

# **RESPONDING TO SEXUAL ASSAULT**

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**TO BE RAPED IS.....**

TO BE OVER POWERED

TO BE DENIED CHOICE

TO BE DEGRADED

TO BE TREATED LESS THAN

TO HAVE HONESTY IGNORED

TO BE USED AND ABUSED

**TO RECOVER IS.....**

TO BE RE-EMPOWERED

TO REGAIN CHOICE

TO BE RESTORED AND HEAL

TO BE EQUAL

TO GAIN RESPECT THROUGH  
HONESTY

TO LOVE AND TRUST

**Dr Wendell Rosevear 1994**

**THE MANAGEMENT OF SEXUAL ASSAULT**  
**THE AIMS OF THESE GUIDELINES ARE TO:**

1. Optimise the recovery and trauma resolution for the victim.
2. Facilitate the safety of the victim.
3. Maximise the achievement of justice as part of the resolution process.
4. Minimise the sequelae of sexual assault e.g. suicide, sexually transmitted disease, etc.
5. Aid in fulfilling the duty of care that carers have to clients. Sexual assault may have male and female victims and male and female perpetrators. It is an issue of unhealthy relationship dynamics not just an issue of gender. This means men and women can both be victims or perpetrators, so gender neutral references will be used as much as possible in these guidelines. Specific issues for men or women will be referred to when relevant.

## **PRESENTATIONS OF SEXUAL ASSAULT**

1. **A DIRECT COMPLAINT OF SEXUAL ASSAULT.** This may not be the most common presentation.

2. **A MEDICAL PRESENTATION.**

2.1 Physical injuries to the body in general or to the genitalia, rectum or anus.

2.2 Depression, anxiety or emotionally disturbed or uncontrolled behaviour. Shock or PostTraumatic Stress Syndrome.

2.3 A request for Sexually Transmitted Disease Testing.

2.4 A request for a pregnancy test, contraception or a termination.

3. **A SUICIDE ATTEMPT.**

Any assessment of suicidal intent or behaviour MUST include giving permission for the individual to disclose sexual assault or threat of it. This may take the form of telling the person you are willing to talk about and listen to any issues including sexual assault or asking a direct question. Failure to give permission is inadequate and negligent.

4. **DRUG OR ALCOHOL USE, ABUSE OR DEPENDENCY.**

Many individuals seek relief through substance abuse.

5. **SOCIAL ISOLATION, WITHDRAWN ATTITUDE, LACK OF ABILITY TO TRUST OR ACHIEVE FUNCTIONAL ADULT RELATIONSHIPS.**

(e.g. Intimacy and trust. Sexual assault survivors often erect walls of denial and defence, trying to achieve safety). Low self-esteem and learned helplessness are common presentation.

6. **ACTING OUT BEHAVIOUR.**

Including physical violence, cynicism, bitterness, revenge, testing behaviour and sometimes intense homophobia or hatred of the opposite sex. Individuals oppressed by power may try to use power to reassert themselves. Some individuals may engage in obsessive /compulsive behaviour as part of seeking safety or sexual attention / validation as a substitute for not feeling valuable.

7. **SELF-HARMING BEHAVIOUR.**

e.g. Self-mutilation.

This may be a cry for help or an acting out of shame or self blame. If they blame themselves they may seek 'relief' by punishing themselves. Sometimes it is a way to distance themselves from others by making themselves look tough, dangerous or unattractive, attempting to prevent further attack.

8. **PERPETRATION OF SEXUAL ASSAULT.**

This may be part of an abuse victim - perpetrator cycle where non-acceptance of self, denial and power domination are common features. A QCSC survey of 45 sex offenders found that 68% identified they had been sexually assaulted.

9. **SEXUAL ORIENTATION CONFUSION OR QUESTIONING.**

This may present in many different ways; e.g. men may question if they unknowingly "invited an attack"? Men may question if their same sex interest was caused by the abuse. They may say: "I don't feel like a man" or men might feel they have to prove that "they are not homosexual". It can lead to acting out ( eg: homophobia) or denial e.g.: if a person was assaulted by the same or opposite sex, they might hate the same or opposite sex and question or blame their sexuality on that event. If a person experienced sexual arousal or enjoyment this may confuse them or induce self-blame or shame. Arousal can be a natural response to fear or sexual stimulation and does not imply consent or desire.

10. **A HISTORY OF VIOLENCE, DELINQUENCY, REBELLION, RUNNING AWAY FROM HOME, SEX INDUSTRY WORK MAY INDICATE PREVIOUS SEXUAL ASSAULT IN ADDITION TO THOSE MENTIONED ABOVE.**

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**VICTIMS COMMONLY DESCRIBE FEELING DEGRADED, DIRTY, ISOLATED, ALONE, ANXIOUS, AFRAID, UNTOUCHABLE, UNLOVABLE, ANGRY, MISUNDERSTOOD AND "LOST IN SPACE".**

## **BARRIERS TO DISCLOSURE**

1. **SPEAKING OUT ABOUT SEXUAL ASSAULT MAY BE VIEWED AS BETRAYAL.** In a prison culture, the victim risks being labelled as ‘a dog’ and so may risk further attack or even life. Hence many victims choose to remain silent or refuse to speak to custodial staff or Police. Some make statements but then refuse to attend or give evidence in court. Being labelled as ‘a dog’ may invite attacks from individuals other than the perpetrators of the assault. Speaking out may necessitate going on to protection but this may be an unattractive or ‘one-way’ option and may not ensure freedom from further assault. Many individuals on protection are there because they are perpetrators of sexual assault. Some victims in the community have emotional attachment to the perpetrator and also hesitate to tell anyone. I have seen cases where the child has been afraid that the parent may kill the perpetrator if they disclosed, and so kept the secret.
2. **VICTIMS MAY FEAR BEING BLAMED FOR THE ASSAULT: They don’t want to be victimised emotionally and so keep silent.** In fact no one deserves or asks to be sexually assaulted. They may feel stupid.
3. **VICTIMS MAY BLAME THEMSELVES** and may feel **SHAME** or **GUILT**.
4. **VICTIMS MAY FEAR BEING SEEN AS WEAK** and therefore vulnerable to further attack (e.g. “easy prey”). Honesty about feelings e.g. tears or fears, may be seen as weakness or defeat. For men it may be seen as non-masculine. Victims will sometimes protect themselves with walls of defence or denial (e.g. acting tough).
5. **INTERNAL CONFLICT ABOUT SEXUAL AROUSAL** which may compound shame or self-blame.
6. **FEAR OF BEING LABELLED HOMOSEXUAL** if the assault was perpetrated by a person of the same sex. Homophobia means a label of being homosexual has negative consequence’s independent of the individuals true sexuality.
7. **BEING IN A STATE OF SHOCK, LOSS OF SELF-CONFIDENCE OR POST-TRAUMATIC REACTION:** Often they just want to forget about it or imagine it was a bad dream.
8. **VICTIMS MAY SHIELD THEMSELVES FROM FURTHER PAIN OR LOSS.** They may feel that they will be **STIGMATISED** as **VICTIMS** or that people will look at them differently (**especially those close to them**). They may feel making statements or going to court may be unwanted further trauma. A community survey by QLD Police in 1993 reported that many individuals found the legal and court process was as traumatic as the sexual assault: only about 10% report to the police. Our current adversarial court system may mean that victims don’t feel believed or resolved by the process. It may exacerbate their sense of violation and injustice. They may fear publicity or loss of privacy. Whilst names can sometimes be suppressed by order of a court this may not be adequate safety for the individual.

9. **THEY MAY FEEL THAT NO ONE CAN HELP THEM.** They may have learned not to trust anyone or to be strong on their own. Attempts to get help may have been unsuccessful and they shield the most sensitive issues.
10. **THEY MAY NOT WANT TO BURDEN OTHERS.** They may feel that they have failed their family or partner and not want to worry them further.
11. **GENDER CULTURES IN OUR SOCIETY** mean men are less likely to seek help for depression, anxiety or abuse despite being three times more likely to suicide. (Goldman & Rarrid 1980: Nolen - Hochsema 1987). Men are generally less expressive of negative experiences than women (with the exception of anger (Wood, Rhodes & Whelan 1989)) and may be more likely to be negatively evaluated if they do disclose (e.g. Derelega & Chaikin,1976).

Women are more likely to ask for help (verbalise) whereas men are more likely to 'bottle-up' or 'act-out'. 'Acting out' means they might elicit a negative reaction rather than help from those about them. If they are aggressive they are more likely to be labelled as bad than as needing help.

It is helpful to see *behaviour as an expression of unfulfilled need*. If through *acceptance of the individual*, we can create the environment where the *need* can be *identified and filled*, then the *behaviour will correct itself*. (e.g. *if the baby is crying because he is hungry, feeding him will stop the crying*). If someone is acting out because they have been raped, it is vital to resolve that, for the behaviour to change.

## **SEXUAL ASSAULT IN THE PRISON CONTEXT**

Sexual assault is more about power than it is about sex. A common scenario is that a new inmate of unknown status in the power hierarchy will be attacked by a group of 3 to 5. They may be entrapped or a blanket may be thrown over them. They may be tested with physical assault prior to this. Then they may be raped. Threat, fear and violence may be part of the overpowering.

Individuals higher up the power hierarchy or groups who depend on the collective power of the group may then try to use the power gained by the rape to get the victim to be their 'slave'. e.g. to get them to traffic their drugs for them; buy things for them; fight their fights for them; provide them with sexual favours etc.

The victim will feel disempowered, degraded, dirty and trapped. They will feel helpless and hopeless. They may feel suicidal, they may comply for the sake of survival, or may attempt revenge by fighting back or joining the group-power process: getting power by oppressing others. This often leads to self-hate or a 'don't care' attitude. Hence we see the victim - perpetrator cycle.

## **DEALING WITH A DISCLOSURE OF SEXUAL ASSAULT.**

### **1. THE ENVIRONMENT.**

Individuals need to *trust* the person that they disclose to. They need to be assured of privacy and confidentiality. They will benefit from being *given permission* to disclose.

**Permission** may be facilitated by posters or information leaflets in waiting rooms or cellblocks. If someone exhibits signs of distress or sexual assault they may disclose if privacy is achieved. e.g. closing a door or asking a third person to leave the room.

**Permission to disclose** can be given by:

1. I am *comfortable to* talk about anything and then list the options: feelings, drugs, rape, sexual issues, coping etc.
2. Taking a thorough history, which lets the individual know that you *care* enough to *listen* and see them as a whole person.
3. Asking a *direct question* e.g. 'Have you been raped?' or 'Is anyone giving you a hard time?'

Even if the individual doesn't give an answer or tell the truth in response, they will remember that you are willing to listen and approach you when they are ready.

### **2. WHAT THE SURVIVOR NEEDS IS ...**

- an open mind.
- a listening ear.
- information.
- options.
- safety.
- Resolution opportunities.
  - i) Legal - judicial.
  - ii) Counselling.
  - iii) Support network / Buddy / Self help group.
  - iv) Occasionally referral to specialist services. While these resource people may have previous experience or skills, the fact that the victim trusts the person that they disclose to is even a more important resource for them. If you don't feel you have the experience necessary, it is healthy to honestly say: "I don't have the expertise to help you, I'd like you to see a specialist, but I'll support you whatever your decision."

### 3. **THE APPROACH**

3.1 **LISTEN:** ‘Do you want to talk?’  
Avoid interrupting. Allow them to share events and feelings.

3.2 **ACCEPT:** “I accept what you say”.  
“I accept how you feel”.  
Be non-judgmental.

Avoid saying: **“I understand”** or they will say:  
**“No you don’t”**.

Avoid passing judgements about something you don’t know or feel.

Even if they are telling lies, it must be for a reason. Once they trust that you accept them, they will be comfortable to tell the truth. They may need to test the trust first.

3.3 **AFFIRM:** Validate the survivor’s feelings and the importance of sharing them.  
“Your feelings are normal. It took courage to tell me”.

3.4 **SUPPORT:** Avoid rescuing. Help them decide what they want to do. They must *retain control* over the decisions for resolution if healing and safety are to be achieved. Otherwise they will place themselves *beyond your care*.

If they can’t make their own decisions they close up, feel further victimised and are vulnerable to further assault or suicide.

3.5 **EMPOWER:** Give options. Let them know they have a choice. Let them know you respect them with regard to their feelings, decisions and pace of resolving what has happened. Options will be discussed further.

3.6 **OFFER REFERRAL TO WHATEVER IS THE BEST RESOURCE FOR THEM.**

The fact that they have disclosed to you means that they trust you. That TRUST is the most vital resource. If you are uncomfortable about the disclosure, it is alright to be honest with them. *Honesty is not rejection*.

If you can offer the support and counselling that they need, tell them you are willing to work together, otherwise offer referral to the resource that they trust the most. Ensure confidentiality and that you would only inform others with their permission.

The gender and role of the support person may have bearing on the suitability.

e.g. some individuals are more comfortable relating to the same sex, some prefer to tell the opposite sex.

e.g. some inmates may not cope with informing custodial staff as this may risk being labelled as 'a dog' and put their life in jeopardy.

#### 4 **THE CHOICE**

The choice to pursue a medico-legal or a counselling resolution must belong to the victim. They may choose a combination of both. They must be informed of the options and their choice needs to be recorded even if it is a refusal.

##### 4.1 **A medico-legal involves:**

- 4.1.1 Collection of evidence.
- 4.1.2 Treatment of the individual.
- 4.1.3 Referral to the Police.
- 4.1.4 Follow up care and support.

##### 4.1.1 **Collection of Evidence involves:**

- a) Taking a complete history - asking open rather than leading questions.
- b) Recording the history in the victim's words. If you are the first person the victim discloses to you, your evidence is especially important in a court case.

Additional Role if you are the doctor:

- c) Obtaining consent for examination.
- d) Having a Witness / Support Person present for the Examination. The victim may feel vulnerable during the examination and a support person can help. Their role as a witness is a safety function for both the victim and the examiner. They protect against false accusations. The victim needs to agree to the presence of a witness and who that person is.
- e) A complete body examination - recording any sign of injury e.g. scratches, bruises, trauma.
- f) An oral / genital / anal / rectal examination using the forensic evidence collection kit. (Obtained from the police). Any signs must be recorded.
- g) Collection of forensic specimens including pubic hair brushings, pubic hairs from the victim, swabs of orifices, mouth, vagina: - introitus and high anus/rectum. All specimens must be labelled as to site, time, person and sealed in front of the patient. The site of swabs can be influenced by the history.
- h) Collection of specimens for sexually transmitted disease assessment. This should be done only with the patient's informed consent. Base line and follow-up tests need to be performed e.g. HIV needs to be tested for at the time of complaint and 12 weeks later.

- i) The timing of the examination and specimen collection is important. Forensic evidence e.g. presence of sperm or blood may change over time. The patient must be informed of this. If they refuse examination it must be recorded. They may choose to have the examination and decide later whether to use the evidence to lodge a complaint with the Police.
- j) Testing for pregnancy - needs to be done with the patient's consent and timed according to the menstrual history.

#### 4.1.2. **Treatment of the individual.**

- a) Supportive Care.
- b) Respect for their choices. Giving them information so that they can make the optional choices and enhance their recovery.
- c) Allowing them to set the pace of recovery.
- d) Medical treatment of any injuries e.g. cuts, tears, and bruises. If there has been anal damage, the prevention of constipation is important. Surgical / Gynaecological / Urological referral may be indicated.
- e) Treatment of specific sexually transmitted diseases.
- f) Post coital contraception or management of a pregnancy are decisions that the patient must make with informed consent and support.

4.1.3 Referral to the police is only done with the permission of the victim. If they refuse, it must be recorded. If they chose to report, they will need support if they pursue it right through to the court. The police inform the victim of the process and what options they have, including at what point the case must be settled by a court. The questioning, the collection of evidence, the adversarial system (which may attempt to discredit their evidence) and the possible failure to achieve an expected outcome may be traumatic. The process is a long one. It is important to make and record full statements as early as possible. There will be a special need to discuss achieving emotional safety if the victim chooses this course.

#### 4.1.4 **Follow-up care / support.**

The victim needs to know that they can ask for help 24 hours a day. They must have access to impartial medical, nursing, counselling or other help 24 hours a day. They may benefit from a buddy (friend) support system. Often in prison, for safety reasons they are observed or managed in isolation: it is ideal if they can have a choice or they may feel punished for disclosing. Often they will not ask for help, so help must be pro-actively offered. A counselling contract may be useful and give an expectation of recovery.

## 4.2 **A Counselling Resolution**

This option may be chosen as well as, or instead of a medico-legal option. It means that the victim talks through the trauma of the sexual assault and their feelings to achieve resolution and recovery. The victim chooses the counsellor and the pace in resolving the issues. Counsellors could be a trusted friend, a recovered self identified survivor who is willing to provide support, a self help group process, a trained counsellor, a Psychologist, a Social Worker, or Doctor, or Psychiatrist or a trusted Correctional Officer. The ability to listen and accept are the most important features of a successful counsellor. It is most important that the victim makes their own choices and realises that they are responsible for them.

The victim needs to be allowed to feel and assess what happened to them ‘through their own eyes’. There is no place for minimisation, rationalisation, justification or comparison. For example, I’ve heard some therapists reportedly say, “you were raped because that is what prison is like” or “you were raped because you’ve got a baby face”. The client then feels bad about their good looks. It is empty to say ‘Don’t cry’ when in fact crying is honest and relief. It is useless to say, “Be strong” because the client has already tried that and feels bad for “being weak”. It is helpful to say “I support and respect you for being honest” “It is your right to be honest about what happened, how you feel, about the pace of recovery and what choices you want to make.”

There is a real place for support from other recovering survivors, as it allows identification and relief. It helps stop isolation, self blame and shame. It allows feelings to be accessed and resolved more efficiently than just an ‘intellectual type’ approach to counselling.

## 5. **The achievement of safety**

The victim must make the decisions if they are to perceive that they have achieved safety. If the decisions are taken out of their control they will feel ‘raped again’: e.g. in prison if they feel that by telling someone they will be put on ‘the dog’ or put in protection, they may feel vulnerable and their life may be endangered.

Confidentiality is the first element of safety. The victim making their own decisions, is the rest. They need to know that they are valuable individuals who have the right to say ‘no’ in every setting. Hence self-esteem and honesty are the important ingredients in asserting oneself in achieving safety and trust.

Mutual acceptance and honesty are efficient in diffusing the power games of prison life. e.g. “I do my time, you do yours” is a message of I accept you, I invite you to accept me and respect my choice e.g. “I am not a dog or a threat, I make my own decisions and you can make your own decisions.”

I have found it useful to help potential victims make friends of their potential enemies: 'to come in as equal'. This way they are not seen to be a threat or easy prey and hence achieve mutual respect and safety.

Friends don't rape each other.

Even if you win a power game in prison, you are just inviting an attack from someone who wants to 'big note' himself or herself or from a collection of individuals who don't have power on their own ('a gang').

Giving in to power threats means you are seen as weak or easy prey and makes you vulnerable to attack.

Acceptance of each other as equals plus honesty gets respect within prisons, even though predictably it will be tested: Tested for the purpose of trust even more than for where you stand on the power ladder.

All inmates need instruction in these dynamics at induction.

It also helps to always be visible within the communal living until you know whom you can trust. It helps to keep your eyes and ears open to see whom you can trust rather than to 'blindly trust'.

In prison it helps to know that you can ask help anytime from the nursing or counselling staff, even if it is too risky to ask help of a custodial officer.

It may be necessary to ask for a transfer and some times to ask for Protection. As described earlier protection may not be seen as the best alternative especially as it may risk being labelled as a dog, may mean limited potential in terms of future placement options, and may mean being housed with perpetrators of sexual offences. Sexual assault also occurs within protection and is a symptom of the power dynamics people use when they don't accept themselves or others as equal. These dynamics are predictable, despite whatever external controls the system may devise.

### **Confidential telephone counselling.**

Some individuals can't seek help face to face so anonymous phone counselling can be a relief eg. Rape Crisis Line, Men's /Kid's/Parent's/ Gay & Lesbian Help Line.

Prisoners now have phone cards with access numbers stored in them allowing them to call those known numbers. If prisoners could confidentially and if desired anonymously call for telephone counselling, they could get help without risking being labelled as 'a dog' and putting their life at risk. It would remove some of the barriers to disclosure and help save lives. In the future, a phone could be installed in each cell. The preventative costs would be less than the compensation and life costs of prison violence to individuals and society.

## **6. THE PREVENTION OF SEXUAL ASSAULT: ESPECIALLY IN THE PRISON AND COMMUNAL SETTING**

Individuals accepting themselves and accepting others as valuable and having the right to say 'yes or no' is the environment that allows consent. This is not commonly found within prisons but all attempts to achieve it must be supported to prevent the dynamics that generate sexual assault. Only individuals that accept themselves *accept* others. The others are prone to *use* others in some way. Hence any attempt to create and develop a sense of community where the individual is valued and respected independent of their previous unhealthy choices, will be helpful. Having useful, fulfilling employment, interests, education and sport will help self-esteem. Team activities and decisions will help in individuals valuing each other. Opportunities for individuals to meet their needs in healthy ways, minimises drug taking and power games. Drug dependency predisposes to power games to support the drug supply. Contact with counsellors, chaplains and families is important in providing options for individuals to share and fill their needs healthfully.

Decriminalising drugs or making Methadone an optional choice would decrease drug stand-over behaviour and help prevent rape, bashings, murder, and suicide.

Removing communication barriers as much as possible helps build a sense of community. e.g. having custodial staff as part of a functioning cellblock means that workable relationships are formed with understanding as opposed to having them removed in isolation (e.g. 'a fish bowl'). Having a 'we approach' rather than an 'us and them approach' builds community. Part of the 'dobbing' or 'dog' philosophy is that custodial staff are seen as the opposition. Communication within a team approach will help to diffuse this problem. Currently there are major barriers to communication in some prison settings. If there is no communication there can't be a team approach. Often inmates can only talk to officers by speaking publicly and loudly through a small hole in a glass wall while stooping. This makes understanding or asking for help difficult.

For an officer to be in touch with the needs of a victim or potential victim they need to be in *contact*.

The architecture of cellblocks is important. Inmates need individual cells for one person. They need their own shower and toilet. Communal facilities for showering and toileting are dangerous.

Individual cells need to open to populated communal areas so that everyone knows what is happening and individuals can always ask for help. Blind spots need to be eliminated. Individuals need to be able to make themselves visible to achieve safety.

Inmates need instruction in Prison Relationship Dynamics on induction. They need to be taught how to ask for help and how to achieve safety.

They need to know that consent is their right: that it is "ok to be honest".

Peer support systems for victims in recovery within prison and communicating openly or anonymously with Community Peer support system will help individuals recover and achieve a sense of self-esteem that will prevent further attack. Individuals with low self-esteem are vulnerable to further attack or to joining *gangs* that in turn perpetrate abuse on others down the power ladder.

## 7.SUMMARY.

Rape is the unhealthy dynamic where one or a group of individuals use another individual through power, manipulation, obligation, dependency or threat to attempt to get their needs met. It results in the victim feeling abused, devalued, degraded and protective /defensive.

Consent is the mutual acceptance of each individual's right to personhood, body-space, control and choice. It allows each individual to communicate honestly what that choice is - a 'yes' or a 'no'. It provides the safety for a meaningful, trusting, intimate interaction. It is healthy.

**Recovery is more than telling someone; it is the regaining of a sense of personal value and safety in a way that doesn't limit your future freedom or relationships.**

Prison dynamics often predispose to unhealthy interactions and hence rape is not uncommon. Prison is a microcosm of society and the same dynamics can occur outside although they are often more masked. Understanding prison and rape dynamics helps so that healthy dynamics can be instituted to correct the problem.

It is everyone's right to be loved not raped. No one deserves to be raped.

**A BASIC CONCEPT IS: 'MATES DON'T RAPE'. TO NURTURE MATESHIP WE NEED TO AFFIRM THE VALUE OF EACH INDIVIDUAL, RESPECT INDIVIDUAL CHOICE IN HARMONY WITH THAT VALUE, AND FOSTER COMMUNICATION.**

**The more community ..... the less rape.**

**The more zoo ..... the more rape.**

*Wendell Rosevear 1994.*

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