

# Self-Efficacy, Male Rape Myth Acceptance, and Devaluation of Emotions in Sexual Trauma Sequelae: Findings From a Sample of Male Veterans

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Sexual trauma is an understudied but regrettably significant problem among male Veterans. As in women, sexual trauma often results in serious mental health consequences for men. Therefore, to guide potential future interventions in this important group, we investigated associations among self-efficacy, male rape myth acceptance, devaluation of emotions, and psychiatric symptom severity after male sexual victimization. We collected data from 1,872 Gulf War era Veterans who applied for posttraumatic stress disorder (PTSD) disability benefits using standard mailed survey methods. The survey asked about history of childhood sexual abuse, sexual assault during the time of Gulf War I, and past-year sexual assault as well as Veterans' perceived self-efficacy, male rape myth acceptance, devaluation of emotions, PTSD, and depression symptoms. Structural equation modeling revealed that self-efficacy partially mediated the association between participants' sexual trauma history and psychiatric symptoms. Greater male rape myth acceptance and greater devaluation of emotions were directly associated with lower self-efficacy, but these beliefs did not moderate associations between sexual trauma and self-efficacy. In this population, sexual trauma, male rape myth acceptance, and devaluation of emotions were associated with lowered self-efficacy, which in turn was associated with more severe psychiatric symptoms. Implications for specific, trauma-focused treatment are discussed.

*Keywords:* sexual trauma, adjustment, self-efficacy, rape myths, Veterans

Until recently, most sexual victimization research has focused on women and children. Fortunately, researchers and clinicians have increasingly recognized that men's experiences must also be accounted for. For example, between 2% and 15% of U.S. men report childhood sexual abuse and 4–8% report

adult sexual victimization (e.g., Elliott, Mok, & Briere, 2004; Kendall-Tackett, Williams, & Finkelhor, 2001). Although many cultural beliefs imply that men are left unaffected by unwanted sexual experiences (e.g., Struckman-Johnson & Struckman-Johnson, 1992), a growing scientific literature contradicts this

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(Davies, 2002). As with women, sexual trauma often leads to multiple adverse consequences for male survivors, including depression, anxiety, substance abuse, and self-harm (Peterson, Voller, Polusny, & Murdoch, 2011). Furthermore, some studies have documented higher rates of psychopathology among male survivors of sexual assault compared with women (Elliott et al., 2004; Kimerling, Gima, Smith, Street, & Frayne, 2007), but male survivors are less likely to seek treatment (Kimerling, Street, Gima, & Smith, 2008).

For both men and women, several theoretical models highlight the role of cognitive factors in explaining posttrauma difficulties (e.g., Brewin & Holmes, 2003; Ehlers & Clark, 2000) and point to the importance of targeting maladaptive beliefs in trauma-focused treatment (e.g., Foa & Rothbaum, 1998; Hoyt, Rielage, & Williams, 2012; Resick & Schnicke, 1993). However, for male sexual trauma survivors, there may also be a unique set of gendered beliefs relevant to their recovery (Peterson et al., 2011). For example, in traditional U.S. culture, men are socialized to conform to masculine norms such as self-reliance and emotional toughness (Mahalik, Good, & Englar-Carlson, 2003). This is especially true for men in military training (Barrett, 1996; Brooks, 2001). Researchers have found that male military personnel tend to report high levels of conformity to these norms (Jakupcak, Osborne, Michael, Cook, & McFall 2006; Robinson Kurpius & Lucart, 2000; Rosen, Weber, & Martin, 2000). What is more, Jakupcak, Blais, Grossbard, Garcia, and Okiishi (2014) found that Veterans who more highly endorsed emotional toughness were more likely to screen positive for posttraumatic stress disorder (PTSD) and depression. In addition, the stress associated with violating traditional gender role norms has been related to higher levels of alexithymia (Jakupcak et al., 2006) and greater self-reported PTSD symptoms (Morrison, 2012) in male Veterans. It is possible that the perceived violation of such masculine norms contributes to men's distress after sexual trauma. Therefore, it was this study's purpose to further explore the role that such beliefs might have in explaining sexual trauma sequelae in male military Veterans.

### Perceived Self-Efficacy

Self-efficacy reflects beliefs about one's ability to exert control over the environment and to master challenging situations (Bandura, 1982). Individuals with poor self-efficacy tend to avoid challenges and are more likely to suffer negative outcomes after major stressors compared with those with high perceived self-efficacy (Benight & Bandura, 2004; Benight et al., 1999; Solomon, Benbenishty, & Mikulincer, 1991; Lerner & Kennedy, 2000). In small samples of women, higher perceived self-efficacy has been associated with lower rates of depression and posttraumatic stress symptoms after attempted or completed rape in adulthood (Regehr, Cadell, & Jansen, 1999) as well as childhood sexual abuse (Cieslak, Benight, & Caden Lehman, 2008).

However, to our knowledge, we are the first to examine the role of self-efficacy in men's postsexual trauma symptoms. We hypothesized that the profound interpersonal violation of sexual trauma might seriously affect a man's sense of control and ability to cope, which in turn would lead to greater levels of distress. On the basis of findings from other trauma popula-

tions, we further hypothesized that lower perceived self-efficacy would mediate associations between sexual trauma and posttrauma psychiatric symptoms. In other words, poor self-efficacy might be the mechanism through which sexual trauma leads to poorer adjustment.

### Male Rape Myth Acceptance

In women, cultural beliefs about rape can influence survivors' perceptions of the assault, leading to feelings of guilt, shame, and self-blame (Roth & Lebowitz, 1988). Adherence to common cultural beliefs about male sexual victimization might also shape men's reactions after sexual trauma. Common myths about male victims include the belief that men cannot be raped, that men are to blame for not escaping, and that men are not seriously affected by sexual assault (Struckman-Johnson & Struckman-Johnson, 1992). Clinically, we have observed that men who adhere strongly to such rape myths will often experience a disruption in their views of themselves and the world if they are victimized; this often translates into a lowered sense of control over events (i.e., self-efficacy) and, in turn, greater psychiatric distress. Thus, in addition to direct effects on postsexual trauma adjustment, adherence to male rape myths could indirectly affect men's adjustment by adversely affecting their perceived self-efficacy. To our knowledge, this is the first study to examine male rape myth acceptance in a sample of male Veterans.

### Devaluation of Emotions

Other cultural expectations of masculinity, such as avoiding and devaluing one's emotions, may also influence men's adjustment after sexual trauma. Traditional views on masculinity suggest that men should be strong and unemotional (e.g., Berkowitz, Burkhardt, & Bourg, 1994; Funk, 1993; Katz, 2006). Such values may be especially strongly held by members of the Armed Forces and indeed are likely necessary in some military settings (e.g., combat). Indeed, Jakupcak and colleagues (2006) found high levels of emotional restriction and fear of emotions in a sample of male Veterans. For men who believe that expressions of emotion are inconsistent with manliness, being confronted with strong emotional reactions after sexual trauma may be particularly difficult (Eisler & Skidmore, 1987). An unwillingness or inability to express or understand emotions might also contribute to feeling out of control (i.e., experiencing a greater loss of perceived self-efficacy) and in turn, greater psychiatric distress.

In the present study, we evaluate the utility of this conceptual model in a sample of male Gulf War I era Veterans who applied for Department of Veterans Affairs (VA) PTSD disability benefits. We have shown elsewhere that perhaps as many as one in five men in this sample experienced attempted or completed sexual assault during the time of Gulf War I alone (Murdoch et al., 2014). Therefore, they are a group of men in whom it is particularly important to identify correlates and predictors of better posttrauma adjustment. Specifically, we hypothesized that (a) perceived self-efficacy would mediate associations between sexual trauma history and psychiatric symptoms and (b) adherence to male rape myths and devaluation of emotions would moderate the association between sexual trauma and self-efficacy such that men who report greater levels of rape

myth acceptance and devaluation of emotions would have a stronger association between sexual trauma and self-efficacy compared with men who report lower levels.

## Method

### Participants

The study was a cross-sectional, mailed survey of male Gulf War I era Veterans who applied for VA PTSD disability benefits between 1990 and 2007. Veterans were defined as a Gulf War I era Veteran if they served in the Armed Forces at any time between August 2, 1990 and July 31, 1991. From a national sampling frame of approximately 47,000 men, we randomly selected 2,653 for survey.

Data collection occurred from July 23, 2007 to July 28, 2008. Surveys with a cover letter that contained all of the elements of informed consent and a cash incentive were mailed to Veterans' home addresses following a modified Dillman (2007) approach. The cover letter emphasized the voluntary nature of the study, and return of the survey signified the Veteran's consent to participate in the study. The Minneapolis VA Medical Center's Human Studies Subcommittee reviewed and approved the study protocol.

Of 1,910 Veterans who returned surveys (response rate = 71.9%), 1,827 (68.9%) were usable (26 Veterans returned surveys after the closeout/analysis date and 57 returned completely blank surveys. All other surveys were used). On average, 56% of respondents were younger than 49 years of age; 55% were White, 25% were Black or African American, and 8% reported Hispanic ethnicity. Seventy-four percent reported some college experience and 68% were married. Ninety-two percent had been in the enlisted ranks during the Gulf War and 67% had deployed to the Gulf. Of these, 81% said they had been exposed to combat in the Gulf (approximately one third of respondents overall).

### Measures

**Sexual trauma exposure.** Participants reported on unwanted sexual experiences during childhood, the time of Gulf War I, and in the past year. Childhood sexual abuse was assessed using three items from the sexual abuse subscale from the Childhood Trauma Questionnaire (Bernstein et al., 1994). Participants rated each of three items on a 5-point Likert scale ranging from 1 (*never*) to 5 (*very often*) to indicate how true each item was for them when they were growing up: "I believe that I was sexually abused," "Someone molested me," and "Someone tried to touch me in a sexual way or tried to make me touch them." Participants were classified as having experienced childhood sexual abuse if they rated any of these three items as 2 (*rarely*) or greater. The three items' internal consistency was .95. Sexual assault during Gulf War I was assessed using three items from the Sexual Harassment Inventory's criminal sexual misconduct scale (Murdoch & McGovern, 1998) plus one additional item (Murdoch, Pryor, Polusny, Gackstetter, & Ripley, 2009). The criminal sexual misconduct questions ask whether a coworker(s) or supervisor(s) ever attempted or succeeded in forcing a respondent to have sex against the respondent's will during Gulf War I. The fourth item asks about completed or attempted sexual assault by someone other than a coworker or supervisor during Gulf War I. Using a 3-point scale ranging from 1 (*never*) to 3 (*more than once*), participants were classified as having experienced sexual trauma during Gulf War I by answering 2 (*once*)

or greater to any one of the four items. Postservice sexual assault was assessed using an item adapted from the Life Stressor Checklist (Wolfe, Kimerling, Brown, Chrestman, & Levin, 1996), which asks a "yes/no" question about unwanted sexual contact through the use of force or threat of force in the past year. Sexual trauma was modeled as a dichotomous variable; if participants endorsed experiencing sexual abuse in childhood, sexual assault during Gulf War I, or sexual assault in the past year, then they were classified as having experienced sexual trauma.

**Perceived self-efficacy.** Perceived self-efficacy was assessed using eight items from the Expanded Personal Attributes Questionnaire (EPAQ; Spence, Helmreich, & Holahan, 1979). Following Koss and Dinero (1989), respondents rated each statement according to how closely it described them on a 5-point scale ranging from 1 (*not at all like me*) to 5 (*very much like me*), with higher scores indicative of greater perceived self-efficacy. Examples of items include "I get bothered and don't know what to do in tough spots" (reverse-scored), "I give up very easily" (reverse-scored), and "I feel sure I can do most things I try."

**Male rape myth acceptance.** Acceptance of male rape myths was assessed using six items that reflect three general beliefs identified by Struckman-Johnson and Struckman-Johnson (1992). These include (a) male rape does not happen (e.g., "It's impossible to rape a man"), (b) rape is the victim's fault (e.g., "If a man gets raped by another man, he was asking for it"), and (c) men would not be traumatized by rape (e.g., "Most men who get raped by other men don't need counseling afterward"). Respondents answered to the extent they agreed with each statement on a 5-point Likert scale ranging from 1 (*strongly disagree*) to 5 (*strongly agree*), with higher scores indicative of greater rape myth acceptance.

**Devaluation of emotions.** Devaluation of emotions was assessed using three items from Burk, Burkhart, and Sikorski's (2004) Devaluation of Emotions subscale from the Auburn Differential Masculinity Inventory (ADMI). The items we used included the statements, "Men who often show their emotions are sissies," "Men who show fear are weak," and "Men who cry are weak." Responses ranged from 1 (*strongly disagree*) to 5 (*strongly agree*), with higher scores indicating more devaluation of emotions.

**Psychiatric symptoms.** We examined participants' current PTSD and depression symptom severity. PTSD symptom severity was assessed using the 4-item Primary Care-PTSD screen (PC-PTSD) for the *Diagnostic and Statistical Manual of Mental Disorders* (4th edition; *DSM-IV*) that is widely used within VA settings (Prins et al., 2003). The PC-PTSD asks four "yes/no" questions that focus on empirically derived symptom clusters of PTSD: reexperiencing, avoidance, hyperarousal, and numbing. It is scored by summing affirmative responses, with scores ranging from 0 to 4. The PC-PTSD been validated using the gold standard Clinician Administered PTSD Scale (Weathers, Keane, & Davidson, 2001) and has sensitivity of .78, specificity of .87 (Prins et al., 2003), and test-retest reliability of .80 over a 1-week time period (Kimerling, Trafton, & Nguyen, 2006).

Depression symptom severity was assessed using the five-item Mental Health Inventory (MHI-5; Berwick et al., 1991). The MHI-5 was derived from the original 38-item version (Veit & Ware, 1983) and measures depression, anxiety, general positive affect, and behavioral/emotional control. Respondents rate their mood in the past month on a 5-point scale ranging from 1 (*none of the time*) to 5 (*all of the time*). The MHI-5 has been shown to be an effective measure

Table 1  
Means and Standard Deviations of the Overall Scale and Subscale Scores, and Cronbach's Coefficient  $\alpha$  Measures of Internal Consistency Among the Items Comprising These Scales

Scales and subscales	<i>M</i>	<i>SD</i>	$\alpha$
Self-efficacy	27.40	6.86	.77
Psychiatric symptoms	13.30	4.01	.86
MHI-5	15.60	4.82	.89
PTSD-4	3.20	1.36	.86
Rape myth acceptance	13.06	4.36	.82
Devaluation of emotions	5.93	2.59	.86

*Note.* Self-efficacy = Eight items from the Expanded Personal Attributes Questionnaire (Spence, Helmreich, & Holohan, 1979); Psychiatric symptoms = principal component of the combined MHI-5 and PTSD-4 items; MHI-5 = five items from the Mental Health Index-5 (Berwick et al., 1991); PTSD-4 = four-item Primary Care-PTSD questionnaire (Prins et al., 2003); Rape myth acceptance = six items from Struckman-Johnson and Struckman-Johnson (1992); Devaluation of emotions = three items from the Auburn Differential Masculinity Inventory's Devaluation of Emotions subscale (Burk, Burkhart, & Sikorski, 2004). *N* = 1,827.

of depression severity (Berwick et al., 1991; Rumpf, Meyer, Hapke, & John, 2001) and has sensitivity of .83 and specificity of .78 for detecting mood disorders (Rumpf et al., 2001). Using the MHI-5 and PC-PTSD, we created a latent variable, "psychiatric symptoms," using principal component analyses; the principal component accounted for 77% of the variability in the items used and had an  $\alpha$  of .86 (see Table 1).

**Demographics.** Race, education level, military status, sexual orientation, marital status, and employment status were each assessed using a single survey item.

### Data Analyses

Using the Mplus software package (version 3.13), we conducted structural equation modeling (SEM) to test our conceptual model. Analyses were adjusted for age (<50 years vs.  $\geq$ 50 years) and race (White vs. non-White). We used Sobel's (1982) method to test for mediation. Effect sizes are reported as standardized coefficients with their standard errors.

Sixteen percent (288) of the 1,827 responding Veterans failed to complete at least one of the variables or construct items used in the

analyses, but two thirds of these participants were missing only a few items (four or less). To address possible bias due to nonresponse, we used multiple imputations (Little & Rubin, 2002; Rubin, 1987). We constructed five imputed data sets assuming missingness was at random (MAR). Imputations were based on estimating propensity of missingness and using Bayesian bootstrapping to impute the missing values. The final analyses were based on the combined covariance matrix that accounted for the extra variation due to imputations. The combined covariance was calculated using the law of total covariance.

## Results

### Descriptive and Reliability Data

On the basis of respondents' scale scores, 76.4% met screening criteria for PTSD (using a cutoff score of 3) and 44.6% met screening criteria for depression (using a cutoff score of 16); 24.7% of participants reported a history of sexual trauma. Table 1 lists the means, standard deviations, and Cronbach's  $\alpha$  of the scales used in analyses. The internal consistency of all scales was adequate ( $\alpha$ s ranging from .77 to .89). Table 2 presents a correlation matrix of all study variables. In these unadjusted analyses, findings showed that, as expected, sexual trauma history was statistically, significantly, and positively correlated with psychiatric symptoms. Likewise, perceived self-efficacy was statistically, significantly, and inversely correlated with sexual trauma history and with psychiatric symptom severity. Devaluation of emotions was also significantly and inversely correlated with psychiatric symptom severity. However, with the exception of the correlation between psychiatric symptoms and perceived self-efficacy ( $r = -.50$ ) and the correlation between devaluation of emotions and rape myth acceptance ( $r = .43$ ), most unadjusted correlations were small.

### Test of Hypothesis 1: The Mediating Effect of Self-Efficacy

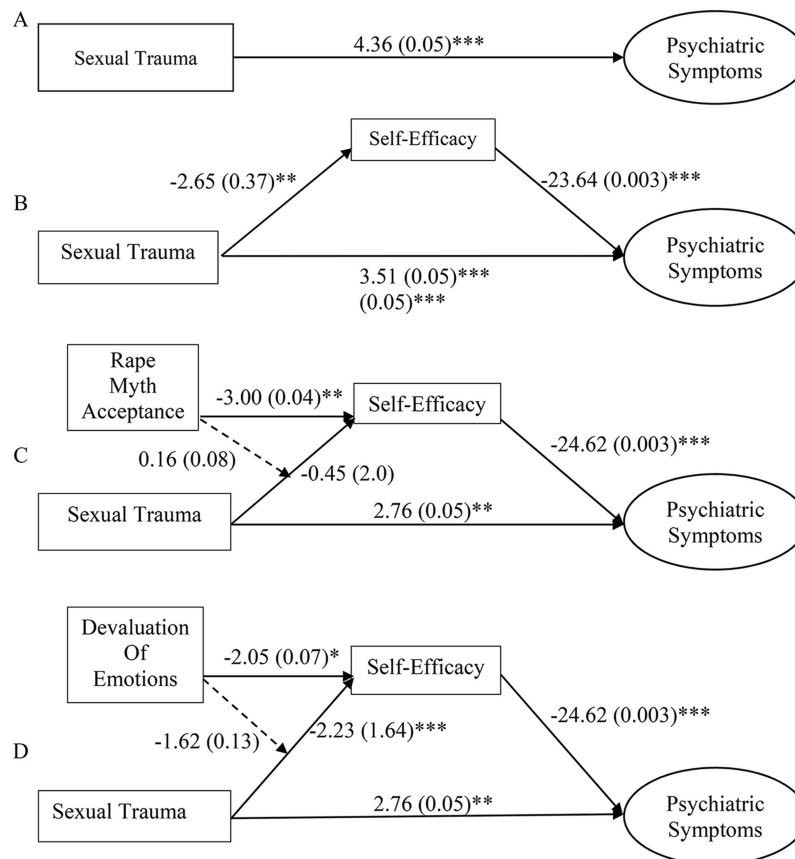
As shown in Figure 1A, after adjustment for age and race, the total effect of sexual trauma on psychiatric symptoms was statistically significant. As shown in Figure 1B, sexual trauma

Table 2  
Correlation Matrix

	Sexual trauma	Psychiatric symptoms	Rape myth acceptance	Devaluation of emotions	Self-efficacy
Sexual trauma	1.00				
Psychiatric symptoms	.09**	1.00			
Rape myth acceptance	.11**	-.03	1.00		
Devaluation of emotions	-.03	-.14**	.43***	1.00	
Self-efficacy	-.07**	-.50***	.07**	.08**	1.00

*Note.* Self-efficacy = Eight items from the Expanded Personal Attributes Questionnaire (Spence, Helmreich, & Holohan, 1979); Psychiatric symptoms = principal component of the combined MHI-5 and PTSD-4 items; MHI-5 = five items from the Mental Health Index-5 (Berwick et al., 1991); PTSD-4 = four-item Primary Care-PTSD questionnaire (Prins et al., 2003); Rape myth acceptance = six items from Struckman-Johnson and Struckman-Johnson (1992); Devaluation of emotions = 3 items from the Auburn Differential Masculinity Inventory's Devaluation of Emotions subscale (Burk, Burkhart, & Sikorski, 2004). *N* = 1,827.

\*\*  $p < .01$ . \*\*\*  $p < .001$ .



*Figure 1.* The proposed moderated/mediational model based on 1,827 respondents. All analyses control for race and age. (A) Total, direct effect of sexual trauma on psychiatric symptoms. (B) Partial mediating impact of self-efficacy on the effect of sexual trauma on psychiatric symptoms. (C and D) Direct associations between rape myth acceptance and devaluation of emotions and self-efficacy, but no moderating effects on the association between sexual trauma and self-efficacy (dashed lines). Standardized coefficients are shown with standard errors in parentheses. Standardized coefficient = the change in the dependent variable  $y$  in standard deviation units associated with a 1  $SD$  increase in predictor variable  $x$  when  $x$  is continuous, or a change from 0 to 1 when  $x$  is a binary indicator. \*  $p < .05$ , \*\*  $p < .01$ , \*\*\*  $p < .001$ .

was also associated with lower self-efficacy whereas self-efficacy was, in turn, associated with greater psychiatric symptoms. Sobel's (1982) test indicates that this observed mediation was statistically significant (Sobel  $z = 2.627$ ,  $df = 1$ ,  $p = .009$ ). However, the direct effect of sexual trauma on psychiatric symptoms after controlling for self-efficacy, age, and race remained significantly greater than zero. This indicates that self-efficacy only partially mediated the effect of sexual trauma on psychiatric symptoms.

### Test of Hypothesis 2: Moderating Effect of Male Rape Myth Acceptance and Devaluation of Emotions on the Mediating Role of Self-Efficacy

As Figure 1, C and D, show, endorsement of rape myths and devaluation of emotions were directly associated with lower self-efficacy, but in contrast to our expectations, these variables did not moderate the association between sexual trauma and self-efficacy.

## Discussion

The results of the present study partially supported our conceptual model. First, we found support for the hypothesis that perceived self-efficacy would at least partially mediate the relationship between sexual trauma and psychiatric symptoms for the men in this sample. As expected, participants with a history of sexual trauma generally had more severe psychiatric symptoms than men without such history. However, when perceived self-efficacy was included in the model, this association decreased by one fourth, suggesting that it is at least part of the mechanism through which sexual trauma leads to psychiatric symptoms. Although prior research has pointed to the beneficial role of perceived self-efficacy on recovery after various traumas (e.g., Benight & Bandura, 2004; Benight et al., 1999; Lerner & Kennedy, 2000; Regehr et al., 1999; Solomon et al., 1991), studies investigating the link between self-efficacy and distress after sexual trauma have been limited to women.

As we expected, male rape myth acceptance and devaluation of emotions were inversely related to self-efficacy, suggesting that these constructs, which can be understood as different aspects of hypermasculinity, negatively affect men's believe in their own ability to exert control over their environments or to master challenging situations. However, contrary to our hypothesis, neither of these variables moderated the association between sexual trauma and perceived self-efficacy. This pattern of results suggests that these measures of hypermasculinity are important indicators of poor perceived self-efficacy for all men, not just those who have experienced sexual trauma. That is, the more that men reject cultural myths about rape and traditional attitudes about masculinity (e.g., the acceptability of expressing emotions), the more their perceived sense of agency increases. Alternatively, men with an inherent, innate ability to reject traditional but limiting cultural beliefs might carry a broader trait of open-mindedness and see the world in a more flexible way. Flexibility in thinking is generally associated with greater adjustment and well-being. Coupled with the finding that greater devaluation of emotions was directly associated with more severe psychiatric symptoms, these results suggest that this construct is important to attend to during treatment, perhaps through the use of effective treatments that challenge rigid, problematic beliefs and help clients achieve more realistic and balanced thinking (Resick & Schnicke, 1993).

The use of a large sample of Gulf War era Veterans who were seeking disability benefits for PTSD represents a strength and a limitation of the current study. Because sexual assault among men is a relatively low base rate event and male survivors often do not report such events (e.g., Finkelhor, Hotaling, Lewis, & Smith, 1990), research among this cohort is logistically difficult. Use of a sample of Veterans seeking disability related to PTSD allowed us to identify a male sample enriched with sexual trauma survivors, which was extremely important for feasibility and power considerations. Furthermore, use of a military sample in which many participants endorse traditional attitudes toward masculinity offers an important opportunity to examine these theoretically important constructs. However, use of this sample introduces concerns about generalizability because it is unclear the extent to which these data will generalize to other men. For example, future research should explore these variables in a non-help-seeking sample because research has shown that those who adhere more strongly to traditional masculine norms are less likely to seek help (Addis & Mahalik, 2003).

Other limitations warrant discussion. First, our measure of sexual trauma asked participants whether they experienced sexual abuse during childhood, during the time of Gulf War I, and in the 1-year period before completing the survey. Sexual traumas occurring outside of these time points would not have been captured, potentially resulting in the misclassification of some Veterans' sexual trauma status. Although a shortcoming, concerns are somewhat alleviated by the fact that misclassification would weaken, rather than inflate, the associations examined, rendering this a conservative test of the hypotheses. Another limitation is the cross-sectional nature of the data, which prevents causal conclusions about the variables involved. Although we speculate that sexual trauma leads to distress via poor perceived self-efficacy, it is possible that poor perceived self-efficacy predicted the sexual trauma experience and even increased the risk of being targeted by perpetrators (Messman-Moore & Long, 2003). Future research using longitudinal designs may help clarify the tem-

poral associations. Finally, all data were based on mailed, brief, self-report measures. This monomethod approach introduces potential for respondent bias and/or reduced ability to adequately reflect the constructs of interest. Although we had an exceptional response rate (71.9%), we know that Veterans with a history of military sexual assault were nonetheless more likely to opt out of the study than were men without such history (Murdoch et al., 2014). The effect of this differential dropout on parameter estimations is uncertain.

Despite these limitations, results from this study provide new information and begin to address the gap that exists in the literature on male sexual trauma. Findings point to the importance of considering perceived self-efficacy in understanding the impact of sexual trauma on men's long-term distress, findings that have important implications for clinical interventions and future research. Furthermore, to our knowledge, no prior research has examined the impact of male rape myth acceptance, devaluation of emotion, or the broader construct of hypermasculinity on a man's adjustment after sexual trauma. Despite some negative findings, we believe this is a key area for future investigation. Studies have shown that male victims worry about their masculinity after sexual assault and report long-term crises and confusion over their sexual orientation (Lisak, 1994; Walker, Archer, & Davies, 2005). Research addressing the role that these cognitions may play in a military population seems particularly important given the cultural ideals that Veterans should be especially strong, heroic, and invulnerable. It would also be interesting to explore whether differences exist among these variables after different types of sexual trauma (e.g., childhood, adult, military). Overall, understanding factors that affect the effect of male sexual trauma on adjustment seems vital to the development of effective systems of responding to men's reports.

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