Male victims of sexual assault
An exploratory study

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Summary

Objective: Twenty percent of the male population becomes a victim of sexual assault at least once in their life. Thus far, studies and post-assault care are mostly focussed on female victims. The purpose of the present study was to investigate whether the risk factors for experiencing sexual assault, the use of post-assault crisis care and the need for trauma therapy differ between male and female victims. *Methods:* This study was conducted at a Dutch sexual assault centre and included a sample of 25 male and 25 female victims of sexual assault matched on age and type of sexual assault. Information about risk factors, use of crisis care and referrals were based on retrospective self-report. *Results*: The findings indicated that male victims are more often homo- or bisexual than female victims. No significant differences were found between the genders concerning cognitive disabilities, having divorced parents, having a history of sexual assault or the presence of pre-existing health care. Significantly less male victims used the medical care. No significant differences were found between the genders concerning the use of the forensic or psychological crisis care. Also no differences were found between the genders concerning the amount of referrals for trauma therapy. *Discussion:* The present study showed that homo- and bisexual men seem to be particularly vulnerable for experiencing sexual assault. The present study also suggests a possible improvement concerning more male centred post-assault medical care. More knowledge is essential to facilitate more fitting post-assault care.

Introduction

The lifetime prevalence for experiencing sexual assault is approximately 20 percent in the male population (De Graaf & Wijsen, 2017; Silent Screams Inc., 2014). Yearly, 4 to 7 percent gets confronted with one or more sexual assaults (Black et al., 2011; Merens, Hartgers, & van den Brakel, 2012; De Graaf & Wijsen, 2017). However, the prevalence of sexual assaults that is reported in general practitioners and police registrations seem to underrepresent the actual number of sexual assaults. Using data from the National Crime Victimization Survey, it is estimated that in the period of 2006 to 2010, 65 percent of the sexual assaults went unreported (Langton, Berzofsky, Krebs & Smiley-McDonald, 2012). Among male victims, disclosure seems to be even more difficult than among female victims. A third of the male victims has never disclosed to anyone about the sexual assault, while this is only a fourth of the female victims (De Graaf & Wijsen, 2017). The higher numbers of non-disclosure and less help seeking among men than women can be explained by the commonly held myths and disbeliefs about male victimisation (Young, Pruett & Colvin, 2016).

First, rape has become a widely approached theme since it was addressed as a women's health issue within the rise of feminism. This, however, means that male victims of sexual assault have been neglected by both research and the wider public (Davies & Rogers, 2006). Myths that are commonly held suggest that men cannot be raped or sexually assaulted (Young et al., 2016). The definition of rape is often described as 'involving vaginal penetration', but with this definition men who are raped by men are already excluded as being possible victims (Peterson, Voller, Polusny & Murdoch, 2011). In addition is 'forced penetration', a type of rape in which a woman forces a man to penetrate her against his will, not punished as rape by the current law (Prins & Hondema, 2017). Furthermore, it is often believed that if men are sexually assaulted, they do not develop any distress by the experience and may even find it pleasurable (Peterson et al., 2011). Consequently, there is evidence to suggest that male victims believe that professionals will not be helpful to them because their rape experience does not match stereotypical conceptions of rape (Bicanic, Hehenkamp, Van de Putte, Van Wijk & De Jongh, 2015).

Sex roles are also important contributors to the higher numbers of non-disclosure and less help seeking among men (Dorahy & Clearwater, 2012). Male victims tend to be more blamed by others for their assault. Female victims get judged on characterological factors such as being careless, not cautious or flirty, while male victims get judged on their behaviour prior or during

the assault. Male victims get blamed for not fighting back, appearing scared, failing to escape or not resisting since the societal stereotypes portray men as strong, assertive and able to escape from confrontational situations (Davies & Rogers, 2006).

As a consequence of these myths and the lack of understanding from the social surroundings, male victims seem to experience more feelings of shame and guilt (Davies & Rogers, 2006; Dorahy & Clearwater, 2012). These feelings enhance the difficulties among men for disclosure, help seeking and obtaining treatment services (Davies & Rogers, 2006; Dorahy & Clearwater, 2012). They often prefer hotlines rather than face-to-face services due to their anonymous nature as to protect themselves from possible judgements or disbeliefs (Young et al., 2016). Early disclosure and help seeking is nevertheless of great concern regarding the immediate physical and emotional harm caused by rape which can lead to long-lasting negative psychological consequences if not treated (e.g. post-traumatic stress disorder (PTSD), low self-esteem, depression, anti-social behaviour, substance abuse, risk taking and self-harming behaviour) (Ullman, 2008; Young et al., 2016). For male victims, the risk of developing these symptoms is 20 percent higher than for female victims (Kessler, Sonnega, Bromet, Hughes & Nelson, 1995). Compared to 45 percent of the female victims, 65 percent of the male victims develop PTSD after experiencing sexual assault (Kessler et al., 1995). It has been found that the higher levels of shame and guilt contribute to this increased risk for men to develop PTSD (Wong & Cook, 1992).

Compared to the male victim population, much more research has been done on the female victim population. In the female population, several pre-trauma factors have been found that seem to be associated with an increased vulnerability for experiencing sexual assaults. It has been found that a substantial number of the victim sample were adolescents and reported prior sexual abuse, pre-existing use of mental health services, having divorced parents and/or not living with both biological parents (Bicanic, Snetselaar, De Jongh & Van de Putte, 2014; Brown, Du Mont, Macdonald & Bainbridge, 2013; Campbell, Keegan, Cybulska & Forster, 2007; De Haas, Van Berlo, Bakker & Vanwesenbeeck, 2012; Elwood et al., 2011). Important to highlight is that male victims were often excluded from these studies considering the small amount of male victim population seeking help. On this note, it was not possible to report whether the risk factors are the same for male victims as for female victims.

However, studies including male victims suggest additional pre-trauma risk factors for experiencing sexual assault (Black et al., 2001; De Graaf & Wijsen, 2017; Peterson et al., 2011). It was found that boys and girls with lower intellectual performances were at greater risk for experiencing sexual assault (Black et al., 2001). Moreover, it was found that sexual assault is more common among homosexual and bisexual men (De Graaf & Wijsen, 2017; Peterson et al., 2011). According to a Dutch population study, 18 percent of the homo- and bisexual men has been confronted with sexual assaults concerning manual, oral, vaginal or anal sex against their will at least once in a lifetime, while this was only 6 percent among the hetero men (De Graaf & Wijsen, 2017). Within the female population, no differences were found in the rates of these experiences between lesbian and bisexual women as opposed to heterosexual women (De Graaf & Wijsen, 2017).

The risk groups for experiencing sexual assaults thus seem to differ between male and female victims, as well as their help-seeking behaviour. However, due to the lack of specific research on the male victim population and the smaller number of male victims seeking help, current sexual assault crisis services mainly focus on the care for female victims (Young et al., 2016). Recognition of the specific male risk groups for sexual assault and providing appropriate care for male victims is important since this might facilitate psychological recovery and prevent re-victimisation in the future (Young et al., 2016). It is therefore important to gain insight in the current differences in help-seeking behaviours between male and female victims and their need for help. This way the current care is evaluated and can function as a baseline for improvements for the appropriate care.

The present study has three aims. First, the present study will examine whether the risk factors for experiencing sexual assault differ between male and female victims. Based on prior studies, the following factors will be compared: sexuality, intellectual performances, whether or not the parents are divorced, history of sexual assault and pre-existing use of health services (Bicanic et al., 2014; Black et al., 2001; Peterson et al., 2011). It is expected that the association between experiencing sexual assault and homo- and bisexuality is stronger for male than for female victims (De Graaf & Wijsen, 2017; Peterson et al., 2011). In this aim, it is important to control for the effect of age on the history of sexual assault since the possibility of having experienced sexual assault increases with the increase of age. In addition, it is important to control for the effect of age on the pre-existing health services as younger children seem to make

more use of health services than adolescents (Copeland et al., 2015; Yu et al., 2008). This difference relies on the changes in insurance and the fact that elementary and high schools have an important role in identifying problems and providing services for children (Copeland et al., 2015; Yu et al., 2008). Secondly, the present study compares the use of medical, forensic and psychological post-assault crisis services between the male and female victims. It is expected that male victims make less use of the medical and forensic post-assault crisis services than female victims, due to their preference for hotlines rather than face-to-face services (Young, 2016). Thirdly, a comparison between the male and female victims will be made in the number of recommended referrals for psychological trauma therapy at the end of the crisis care. It is expected that male victims might more often need psychological trauma therapy than female victims, due to the increased risk for developing PTSD among male victims of sexual assaults (Kessler et al., 1995; Wong & Cook, 1992).

The results will provide a closer look into the specific services and special focusses the male victims might need, which may be different from the current post-sexual assault care that is mainly focussed on female victims.

Methods

Participants

The study was conducted at the Dutch sexual assault centre '*Centrum Seksueel Geweld*' (further to be referred to as '*CSG'*) which is located in the University Medical Centre Utrecht (UMCU). The CSG is a multidisciplinary centre combining 24/7 acute medical, forensic and psychological services for anyone who believes that he or she has been a victim of a recent (< 7 days) sexual assault. The participants of this study were either referred to the CSG by themselves, their direct environment, the police, medical practitioners or other professionals like psychological or social health services. Ninety-two percent of the male and 75 percent of the female victims reported rape as the experienced assault. Every victim that used the emergency care services in the period of January 2012 to December 2017 was included in the study. The study included a total number of 428 participants, consisting of 25 men and 403 women. The average age of the male participants was 18.72 years (SD= 9.48) with a minimum of 6 and a maximum of 47 years. The average age of the female participants was 22.46 years (SD= 9.61) with a minimum of 2 and a maximum of 59 years.

All victims were anonymised and specific details of the assault were omitted. The ethical approval of the study falls within the ambit of the Dutch Law for Medical Treatment Agreement (Wet Geneeskundige Behandelingsovereenkomst, WGBO) to which the UMCU is connected (Centrale Commissie Mensgebonden Onderzoek, 2017). According to this law, no individual permission of the client is needed for retrospective research on client files, as long as the information cannot be traced back to the client. The approval is grounded on the fact that the participants are not physically involved in the study and on the fact that the information was not collected for scientific purposes. The participants were also not required to (not) do anything for the study apart from what was needed for the emergency care (Centrale Commissie Mensgebonden Onderzoek, 2017).

Procedure

During admission, all victims were offered a psychological stress reaction monitoring process during the first four weeks post-assault. This monitoring is called "watchful waiting" and is the recommended approach for early intervention after a traumatic event as set out by the NICE guidelines (National Institute for Clinical Excellence [NICE], 2005). The watchful waiting approach entails an inventory on the stress reactions related to the assault and was carried out by telephone calls. The victim or their parents/formal care givers (when victim is younger than 14 years) gets appointed to a case manager of the CSG who has contact with the victim once in the first seven days post-assault. The follow-ups take place on the second and fourth week post-assault in which the case manager screens for PTSD symptoms. When the case manager detects a need for further diagnostics and/or therapy, the victim will be referred for active treatment. During the watchful waiting, information concerning demographic and victim characteristics, the type of assault and use of crisis services were collected. The information about these variables thus relies on retrospective self-report. Information that remained unclear and detailed information concerning the use of emergency services were deducted from the medical and clinical files of the clients. At the end of the watchful waiting process, the information was transcribed and registered in the CSG database for the purpose of descriptive research.

Demographic and victim characteristics

The victims were asked about their gender (male/female), age and the presence or absence of cognitive disabilities (yes/no). The victims were also asked to confirm current use of mental health services (yes/no) and prior negative sexual experiences (yes/no). No questions were asked concerning the sexual orientation of the victims, but when this information was reported by the victim, it was added to the database as heterosexual or homo-/bisexual.

Rape characteristics

The victims were asked to describe the sexual assault. Their response was categorised into either sexual touching or rape.

Services and referrals

Information was retrieved about the victim's post-assault use of the medical services (yes/no), involvement of the police (yes/no) , engagement of the client in the watchful waiting process (yes/no) and whether or not the client was referred for further help after the emergency care ended (yes/no).

Data analyses

Missing data and outliers

For the categorical variables, missing data and outliers were checked to search for deviating scores and mistakes in registrations. For 'sexuality' a large amount of data was missing because the victims were not actively asked to provide information about this variable. However, the data for sexuality was known for 28 percent of the female and 32 percent of the male victims and was included for exploratory purposes.

Statistical analyses

All statistical analyses were conducted using the Statistical Package for Social Sciences (IBM SPSS Statistics for Windows, Version 22.0. Armonk, NY: IBM Corp.). To compare the two groups, every male victim was matched to a female victim who was of the same age and reported the same type of sexual assault (sexual touching or rape). Consequently, the sample consisted of 25 males and 25 females, resulting in a total number of 50 participants. The gender was converted into dummy variables with the female gender as reference group (0) and the male gender as the experimental group (1).

Descriptives in the form of frequencies and percentages were computed to describe the risk factors, emergency care and number of referrals of the sample population. Means were used for the continuous variable age. Frequency counts and percentages were used for the categorical variables 'sexuality', 'history of sexual assault', 'cognitive disabilities', 'divorced parents', 'presence of pre-existing health care', 'type of sexual assault', 'medical care', 'police involved', 'watchful waiting process' and 'referrals'. Chi-square analyses were conducted to compare the risk factors (sexuality, cognitive disabilities and divorced parents), the use of emergency services and the number of referrals for further help between male and female victims. A binary logistic regression was conducted to compare the risk factors 'prior sexual abuse' and 'pre-existing health services' between the male and female victims while controlling for the effect of age.

For the chi-square analyses, the assumptions for independence and expected frequencies were checked. The assumption for independence was met. However, the assumption of expected frequencies was violated for all variables and instead, Fisher's exact test was used. Regarding the binary logistic regression, the assumption of multicollinearity among the independent variables and the assumption for linearity of the relationship between the independent variables and the log odds were both checked and met.

Results

Matching the sample population

The male and female sample population were matched on the victim's age at the time of the assault and the type of sexual assault (sexual touching or rape). Table 1 compares the mean age, the standard deviation, the maximum and minimum age and the frequencies of the reported type of sexual assault for both genders.

Table 1
Mean age, standard deviation, maximum age and minimum age and frequencies of the reported sexual assault for the female (N = 25) and male (N = 25) sample population

	Age				Type of sexual assault	
	Mean	SD	Minimum	Maximum	Touching	Rape
Female	18.92	9.42	6	47	4%	96%
Male	18.72	9.48	6	47	4%	96%

Descriptives

Table 2 shows the distribution of the researched variables over the male and female sample population.

Table 2

Descriptives of risk factors, emergency care and referral for the female (N= 25) and male (N= 25) sample population

		Gender			
		Female		Male	
		N	*%*	*N*	*%*
Sexuality					
	Heterosexual	7	28%	3	12%
	Homosexual	0	-	5	20%
	Unknown	18	72%	17	68%
Cognitive disabilities					
	Yes	3	12%	7	28%
	No	21	84%	15	60%
	Unknown	1	4%	3	12%
Divorced parents					
	Yes	8	32%	9	2%
	No	8	32%	3	36%
	Unknown	9	36%	13	12%
History of sexual assault					
	Yes	9	44%	5	20%
	No	11	36%	13	52%
	Unknown	5	20%	7	28%
Pre-existing health care					
	Yes	14	56%	10	48%
	No	10	40%	12	40%
	Unknown	1	4%	3	12%
Medical care					
	Yes	24	96%	19	76%
	No	1	4%	6	24%
Police involvement					
	Yes	22	88%	18	72%
	No	3	12%	7	28%
Watchful waiting process					
	Yes	23	92%	21	84%
	No	2	8%	4	16%
Referrals					
	Yes	22	88%	15	60%
	No	2	8%	5	20%
	Unknown	1	4%	5	20%

Risk factors

To test whether the risk factors for experiencing sexual assault differ between male and female victims a Fisher's exact test was conducted for the risk factors 'sexuality', 'cognitive disabilities' and 'divorced parents'. The results showed that male victims of sexual assault are significantly more often homo- or bisexual than female victims (*p= .02, one-sided Fisher's exact test*). No significant difference was found between the genders concerning cognitive disabilities (*p= .29, two-sided Fisher's exact test*). Also no significant difference between the genders was found concerning having divorced parents (*p= .25, two-sided Fisher's exact test*).

A binary logistic regression was conducted to test whether the risk factors 'history of sexual abuse (yes/no)' and 'pre-existing health care (yes/no)' differ between male and female victims when controlled for age. The results of the binary logistic regression indicate that there is no significant association between gender and the history of sexual assault when controlling for the effect of age (*B*= -.12, *SE*= .84, *p= .16*). Also no association was found between gender and the pre-existing health care services when controlling for the effect of age (*B*= .-12, *SE*= .60, *p = .38*).

Emergency care

To test whether the male and female victims make use of different post-assault crisis services a Fisher's exact test was conducted for the variables 'medical care', 'police involved' and 'watchful waiting'. Significantly less male victims made use of the medical care than female victims (*p= .05, one sided Fisher's exact test*). No significant difference was found in the amount of victims that made use of police services between the males and females (*p= .15, one-sided Fisher's exact test*). Further, no significant difference was found in the amount of victims who made use of the watchful waiting process between males and females (*p= .67, two-sided).*

Referral

To test whether male victims would be referred for trauma therapy more often than female victims, another Fisher's exact test was conducted. The results of the Fisher's exact test indicate no significant differences in the number of referrals between the male and female victims (*p= .14, one-sided Fisher's exact test*).

Discussion

The current study examined the differences between male and female victims of sexual assault regarding risk factors for experiencing sexual assault, use of post-assault crisis services and number of referrals for further psychological help after the crisis services. The results showed that male victims are more often homo- or bisexual than female victims of sexual assaults. This finding is in line with the Dutch annual rates of sexual assault (De Graaf & Wijsen, 2017). The finding provides support for homo- and bisexuality among males as a risk factor for experiencing sexual assaults and the need for more research among this particular group (Peterson et al., 2011). The gender of the intimate partner may influence this risk for victimisation, since the majority of the perpetrators is male (De Graaf & Wijsen, 2017). Homo- and bisexual men have more intimate relationships with men in adulthood than heterosexual men do, which may place them at higher risk for domestic violence and sexual assault (Balsam, Rothblum & Beauchaine, 2005). Lesbian and bisexual women, however, have fewer intimate relationships with men in adulthood, which may place them at lower risk for these experiences (Balsam et al., 2005).

Furthermore, the results showed that male victims made less use of the offered medical care than female victims. This finding is in line with the idea that male victims are more likely to use hotlines from for example voluntary organisations, rather than professional face-to-face services due to the commonly held stigmas that men cannot be sexually assaulted and if so, that they either find it pleasurable or get blamed for not fighting back (Young et al., 2016). As a consequence of these stigmas, male victims experience higher levels of guilt and shame (Davies & Rogers, 2006; Dorahy & Clearwater, 2012). Hotlines would therefore be preferred above face-to-face services because of their anonymous nature which protects the victims from possible judgements or disbeliefs (Young et al., 2016). Using the medical care from the current post-assault crisis services means a registration in the hospital and health insurance systems, making male victims lose their anonymity. This could be a contributor for male victims not to use the offered medical care. It suggests a point of possible improvement towards more male-centred post-assault crisis services.

The present study found no differences between men and women regarding the risk factors of cognitive disabilities, having divorced parents, earlier experiences of sexual assault and the presence of pre-existing health care. Concerning the association between these factors and the increased vulnerability for experiencing sexual assaults previously found in women, the lack of

differences in the current finding might imply that the factors increase the risk for experiencing sexual assaults equally for both men and women (Bicanic et al., 2014; Black et al., 2001; Brown et al, 2013; Campbell et al., 2007; De Haas et al., 2012; Elwood et al., 2011).

Also no differences were found in use of post-assaults crisis services, other than for medical care. The lack of difference between men and women regarding police involvement differs from the expectation that male victims would less often report the assault to the police than female victims, due to the resistance of the male victims towards face-to-face contact (Young et al., 2016). The current finding may be explained by the fact that the police was one of the centre's primary referral sources which indicates that the police was already involved. Moreover, the collaboration between the case manager and the police may have lowered the male victims' threshold to report to the police. The close collaboration between the different disciplines has been found to prevent victim blaming and thus empowers the victims in their decision to report to the police (Campbell, Patterson & Bybee, 2012). The finding that there was no difference between the groups in use of the watchful waiting process by phone is in line with the finding that male victims prefer hotlines rather that face-to-face contact (Young et al., 2016). It suggests that the watchful waiting process attracts men as well as women. This is a positive note to the current services.

At last, no difference was found between male and female victims concerning the number of referrals for trauma therapy after screening for PTSD symptoms. This result is not in line with the findings that male victims of sexual assaults are at increased risk for developing PTSD (Kessler et al., 1995; Wong & Cook, 1992). It has been found that victims who wait longer than 1 month to disclose the assault are more likely to suffer from PTSD and depression compared to early disclosers (Bicanic et al., 2015). It is imaginable that due to their higher levels of guilt and shame, plus their belief that professionals will not be helpful to them, male victims commonly delay to disclose about the sexual assault. In general, the risk for developing PTSD among men compared to women enhances this way (Bicanic et al, 2014; Bicanic et al., 2015). However, the lack of differences in the current finding may be explained by the fact that the victims included in the study all reported the assault within 7 days, thus reducing the risk for developing PTSD.

Few limitations of the study should be acknowledged. Research in the area of male victims of sexual assault is difficult. There are only few males that report their victimisation of sexual assaults to professionals. Therefore the present study was limited in its sample. Not only

was the sample size small, the population was also limited to the victims who reported their victimisation within 7 days post-assault and who then made use of the services of the Dutch sexual assault centre in Utrecht. Due to the small sample, the amount of missing data may have had an increased influence on the results. However, these limitations demonstrate the importance of further research.

In conclusion, the present study suggests that homo- and bisexual men are particularly vulnerable for experiencing sexual assault. The findings also suggest a possible improvement concerning more male centred post-assault medical care. To study risk factors and help-seeking behaviour of the male victims of sexual assault is of great clinical relevance. Research has already shown that male victims of sexual assault experience more difficulties compared to females. It would not only be harder to disclose but also to recover from the sexual assault. Therefore more studies are needed to gain more knowledge and enhance acknowledgement. This will also help to facilitate more fitting post-assault care, for example, more anonymous.

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