

Effects of Rape on Men: A Descriptive Analysis

Jayne Walker, B.Sc., John Archer, Ph.D., and Michelle Davies, Ph.D.^{2, 1}

¹Department of Psychology, University of Central Lancashire, Preston, United Kingdom.

²To whom correspondence should be addressed at Department of Psychology, University of Central Lancashire, Preston, Lancashire PR1 2HE, United Kingdom; e-mail: mdavies3@uclan.ac.uk.

Running head: Effects of Male Rape

Correspondence and proofs

Michelle Davies, Ph.D.
Department of Psychology
University of Central Lancashire
Preston
Lancashire
United Kingdom
PR1 2HE

ABSTRACT

Previous studies of the effects of rape on men have focused mainly on clinical populations. This study extended current research by investigating the effects of rape on a non-clinical sample of men recruited from the general population by media advertising. Forty male rape victims were asked to provide details of their assaults, levels of psychological disturbance, long-term effects, and reporting issues. Results revealed that most assaults had been carried out using physical or violent force, in a variety of different circumstances. All of the victims reported some form of psychological disturbance as a result of being raped. Long-term effects included anxiety, depression, increased feelings of anger and vulnerability, loss of self-image, emotional distancing, self-blame, and self-harming behaviors. Findings are discussed in relation to previous research in the area and perceptions of rape.

KEY WORDS: male rape; sexual assault; long term effects.

INTRODUCTION

The occurrence of male rape outside of institutionalized settings, such as prisons, is an issue that has been neglected by society and the research literature (Stermac, Sheridan, Davidson, & Dunn, 1996). It is estimated that the help and support for male victims of rape is more than 20 years behind that of female victims (Rogers, 1998). Official Home Office figures in the United Kingdom regarding the sexual assault of adult males show that although the reporting of male sexual assault is increasing year by year, recorded sexual offences against men are much lower than those recorded against women. In 2002, 4,096 indecent assaults and 852 rapes were recorded against men, compared with 24, 811 indecent assaults and 11, 441 rapes recorded against women³³. However, official figures are grossly misleading when evidence from victimization surveys are considered. Stermac et al. (1996), for example, found that 7.2% of men in a general household sample of the U.S. population had experienced some form of sexual assault. Some research (e.g., Mezey & King, 1989) has found that gay and bisexual men are more likely to report sexual assault by other men than heterosexual men. Hickson, et al. (1994) found that 27.6% of a sample of 930 British gay and bisexual men had experienced some form of sexual assault. In 45% of these cases, the assault committed was anal rape.

Few male rapes appear in police files or other official records. Very few male rape victims report their assault to the police because they think that they will experience negative treatment, be disbelieved, or blamed for their assault (e.g., Hodge & Cantor, 1998; King & Woolett, 1997; Mezey & King, 1989). Further, fear of negative reactions from those to whom they disclose prevents men in many cases from seeking medical attention

³ At the end of 2003, the legal categorization of sexual offences in the United Kingdom was subject to major change. The Sexual Offences Act 2003 includes non-consensual oral as well as anal and vaginal penile penetration as rape. The offence of indecent assault is no longer in statute and has been replaced by two offences: assault by penetration and sexual assault. Assault by penetration includes non-consensual sexual penetration by any object other than the penis while sexual assault covers every other non-consensual sexual

after rape. Frazier (1993) studied 74 male and 1380 female rape victims reporting to a United States hospital emergency department within three days of being raped. The men had more severe physical injuries and were significantly more likely to have been sexually assaulted by more than one perpetrator than the women were. Frazier suggested that men might only report rape to medical services under extreme circumstances, such as gang rape. In some cases, male victims approach medical services for help with physical injuries while concealing the sexual context of their assault (Kaufman, Divasto, Jackson, Voorhees, & Christy, 1980). This means that many male rape victims do not receive testing for sexually transmitted diseases that they may have contracted during their rape.

Research has shown that criminal victimization is not randomly distributed across members of society (Tewksbury & Mustaine, 2001). Victimization is associated with routine and lifestyle activities of individuals, which influence, for example, the amount of exposure a person has to potential perpetrators, and how vulnerable he is as a potential target. Previous research has suggested that gay and bisexual men are more at risk of rape than heterosexual men for two reasons (Davies, 2002). The first is that they are at risk of being raped by dates or while in relationships with men. Hickson et al. (1994) found that current or ex-sexual partners were responsible for 65% of the assaults in their study of gay and bisexual men. Likewise, women who spend more time with men are more likely to be sexually assaulted than those who do not (Tewksbury & Mustaine, 2001). The second reason that gay and bisexual men are more at risk is through homophobic sexual assaults; for example, Comstock (1989) found that 10% of anti-gay attacks involved sexual assault.

Most victimological research on effects of post-rape trauma has focused on female victims, using either the characteristics of the victim (e.g., the victim's age) or the assault (e.g. the severity of the assault) as correlates of trauma and recovery (Frazier & Schauben,

act. Because the data for this study were collected before the changes in law, our definition of rape includes non-consensual anal penetration only.

1994). Frazier (1993) found some differences in the ways that male and female victims coped immediately after the rape. In Frazier's study, male victims reported significantly more hostility, anger, and depression than females did. Frazier concluded that men were more likely to react with anger immediately after rape because anger is a "masculine" way to deal with trauma. However, many male victims reacted with a "controlled" style of coping exemplified by subdued acceptance, minimization of the assault, or denial (Kaufman et al., 1980; Walker, 1993). Kaufman et al. suggested that a controlled reaction reflects one aspect of male socialization, to be emotionally inexpressive to aversive situations. Furthermore, Rogers (1998) suggested that this type of coping strategy renders male victims prone to long-term psychological problems as it makes help-seeking less likely, and denial undermines men coming to terms with their rape.

After rape, most victims experience an increased sense of vulnerability. Some victims become overly concerned with taking safety precautions (Mezey & King, 1989) or change their lives drastically to avoid the possibility of rape happening again. In addition, victims may change the perceptions they have of themselves after rape. They may feel ashamed or blame themselves for their assault. In order to regain their sense of controllability of the world, they may think that they were raped because something they did caused the rape or they were raped because of the type of person they are. Although making sense of the event can be constructive, self-blame can be detrimental to the victim's recovery (Frazier & Schauben, 1994). Self-blaming also affects how people respond to the victim. For example, those who blame themselves are perceived as less well-adjusted and more responsible for the rape than those who do not (Thornton et al., 1988).

There is sufficient research on male victims of rape to note that some negative attributions occur in males above and beyond those expected of victims generally. Many male victims become confused about their sexual orientation (e.g., Mezey & King, 1989).

Research on the effects of rape in male prisoners provides some indication on how men in general react to rape. Lockwood (1980) showed that some of the stress associated with male rape within prison related to the victim's horror of appearing gay or not masculine. For heterosexual victims, the rape may be their first experience of homosexual contact. They may question the extent to which they may have "contributed" to the assault, making attributions such as, "I must be gay" for "letting" the assault occur. McMullen (1990) suggested that it is not unusual for heterosexual victims to seek out homosexual contact after rape or, in contrast, manifest irrational loathing or hatred of all gay men (because they assumed the perpetrator(s) to be homosexual). Walker (1993) reported that 80% of the heterosexual victims in her study reported experiencing long-term crises over their sexual orientation. One victim stated:

Since the assault I have trouble relating to my wife. I have found myself in homosexual relationships that disgust me afterwards...it is almost as if I am punishing myself for letting the assault happen in the first place. (p. 26)

Gay male victims may also experience problems with their sexual orientation. When behavior that is formerly associated with consensual sexual activity becomes associated with violence, gay men can experience difficulty in defining their sexuality in a positive way. They might, for example, experience internalized homophobia or interpret the assault as "punishment" for their sexuality (Garnets, Herek, & Levy, 1990). As in the case of female victims, male victims may perceive consensual sex after rape as "dirty" or they may lose trust in their partners or in men in general. Walker (1993), for example, reported that all of the gay men in her study experienced long-term problems with their sexuality. One victim stated:

Before the assault I was proud to be a homosexual; however, now I feel “neutered”. I feel sex is dirty and disgusting and I have a real problem with my sexual orientation.
(p. 27)

Sexual dysfunction is common in male rape victims, as in females (e.g., Mezey & King, 1989) and can continue for years after the assault. This may cause problems in existing relationships, with partners of the victim having to come to terms with the realities of living with a rape victim. Keane, Young, Boyle, and Curry (1995) reported that 44% of sexually assaulted men reported problems with sexual relationships. Similarly, Mezey and King (1989) reported that half of the 22 victims in their study experienced on-going sexual problems, such as complete aversity to sex or, conversely, sexual promiscuity. Walker (1993) reported that the majority of the men (90%) in her sample had some form of sexual dysfunction that continued in some cases years after the assault. Their sexual problems ranged from complete inactivity to promiscuity or, in 19% of cases, problems with the sexual act, such as fear of “re-creating” the assault either as a victim or perpetrator.

Some male victims perceive a loss of masculinity directly, feeling less of a man. In others, it results in destructive or violent behavior towards others. Anger, revenge fantasies towards the perpetrator(s), or at society in general for being insensitive to him as a male victim are common (Anderson, 1982; Myers, 1989; Walker, 1993).

Although there is enough research on male victims of rape to outline the negative effects of it, it is limited in several ways. First, data are typically derived from very specific samples of men, such as victims contacting counselling services (e.g., Hillman, O’Mara, Taylor-Robinson, & Harris, 1990; King & Woollett, 1997) or emergency departments in hospitals (Frazier, 1993; Pesola, Westfal, & Kuffner, 1999). Much of what is known about the effects of male rape comes from clinical patients, such as those referred to psychiatric services (e.g., Huckle, 1995; Myers, 1989) or men who have presented at GUM clinics or

GP practices (e.g., Coxell, King, Mezey, & Kell, 2000; King, Coxell, & Mezey, 2001).

Some studies have examined male rape in settings other than clinical ones, such as the military (Goyer & Eddleman, 1983). Although useful, assessing the effects of rape in only clinical or very specific samples means that victims who do not belong to these populations have rarely been investigated (Mezey & King, 1989).

In addition, some studies include assaults other than anal rape (e.g., Coxell et al., 2000; King et al., 2001; Mezey & King, 1989), which could confound the findings, as some types of assault may have more serious consequences than others. It is important to control for the type of assault and the age of the survivor, either statistically or by only including certain types of assault in the research design.

The aim of the current research was to provide a detailed descriptive analysis of the nature and effects of rape on a non-clinical sample of men who had been anally raped as adults (over the age of 16 years). Men were recruited from a variety of sources, mainly from press advertisements from around the United Kingdom. They were required to complete a questionnaire detailing firstly the characteristics and nature of the assault (e.g., type of criminal acts committed in addition to anal rape, and type of perpetrator). Secondly, victims were asked their perceptions of the assault (e.g., how they responded during the assault). Thirdly, victims were asked about disclosure to other people, and about medical and legal treatment. Finally, they were asked about long-term effects of the assault (e.g., how the assault had affected their lives). These data provide a more detailed account of the nature and effects of male rape than has previously been published on a non-clinical sample of male victims.

METHOD

Participants

Advertisements were placed in newspapers, magazines aimed at men, and on a sexual abuse victim's page on the Internet. 50 newspapers were contacted but only one national newspaper (the *Daily Telegraph*⁴) was willing to publish the advertisement without payment. Other non-national newspapers, such as *The Big Issue* and *Loot*⁵, were willing to publish it. In addition, three magazines aimed at gay men, and three general magazines aimed at men also published the advertisement. The sexual abuse survivor's Internet page, www.xris.co.uk, is a web site set up as a support facility for abused men. The advertisement gave brief details of the aims of the study and contact details of the first author. A total of 52 responses were received and 73% returned questionnaires. To further enhance the sample, advertisements were placed in five genitourinary departments in England; however, only two responses were received from these sources, making the total sample 40.

At the time of the study, respondents had a mean age of 34 years (range, 19-75 years). At the time of the assault, most victims (70%) were between 16 and 25 years of age. Only one man was over 50 at the time of the assault. The mean age at the time of the assault was 24 years, and the mean time between the assault and participation in the study was 10 years. All respondents reported that they were white and of British nationality.

The majority of respondents had some educational qualifications. Forty two percent had attained O or A levels⁶, a further 28% had attained graduate status, and 12% some level of post-graduate qualifications. However, 17% had no educational qualifications. The majority of respondents were employed at the time of the study: 3% as unskilled workers,

⁴ The *Daily Telegraph* is a British broad-sheet newspaper.

⁵ The *Big Issue* is a current affairs magazine, which focuses on homelessness issues. *Loot* is a magazine in which people place advertisements for various kinds of sales, including cars, furniture, personal services, etc. Both the *Big Issue* and *Loot* have a very wide readership.

15% as semi-skilled workers, 12% as skilled workers, and 28% in professional occupations; 35% of respondents were unemployed at the time of the study.

Of the 40 respondents, 21 (53%) reported that at the time of completing the questionnaire, they identified as gay, 4 (10%) as bisexual, 13 (32%) as heterosexual, and 2 (5%) as asexual. Sixty percent of respondents were not in a relationship at the time of the study; however, 17% reported that they were in a heterosexual relationship and 23% in a homosexual relationship at the time of the study. Regarding their past experiences of sexual abuse, six (15%) reported to have been raped on more than one occasion, and three (7.5%) to have experienced childhood sexual abuse as well as rape as an adult.

Materials

Respondents were asked to complete a test battery that consisted of five questionnaires. The first author developed the first questionnaire in the test battery, the Male Rape Questionnaire (MRQ); see the Appendix for a copy of MRQ items used in this study. Respondents were also required to complete the General Health Questionnaire (Goldberg, 1981), the World Assumptions Scale (Janoff-Bulman, 1989), the Impact of Events Scale (Horowitz, Wilner, & Alvarez, 1979), and the State Self Esteem Scale (Heatherton & Polivy, 1991). The findings from these four standardized questionnaires, and from a comparison group, are presented separately. Rape help-line numbers that could offer counselling were included within the questionnaire booklet. The study was passed as being ethical by the Department of Psychology, University of Central Lancashire, Ethical Standards Committee.

⁶ O-levels (now known as GCSEs) are the UK school-leaving qualifications, taken at age 16. A-levels are further education qualifications, taken at age 18. These are roughly equivalent to the US High School Diploma and Associate Degree respectively.

RESULTS

Characteristics and Nature of the Assault

Victims were asked to indicate several characteristics of the assaults, such as the location in which it occurred, the level of coercion used, the type and number of perpetrators, and the types of assaults committed in addition to anal rape. Table I details the assault characteristics.

Location of Assaults

The highest proportion of assaults took place in the perpetrator's home. In one instance, the perpetrator had offered to put the victim up for the night. The victim was awoken in the early hours of the morning being assaulted by the perpetrator. Assaults were also carried out in the victim's home or in a vehicle. For example, one victim was given a lift by the perpetrator. During the course of the ride, the perpetrator offered a sum of money to have sex with the victim. When he refused the perpetrator produced a knife and made the victim get in to the back seat of the car where he was both orally and anally raped.

The remaining assaults were carried out in the street, public toilets, in the workplace, a party, and, in one case, a health club. In the last instance, five men whom the victim did not know came in to the sauna where the victim was relaxing and took it in turns to anally rape him. The victim was also forced to perform oral sex on all of the perpetrators.

Level of Coercion

Some form of coercion was reported in most cases. Physical force (e.g., kicking, punching, and slapping) was used in more than half the cases. Four also involved the use of a weapon (e.g., knife, baseball bat, and in one case, a gun). In addition, the threat of HIV infection was used against six of the victims. The majority of the victims experienced physical injuries during the assault, including anal lacerations and bleeding, bruises, broken

bones, knife wounds, and burns. Only 14 of the victims sought medical treatment for their injuries and, and only a minority (five) disclosed the sexual nature of the assault during medical treatment (see also below). In seven cases, a non-sexual crime was also committed at the time of the rape (e.g., kidnapping, robbery, and criminal damage). In one of the most violent cases, the victim was attacked with a knife, his body was badly cut and then a noose was put around his neck. His rapists stripped him down to his underpants, poured petrol over his genital area and then set fire to him. He was later anally raped several times by the gang of men and left for dead. In another particularly violent case, the victim was anally raped by three men he met at a party. In between each assault the victim was held down and the assailants took it in turns to burn him with a cigarette lighter. The victim was so severely injured he was hospitalised for one month, spending several days in intensive care.

Type and Number of Perpetrators

Someone known to the victim (e.g., acquaintance, lover, or family member) was responsible for most of the assaults, although strangers carried out a significant number (25%). In most cases (62.5%), one perpetrator raped the victim, although in 25% there were two perpetrators. Three or more perpetrators were involved in the assault in 12.5% of cases.

Type of Assaults Committed

In addition to being anally raped, 55% of victims had also experienced oral penetration by one or more of the perpetrators. In half of the cases, the victim had been masturbated by the perpetrator(s), and, in four cases forced to masturbate the perpetrator(s). In six cases, objects had been used to penetrate the victim.

Insert table 1 about here

Victims' Perceptions during the Assault

Victims were asked to recall certain details of the assault, such as the ethnicity of the perpetrator(s) and their perceived sexual orientation, remarks made by the perpetrator(s) during the assault, and their own responses (e.g., fear, fighting back) at the time of the assault. Table II shows victims' perceptions of the assault and of the perpetrators.

Perceived Characteristics of Perpetrators

The majority of victims (92.5%) recalled the perpetrator(s) being white. Only three perpetrators were non-white. Most victims knew or perceived the perpetrator(s) to be gay (42.5%) or bisexual (12.5%). A total of 22.5% believed the perpetrator(s) to be heterosexual, and the remaining 22.5% said that they did not know the perpetrator's sexual orientation.

Remarks during the Assault

Victims were asked whether the perpetrator(s) made remarks during the assault. A quarter of the men were asked whether they were enjoying the rape. For example, one man was told: "Be a good boy and you will enjoy it". In some cases, attackers told the victim how much they were enjoying the experience, as this man explained:

One said how physically attractive I was and told me how many orgasms he had and how much he enjoyed it. Another talked to me while anally penetrating me and masturbating me about how he and his partner did this and similar awful things to men...

It was also common for perpetrators to verbally abuse the victim during the rape, using misogynistic (e.g., slut, bitch, whore) or anti-gay language (e.g., "you filthy queer"). This man explained how his attacker intimidated him by the use of misogynistic terminology:

He called me a bitch and a cunt—then called me filthy for sucking his penis—which he had forced me to do. He repeatedly said I wanted it.

Another man was subjected to homophobic comments during the assault. The attackers told him that:

I was a filthy queer and that I deserved all I got and he knew I was secretly enjoying it. To each other they shouted out encouragement and egged each other on to do more brutal things to me.

In other instances, the perpetrator(s) tried to act as if the assault was a consensual activity. This man’s attacker, for instance, told him that he was in love with him during the assault:

He told me how much he loved me and that I could never leave him.

Responses to the Assault

When asked what their responses were at the time of the assault, the majority of victims said that they reacted with frozen fear, helplessness or submission. However, 27% said that they were able to put up at fight at some point during the assault. A total of 65% said that they feared for their lives. When asked their responses in the hours and days after the assault, the majority (78%) said that they reacted in a “controlled” style (e.g., calm, composed or subdued). A total of 72% also reported that the sense of helplessness and loss of control during the assault was worse than the sexual aspects of the encounter.

Insert table 2 about here

Disclosure of the Assault to Other People

The men were asked to identify the first person to whom they disclosed their assault. The majority (60%) stated that it was someone they knew, including friends (54%), partners (29%), and family members (17%). Of the remaining 40%, 11 (27.5%) said that it

was a professional, such as a work colleague, health care professionals, social workers, therapist or the police (only five men ever reported their assault to the police; see below). The remaining five (12.5%) said that they had never told anyone until they participated in this study.

The length of time that passed before victims disclosed their assault ranged from a few hours to 20 years. In many instances, there was a long time between the assault and disclosure. Nine men waited between one and five years before they disclosed, six took between five and 10 years, and four men over 10 years. When asked about reactions that they received from the people to whom they disclosed, many reported positive reactions, such as offers of help and support. Others reported lack of support, such as insensitive remarks, or homophobic victim-blaming (such as “you deserved it”, “you asked for it”, or “you enjoyed it”).

Reporting to the Police

Only five men ever reported their assault to the police. Reasons for not doing so are shown in Table III. Of those who did report, only one man said that the police were responsive and helpful. The other four found the police to be unsympathetic, disinterested, and homophobic. They felt that their complaint was not taken seriously and all four regretted their decision to tell the police. Only one perpetrator was subsequently convicted (and sentenced to 10 years imprisonment). However, having gone through a court case, this victim was distressed at the way he was treated in court. He stated that he was made to feel that he--rather than the victim--was the assailant, and that his ordeal in court probably had a worse effect on him than the rape itself. In the other four cases, the police did not press charges.

Medical and Psychological Treatment

Medical services were utilized by 14 (35%) of the men. However, of these, only five reported the sexual context of the assault, the others only disclosing their physical injuries. Of the 14, seven men reported to a genitourinary clinic, six to hospital emergency departments, while one man sought help from his GP. All of these men reported that the attitudes of the medical staff were helpful, understanding, and supportive.

Over half (58%) of the men sought psychological treatment at some point after the assault. However, in most cases help was not sought until long after the assault occurred. Types of treatment comprised counselling, psychotherapy, or psychiatric care. Issues dealt with included sexuality, anger, guilt and shame, and relationship problems. All of the men who sought treatment reported that it was beneficial to some degree. In general, the most helpful aspects of the treatments included being told that it was not their fault, having someone to talk to, and someone to listen and express care and concern. However, even though the men said that the attitudes of therapists were helpful and supportive, they also felt that the professionals lacked the expertise to deal with male sexual assault issues. In addition to psychological treatment, 11 men were prescribed medication, such as anti-depressants, sleeping tablets, or anti-psychotic drugs.

Other Issues Concerning Reporting

The men were asked what advice they would offer to the police and other professionals dealing with male rape victims. The most common responses were to offer the same support to male as to female victims, such as to listen to and believe the victim, and to offer more publicity that men can become victims of rape. Further to these statements, the men felt that professionals should be more empathic to men, and that work should be done to eliminate homophobia within professional services. When asked what support services they would like to see available, the men said that services such as male

rape crisis centres, and support groups in all major towns, 24-hour help-lines, more easily available therapy services, and the police specially trained to deal with male rape victims.

When asked why they had participated in the study, responses focused on promoting informed publicity about male rape. For example, men said that they responded to the advertisement to try to help professionals understand male rape and what victims experience, to bring male rape to the attention of the public, to help future victims, and to establish support for male victims.

The men were also asked whether the fact that the researcher they were in contact with was female made it easier for them to participate: 19 (47.5%) men said that it was, 13 (32.5%) said that it was a little easier, and 8 (20%) said that the sex of the researcher was not an important issue in whether or not they participated, because they did not have to meet her face-to-face. None of the men stated that it would have been easier to participate if the researcher had been male.

Long Term Effects of the Assault

All of the men experienced long term negative psychological and behavioral effects after the assault. Table IV shows the range of effects that the men reported.

The following victim-reports highlight some of the specific reactions to the assaults.

Depression, Anxiety, and Anger

Almost all the men reported depression in the weeks and months following their assaults. This man stated that in the six years after his rape he suffered from periods of severe depression:

I have felt like I have been living in a void since the assault. I suffer panic attacks, mood swings, total depression, but the medical profession have given up on me and said I am too damaged to help. I feel I have no future.

Some form of anxiety was felt by almost all the men after the assault. In some cases, anxiety focused on their interactions with men. As the following man stated:

I am extremely anxious around straight men, especially in social situations. What often can be genuine friendliness on their part can put me on edge and I think they are going to make a move on me.

Another common response to the assaults was anger. This man was still struggling to deal with feelings of anger and revenge fantasies:

In an attempt to deal with my anger, I am attending anger management classes and I also see a psychiatrist. My need for revenge is so strong that it is as damaging as the rape itself. My anger has led me to be a psychological abuser and a bully.

Almost all the men reported that they had fantasized about gaining revenge or retaliation against the perpetrator(s). Some fantasized about killing them. One man recalled that he was so angry that he bought a knife with the intention of killing his assailant; however, he could not go through with it. Another respondent fantasized about buying a gun and shooting his assailant.

Confusion about Sexuality and Masculinity

A total of 70% of the men reported experiencing long-term crises with their sexual orientation and 68% with their sense of masculinity after the assault. This man stated that since he felt that he was capable of handling confrontational situations, being raped was a shock both to his self-image and masculinity:

The sense of powerlessness I experienced during the assault totally surprised me. I thought I was pretty good at handling potentially violent situations as I worked in a night shelter for men. However, I never imagined I could be so vulnerable and become a victim. It was a big shock to my male ego.

The following man similarly wrote of the shock and long-term effects on his self-image and masculinity:

The assault was a threat to my male pride and dignity. It was a shock to find that a so-called “strong man” could become a helpless victim of sexual assault at the hands of another man. My sense of who I was (ex-army) was destroyed for about 10 years.

Another man equated his perceived loss of masculinity with his inability to prevent his assault. He also stated that negative reactions from others reinforced this view:

For a long time after the assault, I felt a failure as a man for not being able to protect myself. Other people’s attitudes reinforced my feelings of inadequacy, so to compensate for my feelings I became aggressive and a bully.

Changes in Sexual Behavior

Several men reported changes in their sexual behavior after the assault. Some became promiscuous, while others refused to have sexual relations with either men or women for a considerable time after the assault. Sexual problems included erectile failure and lack of libido. One described his sexual experience after his assault as one of promiscuity and sexual compulsion:

Before the assault I was straight; however, since the assault I have begun to engage in voluntary homosexual activity. This causes me a great deal of distress as I feel I am not really homosexual but I cannot stop myself having sex with men. I feel as if having sex with men I am punishing myself for letting the assault happen in the first place.

Unlike this man, since his assault the following had not engaged in sexual relations with anyone:

Since the assault I believe I no longer have a sexual orientation. I no longer want a sexual relationship with a man or a woman. I feel sex is a horrible act and just an excuse for an individual to experience self-satisfaction.

Some of the men also expressed confusion and disgust about their sexual responses during the assault. Several of the men reported getting erections and ejaculating during the assault. These men reported that prior to the assault they had equated sexual responses with pleasure; however, after experiencing sexual responses during sexual assault, they felt that, although they were disgusted at the thought of the assault, they must have enjoyed it really because they responded sexually. This (heterosexual) man stated:

If I really thought that the sexual acts I was subjected to during the assault were so degrading and perverse, why did I ejaculate? For a long time I thought I must have really enjoyed it, therefore, I must have homosexual tendencies. I was confused for a very long time.

Loss and Grief Reactions

Almost all of the men reported feeling a loss of self-respect or self-worth after the assault. Some of the men equated losses to their self-image or their feelings of powerlessness as grief. For example, this man wrote:

I don't care about myself any more, if someone could assault me in such a way (*he was anally and orally raped*) how can I be worth anything? The pain I feel is like grieving over the death of a loved one...now a big chunk of me is missing.

Another similarly stated:

The loss of dignity can be quite overwhelming. The very essence of one's character and being has been invaded and treated as worthless, just there for the taking.

Guilt and Self-Blame

Over 80% of the men reported that they experienced profound feelings of guilt and self-blame following the assault. Commonly, these feelings focused on failure to prevent the assault or inability to fight back. Some of the men blamed themselves for willingly putting themselves in a situation where they were vulnerable to assault. For example, this man stated:

For me, the worst part of the assault was I put myself at his hands. I willingly went to his house; hence, I put myself in a vulnerable position. So the blame will always be on my shoulders and the guilt will never go away.

Suicide Ideation and Self-Harm

Many of the men reported partaking in self-destructive behaviors as a consequence of the assault, such as self-harming, suicide ideation or attempts, or abuse of alcohol, drugs, tobacco or food. Twenty-two men reported fantasizing about suicide and 19 had actually made attempts to end their own lives. This man stated:

I dream of killing myself to forget what happened.

Another man reported that his attempt at suicide was at the location where the assault took place (a public toilet):

In an attempt at killing myself, I drove my car into a wall next to the toilets where the assault took place.

Another reported that since the assault he has had both alcohol and eating problems, as well as experiencing mood swings and problems interacting with others:

Since the assault I have developed bulimia and an alcohol problem. I avoid physical contact with people and I have become withdrawn and moody.

Another stated that he self harms and has severe mood swings in an attempt to cope with his problems with sex and relationship difficulties following his assault:

I have a distaste for sex and sexual acts hence I no longer have a full relationship.

This has led me to self harm, have violent outbursts and severe mood swings.

Insert table 3 about here

Resolution

The men were asked how much they felt they had recovered from the assault. Only one man recorded his recovery as complete; 18 (45%), however, said that they had “mostly” recovered. Thirteen (32.5%) described their recovery as “somewhat complete,” and 8 (20%) said that they had not recovered at all.

DISCUSSION

This study provided a descriptive analysis of the experiences of 40 British male rape victims. Previous research on male rape has largely been of a clinical nature or has utilized very small samples. Although still a relatively small sample, due to difficulties in gaining a non-clinical sample of men, this study provided a more detailed account of the experiences of male victims than has previously been available, both in the range of topics the men were asked about, and in the depth of the material that was gained from them.

The demographic characteristics of the men were consistent with previous research. More than 60% reported that they were either gay or bisexual. This is consistent with research that has found that gay and bisexual men are more likely to report sexual assault by other men than are heterosexual men (e.g., Mezey & King, 1989). Previous research has found that gay and bisexual men are more at risk of rape than heterosexual men are, because they are at risk of sexual assault by dating men, and because they are more likely to find themselves victims of anti-gay violence (Davies, 2002). The use of anti-gay language

by some perpetrators in the current study denoted the homophobic context of some of these rapes.

The method of recruitment could have affected the demographic characteristics of the sample. The greater number of responses by gay and bisexual men to the advertisements for this study could have arisen because some had been placed specifically in the gay press. Nevertheless, as only six of the men were recruited from advertisements placed in magazines specifically aimed at gay men and most of the sample came from general sources, such as newspapers, this does not explain the greater number of gay and bisexual men in the study.

The majority of the men were young, between the age of 16 and 25 (mean age, 24) at the time of assault. However, most of the sources of recruitment were general, and newspapers, such as *Loot* and *The Big Issue*, are not exclusively read by young adults. Furthermore, the figures in this study are consistent with other studies (e.g., Mezey & King, 1989; Stermac et al., 1996), and with routine activity theory, in that young men are more likely to put themselves in situations where sexual assault may occur than older men are (Tewsbury & Mustaine, 2001). It is possible that young men are more likely to report sexual assaults, but are no more at risk than older men. Further research is needed to investigate this possibility.

All of the men in this study were white and of British nationality. It is not clear whether this was because white men are more likely to be sexually assaulted than non-whites, because men of ethnic minorities are not as likely to report it as white men are, or because the recruitment method was inadvertently discouraging to ethnic minorities. In a study on the prevalence of sexual assault among a male U.S. student sample, Tewsbury and Mustaine (2001) found that non-white men were more likely to report sexual assault experiences than white men. The current study is, therefore, inconsistent with this research;

however, the two studies are not directly comparable due to the different recruitment methods and sample characteristics. Furthermore, the racial mix of the UK and the U.S. is very different, which might affect prevalence rates of sexual assault among ethnic groups between the two studies.

The majority of assaults took place indoors, namely in the perpetrator's or the victim's home, and someone the victims knew carried out most assaults. This is consistent with research on female rape victims. The locations in which assaults took place are also consistent with routine activity theory. The circumstances of the male rapes described in this study are inconsistent with people's perceptions of what is considered the "stereotypic rape" (Krahé, 2000). Most people view rape as a crime that takes place outdoors, as a violent assault between two strangers (Krahé, 2000). Although the assaults described here were not stereotypical in terms of location or type of perpetrator, the majority of the assaults did involve some form of violence. Physical force (e.g., kicking, punching, and slapping) was used in more than half the cases. The majority of the victims experienced physical injuries during the assault, including anal lacerations and bleeding, bruises, broken bones, knife wounds, and burns. Frazier (1993) suggested that men were more likely to report rape if they had been seriously injured. Thus, the relatively high number of violent assaults could be a result of reporting bias. In addition to being anally raped (which was a condition for inclusion in the study), 55% of victims had also experienced oral penetration by one or more of the perpetrators and, in most other cases, other types of sexual assault were carried out in the course of the rape. In a considerable minority, more than one perpetrator carried out the assault. This is consistent with Frazier's research in which it was found that male victims were more likely to have been assaulted by more than one man than females were.

When asked what their responses were at the time of the assault, the majority of victims said that they reacted with frozen fear, helplessness, or submission; however, just over a quarter of the men said that they were able to put up a fight at some point during the assault. Further, 72% reported that the sense of helplessness and loss of control during the assault was worse than the sexual aspects of the encounter. The findings from this study are consistent with others (Anderson, 1982; Groth & Burgess, 1980; Mezey & King, 1989), indicating that men (like women) react to extreme personal threat with frozen helplessness. The belief that men should be able to fight back during sexual assault contributes to secondary victimization (Williams, 1984). Experimental studies (Davies, Pollard, & Archer, 2001; Howard, 1984a, 1984b) have shown that male victims are blamed more than female victims for rape when they are perceived to have been able to fight back. As the majority of male rape victims cannot fight back, self blame for not being able to do so may contribute to the victim failing to seek help from the police, medical sources or friends and family.

Socialization can also explain the gender difference reported in initial reactions to rape. The majority of female victims are said to display an emotional “expressive” reaction to rape (Burgess & Holstrom, 1974); however, a “controlled” reaction was reported by the majority of men in this study and this is consistent with other studies (Groth & Burgess, 1980; Kaufman et al., 1980; Mezey & King, 1989). It reflects a gender role expectation that it is unmanly for men to express negative emotion even in the face of physical and emotional trauma. The majority of female victims who receive immediate support and ongoing counselling are reported by Burgess and Holmstrom (1974) and Mezey and Taylor (1988) to lose their acute symptoms within one year; however, the reluctance of male victims to tell anyone about the assault, coupled with the lack of counselling and support for male victims, could explain the findings of this study and previous research (e.g.,

Anderson, 1982; Mezey & King, 1989; Myers, 1989), which show that many male victims suffer deep and long lasting psychological and behavioral effects. Although each victim has a different set of long term consequences, common reactions reported include emotional disruption manifested by depression and increased anger. There is also disturbed cognitive functioning taking the form of flashbacks to, or preoccupation with, memories of the assault and increased thoughts of suicide. Psychologically, the victims reported feeling devalued with regard to their identity and self-esteem, and they experienced a disruption in social relations due to feelings of emotional distancing. Victims also reported long-term crises with their sexual orientation, with sexual dysfunction, and suicide attempts.

How representative this sample is of all male rape victims is difficult to determine because the present research is based on victims who responded to media advertising. However, it does offer a valuable insight into the experiences of male rape victims of non-clinical origin, which to date has been missing from the research literature. Future studies might extend the current work to investigate differences between men who have been anally raped, as in the present study, compared with those sexually assaulted in other ways, such as oral rape. Future studies might also investigate the effects of repeat sexual victimization in men, such as those repeatedly sexually victimized in the course of relationship violence, and the effects of sexual violence compared with physical abuse.

REFERENCES

- Anderson, C. L. (1982). Males as sexual assault victims: Multiple levels of trauma. *Journal of Homosexuality*, 7, 145-162.
- Burgess, A. W., & Holmstrom, L. L. (1974). Rape trauma syndrome. *American Journal of Psychiatry* 131, 981-986.
- Comstock, G. D. (1989). Victims of anti-gay/lesbian violence. *Journal of Interpersonal Violence*, 4, 101-106.
- Coxell, A.W., King, M.B., Mezey, G.C. and Kell, P. (2000). Sexual molestation of men: interviews with 224 men attending a genitourinary medicine service. *International Journal of STD and AIDS*, 11, 574-578.
- Davies, M. (2002). Male sexual assault victims: A selective review of the literature and implications for support services. *Aggressive and Violent Behavior*, 7, 203-214.
- Davies, M., Pollard, P., & Archer, J. (2001). The influence of victim gender and sexual orientation on judgements of the victim in a depicted stranger rape. *Violence and Victims*, 16, 607-619
- Frazier, P. A. (1993). A comparative study of male and female rape victims seen at a hospital-based rape crisis program. *Journal of Interpersonal Violence*, 8, 64-76.
- Frazier, P. A., & Schauben, L. (1994). Causal attributions and recovery from rape and other stressful life events. *Journal of Social and Clinical Psychology*, 13, 1-14.
- Garnets, L., Herek, G., & Levy, B. (1990). Violence and victimization of lesbians and gay men: Mental health consequences. *Journal of Interpersonal Violence*, 5, 366-383.
- Goldberg, D. (1978). *Manual of the General Health Questionnaire*. Nfer-Nelson: England
- Goyer, P.F., & Eddleman, H.C., (1984) Same sex rape of nonincarcerated men. *American Journal of Psychiatry*, 141, 576-9.
- Groth, A. N., & Burgess, A.W. (1980) Male rape: Offenders and victims. *American Journal of Psychiatry*, 137, 806-810.

- Heatherton, T., & Polivy, J. (1991). Development and validation of a scale for measuring state self-esteem. *Journal of Personality and Social Psychology, 30*, 895-910.
- Hickson, F.C.I., Davies, P.M., Hunt, A.J., Weatherburn, P., McManus, T.J., & Coxon, A.P.M. (1994). Gay men as victims of non-consensual sex. *Archives of Sexual Behavior, 23*, 281-294.
- Hillma, R., O'Mara, N., Taylor-Robinson, D., & Harris, J.R. (1990). Medical and social aspects of sexual assault of males: a survey of 100 victims. *British Journal of General Practice, 40*, 502-504.
- Hodge, S., & Cantor, D. (1998). Victims and perpetrators of male sexual assault. *Journal of Interpersonal Violence, 13*, 222-239.
- Horowitz, M., Wilner, N., & Alvarez, W. (1979). Impact of Events Scale: Measure of subjective stress. *Psychosomatic Medicine, 41*, 209-218.
- Howard, J. (1984a). The "normal" victim: The effects of gender stereotypes on reactions to victims. *Social Psychology Quarterly, 47*, 270-281.
- Howard, J. (1984b). Societal influences on attribution: Blaming some victims more than others. *Journal of Personality and Social Psychology, 47*, 494-505.
- Huckle, P.L. (1995). Male rape victims referred to a forensic psychiatric service. *Medicine, Science and Law, 35*, 187-192.
- Janoff-Bulman, R. (1989). Assumptive worlds and the stress of traumatic events: Applications of the schema construct. *Social Cognition, 7*, 113-136.
- Kaufman, A., Divasto, P., Jackson, R., Voorhees, H., & Christy, J. (1980). Male rape victims: Non-institutionalized assault. *American Journal of Psychiatry, 137*, 221-223.
- Keane, F. E. A., Young, S., Boyle, H. M., & Curry, K. M. (1995). Prior sexual assault report by male attenders at a department of genitourinary medicine. *International Journal of STD & AIDS, 6*, 95-100.

- King, M., Coxell, A., & Mezey, G. (2002). Sexual molestation of males: associations with psychological disturbance. *British Journal of Psychiatry, 181*, 153-157.
- King, M., & Woollett, E. (1997). Sexually assaulted males: 115 men consulting a counselling service. *Archives of Sexual Behavior, 26*, 579-583.
- Krahé, B. (2000). Sexual scripts and heterosexual aggression. In T. Eckes, & H.M. Trautner. *The Developmental Social Psychology of Gender* (pp. 273-292). New Jersey: Erlbaum.
- Lockwood, D. (1980). *Prison sexual violence*. New York: Elsevier.
- McMullen, R. J. (1990). *Male rape: Breaking the silence on the last taboo*. London: GMP Publishers Ltd.
- Mezey, G., & King, M. (1989). The effects of sexual assault on men. *Psychological Medicine, 19*, 205-209.
- Mezey, G., & Taylor, P. J. (1988). Psychological reactions of women who have been raped. *British Journal of Psychiatry, 152*, 330-339.
- Myers, M. F. (1989). Men sexually assaulted as adults and sexually abused as boys. *Archives of Sexual Behavior, 18*, 205-209.
- Pesola, G.R., Westfal, R.E. & Kuffner, C.A. (199). Emergency department characteristics of male sexual assault. *Academic Emergency Medicine, 6*, 792-798.
- Rogers, P. (1998). Call for research into male rape. *Mental Health Practice, 1*, 34.
- Stermac, L., Sheridan, P. M., Davidson, A., & Dunn, S. (1996). Sexual assault of adult males. *Journal of Interpersonal Violence, 11*, 52-64.
- Tewksbury, R., & Mustaine, E. E. (2001). Life-style factors associated with the sexual assault of men: A routine activity theory analysis. *Journal of Men's Studies, 9*, 153-182.
- Thornton, B., Ryckman, R., Kirchner, G., Jacobs, J., Laczor, L., & Kuehnel, R. (1988). Reactions to self-attributed victim responsibility: A comparative analysis of rape crisis counsellors and lay observers. *Journal of Applied Social Psychology, 18*, 409-422

Walker, J. L. (1993). *Male rape: The hidden crime*. Unpublished honors thesis, University of Wolverhampton, UK.

Williams, J. E. (1984). Secondary victimization: Confronting public attitudes about rape. *Victimology*, 9, 66-81.

Table I

Assault Characteristics

Characteristic	N	%
Victim's age at time of assault		
16-25	28	70
26-30	4	10
31-40	5	13
41-50	2	5
Over 50	1	2
Location of assault		
Victim's home	8	20
Perpetrator's home	18	45
Vehicle	2	5
Street	4	10
Other	8	20
Use of Violence		
No force	4	10
Physical force	21	52.5
Violent force	11	27.5
Weapon used	4	10
Number of Perpetrators		
One	25	62.5
Two	10	25
Three or more	5	12.5
Victim-perpetrator relationship		
Male family member	4	10
Brief acquaintance	8	20
Well established acquaintance	7	17.5
Lover or ex-lover	6	15
Person in position of trust	5	12.5
Stranger	10	25
Sexual acts performed during assault		
Anal penetration	40	100
Anal and oral penetration of victim	22	55
Victim masturbated	20	50
Victim penetrated by object(s)	6	15
Sadomasochistic practices	7	17.5
Victim forced to penetrate perpetrator(s)	17	42.5
Forced to masturbate perpetrator(s)	4	10
Forced to watch sexual assault on another person	1	2.5

Table II

Victims' Perceptions of the Assault

Characteristic	N	%
Perpetrator Ethnicity		
White	37	92.5
Black	1	2.5
Moroccan	2	5
Perceived sexual orientation of perpetrator		
Heterosexual	9	22.5
Homosexual	17	42.5
Bisexual	5	12.5
Unknown	9	22.5
Victim responses during assault		
Frozen fear, helplessness, submission	35	87
Able to fight back	11	27
Fear for life	26	65
Remarks made by perpetrator(s) during assault		
Said nothing or not remembered	13	32.5
Threats if tell anyone	2	5
Victim asked if enjoying it	10	25
Taunts and insults from onlookers	9	22.5
Pretence of love or consensual sex	7	17.5
Homophobic comments	2	5
Instructions on what sexual acts to perform	3	7.5
Perpetrator(s) claimed to have raped other men	1	2.5

NOTE: The total N does not equal 40 in some categories due to some men reporting more than one response to the question.

Table III

Long Term Effects of the Assault

Reaction	N	%
Depression	39	97.5
Fantasies about revenge and retaliation	38	95
Flashbacks of the assault	37	92.5
Feelings of anxiety	37	92.5
Loss of self respect/damaged self image	36	90
Increased sense of vulnerability	36	90
Emotional distancing from others	34	85
Fear of being alone with men	33	82.5
Guilt and self-blame, e.g. for not being able to prevent the assault	33	82.5
Increased anger and irritability	32	80
Low self esteem	31	77.5
Intrusive thoughts about the assault	30	75
Withdrawal from family and friends	29	72.5
Impaired task performance	28	70
Long term crisis with sexual identity	28	70
Damaged masculine identity	27	68
Increased use of tobacco	27	67.5
Abuse of alcohol	25	62.5
Increased security consciousness	23	57.5
Suicide ideation	22	55
Abuse of drugs	21	52.5
Self harming behaviors	20	50
Suicide attempts	19	47.5
Eating disorders, e.g. bulimia, anorexia	11	27.5

Appendix

MRQ Items used in the Study. Due to space limitations, the version included here has been condensed and is not exact to the one used in the study. Please contact the authors for the full version of the MRQ

Item 1-7 inclusive included the demographics, age, ethnicity, sexual orientation, relationship status, occupation, educational level, and age of assault.

Item 8 – place of assault (specify from a list of options)

Item 9 – type of threat used (from no threat to threat with a weapon)

Item 10 – level of force used (from no force to weapon use)

Item 11 – other crimes committed as well as rape (specify)

Item 12 - physical injuries (specific)

Item 13 – was the threat of HIV used (yes/no)

Item 14 – number of perpetrators

Item 15 – type of perpetrators (specify)

Item 16 – age of perpetrators (specify)

Item 17 – details of acts committed using the rape (specify)

Item 18 – perceived sexuality of the perpetrators (specify)

Item 19 – perceived motivation of perpetrators (specify from a list including sexual gratification, power and control, other)

Item 20 – remarks made by the perpetrators during the assault (specify)

Item 21 – remarks made by the perpetrators after the assault (specify)

Item 22 – time of day the assault took place (specify from a list)

Items 23-26 inclusive asked about victim reactions during the assault and were measured by yes/no responses: items included, fighting back, submission, fear for life, and revenge fantasies (if yes to the latter, victims were asked to state the nature of the fantasy)

Item 27 – perceived damage caused by the assault (specify)

Item 28 – reactions immediately after the assault (specify from a list, including: crying, restlessness, calm, subdued, other)

Item 29 – length of time until disclose (specify)

Item 30 – who was the first disclosure to, and this person’s reaction (specify)

Item 31 – details of support from the above person (specify)

Item 32 – details of any negative reactions received from other people disclosed to (specify)

Items 33 – 38 inclusive asked about disclosure to and reactions of the police, including: was it reported, outcome for the perpetrators, reactions of the officers involved, and treatment in court)

Items 39- 41 inclusive asked about medical treatment, including: which facility used, attitudes of the medical staff

Items 42-60 inclusive asked about long-term reactions to the assault, which were answered by yes/no responses. These included: increased vulnerability, anger, crisis with sexuality, loss of self image, emotional distancing, low self esteem, anxiety, depression, self-mutilation, suicide ideation, suicide attempts, increased intake of food, alcohol, drugs or tobacco, experience of flashbacks, experience of intrusive thoughts, security consciousness, withdrawal from friends and family, fear of being alone with men, impaired task performance, and guilt and self blame.

Item 61 – insecurity with sexual orientation (specify)

Item 62 – insecurity about sense of masculinity (specify)

Items 63-66 inclusive – experiences with psychological treatments, including: type of treatment, help and support of treatments, type of prescribed drugs used

Item 67 – has the rape had a lasting detrimental effect (specify yes/no)

Item 68 – specify long-term effects of the assault in own words

Item 69 – degree of recovery (from not at all to completely)

Item 70 – ideally, what support should be available for male rape victims (specify)

Items 71 and 72 – other issues not covered in the questionnaire that the victim felt was important (specify)

Item 73 – What advice would the victim offer to police and other services (specify from a list)

Item 74 – did the fact that the research was female make it easier to take part in the study (much easier to more difficult)

Item 75 – was it worth participating in the research (specify)