Assailants' Sexual Dysfunction during Rape Reported by their Victims

IAN T. BOWNES, MB MRCPsych
Research Fellow, The Department of Mental Health, The Queen's University of Belfast, Belfast, Northern Ireland

ETHNA C. O'GORMAN, MD DPM FRCPsych
Senior Lecturer, The Department of Mental Health, The Queen's University of Belfast and Consultant Psychiatrist, Windsor House, Belfast City Hospital, Belfast, Northern Ireland

ABSTRACT
Sexual dysfunction is known to occur in a proportion of rapists during the assault. The most common dysfunctions are erectile insufficiency and absent or retarded ejaculation. The study assessed the incidence and characteristics of assailants' sexual dysfunction reported by 50 victims of rape. 20% of victims reported that their assailant experienced erectile insufficiency at some point during the assault, and a further 12% reported retarded ejaculation or failure to ejaculate by their attacker. In attacks where sexual dysfunction occurred, there was a higher incidence both of intra-rape violence and commissioning of degrading sexual activity and this behaviour was related to the onset of the dysfunction. It was felt that the pattern of behaviour reported in those attacks where rapists' sexual dysfunction occurred might reflect a typologically distinct subgroup of offender. This finding has implications both for the safety of the victim during the attack and subsequent offender assessment.

INTRODUCTION
The rape offence is a multi-dimensional process; both perpetrator and victim are involved in a psychodynamically complex interaction that is expressed in terms of varying degrees of domination, anger and sexuality. Each interaction has its own distinct psychodynamic, psychosexual and physical characteristics. Few of their determinants are fully understood.

Sexual dysfunction occurring in the assailant during the rape episode has been described by several researchers. McDonald (1971) described 'situational impotence', stating that rapists may have difficulty sustaining an erection during rape. Ejaculatory failure during rape was described by Cohen et al. (1971). Prentky et al. (1985) described an association between premature ejaculation during rape and other aspects of the rapist's behaviour. Sexual dysfunction in rapists has also been noted by Nadelson (1977), Schiff (1973) and Shainess (1976). Rada (1978) and Gebhard et al. (1965) reported sexual difficulties experienced by a minority of attackers during sexual assaults on women. Some further evidence for sexual dysfunction during rape may come from examination of rape victims. It has been reported that in 60% of female victims where vaginal penetration had been attempted no clinical evidence of sperm could be detected (Evard and Gold, 1979) and it has been suggested that in a proportion of these cases the absence of sperm may be due to erectile failure or ejaculatory failure on the part of the assailant (Glaser et al., 1989).

With respect to the prevalence of sexual dysfunction during rape, Groth and Burgess (1977) found that in a cohort of non-interrupted assaults, 34% of the rapists reported having experienced some degree of context specific dysfunction. The most common dysfunctions were erectile impotence (46%), retarded ejaculation (45%) and premature ejaculation (9%). Erectile impotence, defined as partial or complete failure to maintain an erection sufficient for coitus, is a common complaint amongst the general population with a reported incidence of 23% among male at-

tenders at a general practice clinic (Rust and Golombok, 1984). Retarded ejaculation, defined as difficulty or failure to ejaculate during intercourse is a relatively rare disorder in the general population (LoPiccolo, 1977).

The purpose of the present study was to determine the incidence of sexual dysfunction experienced by assailants during 50 reported rape attacks and to compare the characteristics of these attacks with those of assaults where sexual dysfunction did not occur.

METHOD

The population studied had all been referred to and examined by a consultant psychiatrist (E.C.O'Gorman) for medico-legal assessment between January 1983 and December 1988. Each individual had been the victim of a rape (i.e., vaginal penetration without her consent) which had been reported to the police, and was seeking compensation under the Criminal Injuries (Northern Ireland) Order.

The case notes for each referral were studied by the research team members including where appropriate medical and surgical reports. Details of the rape incident were obtained from the history and from police reports, forensic medical officers' reports and statements. Rapes involving multiple assailants, those where the victim was less than 16 years old at the time of the assault and those where the assault was interrupted were not included in the study. The mean age of the victims at the time of the incident was 21.8 yrs (SD 5.8, range 16–47 yrs), 84% were single, 78% were employed or students. None of the sample had a previous history of sexual assault.

Sexual dysfunction was deemed to have occurred if the victim reported that at some point during the attack her assailant failed to achieve vaginal penetration due to erectile insufficiency, lost his erection during vaginal intercourse, experienced premature ejaculation or failed to ejaculate during vaginal intercourse. The sample comprised 50 referrals, of which 16 (32%) reported that their assailant had experienced sexual dysfunction during the attack. The data collected was subjected to computer analysis and Fisher's Test of Exact Probability was used to compare results from the group of victims who reported sexual dysfunction with those from the group who did not.

RESULTS

Sixteen (32%) of the victims reported that their assailants had experienced sexual dysfunction at some point during the attack. The dysfunction most commonly reported was erectile insufficiency (20% of all assaults) which in 12% led to failure to achieve vaginal penetration and in 8% occurred during vaginal intercourse. Retarded ejaculation or failure to ejaculate was reported by the victim to have occurred in 12% of attacks. None of the victims reported that their attacker experienced premature ejaculation.

With respect to the assailant's activity after the onset of the dysfunction, 63% of the victims in this group reported a marked increase in angry and aggressive verbalizations by their attacker and 38% reported a concomitant increase in physical aggression. In only 12% of assaults no attempt was made by the assailant to resume sexual activity after sexual dysfunction had occurred.

Table I. Highest level of force used to gain victim compliance

	Overall n=50	Dysfunction n=16	No Dysfunction n=34
Verbal threats	12 (24%)	2 (13%)	10 (29%)
Physical restraint/ non-brutal aggression (holding, pushing, slapping, hair-pulling)	19 (38%)	8 (50%)	11 (32%)
Punching/kicking/choking	11 (22%)	5 (31%)	6 (18%)
Displayed weapon	7 (14%)	1 (6%)	6 (18%)
Used weapon	1 (2%)	0 (0%)	1 (3%)

Table II. Injuries sustained

	Overall ' n=50	Dysfunction n=16	Non Dysfunction n=34
No injury	18 (36%)	2 (13%)	16 (47%) *
Abrasions/minor bruising/cuts/ bite marks	19 (38%)	9 (56%)	10 (29%) **
Severe bruising/teeth lost/ genital lacerations	12 (24%)	5 (31%)	7 (21%)
Stab wounds	1 (2%)	0 (0%)	1 (3%)

* p = 0.0168 ** p = 0.0661

The assault characteristics of attacks where sexual dysfunction was reported to have occurred were compared with those where it was not reported. The victim and assailant were strangers in significantly more of the attacks where dysfunction was reported (81% as opposed to 47%, p = 0.022). There was no significant difference between the two groups with respect to the age or marital status of the victims. Significantly more of the non-dysfunctional attacks took place in an indoor setting (44% as opposed to 12%, p = 0.026).

Alcohol use by rapists in relation to the attack has been described by several researchers including Gebhard et al., 1965; Amir, 1971; and Baxter et al., 1986. Rada (1975) noted that 57% of a sample of rapists reported that they had been drinking at the time of the attack. Alcohol consumption has been associated with increased sexual activity and disinhibition with respect to sex (Wilson, 1977) and it has been suggested that alcohol intoxication can disinhibit sexual arousal to rape cues (Barbaree et al., 1983). Only a small proportion of victims (12%) in our study reported that their assailant 'smelled of drink', none of these were in the group reporting rapist sexual dysfunction and this difference was not statistically significant. This incidence of alcohol consumption is lower than that reported by convicted rapists in relation to their attacks and may reflect the tendency of rapists to use alcohol consumption to excuse or explain their offences. Use of alcohol by the victim prior to the attack may have relevance both with respect to her selection by the rapist as his victim and to her ability to resist during the attack. Equal proportions (32%) of victims in each group reported that they had had more than two alcoholic drinks prior to the attack.

There was no significant difference between the two groups with respect to the level of force used to gain victim compliance (Table I). In both groups physical restraint or non-brutal aggression, including slapping and pushing, was most commonly used. With respect to victim resistance, all of the women reported having made verbal protests, 80% of women in the non-dysfunctional group and 75% of women in the dysfunctional group reported having struggled at some point during the assault. However, significantly more of the women who reported sexual dysfunction having occurred during their attacks had physical injuries (Table II, 87% as opposed to 53%, p = 0.0168). This may reflect the increase in physically aggressive behaviour by the assailant after the onset of the dysfunction which was reported by 38% of victims in the dysfunctional group.

The sexual activities performed and attempted by the assailants before and after the onset of sexual dysfunction were recorded. The most common activities performed before the onset of dysfunction were breast fondling or kissing (75%), digital penetration of the victim's vagina (47%) and manual touching or fondling of the victim's genitals (44%) (Table III). No significant differences were found between dysfunctional and non-dysfunctional groups with respect to the incidences of the activities carried out before the onset of the dysfunction. The most commonly reported sexual activity after the occurrence of sexual dysfunction was a repeated attempt at vaginal intercourse (56%) (Table IV). 38% of victims reported that their assailants demanded a

Table III. Actual/attempted sexual activities before dysfunction

	Dysfunctional n=16	Non dysfunctional n=34
Vaginal intercourse	16 (100%)	34 (100%)
Breasts touched/kissed	12 (75%)	25 (74%)
Rapist kissing victim	3 (19%)	6 (18%)
Manual touching of victim's genitals/ clitoral stimulation	7 (44%)	14 (41%)
Digital penetration of victim's vagina	4 (47%)	7 (21%)
Cunnilingus	1 (6%)	2 (6%)
Victim forced to masturbate	1 (6%)	0 (0%)
Fellatio	1 (6%)	4 (12%)

change in position for vaginal intercourse following the onset of the dysfunction. The incidence of repeated vaginal intercourse among the group where sexual dysfunction was not reported was 21% and the incidence of variation in position for vaginal intercourse was 9%. Both these differences were statistically significant ($p = 0.0150$, $p = 0.0219$).

Fellatio was demanded by 31% of assailants following the onset of dysfunction. In 12% the assailant ejaculated into the victim's mouth. The incidence of fellatio in the non-dysfunctional group was 12%, this difference was statistically significant ($p = 0.0164$).

44% of victims reported that they were forced to touch the assailant's penis or masturbate him after the onset of sexual dysfunction. The incidence of victims forced to carry out this activity in the non-dysfunctional group was 3% ($p = 0.001$).

31% of victims reported that their assailants masturbated themselves or rubbed or stroked their victim's body with their penis following the onset of sexual dysfunction. One assailant (6%) ejaculated over the victim and smeared semen on her body. The incidence of rapists masturbating in the non-dysfunctional group was 6% ($p = 0.0274$).

Table IV. Actual/attempted sexual activities after dysfunction

	Dysfunction n=16	Non- dysfunction n=34	
Repeated vaginal intercourse	9 (56%)	7 (21%)	*
Variation in position for vaginal intercourse	6 (38%)	3 (9%)	**
Anal intercourse	3 (19%)	3 (9%)	
Victim forced to touch rapist's penis/ masturbate rapist	7 (44%)	1 (3%)	***
Rapist masturbating/ rubbing penis on victim's body	5 (31%)	2 (6%)	****
without ejaculation	4 (25%)	2 (6%)	
with ejaculation	1 (6%)	0 (0%)	
Victim forced to kiss rapist	0 (0%)	5 (15%)	
Victim forced to masturbate	1 (6%)	0 (0 %)	
Fellatio	7 (33%)	4 (12%)	*****
without ejaculation	5 (31%)	4 (12%)	
with ejaculation	2 (12%)	0 (0%)	
Object inserted in victim's vagina	2 (12%)	0 (0%)	

* $p = 0.0150$; ** $p = 0.0219$; *** $p = 0.0010$; **** $p = 0.0274$; ***** $p = 0.0164$

Two of the assailants (12%) inserted inanimate objects into their victim's vagina following erectile failure. This type of behaviour did not occur at all in the non-dysfunctional group; however, the difference in incidence was not statistically significant.

Other sexual activities performed after the onset of sexual dysfunction were anal intercourse (19%) and forcing the victim to masturbate herself (6%). The incidences were not significantly different from those in the non-dysfunctional group.

DISCUSSION

The results of this study indicate that a significant minority (32%) of rapists experienced specific sexual dysfunction at some point during the attack. In our study, the results with respect to sexual dysfunction are based on the victims' perception of their attackers' sexual functioning during the assault. It is clear there is a possibility that what the victim perceives as dysfunctional might not be similarly regarded by the rapist. Conversely the rapist may perceive dysfunction to have occurred where the victim does not. This is especially likely to occur with respect to premature ejaculation. However, the incidences of both erectile insufficiency (20%) and of retarded ejaculation/failure to ejaculate (12%) in our study are broadly in agreement with those of 16% for erectile insufficiency and 15% for retarded ejaculation described by Groth and Burgess (1977). They based their results on the rapists' reporting of the occurrence of specific sexual dysfunction during assaults. Thus it would appear that the victim's description of the offence can allow reliable evaluation of the attacker's sexual functioning during the assault.

Comparison of the group where sexual dysfunction occurred with the non-dysfunctional group showed a number of differences. Significantly more of the dysfunctional rapists were unknown to the victim; in addition more of these attacks occurred in an outdoor setting. There was no significant difference between the two groups with respect to the level of force used by the attacker to gain initial victim compliance or the incidence and nature of sexual activities performed by the assailants both precoitally and prior to the onset of the sexual dysfunction. However, a large proportion of the victims in the dysfunctional group reported that their assailant's behaviour changed markedly after the occurrence of the sexual dysfunction. An increase in angry and aggressive verbalizations was reported by 63% of victims. In addition 38% reported a concomitant increase in physical aggression and significantly fewer of the women in this group escaped without physical injury.

Only 12% of victims in the dysfunctional group reported that their assailants failed to resume some form of sexual activity after the dysfunction. Furthermore the nature and incidence of specific sexual activities carried out or attempted by the assailants after the onset of their sexual dysfunction differed both from those prior to dysfunction onset and from those recorded in the non-dysfunctional group. For example, after sexual dysfunction had occurred, significantly more victims were subjected to repeated attempts at vaginal penetration, demands for change of coital position and for active victim participation, e.g., fellatio or manual stimulation of the assailant's penis.

In interpreting the results of this study it should be appreciated that the reported sexual behaviour shows a variability in keeping with the heterogencity of sexual offenders. In addition it may not be valid to extrapolate the aetiologies and characteristics of sexual dysfunctions in non-offender populations to sexual dysfunctions experienced by an assailant during sexual assault. In the general population, sexual dysfunction is known to correlate with a dysfunctional marriage or long-term relationship (Rust and Golombok, 1988). Sexual dysfunction can also be subsequent to sexual inexperience, to sexual anxiety leading to performance fears and to conditions where cognitive interferences occur, e.g., fear of being caught (Kinder and Curtiss, 1988). Sexual dysfunction may also be related to preoccupation with breaking societal or religious taboos and may occur as a result of drug or alcohol abuse (Benkert et al., 1985). It is possible that in some rapists sexual dysfunction experienced during

rape attacks may be influenced by one or a combination of these factors.

The characteristics of the sexual interactions occurring during rape attacks also have their basis in the preferred sexual arousal patterns of the rapists (Abel et al., 1977). Rapists are known to be more aroused by non-consensual intercourse situations than non-rapists (Quinsey et al., 1981). The majority of rapists in our study who experienced sexual dysfunction continued sexual activity. The most commonly reported reactions to the onset of the dysfunction were an increase in verbally aggressive behaviour (63%) and in coercive sexual activity, especially demands for oral (31%) and manual (44%) stimulation. An increase in physical aggression was reported by 38% of victims. Anger has been shown to disinhibit sexual arousal to rape cues (Yates et al., 1984), and it has been suggested that sexually anxious and dysfunctional males may find cues of physical violence and sexual coercion enhancing of arousal although this is not the case with non-dysfunctional males (Barlow, 1986). Thus it may be that rapists who experience sexual dysfunction during rape attacks require intra-rape violence and degrading sexual activity directed at the victim to enhance sexual arousal and ensure gratification. Such aggressiveness may serve both to block emotions for the victim and to remove any threat of being dominated by her. Variation in coital position and sexual activity may enhance sexual arousal and also depersonalize the victim (Crepault and Couture, 1980).

In conclusion, the results of this study indicate that in rape attacks where the rapist experiences sexual dysfunction there is likely to be an increase in aggressive behaviour following the onset of the dysfunction together with demands for additional coercive sexual activity. Thus sexual dysfunction experienced by the assailant has implications for the victim. On this basis we feel that further research to explore the aetiology of sexual dysfunction during rape is required. Previous studies have shown that rapists in general are aroused equally by rape depictions and depictions of mutually consenting sex (Abel et al., 1977; Quinsey et al., 1981). It may be that the minority of rapists who experience sexual dysfunction during the rape episode constitute a typologically distinct group of offenders for whom sexual arousal and gratification may only be assured through the victim's fear and humiliation. Treatment programmes constructed to address sexual arousal and functioning in this group may prove valuable in reducing proclivity to rape.

REFERENCES

Abel C. G., Barlow D. H., Blanchard E. B. and Guild D. (1977) The components of rapists' sexual arousal. *Arch. Gen. Psychiat.*, **34**, 895-900.

Amir M. (1971) Patterns of forcible rape. *The University of Chicago Press*, Chicago, Ill.

Barbaree H. E., Marshall W. L., Yates E. and Lightfoot L. O. (1983) Alcohol intoxication and deviant sexual arousal in male social drinkers. *Behav. Res. Ther.* **21**, 365-73.

Barlow D. H. (1986) Causes of sexual dysfunction: the role of anxiety and cognitive interference. *J. Consulting and Clinical Psychology*, **54**, 140-8.

Baxter D. J., Barbaree H. E. and Marshall W. L. (1986) Sexual responses to consenting and forced sex in a large sample of rapists and non-rapists. *Behav. Res. Ther.* **5**, 513-20.

Benkert O., Maier W. and Holsboer F. (1985) Multiaxial classification of male sexual dysfunction. *Brit. J. Psychiatry*, **146**, 628-32.

Cohen M. L., Garofalo R., Boucher R. and Seghorn T. (1971) The psychology of rapists. *Seminars Psychiatry*, **3**, 307-27.

Crepault C. and Couture M. (1980) Men's erotic fantasies. *Arch. Sex. Behaviour*, **9**, 565-82.

Evard J. R. and Gold E. M. (1979) Epidemiology and management of sexual assault victims. *Obstet. Gynaeol.* **50**, 88-90.

Gebhard P. H., Gagnon J. H., Pomeroy W. B. and Christenson C. V. (1965) *Sex offenders*. New York, Harper and Row.

Glaser J. B., Hammerschlag M. R. and McCormack W. M. (1989) Epidemiology of sexually transmitted diseases in rape victims. *Reviews of Infectious Diseases*, **11**, 246-54.

Groth A. N. and Burgess A. W. (1977) Sexual dysfunction during rape. *N. Engl. J. Med.* **297**, 764-6.

Kinder B. N. and Curtiss G. (1988) Specific components in the aetiology, assessment, and treatment of male sexual dysfunctions: controlled outcome studies. *J. Sex. Mar. Ther.* **14**, 40-7.

LoPiccolo J. (1977) Direct treatment of sexual dysfunction. In Money J. and Musaph H. (Eds) *Handbook of Sexology*. Amsterdam, ASP Biological and Medical Press.

McDonald J. M. (1971) *Rape offenders and their victims*. Springfield, IL, Charles C Thomas.

Nadelson C. C. (1977) Rapist and Victim *New. Eng. J. Med.* **297**, 784-5.

Prentky R., Cohen M. and Seghorn T. (1985) Development of a rational taxonomy for the classification of rapists: The Massachusetts Treatment Centre System. *Bull. Am. Acad. Psychiatry Law*, **13**, 39-70.

Quinsey V. L., Chaplin T. C. and Varney G. A. (1981) A comparison of rapists' and non-sex offenders' sexual preferences for mutually consenting sex, rape and physical abuse of women. *Behavioural Assessment*, **3**, 127-35.

Rada R. T. (1975) Alcoholism and forcible rape. *Am. J. Psychiatry*, **132**, 444-6.

Rada R. T. (1978) Psychological factors in rapist behaviour. In Rada R T. (Ed) *Clinical Aspects of the Rapist*. New York, Grune and Stratton.

Rust J. and Golombok S. (1987) Marital problems in general practice. *J. Sex. Mar. Ther.* **2**, 127-31.

Rust J. and Golombok S. (1988) Marital problems and sexual dysfunction: how are they related? *Brit. J. Psychiatry*, **152**, 629- 31.

Schiff A. R. (1973) A statistical evaluation of rape. *Forensic Science*, **2**, 339-49.

Shainess M. (1976) Psychological significance of rape: Some aspects. *New York State J. Med.* **Nov**. 2044-48.

Wilson G. T. (1977) Alcohol and human sexual behaviour. *Behav. Res. Ther.* **15**, 239-52.

Yates E., Barbaree H. E. and Marshall W. L. (1984) Anger and deviant sexual arousal. *Behav. Ther.* **15**, 287-94.