

Rape and Sexual Assault Victimization

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Rape and Sexual Assault Victimization Definitions

Rape and sexual assault remain pervasive phenomena in our society today, despite increased understanding of the negative consequences of such victimization. Sexual victimization can occur across the lifespan in childhood, adolescence, and adulthood, and among both men and women. Accurate definitions and measurement of sexual victimization experiences are crucial for our understanding of this phenomenon and for informing public policies, and risk reduction, prevention, and treatment programming.

Legal definitions of sexual assault and rape vary somewhat across legislatures and can vary in degree of severity of offenses. In general, sexual assault has been defined as unwanted behaviors that can consist of exhibitionism, unwanted exposure to pornography, public show of images that were taken in private or without a victim's awareness, voyeurism, sexual contact of breasts, genitals, or anal orifice with a part of the body or an inanimate object, and penetration. Such behaviors are attempted or committed either against a victim's will or when consent cannot be obtained due to age (e.g., status as a minor), disability (e.g., mental or cognitive disability), or the influence of alcohol or drugs. Across legislations, specifics of age criteria vary somewhat with respect to victim and perpetrator ages and age differences (e.g., statutory rape). Additionally, sexual assault may be committed through use of coercion, intimidation, pressure, use of a weapon, and threat, or actual use of physical force (National Institute of Justice, 2010). More recently, most states have amended sexual assault laws to make these crimes gender neutral such that victims and perpetrators can be both male and female; for example, penetration qualifications for rape extended beyond just vaginal penetration to include oral or anal penetration (Koss et al., 2007). Legal definitions of sexual victimization differ somewhat from research definitions, and not all incidents defined as sexual victimization in research may qualify as criminal acts. However, legal definitions and public policy of sexual assault and rape have been informed by advancements in research methodology and results, which allow for more accurate assessment of such victimization.

Incidence and Prevalence

Currently, it is widely understood that assessment and measurement of history of sexual assault and rape is more valid when assessed with behaviorally specific descriptions of unwanted sexual experiences that describe the specific act and tactic used (Fisher & Cullen, 2000; Koss et al., 2007). Use of broader questions with terms such as “rape” or “sexual assault” (e.g., asking “have you ever been raped?”) in assessment of sexual victimization histories can result in underestimates in rates of such experiences, given that these terms are typically poorly, or differentially, understood by men and women (Harned, 2005; Koss, Gidycz, & Wisniewski, 1987). For illustration, Fisher and Cullen (2000) compared prevalence rates of rape obtained through behaviorally specific assessment to measurement from a US national survey using broader terminology, and found that rates were nine times higher using the behaviorally specific methodology. In fact, many men and women do not label their sexual victimization experiences as such, even when their experiences meet the research or legal definitions of sexual assault (Fisher, Cullen, & Turner, 2000). The term “unacknowledged victim” has been used to describe someone who has had an experience that meets the research and/or legal definition of sexual assault or rape but does not conceptualize or define it as such.

Unacknowledgement is a fairly common phenomenon, with estimates of unacknowledgement of rape occurring in up to 68% of female victims (Dardis & Gidycz, 2012). Although rates of unacknowledgment in male victims have been virtually ignored in the empirical literature, it could be assumed that because being victimized is incongruent with our society’s traditional view of masculinity, and rape myths suggest that “real men can defend themselves against rape” (Turchick & Edwards, 2012), men might be even more reluctant than woman to label a sexual assault as such. Indeed, data from narratives of male sexual assault victims gathered in the context of the National Crime Victimization Survey (NCVS) suggest that few men used the word rape to describe what had happened to them, although they experienced a range of sexually aggressive experiences which included rape, attempted rape, and coercion (Weiss, 2010).

In general, research using such behaviorally specific methodology has documented that a large proportion of women and men experience some form of sexual victimization in their lifetime. However, variability in general incidence and prevalence rates reflects differences in definitions of sexual victimization, methodologies, and populations studied. The majority of sexual victimization research thus far has focused on women, although recently increased attention has been on men. Lifetime prevalence rates indicate that between 17% and 25% of women experience rape (Fisher et al., 2000; Koss et al., 1987). In terms of history of any type of sexual victimization, estimates range between 45% and 75% of women reporting such victimization in adulthood (Brecklin & Ullman, 2002; Koss et al., 1987). In a recent investigation, data collected from women in 23 states and two US territories suggested that the 12-month prevalence rate for attempted or completed nonconsensual sex was 1.2% (Blac, Basile, Breiding, & Ryan, 2014). Further, college-aged women are at particular risk for sexual victimization; longitudinal studies indicate that over 22% of college women report an experience of any type of sexual assault over a 2 month interval, and between 3% and 8% of college women experience rape in just a 2 to 3 month time span (Gidycz, Hanson, & Layman, 1995; Gidycz, Loh, Lobo, Rich, & Lynn, 2007; Gidycz, McNamara, & Edwards, 2006).

Rates of sexual victimization among men are generally lower, accounting for approximately 5% to 10% of rapes reported annually (Scarce, 1997). For example, in a recent study, Gardella et al. (2015) found that in a college student sample, women experienced four times the amount of sexual victimization as men. According to a review by Peterson and colleagues (Peterson, Voller, Polusny, & Murdoch, 2011), lifetime rates of forceful rape among men varied from between 0.2% (married/cohabitating community sample; Tjaden & Thoennes, 2000) to 14% (college student sample; Aizenman & Kelley, 1988). In general, rates of sexual victimization of men are somewhat higher among college samples compared to community samples. Research indicates that up to 73% of college men report experiencing some form of unwanted sexual behavior (Peterson et al., 2011); whereas between 25% and 30% of community men experience some form of attempted or completed sexual victimization (through use of force, coercion, or incapacitation from alcohol/drugs) (Krahe, Scheinberger-Olwig, & Bieneck, 2003).

Sexual victimization is experienced in essentially all demographic groups, regardless of gender, age, race, ethnicity, sexual orientation, or socioeconomic status. Just as rates of sexual victimization vary across gender, they tend to vary similarly across demographic groups and geographic regions. There is information that some subpopulations may be at greater risk for sexual victimization, as are women. For example, data from the 2008 NCVS indicated that age-adjusted rates of rape/sexual assault were two to three times greater in persons with disabilities who were aged 12 years or older, compared to persons without disabilities (Harrell & Rand, 2010). Other research indicates that women who identify as Native American or African American report greater rates of sexual victimization (Lodico, Gruber, & DiClemente, 1996), highlighting differential rates of sexual victimization among different racial groups.

In terms of international sexual victimization statistics, rates tend to vary somewhat across geographic region and are difficult to integrate for a variety of reasons. For example, rates of sexual violence among women committed by a nonpartner range from approximately 1% in Ethiopia and Bangladesh to between 10% and 12% in Samoa and Peru (e.g., UN Department of Public Information, 2011). It has been proposed that rates of rape of women in South Africa are among the highest, with about 2,070 attempted or completed rapes per 100,000 women per year (Jewkes & Abrahams, 2002). Rates of rape among women in the Democratic Republic of the Congo are also markedly high with an average of around 36 women and girls raped every day; with some researchers noting the influence of the use of rape as a weapon of war (UN Department of Public Information, 2011). Furthermore, research on international statistics of sexual violence among men is less prevalent (Stemple, 2009). The rate of lifetime prevalence of attempted or completed rape among American men is estimated around 3% (Tjaden & Thoennes, 1998), with a similar rate found in England (Stemple, 2009). An aggregate of 120 prevalence studies found an average of 3% of men worldwide had experienced rape in their lifetime (Spitzberg, 1999). International rates of sexual victimization must be interpreted with high caution at this time; many developing countries do not yet have a sufficient amount of data available nor the infrastructure for accurate crime reporting (e.g., Jewkes & Abrahams, 2002), and there exist many cultural factors (e.g., existence of forced marriages) and barriers to reporting or assessing sexual violence that may complicate a comparison of international statistics.

Unfortunately, rates of sexual victimization have increased among lesbian, gay, bisexual, and transgender (LGBT) populations, which may be partially reflective of increases in anti-LGBT crimes in general (National Coalition of Anti-Violence Programs, 2009). Among victims presenting for emergency medical care, LGBT victims reported greater rates of sexual assault than heterosexual victims (Cramer, McNeil, Holley, Shumway, Boccellari, 2012). In a review of studies conducted in the United States from 1989 to 2009, Rothman, Exner, and Baughman (2011) found that lifetime sexual assault prevalence rates reported by gay and bisexual men ranged from 12% to 54%, and between 16% and 85% among lesbian and bisexual women, with median prevalence at 30% and 43% for these groups, respectively. Finally, in a recent study, Edwards, Sylaska et al. (2015) found a significantly higher 6-month incidence rate for sexual assault for sexual minority college students (24.3%) compared to heterosexual students (11.0%). As these findings reflect wide ranges in estimates of prevalence, further research is needed to fully understand the impact of sexual victimization in LGBT communities; and similarly to better understand what factors may account for differential rates of victimization among different subpopulations.

Overall, researchers have highlighted the variance in victimization among subpopulations. The identification of such characteristics of sexual victimization is important for building general public awareness of the continuum of sexual victimization experiences that can occur.

Contextual Factors

Much research has been conducted to better understand the characteristics and contextual factors of sexual victimization. Regarding characteristics of victims and perpetrators, research indicates that the majority of sexual assault experiences, approximately 66% to 80%, are committed by an acquaintance of, or someone known to, the victim, rather than by a stranger (Koss, Dinero, Seibel, & Cox, 1988; Truman, 2011). However, in comparing the victimization of men and women, although the percentage assaulted by strangers is comparable, there is some evidence that more women than men are assaulted by intimate partners (Weiss, 2010). The frequency of involvement of alcohol or substances in sexual victimization has also been documented. The Alcohol and Crime Study sponsored by the US Department of Justice found that one-third of perpetrators of sexual assault were intoxicated during the incident; 30% with alcohol and an additional 5% with other drugs (Greenfield, 1998). Additionally, research with community women indicates that incapacitated rape (i.e., rape occurring when a victim is either unable to consent to or resist sexual intercourse due to alcohol or drug intoxication) occurs at least as often as forcible rape (Testa, Livingston, VanZile-Tamsen, & Frone, 2003), whereas research with college women indicates that incapacitated rape is more common than forcible rape in this population (Lawyer, Resnick, Von Bakanic, Burkett, & Kilpatrick, 2010). In one study with men it was found that for female to male sexual assault exploiting the man's ability to resist through alcohol or drugs was the most frequently utilized tactic (Krahe et al., 2003). The study of common characteristics of sexual assault, including but not limited to victim-perpetrator relationship and substance use, allows for a better understanding of such victimization.

Risk Factors and Correlates

In addition to the noted subpopulation differences in rates of sexual assault, researchers have examined factors that increase risk for sexual victimization or are correlated with such experiences. This information is important for intervention and prevention programming, as well as the provision of treatment for survivors of sexual assault. Risk for sexual victimization involves a number of environmental, contextual, cognitive, and behavioral variables that can be either distal or proximal in temporal relationship to the unwanted sexual experience.

Sociocultural Factors

For both men and women, rape is embedded within a larger context of sociocultural factors, which may demonstrate a dynamic nature across time, populations, and geographic regions. It has been proposed that sexual aggression is a product of cultures in which such aggression is accepted or tolerated. From a feminist perspective, sexual violence is a result of normal male socialization and sociocultural conditioning (e.g., Rozee, 1993). In this framework, sexual violence and attitudes that are accepting of sexual violence serve to maintain patriarchal ideals of male as dominant and female as submissive; ideals that are often reflected in institutional and social settings (Anderson & Doherty, 2008). Similarly, gender role socialization theory outlines that girls and women are socialized to be compliant, passive, and submissive via their family environment, peer groups, and school environment; whereas boys and men are socialized to be tough, assertive or aggressive in order to obtain their goals (Letendre, 2007). Further, men and women often differ in terms of size, strength, and economic dependency (Anderson, 2005); all factors that contribute to a sociocultural context that maintains violence against women. Also within the feminist perspective, anger towards women may be culturally disseminated when women are subordinated, making them viable targets for aggression (Hall & Barongan, 1997). Cognitive distortions (e.g., rape myth acceptance) about the impact and meaning of sexually aggressive behavior are prevalent in patriarchal societies and contribute to sexual assault perpetration. Ethnic minority groups adopting a collectivist orientation may exhibit increased risk for victimization among individuals perceived to be part of an outgroup with less status and power (Hall & Barongan, 1997). Among women, the experience of sexual violence may be partially influenced by social and sexual role expectations whereby a woman must place men's sexual needs above her own, and by conflicting messages regarding female sexuality (e.g., a woman must please her male partner, yet be assertive enough to set boundaries) (Philips, 2000). Traditional social role expectations influence men to exhibit greater agency and women to exhibit other-focused and affiliative qualities (Helgeson, 1994). These expectations and roles are related to unwanted sexual experiences among women. For example, belief in the sexual double standard is associated with decreased communication and levels of assertiveness in initiation and refusal of sex (Greene & Faulkner, 2005). Furthermore, Hynie and Lydon (1995) proposed that social norms discourage women from being sexually assertive in sexual situations which may increase the likelihood for sexual assault. To the extent that such social role expectations are held within a population, these

factors may influence rates of sexual victimization among women as well as influence their reluctance to come forward when they are assaulted.

Although sociocultural theories to explain sexual violence have their roots in feminist theory and have focused on sexual violence perpetrated by men against women, Hines (2007) argues that, regardless of the sex of the perpetrator, when individuals view relationships as exploitative, deceptive, manipulative, and as a means of gaining power rather than obtaining love and tenderness, that forced or verbally coerced sex is more likely to occur. Illustrative of this point, Hines (2007) conducted a large-scale study of sexual coercion among men and women across a number of countries and found that the greater level of reported gender hostility against men at a particular site, the higher rates of verbally coerced and forced sex against them.

Past History of Victimization

Throughout the period since the mid-1990s, researchers have explored the link between early sexual abuse in childhood and risk for sexual victimization in adolescence and adulthood (see Gidycz, 2011). Data consistently underscore that an individual's experience of sexual abuse in childhood is associated with an increased risk for subsequent sexual assault(s) in adolescence and/or adulthood (Gidycz et al., 1995; Messman-Moore & Long, 2003; Waldron, Wilson, Patriquin, & Scarpa, 2015). Whereas the bulk of the research in this area has focused on the sexual victimization of women, more recent research has also substantiated this link among men (see Coxell & King, 2010; Hines, 2007 for example) and across various cultures (Hines, 2007). For example, Elliott, Mok, and Briere (2004) found in their national sample of men that those who were victimized in adulthood were five times more likely than nonvictims to have a history of childhood sexual abuse. Further, in a recent study, Aosved, Long, and Voller (2011) found that 37% of male victims of child sexual abuse reported an adult sexual victimization compared to 15% of men without a history of childhood sexual abuse.

Increasingly researchers are going beyond describing this robust link between early sexual victimization and victimization during a subsequent developmental period and addressing important mediators and moderators of this relationship. For example, this association may be moderated by the severity of previous sexual victimization experiences. Indeed, Humphrey and White (2000) found that among college women, increased severity of victimization in adolescence (i.e., prior to age 18) was associated with greater risk of victimization during college years. Furthermore, Messman-Moore, Walsh, and DiLillo (2010) found that emotion dysregulation (involving the control of emotional experience, understanding, expression, and management), resulting from history of victimization in childhood, increased risk for subsequent sexual assault through its effect on risky sexual behaviors for women. Other factors including interpersonal difficulties, substance use, and changes in cognitive representations of sexuality have been found to play a role in later sexual behavior and risk for subsequent revictimization (Gidycz et al., 2007; Messman-Moore & Long, 2003; Niehaus, Jackson, & Davies, 2010). Finally, in addition to victim characteristics, environmental and contextual factors have been proposed as important variables to consider when examining sexual revictimization (Messman-Moore & Long, 2003). Much of the research on revictimization has been conducted with women; research exploring mediators of sexual revictimization in men is comparably lacking.

Risky Sexual Behavior

An additional risk factor for sexual victimization is heightened engagement in risky sexual behavior, which is also correlated with alcohol use (Kilpatrick, Acierno, Resnick, Saunders, & Best, 1997). In general, the term risky sexual behavior refers to behaviors including (but not limited to) high number of sexual partners, early age of onset of engagement in sexual behaviors, early engagement in sexual intercourse in a relationship, engagement in sexual activity while under the influence of alcohol or other drugs, and lack of contraceptive use (Davis, Combs-Lane, & Jackson, 2002; Koss & Dinero, 1989). It has been suggested that early childhood sexual abuse can lead to risky sexual behaviors that then act as a risk factor for continued abuse (see Finkelhor & Browne, 1985). More specifically, an increased number of sexual partners is associated with an increased risk for sexual assault among women (Gidycz et al., 1995). Whereas the bulk of this research has been conducted with women, in a recent study, Turchik (2012) found that male sexual victimization was associated with increased risky sexual behaviors that encompassed impulsive and casual sexual experiences. Such risky sexual behavior can thereby increase risk for sexual victimization by increasing the exposure to potentially dangerous situations. It should be noted, however, that the direction of the relationship between sexual victimization and risky sexual behavior is unclear. It is possible that risky sexual behavior can lead to sexual victimization, that sexual victimization can lead to risky sexual behavior, or that there is a reciprocal relationship between risky sexual behavior and sexual victimization (Messman-Moore & Long, 2003; Orcutt Cooper, & Garcia, 2005; Turchik, 2012).

Alcohol

Alcohol use has also been identified as a risk factor for sexual victimization experiences, especially among college populations where use of alcohol is quite high (Gidycz et al., 2007). Data suggest that alcohol use in general, as well as immediately preceding a sexual assault experience, is a relevant factor in sexual assault; with estimates that an average of 50% of sexual assaults against college women involve the use of alcohol and/or other drugs by the victim, perpetrator, or both (Abbey, Wegner, Woerner, Pegram, & Pierce, 2014; ; Fisher et al., 2000). Further, although data suggest that men drink more than women, alcohol use in general, as well as other drug use, have been related to sexual victimization in both men and women (Banyard, Ward, Cohn, Plante, Moorhead, & Walsh, 2007; Turchik, 2012). A study examining sexual assault among college men and women found that the prevalence of alcohol-related sexual assault among college men aged 19 and above was lower than that of women in the same age group (8.6% and 26.7%, respectively) (Howard, Griffin, & Boekeloo, 2008).

The specific relationship between alcohol use and victimization is somewhat unclear and complex; although it is likely that alcohol use plays both an indirect and direct role in sexual victimization (e.g., Ullman, Karabatsos, & Koss, 1999). Some research indicates that both women and men with a history of sexual assault consume alcohol as a means to cope with the negative effects of the victimization and to cope with future sexual interactions (Turchik, 2012) which can increase risk for subsequent unwanted sexual experiences. Further evidence exists that among childhood sexual

assault survivors, alcohol misuse is prevalent and is associated with risky sexual behaviors and adolescent/adult sexual assault risk (Siegal & Williams, 2003). Alcohol use may also directly increase risk for sexual assault because it impairs the ability to recognize sexual aggression risk cues and engage in effective resistance (Gidycz & Dardis, 2014). Furthermore, the social settings in which individuals drink alcohol (e.g., in bars and at parties) include intoxicated men and women in a sexually laden context, and pose increased risk for aggression such as sexual assault (Norris, Nurius, & Dimeff, 1996; Parks & Zetes-Zanatta, 1999). The complex interplay between substance use, context, and risk for sexual victimization highlights the multilayered nature of the sexual victimization phenomenon.

Risk Perception

Sexual assault risk perception and response to danger cues in dating or sexual situations have also been explored as risk factors for sexual victimization. Gidycz and her colleagues (2006) identified two important levels of risk recognition: general understanding and estimate of perceived vulnerability, and identification of situational risk in a review of women's risk perception and sexual victimization. They found that women are generally aware that sexual assault occurs but exhibit an optimistic bias regarding their personal risk for sexual victimization, such that they believe they are less likely to encounter sexual aggression than their peers or the average college woman. Whereas some early research indicated that risk for sexual assault is increased among individuals who are less able to recognize potential threats; more recently, it appears that inhibited behavioral responses (e.g., low assertiveness) to assault-related danger cues is more predictive of sexual victimization risk (Messman-Moore & Brown, 2006). Lower levels of assertiveness and self-efficacy in behavioral response and resistance are also an important factor in sexual revictimization. Furthermore, behavioral response can be affected by social demands and concerns about the relationship (Kearns & Calhoun, 2010); especially considering the high rates of sexual assault committed by acquaintances of the victim. Therefore, risk for sexual victimization is influenced by perception and behavioral response to danger cues. Although research on risk perception has been only conducted with women, it is likely that men may have difficulty recognizing risk cues given to the general lack of public awareness and educational programs geared towards male sexual victimization risk.

In sum, the contribution of each of these risk factors may vary across subpopulations and types of sexual victimization; however, it is clear that a combination of such factors, rather than a single factor, increases an individual's vulnerability to sexual assault. It should be noted that although these are correlates of sexual assault documented in samples of victims, there are also identified risk factors associated with sexual violence perpetration (e.g., history of past sexual violence, perceived past token resistance, adherence to hypergender ideologies; accepting attitudes towards the use of sexual violence; Loh, Gidycz, Lobo, & Luthra, 2005). When examining correlates of sexual victimization it is important to remember that it is ultimately the perpetrator(s) who is responsible for committing sexual violence. Rape myths that are victim blaming and attitudes that are supportive of sexual violence (e.g., it was the victim's fault they were raped; they were asking for it) only serve to maintain the sociocultural context that is accepting of sexual violence.

Outcomes

Over the past 40 years, substantial research has emerged that documents the traumatic impact of sexual victimization. Sexual victimization is associated with a number of psychological, interpersonal, and physical health consequences both among women and among men.

Regarding outcomes of sexual victimization among women, research has fairly consistently documented that sexual victimization among women is associated with a myriad of psychological effects including increased rates of anxiety, depression, posttraumatic stress disorder (PTSD), interpersonal problems, sexual problems, health risk behaviors, including alcohol use and suicidal ideation as well as a number of physical health complaints (e.g., Briere, Elliott, Harris, & Cotman, 1995; Golding, 1999; McMullin & White, 2006; Rumstein-McKean & Hunsley, 2001; Shapiro & Schwartz, 1997; Tomasula, Anderson, Littleton, & Riley-Tillman, 2012; Turchik, 2012; Weaver, 2009). Physical health complaints include gastrointestinal and gynecological problems, poorer health perceptions as well as increased somatization and unexplained medical symptomology (Tansill, Edwards, Kearns, Gidycz, & Calhoun, 2012). Further, data also underscore that the negative health outcomes may at least be partially mediated by the negative psychological effects associated with sexual victimization (see Tansill et al., 2012). Research also documents a wide range of negative sexual functioning outcomes following sexual victimization in childhood or adolescence/adulthood among women. The range of such outcomes span from sexual difficulties and dysfunctions (e.g., vaginismus, dyspareunia) or anxious-avoidance of sexual stimuli (e.g., decreased sexual desire, sexual aversion), to increased rates of dysfunctional/risky sexual behavior (e.g., using sex to meet nonsexual needs; lack of contraceptive use) and increased risk for sexually transmitted infections (STIs) and unwanted pregnancies (Turchik, & Hassija, 2014; Van Berlo & Ensink, 2000; Weaver, 2009). Some proposed mechanisms of the relationship between sexual victimization include changes in cognitive variables and disturbances of the self (e.g., self-esteem, sexual self-schemas) and maladaptive coping strategies (Kelley & Gidycz, 2015; Merrill, Guimond, Thomsen, & Milner, 2003). It is evident that sexual victimization in women can negatively influence mental, physical, sexual health across the lifespan and involves a complex interplay of factors.

Although the vast majority of research that addresses the consequences of sexual assault has focused on women, and some data suggest that assaults against men, particularly when they are perpetrated by women, may be less upsetting to men than they are to women (e.g., Krahe et al., 2003), more recent data for male victims indicate that men experience many of the same consequences to sexual assault as do women (see Peterson et al., 2011 for a review). Psychological consequences include anxiety, PTSD, increased distress, anger, self-harm, and alcohol problems (Turchik, 2012). Similar to reactions for women, men who are assaulted also report interpersonal consequences which include mistrust, being nervous around people, and uncomfortable about being physically close to others (Struckman-Johnson & Struckman-Johnson, 2006). Men are also likely to experience physical consequences that include injuries as a result of the assault as well as STIs. Similar to outcomes for women, men report sexual problems following an assault which include sexual inactivity as well as sexual promiscuity (Mezey & King, 1989) and sexual functioning difficulties (Turchik, 2012). Such research points to many common negative

health outcomes of victims of sexual violence that may be reflected across gender; however, sociocultural context (e.g., gender role expectations) is also important to consider in understanding men's and women's potential unique health outcomes.

For instance, when men are assaulted, in addition to the correlates that women experience, they appear to also experience sexual identity issues (Peterson et al., 2011; Struckman-Johnson & Struckman-Johnson, 1994). It has been suggested, for example, that when a man is assaulted by a woman it can lead to doubts about his sexuality because he resisted a sexual opportunity with a woman. Similarly, when men are assaulted by other men, this can also lead to sexual identity confusion as the victims may believe that there might be something "homosexual" about them that led to the assault (Struckman-Johnson & Struckman-Johnson, 1994). These data also suggests that men who are assaulted by other men may experience stronger negative reactions than those assaulted by women (Peterson et al., 2011; Struckman-Johnson & Struckman Johnson, 1994). Unfortunately, such concerns are likely related to a number of other variables (e.g., whether they disclose or not) that interact to lead to negative outcomes.

Factors that Influence Outcomes

Polyvictimization

Whereas the early research on revictimization in sexual assault survivors focused on the experience of early sexual abuse as a risk factor for subsequent sexual victimization, more recently, researchers have explored the link between a number of different types of nonsexual traumas (e.g., physical and emotional abuse) either during childhood or adolescence and their relationship to subsequent sexual victimization (Casey & Nurius, 2005). Sexual victimization risk is heightened among individuals with histories of other types of victimization including physical and psychological abuse in childhood (Cloitre & Rosenberg, 2006). Data from diverse samples suggest that various forms of violence tend to co-occur and it is noteworthy that this pattern has been found in male and female teenagers (Hamby, Finkelhor, & Turner, 2012); men and women college students (Sabina & Straus, 2008), a national sample of Latino women (Cuevas, Sabina, & Picard, 2010) and general community samples of women. Further, there is some evidence that patterns of co-occurrence of various forms of abuse are similar for men and women (Hamby et al., 2012). Overall, polyvictimization appears highly prevalent with a national study of university students finding that approximately 20% of them were victims of sexual, physical, and psychological abuse (Sabina & Straus, 2008). These findings are alarming as data is accumulating which highlights that experiencing multiple forms of victimization leads to heightened distress in terms of increased likelihood of posttraumatic symptomatology, heightened anger, depression, and dissociation (see Sabina & Straus, 2008; Cuevas et al., 2010). Thus, it is important to consider the notion that sexual victimization often does not occur in isolation.

Disclosure and Social Reactions

Whether or not a survivor discloses a sexual assault, and to whom, is a decision that presents itself after a victimization experience. Given that sexual assault is a crime, much research has been conducted on the extent of disclosure to the police. Most of

this research has been conducted with women victims. Unfortunately, recent data from a national sample of adult women suggest that only approximately 16% of rapes were reported; a percentage that has remained virtually unchanged over the past twenty years (Wolitzky-Taylor, Resnick, McCauley, Amstadter, Kilpatrick, & Ruggiero, 2011). Data with female college students further corroborates even lower rates of disclosure to the police as Fisher, Daigle, Cullen and Turner (2003) documented that less than 5% of attempted rape and rape victims report their experience to the police; also a percentage that has remained fairly constant on college campuses over the past twenty years. Data for men indicate that they disclose to the police much less frequently than women (Weiss, 2010) and data for other minority populations reflect similar differential rates of disclosure and reporting of sexual assault. For example, African American women are less likely to report their sexual assault experiences as compared to White women (Wyatt, 1992). Asian American and Latina women also exhibit low rates of sexual assault reporting for a number of sociocultural reasons such as language barriers, religious beliefs, fear of shaming one's self and family, social stigma, mistrust of government officials stemming from previous experiences of violations, and lack of education and psychoeducation regarding sexual assault (Bryant-Davis, Chung, & Tillman, 2009).

Factors found to be related to likelihood of reporting victimization to the police include demographic characteristics and characteristics and context of the sexual victimization incident such as severity of assault, relationship between victim and perpetrator, locale of incident, and use of alcohol or substances (Fisher et al., 2003). More specifically, older age, existence of injury as a result of the incident, use of a weapon, less intimate/familiar victim-perpetrator relationship, presence of alcohol/drugs, and unfamiliar location of the incident are each related to greater likelihood of reporting the incident to police (e.g., Bachman, 1998; Fisher et al., 2003; Gartner & Macmillan, 1995; Hanson, Resnick, Saunders, Kilpatrick, & Best, 1999). Interestingly, more recent research suggests that rates of reporting by third parties and by female victims who had experienced rape committed by an acquaintance or intimate partner have increased significantly between 1973 and 2000 (Baumer, 2004), perhaps in part due to changes in institutional and social barriers.

The secondary victimization of those who report is likely another factor contributing to victims' nondisclosure to police (Campbell, Wasco, Ahrens, Sefl, & Barnes, 2001). Indeed, Campbell et al. (2001) compared female survivors' experiences with different types of community service providers, and found that the majority of rape survivors who had contact with legal services did not get their needs met. In fact, of the various support systems that were investigated in this study (i.e., medical, mental health, rape crisis center, or religious community), survivors had the most trouble with the legal system. Only 25% of the cases that were reported to the legal system were prosecuted and 75% of the reported rapes did not result in prosecution. Other reasons for nonreporting include not acknowledging a rape as such (Cohn, Zinzow, Resnick, & Kilpatrick, 2013), fear of blame from others (Kilpatrick, Edmunds, & Seymour, 1992), not wanting their families or others to know, not having enough proof, and fears of reprisal from the perpetrator (Wolitzky-Taylor et al., 2011).

For men, additional fears about reporting to the police center around concerns about being labeled "gay" if they are heterosexual, and if they are gay, there may be concerns about having their sexual orientation disclosed (Weiss, 2010). Individuals who are transgendered have also reported concerns about seeking police assistance

(Grant, Mottet, Tanis, Harrison, Herman, & Keisling, 2011). These data are problematic because when a victim does not report the incident, it allows perpetrators to repeatedly victimize others and likely puts the victim at risk for revictimization (Miller, Canales, Amacker, Backstrom, & Gidycz, 2011). However, when they do report the crime to authorities, the difficulties that they encounter are related to negative health outcomes (Campbell et al., 2001).

Whereas data suggest that survivors tend not to disclose to legal personnel, there is substantial evidence that suggests that the majority of them do disclose to others, in particular informal support providers. Orchowski and Gidycz (2012) in a study with female sexual assault survivors found that 75% of college student sexual assault survivors disclosed the experience to someone, with 86% of those who disclosed disclosing to a female peer and 36% of disclosers telling a male peer. In Banyard, Ward, et al.'s (2007) comparison of college student male and female victims of unwanted sexual contact (excluding unwanted intercourse), they noted that men were significantly more likely (33%) than women (15%) to tell no one about the assault. Interestingly, London, Bruck, Ceci, and Shuman (2005) found in a review of retrospective studies with adults, that only about one third of individuals with histories of child sexual abuse reported telling anyone during childhood about the abuse. Furthermore, they found in several studies that there was often a delay in disclosing childhood sexual abuse among these samples; for example, Smith et al. (2000) found that 47% of women with a history of childhood rape reported waiting more than five years to disclose the abuse. Patterns of disclosure of sexual victimization is likely influenced by contextual and sociocultural variables including victim-perpetrator relationships (e.g., perpetration committed by a family member is more common in child sexual abuse), social stigma, and access to resources.

Social support for sexual assault survivors can be an important variable in the recovery process, and is certainly important in promoting self-worth and wellbeing in general. Types of social support include both structural (e.g., type of support system size, frequency of contact) and functional (e.g., types of response or assistance provided) constructs. Subsequently, research has identified social reactions or responses to the disclosure of sexual victimization experiences as a significant factor influencing the outcomes of victimization. Social reactions to disclosure refer to the responses of recipients of the disclosure of sexual victimization experiences by the survivor. Types of social reactions can be positive or negative in terms of how they are perceived by the victim and their consequences for the sexual trauma victim. Types of positive social reactions include feeling believed, receiving emotional support and comfort, receiving tangible aid, and being listened to by the recipient of disclosure (Ullman, 2003). Negative social reactions to disclosure include assault-specific responses that are less supportive, such as blaming or stigmatizing the victim and treating the victim differently (e.g., withdrawing from the victim), attempting to control the victim or take control away from the victim, minimizing the sexual assault event, and engaging in egocentric reactions such as expressing or demonstrating anger in a way that victims are distracted from focusing on their own needs and care (Orchowski, & Gidycz, 2012; Ullman, 2003). Most sexual assault victims, if they disclose their experience to others, receive a mixture of both positive and negative social reactions.

Some research indicates that more positive reactions to disclosure are related to better recovery of sexual assault survivors (Orchowski, Untied, & Gidycz, 2013); still other research suggests a rather minimal or even nonexistent relationship between

positive social reactions and psychological and physical health outcomes (e.g., Ullman, 2003). Unfortunately, many victims of sexual assault report experiencing reactions to their sexual assault disclosure that are negative, with up to 75% of women reporting responses that leave them feeling hurt, not believed, or that they were to blame for the incident (Campbell & Raja, 1999; Campbell et al., 2001). These types of negative responses to sexual assault disclosure are related to more detrimental outcomes and may even create additional harmful effects to the victim (Edwards, Dardis, Sylaska, & Gidycz, 2015; Ullman, 2007). For example, negative social reactions can lead to greater psychological distress and poor adjustment, as well as more physical health symptoms (Davis, Brickman, & Baker, 1991; Ullman & Filipas, 2001a). Data also show an association between the experience of multiple victimizations (compared to single victimizations) and the perception of less helpful reactions from informal support providers (Casey & Nurius, 2005). Interestingly, a sexual assault survivor's expectations of such negative reactions are associated with decreased likelihood that they may disclose the event (Ullman & Filipas, 2001b), which may inhibit their access to care. Whereas this research has been primarily conducted with women, the limited studies that exist on this topic for men suggest that they fear disclosure and are particularly vulnerable to secondary victimization when they disclose to others, resulting in men being "silent victims." It has been suggested that men may disclose or go for help only when they consider the trauma severe enough to warrant attention (Ellis, 2002).

In general, these findings are important to recognize because they highlight the need for education and increased awareness of sexual victimization. Given the high rate of sexual victimization it is likely that many people, in both informal and formal roles, would receive a sexual assault disclosure. It is important that programming efforts provide education on the most helpful ways to respond to a sexual assault victim, and certainly aim to decrease negative types of reactions.

Attributions

Variables that relate to the perception of specific sexual assault experiences can contribute to the outcomes of such victimization. Much research has been conducted on attributions of blame and responsibility for sexual victimization. These attributions typically involve the role and focus of blame for the assault (e.g., victim-blame, self-blame, perpetrator blame, societal blame). Self-blame is associated with more negative recovery trajectories, such as increased rates of PTSD and depression (e.g., Ullman, Townsend, Filipas, & Starzynski, 2007). Levels of self-blame can be affected by a number of sources, such as characteristics of the assault itself (e.g., use of alcohol) as well as social reactions from others (e.g., victim-blaming responses from others). Self-blame and negative social stigmatization can even increase vulnerability to sexual revictimization (e.g., Arata, 1999) and psychological trauma.

Unfortunately, many victims of sexual assault experience victim-blaming responses from both informal and formal systems. Racial and ethnic minorities are more likely to receive such responses (Campbell et al., 2001), and homosexual victims are more likely to be blamed and are incorrectly believed to experience less trauma than heterosexual victims (Doherty & Anderson, 2004; Mitchell, Hirschman, & Hall, 1999). Experiencing blame from community service personnel was associated with increased psychological distress in a sample of community women (Campbell, Sefl, Barnes, Ahrens, Wasco, & Zaragoza-Diesfeld, 1999). Further, certain characteristics of sexual

assault experiences (e.g., when the perpetrator is an acquaintance of the victim) are related to increased likelihood of victim-blaming responses as well as self-blame (Filipas & Ullman, 2006). As noted earlier, such negative social reactions can contribute to increased negative symptomatology, or, in the case of men or certain minority groups, a reluctance to seek help. In an analogue study of male rape, for example, Mitchell and colleagues (1999) found that participants held homosexual men who were raped more responsible than heterosexual men who were raped. Undoubtedly, sexual assault survivors are influenced by societal attitudes towards sexual victimization highlighting the need for sexual victimization to be considered a matter of global and public concern.

Services and Treatment for Victims

Since the advent of the rape crisis movement in the 1970s there have been several noted advancements in the treatment services and protocols available for sexual assault survivors. For example, in response to inadequate and insensitive treatment of victims in medical settings, Sexual Assault Nurse Examiner (SANE) programs began in the 1970s (Campbell & Patterson, 2011; Maier, 2012). SANEs are nurses who have been trained to collect forensic evidence, provide emotional support to victims, and to coordinate with others for the optimal treatment of victims (Maier, 2012). In a review of the effectiveness of SANE programs, Campbell, Patterson, and Lichty (2005) highlighted many benefits of these programs including the promotion of psychological recovery in victims, the facilitation of interagency coordinated care, the collection of forensic evidence, and the facilitation of prosecution of sexual assaults. Regarding the prosecution of assaults, empirical studies, note that the inclusion of medical forensic evidence collected by SANEs did lead to a greater number of prosecutions (Campbell, Bybee, Townsend, Shaw, Karim, & Markowitz, 2014; Campbell, Patterson, Bybee, and Dworkin, 2009). Further, many SANE programs are a critical part of Sexual Assault Response Teams (SART) which consist of health care providers, law enforcement personnel, advocates and other community providers whose goals are to better coordinate care for victims (Cole & Logan, 2012).

The past 20 years has also evidenced a proliferation of treatment approaches for victims of sexual assault with the majority of the investigations of their efficacy being conducted in the United States and consisting of cognitive-behavioral approaches (Taylor & Harvey, 2009). Overall, it has been shown that these treatments typically evidence large effect sizes, resulting in beneficial outcomes for numerous victims, and results have been maintained over follow-up periods that range between 6–12 months (Taylor & Harvey, 2009). Two trauma focused cognitive-behavioral approaches that have been most widely investigated include Cognitive Processing and Prolonged Exposure Therapy. Both treatments are believed to lead to change through prolonged exposure to the traumatic event which leads to emotional processing of it as well as a change in meaning of the trauma (Resick et al., 2008). Well controlled clinical trials suggest that both treatments are effective for sexual assault victims (e.g., Foa et al., 1999; Resick, Nishith, Weaver, Astin, & Feuer, 2002) and positive results are maintained for up to 5–10 years post-treatment (Resick, Williams, Suvak, Monson, & Gradus, 2012). Such current interventions that have been supported by the literature are in contrast to

historical approaches to intervention that were sorely lacking in support and victim blaming.

Summary and Recommendations

Over the past 30 years, researchers have made significant progress in the identification and measurement of sexual assault. Awareness efforts have called attention to the widespread occurrence of sexual victimization, particularly among acquaintances, which has led to significant developments in better understanding the aftereffects of these experiences as well as risk factors and correlates. Community resources for sexual assault victims have increased including the presence of SANE nurses and SART programs. Currently, for example, it has been estimated that over 590 SANE programs are operating in the United States (National Institute of Justice, 2012). Additionally, empirically supported interventions that target PTSD symptoms in sexual assault survivors have also been developed and demonstrated to be effective over both the short- and long-term. Despite these significant advancements, there is still much work to be done.

Given the high rates of polyvictimization among individuals that has been documented in a number of recent studies, investigating sexual victimization in isolation from other forms of abuse no longer seems warranted. It is important to explore the relationship among the different forms of abuse as well as to try to identify factors that likely represent shared vulnerability for the different forms of abuse. It also seems increasingly important for treatment protocols to address polyvictimization. We know that approximately 15% to 50% of individuals who are treated do not show substantial improvement (e.g., Vickerman & Margolin, 2009) and the extent to which multiply victimized women may need more specialized interventions has not been explored.

Whereas the existence of programs that are empirically supported for sexual assault survivors is a major advancement in our field over the past 20 years, it has been argued that the majority of evidence documenting the efficacy of such cognitive-behavioral approaches with sexual assault survivors comes from well controlled research studies conducted under conditions where there is greater client and therapist selectivity than what occurs in community and naturalistic settings (Forbes et al., 2012). Indeed, the extent to which such programs can be transported to community agencies and demonstrate success within such populations warrants further investigation. Although not specific to sexual assault victims, it is positive that cognitive processing therapy has demonstrated success with community-based studies with refugees (who experienced various traumas), and military veterans (Alvarez, McLean, Harris, Rosen, Ruze, & Kimerling, 2011; Forbes et al., 2012; Schulz, Resick, Huber, & Griffin, 2006). Future research is needed which further substantiates the efficacy of such programs with victims who seek services in naturalistic settings.

Although in this chapter we attempted to highlight differences in the experience of sexual assault as a function of ethnicity, gender, and sexual minority status, there are still rather limited data about how such background factors influence one's experience of sexual assault as well as what occurs postassault. For example, few studies have explored differences in treatment outcome for individuals from different cultural backgrounds. In one recent study, Lester, Resick, Young-Xu, and Artz (2010) did not find differences in treatment outcome between African Americans and Caucasians,

however, African Americans dropped out (55%) at higher rates than Caucasians (27%). Given these disparities in treatment engagement have been found in other studies as well (Alvidrez, Shumway, Morazes, & Boccellari, 2011), further research is needed to explore the barriers that individuals from diverse backgrounds experience when they seek services. Further, the vast majority of well-controlled treatment outcome research for sexual assault victims has been conducted with women. The extent to which the positive findings are generalizable to male sexual assault victims is unclear.

Whereas both community resources for victims have improved as well as the advent of empirically supported interventions, very limited research exists on the effectiveness of community-based resources. The need for methodologically sound research has been highlighted by others (Campbell & Patterson, 2011). In a review of eight investigations of SART's effectiveness, promising findings were suggested including improvements in cross-disciplinary relationships, increased participation of victims in the criminal justice process, as well as improvement in victims' help-seeking experiences. However, significant challenges were identified for SART as well (e.g., organizational barriers, issues with confidentiality) and resources are needed to continue evaluation of such a promising approach to intervention (Greeson & Campbell, 2012). These community-based resources not only provide much needed care for victims of violence, they are likely a critical component to helping to stop the repeated victimizations that often occur for many individuals. In addition to both a needed increase in both integrated community-based services and the evaluation of such services, the development and evaluation of primary prevention efforts needs to be enhanced. The majority of the empirical work evaluating primary prevention programming has occurred on college campuses (see Gidycz, Orchowski, & Edwards, 2011 for a review). Whereas early efforts demonstrated short-term changes on attitudes as a function of programming efforts, more recent work has focused on the examination of programming efforts on actual rates of victimization (see Orchowski, Gidycz, & Raffle, 2008) and perpetration (Gidycz, Orchowski, & Berkowitz, 2011) and the results have been promising. Further, recent approaches have focused on targeting the wider community through bystander intervention programming. Bystander (i.e., third-party witnesses to situations of high risk for sexual assault) interventions have gained support in their effectiveness in sexual assault prevention (Moynihan, Banyard, Cares, Potter, Williams, & Stapleton, 2015). Bystanders in such situations have the ability to effect sexual victimization risk in a number of ways; by not responding; by ignoring or supporting the perpetrator thereby making the situation worse, or acting in a prosocial way to intervene (McMahon & Banyard, 2012). Bystander intervention programs work to empower and encourage individuals to intervene, and attempt to stop potentially threatening dating situations when they encounter them (Banyard, Moynihan, & Plante, 2007). Bystander prevention efforts also involve helping individuals to overcome psychological barriers that might inhibit prosocial action as well as strengthening the safety and support networks for victims after an incident (Banyard, Moynihan, et al., 2007). Future research is needed to link such approaches with reductions in sexually aggressive behavior.

In summary, it is clear from the existing research that sexual victimization is a complex phenomenon influenced by sociocultural factors and experienced by individuals across a range of demographic factors. Whereas the past several decades of research have profoundly increased our understanding of the characteristics, risk factors, correlates, and outcomes of such victimization; continued work is needed to

better inform public policy, risk reduction, prevention, and treatment for all individuals at risk. Increased funding to conduct evaluation of our efforts to better understand sexual violence is sorely needed. Further, it is hoped that over the next couple of years, that increased resources will be allotted to greater exploration of the experiences of violence among diverse groups such as LGBT individuals as well as individuals from various other minority groups. Although a discussion of perpetrators was outside of the focus of this chapter (see Chapter 24 for a review), it is crucial to obtain a better understanding of the myriad of factors that contribute to the perpetration of violence in our society in order to most effectively use resources to prevent it.

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**Carlos A. Cuevas
and Callie Marie Rennison**

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