Effects of Sexual Assaults on Men: Physical, Mental and Sexual Consequences

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Research addressing the sexual assault of men is a fairly recent development in the medical, health care, psychological and sociological literature. Research in both community and institutionalized populations has focused on documenting the existence of this phenomenon and establishing prevalence or incidence rates, however, understandings of effects on male victims lag behind those regarding women. Only recently have the consequences of sexual assault victimization for men been thoroughly addressed. This review summarizes the research literature concerning the physical, mental health, and sexual consequences of sexual assault victimization for men. The literature suggests a range of possible/occasional consequences, but no well-established patterns of injuries, psychological/emotional reactions or sexual responses/adjustments for male sexual assault victims.

Keywords: victimization, sexual assault, injuries, male sexual assault victims

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This paper presents an overview and summary of the consequences of male sexual assault. At present there are few discussions of the physical, mental health and sexual consequences for men who are sexually assaulted (however, see Davies, 2002 for a "selective review of the ... prevalence and effects of male sexual assault victims" [p. 203]). The present discussion presents an update to the existing literature and a more focused discussion of the health consequences than is presently available. The intent is to provide both scholars and practitioners with a concise resource for guidance on what to expect in cases of reported male sexual assault so as to facilitate formulating effective, efficient and sensitive systems for receiving and responding to reports of men's sexual victimization.

Research addressing sexual assault/rape of men did not appear until less than 30 years ago (and, most of the early literature focuses on male children rather than adults [e.g., Josephson, 1979]). Although a few studies addressing sexual assault in correctional facilities were available prior to 1980, it was not until the early 1980s that any research specifically addressing the consequences of "male rape" in the community

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appeared. Most of the sexual assault/rape literature that is available focuses on female victims/survivors.

The existing literature encompasses both documentation and estimates of rates of men's victimization and clinical assessments of consequences of victimization. However, public perceptions of, and education about, male sexual assault in the free community continue to lag behind that which is known about sexual assault victimization of females.

To date the most comprehensive discussion of the consequences of sexual assault for men is that provided by Davies (2002). In this overview, drawing on the research published prior to and including the year 2000, the author shows that community and service providers' reactions to male sexual assault victims are often dependent on the victim's sexual orientation and the perpetrator's gender. Also included are discussions of the difficulties such victims may experience in (and in deciding to) report their victimization, stigmas service providers may apply to reporting victims, and the importance of service providers to be cognizant of such experiences and to work to overcome or alleviate such obstacles. Davies' discussion is organized around identifying the ways such reactions are constructed and the effects of such on service provision. What Davies does not provide is a discussion organized around the varieties of consequences for male victims, specifically the physical, mental health and sexual consequences that may be experienced by victims.

In pursuit of providing both scholars and service providers with a concise overview of the diverse consequences male victims of sexual assault experience, the discussion that follows draws from a diverse body of literatures, informed by medical, health care, forensic, psychological, sociological and criminological research. This discussion is intended to provide scholars and practitioners with a comprehensive overview of the physical, mental health and sexual consequences of the sexual assault of males. Discussion begins with a review of what is known about the prevalence of male sexual assault and an overview of the likelihood of men to report their victimization (and reasons for not reporting).

Prevalence of Male Sexual Assault

The currently available research literature on male sexual assault has a primary focus on documenting the existence of such events. The research literature suggests that a significant number of men do report at least one instance of sexual assault. One community-wide epidemiological study in Los Angeles reported 7.2 percent of men were sexually assaulted (after age 15) at least one time (Sorenson, Stein, Siegel, Golding & Burnam, 1988). Elliott, Mok, and Briere (2004) report that among a stratified random sample of the American population 3.8 percent of men report sexual assault victimization during adulthood (with 61% of these men also reporting a sexual victimization during childhood). An Australian study using data from a representative sample of more than 10,000 men shows a sexual victimization rate of 4.8 percent for adulthood and 2.8 percent for childhood. In the United States, data from the National

Violence Against Women Survey showed three percent of men had experienced some form of sexual victimization (Desai, Arias, & Thompson, 2002; Pimlott-Kubiak & Cortina, 2003). Martin and colleagues (1998) report a 6.7 percent sexual victimization rate among male members of the U.S. Army. Three clinic based studies in the United Kingdom report rates of 6.6 percent adult victimization (Keane, Young, Boyle, & Curry, 1995), 8 percent victimization during adulthood and 12 percent during childhood (Coxell, King, Mezey, & Kell, 2000) and 2.89 percent and 5.35 percent adult and childhood victimization rates (Coxell, King, Mezey, & Gordon, 1999). Also from the United Kingdom, Plant, Plant, and Miller (2005) report a sexual abuse rate of 3.2 percent for men post age 16 and 11.7 percent for victimization prior to age 16. Other research, reviewing cases in hospital emergency rooms or rape crisis centers suggests between four percent and 12 percent of sexual assault victims are male (Forman, 1983; Frazier, 1993; Grossin, Sibille, Grandmaison, Banasr, Brion, & Derigon, 2003; Kaufman, Divasto, Jackson, Voorhees, & Christy, 1980; Pesola, Westfal, & Kuffner, 1999; Riggs, Houry, Long, Markovchick, & Feldhaus, 2000; Scarce, 1997; Stermac, Sheridan, Davidson, & Dunn, 1996).

Research with college student samples has reported rates of victimization suggesting between one in five and one in eleven males being victims of some form of sexual victimization. Struckman-Johnson (1988) reported 16 percent of a sample of male undergraduates had been pressured or forced to have sex at some point in life. Tewksbury and Mustaine (2001) reported 22.2 percent of male undergraduates at 12 universities had been victimized by some form of sexual assault and 8.3 percent had been a victim of a "serious sexual assault" at some point in time. Similar results (14%) have also been reported with a British sample of college students (Davies, Pollard, & Archer, 2001).

Others (Hickson, Davies, Hunt Weatherburn, McManus, & Coxon, 1994; Island & Letellier, 1991; Krahe, Schutze, Fritscher, & Waizenhofer, 2000; Waterman, Dawson, & Bologna, 1989) have reported sexual assault victimizations among gay/bisexual men dating or in relationships with other men. These studies have reported rates of victimization ranging from 12 percent to 27.6 percent.

It is important to acknowledge, however, that most researchers believe that male sexual assault (perpetrated by any variety of assailant) is severely under-reported, perhaps even more so than sexual assaults of women (see discussion below).

Stermac, del Bove, and Addison (2004) report that few differences are seen between men sexually assaulted by a stranger and those assaulted by an acquaintance, with the exception that those who are victimized by strangers are more likely to be single, to be assaulted in an outdoor location, and, if the assault is reported, it is so in a shorter period of time (Stermac et al., 1996). Some scholars (and other observers), however, believe that male sexual assault is primarily an occurrence between homosexual men, similar to either heterosexual date rape or marital rape. Support for this view comes from the research that suggests that gay and bisexual men are over-represented among male victims (Keane et al., 1995; Mezey & King, 1989) and others who also report that either current or former intimate partners are responsible for 65 percent of sexual assaults on gay/bisexual men (Hickson et al., 1994).

One commonly reported correlate of men's sexual victimization as adults is the high rate of these men to have also been sexually victimized during childhood. Two major studies, drawing on data from both the United Kingdom (Coxell et al., 1999) and the United States (Desai et al., 2002) have shown a strong correlation between childhood sexual victimization and subsequent adult sexual victimization. Coxell et al. (1999) report that consensual childhood sexual experiences are also statistically related to men's adult sexual victimization. Additionally, Elliott et al. (2004) report that among a representative community sample, 61 percent of men who report a sexual victimization during adulthood also report having been sexually victimized as a child.

Reporting and Seeking of Services

Throughout the literature there is both frequent discussion of what scholars believe to be under-reporting of male sexual assault victimization and documentation of research subjects that have never reported their victimization (to law enforcement, health care, mental health, or social services providers). Numerous reports suggest that male sexual assault victims (both adult and child) are far less likely to report their victimization than are female victims (Calderwood, 1987; Hodge & Cantor, 1998; Kaufman et al., 1980; McLean, Balding, & White, 2005). However, this differential rate of reporting may be dissipating or disappearing (McLean et al., 2005). Individuals sexually assaulted during childhood, however, are more likely than those assaulted as adults to subsequently seek mental health services (Golding, Stein, Siegel, Burnam, & Sorenson, 1988). Often, but not universally, implicit is the belief that victims anticipate rejection and authorities not to believe them if they should report. Central to the discouragement to report are issues of stigma, shame, fear, and a belief victims may have their sexuality questioned (Anderson, 1982; Scarce, 1997).

Several sets of researchers (King & Woollett, 1997; Lacey & Roberts, 1991; Walker, Archer, & Davies, 2005) have reported that men who are sexually assaulted and seek mental health services frequently do not do so for lengthy periods of time. King and Woollett (1997), drawing on data from 115 men sexually assaulted in the community, show a mean of 16.4 years between victimization and seeking of mental health services. Lacey and Roberts (1991) report fewer than one-half of victims reported the incident or sought services within 6 months, and an average of approximately 2.5 years passed between occurrence and seeking of services. Walker et al. (2005) reported that 12.5 percent of victimized men never disclosed their victimization to anyone, and among those who did disclose, 54 percent did not do so for at least one year. However, Pesola et al. (1999) report that among male sexual assault victims seeking services in a New York City (Greenwich Village) hospital emergency department, 94 percent do so within 36 hours.

It is not uncommon, especially for victims who do not have serious physical injuries, for male sexual assault victims to deny victimization (Kaufman et al., 1980; Scarce, 1997). Denial directly links to a low likelihood of reporting or seeking services (medical and/or mental health) following victimization. Or, when seeking medical or

mental health services victims may do so by claiming an alternative reason or need, or will do so and be very vague in explaining injuries and requests for services.

One major problem identified in the research literature, however, is that many rape crisis centers either explicitly refuse services to male victims, or are highly insensitive to male victims needs (Donnelly & Kenyon, 1996). Furthermore, when services are offered for men they are rarely designed specifically for men; one study of service availability reports that only five percent of programs that serve male victims have any programs or services specifically designed for men (Washington, 1999). It is not surprising, then, that male sexual assault may be severely under-reported.

Physical Consequences of the Sexual Assault of Men

At the baseline level, men who report having been sexually assaulted as adults (post age 16) report poorer physical health statuses than men who do not report adult sexual victimization (Plant et al., 2005).

Most research suggests that the sexual assault of men is more likely to be violent, and accompanied by more and greater corollary injuries, than sexual assaults of women (however, also see Kimerling, Rellini, Kelly, Judson, & Learman, 2002; and McLean et al., 2005). Here it is important to acknowledge that not all sexual assaults are violent, and often center on coercion of victims. However, "rapes" in the traditional sense of the word have been shown to be more violent when perpetrated against male victims. King (1995) reported that when men are raped in almost all instances some form of physical force is used against the victim, and weapons are commonly involved. Weapons are most likely to be involved when men are sexually assaulted by a stranger (Stermac et al., 2004). Kaufman et al. (1980), describing data drawn from male rape survivors seen in hospital emergency rooms, report men who are sexually assaulted are more likely than women to have nongenital injuries (see also Hillman, Tomlinson, McMillan, French, & Harris, 1990). However, they also conclude that men who are sexually assaulted are not likely to seek medical attention, unless they suffer significant physical injuries.

Only one study to date (Lipscomb, Muram, Speck, & Mercer, 1992) compares the experiences and consequences of men sexually assaulted in the community (n = 19) with those sexually assaulted while incarcerated (n = 80). This study suggests that men sexually assaulted while incarcerated are less likely to be assaulted with a weapon (67.5% vs. 31.6% report no weapon involved), and to have their assault be either only oral or a combination of oral and anal penetration (62.5% vs. 52.6%). And, although not a statistically significant difference, men sexually assaulted while incarcerated may be more likely to exhibit an absence of physical trauma resulting from their assault (75% vs. 58% having no physical trauma observed by examining health care professionals). Hodge and Canter (1998) reporting on cases in the community report that gay male sexual assault victims are more likely than heterosexual male victims to sustain serious injuries.

Studies of the incidence of physical trauma or injuries of male sexual assault victims suggest that while some victims do experience significant physical injuries, a majority of victims do not. Five studies in hospital emergency rooms report disparate results for the presence of injuries. Genital or rectal trauma is reported in 35 percent of male victims in a Denver-based study (Riggs et al., 2000). However, "general body trauma occurred more often than genital trauma" (p. 360) with approximately two-thirds of victims having some form of general injury. A second study, in a NYC hospital emergency room reports 25 percent of male sexual assault victims have some form of "documented trauma or physical injury" (Pesola et al., 1999). Stermac et al. (2004) report that 45 percent of male sexual assault victims seen in a large, urban Canadian hospital-based sexual assault care center present with some type of physical injuries. The most common type of injury was some form of soft tissue injury (approximately 25% of male victims), most frequently seen in the perineal and anal areas. Also, 20 percent present with lacerations. Grossin et al. (2003), however, report that only 5.6 percent of male sexual assault victims seen in a French medical clinic suffered any type of genital trauma. And, McLean, Balding, and White (2004) report that 66 percent of a sample of 376 cases of male sexual assault victimizations in Manchester, UK are rapes, with 18 percent of the sample presenting with anal injuries. However, these researchers also report that fewer male than female sexual assault victims present with non-genital injuries.

Among men who are anally penetrated during sexual assault, a majority (63%) who present to health care professionals do exhibit at least one form of rectal injury (Ernst, Green, Ferguson, Weiss, & Green, 2000; Hillman et al., 1990; however, also see McLean et al., 2004). The types of injuries seen include tears of the anus, abrasions, bleeding, erythema, hematoma, discoloration with tenderness, fissures, the presence of dirt, vegetation or hair in the anus, engorgement, and friability. It is important to note that no male victim had "gross active bleeding on examination of the external genitalia" (p. 434), although fully 18 percent of victims reported such had occurred prior to seeking medical care (Ernst et al., 2000).

Injuries to victims may also come as a result of assailants' means of controlling victims. One-third of victims in Struckman-Johnson et al.'s (1996) Nebraska study reported having been restrained during their assault. Not infrequently the act of restraint itself can lead to injuries. Also, abrasions to the throat and abdomen may be common, as these are consequences of victims being held down and attempting to resist (Shiff, 1980). Bruises, broken bones and black eyes may be found, as these can be indications of "submissive injuries" (striking the victim in a way that will quickly and effectively subdue them) (Shiff, p. 1499). Stermac et al. (2004) reported that in addition to perineal/anal area injuries, other common locations for injuries are head/neck/face (16% of victims), leg/knee/feet (10%), and arm/hands (15%).

Male sexual assault victims also report somatic symptoms, including tension headaches, nausea, ulcers, and colitis (Anderson, 1982; Rentoul & Appleboom, 1997). In some cases male sexual assault victims have also been identified as hypochondriacal (Anderson, 1982).

A number of symptoms have been reported by male sexual assault victims, although few are unique to this population, and no constellation of symptoms has yet to be identified as indicative of sexual assault victimization. Included among the symptoms reported have been decreased appetite and weight loss (Anderson, 1982; Huckle, 1995; Mezey & King, 1989), nausea and vomiting (Huckle, 1995; Mezey & King, 1989), constipation and abdominal pain (Goyer & Eddleman, 1984; Mezey & King, 1989) and fecal incontinence (Shiff, 1980). One study of long-term consequences of sexual victimization among adolescents suggests that for boys there is a relationship between sexual assault victimization and sleep difficulties, depression, somatic complaints, alcohol, drug and tobacco use, suicide attempts, and violence (Choquet, Darves-Bornoz, Ledoux, Manfredi, & Hassler, 1997).

There is also evidence in the literature of the transmission of sexually transmitted diseases as a result of male rape (Hillman et al., 1990, 1991). However, while instances of STDs being transmitted during a sexual assault have been documented, they are also infrequent and involved only a very small proportion of sexually assaulted men (Lacey & Roberts, 1991). Others have documented that men with a history of sexual victimization are more likely to (at some point in time) acquire a sexually transmitted disease (deVisser et al., 2003).

While some identification of symptoms and physical markers/consequences have been identified, there is very little guidance provided in the research literature regarding prevalence of encountered injuries, what clinicians can/should expect to encounter with "typical" male sexual assault victims or other consequences that may be reported. Similarly, while some medical literature (Josephson, 1979; Schiff, 1980; Wiwanitkit, 2005) purports to present guidance on how to conduct examinations of male victims, and where examinations should focus, these discussions are brief and lacking in specifics and details. Finally, readers are cautioned that the findings of studies conducted in clinical settings need to be viewed as representing only a subset of the population of male sexual assault victims; as reported above, most male sexual assault victims do not seek services, therefore studies based on those who do seek services need to be viewed and generalized with caution.

Mental Health Consequences of the Sexual Assault of Men

Scarce (1997) reports that in his review of the available research on male rape there is no "typical" emotional/psychological response. Rather, responses range from apparent calm and composure to near complete emotional breakdown. However, men who are sexually victimized are more likely than non-victimized men to display psychological disturbances. Male children who are sexually victimized are more likely than victimized adults to report mental health problems. King, Coxell, and Mezey (2002) report that men victimized during childhood have a 2.4 times greater likelihood of reporting psychological disturbance and men victimized as adults have a 1.7 times greater likelihood of psychological disturbance than non-victimized men. Similarly, Burnam et al. (1988) report that among a cross-sectional probability sample of more than 3,000 adults in two Los Angeles communities, not only is sexual assault victim-

ization related to later onset of depression, anxiety disorders and substance abuse, but the likelihood of such consequences are greater for men victimized as children, rather that for those first victimized as adults. And, the presences of such consequences are also statistically significant predictors of subsequent sexual assault victimization.

More specifically, drawing on a stratified random sample of the American population, Elliott et al. (2004) report higher scores on the Trauma Symptom Inventory for sexually assaulted men than women. On eight of the ten scales of the Inventory, sexually assaulted men report higher levels of distress than sexually assaulted women. Depression also frequently leads to attempts to self-medicate (Burnam et al., 1988; Choquet et al., 1997; Coxell et al., 1999; Iseley & Gehrenbeck-Shim, 1997; Plant, Miller, & Plant, 2004; Ratner et al., 2002; Walker et al., 2005) in efforts to block out memories or overcome feelings of low self-worth (Scarce, 1997). Self-medication includes use/abuse of alcohol, illicit drugs and licit (both prescription and over-the-counter) medications. Male sexual assault victims are more likely than female sexual assault victims to report subsequent alcohol abuse problems, although abuse of illicit drugs does not show a gender difference (Burnam et al., 1988). Additionally, researchers in both England (Plant, et al., 2004) and Australia (deVisser et al., 2003) report that sexually assaulted men are more likely than other men to smoke tobacco.

The most common emotional response of men to sexual assault victimization is a sense of stigma, shame, and embarrassment, and, at least in part, because of such perceptions male sexual assault victims more often than not "cope" while displaying a "calm, composed and subdued demeanor" (Rentoul & Appleboom, 1997, p. 270). King et al. (2002) also report that subsequent self-harming behaviors are more likely for males victimized as children (as compared with adult victims). Compared with non-victimized men, rates of self-harm are 3.7 times higher for men sexually victimized as children and more than twice as likely to be seen in men victimized as adults. Clearly, shame is directly tied to frequent expressions of self-blame from victims and importantly serves to inhibit reporting or seeking of medical or mental health services.

Men who are sexually assaulted commonly present a high degree of depression and hostility (Iseley & Gehrenbeck-Shim, 1997; Walker et al., 2005). Several community-based studies have shown that male sexual assault victims are, in the short run at least, more likely than female victims to present with greater degrees of depression and hostility (Carmen, Ricker, & Mills, 1984; Frazier, 1993; Goyer & Eddleman, 1984). Depression often includes shame, questions of one's efficacy in general, sexually and in regards to constructions/presentation of masculinity, and changes toward a more negative body image. Not infrequently sleep disturbances (Anderson, 1982; Goyer & Eddleman, 1984), and/or thoughts and attempts at suicide may result (Choquet et al., 1997; Isely & Gehrenbeck-Shim, 1997; Lockwood, 1980; Ratner et al., 2002; Scarce, 1997; Struckman-Johnson et al., 1996; Walker et al., 2005). Suicidal attempts are most likely among adolescent and young adult victims (Calderwood, 1987). And, as reported in numerous studies (see Rentoul & Appleboom, 1997) male rape victims also frequently report heightened levels of anxiety, both related to fears of re-victimization and free-floating. Decreased levels of self esteem among male sexual assault victims is common

(Ratner et al., 2002; Walker et al., 2005). Some observers (Calderwood, 1987) have suggested that men's emotional reactions are at least in part a result of shock as men are not socialized (as are women) to fear and be aware of the risk of rape.

Male sexual assault victims have also been shown to be more ready to acknowledge and express anger and hostility following victimization than female victims (Groth & Burgess, 1980). Expressions of anger and hostility may be directed/focused on nearly any others in the immediate environment, including one's assailant, support system members or caretakers (Anderson, 1982). Withdrawal from social settings and social contacts also commonly occur among male sexual assault victims (Walker et al., 2005).

Victims may also experience rape trauma syndrome (a form of posttraumatic stress disorder). Rape trauma syndrome (RTS) is conceptualized as composed of two phases: acute and long term (however, others [Calderwood, 1987] have conceptualized RTS as a three stage process: acute, re-organization, and latent phases). The acute phase is characterized by a period of extreme disorganization and chaos in the victim's life. The acute phase also is frequently accompanied by physical symptoms, including skeletal muscular tension and pain, gastrointestinal irritability, genitourinary disturbances, impotence and extreme emotional expressions. The long term phase is typically characterized by efforts to re-organize one's life and some form of avoidance/withdrawal behaviors. Long term symptoms of RTS also include nightmares/flashbacks, fear of places similar to where victimization occurred, fear of crowds, and fear/avoidance of consensual sexual activities. Additionally, while RTS is not a universally accepted diagnosis (especially in the judicial system), there are also multiple researchers who have reported male sexual assault survivors near-universally experience some form of posttraumatic stress disorder (Huckle, 1995; Isely & Gehrenbeck-Shim, 1997; Mezey, 1992; Mezey & King, 1989; Myers, 1989; Rogers, 1997).

Effects on Sexuality and Identity

In addition to physical and mental health consequences many sexually assaulted men also report effects on their sexuality and sexual activities. These effects include consequences for how sexually assaulted men think of themselves sexually, as gendered beings and how men construct and manage a sexual identity.

The most common sexual consequence reported in the literature for sexually assaulted men are questions about one's "true" sexuality (Forman, 1983; Huckle, 1995; Isely & Gehrenbeck-Shim, 1997; King & Woollett, 1997; Mezey & King, 1989; Scarce, 1997; Struckman-Johnson & Struckman-Johnson, 1994; Walker et al., 2005). Victims often question whether being raped "makes" them gay and may question whether there is something about them that leads others to perceive them as gay. Perhaps the most serious and significant questions and concerns arise related to sexually assaulted men questioning their "true" sexuality if and when during the course of being assaulted men experience any form of sexual arousal. However, erections are a common involuntary response for many men in times of intense pain, anxiety, panic and/or fear (see Redmond, Kosten, & Reiser, 1983).

Relatedly, men who are sexually victimized (especially those perpetrated against by males) may be expected to question their gender and gender role presentations. Walker et al. (2005) report that 70 percent of a sample of male sexual assault victims report long-term crises with their sexual orientation and 68 percent with their sense of masculinity. These reactions may be most acute for men who hold traditional or stereotypical views about sexuality and gender; to be put into a "homosexual" or "feminine" role may lead to questions about whether one is "sufficiently" masculine. This type of reaction is found among both heterosexual and gay/bisexual men (Garnets & Herek, 1990). Similarly (see Struckman-Johnson & Struckman-Johnson, 1994) men who are victimized by female assailants may question how they could be victimized by a "weaker" female. This too may contribute to questions about gender role fulfillment.

Male sexual assault victims also are likely to report sexual anxieties (deVisser et al., 2003), sexual dysfunction, and possibly impotence, following victimization (Huckle, 1995; Lacey & Roberts, 1991; Walker et al., 2005). For other men periods of frequent sexual activity, including with a number of different partners, is common following victimization (Plant et al., 2005; Walker). Some heterosexual men may also begin to engage in consensual same-sex sexual behaviors following victimization (Walker). Plant et al. report that male sexual assault victims (whether victimized as children or adults) are more likely than their non-victimized peers to report that sexual activity has "interfered with" their everyday lives.

Sexual identity questions and sexual dysfunction are commonly reported consequences of sexual assault for victimized men. While often overlooked, or not recognized for extended periods of time, they may, in fact, be among the most severe and longest lasting consequences for victimized men.

Summary

In sum, the existing literature suggests that men who are sexually assaulted are highly unlikely to report their victimization or to seek medical or mental health services. Among those who do seek services, it is frequently a long time (perhaps one year or longer) after victimization when medical or mental health services are accessed, except in cases where significant injuries are suffered during the assault and immediate care is necessary. When services are sought, those presenting with health care needs often present either due to suffering significant injuries that cannot be ignored or with myriad different symptoms or problems, most of which will either be non-sexual/non-genital in nature or vague and difficult to initially connect to sexual victimization. Because many sexual assaults on men do not involve anal penetration (Hickson et al., 1994; Lacey & Roberts, 1991; Lipscomb et al., 1992; Ratner et al., 2003; Stermac et al., 2004) it may be extremely difficult to identify physical markers of an assault. The mental health status of men who are sexual assault victims can vary quite widely, ranging from highly emotional responses that inhibit normal functioning to very calm and subdued approaches where victims are highly introspective and would not likely be perceived to have suffered trauma. However, depression, anxiety, anger/hostility and on

occasional suicidal ideations/attempts are common. Sexually assaulted men also commonly suffer from sexual dysfunction and questions about their sexuality.

There are no universal signs, symptoms, consequences or markers of sexual assault victimization for men. Some sexually assaulted men will experience some forms of physical injuries, some will experience some forms of psychological/emotional disturbance, and some may experience sexual dysfunction or identity questions. Many sexually assaulted men, however, will not exhibit physical or mental health indications, or will present themselves to service providers under false pretenses or so long after being victimized that connecting symptoms/injuries to sexual assault victimization may not be likely/possible.

In the end, it is important to understand that some sexually assaulted men may not exhibit any visible or identifiable consequences of sexual assault victimization, and that men reporting (or suspected of having experienced) a victimization need to be viewed with an eye toward questioning the cause of any physical or mental health issues that are presented. Because of the nature of many male sexual assaults and the socialized expectations for how men manage and cope with victimization(s), this may continue to be both one of the most under-reported and misunderstood forms of violence and health problems in our society.

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Staff Sexual Misconduct

Submitted by Richard Tewksbury, Ph.D.

Sexual violence and misconduct in correctional facilities is a major problem that harms all aspects of institutional operations. Recognition of this factor is a central component of the Prison Rape Elimination Act of 2003. As a result of this federal act, attention has been brought to all aspects and types of sexual violence/misconduct; numerous resources have been developed and made available; and greater accountability is being imposed on and expected from correctional systems, facilities and administrators.

The Bureau of Justice Statistics (2006) reviewed of 2005 records from 1,867 prisons and jails has identified that staff sexual misconduct accounts for 38.2% of all reported cases of sexual violence and sexual harassment accounts for 17.4% of all reported incidents. These statistics, however, may be only the tip of the iceberg, as they represent only cases brought to the attention of correctional administrators. Additionally, it is important to recognize that most reported cases of staff sexual misconduct are either unsubstantiated by investigation (62%) or shown to be unfounded (17.2%). Undoubtedly, there are many more incidents that are unreported, thus weakening the security of institutions, weakening staff morale and making institutions more dangerous places to work and live.

While there is no one set profile of staff involved in sexual misconduct, we do know that female inmates are more likely than male inmates to be sexually victimized by a staff member, and in prisons female staff account for nearly two-thirds (62%) of involved staff. In jails, female inmates (78%) and male staff members (87%) are the majority of involved individuals. Based on the official reports of sexual misconduct, the Bureau of Justice Statistics reported that 73% of cases in prisons and 56% of cases of sexual misconduct by staff were "romantic"

in nature.

Slightly more than one-half of all reported instances of staff sexual misconduct are report to authorities by inmates. While most (82%) staff involved in sexual misconduct are fired or asked to resign their positions, less than one-half (45%) of involved staff were referred to prosecution. This is despite state laws making staff-inmate sexual contact illegal.

Administrators, and in fact all institutional staff members, need to be aware of the possibilities of sexual misconduct, and the serious threats that can arise from such events. Good correctional policy should call for continuing education of staff and inmates about sexual misconduct and the serious deleterious effects it can have on facility operations, safety and security.

Good institutional policy and procedure needs to address four important tasks:

- **Task #1**: Educate both staff and inmates about what constitutes sexual misconduct, the types of behaviors and events that may signal sexual misconduct is occurring, and the dangers of such misconduct presents to the safety of staff and inmates.
- **Task #2:** Know and publicize policy and law in your system/jurisdiction related to staff misconduct.
- **Task #3:** Establish and publicize a means for staff and inmates to report staff sexual misconduct to the administration of the institution. Preferably, this is a reporting mechanism that allows anonymous reporting — at the very least it must be confidential.
- **Task #4:** Follow through on investigations, administrative responses and referrals to prosecution for staff involved in sexual misconduct. Complete investigations and publicizing outcomes of investigations and referred cases (as much as possible, considering legal restrictions) are critical to communicating to staff (and inmates) that sexual misconduct is taken seriously. Staff members who see that there are serious repercussions for sexual misconduct are likely to be deterred from involvement in such dangerous relationships.

For more information, visit the National Prison Rape Elimination Commission at www.nprec.us.

Check out the Workforce/Human Resources Committee Web Site at http://www.aca.org/committee/home.asp