2008

Male Survivors: Walking the Tightrope of Masculinity

Luke Rogers
Virginia Commonwealth University

L. Douglas Wilder School of Government and Public Affairs
Virginia Commonwealth University

This is to certify that the thesis prepared by Luke Timothy Rogers entitled Male Survivors: *Walking the Tightrope of Masculinity* has been approved by his committee as satisfactory completion of the thesis or dissertation requirement for the degree of Master of Science in Sociology

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Sarah Jane Brubaker, Ph.D., L. Douglas Wilder School of Government and Public Affairs, Virginia Commonwealth University

---

Julie Honnold, Ph.D., L. Douglas Wilder School of Government and Public Affairs, Virginia Commonwealth University

---

Rebecca Odor, MSW, Director of Sexual Violence Prevention, Virginia Department of Health

---

Saba Masho, M.D., Dr.P.H., Department of Epidemiology and Community Health, Virginia Commonwealth University

---

Li Zhang, Ph.D., L. Douglas Wilder School of Government and Public Affairs, Virginia Commonwealth University

---

Michael Pratt, Ph.D., Interim Director of the L. Douglas Wilder School of Government and Public Affairs

---

Robert Holsworth, Dean, College of Humanities and Sciences

Dr. F. Douglas Boudinot, Dean of the School of Graduate Studies

July 25, 2008

MALE SURVIVORS OF SEXUAL ABUSE: WALKING THE TIGHTROPE OF MASCULINITY

A thesis submitted in partial fulfillment of the requirements for the degree of Master of Science in Sociology at Virginia Commonwealth University.

by

LUKE TIMOTHY ROGERS
B.S., Radford University, 2006
Certificate in Gender Violence Intervention, Virginia Commonwealth University, 2008

Director: DR. SARAH JANE BRUBAKER
Assistant Professor, Sociology

Virginia Commonwealth University
Richmond, Virginia
August, 2008

Acknowledgement

I would like to thank the many people who have helped and supported me in my pursuit of a graduate degree in Sociology. First and foremost, I owe many thanks to my family, whom, without their support, I would not be where I am today. To them I send my love and thanks, and apologize for the many, likely boring, conversations where I "thought out loud" to sort my thoughts. You never complained and were always there when I needed you the most.

There is not enough time to express the amount of thanks I owe to Dr. Sarah Jane Brubaker and Dr. Danielle Currier, for their time, patience, and support throughout my time as graduate and undergraduate student. Particularly regarding this thesis, Dr. Brubaker went above and beyond her duties to assist me in writing, revising, and completing this project. I would also like to thank Gay Cutchin for her willingness to always listen and provide honest and caring assistance whenever I needed it.

I owe much appreciation to the members of my committee: Dr. Masho, Dr. Honnold, Dr. Zhang, and Professor Odor. All of the members of my committee gladly made themselves available even though they knew there was a time constraint regarding my deadline to finish. They all were very helpful when I asked questions, which were often simplistic in nature, and guided me through this learning experience.

Finally, I would like to thank all of my friends, fellow students, and the advocates who provided me with great insights, real-world experiences, and, when needed, a beer to relax. Thank you.

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Abstract

MALE SURVIVORS OF SEXUAL ABUSE: *WALKING THE TIGHTROPE OF MASCULINITY*

By Luke Rogers, M.S.

A thesis submitted in partial fulfillment of the requirements for the degree of Master of Science at Virginia Commonwealth University.

Virginia Commonwealth University, 2008

Major Director: Dr. Sarah Jane Brubaker
Assistant Professor, Wilder School of Government and Public Affairs

Sexual assault of men is a serious social problem and has drawn well deserved attention from many different researchers as well as the general public. Even though there is much concern and interest in this troubling crime, limited research has been conducted on the long-term effects of sexual abuse on male survivors. Using data collected by the Virginia Department of Health, this study investigated the effects of sexual abuse of men. Specifically, this inquiry examined specific emotional and physical conditions as potential consequences of sexual victimization among men and the extent to which those conditions

vary between male victims and male non-victims. Using Chi-Square tests of independence this study found that survivorship is related to Post-Traumatic Stress Disorder (PTSD), depression, and suicidal tendencies. A statistically significant association was not found regarding alcohol and drug use, or self-rated health. Further research is recommended to investigate the health seeking behaviors among survivors and also how one's adherence to masculine values influences their recovery from a sexual abuse.

Chapter 1 Introduction and Statement of the Problem

Sexual assault of men is a serious social problem and has drawn much needed attention from researchers and non-researchers alike. Even though there is a profound interest in this disturbing crime, little research has been conducted on the comprehensive long-term effects of sexual abuse on male victims. Without sufficient knowledge about the impacts of childhood sexual abuse on men little can be done to alleviate the consequences of abuse.

Using data collected by the Virginia Department of Health, I investigated the effects of sexual abuse of men. Specifically, this inquiry examined specific emotional and physical conditions as potential consequences of sexual victimization among men and the extent to which those conditions vary between male victims and male non-victims. After male victims and non-victims were compared, existing research regarding the impacts of sexual abuse on female victims was used to identify differences between male and female survivors. Specifically, I examined five specific consequences of sexual assault common among women survivors. The findings suggest that while there were no statistically significant differences between men defined as survivors of sexual assault and those who were not sexual assault victims in terms of self-reported health or abuse of drugs and alcohol, those suffering from post-traumatic stress disorder, depression, and its extreme

form, suicidal thoughts, were more likely to be survivors of sexual abuse. The findings suggest the need for further research on male victims of sexual assault.

Literature Review

The effects of sexual assault on men are under-researched. Much more is known about its impact on women. To create a cogent understanding of the impacts of sexual abuse on men, and how they might differ from impacts on women, the following review will summarize literature on the prevalence of sexual assault, the physical and emotional impacts on women, as well as the limited literature on sexual assault victimization of men. I then review literature on sexual assault of children.

Sexual Assault of Women

Reported prevalence rates of sexual assault where females are the victims vary by source; according to the National Violence Against Women Survey (NVAWS), one in six women have been raped at some point in their lifetime (Tjaden and Thoennes, 2006). For the sake of continuity, this paper relies on the NVAWS as a source of prevalence rates and statistics.

Women who have been sexually assaulted report a variety of effects as a result of their victimization. Research has suggested that, emotionally, female victims of sexual assault adhere to less traditional feminine roles and are more consistently self-focused than non-victims (McMullin and White, 2007), demonstrating the heavy impact that a sexual assault can have on female victims. An additional emotional consequence of sexual assault that is common among women victims is post traumatic stress disorder (PTSD) (Martin

and Taft, 2007). PTSD is an unrelenting condition, which can have serious, life-altering, consequences. Symptoms of PTSD include, but are not limited to, the victim reliving the experience through nightmares, heightened anxiety, self-blame, hopelessness, detachment, and increased risk of substance abuse (Le, Bhushan and Skapik, 2007). PTSD can have long lasting effects if the victim is not properly de-briefed, which in most cases involves an immediate (usually within 48 hours of victimization) intervention with a professional counselor, psychologist, or psychiatrist.

Along with a heightened risk of PTSD, women who are survivors of sexual assault experience negative social reactions and avoidance coping (Ullman and Filipas, 2007). These reactions to their assault can severely damage relationships, friendships, and place an incredible amount of strain on the victim's personal support network. If such personal ties break, it could leave the victim further isolated and make help inaccessible.

Although the previously mentioned emotional consequences are possible for all female victims of sexual assault, women who were assaulted by an intimate partner may experience significantly more traumatic emotional costs than those women who did not know their perpetrator (Temple, Weston and Rodriguez, 2007). This may be partly due to the violation of the victim's trust by a friend or loved one, which adds to the damaging impact of their sexual abuse. Regardless of their relationship to the perpetrator, all victims should be treated on an individual basis to take care of any emotional consequences they may be experiencing, despite the circumstances of their abuse.

Physical impacts of sexual violence are just as troubling. Women can experience a wide variety of physical problems consistent with other forms of violence, but also are

forced to deal with the gynecological impacts of abuse that are sexual in nature. Women can suffer problems such as pelvic pain, sexually transmitted infections (STIs), or feel discomfort during future intercourse, among other symptoms (Campbell, Lichty, Sturza and Raja, 2006). Survivors also have been found to have a lower immune system response as a result of the stress caused by their ordeal, which could lead to chronic health problems and sickness (Groer, Thomas, Evans, Helton and Weldon, 2006). The physical impacts alone should be enough to attest to the monstrous nature of sexual assault, since many of the symptoms associated with such violence can be life-long burdens the victim has no choice but to cope with.

Sexual Assault of Men

According to the NVAWS, one in thirty-three men have been raped at some point in their life lifetime (Tjaden and Thoennes, 2006). This is not as high as the rate found among females, but a high number of men are nonetheless affected by sexual violence directly, as survivors.

Male survivors deal with many of the same emotional consequences as women. Much of the research on male victims is focused on male adolescents, since, understandably, sampling issues plague the research of adult male sexual assault survivors due to under reporting. An example of underreporting can be seen in one Ohio-based study that found teachers are more likely to under-report than over-report childhood abuse (Webster, O'Toole, O'Toole, and Lucal, 2005). Current research also suggests that most men are victimized as children; about 71 percent of male rape victims were raped before the age of 18 (Tjaden and Thoennes, 2006). Research demonstrates that if most men are

victimized as children and underreporting among teachers is a likely problem, then many male victims' abuse may never be identified.

Underreporting is a major complication within research being conducted on male victims, who are even more reluctant than female victims to report their abuse. The research that has been carried out is finding, however, that men who have been victimized have problems with their dating relationships and are less willing to get married. Male survivors report less empathy for their partners, which may give insights into their negative experiences with regards to relationships (Larson, Holman and Feinauer, 2007). Male victims were more likely to be assaulted with a weapon, such as a knife or gun, and their injuries were just as severe and required the same amount of medical attention as those of female victims (Stermac, Bove and Addison, 2004).

Both male and female survivors experience problems such as depression, PTSD, and self-blame, but in one mixed-gender study men reported significantly higher levels of suicidal thoughts and attempts when compared to women (19% of men compared to 4% of women) (Struckman-Johnson and Struckman-Johnson, 2006). Such differences may be a result of the culture surrounding male victims, where men rely on their own devices for relief, since it is less socially acceptable for them to seek help (both because of our social construction of masculinity and because of the services literally unavailable to men). In fact, several shelters in Virginia alone do not admit men over the age of 16, although they still offer other services (such as providing a stipend for third party housing, e.g. a motel). Still, many of the shelters and services available to women and children who are victims of

abuse are catered to just that group, women and children, leaving their shelter's capabilities to help men, even if they want to, inadequate.

Childhood Sexual Abuse

Sexual assault can have a lasting impact on a child. Childhood victims can experience many of the same problems as adult victims. Posttraumatic stress disorder, delinquency, low self-esteem, and major depressive disorder are only a few of many different consequences among male and female victims (Lawyer, Ruggiero, Resnick, Kilpatrick and Saunders, 2006). Youth who have been abused can also demonstrate anti-social behavior (Schilling, Aseltine and Gore, 2007), which can distance them from services.

As a result of their abuse, many victims may participate in more high-risk behaviors. Research has found that women who have experienced childhood trauma are more likely to participate in HIV-related risk behaviors, such as negative attitudes toward condom usage (Klein, Elifson and Sterk, 2007). Other risky behavior has been associated with sexual assault; girls within the juvenile justice system have extraordinarily high rates of past sexual abuse (Goodkind and Sarri, 2006). Children are also more likely to run away and become homeless due to a sexual assault (Tyler and Johnson, 2006), which then makes them more at-risk for another negative sexual encounter (aside from exposing them to the usual risks unsupervised children face) (Johnson, Rew and Kouzekanani, 2006). Other studies suggest that people who have been victimized as a child may be more likely to have mood and anxiety disorders, and, in some cases, eating disorders (Wonderlich, Rosenfeldt, Crosby, Mitchell, Engel, Smyth and Miltenberger, 2007).

Victims of childhood abuse are more prone to attempt suicide, where the most endangered are those violently sexually abused (Joiner, Sachs-Ericsson, Wingate, Brown, Anestis and Selby, 2007). Much like adult victims, children who are sexually abused can experience serious, and compounding, health complications. This is further demonstrated by research that has shown that women who were abused as children report lower self-rated health when compared to non-abused women (Irving and Ferraro, 2006).

Since most male victims are younger than 18 years of age (Tjaden and Thoennes, 2006) and many schools still lack the awareness about male victims, boys are regularly being sent for punishment rather than counseling when they misbehave, even though a simple assessment could make a major impact and give them an opportunity to be directed to the services needed to help them (Bogin, 2006). This unfortunate reality can lead to severe consequences in the future, for the survivor, their loved ones, and society as a whole.

Summary of Literature

The impact of sexual assault is tremendous. Both male and female victims suffer similar symptoms that are a direct result of their victimization. Emotional symptoms include PTSD, anxiety, depression, coping avoidance, and suicidal tendencies. Sexual assault can also result in the victim participating in higher risk behavior, such as the reluctance to use condoms.

Physical impacts are similar for both women and men, which includes decreased immune response and Sexually Transmitted Infections, among other symptoms common of other, more general, forms of violence. In addition, female victims may suffer from a wide

variety of gynecological complications, both short and long term. Male victims experience the same severity of physical effects when compared to women.

Theoretical Framework

In order to better understand male sexual assault victims' experiences, I have identified specific conceptual frameworks to guide the data analysis for this project. Feminism in particular offers important insights into the social construction of gender under patriarchy, and how it contributes to men's definitions and uses of violence as they act out masculinity and develop masculine identities. Because of the large scale of men's violence against women and men, masculinity not only plays a role in the perpetration of violence, but I propose that traditional constructions of masculinity may impact experiences of male victims as well.

In this section, I define patriarchy and its connection to men's violence against women, and I describe the social construction of gender. I then describe the social construction of masculinity in particular and its connection to violence. Finally, I propose potential influences of the social construction of masculinity and its connection to violence on male victims' experiences of sexual assault.

Patriarchy and Violence

Patriarchy is a primary concept of focus among feminist scholars in general and sociologists in particular, and in general describes social arrangements based on masculine privilege. Lorber (1994) describes patriarchy as a series of social processes that lead to the "devaluation of 'women' and the social domination of 'men'" (pg. 8). The devaluation that Lorber describes manifests itself in a variety of ways including economic inequality

(Charles and Grusky, 2004), distinct levels of sexism including blatant, subtle and covert ways that society and individuals prioritize men while devaluing and/or harassing women (Benokraitis and Feagin, 1995), and the sexual objectification of women (Katz, 2006). Feminists view sexual violence as a means of enforcing patriarchy (Brownmiller, 1975). Johnson (2005) defines patriarchy as a society that reserves positions of authority for men, within social arenas such as the political realm, military, educational system, religious institutions, etc.

Brownmiller (1975) suggests that it is through the fear and domination of women that patriarchy gives men the structural capacity to commit acts of violence and leaves women in a position of vulnerability. National data confirm this trend in society, where men perpetrate the majority of sexual abuse against both male and female victims, women representing the largest proportion of victims (Tjaden and Thoennes, 2006), and, although most men do not commit acts of sexual violence, all men benefit from it through the fear the violence instills in all women, not just the victims of violence (Brownmiller, 1975). Johnson (2005) is clear to point out that not all men have the same amount of power in patriarchy; some men are extremely powerful while others have relatively little power when compared to their counterparts. Many factors can contribute to this differential in power among men; social inequalities (e.g. class, race, religion, ethnicity, sexual orientation, adherence to masculinity) distribute power to some men and deny it from others. This idea of the existence of a spectrum of power among men, and not just between men and women, is a useful tool in understanding sexual abuse perpetrated against men by

other men. For example, men in positions of power over other men in terms of age, occupation, size, or strength may exert that power through sexual violence.

Patriarchy manifests itself in other ways as well. Contemporary society has idealized masculine values, and places masculinity in contrast to femininity. Patriarchy is such an integrated part of contemporary society; individuals, groups, and nations perpetuate patriarchal values through the positive construction of honor, strength, defending oneself with violence, excelling at athletics, and the sexual conquest of women. Patriarchy also influences individuals in ways that permeate every individual interaction, including how we perceive situations and act according to gender roles (Lorber, 2005). In the end, both men and women become indoctrinated on gender through the process of socialization and constant reinforcement (Johnson, 2005).

Social Construction of Gender

Critical to the conceptualization of gender within both feminist and sociological scholarship is the social construction of gender, and in particular, the distinction between sex and gender. For the purpose of this study, gender is a social construction, and sex is a reference to an individual's anatomic characteristics - a biological distinction. There are different theories about how gender is achieved, but two main frameworks will be discussed in the following paragraphs. First to be discussed is how Lorber identifies the two levels through which gender socialization is accomplished, then, Anderson's three levels of gender construction will be identified and conferred.

The social construction of gender is accomplished in part through gender socialization, and starts with the born sex of an individual, where young babies are treated

differently based on whether they are male or female (Lorber, 1994). Throughout one's life, on the individual level, gender is achieved through conformity with others within the same gender category. An individual can pursue gender through ways of speech, clothing, or any other gender-specific behavior (e.g. girls wear pink, boys wear blue). From a very young age, boys and girls are taught about different methods for achieving group conformity with other boys and girls, creating a strong individual desire to maintain personal identity that is within the status quo (Lorber, 1994).

Gender is also socially constructed at the societal level, where gender is used as a way to differentiate between groups. Even though an infinite spectrum of variance exists with regards to individual "gendered" characteristics, gender still remains dichotomous on the societal scale and only two gender types are recognized, feminine and masculine. This grouping serves an important function in patriarchy, since it largely helps determine which group enjoys privilege (men) and which does not (women). Social stratification is achieved in part based on gender roles, or preconceived notions society holds for particular groups (e.g. men as the breadwinner) (Lorber, 1994). Such preconceived notions help keep patriarchy as a powerful institution in contemporary society.

Anderson (2005) provides a useful framework for examining three distinct levels of gender construction, and she relates these to the use of interpersonal violence. The three levels are the individual, interactional, and structural levels. First, the individual level, as applied to the distinction between gender and sex above, is where gender is an internal characteristic, either biological or social, which women and men internalized and make a part of themselves (Risman, 1998). Based on the survey instrument used in this study,

participants self-identified as either male or female, which illustrates the individual level of gender. However helpful the individual approach may be in identifying the differences between gender and sex, there are limitations that hinder the individualist perspective. First, by focusing solely on the individual, it becomes difficult to see how a particular individual influences the larger group or society as a whole. Second, the individualist perspective offers little insight into how the social structure may, in turn, influence the individual (Johnson, 2005). Both limitations involve different ways the individualist perspective is unable to explain socialization's and, more broadly, patriarchy's role in the social construction of gender. Anderson (2005) discusses two other perspectives, which are more helpful in understanding social aspects of gender in violence. These two approaches are the structuralist and interactionist approaches.

The structuralist approach is useful in trying to understand how the social construction of gender within patriarchy is a factor in the coping and recovery of victims of sexual assault. According to this perspective, it is possible to identify distinct differences between men and women in how they use violence, which can be traced back to the socialization embedded within social institutions in society (e.g. men are taught to use violence more than women) (Katz, 2006). In particular, the structuralist approach can reinforce our theoretical constructions of the socialization of men, where the cultural and structural environment can greatly influence victims' responses to abuse. An example of cultural and structural factors influencing masculinity can be seen when someone tries living up to what it means to be a "man" and how that may be different depending on a male's position in society (e.g. wealthy vs. poverty stricken, military vs. civilian), all of

which will change how they establish their manhood. Anderson's (2005) definition of the structuralist approach can also help identify how some men differ from others, and how certain men have more power and fit into cultural norms of masculinity better than others. This macro-level basis for differences among men is important because it could help shed light on why some men perpetrate abuse, and how male victims internalize and respond to abuse.

The interactionist approach focuses on the practice of violence and how it is one of the ways men construct masculinity. In this view, male perpetrators enhance their masculinity by victimizing women (Brownmiller, 1975). Brownmiller points out that as a result of the patriarchy women are dehumanized and become a means through which men can demonstrate their superiority to other men. Brownmiller (1975) fails to recognize how targeting women for sexual abuse may not be the only way to enhance masculinity, but targeting men may also be a means of enhancing it as well. Despite this shortcoming of applying the interactionist approach, explaining how social factors such as gender are internalized beyond the structuralist approach makes the interactionist perspective a unique and valuable theoretical tool for this analysis.

Masculinity

Masculinity scholars have recently begun to identify and describe ways in which patriarchy is harmful not only to women, but also to men. Several theorists suggest that patriarchy creates a paradox for men, where conformity to dominant norms of masculinity is rewarded, and failure to conform is punished. This dominant form of masculinity can be seen within popular culture and in daily interactions between men, and is referred to as

"hegemonic masculinity". Hegemonic masculinity can be seen everywhere in our society, whether on a billboard portraying a dominant athlete or when watching two boys play war at a playground, and can be further defined as promoting men to be strong, heterosexual, violent, wealthy, tough, emotionless (other than anger), and militaristic, among other things (Katz, 2004). In extreme cases hegemonic masculinity may also involve victimizing women (Brownmiller, 1975), but never does it promote men to become a victims. Hegemonic masculinity is contradictory or "blurry", creating an unspoken confusion among men who continually seek acceptance while simultaneously fearing that they will be stripped of their manhood (Katz, 2006; Johnson, 2005). An example of this concept can be seen in the constant encouragement men receive to be violent, while being taught that certain types of violence against certain types of people is not acceptable (e.g. society teaching boys to "never hit a girl" but to objectify them and freely hit other boys). This creates a strict system of adherence, which gives men few ways of coping with many of life's trials. Violence is one of few ways men are socialized to express their emotions. Violence is not only used to express emotion and control over women, but also a way to gain masculinity through one's interactions with other men.

Combined with other strong policing mechanisms embedded in masculinity, especially homophobia and sexism (Johnson, 2005), hegemonic masculinity becomes a reflection of the patriarchy that promotes its very existence. The risk of challenging hegemonic masculinity, or patriarchy itself, is being stripped of one's "manhood", being the victim of violence, or being labeled as "gay" or a woman, all ways of denying male privilege from men (Katz, 2006). This process strongly reflects the inherent homophobia

and sexism within hegemonic masculinity, where any deviations, including a critical lens of what it means to be a man, are punished. Parents too fall into this line of thought, where they often fear their child will be homosexual if they have survived an incident of same-sex sexual abuse (McGuffy, 2008), further enforcing the confines of hegemonic masculinity. As a result of this process of reward and punishment, strict widespread conformity to traditional masculinity is socially achieved.

Masculinity and Male Survivors

Sociological and feminist frameworks of the social construction of masculinity offer insight into the potential outcomes that male victims experience as a result of sexual abuse. Most notably a feminist construction of masculinity can be applied when hypothesizing why and how men respond to abuse and in which ways the male victim's experience may differ from that of female victims. First, it is important to identify that even though both men and women are victims, an overwhelming majority of perpetrators are men (Tjaden and Thoennes, 2006). This has important implications for male victims, since the standard explanation of why men rape, such the outward expression of patriarchal control of a man over a woman, does not apply. However, as stated before, feminism still offers the most useful framework for attempting to understand the dynamics behind sexual violence perpetrated against men.

Brownmiller (1975) suggests that men use rape as a means of enhancing the level of masculinity among abusers, a test of manhood. The previous discussion of masculinity, however, suggests that there is a contradiction between views. If men use sexual assault as a means to enhance a sense of masculinity that is defined and maintained through

homophobia, then how does the act of a man abusing a male victim fit in? Although these ideas seem incompatible, they both provide insight into the experience of the male victim. Brownmiller shows how male perpetrators may still be attempting to enhance their own masculinity, i.e. by assaulting another man they are enhancing their own power, while the previous section's analysis sheds light on how male victims may experience their masculinity being stripped away (through the loss of control, homophobia, and being treated like a woman). Because of the social construction of masculinity, one might expect that male survivors would be less likely than female victims to report a sexual assault or seek help, out of fear of being labeled homosexual or perceived as weak, in an attempt to recover or salvage whatever masculinity is left after their abuse. Research has already demonstrated that the majority of female victims do not report the crime committed against them; an estimated 36% of rapes, 34% of attempted rapes, and 26% of sexual assaults were reported between 1992 and 2000 (Rennison, 2002). It should be kept in mind that this analysis is limited by the strong likelihood of male victims having even lower rates of reporting sexual abuse, because of the social and internal pressures discussed above.

Masculinity may also influence how male victims cope with their abuse. Coping with not only physical trauma, but also with a symbolic assault on their gender identity, some may experience high rates of alcohol or drug abuse. An increased likelihood of attempting suicide could also be a by-product for male survivors (Struckman-Johnson and Struckman-Johnson, 2006). In both instances, this study investigated whether or not male victims experienced different levels of drug and alcohol use and different levels of thoughts about self-harming or suicidal behavior when compared to male non-victims.

There is also significant and consistent evidence that, although not always the case, there is a strong possibility that the perpetrator is a friend or relative of the victim (Masho and Odor, 2003). Scholars have suggested that father-daughter incest taboo is a "peace treaty" of a patriarchal culture, and that, since men created and are the enforcers of incest taboo, they also have the most access to the violation of the taboo (Herman and Hirschman, 1977). By including such theoretical conceptualizations about incest and applying it to male victims of sexual violence, it may begin to be possible to explain why men commit most of incest regardless of gender, and we can begin to understand how there is much more involvement in male sexual abuse than sexual desire. Indeed, there is also a strong, possibly even dominant, element of power and control involved in sexual violence committed against men. Cossins (2000) argues that male perpetrators may feel powerless among other men, using children as a way to reestablish their sense of masculinity, where power is central to their masculine self identity. The argument made by Cossins further illustrates how important power is to the construction of masculine identities; if the desire to reestablish power is a motivating factor among male perpetrators, it may also play a significant role in the ways male victims cope in response to their abuse.

Men's gender socialization to use violence is commonly viewed as a contributory factor to men's violence against women. It may also shed light on how male victims recover and which coping mechanisms they adopt when dealing with their own abuse and victimization. Since homophobia and the perpetration of violence are pervasive components of hegemonic masculinity, male survivors may have to cope with assault as a threat to their identity, increasing their likelihood to encounter things such as alcohol/drug

abuse, PTSD, depression, suicidal tendencies, and overall lower self-rated health, all which will be looked at more in-depth in this analysis.

Limitations

Throughout the above discussion about gender socialization and masculinity, and how it is anticipated to influence the recovery of survivors of sexual abuse, I have tried to demonstrate that there is a link between how men are socialized and how they will recover. It is important to note that following data analysis is unable to explicitly determine the presence of the relationship previously discussed because the instrument being used was originally intended to determine prevalence and not designed for the intentions of this study. More directly, the instrument lacks any measure of masculinity, which is an important aspect of the research question and hypotheses (to be discussed in the next chapter). Another problem resulting from the fact that the data was originally intended for establishing prevalence was that sampling size (small number of survivors and unequal sized groups) made several statistical methods unavailable. Despite these limitations, the lack of information available on the topic makes it important to explore the outcomes of sexual abuse on men. The literature review and theoretical approach presented here act as a tool to guide hypotheses and provide an initial examination of possible outcomes of sexual victimization of men. Hopefully, as a result of this research, future research can be better suited to explore the role of masculinity in the recovery of survivors.

Chapter 2 Methodology

The data for this analysis were collected by Virginia Commonwealth University and the Virginia Department of Health through a statewide study approved the Institutional Review Board (IRB) at Virginia Commonwealth University. Quantitative statistical analysis was employed to test the specific hypotheses regarding men's victimization of sexual assault suggested by the literature review and theory, outlined below. Male survivors were compared to men who have not experienced abuse. Findings were also compared to the existing research that focuses on female victims. In this chapter, I discuss data collection, the instrument, definitions of sexual victimization, research questions and hypothesis, data analysis, and sample.

Data Collection

The data used in this analysis originated from a telephone interview conducted between November of 2002 and February 2003. Two independent samples were acquired through the use of random digit dialing (RDD). The sample consisted of a total of 1,769 women and 705 men randomly selected from across the state of Virginia. The sampling consisted of two independent samples specifically selected to be representative of Virginia's male and female population. Telephone numbers were each called a maximum of 15 times at different times and days of the week to try and contact any eligible respondents. To make the survey more convenient, a toll-free number was provided to

participants, allowing them to call back when they had time. Unless they specifically requested not to be called again, respondents were called back after a abstaining from the survey for a "refusal conversation".

For the purpose of this study, "eligible participants" means an adult male or female. When more than one adult was present, the adult with the most recent birthday was asked to participate.

To minimize the potential impact of the sensitive questions included in this survey, only trained, experienced, interviewers were allowed to administer the survey. Female interviewers surveyed all female respondents. The option of switching to a male interviewer at anytime was made available to the participant if they so desired.

Even though extensive steps were taken to insure a good response rate, only 36 percent of females and 21 percent of males selected agreed to participate.

Instrument

Three surveys were used to help design the survey instrument administered in this study. The first was a survey completed in the state of Washington and the other two were both national studies (the National Violence Against Women Survey (NVAWS) and the National Women's Study (NWS)). Respondents were presented with clear, specific, language when notified of the potential benefits and risks of their involvement in this study. Copies of the instructions and questionnaire can be acquired from the Virginia Department of Health, Center for Injury & Violence Prevention (can be accessed via the internet at: http://www.vahealth.org/civp/sexualviolence/data.asp).

The instrument included questions pertaining to the participant's history of sexual

assault, consequences of the assault if one was experienced, their relationship to the perpetrator, the type of assault, their perception of safety, world view, and their availability to services. General questions of a non-sexual nature were asked initially, with the intention of creating a comfortable environment for the respondent and promote reliability. After several general questions were asked, the interviewer moved on to screening questions, and, if appropriate, the interviewer then asked more sensitive questions. This progression built up over the course of the survey, and all participants were notified of the sensitive nature of the questions and that they were allowed to withdraw at any time. Respondents were also provided the telephone number for the Virginia Family Violence and Sexual Assault hotline number (1-800-838-8238).

Through the progression of this survey the nature of abuse for the respondents who experienced assault was determined. Questions determined whether the participants experienced rape or attempted rape, were forced to have vaginal sex, anal sex, oral sex, forced sex with objects, or if alcohol consumption or illicit drug(s) were used to hinder the ability to give consent. If the participant experienced any of the above forms of assault, their age at the time of the event was established as was whether or not it had happened in the past year. If the participant was a child during the assault, the age of the perpetrator was asked. Questions about the first assault, worst experience, and, if applicable, details about any assaults in the past year were also asked.

Definitions of Sexual Victimization

Sexual victimization is conceptualized and operationalized in a variety of ways. The survey instrument used in this study included questions that cover a wide range of

sexual abuse. Definitions of the different types of sexual abuse are adopted from the National Violence Against Women Survey (Tjaden and Thoennes, 2006) and the Virginia Department of Health (VDH) report on the Prevalence of Sexual Assault in Virginia (Masho and Odor, 2003). The NVAWS defines rape "as an event that occurred without the victim's consent, that involved the use or threat of force to penetrate the victim's vagina or anus by penis, tongue, fingers, or object, or the victim's mouth by penis" (Tjaden and Thoennes, 2006). For the data analysis, the six definitions used to categorize the different types of victimizations (rape, attempted rape, inappropriate touch, unable to consent due to alcohol or drug use, non-forcible child rape, and non-forcible child molestation) were collapsed into one variable, sexual abuse. All of the definitions used were initially used in the VDH report titled Prevalence of Sexual Assault in Virginia (Masho and Odor, 2003).

Four questions were included in the instrument to identify the occurrence of "rape", they were as follows:

- Regardless of how long ago it happened or who did it, has a woman or girl, man or boy ever made you have sex by using force or threatening to harm you or someone close to you?
- Has anyone EVER made you have oral sex by using force or threat of harm?
- Has anyone EVER made you have anal sex by using force or threat or harm?
- Has anyone, male or female, EVER put fingers or objects in your anus/vagina against your will by suing force or threat of harm?

If a participant responded "yes" to any of the following question then "attempted rape" was defined:

- Has anyone, male or female, EVER attempted to make you have vaginal, anal oral or anal sex against your will, but intercourse or penetration did not occur?

The following question was used to classify "Unable to consent due to alcohol or drug use":

- Has anyone EVER made you have any kind of sexual intercourse when you had too much alcohol to drink or had taken drugs and could not agree to have sex or say no to having sex?

"Inappropriate touch" was identified using the following question:

- Has anyone EVER touched your (breasts), buttocks or genital area by using force or threatening to hurt you or someone close to you?

The next two questions were structured around the legal definitions found in Virginia (Code of Virginia §18.2-63), which states that if the victim is under 13, s/he is a child too young to understand consent and, as a result, cannot give consent. The law further states that it is a more severe crime if the perpetrator is three or more years older than the victim. Since the groups being compared are solely from Virginia this three-year age gap is used to define victim's experiences. Applying this three-year age difference between victim and perpetrator consistently throughout the definitions for both non-forcible child rape and non-forcible child molestation allows for consistency. It is necessary to point out that the report Prevalence of Sexual Assault in Virginia (Masho and Odor, 2003), from which the definitions for this study were adapted, used a five-year, rather than a three-year age gap. The three-year gap was used in this study to make it more consistent with Virginia law (as discussed above).

If the perpetrator was at least three years older than the victim and the respondent answered "yes" to the following question, "non-forcible child rape" was identified:

- When you were a child, by this we mean 17 years old or less, did anyone older than you EVER have any kind of sexual intercourse with you WITHOUT using force or threatening to harm you or someone else?

If the participant affirmed the next question and the perpetrator was at least three years older than the victim, "non-forcible child molestation" was defined:

- When you were a child, by this we mean 17 years old or less, did anyone older than you ever touch your (breasts), buttocks or genital area WITHOUT using force or threatening to harm you or someone close to you?

Research Question and Hypotheses

Using data collected by the Virginia Department of Health, I have investigated the effects of sexual abuse on men. Specifically, this inquiry looked at the emotional and physical impacts of victimization and the differences of reported effects between victims and non-victims.

Exploratory research was conducted through quantitative data analysis. Since little is known about the impacts of sexual abuse on men, differences between male victims and non-victims were examined. To identify the differences between male and female victims, the results of this study were compared to the existing research regarding female victims of sexual abuse; a comparison that will take place in the discussion. It was hypothesized that male victims will experience increased amounts of substance abuse and mental health issues when compared to male non-victims, because men are socialized to perpetrate

violence and be dominant. When men become the victims of sexual abuse, their experience is expected to challenge their sense of masculinity, a core aspect of their identity, resulting in the previously discussed impacts. The following five hypotheses were examined for this study:

1) Men who are survivors of sexual abuse are more likely to have depression.
2) Men who are survivors of sexual abuse are more likely to use recreational drugs more often.
3) Men who are survivors of sexual abuse are more likely to fit the criteria for Post Traumatic Stress Disorder.
4) Men who are survivors of sexual abuse are more likely to have suicidal tendencies.
5) Men who are survivors of sexual abuse are more likely to report lower overall health.

The survey instrument included a number of specific questions that can be used to explore the above hypotheses. Only questions that asked "have you EVER" were included for consistency in all of the hypotheses. This exclusivity to the "ever" questions makes determining causality difficult and is not recommended. Even with this limitation, associations were still accurately identified. Aside from the definitions detailed above, which were implemented to determine which participants were victims and which were not victims, artificially constructed variables were tested. Specific variables to be analyzed as dependent variables in this analysis were depression, alcohol/drug abuse, PTSD, suicide,

and self rated health. The independent variable was whether or not the respondent was a survivor of sexual abuse.

To determine the occurrence of depression, the Diagnostic and Statistical Manual of Mental Disorders' (DSM-IV) definition of a Major Depressive Episode was implemented[1]. If the respondent answered "yes" to five or more of the following questions, they were considered to have experienced a Major Depressive Episode. The questions used to measure depression (as they appear in the instrument) are as follows:

- Have you EVER had a period of two weeks or longer when you were feeling depressed or down most of the day or nearly everyday?
- Have you EVER had a time of two weeks or longer when you were uninterested in most things or unable to enjoy things you used to do?
- Have you EVER had a period of two weeks or longer when you lost or gained weight without dieting?
- Have you EVER had a period of two weeks or longer when you slept too little or a lot more than normal for you?
- Have you EVER had a period of two weeks or longer when you felt so fidgety or restless that you were unable to sit still?
- Have you EVER had a period of two weeks or longer when you felt tired all of the time or low in energy all of the time?
- Have you EVER had a period of two weeks or longer when you felt worthless or felt guilty about things that you had done or had not done?
- Have you EVER had a period of two weeks or longer when you had a hard time thinking, or concentrating or making decisions about everyday things?
- Have you EVER had a period of two weeks or longer when you felt that things were so bad that you thought about hurting yourself or that you'd be better off dead?

Alcohol/drug abuse was created by constructing a scale, which was categorized from one to six (one equaling low/no usage and 6 equaling high usage). The scale was

[1] Conrad (2006) suggests that the DSM is intended for use by psychiatrists and other health professionals with access to patient histories. He argues that the use of DSM symptom descriptions by researchers to operationalize mental health conditions should be treated with caution. This is a common practice among researchers, however, so it is utilized in this research. The author acknowledges the limitations of this method based on Conrad's assessment.

determined by adding up the results of the following three questions (as they appear in the instrument), which were all also one to six, and then breaking the results up into comparable groups:

- How often do you have a drink containing alcohol?
- How often do you have four or more drinks on one occasion?
- How many days have you taken drugs, such as marijuana, cocaine or other "street drugs" in the past 30 days?

A measure of PTSD was constructed, based on the DSM-IV that included questions that asked participants about the various symptoms associate with the disorder. To insure accurate results the respondent must have fit into all four major criteria for PTSD to be considered as having PTSD.

The first criterion for PTSD was the reoccurrence of feelings or memories associated with a traumatic event. It was established by the answer of “yes” to one or more of the following questions:

- Have you EVER had a period of a month or longer when you had unpleasant memories or disturbing images that kept coming into your mind whether you wanted them or not?
- Have you EVER had a period of a month or longer when you had repeated bad dreams or nightmares?
- Have you EVER had a flashback -- that is, have you EVER had an experience in which you felt like something that happened in the past was happening all over again?
- Have you EVER had a period of a month or longer when you found yourself reacting physically to things that reminded you of something that had happened to you in the past? By reacting physically we mean breaking out in a sweat, breathing heavily or irregularly or heart pounding or racing?
- Have you EVER had a period of a month or longer when you felt a lot worse because you were in a situation that reminded you of something that happened in the past?

The second criterion was an increased level of arousal. This was determined by a "yes" answer to two or more of the following questions:

- Have you EVER had a period of a month or longer when you had difficulty falling or staying asleep?
- Have you EVER had a period of a month or longer when you had irritable outbursts of anger toward other people, things or situations?
- In the last month, have you had a hard time thinking, or concentrating or making decisions about everyday things?
- Have you EVER had a period of a month or longer when you found yourself jumpy or suddenly feeling scared or panicky?
- Have you EVER had a period of a month or longer when you felt you had to be on guard or extra alert?

The third criterion for PTSD was avoidance coping. Avoidance was determined by the response of "yes" to three or more of the following:

- Did you ever forget some or all of what happened during this unwanted sexual experience?
- Did you forget some or all of what happened because you drank too much alcohol or taken drugs and couldn't remember or passed out?
- For the next questions, I'm going to ask about feelings you may have had in the LAST MONTH or sometime in your life. Have you EVER had a period of a month or longer when you deliberately tried to avoid thoughts, feelings or conversations about something that had happened to you?
- Have you EVER had a period of a month or longer when you've gone out of your way to avoid certain places or activities that might remind you of something that happened to you in the past?
- Have you EVER had a period of a month or longer when you felt cut off from other people or found it difficult to feel close to other people?
- Have you EVER had a period of a month or longer when it seemed you could not feel things anymore or that you had much less emotion than you used to?
- Did something that happened to you in the past EVER change the way you think about or plan for the future?

The fourth and final criterion for PTSD was a history of trauma, whether as a victim or witness. The presence of trauma was determined by a "yes" to one or more of the following questions:

- Have you ever seen someone seriously injured or violently killed?
- Have you ever been stalked? By this we mean someone following, calling or trying to make contact with you when you didn't want them to and it made you feel scared?
- As an adult age 18 or older, have you ever been beaten or hurt so badly you had to see a doctor?
- As a child, by this we mean 17 years old or less, have you ever been beaten or hurt so badly you had to see a doctor?
- Has a close friend or family member of yours ever been deliberately killed or murdered by another person or killed by a drunk driver?

A measure of suicidal thoughts/tendencies was based on the following question, which respondents answered "yes" or "no" (as it appears in the instrument):

- Have you EVER had a period of two weeks or longer when you felt that things were so bad that you thought about hurting yourself or that you'd be better off dead?

Finally, one question was included in the instrument about the participant's physical health; it was determined by the following inquiry (as it appears in the instrument):

- Compared to other people YOUR OWN AGE, would you say that your health is EXCELLENT, VERY GOOD, GOOD, FAIR or POOR?

Additional demographic questions were also included in this analysis such as age of respondent, income (before taxes), marital status, race/ethnicity, and highest education level completed.

Data Analysis

SPSS 16.0 was utilized as a means of data processing. Univariate and bivariate statistical analyses were used to identify significant relationships. Specifically, cross tabulations were used as a tool to describe the distribution of variables within the sample, and chi-square tests of independence were implemented to describe whether or not significant relationships were present. For more information regarding the relationships,

Gamma was used to look at associations where both variables were dichotomous and ordinal.

Sample

As discussed previously, the sample analyzed in this study consisted of 705 randomly selected men who were residing in Virginia. Of these men, 299 (42.5%) had a four-year college degree or higher, 175 (24.9%) had attended some college or had a two-year college degree, 163 (23.2 %) had a high school diploma or equivalent, and 67 (9.5%) did not complete high school. The median age among participants was 46 years old with a range of 18 to 92 years old, and their median income was $60,000 to $70,000 per year (before taxes).

A majority of the sample identified as being white (n=536, 78.0%), while the second largest racial/ethnic group represented in the sample were those who responded as being black or African American (n=91, 13.2%). The remaining 60 (8.7%) respondents were of varying racial/ethnic groups, where 41 responded “other”. After separating survivors from non-victims there were 116 (16.5%) survivors and 589 (83.5%) non-victims of 705 overall respondents.

Chapter 3 - Results

The findings of this study are presented and discussed in terms of each hypothesis. Cross tabulations are presented for all hypotheses, but the results for only statistically significant findings will be discussed ($p < .05$). The cross tabulation describing the distribution will be presented following the statement of the hypothesis and before a discussion for each hypothesis. Overall, several significant findings were found, but more than one hypothesis turned out to lack any statistical significance.

Hypothesis #1: Men who are survivors of sexual abuse are more likely to have depression.

Table 1: Cross Tabulation: Survivor and Depression

			Did the respondent fit the criteria of a survivor of sexual abuse?		
			No	Yes	Total
Did the respondent fit the criteria for a Major Depressive Episode?	No	Responses	460	129	589
		Percentage (%)	78.1%	21.9%	100.0%
	Yes	Responses	76	40	116
		Percentage (%)	65.5%	34.5%	100.0%
	Total	Responses	536	169	705
		Percentage (%)	76.0%	24.0%	100.0%

The first hypothesis proposed that men who are survivors of sexual abuse are more likely to have depression. A chi-square test of independence was calculated comparing the frequency of a major depressive episode for male survivors and non-victims. A significant relationship was found ($\chi^2(1) = 8.14$, $p < .05$). Survivors had a higher proportion of those who suffered from a major depressive episode (34.5%) when compared to non-victims (21.9%). Gamma was found to be moderate and significant (.305, $p < .05$), and survivors were found to be more likely to experience a major depressive episode.

Hypothesis #2: Men who are survivors of sexual abuse are more likely to use recreational drugs more often.

Table 2 - Cross Tabulation: Survivor and Alcohol/Drug Use

			Respondent's Alcohol/drug Usage (1=low, 6=high)						
			1	2	3	4	5	6	Total
Did the respondent fit the criteria of a survivor of sexual abuse?	No	Responses	157	143	65	25	10	1	401
		Percentage (%)	39.2%	35.7%	16.2%	6.2%	2.5%	.2%	100.0%
	Yes	Responses	25	34	21	6	2	1	89
		Percentage (%)	28.1%	38.2%	23.6%	6.8%	2.2%	1.1%	100.0%
	Total	Responses	182	177	86	31	12	2	490
		Percentage (%)	37.1%	36.1%	17.6%	6.3%	2.5%	.4%	100.0%

The second hypothesis explored the possibility that men who are survivors of sexual abuse are more likely to use recreational drugs more often. A chi-square test of

independence found no significant relationship ($\chi^2(10) = 7.48$, $p > .05$) when whether or not the respondent was a survivor or non-victim was compared to the frequency of alcohol and drug usage.

Hypothesis #3: Men who are survivors of sexual abuse are more likely to fit the criteria for Post Traumatic Stress Disorder.

Table 3 - Cross Tabulation: Survivor and Post Traumatic Stress Disorder

			Did the respondent fit the criteria of a survivor of sexual abuse?		
			No	Yes	Total
Did the respondent fit the criteria for Post Traumatic Stress Disorder (PTSD)?	No	Responses	518	71	589
		Percentage (%)	87.9%	12.1%	100.0%
	Yes	Responses	74	42	116
		Percentage (%)	63.8%	36.2%	100.0%
	Total	Responses	592	113	705
		Percentage (%)	84.0%	16.0%	100.0%

The third hypothesis proposed that men who are survivors of sexual abuse are more likely to fit the criteria for Post Traumatic Stress Disorder. A chi-square test of independence was calculated comparing the frequency of PTSD for male survivors and non-victims. A significant relationship was found ($\chi^2(1) = 42.00$, $p < .05$). Survivors had higher proportions of PTSD (36.2%) than non-victims (12.1%). With a moderately strong

Gamma of .611 ($p < .05$), respondents who were survivors of sexual abuse were more likely to have experienced PTSD.

Hypothesis #4: Men who are survivors of sexual abuse are more likely to have suicidal tendencies.

Table 4 - Cross Tabulation: Survivor and Suicide

			Did the respondent fit the criteria of a survivor of sexual abuse?		
			No	Yes	Total
Did the respondent have suicidal thoughts?	No	Responses	543	45	588
		Percentage (%)	92.3%	7.7%	100.0%
	Yes	Responses	97	19	116
		Percentage (%)	83.6%	16.4%	100.0%
	Total	Responses	640	64	704
		Percentage (%)	90.9%	9.1%	100.0%

The fourth hypothesis proposed that men who are survivors of sexual abuse are more likely to have suicidal tendencies. A chi-square test of independence was calculated comparing the frequency of suicidal thoughts for male survivors and non-victims. A significant relationship was found ($\chi^2(1) = 8.93$, $p < .05$). Survivors had a higher proportion of those with suicidal tendencies/thoughts (16.4%) than non-victims (7.7%), with a

moderate strength Gamma (.405, $p < .05$). Survivors of sexual abuse were more likely to have suicidal tendencies.

Hypothesis #5: Men who are survivors of sexual abuse are more likely to report lower overall health.

Table 5 - Cross Tabulation: Survivor and Self-Reported Health

			Respondent's Self -Reported Health					
			Poor	Fair	Good	Very Good	Excellent	Total
Did the respondent fit the criteria of a survivor of sexual abuse?	No	Responses	19	60	182	202	125	588
		Percentage (%)	3.2%	10.2%	30.9%	34.4%	21.3%	100.0%
	Yes	Responses	3	16	34	38	24	115
		Percentage (%)	2.6%	13.9%	29.6%	33.0%	20.9%	100.0%
	Total	Responses	22	76	216	240	149	703
		Percentage	3.1%	10.8%	30.7%	34.2%	21.2%	100.0%

The final hypothesis in this analysis investigated the possibility that men who are survivors of sexual abuse are more likely to report lower overall health. A chi-square test of independence found no significant relationship ($\chi^2(4) = 1.46$, $p > .05$) when whether or not the respondent was a survivor or non-victim was compared with self reported health.

Summary of Findings

This analysis tested five hypotheses and found three to be statistically significant. Based on the results of Gamma, the presence of a relationship between the occurrence of PTSD, depression, and suicidal tendencies and their experience by survivors has been supported. No statistically significant association (based on Chi Square and Gamma) was found between the presence of sexual abuse and increased alcohol/drug usage or decreased self-rated health. As I discuss below, most of these findings are consistent with previous research and the social construction of masculinity, while two of the findings, alcohol/drug and self-rated health, were not consistent with the existing literature on male and female victims.

Chapter 4 – Discussion and Conclusions

Since all five hypotheses were adapted from the existing literature, it was anticipated that all would be found to be significant with a stronger association – this was not the case. Neither alcohol/drug abuse nor self-rated health, which were anticipated to be related to sexual abuse, were found to be significantly related to victimization. This could be partly due to the limitations of this study, that male survivors responded differently to abuse than women, or that their social behaviors related to drugs and alcohol and health are different from women's. Looking exclusively at the hypothesis on self-rated health, which was based on the research conducted by Irving and Ferraro (2006) that found women who were sexually abused as children had lower self-reported health, made the groups seem comparable since most all (94%) of the men included in the sample for this analysis were minors at the time of their abuse.

If further research results in similar findings as this study, and male survivors do not report lower self-rated health, self-reported health could be a good avenue for future research on how male survivors recover differently than female survivors, since self-reported health is a broad measure blanketing many different aspects of one's life. Part of this finding may be explained if we take into account the strength of gender socialization and hegemonic masculinity's, with parental encouragement, emphasis on men to be more active in athletics (McGuffy, 2008), which may have a positive role in a survivor's health.

Male survivors may feel a need to compensate for their abuse, which complicates a survivor's ability to fit neatly into a masculine identity (as demonstrated in the theoretical framework), and, as a result, they could likely turn to athletics, which is a focus of hegemonic masculinity, to recover from this identity conflict.

Men are also socialized to be strong and ignore health problems. Women are more likely to report health problems and seek medical attention (Bury, 2005). This finding may reflect traditional gender socialization around health behavior in general.

Alcohol and drug usage was expected to yield strong associations, since the theory that was the foundation of this analysis implied such behavior as a coping mechanism for men. The reason for this discrepancy is unknown, and may be a result of grouping alcohol and drug use into one category. Although it would have been possible to resolve the problems associated with combining alcohol and drug use (by separating the two variables), the hypothesis grouped them together so separation was not attempted. With that in mind, previous research utilizing the same dataset has separated alcohol and drug use, finding male victims were more likely to consume alcohol, a statistically significant relationship, while the same study was unable to find a significant association with drug usage (Masho and Odor, 2003). This finding may also be related to traditional gender socialization. Research suggests that men engage in more recreational drug use than do women in general, and that where men's engagement is typically motivated more by risk-taking and recreation, women who use drugs and alcohol are more likely to do so as a coping mechanism (Plumridge and Chetwynd, 1999). Men may use drugs and alcohol at higher rates than do women, regardless of victimization.

The findings that were significant were consistent with previous research and theories regarding the recovery of survivors of sexual abuse. In several ways, male survivors face similar consequences of abuse when compared to female survivors. Post traumatic stress disorder, the strongest association found in this study, may remain untreated among men because of hegemonic masculinity's emphasis on men denying themselves emotions and being "tough". Related to PTSD, depression and, its extreme form, suicidal thoughts and tendencies, were also found to be more common in male survivors. Because of this association, those who suffered from depression and suicidal tendencies were disproportionately survivors of sexual abuse. Previous research found that male survivors had higher rates of suicidal tendencies when compared to women (Struckman-Johnson and Struckman-Johnson, 2006) and while the numbers were slightly lower in this analysis than its predecessors (16.4% compared to 19%), the results are still much higher when held in contrast to the percentage of female survivors with suicidal tendencies (4%) (Struckman-Johnson and Struckman-Johnson, 2006).

Overall, the findings of this study suggest that men who experience several different types of severe mental health problems (PTSD, depression, suicidal tendencies) are more likely to be survivors of sexual abuse when compared to non-victims. Theories of the social construction of masculinity suggest that sexual assault may be experienced by men as a threat to their gender identity and status, and that this threat may result in the negative outcomes detailed in this study. Although this research could not test this hypothesis specifically, the findings suggest that gender socialization and masculinity may be important issues to pursue more explicitly in future research.

Implications and Future Research

With knowledge of the findings presented in this study and the support it lends to previous studies, treatment aimed at male survivors needs to focus on mental health issues, particularly suicidal tendencies. Suicide is a last resort for those suffering from other mental disorders/disabilities when they feel as though they have no alternative. To remedy this notion among male survivors, efforts need to increase in order to provide mental health and other services to men. After adequate efforts have been made with regards to suicide prevention, then a more concerted focus on treatment of PTSD and depression should be provided, although their treatment and the prevention of suicide may go hand in hand.

A major limitation of this analysis was that the data were originally intended as a study of prevalence and not explicitly designed for the study of male survivors; as such results are limited by sample size. To avoid these sampling issues, future research should over-sample male survivors in order to have a balanced comparison between male survivors and non-victims.

Future research is needed to flesh out specific revelations presented as a result of this study. While many findings are consistent with previous research, the differences between men and women with regards to self-rated health needs to be of focus. This is key to identifying if/how male survivors recover differently, and with such knowledge, better, more effective programs and treatment can be developed specifically targeting male survivors of sexual abuse. Future research could go about this endeavor in many different ways, from simply assessing the prevalence of survivors among a group of athletes

compared to a group of non-athletes to including a measure of activity level in studies pertaining to male survivors of sexual abuse.

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