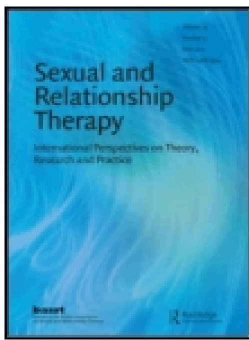

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Male victims of male sexual assault: a review of psychological consequences and treatment

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ABSTRACT *Sexual assault/rape of women have received considerable attention in the literature. This paper attempts to extend the discussion by highlighting the impact of sexual assault on men. The legal system in the UK only recently included male sexual assault (MSA) as a crime and the paper argues for continued debate around legislation. We also discuss the impact of MSA in terms of self disclosure, psychological consequences, impact and pathways into receiving medical and psychological support. With an increase in culturally diverse populations we explore MSA in terms of cultural differences and the role of sexual and relationship therapists. Finally we discuss future directions for research.*

Introduction

The sexual assault of males by males has received little attention in the psychological literature (Hodge & Canter, 1998). Indeed, Groth and Burgess (1980) suggested in a significant paper that male sexual assault (MSA) is one of "the most under addressed issues in our society". There has been an assumption that male on male assault is unusual and infrequent outside prisons. It is known that such assaults are infrequently reported to the police (Hodge & Canter, 1998). This underreporting has been the result in part, in the UK at least, of the narrowness of the definition of rape, as until 1994 legislation in did not allow for the possibility of male rape. The lack of clarity around the definition of MSA has been mirrored in the literature around male sexual assault, and the terms 'rape' and 'sexual assaults' have been used interchangeably (Rogers, 1995), adding to the difficulty of definition.

Until 1994 the offence of rape of males did not exist under English law, although there were categories of sexual offences against males (e.g. indecent

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assault, buggery). The present definition of rape in English law is the "vaginal penetration of a woman, or anal penetration of a person of either gender, without their consent, or with wilful disregard to their consent". This change to the law was welcomed as an acknowledgement that such offences were more common than had been previously thought (King *et al.*, 2000) but Rogers (1995) has pointed out that the legislation is extremely specific in defining what sexual act constitutes rape. For example, forced fellatio, insertion of objects into the anus and forced masturbation of the offender do not constitute rape under this definition. Within at least two of the above examples there is penetration of the victim by the offender, albeit in an orifice other than the anus, or with an object other than the penis. While these actions would be considered serious sexual assaults, they do not meet the definition of rape provided by the legislation. Yet, as Rogers (1995) points out, the victims may consider that they have been raped because some form of penetration has taken place. This specific definition may also pose some difficulty in defining what constitutes MSA. While some men are raped (as defined in the legislation), the majority are not penetrated anally (Coxell *et al.*, 2000). However, the psychological and emotional effects of the sexual violation/assault may not be any less severe than in the case of rape.

Theories about male sexual assault

The literature identifies two predominant trains of thought concerning the victims and the perpetrators of MSA. First, it has been suggested that MSA is a sexually motivated crime and predominately occurs between homosexual men, particularly those who have had some kind of previous contact, i.e. acquaintances (King *et al.*, 2000). Hickson *et al.* (1994) explored this issue and conducted a study of non-consensual sex among 930 gay men recruited through a snowballing sampling procedure using the following: the gay press, pubs, clubs, social and political organizations. Of this sample 27.6% stated they had been sexually assaulted at some point in their lives. This study did not separate men who had been the victims of MSA as adults and those who had been sexually assaulted at an earlier age, i.e. as teenagers or children. Nearly one-third of the victims had had previous consensual sexual contact with the perpetrator before the assault took place. The authors concluded that MSA is sexually motivated and is exacerbated by sexual fantasies and stereotypes that are common within the gay community, e.g. the forceful, dominating man, the initially unwilling partner who changes his mind.

Coxell *et al.* (2000) also noted that men who have sex with men (gay and bisexual men, and men who identify as heterosexual but have sex with men) are also more likely to be the victims of MSA than men who only have sex with women. This may provide further evidence for MSA being primarily a sexually motivated crime. However, both these studies suffer from sampling bias. The first was concerned with the experiences of gay men and recruited the sample via a variety of gay sources, e.g. the gay press and gay organisations; as such it has little to say about MSA and heterosexually identified men. The sample in the second study was recruited

from genitourinary medicine clinics and is not representative of the general population.

The second school of thought suggests that MSA is a reflection of issues of power, aggression and domination and that the perpetrators are generally heterosexual men (Hodge & Canter, 1998). This understanding of MSA has been taken directly from the feminist analysis of female sexual assault. This issue was investigated by King *et al.* (2000) in a study of 3142 men (2474 of whom agreed to participate), carried out within 18 general practices, both urban and rural, throughout England. The majority of victims who reported MSA in this study were heterosexual (97%) but men who reported having sex with men were more likely than other heterosexual men to report MSA. The sample found 71 people had experienced non-consensual sex after the age of 16, compared with 128 before the age of 16. The study did not speculate about the sexual orientation of the perpetrators.

An early study by Groth & Burgess (1980) analysed the characteristics of six victims of MSA and 16 perpetrators. Most of the perpetrators lived heterosexual lifestyles, although 38% were married but had sex with men (this is to differentiate men who identify as gay from men who are behaviourally bisexual). The majority were white young men with a mean age of 24. The majority (75%) of this group had assaulted strangers using physical force, intimidation or entrapment. The victims comprised a younger group—average age was 17 at the time of the assault. Half this group had been assaulted by men they were acquainted with and the other half by strangers. Fifty percent were heterosexual and the rest were bisexual or homosexual. Groth & Burgess (1980) concluded that, when victims are young, their attackers are more likely to be older, in positions of authority, or family members. When victims are older, the perpetrators are more likely to be from their peer group and sexual assaults by strangers show an increase in frequency. The authors support the notion that power and aggression motivate assaults. However, this study is based on a small sample and the perpetrator sample was drawn from a group of convicted sex offenders. It is likely that this group is quite different from other populations of offenders who commit fewer serious assaults.

A more recent study by Hodge & Canter (1998) suggest that both of the above viewpoints have merit. They analysed data from 83 victim self-report questionnaires and 36 investigated police cases. They concluded that homosexual perpetrators were more likely to be motivated by sex then heterosexual perpetrators, who were more likely to be motivated by power and the desire to dominate. Heterosexual perpetrators targeted victims of all ages and were more likely to operate in gangs. By contrast, homosexual perpetrators were more likely to have had an acquaintance with their victims who were usually aged between 16 and 25 years.

Pathways into care

It is well documented in the literature that many men who have been sexually assaulted/raped do not report their assaults. Various suggestions have been posited around social stigmas, fear of rejection and not being believed, or generally having

no idea to whom or where to report such assaults. Since legal changes and more public debate around MSA have occurred, a variety of specialist organizations (Survivors) and services with better refined protocols in NHS settings (sexual health/GUM clinics) have seen an increase in people disclosing MSA. However, it is still unclear how many people do not come forward at the time of the assault, or how many may present weeks, months or even years later. When people present at a specialist sexual health service, a medical clinician trained in forensic sexual assault work should undertake a full medical/forensic examination (Ryder-Lewington & Rogers, 1995). The victim would not be forced into disclosing information to the police although he would be encouraged and supported by a variety of professionals and referred for psychological assessment and support. In a paper on a specialist clinic for female survivors of sexual assault Petrak *et al.* (1997) highlighted the importance of access to professional psychological services.

Psychological interventions with victims of MSA

There is little empirical literature on the effectiveness of psychological interventions with men who are victims of MSA (Coxell & King, 1996). Interventions tend, therefore, to be based on clinical experience and on the application of interventions with female victims of sexual assault. As stated earlier in this paper, many victims do not report the assault or seek help for the physical or psychological consequences (Mezey & King, 1989). There is little empirical evidence on how to decide which type of intervention or approach to take. However, Coxell and King (1996) proposed that treatment might be divided into two categories: early and delayed. Early management is characterized by offering the victim an opportunity to consider and talk about the assault in a supportive context. This intervention is usually client-centred, humanistic and non-directive. Mezey and King (1987) suggested that common feelings among victims are shame that the attack has taken place, embarrassment and anger at having been unable to prevent it, depression, fear, sexual dysfunction, and a feeling that their sense of masculinity has been threatened. Victims may have concerns about sexually transmitted diseases and HIV (Coxell & King, 1996), especially if the perpetrator has ejaculated into the victim. Such concerns require careful management by a therapist.

Some victims of MSA require longer-term and more specialized help in order to cope with the consequences of the MSA (Mezey & King, 1989). Symptoms may persist for years. Mezey and King (1989) reported that eight of a sample of 22 men in a study of the effects of sexual assault had persistent symptoms lasting from two to 44 years after the assault. Victims' concerns about their sexual identity were particularly prominent in this study. Men reported that they doubted their heterosexual identity because they had failed to prevent the assault from taking place. This may be less of an issue for homosexual victims. Specific interventions for such symptoms may be required, e.g. cognitive–behavioural approaches for intrusive thoughts or other symptoms of post-traumatic stress disorder (PTSD), depression, panic attacks and low self-esteem. There has been almost no research into the most effective treatments for such problems. If symptoms persist or deteriorate,

psychiatric interventions may be considered instead of, or alongside, psychological, interventions.

The severity of sexual assault and severity and extent of reported psychological problems suggest a possible link, though this requires further investigation King *et al.* (2000).

A general practice survey (Coxell *et al.*, 2000), also found higher levels of psychological problems, including self-harm and alcohol misuse. The authors speculated that, in people presenting with a history of self-harm, there may also be a history of a male sexual assault, highlighting the need for comprehensive assessment tools. The aims of the study were to find out the lifetime prevalence of non-consensual sexual experiences; the relationship between such experiences in childhood or as an adult; psychological and behavioural disturbances; and medical assistance received.

Effect on sexual functioning and intimate relationships

There is some limited information to support the notion that sexual trauma/sexual assault often results in a variety of sexual dysfunctions. It also appears that adverse sexual experiences in childhood and adulthood may result in later sexual difficulties for some victims (Hawton, 1985).

Among a series of 22 men having experienced MSA, Mezey and King (1989) found that sexual dysfunctions were almost universal, although they did not break down the generic term sexual dysfunction into individual sexual problems, i.e. primary erectile dysfunction, premature ejaculation, situational problems, etc. It was also found that most of the men reported an inability to form close and trusting relationships as a direct result of MSA. Men also showed marked psychological disturbances ranging from irritability, emotional distancing and loss of self-respect. Many reported findings suggest similarities with female sexual assault (Burgess & Holmstrom, 1974). Myers (1989) also found high levels of sexual inactivity and promiscuity. Much of the literature relies heavily on clinical observations; the reports on psychological effects of MSA are usually based on small clinical samples with poor sampling techniques and are therefore mainly speculative.

Issues for sexual and relationship therapists

The scant literature on the psychological effects of MSA highlights the fact that men who have been sexually assaulted show a wide range of psychological concerns in early and longer-term presentations. The studies show the main areas that men report are difficulties with sexual identity, sexual problems and developing close and trusting intimate relationships. No data exist on the impact of sexual assault on partners (if the victim is in a relationship) although we can speculate that, as in childhood sexual abuse, it will have an impact on relationships and sexual functioning. We may therefore at some stage involve a partner both to support the relationship and to assess the impact on the relationship factors like communication, increasing arguments, depression, withdrawal and sexual functioning.

When people present as individuals, therapists still need to be aware, during the assessment phase of the impact, of previous sexual assault or childhood sexual abuse and to formulate a treatment strategy accordingly. As for sexual dysfunction, standard treatments like behavioural sexual therapy techniques, accompanied by cognitive strategies used for post-traumatic stress disorder, can be incorporated into a supportive holistic approach to the individual or couple. Often the stories that individuals present are very distressing for the clients and therapists alike (Weaver, 1998). Therapists should be aware of the impact on themselves and seek support from colleagues, in addition to regular supervision and possible client referral to more specialist services including PTSD clinics and /or community mental health teams.

Cross-cultural aspects of MSA

Studies of MSA have primarily focused on Caucasian males, with limited data available on men from different ethnic backgrounds (Jones, 2000). Therefore, we have little idea how someone from a different ethnic group or culture may respond psychologically to MSA. Future research should gather information on MSA from different ethnic/cultural backgrounds that will help inform prevention and psychological intervention strategies. Another important area of the cross-cultural aspects of MSA is torture. We have increasing numbers of people seeking asylum, and refugees with multiple and complex needs, including a history of sexual assault and sexual torture. We need more research on the psychological effects, short- and longer-term, on their problems and we need to develop culturally sensitive research tools, methodologies and interventions.

Therapist training needs

During training some therapists will have explored issues around female sexual assault (FSA) from a theoretical standpoint and the use of different therapeutic models which may support a female victim. However, from the above literature it is clear that although the research conducted on MSA shows some similarities with FSA, gender differences are also highlighted.

Discussion

While there is a tight legal definition of male rape, the definition does not allow for other forms of sexual assault, including forced fellatio or insertion into the anus of objects other than a penis. These forms of assault may be as distressing as penile–anal penetration and may be considered by the victim to be rape, but under the current definition they are not considered to constitute rape. This is an obvious difficulty in current English law and it may not do justice to the trauma experienced as a result of an assault accompanied by penetration that is non-anal.

MSA is almost certainly underreported to the police. Epidemiological studies cited in this paper point to a high incidence of MSA which is not reflected in crime

statistics. There is a number of factors to account for this: the victim's fear that he will be considered to have provoked the assault in some way, stigma, a sense of loss of masculinity, either through being penetrated or not having fought hard enough to prevent the attack (or both), fear of not being believed by the police and judiciary, and fear of being perceived as homosexual. The current English legislation has gone some way towards taking away the stigma associated with reporting MSA and rape, but societal attitudes will take longer to change.

There appear to be many psychological and emotional consequences of MSA, including shame, depression, anger, sexual dysfunction and a questioning of the victim's own sexual orientation. Few studies have looked at the most effective treatment interventions for these consequences. Many interventions appear to be short-term, using non-directive techniques that encourage the victims to talk about their experience. This may be a helpful intervention but until there are properly controlled clinical trials it is impossible to state what is the most effective intervention with what type of victim or assault. There is also very little information about any long-term consequences of MSA. The small amount of information available suggests that alcohol abuse and self-harm might be more common in men who have been the victims of MSA. It is, however, impossible to state with any certainty what the consequences might be because of the serious lack of data.

Further research is urgently needed in this area. Priorities might include the epidemiology of MSA, the emotional, physical and psychological consequences and the most effective psychological interventions. Differences between men will also have to be considered; for example MSA may differently affect men from different ethnic backgrounds, or with different in sexual orientations. Clinical priorities are also needed, including the development of comprehensive and multidisciplinary approaches to the management and treatment of male sexual assault.

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