

## Rape, vulnerability and doubt

### Issues for healing and care

Diana Gibson

*Rape, its prevalence, survival and efforts to deal with its physical and psychological aftermath, are full of contradictions and ambiguities which, in turn, increase the vulnerability of the body. The paper gives attention to the complex and shifting nature and impact of various historical and other factors such as space, gender, family relations and violent masculinities and its intersection with stereotypical linkages made between sex and rape. The paper argues that rape survival, individual, institutional and societal responses to it are complicated because rape is often confused in the public imaginary as sex. It is further shown that certain women in South Africa are more vulnerable to rape involving multiple perpetrators. The paper also looks at some of the health issues related to rape and dealing with survivors.*

*[rape, survivor, sex, ambiguity, health, space, gender, masculinity, meaning]*

The experience of rape is fraught with ambiguities, contradictions, the continuous abrogation and permeability of boundaries of the body and of space. This paper focuses on the many layers of vulnerability of the body in the case of rape. Special attention is given to the phenomenon of multiple rape of young women in marginalized township spaces around Cape Town, South Africa. These were formerly the sites in which a violent apartheid State tried to order and contain the messy heterogeneity of experience and population (cf. Bremner 2002; Douglas 1966). Historically, townships and their inhabitants have loomed large in public imagery as wild and 'othered' spaces. Mudimbe (1988: 5) argues in *The Invention of Africa* that the organization and arrangement of space was one imperative of colonisation, and by extension apartheid. Of its own and in conjunction with other strategies, this produced marginal societies in peripheral spaces. Around Cape Town, townships were established to which certain population groups were forcibly removed, notably from the inner city to the Cape Flats. In public imagination, the Cape Flats constituted the wild, 'no-go' spaces of the Peninsula, and their inhabitants came to be represented as dark and savage, prone to the eruption of unspeakable political violence (Bremner 2002: 4).

Writing about apartheid Johannesburg, Bremner (2002: 3-4) refers to the often-shocking images of young, aggressive, violent inhabitants revelling in destruction and defiance, and subsequent fearful imaginings of the White population about the 'othered'

township spaces. These were dangerous spaces where crime and violence were rampant among the unemployed youth. In such spaces

Bodies were not individually distinguishable, but embedded in the seething, writhing, 'toy-toy-ing', grotesquely frightening body of the mob...

It was permeated and domesticated by what Mbembe (2001: 175) called an 'omnipresence of violence,' and this legacy still lingers on.

The volatile lifestyles that give rise to disruptions in these spaces, have almost become the norm. Kinship, family and community relationships are frequently disjointed, unpredictable and threatening (cf. Abrahams et al. 1999, Campbell 1996, Glanz & Spiegel 1996, Henderson 1994, Kotze & Van der Waal 1995, Salo 2000). While such relations have become increasingly disrupted, disruptive and violent, they are nevertheless an essential resource for personal and group survival.

The interrelationship of State and other forms of structural violence such as forced relocation, racial differentiation, prevailing economic inequalities and high unemployment further contributed to the disrupted and violent nature of family and everyday life. All of these factors still exacerbate and reinforce patterns of sexual abuse perpetrated especially on the bodies of women (Jensen 1999, 2001, Pinnock 1995, Salo 2000).

The body is always spatially, temporally, phenomenologically, relationally and structurally situated (Haraway 1991). One can argue that the bodies of rape survivors bear the marks of the spaces in which they live. They are living testimonials – embodied spaces where the discourses of institutionalised racism, violent communities, patriarchy, oppression, alcohol abuse, poverty, adversity and particular kinds of masculinity are inscribed on the body in the most intimate and invasive ways. Women are often raised to believe that their selfhood and self-worth lies in the control of physical access to their bodies (Dworkin 1979). Because rape is frequently accompanied by extreme and humiliating forms of violence against a woman and her body, it is experienced by the perpetrator(s) as an expression of power, hostility, aggression and dominance (Feldmann 1992: 7). Rape forcefully penetrates boundaries and it conspires to annihilate personhood. The survivor's body is exposed, invaded, hurt and commented on. It entails the loss of personal dignity and self-determination, even the loss of sense of identity.

In South Africa and other HIV/AIDS-prone communities, a new dimension of vulnerability has been added. Having lived through rape, the survivor thereafter dreads the possibility of being diagnosed HIV-positive. Because HIV/AIDS is not a notifiable disease in South Africa, suspected rapists can only be tested for the presence of the immuno-virus with their permission. Legislation to change this will make it possible to test suspects, but the draft law provides for a 5-day window (presumably to test and finalise forensic evidence). It also binds the physician team and the survivor to secrecy regarding the HIV status of the attacker. However, to be effective against the transmission of the HI-virus, anti-retrovirals (ARV's) must be administered within 72 hours, and rape survivors can be left in limbo if they do not know the status of their attackers. Organisations that are monitoring the legal process want to redirect the infrastructure required for testing, in order to ensure that ARV's are available to all rape survivors.

Therapeutic interventions and court procedures are disturbingly reminiscent of the embodied experiences, emotions and memories of the rape survivor, recreating the original violation. Thus, what is meant to be a form of healing or redress can equally become a wounding or even a travesty of justice. For men who are raped, the experience is equally devastating as they often feel that everything masculine they believed about themselves has been destroyed. Having been 'feminized' in the most brutal way, robs them of a fundamental sense of masculinity. The high incidence of HIV/AIDS in South African prisons adds to the trauma, whether the rapists are convicts or awaiting-trial suspects. Male rape often begins in the holding-cells, as soon as the charge-of-fice procedures have been completed. In prisons with a gang culture it has almost become endemic.

To assist women and men who have been raped, the act of rape must be understood as a form of structural violence or oppression, insidious, easily distorted and destructive. The paper examines several aspects of vulnerability of the body in a post-apartheid society. These may:

- 1 be created and perpetuated by the historical legacy;
- 2 result from constructions and practices of gender;
- 3 be created by particular practices of masculinity;
- 4 relate to perceived complicity;
- 5 relate to the experience of rape;
- 6 be influenced by talk, meaning and institutional interventions;
- 7 relate to the survivor's health.

Using the above layers of vulnerability as starting point the paper tries to show how the constant shifting of margins at each level intersects with and contributes to enduring societal ambiguity towards rape and rape survivors. This, in turn, impacts on the resultant difficulties they, as well as the institutional efforts to deal with rape, have to deal with.

### **The vulnerability embedded in history and space**

Townships in South Africa are situated on the margins of the cities, spaces that were and still are not easily surveilled. State institutions cannot always police them and for young women who live in townships it means that the spaces may be safe for them at times and dangerous at others. Often those whom they should have the least cause to fear, are the most likely to sexually assault them.

According to Ramphele (2000: 103) structural and physical violence, private and public, has become part of the everyday reality of the lives of many South Africans. This includes sexual violence against women and children by family, friends, neighbours, carers and acquaintances. The high prevalence of violence and rape in marginalized areas must be seen against the background of the legacy of apartheid "with its use of brute force to subjugate large sections of the population and confine them to overcrowded and under-resourced areas, and is likely to remain important in the lives

of many South Africans” (Ramphela 2000: 103). Large numbers of people were affected and traumatized by the political violence of the past and its consequent disruption of communities and families, high levels of poverty and of all forms of violence (Jewkes 2002). Cape Town’s high incidence of rape (SAPS Crime statistics) is particularly prevalent in certain areas such as the townships on the Cape Flats, (unpublished research conducted for Western Cape Departments of Health and -Community Safety), where most of the rape survivors that are included in this paper resided.

The first case study I present, is Amelia Abrahams, a young woman living in an informal settlement near Lavender Hill.<sup>1</sup> She became pregnant at the age of 14 when she was raped and stabbed by two young men. She was treated for the stab wound. The child died soon after birth. Amelia knew nothing about contraceptives and when she was forced to have sex with an older boy at the age of 15, she became pregnant again. The father of her oldest surviving child has never paid maintenance for them and she has not seen him for many years. Amelia’s oldest child is seven and lives with her cousin in Elsies River. She lives in a shack with the father of her youngest child, who is three years old.

We met Amelia at Retreat clinic where she was being treated for broken ribs, and lacerations of her mouth and eye, the work of her common-law husband. He had assaulted her with a clothes-iron and she had two broken fingers and a number of scars on the back of her head as a result of earlier beatings. She was unemployed and had only had three years of schooling. When Amelia’s child was still a baby her common-law husband began to beat her. In the daytime her neighbours would assist her afterwards but at night, she was too afraid to go outside and ‘I just had to lay there and wait for the next morning’.

It was clear that Amelia was very fearful of the area at night and especially being ‘dragged into the bushes’, raped by a stranger and ‘getting AIDS’. Amelia used the injectable contraceptive from time to time but they had never used a condom. Her common-law husband often accused her of being unfaithful, despite the fact that he had another girlfriend. He sometimes sexually assaulted her or forced her to have sex with him. If she resisted or he felt that she was unwilling, he would beat her. Amelia got an interdict against him and he served time in jail, but afterwards he came back, broke into the shack and sexually abused her again. He also burnt the interdict. According to her, she had been to the police so often that they once said: ‘Oh, it’s you again’, although they did arrest her partner afterwards. When it was Friday and he received his wages and bought alcohol, he became drunk and violent. She expected him to beat her that weekend but did not know where to go. We recommended a shelter, but she refused. When the attack came on the Sunday her screams attracted a group of men passing by. They came into the shack (the door did not have a latch and the windows were broken) and beat her husband up so badly that he was hospitalised. Amelia was always afraid and hungry, and she had reduced to begging for food.

Amelia, and two other participants, Nomsa Makubalo and Sera Samuels, had been sexually assaulted at home, which was both a violent and an unsafe space to be, but they still had a more intense fear of rape outside the home. According to Sera Samuels:

I knew he was going to be drunk, it is like that on Fridays.... He grabbed me by the hair... he was swearing... the wood was thick and he hit me so hard it broke. This made him angrier, I screamed and begged, but I did not go outside, it was so late and I am always afraid of what waits in the dark... (I can) get raped and killed outside. He tied my hands and feet together and pulled off my panties... rammed a bottle in... he broke my arm and kicked me ....

All three women viewed the familiar areas within which they themselves lived and moved as relatively safe during the day but distinguished it from areas such as the 'bushes'. Night time was perceived as the most dangerous (cf. Jensen 1999).

This fear of the dark spaces was expressed by many of the women we interviewed in the townships. Nine per cent (9% of 40) of the women in a community sample in Lavender Hill had been sexually assaulted outside their homes in the previous six months. In a sample of abused women, 18% (of 90) reported sexual assault outside their homes in the past six months. The high level of sexual assault outside the home was often marked by forced sex with more than one male. Often these males were known to the survivor. Sexual assault inside the home always involved a partner, family member or acquaintance.

As indicated above, while living with a man, women were not free from the threat of forced sex. According to provisional statistics from rape crisis centres in the Western Cape 58% of rape survivors were sexually assaulted by perpetrators who were in some way known to them. This trend was especially prevalent in the case where the survivors were between the ages of 15 and 19 years (Denny et al. 2002). For many women, the home, a supposedly private and safe where they should feel protected, proved to be very dangerous. In the study done in Lavender Hill, 5% (2/40) of the women in a random community sample reported being sexually assaulted in their homes in the previous six months. Eight percent 8% (7/90) of a purposive sample of abused women reported sexual assault in the home.

For women survivors the choice seemed at times almost intolerable. Whereas domestic, inside space was supposedly safe, in many townships the nature of inside and outside space could shift between day and night, work days and weekends. At night dangerous spaces easily interpenetrated into the home and women had to choose between what would at times be a certainty of 'familiar' sexual violence inside and 'othered' sexual assault outside. After dark many public spaces were dangerous to even the most affluent women, but those living in townships lacked access to high security measures and other resources that might enhance their safety. For many township women the threat of rape lay outside, while it also lurked and was enclosed within the boundaries of the body social.

### **The vulnerability of gender**

Rape is essentially gendered. It should be understood in relation to State supported patriarchal social and family relations. In South Africa rape was until recently defined

as a man having intentional unlawful sexual intercourse with a woman, without her consent. For rape to take place there had to be penetration of the vagina by the penis, and non-consensual anal or oral penetration did not constitute rape. Forced sex within a marriage has been re-defined as rape, but previously society condoned sexual aggression within marriage and 'obscured the gravity of other forms of sexual abuse' (South African Law Commission 1999).

The vulnerability of the raped body can thus never be understood by looking at one level only. It is always necessary to try and disentangle all the interwoven skeins that intersect with each other and makes rape so complex. According to Jewkes (2002) much of the current violence in South Africa is directed at women and girl children and is 'a result of the marked gender inequalities in our society, a culture of male sexual entitlement and climate of relatively impunity in which rape is perpetrated. Because of under-reporting, it is difficult to ascertain the exact prevalence of rape in South Africa (Jewkes & Abrahams 2002). According to the Policy and standardized management guidelines for survivors of rape and sexual assault in the Western Cape, the estimated incidence of reported rape of women is 311 per 100 000 women living in the province (SAPS statistics and the 1996 population census). In a Demographic & Health Survey compiled in 1998, 4.4% of all women interviewed between the ages of 15 to 49 years reported having been raped before. Studies of teenagers in South Africa found that almost one third of teenage girls reported forced sexual initiation (Bugra et al. 1996). No reliable information is available on the rape of men, even though it occurs regularly in prisons and occasionally amongst gang members.

Provisional results presented earlier in 2002 at a conference on gender violence indicated that of rape cases presented by women at one of the biggest rape crisis centres on the Cape Flats between January 1998 and September 2001, 37% occurred in the age group 15-19, followed by 21% in the age group 20-24 years. Even while living with a man, women were not free from the potential of forced sex. According to provisional statistics from rape crisis centres in the Western Cape, 58% of rape survivors were sexually assaulted by perpetrators that they knew. This trend was especially prevalent in the case where the survivors were between the ages of 15 and 19 years (Denny et al. 2002). For many women, the home, a supposedly private and safe where they should feel protected, proved to be a very dangerous space.

In research in Lavender Hill, 5% (2/40) of the women in a random community sample reported being sexually assaulted in their homes in the previous six months. Eight percent 8% (7/90) of a purposive help-seeking sample reported sexual assault in the home. The percentages are probably higher than reported because when the perpetrator was within a relationship or marriage most of the women did not define forced sexual activity, however violent, as rape. As one participant, San Uithaler said:

He does the most revolting things to me, I fight, but we live in a tiny shack, the children can hear when I scream, then I give in, he is their father, it is probably his right, who can say it is rape ... he has many women and he slaps me when I say anything about condoms, so I just pray, pray that I do not get AIDS, then I will be gone[dead].

When we first met our second participant Nomsa Makubalo at a police station in 2001, she had already contracted HIV/AIDS and was pregnant with her second child. She met her husband in Johannesburg, had a child with him and became his wife in a traditional marriage. In Cape Town, her husband was consistently unfaithful to her and would physically and sexually assault her when she complained or when he was dissatisfied with her. Her husband neither used a condom when they had consensual sex nor when he sexually abused or had forced intercourse with her. Nomsa never complained to the Police because she had been raised to believe that men had little control over their sexual impulses and that sexual intercourse, even if violently forced on her and painful, was part of marriage and her husband's marital right. He did not want her to use contraceptives because he said it meant she was being unfaithful to him. For a while she received contraceptive injections because her husband would not know and she pretended to menstruate. When Nomsa constantly fell ill in 2001, she stayed with family in Johannesburg to recover. While she was away from Cape Town she realised that she was pregnant and returned home, to find that her husband had moved in with his lover, who later bore him a child. When Nomsa arrived at their house, her husband had sold or all her property and ransacked the house. He refused to assist her financially and sexually abused her again. Apparently fearful that she might be abandoned with a small baby, his new lover swore at Nomsa in the street or when Nomsa asked her husband for money for food. Nomsa was continuously harassed by her husband and lived in fear of him breaking into the house and assaulting her. She wanted to move elsewhere, but was afraid of being on the streets, especially after dark. When Nomsa went to the antenatal clinic she was diagnosed as being HIV positive. She received a short course of anti-retrovirals as part of the campaign in the Western Cape to reduce mother-to-child transmission of the HI-virus. At this time Nomsa was fortunate to be in Cape Town and not in Johannesburg, where AZT or nevirapine were not yet widely used to prevent mother-to-child transmission. We all rejoiced when Nomsa's baby finally tested HIV-negative.

As with Nomsa's acceptance of her husband's violent right to sex, research in Khayelitsha (Tuba 2002) also links rape to stereotypical understanding and practices of gender relations. Interviews with 30 survivors of rape indicated that the perpetrators were mostly men who were in some way related to the survivors. Tuba's study indicates that in a process of rapid urbanisation, rape has apparently become a way to control younger women who move outside the boundaries or are somehow perceived to transgress reified notions of culturally appropriate or 'traditional' gendered behaviour, responsibilities and social status. In most of the cases she examined, males tried to justify rape as a form of 'punishment'.

Ultimately Nomsa knows that she is going to die from AIDS. Her story, harrowing as it is, is not exceptional for Cape Town or South Africa because domestic and sexual violence are closely intertwined and multifaceted in this country. Gender relations are in flux. While the state is pushing for more gender equity and many women have to take on the roles and responsibilities of breadwinners and heads of households, many stereotypical notions of gender roles nevertheless remain. The prevalence of certain types of masculinities further contributes to the ambiguity with which sexual violence and rape is perceived.



## The vulnerability created by violent masculinities and group rape

According to Annie, another survivor of multiple rape:

They were three... I was afraid, ahhh so very very they will kill me, they say 'keep your fucking mouth (shut), do you want to die' (vrek – the word used for an animal) tell me 'we will kill you, you remember Valencia' [Farmer]. They stabbed her so many times. I was mad with fear.

An added dimension to violation in South Africa is the relatively high incidence of rape by more than one perpetrator. At the age of 14, Amelia Abrahams was raped by more than one boy, but neither she nor Annie reported the incidents. This was very similar to the findings of Jensen (2001: 331) in Mitchell's Plain. He reports that women who had been subjected to multiple rapes either did not want to make this public or they did not report them because such incidents had almost become the norm. For young women, especially if they became involved with or were targeted by gangs, the rule of *sterk-bene* (strong legs) meant having sex with several gang members. According to Jensen (2001: 331) males denied that the rapes were violent and contended that the women consented to it, or even 'deserved' it.

In our own ongoing research on community, domestic and sexual violence in townships in Cape Town it was found that the sexual debut of young women was often a sexual encounter so violent that in South African law it would be defined as rape. (Makhubele 1999, Mfecane 2002). Sexual and interpersonal relations were also frequently marked by physical abuse and violence (Sauls 2000, Mfecane 2002). It was clear that cultural constructions of gender roles and masculinity had an influence on the violent nature of personal relations, and a high incidence of rape was reported by female participants in several studies (Makhubele 1999, Mfecane 2002, Tuba 2002). This trend was confirmed by research elsewhere in South Africa (Campbell 1992, Jewkes et al. 1991, Mokwena 1992, Shaik & Park 1998).

In order to understand why rape is so prevalent in certain areas, the work of the anthropologist Peggy Sanday (1990) can be useful. She argues that particular discourses, rituals, sexual ideologies and practices make some environments what she calls 'rape prone'. Although the notion of rape-prone communities may be viewed as too negative and deterministic, there are commonalities in areas where the incidence of rape is high or low. Because we worked specifically in high prevalence areas in Cape Town, some of Sanday's findings shed light on our own research. She said in communities with a high prevalence of rape the reported incidence of rape was correspondingly high. Rape was justified as a ritual and ceremonial expression of masculinity, and men in these communities felt that they were 'allowed' to physically chastise or threaten women through the act of rape (Sanday 1996: 191-208).

Sanday (1996: 191-208) argues that rape forms 'part of a cultural configuration that includes interpersonal violence, male dominance and sexual separation'. She argues that in areas with a high incidence of rape, related behaviour is often associated with environmental insecurity. As men struggle to gain or retain control of their environment, females are turned into objects to be controlled. Sexual violence becomes a way



for men to confirm their dominance. 'As such, rape is part of a broader struggle for control in the face of difficult circumstances' (Sanday 1996: 191-208).

Sanday's intimations are reflected in the research of Johnson (1989), Mathiane (1990), Simpson (1992) and more recently Bongiwe (1996), Burbidge 1998 and Leclerc Madlala (1997). Salo (2000) writes about, and Annie refers to the gang rape and murder of a young girl, Valencia Farmer, in Manenberg, Cape Town. Salo also (2000) points out that unemployment among working class males in the area is very high and that they have minimal control over their economic circumstances. There is scant opportunity to escape from life-long poverty and men are unable to answer to dominant masculinities. Compared with this women can get access to State grants and housing or improve their circumstances through a good marriage.

Gendered violence ... then becomes their means of asserting control over women, and a resistance to the dominant masculinity's purchase on women... At the same time its socialised quality is also a manifestation of the gang members' loyalty to each other as men on the margins (Salo 2000:3).

Apart from the violent constructions of masculinity and the ongoing effort to get control under circumstances of adversity, Sanday (1990) suggests that forms of group rape are indicative of such attitudes and behaviour and representative of male insecurity and efforts to bond through 'getting sex', and argues that men display their masculinity through heterosexual exhibits of sexual performance as a form of homoerotic bonding (Sanday 1996: 191-208).

Discussing gang rape on the Cape Flats, Jensen (2001: 330), like other South African researchers, places sexual violence within wider processes of emasculation. In the case of Coloured males, there is the stereotypical portrayal 'of the abstract Coloured man who is weak, happy-go-lucky, not to be trusted and irresponsible'. Jensen argues that in the assertion of masculinity, Coloured women serve a double function as a site for the assertion of male power, while at the same time preventing male bonding (2001: 331). Women are objectified as '*pompdinge*' (things to fuck) and 'poison' to be exorcised and reduced to sexual objects through gang-rape (Pinnock 1987: 428). Jensen (2001: 331-332) indicates that there are probably also constructions of the gangster as the soldier-male and homoerotic sexual bonding involved in gang rapes. Other researchers refer to the ritualistic pattern of rape by multiple perpetrators, i.e. the status of the different men within the group determines the sequence in which the rape is carried out. The aim of the rape is apparently to prove masculinity to the other group members and the victim is a faceless representative of all women, not a particular individual. Historical factors, structural relations, space, gender and masculinity thus intersect in ways that increases the vulnerability of female bodies to the threat of rape. This is exacerbated by the ambiguity with which rape is often viewed.

### The vulnerability of perceived complicity

Rape is deceptive because it is camouflaged as a sexual act that can create life (Raine 1998). This contradiction complicates rape survival, and individual and societal responses to it. Such ambiguity was expressed by Annie, a survivor of multiple rape:

They know, but do not want to (know)... say keep quiet, who will believe you, you must have been looking for it (sex)... (rapists) said she '*smaak vir piel*' (she has a hunger/taste for/ likes penis). Another girl, they now call her a '*vuilbroek*' (soiled pants), she is always afraid. They (female family members she told) keep asking why was I there, what did I do, why this and that? I have made myself hard, I make like it never happened, they are *skollies* (gangsters/ape hooligans), it can happen to anyone... I sometimes get that burning pain of being afraid... it happens, I am alive, I hope I do not get sick (HIV), it happens... I go on.

As indicated above, certain groups, particularly young women like Annie and Amelia who live in the townships, are not only more vulnerable to rape, but also to rape involving multiple perpetrators (see Jewkes, Abrahams 2002, Wojcicki 2002). Yet, like many survivors, Annie found it extremely difficult to talk about her experience. Like the other girl she refers to, she runs the risk of being reviled, or being held responsible as someone who somehow had a hunger or a taste for 'it'.<sup>2</sup> The response to Annie's ordeal was complicated by the fact that many young girls exchanged sex for money, sweets, taxi rides and such. Wojcicki (2002) describes what she calls 'survival sex' in *shebeens* (drinking places) in Gauteng province where women expect to be raped if they do not have sex with a patron who bought her drinks. Owners and other patrons were quite unwilling to assist such women in the event of rape, as accepting liquor was viewed as consenting to sex (Wojcicki 2002: 276). In Cape Town, Annie never went to the Police although she eventually visited the local health facility for '*vrouekwale*' (women's ailments) and was treated with antibiotics.

Survivors of rape and health care-givers who try to deal with the aftermath face many contradictions. Like pain inflicted on a victim, rape can be equivocal, and open to different interpretations or meanings. When Annie tried to verbalize this experience, those she told did not quite believe her, or even insinuated that she was somehow responsible. Like pain inflicted through torture, rape and sexual assault is political; yet it masquerades as sex rather than power, patriarchy, and the inflicting of pain, terror and humiliation. Finally, as in the case of confession under torture, society displays a covert disdain for survivors who acquiesce, who 'look for it' by wearing short skirts, accepting drinks or gifts, are in places where they should not be, or who do not fight back and thus 'consent' to rape (cf. Scarry 1985, Wojcicki 2002). This ambiguity concerning rape and its impact has recently featured in discussions in the media in South Africa. It also impacts on health issues, as seen later in the discussion of condom use.

### **The vulnerability of the unshareable experience**

In an article in the *Weekly Mail and Guardian* (17 to 23 May 2002) a South African journalist argued against the notion that rape destroys women's lives, saying they give what is basically gristle far too much credit for wreaking such havoc on them. It is this kind of perception that makes it so difficult for survivors of rape to publicly acknowledge the life-altering experience of rape. A survivor like Annie talks about feeling like she had been seared inside and out, being full of pain, but also cold and dead. If she repeats this too often she is pathologised as someone who cannot 'cope'. This phenomenon seems to be prevalent in most cultural settings. Annie told about the experience and the involuntary return of searing pain and gagging fear. On another continent a survivor, Nancy Raine, wrote that the rape had changed her cell by cell – she was neither dead nor as she was before (1998: 27). She described how her rapist overwhelmed her, tied her up and covered her face with tape. I quote:

At that moment, time disappeared into a continuous present. Over the next three hours he raped me and tormented me with descriptions of how he would kill me with a knife, telling me exactly where he would cut me... Many times he did cover my face with the pillow and press it down so I could not draw a breath. Each time I expected to die, but he always relented before I lost consciousness. He slapped my head with open palms after these episodes... In the scheme of things, his penis, although employed as a bludgeon, did not make much of an impression. What he did with it was the least of my worries. Those parts of my body that hitherto had been reserved and private were no longer mine, but in this they were indistinguishable from the rest of my body, also no longer mine. It was his rage, a fierce, unearthly tempest, that cast me into an immensity of dread (Raine 1998: 11).

A South African rape survivor, Alison, whose experience is documented in a book, wrote about her rape (Thamm 2002: 22):

As far as he was concerned I did not really exist. I was not human... This man knew what he was doing. And he was determined to do it. As he lunged forward and squeezed my neck, I felt my bowels move. The last thing I felt was embarrassment (Thamm 2002: 25).

Of her own multiple rape Annie said:

they called me terrible names... that I stank, that they will cut me open. I soiled myself. They rubbed my face in it. I get cold and hot when I think... was so ashamed. I was like a plank ... getting full of nails and splinters, hot (liquid) from a tin cup, it burns so much it is past pain, open... it burned so, my mouth, my whole body you know, I felt it, think they burn my skin off, inside. But I was also cold, dead like ice, feeling like burning but ice, dead.

As Annie describes it, the sentient experience of rape is very real and very present for the person who is being raped. Like Annie, many survivors of rape report afterwards that they feel as if their skin had been ripped off, like a searingly painful body from which the protective layer had been stripped, exposing it to the world (personal communication, Prof. Lyn Denny, Groote Schuur hospital and University of Cape Town).

Whether it is as a result of contracting HIV, rape or physical assault, the bodies of Nomsa, Amelia, Annie, Alison and Nancy, particularly their sexed bodies, were at the mercy of forces and dangers beyond their control, forces which could in visible and invisible ways maim their bodies, their sense of femaleness and of self (Wallace 2001). At the same time the rapists (and wider society) often make them responsible for their own rape – they might have looked for it, they did not fight hard enough, they were raped by people they knew.

In the somewhat different high profile case mentioned above the young South African woman, Alison, was abducted, raped, had her throat cut so viciously that her head was almost severed, was disembowelled and left for dead. She managed to struggle to a road where a passing motorist stopped and stayed with her until an ambulance arrived. In this case public sentiment turned overwhelmingly to the brave young woman – it was a ‘classical’ rape by two strangers who abducted her from her car outside her flat and tried to kill her in the most horrific way. She said afterwards she was too paralysed by fear to move, yet when she regained consciousness she kept up her struggle to survive. The focus on Alison was ultimately on her physical injuries, which had almost annihilated her. It was the very visibility of the scars on her body that contributed to public outrage.

Yet at the same time to have been raped is often to have its very impact and sometimes even its factuality doubted by others. As in the case of pain under torture, experiencing rape can become a life-destroying fact for the survivor, but if the harm is not visible, its impact is not always completely believed either. In instances of torture, severe pain and rape the formation of community through memory, for example, is so difficult because the experiences themselves are unspeakable and not shared (Wallace 2001). Annie, Nomsa and Amelia have in a sense been able to find some meaning in their experiences – for Annie it was ‘something that could happen to anybody’, it was senseless. She has terrible dreams, drinks too much and fights with others. But she is being strong and ‘goes on’. Nomsa is (for me) strangely tranquil and accepting – her baby will live and she is still alive. Amelia is the one who is most distressed – she lives in a world where rape and violence seems random, she can anytime be the victim of either or both, but bears with it to survive and to do so with dignity.

Alison has used her ability to express herself and describe her experience to become an advocate for rape survivors, whereas Annie, Nomsa and Amelia would never share their experiences – because of shame, fear and the inarticulated need to survive.

### **The vulnerability of talk and meaning**

Writing about the kind of pain under torture that reduces a person to a state beyond the language of screams, cries and shrieks, Elaine Scarry (1985: 6) says:

Through there are very great impediments to expressing another’s sentient distress, so are there also very great reasons why one might want to do so, and thus there come to be avenues by which this most radically private of experiences begins to enter the realm of public discourse.

It is necessary to talk and write about rape, about what it does to individual survivors. In order to soothe it, it is supposed that the pain and agony of the survivor should somehow be verbally expressed. It 'is a necessary prelude to the collective task of diminishing pain' (Scarry 1985: 9). According to Broyard (1992: 12) people have a deep need to give meaning to and make sense of devastating and life-altering experiences. According to him 'narrativization' is a way to gain control over emergencies and shocking experiences. For the sufferer or survivor of a traumatic experience, narratives, or 'telling about', are often presented as ways of thinking through what has happened and to assist them to reconstruct a 'new' outcome for their future. Both in telling and interpreting experiences, 'telling about' mediates between the inner world of thought and feelings and for example, the observable world of medical interventions and of dealing with everyday life (Garro & Mattingly 2000).

The use of narratives can give us insight into the experience of a woman who has suffered a traumatic event such as rape or sexual assault. Through the telling and listening we can gain greater understanding of what has been dealt with, the meaning attached to it, and even whether the process of telling, ultimately promotes or retards the rape survivor's efforts to find healing (Becker 1997). Robertson nevertheless (1998) reports that many survivors of rape or sexual assault still experience secondary traumatization when the Police and hospital personnel respond insensitively to them. She argues this might be the result of lack of awareness and training, understaffing and the emotional exhaustion of staff. A spokesperson for Rape Crisis in the Western Cape expressed similar concerns (personal comment). In South Africa the National Police Instructions on Sexual Offences (NI022/1998) stipulate that a medical examination must take place as soon as possible after a sexual assault or rape is reported. If the survivor reported to the police, an in-depth statement must be taken from the survivor preferably after recuperation but nevertheless ideally within 24-36 hours. The collection of forensic evidence involves an internal examination, combing of pubic hair, nail scrapings, saliva samples, swabs for foreign materials on the victim's body, and an overall examination for bruises and lacerations and other physical trauma. The forensic examination, even when done with great sensitivity and care by a trained professional can be potentially invasive and traumatic for the survivor of sexual assault and rape (Seymour et al. 2000, Speck 1999, Resnick et al. 1999).

For the institutional necessity of collecting evidence, the in-depth interview as part of the forensic examination, which is expected of survivors of rape and sexual assault, takes a particular narrative form. This is often to enable the institutional listener to develop a 'logical' sequence in response to the argument or formulation circumscribed by law. Clinical work itself involves particular kinds of narratives such as case studies, taking histories and the like (Eisenberg 1981, Hunter 1991, Mattingly 1998, Sacks 1995). At the same time efforts to treat survivors of traumatic events may work on the assumption that personal recovery is precipitated by recounting or telling a traumatic memory or incident to others.

The narrative is assumed to be important for the healing process, and it can be a way to interpret what has happened, to develop alternative narratives, create new understandings, create new possible outcomes for the future. It may help in finding an inter-

pretation with which the survivor feels comfortable and which enables her to no longer feel that she is a victim. The use of narratives is thus perceived as a medium to understand and contextualize actions and feelings related to some specific event that the researcher has not personally experienced (Capps & Ochs 1995).

At the same time, as with all activities and human experiences, traumatic events are filled with 'meaning' that is communicated through narratives. Through 'telling about' a traumatic experience, psychologists try to assist survivors to find a way to give meaning to what has happened, to find some kind of self-coherence after a rupture (Murray 1995). Spence (1986) argues that successful self-narrative, or 'telling about', is a precondition for psychological well-being. However, people do not automatically find that everything can be 'narrated'. To identify specific areas of life constituted through the act of storytelling, Young (1989) uses the concept of 'Taleworld' (Murray 1995). The purpose of this concept is to identify where conflict occurs in what is deemed to be 'narratable'. She discusses the problems involved in the narration of the internal experience of the body and the political dimension of routines of medical examination in the torture camps of Auschwitz, during World War II. This was a case of the transgression of the 'taleworld'. Young analyzes and stresses the importance of the ontological dimension of narrative, and the way it isolates certain elements as allowable or not allowable, for telling about (Murray 1995).

Rape can be compared to the experiences narrated or silenced by the aforementioned survivors. Measuring the symptoms of post-traumatic stress disorder (PTSD) also occurs through narratives, i.e. structured questionnaires that help to guide interventions. While useful, this approach gives no indication as to the meaning attached to the trauma of rape and whether women and clinicians who come from different backgrounds attach different meanings to it. It might in turn be expressed through different metaphors indicating distress, moral conflict or even discontent, contestation or commentary. The meaning attached to rape by a survivor has relevance for clinicians who wish to provide empathetic medical care and to link it to the local worlds of experience of traumatized survivors (cf. Campbell & Raja 1995). By doing research, talking and writing about rape and through advocacy, ways can be supposedly be found to politically represent it and to bring about legal reform and the universal implementation of the protocol for rape survivors. The narratives of rape survivors also present a conundrum, particularly in South Africa where narrativization and communal remembrance have become ways to (re)construct both the past and the imagined future. In under-resourced situations, talking might even do more harm than good. As one survivor said:

all of this does not change my life. I can get raped again tomorrow. That is how things are here. You make yourself strong and stay as safe as you can. All this about not my fault, it makes me careless. I need to look out all the time.

### **The vulnerability posed to health**

Rape and sexual violence expose survivors to harm and infections. The risk of micro-trauma to the vagina and genital injury increases during rape, particularly if it was violent, if it was accompanied by multiple penetrations, if there was more than one perpetrator or when there was ejaculation. All of these factors increase the risk of contracting HIV/AIDS. While anti-retrovirals are available for rape survivors at government funded rape crisis centres in the Western Cape, this is not always the case for private patients. When we were doing research on domestic and sexual violence in Lavender Hill, a rape survivor who lived in my own area and who was a private patient, reported that she had been unable to get access to the prophylaxis from her general practitioner within the recommended 72 hours. These are the contradictions rape survivors face – if living in marginalized areas they are more exposed to the risk of being raped. When living in more affluent areas and having access to more resources and care, the rape protocol is implemented more arbitrarily and health care givers are not always capable of dealing with survivors.

Sexual violence or fear of violence hampers a woman's ability to negotiate condom use. Both Nomsa and Amelia intimated, and research shows, that (Heise et al. 1993). For a woman to suggest the use of a condom in consensual sex is often interpreted as an indicator of female infidelity (Jewkes et al. 1999, Jewkes & Abrahams 2002). To suggest condom use when faced with rape, is viewed as complicity at best and condoning it at worst.

Studies also show a strong link between violent sexual abuse and reproductive health issues such as HIV/AIDS and other STD's, chronic pelvic pain and unwanted pregnancies. Research in South Africa indicates that violent sexual abuse often continues when a woman is pregnant and that this may have serious health consequences (Jewkes et al. 1999) for both mother and child. The inability of women like Nomsa and Amelia to refuse sex undermines their ability to negotiate condom use, even if their partner has a visible STD, and this ultimately leads to earlier death (cf. Jewkes et al. 1999).

According to current research HIV prevention is discussed significantly less often in relationships where there is sexual violence. The massive presence of HIV/AIDS in South and Southern Africa is seen as a major reason to move the growing prevalence of sexual abuse firmly onto the political agenda. As indicated, research increasingly shows that sexual and other forms of gender abuse contributes and is linked to some intractable reproductive health issues, including:

teenage pregnancy, high-risk sexual behaviour (such as unprotected sex with multiple partners and prostitution), sexually transmitted diseases (STDs), neonatal and maternal mortality and chronic pelvic pain. In addition, there is a growing consensus among scholars, jurists and human rights activists that reproductive health services are a logical point to identify and provide referrals to women in need of social or legal services precisely because health clinics are one of the few institutions that regularly have contact with women (Jewkes 1999).



Sexual assault and gender violence have important implications for reproductive health. Amelia's case represents a number of the reproductive health issues involved in sexual violence – she was injured and had an unwanted teenage pregnancy. Nomsa contracted an STD and soon after HIV, which has since developed into full-blown AIDS. Both women suffered from chronic pelvic pain. Other potential outcomes of sexual violence includes sexual dysfunction, infertility and psychological problems. If in addition the women faced abuse during pregnancy they ran the risk of miscarriage, premature labour, low birth weight, still-birth, or peri-natal, neo-natal or maternal mortality (Jewkes 1999).

### **Conclusions – the way forward**

In attempting to address at least some of the issues concerning rape and sexual assault in the Western Cape, the Department of Health has developed and implemented a protocol and standardized management guidelines for survivors of rape and sexual assault. The guidelines are aimed at the optimal management at Primary Health Care centres for survivors of rape and sexual assault (Department of Health 2000: 1). Treatment includes emergency contraception, STD prophylaxis, and anti-retroviral post-exposure prophylaxis. This protocol is supported in principle or under consideration by health departments in other provinces, but in the end it addresses the physical consequences and the aftermath of sexual abuse and not its 'unspeakable', contradictory and ambiguous facets.

These lay in the continuous blurring of boundaries and concomitant perceptions and practices – between being safe and at risk, inside and outside, day and night, victimhood, complicity and culpability, rape and sex, private and public meaning and memory, political and private, masculinity and femininity and the ways these intersect and shift at different levels to form interwoven layers of vulnerability that cannot be easily disentangled, yet serves to obfuscate many of the realities and negative outcomes of rape and its aftermath.

I want to refer to two quotes, the first to explain to some extent why Amelia cannot see the father of her child as her rapist or why the raped are often implicated in the crime. This happens firstly because sex and rape are fused in the mind of society (Raine 1998: 212). According to Raine (1998: 225):

Rape is a death force that can disguise itself as the life force to which all human beings are inexorably drawn. Rape mimics what it aims to devour – the mysterious life-affirming force that renews us and fulfills our most profound longing for union.

As indicated at the outset, the experience of rape is already fraught with ambiguities and contradictions. This is further complicated by the fact that the rapist can also be a loved one or somebody the survivor is familiar with. I would also like to quote Heise and Toubia (1995: 1):

Women deserve broader choices and the basic right to be safe and free from violence. We should also remember that women are ...survivors ... we must bear in mind that although men commit the majority of abuse against women, not all men are violent. As professionals and activists, we need to create coalitions between men and women to eradicate all forms of violence and abuse. For most women, men are fathers, sons and partners in life. In raising these difficult issues, we seek to equalize and improve partnerships, not to point blame or promote antagonism between men and women.

Ultimately rape is a bodily wounding or form of annihilation that is all the more deceptive because it is camouflaged as a sexual act of life creation. This contradiction complicates rape survival, and individual and societal responses to it. Certain groups, like young women in townships in Cape Town, are not only more vulnerable to rape, but also to rape involving multiple perpetrators. For such vulnerable groups the effect of rape is in a sense the experience of violent communities, patriarchy, institutionalised racism, oppression, alcohol abuse, poverty, adversity and particular kinds of masculinities written on the surfaces of the bodies of survivors. Because the risk of micro-trauma to the vagina and genital injury increases during rape, particularly when violence, multiple perpetrators or penetrations, or ejaculation takes place, the risk of contracting HIV/AIDS or other STI's also increases. The aftermath of rape is filled with ambiguity, humiliation and, in a country with a high HIV prevalence, the fear that the ultimate outcome might be a slow death. Through rape, survivors are made vulnerable. Because the impact of rape cannot always be seen, it exposes survivors to disbelief, often precisely because of the effort to survive it. All of these factors create extreme emotional distress, which many survivors describe as life-altering. Yet even this aspect is often doubted, increasing the vulnerability of survivors, particularly where resources are scarce.

## Notes

Diana Gibson has a doctorate in anthropology and is working in the field of health and health care in South Africa. She is currently attached to the Medical Anthropology Unit and the Department of Sociology and Anthropology, University of Amsterdam (e-mail: dgibson@fmg.uva.nl). I would like to thank the participants in the study as well as Stella Nyanchama-Okemwa and the reviewers for their suggestions.

- 1 The study was done over a period of 18 months. During this time a random survey was done of 40 women and a purposive survey of 90 abused women. Police and hospital staff were interviewed.
- 2 In *S v Mahamotsa*, two women under the age of 16 were raped on separate occasions by a 23-year-old man. The second rape was committed after the accused had been arrested for the first incident and released in the care of his guardian. Presiding Justice Kotze listed as mitigating factor the fact that the complainants did not lose their virginity as a result of the incidents. They had already been sexually active, and 'one of them, although only at school, had sexual intercourse with another person two days before the incident' (*translation from the Afrikaans original*). In addition, the complainants had not sustained any physical injuries or

psychological harm. The court then held that the following constituted a 'substantial and compelling circumstance': 'Although there was intercourse with each complainant more than once, this was the result of the virility of a young man still at school who had intercourse with other school pupils against their wishes, and, note, school pupils who had previously been sexually active... Where one is dealing with school pupils, and where, in addition, it appears that the two girls concerned had already had intercourse before, one really shouldn't lose perspective, especially not in relation to the first count, which dealt with a complainant who had in any event been naughty a few days earlier and had intercourse with someone else. The injustice which she suffered in this case does not demand an unusually severe sentence' [Translation from the Afrikaans original]. Joint Monitoring Committee on the Improvement of Quality of Life and Status of Women. Parliament of the Republic of South Africa. Report on Violence against Women. May 2002.

## References

- Abrahams, N., R. Jewkes & R. Laubscher  
 1999 "I do not believe in democracy in the home". *Men's relationship with and abuse of women*. CERSA. Tygerberg: Medical Research Council.
- Becker, G.  
 1997 *Disrupted lives: How people create meaning in a chaotic world*. Berkeley & Los Angeles: University of California Press.
- Bongiwe, M.  
 1996 Rape of schoolgirls rite in Soweto and Tembisa. *The Star* 4/11/96.
- Bremner, L.  
 2002 *Bounded spaces: Democratic anxieties in post apartheid Johannesburg*. Department of Architecture. Johannesburg. University of the Witwatersrand.
- Bryoard, A.  
 1992 *Intoxicated by my illness*. New York: Potter.
- Buga G.A.B, D.H.A Amoko & D. Ncayiyana  
 1996 Sexual behaviour, contraceptive practices and reproductive health among school adolescents in rural Transkei. *South African Medical Journal* 86: 523-27.
- Burbidge, M.  
 1998 AIDS-infected gang targeting schoolgirls. *The Star* 19/05/98.
- Campbell, C.  
 1992 Learning to kill? Masculinity, the family and violence in Natal. *Journal for Southern African Studies* 18: 614-28.  
 1996 Social identity and violence in the domestic spheres: a gendered common denominator? In: L. Glanz & A. Spiegel (eds), *Violence and family life in a contemporary South Africa: Research and policy issues*. Pretoria, HSRC, pp. 1-337.
- Campbell, R. & S. Raja  
 1999 Secondary victimization of rape victims: Insights from mental health professionals who treat survivors of violence. *Violence & Victims* 14 (3): 261-75.
- Capps, L. & E. Ochs  
 1995 *Constructing panic: The discourse of agoraphobia*. Cambridge, Massachusetts: Harvard University Press.

- Department of Health. Provincial Administration Western Cape.  
2000 *Management policy on the survivors of rape.*
- Denny, L. et al.  
2002 Experience of standardised assault examination protocol. Paper presented at the First South African Gender Violence and Health Conference. Glenburn Lodge.
- Douglas, M.  
1966 *Purity and danger.* New York: Routledge & Kegan.
- Dworkin, A.  
1979 *Pornography: Men possessing women.* New York: E.P. Dutton.
- Eisenberg, L.  
1981 The physician as interpreter: Ascribing meaning to the illness experience. *Comprehensive Psychiatry* 22: 239-48.
- Feldmann, H.  
1992 Vergewaltigung und ihre psychischen Folgen: Ein Beitrag zur post-traumatischen Belastungsreaktion. *Unpublished paper.* Stuttgart.
- Garro, L.C. & C. Mattingly  
2000 Narrative as construct and construction. In: L.C. Garro & C. Mattingly (eds), *Narrative and the cultural construction of illness and healing.* Berkeley & Los Angeles: University of California Press, pp. 1-49.
- Glanz, L.E. & A.D. Spiegel (eds)  
1996 *Violence and family life in contemporary South Africa: Research and policy issues.* Pretoria: HSRC Publishers.
- Haraway, D.  
1991 *Simians, cyborgs, and women: The reinvention of nature.* New York: Routledge.
- Heise L., J. Pitanguay & A. Germain  
1993 *Violence against women. The hidden health burden.* World Bank Discussion Paper 255.
- Heise, L. & N. Toubia  
1995 Foreword. In: L. Heise, K. Moore & N. Toubia (eds), *Sexual coercion and reproductive health. A focus on research.* New York: The Population Council, pp. 1-4.
- Henderson, P.  
1994 Silence, sex and authority: The contradictions of young girls' sexuality in New Crossroads, Cape Town. *VENA Journal* 2: 33-39.
- Hunter, K.  
1991 *Doctors' stories: The narrative structure of medical knowledge.* Princeton, N.J.: Princeton University Press.
- Jensen, S.  
1999 Discourses of violence : coping with violence on the Cape Flats. *Social Dynamics* 25 (2): 1-10.  
2001 *Claiming community – negotiating crime. State formation, neighbourhood and gangs in a Capetonian township.* PhD Thesis. International Studies. Roskilde University.
- Jewkes, R.  
1999 The impact of violence against women on sexual and reproductive health. Paper presented at IPPF at CHOGM, Durban.

- Jewkes, R., J. Levin & L. Penn-Kekana  
 2002 Risk factors for domestic violence: findings from a South African cross-sectional study. *Social Science & Medicine* 55 (9): 1603-17.
- Jewkes R., L. Penn-Kekana & J. Levin  
 1999 "He must give me money, he mustn't beat me". *Violence against women in three South African provinces*. Medical Research Council Technical Report, Pretoria.
- Jewkes, R. et al.  
 2000 *Stepping stones: Feedback from the field*. Pretoria: Medical Research Council.
- Jewkes R. & N. Abrahams  
 2002 The epidemiology of rape and sexual coercion in South Africa: An overview. *Social Science & Medicine* 55 (7): 1231-44.
- Johnson, R.W.  
 1989 Terror in the Townships. *New Statesman and Society* 8: 14-16.
- Kotze, J.C. & C.S. van der Waal  
 1995 *Violent social relationships and family life in two Transvaal lowveld settlements*. Pretoria: Human Sciences Research Council.
- Leclerc-Madlala, S.  
 1997 Infect one, infect all: Zulu youth response to the AIDS epidemic in South Africa. *Medical Anthropology* 17: 363-80.
- Makhubele, B.  
 1999 *Perceptions of adolescents in Khayelitsha, Cape Town: On sexual and reproductive health*. Faculty of Arts, Department of Anthropology and Sociology, University of the Western Cape. Unpublished Masters thesis.
- Mathiane, N.  
 1990 *Beyond the headlines. Truths of Soweto life*. Pretoria: Southern Book Publishers.
- Mattingly, C.  
 1998 *Healing dramas and clinical plots. The narrative structure of experience*. Cambridge: Cambridge University Press.
- Mbembe, A.  
 2001 *On the postcolony*. Berkeley: University of California Press.
- Mfecane, S.  
 2002 *Xhosa youth constructions of masculinity and their impact on the spread of HIV/AIDS*. MA thesis. Department of Anthropology and Sociology. University of the Western Cape.
- Mokwena, S.  
 1992 Living on the wrong side of the law. Marginalisation, youth and violence. In: D. Everatt & E. Sisulu (eds), *Black youth in Crisis: Facing the future*. Braamfontein: Ravan.
- Mudimbe, V.Y.  
 1988 *The invention of Africa. Gnosis, philosophy and the order of knowledge*. Bloomington: Indiana University Press.
- Murray, K.  
 1995 Narrative partitioning: The ins and outs of identity construction. In: J. Smith, R. Harré, & L. van Langenhove (eds), *Rethinking psychology: Volume 1 – Conceptual Foundations*. London: Sage. Available online: <http://werple.net.au/~kmurray/psych/in&out.html>.

- Pinnock, D.  
 1987 Stone's boys and the making of a Cape Flats mafia. In: B. Bozzoli (ed.), *Class community and conflict*. Johannesburg: Ravan Press, pp. 418-35.
- Pinnock, D. & D. Douglas-Hamilton  
 1997 *Gangs, rituals and rites of passage*. Cape Town: African Sun Press.
- Raine, N.  
 1998 *After silence. Rape and my journey back*. New York: Three Rivers Press.
- Ramphela, M.  
 2000 Teach me how to be a man: An exploration of the definition of masculinity. In: V. Das et al. (eds), *Violence and subjectivity*. Berkeley: University of California Press, pp. 102-119.
- Resnick, H. et al.  
 1999 Prevention of post-rape psychopathology: Preliminary findings of a controlled acute rape treatment study. *Journal of Anxiety Disorders* 13 (4): 359-70.
- Robertson, M.  
 1998 An overview of rape in South Africa. *Continuing Medical Education Journal*, February (On-line): [www.wits.ac.za/csvr/articles/arttrapem.htm](http://www.wits.ac.za/csvr/articles/arttrapem.htm)
- Sacks, O.  
 1995 *An anthropologist on Mars*. New York: Knopf.
- Salo, E.  
 2000 Gangs and sexuality on the Cape Flats. *AGI Newsletter* 7: 1-6.
- Sanday, P.R.  
 1990 *Fraternity gang rape: Sex, brotherhood and privilege on campus*. New York: New York University Press.
- Sauls, H.  
 2000 *Masculinity and violence: Live fast, die young and have a good-looking corpse*. MA thesis. Department of Anthropology and Sociology. University of the Western Cape.
- Scarry, E.  
 1985 *The body in pain: The making and unmaking of the world*. New York: Oxford University Press.
- Seymour, A. et al. (eds)  
 2000 *National Victim Assistance Academy*. Available on: <http://www.ojp.usdoj.gov/ovc/assist/nvaa2000/academy/welcome.html>
- Shaik, F. & Y.J. Park  
 1998 Highest incidence of rape – A “culture of violence”. *WIN News* 24 (2): 65.
- Simpson, G.  
 1992 *Jackasses and jackrollers. Rediscovering gender in understanding violence*. Johannesburg: Centre for the Study of Violence and Reconciliation, University of the Witwatersrand.
- Speck, P.  
 1999 Sexual assault. In: S. B. Sheehy & G. P. Lenehan (eds), *Manual of emergency care*. St. Louis, MO: Mosby, pp. 300-35.
- Spence, D.  
 1986 Narrative smoothing and clinical wisdom. In: T. S. Sarbin (ed.), *Narrative psychology: The storied nature of human conduct*. New York: Praeger, pp. 3-21.

- Thamm, M.  
2002 *I have life. Alison's journey as told to Marianne Thamm*. Johannesburg. Penguin Books (reprint).
- Tuba, M.  
2002 *Use patterns of therapeutic support systems by rape survivors 15-19 years old in Khayelitsha, South Africa*. MA thesis, University of the Western Cape.
- Wojcicki, J.  
2002 "She drank his money": Survival sex and the problem of violence in taverns in Gauteng province, South Africa. *Medical Anthropology Quarterly* 16 (3): 267-93.
- Young, K.  
1989 Narrative embodiments: Enclaves of self in the realm of medicine. In: J. Shotter & K.J. Gergen (eds), *Texts of identity*. London: Sage, pp. 152-65.