Sexual assault and rape

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Abstract

Sexual violence is pervasive in all societies. It can affect men, women and children. Every clinician will come into regular contact with sexual violence victims in one form or another. This review gives a brief overview of the considerations that should be given when dealing with an acute presentation as well as considering the other ways victims of sexual violence may present.

Keywords child sexual exploitation; forensic examination; rape; SARCS; sexual violence

Introduction

Sexual violence is defined as "*any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic women's sexuality, using coercion, threats of harm or physical force, by any person regardless of relationship to the victim, in any setting, including but not limited to home and work*"

Many who have studied sexual violence have concluded that rape and sexual assault are not primarily sexual acts. Their understanding is of rape as a violent act expressed sexually, rather than a sexual act expressed violently.

Due to the high prevalence of the problem, whilst not all doctors will have *knowingly* dealt with victims, all *will* have done so to better or not effect. The aim of this review is to raise awareness, outline some of the main issues that a doctor should consider and attempt to dispel some of the myths that tend to permeate the topic.

The sexual assault forensic medical examination is a complex process, addressing forensic aspects for the criminal justice process and also the medical and psychological needs of the patient. This should be done in a dedicated unit by staff with the requisite qualifications, knowledge, experience, skills and attitudes. In the UK this would usually be in a SARC (Sexual Assault Referral Centre).

Terminology is important. In the criminal justice process the terms complainants and victims are used. As this article is primarily dealing with the medical aspects, the term patient will be used. The feminine will be used (she, woman) as although it is acknowledged that man and boys are also subject to sexual violence the majority of victims are female.

Prevalence

The accurate prevalence of sexual violence in any particular society is difficult to determine as, for a variety of reasons, under reporting is an issue. Comparison of rates between countries is difficult: not only are cultural issues at play such as propensity to report but also the definition of sexual violence varies from country to country as do the relevant laws.

It is estimated that for England and Wales only approximately 15% of victims of the most serious sexual offences reported the incident to the police.

For the year ending March 2017 the Crime Survey for England and Wales (CSEW) estimated that 2.0 % of adults aged 16 to 59 experienced sexual assault (including attempts) in the previous 12 months, equivalent to an estimated 646,000 victims. 0.46% experienced rape or assault by penetration (including attempts) in the previous 12 months.

When asked about their experience since the age of 16 years, approximately 20% of females (aged 16–59 years) and 4% of males (aged 16–59 years) reported being a victim of any sexual assault with 4.5% of the females and 0.2% of males giving a history of rape.

There were a total of 121,187 sexual offences recorded by the police in England and Wales in the year ending March 2017 equating to 2.1 sexual offences per 1000 population. Of these, 41,186 were police recorded rapes, an increase of 15% from the previous year. 88% of these the complainant was female, 12% male.

The March 2017 CSEW report shows that the vast majority of victims of rape know their attacker, with only 13% being reported as strangers.

Whilst for some victims sexual violence will be an isolated and one off event, for many there will be an overlap with other types of abuse such as domestic abuse, emotional abuse and unfortunately this will form part of an ongoing situation.

The law

The Sexual Offences Act 2003 (England and Wales) applies to offences committed (in England and Wales) after 1st May 2004. Prior to that the Sexual Offences Act 1956 would apply. The 2003 Act covers numerous different offences including:

Section 1 (Statutory definition of rape)

1. A person (A) commits an offence if:
    a. he intentionally penetrates the vagina, anus or mouth of another person (B) with his penis.
    b. B does not consent to the penetration, and
    c. A does not reasonably believe that B consents.
2. Whether a belief is reasonable is to be determined having regard to all the circumstances, including any steps A has taken to ascertain whether B consents.

Section 5 (Statutory definition of rape of a child under 13 years)

1. A person commits an offence if:
    a. he intentionally penetrates the vagina, anus or mouth of another person with his penis, and
    b. the other person is under 13 years.

Sexual activity with a child under 16 is an offence, including non-contact activities such as involving children in watching sexual activities or in looking at sexual online images or taking part in their production, or encouraging children to behave in sexually inappropriate ways.

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In addition, the Crown Prosecution Service for England and Wales has a Violence Against Women and Girls (VAWG) strategy which provides an overarching framework for crimes identified as being primarily committed, but not exclusively, by men against women within a context of power and control. As part of this Section 76 of the Serious Crime Act 2015-Controlling or Coercive Behaviour in an Intimate or Family relationship came into force in December 2015. As many sexual assaults take place within relationships this new law should assist in prevention and prosecution.

Presentation

Modes of presentation may be obvious or obtuse, such that only the clinician with the most alert mind set would recognize it.

As has already been discussed many patients who have been victims of abuse will never disclose the abuse. They may still present with medical issues that are directly related to the abuse and may do so either directly or indirectly (Figure 1).

The degree to which a patient may discuss past events will be dependent upon issues particular to them, the setting and the degree of confidence they have in the clinician to respond appropriately with the information.

Where a patient has either made a disclosure or the clinician has a high degree of suspicion that it has happened, a number of issues must be considered:

- What needs the patient may have:
  - Medical
  - Forensic
  - Psychological
  - Social/Practical
  - Safeguarding
- What legal/statutory duties the clinician may have such as:
  - Safeguarding referrals
  - Female Genital Mutilation reporting.
- What are the options for the patient and what are their ideas, concerns and expectations.
- What resources are available to assist (the patient and the clinician) and how they might be accessed.

The clinician will need to have an understanding of the ethical issues around assessing a patient's capacity to make decisions, the possible limitations of confidentiality and potential competing duties towards the patient, others potentially at risk from the alleged perpetrator and public interest. Whilst any person may become the victim of sexual violence it remains the case that perpetrators will tend to target those individuals who are vulnerable, for example those with reduced mental capacity such as learning disability, intoxication or mental health problems, the young and the elderly. Vulnerability leads to victimization which leads to vulnerability which leads to victimization … and so the cycle continues.

The clinician must be able to communicate all of the above in a manner that allows the patient to feel empowered and start the process of regaining autonomy.

Many of these cases can be complex and often made even more so by the high level of emotion that they can generate. Ideally patients should be referred to a Sexual Assault Referral Centre (SARC) who will have the staff, including Forensic Physicians with the knowledge, experiences and skills to deal with these cases, providing a holistic response with ongoing support. That said, all clinicians need to be able to provide a safe initial response.

Children

The World Health Organisation (WHO) defines child sexual abuse as:

> *"The involvement of a child in sexual activity that he or she does not fully comprehend, is unable to give informed consent to, or for which the child is not developmentally prepared, or else that violate the laws or social taboos of society. Children can be sexually abused by adults or other children who are – by virtue of their age or stage of development"*

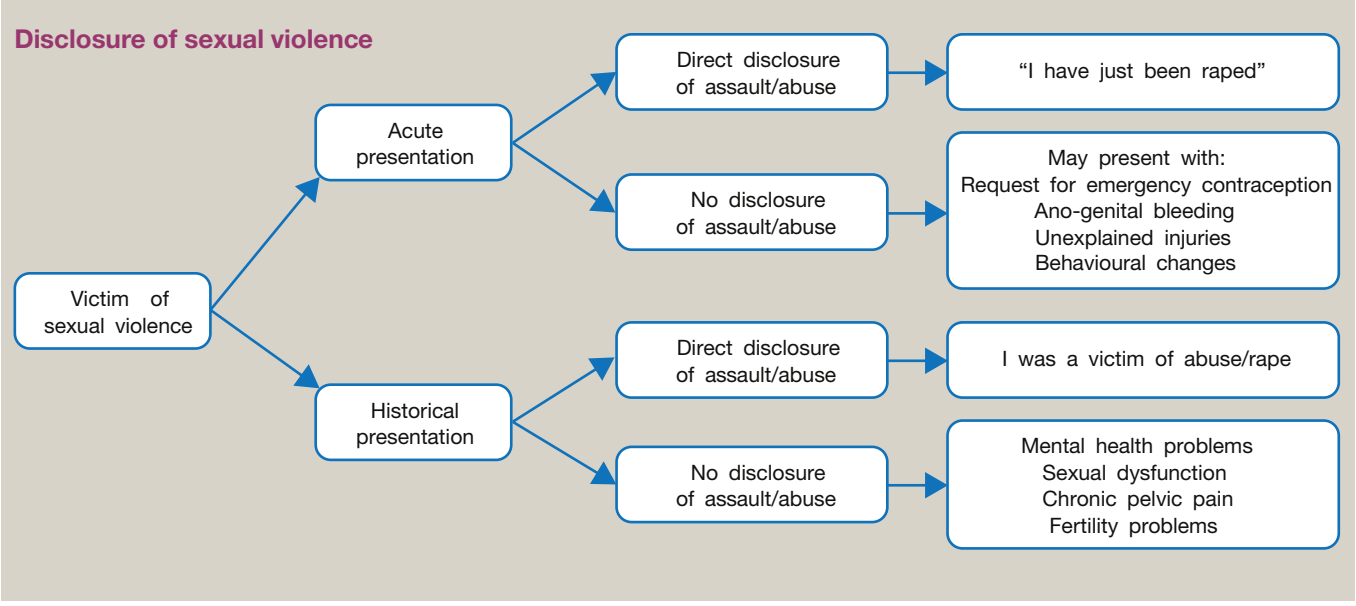

Figure 1