

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

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ABSTRACT

Male-on-male rapes and sexual assaults comprise fewer than 10% of such assaults reported to the police, and so many physicians seldom encounter them. This paper provides an overview of the nature of sexual assault encountered by males, ensuing injuries, and comparisons to male-on-female assault cases.

The retrospective epidemiological study was on two cohorts seen at St. Mary's Sexual Assault Referral Centre, Manchester. The participants were Centre clients seen between October 1986 and mid-May 2003; 376 male cases (370 individual clients) and 7,789 female cases (7,403 individual clients). The main outcome measure was the presence of injury (abrasion, laceration, or bruise) to defined body areas. The results showed that 66% of male cases (when assault type was known) had been raped, significantly fewer than in female cases, ($p < 0.00$, $\alpha < 0.05$, O.R. 0.474, 95% C.I. 0.357 to 0.63). Eighteen per cent of male cases that had a forensic medical examination presented with an anal injury, significantly more than in females ($p < 0.00$, $\alpha < 0.05$, O.R. 6.101, 95% C.I. 4.216 to 8.829). Significantly fewer males than females sustained injuries to other body areas.

The conclusion was that males were significantly more likely (six times) than females to receive at least one injury to the anal area. Even so, males are five times more likely to have no anal injury.

INTRODUCTION

Background

This paper presents some medical features of cases seen at a sexual assault referral centre (SARC) in Manchester, UK. Established in

1986, the St. Mary's Centre was the first comprehensive forensic medical, counselling and aftercare service in the UK for people alleging rape or sexual assault. It is a collaboration of Greater Manchester Police (GMP), Greater Manchester Police Authority, and Central Manchester and Manchester Children's University Hospitals NHS Trust and sees females and males that either live in or were assaulted in Greater Manchester. Based at dedicated accommodation in St. Mary's Hospital, counselling and other support services are provided free as well as forensic medical examinations conducted by a specially trained staff of female doctors on behalf of GMP. The number of male clients seen at the Centre has doubled from fewer than 20 per year in the first five years to more than 40 in 2002. Similarly, the proportion of male clients seen that were referred via the police has more than doubled from below 30% in those first five years to over 70% in 2002.

Defining rape and sexual assault

In forensic medicine, rape is not a medical diagnosis but a legal term. Doctors cannot determine whether or not a person they examine was raped, a jury in a court of law decides that. The rape of a male was first legally recognised in the English and Welsh legal system in 1994. Prior to that it was covered by the offence of buggery, which

carried a lesser penalty than rape (Rogers, 1995). The Sexual Offences Bill (Home Office, 2003) currently being considered by Parliament, removes all reliance on the gender of the victim and defines rape, thus:

‘A person (A) commits an offence [of rape] if (a) he intentionally penetrates the vagina, anus or mouth of another person (B) with his penis, (b) B does not consent to the penetration, and (c) A does not reasonably believe that B consents’ (s.1.1, Home Office, 2003).

That definition is adopted here, although others (e.g., Scarce, 1997) have defined rape as the penetration of the vagina, anus or mouth by a penis or any other object without consent. The sexual penetration of the vagina or anus (although not mouth) by any object or body part other than the penis is covered in the Bill by the offence of assault by penetration (s.3, Home Office, 2003). Sexual assault is similarly defined as unconsenting, sexual, physical contact (s.4, Home Office, 2003). The term ‘male-on-male rape’ is used in this paper in preference to simply ‘male rape’ to clarify that the assault involves a male perpetrator and a male victim.

Injuries

There is a growing literature of research regarding the ano-genital injuries to females caused by rape (Lincoln, 2001), although few compare findings to consensual sexual intercourse in studies with large numbers (Goldman et al., 1998) or with an adequate control group (Slaughter et al., 1997). These studies have found, to varying degrees, a higher proportion of injuries in assault cases than in control groups. Present research attention to anal abnormalities in males predominantly relates to child sexual abuse (Muram, 1989). Kaufman et al. (1980) found that males sustained more physical trauma than females. However, it is clear that research regarding anal injuries to males resulting from a single incident of sexual assault is required.

METHOD

Aims

The aim of this study was to ascertain the differences and similarities in the character-

istics, particularly ensuing injuries, of male-on-male assaults compared with male-on-female assaults. It is intended that these findings assist physicians treating or examining male victims of sexual assault to develop a gender-sensitive rather than female-specific approach.

Design

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

Participants

St. Mary’s Centre mainly sees adults from Greater Manchester that have been raped or sexually assaulted by a non-family member on a single occasion, as opposed to cases of child sexual abuse. This study includes clients seen at the Centre from its opening in October 1986 up to mid-May, 2003. In that time a total of 8,165 cases of alleged rape or sexual assault have been seen at the Centre. 7,789 cases involved female clients, 376 male; and comprised 7,773 individual clients. The extra 392 cases comprised 284 female and six male clients who attended the Centre on more than one occasion because of separate incidents of assault. This is why the term ‘case’ is mainly used here rather than ‘client’. Of these 7,773 individual clients, 7,403 (95.2%) were female and 370 (4.8%) male.

Treatment of the data

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

RESULTS

Assault type

Assault type was known in 224 (59.6%) of the 376 male cases. In 147 (65.6%) of the 224

Table I. Chi-square test of assault types reported by male and female clients at the St. Mary's Centre (October 1986 to May 2003), excluding unknowns.

Assault type	Male (n=224)		Female (n=5,497)		Asymp. sig. (two- tail)**	Odds ratio value	95% confidence interval	
	N	%	N	%			Lower	Upper
	Rape*	147	65.6	4,403			80.1	0.000
Digital/object penetration*	47	21.0	509	9.3	0.000	2.602	1.863	3.635
Indecent assault	12	5.4	303	5.5	0.921	0.970	0.536	1.756
Attempted rape	18	8.0	282	5.1	0.056	1.616	0.984	2.655

* Statistically significant difference at the 0.05 level.

** Asymptotic significance of Pearson Chi-Square.

known assault type cases the male client had been (anally) raped. In 47 (21%) of the cases the assailant had anally penetrated the victim, digitally or with an object. Twelve (5.4%) had been indecently assaulted, and 18 (8%) had experienced an attempted rape. Assault type was not known in 152 cases. This may be due to unconsciousness of the client during the suspected assault or lack of recording in cases where a client has attended the centre seeking counselling some time after the event or possible reluctance on the part of the client to disclose the nature of the incident.

Of the 7,789 female cases assault type was known in 5,497 (70.6%) cases. Of these, 4,403 (80.1%) involved alleged penile rape (either vaginally or anally). A further 509 (9.3%) had been penetrated vaginally or anally by fingers or object, or orally by fingers, object or penis. Three hundred and three (5.5%) had been otherwise indecently assaulted, and 282 (5.1%) had experienced an attempted rape.

Four chi-square tests were conducted for each of the assault types (e.g., rape or other assault type), with assault type in question coded as 1 and others as 0. The proportion of male clients reporting rape was significantly smaller than for female clients, but greater for penetration by fingers or other objects. The proportion of male and female clients reporting an indecent assault or attempted rape did not differ significantly, using the 0.05 level. See Table I for details.

Forensic medical examination

A total of 5,359 forensic medical examinations were conducted at the Centre by one the Centre's team of forensic physicians (and since late 2001 the first forensic nurse examiner to practice in the UK, employed at St. Mary's): 228 (4.3%) and 5,131 (95.7%) were with male and female clients respectively. This represents 228 (60.6%) of the 376 male cases and 5,131 (65.9%) of the 7,789 female cases presented at the Centre.

Injuries

Due to the method by which injury data had been recorded, statistical analyses were restricted. Table II shows how many examined cases had at least one injury (bruise, laceration or abrasion) to a given body area. Female cases recorded injuries to all body areas more often than male, with the exception of the anus, which indicates the nature of male-on-male rape.

Differences between the sexes for injury to each body area were analysed using chi-square tests, with injury coded as 1 and no injury as 0. Eighteen per cent of examined male cases (n=228) had at least one injury to the anal area compared with 3.5% of females (n=5,131), which was statistically significant. Injuries were significantly more common in female cases for the following body areas: neck; chest/breasts; outer thighs; inner thighs; lower legs; and genitalia. See Table II for more details. Of the 197 examined male cases where

Table II. Chi-square test of body areas where injuries were recorded in cases that involved a forensic medical examination at the St. Mary's Centre (October 1986 to May 2003).

Body area	Injury				Asymp. sig. (two-tail)**	Odds ratio value	95% confidence interval	
	Male (n=228)		Female (n=5,131)				Lower	Upper
	N	%	N	%				
Head	12	5.3	375	7.3	0.243	0.705	0.390	1.272
Face	19	8.3	538	10.5	0.297	0.776	0.481	1.252
Inside mouth	1	0.4	85	1.7	0.152	0.262	0.036	1.886
Neck*	10	4.4	509	9.9	0.006	0.417	0.220	0.790
Chest/Breasts*	3	1.3	265	5.2	0.009	0.245	0.078	0.770
Arms	19	8.3	612	11.9	0.099	0.671	0.417	1.082
Trunk	23	10.1	607	11.8	0.424	0.836	0.539	1.297
Outer thighs*	11	4.8	493	9.6	0.015	0.477	0.258	0.880
Inner thighs*	3	1.3	467	9.1	0.000	0.133	0.042	0.418
Lower legs*	17	7.5	648	12.6	0.020	0.557	0.338	0.920
Genitalia*	7	3.1	648	12.6	0.000	0.219	0.103	0.467
Anus*	41	18.0	178	3.5	0.000	6.101	4.216	8.290

* Statistically significant difference at the 0.05 level.

** Asymptotic significance of Pearson Chi-Square.

assault type was known, 34 (26%) of 131 rape cases had at least one anal injury, as did two (3.9%) of 51 indecent assault cases, and one (7.1%) of 14 attempted rape cases. 82.9% of the male cases with at least one anal injury were alleged rape cases.

DISCUSSION

Assault type

Male cases involve a much greater proportion of digital or object penetration compared with females, a fifth as opposed to a tenth: a significant difference. Conversely, of all male-on-male assaults, two thirds of cases involved male-on-male rape, whereas four fifths of male-on-female assault cases involved rape. However, the reason for this difference is not clear. Male anal rape is clearly a different assault to female vaginal rape, and comparisons between the sexes for incidence of assault types are therefore not direct, like-for-like comparisons. For example, if men are more likely to report all sexual assaults, and not just the most serious (i.e. rape), then there should

be a larger number of assaults reported by males than is the case. Conversely, men may be less likely to report the most serious assaults (i.e. rape) and so the number of other assaults is disproportionately large. Further, it may be more difficult for a male to physically overpower a male so that penetration is achieved less often. The rate of male-on-male attempted rape was higher than that for females, and very closely approached statistical significance. Or, it may simply be that rape is not the ultimate goal of male-on-male assailants as often as it is for male-on-female assailants.

Forensic medical examination and injuries

Overall numbers of males having forensic medical examinations were similar, if a little below, those of females. These examinations found that males were significantly less likely to be injured during an assault. This may be because females injured more easily than males, or they resisted more strongly. Males were significantly more likely (six times) than females to receive at least one injury to the

anal area, which points to the nature of male-on-male rape. However, every other body area was more frequently injured in female cases, significantly so in that case of the neck, breasts/chest, outer and inner thighs, lower legs, and genitalia. Violence to the neck suggests the assailant's attempt to exert control, whilst the arms and lower legs suggest resistance from the victim. Injuries to thighs may be due to the assailant seeking access to the genitalia. It should be noted that the highest proportion of cases with an injury to any body site, was 18% of males with an injury to the anus (26% of alleged rape cases). The second was 12.6% of females with an injury to the lower legs. The fact that no body area receives an injury in more than one fifth of cases suggests that injuries are far from certain to result from sexual assault.

Conclusions for forensic physicians

The statistical findings from secondary research with categorical data may not be considered especially forceful, even with such large numbers as these. But, we contend that these findings do give a clear indication of the nature of reported sexual assault of males, and how that varies from the experiences of females. Support services will perhaps always receive more reports from males than will the police; so as the incidence of reported male-on-male sexual assaults rises, the inclusion of male clients into services for rape and sexual assault survivors, previously reserved for females, becomes more pressing. In so doing, greater levels of reporting may be encouraged as males find that their experiences and needs for assistance are acknowledged. Such inclu-

sion requires that service providers familiarise themselves with the different and/or additional needs of their male clients. It is hoped that the circumstances relating to male victims described here will assist that process. In particular, the terms male-rape or male-on-male rape overshadow the fact that a third of male cases seen at the Centre did not involve penile/anal rape. The high level of anal injuries in males suggest that forensic medical examiners should, with the client's consent, always consider some form of anal inspection even when that area was not reported to have been involved in the assault.

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