MALE RAPE – THE SILENT VICTIMS

This literature review examines the issue of male rape and the possible counselling strategies that may assist in recovery. There are several misconceptions surrounding male rape which can result in the under-reporting and secondary or sanctuary victimisation of the survivor. Men who have been raped may believe that it attacks the very essence of what it is to be masculine and male. Many may not seek help unless they perceive a need for immediate attention, such as physical trauma requiring medical assistance.
The literature also reveals that when men do seek help they may be treated poorly. Secondary victimisation or sanctuary trauma results when there is a lack of empathy and understanding of the effect that rape can have on the survivor, such as rape-trauma syndrome. Training in this area is needed for the police, emergency department staff, nurses, general practitioners, and community health services.
Management of survivors starts with examining our own beliefs about male rape. Many of the reported counselling strategies are based on therapists' observations, trauma theories, and research related to child abuse or sexual assault of females which may not be transferable to men who have been raped. Education and counselling of survivors' support networks must be considered as part of a holistic approach to management. Secondary prevention strategies aimed at the broader community are required to assist survivors to come forward without fear of further victimisation because of stereotyping. By **Colin Derek Ellis**

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Introduction

Australian figures on male rape are not available, with most studies originating in the United States of America or the United Kingdom. However, a common theme throughout the extant literature is that the true incidence of male rape is under-reported. Many male rape survivors accessing health or emergency services do so because of severe physical and/or psychological trauma that requires immediate treatment. In New South Wales in 1997/98, the approximate ratio of women to men presenting at sexual assault services was 10:1 (Hodge & Canter 1998, Isely et al 1998, Tomlinson & Harrison 1998, Anderson 1999, Mitchell et al 1999, Pino & Meier 1999, NSW Health 1999).

Washington (1999) reported that approximately 5% to 10% of men were raped each year in the USA. This figure was supported by Anderson (1999) who quoted statistics from an unspecified

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number of American rape crisis centres which indicated that 6% to 20% of their cases were men. One report estimated that approximately 27% of homosexual men had been raped (Poropat & Rosevear 1992, Scarce 1997, Isely et al 1998, Anderson 1999, Mitchell et al 1999, Washington 1999).

Perpetrators and patterns of offending

Male rape can be perpetrated by both sexes, although little has been reported about female perpetrators. In the case of male perpetrators, common myths revolve around the sexuality of the individual and the survivor of his assault. The literature revealed that male and female perpetrators could be heterosexual or homosexual, and that male perpetrators seldom raped for sexual gratification, the rationale being predominantly related to power, dominance, and control through humiliation and degradation (Hodge & Canter 1998).

Rape survivors have reported being forced to have anal and/or oral sex, although the nurse, doctor, or counsellor needs to be aware of other sexual acts that may have been performed or attempted. The survivors are likely to have been held captive, with most attacks occurring away from home. Some research has argued that perpetrators who raped gay men were known to the survivors, possibly in a form of date rape (Hodge & Canter 1998, Mitchell et al 1999). However, this has been disputed by other research that concluded that the perpetrator was usually unknown to the survivor regardless of their sexuality (Hodge & Canter 1998). In addition, a survivor may have been raped by an individual or gang-raped (Hodge & Canter 1998, Mitchell et al 1999, Pino & Meier 1999, Peel et al 2000).

Apart from the physical violence of the attack, which may result in external and internal trauma, survivors are also exposed to hepatitis, HIV, and other sexually transmitted infections (STIs). It has been reported that 7% of perpetrators told their victims they would contract HIV or AIDS from the rape (Isely et al 1998, Tomlinson & Harrison 1998).

Culture factors

Male rape survivors do not always seek help unless they consider that the trauma is severe enough to warrant attention. Failure to report being raped can often be due to assumptions and misunderstandings on the part of the individual survivors and the communities in which they live; for instance, that men do not get raped because they are strong and can fight off an attacker. This belief attacks the core of what it is to be male and to be masculine. A survivor who cannot fight back may be seen to be homosexual, or less of a man. Survivors may report that they had an erection, or even ejaculated. For heterosexual and homosexual males, especially in adolescence, erection and ejaculation have been shown to support internal conflicts regarding sexuality (McMullen 1990, Davies 1996, Scarce 1997, Hodge & Canter 1998, Isely et al 1998, Tomlinson & Harrison 1998, Mitchell et al 1999, Peel et al 2000).

Unfortunately 'second assault', a term introduced by Williams and Holmes in 1981, is a real possibility. This has also been termed secondary victimisation or trauma. However, a more appropriate term may be 'sanctuary trauma' (Hart et al 1998) in that the victim is further traumatised in environments in which he should feel safe, such as emergency departments, police stations, or at home. Reports on this phenomenon have emanated from the experiences of survivors who received negative responses from people to whom they turned for help, such as the police, doctors, nurses, counsellors, friends, and family members. Many of these support people believed in the myths mentioned earlier, which in turn influenced their responses by stereotyping and thus further victimising the survivors. Sexual assault services based on feminist-orientated methodology and treatment modalities have been shown to provide additional problems as they focus primarily on the perpetrators being male and survivors being female. Some services are for women only, and although male survivors may prefer female counsellors, this is not always the case. Centres that do provide assistance to men are reported to have few or no male staff. This can result in the individual being poorly served and possibly re-victimised by the very people from whom he requires support (Raphael et al 1996, Yee et al 1998, Anderson 1999, Pino & Meier 1999, Washington 1999).

An ethno-religious culture or background that feeds into self-blame or is related to a fatalistic belief system may be a further factor in the failure of men to report rape (DeVries 1996, Rogers 1999). However, further research in this area is required.

New South Wales has legislation that refers to the unlawful penetration of the vagina or anus, and includes foreign objects being inserted. Oral sex and cunnilingus are included within the legislation. It should be noted that each State and Territory within Australia has legislation in regard to sexual assault and that these may differ from NSW legislation. In some countries, however, the law does not recognise male rape. The UK made changes to legislation in 1994 to include anal penetration, but this legislation still ignores oral penetration or other sexual acts (Salmelainen & Courmarelos 1993, DeVries 1996, Rogers 1999).

Presentations

The Diagnostic and Statistical Manual IV (American Psychiatric Association 1994) provides possible medical diagnoses for survivors of trauma such as rape that include 'acute stress disorder' and 'post-traumatic stress disorder' (PTSD). However, it does not address specific responses to rape, for example 'rape trauma syndrome' or 'rape-related post-traumatic stress disorder' (RR-PTSD). Such diagnoses may assist the nurse, doctor, or counsellor in knowing what symptoms may present. It is important to understand that although an individual may not meet

the specific criteria for a diagnosis, this does not necessarily mean that the person has no need for help, nor does it give an indication of the level of help that is required. One third of all rapes (male and female) may result in the survivor experiencing RR-PTSD, resulting in two thirds not meeting the criteria for a medical diagnosis (National Center for Victims of Crime and Crime Victims Research and Treatment Center 1992, Healy 1993, Isely et al 1998, Peel et al 2000).

Using the medical model, the 'rape trauma syndrome' concept can be useful in providing an outline of the possible experiences of the survivor. The US National Center for Victims of Crime and Crime Victims Research and Treatment Center (1992) have suggested that one third of all rape survivors develop RR-PTSD sometime in their life time. Table 1 compares RR-PTSD with rape trauma syndrome as defined by the Fourth Conference on the Classification of Nursing Diagnoses (Kim & Moritz 1982, Healy 1993, Anderson et al 1998, Isley et al 1998, Tomlinson & Harrison 1998, Anderson 1999, Peel et al 2000).

Taking into account that most male rape survivors do not disclose what has happened to them, descriptions of RR-PTSD and rape trauma syndrome can provide a generalised medical understanding of the experience of rape. Figure 1 provides other possible considerations that can have an effect on survivors. However, these descriptions do not include gender differences due to the lack of research in this area. Men may have to deal with issues surrounding their masculinity, sexuality, and sexual dysfunction, each possibly overlapping with the other. There also needs to be awareness of and strategies to identify and respond to the possibility of attempted suicide (McMullen 1990, McFarlane & Yehuda 1996, Scarce 1997, Pino & Meier 1999, Washington 1999).

Counselling techniques

Counselling techniques for male survivors of rape have been poorly researched. It has been suggested that techniques used for female survivors of rape may be considered for males (Washington 1999). However, there is little evidence to confirm that these techniques are transferable between the genders, or if a comparison could or should be made between child sexual abuse and rape. Men often do not present unless the symptoms are believed to be severe enough to warrant medical or psychological attention. Therefore the timing of presentation for assistance impacts on their needs as well as the types of intervention required (Isely et al 1998, Tomlinson & Harrison 1998, Pino & Meier 1999, Washington 1999).

Using a concept based on trauma counselling, men who present immediately or soon after the rape could benefit from the use of the principles of psychological first aid (see Table 2). These principles are based on establishing a connection with the patient and where possible removing him from harm. Bearing in mind the possibility of sanctuary trauma, the patient should be reconnected to his support network as soon as possible. The survivor should be given time for defusing or debriefing and encouraged to have a feeling of control throughout his immediate and future care. When indicated, and noting that men are reluctant to participate, he should be linked with resources including counselling (Raphael et al 1996). This may need to be provided alongside medical interventions and legal considerations, the latter varying between States and Territories (Isely et al 1998).

Education and general counselling of the client is also vital; this includes normalising the feelings he is experiencing and providing clear explanations regarding his psycho-physiological responses to rape such as erection or ejaculation. The client needs to know that fear and direct genital stimulation, including rubbing of the prostate gland during anal sex, may result in physical arousal to climax (Guyton 1991, Ochberg 1993, Isely et al 1998, Tomlinson & Harrison 1998, Mitchell et al 1999).

With the possibility of secondary victimisation from health or emergency services, the survivor may require the additional assistance of an advocate. Most sexual assault services are focused on the female as survivor, leaving men who are raped at a disadvantage. Considerations are required as to the gender of the therapist and/or other service providers involved. The male client will require clear explanations for the need of and rationale for any invasive medical assessment which might compound the trauma experienced, such as rectal or oral examination. It is important that the client is given control during any interventions (Ochberg 1993, Tomlinson & Harrison 1998, Yee et al 1998, Mitchell et al 1999).

There is a necessity to respect and work with the client to develop a therapeutic alliance. This alliance will need to help the man to consider the appropriate interventions and techniques to be used, noting that the therapy will be chosen and adapted to suit the individual. It is also necessary to note that the client may experience a state of crisis at any time and on more than one occasion, and therapists

TABLE 1: DEFINITIONS FOR RR-PTSD (National Center for Victims of Crime and Crime Victims Research and Treatment Center 1992) AND RAPE TRAUMA SYNDROME (Kim & Moritz 1982)

Four major elements of rape-related post-traumatic stress disorder	Four major elements of rape trauma syndrome
• Continually re-experiencing the trauma, eg. nightmares, dreams, and flashbacks • Social withdrawal, eg. numbing, denial, amnesia • Avoidance behaviours • Increased physiological arousal, eg. hypervigilance, exaggerated startle response	• Rape trauma: anger, guilt, embarrassment, fear of violence, death, humiliation, wish for revenge, somatic reactions, avoidance, and/or nightmares • The compound reaction: as above but can include use of alcohol and/or other drugs, or recurrence of other pre-existing conditions • The silent reaction: this may occur in place of rape trauma and compound reaction. Symptoms can occur but the client denies or refuses to discuss the trauma

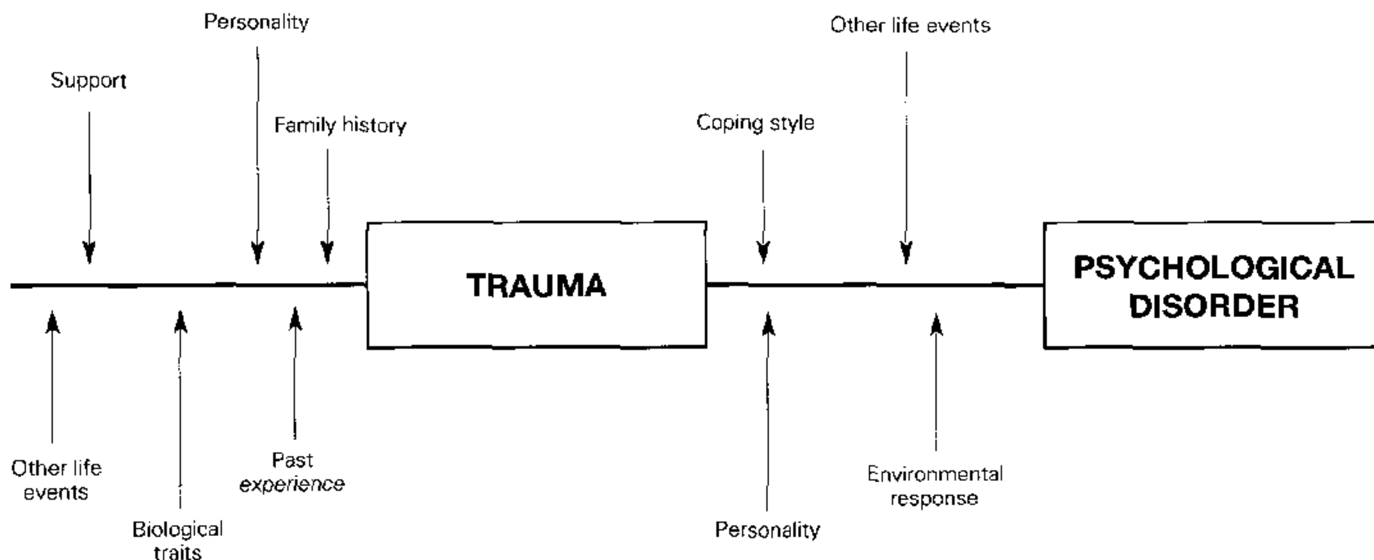

Figure 1: Aetiological factors influencing the transition from distress to disorder (adapted from McFarlane & Yehuda 1996)

must take into account and ensure the client's emotional and physical safety at all times (Herman 1992, Kinchin 1994, Reynolds & Allison 1996, Tomlinson & Harrison 1998).

As noted earlier, counselling techniques for men who have been raped are poorly researched and provided. This is due to the sensitive nature of the event, community stereotypes of male sexuality, and the small number of men who report the event. The literature generally discusses counselling techniques that have been observed to be useful for survivors of other forms of trauma, and are primarily drawn from cognitive behavioural and psychoanalytic therapies. Although other theories may exist, these are the main ones identified within the trauma literature reviewed. The rationale for the use of these medical and behavioural theories is based on the need to reduce the severity of the symptoms presented. Therapeutic goals are aimed at reducing hyperarousal and/or the re-experiencing of the event, and social re-integration and regaining a sense of self. Although therapists from either type of theory may claim that each can stand alone, it could be argued that a combination of techniques be drawn from each. This may be more beneficial as generally men may find it more difficult to talk about what has happened to them than to act on what is happening. An example could be that 'Michael' finds it hard to talk about how he felt being powerless, but he finds it easier to use a cognitive behavioural technique to help him confront being powerless. This combination would provide a more individualistic approach tailored to the symptoms and needs presented (Hartman & Burgess 1993, Ochberg 1993, Lindy 1996, Rose 1996, Turnbull & McFarlane 1996, Ellis 1997, Rothbaum & Foa 1998, Barker-Collo et al 2000).

Techniques taken from other counselling theories, such as narrative, multimodal, existentialist, Gestalt, transactional analysis, neuro-linguistic programming, and family therapy, could provide additional help for men who have been raped. However, each of these also requires further research as there is little evidence to support one model over another, and what research is available is primarily based on clinical experience and descriptive studies. Once again a combination may be more useful; for example, using a Gestalt model of therapy but being open to experimenting with other approaches allows the counsellor to tailor interventions to the needs of each client. In the case of narrative therapy, externalising and deconstructing the experience helps the client to challenge negative meanings and thus to reconstruct alternatives, in this case what is meant by masculinity or being a survivor. Concern has been raised over using techniques that cause the client to re-experience the traumatic event and thereby re-traumatise the client. White (1995) and Harker (1997) believed that using narrative therapy provided a safe way to look at the individual's construct of a situation. White (1995) acknowledged that distress can occur during this therapy, but argued against the notion of re-traumatising the client (Ochberg 1993, Bott 1996, Hossack & Standidge 1996, Mackewn 1996, Palmer 1996, van Deurzen-Smith 1996, Harker 1997).

Existentialists focus on the philosophy of meaning, of life and death: in other words, on what the event means to the client. Both narrative and existentialist approaches may or may not be useful for those experiencing anxiety or panic attacks, but their methods of assisting the

TABLE 2: PRINCIPLES OF PSYCHOLOGICAL FIRST AID (adapted from Raphael et al 1996)
Comfort and console the victim
Keep the person safe from further trauma where possible
Establish physical needs and provide them where possible
Connect person with his own support network
Allow time for defusing or debriefing
Link person to resources, eg. support agencies
Facilitate a sense of control for the victim
Identify needs for additional counselling

individual to tell his story could be useful. Ochberg (1993) suggested that clients who reach a stage of searching for philosophical meaning are uncommon and that such therapies may be useful for some clients further along the time-line of their experience (Ochberg 1993).

Family therapy may be another consideration for male survivors of rape. Clearly, as indicated earlier, there needs to be a way of connecting the client with his support systems such as family and friends, at the same time reducing the effects of secondary or sanctuary trauma. Family therapy acknowledges that violations against an individual have an impact on his immediate support network and community (Ochberg 1993, Raphael et al 1996, Washington 1999).

Although medications need to be prescribed by a medical officer, it remains important for nurses and counsellors to be aware of the reasons for and effects of medications being used.

Multi-modal therapy has the opportunity of bringing other therapies together for the benefit of the individual. It takes into consideration the psychological and physical wellbeing of the client, noting that these also are interconnected. Therapy acknowledges the need for nutrition, exercise, and medications where warranted, thus allowing the client to work on several levels at the same time (Ochberg 1993, Palmer 1996).

Arguments exist between clinicians and between services about the preferences of men to engage in group therapy to assist with their emotional healing. These conflicts can arise from the type of group developed, such as male only or male/female combined, and whether groups should include adults who are survivors of child sexual assault. The issue of male rape is sensitive and men generally only seek one-to-one help when there is no alternative. The number of men who have survived rape in a specific geographical area is also unknown, and whether men in a specific location would seek help in that same area is questionable due to concerns about their identity and confidentiality being compromised. For some men it is difficult to engage with other men because of the nature of the attack. Washington (1999), however, noted that there is benefit in re-engaging with other men in a safe environment. If accessing specific men's groups is not possible, it is argued that accessing a group for both genders may be useful, although problems may exist in regards to the acceptance of male survivors by women. A combination of individual and group therapy may be of use or individual therapy followed up with group therapy, but once again the numbers accessing services are believed to be low resulting in a vicious circle (McMullen 1990, Linehan 1993, Ochberg 1993, Ellis 1997, Washington 1999).

Medications may be required for the control of some physical or emotional symptoms. Although medications need to be prescribed by a medical officer, it remains important for nurses and counsellors to be aware of the reasons for and effects of medications being used. Knowing when a referral to a medical officer is indicated is also necessary. Additionally, it is necessary to ascertain whether male clients are using non-prescription medications, illegal drugs, and/or alcohol because of the possible increased use of these at times of great stress (Poropat & Rosevear 1992, Davidson & van der Kolk 1996, Hammersley & Beeley 1996).

Conclusion

There is little international research on male rape or on counselling responses that are effective. Understandably this is a very sensitive area and researchers' access to survivors or perpetrators is limited due to the low numbers of men who report such violations either to the police or health care services and their need for confidentiality to be protected. Knowledge in this area is primarily drawn from therapists' observations or small studies by health organisations, the majority of information being based on studies that have focused on female rape or a history of childhood sexual abuse of males and females.

The incident of male rape in Australia is unknown due to under-reporting of such incidents. Men who have been raped are reluctant to seek help for a variety of reasons related to common myths surrounding gender stereotyping, and confusion about men's possible psychophysiological responses during an attack. Survivors and perpetrators can be heterosexual or homosexual, and it is theorised that, as with female rape, the main causative factor of male rape is the perpetrator's need for control and dominance rather than sexual gratification.

Because society generally holds myths about gender and sexuality, men and women who have been raped can be further traumatised by clinicians, counsellors, and organisations from whom they seek help. This has been termed secondary or sanctuary victimisation, and needs to be addressed.

It is important for nurses, counsellors, and other health care professionals to be aware that the male rape survivor who is seeking help may have experienced physical as well as psychological trauma. Apart from possible external injuries he may have been the recipient of forced oral and/or anal sex by one or more perpetrators, and may have significant internal trauma. Further, this distress is complicated by the possibility of being infected by sexually transmitted diseases such as hepatitis or HIV. The survivor may not be aware of the possibility of such infection unless advised.

Current counselling techniques vary from therapist to therapist, and it is generally believed that using cognitive behavioural therapy, psychotherapy, or a combination of the two can be used. The effectiveness of these therapies requires careful scrutiny in the treatment of male rape, and therapies taken from trauma and counselling theories may or may not be transferable when counselling male survivors of rape.

Urgent and appropriate research is required in the area of male rape. While the numbers of men presenting or reporting may be small, it is necessary to develop methodologies that can take this into account and permit access to survivors

and perpetrators so as to explore the issues in order to develop well targeted and appropriate prevention, education, and counselling programs.

Equally important is the need for research in the area of secondary or sanctuary victimisation as this covers a broader population, that is both men who have experienced sexual abuse, including survivors of rape, and their support networks. Research in this area needs to examine the attitudes of police, health care providers, and individuals' support networks towards male rape survivors.

Researching the attitudes of the general population towards male rape could be useful in developing a public education program to raise awareness, dispel myths, and help survivors and their support networks.

Education and training is needed to stop sanctuary victimisation. Police and health care workers, in particular those on the front line such as emergency department staff, general practitioners, and community health services, should receive training on working with men who have been raped. Topics to be covered might include: barriers to working with men who have been raped; issues of masculinity and sexuality; psycho-physiological responses to rape; ethical and legal issues; and working with men and their support networks.

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