2004) measured sexual aggression and Confluence Model variables at two time points, one year apart. They found that men who reported aggression at the first time point but not the second evidenced less hostility toward women than men who were aggressive at both time points. Furthermore, men who were aggressive at only one time point also had a stronger tendency to misperceive women's sexual intentions, were more influenced by situational factors (e.g., alcohol consumption, peer approval of sexual aggression, misperception of women's intentions) and tended to show more remorse than men who were aggressive at both time points. Based on these results, Abby and McAuslan (2004) conclude that some men (26% of the aggressive men in this sample) may utilize sexual aggression as a strategy for sexual access during adolescence, but then desist from using that strategy in future interactions.

Other studies have looked at the variable of empathy as a potential moderator of the effects of the Confluence Model predictor variables.

Dean and Malamuth (1997) measured the construct of Dominance/Nurturance. In that study, male participants were divided on the basis of their responses to the Bem Sex Role Inventory. Men who reported high scores on the Confluence Model variables were analyzed for sexual assault risk. The results indicated that men who were relatively less nurturant were substantially more likely to report that they had engaged in sexual aggression than men who were more nurturant. Similarly, Wheeler, George, and Dahl (2002) used the Interpersonal Reactivity Index (Davis, 1980) as a more direct measure of empathy. They found that including empathy with other Confluence Model variables improved the amount of variability accounted for in sexual coercion. The men at highest risk for aggression were low in empathy, but had high scores on the hostile masculinity and impersonal sex variables. Martin, Vergeles, de la Orden Acevedo, del Campo Sanchez, and Visa (2005) found that, for men who were low in empathy, the need for control and dominance in relationships with women, along with a tendency toward impersonal sex, best predicted sexual aggression.

Other researchers have focused on aspects of the social environment as predictors of aggression. Among college students, most sexual assaults occur in the context of dates or parties (Abbey, McAuslan, & Ross, 1998; Koss et al., 1987). The actual assault was found to be most likely to occur at the home of either the woman or the man, where the perpetrator may sense that he has control of the isolated environment (Abbey, McAuslan, Zawacki, Clinton, & Buck, 2001). Abbey and her colleagues (Abbey & McAuslan, 2004; Abbey et al., 1998; Abbey et al., 2001; Abbey, Zawacki, Buck, Clinton, & McAuslan, 2004; Muehlenhard & Linton, 1987) have found that alcohol use by the perpetrator or the victim occurred in about one-third to one-half of sexual assaults reported by this population. Although alcohol use may lead to a general disinhibition, the cognitive impairments associated with alcohol intoxication are believed to influence both perpetrator judgment and victim resistance (Abbey et al., 2004; Norris, Nurius, & Dimeff, 1996). Finally, sexual assault appears to be more likely when a woman does not want consensual sexual contact to escalate to sexual intercourse (Abbey et el., 2001).

Although much of the research described here has studied men who report that they have been sexually aggressive, an important line of research has examined men who indicate that they have never raped but that they have a proclivity or interest in being sexually aggressive. Men who report this pattern, termed ''attraction to sexual aggression'' (Malamuth, 1989), indicate that they would be interested in rape or ''forcing a female to do something sexual she didn't want to'' if they did not fear punishment. A surprisingly large percent of male participants, approximately 35 percent, indicate some likelihood of engaging in these behaviors (Malamuth, 1981).

The majority of the empirical psychological research conducted on explanations of rape has focused on identifying the personality characteristics and the environmental or situational concomitants of sexual aggression. However, evolutionary psychologists have also explored rape as a sex-differentiated strategy used in mating. Although this theory is frequently criticized by feminist theorists, understanding the theory and critiques of it are essential for anyone seeking a comprehensive understanding of research on rape.

Evolutionary Theory

Evolutionary theorists have described rape as an evolutionarily adaptive approach for mating (see, for example, Buss, 1994; Shields & Shields, 1983; Symons, 1979; Thornhill & Palmer, 2000; Thornhill & Thornhill, 1983). The premise of the theory is that women and men have evolved gender-differentiated adaptations in response to different biological structures and constraints in reproduction. For females, the most adaptive approach to mating is to have fewer, high-quality partners who can provide resources to assist in the care of offspring. In pursuing access to females, males can potentially utilize several strategies, including honest courtship, deceptive courtship, and forced sex. Forced sex is only employed when the conditions are beneficial to men—that is, when they cannot achieve sexual access using other strategies (perhaps because of low status or poor genetic quality) or when they perceive the potential risks (e.g., likelihood of punishment) to be low relative to the potential benefit of successful mating.

Because the evidence needed to support these theories about the evolutionary origin and primary motivation and purpose of rape is not readily accessible to researchers, theorists in this area have developed research predictions concerning specific aspects of sexual aggression. For example, Thornhill and Thornhill (1983) suggested that men with low status (and presumably less access to resources considered desirable by women) would be more likely to rape than men of high status.

Vaughan (2001, 2003) tested this prediction utilizing data from the British Prison Service, Law Reports, and Probation Probation Service about reported rapes. She found that there were fewer high-status than low-status offenders. In further analysis of the types of rape committed, she found that low-status men were more likely to rape strangers than high-status men, and that high-status men were more likely to rape partners and step-relatives than low-status men. However, as Vaughn points out, high-status men may be more likely to avoid prosecution and conviction than low-status men. In addition, the operational definition of status used in the study was occupation. This may be an oversimplified approach to categorizing resources and may be quite unrelated to the meaning of status in the early evolutionary

environment in which these adaptations are theorized to have formed (Gard & Bradley, 2000).

As this example illustrates, empirical evidence for many of the predictions stemming from evolutionary theory does not provide unequivocal support for the stated hypotheses. In addition, evolutionary theory concerning rape has been criticized on the basis of several substantive issues (see Travis, 2003). First, evolutionary theorists utilize a narrow definition of rape and have excluded from the analysis, or ignored, examples or circumstances of rape that are not easily explained by the theory (e.g., homosexual rape, rape that is not for reproductive purposes, rape in the context of war) (Gard & Bradley, 2000; Poulin, 2005; Tobach & Reed, 2003). Second, a standard methodology in evolutionary theory has been to use a comparative approach, in which nonhuman animal behavior is offered as an analogue to human behavior. However, evolutionary psychology has been criticized for its failure to use this approach in a scientifically rigorous manner. For example, when Thornhill and Palmer (2000) advanced their comparative argument, they ignored low rates of rape among the closest nonhuman relatives (i.e., chimpanzees and bonobos) in favor of examples of scorpion flies (Lloyd, 2003). Finally, the insistence by some evolutionary theorists that rape is always and only focused on sexual access to females, to the exclusion of other potential motivations, oversimplifies this complex behavior in pursuit of a single explanatory factor. This pursuit damages efforts to integrate aspects of evolutionary theory with existing psychological research concerning psychopathology, personality, and social explanations (Koss, 2003; Ward & Siegert, 2002).

THE IMPACT OF SEXUAL ASSAULT ON MENTAL AND PHYSICAL HEALTH

While much of the energy of the antirape movement has been focused on identifying and transforming cultural supports for rape, concern for victimized women has always been a priority as well. Since the beginning of the movement, activists and researchers alike have sought to document the profound impact that rape can have on women's lives. The ways in which rape survivors process their assaults depend on many factors, including cognitive evaluations of the assault, physiological reactions, past victimizations, and social support. A great deal of research has documented the short-term and long-term effects of rape trauma, as well as the extensive symptoms that may be experienced. Given the nature of rape, the mental and physiological impact can be severe. Mental health conditions associated with rape include depression, posttraumatic stress disorder, generalized anxiety disorder, panic disorder, obsessive-compulsive disorder, social phobia, agoraphobia, somatization disorder, alcohol/substance abuse, and bulimia

(Boudreaux, Kilpatrick, Resnick, Best, & Saunders, 1998; Dickinson, deGruy, Dickinson, & Candib, 1999; Ullman & Brecklin, 2002b). All of these conditions, as well as physical symptoms, can have a profound influence on how survivors are able to recover from the trauma.

Posttraumatic Stress

Sexual or physical assaults are the strongest predictors of posttraumatic stress disorder (PTSD)—more than other traumatic events such as natural disaster, serious accidents or injuries, witnessing homicide, or tragic death of a close friend or family member (Resnick et al., 1993). PTSD is one of the most common effects of rape. It is characterized by reexperiencing symptoms (such as distress caused by recurrent thoughts or dreams of the rape), avoidance symptoms (such as efforts to avoid anything associated with the rape or emotional numbing), and arousal symptoms (such as hypervigilance, sleeping problems, or irritability).

Researchers have assessed the intensity and longevity of PTSD symptoms on rape survivors and have found that, although symptoms are most severe immediately after the rape, many women still have PTSD symptoms even many years postassault. As many as 78 percent of survivors have met the criteria for PTSD from two weeks up to a year after the assault (Frazier, Conlon, & Glaser, 2001). Even several years later, more than a third of survivors still met the criteria for PTSD (Ullman & Brecklin, 2002a, 2002b, 2003) and report an average of five current PTSD symptoms; reexperiencing the rape was the most commonly reported symptom (Frazier, Steward, & Mortensen, 2004).

Sleep problems are a frequent symptom reported by rape survivors. Poor sleep quality has been linked to PTSD symptom severity and has a profound impact on daytime dysfunction and fatigue (Krakow et al., 2001). Nightmare frequency has been linked to anxiety and depression for survivors with PTSD (Krakow et al., 2002). Other stressors appear to exacerbate PTSD symptoms in rape survivors. PTSD symptoms are elevated among rape survivors who get pregnant, have an abortion, or test positive for HIV. PTSD is also related to suicidal ideation, engaging in self-hurting behaviors, and engaging in dangerous sexual behaviors (Green, Krupnick, Stockton, & Goodman, 2005). Survivors with PTSD also appear to have higher rates of drinking problems, related in part to higher tension reduction expectancies and thinking that drinking could help them cope (Ullman, Filipas, Townsend, & Starzynski, 2006).

The mental processes survivors experience in order to understand their rape can have a substantial impact on how they cope. Some cognitions increase PTSD symptom severity, including cognitive processing style during the assault, appraisal of assault-related symptoms, negative beliefs about the self and the world, and maladaptive control strategies (Dunmore, Clark, & Ehlers, 2001). Reexperiencing rape also affects PTSD

severity. Women who have more than one traumatic life event, including rape, have higher rates of PTSD (Ullman & Brecklin, 2002b).

Self-Blame

Studies on rape survivors' self-blame have been growing in number. Survivors often use some form of external or internal blame to understand what they have been through. Survivors can attribute the rape to external factors, including rapist blame and social blame, or to internal factors, including perceived controllable aspects of the survivor's behavior and uncontrollable aspects of her character.

While early research suggested that behavioral self-blame might help survivors feel more in control of future rapes (Janoff-Bulman, 1989), most subsequent research has suggested that both behavioral and characterological self-blame are detrimental to survivors' health (Frazier, 1990, 2003). The discrepancy appears to lie with the notion of future control. While Janoff-Bullman (1989) assumed that blaming your own behavior would help rape survivors feel in control of future assaults, Frazier and colleagues (2004) have demonstrated that blame and control are actually separate constructs. According to Frazier et al. (2004), many survivors perceive future assaults as preventable or controllable, even if they were not able to control their past assault.

This distinction is important, because it suggests that all forms of self-blame should be avoided. Interestingly, recent research also suggests that other forms of blame such as blaming the rapist or blaming society may also be related to higher levels of emotional distress (Frazier, 2003; Koss & Figueredo, 2004a). This may be because higher levels of blame are reflective of rumination and the lack of cognitive resolution.

Fear and Anxiety

Rape survivors have significantly higher reports of anxiety within a year of the rape (Frazier, 2003) and several years postassault (Frazier, Steward, & Mortensen, 2004). Perceived life threat is a significant predictor of the severity of panic responses after an assault (Nixon, Resick, & Griffin, 2004). Survivors are three times more likely than nonvictims to have a generalized anxiety disorder or a panic disorder (Dickinson et al., 1999) and report higher levels of fear (Harris & Valentiner, 2002) and health anxiety than nonvictims (Stein, Lang, & Laffaye, 2004). Survivors who feel like they have more control over their recovery process have fewer anxiety symptoms (Frazier, Steward, & Mortensen, 2004).

Depression

The impact of rape on depression can be temporary or long-term. Rape survivors report higher immediate depression symptoms, and

still report higher levels up to a year after the rape (Frazier, 2003). Rape survivors also have significantly elevated rates of suicidal ideation during the first year (Stephenson, Pena-Shaff, & Quirk, 2006). Even many years postassault, survivors report higher long-term rates of depression, including lifetime major depression and dysthymia, when compared to nonvictimized women (Dickinson et al., 1999; Frazier, Steward, & Mortensen, 2004; Harris & Valentiner, 2002; Kaukinen & DeMaris, 2005; Ullman and Brecklin, 2002a, 2003). Rape survivors also report higher levels of suicidal ideation and of attempted suicide at some point in their life, with a significantly increased risk for lifetime suicide attempts among women who experienced both childhood and adulthood sexual assault (Ullman & Brecklin, 2002a).

Social Adjustment

Many aspects of survivors' lives can be impacted by rape, including family, friends, and work. Work adjustment was impaired up to eight months postassault (Letourneau, Resnick, Kilpatrick, Dean, & Saunders, 1996). The literature is limited in findings about other aspects of survivors' lives. As far as positive life changes, survivors report having increased empathy, better relationships with family, and greater appreciation of life as soon as two weeks after the assault (Frazier et al., 2001).

Several years afterward, rape survivors report that they have a fairly high level of support and a moderate level of social conflict, perceived stress, and conflict in interpersonal relationships (Ullman & Brecklin, 2002b), and social functioning only slightly below that of nonvictims (Dickinson et al., 1999). Survivors who perceived having more control over their recovery process had better psychological adjustment and greater life satisfaction (Frazier, Steward, & Mortensen, 2004). Survivors of acquaintance rape perceived a larger risk in intimacy when compared to nonvictims (McEwan, de Man, & Simpson-Housley, 2002, 2005).

Sexual Functioning

The literature shows that the impact of rape on sexual functioning can be extensive, but the quantity of research in the area is limited. Survivors report many problems with sexual functioning, primarily related to sexual avoidance or sexual dysfunction, and as many as 90 percent of survivors report a sexual disorder within the first year of rape (Faravelli, Giugni, Salvatori, & Ricca, 2004). The absence of sexual desire is the most reported symptom experienced by survivors, followed by sexual aversion (Faravelli et al., 2004).

Rape survivors several years postassault had significantly higher scores for sexual anxiety and avoidance than nonvictims did (Harris & Valentiner, 2002). Almost half of survivors eight years after the assault

had low sexual health risk, which included sexual avoidance, sexual abstinence, fewer sexual partners, increased condom usage, and decreased alcohol and/or drug usage during sex (Campbell, Sefl, & Ahrens, 2004). In contrast, one-third of survivors showed patterns of high sexual health risk, including increased sexual activity frequency, reduced condom usage, and increased alcohol and/or drug usage during sex (Campbell et al., 2004). College rape survivors report higher rates of sexual dysfunction and dangerous sexual behaviors than others in their cohort, including irresponsible sexual behaviors, potentially self-harmful behaviors, or inappropriate usage of sex to accomplish nonsexual goals (Green et al., 2005).

PHYSICAL HEALTH

Rape survivors have an increased rate of health problems throughout their lifetime. Survivors report higher levels of somatization and health anxiety (Stein et al., 2004); more health complaints and higher-intensity complaints (Conoscenti & McNally, 2006); more frequent visits to health care professionals (Stein et al., 2004; Conoscenti & McNally, 2006); and multiple sick days (Stein et al., 2004). Forty-three percent of women who were assaulted in childhood and adulthood had lifetime contact with health professionals for mental health or substance abuse problems (Ullman & Brecklin, 2003). Survivors also report more incidence of headaches, chest pains, overwhelming fatigue (Stein et al., 2004), chronic medical conditions (Ullman & Brecklin, 2003), pelvic pain, painful intercourse, rectal bleeding, vaginal bleeding or discharge, bladder infection, painful urination (Campbell, Lichty, Sturza, & Raja, 2006), pregnancy, abortion, HIV testing, and STD infection (Green et al., 2005).

With higher frequency of mental and physical health problems, rape survivors have a higher prevalence of taking prescription drugs and alcohol. Rape survivors use antidepressants, alcohol, sedatives/tranquilizers, and other prescription drugs more than nonvictimized women (Sturza & Campbell, 2005). Survivors with mental health disorders such as PTSD or depression are as much as 10 times more likely than nonvictims to use prescription drugs (Sturza & Campbell, 2005).

Despite such high levels of physical health problems, less than a third of rape survivors have a medical examination or receive medical care postassault (Monroe, Kinney, Weist, Dafeamekpor, Dantzler, & Reynolds, 2005; Resnick et al., 2000). Major injuries during rape are uncommon, with less than half of survivors sustaining injuries; minor physical injuries, involving cuts, bruises, or soreness, are more common than serious injuries (Resnick et al., 2000; Ullman et al., 2006). When survivors do seek medical care, a little more than half inform

their health care providers about the rape (Resnick et al., 2000). Fear of having contracted an STD or HIV/AIDS is a major motivator to receive medical care postassault (Resnick et al., 2000). Most survivors report having some degree of fear or concern about contracting HIV from the rape (Resnick et al., 2002). Less than half of postassault medical exams included testing for gonorrhea, chlamydia, HIV, syphilis, and hepatitis (Monroe et al., 2005).

While it is clear that rape can have profoundly negative psychological and physical health consequences for survivors, the recovery process allows many survivors to identify personal or relational strengths they had not previously recognized. Although a variety of terms are used to describe this aspect of recovery (e.g., *personal growth*, *positive change*, *stress-related growth*), the most common term is *posttraumatic growth* (Tedeschi & Calhoun, 1996). Posttraumatic growth is said to occur when victims of traumatic events reassess their lives and adopt new perspectives in a number of domains, including perceiving new possibilities, relating better to others, perceiving new personal strengths, experiencing spiritual change, and experiencing a greater appreciation of life (Tedeschi & Calhoun, 1996). While posttraumatic growth can be seen as a positive outcome in its own right, it has also been linked to higher overall levels of psychological adjustment and lower levels of distress and depression (Frazier et al., 2001).

It is therefore heartening that rates of positive growth are so high. Across studies, between 50 and 60 percent of individuals who have experienced a traumatic event subsequently experience some form of positive change (Tedeschi & Calhoun, 1996). Women may be particularly likely to experience positive growth after a traumatizing situation (Park, Cohen, & Murch, 1996; Tedeschi & Calhoun, 1996) and African American women may be more likely to experience positive changes than Caucasian women (Kennedy, Davis, & Taylor, 1998). Among rape victims in particular, Frazier and colleagues (Frazier, Steward, & Mortensen, 2004) examined a number of immediate and long-term predictors of posttraumatic growth. Social support, approach coping, religious coping, and control over the recovery process were all significant predictors of posttraumatic growth two weeks post assault. Furthermore, increases in each of these variables were associated with increases in posttraumatic growth over time.

COPING WITH RAPE

The methods survivors use to cope with the rape have a substantial impact on the course of their recovery. Whereas some survivors avoid thinking about the rape and may even resort to maladaptive coping strategies such as using alcohol or drugs, others deal with their feelings directly by talking to other people and seeking help.

Avoidance Coping

Avoidance coping involves efforts to suppress or avoid thinking about the stressor or one's emotional reaction to the stressor (Roth & Cohen, 1986). In the case of rape, survivors may engage in a number of avoidance strategies such as keeping busy, isolating themselves, and suppressing thoughts about the assault (Burt & Katz, 1987; Meyer & Taylor, 1986). There is also a growing body of literature that suggests that many survivors may use drugs or alcohol to help them suppress thoughts and feelings associated with the assault (Sturza & Campbell, 2005; Miranda, Meyerson, Long, Marx, & Simpson, 2002). Survivors may also actively avoid people, places, and activities that remind them of the rape (Feuer, Nishith, & Resick, 2005). While many survivors may use avoidance coping strategies periodically, survivors with high levels of self-blame and survivors who received negative social reactions tend to use avoidance coping more frequently (Littleton & Breitkopf, 2006; Ullman, 1996**a**).

These efforts to avoid thinking about the rape may initially help survivors cope with overwhelming emotions (Cohen & Roth, 1987), but using avoidance coping as a long-term strategy has been shown to be detrimental to survivors' recovery (Arata, 1999; Frazier & Burnett, 1994; Frazier, Mortensen, & Steward, 2005; Neville, Heppner, Oh, Spanierman, & Clark, 2004; Valentiner, Foa, Riggs, & Gershuny, 1996). This is particularly true when survivors engage in cognitive avoidance that prohibits them from integrating or making meaning of the assault (Boeschen, Koss, Figueredo, & Coan, 2001; Foa & Riggs, 1995).

Approach Coping

On the opposite end of the spectrum, *approach coping* involves dealing directly with a stressor or with one's emotional reaction to the stressor (Roth & Cohen, 1986). In the case of rape, the assault itself cannot be changed, so approach coping involves dealing directly with emotional responses to the rape and the recovery process itself. Examples of approach coping include strategies such as help-seeking, cognitive reappraisal, and letting one's emotions out (Burt & Katz, 1987; Meyer & Taylor, 1986). These strategies are consistently found to be beneficial to survivors' recovery (Arata, 1999; Arata & Burkhart, 1998; Frazier & Burnett, 1994; Valentiner et al., 1996), particularly when they help survivors feel in control of the recovery process (Frazier et al., 2005).

HELPING SURVIVORS

While rape survivors' own coping strategies may help mitigate harmful outcomes and promote posttraumatic growth, there is a substantial amount that the larger community can do to assist rape

survivors as well. Both formal support providers (such as legal, medical, and mental health personnel) as well as informal support providers (such as friends, family, and romantic partners) play important roles in helping survivors heal. Unfortunately, these same sources of support may also inadvertently harm survivors who turn to them for help. A growing body of research suggests that survivors receive high levels of both positive and negative social reactions when they turn to others for help (Campbell, Ahrens, Sefl, Wasco, & Barnes, 2001; Filipas & Ullman, 2001; Golding, Siegel, Sorenson, & Burnam, 1989; Ullman, 1996a). Positive social reactions include efforts such as listening, comforting, emotionally supporting survivors, and providing tangible assistance. Negative social reactions include actions such as disbelieving the survivors, holding survivors accountable, pulling away from survivors, and trying to control survivors' behaviors (Davis, Brickman, & Baker, 1991; Golding et al., 1989; Herbert & Dunkel-Schetter, 1992; Sudderth, 1998; Ullman, 2000). Overall, survivors receive more types of positive social reactions, but they receive negative social reactions more frequently (Filipas & Ullman, 2001)

As a result, many rape survivors are extremely cautious when selecting support providers to whom to disclose. While more than two-thirds of rape survivors disclose the assault to at least one person (Ahrens, Campbell, Ternier-Thames, Wasco, & Sefl, 2007; Fisher, Daigle, Cullen, & Turner, 2003; Golding et al., 1989; Ullman & Filipas, 2001a), survivors tell an average of only three different people (Ahrens, Cabral, & Abeling, under review; Filipas & Ullman, 2001). Most often, these disclosures are to informal support providers such as friends and family rather than to formal support providers such as the police or medical personnel (Campbell, Ahrens, et al., under review; 2001; Filipas & Ullman, 2001; Fisher et al., 2003; Golding et al., 1989; Ullman, 1996a). Overall, informal support providers engage in more positive social reactions and fewer negative social reactions than formal support providers (Ahrens et al., 2007; Filipas & Ullman, 2001; Golding et al., 1989), but specific relationship contexts and organizational demands affect the nature of support received. These contexts are described in greater detail below.

Friends, Family, and Romantic Partners

Research on disclosure and social reactions has consistently shown that friends are the most common disclosure recipient, are rated as more helpful than other sources of support, and appear to have a greater impact on survivors' recovery than any other support provider (Ahrens et al., 2007, under review; Davis et al., 1991; Filipas & Ullman, 2001; Littleton & Breitkopf, 2006; Ullman, 1996a, 1999). On the other hand, research on the support provided by family members and romantic

partners is mixed. While many family members and romantic partners react well, both family members and romantic partners have also been found to react in extremely egocentric ways, focusing more on their own anger and frustration than on survivors' needs (Ahrens & Campbell, 2000; Emm & McKenry, 1988; Filipas & Ullman, 2001; Littleton & Breitkopf, 2006; Smith, 2005). Family members and romantic partners also appear to have a greater tendency to be overprotective and react by trying to control the survivors' decisions and behavior (Davis, Taylor, & Bench, 1995; Remer & Elliott, 1988). Some family members and partners also appear to be ashamed of what happened to the survivor, resulting in relationship problems and efforts to silence the victims so other people do not find out (Ahrens, 2006; Riggs & Kilpatrick, 1997).

Not surprisingly, such negative reactions from romantic partners have been associated with worse recovery outcomes than negative reactions from other sources (Davis et al., 1991; Filipas & Ullman, 2001; Ullman, 1996a), perhaps because of the betrayal of trust and intimacy that is involved in negative reactions from loved ones. In fact, negative social reactions received at the time of rape disclosure and low social support are related to greater PTSD symptom severity (Ullman & Filipas, 2001a). But nondisclosure appears to have its costs as well. Survivors who did not disclose their assault were found to have less satisfaction in their friendships than survivors who disclosed (Littleton & Breitkopf, 2006).

Legal System

Between 10 and 40 percent of rape survivors report the assault to the police (Campbell, Wasco, Ahrens, Sefl, & Barnes, 2001; Filipas & Ullman, 2001; Fisher et al., 2003; Golding et al., 1989; Ullman, 1996a), and very few of the cases that are reported ever result in jail time (Frazier & Haney, 1996; Phillips & Brown, 1998). One study of 861 reported rapes found that only 12 percent resulted in convictions and only 7 percent in a prison sentence for the convicted rapist (Frazier & Haney, 1996).

Such low rates of sentencing are the result of attrition at each stage of the legal process (Frazier & Haney, 1996; Lee, Lanvers, & Shaw, 2003). For example, both the patrol officers who respond to the crime and the detectives who investigate it have been known to question victims' credibility (Campbell & Johnson, 1997; Jordan, 2004) and have even been known to subject survivors to polygraph tests (Sloan, 1995) despite the fact that false claims of rape are no higher than for any other felony. These doubts affect the amount of time and effort that police put into investigating and building a case (Campbell & Johnson, 1997; Jordan, 2004), which may, in turn, affect the likelihood that a case will be accepted for prosecution. Both the amount of corroborating evidence (e.g., injuries, witnesses) and the extent to which the case

matches stereotypical assumptions about rape affect whether a case will be accepted for prosecution. Only those cases that prosecutors feel they can win are ever brought to trial. This is because district attorneys are promoted based on their win–loss ratios. If prosecutors are not confident that a jury will find the defendant guilty, they tend to not prosecute cases, even if the cases meet all of the legal requirements of a crime (Frohmann, 1991, 1997, 1998; Martin & Powell, 1994).

Prosecutors are particularly concerned about how a jury will perceive a case because it is the defendant who gets to choose between a jury trial or a bench trial. Not surprisingly, most rapists choose jury trials, because defense attorneys know they can rely on the faulty beliefs held by most jurors (Bryden & Lengnick, 1997; Tetreault, 1989). This is an effective strategy for defense attorneys, since criminal trials require that the prosecutor prove ''beyond a reasonable doubt'' that the sexual act did occur, that the rapist was the one involved in the act, and that the sexual act was unwanted. Advances in forensic evidence collection techniques and DNA technology have made it harder to call the first two points into question, but defense attorneys are still able to cast doubt on issues of consent. Despite the development of rape shield laws, rape victims' past sexual history, manner of dress, risky behavior, and behavior both during and after the assault continue to be questioned during trials. Every effort is made to discredit the victim and hold her responsible for the assault (Frohmann, 1991, 1997, 1998). It is therefore not surprising that many rape survivors refer to the court process as a ''second assault'' (Campbell et al., 1999; Madigan & Gamble, 1991; Martin & Powell, 1994). This trauma is then exacerbated when defendants are found not guilty or receive only minimal sentences involving probation and community service only, an occurrence that is all too common (Frazier & Haney, 1996).

As a result of these problems with the criminal justice system, there has been a push toward considering alternative responses to rape. Two alternative approaches have received the most attention: civil remedies and restorative justice programs. Advocates of the civil court approach argue that the lower standard of proof in civil trials (''preponderance of evidence'' rather than ''beyond a reasonable doubt'') would make it easier to hold assailants responsible for their actions (Des Rosiers, Feldthusen, & Hankivsky, 1998). While civil trials do not result in criminal sentencing, victims could receive monetary compensation and the knowledge that a court of law found the assailant to be responsible for causing the victim undue harm. Advocates of this approach argue that civil trials could be more empowering for survivors than the current system (Des Rosiers et al., 1998).

Proponents of restorative justice approaches are also concerned about the empowerment of survivors. While there are many different types of restorative justice programs, the most widely touted

approaches for cases of sexual assault include peacemaking and community conferencing. Emanating from indigenous practices of the Navajo and Maori peoples, these approaches bring together the survivor, the assailant, their friends and family, and other community members with expertise relevant to the process (Coker, 1999; Braithwaite & Daly, 1998). The goal of this meeting is to discuss the impact of the incident on both parties, come up with a solution to repair the damage, and ensure that further harm does not ensue (Koss, Bachar, Hopkins, & Carlson, 2004). Proponents of this approach suggest that it is beneficial for several reasons. First, this approach may be empowering for survivors because it gives them decision-making authority about acceptable solutions, allows a survivor's emotional pain to be acknowledged rather than refuted, and includes the whole community in providing support to the survivor (Koss, 2000). This approach may also be effective in creating change in the assailants' behavior by engaging the assailant's family and entire community in shaming the assailant and monitoring future behavior (Braithwaite & Daly, 1998; Koss, 2000). While the effectiveness of these approaches may hinge on the nature of the families and communities involved, these approaches have been rated quite highly by survivors and have been found to result in lower rates of recidivism (Koss, 2000; McCold & Wachtel, 2002).

Medical System

Less than half of all rape survivors disclose the assault to medical personnel (Ahrens et al., under review; Filipas & Ullman, 2001; Fisher et al., 2003; Golding et al., 1989; Ullman, 1996). Survivors who do turn to medical personnel are typically seeking sexual health-related services such as STD screening and treatment, pregnancy tests and prevention, and treatment for external and internal injuries (Osterman, Barbiaz, & Johnson, 2001; Resnick et al., 2000). Survivors who disclose the rape are also required to be given a forensic medical exam to collect evidence for prosecution. Forensic evidence collection procedures typically include the confiscation of survivors' clothes, a gynecological exam, documentation of external and internal injuries, swabs of affected orifices, and collection of specimens from survivors' hair, nails, and pubic area (Ledray, 1995). According to the Violence against Women Act of 1994, these forensic examinations should be free of charge, but in one study, only a small percentage of women were aware of this, and more than half were charged for their postassault medical exam or related medical services (Monroe et al., 2005).

While most survivors who turn to the medical system are expecting support and assistance, many survivors report feeling retraumatized by their interaction with medical personnel. In some cases, survivors appear to be retraumatized by the invasive nature of the forensic

medical exam (Ahrens, 2006; Campbell, 2006; Domar, 1986), and in other cases by the cold or hostile way some medical personnel respond to them (Ahrens et al., 2007; Campbell, Sefl, Barnes, Ahrens, Wasco, & Zaragoza-Diesfeld, 1999). According to one study, many women express being disappointed, surprised, or troubled with the way in which their doctors reacted to their assault disclosure, often feeling like their doctors were uncomfortable with the disclosure and wanted to write a prescription and dismiss them as fast as possible (Sturza & Campbell, 2005). In still other cases, survivors feel retraumatized by the denial of needed medical services such as testing and treatment for STDs and pregnancy (Campbell & Bybee, 1997).

This insensitivity to rape survivors' needs is partially a result of organizational characteristics of medical settings, particularly emergency rooms. Emergency rooms are set up to handle emergent, life-threatening cases in a quick and efficient manner; they are not structured to provide counseling and support to traumatized rape survivors. This disconnect between the organizational demands of the setting and rape survivors' needs may result in inadequate care and secondary victimization, particularly when medical personnel do not consider taking time to support rape victims and conduct forensic exams to be part of their job (Martin & Powell, 1994).

As a result of drawbacks associated with traditional medical settings, rape crisis centers and hospitals across the country are increasingly teaming up to create specialized sexual assault units. Known as Sexual Assault Nurse Examiner (SANE) programs or Sexual Assault Response Teams (SART), these units provide coordinated medical services in safe, quiet settings staffed by specially trained personnel in a manner consistent with rape survivors' needs (Ahrens, Campbell, Wasco, Aponte, Grubstein, & Davidson, 2000; Campbell, Townsend, et al., 2006; Ledray, 1995). It is not surprising that such programs increase the number of services and decrease the amount of distress experienced by survivors who seek medical attention in these settings (Campbell, Patterson, & Litchy, 2005; Campbell et al., 2006).

Mental Health System

Rates of disclosure to rape crisis centers and counselors vary dramatically from study to study. While some studies have found rates of disclosure as high as 52 percent, others have found rates as low as 1 percent (Filipas & Ullman, 2001; Fisher et al., 2003; Golding et al., 1989; Ullman, 1996). There is also some discrepancy in the types of reactions that counselors and advocates have been found to engage in. While counselors and rape crisis advocates have been found to be among the most helpful support providers to whom survivors disclose (Ahrens et al., under review; Ullman, 1996), there is evidence that some

counselors engage in negative social reactions toward survivors (Campbell & Raja, 1999). Such differences in survivors' experiences may hinge on the extent to which counselors have been trained in rape and on organizational philosophies about the causes and resolutions of rape, both of which may still vary considerably from counselor to counselor and agency to agency.

This variation likely emanates from the fact that the rape crisis movement is still relatively young. Emerging out of grassroots efforts to ensure equal rights for women, the first rape crisis centers emerged in the 1970s and focused primarily on social change. Although early centers also focused on the needs of current victims by providing peer support and advocacy, their guiding philosophy was embedded in notions of patriarchy, power inequities, and violence as a form of social control (Campbell & Martin, 2001; Matthews, 1994). Peer support and advocacy were therefore focused on helping victims locate their personal experiences in a larger political context and empowering women not only to overcome their own rape but also to work for changes in the larger society as well (Campbell, Baker, & Mazurek, 1998).

As funding sources increased, however, there was a push for rape crisis centers to become more institutionalized. Funding agencies began to require a more hierarchical organization, including boards of directors, executive directors, and licensed counselors (Matthews, 1994). Funding agencies also began to redirect the centers' efforts away from larger social change and toward the provision of direct counseling services. As a result, many rape crisis centers have lost their activist agenda, and some have even merged with larger agencies focused on helping crime victims more generally (Campbell et al., 1998; O'Sullivan & Carlton, 2001). Sadly, agencies that lack a specific focus on sexual assault tend to downplay the importance of social factors, focusing instead on rape victims' coping strategies and relationship patterns. Such agencies are also less likely to engage in wider community collaboration, community education, or in-service training efforts with other agencies who work with rape victims (Campbell & Ahrens, 1998; Campbell et al., 1998; O'Sullivan & Carlton, 2001).

As a result, many counselors focus almost exclusively on individualistic solutions rather than societal solutions. This tendency is exacerbated by a relative lack of training on women's issues in many graduate clinical or counseling psychology programs. Although most graduate programs address rape at some point, rape and other women's issues are not always incorporated into core courses, and programs do not always offer courses specifically about these topics (Campbell, Raja, & Grining, 1999; Mintz, Rideout, & Bartels, 1994). Counseling interns have also been found to endorse high levels of rape myths (Kassing & Prieto, 2003; McKay, 2002) and a number of misconceptions about rape in culturally diverse communities (Neville & Heppner, 2002).

PREVENTION AND RESISTANCE

Rape Prevention

Since the 1970s, rape prevention programs have been integral to empowering women and providing a safe place to discuss and address victimization experiences. Rape crisis centers, universities, and various community organizations have developed myriad rape prevention and education programs offered in multiple settings in the community.

Typically, rape *prevention* programs focus on changing the attitudes/behaviors of potential rapists, while rape *avoidance* programs focus on teaching potential victims to avoid rape. However, this distinction is not always made in the literature, leading to some confusion in interpreting this body of research. The most problematic issue is the focus of most programs on changing women's behavior and attitudes, while far fewer programs have systematically examined men's behavior. One multivariate study found that women's precautionary behavior had no preventive effects on the occurrence of subsequent crimes (Norris & Kaniasty, 1992). Yet Cahill (2001) notes that most women continue to take these precautions because they believe that the risk of rape can be significantly reduced, or even eliminated, simply by changing their own behavior. Such precautions by women must be viewed as somewhat tangential, since gender is the primary predictor of being a rape victim, and rape prevention can only be accomplished by changing men's behavior (Rozee & Koss, 2001).

Since most rape prevention programs lack published empirical studies of their effectiveness, there is very little information about how many programs exist, how they are designed and conducted, or their theoretical viewpoints (Anderson & Whiston, 2005). Researchers have found that very few programs include any kind of theoretical grounding or evaluative component (Bachar & Koss, 2001; Schewe & O'Donohue, 1993).

Most studies assessing the effectiveness of rape prevention education programs have found support for short-term change in rape-supportive attitudes, but there is little support for any impact past the immediate attitude change (Anderson & Whiston, 2005). A recent review found that most programs were aimed at mixed-sex audiences, with content related to challenging rape myths, decreasing rape-supportive attitudes, and increasing knowledge about rape (Bachar & Koss, 2000). Evaluations show small but favorable attitude change that tends to decay or regress to pretest levels in a relatively short period of time (Anderson & Whiston, 2005; Bachar & Koss, 2001). Lonsway (1996) conducted a comprehensive review of all published rape education programs targeting women and men. Nearly all programs focused on attitude change, but only half actually decreased rape-supportive attitudes. Even among these, the change did not remain in long-term follow-up.

Recent studies of programs that assessed rape reduction as an outcome measure found disheartening results. Most researchers in this area have concluded that there is no evidence for the effectiveness of current rape prevention programs on reducing the incidence of sexual victimization, rape, or attempted rape (Anderson & Whiston, 2005; Bachar & Koss, 2001; Breitenbecher & Gidycz, 1998; Breitenbecher & Scarce, 1999; Campbell & Wasco, 2005; Sochting, Fairbrother, & Koch, 2004). For example, Breitenbecher and Scarce (1999) found no reduction in the incidence of sexual assault despite an increase in knowledge about sexual assault. A later meta-analytic study of both published and unpublished empirical research concluded that there is little support for the effectiveness of current rape education efforts in reducing sexual assault, but the authors note the difficulty in obtaining accurate follow-up information on participants (Anderson & Whiston, 2005). A review of empirical studies by Sochting, Fairbrother, and Koch (2004) confirms these findings.

While the educational *content* necessary to make lasting change and long-term impact on the incidence or rape is not clear, there does seem to be consistent agreement on ways to improve the *structure* of future educational programs. Studies show that more interactive, focused interventions, of longer duration, consisting of multiple sessions, presented by professional educators, are most effective (Anderson & Whiston, 2005). There is some evidence that providing education in single-sex rather than mixed-sex groups is more effective for women, especially if the group focuses on risk reduction (Anderson & Whiston, 2005); others found single-sex groups more effective for men, as well (Brecklin & Forde, 2001).

In a recent reflection on 20 years of research, Campbell and Wasco (2005) note, ''Neither community-based practitioners nor academic researchers have been able to identify models of prevention effective enough to put a dent in incidence rates'' (p. 120). This conclusion was echoed by Rozee and Koss (2001), who conclude that the incidence of rape has remained at a steady 15 percent despite growing efforts at prevention.

Feminist scholars have suggested that a more effective approach to rape prevention efforts would be to target men's behavior (Rozee & Koss, 2001). Yet there are few rape prevention programs aimed at men and fewer studies targeting men's behavior, and these have been unable to identify factors critical to changing men's behavior (Campbell & Wasco, 2005). Many of these efforts have identified important proxy variables, such as modifying rape myths and creating empathy, yet have not examined reduction in sexually aggressive behavior (O'Donohue, Yeater & Fanetti, 2003). Despite an emphasis on enhancing male empathy, most programming was not effective in creating sustained empathy that affected change in sexually aggressive behavior (Anderson & Whiston, 2005; Foubert, 2000; Lobo, 2005).

Community-based programs focused on men working with men seem to have some promise for future rape prevention efforts. Such programs generally consist of support and education programs focused on improving communication between men and women, strengthening men's resistance to depictions of appropriate (aggressive) male sexual behavior, encouraging men to confront peers who engage in rape supportive beliefs and behaviors, recognizing that rape prevention is a men's issue, and encouraging men to organize, learn about rape, and speak up against male aggression, including donating time and money to rape prevention efforts.

Rape Resistance

While it is clear that efforts to reduce the prevalence of rape must ultimately change the beliefs and behavior of potential perpetrators, the fact that these programs have yet to work highlights the importance of helping potential victims remain safe. Rape avoidance training targeted at women would benefit by focusing on:

- risk reduction (Anderson & Whiston, 2005)
- identifying and repelling sexually aggressive men (Bachar & Koss, 2000; Rozee & Koss, 2001)
- predicting behaviors of aggressive men (Rozee, Bateman, & Gilmore, 1992)
- selection and approaches toward potential victims (Stevens, 1994)
- known rape tactics that may alert women to potential danger (Cleveland, Koss, & Lyons, 1999)

In addition, based on consistent evidence of the effectiveness of physical resistance strategies over passive strategies in avoiding rape (Rozee & Koss, 2001; Ullman, 1997) rape prevention programs must devote time to physical self-defense.

The importance of rape resistance is highlighted by research suggesting that women who do not resist are more likely to be raped (Clay-Warner, 2002; Furby & Fischhoff, 1986; Kleck & Sayles, 1990; Koss & Mukai, 1993; Rozee & Koss, 2001; Ullman, 1997, 1998; Ullman & Knight, 1991, 1992, 1993, 1995; Ullman & Siegel, 1993; Zoucha-Jensen & Coyne, 1993). Yet most rape prevention programs focus on risk reduction and avoidance, rather than self-defense training.

Although the empirical evidence strongly supports the efficacy of physical self-defense, it is important to note that not all women are able to physically resist, due to characteristics of the situation, the perpetrator, or the woman herself. This does not mean that the victim is at fault if she does not fight back. The woman's choice of response in the given situation must be honored and respected. We all make the best

choices we can under our given circumstances. By focusing on empowerment, we do not undermine the reality of women's victimization.

The problem is that most women have been taught that to physically resist a rapist is both futile and foolish (Rozee, 2003). One common myth is that because of men's greater size and strength, it is unlikely that a woman can successfully defend herself. Research on rape resistance has consistently determined that women who fight back immediately are less likely to be raped than women who do not (Furby & Fischhoff, 1986; Ullman, 1997). Furby and Fischhoff (1986) found that these results held in both stranger and acquaintance rape situations and even in the presence of a weapon.

A second myth is that if a woman tries to fight off her attacker, she is more likely to be injured. Despite evidence that risks for serious injury are minimal, a widespread belief is that injuries are common in rape cases when the woman resists (Ryckman, Kaczor, & Thornton, 1992). In fact, injuries stemming from resistance tend to be minor, consisting mainly of cuts and bruises, with less than 3 percent suffering more serious injury such as a broken bone (Ruback & Ivie, 1988). Recent evidence clearly shows that women who fight back are no more likely to be injured than women who do not (Ullman, 1997). Ullman's (1997) research demonstrated that it is important to consider the *sequence* of events. She found that women fought back because they were being hurt; they were not hurt because they resisted. Physical self-defense often occurred in response to physical attack. Resistance is likely to prevent rape and result in no more injury than no resistance.

A further advantage of resistance is that women who do not resist are more often blamed for the rape (Ong & Ward, 1999) and get negative reactions from juries. Juries tend to assume consent in the absence of verbal or physical resistance (Warner & Hewitt, 1993). The more the victim-survivor resisted, the more certain are the observers that a rape occurred (Krulewitz & Nash, 1979). In addition, resistance may facilitate faster psychological recovery whether or not a rape occurs (Bart & O'Brien, 1985). Women who resist may blame themselves less for what happened and have more positive attitudes toward themselves because, despite the outcome, they did all they could do to prevent the rape (Furby & Fischhoff, 1986). The unfortunate truth is that many women enroll in self-defense classes only *after* they are raped (Huddleston, 1991; Brecklin, 2004).

A second line of research has examined the efficacy of participating in self-defense classes. Self-defense classes teach skills for preventing and responding to sexual violence, yet are not typically part of rape education programs. Instead, women must seek out instruction in the community, generally paying a fee for the service. McCaughey (1998) argues that one reason feminists should embrace self-defense is so that it will reach more women, much as rape education does currently.

Recognizing the importance of preventing rape on campus, many universities are now offering self-defense courses as part of their curricular offerings.

Experimental tests of the efficacy of self-defense training in reducing the incidence of future rapes are few and far between. In general, these studies have found that self-defense training may facilitate rape avoidance. A recent multivariate analysis found that women with self-defense training, compared to women without such training, were more likely to say that fighting back stopped the offender or made him less aggressive (Brecklin & Ullman, 2005). Women in this study who had self-defense training were also more likely to have experienced attempted rape versus completed rape, thus supporting the effectiveness of trained resistance.

Some researchers have pointed out that self-defense training may have other positive effects that could reduce women's risk of assault (Brecklin & Ullman, 2005). In a longitudinal study of self-defense training, Hollander (2004) found that the classes gave women more confidence in potentially dangerous situations, less fear of strangers, and more positive feelings about their bodies. Several authors have suggested that self-defense classes are life-transforming learning experiences for many women (Cermele, 2004; Hollander, 2004). Thus, while rape resistance supporters have been criticized for reinforcing the notion that women are responsible for rape prevention, the evidence is strong that rape resistance is the best stopgap measure for women until effective primary prevention programs with men are designed and implemented.

SUGGESTIONS FOR CHANGE

The preceding review suggests that rape continues to be a pandemic problem in the United States and that it has long-lasting effects on survivors and society as a whole. While our understanding of the causes of rape has increased dramatically over the past three decades, our ability to effectively intervene and prevent rape has lagged behind. Even though substantial efforts are being made to combat this problem, much remains to be done. Based on problems identified in the preceding review of the literature, this concluding section focuses on potential areas for change, in the hope that, together, we can continue to combat the problem of rape.

Preventing Rape

Although prevention programs aimed at changing simple attitudes about rape have not been effective in reducing rape incidence, feminist efforts to change sociocultural conditions are still vital to rape reduction. Continued efforts to challenge traditional gender-roles, sexual scripts, and rape myths are clearly needed. If anything, the past decade has been

characterized by a backlash against such efforts. Whereas changing social norms in the 1970s and 1980s raised societal awareness of the negative effects of gender socialization, the turn of the century has been marked by highly gendered marketing and merchandise aimed at children. This retraditionalization of our children is bound to have long-lasting impacts on our society. It is also bound to affect rates of rape. Continued efforts to raise awareness of the problematic nature of gender socialization and ''normal'' sexual scripts are therefore essential.

The past decade has also been marked by dramatic technological advances that have substantially altered our access to information. Unfortunately, these advances have also made pornography and other degrading images of women much more accessible. Whereas the social stigma of walking into an adult bookstore or strip club may have kept some men (and certainly children) from being exposed to these images, the proliferation of pornography on the Internet has made such images almost commonplace. Enhancing the quantity of more positive and accurate images of women in mass media may counteract the potential negative effects of these images.

In addition, more research is needed to identify effective rape prevention programs. Psychological research on the causes of rape has identified points of intervention that may be further explored in terms of their ability to truly change men's behavior, but this research is not always incorporated into the design of rape prevention programs. In designing such programs, practitioners should focus on empirically supported causes of rape. They should also explore innovative ways of changing personality constructs such as hostility toward women and lack of empathy that have been identified as correlates of rape in the literature.

Prevention programs should also focus more specifically on engaging men in the fight against rape. Too often, men are resistant to the messages promoted by current rape prevention efforts. More attention needs to be paid to developing programs that give men a proactive role, allowing them to act as allies with women and role models for other men. Simply providing information about rape is not enough. To change the incidence of rape, we need to engage men in the process of changing the rape-supportive environments in which they live. There are now a number of websites by and for men on how men can work together to reduce male violence toward women, particularly sexual assault. A few of these are:

- www.stopviolence.com/domviol/menagainst.htm
- www.mencanstoprape.org/
- www.menendingrape.org/index.htm
- http://menagainstsexualviolence.org/
- www.menstoppingviolence.org/index.php

Rape prevention programs should also heed the cumulative results of evaluation studies. While the overall picture remains somewhat bleak, it is clear that specific structural aspects of prevention programs work better than others. Prevention programs that are experiential rather than didactic, that focus on one gender rather than mixed groups, that extend over a substantial period of time rather than a one-shot effort, and that are run by professionals rather than peers appear to be the most effective. At the very least, rape prevention programs should follow these structural guidelines in order to increase their chance of success. In the meantime, schools and universities, as well as communities, should also expend the resources necessary to provide self-defense training for women and girls. While such programs should by no means take the place of prevention programs targeting men, the benefits of self-defense training for women is clear.

Improving the Community Response to Rape Survivors

Most rape survivors are in need of help and assistance from both loved ones and professionals. Unfortunately, not all survivors receive the support they need. The continuing prevalence of negative social reactions toward rape survivors highlights the need for ongoing community education programs and training for community personnel. Such programs should focus proactively on how to best help rape survivors and avoid negative social reactions. Research suggests that friends, family, and romantic partners are often confused about how to best help their loved one (Ahrens & Campbell, 2000; Smith, 2005). Instruction before the fact on how to help survivors may help reduce negative reactions that stem from ignorance about how to help. The same may be true for community personnel, who may benefit from information about survivors' needs and training on how to most effectively support survivors.

Improving the community response to rape may also require a critical examination of the organizational structures of the legal, medical, and mental health systems. It is possible that strategic changes to the protocols, reward structures, and daily operations of these organizations could lead to substantial changes in how rape survivors are treated. For example, the current system rewards police officers for weeding out false claims. Imagine the changes that would occur if they were instead rewarded for thorough investigations and survivor satisfaction. Similarly, the current system rewards prosecutors for their win–loss ratios. Imagine the changes that would occur if they were instead rewarded for prosecuting every crime that meets the legal definition of rape. In the medical system, emergency room protocols are oriented for fast, efficient care that prioritizes life-threatening emergencies. Imagine the changes that would occur if medical personnel were rewarded for taking the time to emotionally support rape survivors

and conduct thorough forensic examinations. And imagine the changes that would occur if counselors were required to take an entire class dedicated to working with survivors of interpersonal violence in order to be licensed.

Of course, such organizational changes would require substantial increases in funding, resources, and political will. Sadly, rape is not at the top of society's political agenda, and without public outcry, it is not likely that large-scale social change will happen soon. This highlights the importance of continued activist and social change efforts to keep rape in the forefront of the public's eye and to pressure politicians to make important changes to public policy and funding initiatives to effectively address rape. While rape crisis centers used to play a key role in such social change efforts, many centers have abandoned their social change initiatives in favor of more individualized treatment approaches. This has left a vacuum that must be filled by those of us interested in social change.

While many researchers feel that social action is beyond the scope of their training and responsibilities, increasing numbers of academics have stepped into the public policy arena and have begun to focus on conducting social action research that aims to effect substantial social change in the organizations, communities, and societies in which they work. Changing our rape culture will require the dedication and contributions of a multitude of individuals, and there are certainly important roles that students and academics can play. We encourage everyone reading this chapter to consider the role that they themselves can play and to join us in the fight against rape.

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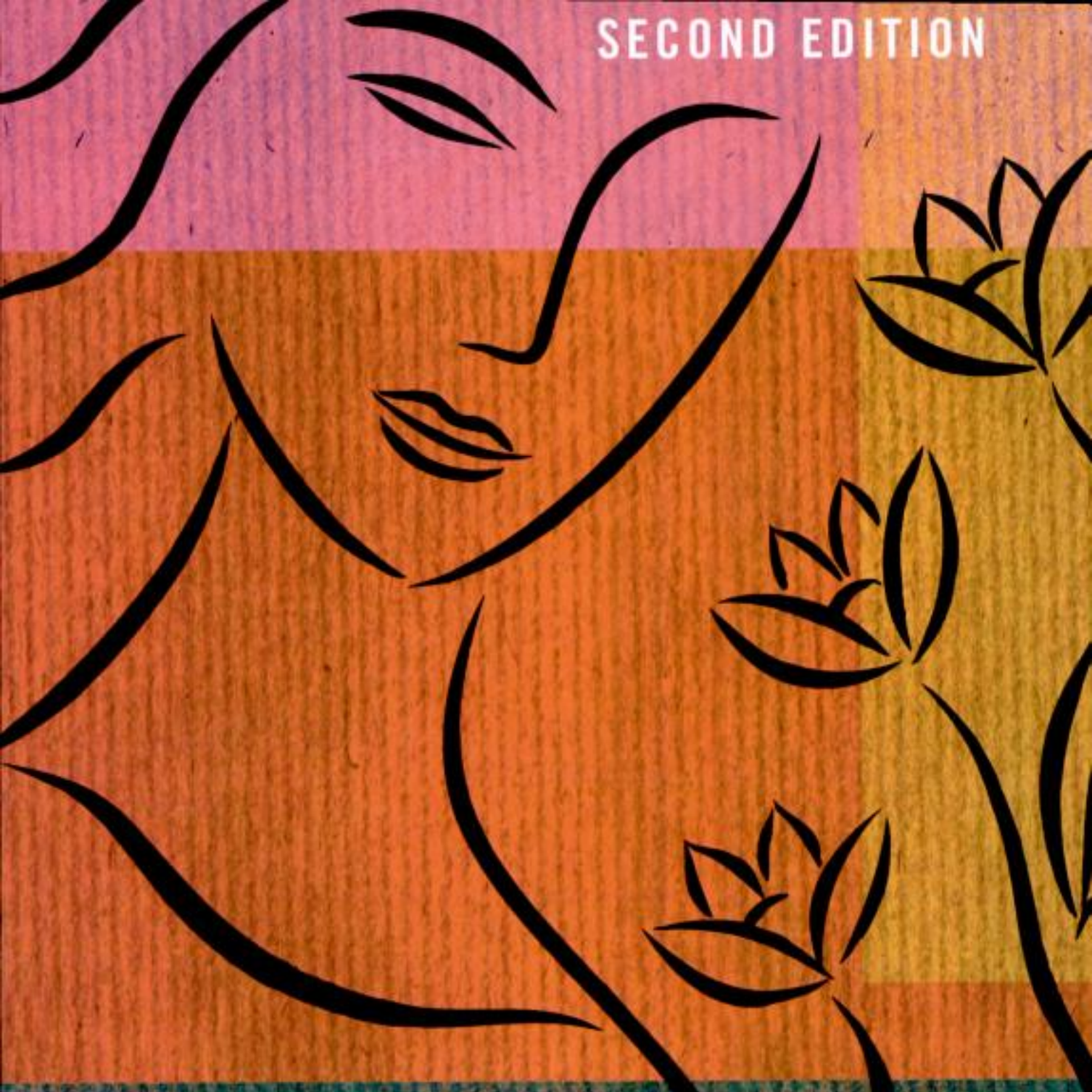

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In memory of the first generation of women psychologists, we dedicate this handbook to future scholars in the psychology of women.

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