

Long-Term Psychological and Physiological Effects of Male Sexual Trauma

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Male sexual trauma presents multiple clinical challenges. Although the topic has received increased attention in the last couple decades, male sexual trauma continues to be underreported and under-recognized. This study aimed to investigate the long-term effects of sexual trauma for men who were victimized within an institutional environment by a person in a position of power. This study included data from 47 adult men who were victims of sexual abuse or misconduct by an assigned physician at a higher education academic institution between 1966 and 2003. A primary finding was elevated rates of intimacy and sexual problems and erectile dysfunction, which started shortly after the abuse and persisted over time. We found that there was an association between intimacy and sexual problems and difficulty maintaining employment, drug addiction, erectile dysfunction, and loss of meaningful and romantic relationships. Levels of potential psychopathology were prominently linked to loss of sexual interest or pleasure, intimacy concerns, and loss of intimate and other personal relationships. Men who experienced sexual abuse as adults within an institutional environment developed long-standing patterns of interpersonal and professional problems. This study emphasizes the need for nuanced screening, evaluation, and treatment for male sexual trauma.

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Male sexual trauma presents identification, diagnostic, and treatment challenges. Most researchers and clinicians agree that this population has been underestimated, because of underreporting and the stigmatization associated with men disclosing sexual abuse.^{1–4} Researchers also agree that male sexual abuse (MSA) is far from being inconsequential, from both physical and psychological perspectives.² Furthermore, evidence suggests that the detection, prosecution, and treatment of cases involving male victims remains particularly problematic.^{3–5}

In the United States, several landmark decisions over the past two decades have facilitated attention to males who were sexually victimized. In 1992 Congress required that the Department of Defense

(DOD) take action to prevent and treat sexual harassment and sexual assault in the military, followed by the U.S. Department of Veterans Affairs adoption of the term military sexual trauma (MST).⁶ In 2004, the DOD established the Sexual Assault Prevention and Response Office (SAPRO).⁷ On January 6, 2012, the FBI updated its definition of rape in their Uniform Crime Report (UCR) Summary Reporting System (SRS),⁸ with the new definition being: “The penetration, no matter how slight, of the vagina or anus with any body part or object, or oral penetration by a sex organ of another person, without the consent of the victim.”⁹ This new definition included any gender of victim and perpetrator and recognized that rape with an object could be as traumatic as penile rape. The new definition included instances in which the victim was unable to give consent because of temporary or permanent mental or physical incapacity, and recognized that a victim could be incapacitated and thus unable to consent because of ingestion of drugs or alcohol and that a victim could be legally incapable of consent because of age. The importance of this change included the fact that the UCR is

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viewed as the national “report card” on serious crime, which influences how crime is viewed in the United States at large.⁸

Additionally, on September 4, 2003, the Prison Rape Elimination Act (PREA) of 2003 was signed into law with the goal to eradicate prisoner rape in correctional facilities.¹⁰ These political and legal actions in conjunction with research that demonstrates that this phenomenon is not exclusive to prisons,¹¹ as well as acknowledgments by medical organizations, such as the American Medical Association, that MSA is a “silent-violent epidemic,”¹² have brought greater recognition of this form of violence, even though specific knowledge regarding victim–patients’ biopsychosocial profiles, long-term functioning, and treatment guidance are still scarce.

Studies of male sexual physiology have also raised awareness that male victims, either because of physiological effects of anal penetration or direct stimulation by their assailants, could experience an erection, or ejaculate, or both during an assault, a fact that was incorrectly understood by assailants, victims, the justice system, and the medical community as signifying consent by the victim. Erections and ejaculations are only partially under voluntary control and are known to occur during times of extreme duress in the absence of sexual pleasure.¹¹ Other studies cite similar anecdotal evidence of involuntary arousal. It has been proposed that several myths pertaining to sexual abuse, ranging from how it is perceived by victims, perpetrators, and society, contribute to the unfounded belief that sexually abused men are less traumatized than female victims.^{13,14}

There are varying types of sexual abuse or harassment. Sexual victimization in which one person exerts force over another person sexually without consent is legally defined as rape. Sexual victimization may also involve inappropriate touching, unwanted intimate contact, and sexual coercion. Sexual victimization may also take place in contexts in which physical force is not used but one person exerts pressure or control over someone else of unequal status. This type of sexual abuse usually involves authority figures such as coaches, teachers, or health care providers and may be associated with a male victim’s further reluctance to disclose sexual abuse.¹⁵

This current study provided a subsample of data from 47 men who experienced sexual misconduct by the same physician within a higher education institutional environment across a five-decade span.

The male students experienced some form of inappropriate touching, including anal penetration during what was posed as a rectal exam, or intentional genital manipulation during physical examinations, or both. Given the gap in the literature and this cohort’s experience, we examined the long-term effects (e.g., physiological, psychological, social) for adult males who were subjected to sexual misconduct in an institutional environment.

Methods

Design and Sample

In this study, data were derived from evaluations conducted as part of legal proceedings related to a civil class suit brought in 2018, 55 years after the first subjects had been victimized. As part of the legal process, the victims were evaluated and reports were produced. The records studied included reports from forensic evaluation interviews, as well as Symptom Checklist 90–Revised (SCL-90-R) scores, a self-administered standardized instrument that had been administered as part of the original evaluation process in the legal proceedings. The SCL-90-R instrument is described further below. The study consisted of a secondary data analysis of the materials gathered and produced for the legal procedures. All records made available to the research team were provided by two law firms who had represented a number of victims in the lawsuit and retained these evaluation documents. Permission to use the data for research purposes was provided by the law firms and by the individuals represented in the dataset. To ensure confidentiality, all documents were de-identified and any personally identifying information was redacted. The study was approved by the Institutional Review Board of Boston College.

All of the men included in the study were sexually exploited by an assigned medical provider at an academic institution. Several of the men had been required to obtain periodic physical exams as a requirement for their academic, athletic, or professional standings. Over the span of more than five decades, the perpetrator engaged in sexual misconduct, misleading the victims to believe that examinations or treatments (including anal exams, fondling of genitals, and “semen collection”) were medically necessary, when in fact they were being performed for his own personal sexual gratification.

Measures and Data Analysis

The data included comprehensive biopsychosocial interviews, as well as results from a psychometric instrument, the SCL-90-R. The SCL-90-R respondents' scores were used in this study, because the instrument contributes to assessing accurately a person's subjective experience of mental health symptoms and potential psychological disturbances.¹⁶ Moreover, it is a self-report tool that does not necessitate the involvement of a mental health professional to identify the likelihood of psychopathology.¹⁶ The SCL-90-R is a broadly used questionnaire originally developed by Derogatis,¹⁷ and despite some limitations (e.g., self-report bias, lack of inference of causal relationships and contextual information, limited discriminant validity across dimensional subscales),¹⁷ the SCL-90-R remains a valuable tool. The instrument has been validated and used widely in international research,^{18–23} and its use has been supported in clinical practice.¹⁶

As the name suggests, the SCL-90-R assesses for 90 symptoms that are further categorized within nine symptomatic dimensions: depression, anxiety, phobic anxiety, paranoid ideation, psychoticism, somatization, obsessive–compulsive disorder, interpersonal sensitivity, and hostility.^{16,17} Individuals are asked to rate how much they were bothered by a specific symptom within the past week, rating it from 0 (not at all) to 4 (extremely). Additionally, the instrument contains three indices of general distress: positive symptom total (PST), positive symptom distress index (PSDI), and the global severity index (GSI).^{17,18} In terms of interpretation, the PST reveals the number and degree of symptoms endorsed by respondents and may also indicate whether they may be attempting to misrepresent their current functioning. The PSDI is an intensity measure that can also provide insight to the individual's distress style. The GSI is particularly useful for the purpose of this study, because the index is the most sensitive quantitative indicator for level of psychological distress.¹⁷ Moreover, the GSI can also be used to identify three population groups: functional, moderately symptomatic, and severely symptomatic.¹⁸

All cases were retrospectively analyzed for the victim's characteristics and background (e.g., age, level of education, employment status, marital status), nature of the abuse, and several other variables pertaining to their functioning following the abuse (e.g., relationship status, substance abuse, ability to sustain employment, erectile dysfunction, intimacy problems, etc.). To classify the data and establish

quantitative parameters, the researchers developed a tool that included variables of interest. The variables were informed by previous studies examining sexual abuse²⁴ and based on data obtained from the forensic evaluations that had been performed as part of the civil lawsuit, which encompassed prior history and current functioning and mental health status, including quotations from the transcribed interviews included in the evaluations. Variables pertaining to life course, development, and postabuse functioning were divided into six categories: developmental, educational, professional, interpersonal, romantic, and physical and mental. (The list of the original variables is available from the authors on request.) These variables were rated based on information from the evaluations, reports, and interview transcripts. To determine inter-rater reliability, 20 percent of the cases were randomly selected and coded by two persons and then analyzed with Cohen's kappa.

The data incorporated in the present study were analyzed with SPSS version 27, using the chi-square test and Fisher's exact test when appropriate. Independent sample *t* tests were used for parametric analysis. Findings were deemed significant if $P < .05$.

Results

The two primary findings of this study, intimacy and sexual problems (78.7%) and erectile dysfunction (ED; 51.1%), were contrasted with other variables for discussion in this article.

Sample Description

The physician's sexual misconduct continued across four decades when the participants were between 18 and 22 years of age. The oldest encounter took place in 1966, and the most recent occurred in 2003, with mean time between the last assault and participation in the data collection being 41.7 years. More than 70 percent of the men were White, with 20 percent identified as Black or African American and four percent identified as Native American or Hispanic or Latino. The youngest study participant was 40 years and the oldest 77, with the average age of participants being 64.4 (SD = 8.97) at the time of data collection in 2022. All the encounters between perpetrator and victims were in the context of medical visits, and the abuse was framed as a necessary medical exam in all cases.

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Table 1 Educational Achievements, Marital Status, and Employment After Abuse

Measure	%
Highest Level of education	
Bachelor's degree	48.9
Doctorate or professional degree	17.0
Master's degree	27.7
Some college or no degree	6.4
Employment status at the time of the data collection	(%)
Employed full-time	48.9
Employed part-time	2.1
Retired	34.0
Self-employed	6.4
Unable to work	2.1
Unemployed and currently looking for work	4.3
Unemployed and not currently looking for work	2.1
Marital status	
Married, or in a domestic partnership	66.0
Divorced	14.9
Separated	2.1
Widowed	4.3
Single (never married)	12.8

The sample of 47 men included 31 participants who were married or in a domestic partnership, seven who were divorced, one who reported being separated, six who were single (never married), and two who were widowed. One of the participants identified as gay, one identified as bisexual, and the others identified as heterosexual. There was a statistically significant association between loss of romantic partners and sexual or intimacy problems ($P = .008$, Fisher's Exact Test (FET)): 69 percent of participants who struggled with achieving or sustaining an erection after abuse reported loss of romantic partners.

Participants' Background

Participants' academic achievements, employment history, and marital status varied within the group (Table 1).

In the sample, 91.5 percent of the participants reported having minimal or no sexual experience before the abuse. Moreover, 17 percent described questioning their sexuality after the encounter(s) in which the abuse took place, with two participants describing hypersexuality or "sex addiction" over the years, as a way to "prove their masculinity."

Frequency and Nature of the Abuse

In this group, 21.3 percent had a single contact with the perpetrator, 23.4 percent had two to 10 contacts with the perpetrator, and 55.3 percent had

Table 2 Frequency of Specific Types of Abuse Experienced

Type of Abuse	Frequency
Use of force during abuse	0
Anal penetration (digital)	36
Anal penetration (object)	2
Penis or testicles fondled	46
Victim made to touch or fondle the abuser's genitals	3
Victim was masturbated	14
Victim was caused to orgasm or ejaculate	6
The abuser exposed his genitals to the victim	10
Victim was made to masturbate the abuser	2

more than 11 contacts with the perpetrator. Those who had multiple encounters were generally college students who had been assigned to the medical provider at the university's medical center, with the exception of three participants (one continued to have the perpetrator as his primary care provider postgraduation and two who randomly selected the perpetrator as their medical provider, even though they were not enrolled students at the institution). In the sample, 74.5 percent of the participants described that physical exams were required either to maintain their athletic or varsity standing or to renew a license (e.g., pilot license). Within that group, there were four participants who also reported that between 1969 and 1971 they were required to obtain physical exams as part of the Vietnam War draft, indicating that the assigned physician for draft physicals was the same perpetrator who oversaw the institution. In 94 percent of the cases, the participant did not have a choice of medical provider. Participants' role within the institution varied within the sample, with 72.3 percent of them being involved in sports and 59.6 percent having an athletic scholarship.

The abuse experienced by the men involved a range of actions, including: having their genitals fondled under the guise of a hernia examination; having their anus digitally penetrated or penetrated with an object, under the premise of a prostate exam; having the physician expose his genitals to them; being masturbated by the physician; being made to ejaculate; being made to touch the physician's genitals; and being made to masturbate the physician. There were no cases that involved the use of force (Table 2), but 21 percent reported experiencing physical pain or discomfort. In total, 76 percent indicated that they were unaware that they were being sexually exploited during their encounter(s), and it was not until the class action lawsuit started and more information was unveiled that they recognized

that the physician did not perform examinations or provide treatment, but instead abused them for his own personal sexual gratification. Participants reported that although there was “chatter” among students and athletes regarding the abuse taking place at the institution, they never formally reported it to the university. In some cases, participants described informal discussions with coaches, indicating that they felt uneasy about the sexual nature of their physical exams. They reported being told to “be a man” and repress their concerns; there was no follow-up in any instances. All participants indicated that they were unaware of any formal channels to report the abuse, and 97.9 percent feared the consequences of reporting the abuse.

Postabuse Functioning

Approximately 20 percent of the participants dropped out of college following the abuse. From the time of the abuse until the point at which data were collected, 38 percent of the participants reported a difficult time holding a job. Statistical associations between having sexual or romantic intimacy problems were contrasted with different dimensions of postabuse functioning (Table 3).

In our sample, 59.6 percent of the participants described losing romantic partners and 74.5 percent noted difficulty establishing meaningful relationships and losing contact with family and friends in the years following the sexual abuse. A chi-square test of independence also showed that there was a significant association between ED and loss of romantic partners ($P = .008$, FET, $\phi = .401$). The SCL-90-R was completed by 46 participants. The Global Severity Index (GSI), which is derived from the SCL-90-R and serves to identify the presence of potential psychopathology, was statistically associated with the age group of the participant, chi-square (1, $N = 46$) = 14.146, $P = .028$, with symptomatic severity lessening as one ages. Within age groups, the “severely symptomatic” index was observed in 66.7 percent (four of six) of 45- to 54-year-olds and 69.2 percent of those aged 55–64 years (nine of 13). For the men aged between 65 and 74, approximately half (nine of 19) had a GSI consistent with the “functional population,” and the remainders were evenly distributed between “moderately symptomatic” and “severely symptomatic.” Of the men who were 75 and older, 62.5 percent (five of eight) had an index consistent with

Table 3 Relationships between Romantic or Sexual Intimacy Problems and Postabuse Variables

Variable	<i>n</i>	χ^2	<i>P</i>	Fisher's Exact Test	Φ
Loss of romantic partners					
Yes	29	15.333	<.001*	<.001*	.575
No	18				
Loss of meaningful relationships					
Yes	37	16.613	<.001*	<.001*	.595
No	10				
Difficulty sustaining employment					
Yes	19	6.542	<.011*	<.015*	.373
No	28				
Alcohol addiction					
Yes	16	1.993	.158	.234	—
No	31				
Drug addiction					
Yes	15	4.519	.034*	.042*	.310
No	32				
Difficulty achieving or sustaining an erection (erectile dysfunction)					
Yes	25	10.956	.001*	.001*	.483
No	22				
Loss of sexual interest or pleasure					
Yes	32	1.451	.228	.245	—
No	15				
Bothersome thoughts about sex					
Yes	20	3.562	.059	.114	—
No	27				
Never feeling close to another person					
Yes	24	.710	.400	.461	—
No	23				
Feeling self-conscious around others					
Yes	21	4.039	.044	.059	—
No	26				
Problems trusting others					
Yes	39	.210	.647	1.000	—
No	8				
Humiliation or embarrassment associated with the abuse					
Yes	39	.428	.513	1.000	—
No	8				
GSI					
Functional population	15	8.349	<.039*	—	.421
Moderately symptomatic	11				
Severely symptomatic	20				

* $p < 0.05$.

the “functional population,” and 37.5 percent were “moderately symptomatic” (three of eight). Hence, there was an overall decrease in GSI score as individuals got older.

Psychological Wellbeing

Given the study’s focus on long-term effects and outcomes after sexual victimizations, we compared variation in SCL-90-R with other variables of interest. Variables that had a significant association with SCL-90-R scores included alcohol addiction, sexual or intimacy problems, and difficulty with employment (Table 4).

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Table 4 Independent *t* Test: SCL-90-R Scores and Variables of Interest

Variable	<i>n</i>	Mean (SCL-90-R)	SD	<i>t</i> Test	<i>P</i> Value	Cohen's <i>d</i>
Genitals were fondled						
Yes	46	109.65	72.66	1.289	.204	—
No	1	15.00	—			
Anal penetration (digital)						
Yes	36	103.00	69.92	−.783	.438	—
No	11	122.82	84.82			
Made to orgasm or ejaculate during abuse						
Yes	6	148.33	49.68	1.477	.147	—
No	41	101.68	74.69			
Loss of sexual interest or pleasure						
Yes	31	134.90	69.68	4.424*	<.001*	1.210
No	15	58.47	46.14			
Alcohol addiction						
Yes	16	145.94	61.50	2.756*	.008*	.848
No	31	87.87	71.66			
Drug addiction						
Yes	15	129.67	60.30	1.429	.160	—
No	32	97.31	77.20			
Feelings of shame or humiliation						
Yes	45	103.82	72.45	−1.732	.09	—
No	2	193.50	.707			
Sexual or intimacy problems						
Yes	39	118.33	68.57	2.315*	.025*	.898
No	8	55.50	76.98			
Loss of romantic partners						
Yes	29	128.69	68.79	2.664*	.011*	.799
No	18	73.72	68.72			
Loss of meaningful relationships						
Yes	37	126.65	69.14	5.582*	<.001*	1.399
No	10	37.30	35.63			
Erectile dysfunction						
Yes	25	116.88	67.89	.921	.362	—
No	22	97.14	79.04			
Difficulty with employment						
Yes	19	149.11	62.03	3.590*	.001*	1.067
No	28	79.40	67.31			

SCL-90-R = Symptom Checklist 90–Revised.

**p* < 0.05.

Discussion

Most victimological research on the effects of sexual trauma has focused on victims of child sexual abuse or adult female victims.²⁵ Although some studies have explored male sexual abuse that takes place in stages of adulthood, the focus has been primarily on describing immediate or short-term reactions to the trauma or identifying risk factors related to sexual victimization.^{15,26–29} To our knowledge, a single study by Walker, Archer and Davies,³⁰ which was based on self-administered surveys, explored the effects of rape on a nonclinical sample of men, finding that long-term effects included anxiety, depression, feelings of anger, loss of self-image, emotional disconnection, self-blame, and self-harming behaviors.

The major findings among this group of young adults were pervasive problems with relationships and intimacy, as well as chronic sexual dysfunction, potentially suggesting the serious psychological and physiological impact that negative sexual experiences or abuse, whether explicit or not, can have on sexual arousal.³¹ Most of the participants had little to no sexual partner activity when the abuse occurred. In several cases, the physician's genital fondling and digital anal penetration caused confusion over their sexual identity or orientation, and, in some, set into motion a phase of hypersexuality to try to "prove" their masculinity. Frequently, sexual dysfunction consisted of ED or loss of libido. Approximately half of our sample reported persistent ED immediately postabuse, substantially high numbers compared with the overall prevalence of ED in the general population of 16 to 30 percent.^{32–34} It is noteworthy that although data collection occurred decades after the abuse, participants described sexual dysfunction that started shortly after experiencing the sexual abuse.

None of the participants reported the incident when it first occurred. In fact, they all denied sharing that they had been victimized to anyone, including family and friends, until the case gained notoriety and was litigated years later. Although the participants acknowledged that there was discussion among students regarding the perpetrator's sexual misconduct, they described three primary reasons for not reporting or fully disclosing their own experiences: they feared not being believed and experiencing repercussions (e.g., losing scholarships or their academic or athletic status within the institution); they needed medical clearance, whether it was to maintain scholarships, athletic status, or receive letters excusing them from the war draft; and despite questioning the actual necessity of certain steps of the examination, they trusted the physician's recommendations. It was not until years or decades later that they discovered that the medical provider did not perform examinations or provide treatment because they were necessary but instead used the procedures as a disguise to exploit them for his own sexual pleasure.

Concerns of not being believed or choosing not to report the abuse because of fear of consequences have been shown in research examining institutional betrayal, which occurs when there are acts, deliberate or otherwise, committed by systems on individuals who put their trust in the institutions to support and protect them.³⁵ Studies have found that institutional

failure to prevent sexual assault, facilitate reporting, or respond supportively when the abuse occurs may exacerbate anxiety, trauma-related symptoms, and problematic sexual functioning. In these instances, the impact of the abuse is intensified by the betrayal of the institution, causing additional harm to assault survivors.³⁶

For participants who described accepting sexual exploitation as part of their course within the institution, it emphasizes a system of subjugation, in which power differential, persuasion, and coercion serve to perpetuate abuse and silence victims.^{37,38} This process has similarities to instances in which children are groomed through verbal coercion by perpetrators who use their status or authority to abuse the victim, promise special treatment in exchange for sexualized interactions, or disguise the sexual contact as something that is for the victim's benefit.³⁸ In a study exploring the effects of grooming on psychological symptoms in adults who experienced child sexual abuse, Wolf and Pruitt³⁹ determined that verbal coercion was a significant predictor of sexual problems for the victim.

There was a statistically significant relationship between sexual and romantic intimacy and one's ability to sustain employment and relationships, romantic or otherwise. Moreover, there was a large effect between ED and intimacy problems. This finding is consistent with previous research on primary ED, which found that personal relationships in general can be significantly affected by the sexual dysfunction, as the individual tends to experience acute embarrassment and withdraw from others.^{40,41} About half of the participants reported ED that started shortly after the abuse took place, when they were still in their twenties, and persisted over the years. They described being able to achieve an erection on their own but having difficulties with arousal with a partner. Two of the participants reported pharmacological treatment for ED with minimal success. The description of the symptoms, in connection with the prominent problems with intimacy, suggest psychogenic ED, defined as the persistent inability to achieve or sustain erection that allows for sexual performance, primarily or exclusively related to interpersonal psychologic factors.⁴²

Although sexual dysfunction is not a specific symptom of trauma-related disorders, it is a frequent clinical complaint among trauma survivors of both genders.^{38,43} In this study, intimacy problems were

associated with elevated SCL-90-R scores, suggesting psychopathology. Research involving female victims of sexual abuse has demonstrated that timely identification of the abuse, immediate support, and continued mental health treatment are associated with lessened acute symptoms within one year post-incident.⁴⁴⁻⁴⁶ Comparatively, delayed reporting of abuse by male victims or recognition by professionals greatly affects prompt care and results in persistent and pervasive psychological and behavioral disturbances.⁴⁷ For that reason, sexual health has been emphasized as an area of clinical importance that should also be assessed and targeted in trauma-focused treatment.^{44,46,48}

Delay in reporting seems to be influenced by stigma and potential cognitive distortions. It has been argued that males may be less likely to perceive inappropriate sexual activity as abusive. Gerber¹⁴ described the "myth of complicity," in which some child male victims who are aroused during sexual abuse internalize the blame for the assault. In this case, given overt physiological reactions (e.g., erection, orgasm), victimized boys may process and rationalize the event, positioning themselves as a willing participant who desired or enjoyed the sexual activity. Coupled with grooming behavior, male victims may struggle to identify readily the abuse that took place.^{49,50} Denial, avoidance, and strong efforts to minimize or disregard past sexual victimization have been demonstrated in research on the treatment of victims of sexual abuse.⁵⁰⁻⁵⁴ Rando and colleagues⁵⁵ argued that this type of coping strategy renders male victims prone to long-term psychological problems because it makes help-seeking less likely, and denial undermines men coming to terms with their sexual abuse.

Men's hesitation in disclosing past abuse may come from concerns about the stigma of homosexuality or tension with the male ethic of self-reliance, in which help-seeking behaviors are perceived as unmasculine.^{56,57} This theory may prove particularly true in our sample, with participants describing a culture in which sexual misconduct was mocked among peers and self-advocacy was framed as unwarranted complaining and unmasculine when broaching the topic to coaching staff. In consequence, in such contexts, men who are sexually victimized may internalize the belief that the abuse was a result of their own weakness.⁵⁸ These patterns perpetuate the myth that men carry greater responsibility for their assaults.⁵⁹ Combined with other existing societal perceptions of

men and sexual victimization, men are prevented from identifying themselves as victims and seeking necessary help to address the detrimental ramifications of sexual victimization.⁵⁶

It was evident in our sample that, as a result of lacking resources to recognize, identify, and disclose the abuse, participants relied on primitive strategies, such as suppression and repression, as their primary means of coping. Coupled with a variety of complex psychological symptoms which were evidenced through the SCL-90-R, there was an apparent shift in the overall traits and functioning postabuse, including addiction, mistrust, and humiliation. Past research has linked trauma to potential personality disturbances, behavioral disorders, and addiction, particularly in cases of childhood maltreatment and childhood sexual abuse.^{60–65} The present study suggests that sexual dysfunction in men may have sexual abuse as a point of origin, not just in early childhood but also in adulthood. Our findings provide support to previous research, indicating that similar to those who experienced child sexual abuse, it appears that within the overarching biopsychosocial context, the traumatic response for those who were victimized as adults yielded higher than expected rates of psychopathology and permeated to other areas of functioning, affecting their professional trajectory and their ability to develop strong friendships or form and sustain stable intimate relationships.⁶⁶

The primary limitation of this study is the absence of a control group or direct comparisons with the general population, which provides an opportunity for future inquiry. Another potential limitation in this study is the fact that information shared by participants relied on their memory of events that took place over decades. Additionally, this sample represents a distinct segment of the male population. Still, the study offers a descriptive analysis of a unique group that, to the best of our knowledge, has not been examined before. The findings provide valuable knowledge regarding the long-term effects of sexual trauma, which may translate to other groups in whom sexual victimization is repressed. Future research comparing this group with the general population or a control group is warranted to identify whether features observed in this study can be further attributed to their experience of sexual abuse or if they are better explained by other factors. Additionally, exploring specific screening methodologies and treatment modalities dedicated to male

sexual trauma is recommended. Further examination of psychological mechanisms that implicate delayed reporting of MSA could extend this work and guide future interventions. This study's findings emphasize the dire need for active and careful screening of sexual victimization among adult males in health care settings and beyond, in addition to specific counseling and psychosocial interventions.^{57,66,67} Additionally, continued efforts to destigmatize MSA and create institutional structures that facilitate reporting are highlighted by our findings, so as to facilitate a culture in which men feel secure,⁶⁸ within themselves and society around them, to disclose abuse and seek help, instead of suffering in silence.

References

1. Hlavka HR. Speaking of stigma and the silence of shame. *Men Masculinities*. 2017 Jun; 20(4):482–505
2. Hiquet J, Gromb-Monnoyeur S. Men victim of sexual assault of concern into the first Emergency Medical Unit for Victims of Assaults in France. *J Forensic Leg Med*. 2013 Oct; 20(7):836–41
3. Romano E, De Luca RV. Male sexual abuse. *Aggress Violent Behav*. 2001 Jan; 6(1):55–78
4. McLean IA. The male victim of sexual assault. *Best Pract Res Clin Obstet Gynaecol*. 2013 Feb; 27(1):39–46
5. Mezey G, King M. The effects of sexual assault on men: A survey of 22 victims. *Psychol Med*. 1989 Feb; 19(1):205–9
6. Lofgreen AM, Carroll KK, Dugan SA, Karnik NS. An overview of sexual trauma in the U.S. military. *Focus (Am Psychiatr Publ)*. 2017 Oct; 15(4):411–9
7. Godier-McBard LR, Jones ML. Same-sex sexual violence in the military: A scoping review. *J Mil Veteran Fam Health*. 2020 Aug; 6(2):68–84
8. Strom KJ, Smith EL. The future of crime data. *Criminology & Pub Pol'y*. 2017 Nov; 16(4):1027–48
9. U.S. Department of Justice, Federal Bureau of Investigation. Crime in the United States [Internet]; 2013. Available from: <https://ucr.fbi.gov/crime-in-the-u.s/2013/crime-in-the-u.s.-2013/violent-crime/rape>. Accessed July 21, 2023
10. Prison Rape Elimination Act of 2003. Public Law 108-79 2003. Available from: <https://www.govinfo.gov/content/pkg/PLAW-108publ79/html/PLAW-108publ79.htm>. Accessed July 21, 2023
11. Lipscomb GH, Muram D, Speck PM, Mercer BM. Male victims of sexual assault. *JAMA*. 1992 Jun; 267(22):3064–6
12. Washington Post. Sexual assault called silent violent epidemic [Internet]; 1995 Nov 7. Available from: <https://www.washingtonpost.com/archive/politics/1995/11/07/sexual-assault-called-silent-violent-epidemic/d559dce9-8e01-484c-98ab-c90d5de2ead1/>. Accessed July 21, 2023
13. Bullock C, Beckson M. Male victims of sexual assault: Phenomenology, psychology, physiology. *J Am Acad Psychiatry Law*. 2011 Jun; 39(2):197–205
14. Gerber PN. Victims becoming offenders: A study of ambiguities. In Hunter M, editor. *The Sexually Abused Male*. Hoboken, NJ: Jossey-Bass; 1990. p. 153–79
15. Tewksbury R, Mustaine E. Lifestyle factors associated with the sexual assault of men: A routine activity theory analysis. *J Men's Studies*. 2001 Jan; 9(2):153–82

16. Gomez R, Stavropoulos V, Zarate D, Palikara O. Symptom Checklist-90-Revised: A structural examination in relation to family functioning. *PLOS One*. 2021 Mar; 16(3):e0247902
17. Derogatis L. SCL-90-R: Administration, Scoring, and Procedures Manual II for the Revised Version. Towson, MD: Clinical Psychometric Research; 1983
18. Schmitz N, Hartkamp N, Franke GH. Assessing clinically significant change: Application to the SCL-90-R. *Psychol Rep*. 2000 Feb; 86(1):263-74
19. Akhavan Abiri F, Shairi MR. Validity and reliability of Symptom Checklist-90-Revised (SCL-90-R) and Brief Symptom Inventory-53 (BSI-53). *Clin Psychol Personal*. 2020 Sep; 17(2):169-95
20. Carlozzi NE, Long PJ. Reliability and validity of the SCL-90-R PTSD. *J Interpers Violence*. 2008 Feb; 23(9):1162-76
21. Carpenter KM, Hittner JB. Dimensional characteristics of the SCL-90-R: Evaluation of gender differences in dually diagnosed inpatients. *J Clin Psychol*. 1995 May; 51(3):383-90
22. Carrozzino D, Christensen KS, Patierno C, et al. The Hopkins Symptom Checklist (SCL-90-R): A patient-reported outcome measure in Parkinson's disease. *J Geriatr Psychiatry Neurol*. 2022 Dec; 35(5):689-97
23. Martinez S, Stillerman L, Waldo M. Reliability and validity of the SCL-90-R with Hispanic college students. *Hispanic J Behav Sci*. 2005 May; 27(2):254-64
24. Burgess A. Physician sexual misconduct and patients' responses. *Am J Psychiatry*. 1981 Oct; 138(10):1335-42
25. Khan S, Greene J, Mellins CA, Hirsch JS. The social organization of sexual assault. *Ann Rev Criminology*. 2020 Jan; 3(1):139-63
26. Goyer PF, Eddleman HC. Same-sex rape of nonincarcerated men. *Am J Psychiatry*. 1984 Apr; 141(4):576-9
27. Groth N, Burgess AW. Male rape: Offenders and victims. *Am J Psychiatry*. 1980 Jul; 137(7):806-10
28. Littleton H, Downs E, Rudolph K. The sexual victimization experiences of men attending college: A mixed methods investigation. *Sex Roles*. 2020 Feb; 83(9-10):595-608
29. Turchik JA. Sexual victimization among male college students: Assault severity, sexual functioning, and health risk behaviors. *Psychol Men Masculinity*. 2012; 13(3):243-55
30. Walker J, Archer J, Davies M. Effects of male rape on psychological functioning. *Br J Clin Psychol*. 2005 Sep; 44(Pt 3):445-51
31. Graziottin A. Sexual arousal: Similarities and differences between men and women. *J Men's Health Gender*. 2004 Sep; 1(2-3):215-23
32. Kohn TP, Rajanahally S, Hellstrom WJG, et al. Global trends in prevalence, treatments, and costs of penile prosthesis for erectile dysfunction in men. *Eur Urol Focus*. 2022 May; 8(3):803-13
33. McKinlay J. The worldwide prevalence and epidemiology of erectile dysfunction. *Int J Impot Res*. 2000 Oct; 12 Suppl 4: S6-S11
34. Rosen RC, Fisher WA, Eardley I, Men's Attitudes to Life Events and Sexuality (MALES) Study, et al. The multinational Men's Attitudes to Life Events and Sexuality (MALES) study: I. Prevalence of erectile dysfunction and related health concerns in the general population. *Curr Med Res Opin*. 2004 May; 20(5):607-17
35. Smidt AM, Freyd JJ. Government-mandated institutional betrayal. *J Trauma Dissociation*. 2018 Jul; 19(5):491-9
36. Smith CP, Freyd JJ. Dangerous safe havens: Institutional betrayal exacerbates sexual trauma. *J Trauma Stress*. 2013 Feb; 26(1):119-24
37. Hines DA. Predictors of sexual coercion against women and men: A multilevel, multinational study of university students. *Arch Sex Behav*. 2007 Feb; 36(3):403-22
38. Tuana N. Sexual harassment in academe. *College Teaching*. 1985 May; 33(2):53-63
39. Wolf MR, Pruitt DK. Grooming hurts too: The effects of types of perpetrator grooming on trauma symptoms in adult survivors of child sexual abuse. *J Child Sex Abus*. 2019 Mar; 28(3):345-59
40. Latini DM, Penson DF, Colwell HH, et al. Psychological impact of erectile dysfunction: Validation of a new health related quality of life measure for patients with erectile dysfunction. *J Urol*. 2002 Nov; 168(5):2086-91
41. Tomlinson J, Wright D. Impact of erectile dysfunction and its subsequent treatment with sildenafil: Qualitative study. *BMJ*. 2004 May; 328(7447):1037
42. Rosen RC. Psychogenic erectile dysfunction. *Urol Clin North Am*. 2001 May; 28(2):269-78
43. Yehuda R, Hoge CW, McFarlane AC, et al. Post-traumatic stress disorder. *Nat Rev Dis Primers*. 2015 Oct; 1:15057
44. Burgess AW, Holmstrom LL. Crisis and counseling request of rape victims. *Nurs Res*. 1974 May; 23(3):196-202
45. Mezey GC, Taylor PJ. Psychological reactions of women who have been raped. *Br J Psychiatry*. 1988 Mar; 152(3):330-9
46. O'Driscoll C, Flanagan E. Sexual problems and post-traumatic stress disorder following sexual trauma: A meta-analytic review. *Psychol Psychother Oct*. 2016; 89(3):351-67
47. Dhaliwal GK, Gauzas L, Antonowicz DH, Ross RR. Adult male survivors of childhood sexual abuse: Prevalence, sexual abuse characteristics, and long-term effects. *Clin Psychol Rev*. 1996 Jan; 16(7):619-39
48. Velurajah R, Brunckhorst O, Waqar M, et al. Erectile dysfunction in patients with anxiety disorders: A systematic review. *Int J Impot Res*. 2022; 34(2):177-86
49. Holmes G, Offen L, Waller G. See no evil, hear no evil, speak no evil: Why do relatively few male victims of childhood sexual abuse receive help for abuse-related issues in adulthood? *Clin Psychol Rev*. 1997; 17(1):69-88
50. Romeo T, Otgaar H, Landstrom S. Coping with sexual abuse. *PROUST*. 2018 Apr; 1(1):46-54
51. Sigmon ST, Greene MP, Rohan KJ, Nichols JE. Coping and adjustment in male and female survivors of childhood sexual abuse. *J Child Sexual Abuse*. 1997 Jan; 5(3):57-75
52. O'Leary PJ. Men who were sexually abused in childhood: Coping strategies and comparisons in psychological functioning. *Child Abuse & Neglect*. 2009 Jul; 33(7):471-9
53. O'Leary PJ, Gould N. Exploring coping factors amongst men who were sexually abused in childhood. *Br J Social Work*. 2010 Aug; 40(8):2669-86 20
54. Valente SM. Sexual abuse of boys. *J Child Adolesc Psychiatr Nurs*. 2005 Jan; 18(1):10-6
55. Rando R, Rogers J, Brittan-Powell C. Gender role conflict and college men's sexually aggressive attitudes and behavior. *J Mental Health Counseling*. 1998 Oct; 20(4):359-69
56. Depraetere J, Vandeviver C, Keygnaert I, Vander Beken T. Gender role norm conformity and sexual assault risk among male and female university students. *Victims & Offenders*. 2021; 16(6):847-68
57. Chan STM. The lens of masculinity: Trauma in men and the landscapes of sexual abuse survivors. *Journal of Ethnic And Cultural Diversity in Social Work*. 2014 Sep; 23(3-4):239-55
58. Ryan G, Lane S, Davis J, Isaac C. Juvenile sex offenders: Development and correction. *Child Abuse Negl*. 1987 Sep; 11(3):385-95
59. Huckle PL. Male rape victims referred to a forensic psychiatric service. *Med Sci & L*. 1995 Jul; 35(3):187-92
60. Boland J, Rock R, Johnson AK, et al. Pathways to incarceration: An examination of childhood maltreatment and personality psychopathology in incarcerated adults. *Psychol Crime & L*. 2021 Jul; 27(3):253-64

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61. Romero-Martínez A, Figueiredo B, Moya-Albiol L. Childhood history of abuse and child abuse potential: The role of parent's gender and timing of childhood abuse. *Child Abuse Negl.* 2014 Mar; 38(3):510–6
62. Tonmyr L, Shields M. Childhood sexual abuse and substance abuse: A gender paradox? *Child Abuse Negl.* 2017 Jan; 63(63):284–94
63. Wonderlich SA, Crosby RD, Mitchell JE, *et al.* Sexual trauma and personality: Developmental vulnerability and additive effects. *J Pers Disord.* 2001 Dec; 15(6):496–504
64. Zink T, Klesges L, Stevens S, Decker P. The development of a sexual abuse severity score. *J Interpers Violence.* 2009 May; 24(3):537–46
65. Easton SD. Disclosure of child sexual abuse among adult male survivors. *Clin Soc Work J.* 2013 Oct; 41(4):344–55
66. Anderson CL. Males as sexual assault victims. *J Homosex.* 1982 Jun; 7(2-3):145–62
67. Davies M. Male sexual assault victims: A selective review of the literature and implications for support services. *Aggression and Violent Behavior.* 2002 May; 7(3):203–14
68. Edwards KM, Turchik JA, Dardis CM, *et al.* Rape myths: History, individual and institutional-level presence, and implications for change. *Sex Roles.* 2011 Feb; 65(11-12): 761–73