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Region I: Western Massachusetts
Abuse and Rape Crisis Hotline (ARCH), YWCA, Springfield
Every Woman's Center Against Violence Against Women Programs, University of Massachusetts, Amherst
Hotline to End Rape and Abuse, Inc. (HERA), Springfield
New England Learning Center for Women in Transition, Inc. (NELCWIT), Greenfield
Rape Crisis Center of Berkshire County, Inc., Pittsfield

Region II: Central Massachusetts
Let Us Know Crisis Center, Inc. (L.U.K.), Fitchburg
Rape Crisis Project of Worcester, Inc.

Regions III & IV: Northeastern Massachusetts
Greater Lawrence Action Against Sexual Assault, Greater Lawrence Mental Health Center
Rape Crisis Services of Greater Lowell, Inc.
Unit Against Rape and Sexual Assault, Project RAP, Beverly
Women's Resource Center, Lawrence

Region V: Southeastern Massachusetts
Cape Cod Sexual Assault Unit, Center for Individual and Family Services, Hyannis
Plymouth County Rape Crisis Center, Healthcare of Southeastern Massachusetts, Brockton
North Bristol County Sexual Assault Program, New Hope, Attleborough
Rape Crisis Project of New Bedford, New Bedford Women's Center, Inc.

Region VI: Greater Boston
Boston Area Rape Crisis Center, Inc. (BARCC), Cambridge
Community Programs Against Sexual Assault (CPASA), Roxbury Multi-Service Center
Women's Protective Services, West Suburban YWCA, Natick
(Since April 1989, part of the Southern Middlesex Opportunity Council)

SEXUAL ASSAULT IN MASSACHUSETTS 1985-1987: SHATTERING THE MYTHS

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EXECUTIVE SUMMARY

Violence is endemic to life in Massachusetts and throughout the United States. Sexual assault is not sex; it is violence and violation acted out by sexual means. Rape and other sexual assaults are violent crimes that have a devastating, long-term effect on the lives and health of survivors. As with all crimes of violence, sexual assaults contribute to morbidity and mortality. Therefore, the prevention of sexual assault must be recognized as an important part of the public health agenda.

This report, the first of its kind to be presented by the Massachusetts Department of Public Health, is a product of public health involvement in sexual assault. It is a summary of data collected from publicly funded Rape Crisis Centers (RCCs) in Massachusetts during the three-year period, January 1, 1985, through December 31, 1987. The major goal of RCCs is to assist survivors and significant others in the recovery process following the trauma of sexual assault. The data set in this report is unique in that it provides information on a large number of sexual assaults that have never been reported to a hospital or police department. The data help to clarify the true nature, broad scope, and effect of sexual assaults. The report also shatters myths about sexual assault that harm survivors and limit the ability of professionals to help survivors.

Some of the more important and disturbing findings from the RCC data follow:

- A total of 7254 incidents were reported to Rape Crisis Centers (RCCs) during the three-year period from January 1, 1985, through December 31, 1987.
- Half of all assaults reported to RCCs were completed rapes.
- The overwhelming majority of all reported sexual assaults were perpetrated by someone the survivor knew. Only 18% reported that their attacker was a stranger.
- Most sexual assaults were committed in a home setting, the survivor's or the assailant's home. One half of all reported assaults were committed in the survivor's own home, including the shared home of the survivor and the assailant.
- Half of the survivors were under 18 years of age at the time of the reported sexual assault. One quarter of the survivors were 13-17 years old; one quarter were under 13. Among child victims under age 13, 62% were assaulted by a parent or other relative. Strangers accounted for only 3% of the reported incidents in the under 13 age group.
- Of the 3010 survivors who were children (under age 18) at the time of the reported assault, nearly one third were 18 or older when the incident was reported to an RCC. In some instances, the assault had occurred many years earlier and this reporting was the first time the survivor had disclosed the assault to anyone or sought help.
- In this data set, 6757 survivors were female, 452 were male. Among younger age groups, the proportion of males was higher: Under age 18, about one survivor in 10 was male; under age 13, about one in seven was male.
- Nearly two thirds of survivors did not receive any medical attention after the sexual assault.
- Weapons were involved in 14% of reported sexual assaults.

- More than one tenth of the assaults were committed by multiple assailants.

- Only a third of survivors who reported an assault to RCCs also notified the police; only a quarter reported to a hospital. One quarter reported the assault only to an RCC.

Perhaps the most significant finding from the Massachusetts Rape Crisis Center data in terms of the public's health and safety indicates that most of these survivors did not turn either to law enforcement or health care providers after the assault.

Sexual assault is both a personal crisis and a social pathology. Efforts to prevent sexual assault must, therefore, work on two levels. The first must address the need for services to survivors and their families. The second must address the need for preventive education and increased community awareness about the realities of sexual assault, to change the social problems that create a climate where sexual violence can flourish.

In the 1985 Surgeon General's Workshop on Violence and Public Health, working groups on sexual assault outlined 12 educational and 10 direct service recommendations. Working groups on child sexual assault outlined additional recommendations specific to children. The following is based upon these guidelines and is supported by the findings outlined in this report.

I. Sexual violence prevention strategies: Efforts to prevent violence must become a public health priority.

Violence prevention programs must recognize, and work to change, current social values that support a climate of violence and make certain communities more vulnerable to victimization. Culturally sensitive approaches must be an integral component of all violence prevention strategies.

Since violent behavior is learned from various sources, including childrearing practices, family violence, peers, and the media, alternatives to violence must be taught in schools, colleges, and religious and community organizations.

In an effort to increase public awareness about sexual assault and the effect of sexual violence upon survivors and their families, as well as the negative social consequences of a high tolerance for violence, educational programs must be targeted to the following groups: potential victims--especially children, and adolescent and young adult females; potential offenders--preadolescent, adolescent and young adult males; school systems and colleges; parents; religious/cultural groups; and the media.

II. Direct services for survivors of sexual assault and their significant others are essential to the public health. Culturally sensitive approaches must be integral to all program components.

Rape Crisis Centers (RCCs) must be seen as a valid community response to the social problem of sexual assault and must become fully accessible to all communities. Services and scope of RCCs must be expanded throughout Massachusetts to enable them to provide services to the varied populations they serve, including survivors of rape by strangers and of rape by assailants known to them and victims of child sexual assault.

Technical assistance must be available to ethno-linguistic minority communities that are beginning to develop service programs for survivors of sexual assault.

III. Interagency coordination is needed to create a consistent and comprehensive response to survivors of sexual assault in Massachusetts.

Strategies for the prevention of sexual violence should be incorporated into all state human service agencies with protocols for handling sexual assault cases.

Training materials that are consistent statewide and sensitive to the needs of sexual assault survivors of all ages and cultures must be developed and implemented by an interdisciplinary task force that includes hospital and medical professionals, rape crisis and mental health professionals, law enforcement, criminal justice and victim-witness advocacy professionals, and state agency staff.

Early identification and treatment are also essential. Since survivors of all ages may seek help through various avenues and at various stages following sexual assault, core curriculum requirements that teach awareness of, and sensitivity about, sexual assault must be broad in scope and health professionals; mental health and human service professionals; educators, teachers, daycare workers and foster parents; law enforcement and criminal justice professionals; and clergy/religious professionals.

IV. Criminal sanctions and treatment for offenders: All components of the criminal justice system must recognize sexual assaults as serious violent crimes, and must be prepared to impose sanctions commensurate with the effect of these crimes on their victims.

Research must be conducted to measure the efficacy of various treatment programs for offenders.

Early identification, evaluation, and treatment of all sex offenders--especially adolescents and pre-adolescents--should become a priority since sex offenders often begin at a young age and usually repeat their offenses.

Prison sentences for offenders must incorporate appropriate treatment aimed at the prevention of future violent behaviors.

V. Expanded data collection efforts and research on rape and all other sexual assaults must be carried out to understand the issues more fully.

To receive more adequate statewide statistics, data collection from statewide rape crisis centers must be expanded to include centers that do not receive funding from the Department of Public Health. Hospitals and emergency rooms should also be encouraged to develop a data base on rape and all other sexual assaults.

Longitudinal data on arrest, conviction, and sentencing rates for offenders are also needed throughout the state since this information is often crucial to the survivor in making the choice whether or not to report to police and proceed with prosecution.

Additional research is needed in the following areas: evaluation of effective treatment approaches for survivors and their significant others regarding the process of recovery after sexual assault; offenders and factors associated with sexually assaultive behavior, as well as the effectiveness of treatment programs aimed at deterring continued violence; evaluation of the most effective educational curricula aimed at preventing rape and all other sexual assaults, as well as changing social attitudes that create a climate for violence; and statewide collection of data from law enforcement agencies regarding rape homicides.

The scope of preventive strategies, service provision, and further research must be as broad as the scope of the problem of sexual assault. It is hoped that this report, made possible by the efforts of Massachusetts Rape Crisis Centers in public education, data collection, and service provision, will assist in illuminating the scope of the problem by shattering many deeply entrenched and harmful myths about sexual assault.

INTRODUCTION

Violence is endemic to life in Massachusetts and throughout the United States. Sexual assault is not sex, it is violence and violation acted out by sexual means. Rape and other sexual assaults are violent crimes that have a devastating, long-term effect on the lives and health of survivors, their family, and friends. As with all crimes of violence, sexual assaults contribute both to morbidity and mortality. Therefore, the prevention of sexual assault must be recognized as an important part of the public health agenda.

Sexual assaults have traditionally been viewed as issues of criminal justice. Traditional law enforcement and public safety responses, however, are often ineffective in preventing sexual violence or in caring for the survivor. This situation is particularly true when the assailant is a family member or an acquaintance. Responding to the need for preventive efforts and improved care for survivors, national and state public health agendas now address violence and sexual violence. This report, the first of its kind to be presented by the Massachusetts Department of Public Health, is a product of public health involvement in this area.

The Scope of the Problem

Sexual violence robs people of the basic right to personal safety and bodily integrity. The fear of sexual assault can severely limit the actions and behavior of substantial portions of the population. This restriction is particularly true for people who are vulnerable because they are perceived to be less powerful, such as women, children, the poor, communities of color, the elderly, people who have various disabilities, lesbians and gay men. Attitudes that perpetuate sexual violence are pervasive in American society and affect everyone, either as a potential victim, significant other of a victim, or as a perpetrator.

Research on sexual assault beyond law enforcement statistics is relatively recent. Efforts to ascertain actual versus reported incidents suggest that law enforcement data do not reflect the scope of the problem. National reports to law enforcement agencies indicate that 378 rapes occur every day, or one rape every four minutes.[1] The Federal Bureau of Investigation Uniform Crime Reports estimate that rape is under-reported. A 1983 victimization survey conducted by the Department of Justice's Bureau of Justice Statistics recorded one rape for every 600 women, a figure close to twice as many as indicated by official police records.[2]

Although everyone is at risk of sexual assault, women and children are at the highest risk. The figures from the FBI Uniform Crime Reports for Massachusetts indicate the following numbers of reports to local and state police on rapes against women: 1646 in 1985; 1489 in 1986; 1529 in 1987. Even with only 16 publicly funded Rape Crisis Centers collecting data statewide, the numbers of rapes against women reported to RCCs were similar: 1210 in 1985; 1064 in 1986; 1156 in 1987. Rapes against males reported to RCCs during these years were 43, 47, and 46, respectively.

In addition to reports of rape, Rape Crisis Centers also received many reports of attempted rapes and other sexual assaults. Attempted rapes and other sexual assaults are part of the problem of sexual violence, but information about sexual assaults other than rape is generally unavailable or unreliable. The lack of such information further masks the true scope of the problem.

Incidents of child sexual abuse and child rape are another growing concern among health and human service professionals in the Commonwealth. The number of substantiated child sexual abuse reports to the Department of Social Services (DSS) rose from 1386 in 1983 to 2826 in 1984, a 104% increase. Reports in 1985 rose to 3533, a 25% increase from 1984. These reports appeared to level off somewhat with a 16%

decrease from 1985 to 1986 (2965 cases in 1986) and a 14% decrease in 1987 (2554 substantiated cases).[3] The fact that many health and human service professionals were legally designated mandated reporters of child abuse and neglect is an indication of increasing concern about all forms of child abuse. The new laws concerning mandated reporting may also account for the dramatic increase in reports of child sexual abuse in 1984. DSS investigates child sexual abuse only in cases where the alleged assailant is a caretaker of the child. Thus, many child sexual assaults go unreported and unexamined.

RAPE CRISIS CENTERS

History and Funding of Rape Crisis Centers

The rape crisis movement began nearly 20 years ago as a grassroots volunteer effort. Women concerned with the magnitude of sexual violence against women began organizing in communities throughout the country. The first rape crisis centers began providing services in the early 1970s. By 1976, there were approximately 400 rape crisis centers nationwide. Their primary goals were to provide information, assistance, and support services for survivors of sexual assault, to educate the public, and to institute change in public institutions, such as the criminal justice system.

Publicly funded rape crisis centers in Massachusetts were initiated in August 1982. At that time, eight RCCs were funded by the Massachusetts Department of Public Health (MDPH), with contracts ranging from $5,000-$10,000 for each RCC annually. In 1983, with the support of the Masschusetts Caucus of Women Legislators, the state legislature allocated funding for an additional seven RCCs. Concurrent with these efforts to increase services, the Department of Public Health worked with the Governor's Statewide Anti-Crime Council and the Massachusetts Coalition of Rape Crisis Services to improve cooperation and case coordination with law enforcement, medical, and criminal justice systems.

During 1985-1987, 16 RCCs received funding from MDPH. These 16 centers responded to over 7200 callers during these three years (Table 1). Statewide funding for RCC services during 1985-1987 was approximately $600,000 per year, with individual RCC contracts ranging from $17,000-$50,000 per year.

Department of Public Health funding for RCC services for fiscal year 1989 was $635,376, with individual RCC contracts ranging from $33,000- $64,000. Currently, there are 15 RCCs across Massachusetts that receive funding through the Department of Public Health (Figure 1). The Department has worked to strengthen these programs through the provision of technical assistance and training, with special emphasis on service delivery to communities of color and other underserved populations. Funding for Rape Crisis Centers has generally been limited and volunteers continue to perform many of the most essential duties of Rape Crisis Centers. Generally, for every paid staff person at a center, there are 10 to 20 unpaid workers. Most RCCs still rely heavily on trained volunteers to provide 24-hour crisis services. Rape crisis services in Massachusetts are often linked with other human service agencies, such as battered women's shelters, although some operate independently.

Table 1

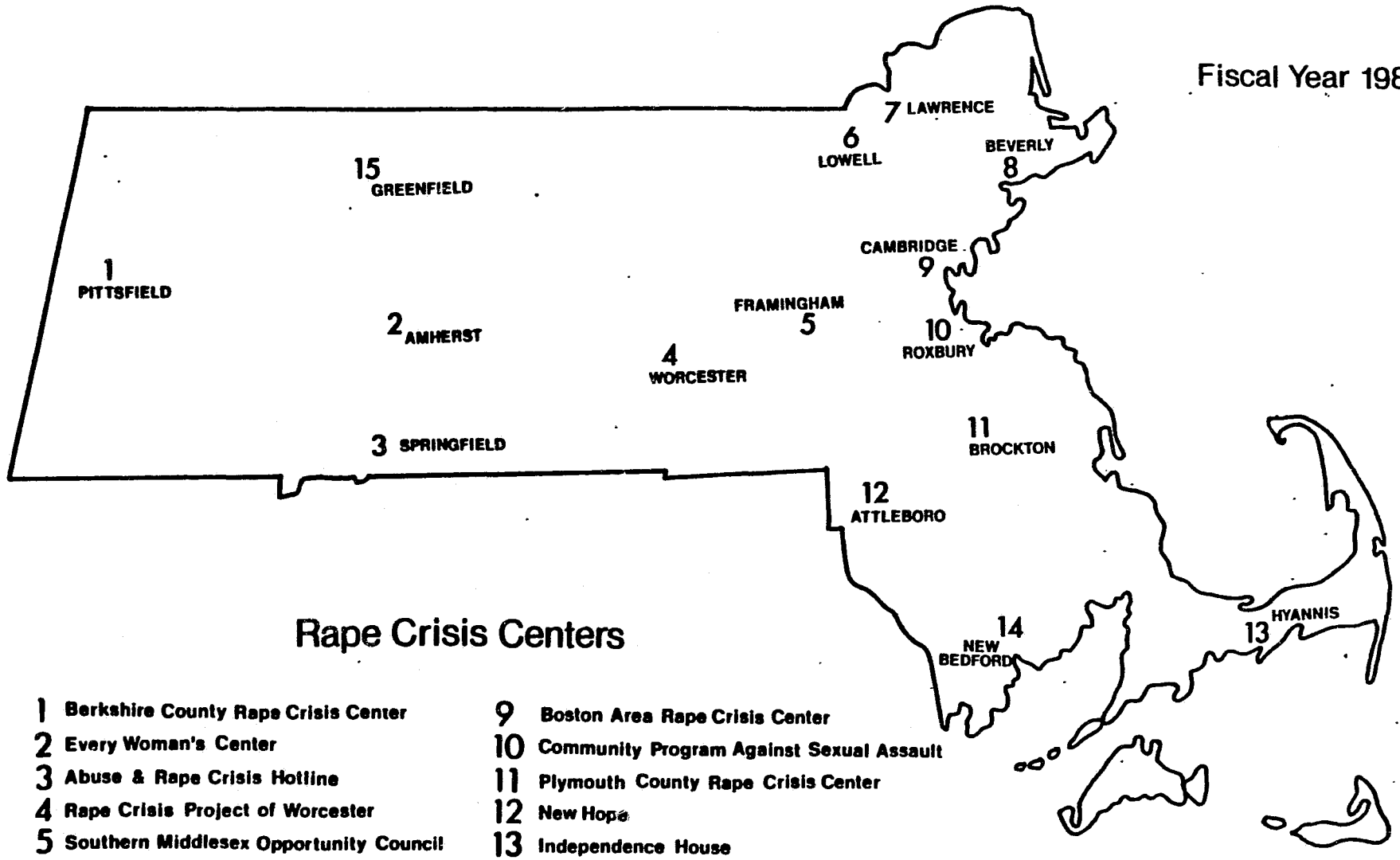
NUMBER AND PERCENT OF INCIDENTS 1985-1987
BY MASSACHUSETTS RAPE CRISIS CENTER.

Rape Crisis Center	Number of Incidents	Percent of Total
Boston Area RCC, Inc. (BARCC), Cambridge	1517	21
Rape Crisis Project of Worcester, Inc.	936	13
Every Woman's Center, Amherst	771	11
Plymouth County RCC, Brockton	542	7
RCC of Berkshire County, Inc. Pittsfield	522	7
Hotline to End Rape and Abuse, Inc. (HERA), Springfield*	418	6
Rape Crisis Project of New Bedford	377	5
Rape Crisis Services of Greater Lowell, Inc.	345	5
Unit against Rape and Sexual Assault, Beverly	267	4
N.E. Learning Center for Women in Transition, Inc. (NELCWIT) Greenfield	257	4
N. Bristol County Sexual Assault Program, Attleborough	230	3
Women's Protective Services, Natick	224	3
Community Programs Against Sexual Assault (CPASA), Roxbury	223	3
Let Us Know Crisis Center, Inc. (L.U.K.), Fitchburg	219	3
Cape Cod Sexual Assault Unit, Hyannis	192	3
Greater Lawrence Action Against Sexual Assault*, Lawrence	137	2
Abuse and Rape Crisis Hotline (ARCH), Springfield**	51	<1
Women's Resource Center, Lawrence **	25	< 1
Total	7253	100

*Stopped receiving public funds as of July 1987. **Began receiving public funds as of July 1987. Missing=1

RAPE CRISIS CENTERS FUNDED BY MASSACHUSETTS DEPARTMENT OF PUBLIC HEALTH

Fiscal Year 1989



Rape Crisis Centers

1 Berkshire County Rape Crisis Center
2 Every Woman's Center
3 Abuse & Rape Crisis Hotline
4 Rape Crisis Project of Worcester
5 Southern Middlesex Opportunity Council
6 Greater Lowell Rape Crisis Service
7 Lawrence Women's Resource Center
8 North Shore Rape Crisis Center
9 Boston Area Rape Crisis Center
10 Community Program Against Sexual Assault
11 Plymouth County Rape Crisis Center
12 New Hope
13 Independence House
14 Rape Crisis Project of New Bedford
15 New England Learning Center for Women in Transition

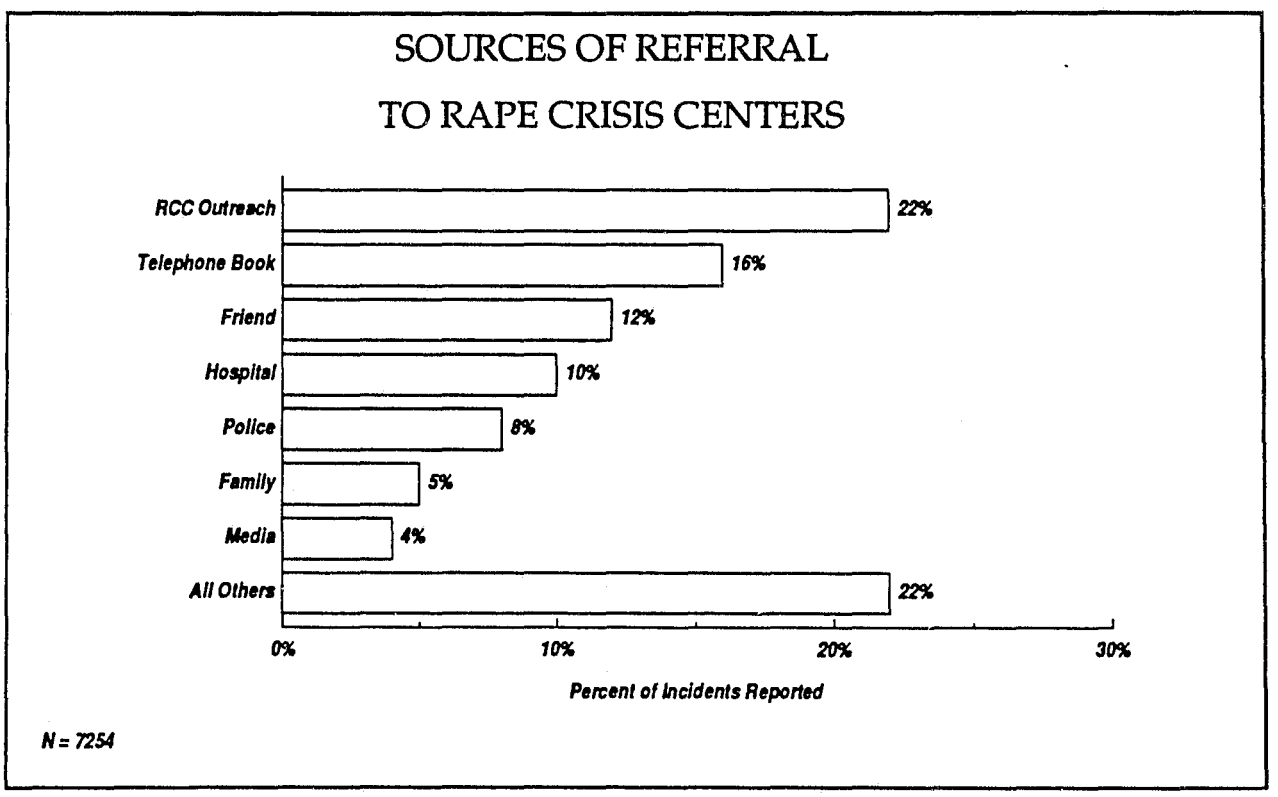
Rape Crisis Center Services

The goals of RCC services are to assist survivors and significant others in the recovery process after the trauma of sexual assault, and to decrease the incidence of sexual assault.

RCC staff and volunteers provide 24-hour telephone hotline services to survivors and significant others. Calls to the hotline receive a response immediately or within 15 minutes by a trained crisis counselor who is able to provide crisis counseling by telephone, immediate emotional support, and emergency client advocacy with hospital/police as needed, as well as practical medical/legal information and appropriate referrals. Supportive short-term (8-12 weeks) individual and group counseling is available for survivors and significant others to aid in the recovery process. RCCs regularly provide group counseling for adult survivors of incest and for adolescent and adult survivors of sexual assault. Culturally specific services developed for particular communities are not required to have a 24-hour hotline but must have outreach strategies that are culturally appropriate for the target community. The strategies may include home visits, self-help support groups, coffee hours and other specially designed outreach efforts.

RCC rape awareness education is provided to dispel racial, cultural, sexual and economic stereotypes that promote a climate of violence. Educational services aim at increasing knowledge and understanding of the issues surrounding rape, in order to decrease sexual violence and remove the socially imposed barriers to seeking services and reporting assaults. RCC educational activities include presentations to professional and community groups, schools, churches and law enforcement agencies. RCCs also make use of posters and pamphlets in strategic locations as part of outreach and community education. During 1985-1987, the source of referral to an RCC most commonly cited by callers was the RCC itself through outreach efforts (Figure 2).

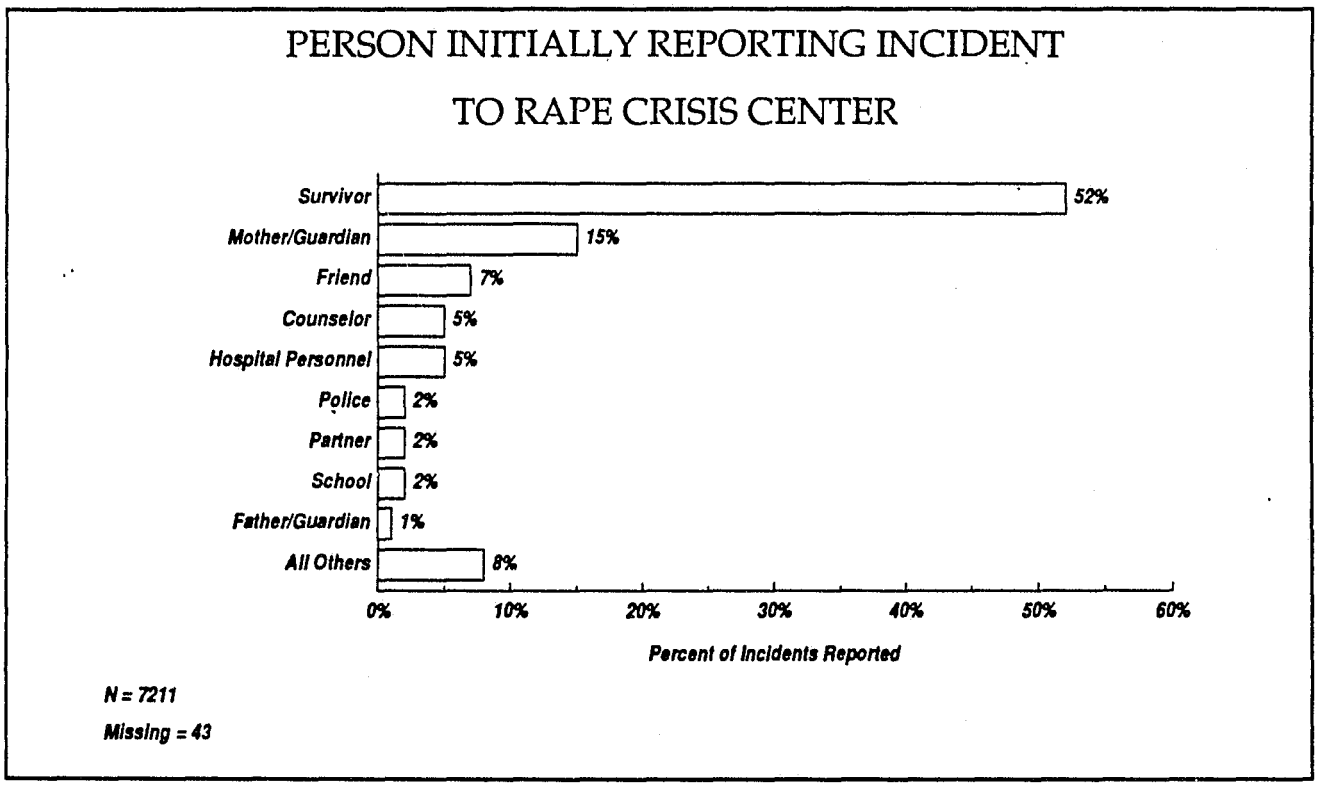
Figure 2



Source: Massachusetts Department of Public Health, Rape Crisis Centers 1985-1987

During 1985-1987 RCCs responded to over 7200 callers in need of services. The majority of persons making the initial call to an RCC were the actual survivors of the reported sexual assault. The survivor's mother was the second most frequent person to make the initial call to the RCC. The mother was the caller in 29% of the incidents in which the survivor was a child, that is, under 18 years old at the time of latest assault) (Figure 3). In about 14% of the reported incidents, the person who made the initial call was a professional, such as a counselor or hospital staff person.

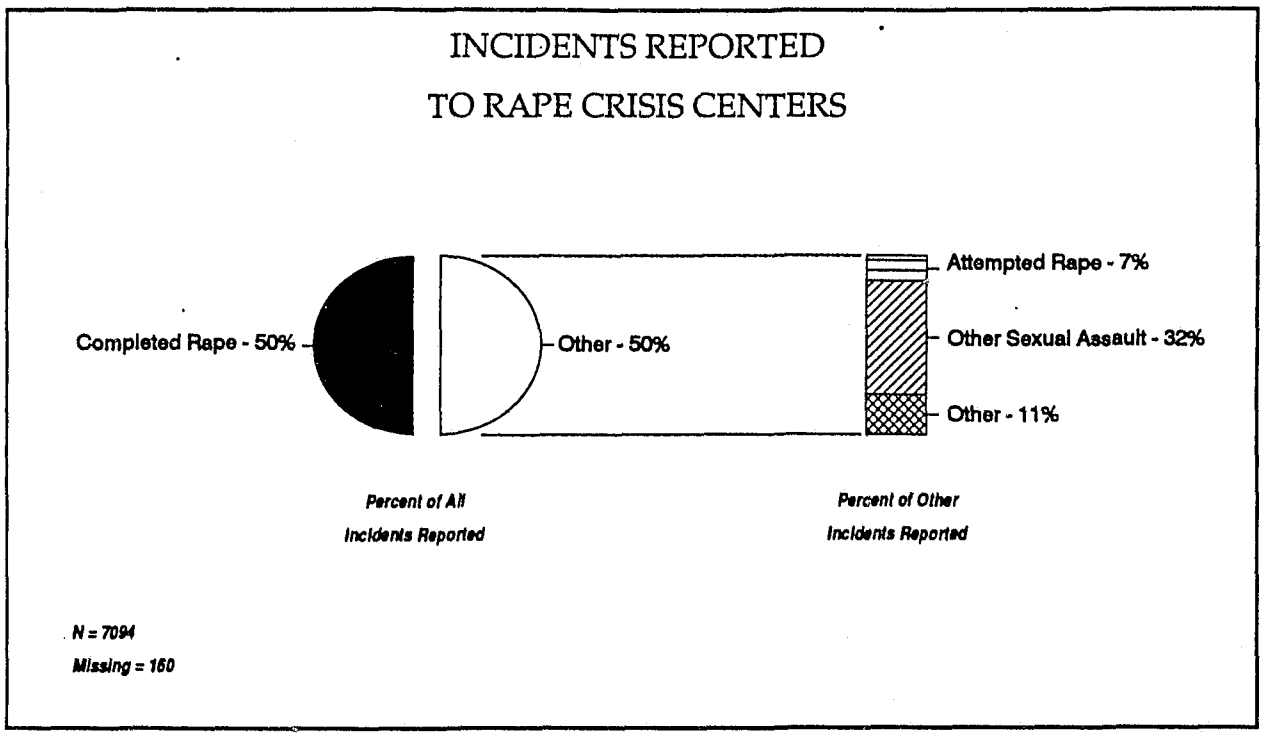
Figure 3



Source: Massachusetts Department of Public Health, Rape Crisis Centers 1985-1987

During this period, half (50%) of the incidents reported to RCCs were completed rapes. A completed rape is defined as forced intercourse with vaginal, anal or oral penetration by an object or part of the rapist's body, regardless of the survivor's age or the relationship between the survivor and assailant (Figure 4).

Figure 4



Source: Massachusetts Department of Public Health, Rape Crisis Centers 1985-1987

Importance of Rape Crisis Center Services and Data

The importance of RCC services is well documented. First and foremost is the fact that RCCs provide services to a large number of survivors of sexual assault who either have never reported the assault to law enforcement or health care agencies, or have indeed never reported the assault to anyone except the RCC. These survivors, in clear need of services, may be receiving support and other services only from RCCs. RCCs also serve survivors who have reported the assault elsewhere by providing support and advocacy that are not always available from other agencies.

Further, the Women's Health Division of the Massachusetts Department of Public Health is recognized statewide as a source of vital information on sexual assault and service provision to survivors of sexual assault. A statewide training manual, compiled to assist RCCs in staff development, has gained national attention as Massachusetts RCCs have become increasingly involved in the National Coalition Against Sexual Violence. The Governor's Statewide Anti-Crime Council continues to rely on information from RCCs regarding public policy, most recently during the development of a standardized rape examination kit to be used by hospitals for the collection of evidence.

PROFILE OF THE ASSAILANTS AND THE ASSAULTS

Introduction

Since many survivors never report to police or health agencies, the data collected by police and health agencies can describe only the tip of the iceberg of sexual assaults and assailants. The data presented here allow a glimpse of the reality submerged below the surface, and provide evidence that contradicts commonly held myths about sexual assault.

As more research is conducted outside law enforcement, additional facts about assailants and sexual assaults are emerging. Data sets such as the one presented in this report give us a broader understanding of the incidents and the circumstances under which they occur. The Rape Crisis Center data set contains information about the relationship between survivor and assailant and where assaults took place. Data on sexual assailants and violence gathered from a variety of sources are beginning to influence and inform not only our understanding of how sexual assaults really occur, but of how the criminal justice system and health and human service agencies can respond more appropriately to these realities.

Findings: Survivor/Assailant Relationship

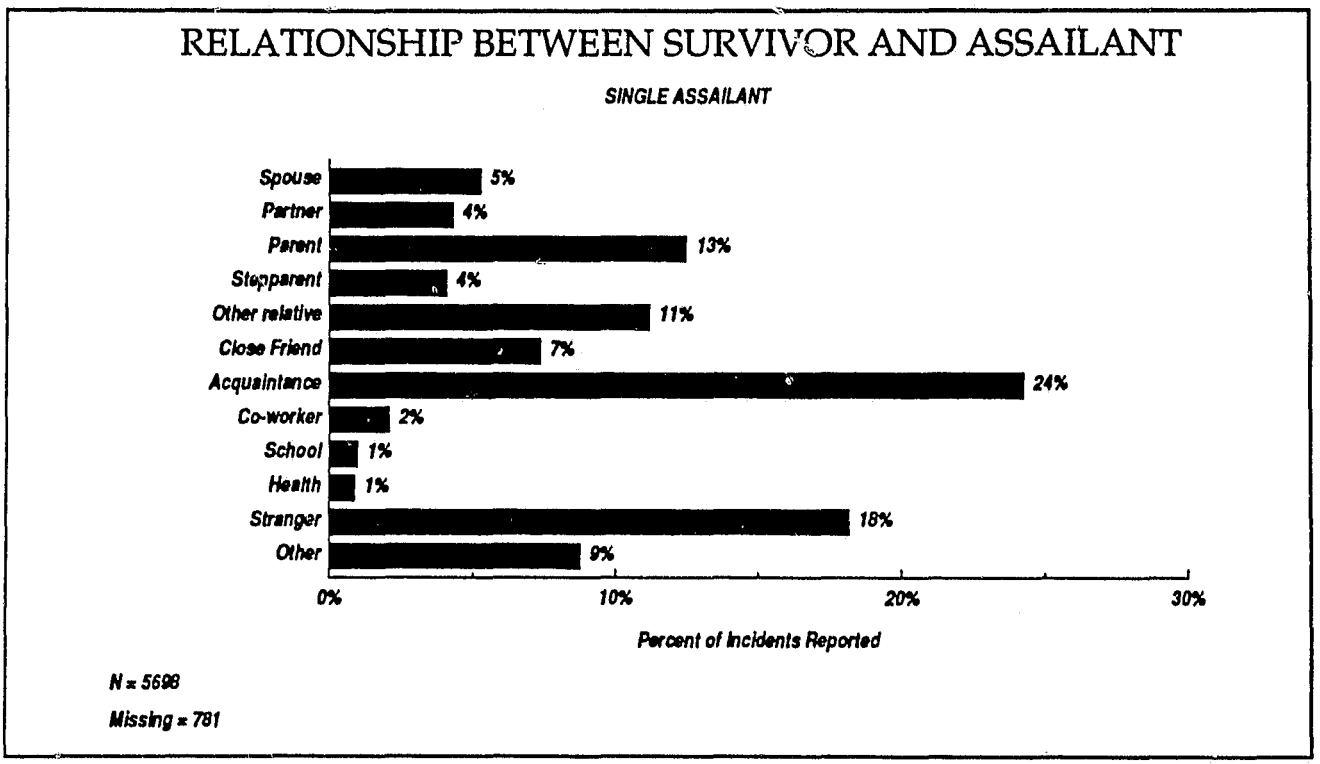
MOST SEXUAL ASSAULTS WERE PERPETRATED BY SOMEONE THE SURVIVOR KNEW.

Survivor/ Assailant Relationship

One of the most compelling findings from this data set was that the overwhelming majority of all assailants were known to the survivor. Only 18% of survivors reported that their attacker was a stranger. All figures on the survivor/assailant relationship apply to single-offender incidents only.

More than one-quarter of these assaults (28%) involved incest, incidents in which offenders were parents, relatives, or stepparents. Nine percent were committed by the survivor's spouse or partner. Another third of the survivors were victimized by their close friends and acquaintances. People in professional association with the survivor, such as day care, school and health personnel, and coworkers, were the assailants in 4% of the incidents (Figure 5).

Figure 5



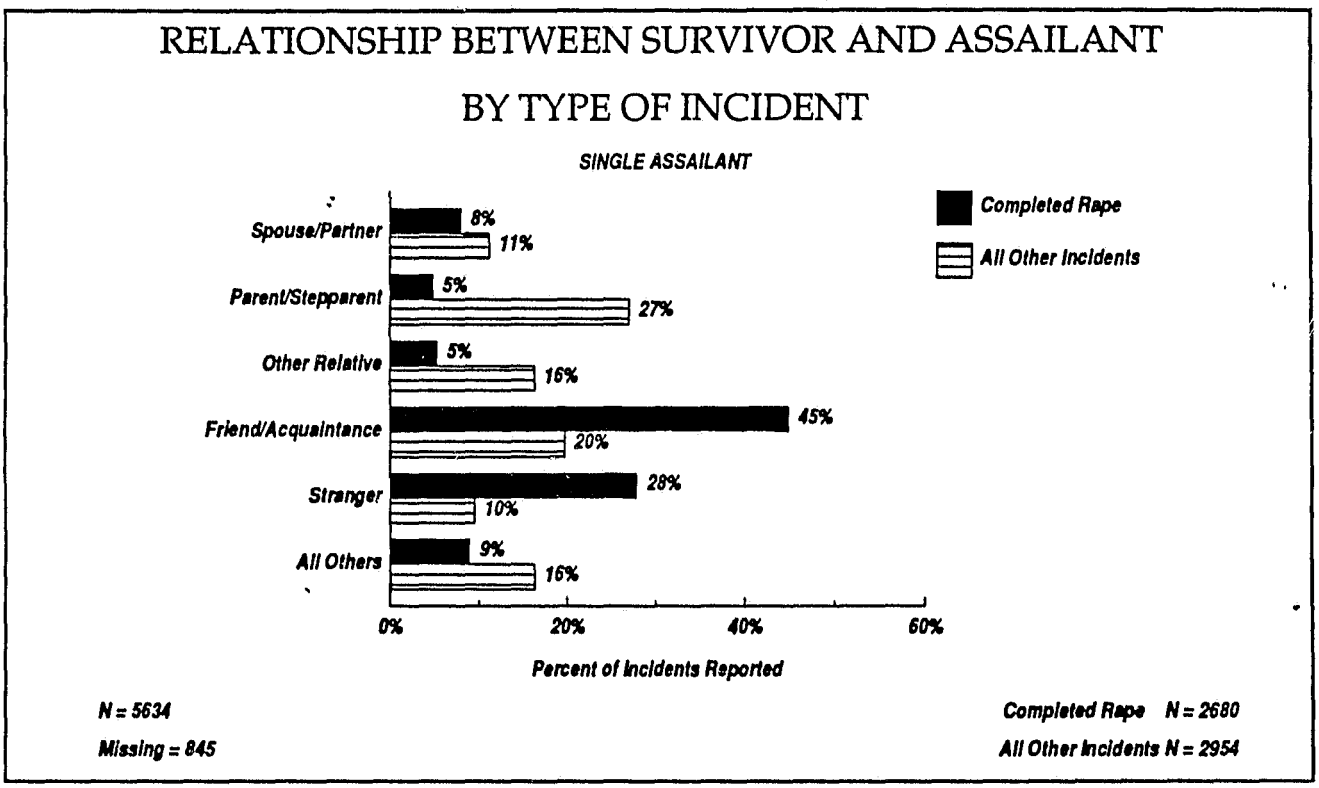
Source: Massachusetts Department of Public Health, Rape Crisis Centers 1985-1987

Findings: Survivor/Assailant Relationship

Rapists vs. All Other Sexual Assailants

Although strangers comprised over a quarter (28%) of the rapists in this data set, friends and acquaintances committed nearly half (45%) of completed rapes reported to RCCs. Relatives (parents, stepparents, spouses, other relatives) committed 18% of the reported completed rapes. In contrast, relatives committed 54% of all other sexual assaults (Figure 6). These patterns may be explained by the fact that so many of the incidents involving children were not reported as completed rapes to the RCC.

Figure 6



Source: Massachusetts Department of Public Health, Rape Crisis Centers 1985-1987

Age of Survivor

The persons in the RCC data set were apparently at greatest risk of sexual assault from persons to whom they were closest. Regardless of the survivor's age, the assailant generally came from social and familial groups close to the survivor (Table 2).

Children

Children (<13 years) were survivors of incest in 62% of the reported cases. Contrary to one commonly held myth, parents were offenders three times more frequently than stepparents (parents: 29%, stepparents: 9%, other relatives: 24%). The fact that so many child sexual assaults involved the survivor's caregiver makes recovery particularly problematic. In addition, contrary to recent attention in the media, school and day care personnel were involved in fewer than 2% of these incidents. Strangers accounted for only 3% of the reported incidents in this age group.

Findings: Survivor/Assailant Relationship

Adolescents

Adolescents (13-17 years) were most commonly assaulted by a friend or acquaintance. Relatives, however, still accounted for 32% of the sexual assaults on survivors in this age group (parents: 12%, stepparents: 6%, other relatives: 14%). Strangers were the assailants in 16% of these cases, a finding perhaps indicating this age group's increasing exposure to people other than family.

Table 2

AGE OF SURVIVOR BY RELATIONSHIP

BETWEEN SURVIVOR AND ASSAILANT

SINGLE ASSAILANT

	Spouse/ Partner	Friend/ Acquaintance	Parent/ Stepparent	Other Relative	Stranger	All Others
<13 (1209)	0%	19%	38%	24%	3%	16%
13-17 (1273)	3	40	18	14	16	10
18-29 (1676)	14	38	6	4	26	12
30-45 (579)	24	30	2	3	26	15
46-59 (54)	13	26	0		41	17
60+ (27)	22	33	0	0	33	

N = 4817
Missing = 1662

Table presents row percents
% not calculated for less than 5 incidents

Source: Massachusetts Department of Public Health, Rape Crisis Centers 1985-1987

Adults

Young adults (18-29 yrs) were most commonly assaulted by friends and acquaintances. In this age group, spouses and partners emerge as a sizable number of the assailants; and strangers account for over a quarter of the assaults.

Adults (30-45 yrs) comprised a smaller group of survivors, and their assailants were split almost evenly between friends and acquaintances, spouses/partners, and strangers.

Older adults (45+ years) accounted for a very small fraction of the total sample, which may indicate that few older survivors chose to contact an RCC. Unlike the finding in younger groups, however, strangers were more likely to be the assailant. The small number of persons in this group (n=81), however, makes comparisons difficult.

Findings: Age of Assailant

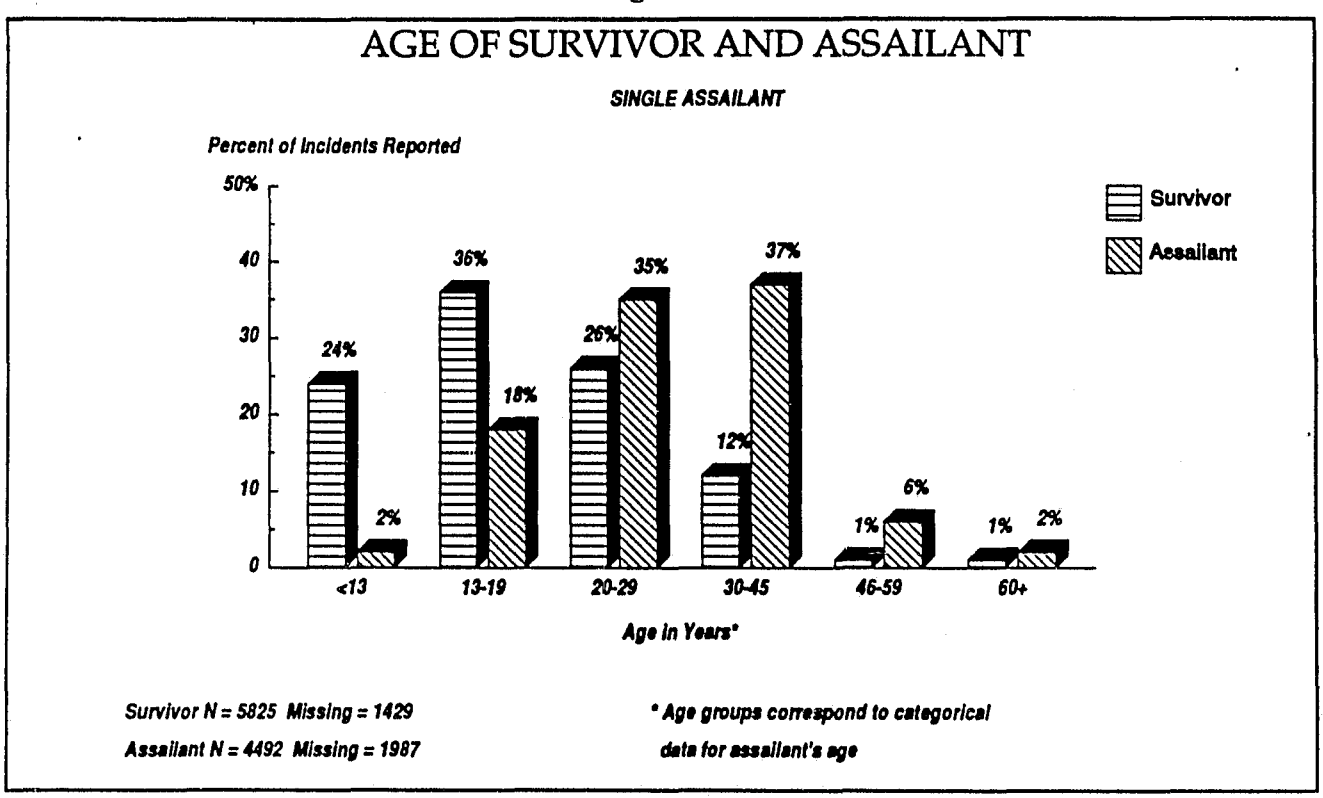
IN GENERAL, ASSAILANTS WERE THE SURVIVORS' AGE OR OLDER.

Age of Assailant

Persons reporting sexual assaults to RCCs were asked to estimate the age of the assailant. Since this information was gathered from the survivor or another person reporting the assault and not from police or court records when assailants have actually been apprehended or convicted, there is no way to verify the actual age of offenders in many incidents.

In general, the assailants were the survivors' age or older. Nearly three quarters (72%) of all single-offender incidents were committed by adults between the ages of approximately 20 and 45 years. Adolescents 13-19 years of age accounted for nearly one fifth of the single assailants (Figure 7).

Figure 7



Source: Massachusetts Department of Public Health, Rape Crisis Center 1985-1987

Findings: Age of Assailant

Ages of Assailant and Survivor

When the age of the assailant was contrasted with the age of the survivor, the comparison revealed that children under age 13 were most often assaulted by adults aged 30-45 years (43%), followed by adolescents aged 13-19 years (23%), and young adults aged 20-29 years (18%).

Adolescents (13-17 years old) were most often assaulted by their peers aged 13-19 years (37%), followed by adults aged 30-45 years (34%), and young adults aged 20-24 years (23%).

Young adults aged 18-29 years were most at risk from their peers aged 20-29 years (62%), followed by adults aged 30-45 years (26%).

Survivors aged 30-45 years were at highest risk from their peers (66%).

Rapists vs. All Other Sexual Assailants

Rapists were generally younger than all other sex offenders. Adolescents and young adults (13-29 years) were responsible for 67% of all completed rapes. Adults over 30 years of age committed 33% of the completed rapes reported to RCCs and 56% of all other sexual assaults. These numbers are probably due to the fact that so many of the incidents reported as other than rape involved sexual assault against children, most often committed by adults in the family, who were likely to be older than the survivor.

Findings: Location of Incident

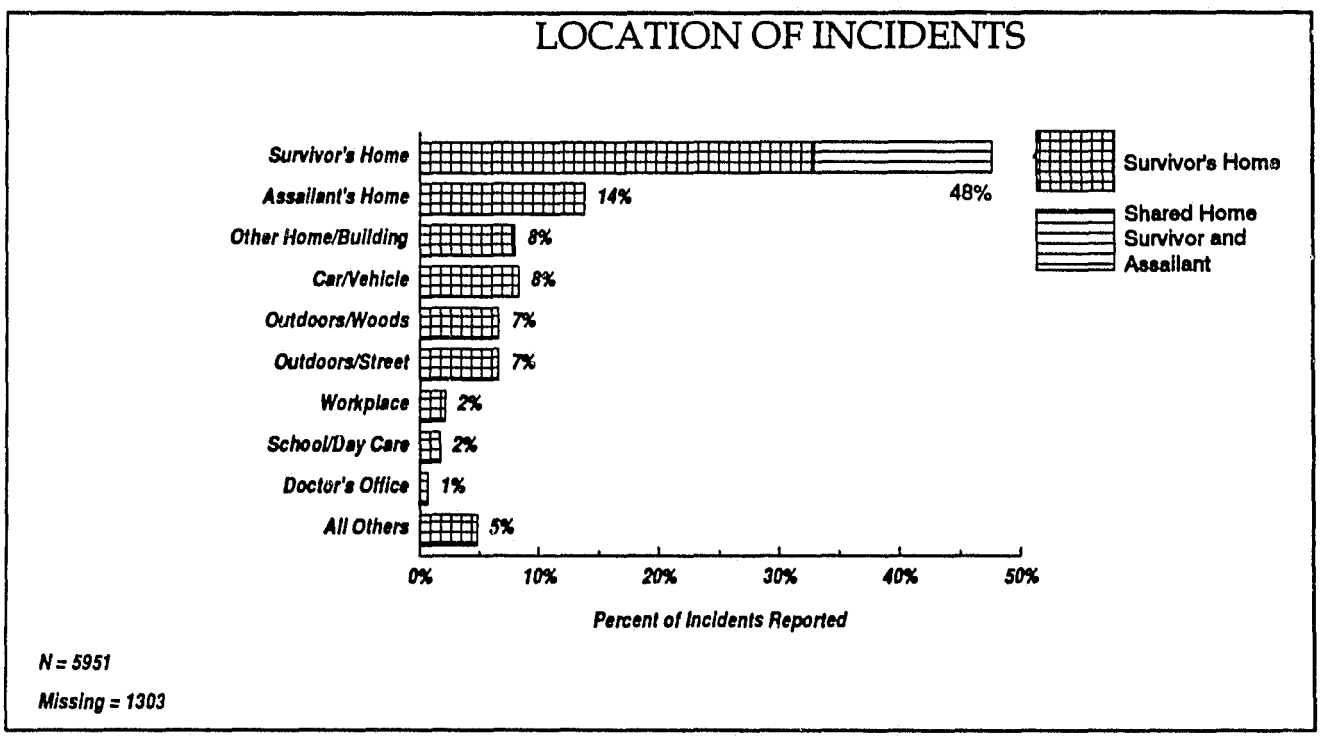
MOST SEXUAL ASSAULTS WERE COMMITTED IN A HOME SETTING, THE SURVIVOR'S OWN HOME OR THE ASSAILANT'S HOME.

Location of Incident

One half (48%) of all reported assaults were committed in the survivor's own home, including the shared home of the survivor and the assailant. This number was followed by assaults in the offender's home, making a home setting the most common location for sexual assault.

Outdoor locations, cars and other vehicles were the site for 22% of the reported incidents (Figure 8).

Figure 8



Source: Massachusetts Department of Public Health, Rape Crisis Centers 1985-1987

Survivor/ Assailant Relationship

The location of the incident was, in large part, linked to the survivor/ assailant relationship (Table 3). The survivor's home was the most frequent site of sexual assaults by all assailants known to her/him. When the offender was a parent or stepparent, the offense occurred in the survivor's home 89% of the time (45% were in the shared home of the survivor and assailant). Similarly, when the offender was the survivor's spouse or partner, the assault occurred in the survivor's home 84% of the time (38% were in the shared home). When the offender was a relative, the assault occurred in the survivor's home 70% of the time (26% were in the shared home).

Findings: Location of Incident

Table 3

LOCATION OF INCIDENT BY

RELATIONSHIP BETWEEN VICTIM AND ASSAILANT

SINGLE ASSAILANT

	Survivor's Home (2538)	*Assailant's Home (727)*	*Car/Vehicle (398)*	*Outdoors (620)*	*All Others (836)*
Spouse/Partner (490)	*84%*	*7%*	*3%*	*2%*	*4%*
Parent/Stepparent (880)	*89*	*9*	*0*	*1*	*1*
Other Relative (557)	*70*	*22*	*1*	*2*	*5*
Friend/Acquaintance (1563)	*31*	*24*	*11*	*12*	*23*
Stranger (947)	*22*	*4*	*17*	*40*	*16*
All Others (682)	*39*	*12*	*6*	*4*	*40*

N = 5119 Missing = 1360

Table presents row percents

Survivor's home includes home shared between survivor and assailant

Source: Massachusetts Department of Public Health, Rape Crisis Centers 1985-1987

When the assailant was a friend or acquaintance, 31% of the assaults occurred in the survivor's home, 2% in the shared home, and another 24% in the assailant's home. Hence, assaults in the offender's home may indicate a relationship of trust whereby the survivor enters the home willingly.

Even when the assailant was a stranger, 22% of these assaults were committed in the survivor's own home, a figure that suggests a break-in. Most assaults by a stranger, however, occurred outdoors (40%) or in a car/vehicle (17%), suggesting abduction or hitchhiking.

Age of Survivor

For all age groups, the survivor's own home--often shared with the offender--was the most common location of sexual assaults, especially for the youngest (under 13 years old) and oldest (over 59 years old) survivors. For children under 13 years of age, 67% of the assaults occurred in their own home, a home they shared with the offender 26% of the time (Table 4).

Findings: Location of Incident

Table 4

AGE OF SURVIVOR BY LOCATION OF INCIDENT

	Survivor's Home (2194)	Assailant's Home (681)	Car/Vehicle (369)	Outdoors (575)	All Others (742)
<13 (1163)	67%	17%	1%	5%	10%
13-17 (1156)	39	19	10	14	17
18-29 (1589)	38	14	11	16	21
30-45 (571)	54	7	9	13	16
46-59 (55)	60		9	16	11
60+ (27)	81	0	0		

N = 4561 Missing = 1918

Table presents row percents

% not calculated for less than 5 incidents

Survivor's home includes home shared between survivor and assailant

Source: Massachusetts Department of Public Health, Rape Crisis Centers 1985-1987

Rapists vs. All Other Sexual Assailants

In a comparison of the locations where completed rapes versus all other incidents occurred, a view of the more classic rape scenario emerges. Survivors were raped outdoors in 19% of the reported incidents and in cars or other vehicles in 13% of the cases; however, 35% of the completed rapes took place in the home of the survivor or of the survivor and assailant. Conversely, all other sexual assaults occurred more frequently in the home (59%), and less frequently outdoors (9%) or in a car or vehicle (4%).

Findings: Presence of Weapon

SEXUAL ASSAULT IS INHERENTLY VIOLENT: THE VIOLENCE IS SOMETIMES EXPRESSED THROUGH THE PRESENCE OF A WEAPON.

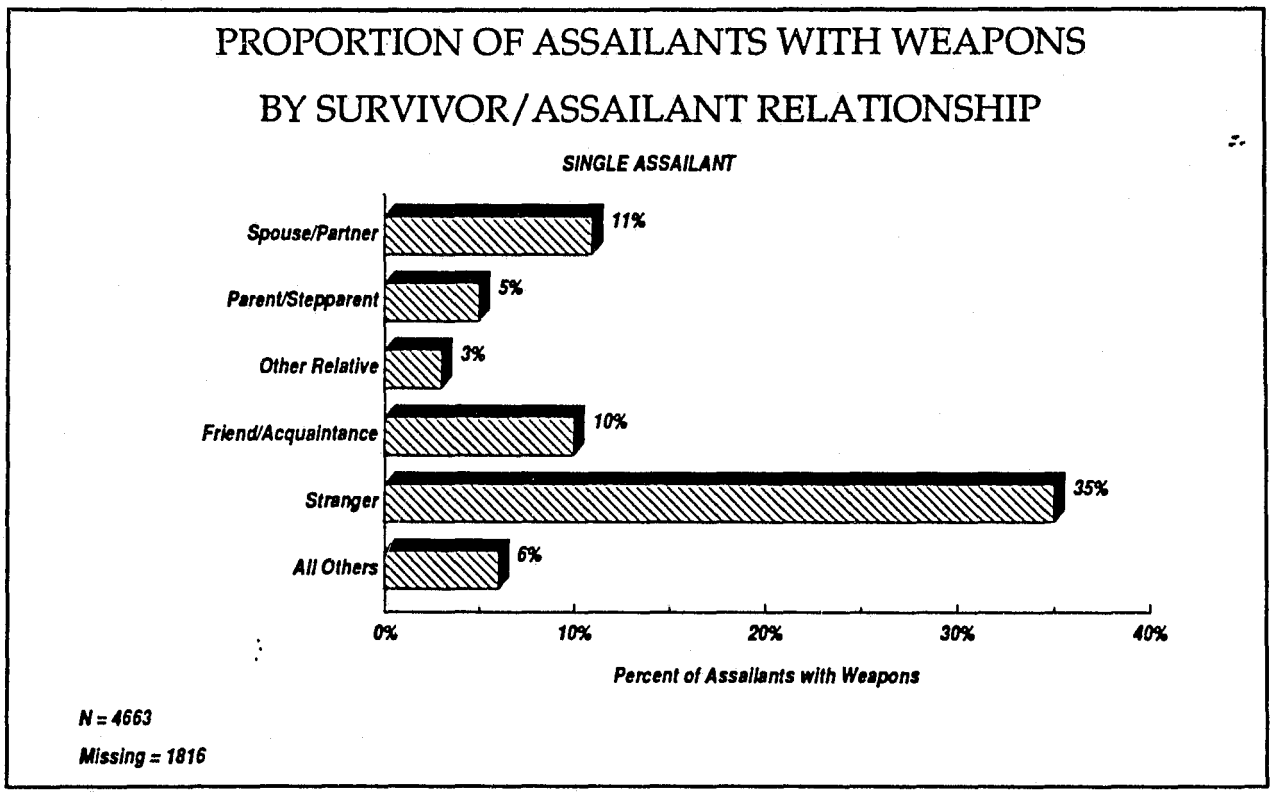
Weapons

For the purposes of coding this data set, a weapon was defined as any item aside from the assailant's body that was used to coerce or intimidate the survivor. A weapon, therefore, is interpreted broadly to include not only guns and knives, but also blunt objects, broken glass, and other instruments.

Survivor/ Assailant Relationship

Strangers were more apt to use weapons than all other assailants (Figure 9). Strangers had weapons in over a third of the assaults they committed. Spouses and partners ranked second in weapon use; more than one of every 10 assaults committed by them involved a weapon, a fact indicating a high level of violence. When parents and stepparents are grouped together, one in 20 used weapons. Weapon use was low in incidents involving other assailants (6%), including coworkers, school personnel, and health personnel.

Figure 9



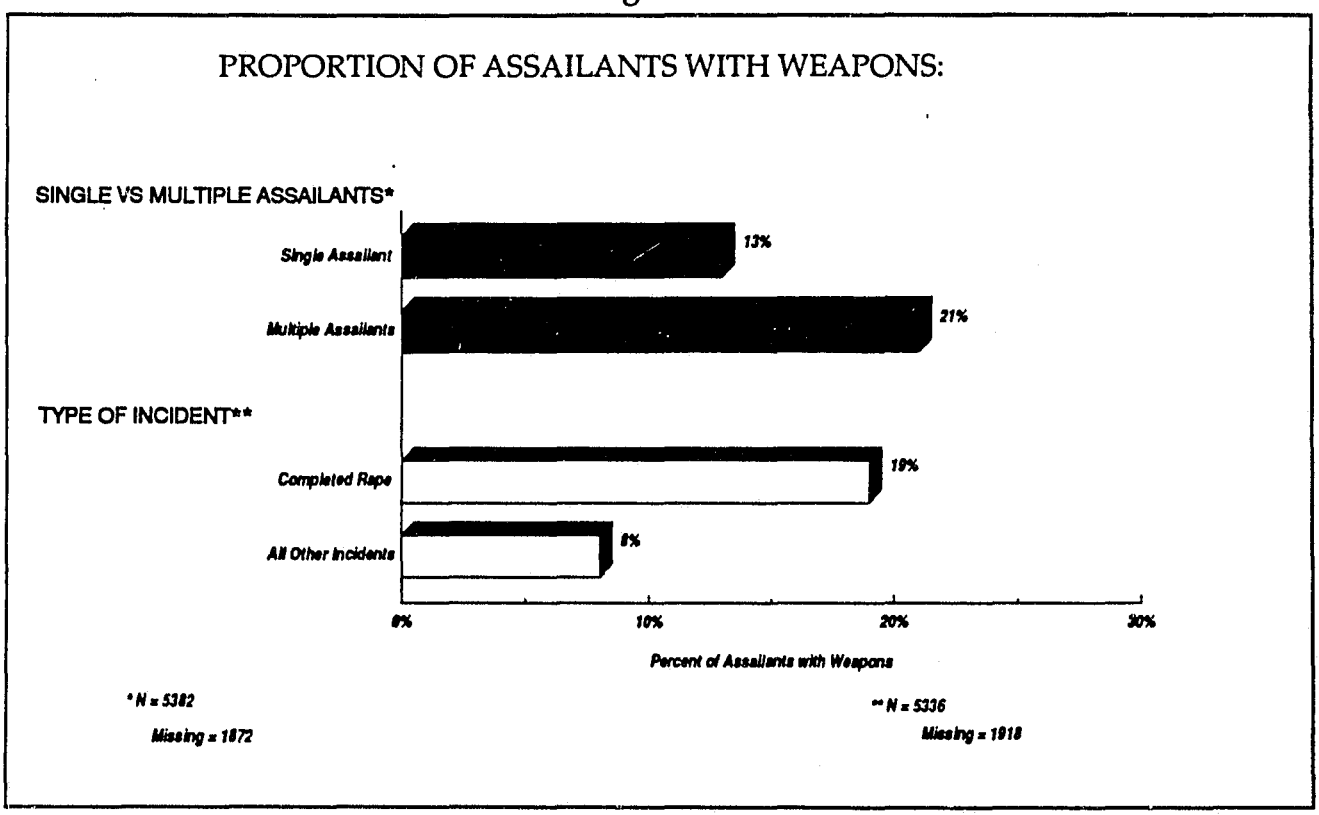
Source: Massachusetts Department of Public Health, Rape Crisis Centers 1985-1987

Findings: Presence of Weapon

Multiple Assailants and Completed Rape

Overall, weapons were involved in 14% of all reported sexual assaults. Weapons, however, were more often present in assaults by multiple assailants and in completed rapes (Figure 10). Where incidents were committed by more than one assailant, 21% involved weapons as compared to 13% for single assailants. Furthermore, although weapons were only present in 8% of all other incidents, they were present in 19% of all completed rapes.

Figure 10



Source: Massachusetts Department of Public Health, Rape Crisis Centers 1985-1987

Location of Incident

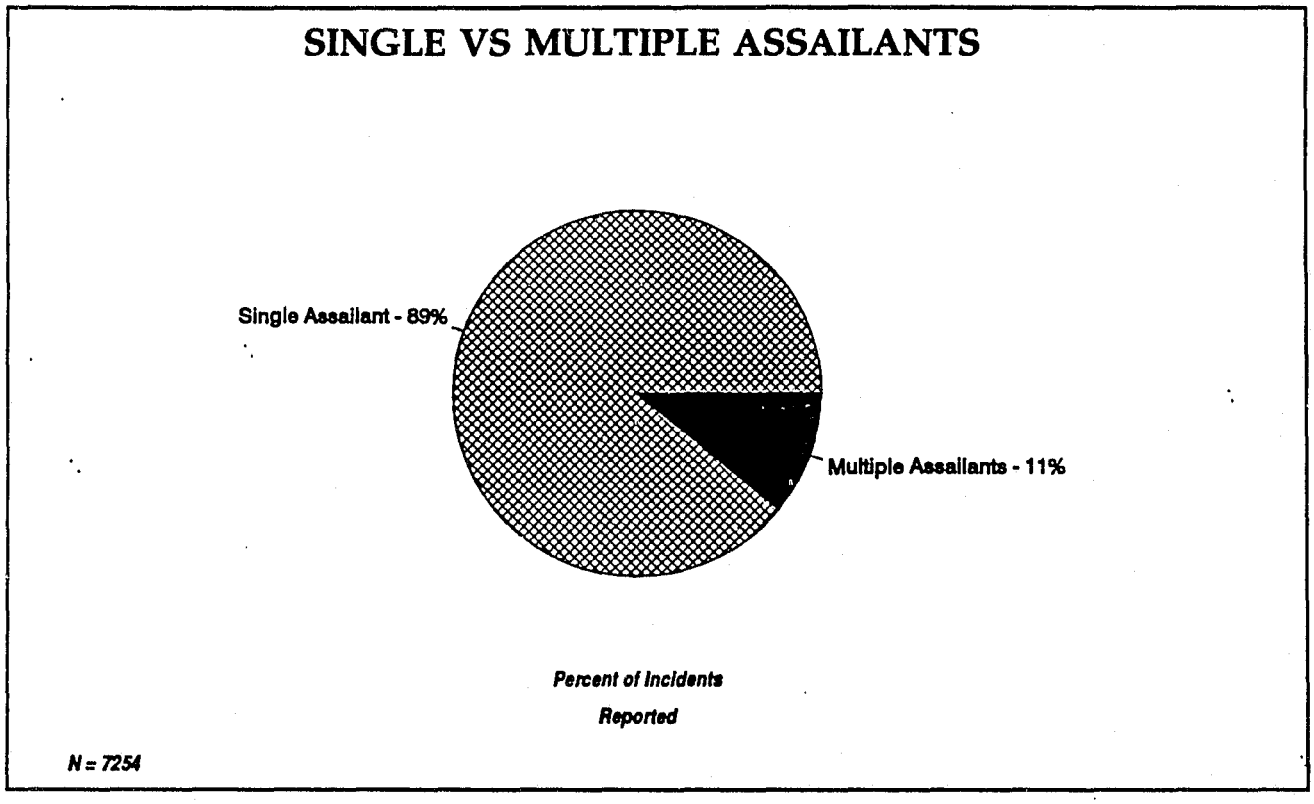
Weapons were used most frequently in the survivor's own home (36%), followed by use outdoors (27%) and in a car/vehicle (15%). If the presence of a weapon is any indication of the level of force or violence, one's own home may be viewed as the most dangerous place of all. This finding debunks a common myth that has instructed women that their own homes are their safest refuge from sexual assault.

Findings: Multiple Assailants

MORE THAN ONE IN TEN SEXUAL ASSAULTS WERE COMMITTED BY MULTIPLE ASSAILANTS.

Of a total of 7254 incidents reported, 11% were committed by more than one assailant (Figure 11).

Figure 11



Source: Massachusetts Department of Public Health, Rape Crisis Centers 1985-1987

Sex of Assailant and Survivor

Males were the assailants in 97% of all incidents (including both multiple- and single-assailant offenses), with females comprising 2% of assailants, and groups of mixed males and females, 1% of all incidents. Several assailants were twice as likely as single assailants to attack male survivors (12% versus 6%).

Rapists vs. All Other Sexual Assailants

Twelve percent of all completed rapes were committed by more than one assailant, whereas multiple offenders were involved in 9% of all other incidents.

Location of Incident

Nineteen percent of multiple-assailant incidents occurred outdoors; 11% occurred in cars or other vehicles, as compared with 12% and 8% for single-assailant incidents. Single-assailant incidents were more likely to occur in a home setting, the survivor's, the offender's, or the shared home of the survivor and offender.

PROFILE OF THE SURVIVORS OF SEXUAL ASSAULT

Introduction

This section discusses characteristics of the survivors of the sexual assaults reported to the MDPH RCC services during 1985-1987. The data presented in this section help shatter myths about the age, sex, and race of sexual assault survivors. These myths have originated in popular misconceptions and the limited sexual assault data available from traditional sources. Shattering these myths is a first step to understanding who the survivors of sexual assault really are.

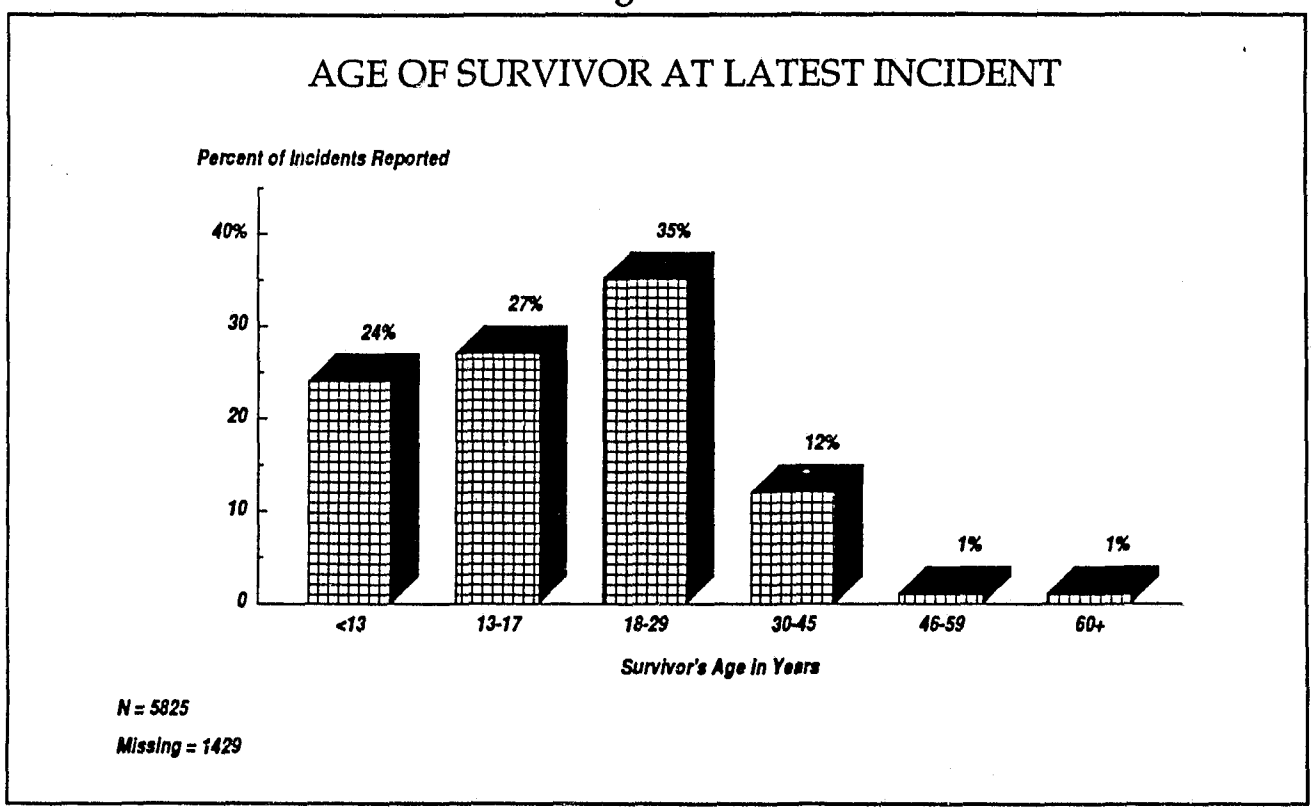
Findings: Age of Survivor

HALF OF THE SURVIVORS WERE UNDER 18 YEARS OLD AT THE TIME OF THE LATEST SEXUAL ASSAULT.

Age of Survivor at Latest Incident

Almost all specific information in the data set pertained only to the latest or most recent incident. Thus, in this report, unless otherwise specified, the age of the survivor refers to age at the latest incident (Figure 12).

Figure 12



Source: Massachusetts Department of Public Health, Rape Crisis Centers 1985-1987

Children

One of the most striking and disturbing facts to emerge from this data set concerns the proportion of very young survivors of sexual assault. Children 17 years and younger comprised over half (n=3010) of the survivors whose age was reported at the latest incident. Half of these children were under 13, half were 13-17 years old.

Adults

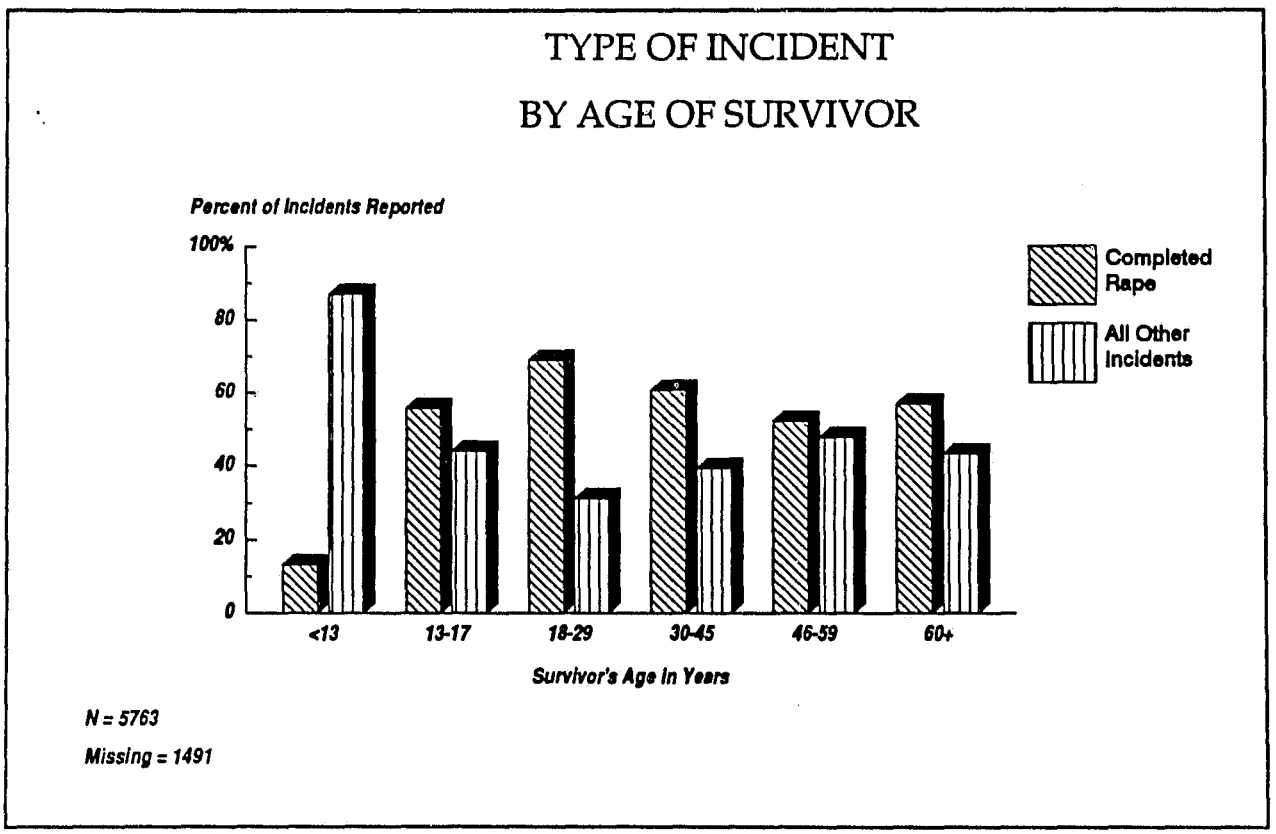
As popular perception suggests, survivors who were young adults (18-29 years) at the latest incident comprised the largest single group who reported to Rape Crisis Centers. The proportion of survivors over age 29 was low as compared to the proportions of younger adults and children. Twelve percent were adults between the ages of 30 and 45 years at the time

of the assault, and 105 survivors (2%) reporting to RCCs were over 45 years old at the time of their latest assault. More research is required on sexual assault among older women in order to draw conclusions about the reason for the extremely low numbers of older survivors who report to an RCC.

Completed Rape vs. All Other Incidents

Completed rape is often singled out from all other incidents because of the medical and legal implications. When RCC data were analyzed by type of incident, survivors 13 years of age and older were victims of completed rape more frequently than younger children (Figure 13).

Figure 13



Source: Massachusetts Department of Public Health, Rape Crisis Centers 1985-1987

MANY SURVIVORS OF CHILD SEXUAL ASSAULT REPORTED THE INCIDENT YEARS LATER, AS ADULTS.

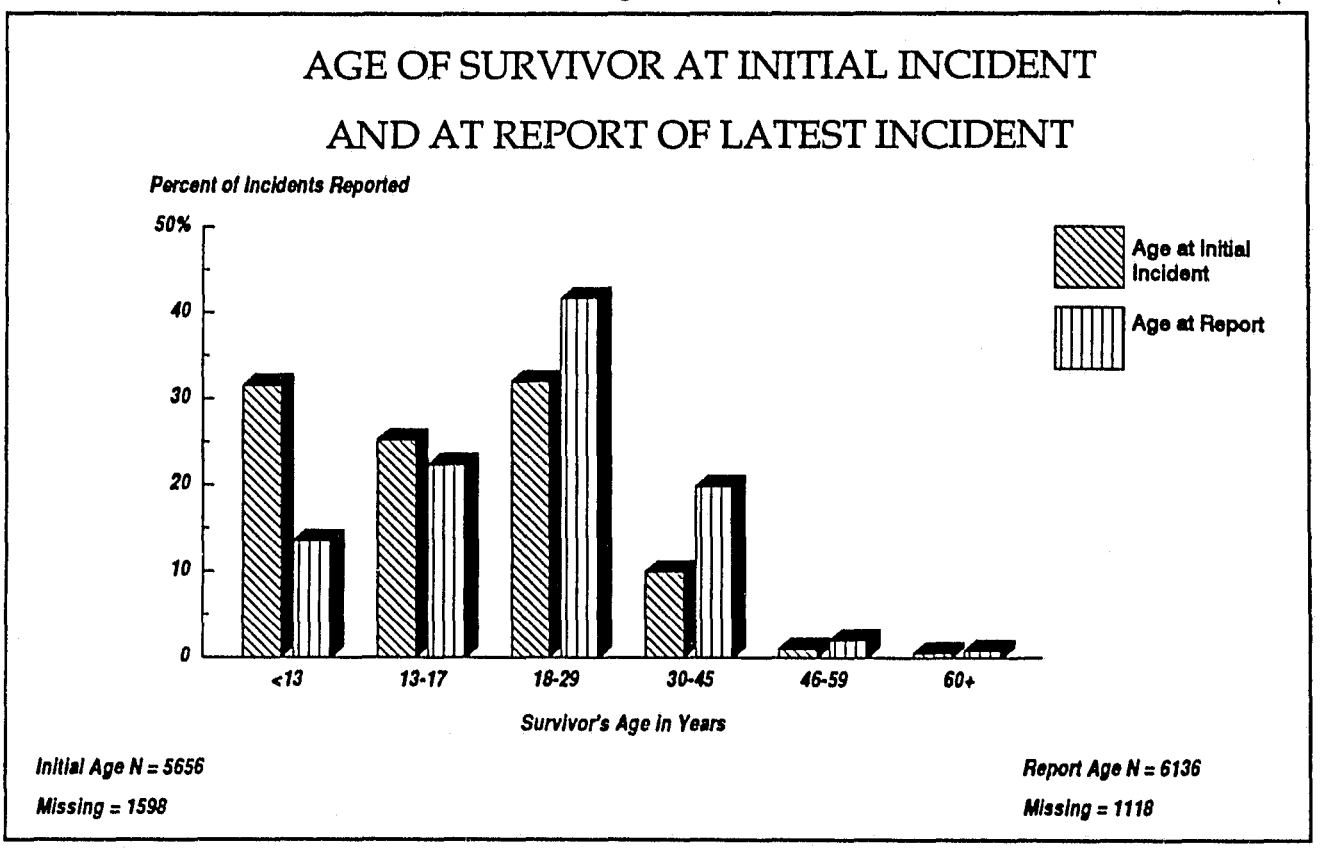
Age at Initial Incident

It is important to note that many survivors experienced more than one sexual assault in their lifetime. Although 51% were under the age of 18 at the latest incident, an even larger proportion (57%) were under the age of 18 years at their initial sexual assault, perhaps indicating multiple assaults over the years.

Age at Time of Report

There often appeared to be a considerable waiting period between when incidents occurred and when they were reported to an RCC and help sought. Figure 14 shows survivors' age when the initial incident occurred versus their age when the latest incident was reported.

Figure 14



Source: Massachusetts Department of Public Health, Rape Crisis Centers 1985-1987

Findings: Current and Adult Survivors of Child Sexual Assault

Current and Adult Victims of Child Sexual Assault

Of the 3010 survivors who were children (under age 18) at the time of the latest incident, 70% were "current victims of child sexual assault." Current victims of child sexual assault are defined in this report as survivors who were under 18 when they were assaulted and who were still under 18 when they reported the assault to an RCC. Almost one third (30%) of these 3010 survivors were "adult victims of child sexual assault." This term refers to a survivor who was under 18 at the latest incident, but 18 or older when the incident was reported to an RCC. In some instances, the assault had occurred many years earlier and this was the first time the survivor had disclosed it to anyone or sought help.

Survivor/ Assailant Relationship

Adult victims of child sexual assault reported more assaults by assailants closest to them than did current victims of child sexual assault. Adult victims were most frequently assaulted by a parent or stepparent (43%), other relative (28%), or friend/acquaintance (16%), as compared to current victims, who were most frequently assaulted by a friend or acquaintance (34%), parent or stepparent (24%) or other relative (16%). Furthermore, twice as many current victims as adult victims of child sexual assault were assaulted by a stranger (11% versus 5%).

Incidents Reported

There were some noticeable differences between the types of incidents reported by adult victims as compared to the incidents reported by current victims of child sexual assault. Forty percent of current victims reported a completed rape and 5% experienced an attempted rape. In contrast, 26% of adult victims of child sexual assault reported a completed rape and only 2% reported an attempted rape.

Findings: Sex of Survivor

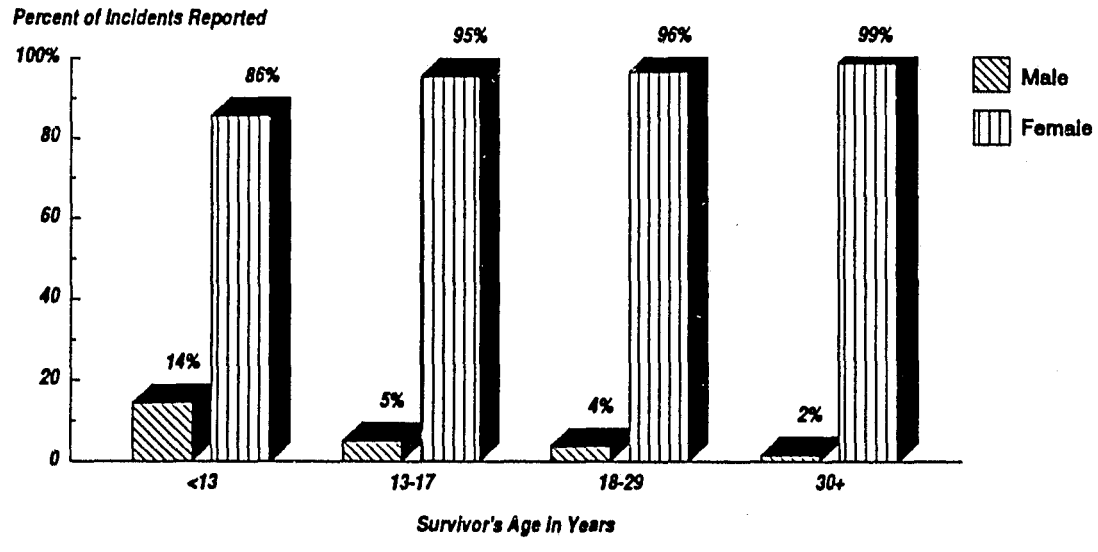
ALTHOUGH THE LARGE MAJORITY OF SURVIVORS WERE WOMEN AND GIRLS, MEN AND BOYS WERE ALSO VICTIMIZED.

Age of Survivor

Completed rape and all other sexual assaults are crimes that disproportionately affect the lives and health of females. In this data set, 6757 survivors (94%) were female, and 452 (6%) were male. Among younger age groups, however, the proportion of males was higher. Among survivors under age 18, about one in 10 (9%) was male. Among survivors under age 13, about one in seven (14%) was male (Figure 15).

Figure 15

SEX OF SURVIVOR BY AGE OF SURVIVOR



N= 5814

Missing = 1440

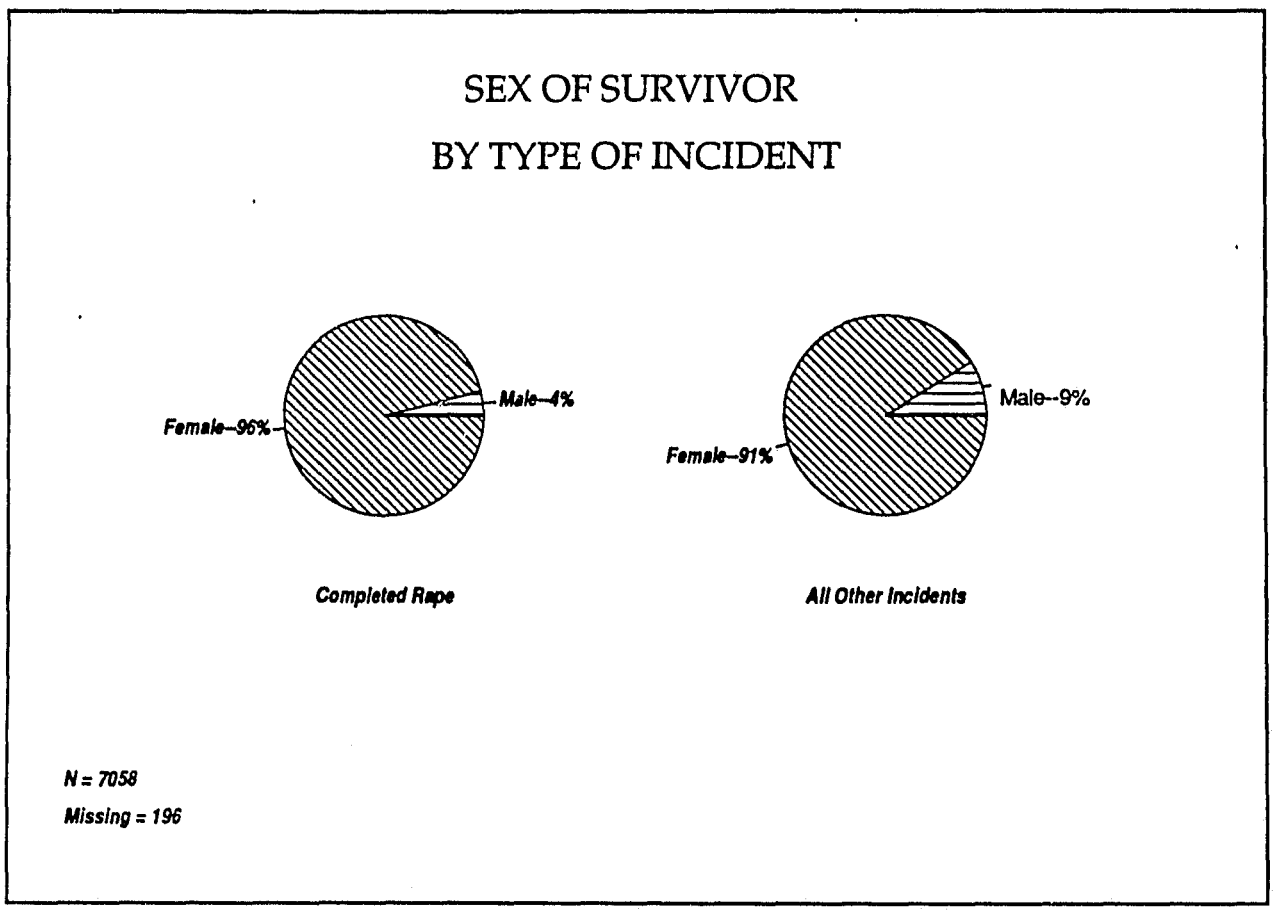
Source: Massachusetts Department of Public Health, Rape Crisis Centers 1985-1987

Findings: Sex of Survivor

Completed Rape

Among survivors of completed rapes reported to RCCs, 96% were female. An examination of completed rapes against adults shows that 87% of male rape victims were 18-29 years of age at the time of the rape, as compared to 74% of the female rape victims. Very few reports of sexual assaults against males over age 29 were reported, while a substantial number of females over age 29 reported completed rapes as well as all other sexual assault incidents (Figure 16).

Figure 16



Source: Massachusetts Department of Public Health, Rape Crisis Centers 1985-1987

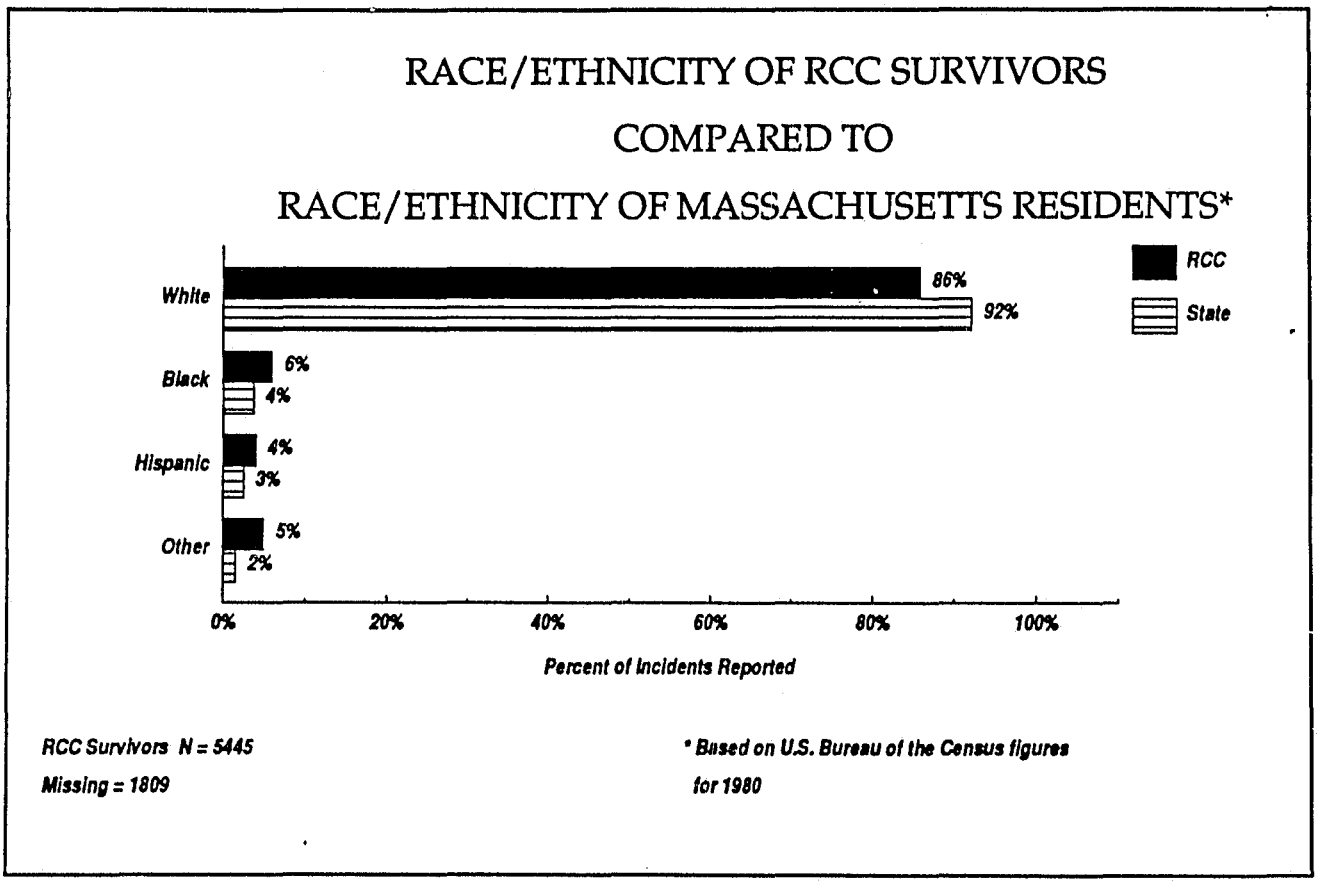
Findings: Race/Ethnicity of Survivor

THE RACIAL/ETHNIC DISTRIBUTION OF THE SURVIVORS WAS SIMILAR TO THE OVERALL RACIAL/ ETHNIC COMPOSITION OF MASSACHUSETTS.

Race/Ethnicity of Survivor

Of the 5445 reported incidents for which race/ethnicity of the survivor was given, the racial/ethnic breakdown was similar to the composition of the state based on the 1980 census figures (Figure 17), although there was a slightly higher proportion of people of color among survivors. There is reason to believe, however, that the racial/ethnic breakdown of these survivors under-represents the actual proportion of communities of color among sexual assault survivors. In this data set, survivors of Portuguese and Asian ancestry were included in the category "other race/ethnicity," because of the small numbers of survivors in these groups.

Figure 17



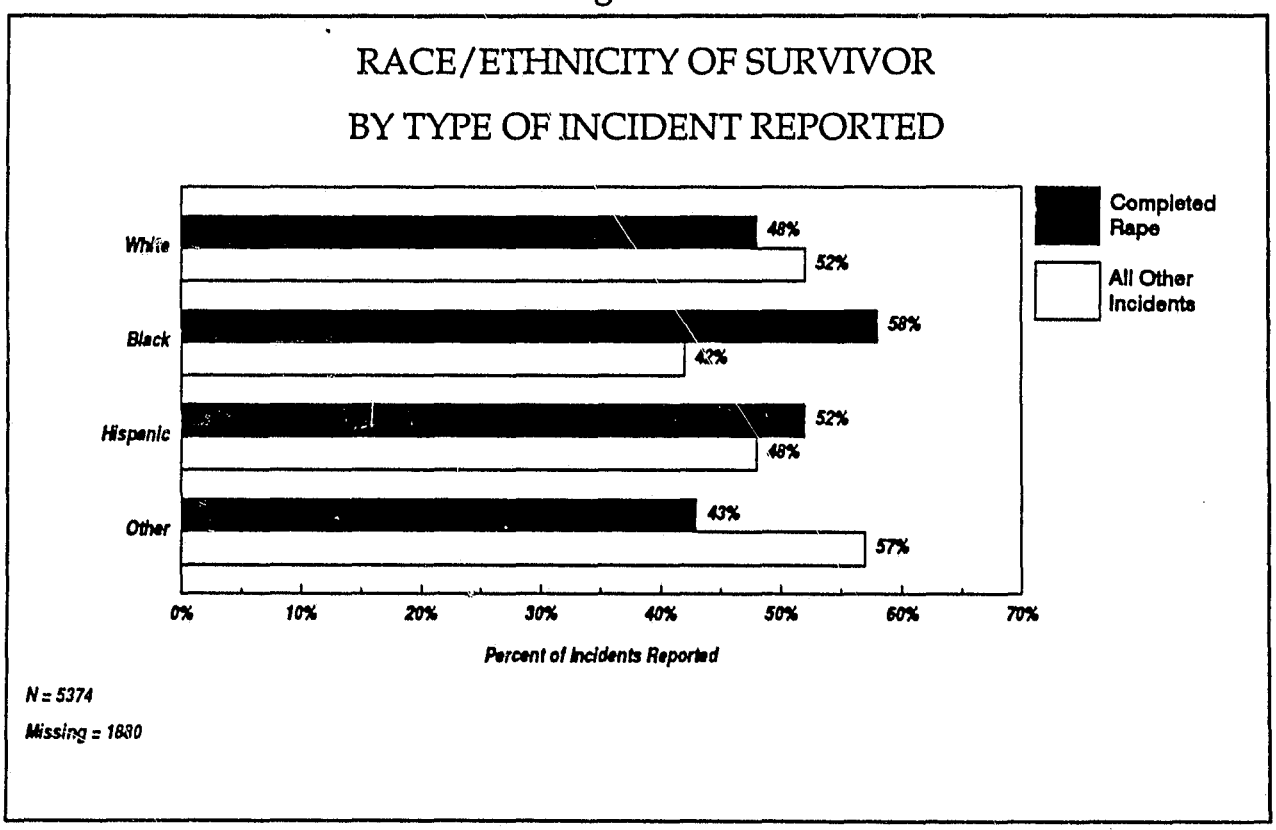
Source: Massachusetts Department of Public Health, Rape Crisis Centers 1985-1987

Findings: Race/Ethnicity of Survivor

Black Survivors of Sexual Assault

Black women (98% of all black survivors were female) reported a higher proportion of completed rapes than all other racial/ethnic groups combined (58% versus 48%). Black survivors were also, by a small percentage, more frequently assaulted by strangers (22% versus 18% among all other groups) and weapons were present more frequently (18% versus 13% among all other groups) during the incident (Figure 18). Whether this finding indicates a higher level of violence in this population or an example of selective reporting based on the classic violence of an assault is impossible to determine.

Figure 18



Source: Massachusetts Department of Public Health, Rape Crisis Centers 1985-1987

THE AFTERMATH OF THE ASSAULT

Introduction

The data presented in this section demonstrate that many survivors of sexual assault never reported the incident to legal or medical authorities and never received medical care. The implications are serious: data available to authorities are limited; many survivors do not receive needed care; and many perpetrators are not apprehended or brought to trial.

Because sexual assault is a violent crime for which the victims are often blamed, many never disclose the incident to anyone. Social attitudes about sexual assault are still based on misconceptions about what constitutes a "real" sexual assault and who is "really" at fault. Survivors themselves have come to believe many of the myths surrounding sexual violence. These misconceptions about sexual assault hinder the survivor's recovery process because they reduce the likelihood that the survivor will disclose the assault and that persons who are in positions to help (professionals, friends, and family) will accurately understand the realities about sexual assault and will have an empathetic response to the survivor. Indeed, legal and medical authorities, families, and human service providers can actually re-victimize survivors of sexual assault by acting on the basis of commonly held myths and biases about sexual assault. Precisely because of such myths and biases, results from data sets such as this one should play an important role in informing care providers, law enforcers, and policy makers.

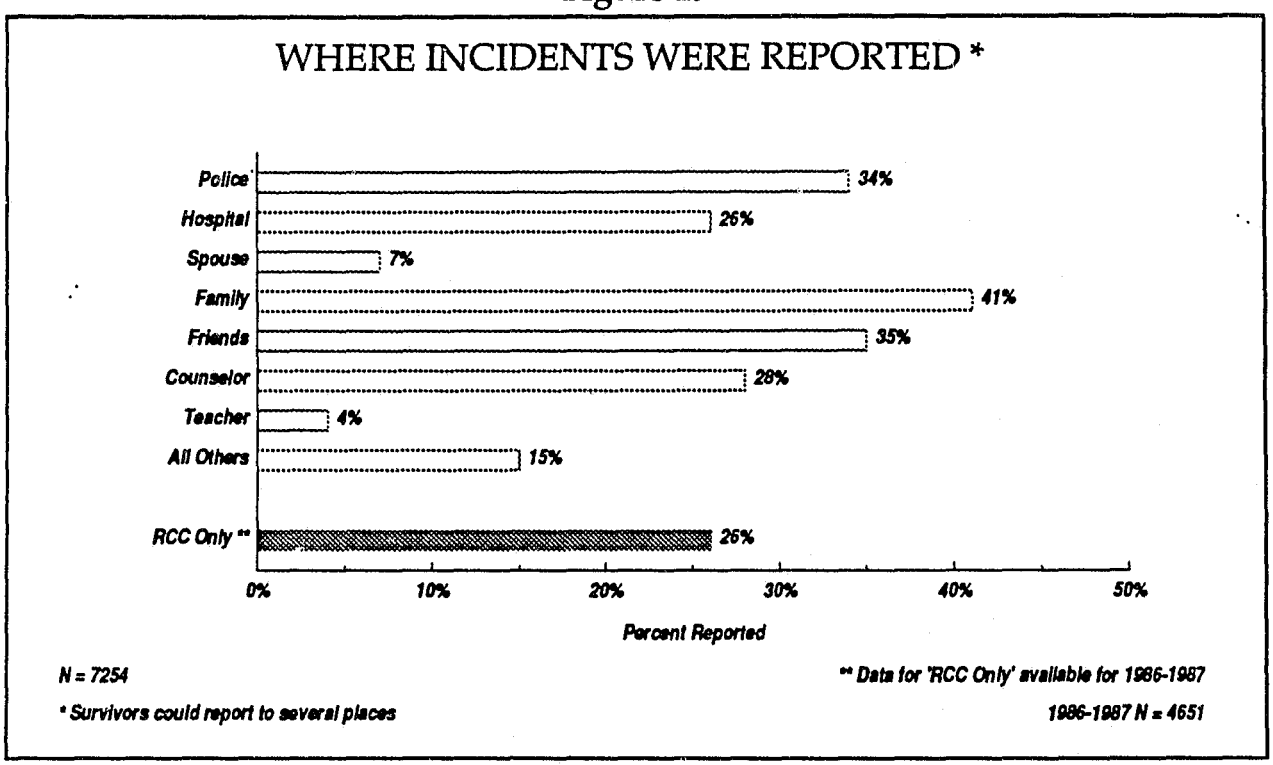
Findings: Where Incidents Were Reported

ONE QUARTER (26%) OF THE SURVIVORS REPORTED THEIR ASSAULT ONLY TO AN RCC.

Where Incidents Were Reported

One quarter of all survivors stated that they had reported the assault solely to an RCC. Only a third (34%) of the survivors who reported their assault to RCCs also notified the police; only a quarter (26%) reported it to a hospital (Figure 19). Survivors most frequently disclosed the assault to their families (41%) and friends (35%). Reporting patterns were influenced by the type of incident, the survivor/assailant relationship, and the age of the survivor at the time of the incident.

Figure 19



Source: Massachusetts Department of Public Health, Rape Crisis Centers 1985-1987

Survivor/ Assailant Relationship

Perhaps most important to the decision either to report a sexual assault to authorities (police and hospital) or not was the relationship between the survivor and assailant. The closer the survivor/ assailant relationship, the less frequently the incident was reported to authorities. Table 5 presents the sites where survivors reported their assaults according to the survivor/assailant relationship. Survivors of incest (perpetrated by parent, stepparent, and other relatives) were the least likely to report to the police or hospitals and the most likely to discuss their abuse with their family. When the assailant was a relative other than a parent or steppar-

Findings: Where Incidents Were Reported

ent, reporting to the police and hospitals was particularly low; however, the disclosure to family was more frequent. Conversely, survivors of assaults by strangers reported the incident to the police (61%) and hospitals (54%) most frequently; they confided to family and friends in almost half of these incidents (49% and 42%, respectively). When the assailant was a friend or an acquaintance, survivors reported the incident to police and hospitals more frequently than when the assailant was intimately known to the survivor, but less frequently than when the assailant was a stranger. Survivors of spouse or partner sexual abuse were apparently particularly isolated. One third (32%) reported only to RCC counselors. Only 28% discussed the assault with their families; 31%, with their friends. Overall, the more distant the relationship between survivor and assailant, the more frequently the incident was reported to authorities. Survivors of incest discussed the incident within the family; survivors of spouse abuse infrequently disclosed the assault to anyone other than the RCC.

Table 5

WHERE INCIDENTS WERE REPORTED

BY SURVIVOR/ASSAILANT RELATIONSHIP

SINGLE ASSAILANT

	Police (2029)	Hospital (1534)	Family (2526)	Friends (2065)	RCC Only * (980)
Spouse/Partner (546)	24%	16%	28%	31%	32%
Parent/Stepparent (945)	20	13	44	30	24
Other Relative (638)	17	11	53	25	29
Friend/Acquaintance (1804)	40	32	45	43	27
Stranger (1036)	61	54	49	42	25
All Others (729)	35	19	43	34	26

N = 5698 Missing = 781

Survivors could report to several places

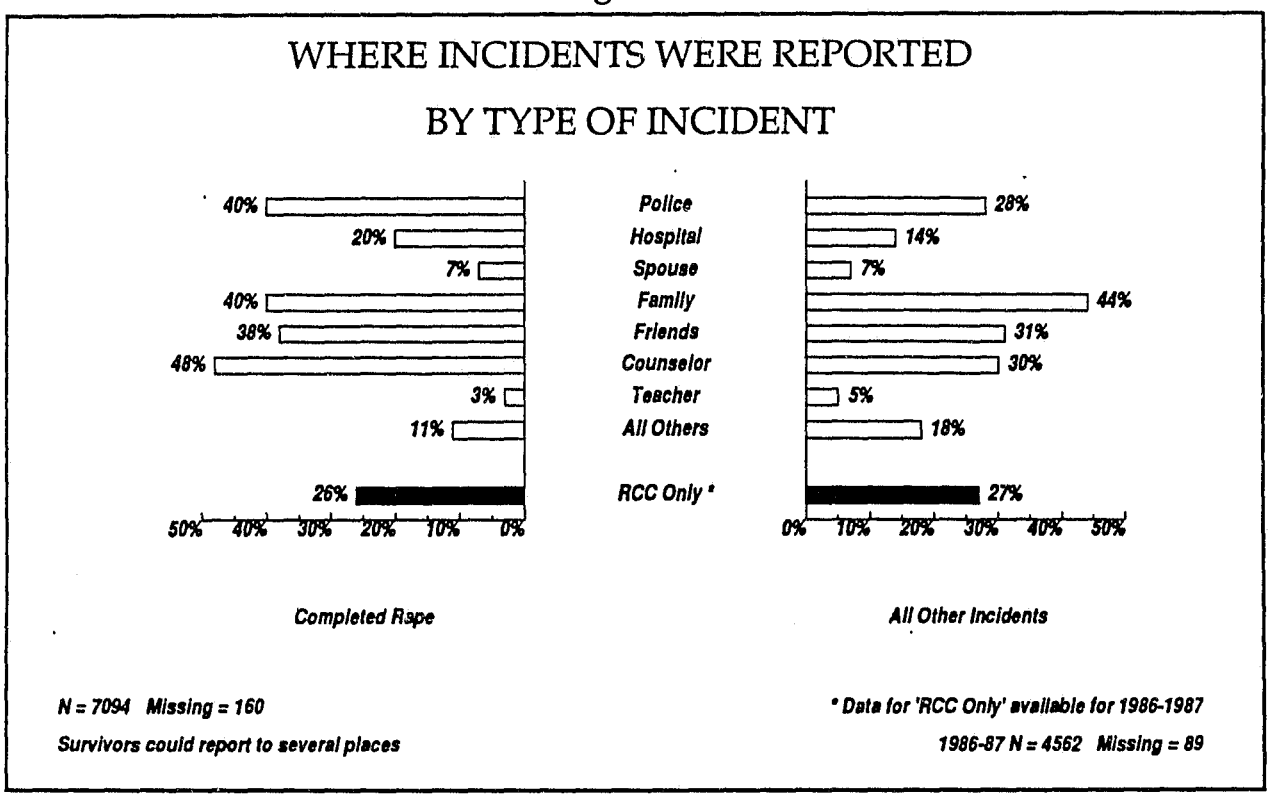
** Data for 'RCC Only' available for 1986-1987*

1986-87 N = 3667 Missing = 489

Source: Massachusetts Department of Public Health, Rape Crisis Centers 1985-1987

Findings: Where Incidents Were Reported

Figure 20



Source: Massachusetts Department of Public Health, Rape Crisis Centers 1985-1987

Completed Rape vs. All Other Sexual Assaults

Survivors of completed rape reported the assault to the police, hospitals, counselors and friends more frequently than survivors of all other incidents (Figure 20). On the other hand, survivors of all other sexual assaults reported most often to the family (in addition to RCC). An almost equal percentage of survivors of rape and of all other incidents reported only to RCCs.

Age of Survivor

Reporting behaviors by different age groups after a sexual assault were related to the relationship of the assailant to the survivor (Table 6).

Children

Very young survivors (under 13) were most frequently assaulted by someone they knew intimately (parent, stepparent or other relative). Not surprisingly, these incidents were reported the least often to the police (30%) or a hospital (18%). These assaults were often not reported to RCCs as completed rapes, the sexual assault most frequently associated with reporting to authorities. Besides disclosing to RCCs, survivors in this age group most commonly discussed the incident with family members. It should be noted, however, that only 56% of the survivors in this age group turned to their families, and only 26% disclosed the assault to their friends.

Findings: Where Incidents Were Reported

Table 6

WHERE INCIDENTS WERE REPORTED

BY AGE OF SURVIVOR

	Police	Hospital	Family	Friends	RCC Only *
<13 (1422)	30%	18%	56%	26%	27%
13-17 (1588)	36	29	55	33	24
18-29 (2019)	40	36	39	43	29
30-45 (691)	40	36	31	41	29
46+ (105)	54	40	40	30	21

N = 5825

Missing = 1429

Survivors could report to several places

Table presents row percents

* Data for 'RCC Only' available for 1986-1987

1986-87 N = 3721 Missing = 930

Source: Massachusetts Department of Public Health, Rape Crisis Centers 1985-1987

Adolescents

Adolescent survivors (13-17 years) were somewhat more likely to report incidents to the police and hospitals. Such behavior relates to the fact that this age group was more frequently assaulted by strangers and acquaintances, and that the assault was often reported as a completed rape.

Adults

Forty percent of the adults (18-45 years) in the data set reported the assault to the police and 36% reported to hospitals. This age group was less likely to report to their families and somewhat more likely to disclose the incident to their friends. Survivors in this age group were assaulted by strangers in about a quarter (26%) of the incidents, and the assault was often reported as a completed rape.

Older survivors (46+ years) were the most likely to report the incident to the police (54%) and hospitals (40%). This group was the least likely to report only to RCCs (21%). Although the proportion of reported completed rapes was higher among younger adults than in this age group, assaults by strangers were more frequent. However, since reporting information was available for only 105 survivors over the age of 45, comparisons with other age groups should be interpreted cautiously. More information on older survivors is needed.

Findings: Where Incidents Were Reported

Race/ Ethnicity of Survivor

Reporting patterns among various racial/ethnic groups revealed some interesting differences. Black survivors reported most frequently to the police (43%) and hospitals (37%), but were also the most likely to report the incident only to RCCs (38%). Other racial/ethnic groups, including Portuguese, Asian and other, reported least frequently to police (34%) or hospitals (22%), but were also the least likely to report only to RCCs (15%) (Table 7). The number of survivors in each racial/ethnic category other than white was quite small; therefore, comparisons are inconclusive.

Table 7

WHERE INCIDENTS WERE REPORTED

BY RACE/ETHNICITY OF SURVIVOR

	Police (2053)	Hospital (1599)	Family (2525)	Friends (1968)	RCC Only * (979)
White (4663)	37%	29%	47%	37%	28%
Black (307)	43	37	41	30	38
Hispanic (228)	39	36	47	27	26
Other (247)	34	22	42	39	15

N = 5445
Missing = 1809
Survivors could report to several places

Table presents row percents
* Data for 'RCC Only' available for 1986-1987
1986-87 N = 3484 Missing = 1167

Source: Massachusetts Department of Public Health, Rape Crisis Center 1985-1987

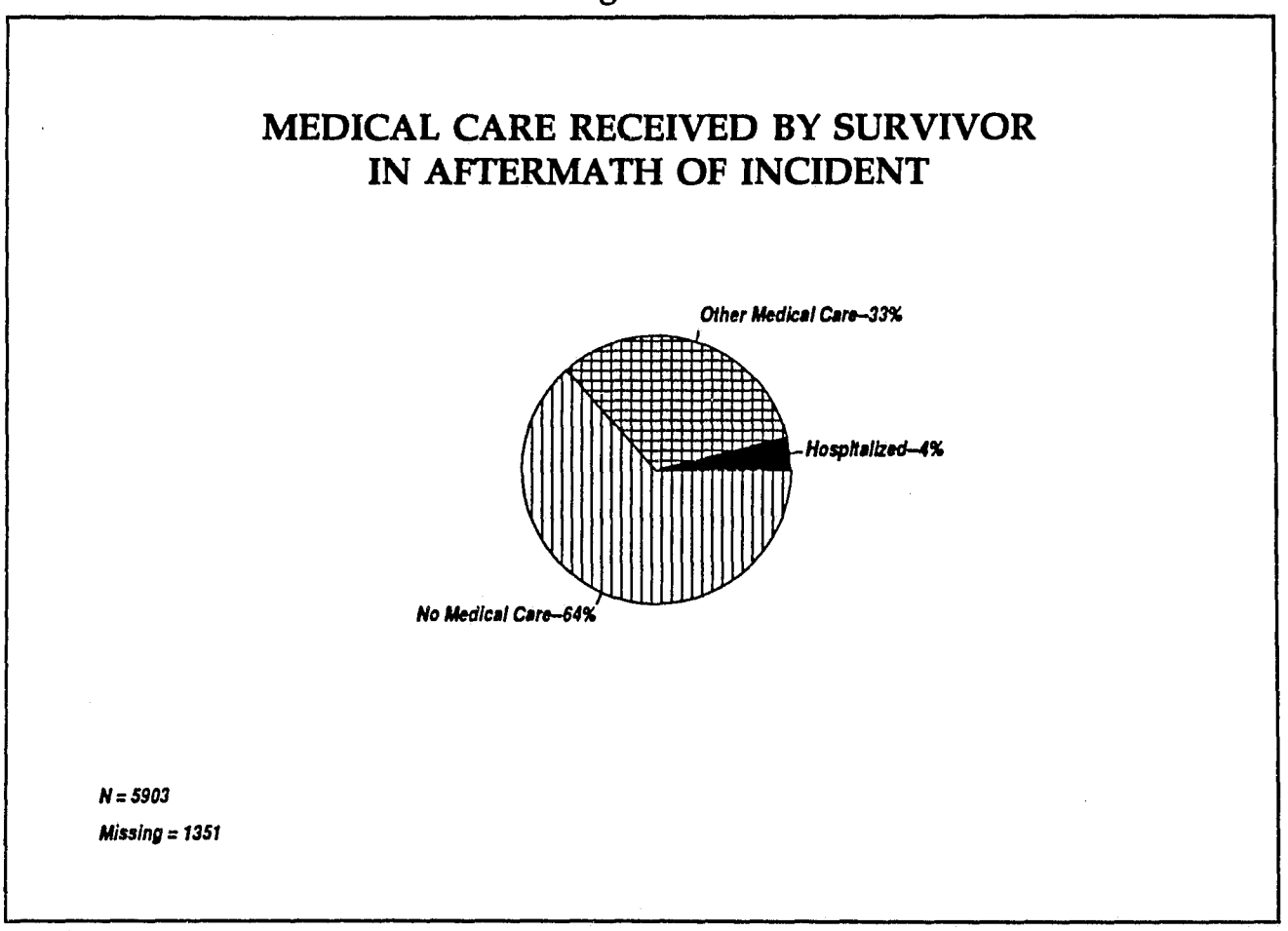
Black survivors were slightly more likely to have reported a completed rape, and strangers were the assailants in a slightly disproportionate number of cases. This disparity may partially explain the differences in reporting patterns. However, it is impossible to determine or explain any underlying differences. Apparently RCC services, for whatever reasons, are particularly crucial for black survivors of sexual assault, as suggested by the high rate of persons in this group reporting only to RCCs.

ONLY A THIRD (37%) OF THE SURVIVORS WERE HOSPITALIZED OR RECEIVED OTHER MEDICAL CARE IN THE AFTERMATH OF AN INCIDENT.

Medical Care

Nearly two thirds (64%) of the survivors of sexual assault did not receive any medical attention after a sexual assault (Figure 21). Whether a survivor received medical care was associated with many of the same variables linked with reporting patterns: the survivor/assailant relationship, the type of incident reported (completed rape versus all other sexual assaults), the survivor's age and whether a weapon was present.

Figure 21



Source: Massachusetts Department of Public Health, Rape Crisis Centers 1985-1987

Survivor/ Assailant Relationship

The medical care received by the survivor varied according to the survivor/assailant relationship in ways similar to the variations in reporting patterns discussed earlier (Table 8). Except for survivors of spouse or partner assault, medical care was required or received more frequently when the relationship between survivor and assailant was distant. When the assailant was a relative (parent, stepparent or other relative), fewer than 20% of the survivors received medical care.

Table 8

MEDICAL CARE RECEIVED

BY SURVIVOR/ASSAILANT RELATIONSHIP

SINGLE ASSAILANT

	Hospitalized (166)	*Other Medical Care (1569)*	*No Medical Care (3206)*
Spouse / Partner (447)	*5%*	*26%*	*69%*
Parent/Stepparent (793)	*2*	*17*	*81*
Other Relative (536)	*1*	*14*	*84*
Friend/Acquaintance (1597)	*3*	*38*	*59*
Stranger (921)	*5*	*52*	*43*

N = 4941

Missing = 1538

Table presents row percents

Source: Massachusetts Department of Public Health, Rape Crisis Centers 1985-1987

Findings: Medical Care

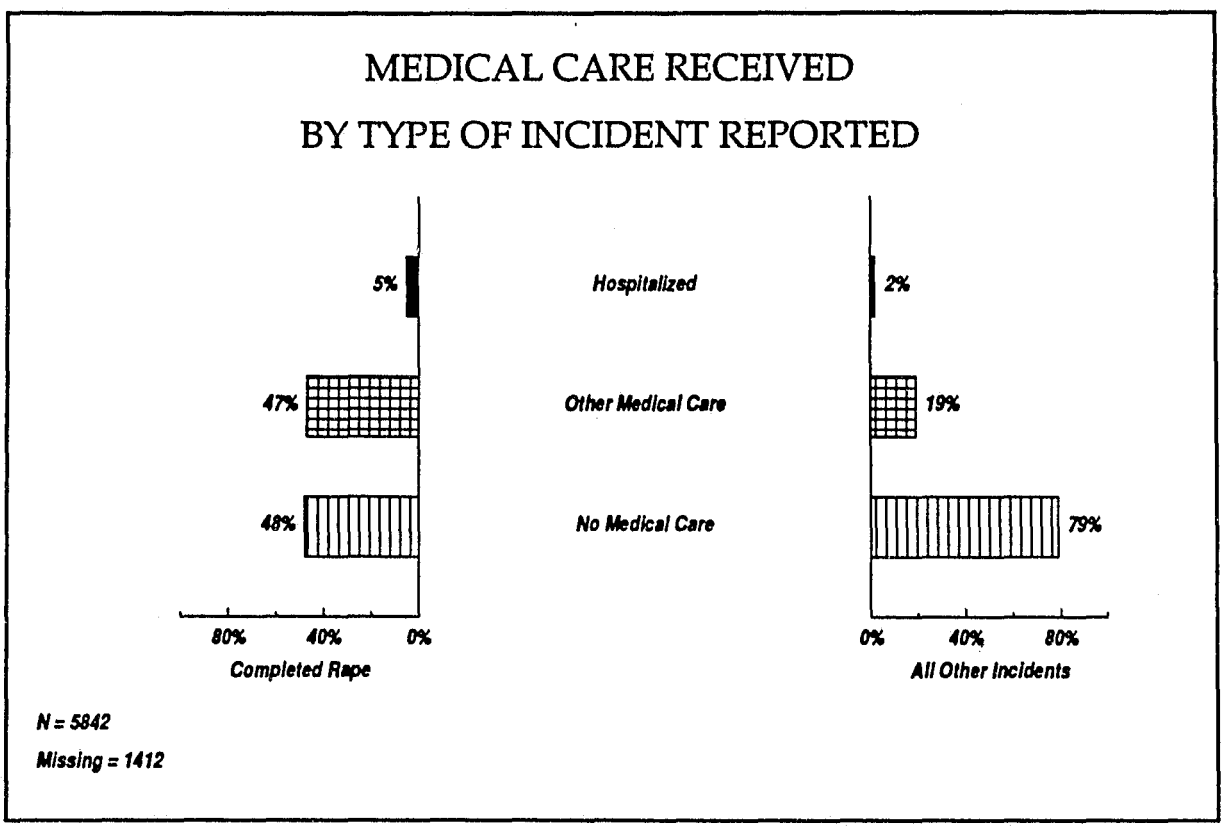
It is disturbing that spouse/partner assaults resulted in hospitalization for 5% of the survivors, a percentage equal to stranger assaults. It is unclear whether the level of medical care received reflected the actual level of violence, or whether the relationship between the survivor and assailant determined the care received. Both patterns are probably operating here.

Completed Rape vs. All Other Sexual Assaults

Survivors of completed rape were hospitalized over twice as often (5% versus 2%) as survivors of all other incidents, a percentage also true of medical care other than hospitalization (47% versus 19%). However, almost half (48%) of all survivors of completed rape did not receive medical care (Figure 22). These patterns have important public health implications, since penetration during rape can expose the survivor to sexually transmittable diseases, pregnancy, and, especially for children, internal injuries.

Seventy-nine percent of the survivors of all incidents other than completed rape did not receive medical care. Although rape victims are exposed to an unusual variety of risks, all survivors of sexual assault are at risk for "rape trauma syndrome" and physical injuries.

Figure 22



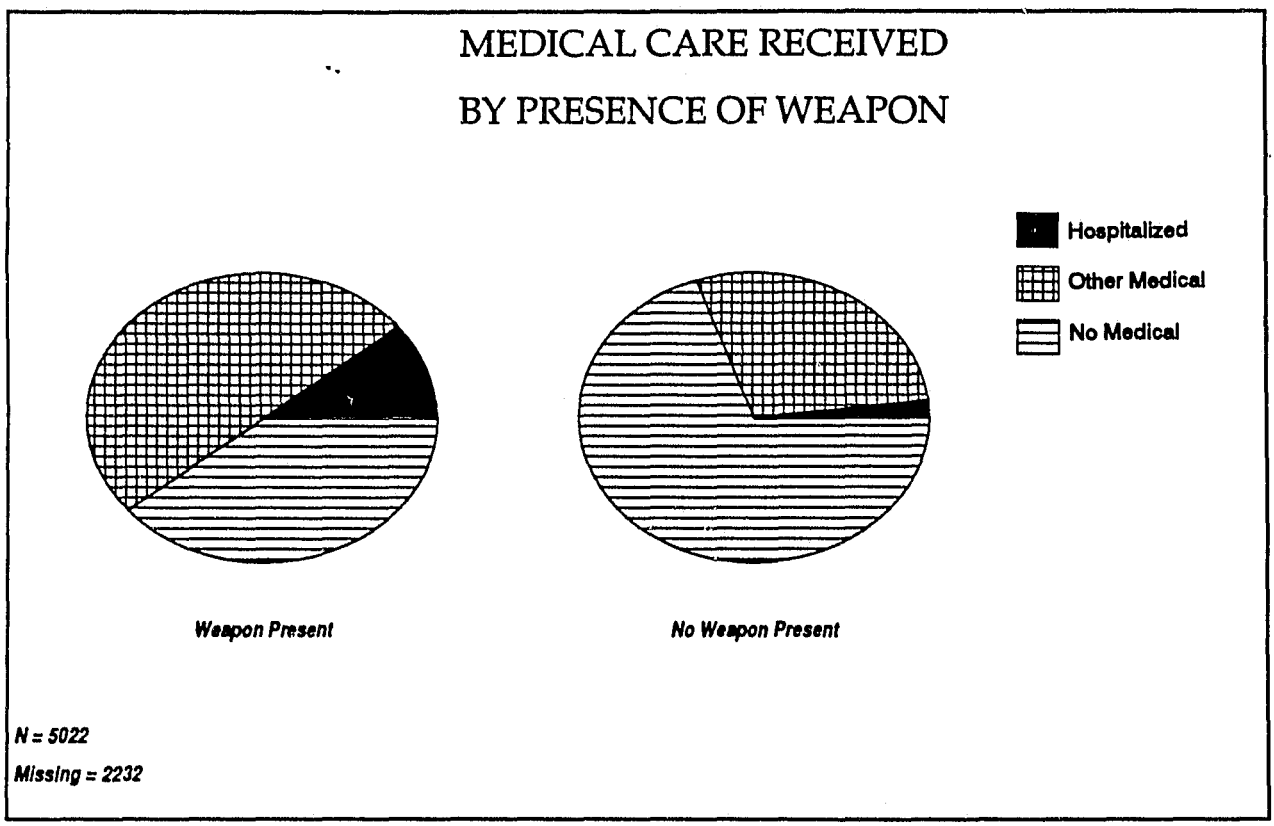
Source: Massachusetts Department of Public Health, Rape Crisis Centers 1985-1987

Findings: Medical Care

Presence of Weapon

Not surprisingly, when a weapon was present during the incident, the survivor was hospitalized or received other medical care much more often than when no weapon was present. The greater frequency was probably associated with a higher level of injury, but was probably also associated with the survivor's perception of the type of violent crime for which medical care should be received. The presence of a weapon was associated with completed rapes and assailants who were strangers. Even when a weapon was present, however, 39% of the survivors did not receive medical care (Figure 23).

Figure 23



Source: Massachusetts Department of Public Health, Rape Crisis Centers 1985-1987

Age of Survivor

Variations in hospitalization and other medical care received after a sexual assault were similar to the reporting patterns by age group described earlier in this section (Table 9). The youngest survivors were the least likely to receive medical care, whereas the oldest survivors were the most likely to receive medical care. The fact that children reported comparatively few completed rapes probably influenced the seeking of medical care.

Findings: Medical Care

Table 9

MEDICAL CARE RECEIVED

BY AGE OF SURVIVOR

	Hospitalized (181)	Other Medical Care (1725)	No Medical Care (3279)
<13 (1247)	2%	25%	74%
13-17 (1375)	2	33	65
18-29 (1838)	4	38	58
30-45 (630)	8	38	54
46-59 (64)	3	44	53
60+ (31)	16	36	48

N = 5185

Missing = 2069

Table presents row percents

Source: Massachusetts Department of Public Health, Rape Crisis Centers 1985-1987

Child Sexual Assault

Adult and current victims of child sexual assault exhibited different patterns of receiving medical care. More than half (62%) of current victims of child sexual assault received no medical care. One third (36%) received medical care other than hospitalization, and 2% were hospitalized. A different pattern emerged for adult victims of child sexual assault: 89% received no medical care, 3% were hospitalized, and 8% received medical care other than hospitalization.

For both current and adult victims of child sexual assault, medical attention was less often received when the offender was a family member than when the offender was a stranger. Of current victims, 71% received no medical care and 94% of adult victims received no medical care when the assailant was a parent or stepparent. When the assailant was a relative (other than a parent or stepparent), 78% of current victims and 95% of adult victims of child sexual assault received no medical care. For assaults by strangers, 46% of current victims and 58% of adult victims received no medical care.

Where Incidents Were Reported

When survivors of sexual assault were hospitalized or required other medical care, the percentage of survivors reporting the incident to the police and/or hospitals was much higher than when there was no medical care.

Findings: Medical Care

Only 22% of survivors who did not receive medical care reported the incident to the police, as compared to 65% of persons who received medical care other than hospitalization and 56% of those who were hospitalized (Table 10).

Survivors who did not receive medical care were also less likely to discuss the incident with their family or friends. For a third (32%) of these survivors, an RCC was the only place where the incident was reported. It should also be noted that even among survivors who were hospitalized or received other medical care, at least 20% reported the sexual assault only to RCCs. This number highlights the importance of RCC services for all survivors, and further illustrates the value of this data set for examining sexual assaults not included in police or hospital records.

Table 10

MEDICAL CARE RECEIVED BY

WHERE INCIDENT WAS REPORTED

	Police (2179)	*Hospital* (1791)	*Family* (2688)	*Friends* (2192)	*RCC Only* * (1078)
Hospitalized (227)	*56%*	*70%*	*54%*	*48%*	*20%*
Other Medical (1923)	*65*	*72*	*57*	*41*	*23*
No Med. Care (3753)	*22*	*7*	*39*	*35*	*32*

N = 5903

Missing = 1351

Survivors could report to several places

Table presents row percents

** Data for 'RCC Only' available for 1986-1987*

1986-87 N = 3752 Missing = 899

Source: Massachusetts Department of Public Health, Rape Crisis Centers 1985-1987

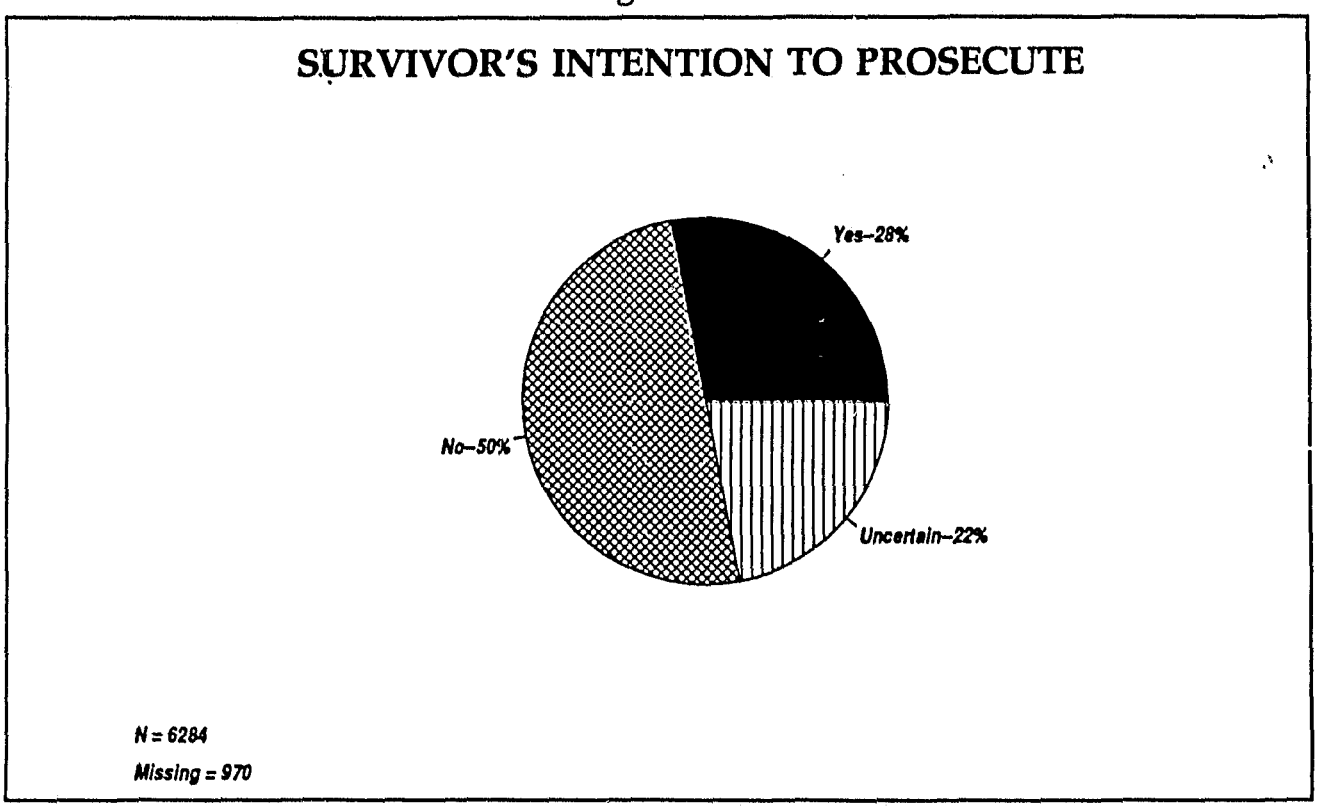
Findings: Intention to Prosecute

ONLY 28% OF THE SURVIVORS PLANNED TO PROSECUTE THEIR ASSAILANTS.

Intention to Prosecute

Only 28% of the survivors in this data set stated that they intended to prosecute their assailant (Figure 24). Half (50%) of the survivors did not plan to prosecute. Another 22% were uncertain about their intentions to prosecute. As with reporting patterns and medical care, the nature of the assaults (completed rape versus all other incidents), the survivor/assailant relationship and the age of the survivor at the latest incident influenced the survivor's intention to prosecute.

Figure 24



Source: Massachusetts Department of Public Health, Rape Crisis Centers 1985-1987

Survivor/ Assailant Relationship

The survivor's intention to prosecute was largely influenced by who the assailant was. Survivors of assaults by strangers were much more likely to intend prosecution (42%) than were survivors of assaults by assailants more intimately known (Table 11). When a friend or acquaintance was the assailant, about a third (31%) of the survivors intended to prosecute. For parent or stepparent assaults, prosecution was intended in only 21% of the cases; for spouse or partner assaults, 19%, and other relatives, only 15%. Prosecuting family members clearly adds another dimension of complexity to an already volatile and intrusive situation.

Findings: Intention to Prosecute

Table 11

SURVIVOR'S INTENTION TO PROSECUTE
BY SURVIVOR/ASSAILANT RELATIONSHIP

SINGLE ASSAILANT

	Intends to Prosecute (1498)	*No Intention to Prosecute (2549)*	*Uncertain (1166)*
Spouse/Partner (488)	*19%*	*55%*	*26%*
Parent/Stepparent (861)	*21*	*62*	*17*
Other Relative (576)	*15*	*66*	*19*
Friend/Acquaintance (1666)	*31*	*46*	*23*
Stranger (939)	*42*	*35*	*24*

N = 5213
Missing = 1266
Table presents row percents

Source: Massachusetts Department of Public Health, Rape Crisis Centers 1985-1987

Completed Rape vs. All Other Sexual Assaults

Survivors of completed rape were more likely to intend prosecution (32%) than were survivors of all other incidents (25%) (Figure 25). Twenty-two percent of completed rape survivors and survivors of all other incidents were uncertain about their intentions to prosecute their assailant. Interestingly, survivors of attempted rape (7% of all reported sexual assaults) intended prosecution more often than survivors of completed rape (32% completed rape versus 40% attempted rape).

Presence of Weapon

Not surprisingly, survivors were more likely to consider prosecution of the assailant if a weapon was present during the incident. If a weapon was present, 44% of the survivors intended prosecution as compared to 26% if no weapon was present (Figure 26).

Medical Care

Similarly, 49% of survivors who were either hospitalized or received other medical care intended to prosecute their assailant, as compared with 17% of survivors who did not receive medical care. Apparently, the actual or perceived severity of the assault (completed rape, weapon present, hospitalization or receipt of other medical care), as well as the relationship between the assailant and survivor, played key roles in the survivor's decision to prosecute.

Findings: Intention to Prosecute

Figure 25

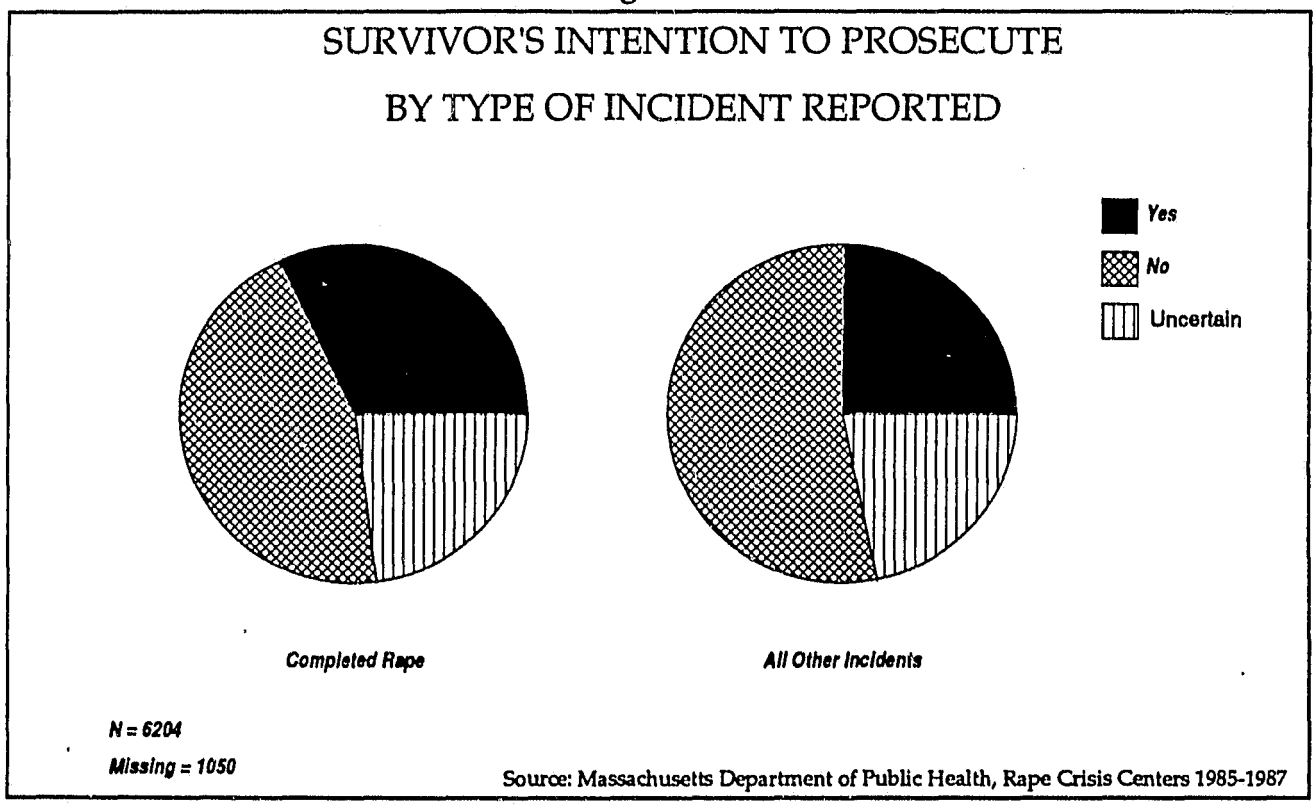
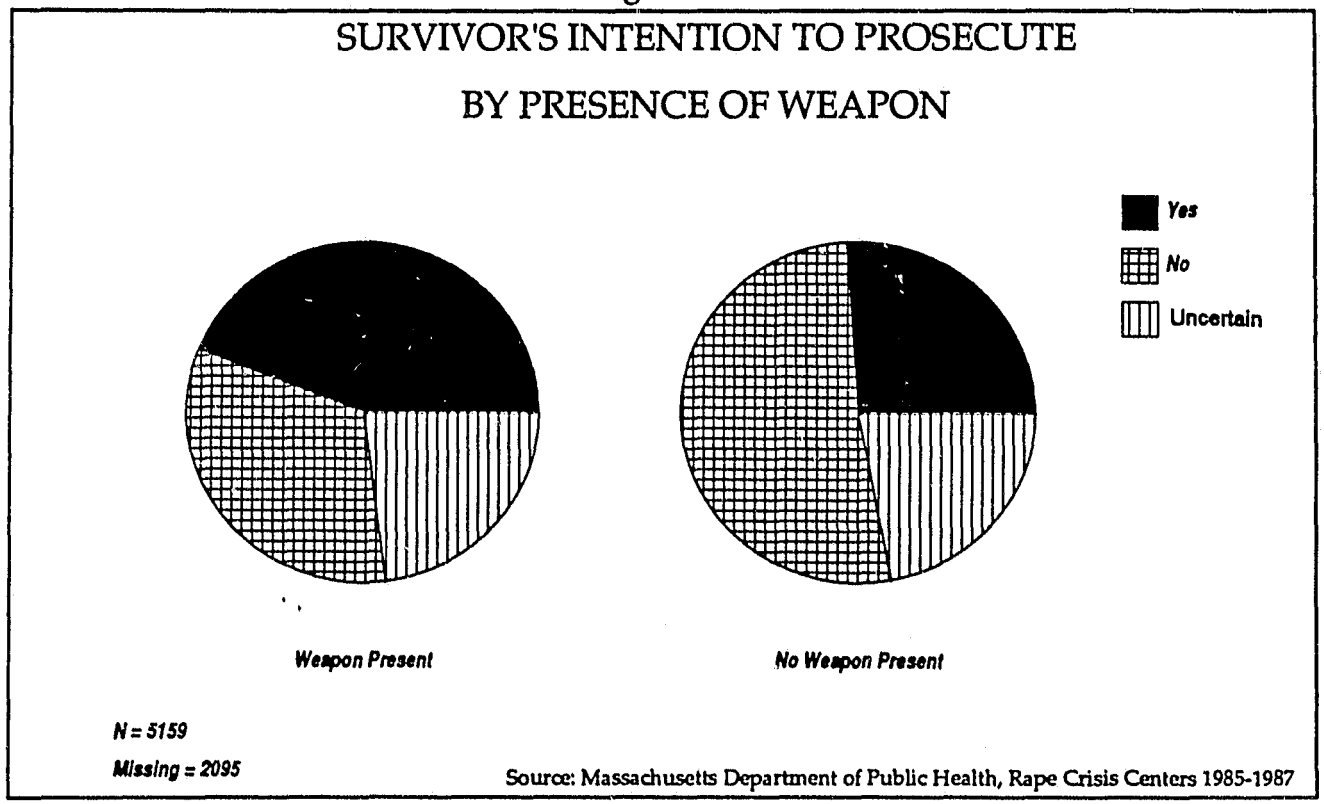


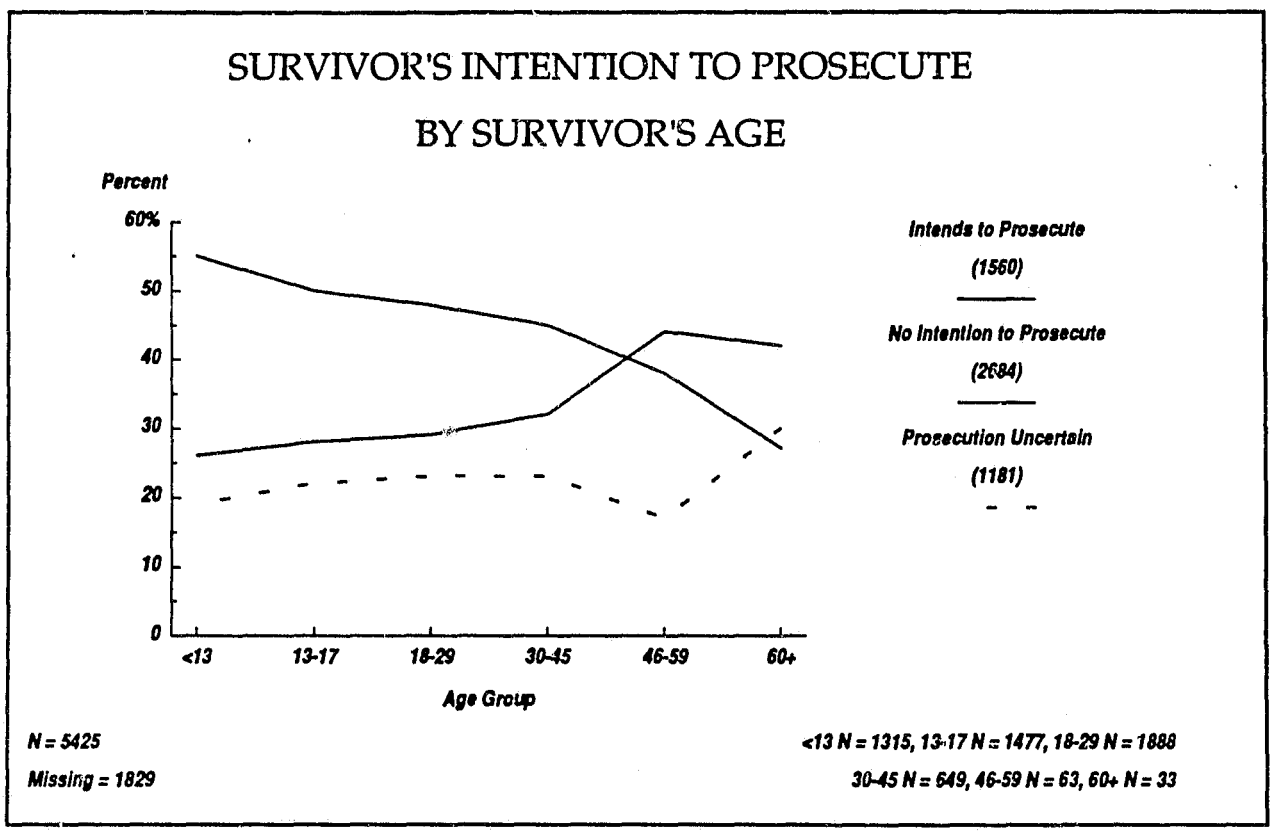
Figure 26



Findings: Intention to Prosecute

Age of Survivor As was the case in reporting patterns of medical care utilization, the survivor's intention to prosecute increased dramatically with the age of the survivor from 26% for young children to 44% for 46-59 year olds (Figure 27). This finding is not surprising since the age of the survivor was closely associated with the survivor/assailant relationship. Moreover, younger survivors were less likely to have experienced a completed rape.

Figure 27



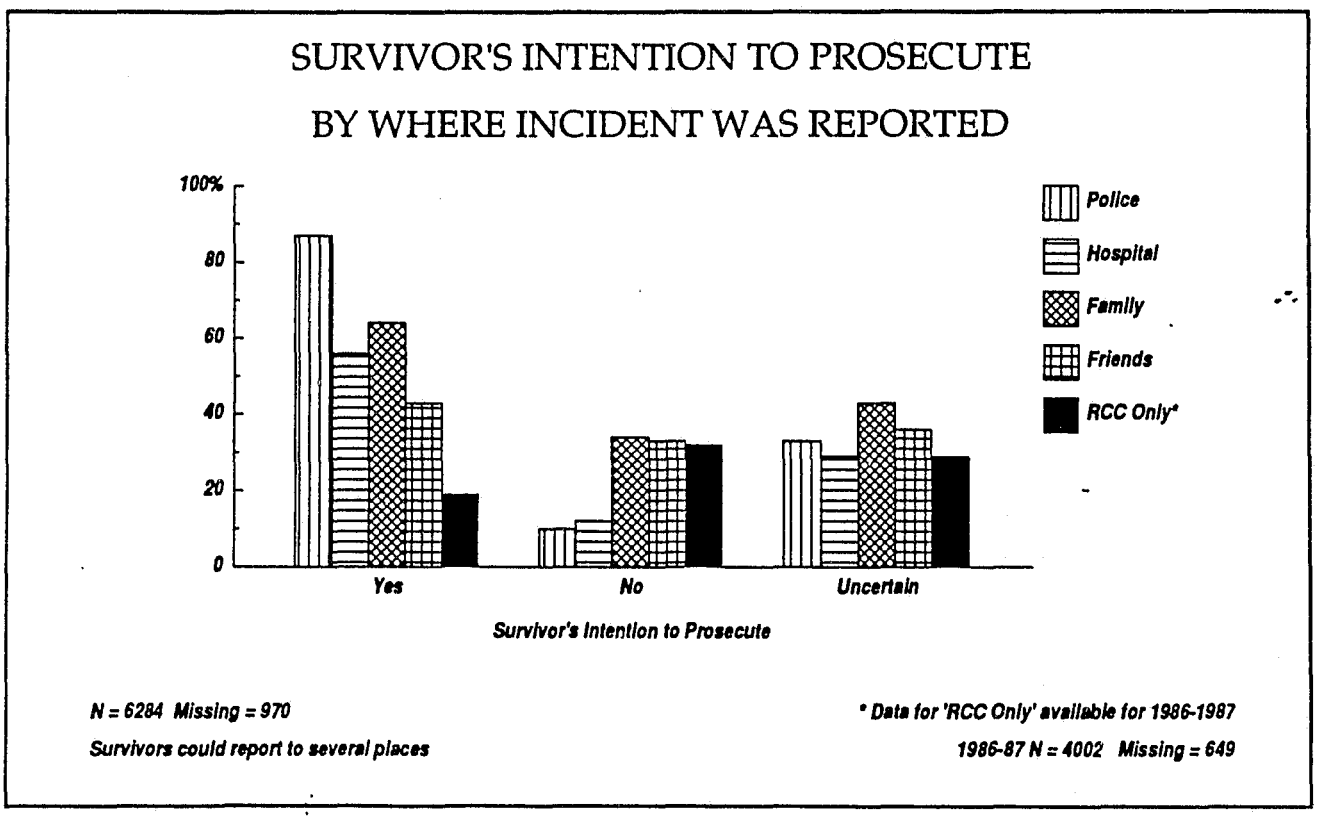
Source: Massachusetts Department of Public Health, Rape Crisis Centers 1985-1987

Findings: Intention to Prosecute

Where Incidents Were Reported

Survivors planning to prosecute their assailants were considerably more likely to report their assault to the police (87%) and hospitals (56%), as compared to survivors not intending prosecution – police (10%) and hospitals (12%) (Figure 28). They were also most likely to disclose the incident to family and friends. Survivors uncertain about prosecution were, as would be expected, less likely to report than survivors with intentions to prosecute and more likely than persons without such intentions. Such survivors, who were uncertain, reported to the police in about a third (33%) of the cases and to hospitals 29% of the time. One third (32%) of the survivors with no intentions of prosecuting their assailant disclosed the assault only to RCC counselors. They were the least likely to discuss the event with their family and friends. Thus, especially for this group of isolated survivors, RCCs play a crucial role for service provision and data collection.

Figure 28



Source: Massachusetts Department of Public Health, Rape Crisis Centers 1985-1987

Findings: Intention to Prosecute

Race/Ethnicity of Survivor

The intentions of the different racial/ethnic groups, represented in this data set, to prosecute are presented in Table 12. There appear to be some interesting differences in survivors' intentions to prosecute. Because the number of survivors in each racial/ethnic category other than white was quite small, comparisons are inconclusive. It appears, however, that black survivors were more likely to intend prosecution (40%) than white (28%) or Hispanic (34%) survivors. These differences may relate to differences in the circumstances surrounding the incidents against blacks and against whites, as reported to RCCs. As mentioned earlier in the report, 58% of blacks as compared to 48% of whites and 52% of Hispanics were survivors of completed rape. A weapon was present in 18% of the assaults against blacks, 13% for whites, and 16% for Hispanics. Strangers accounted for 22% of the assaults against blacks, 19% for whites, and 14% for Hispanic survivors. More data are needed, however, to interpret adequately differences in intentions to prosecute.

Table 12

SURVIVOR'S INTENTION TO PROSECUTE

BY RACE/ETHNICITY OF SURVIVOR

	Intends to Prosecute (1484)	*No Intention to Prosecute* (2499)	*Uncertain* (1119)
White (4385)	*28%*	*50%*	*22%*
Black (277)	*40*	*39*	*21*
Hispanic (206)	*34*	*41*	*24*
Other (234)	*27*	*51*	*22*

N = 5102

Missing = 2152

Table presents row percents

Source: Massachusetts Department of Public Health, Rape Crisis Centers 1985-1987

DISCUSSION

Realities of Rape

The findings in this report underscore the fact that most sexual assaults do not fit commonly held stereotypes. This data set contains large numbers of child sexual assaults and incidents of incest, date and/or acquaintance rapes, sexual assaults by the victim's partner and assaults occurring in the ostensible safety of one's own home.

Sexual assault has traditionally been defined on the basis of reports to police. Since reporting has been inadequate, our definitions have also been inadequate. Incidents reported to Rape Crisis Centers more fully reveal the true character of sexual assault. Therefore, these incidents must become the basis upon which definitions are developed so that we can better understand the dynamics of sexual violence.

Research shows that the vast majority of perpetrators of sexual assault are males, even when the survivors are men and boys.[4] Many people assume that the rapist is a rare, sociopathic individual with a psychological profile vastly different from the "average" male. This characterization may be accurate in many of the serial rapes or rape-homicides that appear in the media. Recent research, however, indicates even men who are seemingly "normal", with no other evidence of violent behavior or criminal record, resort to coercive sex.

A three-year study of rape among college students during the 1980s indicated that one out of 12 male college students reported behavior that met legal rape or attempted rape definitions during the previous year. Yet none of them identified themselves as rapists.[5] In a similar study of male college students in the United States and Canada, 35% indicated some likelihood of committing a rape if there was no chance that they would be caught.[6] In a 1988 Rhode Island study, 1700 young adolescents (6th to 9th graders) were asked to respond to a questionnaire regarding circumstances when the male had the right to sexual intercourse against the woman's consent. The results were alarming: 20% of the respondents condoned forced sex when the male spends a lot of money on the woman; 29%, when the male is so turned on he can't stop; 59%, if they have been dating a long time and 80%, if they are married.

Surveys like these demonstrate that sexual assault reflects a widespread societal pathology that condones violence in general and violence against women in particular. Societal attitudes about power, vulnerability, sexuality and sex roles perpetuate sexual violence. Vulnerable groups, such as women, children, and people of color, are often characterized as accepted targets of violence. Media images that debase women and depict women enjoying violent sexual encounters support these attitudes as does the present trend toward the sexual exploitation of children.

Reporting

Historically, sexual violence has been treated as a taboo subject, primarily because sexual assault was considered to be motivated by sexual desire rather than by aggression. Consequently, response to the incident often focused on the survivor and how she/he had aroused the offender's sexual impulses beyond his control. For generations, women were taught that sexual assault occurred because of how they dressed, how they spoke, where they went, whether they were attractive, young, and so on. Conversely, males were taught that only females could be sexually assaulted and that males who were assaulted were particularly weak.

In the aftermath of sexual assault, the survivors presented in this data set had a myriad of options to pursue. It was striking that, in general, the closer the circumstances surrounding a sexual assault resembled a classic, stranger rape scenario, the more likely classic channels of support and help (reporting to police and hospitals, receiving medical care, and prosecuting the assailant) were pursued. The less the sexual assault resembled a stereotypical rape, the more important alternative sources of support (such as RCCs) became. Regardless of the circumstances surrounding the reported incidents, however, as the findings in this report clearly show, survivors very often did not report the crime to police or hospital authorities, often did not receive any

medical care, and often did not intend to prosecute the assailant. Thus, survivors of sexual assault often remained isolated with their physical insults unattended, and the assailants unprosecuted.

Specific health concerns as a result of sexual assault may include physical injuries such as broken bones; internal injuries and scarring (especially for child victims and older women); exposure to sexually transmitted diseases and to the human immunodeficiency (HIV) virus; infertility, pregnancy and abortion. For these reasons, rape crisis counselors encourage survivors to seek medical care after a rape and other sexual assaults.

Medical facilities also provide a setting for the collection of physical evidence for criminal prosecution of the assailant. Survivors who report the sexual assault to police and who intend to prosecute are strongly encouraged by police to receive medical care and undergo the extensive process of collecting evidence. Unfortunately, because of past legal procedures, many persons link receiving medical care with reporting to police. The result is that survivors who do not want the police involved tend to avoid medical care. Another barrier to medical care is the expense--particularly for survivors with no health insurance.

The circumstances of a sexual assault not only have a bearing on receiving medical care but also influence the decision about attempting prosecution. No survivor makes this decision lightly since conviction rates and sentencing seem to indicate a poor chance that the survivor will be vindicated by the courts. One national study in 1975 indicated that only 3% of reported rape cases ended in a conviction.[7] The last year in which statistics on the disposition of rape cases were reported to the FBI was 1977, at which time arrests occurred in only 50% of reported cases, with only 75% of the accused ever going to trial. Of those who went to trial, only 47% of assailants were convicted of rape. Hence, less than 16% of rapes reported in that year led to a conviction.[8] In Massachusetts, the average sentence received is five years for the rape of an adult and only two years for the rape of a child.[9]

Attitudes and practices of the legal system influence decisions about attempting prosecution. Since most courts and jurors are more familiar with rape scenarios that involve strangers, that occur outdoors and involve physical injury in addition to rape, the court system is often ill-equipped to deal with the far more common sexual assault that occurs in a home setting and involves an assailant known to the survivor. Until the courts and the public become more informed about how sexual assault really occurs, survivors of "non-classic scenario" asaults will likely remain reluctant to use the criminal justice system.

Rape and Racism

Rape and assault are primarily intraracial crimes. Yet the history of rape laws in this country have focused on the rape of white women by black men--so much so that an assailant who was black was likely to receive the death penalty if his victim was white. The rape of a black woman, on the other hand, by a black or white assailant, was legal.[10] The racist attitudes that gave rise to an unequal system or justice remain to this day in the myth that black men disproportionately rape white women. The fact is, according to Justice Department statistics, seventy percent of black rape victims were raped by blacks and an even larger number--seventy-eight percent--of white rape victims were raped by whites.[11] However, recent studies show that judges continue to impose harsher sentences when the victim is white than when she is black and that police are more likely to believe white women than women of color.[12] This data set did not gather information on the assailant's race, but since so many of the sexual assaults in this study were committed by acquaintances and family members, it is reasonable to assume the percentage would be even higher for the population in this data set than in those compiled by law enforcement agencies.

Because sexual violence in this country has been an integral component of oppression, many communities of color continue to remain suspicious of law enforcement and service providers. Until programs and policies address specific risk populations, certain vulnerable groups will continue to experience undocumented "hidden" sexual assault of unknown magnitude in addition to other forms of oppression and violence.

Recovery from Rape

Sexual assault survivors, like victims of other violent crimes, suffer physical and emotional trauma during the assault, immediately following the assault, and over a considerable period of time thereafter.

"Rape trauma syndrome" is the technical term used to describe the symptoms following rape and other sexual assaults and the stages of the recovery process. These symptoms may include sleep disturbances, eating pattern disturbances, mood swings, feelings of humiliation, anger, and self-blame; nightmares and flashbacks; development of phobias specific to the attack and a fear of sex.[13] Each person is unique in her/his recovery so there are no real guidelines on how long it will take someone to resume her/his previous level of functioning. There is agreement, however, on the fact that sexual assault makes permanent changes in a person's life.

Survivors of incest, domestic assaults, and date or acquaintance rape may have particularly difficult recoveries because of the betrayal of trust inherent in these types of assaults. Furthermore, survivors of child sexual assault often have difficult recoveries due to several additional factors, including the fact that the victim has often been coerced, threatened or bribed into keeping the assault(s) a secret; the victim may not have been believed when initially disclosing the assault and may have thereby been deprived of the proper care and protection from trusted adults in her/his life; the offender is often a trusted caregiver and authority figure so that the victim must cope with confusion, distrust, and betrayal. Some child sexual abuse is repetitive and ongoing--sometimes spanning a number of years. Flashbacks of early, distasteful, and forced sexual activity may make sexual pleasure and intimacy difficult.

Many adult victims of child sexual assault report feelings of being different, of being isolated from others because of the hidden fact of the sexual abuse. These feelings, often unexpressed until long after the assault, may cause loneliness and depression, which sometimes lead to alcohol and/or drug dependency or suicide attempts. This feeling of isolation may also compromise the victim's ability to develop close, trusting relationships.

Recovery from sexual assault is a long and difficult journey. For some it is impossible. Some survivors eventually commit suicide. Suicide may be more prevalent within cultures that view sexual assault as bringing disgrace not only upon the survivor but upon her whole family as well. Although suicide after a sexual assault is the extreme and not the norm, care providers cannot ignore this extreme.

More commonly, survivors of completed rape and all other sexual assults go on to overcome their painful memories and mourn their losses--but not without considerable effort and the support of persons around them. Though the full impact of sexual violence on morbidity and mortality has not yet been quantified, there is a definite need for a range of services for survivors, including the unique services of Rape Crisis Centers.

Role of Rape Crisis Centers

These data demonstrate that the role of the RCC is crucial for many survivors of sexual assaults--particularly those who fall outside the stereotypical sexual assault. Survivors tended to be less reluctant to report non-classic incidents to RCCs--perhaps because they assumed they would be believed regardless of corroborating evidence such as physical injuries. The services of an RCC may be especially important for adult victims of child sexual assault. Other avenues for seeking help (such as a hospital or the police) are frequently closed to them since the immediacy of the physical trauma has passed, as has the statute of limitations for prosecuting in many instances. The emotional trauma experienced by the adult victim or child victim of sexual assault can be very intense during disclosure since it may be the first time the incident has ever been discussed. The large number of adult victims of child sexual assault now coming forward bears testimony to the fact that until very recently there were virtually no services for sexual assault survivors of any age. Counseling survivors of past, undisclosed sexual assault(s) is an essential service of an RCC--one that few other agencies provide.

Since rape crisis counselors are now mandated reporters under the 1983 Massachusetts Department of Social Services' reporting law, all cases of sexual abuse involving children under 18 years of age that are reported to RCCs must be reported to the Department of Social Services, which, in turn, reports these cases to the district attorney. Other mandated reporters include physicians and hospital personnel, psychologists, dentists, teachers, guidance and family counselors, daycare workers, social workers, foster parents, police and firefighters. The hope is that with this law, Rape Crisis Center staff and others will be involved in the early identification and investigation of child sexual assault offenders, thereby reducing sexual victimization of children.

Rape Crisis Center services are also important as an emotional support and follow-up for survivors who did report to police and hospitals as well as for victims who are attempting to prosecute their assailants. Rape crisis counselors frequently accompany survivors throughout the entire criminal justice process. For some, the ability to go forward with prosecution may not have been possible without the support of an RCC. The fact that 26% of all survivors disclosed the incident only to an RCC staff member attests to the importance of these services in providing support to victims of sexual violence.

Rape Crisis Centers also play a key role in providing education and community awareness about the realities of sexual assault and in helping to develop strategies aimed at prevention. In addition, RCCs have been instrumental in promoting sensitive, non-judgmental, and accessible medical and law enforcement responses, which, in turn, may help to increase the overall reporting rate of sexual assault. It has been the work of RCCs that has helped to educate all of us on the alarming frequency of incest, domestic sexual assault, and date rape, thereby necessitating a revised definition of the realities of sexual violence.

RECOMMENDATIONS

The data collected by Massachusetts Rape Crisis Centers and presented in this report provide grim views of some of the realities about sexual assault.

Sexual assault is both a personal crisis and a social pathology. Efforts to prevent sexual assault must, therefore, work on two levels. Recommendations that focus on the person's crisis after a sexual assault address the need for appropriate services to survivors and their families. Recommendations focusing on the social problems that create a climate where sexual violence can flourish address the need for preventive education and increased community awareness about the realities of sexual assault. Additional recommendations assist in creating an infrastructure and knowledge base necessary for effectively carrying out direct services and educational efforts.

In the 1985 Surgeon General's Workshop on Violence and Public Health, two working groups on sexual assault outlined 12 educational recommendations and 10 direct service recommendations. The working groups on child sexual assault outlined additional recommendations specific to children. The following is based upon these guidelines and is supported by the findings outlined in this report. Specific recommendations fall into five main categories:

I. Sexual violence prevention strategies
II. Direct services for survivors of sexual assault and their significant others
III. Interagency coordination
IV. Criminal sanctions and treatment for offenders
V. Expanded data base to more fully understand the issues.

I. Sexual violence prevention strategies: Efforts to prevent violence must become a public health priority.

A. Violence prevention programs must recognize, and work to change, some of the current social values that support a climate of violence and make certain communities more vulnerable to victimization than others. Educational programs must effectively challenge racism, sexism, and other forms of prejudice that are the pillars of violent behavior. Culturally sensitive approaches must be an integral component of all violence prevention strategies.

B. Since violent behavior is learned from various sources, including childrearing practices, family violence, peers, and the media, alternatives to violence can and must be taught in schools, colleges, and religious and community organizations.

C. In an effort to provide greater public awareness about the facts of rape and all other sexual assaults and the effect of sexual violence upon survivors and their families, as well as the negative social consequences of a high tolerance for violence and aggressive behavior, specific educational programs and curricula must be targeted to the following groups:

1. High-risk groups

a. potential victims: especially male and female children, and adolescent and young adult females

b. potential offenders: pre-adolescent, adolescent and young adult males

2. General public

    a. school systems and colleges
    b. parents
    c. religious/cultural groups
    d. media

II. Direct services for survivors of sexual assault and their significant others are essential to the public health. Culturally sensitive approaches to counseling and direct services must be integral to all program components.

A. Rape crisis centers (RCCs) must be seen as a valid community response to the social problem of sexual assault and must become fully accessible to diverse communities--including ethno-linguistic minority communities, rural areas, adolescents, older survivors, lesbians and gay men, and persons with various disabilities. Services and scope of RCCs must be expanded throughout Massachusetts to enable them to provide services to the varied populations they serve, including:

1. Survivors of completed rape: survivors of rape by strangers and of rape by assailants known to them
2. Victims of child sexual assault: current victims and adult victims.

B. Technical assistance must be available to ethno-linguistic minority communities that are beginning to develop service programs for survivors of sexual assault.

III. Interagency coordination is needed to create a consistent and comprehensive response to survivors of a sexual assault in Massachusetts.

A. Strategies for the prevention of sexual violence should be incorporated into all state human service agencies with protocols for handling sexual assault cases.

B. Training materials that are consistent statewide and sensitive to the needs of sexual assault survivors of all ages and cultures must be developed and implemented by an interdisciplinary task force that includes hospital and medical professionals, rape crisis and mental health professionals, law enforcement, criminal justice and victim-witness advocacy professionals, and state agency staff.

C. Secondary prevention -- early identification and treatment -- is also essential. Since survivors of all ages may seek help through various avenues and at various stages following sexual assault, core curriculum requirements that teach awareness of, and sensitivity about, sexual assault must be broad in scope and include all mandated reporters of child sexual assault:

1. Medical and health professionals

2. Mental health and human service professionals

3. Educators, teachers, daycare workers and foster parents

4. Law enforcement and criminal justice professionals

5. Clergy/religious professionals.

IV. Criminal sanctions and treatment for offenders: All components of the criminal justice system must come to recognize sexual assaults as serious violent crimes, and must be prepared to impose sanctions--including incarceration--commensurate with the effect of these crimes on their victims.

A. Research must be conducted to measure the efficacy of various treatment programs for offenders.

B. Early identification, evaluation, and treatment of all sex offenders--especially adolescents and pre-adolescents--should become a priority since sex offenders often begin at a young age and usually repeat their offenses.

C. Prison sentences for offenders must incorporate appropriate treatment aimed at the prevention of future violent behaviors.

V. Expanded data collection efforts and research on rape and all other sexual assaults must be carried out to understand the issues more fully.

A. To receive more adequate statewide statistics, data collection from statewide rape crisis centers must be expanded to include centers that do not receive funding from the Department of Public Health. The existing data base should also be expanded to include questions on additional physical injuries and reasons for seeking medical care; the type of coercion involved in the assault; whether there were previous experiences of sexual assault; reasons why the survivor may have decided not to report to the police; and additional information on survivor/assailant relationships such as sexual assault by health professionals, counselors/therapists, religious professionals, supervisors and siblings. (See Appendix B for new questionnaire.) Hospitals and emergency rooms should also be encouraged to develop a data base on rape and all other sexual assaults.

B. Longitudinal data on arrest, conviction, and sentencing rates for offenders are also needed throughout the state since this information is often crucial to the survivor in making the choice whether or not to report to police and proceed with prosecution.

C. Additional research is needed, which focuses on:

1. Evaluation of effective treatment approaches for survivors and their significant others regarding the process of recovery after sexual assault, including thoughts, feelings, behaviors, and general health status.

2. Offenders and factors associated with sexually assaultive behavior, as well as the effectiveness of treatment programs aimed at deterring continued violence.

3. Evaluation of the most effective educational curricula aimed at preventing rape and all other sexual assaults, as well as changing basic social attitudes that create a climate for violence.

4. Statewide collection of data from law enforcement agencies regarding rape homicides.

The scope of preventive strategies, service provision, and further research must be as broad as the scope of the problem of sexual assault. It is hoped that this report, by shattering many deeply entrenched and harmful myths about sexual assault, will assist in illuminating the scope of the problem. Through public education, service provision, and data collection, Massachusetts Rape Crisis Centers have played a unique role in shattering the myths.

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APPENDIX A: METHODOLOGY

The data summarized in this report were collected by means of a questionnaire (see Appendix B) completed by a rape crisis counselor for each incident of sexual assault reported to an RCC during 1985-1987. Most of the questions on the form concerned the most recent incident; for many survivors the latest incident was not the first or only assault. Forms were completed during telephone contacts, individual counselling sessions, or a combination of these services. The questionnaire included data about the reported incident, the survivor, the assailant and the survivor's actions following the assault. To preserve confidentiality, no information that could identify the survivor was included on the questionnaire.

Much of the information was gathered during the initial telephone contact with a rape crisis counselor, whose primary objective is to attend to the caller's emotional needs. It was therefore not always feasible to complete the entire questionnaire for each caller. For this reason, a substantial amount of information on individual variables is missing in the RCC data set. When there were subsequent calls or counselling sessions, counselors attempted to complete the questionnaire. To ensure consistency of data collection, all counselors receive standard training and supervision by RCC program coordinators.

In common with most information related to sexual assault, the RCC data set contains self-reported data from a self-selected population. Since many survivors stated that they had never reported the assault to any other organization that collects sexual assault data, such as law enforcement agencies, this data set presents a rare look at hidden assaults. Another strength of this data set is the breadth of information gathered by the questionnaire. The size of the data set, 7254 incidents reported over three years, is a third strength.

Definition of terms

Throughout this report, the general terms "sexual assault," "assault," and "incident" include any sexual contact that occurs without consent and is forced, manipulated or coerced. These terms are used to include rape, child molestation, incest, same-sex assault, acquaintance or date rape and marital rape, as well as attempted rape and the broad range of incidents described below. The legal definition of rape in Massachusetts is "sexual intercourse or unnatural sexual intercourse by a person against another person's will, by force or threat of force" (M.G.L. C. 265, s. 22b). With regard to age, this report, using the Massachusetts Department of Social Services' definition, defines a child victim as anyone under 18 years old at the time of assault.

The 1985-1987 questionnaire gave the counselor a choice of terms to describe the latest assault. The list included terms that defined the incident by what type of assault had occurred (such as "attempted" or "completed rape"); and terms that defined the incident by survivor or assailant characteristics (such as "child sexual abuse" and "spouse abuse"). Counselors were trained to choose the most serious appropriate term, i.e., the completed rape of a child should have been indicated as "completed rape," not "child sexual abuse."

In this analysis, incidents reported to RCCs were grouped into two major categories (see Figure 4). Half (50%) of the reported incidents were coded as "completed rape." Completed rape was defined as forced intercourse with vaginal, anal or oral penetration by an object or part of the rapist's body, regardless of the survivor's age.

Throughout the report, the category "completed rape" is contrasted with the second major category, referred to by the terms "all other incidents," "all other assaults," or "all other sexual assaults." This category comprised 50% of all reported assaults, and includes the following incidents: "attempted rape," "other sexual assaults," and "other" (see below).

Seven percent of the assaults were coded as "attempted rape." Attempted rape was defined as forced sexual contact that would have resulted in vaginal, anal or oral penetration by an object or part of the rapist's body had the assault not been interrupted in some way (such as the assailant being scared off). Again, this term was used regardless of the survivor's age.

On the 1985-1987 data form, the term "sexual assault" included forced sexual contact other than attempted or completed rape. Examples of such contact were provided for rape crisis staff: sexual fondling, physical pressure to have sexual contact, and indecent exposure. Counselors were to use this term on the data form when the survivor was an adult. When the victim of such actions was under 18 years old, the counselor was instructed to choose the term "child sexual abuse" from the list on the data form. In this report, "adult sexual assault" and "child sexual abuse" have been grouped together as "other sexual assault." One third of all reported incidents (32%) were "other sexual assaults."

The fourth category used for this report--"other"--includes three terms from the data form. "Spouse abuse" (3% of all reported incidents) was defined as emotional abuse, verbal threats or physical battering of a spouse or partner. "Sexual harassment" (3% of all reported incidents) covered unwanted touches, remarks or pressure for sexual contact. The term "other" (5% of incidents) on the data form was defined as any sexually violating behavior not mentioned in the above definitions, such as obscene phone calls or letters.

As the 1985-1987 data form did not specifically ask for the survivor's age at latest assault, age was calculated by the following method: the date of latest assault was subtracted from the date of call to the RCC, then the result was subtracted from the survivor's age at time of call.

The question on the data form concerning medical care after a sexual assault was directed toward whether or not the physical injuries received during the incident required hospitalization or other medical care, and whether that care was sought. In the analysis, the two responses "required medical care but did not seek it" and "did not require medical care" were combined to describe all situations where the survivor "did not receive medical care."

Modifications to the 1985-1987 questionnaire

An extensively modified rape crisis data form was implemented January 1, 1988. (See Appendix C.) The new form includes the survivor's age at latest assault and a list of incidents defined solely by what type of assault occurred. There are separate questions for the type of physical injury sustained and the type of medical care sought after an assault. In addition, the updated form is much more comprehensive, gathering detailed information of interest to a wide variety of professionals. Future reports based on the revised form will address a number of salient issues, such as the nature of survivors' injuries, medical care received, and reasons for not reporting the assault to police.

Department of Public Health
Division of Family Health Services

Rape Crisis Data Form
Client Intake

1. Rape Crisis Center Name: _____

2. Program/Client ID: _____ ☐☐/☐☐☐☐

3. Date: _____ ☐☐/☐☐/☐☐
month day year — month day year

4 Caller:

1. victim
2. victim's partner
3. victim's mother/guardian
4. victim's father/guardian
5. hospital personnel
6. police/criminal justice personnel
7. school personnel
8. counselor/therapist
9. friend
10. other (specify: _____)

☐☐

NOTE: Use **0** with single digits, Ex: 01, 04, etc. **USE PENCIL**

Victim/Survivor

5. Sex: 1. female 2. male ☐

6. Age of victim now: _____ ☐☐

7. Age at initial abuse/assault: _____) ☐☐

8. Race/ethnicity of victim: ☐

1. white
2. black
3. Hispanic
4. Portuguese
5. Asian or Pacific islander
6. other (specify: _____)

9. Is victim English-speaking? 1. yes 2. no ☐

10. Physical injuries: ☐

1. required hospitalization
2. required medical care but not hospitalization
3. required medical care but did not seek it
4. did not require medical care

11. Intends to prosecute: 1. yes 2. no 3. victim uncertain ☐

12. Prosecution attempted: 1. yes 2. no 3. not applicable ☐

Assault

13. Latest incident: ☐

1. attempted rape
2. completed rape
3. child sexual abuse
4. sexual assault
5. spouse abuse
6. sexual harassment
7. other (specify: _____)

14. Date of latest abuse/assault: (please approximate _____) ☐☐/☐☐/☐☐
mo day year — month day year

15. Time elapsed since latest assault: ☐

1. less than 24 hours
2. 1-2 days
3. 3 days to one week
4. 2-4 weeks
5. 1-6 months
6. 7-12 months
7. 1-6 years
8. more than 6 years

16. Place of latest assault: ☐☐

1. victim's home
2. offender's home
3. victim and offender's home
4. other home/building (specify: _____)
5. workplace
6. car/vehicle
7. school/day care
8. physician's office/hospital
9. outdoors in woods/park/beach
10. outdoors in street/parking lot
11. other (specify: _____)

17 Was a weapon present? 1. yes 2. no ☐

18 Assault reported to: (check all that apply)

1. police ☐
2. hospital ☐
3. spouse ☐
4. family ☐
5. friends ☐
6. counselor ☐
7. teacher ☐
8. Rape Crisis Center ☐
9. other (specify: _____) ☐

Offender

19. Sex of offender(s): ☐

1. male
2. female
3. multiple males
4. multiple females
5. mixed males and females

20. Victim/offender relationship ☐☐

1. spouse
2. partner
3. close friend
4. acquaintance
5. stranger
6. parent
7. step-parent
8. other relative (specify: _____)
9. co-worker
10. school personnel (specify: _____)
11. health professional (specify: _____)
12. multiple offenders (specify relationships: _____)
13. other (specify: _____)

21. Age of offender at time of latest assault ☐☐

If single offender

0. child under 13 years
1. teenager (13-19 years)
2. young adult (20-29 years)
3. adult (30-45 years)
4. mature adult (46-59 years)
5. elder adult (60+ years)

If multiple offenders:

6. teenagers
7. young adults
8. adults
9. mature adults
10. elder adults
11. mixed ages

Referral

22. Source of RCC referral (check all that apply)

1. telephone book ☐
2. friend ☐
3. family ☐
4. police ☐
5. hospital ☐
6. school counselor ☐
7. work colleague ☐
8. media ☐
9. RCC outreach ☐
10. other (specify: _____) ☐

Rape Crisis Data Form

Massachusetts Department of Public Health

Instructions: Enter answers in box. Use pencil.

1. Rape crisis center name: _____

2. Program/incident ID number: _____ ☐☐/☐☐☐☐

3. Date of report to RCC: _____ ☐☐/☐☐/☐☐ (Month / Day / Year)

4. Data gathered by: ☐

   (1) telephone only (2) in-person session only (3) both

5. Caller ☐☐

   (1) victim
   (2) victim's partner/spouse
   (3) victim's mother/guardian
   (4) victim's father/guardian
   (5) hospital personnel
   (6) police/crim. justice personnel
   (7) school personnel
   (8) counselor/therapist
   (9) friend/co-worker
   (10) offender
   (11) other (specify) _____

Victim/Survivor

6. Sex (1) female (2) male ☐

7. Age now: _____. ☐☐

8. Race/ethnicity of victim: ☐
   (1) White
   (2) Black
   (3) Hispanic
   (4) Asian
   (5) Native American
   (6) Other
   (7) Mixed

9. Is victim physically challenged? (1) yes (2) no ☐

10. If yes, please check all that apply:
    ☐ (1) visually impaired
    ☐ (2) hearing impaired
    ☐ (3) physically challenged
    ☐ (4) mentally retarded
    ☐ (5) emotionally/mentally impaired
    ☐ (6) other (specify) _____

Assault

11. Latest incident: ☐
    (1) completed rape
    (2) attempted rape
    (3) sexual assault (physical)
    (4) sexual assault (verbal)
    (5) sexual harassment
    (6) other physical assault
    (7) other

12. Has victim been sexually assaulted before latest incident? ☐
    (1) yes (2) no

13. Date of latest incident: (☐☐/☐☐/☐☐)
    month/day/year

14. Age of victim at latest incident: _____ ☐☐

15. Location of latest incident:
    (_____/_____) ☐☐☐
    city state or country DPH Code Only

16. Time elapsed since latest assault: ☐
    (1) less than 24 hours
    (2) up to 1 week
    (3) up to 1 month
    (4) up to 6 months
    (5) over 6 months

17. Place of latest incident: ☐☐
    (1) victim's home
    (2) offender's home
    (3) victim and offender's home
    (4) residential facility/institution
    (5) other home/building (specify) _____
    (6) workplace
    (7) car/vehicle
    (8) school/day care
    (9) physician's office/hospital
    (10) therapist's/counselor's office
    (11) outdoors in woods/park/beach
    (12) outdoors in street/parking lot
    (13) other (specify) _____

18. Type of coercion/force involved (check all that apply):
    ☐ (1) verbal
    ☐ (2) physical (hitting, pushing, kicking, etc.)
    ☐ (3) presence of gun
    ☐ (4) presence of a knife/cutting instrument
    ☐ (5) presence of blunt object
    ☐ (6) abduction
    ☐ (7) threats to significant other(s)
    ☐ (8) other

19. Type of physical injury (check all that apply):
    ☐ (1) bruises, scratches, abrasions
    ☐ (2) laceration requiring sutures
    ☐ (3) loss of teeth
    ☐ (4) broken bones
    ☐ (5) internal injury
    ☐ (6) other major injury
    ☐ (7) unconsciousness
    ☐ (8) other
    ☐ (9) none

20. Medical attention sought (check all that apply):
- ☐ (1) internal/pelvic exam
- ☐ (2) treatment of physical injuries
- ☐ (3) hospitalization for physical injuries
- ☐ (4) hospitalization for other reasons
- ☐ (5) none

21. Assault reported to (check all that apply):
- ☐ (1) police
- ☐ (2) hospital
- ☐ (3) family
- ☐ (4) friends
- ☐ (5) counselor (other than RCC)
- ☐ (6) private physician
- ☐ (7) teacher
- ☐ (8) DSS
- ☐ (9) other (specify:_____)
- ☐ (10) RCC only (none of the above)

22. If victim didn't report to police, why? (check all that apply):
- ☐ (1) lack of confidence in criminal justice system
- ☐ (2) fear of retaliation by offender
- ☐ (3) concern about effect on family/significant others
- ☐ (4) embarrassment/shame—desire to keep assault a secret
- ☐ (5) fear of not being believed
- ☐ (6) language/cultural barriers
- ☐ (7) insufficient time
- ☐ (8) prior bad experience with police/criminal justice system
- ☐ (9) pain of retelling incident
- ☐ (10) fear of media publicity
- ☐ (11) other _____

23. If offender is apprehended, does victim intend to prosecute? ☐
(1) yes (2) no (3) uncertain

Offender

24. Sex of offender(s): ☐
(1) male
(2) female
(3) multiple males
(4) multiple females
(5) mixed males and females

25. Race of offender(s): ☐
(1) White
(2) Black
(3) Hispanic
(4) Asian
(5) Native American
(6) Other
(7) Mixed
(8) Multiple offenders of different races

26. Victim/offender relationship: ☐☐
(1) spouse
(2) partner/lover
(3) ex-spouse
(4) ex-partner/ex-lover
(5) friend
(6) acquaintance
(7) met same day
(8) stranger
(9) parent
(10) stepparent
(11) caretaker/babysitter
(12) sibling
(13) other relative
(14) co-worker/colleague
(15) boss/supervisor
(16) school personnel
(17) health professional
(18) counselor/therapist
(19) religious professional
(20) other

27. Age of offender at time of latest assault: ☐☐

If single offender:
(1) child under 13 years
(2) teenager (13-19 years)
(3) young adult (20-29 years)
(4) adult (30-45 years)
(5) mature adult (46-59 years)
(6) elder adult (60+ years)

If multiple offenders:
(7) children under 13
(8) teenagers
(9) young adults
(10) adults
(11) mature adults
(12) elder adults
(13) mixed ages

Referral

28. Source of RCC referral (check all that apply):
- ☐ (1) telephone book
- ☐ (2) friend
- ☐ (3) family
- ☐ (4) police
- ☐ (5) hospital
- ☐ (6) therapist/counselor
- ☐ (7) school counselor
- ☐ (8) work colleague
- ☐ (9) media
- ☐ (10) RCC outreach
- ☐ (11) other (specify) _____