

Psychological Symptomatology Experienced by Victims of Sexual Violence

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Abstract

This thesis examines the psychological symptomatology that male and female victims describe following their experiences of sexual violence. An introduction to the area provides definitions, prevalence rates and theories associated with sexual violence. In particular, rape trauma symptomology provides insight into the short and long term symptoms of rape. An ecological perspective is also provided which considers sexual violence in terms of the interrelationships between the characteristics of the victim, the sexual violence itself and the social environment where recovery can take place. Chapter 1 provides a systematic literature review examining the range and measurement of psychological symptomatology of male victims. Findings here indicated that male victims of sexual violence experience an array of negative and harmful psychological symptomatology. In addition, findings identified that more consistent approaches to assessment are needed as are assessments that examine male specific symptomatology. Chapter 2 provides a critique of a relevant psychometric assessment of trauma symptoms namely, the Trauma Symptom Inventory. Findings of the critique highlighted that the TSI could be considered a reliable and valid assessment when examining trauma symptoms. However, its use as a standalone measure was thought to be limited due to factors it does not account for such as the time passed since the incident of sexual violence, whether the trauma occurred during childhood or adulthood etc. Chapter 3 provides an empirical research study that examines and compares the types of psychological symptomatology male and female victims of sexual violence experience. Findings identified that male and female victims of sexual violence significantly associated different psychological symptoms to their experiences. Moreover, male victims significantly described more externalising symptoms in comparison to female victims, who described more internalising symptoms. Finally, Chapter 4 is a discussion of the implications of the thesis findings in relation to assessment, treatment and services for victims of sexual violence. In

particular, more multi method approaches of assessment that are grounded within relevant theories are called for.

Dedication

I dedicate this thesis to my mummy who is the strongest, bravest and loveliest mummy in the whole world. Indeed you are practically perfect in every way!

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Firstly I would like to thank specific individuals at the University including Professor Anthony Beech and Dr Catherine Hamilton-Giachritsis for allowing me the opportunity of completing my Doctorate. Secondly I would like to offer considerable thanks and gratitude to Dr Louise Dixon who has guided and focused me throughout my thesis. Thirdly I offer thanks to Dr Jessica Woodhams who enlightened me on the process of cluster analysis and who also shared an interest in the area of sexual violence. I would also like to thank Sue Hanson who has supported me throughout my entire time at the University which I will always be grateful for.

I acknowledge and thank Coventry Rape & Sexual Abuse Centre for the opportunity to research the area of sexual violence. In particular I would like to thank Ms Dianne Whitfield and Ms Sylvie McGuire for their support and for always believing in me.

I would like to thank my pop who has always thought I am the best at everything and been sure to tell that to anyone who will listen.

My final thank you is for my mummy. I have been blessed to have had her unconditional support, love, guidance and belief. You believed in me even when I didn't – Thank you.

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INTRODUCTION

Introduction

The overall aim of this thesis is to explore the psychological symptomatology experienced by male and female victims of sexual violence. This introduction provides the context for which the collective body of research in the thesis is set. As a starting point, definitions and prevalence of sexual violence is presented, followed by an examination of relevant theories and models of sexual violence including that of the Rape Trauma Syndrome (Burgess & Holmstrom, 1974) and an Ecological Theoretical Perspective of sexual assault (Herman, 1981, 1992; Bronfenbrenner, 1979, 1986, 1995; Campbell, Dworkin & Cabral, 2009). Finally the aims and a general overview of each chapter is provided.

Definition of Sexual Violence

When defining sexual violence some researchers only appear to consider sexual violence in the context of violence against women. As to provide a more encompassing and male inclusive definition,

Sexual violence can be defined as:

“Any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic, or otherwise directed, against a person’s sexuality using coercion, by any person regardless of their relationship to the victim, in any setting, including but not limited to home and work” (Sexual Violence Research Initiative SVRI, 2012).

In terms of the types of sexual violence, sexual violence can occur in any environment and can include coerced sex in marriage, dating relationships, rape by strangers, systematic rape during armed conflict, sexual harassment, sexual abuse of children, sexual abuse of people with mental and / or physical disabilities, forced prostitution and sexual trafficking, child marriage, denial of the right to use contraception, forced abortion and violent acts

against the sexual integrity of women, including female genital cutting and obligatory inspections for virginity.

Prevalence of Sexual Violence

Currently in England and Wales 2.5% of females and 0.4% of males reported being victim of a sexual offence during 2011-2012. These figures translate to 404,000 females and 72,000 males experiencing some form of sexual violence on average each year (Ministry of Justice, 2013). In specifically examining childhood sexual abuse, the National Society for the Prevention of Cruelty to Children (NSPCC)'s review Radford et al. (2011) examined 28 recent studies of childhood sexual abuse. When focusing on prevalence here they identified prevalence rates ranging from 1.1% to 32 % for lifetime experiences of sexual abuse. When examining rape specifically, recent findings from the British Crime Survey highlighted that 47,000 of adult women are raped each year in the UK (Fawcett Society, 2007) and approximately 10,000 women are sexually assaulted each week. Prior to this, during 2000 it was reported that 1 in 6 females and 1 in 33 males have experienced some form of sexual violence in their lifetime (Tjaden & Thoennes, 2000). Golding (1999) has highlighted the impact of sexual violence on the mental health of the victim and identified between 35% and 73% of abused women experience depression, anxiety disorders, (including post-traumatic stress disorder) and eating disorders. It is thought this prevalence is at least three times greater than in the general population (Golding. 1999).

Research identifies that sexual violence can lead to detrimental effects in terms of mental harm; presents a threat to an individual's sexual health and often involves alcohol or drugs (almost half of rape cases reported to the Police have involved alcohol or drugs; Ahmad, Moss, O'Brien, Patel, Jackson, Battye and Morgan, (2011). It is therefore suggested

that in addition to being a public health problem in its own right, sexual violence is also related to other wide-ranging public health concerns (Ahmad et al, (2011).

Whilst attention to these wide ranging concerns following sexual violence may be required, focus is also needed in terms of identifying consistent methods when considering prevalence rates. Indeed, estimates in prevalence rates continue to vary (Koss, 1993) and as such, thought regarding the rationales for these differences should be noted. Here, differences within prevalence rates may relate to differences amongst experiences of the victims (e.g. the perpetrator-victim relationship, duration of abuse etc.) but may also relate to methodological differences (Briere, 1992). This may include differences in the manner in which the data is collected, how and when participants are recruited and differences within the origins of the data. For example, if it is obtained from clinical, prison, community or university samples or from an adult, child or professional. Other methodological differences may also relate to differences in definitions used to assess sexual violence and differences in the assessment measures used (Radford et al., 2011). Indeed differences in definitions of sexual abuse between studies have been considered the single most factor accounting for variances amongst prevalence rates (Cutler-Nolen-Hoeksema, 1991). Moreover, there even remain differences amongst the legal definitions, particularly rape. For example, whilst marital rape remains a criminal offence under international law, 127 countries have failed to criminalise marital rape (Turquet, Seck & Azcona, 2012). With all these factors in mind it is inevitable that differences amongst prevalence rates occur. Accordingly, this evokes questions regarding accuracy and how later comparisons may be made in terms of considering increases or decreases in prevalence. Perhaps a more standardised approach in terms of the definitions used and more validated assessment measures of assessment are needed to assist in minimising these differences.

Theories of Sexual Violence

Many of the theories and models relating to the area of sexual violence tend to focus on offenders and their motivations (Finkelhor, 1984), risk factors thought to be associated with victimisation (Fergusson, Lynskey & Horwood, 1996) and the overall impact of sexual violence (Bennice, Resick, Mechanic & Astin, 2003). For the purposes of this thesis, it is the latter which will be focused upon given its overall relevance.

Rape Trauma Syndrome

Rape Trauma Syndrome (RTS) was termed by Burgess and Holmstrom in (1974) to describe the symptoms or consequences for the victim following an experience of rape. Their study examined the effects of rape on 146 victims who presented at hospital within a one-year time frame. Of the sample 109 were adult females, 34 were female children and three were male children (of note, only the data from 92 adult women was utilised). Following their research, Burgess and Holmstrom (1974) argue that all victims of rape experience some or all of the symptoms they describe in their findings. These included symptoms of anger, fear, anxiety, crying, sobbing, smiling, somatic reactions, self-blame, changes to movements, nightmares, sexual fears, fear of others and so on.

The researchers divided RTS into two phases, firstly the short-term “Acute Crisis Phase” and secondly “Long-Term Reactions / Phase”. They suggested the symptoms each victim experiences will depend upon the nature of the rape and the characteristics of the victim. In the acute crisis phase, (occurring within a few hours of the attack), victims are likely to replay the incident over and over in their minds, develop profound cognitive and physiological reactions including shaking, tense muscles, numbness, experience shock, disbelief, guilt, hostility or blame, maintain distorted perceptions and present in a state of helplessness (Allison & Wrightsman, 1993). During the long-term phase, victims are likely to respond by trying to rebuild their lives, regaining a sense of mastery (Burgess & Holmstrom,

1985), are likely to develop phobias, anxiousness, problems with sleeping, difficulties within intimate relationships, sexual problems and symptoms associated with Post-Traumatic Stress Disorder (PTSD) such as difficulties falling or staying asleep, hypervigilance, difficulty concentrating and outbursts of anger or irritability (Allison & Wrightsman, 1993). To note, PTSD can be defined as the *“development of characteristic symptoms following a psychologically distressing event that is outside of the range of usual human experience”* (American Psychiatric Association, 1987, pp156.). Whilst RTS was developed on a female sample, the symptoms it identifies have also been recognised in male rape victims (Sarrel & Masters, 1982), as such, this could provide evidence of similarity in the types of symptoms male and female victims of rape experience. In addition, the RTS theory is useful in providing detailed accounts of the types of symptoms and gives insight in to how victims may present both in the short and long term. Moreover, RTS is worthy in providing an overall framework of how a victim of rape may present.

In terms of its limitations, RTS has been criticised on a number of levels. Firstly, it has been argued that RTS should be considered less as an assessment of symptoms and more as a two stage model of recovery (Trowbridge, 1987). Secondly, there appears to be an evident amount of overlap within the two stages of the model and in relation to PTSD symptoms. Thirdly, the findings could not necessarily be considered generalisable in terms of other forms of sexual violence given that the research was sampled on rape victims only. Finally, whilst an array of psychological sequeale is considered within RTS, it remains limited regarding the depth and variety of symptomatology. Concerns here are also noted in relation to providing a rigid framework and the limitations which this may encourage. For example, it may inhibit professionals working with victims of sexual violence as they may only consider the symptoms the syndrome describes. This could have implications in terms of how the victim is responded to, whether they are believed and the future treatment they

receive. Nonetheless, overall Burgess and Holmstrom's (1974) RTS has been worthy in aiding understanding, insight and knowledge of the symptomatology victims of rape may experience.

An Ecological Theoretical Perspective

The ecological theory of rape trauma can be described as the interrelationships between the characteristics of the victim, the rape event that has occurred and the social environment in which recovery must take place (Green, Wilson & Lindy, 1985; Harvey, 1996). One of the earliest contributors to the ecological perspective lay with developmental psychologist Bronfenbrenner (1979). Here a model was developed that was founded on the person, the environment, and the continuous interaction between the two. Indeed through his research Bronfenbrenner identified that it was not only the environment directly affecting the person, but that there were layers in between this which impacted on the other levels. Previous models had failed to incorporate this and tended to focus upon one level or factor. By doing so such models were potentially ignoring or underestimating the impacts / the roles of the other factors they neglected (Klien, Tosi, & Cannella, 1999).

Bronfenbrenner's theories were later developed by others to include models for the prevention of gender based violence (Centre for Disease Control & Prevention, 2004; World Health Organisation: WHO; Jewkes, Sen & Garcia-Moreno, 2002; Krug, Mercy, Dahlberg & Zwi, 2002) and a culturally inclusive ecological model of sexual assault recovery (Neville & Heppner, 1999).

Whilst one of the most frequently reported limitations to the rape literature is the absence of conceptual models to describe the different outcomes to women's recovery (Crowell & Burgess, 1996), Neville and Heppner (1999) utilised the ecological perspective to develop a model that considers the various factors and interactions in relation to post-rape

affects. The authors were keen to utilise this model to examine why some females responded post- rape with little or no effects whilst others reported as very symptomatic. They developed the culturally inclusive ecological model of sexual assault recovery that allowed insight and assisted in accounting for how each of the factors interacts. A diagrammatical representation of their model is presented in Figure 1:

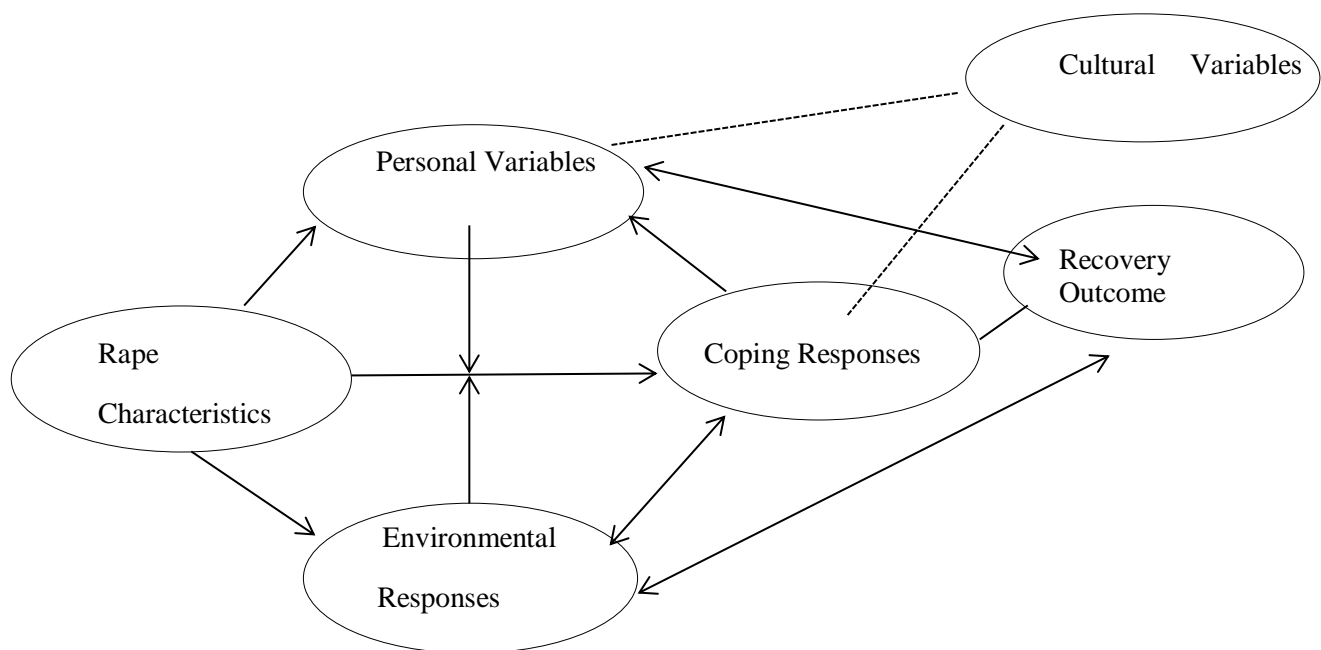


Figure 1:

Culturally inclusive ecological model of sexual assault recovery. Taken from Neville & Heppner (1999).

In observing the model, the various factors can be identified alongside their interactions with one another. This model allows us to consider the differences in symptoms rape victims present with due to the various factors and the interactions of the factors. Neville

and Neppner's model is based on the macrosystem element of the ecological perspective discussed shortly.

In building upon Neville and Heppner's (1999) model, the later research of Campbell, Dworkin and Cabral (2009) provided an ecological model of the impacts of sexual assault on a woman's mental health. Similar to Neville and Heppner, (1999) Campbell et al (2009) incorporated several levels including an individual level, assault level, a microsystem level, a mesosystem / macrosystem and chronosystem levels. A diagrammatical representation of this is provided in figure 2:

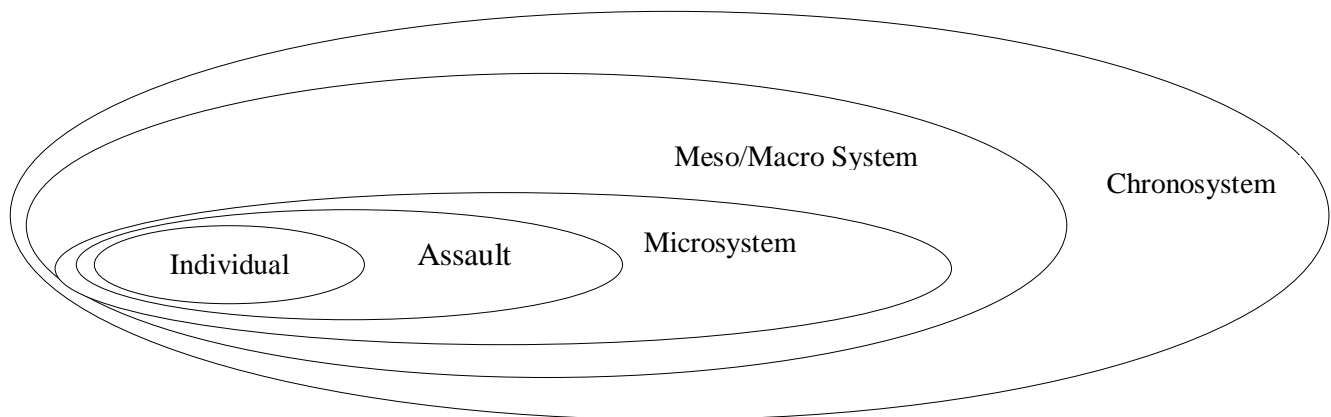


Figure 2:

Ecological Model of the impact of sexual assault on women's mental health.

Adapted from: Campbell et al (2009).

The individual level of the model focuses on the characteristics of the victim that could influence the recovery process. Whilst Neville and Heppner (1999) identified relevant characteristics of the victim (age, race / ethnicity, social class), Campbell et al (2009)

suggested this was limited and therefore extended these to consider additional factors including educational ability, marital status, income, employment status. Moreover, they also highlighted the importance of the victim's personality characteristics, pre-existing mental health conditions and biological / genetic factors in post-assault distress.

In terms of the assault component of the model, whilst Neville and Heppner identified relevant factors when considering the victims psychological distress (e.g. effect of victim-offender relationship, the severity of the injury), Campbell et al (2009) also incorporated the role of threats to kill, weapon use, assault force and substance use. In relation to the microsystem (which considers the role of interactions within the immediate environment), the importance of the impacts of disclosure to family and friends is considered here. Indeed the response of others to the victim's disclosure of abuse has been considered factorial in terms of its impacts on their psychological well-being. For example, were responses to sexual violence disclosures to appear unsupportive, the victim may reformulate the traumatic event which can interfere with their development (Lovett, 2004). Moreover the response to disclosure by others outside of the family has also been considered vital in terms of the consequences to the victim's psychological well-being. Here research identifies how the overall management of the disclosure by medical personnel, legal officials, school officials, and social workers (Bacon, 2001; Elwell & Ephros, 1987; Lusk & Waterman, 1986) can all affect the victim's well-being.

In relation to the fourth component of the ecological model of sexual assault, Campbell et al (2009) in contrast to Bronfenbrenner (1979) combined the mesosystem and macrosystem. These levels examine the links between the individual victim and individual systems (e.g. organisations and social systems, legal, mental health) in combination with the macrosystem which considers societal norms, expectations and beliefs from the wider social environment. The final level of the model relates to the chronosystem (this is an addition to

Neville and Heppner's model), but reflects the concept that person-environment interactions are reciprocal and changeable over time (Campbell, 2009). The authors concluded from their model that the mental health consequences of rape are caused by multiple factors beyond the characteristics of the individual or the assault.

In terms of the limitations of the ecological models provided, whilst they allow for the complexity of interactions and effects for post-rape experiences to be considered, the reality of implementing this type of approach within research remains difficult. Indeed as the models appear to suggest, almost everything within an individual's environment etc. could play a role in their experiences; collecting such data, ordering such data and establishing the point of where one would feel comfortable ceasing this process remains difficult. In essence, when would one decide to stop? At which point do you have "enough" information given that so many factors and dimensions are being considered? Furthermore, in terms of the assessment process in relation to the model, this again would prove difficult given the number of factors to assess or measure.

Nonetheless, the ecological perspective is an extremely informative and encompassing model. In addition, the model offers an excellent framework for considering the impacts of sexual assault and the many factors which can interact and play a significant role in the overall psychological effects of rape on its victims.

Structure of the thesis

Aims of Thesis

Collectively this thesis aims to explore the psychological symptomatology experienced by male and female victims of sexual violence. Specifically it aims to explore how symptoms are measured, examine differences in the symptoms males and females experience and consider whether symptoms can be categorised. Finally, the thesis aims to

consider findings in relation to future assessment, intervention / treatment and the future direction of services.

The thesis consists of four Chapters, each with its own specific aim and content. A brief overview of each is provided below:

Chapter 1 provides a systematic literature review which examines the range and measurement of psychological symptomatology of male victims of sexual violence. This focuses on male victims only, largely as there appeared to be a gap in the literature (in comparison to females) in this area. The review therefore allowed valuable insight into symptomatology experienced by male victims. Overall the systematic review identifies literature that explores psychological symptomatology associated with sexual violence for male victims. In addition, it considers how the researchers measures these symptoms in terms of assessment.

Chapter 2 provides a critique of a psychometric assessment: Trauma Symptom Inventory TSI, Briere, (1995). This measure is often used with victims (male and female) who have experienced sexual violence. The critique explores the measure and considers its validity, reliability and overall use as a measure of trauma assessment.

Chapter 3 is an empirical research study exploring: Psychological symptomatology experienced by victims of sexual violence: A gender comparison. The study examines the psychological symptoms experienced by males and females following sexual violence, explores if there is a gender difference in the symptoms described and examines if symptoms can be categorised.

Chapter 4 provides the reader with a discussion that offers a summary of the thesis findings in the wider literature and a discussion of how these collectively contribute to broadening understanding about psychological symptomatology of victims of sexual violence. Importantly, the implications this has for assessment, treatment and services provided to victims of sexual violence are discussed.

CHAPTER 1:**The Range and Measurement of Psychological Symptomatology of Male****Victims of Sexual Violence:****A Systematic Literature Review.**

Abstract

Aim: This systematic review aims to identify the range and measurement of psychological symptomatology of male victims of sexual violence.

Method: Scoping methods were employed to assess the need for the current review. Studies which explored psychological symptomatology associated with sexual violence of male victims were searched for. This incorporated a systematic approach using inclusion / exclusion criteria and quality assessment of the studies included. Studies were excluded if they failed to demonstrate a high quality assessment score (suggesting they were of poor methodological quality). In total seven studies of high methodological quality were included. A process of data extraction on the included studies and data syntheses incurred.

Results: Seven studies identified psychological symptomatology of male victims of sexual violence. Symptoms identified were placed into five overarching categories of: Dysphoric Mood, Traumatology, Self-Dysfunction, Sexual Relatedness Difficulties and Psychiatric. Findings conflicted as to how prominent symptoms were. Five studies also identified the importance of considering other factors that may be causal of symptomatology outside of the sexual violence experience. In terms of assessing for psychological symptomatology, the studies utilised a variety of assessment measures including both quantitative and qualitative approaches.

Conclusions: The negative psychological consequences of sexual violence for male victims are evident. Findings suggested that further research should consider male specific symptomatology and whether the different genders display differing symptomologies. Limitations of the current review are also discussed as are implications to practice. Future recommendations are made including examining if male and female victims of sexual violence experience different types of psychological symptomatology.

Background.

In general, research examining sexual violence has been neglected (World Health Organisation (WHO), 2002). Indeed of the research available to date, a substantial proportion has focused solely on the effects of sexual violence on female victims. Perhaps this is due to early societal beliefs suggesting that males cannot be raped / sexually assaulted or if they were, they would be unharmed or even find the experience pleasurable (Mitchell & Hirschman & Hall, 1999; Struckman-Johnson & Struckman-Johnson, 1992). Indeed until recently legal definitions in relation to rape failed to account for male victims. Accordingly this may feature as a rationale as to why much of the literature examining male sexual violence has been somewhat ignored historically.

Previous studies of sexual violence have shown that whilst sexual violence can occur at any age, it often occurs in early life and is considered a widespread problem (Kilpatrick, Edmunds, & Seymour, 1992; Tjaden & Thoennes, 2000). In order to provide clarification and context, sexual violence can be directed at both sexes and has been defined as:

“Any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic, or otherwise directed, against a person’s sexuality using coercion, by any person regardless of their relationship to the victim, in any setting, including but not limited to home and work.” (Sexual Violence Research Initiative, (SVRI), 2012)

Sexual violence can also occur in any type of environment and can include coerced sex in marriage and dating relationships, rape by strangers, systematic rape during armed conflict, sexual harassment, sexual abuse of children, sexual abuse of people with mental and / or physical disabilities, forced prostitution and sexual trafficking, child marriage, denial of the right to use contraception, forced abortion and violent acts against the sexual integrity of

women, including female genital cutting and obligatory inspections for virginity (World Health Organisation (WHO), (2002).

Currently in the England and Wales approximately 404,000 females and 72,000 males experience some form of sexual violence on average each year (Ministry of Justice, 2013). Prior to this Tjaden et al 2000 reported that 1 in 6 females and 1 in 33 males have experienced some form of sexual violence in their lifetime. Whilst this figure may appear fairly prevalent to some, in reality it is likely to be an underestimate given these figures excluded non-contact sexual violence and did not account for the significant underreporting of sexual violence. Studies examining prevalence rates of sexual abuse have greatly differed. For example, Browne's (2002) survey of Romanian families, found 0.1% of parents reported sexually abusing their children, whilst 9.1% of the children reported experiencing sexual abuse. In their adult sample of males retrospectively describing the effects of sexual violence, Pederson and Skrondal (1996) found prevalence rates of 1% in comparison to Goldman and Padayachi (1997) whose findings (using a similar sample), reported prevalence rates of 19%. When considering the differences, the studies outline rationales for these variances may relate to differences in how the data is obtained. For example from children, adolescents or adults, whether data is provided by the victim, a parent / carer or a professional's perspective and whether differing definitions within the measures used are employed (WHO, 2002).

It is reported that services, interventions and overall support for male victims of sexual violence are 20 years behind that of female victims (Rogers, 1998). Surveys have shown that the prevalence and incidence of sexual violence against male victims is increasing year upon year, for example the early findings from Mezey and King (1989) highlighted that no information was available on the nature, extent or effects of sexual violence on male victims. In comparison, the more recent findings from the National Intimate Partner and Sexual Violence Survey (Frieden, Degutis & Spivak, 2010) identified that 22% of males experience

sexual violence (other than rape) at some point in their lives and that 1 in 71 men reported being raped in their lifetime. Whilst this last figure may appear slight, in reality it translates to approximately 1.6 million men in the United States. In addition, their survey also reported 6% of men having experienced sexual coercion and 4.8% as being made to penetrate someone else (Frieden et al (2010). It is therefore imperative that our knowledge, research and understanding of sexual violence on men is vastly developed.

This systematic review therefore aims to increase our understanding about the psychological symptomatology of male victims of sexual violence and consider the assessment measures used to assess this.

What Do We Know about the Psychological Symptomatology associated with Sexual Violence?

The impacts of sexual violence have long been recognised as having significant long-term harmful effects. Browne and Finkelhor's (1986) early work on female victims, reported significant impacts on individuals self-esteem, health and functioning, anxiety, depression, relationships and substance misuse. Whilst males and females can both experience sexual violence, research has suggested that females are at a greater risk (Ulman & Filipas, 2005), that their abuse begins at an earlier age, continues for a longer duration (DeJong, Hervada & Emmett, 1983; Finkelhor & Baron, 1986), often consists of more serious sexual behaviors (Cutler & Nolen-Hoeksema, 1991) and is more likely to involve a family member (Chesney-Lind, 1986; DeJong et al, 1983) when compared to male victims of sexual violence. If accurate, these findings suggest that the psychological symptomatology is therefore greater and potentially more varied for female victims of sexual violence than their male counterparts. Accordingly one could expect psychological symptomatology to be more prevalent for female victims of sexual violence than male victims. In support of this, the

findings of Kessler, Sonnega and Bromet, (1995) highlighted that 8.1% of men are at risk of developing post-traumatic stress disorder yet 20.4% for females following a traumatic event such as sexual violence. To note, in addition to sexual violence Kessler et al's (1995) sample also included other types of trauma such as combat and natural disasters. Moreover, Breslau, Davis and Andreski, (1997) also noted a higher prevalence for the risk of developing post-traumatic stress disorder noting 13% for males and 30.2% for females. Rationales for these differences may relate to the previously highlighted factors of longer duration, earlier age of onset, severity of assault etc. for females when compared to males. In terms of the symptomatology female victims of sexual violence experience, Bryer, Nelson, Miller and Krol, (1987), examined post-traumatic stress amongst female psychiatric inpatients and reported that females with histories of sexual abuse had significantly higher scores on standardised measures of somatisation, depression, general and phobic anxiety, interpersonal sensitivity, paranoia and psychoticism.

Rationales for differences amongst the symptomatology males and females of sexual violence experience may relate to the assessment measures used. Here the type of measure, the symptoms examined and the time of its administration may all be factorial in results found. For example whilst standard measures e.g. the Millon Multiaxial Clinical Inventory, Millon, (1994), may link into particular symptoms and function domains, they are likely to neglect more specific symptoms associated with trauma e.g. dissociative symptomatology (Courtois, 2004). As such, more specialised symptom assessments e.g. Dissociative Experiences Scale (DES), Bernstein and Puman, (1986) needs to be considered as does the time of assessment. Here research suggests specific assessments may need to be repeated at differing points of time owing to therapeutic process. For example, Courtois, (2004) notes symptoms may only present once the victim feels a sense of safety within treatment /

therapeutic process. Accordingly assessments may need to be repeated within the therapeutic process as to allow further insight.

In contrast to these findings later research which has moved towards a more male victim focus has identified psychological symptomatology for males as wide ranging and as including: fear, self-destructive behaviours (Beitchman, Zucker, Hood, DaCosta & Akman, 1992); fears of isolation, shame (Polusny & Folletter, 1995; Ray, 1996); difficulties forming and maintaining relationships, anti-social sexual and aggressive activity, sexual orientation and gender confusion, suicide attempts, addictions to alcohol and drugs and a lack of confidence (Draucker & Petrovik, 1996; Etherington, 1995; Fater & Mullaney, 2000; Gill & Tutty, 1999).

In collating and building upon the knowledge of the impact of sexual violence on men over several years, later research has begun to make distinctions between the types of symptoms male victims display in comparison to their female counterparts. Specifically, research identified that male victims of sexual violence display more “externalised” psychological symptomatology, whereas females displayed more “internalised” symptomatology. In accordance with this, the findings of Finkelhor, Hotaling, Lewis and Smith (1990), suggested men externalise their symptoms by “acting out” or using drugs and that females internalise their symptomatology via fear, depression and anxiety. However, more recent findings have conflicted with these theories and suggest instead, that male victims of sexual violence both internalise and externalise psychological symptomatology (Watkins & Bentovim, 1992, Gault-Sherman et al, 2009).

Recent literature has identified male-specific symptomatology. This has included male victims being confused about their sexual orientation (Walker, Archer & Davies, 2005a), maintaining issues relating to a sense of loss of their masculinity (Lisak, 1994) and denoting

confusion about their sexual identity (Davies, Walker, Archer & Pollard, 2010). Indeed even in the earlier work of Fromuth and Burkhart (1989), they identified male-specific symptomatology that included difficulties relating to erection achievement and ejaculation problems.

In essence, whilst a shift has occurred in later research focusing to a greater extent on male victims of sexual violence, the psychological symptomatology it identifies still appears to be within its infancy. In addition, there seems to be a gap in the systematic consideration of the research findings relevant to this area. It is with this in mind, that the current systematic review was developed.

Most studies that have evaluated the effects and impacts of sexual violence have been based on female victims consequently less is known about the effects among male victims (Breiding, Black, & Ryan, 2008; Smith & Breiding, 2011). In accordance with this, a greater understanding and exploration of our current knowledge is called for. This in itself served a worthy rationale to explore psychological symptomatology and the measures used to assess this in male victims of sexual violence.

Aims & Objectives

This systematic literature review aims to explore the range and measurement of:

“Psychological Symptomatology for Male Victims of Sexual Violence”.

Specifically, two research questions will be investigated:

- What does the research identify as psychological symptomatology associated with sexual violence for male victims?
- How does the research measure the psychological symptomatology they identify?

Of note, in examining the psychological symptomatology male victims of sexual violence experience, the studies featured within this systematic review examine various forms of sexual violence including rape, childhood sexual abuse, incest and sexual assault. Therefore in this review the overarching term sexual violence will be used to refer to all of these forms of abuse. In addition, this review is less concerned with comparing some symptoms with others, but rather to identify what these symptoms are as experienced by male victims of sexual violence.

Method

Scoping Exercise

Before conducting this systematic review a search was undertaken to establish if any previous review existed examining the psychological symptomatology male victims of sexual violence experience. As part of this several databases were searched including: Cochrane Database of Systematic Reviews: (http://onlinelibrary.wiley.com/o/cochrane/cochrane_search_fs.html?newSearch=true), The Centre for Review and Dissemination (DARE): (www.crd.york.ac.uk/crdweb) and the Campbell Collaboration (www.campbellcollaboration.org/library.php). Following searches, no existing reviews were identified. Accordingly, a gap within the current literature was identified which further informed the need for the current review. The current review therefore attempted to synthesise and systematically assess research within the chosen area.

Sources of Literature

A search was conducted on a number of electronic databases including PsychINFO (1967-Present), EMBASE (1980-Present) and MEDLINE (1946-2012). The searches were

conducted on Friday 10th February 2012, Thursday 16th February 2012 and Friday 24th February 2012.

Search Strategy

Initially a traditional approach to systematic search was implemented (e.g. mapping to subject headings, mesh headings, exploding of terms etc.). However this approach generated irrelevant material or material which when refined failed to allow relevant material to be kept, whilst disregarding irrelevant material. In addition, this approach also generated colossal amounts of superfluous material such as that focusing on perpetrators of sexual violence or female victims of sexual violence. With this in mind it was deemed more appropriate to conduct a free text adjacency search which would allow relevant text to be searched when in close proximity and in relation to one another. For example, the text terms “male” and “violence” could be searched where it appeared within three spaces of one another. In addition, the text was also refined to search within the parameters of the titles and abstracts (ti,ab.) of the articles as this was deemed the most relevant in terms of the searching strategy. Once generated, the same search strategy was applied to all three electronic databases and appeared as follows:

```
((male* or men or man or boy) adj3 (victim* or survivor*) adj3 ("sexual violence" or rape or "sex* assault*" or "sex* abuse*")).ti,ab.
```

Study Selection

Having performed the search identified, results were then refined to include the following criteria:

- Years of 1980-Present
- English language only

- Journals only (removing conference papers, books, articles, case studies, commentary or opinion papers)

Once completed, the remaining studies were filtered by examining the titles and abstracts of each article. Any reviews were removed at this point as were any duplicate studies. Of those remaining, full texts were obtained where possible and the inclusion / exclusion criteria were applied to each study. In addition, a further 3 papers were included following hand-searching of reference lists. Of note, a considerable number of studies were obtained at this point and hence it was considered unnecessary to continue to add to this by contacting authors or area specific organisations/ sources for further papers. Of the papers searched, one paper could not be obtained owing to time constraints.

Inclusion / Exclusion Criteria

Owing to the area this systematic review examines, it was considered unsuitable to generate a PICO framework as this review does not examine for example, a particular intervention using a comparator etc. As such a more specific and relevant approach was incorporated in generating a more specific inclusion / exclusion criteria. Specifically the following inclusion criteria were applied:

- Male victims of sexual violence
- Studies must examine Males and Effects and Sexual Violence
- Be published in peer reviewed journals within years 1980-2012 and of English Language

The following exclusion criteria were applied:

- Unpublished Doctoral dissertations
- Case studies

- Studies that include only female victims of sexual violence
- Studies that group results / findings together without differentiating those results by gender.
- Those whose primary focus does NOT include the psychological effects of sexual violence
- Studies who group (do not differentiate) between sexual and physical violence
- Papers that primarily focus on coping styles / approaches / the healing process
- Studies whose primary focus is life satisfaction and physical health or physical effects following medical examination
- Studies who fail to examine sufficient psychological affects such as those who examining less than three psychological effects (excluded due to the sparse number of studies identifying this).
- Studies examining how an event is appraised in relation to symptom severity
- Studies focusing on myths and on personality and parenting of victims

Having refined the studies based on inclusion / exclusion criteria, a total of 15 studies were considered for review and quality assessment. A flowchart of the study selection process is given in figure 3.

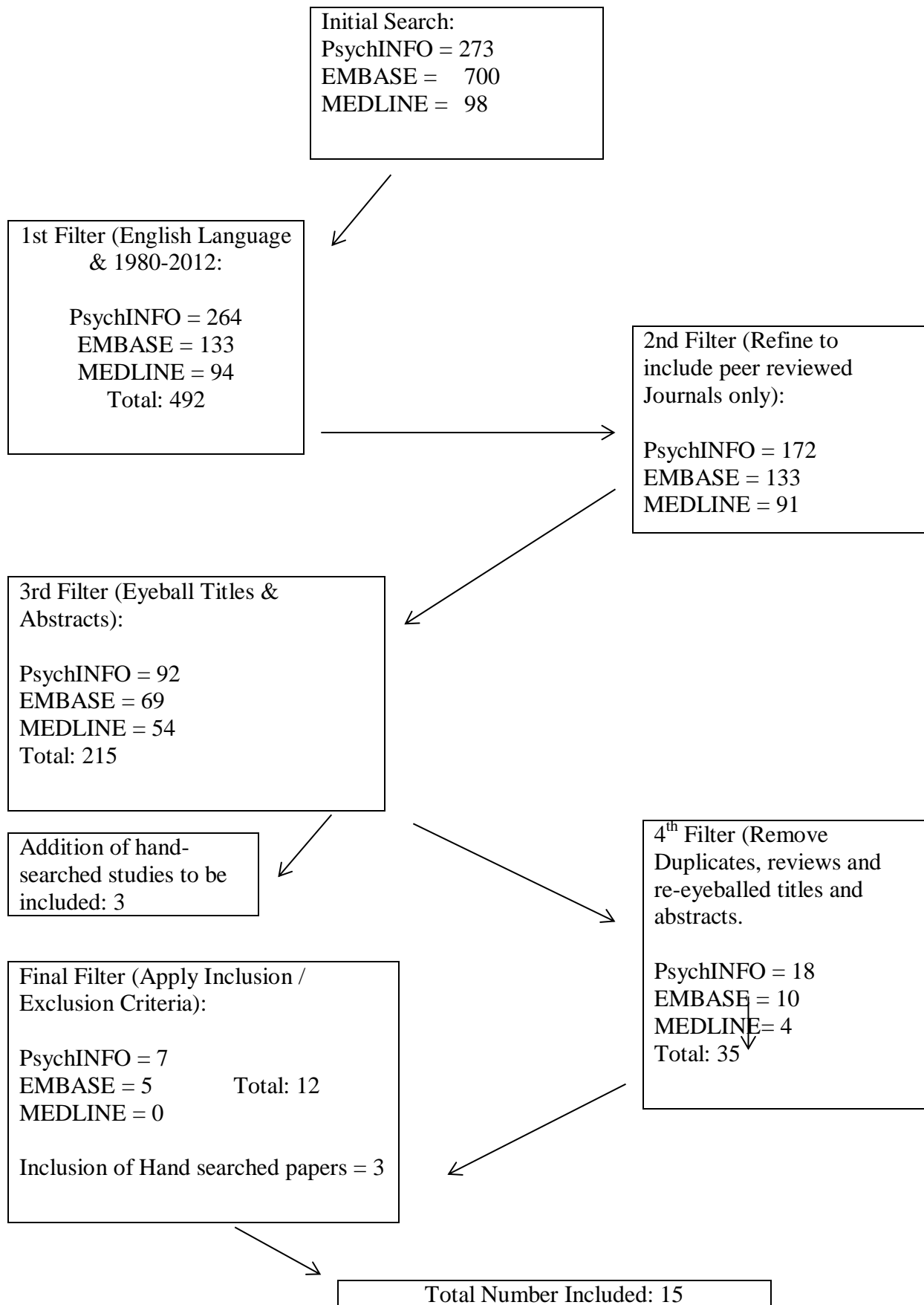


Figure 3: A flowchart of the study selection process:

Quality Assessment

Following the inclusion / exclusion stage, the methodological qualities of the included studies were assessed. Quality assessment checklists adapted from The Critical Appraisal Skills Programme (CASP, 2010) were developed prior to the review. Different quality assessment checklists were applied to different study designs in order to accurately assess the validity of each study (see appendix 1). Where assessment checklists were not available (such as for use with case series and cross sectional studies) checklists were self-devised in accordance with current literature recommendations. Studies were assessed in relation to the aims of the study; study design, sample selection, performance and measurement of outcomes, and attrition bias. Studies that were quality assessed include those of cross-sectional, case control, qualitative and case series design. One researcher quality assessed the studies for inclusion.

To assess the quality of the studies, a scoring system was devised incorporating a three-point scale: 0 = "No", 1 = "Partly", 2 = "Yes" and an "Unknown" option which remained un-scored. A total score was obtained by summing each item score. In total there were four cross sectional studies, four case series studies, two case control studies and five qualitative studies. Having quality assessed each paper; a total quality assessment score was assigned. Collectively 15 studies were quality assessed and assigned an overall percentage score. This could be considered a large number of studies for inclusion therefore the decision to include only studies considered to be of good methodological quality (studies achieving a cut-off score of 70% plus) were included. Whilst this may indicate some bias in terms of selection, it does mean that any conclusions and recommendation can be made based on high quality findings / methodologies. Therefore, in total seven studies were carried forward for final

analysis. Appendix 2 details the 8 studies removed from analysis owing to their poor methodological quality. The quality assessment score, the characteristics of the studies and their strengths and limitations are presented in Table 1.

Table 1:**Characteristics and Quality Assessment Scores of the Seven Included Studies:**

Author/s, Year	Aims & Hypotheses	Study Design & Sample Size	Recruitment Procedure	Strengths / Limitations	Quality Assessment Score (%)
1. Gault-Sherman. M., Silver. E. & Sigfusdottir. I. D. (2009).	<p>To examine a range of impairments that may be associated with sexual abuse.</p> <p>To examine internalised and externalised symptomatology associated with sexual abuse.</p>	<p>Cross Sectional:</p> <p>8618 students.</p> <p>4479 Males (1008 having experienced sexual abuse)</p> <p>3977 Females</p>	<p>Used data from previously recruited high school students in Iceland.</p> <p>Students were asked by teaching staff to participate in the study and completed this within classroom environment.</p>	<p><u>Strengths:</u></p> <p>Uses a large sample.</p> <p>Some sampling bias due to recruitment procedure: teachers asking students to participate.</p> <p>Representative of Icelandic youth thereby allowing for some generalisability.</p> <p>Uses a range of behavioural and emotional outcome measures</p> <p>Included array of demographic information</p>	31 / 36: (86%)

No participant
ethnicity
information
described.

Geographical
location: Iceland

Examines several outcomes across the
same individuals

Allows for various forms of sexual
violence to be considered by making a
single prompt.

Measures used possessed high face
validity and internal reliability re the
constructs they intend to represent.

Considered control variables.

Limitations:

Fails to examine a wide variety of
symptomatology.

Measures used were retrospective.

Survey did not allow for / account for
other forms of abuse (physical /
neglect) that may have occurred
simultaneously with the sexual abuse.

High attrition rate (20% drop-out)

Sample all Icelandic youth so generalisability somewhat limited.

Cross sectional data used so conclusions about causality cannot be made.

Fails to identify various forms of sexual violence by use of single prompt / does not provide information on type of sexual violence.

Only includes 3 types of sexual violence of varying severity.

Fails to describe ethnicities of participants.

Whilst representative of Icelandic youth due to sample covering vast array of schools, it will not have account of those who are failing to attend school.

2. Walker, J., Archer, J. & Davies, M. (2005a).	Examine the effects of rape of male victims.	Case Series:	Recruited via advertising in media and a genito-urinary department in England.	<u>Strengths:</u>	31 / 40: (77%)
		40 Adult Male victims of rape.	Participants were asked to respond to advertisements, contact authors and complete questionnaires.	Examines an array of psychological symptomatology.	
		40 Male victims of rape from a non-clinical sample.		Uses relevant tools for examining possible effects of sexual violence.	
				Uses a non-clinical sample.	
		Age range 19-75 years.		Study elicits detailed information regarding male's experiences of sexual violence.	
		Mean age (34 years).		Findings within the study are consistent with that in the field.	
		All participants were of White British ethnicity.		<u>Limitations:</u>	
		Geographical location: UK.		Uses a relatively small sample size therefore limiting generalisability.	
				Cannot determine causality of	

symptomatology.

Self-report and retrospective data used.

Does not consider confounding variables.

Fails to include a wide range of participants of differing ethnic origins.

Recruitment method may have impacted demographic characteristics in that greater number of gay males responded due to advertising in gay magazines / press.

Do not use vigorous data analysis process, limitation of significance.

Strengths:

3. Ray, S.L.	To understand the long term	Qualitative	Participants were recruited via referral
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(2001).	aftereffects and the overall effects of incest and other forms of sexual abuse from a male victims perspective.	Design:	from eight therapists	Low attrition – No drop outs	28 / 32: (87%)
		25 Adult Males.		Data double coded by separate researchers – strengthening validity.	
		Age range from 23-59.		Large range of symptomatology considered.	
		Mean age = 37.6years.		Considers various types of sexual violence.	
		All participants were White.		Provides a rich description of data	
		Geographical Location: Canada.		<u>Limitations:</u>	
				Retrospective measures used.	
				Small sample used (n= 25).	
				Use of and reliance on self-report data.	

Whilst large array of symptomatology is considered, this may be attributable to the diverse definitions of each derived category (social, physical, psychological) therefore exactness of data may be variable. Links to problems with internal validity.

All participants in the sample were White Canadian therefore findings are not necessarily representative.

Only used a clinical based sample.

Limitation of intervening variables. The symptomatology the study identifies could be attributable to other confounding variables. Of note the study did not intent to explore this.

Data subjective due to analysis procedure.

- | | | | | | |
|---|--|------------------|---|-------------------|----------------|
| 4. Davies. M., Walker. J., Archer. J, & | To examine the long-term psychological | Cross Sectional: | Advertisements placed in 3 English lifestyle magazines. | <u>Strengths:</u> | 27 / 36: (75%) |
|---|--|------------------|---|-------------------|----------------|

Pollard. P. (2010).	functioning in male victims of stranger and acquaintance rape.	38 Adult Males.	When responded, participants spoke with researcher (telephone) re content of research.	In contrast to many studies within this area this study builds on knowledge by using a non-clinical sample.
		Age 16-25 at time of assault.		Uses a range of assessment measures.
		Mean age at time of incidents 24.4years .	Participants wishing to pursue, were mailed questionnaires and instructions.	Provides insight into how the negative long term effects of sexual violence can still be apparent long-term / 10 years since the incident.
		Mean age at time of study 34.7 years		Allows consideration into future interventions / services may need to be tailored to male victims of acquaintance and stranger rape.
		(Indicating an average gap of 10years from time of incident to the time of study.		<u>Limitations:</u>
		All participants were White. Geographical Location: UK.		Small self-selecting sample used.
				Sample all White British therefore is neither generalisable nor representative.
				Focus of the study was on victims of rape. As such findings do not account for any childhood sexual abuse that may have occurred and consequently,

associated symptomatology.

Limited exploration of psychological symptomatology.

Findings cannot necessarily be used to assess causality particularly as study did not account for any confounding variables.

Uncertainty of researcher descriptions of researcher and of this across each telephone call with each participant's, possibility of bias due to this.

High attrition rate

Reliability of participant recall given time passed since incident (10years on average).

5. Lisak, D. (1994).

To examine psychological symptomatology associated with sexual abuse of male victims.

Qualitative Design:

26 American Adult Males.

Participants recruited via posters placed around the University campus.

Strengths:

Considers an array of psychological symptomatology male victims of sexual violence experience.

25 / 32: (78%)

Age range 21-53.

Mean age = 33.7
years.

Ethnicities:

23 European
American, 1
African
American, 2
Native American.

Geographical
Location: USA.

Uses independent raters to develop the psychological themes thereby improving reliability.

Uses a combination of methods (Interviews and assessment via validated measures).

Provides a rich description of data.

Considers the victims descriptions alongside previous findings / themes identified within the area of sexual violence.

Limitations:

Use of and reliance on self-report data.

Sample size is small therefore generaliability cannot be ascertained.

Limited sample: University based sample. Implications to how representative or generalizable the

sample is.

Largely a European American sample (23/26). Implications to generalisability.

Self-selecting sample.

Does not incorporate various types of sexual violence, only childhood sexual abuse.

Does not account for confounding variables or consider other forms of abuse that may link to symptoms described.

Study does not discuss its limitations.

6.	Fromuth, M.E. & Burkhart, B.R. (1989).	Examine long term psychological correlates of men who have experienced childhood sexual abuse.	Case Series: 582 College Men from Midwestern and South-eastern Universities.	Sample recruited from the Universities introductory psychology research pool.	<u>Strengths:</u> Considers confounding variables. Vary of validated assessment	33 / 40: (82%)
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Two samples,
Men from
Midwestern (253)
and South-eastern
(329)
Universities.

Mean age: 20
years.

Samples
predominantly of
White ethnic
origin: (92% of
Midwestern, 95%
South-eastern).

Geographical
Location: USA.

measures used.

Good sample size utilised.

Array of psychological
symptomatology examined.

Utilises a non-clinical sample.

Researcher used the same procedures
across two samples. This approach is
useful as it highlights the importance of
being aware of sample differences and
need for multiple samples to be used.

Limitations:

Sample largely American, of White
ethnic origin and of University
population. Therefore limitations
regarding generalisability and how
representative findings are, needs to be
considered.

Self-report and retrospective data
which has limitations in terms of its

reliability.

The overall mean age of the sample is still relatively young which could indicate that “long term” effects are yet to develop.

Measures used may be more appropriate for female victims of sexual violence than male victims.

28 / 34: (77%)

7. Briere. J. & Elliott.D.M. (2003).

Examine the psychological sequeale of childhood sexual abuse in the general population.

Cross Sectional

Recruited via a geographically stratified random sample from the general population in America.

In total 66 Males and 152 Females reported histories of sexual abuse.

Participants were posted questionnaires.

Ages ranged from 18-90.

Mean age = 46 years.

Ethnic origin of

Strengths:

Examines a relevant and ample amount of psychological symptomatology.

Examines symptomatology in accordance with current knowledge in the area and current widely used measures.

Considered the confounding variable of adult abuse in relation to its potential impact on symptomatology experienced.

participants:

74.7% Caucasian,
11.3% African
American, 7.3%
Hispanic, 3%
Asian, 2% Native
American, 1.7%
as "Other".

Geographical
Location: USA

Examines participants of various ethnic origins.

Acceptable attrition rate for this type of study (mailing out questionnaires).

Uses a random sample from the general population.

Findings derived from the study support those of other studies including longitudinal studies that suggest childhood sexual abuse has long lasting psychological effects on its victims.

Limitations:

Self-report data used. This can impact reliability and validity given that the information participants provided may be affected by their memory recall, memory distortion, symptom endorsement in terms of perceptions of being over symptomatic or under reporting.

Only examines one overall form of sexual violence: childhood sexual abuse.

Not all participants were recruited under the same terms (some received financial reward for participation, others did not).

Findings may have been different were the non-responders to have responded.

Whilst confounding variables were considered within the study, other intervening variables may have been present indicating that a causal link cannot necessarily be ascertained. Study also did not account for other stressors or childhood neglect.

Whilst an overall good sample size is used, the actual number of males having experienced sexual abuse is 66. Accordingly this has some implications regarding the generalizability of the findings.

The size of the abuse-symptom relationships found was relatively



small.

Data Extraction:

Data extraction for the seven studies was completed using a pre-defined pro forma (appendix 3). This allowed general and more specific information to be considered with the aim of informing conclusions made from the review. In brief the following areas were considered:

- Verification of Study Eligibility (Inclusion / Exclusion)
- Study Design
- Specific Information: (e.g. Target Population, recruitment procedures, characteristics of Participants, No. of participants, age, ethnicity etc.)
- Method:
 - Brief outline of Study
 - Quality Assessment Score
 - Study Type: Quantitative / Qualitative
 - Psychological Symptomatology Identified
 - Assessment of symptomatology / Measure used
 - Validity of measure
- Analysis:
 - Analysis used
 - Attrition
 - Confounding variables assessed

Results

Methodological Study Characteristics.

Of the seven studies examined three were of cross sectional design, two of qualitative and two were a case series study. Table 1 illustrated the study designs, recruitment procedures, quality scores and the strengths and limitations of each of the studies.

Of the seven studies, four studies included participants with a mean age range of 33.7 - 37.6 years, two studies of 17.64 - 20 years and one study with a mean age of 46 years. The sample sizes ranged across the studies with five studies ranging from 25-66 participants, one study of 592 and one of 1008. In terms of the ethnic origins of the samples within the studies, all (of those reported), were predominantly of White ethnicity, specifically, 74.7% - 100% of all samples were of White ethnic origin. Of the samples obtained, one was from a clinical based sample, three from a general population / community sample and three from a student population. Four of the studies were based in America and Canada, two in the United Kingdom and one in Iceland.

The psychological symptomatology and the overall findings of each of the seven studies are presented in Table 2.

Table 2:

Indicates the Psychological Symptomatology and Findings Identified Within Each Study.

Author/s, Year	Psychological Symptomatology	Findings
1. Gault-Sherman. M., Silver. E. & Sigfusdottir. I. D. (2009).	Generalised anxiety, eating anxiety, depressed mood and externalising behaviours: theft and violent behaviour.	<ul style="list-style-type: none"> • Males are less likely to experience childhood sexual abuse. • Males less likely to experience internalised symptomatology • Externalised symptomatology did not differ according to gender.
2. Walker. J., Archer. J. & Davies. M. (2005a).	Depression, anxiety, intrusive thoughts, impairments on tasks, crisis with sexual identify, self-harm, fear, emotional distancing etc.	<ul style="list-style-type: none"> • Identifies long term psychological symptomatology including: anxiety, depression, anger, vulnerability, loss of self-image, emotional distancing, self-blame and self-harming behaviours.
3. Ray. S.L. (2001).	Themes derived including 8 areas: social, psychological, physical, sexual, familial, sense of self, relation to men and relation to women.	<ul style="list-style-type: none"> • Identifies themes / effects experienced to include: isolation, anger, depression, suicidal feelings, addictions, low sense of self-worth, distant relationships with others.

Some of the symptomatology within the themes included:

Isolation, not trusting others, anger, depression, suicidal, self-mutilation, blocked emotions, dissociation, numbness, substance abuse, eating issues, fear, guilt, psychosomatic symptoms, avoidance of sex, shame, low sense of self-esteem, hostility etc.

- | | | | |
|----|--|--|--|
| 4. | Davies. M., Walker. J., Archer. J, & Pollard. P. (2010). | Self-esteem, world assumptions and general health. | <ul style="list-style-type: none"> • Survivors of stranger perpetrated rapes had lower psychological functioning overall than survivors of acquaintance perpetrated rapes. • Survivors were affected by their assault negatively in all cases. |
| 5. | Lisak. D. (1994). | Symptomatology derived from the Symptom checklist (SCL-90) and from themes identified via content analysis. | <ul style="list-style-type: none"> • Identified 15 psychological themes / effects including anger, betrayal, fear, homosexuality issues, helplessness, isolation & alienation, legitimacy, loss, masculinity issues, negative peer relations, negative schemas about self and others, sexuality difficulties, self-blame / guilt and shame and humiliation. |
| | | <p>Themes include:</p> <p>Prominent affects and affective states, Salient cognitive sequelae, Issues of gender and sexuality and Interpersonal difficulties.</p> | |
| 6. | Fromuth. M.E. & Burkhart, | Anxiety, hostility, somatization, obsessive-compulsive, interpersonal sensitivity, | <ul style="list-style-type: none"> • Findings indicated a small but significant correlation between a history of sexual abuse and psychological |

- B.R. (1989). depression, phobic anxiety, paranoid ideation, psychoticism.
- adjustment.
 - Few significant correlations were observed between a history of sexual abuse and sexual adjustment and behaviour.
7. Briere. J. & Elliott.D.M. (2003). Anxiety, depression, anger-irritability, intrusive experiences, avoidance, dissociation, sexual concerns, dysfunctional sexual behaviour, impaired self-reference, self-harming behaviours.
- Found that childhood sexual abuse was associated with all 10 trauma symptom scales of the Trauma Symptom Inventory and the sexual abuse predicted more symptom variance (than physical abuse).

What is the Range of Psychological Symptomatology of Male Victims of Sexual Violence?

Of the studies included within the review, all identified an array of psychological symptomatology thought to be associated with male victim's experiences of sexual violence. Each of the symptomatology they identified will be discussed individually, however some such symptoms included: anxiety, depression, dissociation, fear, crisis of sexual identity, self-harming behaviours, negative schema about self and others, paranoid ideation and so on.

Table 3 summarises and categorises the psychological symptomatology of the studies highlighted in Table 2. The categories identified are: Dysphoric Mood, Traumatology, Sexual Relatedness Difficulties, Self-Dysfunction and Psychiatric. By developing these categories the psychological symptomatology can be considered in relation to other similar symptoms and also allow symptoms to be placed within a more meaningful overall context.

Table 3:

Categorising Psychological Symptomatology Male Victims of Sexual Violence:

<i>Category of Psychological Symptomatology</i>	<i>Psychological Symptomatology</i>	<i>Studies</i>
Dysphoric Mood	Anxiety, Depression, Revenge fantasies, Anger / Irritability / Hostility.	Gault-Sherman. M., Silver. E. & Sigfusdottir. I. D. (1). Fromuth. M.E. & Burkhart, B.R. (6) Lisak. D. (5) Briere. J. & Elliott.D.M. (7) Davies. M., Walker. J., Archer. J. & Pollard. P. (4)

		Walker. J., Archer. J. & Davies. M. (2)
		<ul style="list-style-type: none"> • 6/ 7 Studies examined Dysphoric Mood Symptomatology.
Traumatology	Intrusive thoughts, Fear, Dissociation, Avoidance, Emotional Distancing, Social Dysfunction, Isolation.	<p>Briere. J. & Elliott.D.M. (7)</p> <p>Davies. M., Walker. J., Archer. J. & Pollard. P. (4)</p> <p>Walker. J., Archer. J. & Davies. M. (2)</p> <p>Ray. S.L. (3)</p> <p>Lisak. D. (5)</p> <ul style="list-style-type: none"> • 5/ 7 Studies examined Traumatology Symptomatology.
Sexual Relatedness Difficulties	Sexual Concerns, Dysfunctional Sexual Behaviours, Crisis of Sexual Identity, Masculinity Issues.	<p>Fromuth. M.E. & Burkhart, B.R. (6)</p> <p>Briere. J. & Elliott.D.M. (7).</p> <p>Ray. S.L. (3)</p> <p>Lisak. D. (5)</p> <p>Davies. M., Walker. J., Archer. J. & Pollard. P. (4)</p> <p>Walker. J., Archer. J. & Davies. M. (2)</p> <ul style="list-style-type: none"> • 6/ 7 Studies examined Sexual Relatedness Difficulties.
Self-Dysfunction	Self-Esteem Difficulties, Vulnerability, Self-Blame, Loss/Grief, Betrayal, Shame, Trust Issues, Helplessness, Negative Schemas about Self / Others / World, Self-Harming, Obsessive Compulsive Behaviours, Eating Disorders, Suicidal Ideation, Suicide Attempts, Substance	<p>Fromuth. M.E. & Burkhart, B.R. (6)</p> <p>Briere. J. & Elliott.D.M. (7)</p> <p>Ray. S.L. (3)</p> <p>Lisak. D. (5)</p> <p>Walker. J., Archer. J. & Davies. M. (2)</p> <p>Davies. M., Walker. J., Archer. J. & Pollard. P. (4)</p> <p>Gault-Sherman. M., Silver. E. & Sigfusdottir. I.</p>

	Abuse.	D. (1). • All Studies examined Self-Dysfunction Symptomatology.
Psychiatric	Paranoid Ideation, Psychoticism, Psychosomatic Symptoms, Somatisation.	Fromuth. M.E. & Burkhart, B.R. (6) Davies. M., Walker. J., Archer. J. & Pollard. P. (4). • 2 / 7 Studies examined Psychiatric Symptomatology.

Dysphoric Mood Symptomatology.

Table 3 shows that six out of the seven studies reviewed reported Dysphoric Mood type symptoms for male victims of sexual violence. In particular, Fromuth et al (1989) found that male victims of sexual violence were less well-adjusted within several areas (including depression and hostility) than non-victims of sexual violence. Furthermore, Gault-Sherman et al (2009) also identified anxiety and depression as negative effects experienced amongst their sample of victims of childhood sexual abuse. Moreover they reported that male victims demonstrated more “externalising” behaviours such as violence and theft (theft ($b = .41$, $p < .001$], violent behaviour ($b = .62$, $p < .001$], when compared to internalising behaviours (eating anxiety, general anxiety & depressed mood). However, whilst they identified associations between sexual abuse, subsequent depressed mood and generalised anxiety, these associations could not be considered significant. Their findings overall therefore suggested (in contrast to Fromuth et al, 1989), that male victims of sexual violence were no more likely to experience greater depression or general anxiety, than those whom had not experienced sexual violence.

When analysing the effects of rape on men, Walker et al (2005a) noted that over 97% of their sample (N=40) all experienced depression following their assault. This was closely

followed by 95% of the men experiencing fantasies of seeking revenge on their perpetrator, over 92% experiencing anxiety and 80% having an increased sense of anger and / or irritability. In accordance with these findings, Davies et al (2010) recent study exploring rape of known and unknown perpetrators also identified Dysphoric Mood symptomatology. In particular, of their sample of male victims whom were raped by a stranger (N=38), 100% reported having fantasies of revenge against the perpetrator and nearly 90% as having a sense of anger.

Whilst these studies are particularly relevant and informative in identifying symptomatology they remain limited in providing a rich meaning of their data. Lisak (1994) aimed to minimise this limitation by combining an approach that incorporated a standardised measure alongside a qualitative approach. From this he was able to identify psychological symptomatology akin with the Dysphoric Mood category (anger), whilst generating meaning to this symptom. Here he identified that male victims not only experienced the symptom of anger but also the varying contexts this occurred within. For example, victims reported feeling anger in relation to an overwhelmed sense of rage, feeling afraid of how their anger made them feel, having desires to suppress their feelings of anger and generally being afraid of discovering its existence. Such findings are of considerable benefit in terms of expanding our insight into this as a psychological symptom associated with sexual violence for males and by expanding our understanding of how anger may present. Consequently this could inform the way in which male victims of sexual violence are responded too within the services they are offered and the content of the intervention approaches we seek to provide.

Traumatology.

Five out of seven studies identified Traumatology as psychological symptomatology that male victims of sexual violence exhibit. Briere et al (2003) in using a trauma measure of

assessment identified sexual abuse as being uniquely associated with all ten scales of the assessment measures. The assessment measure used (TSI) incorporated various traumatology type symptoms including:

- Intrusive Experiences: flashbacks, nightmare, intrusive thoughts,
- Defensive Avoidance: post traumatic avoidance (pushing painful thoughts away) and behavioural (avoiding stimuli reminiscent of a traumatic event), and
- Dissociation: derealisation, depersonalisation, out of body experiences and psychic numbing.

In addition, Briere et al (2003) reported that these findings were apparent even after controlling for confounding variables (demographic variables and adult trauma). In terms of the greatest elevations on the TSI scales, Briere found that over 64% of participants achieved elevations in 8-10 of the symptomatology scales (10 being all of the scales within the measure). These findings indicated that male victims of sexual violence are likely to display an array of traumatology type symptoms.

When examining fear as part of traumatology type symptoms, Davies et al (2010) and Lisak (1994) recognised its presence within their samples. Lisak's (1994) qualitative study found that 1/6th of his 1004 codable passages fell into the category of fear. Here male victims reported that fear had pervaded their lives since their abuse and into their adulthood. They reported that fear could present as dull, a present reality, a dizzying experience of terror, and a feeling that confines them and undermines their self- confidence. Davies et al (2010) also established that 73% of males who had been raped by a stranger reported experiencing fear and 82.5% of Walker et al (2005a) sample of male rape victims also reported fear in relation to being alone with men. Finally, Ray (2001) also recognised the presence of fear following

sexual violence in her sample of twenty-five males and assigned this to her theme of psychological symptomatology experienced.

Sexual Relatedness Difficulties.

Of the seven studies assessed, six examined sexual relatedness difficulties. The studies generally fell into two categories: issues of masculinity, sexual identity / orientation (SI) or sexual dysfunction / sexual behaviours (SD). Three of the studies found male victims of sexual violence to experience SD symptomatology (Briere et al, 2003), Fromuth et al (1989) and Ray (2001), two studies of SI symptomatology (Lisak, 1994) and Davies et al, 2010) and one study examining both SD and SI symptomatology (Walker et al, 2005a).

SD

Following interviews with male victims of sexual violence, Ray (2001) noted the majority of his 25 participants reported fear and avoidance of sexual intercourse or sexual promiscuity as symptomatology following their experiences of sexual violence. Three of the participants within the sample had reported engaging in prostitution. The findings of Briere et al (2003) indicated that victims with a history of sexual violence had elevated scores on the TSI scale of dysfunctional sexual behaviour ($\beta = -.17, p < .001$).

When examining the long term psychological correlates of sexual violence in men, Fromuth et al (1989) focused on later psychological and sexual adjustment. Here their findings revealed that men who reported being sexually abused were more likely (than non-abused males) to report difficulties in maintaining and achieving an erection (Midwestern sample: $r [251] = .18, p < .01$) and were more likely to have difficulties with premature ejaculation (South-eastern sample: $r [328] = .11, p < .05$) than non-abused males.

SI

Lisak's (1994) research of 26 adult male survivors of childhood sexual abuse reported psychological symptomatology related to masculinity and sexual identity issues. Here participants described feelings of inadequacy, as

- Having a real desire to be perceived as masculine;
- Feeling a dichotomy between wanting to appear masculine yet having feelings which contradicted this, and
- Having a desire to compensate for feelings of masculine inadequacy by for example, joining a largely "masculine" arena such as the armed forces.

Interestingly, they noted exactly one half of their sample had served in the armed forces.

Within the same study and in terms of sexual identify issues, Lisak (1994) reported that the majority of his sample expressed confusion regarding their sexuality and sexual orientation, particularly the victims who experience abuse perpetrated by males ($\chi^2 = 77.8$, $p < .01$). In addition Lisak (1994) observed that a number of victims expressed fear of homosexual males which they believed derived from a fear that they themselves may have homosexual tendencies consequent to their abuse experiences. In considering sexual identity issues further, Davies et al (2010) found that of their sample, more homosexual victims of rape suffered a crisis in their sexual identity than the heterosexual victims (Pearson's chi-square = 4.00, $p = .05$). It is important to note however, whilst significant findings were identified in relation to the crisis in identity outlined, they should be considered with caution given that such a small sample size was utilised in the study.

SI and SD.

Coinciding with Fromuth et al (1989) findings relating to sexual behaviours, Walker et al (2005a) analysis of the effects of rape on men also identified the presence of changes in sexual behaviours and feelings for males following rape. In particular they found changes post assault to include promiscuous behaviours, refusing to have sexual relations with men or women, erectile failure and a lack of libido. In addition to this Walker et al (2005a) also found that male victims felt confused and disgusted with their responses during the assault. For example, those who reported getting erections or as ejaculating within the assault described feeling very confused and as questioning their sexual orientation. Similarly with the findings of Lisak (1994) and Davies et al (2010), the study also found that 70% of their sample reported crisis with sexual orientation and 68% with their sense of masculinity.

Self-Dysfunction.

All of the studies within the review examined psychological symptomatology within the self-dysfunction category. In his sample Lisak (1994) identified psychological symptomatology that included feelings of guilt, shame, having negative schemas about oneself and others, having feelings of self-blame, of being betrayed and experiencing profound feelings of worthlessness, all as being predominant in his analysis (thematic content analysis). In addition, he found feelings of shame and humiliation (within the males who experienced abuse by female perpetrators (N= 9), to be significantly present ($p < .05$) in terms of the frequency they appeared within his analysis. In contrast to this, the earlier findings of Fromuth et al (1989), revealed that actually a history of childhood sexual abuse did not correlate with symptomatology related to self-esteem, ones locus of control, nor ones rating of self-adjustment.

In examining self-esteem across three constructs (performance e.g. "I feel confident about my abilities", social e.g. "I feel others admire me", and appearance e.g. "I feel satisfied

with the way my body looks right now”), Davies et al (2010) found that males who were the victim of stranger rape scored lower on all three of the constructs. Overall their findings revealed that men who had been raped by strangers, had lower self-esteem, greater negative world assumptions and poorer general health scores than men experiencing rape by a known perpetrator. Whilst some of the effect sizes of their findings were small (.3 or below), those relating to self-esteem showed medium effect (.6) and to self-worth, a large effect size. In association with such findings, Walker et al (2005a) noted of their sample (N = 40), between 82%-90% of male victims of rape reported a damaged self-image and feelings of guilt and self-blame. Ray (2001) reported similar findings in that the most commonly reported psychological symptomatology was that related to damage to one’s sense of self.

Briere et al (2003) explored tension reduction behaviour (e.g. self-harm / self-mutilation, suicidal ideation) and an impaired self-reference as part of the psychological symptomatology that male victims of sexual violence experience. Here they found this symptomatology was significantly present ($p < .01$) within their male sample. Ray (2001) observed similar outcomes following her sample of males with a history of sexual abuse. Here she reported self-mutilation, over-eating, low self-esteem, sense of self, self-hatred, shame, humiliation, feelings of inadequacy and substance abuse as all present symptoms for the male victims. In particular she observed 52% of the sample engaging with drugs and alcohol and 60% seeking therapy for suicidal ideation. In contrast to these findings, Walker et al (2005a) reported of his sample (N = 40) substance abuse, suicidal ideation, suicide attempts and eating disorders were the least reported psychological symptomatology. The percentages of the sample reporting such symptomatology ranged from 27%-67%. He continued to report the most reported symptomatology men experienced as associated with rape to include a damaged sense of self image, feelings of guilt and of self-blame. Here he reported 82%-90% of his sample reported these feelings. Of note, Gault-Sherman et al (2009)

also reported eating anxiety (as measured by the Eating Disorders Inventory) as present symptomatology in their sample of 1008 male victims of childhood sexual abuse.

Psychiatric.

Of the seven studies within the review, three included psychiatric symptomatology (Fromuth et al, 1989), Davies et al, 2010) and Ray, 2001). Psychosomatic symptomatology was reported in male victims as derived from Davies et al, (2010) general health questionnaire measure and via Fromuth et al's (2010) measure of psychological adjustment. Ray (2001) also reported 8% of his sample described psychosomatic symptoms. With regards to paranoid ideation and psychoticism, Fromuth et al (1989) also identified a significant relationship ($p < .05$) within his sample of Midwestern male victims of sexual abuse, in that those who experienced sexual abuse were less well-adjusted in terms of paranoid ideation and psychoticism.

How Have the Studies Measured Psychological Symptomatology Male Victims of Sexual Violence Experience?

The seven studies included within the review utilised a range of assessment measures.

The different measures each study used are illustrated below in Table 4.

Table 4:

Assessment Measures Used Within Each Study

Measure Used	Study / Study Number
Standardised assessment	Briere et al (7)
	Fromuth et al (6)

 measure

Survey Measure Gault-Sherman et al (1)

Interviewing Measure Ray (3)

Interviewing & Standardised Lisak (5)

Measure

Questionnaire Measures Davies et al (4)

Walker et al (2)

In addition, three studies accounted for or examined, control / potentially confounding variables (Gault-Sherman et al (2009), Briere et al (2003) and Fromuth et al, 1989). Whilst differences in the type of sexual violence presented, (some studies examined childhood sexual abuse, some rape etc.), all the assessment measures remained relevant to the psychological symptomatology associated with sexual violence.

Below each of the assessment measures is discussed in terms of how they assessed psychological symptomatology, the reliability and validity of the assessment measures and the overall findings generated following assessment.

Standardised Assessment Measures.

Many researchers have noted that the use of generic measures (non-specific to trauma), often underestimate the symptomatology associated with childhood abuse (Carlson, 1997, Elliott, 1994). Accordingly, Briere et al (2003) sought to use a standardised measure of trauma when assessing psychological symptomatology in males following sexual violence. Here they incorporated the Traumatic Events Survey (TES), (Elliott, 1992) and the Trauma Symptom Inventory (TSI), (Briere, 1995) as assessment measures. The TES examines a

range of childhood and adult traumas which is generally considered a valid measure of trauma symptoms. The TSI measure psychological symptomatology via a 100 item test for post-traumatic stress (and other psychological symptomatology) associated with traumatic events. The TSI incorporates 3 validity scales and 10 clinical scales: anxious arousal, depression, anger-irritability, intrusive experiences, defensive avoidance, dissociation, sexual concerns, dysfunctional sexual behaviour, impaired self-reference and tension reduction behaviour (self-harm). The TSI scales can be considered internally consistent with mean alphas of .86, .87, .84 and .84 in general population, clinical, university and military samples respectively. The TSI also demonstrates sufficient convergent, predictive and incremental validity.

The use of Briere et al (2003) trauma measures are fitting in terms of them maintaining relevance to the area examined, in remaining applicable to their sample (males) and the assessments denote good validity and reliability as outlined. In contrast, whilst the assessment measures allow identification of symptomatology, they cannot determine causality. As a way to minimise confounding variables here Briere et al (2003) examined adult trauma (as assessed by the TES). Overall the findings of Briere et al (2003) indicated that sexual violence was associated with all 10 of the trauma scales of the TSI and that the greater the number of elevated TSI scores, the greater the likelihood of the participant having a history of sexual violence [$\chi^2(4) = 75.5, p < .001$]; Somer's $d = .28, p < .001$).

The second study utilising standardised assessment measures was Fromuth et al (1984). They assessed psychological symptomatology in a sample of male victims via measures that included: the Hopkins Symptom Checklist (SCL-90 Derogatis, Lipman & Covi 1977, 1973) a 90 item self-report checklist including several scales: somatization, obsessive-compulsive, interpersonal sensitivity, depression, anxiety, hostility, phobic anxiety, paranoid ideation and

psychoticism. Incorporated within the SCL-90 are three global measures of functioning: Global severity index (GSI), positive symptom total (PST) and positive symptom distress (PSD). In addition to the SCL-90, the Beck Depression Inventory – Short Form (BDI), (Beck & Beamesderfer, 1974), a Locus of Control Scale (LOC), (Coleman et al, 1966), a modified version of Rosenberg’s Self Esteem Scale (SES), (Rosenberg 1965) and Finkelhor’s Sexual Self Esteem Scale (SSE), (1981) were also used as assessment measures. Overall the SCL-90 appeared as a good measure of overall symptom presence / symptom severity. Studies have generally given more support to the SCL-90’s convergent validity (the measure relates to what it should theoretically relate to), particularly regarding the depression and anxiety scales. In terms of the measures discriminant validity, (tests whether concepts or measurements that are supposed to be unrelated are, in fact, unrelated) there is less support for its validity particularly regarding the obsessive-compulsive scale (Derogatis, 1983). In addition to the assessment measures identified, Fromuth et al (1989) also aimed to remove the potentially confounding variables of negative relationships with parents (given that previous studies suggest a history of child abuse was confounded with negative relationships with parents (Finkelhor, 1980). In accordance with this the researchers therefore incorporated two measures of parental adequacy including Finkelhor’s General Inadequacy Scale (1980) and the Parental Bonding Instrument (Parker, Tupling & Brown, 1979).

Overall, the findings deriving from the assessment measure identified a history of sexual abuse correlated with 6 of the SCL-90 scales (obsessive compulsive, interpersonal sensitivity, depression, hostility, paranoid ideation, psychoticism) and the GSI, PSI and PSD. In addition, since no correlation was found between a history of sexual abuse and the measures parental bonding and parental inadequacy, the findings could not be attributed to

confounding negative family relationships. Of note, no relationship between sexual violence as measured by the SES, LOC or BDI was found.

In essence, these findings suggest that men experiencing sexual violence as measured by the assessments discussed are slightly less well psychologically adjusted than men who have not experienced sexual violence.

Survey Measures.

Gault-Sherman et al, (2009) utilised a survey measure previously developed by the Icelandic Centre for social research. Participants who completed the measure did so in a retrospective self-report basis. The assessment measures examined general anxiety (e.g. *“how often in the last week have you felt “tense”, “nervousness”?”*) depressed mood (e.g. *in the past week were you “sad or had little interest in doing things?”*) theft (e.g. *“Have you ever in the last 12 months “stolen something?”*), violent behaviour (e.g. *“have you used physical violence in order to steal?”*) and eating anxiety (eating anxiety scale taken from the Eating Disorders Inventory (Garner, Olmstead & Polivy, 1983), (e.g. *“I am obsessed by the thought of looking thinner”*). Gault-Sherman et al (2009) also examined some potentially confounding variables including age, family structure, parental education, socioeconomic status, parental attachment, peer delinquency and physical abuse. In terms of the reliability of the assessment measures used the following is reported: general anxiety: $\alpha = .77$, depressed mood: $\alpha = .89$, eating anxiety: $\alpha = .95$, theft: $\alpha = .62$ and violent behaviour: $\alpha = .66$. The measures used have demonstrated a good degree of face validity and internal consistency / reliability. Overall their assessment findings indicated that male victims of sexual violence demonstrated more “externalising” behaviours such as violence and theft (theft ($b = .41$,

p<.001], violent behaviour (b = .62, p<.001], when compared to internalising behaviours (eating anxiety, general anxiety & depressed mood).

Interviewing Measures.

Within her assessment of male victims, Ray (2001) utilised interviews as her measure of assessing psychological symptomatology experienced. Interviews were then transcribed and data was separated into categories and subcategories. A double coding qualitative method was used to enhance the reliability of the data. Here two researchers coded the same set of data separately. An inter-coder reliability statistic of 89.6% was obtained. Of the symptomatology reported by the participants, eight areas were identified: social, psychological / emotional, physical, sexual, familial, sense of self, relation to men and relation to women. Overall findings indicated in all eight areas participants reported the long terms effects as negative. In addition Ray (2001) suggests male victims of sexual violence experience both internalised type symptoms (e.g. depression, fear, anxiety) and externalised type symptoms (e.g. anger, substance misuse) of sexual violence.

Interviewing & Standardised Measures.

Lisak (1994) used both interviewing and a standardised measure of assessment when exploring psychological symptomatology in males following sexual violence. Interviews were utilised in relation to their perceived effects of sexual violence which were then considered alongside their responses to the SCL-90 (Derogatis, 1977). Interviews were transcribed and common themes identified which were then compared to similar research methods used in a previous study (Leobowitz, 1990). Following this process a coding manual was developed, given to independent coders and themes identified. Reliability of the coding system was assessed by measuring the agreement between the ratings of the coders. Cohen's

Kappa (measure of percentage agreement which removes the effect of chance agreement) was .89 between coder 1 and the author and .91 between coder 2 and the author. Of the themes analysed, one significant association was observed following Chi Square analysis, that is, the symptomatology related to Homosexuality issues. In terms of the SCL-90 findings the mean GSI (global severity index) score for males was 1.43 (Sd = 0.75), in comparison to the GSI score for non-patients in the SCL-90's normative sample, of 0.31 (Sd = 0.68). The mean score for the PTSD subscale was 1.48 (Sd = 1.48) compared to a mean of 0.39 (Sd = 0.41) for the non-PTSD sample reported in Saunders, Arata and Kilpatrick (1990). Overall, Lisak's (1994) findings following her combined assessment measures allowed identification of four main themes that psychological symptomatology can be considered within: prominent affects and affective states, salient cognitive sequelae, issues of gender and sexuality and interpersonal difficulties.

Questionnaire Measures.

Both Davies et al, (2010) and Walker et al, (2005a) used measures that included: the Male Rape Questionnaire (MRQ Walker et al, 2005a) which includes examination of reactions to rape, the General Health Questionnaire (GHQ Goldberg & Hiller, 1979) examining aspects of psychological functioning including somatic symptoms, anxiety, social dysfunction and depression, the Self-Esteem Scale (SES), (Heatherington & Polivy, 1991) measuring current self-esteem across three subscales: Performance (e.g. *"I feel confident about my abilities"*), Social (e.g. *"I feel others admire me"*) and Appearance (e.g. *"I feel satisfied with the way my body looks right now"*), the World Assumptions Scale (WAS), (Janoff-Bulman, 1989) examined basic assumptions about the world in relation to eight subscales: benevolence about the world, benevolence of people, justice, controllability,

randomness, self-worth, self-controllability and luck) and finally, the Impact of Events Scale (IES Horowitz, Wilner & Alvarez, 1979) relating to serious life events.

In terms of the reliability and internal consistency of the scales, for the GHQ: $\alpha = .85$, for the WAS it ranged from: $\alpha = .40$ -.83, the lowest here related to randomness, $\alpha = .58$ for justice, and $\alpha = .69$ for controllability, for the SES: $\alpha = .91$ (performance), $\alpha = .91$ (social), $\alpha = .92$ (appearance) and for the IES: the overall Cronbach's Alpha = .81.

In terms of the overall findings from Davies et al, (2010), the assessment measures used revealed that men that had been raped by a stranger, had lower psychological functioning overall than men who had been raped by an acquaintance. The findings of Walker et al (2005a) indicated from the assessment measures used, the most commonly reported psychological symptomatology were depression, fantasies about seeking revenge on the perpetrator, flashbacks from the attack, anxiety and damage to their self-image (90-97%). They recognised the least reported symptomatology as eating disorders (27.5%), suicide attempts (47.5%), self-harming behaviours (50%), substance abuse (52.5%) and suicidal ideation (55%).

Discussion

Overall Findings.

The aim of this review was to explore the range of psychological symptomatology of male victims of sexual violence. Of the seven studies included, five categories were identified and all of them identified it as being harmful / negative. Having identified the symptomatology they were placed into categories. The five categories are:

- Dysphoric Mood (DM): Anxiety, Depression, Revenge fantasies, Anger / Irritability / Hostility.
- Traumatology (TY): Intrusive thoughts, Fear, Dissociation, Avoidance, Emotional Distancing, Social Dysfunction, Isolation.
- Sexual Relatedness Difficulties (SRD): Sexual Concerns, Dysfunctional Sexual Behaviours, Crisis of Sexual Identity, Masculinity Issues.
- Self-Dysfunction (SD): Self-Esteem Difficulties, Vulnerability, Self-Blame, Loss/Grief, Betrayal, Shame, Trust Issues, Helplessness, Negative Schemas about Self / Others / World, Self-Harming, Obsessive Compulsive Behaviours, Eating Disorders, Suicidal Ideation, Suicide Attempts, Substance Abuse.
- Psychiatric (PS): Paranoid Ideation, Psychoticism, Psychosomatic Symptoms, Somatisation.

Of the seven studies, six examined psychological symptomatology associated with DM, five with TY, six with SRD, all seven with SD and two with PS. This demonstrates a range of symptoms investigated. Moreover this also supports previous literature (Bryer et al, (1987) indicating female victims of sexual violence also experience similar negative consequences thought to be associated with sexual violence.

In terms of how the studies measured the psychological symptomatology they identified, the following was observed:

- Two studies used standardised assessment measures (Briere et al 2003, Fromuth et al, 1989).
- One study used survey measures (Gault-Sherman et al, 2009).
- One used interviewing measures (Ray, 2001).
- One used interviewing alongside a standardised symptom measure (Lisak, 1994)

- Two studies used questionnaire measures (Davies et al, 2010 and Walker et al 2005a).
- Three studies also examined control or potentially confounding variables, (Gault-Sherman et al (2009), Briere et al (2003) and Fromuth et al, 1989).

Overall, the findings allowed for an array of psychological symptomatology to be identified and provided insight as to how these symptoms can be assessed and measured. In particular the findings identify that a range of assessment measures can be used, that the assessment measures have individual strengths and limitations, that they need to have adequate validity and reliability and that a combination of assessment measures may provide a greater depth of information. Finally, the overall findings can be considered as applicable to my population of interest.

Interpretation of the findings.

One of the most prominent findings within the studies was that different studies perceived different symptomatology as more prominent. For example, Fromuth et al (1989) reported that childhood sexual abuse did not correlate with self-dysfunction symptoms, self-esteem, self-adjustment or locus of control. In contrast, Lisak (1994) in his sample of childhood sexual abuse victims did report self-dysfunction symptoms as being associated with sexual violence and in particular, self-esteem. Interestingly both of these studies used samples of victims experiencing childhood sexual abuse and both used the SCL-90 as an assessment measure. These similarities could therefore suggest that differences in the findings are not attributable to the type of neither abuse experienced, nor the assessment measures used. It may therefore be argued that differences in their findings may be consequent to the vast differences in sample sizes (Lisak (1994): N =26) as compared with Fromuth et al (1989): N = 592) and the differences in their incorporation (or lack of

incorporation) of confounding variables: (Lisak (1994) did not consider these, Fromuth et al (1989) included relationships with parents as control variables.

The findings of Walker et al (2005a), Briere et al (2003) and Ray (2001) also highlighted differences amongst the prominence of specific symptoms. Walker et al (2005a) found that the least reported psychological symptomatology that male victims experienced related to the Self-Dysfunction category. Here they reported substance abuse, suicidal ideation, suicide attempts and eating disorders as least prominent symptoms. In contrast, Briere et al (2003) noted a significant presence of suicidal ideation, self-mutilation and self-harm in their sample, as did Ray (2001), who also reported self-mutilation, suicidal ideation and over eating as prominent symptomatology for males having experienced sexual violence. In considering these contrasts, differences in findings may be due to the differences amongst the assessment measures used. For example, Walker et al, (2005a) utilised Questionnaires, Briere et al, (2003) used standardised assessment measures and Ray (2001), used a qualitative approach. Based on this, differences are apparent in terms of the validity and reliability of the different assessment measures used. Furthermore, differences in findings may also be due to the populations used and type of abuse their victims experienced. Here Walker et al, (2005a) used a sample of male rape victims from the general population, Briere et al, (2003) used a sample of male childhood sexual abuse victims from the general population and Ray (2001) used a sample of male incest and other sexual abuse victims from a clinical sample. Consequently, these differences may have factored in the contrasts amongst findings.

In considering the differences identified further, two of the studies failed to consider any confounding variables. By doing so this has implications in terms of considering if the symptoms reported are indeed associated with sexual violence experience, (as opposed to other factors). For example, the symptomatology described could have been impacted by the gender of the perpetrator, whether the perpetrator was known to the victim, the age of onset

of sexual violence, the type of sexual violence and so on. As such the findings the studies identify may indeed be attributable to other factors as outlined above. As a final point of note, all three studies used male victims that were predominantly of White ethnic origin (74%, 100%, and 100%). The generalisability of the researcher's findings to male victims of other ethnic origins, is therefore questionable.

In interpreting the findings from the assessment measures used and the methodologies the studies employed, several factors can be discussed. In particular, many of the studies relied on retrospective and self-report data. This can be problematic as participants may respond in a socially desirable manner, may over or under report symptoms, or may have their recall affected due to the passage of time. From the studies examined, there was considerable variation in the sizes of samples used ranging from 25 to 1008. Due to this there are limitations in terms of their generalisability to the wider population. In addition, many of the studies used a predominantly White sample, which as mentioned can affect the findings ability to be generalised to a Non-White sample.

In considering how the psychological symptomatology was measured, the studies within this review incorporated many different measures of assessment (as discussed earlier). It is important to consider here, how "good" these assessment measures were at assessing the symptomatology they identified. Psychological tests can be described as a "good" test if they have certain characteristics, including being reliable and being valid (Kline, 1986). Of the assessment measures the studies used, many denoted a good level of reliability and validity. In particular, Briere et al, (2003) standardised measure of the TSI denoted good internal consistency and good predictive and incremental validity. In contrast, whilst there may have been good inter-coder reliability within their assessment measures, Ray's (2001) and Lisak's (1994) qualitative approach by its very nature was more subjective, thereby impacting its reliability. It used smaller sample sizes thereby effecting generalisability of findings and

finally, denotes experimenter bias in terms of loaded assessment questions and participants responding as they feel they ought to etc.

In considering the psychological symptomatology experienced by male victims, a further finding of significance was that male specific symptoms were identified by two of the researchers (Fromuth et al, 1989) and Walker et al (2005a). Here they identified male victims having difficulties in achieving erections and difficulties relating to premature ejaculation. This finding is particularly relevant as often researchers focus on issues of promiscuity or relationship problems in terms of “sexual relatedness difficulties”. By identifying these male specific symptoms as evident, perhaps further assessments could look to include this within their assessment measures or overall assessment process.

In addition, to this Walker et al (2005a) and Davies et al (2010) also recognised one of the most frequently reported symptoms of male victims of sexual violence was having fantasies about and wanting to seek revenge and retaliation against their perpetrator. Ninety five percent of Walker et al sample and 100% of Davies et al sample, who were raped by strangers described such symptomatology. This finding is significant in terms of its implications regarding future treatments provided to male victims and future focus could seek to tailor intervention towards this or at least have awareness of its presence.

Findings in Relation to Practice & Future Recommendations.

Based on the overall findings of the review, several concepts need to be considered. Firstly, when assessing psychological symptomatology experienced by male victims of sexual violence, assessment measures should include an array of symptomatology including both psychiatric and male-specific symptoms such as a desire to seek revenge, difficulties relating to premature ejaculation and difficulties relating to erections.

Secondly, the assessment measures used should incorporate both quantitative (including “good” standardised tests with good validity and reliability) and qualitative measures thereby absorbing the strengths within both these procedures / measures.

Thirdly, clarity needs to be gained via further research regarding the prominence of symptomatology. As noted previously, studies contrasted regarding which symptoms they identified as presenting with greater prominence. If greater clarity and understanding of this was gained, interventions could be more tailored to this and professionals with specific skills relevant to this could be sourced. Moreover, further research needs to examine if there are differences between the types of psychological symptomatology male victims of sexual violence experience in comparison to their female counterparts. By doing so this can inform future practice, the services offered to victims and the assessment procedures we employ.

Fourthly, a proportion of the research suggests that male victims of sexual violence experience more externalised symptomatology such as substance abuse, anger, hostility etc. Greater examination into this area should be gained as to consider if men do indeed experience certain “types” of symptoms. Findings here could inform intervention, practices and assessment procedures.

Finally, future studies should include larger sample sizes where possible, explore a range of psychological symptomatology and incorporate a sample that includes victims of varying ethnic origins.

Strengths & Limitations of the Review.

This review utilised a systematic approach to examine the psychological symptomatology male victims of sexual violence experience which has not been done before. Accordingly not only was this review able to identify a gap within the literature, it also

allowed a systematic examination of studies and only included studies that were of good quality. This was particularly important for providing good insight into the symptomatology and also in providing an overview of a currently developing area in terms of research and our understanding.

In terms of the limitations of the review, the reliability of quality assessment was limited as only one researcher conducted the quality assurance / assessment process. Secondly, not all studies relevant to the area were necessarily included as the review only included English studies, did not include hand-searched references or studies where less than three psychological effects and not all articles could be obtained due to time constraints. In addition, only published studies were included which has implications in terms of publication bias (suggesting those studies with significant findings are more likely to be included), (Torgerson, 2003). Finally a further limitation is that the review brings together literature relating to different forms of sexual violence consequently this may have impacted on the overall findings.

Conclusions.

Overall it is evident that men who have been victims of sexual violence are likely to experience an array of harmful psychological symptomatology (Ray, 2001, Lisak, 1994). Such symptomatology can be considered in terms of overarching categories which help provide an overall context to the individual symptoms. The prominence of different symptoms have conflicted amongst the studies examined within the review, which perhaps is due to the samples they use, the types of sexual violence experienced or the assessment measures they have employed. Indeed by identifying that psychological symptomatology can be measured in a variety of ways this can make it difficult to contrast data from different studies. More consistent approaches in measurement are therefore warranted. What has

presented as an interesting finding is that male-specific symptomatology following sexual violence does appear to be apparent (Walker, Archer & Davies, 2005a, Lisak, 1994, Fromuth & Burkhart, 1989). As such, assessment measures, prevalence of these and greater insight here is required.

Irrespective of the qualitative or quantitative methodologies the studies employ, what remains vital is that further research is more explorative of the symptomatology male victims experience, considers if there are differences in the symptoms men experience (in comparison to female victims), considers the prominence and types of symptoms male victims of sexual violence experience. By doing so our future understanding, practice, interventions and overall services we provide to victims of sexual violence will be more informed, more focused and more victim specific. This in turn will assist in what is undoubtedly a long and difficult recovery process for these victims who need to use such services.

CHAPETER 2: A Critique of a Psychometric Assessment:

The Trauma Symptom Inventory

(TSI, Briere, 1995).

Introduction.

It is suggested that the majority of the population will experience at least one traumatic event during their lifetime (Kessler, Sonnega & Bromet, 1995). When considering the relevance of this to the field of Psychology and our practice within it, it is extremely likely that many of the individuals or patients we have contact with may have had, or currently present with trauma symptomatology. Accordingly, methods that allow us to identify such symptomatology are essential when practising within the psychological arena and it is the traditional method of clinical interview that has played a crucial role in informing this knowledge. In addition, the development of psychometric assessments has extended our abilities to assess trauma symptomatology and have provided us with a more systematic and measurable approach to assessment. In accordance with this and relevant literature within the field, the Trauma Symptom Inventory (TSI), (Briere, 1995) was developed to assess psychological trauma related symptoms.

As part of the critique of the TSI, several areas will be considered including an overview of the tool, characteristics of the TSI and its reliability and validity. The limitations of the TSI will be considered throughout followed by some concluding points and considerations for the future.

An Overview of the TSI.

The TSI was developed as a psychometric tool for assessing post-traumatic and trauma related symptomatology. The tool is used to assess acute and chronic trauma related symptoms following a traumatic event/s. In particular the TSI highlights can be used for sexual violence including experiences of rape, date-rape (Shapiro & Schwarz, 1997), and childhood sexual abuse. In addition the measure is also suitable for trauma such as, domestic

abuse, physical assault, combat, natural disasters, and or other major incidents or other traumatic events that have occurred.

In terms of the rationales for reviewing the TSI as an assessment measure of trauma, this relates to three main factors. Firstly, the TSI can assess for symptoms of trauma following an experiences / s of sexual violence which is the focus of the overall thesis and the research area. Secondly the TSI is an appropriate measure to examine as it can be utilised with both male and female victims of trauma which as noted in the systematic literature review, is evident. In addition, the sample used within the research study includes both male and female victims who have experienced trauma following sexual violence. Finally, the TSI examines psychological symptomatology following trauma (including sexual violence) and general psychological sequelae. This again holds relevance in terms of the research area examined (Chapter 3) effects experienced by male victims (Chapter 1) and the overall thesis.

When developing the TSI, Briere (1995) was keen to devise an assessment that considered and incorporated knowledge and understanding from the field and relevant trauma literature. Indeed this was incorporated by considering literature on Post-Traumatic Stress Disorder (PTSD), symptoms associated with childhood sexual abuse, natural catastrophes, adult interpersonal victimisation and by considering other relevant tools at the time such as the Structured Clinical Interview Scale for the DSM-III-PTSD scale (Spitzer & Williams, 1986). In addition, Briere utilised knowledge gained from the previously developed Trauma Symptom Checklist (TSC) (Briere & Runtz, 1989) to inform the TSI alongside undertaking consultation with several specialist clinicians regarding the TSI item construction.

By incorporating knowledge of the trauma literature Briere was able to devise an assessment that not only measured or allowed for identification of PTSD and / or Acute Stress Disorder (ASD), but also one that assessed for intra and interpersonal difficulties

associated with chronic trauma such as victimisation-related anger, self-harming behaviours, dissociation, dysfunctional sexual behaviours and so on. This approach was particularly beneficial as previous psychometric assessments of a similar nature had failed to incorporate such a variety of interpersonal symptomatology (Herman, 1992).

Characteristics of the TSI.

The TSI is a 100 item self-report measure designed to assess a range of trauma related symptoms. The test was largely designed for use within clinical settings and is appropriate for use on males and females aged 18 years and older. Within the test participants are provided with items/questions and asked to rate (on a 4 point Likert scale) whether the statements described, apply to them currently or within the last 6 months. Examples of the statements include:

In the last 6 months, how often have you experienced:

(Item 8): Flashbacks (sudden memories or images of upsetting things)

(Item 19): Thoughts or fantasies about hurting someone

(Item 70): Violent dreams

Individuals are asked to rate whether they agree with the item statements by rating from 0 (never) to 3 (often).

Within the test the TSI includes 10 clinical scales and 3 validity scales (full descriptions of each of the scales can be located in appendix 4).

The 10 clinical scales include:

Anxious Arousal (AA), Depression (D), Anger / Irritability (AI), Intrusive Experiences (IE), Defensive Avoidance (DA), Dissociation (DIS), Sexual Concerns (SC), Dysfunctional Sexual Behaviour (DBS), Impaired Self-Reference (ISR), Tension Reduction Behaviour (TRB).

Of note, the items in the test are divided into the scales in accordance with the questions posed. For example, in relation to the scale Anger / irritability (AI) the question posed would include: (within item 15):

In the last 6 months have you experienced:

Becoming angry for little or no reason?

The 3 validity scales within the test include:

Response Level (RL), Atypical Response (ATR) and Inconsistent Response (INC) which measure exaggerated, inconsistent, random or unusual responding.

The clinical scales within the TSI were considered in relation to four overarching categories:

Dysphoric Mood, Post-Traumatic Stress, Sexual Difficulties and Self-Dysfunction.

(Identification of which scales relate to which category can be observed in Appendix 4).

In terms of the normative data, the TSI was developed on 836 individuals from the general population. The TSI manual also identifies three additional samples including a University sample, a sample of Navy recruits and a sample of psychiatric inpatients and outpatients.

Having completed the TSI, scores are plotted onto a profile and considered in relation to the mean score of the standardisation sample. Here the more the score deviates from the mean the greater the degree of trauma symptomatology. On all of the 10 clinical scales, those achieving a score greater than 65 are considered clinically significant.

Reliability

Internal Reliability.

Internal reliability is concerned with examining the correlations between different items on the same test. It measures whether several items that propose to measure the same general construct produce similar scores (Field, 2005). If a test denotes good internal consistency / reliability the items will measure the same construct and typically demonstrate an alpha (reliability) score of $>.7$ (Kline, 1999). The clinical scales within the TSI are internally consistent (Mean alpha coefficients = .86, .87, .84 and .85 in the standardisation, clinical, university and military samples). The TSI scales demonstrate sufficient convergent, predictive and incremental validity (discussed further later).

The ten clinical scales of the TSI demonstrate good internal reliability in the standardised sample as alpha ranged from .74 to .91 indicating internal consistency of ($\alpha = .86$). In relation to the three other samples (University, Navy and Psychiatric) the TSI also demonstrated overall high internal consistency. The table below (Table 5) is indicative of this:

Table 5:

Internal Consistency Across the Samples Within the TSI.

<i>Scale</i>	<i>Standard Sample N = 828</i>	<i>University Sample N = 279</i>	<i>Navy Sample N = 3659</i>	<i>Psychiatric Sample N = 370</i>
Atypical Response Level (AR)	.75	N/ A	.75	N/A
Response Level	.80	N/A	.78	N/A

(RL)				
Inconsistent Response Level (INC)	.51	N/A	.55	N/A
Anxious Arousal (AA)	.86	.84	.82	.87
Depression (D)	.91	.87	.88	.90
Anger / Irritability (AI)	.90	.90	.88	.89
Intrusive Experiences (IE)	.89	.87	.87	.90
Defensive Avoidance (DA)	.90	.89	.87	.88
Dissociation (DIS)	.82	.86	.84	.88
Sexual Concerns (SC)	.87	.80	.83	.89
Dysfunctional Sexual Behaviour (DSB)	.85	.77	.85	.89
Impaired Self-Reference (ISR)	.88	.86	.85	.87
Tension Reduction Behaviour (TRB)	.74	.69	.76	.74
α Overall Reliability	.86	.84	.85	.87

Note: Table 5 adapted from *Trauma Symptom Inventory Manual: Briere, (1995)*.

Of note is the INC score of .51. The INC score measures an individual's random and / or inconsistent responses. Based on the reliability score observed, it can be concluded that the

TSI is not particularly reliable in detecting inconsistent or random responses. Accordingly the use of an additional measure to assess these alongside the TSI may be called for.

In terms of the correlations between the scales on the TSI (Appendix 5), an exploratory factor analysis with the standardised sample was conducted. In implementing the analysis, a two-factor model was generated namely, Factor 1: Generalised Trauma & Distress and Factor 2: Self-Dysfunction. On observation it was noted that some of the TSI scales inter-correlated with both Factors 1 and 2.

Such findings are useful when considering this in relation to the four categories (Dysphoric Mood, Post-Traumatic Stress, Sexual Difficulties and Self-Dysfunction) originally identified as whilst symptoms appear to “fit” within these, on analysis, there are some items that fit within both of these factors. As such, the exploratory factor analysis was not supportive of the original four domains / categories in terms of fitting with the trauma theory.

As to assimilate these findings and establish a model of best fit, further confirmatory factor analysis generated both a two and three factor model. A three factor model was deemed preferential as it presented as more fitting with trauma theory and as it yielded a fit index of .95 (.90 is considered a “good fit”). In essence, a three factor model incorporating the following categories was developed: Trauma, Self and Dysphoria. This structure is the underpinning of the TSI.

The figure 4 below provides a pictorial representation of the 3-factor solution (following factor analysis) which underpins the TSI.

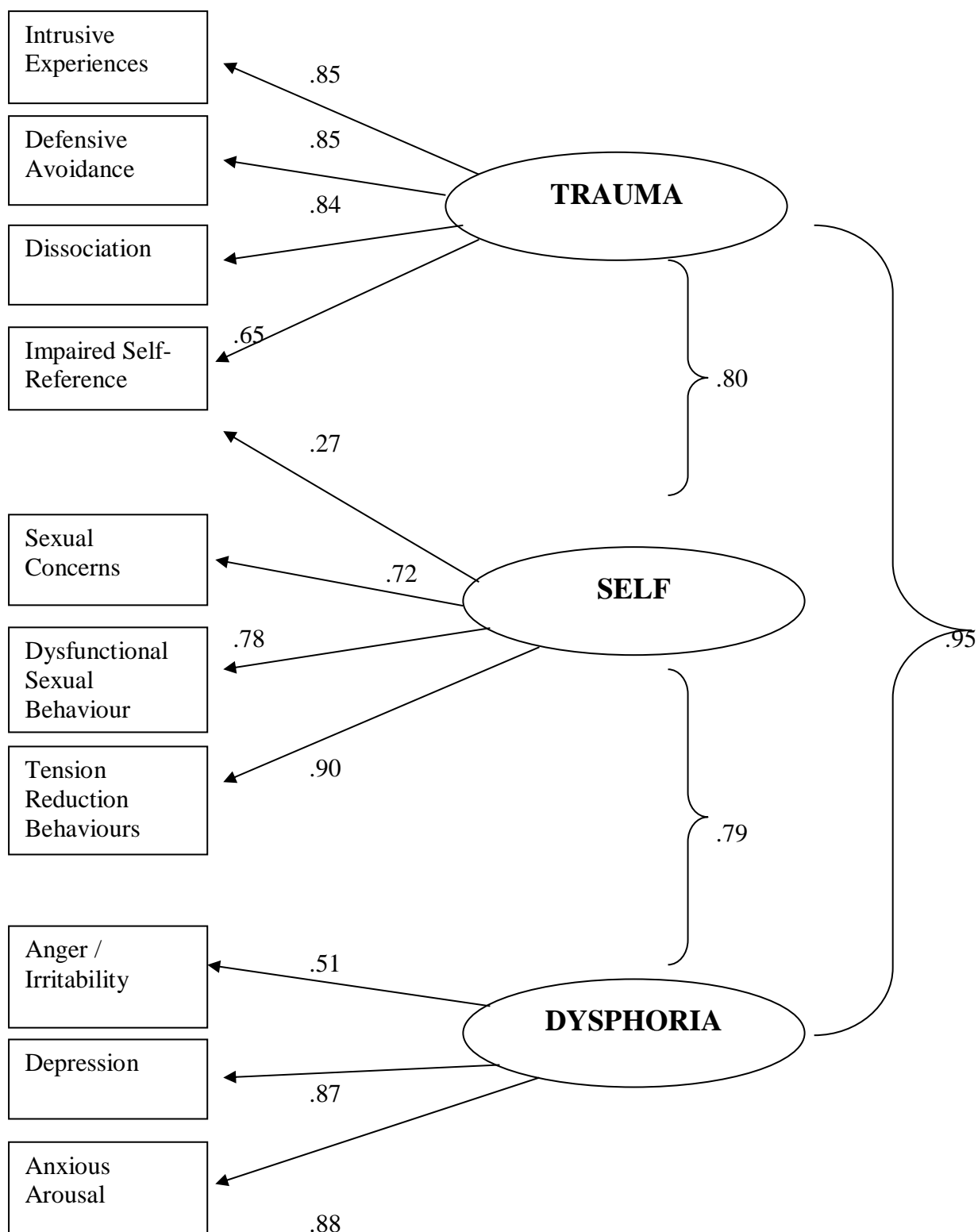


Figure 4: Adapted from Trauma Symptom Inventory Manual: Briere, (1995).

From observing Figure 4 the 3-factor model demonstrates a good fit in terms of the links between the factors and the theory. However, the model appears less reliable when considering impaired self-reference (ISR). Here a score of .65 is noted for ISR and the trauma category yet .27 for ISR and the self-category. As a possible rationale for this Briere (1995) suggests that ISR may refer to “acute disorganisation and fragmentation of self when it appears in the context of elevated trauma scales” pp.36. He suggested this indicates greater difficulty with self-awareness and identity, when it occurs in the context of higher tension reduction behaviour and dysfunctional sexual behaviour scores. Overall, those with inadequate self-capacities are particularly susceptible to the development of PTSD when trauma occurs. This may lead to a correlation between ISR and trauma.

Test-Retest Reliability.

Unfortunately the TSI manual fails to highlight any test-retest analysis and consequently, any statistical information pertaining to this. Nonetheless, there are two main factors to consider. Firstly, test-retest reliability is concerned with a test demonstrating reliability were it conducted again (usually within a small time frame), to yield the same or similar results thus demonstrating reliability (Field, 2005). Should an individual present with genuine trauma symptoms within their initial TSI test it is unlikely that these would have changed, lessened or diminished following re-test irrespective of the passage of time or were they not to have undertaken treatment / intervention. Accordingly were findings replicated following re-test the TSI could be considered as a good measure of test-retest reliability.

Secondly, the TSI incorporates the three validity scales which focus on inconsistency, over endorsement and random responding. When considering this in relation to test retest reliability, one could assume that had a patient over endorsed items or randomly responded on the initial test, were they given the test again, they too would respond in a similar manner. Accordingly the TSI's test-retest reliability could be observed, albeit via the consideration of the validity scales. Furthermore the use of the validity scales in this manner would be particularly useful if, as highlighted, trauma symptoms had changed without intervention.

Validity.

The main aim of validity is to examine if a test correctly measures that which it purports to measure (Dwyer & Scampion, 1995). As a way to ascertain this, several types of validity can be examined within the psychometric assessment including face validity, criterion validity, content validity and construct validity. This shall be critiqued in relation to the TSI.

Face Validity.

Face validity is concerned with how the test may appear to the participant and if on the surface, it appears to test what it intends to (Ley, 2007). Face validity has no statistical significance but is considered in terms of a common sense understanding of the tool. In relation to the TSI, the test does denote acceptable face validity particularly as the items are relevant to the area of trauma. For participants taking the test, the items are fairly indicative of what they are measuring in that it would be unlikely the participant would be shocked or surprised by the questions posed. This is attributable to the good face validity within the test and the test items denoting clarity in their content. If the test were to lack such clarity, this could lead to inaccurate findings, particularly where tests items lack specificity in their content individuals often fail to reveal significant traumatic experiences (Read & Fraser, 1998).

In contrast, should the participant fail to comprehend the test items owing to a significantly traumatised state, they may indeed fail to understand questions and consequently respond inaccurately or in an incomplete manner. As to avoid this however, one would expect that were the participant significantly traumatised the instructor would respond in an appropriate manner to this and possibly omit such testing.

As a further consideration, the test is for use on participants with a minimum reading ability of aged 11-13years, this would need to be adhered to as should participants maintain a reading ability of years less than this, they may be unable to answer questions and fail to understand what they are being asked. In relation to providing responses, the TSI is a self-report measure. Self-report information should always be interpreted with caution given that the participant may have responded in a falsified manner. For example, the participant may want to respond in a manner they believe the instructor would want them to, in a manner they believe they should (socially desirable), may want to present themselves within a favourable manner (faking good) and may underreport the severity or frequency of e.g. their symptoms as to minimise their problems / their trauma for example, due to denial. However it is worthy to highlight that the TSI does incorporate three validity scales (as noted) aimed at accounting for such responses. Irrespective of this, it is necessary to remain mindful that whilst self-report is useful in gaining participants' perspectives, attitudes and beliefs, caution should be applied and often, further measures of assessment administered as to corroborate findings.

Criterion Validity.

Criterion validity seeks to establish if the test itself measures the same constructs as other relevant tests. To establish this, the TSI was considered in relation to two trauma scales, the Impact of Events Scale (IES), (Horowitz, Wilner & Alvarez, 1979) and the Symptom Checklist (SCL), (Saunders, Arata & Kilpatrick, 1990), and one generic measure of psychological symptoms, the Brief Symptom Inventory (BSI), (Derogatis & Spencer, 1982). Findings indicated in relation to females, that the TSI was more able to identify psychological distress associated with interpersonal victimization than all of the other three tests (IES, SCL & BSI). Whilst this finding is informative, two points must be recognised. Firstly, this finding cannot be applied too or generalised towards the male population given that the research was based on a female-only sample. Secondly, questions must be posed in relation to

the appropriateness of comparing the sophistication of the TSI to the somewhat less sophisticated other tests identified. Indeed, these tests (IES, SCL, BSI) consist of a small number of test items, focus on one or two general constructs as opposed to generating meaningful scale scores, have little standardization data and have their origins of development in relation to very specific group's e.g. sexual abuse victims, (Briere, Elliott, Harris & Cotman, 1995). As such it is perhaps of little surprise that when the TSI is utilised in comparison, it somewhat surpasses those identified. Perhaps future research could look to consider the TSI when compared to tests that are similar in sophistication.

Finally, in terms of its predictive validity, the TSI was found to correctly predict 25 out of 26 PTSD positive cases and 385 out of 423 PTSD negative cases (Briere, 1995). With respect to psychiatric inpatients and the clinical scales of the TSI, 89% of those receiving a diagnosis for Borderline Personality Disorder could be correctly predicted and 82% of non-Borderline Personality Disorder accurately predicted. However, this is not to suggest that the TSI is assessing individuals for personality disorder more that it is likely to be detecting trauma associated with borderline personality patients.

Arbisi, Erbes, Polusny and Nelson (2010) found that both the TSI and Minnesota Multiphasic Personality Inventory-2 (MMPI-2) were able to identify females with sexual assault histories who met the criteria for PTSD. These findings do offer support for the use of the TSI in females with a sexual assault history. However, whether the TSI's use in such predictions is accurate and reliable in respect to other traumatic areas such as with natural disaster survivors or extreme combat survivors, is yet to be identified.

Content Validity.

Content validity is concerned with whether the items in the measure are relevant to the construct being examined (Ley, 2007). Were items not relevant to the construct being

examined, the accuracy and relevance of any outcomes would be compromised and any conclusions drawn questionable. To inform test item construction within the TSI, specialist clinicians were consulted as regarding item inclusion or exclusion. Whilst appropriate, perhaps further consultation from previous patient / service users could have also been utilised and further, information pertaining to what type of “specialists” were consulted as to provide credibility of knowledge etc. could have been provided.

Overall the TSI denotes good content validity. This is demonstrated as the scales the TSI identifies are very much linked to the trauma theory. Indeed following in-depth analysis, each of the relevant scales (AA, D, DIS, etc.) adequately fits (a fit index of .95) the categories (Dysphoric, Trauma and Self, Appendix 2) akin to trauma theory. In doing so good content validity is achieved as its measures are relevant to the construct of trauma.

Whilst the TSI demonstrates good content validity particularly in relation to the construct of trauma, it is worthy to consider how this may change should our knowledge and understanding of the area of trauma change or expand. In relation to this, a concept currently under investigation is that of complex trauma and specifically, complex PTSD. Complex trauma relates to traumas that have occurred repeatedly, usually over an extended time period and specific relationships and contexts (Courtois, 2004). Examples considered within this framework include victims of brutal gang rape, victims having been held in captivity for sexual exploitation, on-going combat, victims of concentration camps, human trafficking and so on. It is proposed that these victims may denote more extreme post traumatic responses (Briere & Spinazzola, 2005) and ones that are in addition to those ordinarily observed therefore requiring a far more specific and thorough approach to assessment.

With this in mind, were the TSI to be utilised as a standalone measure in cases where complex trauma / complex PTSD prevails, this tool may indeed fail in providing a detailed

and thorough insight of the specifics of complex trauma outcomes. Indeed more recent findings of Briere and Spinazola (2003) have highlighted the need for psychometric assessments examining complex trauma to be able to accurately predict cases of genuine trauma as opposed to simulated trauma. The TSI's ability to achieve this in terms of being able to identify malingers is questionable (discussed further later). In addition, the use of a wide range of measures that assess a number of different areas of symptomatology simultaneously have been called for when assessing complex PTSD (Briere and Spinazola, 2003) which again highlights the use of multi assessment approaches. The importance of considering historical and more recent history of the individual is also vital when considering complex trauma particularly as research suggests the greater the number / type of traumas the greater the psychological symptomatology (Follette, Polusney, Bechtle and Naugle, 1996 and Runtz et al, 1999). It is with this in mind that there remains a need for consideration into the individual's recent and prior trauma history perhaps via structured diagnostic interview as previously noted, before the origin of their derivation can be established.

Finally , when considering complex trauma as a concept and / or those patients demonstrating complex trauma symptomatology the TSI fails to provide information as to whether outcomes elicited are the consequence of a recent traumatic event, the consequence of chronic childhood abuse or an accumulation of both childhood abuse and adult trauma (Briere, 2004).

In summary, whilst the TSI would still demonstrate good content validity in relation to complex trauma (as it remains relevant to the trauma construct being examined), it remains unable to provide insight into whether the trauma symptoms are a result of one or more traumas nor which trauma an individual has experienced. Furthermore, a more encompassing approach outside of the utilisation of one measure of assessment (the TSI) for examination of trauma symptomatology is required such as the inclusion of diagnostic interview, detection of

malingers and or symptom specific psychometrics. By doing so, greater insight can be gained regarding individual patient's / client's symptoms or trauma outcomes and a more universal all-encompassing best practice approach adopted by the clinicians completing and interpreting the assessments.

Construct Validity.

Following on from content validity, construct validity seeks to examine if the scales within the test "behave" as the theory would suggest (Dwyer et al, 1995). To examine this Briere (1995) considered the mean differences between traumatised and non-traumatised individuals. Findings indicated that the TSI does denote appropriate construct validity as within each sample the traumatised individuals scored highly on the TSI scales whereas their non traumatised counterparts did not. This indeed fits with trauma theory in that traumatised individuals will display traumatised symptomatology.

In relation to trauma symptoms the TSI identifies, the test's inclusion of the three validity scales (RL, ATR and INC) is crucial in obtaining information on the validity of the respondent's self-report of their symptoms, a concept similar tests have often failed to incorporate (Arbisi et al, 2010). When considering the ATR validity scale in particular (this scale identifies over endorsement or deviant responding), we must question its reliability as a validity scale. The possibility of respondents purposefully distorting their responses or the potential for them to report as more symptomatic than they actually are (Ben-Porath & Waller, 1992) must be considered. If for example an individual is undergoing a trauma assessment as part of e.g. a compensation claim following a rape or a pension eligibility requirement, they may indeed be inclined to exaggerate their responses and appear over-symptomatic with the aim of securing or benefiting from such claims. Indeed the exaggeration in PTSD symptoms was observed in 20% of compensation seeking combat

veterans (Frueh, Hamner, Cahill, Gold & Hamlin, 2001) and 20-30% of personal injury litigation contexts (Lees-Haley, (1997).

The aim of the ATR scale in this instance would therefore strive to assess for high scores that in turn suggest suchover-endorsement. With this in mind it is crucial to consider how well the ATR can identify if a respondent is responding in a credible manner. In examining this concept, several studies in contrast to Briere (1995) found that the ATR validity scale of the TSI is not effective in recognising credible nor non-credible responses of test takers (Efendov, Sellborn & Bagby, 2008; Elhai, Butcher, Gray, Jacobs, Fricker-Elhai, North & Arbisi, 2007; McDevitt-Murphy, Weathers, & Adkins, 2005). These findings also suggest that the TSI has limited ability to detect malingers. Whilst the ATR scale was not developed as a malingered PTSD screen (Briere, 1995) but more of general validity scale (Elhai, Grey, Naifeh, Butcher, Davies, Falsetti and Best, 2005) its inability to assess for malingers does serve as a limitation and a highlighter for the use of additional malinger measures or indeed a test which does incorporates such measures e.g. the Minnesota Mutliphasic Personality Inventory-2 (Butcher, Graham, Ben-Porath, Tellegan, Dahlstrom and Kaemmer (2001).Further, in their study of college students, Carmody and Crossman (2005) asked students to initially respond to the TSI in an honest manner and secondly, to respond as though they had developed trauma symptomatology following a traumatic incident. The findings obtained indicted that the ATR validity scale of the TSI was unreliable and performed poorly in differentiating between the falsified reporters and the credible reporters.

Collectively these findings are concerning and indeed suggest that the ATR validity scale of the TSI is not always reliable in being able to differentiate between individuals who report genuine trauma symptoms and those who fabricate trauma symptoms. As such, it is likely that additional assessment methods should be used in conjunction with the TSI in striving to assess such the credibility of individual's self-reported symptomatology.

As a final concept to consider in relation to the ATR scale specifically Briere (1995) notes that an extreme over endorsement of this scale (>90) may suggest the respondent is psychotic. However, questions must be raised as to how a differentiation is made between a respondent that over reports on the ATR scale, to a respondent that is genuinely psychotic. However as to appease Briere (1995) includes critical items which aim to highlight possible psychotic responses. For example, a critical item includes:

Item 65: Have you in the last 6 months:

“Heard someone talk to you who wasn’t really there?”

Whilst this may be somewhat useful in identifying psychotic symptoms, how informative individual’s responses are to this item is questionable given that a psychotic individual may indeed state they are not “hearing someone talk to them who wasn’t really there”. As to that psychotic individual in their perception, that “person” may indeed “be there”. Moreover, it is also possible that traumatised individual’s may also respond to the question positively, stating yes, without actually being psychotic. Whilst the incorporation of such critical items is worthy in striving to identify a psychotic individual, this is by no means a thorough and accurate assessment of psychosis. As such, it would be advisable to utilise knowledge of extremely high ATR scores in the TSI as a “flag” for further assessment.

Norms.

Normative data is obtained by administering tests to a representative sample. Once obtained norms are the values that are representative of a group which can then be used as a baseline measure against which subsequent collected data can be compared to (<http://science.jrank.org/pages/5569/Psychometry-Normative-data.html>). In terms of the normative data within the TSI, this consisted of a national (United States of America)

stratified random sampled of 836 individuals. The mean age of participants was 47.3 years, 50.8% male, 57.1% married and 77.5% Caucasian.

During analysis, differences in scores due to both gender and age were observed leading to the development of separate normative information for these groups. In addition, small differences in scores due to race were also observed with African-Americans and Hispanics scoring higher on all 3 validity scales and 3 of the clinical scales (IE, DA and DSB). As such this needs to be considered when utilising the TSI in relation to these groups and indeed perhaps further investigation into the TSI in relation to other populations is worthy.

The TSI also identifies three additional samples including a University sample, a sample of Navy recruits and a sample of psychiatric inpatients and outpatients. It is unfortunate that there are no United Kingdom samples in relation to this test.

The normative data described, acts as an appropriate data set for comparison. However the extent to which results can be generalised outside of this data set is questionable.

Conclusion.

As one of the most widely used psychological tools of the assessment of trauma symptomatology (Elhai, Gray, Kashdan & Franklin, 2005), it is imperative to consider the reliability and validity of the TSI. This critique has highlighted the benefits and limitations of the TSI as an assessment measure. In particular, the TSI unlike many other self-reported measures of PTSD considers both the core symptoms of PTSD, as well as other common sequelae of trauma. In addition, the level of the test's overall reliability and validity is more than satisfactory, its origins are encompassed within the trauma theory and its components in particular the test items, are all relevant to the construct being examined. Accordingly these

factors indicate this is a good measure for use when assessing sexual violence trauma. However, the TSI in terms of its use as a standalone assessment measure, its inability to consider how much time has passed since the exposure to the traumatic event/s, the number of incidence and whether the trauma has occurred within childhood, adulthood or both, all act as limitations to this assessment measure in terms of understanding trauma outcomes. Indeed when considering this collectively, it may be argued that when examining the area of trauma, an encompassing approach grounded within thorough assessment that includes examination of psychological symptomatology, trauma symptomatology, diagnostic interview and symptom driven assessments is recommended. By doing so a collective, guided and thorough examination of a patient's trauma symptomatology can be gained and in turn the outcomes of such a thorough process can contribute to and inform the intervention and recovery pathway.

**CHAPTER 3: A Research Study Examining:
Psychological Symptomatology Experienced by
Victims of Sexual Violence:
A Gender Comparison.**

Abstract

Aim: This research aims to examine and compare the types of psychological symptomatology male and female victims experience following sexual violence.

Method: The sample consisted of 91 adult male and 91 adult female victims of sexual violence. Retrospective file data was systematically collated from Coventry Rape & Sexual Abuse Centre. Data was obtained on the psychological symptoms victims reported as a consequence of historical sexual violence experience/s. The data was analysed via chi-square and cluster analysis.

Results: Findings identified an array of negative and harmful psychological symptoms following sexual violence experiences. Male victimisation was significantly associated with anger, avoidance of thought, substance misuse, work and sexual difficulties. In contrast, female victimisation was significantly associated with dissociation, fear, self-esteem issues, parenting difficulties and difficulties relating to restrictions to movement. Similarities were found amongst male and female symptoms in relation anxiety, depression, nightmares, self-harm, relationship difficulties and suicidal thoughts / behaviours. In terms of the categorisation of symptoms, results found that male victims significantly describe more externalising and dysphoric type symptoms in comparison to females, who significantly describe more internalising traumatology symptoms. Overall symptoms did not fit explicitly within one specific category for either gender.

Conclusions: Similarities and differences in the psychological symptomatology of male and female victims of sexual violence were found. These findings highlight a need for a more rounded assessment process and tailored treatment that incorporates more male specific psychological symptomatology.

Introduction

Sexual violence is an immense violation of one's human rights and a significant public health concern (Jewkes, 2012)). It is also a pressing international issue in today's society and has generated variations amongst prevalence rates globally (Jewkes, 2012). During 2000 it was reported that 1 in 6 females and 1 in 33 males in America have experienced some form of sexual violence in their lifetime (Tjaden & Thoennes, 2000). The United Nations Women (2012) report identified population based studies examining 39 countries. It found a prevalence of sexual violence amongst females at some point in their lifetime which varied from 0.3% to 39%. In terms of childhood sexual abuse, prevalence rates have ranged from 7% to 36% for females and 3% to 29% for males (Stoltenborgh, Van Ijzendoorn & Euser, 2011).

Several explanations have been put forward for variations in overall prevalence rates, whilst this is not the focus of this research it is worthy to note. Rationales for this have included sexual violence occurring more frequently amongst females (WHO, 2010), males concealing their sexual violence experiences to a greater extent (Vander-Mey, 1988), male victims being less likely to report or disclose their experiences due to fears of being labelled or perceived as "gay" (Mathews, 2008; King, 1992) and overall fears of receiving an unsympathetic response by those who have been reported to (West, 1992). What does remain apparent, is that we are uncertain whether men or women report higher rates, however there is certainty that both men and women can and have been victims of sexual violence.

What are the Psychological Symptomatology Associated with Sexual Violence?

In their early research exploring long-term psychological sequelae associated with childhood sexual abuse, Stein, Golding, Siegel, Burnam and Sorenson (1988) found that of their male and female sample (n=74), the most commonly reported symptoms were anxiety

(49.9%), anger (47.5%), guilt (47.5%) and depression (45.2%). In identifying the least experienced symptoms they reported increased substance abuse (4%), appetite disturbance (8.9%), and a fear of being alone (15.8%). In addition, victims of childhood sexual abuse were considered significantly more likely than non-abused individuals to have a greater prevalence of substance misuse (36.6% vs. 29%), affective disorder (20.5% vs. 7%), major depressive disorder (18.6% vs. 4.74%), anxiety disorder (29.2% vs. 10.9%) and anti-social personality disorder (9.1% vs. 2.4%) (Stein et al, 1988).

More recent research has continued to recognise the psychological symptomatology associated with sexual violence and highlights symptoms including self-esteem difficulties, anger, depression, anxiety, post-traumatic stress, dissociation, substance abuse, sexual difficulties and self-harming / destructive behaviours and discomfort regarding sexual intimacy all as being associated with experiences of sexual violence (Berliner & Elliott, 2002; Briere & Runtz, 1993; Finkelhor, 1990; Kolko, 2002; Neumann, Houskamp, Pollock & Briere, 1996, Denov, 2004).

Since later research has begun to explore issues and effects of sexual violence on male victims, our overall understanding and knowledge base has been informed. In particular, “male specific or male orientated” symptoms have prevailed. Some of this symptomatology has included fears of homosexuality, confusion over sexual orientation, masculinity issues and problems with sexuality (Gilgun & Reiser, 1990; Hunter, 1990, Lisak, 1994, Coxell & King, 1996, Walker, Archer & Davies, 2005a). In relation to masculinity in particular, male victims of childhood sexual abuse (perpetrated by females), have been found to feel humiliated and question their sense of masculinity due to the fact they had been abused by the so-called “weaker gender” (Denov, 2004). In accordance with these male-specific symptoms, research has also suggested that sexual violence against males can lead to significant sexual

dysfunction, including problems with premature ejaculation and achieving and maintaining an erection (Fromuth & Burkhart, 1989).

In considering the psychological symptomatology associated with physical and sexual abuse within an overall trauma based framework, Briere, Elliott, Harris and Cotman (1995) examined male and female victims of childhood and adult victimization. Here they used the Trauma Symptom Inventory (TSI, Briere, 1995) as an assessment measure and found that childhood sexual abuse was associated with all 10 trauma scales on the TSI. These scales were considered within an overall framework of trauma-type symptoms (discussed later).

Moreover, their findings indicated that female victims scored highly on the TSI in relation to symptoms including: anxious arousal, depression, intrusive experiences, defensive avoidance, dissociation, sexual concerns and as having an impaired self-reference. In addition, they found the male victims within their sample denoted elevated scores relating to anger / irritability, dysfunctional sexual behaviours and tension reduction behaviours (e.g. self-harm). A full description of the scales is located in Appendix 4.

Having identified the types of symptoms associated with sexual violence and having briefly highlighted the findings of Briere et al (1995), further insight into the apparent gender similarities and / or differences within symptomatology will now be discussed.

What Are the Similarities and Differences of Psychological Symptomatology reported by Male and Female Victims of Sexual Violence?

Historically research examining the effects of sexual violence has largely assumed that these effects are similar for males as for their female counterparts (Hussey, Strom & Singer, 1992). Whether this is accurate remains questionable, however it is imperative to gain

understanding and knowledge into apparent similarities or differences. By doing so findings can consequently inform the treatments and services victims of sexual violence are provided.

Internalised / Externalised Symptomatology

In considering initial differences amongst the psychological symptoms male and females experience following sexual violence, several authors have noted the internalised / externalised concept. Rew, Esparza, and Sands (1991) found that male victims reported more externalised responses such as aggressiveness, antisocial behaviours and a lack of control over their own behaviours (Friedrich, Urquiza & Beilke, 1987, 1988). This was compared to females who demonstrated more internalised responses (emotional and expressive techniques). In support of this concept, early research also highlighted how males were more likely to act aggressively and fight with siblings (Gomes-Schwartz, Horowitz & Cardarelli, 1990, Tufts, 1984) whereas females were more likely to present as depressed (Conte, Berliner & Schuerman, 1986). In addition, studies have noted that male victims of sexual violence are more likely than female victims to engage in substance abuse, engage in delinquent activities, take greater sexual risks and behave aggressively (Chandy, Blum & Resnik, 1996; Culter & Nolen-Hoeksema, 1991; Martin, Bergen, Richardson, Roger & Alison, 2004).

In contrast to these findings, other research has suggested that female victims of sexual violence are more likely to exhibit externalised behaviours. For example, when exploring adult sexual assault, Elliott, Mok and Briere (2004) noted the externalised behaviour of self-harm (tension reduction behaviours) as being present in their female sample. Self-harming is arguably an external expression of behaviour occurring in a variety of forms including slashing, cutting or burning oneself and all of which have been attributed to some individual's responses following childhood sexual abuse (Heney, 1990; Mitchell &

Morse, 1998). Elliott et al's (2004) findings noted that the female victims of sexual assault utilised tension reduction behaviours to a greater extent when compared to the males in their sample. In addition, they also described females as using self-harm as a way to move forward from internalised discomfort. The researchers continued to observe that the male victims within their sample also displayed externalised behaviours and were more symptomatic in relation to dysfunctional sexual behaviours and sexual concerns.

In contrast to the findings discussed, other studies have found that victims of sexual violence experience both internal and external symptoms irrespective of their gender. Here Friedrich, Urquiza and Beilke (1986) reported that 40% of their male sample (n=64) and 45% of their female sample experienced internalised symptoms including being fearful, feeling inhibited and as having feelings associated with depression. Moreover they reported 40% of males and 37% of females denoted elevated scores relating to the externalised symptoms of aggression, being antisocial and as having uncontrollable behaviours.

Overall the concept of externalised and internalised symptoms relating to male and female victims of sexual violence appears very varied. This may be due to differences in assessment measures, reliability of the measures, differences amongst the samples used etc., all of which will be discussed more thoroughly later.

An absence of long term Psychological Symptomatology Following Sexual Violence?

Findings discussed so far have explored the types of symptomatology following sexual violence and the similarities / differences within this. However, some research findings have completely opposed this concept and rejected the very existence of such long-term effects. The early research findings of Bender and Grugett (1952) examined 15 clinical

case reports of sexually abused children. Their findings indicated there were “no long-term effects” following sexual abuse. However, later examination of these findings suggested that several of the victims later went on to require repeat hospitalisation, engage in drug and alcohol abuse and one victim successfully committed suicide (Conte & Schuerman, 1987). The more recent research of Denov (2004) supports Bender et al (1952) early findings by reporting that one of the seven male victims of childhood sexual abuse (via qualitative analysis) within their sample described their abuse as non damaging stating:

“I don't think the sexual abuse did anything really wrong to me”. pp.1143

However, in contrast, the remaining 93% of her sample reported the abuse as highly damaging and difficult to recover from (Denov, 2004). In addition to this and in further support of these early findings, Mannarino and Cohen (1986) found 31% of their sample of victims of sexual violence to be symptom free. Moreover, Conte and Schuerman (1987) using a list of symptoms for assessment, found that 21% of their sample of abused children, reported no symptoms at all.

In addition to these findings Fromuth and Burkhart (1989) reported that some of their sample of male victims of childhood sexual abuse did not reportedly perceive their abuse as negative and that it had a positive impact on their adulthood sexuality. Interestingly these survivors were victims of abuse from female perpetrators, which evokes questions as to the role of the gender of the perpetrator and if this impacts the symptomatology the victim later experiences. Perhaps further research using both male and female victims and perpetrator gender can examine this.

In essence, whilst prior discussion has highlighted an array of psychological symptomatology associated with sexual violence and identified similarities and differences within symptoms experienced, it was considered worthy to highlight the more contradictory

and controversial findings suggesting sexual violence produces few, or no positive experiences. Rationales for this are discussed later in terms of differences within assessment measures and so on.

Theoretical Frameworks of Psychological Symptomatology Following Sexual Violence.

Two of the most relevant models of psychological symptomatology associated with sexual violence will be considered including the Four Traumagenic Dynamics Model (Finkelhor & Browne, 1985); and the Post-traumatic Stress Model (Briere, 1995).

Finkelhor and Browne's (1985) early research postulated a framework for examining trauma comprising of four traumatic dynamics. This framework sought to guide our understanding of the traumatic impacts of childhood sexual abuse. The framework included four dynamics including: Traumatic sexualisation, betrayal, powerlessness and stigmatisation. The first dynamic considers the impacts of the child's sexual feelings and attitudes being shaped in an inappropriate and dysfunctional manner. The betrayal dynamic, considers the effects of the harm caused by an individual whom the victim is dependent upon / has a relationship with. The third dynamic, powerlessness, can be recognised whereby the offending perpetrator renders their victim powerless in terms of against the child's sense of efficacy and will. The final dynamic of stigmatisation, derives from the effects of the negative connotations associated with the child's experience which can inevitably be incorporated into the child's own self-image.

This model was valuable in providing a broad conceptual framework for gaining greater understanding into the psychological symptomatology of childhood sexual abuse. It further illustrated the importance of recognising that emphasis should not necessarily be placed upon a greater or lesser level of symptom severity, but rather recognised the injurious dynamics the victim may present with. However, in terms of the models limitations, it

incorporated a rigid framework and as such this can hinder the variation of symptomatology, for example by excluding other effects such as dissociation or substance abuse (Briere & Runtz, 1993; Hunter, 1990).

A later model which aimed to allow for a greater level of symptom variation was developed by Briere (1995). This model sought to consider trauma related symptoms and lead to the development of the TSI of which their framework sits. Within this framework various categories are devised relating to individual symptoms. Briere (1995) suggested that the effects of sexual trauma can be considered in relation to Dysphoric Mood (e.g. anger, depression, anxiety), Post-traumatic Stress (e.g. dissociation, stress, flashbacks), Sexual Difficulties (e.g. unwanted sexual thoughts) and Self-dysfunction (e.g. self-harming behaviours) type symptoms (see Appendix 4 for full description of symptoms and the categories they relate to). This model has been particularly useful for considering the variety of impacts of sexual violence in terms of trauma based symptoms which are likely to follow experiences of trauma. The framework has also been valuable by incorporating knowledge and understanding from the field and from relevant trauma literature. By doing so Briere (1995) developed the widely used TSI as a measure that not only identified symptoms of post-traumatic stress but also, those associated with intra and interpersonal difficulties or with chronic trauma such as victimisation-related anger, self-harming behaviours, dissociation and dysfunctional sexual behaviours.

It was with this rationale in mind that Briere's (1995) framework served as one of the models drawn upon to inform the overall framework used within this research. In addition, some specific symptoms victims (within the current sample) described (that were not accounted for within Briere's framework) were incorporated into the framework devised for this research (of note, Appendix 6 provides details of the "categories of psychological

symptomatology following sexual violence (CPSFSV)” that were used / devised for this research).

Objectives of the research

Having considered psychological symptomatology associated with sexual violence and the theoretical frameworks incorporating this, it is apparent that further insight is required into this area. The literature and research provided so far has conflicted in terms of the types of symptoms identified or agreement over whether any long-term effects of sexual abuse exist (Bender, 1952). Further research is therefore required to determine the psychological symptomatology. In addition, as much of the research relating to sexual violence has focused on female victims, there is a need to understand the effects of male victimisation.

The aim of this research is to examine and compare the types of psychological symptomatology of male and female victims following an experience of sexual violence victimisation. For the purposes of this research, all types of sexual violence are included (see method) as the study seeks to consider victims of sexual violence irrespective of the type of sexual violence they had experienced. Specifically, the following research questions will be investigated:

RQ1: What is the psychological symptomatology of the total sample?

RQ2: What is the psychological symptomatology that:

a.) Male victims of sexual violence experience?

b.) Female victims of sexual violence experience?

RQ3: Are there differences between the psychological symptoms males and females report?

RQ4: Do the:

- a.) Male symptomologies fit particular categories?
- b.) Female symptomologies fit particular categories?

RQ5: Are their differences between male and females in the symptomatology categories?

Methodology

Participants

In total, retrospective file data from 182 adults was included in the study, comprising of 91 adult male and 91 adult female victims of sexual violence. All data was collated from participants who had been assessed by Coventry Rape and Sexual Abuse Centre (CRASAC) over a one year duration.

The mean age for males was 31 years (SD= 12.5) and 31.7 years (SD = 10.9) for the females. The majority of the sample was White British (n = 138 / 76%) and of Heterosexual orientation (n = 166 / 91%). Table 6 indicates the ethnic origins and sexual orientations of the overall, male and female sample.

Table 6: Ethnicities and Sexual Orientations of Overall Sample: (n=182).

	Overall	Male	Female
White British	76%	68%	78%
Black African	2.7%	3%	3%
Black British	3.2%	3%	4%
Mixed Race	2.7%	1%	0%
Asian British	1.1%	3%	0%
Chinese	1.1%	1%	0%

African Caribbean	1.1%	0%	0%
Indian & Pakistani	2.2%	0%	6%
Unknown &	11.4%	14%	8%
Other	2.7%	1%	4%
Sexual Orientation			
Heterosexual	91.2%	95%	90%
Homosexual	2.7%	1%	4%
Bisexual	1.1%	0%	2%
Unknown	5%	8%	3%

In terms of the sexual violence the participants experienced, this included an array of acts as described earlier within the outlined definition of sexual violence. However, in brief this included differing acts such as sexual assault, childhood sexual abuse, rape and so on. Moreover, these acts may have occurred within varying time frames thereby including both current and historical experiences. Victims of sexual violence often present as CRASAC both within a few hours of a sexual violence experience or the many years following this. However when victims / professionals / ISVA's are collecting the information, it is done so in relation to the most recent experience of sexual violence.

Procedure

Victims can be referred to CRASAC via several routes, including self-referral, as a referral from professionals e.g. G.P's, police, hospital staff, staff from sexual assault referral centres etc., or via the helpline service based in CRASAC. Within the initial referral process

some basic information is obtained by CRASAC staff. This includes (amongst other details) information relating to the incident of sexual violence, the victims ethnicity, age, gender and sexual orientation. Once initial information is gathered the victims “case” is assigned to one of the three trained Independent Sexual Violence Advisor (ISVA’s) at CRASAC. The small number of ISVA’s collecting the data may encourage a higher level of ascertainment. Indeed when examining survey’s Jewkes (2012,) found a much higher levels of ascertainment when a small numbers of highly trained and supported fieldworkers are used. Once assigned, the ISVA then commences the process of contacting the victim whereby further assessment / needs analysis commences. This process takes the form of both telephone and face to face contact with the victim.

In terms of assessment, the ISVA obtains collateral information from other professionals such as psychiatric reports, G.P. reports / information, reports from other services the victims may have contact with etc. In addition, the ISVA also completes initial and on-going assessment through continued dialogue with the victim, for example during individual one to one emotional support sessions. This process may vary given that one victim may engage with the service for one timeframe whilst another for a differing timeframe. Moreover, victims may remain within the service or leave the service as they choose and consequently a greater level of data may be obtained for one victim over that of another.

The data relating to the psychological effects of the sexual violence is gathered by the ISVA based on information obtained from several sources. Firstly, from any reports / collateral information provided by other professionals or organisations, secondly, as described by the victim themselves and thirdly, as observed / noted by the ISVA within the risk assessment /initial contact (Appendix 7) during their on-going dialogue and contact with the victim e.g. during one to one sessions. In terms of the ISVA’s observations / findings,

they coded symptoms as present or absent onto a database. A symptom, for example Depression would be coded as present if:

- The G.P. report described the victim as depressed or as prescribed anti-depressants following their experience of sexual violence
- The victim described themselves as feeling depressed following their experience of sexual violence or
- If the ISVA observed factors suggesting depression such as the victim describing low mood, being tearful, describing feelings of hopelessness, having no motivation etc.

Full descriptions of the types of features present in order for the ISVA to score a symptom as present are provided in Appendix 8, (information was provided by ISVA's following consultation). Overall symptoms were reported as present if the victims reported the symptom, the ISVA observed the symptom / features of the symptoms or if the collateral information described the presence of symptoms. To note, in terms of the time passed since the sexual violence occurred, sufficient data for analysis was not available and as such, time elapsed varied for each victim.

Measures / Assessment

The data obtained was collected over a period of one year by CRASAC staff (ISVA's). In terms of the reliability of the assessment process, the statistical reliability could not be obtained due to the retrospective nature of the data collection. In addition, the presence or absence of a symptom was noted for each victim by one individual ISVA during their contact with the victim. To encourage reliability it could be argued that more than one ISVA could have assessed each victim however, given the sensitive nature of the victims experience this could be inappropriate and not necessarily in the best interest of the victim. Indeed the

nature of the ISVA service is in working within a one to one therapeutic relationship with the victim and not to overwhelm or over provide services / approaches.

As a further “buffer” in terms of reliability findings from ISVA’s, individual sessions were corroborated with available collateral information. This type of data may be considered less open to interpretation (an example of collateral information is the G.P. report documented depression following sexual violence experience).

Treatment of Data and Ethical Considerations

Following ethical approval for the research (Appendix 9), the researcher accessed the data from the ISVA’s database retrospectively. Data accessed included male and female adult victims (currently over 18years of age) of sexual violence. As previously noted, the psychological symptomatology reported by the participants was collected and entered into CRASAC’s database by the ISVA’s. The ISVA’s all have expertise in the area of sexual violence and have undertaken relevant training in working with victims of sexual violence. In addition, they abide by the codes, ethics and policies that CRASAC works within and have continued professional development in working with victims of sexual violence through further specialised training.

The data collected by the ISVA’s was anonymised and then provided to the researcher meaning at no point did the researcher have access to participants or participant identifying information.

Prior to ISVA’s collecting the data, participants have consented (either verbally or in written format) to the use of their data for purposes including activities that may benefit service development and the area of sexual violence e.g. by conducting research. Once the data was obtained, the researcher analysed the data using a statistical package for social

sciences (SPSS) Version 19. Statistical analysis of the data included Chi Square analysis examining associations and cluster analysis, to be discussed.

In terms of the treatment of data for research questions 5 and 6, a method of Hierarchical Cluster Analysis (HCA) was performed. HCA is an exploratory analysis which seeks to identify themes or categories. The overall concept of HCA is that objects are assigned to groups (clusters) so that the objects within the same cluster are more similar to each other than those in other clusters (Jain & Dubes 1988). Having identified these clusters it is important to consider how to measure the similarities they identify. Accordingly, a process of either similarity measurement or distance measurement is used. Often with binary data / categorical data, similarity measures are more commonly used (Everitt, Landau & Leese 2001). In analysing this research data, the similarity measure used was Jaccard's coefficient measure as this is an appropriate measure for binary data (Everitt et al 2001).

In addition, it is important to consider the reliability of the solution obtained (Everitt et al 2001) and in doing so, the comparison method of Squared Euclidean measurement was utilised. By using both measurements, similarities amongst solutions were observed (indicating reliability) however, the solution chosen was Jaccard's similarity measure as this was the clearest.

Having identified an appropriate similarity measure, a clustering agglomeration was then selected. This determined between which points distances are measured to establish cluster membership. The two clustering methods utilised here were the Centroid method and the Complete Linkage / Furthest neighbour methods. The centroid method measures the distances between two clusters as the sum of the distances between cluster means for all of the variables. The complete linkage method measures the distance between two clusters based on the points in the cluster that are furthest apart. By utilising these two clustering

methods, comparisons between them were considered and based on this; the optimal (clearest) clustering method was selected. The blue dashed line represents where the dendrogram was “cut” to determine the clearest clusters.

Of note when other alternative clustering methods were selected they were considered inappropriate for example, when the single linkage method was utilised, a process of “chaining” which is not uncommon with this method (Everitt et al 2001), was produced. As such, this was considered not suitable for use. An example of the chaining of the data is provided within Appendix 10.

As highlighted, the stability of the clustering solutions was assessed utilising different clustering methods (centroid and complete). Whilst both of these were available, only those considered the most stable or clearest (centroid) are discussed.

Results

RQ1: What is the psychological symptomatology of the total sample following sexual violence victimisation?

The frequency of psychological symptomatology victims experienced following sexual violence, regardless of gender, is shown in Table 7. An array of psychological symptomatology were reported which included a total of 25 separate symptoms. Of the total sample (N=182), the most commonly reported symptom was anxiety (N=101). This was followed by 51.1% of the sample reporting symptomatology associated with Depression (N=93), 40.1% with Anger (N=71) and 40.1% with Fear (N=73).

Table 7: Frequency of Symptomatology Experienced by the total sample (n=182):

Symptomatology Experienced	Frequency (<i>n</i>)	% From Total sample
Anxiety	101	55.5%
Depression	93	51.1%
Anger	73	40.1%
Fear	73	40.1%
Self-Esteem Problems	66	36.3%
Flashbacks	65	35.7%
Relationship Problems	63	34.6%
Nightmares	61	33.5%
Panic Attacks	55	30.2%
Substance Misuse	52	28.6%
Work Difficulties	52	28.6%
Suicidal Thoughts / Suicidal Behaviours	51	28%
Intrusive Thoughts	50	27.5%
Avoidance of Thought	44	24.2%
Sexual Difficulties'	40	22%
Dissociation	39	21.4%
Sleep Difficulties	37	20.3
Self-Harm	28	15.4%
Eating Disorders	27	14.8%
Body Problems	23	12.6%
Parenting Problems	17	9.3%

Loss of Home	16	8.8%
Restrictions to Movements	16	8.8%
Loss of Employment	14	7.7%
OCD	09	4.9%

Note: n = number of participants 182.

RQ2: What is the psychological symptomatology that:

a.) Male victims of sexual violence experience?

b.) Female victims of sexual violence experience?

The frequencies of each symptom are considered for each gender (Table 8).

Table 8: Frequencies of Symptomatology for males (n=91) and females (n=91).

Symptomatology	Males (n %)	Females (n %)	Test Statistic ^a	Odds Ratio
Experienced				
Anger	53.8	26.3	14.30*	3.25
Anxiety	59.3	51.6	1.09	
Avoidance of Thought	37.3	10.9	17.27*	5
Body Problems	10.9	14.2	.449	
Depression	56	46.1	1.78	

Dissociation	10.9	31.8	11.78*	.26
Eating Disorders	10.9	18.6	2.13	
Fear	29.6	50.5	8.26**	
Flashbacks	30.7	40.6	1.94	
Intrusive Thoughts	23	31.8	1.77	
Loss of Employment	8.7	6.5	310	
Loss of Home	7.6	9.8	.274	
Nightmares	35.1	31.8	.222	
OCD	4.3	5.4	.117	
Panic Attacks	28.5	31.8	.235	
Parenting Problems	4.3	14.2	5.26**	
Relationship Problems	37.3	31.8	.607	
Restrictions to Movements	2.1	15.3	9.87**	.01
Self-Esteem Problems	26.3	46.1	7.70**	
Self-Harm	12	18.6	1.52	
Sexual Difficulties	34	9.8	15.50*	3.72
Sleep Difficulties	17.5	23	.848	
Substance Misuse	40.6	16.4	13.03*	3.45
Suicidal Thoughts / Suicidal Behaviours	25.2	30.7	.681	
Work Difficulties	36.2	20.8	5.27**	

^aTest statistics are highlighted in bold to demonstrate significance

*= $p < 0.01$

**= $p < 0.05$

In establishing the most frequently experienced symptoms for males and the most commonly experienced symptoms were (N=91): 53.8% experienced anger, 59.3% anxiety, 56% depression and 40.6% substance misuse. Of the female sample the most commonly experience symptoms were (N=91): 51.6% experienced anxiety, 50.5% depression, and 46.1% self-esteem issues.

RQ3: Are there differences between the psychological symptoms males and females report?

Table 8 shows the χ^2 statistics examining significant differences between male and female symptomatology. There were ten significant differences between the types of symptoms male and female victims reported.

Five significant differences were observed in the male direction, with men showing a higher frequency of anger, avoidance of thought, substance misuse, work difficulties and sexual difficulties.

Five significant differences were found in the female direction with women showing a higher frequency of dissociation, fear, self-esteem, parenting difficulties and restrictions to movements.

RQ4: Do the:

a.) *Male symptomologies fit particular categories?*

b.) *Female symptomologies fit particular categories?*

The findings from the following dendrograms are presented in relation to RQ4. The figures identify male symptomatology, female symptomatology and allow consideration of categories relevant to this.

The figure for the male sample, Figures 5 illustrates the dendrogram that uses a centroid clustering method. Figure 6, illustrates the dendrogram for the female sample also using a centroid clustering method.

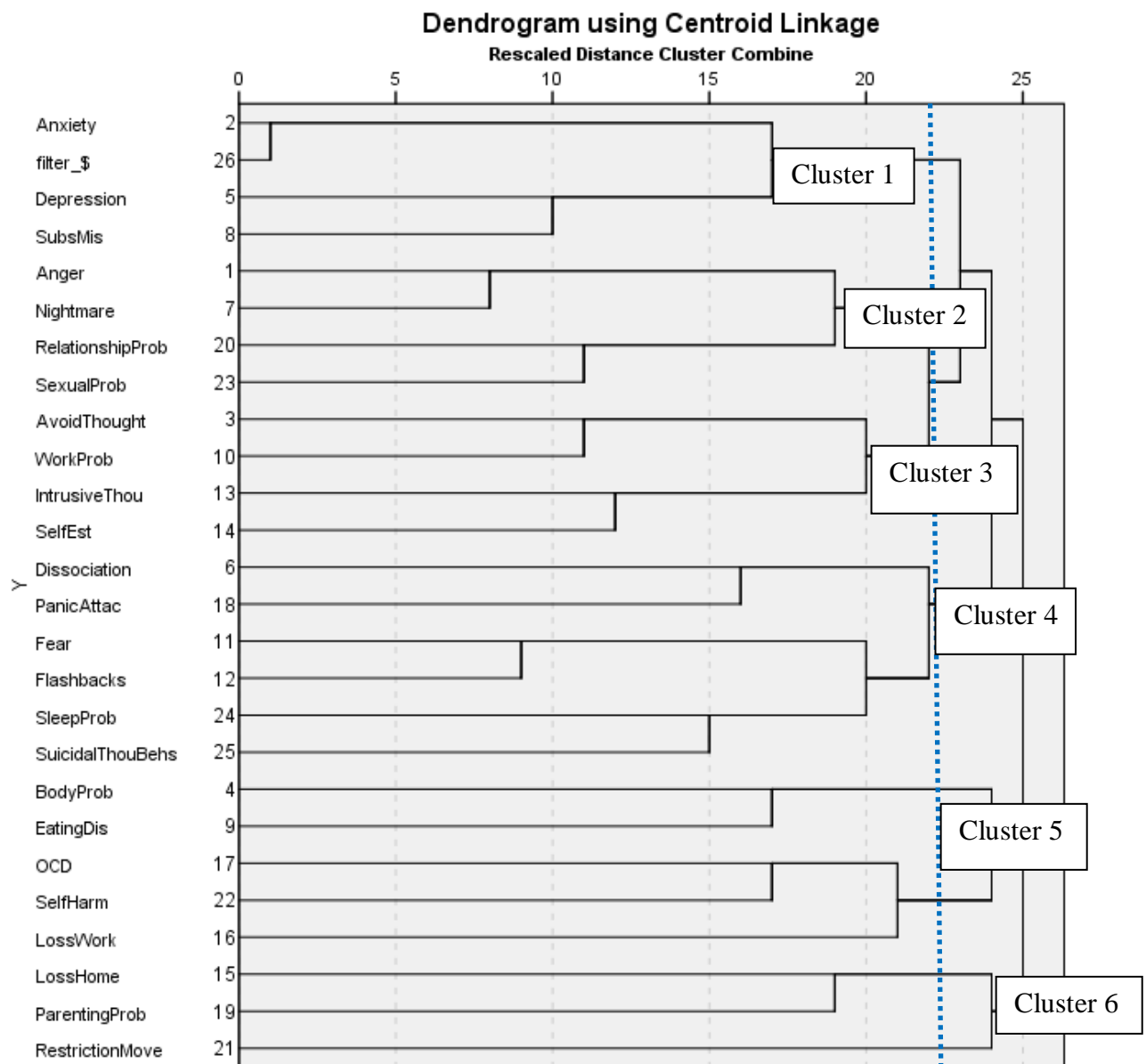


Figure 5: A six-cluster solution dendrogram of the HCA for the psychological symptomatology for male victims using a Jaccard's similarity measure and centroid clustering method.

From examining Figure 5, a six -cluster solution is presented. From this the psychological symptomatology male victims experience can be seen across each of the six-clusters.

Within each cluster, the clusters incorporate the individual psychological symptoms they consider most similar. Once this process has occurred for each individual cluster, the clusters themselves then link to their most similar cluster.

Based on this and in relation to the research question, it is important to consider:

- 1.) What psychological symptomatology clustered together for male victims of sexual violence?
- 2.) Once clustered, did these clusters fit within categories of psychological symptomatology following sexual violence (CPSFSV)?

With these points in mind examination of each cluster is considered:

Cluster 1: The psychological symptomatology that clustered together for male victims in cluster 1 included: anxiety, depression and substance misuse. Interestingly, when considering these findings in line with Briere et al's (1995) categorisations of symptoms, they appear to relate to the dysphoric mood category. It is possible that these symptoms have clustered together owing to the links between anxiety, depression and substance misuse. In particular, research has suggested that male victims of sexual violence often utilise substance misuse as a coping strategy following sexual violence in order to repress memories of their abuse (Hunter, 1990). In addition, substance abuse has also been used as a coping strategy to

manage emotions deriving from the abuse such as powerlessness, low self-esteem and an inability to trust others (Rohsenow, Corbett & Devine, 1988).

Cluster 2: Symptoms within this cluster included anger, nightmares, relationship problems and sexual difficulties. Interestingly, when considering these findings in line with Briere et al's (1995) categorisations of symptoms, they appear to relate to their sexual relatedness category. The similarities or links between these symptoms can be rationalised in terms of the likelihood of their co-occurrence. In particular it is likely that a male having difficulties within his relationship is likely to feed into difficulties with sexual relationships with that partner. Alternatively if sexual difficulties are considered in terms of issues of masculinity, sexual identity, sexual dysfunction (Gilgun & Reiser, 1990; Hunter, 1990, Lisak, 1994, Coxell & King, 1996, Walker, Archer & Davies, 2005a), again it is likely that this will contribute to difficulties within relationships including associated sequale such as emotions of anger.

Clusters 3 & Cluster 4: The psychological symptomatology that clustered together for male victims here included: avoidance of thoughts, work difficulties, intrusive thoughts, self-esteem difficulties, dissociation, panic attacks, fear, flashbacks, sleep difficulties and suicidal thoughts / behaviours. Overall the majority of these symptoms fitted with the traumatology category. This finding is supportive of the concept that trauma type symptoms co-occur (Briere & Runtz, (1989).

Clusters 5 & 6: Symptoms within these clusters included: body perception problems, eating disorders, OCD, self-harm, loss of work, loss of home, parenting difficulties and restrictions to movements. Interestingly, when considering these findings in line with Briere et al's (1995) categorisations of symptoms, all of these symptoms fitted with the Self-Dysfunction category.

From observing the clusters in Figure 5 findings indicated that the majority of co-occurring psychological symptomatology for male victims of sexual violence could indeed fit within the two main categories: Dysphoric Mood and Sexual Relatedness.

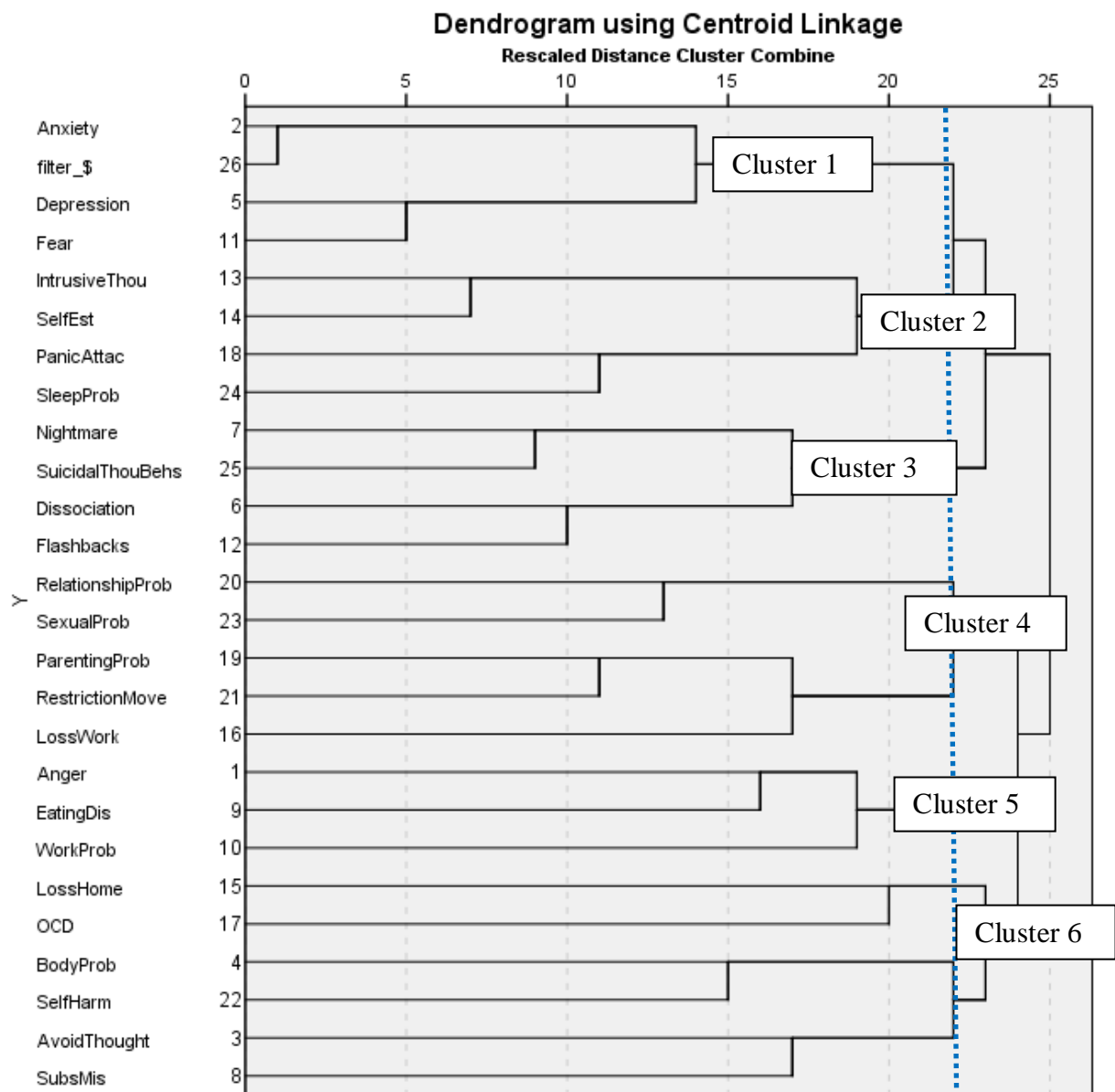


Figure 6: a six - cluster solution dendrogram of the HCA for the psychological symptomatology for female victims using a Jaccard's similarity measure and centroid clustering method.

From examining Figure 6, a six-cluster solution is presented. From this the psychological symptomatology female victims experience can be seen across each of the six-clusters.

As stated in the previous cluster analysis, it is important to consider the following when examining each cluster:

- 1.) What psychological symptomatology clustered together for female victims of sexual violence?
- 2.) Once clustered, did these clusters fit within categories of psychological symptomatology following sexual violence (CPSFSV)?

Cluster 1: The psychological symptomatology that clustered together for female victims in cluster 1 included: anxiety, depression and fear. Interestingly, when considering these findings in line with Briere et al's (1995) categorisations of symptoms, they relate to the dysphoric mood category. Of note, this was also observed within the male sample and exploration of both male and female figures (5 & 6) indicated that they experience similar psychological symptomatology. When observing clusters 1 for males and females, anxiety and depression clustered together for both samples. This suggests there is a level of stability within the clusters as similar symptoms are clustering in the same manner across both samples. In addition, this finding supports previous literature which suggests a strong link between anxiety and depression (Brewin, Dalgleth & Joseph, 1996) as such; one would therefore expect these symptoms to cluster together. In contrast, (also within clusters 1) the symptom of substance misuse clustered with anxiety and depression for males whereas the

symptom of fear clustered with anxiety and depression for females. A rationale for this could relate to the concept that males who experience anxiety and / or depression, often engage in substance misuse as a method of coping / coping strategy (Sturza & Campbell, 2005).

Clusters 2 & 3: Symptoms within these clusters included: intrusive thoughts, self-esteem difficulties, panic attacks, sleep problems, nightmares, suicidal thoughts / behaviours, dissociation and flashbacks. Interestingly, when considering these findings in line with Briere et al's (1995) categorisations of symptoms, these symptoms can be associated with the traumatology category. This finding is supportive of previous literature which indicates that female victims of sexual violence will experience an array of trauma based symptomatology (Stein et al, 1988).

Clusters 4 & Cluster 5: The psychological symptomatology that clustered together for female victims here included: relationship problems, sexual problems, restrictions to movements, parenting problems, loss of work, anger, eating disorders and work problems. When considering these findings in line with Briere et al's (1995) categorisations of symptoms, the majority of these symptoms fitted with the Self-Dysfunction category.

Cluster 6: The final cluster identified the following symptomatology as clustering together: loss of home, OCD, body perception problems, self-harm, avoidance of thought and substance misuse. The majority of these symptoms fitted with the category of Self-Dysfunction as devised by Briere et al(1995).

From observing the dendrogram in Figure 6, the psychological symptomatology for female victims of sexual violence identified the greatest similarity in symptomatology derived within the dysphoric mood and traumatology category. Whilst symptoms within the self-dysfunction categories included the types of similar symptoms one might expect to co-

occur, these symptoms demonstrated the most dissimilarity to other categories (dysphoric mood and traumatology categories) in terms of their similarity / dissimilarity distance.

RQ5: Are their differences between males and females in the symptomatology categories?

In considering the overall findings described within the male and female dendrograms it is concluded that there are both similarities and differences amongst the symptom categories males and females experience. Specifically, similarities were observed as both male and female victim symptoms to be categorised as relating to the dysphoric mood category. In contrast, differences were observed where male symptoms could be categorised in relation to the sexual relatedness category whereas for females, to the traumatology category.

Discussion

This study aimed to examine and compare the types of psychological symptomatology of male and female victims following an experience of sexual violence victimisation. Together findings indicate that psychological symptomatology associated with sexual violence was negative, wide ranging, and encompasses an array of psychological sequale – but that this differs for men and women. The research findings, limitations and their implications for practice are discussed below.

Research Findings

With regards to research question one, initial findings identified that of the overall sample, the most commonly reported symptoms were anxiety, depression, anger and fear.

This finding conflicts with early research that suggests victims of sexual violence are symptom free or indeed, perceived their symptoms as creating a positive experience (Bender 1952; Mannarino et al, 1986; Conte et al, 1987; Fromuth et al, 1989; & Denov, 2004).

However, these differences may relate to differences amongst samples within the current study and the previous literary findings. For example, the current study included individuals who had been referred from their G.P or those seeking help for negative symptoms.

Accordingly these individuals could be considered a self-fulfilling sample as they will inevitable report negative symptoms. In contrast for example, Fromuth et al (1989) utilised a arguable less “self-fulfilling sample” by utilising a general student sample.

Nonetheless it remains important to consider why findings have differed in the psychological symptomatology they identify. Here, such differences may be attributable to differing measures of assessments, differences in abuse experiences or differences in the time the symptoms are evaluated (Finkelhor, 1990). Differences may also relate to participants differing abilities in disclosure. For example Dhaliwal et al, (1996) noted how findings may differ due to the victims diminished or repressed memories impacting disclosures. Moreover Norris (1992) highlights how female victims are more likely to acknowledge their psychological distress than males which is likely to impact the symptoms they identify. Also in relation to disclosure is the element of the self-report and retrospective data the victims provide. This in itself may lead to differences due to problems with recall, over or under reporting of symptoms and the element of falsified data being provided (Fromuth et al (1989).

In addition, differences within terminology used as part of the assessment process is also likely to impact findings derived which may lead to apparent similarities / differences (Dhaliwal et al, 1996). Moreover, the role of differences within the nature and context of the abuse experience needs to be considered. Indeed Fromuth et al (1989) in their study of long-

term effects in male victims of childhood sexual abuse, found findings varied due to the nature of abuse experienced. They also highlighted the role of cultural or regional variations e.g. how different cultures may perceive a women's sexual relationship with a man as less negatively and therefore less associated with later maladjustment. The relationship of the perpetrator to the victim has also been noted as factorial in later psychological adjustment. Indeed some research has suggested the effects are less harmful for male victims if the perpetrator is female (Denov, 2004).

In summary, many factors account for differences within findings and differences within the psychological symptomatology identified following victims experiences of sexual violence.

The second research question shed light on the types of symptomatology experienced by men and women. Men most commonly experienced anger, anxiety and depression (as their top three types of symptomatology expressed). Women most commonly experienced anxiety, depression and self-esteem issues. This finding is interesting as it indicates that both male and female victims of sexual violence are both most likely to experience anxiety and depression. In addition, this finding is supportive of previous research (Brewin et al 1996) and can assist in informing the allocation of resources and treatment approaches services choose to incorporate. For example, service providers may seek to allocate greater funds to anxiety and depression focused interventions based on these research findings. Moreover, given our awareness of how certain treatment approaches can be more beneficial with certain difficulties for example, cognitive behavioural approaches being particularly beneficial for post trauma stress, anxiety and depression (NICE, 2008) services could consider this when considering best practice approaches.

The third research question explored differences between the sexes. This investigation revealed differences in the male direction of anger, sexual difficulties, substance misuse, avoidance of thought and work difficulties. Female victims were significantly more likely to display symptomatology of parenting problems, restrictions to movements, dissociation, self-esteem problems and fear than men. In discussing the findings for males first, each symptom is considered individually and in relation to the previous literature.

Sexual Relatedness: A significant difference was observed in relation to sexual relatedness which is in accordance with previous research indicating male victims of sexual assault are more symptomatic in relation to sexual behaviours (Elliott et al, 2004). In particular, males are likely to present with difficulties here owing to their feelings and confusion around their masculinity, sexual orientation, sexual dysfunction and identity issues all of which are likely to stem from their abusive sexual violence experiences. As noted previously, male victims often endure “male-specific” symptoms such as erectile dysfunction, premature ejaculation (Fromuth & Burkhart, 1984) and so on, of which are likely to have impacted within the area of sexual relatedness and when combined with the issues mentioned (masculinity etc.), have all contributed to their later difficulties / symptoms associated with sexual relatedness.

Anger: This finding supports that of previous literature, which illustrates anger and emotions linked to sexual dysfunctional behaviours are present for male victims of sexual violence / childhood sexual abuse (Briere et al, 1995).

It has been documented that male victims are less likely to seek support from professional services following sexual violence (Mathews, 2008) and as such, are likely to feel less supported and less equipped to manage their emotions, experiences and recovery. In turn they respond to this via less appropriate methods such as the expression of anger, acting

out, and / or hostility. Moreover, it is possible that male victims demonstrate anger or aggression as an effort to transform their internal self-perceptions of weakness and vulnerability into external signs of strength (Hussey et al, 1992).

Substance Misuse:

Findings from the odds ratio score indicated that male victims of sexual violence are 3.45 times more likely to have difficulties relating to substance misuse than female victims of sexual violence. This finding conflicts with the research provided by Rose (1991) which indicated females experience difficulties with substance use to a greater degree when compared with males. In terms of considering the rationales for the finding identified, Grilo et al (1997) highlighted the tendency for male victims to block emotions / feelings and mediate psychological distress (Hussey et al 1992) which they achieve by misusing illegal substances. Moreover, substances are particularly likely to be used in this manner when victims are keen to avoid their own thought processes that relate to their experiences, indeed this was observed within these research findings.

Avoidance of Thoughts:

Findings highlighted that a greater proportion of male victims of sexual violence (compared to females) experienced symptoms of wanting to avoid their thoughts. Indeed findings identified male victims of sexual violence are 5 times more likely to avoid their thoughts than female victims. In accordance with these findings it can be argued that to do so, a coping strategy of using illegal substances is adopted as a manner of facilitating thought avoidance. This externalised coping strategy is also supported by the previous literature (Rew et al, 1991; Chandy et al, 1996). In contrast, it is possible that their female counterparts seek other internalising strategies to manage their emotions such as maintaining symptoms relating

to low-self-esteem, fear or a process of dissociation. Indeed significant associations were observed here:

Employment / Work Difficulties.

When exploring the impact of sexual violence on males, no existing literature could be found that examined the role of employment difficulties for males following sexual violence. Perhaps this is due to the majority of current and previous literature focusing more strictly on the physical, psychological or emotional consequences rather than what could be considered, a less direct or immediate effect. Nonetheless, this research has found that male victims of sexual violence describe their experiences as impacting their working or employment circumstances. Arguably, for many males there is a pressure for them to provide for themselves and their families, for them to maintain employment, progress up the employment ladder and so on. It is probable that should they experience sexual violence, this could impact their functioning leading to for example, taking time off from work, reducing their performance, creating pressures from employer, which may lead to the loss of employment or work disciplinary actions. Indeed, whilst their research used a female sample, Swanberg and Logan (2005) examined the effects of domestic abuse on employment. Here they found the female victims job performance was indeed impacted as measured by absenteeism, and tardiness. It is therefore probable that an experience of sexual violence can impact its victim's employment. Indeed the findings within this research support that. What is evident however is that future research should seek to examine these links further.

To now discuss the differences observed within the psychological symptomatology of female victims, significant findings were observed for females in relation to parenting problems, restrictions to movements, dissociation, self-esteem problems and fear.

Parenting Problems

It is possible that female victims describe greater difficulties with parenting problems in contrast to males, as men are perhaps less involved with parenting. For example, it may be argued that females have a greater involvement with their children in terms of the time spent with them on a frequent daily basis. If accurate, this could imply that males / fathers report less parenting difficulties than females as they are less frequently involved with their children. Whilst this concept may be controversial, research conducted by Craig (2006) suggests females not only spend more time with their children but that they also have more overall responsibility for the management of their children's care, provide more commitment, multitask to a greater extent and provide more physical care than males. With this in mind one would therefore expect females to report parenting difficulties to a greater extent (males to a lesser extent), as they are more involved with their children. Indeed the findings within this research did support this by identifying that female victim of sexual violence experienced more symptoms associated with parenting difficulties.

Of note, consideration should be given as this finding could also be attributable to other factors or confounding variables which have not been accounted for within the research for example, parental background or parental characteristics.

Restrictions to Movements

In relation to the finding that females report greater issues than males in relation to restrictions to movements (fearful of moving around outside locations, safety issues, hyper vigilant), this may relate to the males beliefs around masculinity. For example, males may feel their "outward sense of masculinity / physical stature etc." will warn off potential perpetrators particularly if their previous experiences of sexual violence occurred indoors, in childhood and by a known perpetrator. In this instance males may be less likely to have a strong association with being randomly assaulted outdoors if their previous abuse for

example, always occurred indoors and was always perpetrated by e.g. their uncle. This concept relates to the notion that victims of trauma are likely to experience fears etc. where the circumstances of their experiences are similar / reminiscent of their previous trauma (Briere, 2002).

A significant association between female victims of sexual violence and symptoms relating to restrictions to movements was observed. This finding identifies that females have concerns regarding their geographical movements, overall safety and fears of their own whereabouts. Examination into this concept has suggested females place restrictions on the time they are outdoors, avoid places, opt to only go outdoors when escorted, are watchful and avoid certain localities. Indeed it is argued the females rationally and automatically take account of the situation and mentally calculate the danger present before deciding how to behave / what to do (Gordon & Riger, 1989). These findings offer a rationale as to why female victims of sexual violence are likely to experience symptoms relating to restrictions of movements.

Self-Esteem, Dissociation and Fear

Significant findings were also observed including self-esteem problems and in relation to traumatology type symptoms including dissociation and fear. In addition, the most frequently experienced symptoms females reported also included anxiety, depression, nightmares, panic attacks, relationship difficulties and intrusive thoughts also akin to the traumatology category.

These findings co-inside with research identifying a greater presence of trauma type symptoms for female victims of sexual violence when compared to male victims (Briere & Runtz, 1989; Sigmon et al 1996). It is possible that females experience such symptomatology to a greater extent due to their tendency to internalise symptoms (Rew, Esparza, & Sands,

1991). In addition, females may appear to experience trauma specific symptoms owing to the tendency of largely using trauma symptom measures. Whilst such measures are vital for assessing trauma, by their very nature they are specific to trauma symptoms, it is therefore suggested that were additional relevant yet less trauma specific measures used or used in conjunction, other results / findings may prevail. Perhaps future exploration of this could include assessment that incorporated both a structured trauma assessment alongside a qualitative approach that allows for free flow of dialogue and potentially the identification of other symptoms / effects. Moreover, a general wider focused assessment of symptoms overall could prove useful for considering the wide scope of symptoms reported. Indeed the inclusion within this research of symptoms outside of “trauma specific” assessments such as difficulties / problems relating to restrictions of movements, loss of employment, parenting difficulties etc. were all identifiable due to the approach / assessment method utilised. Accordingly, a greater spectrum and understanding of the effects associated with sexual violence could be obtained. Future research may seek to implement a similar method as a way of increasing richness and depth of data.

Summary of the differences between the psychological symptoms males and females report.

It is clear from the results that female victims demonstrate a more internalised response to their experiences than men. One rationale for these findings links to the suggestion that female victims of sexual violence feel more able to access services, have a greater number of services available to them, which in turn provides them with greater and appropriate support for managing and recovering from their experiences. In comparison, males may feel less able to approach services due to stigma concerns, have fewer services available to them, access services less and consequently, feel less supported and equipped to appropriately manage their emotions. As such, they implement inappropriate, avoidant

coping strategies such as acting out, responding with anger or turning to substance abuse a means to block such emotions Rew et al (1991).

RQ4: Do the male symptomologies fit particular categories?

Categorisation of Male Symptomatology

In considering the male findings relating to categorisation, The most commonly reported psychological symptomatology reported were anger, anxiety, depression and substance misuse. This finding suggests that males most frequently experience symptoms akin to the dysphoric mood category. Whilst this conflicts with research suggesting female victims of sexual violence experience for example, greater depression (Conte et al, 1986), it does remain in accordance with later research illustrating how symptoms such as anger, often follows sexual violence for male victims (Olson, 1990; Rew et al, 1991). Moreover, the findings identified also correspond with the literature and framework provided by Briere (1995) in terms of fitting within the dysphoric mood category he identified.

In considering rationales as to why males experience more dysphoric mood type symptomatology, it is possible that the male victims incorporate more out-ward expressions of managing their emotions such as anger or as engaging in substance misuse as a coping strategy. Whilst this is not to suggest female victims of sexual violence will not also use such strategies or demonstrate such symptoms, these findings provide evidence to suggest that it is the male victims of sexual violence who describe these symptoms to a greater extent.

Significant associations between male victims and symptoms of anger, thought avoidance, substance misuse, work and sexual difficulties were also observed.

The symptoms can be considered across categories suggesting that overall, the psychological symptoms male victims of sexual violence experience do not fit into one particular category over another.

RQ4: Do the female symptomologies fit particular categories?

Categorisation of Female Symptomatology

Of the female findings, symptoms reported largely related to the traumatology category. In addition, findings suggested other significant symptoms (dissociation, fear, self-esteem, parenting difficulties and restrictions to movements) fitted across categories. This suggests that overall, the psychological symptoms female victims of sexual violence experience do not fit into one particular category over another.

RQ5: Are their differences between male and females in the symptomatology categories?

The findings of the cluster analysis indicate there are both similarities and differences in the psychological symptomatology male and female victims of sexual violence report. In addition, whilst victims experience an array of psychological symptomatology which can be assigned to particular categories e.g. the dysphoric category, the traumatology category etc., their symptoms are also likely to prevail across a variety of categories. Whilst this may have been expected, the findings remain useful in allowing further consideration into victims individual needs, the types of categories symptoms may link to, the similarities and differences of symptoms amongst male and female victims, the direction of interventions and future resources and the way in which victim focused services provide their services (discussed further later).

Summary of Overall Findings.

Overall the findings of this research illustrate male and female victims of sexual violence experience an array of harmful psychological symptomatology following their abuse. The evidence within the findings suggests that victims cannot be placed into neat categorical boxes of symptomatology, nor does one gender appear to have one type of symptom over another. However, what is suggested is that male and female victims may experience some symptoms as more prevalent than others and that some symptoms may be more likely to co-occur with one another. In addition, the findings of this research also suggests that male victims of sexual violence are likely to experience more externalised symptomatology and females a more internalised symptomatology.

Limitations and implications for future research.

Whilst the assessment measure used within the research was appropriate, it would have been useful to have combined the interviewing approach with a standardised validated assessment measure of trauma. By adopting this approach further validity and reliability could have been gained. Nonetheless, the use of more than one assessor aided with this. The research also utilised retrospective self-report data which has its limitations as noted earlier. Moreover, the symptoms identified were largely done so by the individual ISVA and therefore may be subjective.

A further limitation of this research relates to the type of sexual violence and the time of assessment. Here differentiation between types of sexual violence (whilst not the aim of this research) was not focused upon. Had this have been incorporated, this may have changed the research findings and indeed the symptoms victims described. For example, it may be that specific symptoms related to specific types of sexual violence. The time of assessment as factorial in symptoms described has previously been discussed. Within this research the time since the sexual violence occurred varied significantly, some victims having been victimised

within days or weeks, others some years ago. As such it is possible that the time passed since the sexual violence occurred may have impacted upon research findings and the symptoms victims' reported. In addition, victims attending CRASAC do so for varying time frames, for example, one victim may engage for one week others for several years. Accordingly data collected may differentiate consequent to this. As a final point in relation to assessment, greater focus was required in relation to the assessment of male specific symptoms. Whilst this was incorporated to a limited degree, a more male symptom specific measure would have been useful. Future research in this area could incorporate this.

A further limitation of this research relates to the concept of causality. Whilst symptoms were identified it must be noted that causality cannot be determined. For example, the symptoms described may in fact be consequent to other factors the research did not account for. This may have included other types of abuse, other life experiences, other trauma's and so on. As such these factors were not accounted for.

Implication for Practice

The research findings have several implications for treatment and services. Given that male victims of sexual violence tend to respond with more externalised symptomatology (anger, hostility, aggression), it is fitting to consider treatment approaches which focus on these symptoms and the coping strategies / methods linked to this (substance misuse, tension reduction behaviours). At present little research exists in the examination of the most effective methods of treatment for male survivors of sexual violence (Coxell & King, 2010) and as such, it would be worthy for future research to examine this. Moreover, pending possible findings, consideration into possible treatment strategies for working with such groups e.g. cognitive behavioural therapy, could then be considered also.

The tailoring of resources and treatment approaches used for male and females displaying anxiety and depression have previously been noted in accordance with the research findings.

Research findings highlighted there may be differences in the coping behaviours of males and females by for example, males adopting a more avoidant approach, females a more emotional one. Based on this future treatment could provide services relating to methods of coping / managing. However, this does link to the issue of males often failing to access services. Based on this it is important to encourage males to seek the support they may need and one way of encouraging this is to raise awareness of male sexual violence. An array of methods can be used for this including events, media, social media, campaigning and so on. All of these methods will be useful to raise awareness of men as victims of sexual violence which can encourage fewer stigmas and therefore encourage the possibility of males feeling able to access the services they require.

By comparison and in relation to the research findings derived, treatment approaches for working with female victims of sexual violence could incorporate a more traumatology and internalised symptom focused approach. This would include methods that work well for the management of trauma specific symptoms such as dissociation, intrusive thoughts, flashbacks, fear, nightmares etc. Approaches which are particularly useful here are mindfulness for trauma and dissociation and cognitive behavioural therapies.

Findings discussed within the literature have highlighted a lack of research in our ability to acknowledge and understand male sexual violence and its impacts. For example, there currently remain many myths amongst professionals and society in relation to males as victims of sexual violence. Such myths have been focused on in the recent research of Coxell and King (2010). Here they highlight many commonly held myths including: that the

presence of an erection or ejaculation during the assault implies consent by the victim, that a male who is sexually assaulted by a male is gay or has been acting in a gay manner, that men cannot be forced to have sex against their will, that males are less effected by sexual violence than females and that males perpetrators assaulting males must be gay (Coxell & King, 2010). Based on this, it is apparent that future work should be provided in terms of a psych-educational approach to professionals and those within society as to aid awareness, knowledge and understanding of the myths and impacts of sexual violence on males. In addition, services offered to male victims of sexual violence could also seek to provide support in relation to the male specific symptoms by for example, providing a group or one to one support which considers this, the impacts of this on the victims and ways to move forward from these issues in terms of helping with their recovery.

In terms of the implications of these research findings in the assessment of victims of sexual violence, several recommendations are provided. Assessment measures need to be both trauma symptom and wider symptom based, for example the inclusion of symptoms such as restrictions to movements, parenting difficulties etc. In addition, the incorporation or development of assessments where male specific needs is considered. This would include assessments focusing on issues such as masculinity, sexual orientation concerns, premature ejaculation, erection problems, crisis of sexual identity and so on. Secondly, assessment measures of both quantitative and qualitative approaches should be utilised as to gain a rounded and fuller account of the area examined. This will provide both an empirical and narrative account thereby aiming to elicit the most optimal data. Moreover, by implementing standardised quantitative measures the reliability and validity of any assessment findings would be encouraged.

Based on the findings of the cluster analyses, insight has been provided in terms of the types of psychological symptoms that are likely to co-occur for male and female victims. As

such this finding is informative for professionals working with victims of sexual violence in terms of encouraging their awareness as to what symptoms may co-occur with one another.

The findings of this research also encourage the possibility of tailoring and focusing of resources. Organisations providing services to victims of sexual violence are often charities with limited funds. The findings here provide insight into the most frequently experienced symptoms for males and females and as such, this allows services focusing on these symptoms to be provided. Indeed it was noted that males are most likely to experience symptoms of anger, depression, anxiety and substance misuse problems, this finding can inform the services offered to males by for example, offering anxiety / mood management groups, ensure a strong referral pathway to substance misuse services, offer anger management and so on. In addition, findings illustrated female victims were most likely to experience symptoms linked to traumatology, anxiety, fear, self-esteem etc. Accordingly services could consider therapeutic approaches that best fit with these symptoms, offer structured, informed guidance on safety planning etc.

Conclusion

This research examined the psychological symptomatology that male and female victims of sexual violence experience. Overall findings indicated males experience more externalised dysphoric mood type symptoms in comparison to females, who experienced more internalised traumatology type symptoms. Interestingly both male and female victims of sexual violence most commonly reported symptoms of anxiety and depression. This finding is particularly important as it can inform the allocation of service resources, tailor the interventions services offer and inform overall approaches used. The overall findings of this research should encourage further exploration of this area and encourage professionals to

consider the tailoring of services and the treatment approaches recommended for use with these groups.

CHAPTER 4:
General Discussion

Discussion

Overall Aim

The overall aim of this thesis is to explore the psychological symptomatology experienced by male and female victims of sexual violence. As part of this a systematic literature review (Chapter 1) of the range of psychological symptoms male victims of sexual violence experienced was completed. This review also allowed for consideration of the types of measurement used when exploring symptomatology which was imperative in informing the research conducted (Chapter 3). Following the review, a critique of the Trauma Symptom Inventory (Briere, 1995) was incorporated (Chapter 2). This allowed for exploration into the characteristics, the reliability and the validity of an assessment measure often used when assessing sexual violence and overall trauma (Elhai et al, 2005). This critique was particularly useful as it informs about categories of symptomatology which were later expanded and incorporated within the empirical research (Chapter 3). The research itself, having been informed by the systematic literature review and the critique of a relevant psychometric assessment; sought to explore the psychological symptomatology victims of sexual violence experience and consider a gender comparison of these. A summary of these findings and those of the critique and review will now be discussed.

Summary of Findings

The systematic literature review explored the range and measurement of psychological symptomatology for male victims of sexual violence. Specifically, exploration of what the research identifies as symptoms of sexual violence for male victims and how the research measure this. The systematic approach implemented found that male victims of

sexual violence are likely to experience an array of harmful psychological effects which can be considered in terms of overarching symptom categories. These categories included dysphoric mood (e.g. symptoms of anger, anxiety, depression), traumatology (e.g. symptoms of dissociation, fear, avoidance), sexual relatedness (e.g. dysfunctional sexual behaviours), self-dysfunction (e.g. symptoms related to low self-esteem, trust issues, suicide attempts) and psychiatric symptoms (e.g. symptoms of psychoticism, paranoid ideation). These categories were valuable in terms of allowing an overall context for individual symptoms to be considered within. In addition, the review revealed psychological symptomatology that was specific to male victims of sexual violence including difficulties relating to a loss of masculinity (Lisak, 1994), achieving an erection and ejaculation problems (Fromuth & Burkhart, 1989). This finding was particularly important as it highlighted how literature within the field has largely recognised male specific symptoms. As such, this further generated a keenness to establish if the current research findings would support or refute this literature. Indeed, the research findings (discussed shortly) were found to be supportive of the previous and current literature regarding male specific symptoms.

In terms of the assessment measures used, the systematic review revealed a variety of measures were utilised including survey measures, standardised measures, questionnaires, interviewing measures or a combination of these measures. Strengths and limitations of the differing assessment measures were noted and overall, findings highlighted a need for a combination of quantitative and qualitative measures of assessment as a way of increasing reliability and validity of findings.

The overall findings of the critique of the TSI indicated that as a measure of trauma related symptoms, the TSI has good content and construct validity and is overall a reliable assessment measure. In contrast, use of the TSI as a standalone measure was thought to be

limited due to its inability to consider variables that may impact trauma outcome such as number of incidence of sexual violence or the time elapsed since the incident.

The research findings proved to be very informative on several levels. Firstly, they allowed an array of negative psychological symptoms following sexual violence experiences to be identified for both male and female victims. Secondly, they allowed identification of significant findings for male victims in relation to symptoms of anger, thought avoidance, substance misuse, work and sexual difficulties. In relation to the female victims, significant associations were found regarding symptoms of dissociation, fear, self-esteem, parenting difficulties and problems regarding restrictions to their movements. Thirdly, similarities between the genders were observed in relation to symptoms of anxiety, depression, nightmares, self-harm, relationship difficulties and suicidal thoughts / behaviours. Whilst some of the findings of the research conflicted with some previous literature (Bender, 1952; Mannarino et al, 1986; Conte et al, 1987) overall; they supported much of the previous research findings (Brewin et al 1996; Elliott et al, 2004; Fromuth & Burkhart, 1984; Briere et al, 1995; Sigmon et al, 1996). Finally, in terms of considering if the symptoms male and female victims experience fit into specific symptom categories, findings were not supportive of this.

Collectively, the systematic literature review, the critique of the TSI and the research study all proved successful in examining the area of sexual violence and in examining the psychological symptomatology males and females describe following sexual violence.

Theoretical & Practical Implications

In considering theoretical and practical implications relevant to the thesis, several areas will be discussed. Firstly, what is concluded regarding the psychological symptomatology for male and female victims and what are the implications of these

conclusions. Secondly, to pose what is implied from the overall thesis findings in relation to the assessments we use when examining sexual violence. Thirdly, to discuss the theoretical implications of the overall findings. Fourthly, to consider the role and relevance of symptom categorisation and finally; to briefly discuss overall difficulties within current literature.

Psychological Symptomatology: The Implications of Findings

Within the research findings both similarities and differences of the symptoms males and females experience following sexual violence were observed. Having identified this it is imperative to discuss the implications of these findings. Firstly, the findings highlighted how males tend to display more externalised and dysphoric mood type symptoms in comparison to females displaying more internalised and traumatology type symptoms. This finding in particular is crucial when considering the type of interventions and the type of services being provided to victims of sexual violence. For example, are the current services meeting this need? Are current services tailored to offer specific groups or interventions that relate to and cater for these findings? Moreover, are the approaches that therapeutic services use relevant and best suited to the symptoms experienced by the victims? As noted previously, particular approaches e.g. cognitive behavioural therapy, can be considered as more beneficial when working with individuals displaying e.g. anxiety. The findings within this research suggest a need for services to begin to consider the types of approaches they are using and to consider if the types of services they are offering are best meeting the needs of the victims using the service. The findings of this research can assist in guiding such decisions and approaches.

The research findings have also highlighted (via cluster analysis) how symptoms are likely to co-occur and what symptoms are likely to co-occur with one another. This finding is particularly beneficial for raising professional's awareness of the co-occurrence of symptoms. For example, by being mindful that a male presenting with anxiety

may also feel depressed or a female experiencing panic attacks may also experience sleep difficulties (dendrogram of female victims, cluster 2) can all inform professional awareness. These findings can not only increase professional awareness but also build upon their professional relationship with the client / victim by allowing them to feel more attuned to their client.

In addition, the research findings have provided awareness of co-occurring symptoms, highlighted the types of symptoms males and females experience and highlighted which symptoms victims describe as experiencing most frequently. This provides services with clear guidance and direction as to where to allocate resources and where to channel their funding. Moreover, when doing so, such services can make these decisions having the reassurance that they are supported by the findings of empirical research.

Finally, the systematic literature review and the research findings were clear in observing male specific symptoms following sexual violence such as difficulties with masculinity, ejaculation and erection problems. The implications of these findings suggest a need for future assessments to include examination of this area, particularly given that many historical assessments of trauma have failed to do so. Furthermore, these findings create a need for either services to be able to appropriately manage and provide therapeutic support relating to these issues, or have a clear referral pathway to other services that specialise in this area or are equipped to manage such issues.

Assessment: The Implications of Findings

In critiquing the TSI as an assessment measure, the importance of using assessments that have been informed by previous theoretical findings became evident. By adopting this approach (the TSI completed factor analysis that generated a 3 factor model) the incorporation of relevant knowledge and theory within an assessment is allowed. This is vital

in terms of an assessment measure remaining true to the area it seeks to test and encourages its findings to be more relevant and generalisable to the overall area. The difficulty with this process is that as our knowledge and theoretical understanding develops, so too must the assessments we utilise. Indeed it is apparent from the research findings here and the systematic literature review that male specific symptoms following sexual violence are observed. Whether current assessment measures of sexual trauma account for these developments remain questionable and highlight an area for future assessments to consider. Moreover, trauma assessment measures as a whole may also need to either become more inclusive of a variety of symptoms or utilise more focused and tailored assessments. For example, within the current research, findings indicated that female victims significantly experience symptoms relating to restrictions to movements and parenting issues. For male victims, significances were observed in relation to difficulties relating to employment. The symptoms identified here for both male and females do not appear to be symptoms of focus for current trauma assessments. Indeed the TSI does not account for such symptomatology. Based on this insight, given that victims of sexual violence report experiencing such symptomatology, it is important that we utilise assessments that capture this.

The importance of utilising a multi-method approach that incorporates both quantitative and qualitative measures here is highlighted. In utilising both types of assessment measures (as discussed within the systematic literature review) a more thorough and detailed account alongside a more standardised and structured method of assessment grounded within the theory can be implemented.

Theory: The Implications of Findings

The most prominent concept to discuss from the thesis findings in relation to the theory within the area is that relating to the ecological perspective of sexual assault

(Campbell et al, 2009). This model has proved extremely credible in terms of providing an encompassing approach to exploring the effects of sexual violence. As discussed within the initial introduction section, the ecological theory considers the interrelationships between the characteristics of the victim, the sexual violence occurred and the social environment in which recovery can take place (Harvey, 1996). In essence the model allows us to consider differences in symptoms victims present with due to various factors and interactions of these factors. Indeed within the current research differences and similarities amongst victims were observed and whilst some factors of the model were included, for example the ethnic origin of a victim (equating to the “individual” level of the model) or the incident of sexual violence (equating to the “assault” level of the model), the research did not incorporate other levels of the model (as this was not the aim of the research). Nonetheless, it could be argued that findings within the current research may relate to other variables or factors not accounted for such as those the model identifies, e.g. effects of response to disclosure (microsystem level), effects of responses of police (macrosystem level).

Overall, it is therefore suggested that a more all-encompassing approach for research is used in the future that is underpinned by theoretical understanding and the levels this incorporates. Such an approach is imperative if we are to fully begin to consider psychological symptomatology following sexual violence and the factors that may impact this. Furthermore, by implementing this type of approach, assessment measures can also be guided based on the relevant theory. For example, implementing the appropriate assessment measure dependant on the factor / level being measured e.g. using a survey measure for microsystem level factors (reactions from friends) or using interview measures for macrosystem factors (cultural stereotypes / societal beliefs). By implementing this approach it is appropriate not only as assessments are underpinned by the theory but also, that the assessment measures are appropriate to the factors they are examining. The implications of

this approach are that insight could be gained by observing which levels / factors influence the outcome of psychological symptomatology. For example, within the microsystem, research may suggest that positive social reactions from friends and family predicts less psychological distress post assault (Cambell, Aherns, Sefl, Wasco & Barnes, 2001) or within the macrosystem, that that acceptance of rape myths within cultures impacts the victims ability to recover (Roze & Koss, 2001). In essence, the factors impacting the psychological symptomatology victims describe could more easily be considered and done so within a larger all-encompassing complex system.

Categorisation of Symptoms: The Implications of Findings

Throughout this thesis the concept of the categorisation of symptoms has prevailed. This has held a relevant place particularly within the systematic literature review in providing an overall context for symptoms to be considered. Moreover, findings within the research indicated that males tend to experience more dysphoric mood type symptoms and females more traumatology type symptoms. This has been particularly useful in terms of informing interventions, resources, funding and approaches as previously discussed. However, overall findings highlighted that psychological symptoms did not fit explicitly within one specific category for either gender. For example, clusters were found to feature both dysphoric mood symptoms and traumatology symptoms as opposed to featuring all dysphoric mood or all traumatology symptoms. This indicated that the gender of the victim does not lead solely to one type of symptom category over another. This finding has led to discussion as to whether categorisation within this specific context is indeed relevant. Essentially, do we need to categorise overall symptoms for males and females? It can be argued that a more optimal approach here is to have awareness of individual symptoms, awareness as to how they may co-occur and awareness of the types of symptoms victims may experience, yet shift away from suggesting symptoms will explicitly fit into one category

over another. By doing so a more individualistic approach that is tailored to the specific needs of the victim can be incorporated.

Overall Difficulties with Current Literature / Research

The main difficulty that has been observed from completing this thesis is that there remains many differences and conflicts across research findings. Indeed many studies appear to examine the same issues across the same populations yet yield differing results. If we are to truly begin to examine the area of sexual violence and compare our research findings, we need to begin to compare research that utilises similar assessment measures, examines victims who have similar experiences of abuse, and evaluates symptoms in a similar way and so on. As such, a true comparison of findings can then occur, as research will be comparing “like for like” as opposed to research that is seemingly examining the same issues.

Limitations of Thesis

Limitations can be observed within the systematic literature review and the research study. Firstly within the literature review, the lack of assessors completing the quality assessment process is noted. Here only one assessor (the researcher) quality assessed the literature due to time and resources constraints. However, whilst more than one assessor is optimal, the quality assessment was conducted in a systematic fashion.

In relation to the limitations of the research, most apparent is the use of one method of assessment (quantitative). As noted previously, a more optimal approach could have included both standardised assessment methods and a qualitative approach such as semi structured interviewing. This may have allowed for a greater richness of data and for the assessment findings to be more grounded with the theory. Whilst this was beyond the scope of this thesis, future research could adhere to this point.

Secondly, the research was of self-report in nature this can generate problems in terms of the reliability of the data obtained, participant recall and the falsifying of information.

Thirdly, the type of sexual violence experienced was not separated and examined individually, this type of examination may find subtleties in the data. In addition the time passed since the incident of sexual violence was not accounted for and as such this may have impacted findings for example more recent incidents may have shown greater symptomatology than more historical incidents. Finally, whilst the results obtained attribute psychological symptomatology described to experience of sexual violence, actual causality cannot be determined.

Future Research and Recommendations

Based on the content of the thesis as a whole, future research should seek to examine the impacts of sexual violence on male victims to a greater extent including the links between this and employment. It is also recommended that assessments are developed to incorporate male specific symptoms and that interventions are focused to the types of symptoms victims are reporting. A greater level of research regarding effective methods of treatment for male victims of sexual violence is developed and that more psycho-educational work around the myths and stereotypes surrounding sexual violence is implemented.

Conclusion

In conclusion, sexual violence has and continues to be a public health problem and an issue that unfortunately affects many individuals of both sexes. Research into the impact that sexual violence has upon its victims has continued. However, it appears difficult to compare findings given that many approaches and methods of assessment are being used. If services and treatments for the victims of sexual violence are to be effective, appropriate multi-method approaches that are grounded within relevant theory are essential. By implementing

this approach, victims of sexual violence can receive the essential and most relevant responses needed to help towards recovery.

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APPENDICIES:

Appendix 1: Quality Assessment Checklists:

Quality assessment criteria for case-control studies

Question	Y	N	P	U	Comments
<i>Initial Screening</i>					
1. Did the study address a clearly focused issue?					
2. Is the study addressing psychological symptomatology male victims of sexual violence experience?					
<i>Study Design</i>					
3. Were the cases representative of the defined population?					
4. Is the type of sexual violence clearly defined?					
5. Was there an established reliable system for selecting the cases?					
6. Has the classification of cases been reliably assessed and validated?					
7. Were there a sufficient number of cases selected?					
8. Were there a sufficient number of comparison cases selected?					
9. Is there a well described sample demographic / background (age, gender, SES, ethnicity) clear?					

10. Were the comparison / controls representative of the defined population?
11. Were the controls selected in a bias reducing manner?
12. Was there a sufficient number of controls selected?
13. Are the cases and controls comparable with respect to demographic / potential confounding variables?
14. Were potential confounding variables controlled for (by matching or through stats?)
15. Were the sample recruited in an acceptable way?

Performance and Detection Bias

16. Was the outcome of assessments blind to all participants?
17. Was the outcome (psychological symptomatology) assessed in the same way for cases and controls?
18. Was the outcome (psychological symptomatology) defined and measured accurately?
19. Was the data analysis rigorous enough (in-depth process / sufficient data to

support findings)?

20. Was an appropriate assessment measure used?
21. Were the assessments (psychometrics /questionnaires) standardised?
22. Were the assessments comparable to instruments used in other studies?
23. Was blinding incorporated where feasible?

Results

24. Are the results significant and are they meaningful?
25. Have limitations been discussed?

Attrition Bias

26. Were drop-out rates and reasons for drop-out similar across groups?
27. Were those who completed the assessments the same as those who did not?

Quality assessment criteria for qualitative studies

Question	Y	N	P	U	Comments
1. Was there a clear statement of the aims of the research?					
2. Is the study addressing psychological symptomatology male					

victims of sexual
violence experience?

3. Is a qualitative methodology appropriate?
4. Was the recruitment strategy appropriate to the aims of the research?
5. Was the research design appropriate to address the aims of the research? (have they discussed how they decided which method to use?).
6. Is the type of sexual violence clearly defined?
7. Were the data collected in a way that addressed the research issue?
8. Has the relationship between researcher and participants been adequately considered?
9. Have ethical issues been taken into consideration?
10. Is there a well described sample demographic / background (age, gender, SES, ethnicity) clear?
11. Were the sample recruited in an acceptable way?
12. Was the outcome (psychological symptomatology) defined and measured

accurately?

13. Was the data analysis rigorous enough (in-depth process / sufficient data to support findings)?
14. Is there a clear statement of findings?
15. Is the research valuable? (e.g. contribution to existing knowledge / understanding? Credibility of findings?)
16. Have limitations been discussed?

Quality assessment criteria for case-series studies

Question	Y	N	P	U	Comments
<i>Initial Screening</i>					
1. Did the study address a clearly focused issue?					
2. Is the study addressing psychological symptomatology male victims of sexual violence experience?					
<i>Study Design</i>					
3. Were the cases representative of the defined population?					
4. Is the type of sexual violence clearly defined?					
5. Was there an established reliable system for selecting the cases?					

6. Has the classification of cases been reliably assessed and validated?
7. Were there a sufficient number of cases selected?
8. Is there a well described sample demographic / background (age, gender, SES, ethnicity) clear?
9. Were the sample recruited in an acceptable way?

Performance and Detection Bias

10. Was the outcome of assessment / survey blind to all participants?
11. Was the data collected in a clear, justified and explicit manner and in a way that addressed the research issue?
12. Was the outcome (psychological symptomatology) assessed in the same way across the sample?
13. Was the outcome (psychological symptomatology) defined and measured accurately?
14. Were the outcomes (psychological symptomatology) validated?
15. Was the data analysis rigorous enough (in-depth process /

sufficient data to support findings)?

16. Was an appropriate assessment measure used?
17. Were the assessments (psychometrics/questionnaires) standardised?
18. Were the assessments comparable to instruments used in other studies?

Attrition Bias

19. Were those who completed the assessments the same as those who did not?
20. Were drop-out rates and reasons for drop-out similar?

Quality assessment criteria for cross-sectional studies

Question	Y	N	P	U	Comments
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Initial Screening

1. Did the study address a clearly focused issue?
2. Is the study addressing psychological symptomatology male victims of sexual violence experience?


Study Design

3. Was the population studied representative?
4. Is the type of sexual violence clearly defined?

5. Is the definition of the type of sexual violence comparable to other studies?
6. Is the description of the sample and distribution of demographic / background (age, gender, SES, ethnicity) clear?
7. Were the sample recruited in an acceptable way?

Performance and Detection Bias

8. Was the outcome of assessment / survey etc. blind to all participants?
9. Was the data collected in a clear, justified and explicit manner and in a way that addressed the research issue?
10. Was the outcome (psychological symptomatology) assessed in the same way across the sample?
11. Was the outcome (psychological symptomatology) defined and measured accurately?
12. Were the outcomes (psychological symptomatology) validated?
13. Was the data analysis rigorous enough (in-depth process / sufficient data to support findings)?

- 
14. Was an appropriate assessment measure used (i.e. a measure relevant to the area being examined)?
 15. Were the assessments (psychometrics/questionnaires) standardised?
 16. Were the assessments comparable to instruments used in other studies?

Attrition Bias

17. Were those who completed the assessments the same as those who did not?
18. Were drop-out rates and reasons for drop-out similar?



Appendix 2: Characteristics and Quality Assessment Scores of the 8 Studies Removed.

Author/s, Year	Title	Study Design & Sample Size	Issues the study considers	Findings	Quality Assessment Score (%)
Gold. S.N., Lucenko. B. A., Elhai. J. D., Swingle. J. M. & Sellers. A.H. (1999).	A comparison of psychological / psychiatric symptomatology of women and men sexually abused as children.	Cross Sectional: 187 Adults.	➤ Considers gender differences in symptomatology experienced by survivors of sexual abuse using a symptom measure.	➤ No differences observed from raw data however conversation of T-scores indicated male survivors of childhood sexual abuse displayed greater interpersonal sensitivity, depressions, anxiety and phobic anxiety than female survivors.	21 / 36: (58%)
Walker. J., Archer. J. & Davies. M. (2005b).	Effects of male rape on psychological functioning.	Case Control 40 Adult Male victims of rape and a matched control group.	➤ Investigated the psychological functioning of male rape victims compared with non-rape victims.	➤ Reports male victims of rape had poorer psychological functioning than controls, lower self-worth and lower self-esteem.	36 / 54: (66%)

Mezey. G. & King. M. (1989).	The effects of sexual assault on men: a survey of 22 victims.	Case Series: 22 Adults.	➤ Considers the immediate and long term effects of men who have been forcibly sexually assaulted.	➤ Reports many of the effects found mirror that reported in the literature relating to female survivors of sexual violence.	10 / 40: (25%)
Fater. K. & Mullaney. J. A. (2000).	The lived experience of adult male survivors who allege childhood sexual abuse by clergy.	Qualitative Design: 7 Adult Males.	➤ Examines the experiences of adult male survivors of childhood sexual abuse via semi-structured interviews. Seeks to provide themes relating to survivors experiences.	➤ Themes of survivor's experiences were developed including rage and spiritual distress.	18 / 32: (56%)
Gill. M. & Tutty. L.M. (1999).	Male survivors of childhood sexual abuse: A qualitative study and issues for clinical consideration.	Qualitative Design: 10 Adult Males.	➤ Examines the effects of childhood sexual abuse on male survivors.	➤ Three central themes emerged from the findings including society's refusal to accept men can be victims of sexual violence, an impaired ability to form relationships and an	21 / 32: (65%)

impaired ability to form satisfying sexual relationships.

Schulte. J.G., Dinwiddie. S.H., Pribor. E.F. & Yutzy. S.H. (1995).	Psychiatric Diagnoses of adult male survivors of childhood sexual abuse.	Case Series: 20 Adult Males.	<ul style="list-style-type: none"> ➤ Considers the psychiatric diagnoses of male victims of childhood sexual abuse. ➤ Examines the level of dissociation and rates of anxiety and mood disorders. 	<ul style="list-style-type: none"> ➤ Male survivors of childhood sexual abuse experienced high rates of mood disorders, anxiety disorders and substance use disorders. 	20 / 40: (50%)
Hussey. D.L., Strom.G. & Singer.M. (1992).	Male victims of sexual abuse: An analysis of adolescent inpatients.	Case Control: 166 Adolescent Males.	<ul style="list-style-type: none"> ➤ Compares psychological symptomatology of adolescent abused and non abused males. 	<ul style="list-style-type: none"> ➤ Findings indicated abused males experienced greater depression, used drugs more frequently, had lower self-esteem, felt more hopeless, had greater difficulty managing their sexual feelings and felt more concerned regarding their appearance than the non abused males. 	36 / 54: (66%)

Denov. M.S.
(2004).

The long-term effects of child sexual abuse by female perpetrators: A qualitative study of male and female victims.

Qualitative:

14 Male and Female victims.

➤ Considers the impacts of female perpetrated sexual abuse on male and female victims. Within this several symptoms are highlighted as possible consequence of the abuse.

➤ Identified long term difficulties including substance abuse, self-injury, depression and rage.

22 / 32: (68%)

Appendix 3:**DATA EXTRACTION FORM****General Information.**

Date of Extraction:

Author:

Title:

Journal:

Notes:

Verification of Study Eligibility (Inclusion / Exclusion):

- Male victim of sexual violence
- Examines Male and Effects and Sexual Violence
- Published between 1980-2012 and is in English language

Study Design.

Longitudinal

Correlational

Case Series

Cohort

Continue: Yes

No

Specific Information.

1. Target Population:
2. Recruitment procedures:
3. Characteristics of Participants:
 - No. Of participants:
 - Age:
 - Ethnicity:
 - Gender:
 - Class:
 - Nationality:
 - Geographical Region:
 - Other Information
4. No of participants in each group (if groups used):
5. Type of abuse experienced / considers different types of sexual violence:

Method:

Brief outline of Study:

Quality Assessment Score:

Study Type: Quantitative Qualitative

Psychological Symptomatology Identified:

Assessment of symptomatology / Measure used:

Validity of measure:

Analysis:

Analysis used:

Attrition:

Confounding variables assessed: Yes / No?

Appendix 4: Description of the Clinical & Validity Scales of the TSI and the Associated Categories

<u>Clinical Scale</u>	<u>Description of Scale</u>	<u>Category</u>
Anxious Arousal (AA)	Examines symptoms of anxiety including those linked to hyper arousal such as tension and jumpiness.	Dysphoric Mood
Depression (D)	Examines depressive symptomatology in relation to mood state (e.g. sadness) & cognitive distortions (e.g. hopelessness).	Dysphoric Mood
Anger / Irritability (AI)	Examines anger or irritability affect & associated angry cognitions and behaviour.	Dysphoric Mood
Intrusive Experiences (IE)	Measures intrusive symptoms associated with post traumatic stress e.g. flashbacks, nightmares, intrusive thoughts.	Post Traumatic Stress
Defensive Avoidance (DA)	Measures post traumatic avoidance, both cognitive (pushing painful thoughts away) and behavioural (avoidance of stimuli reminiscent of a traumatic event).	Post Traumatic Stress
Dissociation (DIS)	Measures dissociative symptomatology e.g. depersonalization, derealisation, out of body experiences and psychic numbing.	Post Traumatic Stress
Sexual Concerns (SC)	Measures self reported sexual distress e.g. sexual dissatisfaction, sexual dysfunction & unwanted sexual thoughts / feelings.	Sexual Difficulties
Dysfunctional Sexual Behaviour (DSB)	Measures sexual behaviour that is dysfunctional either because of its indiscriminate quality its potential for self harm or its inappropriate use to accomplish non sexual goals.	Sexual Difficulties
Impaired Self Reference (ISR)	Measures problems in the "self" domain e.g. identity confusion, self-other disturbance & a relative lack of self support.	Self Dysfunction
Tension Reduction Behaviour (TRB)	Tendency to turn to external methods of reducing internal tension or distress such as self mutilation, angry outbursts, manipulative behaviour & suicide threats.	Self Dysfunction

<u>Validity Scales</u>	<u>Description of Scales</u>
Response Level (RL)	Consists of a number of zeros endorsed for those items least likely to receive a zero in the standardized sample. High scores = a tendency towards defensiveness, a general under endorsement response set or a need to appear unusually symptom free.
Atypical Response (AR)	The least commonly endorsed & most unusual or bizarre items on the TSI. High scores = psychosis or extreme distress, a general over endorsement response set or an attempt to appear particularly disturbed or dysfunctional.
Inconsistent Response (INC)	The sum of the absolute differences of the 10 TSI item-pairs most likely to be endorsed in a similar and consistent fashion. High scores = unusually inconsistent responses, attention or concentration problems or reading / language difficulties.

Appendix 5: Correlations Between the TSI Scales.

<i>Scale</i>	<i>ATR</i>	<i>RL</i>	<i>INC</i>	<i>AA</i>	<i>D</i>	<i>AI</i>	<i>IE</i>	<i>DA</i>	<i>DIS</i>	<i>SC</i>	<i>DSB</i>	<i>ISR</i>	<i>TRB</i>
<i>ATR</i>		-.41	.31	.45	.52	.42	.56	.50	.57	.40	.44	.55	.53
<i>RL</i>			-.37	-.58	-.49	-.56	-.43	-.43	-.48	-	-.27	-.47	-.39
										.35			
<i>INC</i>				.46	.44	.36	.46	.49	.40	.31	.28	.40	.31
<i>AA</i>					.74	.71	.69	.68	.72	.49	.43	.74	.62
<i>D</i>						.65	.66	.68	.70	.53	.45	.79	.65
<i>AI</i>							.60	.59	.63	.53	.45	.67	.72
<i>IE</i>								.83	.69	.52	.48	.67	.60
<i>DA</i>									.66	.51	.48	.70	.59
<i>DIS</i>										.58	.51	.76	.66
<i>SC</i>											.66	.63	.58
<i>DSB</i>												.58	.71
<i>ISR</i>													.70

(Table adapted from *Trauma Symptom Inventory Manual: Briere, 1995*).

Appendix 6: Categories of Psychological Symptomatology within the Current Research.

<u>Psychological Symptomatology</u>	<u>Category</u>
Examines symptoms of anxiety, depression and anger*.	Dysphoric Mood
Examines symptoms including intrusive thoughts, fear, dissociation, avoidance of thoughts, panic attacks, sleep difficulties*, nightmares and	Traumatology

flashbacks.

Examines symptoms including self-esteem difficulties, substance misuse, work / employment difficulties*, suicidal thoughts and / or attempts, self-harming, eating disorders, body problems*, parenting problems, loss of home, restriction to movements*, loss of employment, OCD type symptoms.

Self-Dysfunction

Examines symptoms of sexual difficulties* and relationship difficulties.

Sexual Relatedness

***Further Explanation / Descriptions:**

Anger: includes hostility / irritability and verbal /physical expression of anger.

Work / Employment Difficulties: difficulties with employment for example, taking time off from work, work disciplinary actions, pressures from employer, loosing employment etc.

Sexual Difficulties: Sexual dissatisfaction, dysfunctional sexual behaviours, loss of masculinity, sexual orientation concerns / difficulties, sexual difficulties with other s/ partners /s.

Sleep Difficulties: Insomnia, difficulties falling asleep, difficulties staying asleep, difficulties “switching off” at bedtimes.

Body Problems: Body dysmorphia, distorted perceptions of self / body, desire to alter one’s body.

Restrictions to Movements: Safety issues / concerns, hypervigilant, issues with freely moving as one would hope, is required to due to safety concerns.

Appendix 7: Risk Assessment and Initial Contact Form:

Risk Assessment.

Name:

Address:

D.O.B:

Tel:

Safe to leave messages Y N

ISVA No. / /

CRASAC No. / /

Date of Assessment:

1. Physical Risk.

1.1. Medical Attention Required? Y N

(Hospital / G.P/ A&E/ SARC)

1.2. Does the client require sexual health / pregnancy intervention Y N

1.3. Is any medical follow-up treatment required? Y N

1.4. Additional Information.....

.....

1.5. Referral Made? Y N

To Whom.....

.....

2. Psychological Risk.

2.1. Is the client presenting as a suicide risk? Y N

2.2. Is the client self-harming? Y N

Additional Information:

2.3. Psychological symptomatology – Present or Absent

- Anxiety
- Depression
- Anger
- Fear
- Self-Esteem Problems
- Flashbacks
- Relationship Problems
- Nightmares
- Panic Attacks
- Substance Misuse
- Work Difficulties
- Suicidal Thoughts / Suicidal Behaviours
- Intrusive Thoughts
- Avoidance of Thought
- Sexual Difficulties'
- Dissociation
- Sleep Difficulties
- Self-Harm
- Eating Disorders
- Body Problems
- Parenting Problems
- Loss of Home
- Restrictions to Movements
- Loss of Employment
- OCD

2.4. Does the client have a mental illness? Y N

(If yes, details, professionals involved
 etc.....

2.5 Is the client presenting as depressed? Y N

2.6. Are there any drug and/or alcohol issues? Y N

2.7. Referral Made? Y N

To whom?.....

2.8. Additional information.....

3. Domestic Risk.

3.1. Is the client a victim of Domestic Violence? Y N

3.2. Is the perpetrator a partner? Y N

3.3. Is the perpetrator known? Y N

3.4. Does the client require domestic safety planning? Y N

(E.g. refuge arrangements, changing of locks etc.)

3.5. Referral Made? Y N

To whom?.....

3.6. Additional information.....

4. Child Protection.

4.1. Are there any child protection concerns / issues to be addressed? Y N

Detail.....

4.2. Are there any child care support needs? Y N

4.3. Are there any educational needs / difficulties? Y N

4.4. Referral Made? Y N

To Whom?.....

4.5. Additional Information.....

5. Disabilities.

5.1. Does the client have any physical or learning disabilities? Y N

5.2. Are there any difficulties in their ability to communicate? Y N

5.3. Referral made? Y N

To whom?.....

5.4. Additional information.....

6. Support Network.

6.1. Does the client have adequate support e.g. family / peer network? Y N

6.2. Referral made? Y N

To whom?.....

6.3. Additional information.....



.....
.....

7. Other / Additional information relating to risk and / or psychological well-being / symptomatology?

.....
.....
.....
.....
.....
.....

Initial Contact Form – ISVA.

Name:

Client Id: / /

Crasac Id: / /

Address:

Telephone:

Safe to Leave Messages? Y N

Date of referral:

Age (d.o.b&yrs):

Ethnic Origin:

White British

Black African

Black British

Mixed Race

Mixed Other

Asian British
Mixed White Asian
Chinese
Mixed White African
Caribbean
Indian
Pakistani
Mixed White Black
African
Unknown
Other

Sexual Orientation:

Heterosexual
Homosexual
Bisexual
Unknown

Appendix 8:**Table A:** Descriptions of the types of features present in order for the ISVA to score a symptom as present

Symptom	Description / Victim Presents As:
Anger	Hostile, irritable, verbal /physical expressions of anger.
Anxiety	Restless, as having feelings of dread, seeming “on the edge”, are impatient, seemed panic or tense.
Depression	Low in mood, being tearful, describing feelings of hopelessness, appears to have little or no motivation.
Fear	Appears scared, fearful of others, those around them, fearful of environment, situations.
Self-Esteem Problems	Low sense of self-worth, feelings of inadequacy, lacking in confidence.
Flashbacks	Presents with flashbacks of the sexual violence experience, re-experience event in their mind, loose awareness of where they are at present.
Relationship Problems	Difficulties with interactions with others including partners, difficulties communicating with partners, maintaining functional relationships.
Nightmares	Victim experiences nightmare of attack and nightmare in general following experiences.
Panic Attacks	Presents with feelings of panic, as breathless, sweats, feels dizzy etc.
Substance Misuse	Has problems with drugs and / or alcohol : presents as intoxicated, under influence

	of alcohol or drugs. Reports substance misuse.
Work Difficulties	Problems functioning at work, difficulties completing their job, communicating with colleagues, concerned at consequences of time off work sick, concerned colleagues may find out of experiences.
Suicidal Thoughts / Suicidal Behaviours	Reports previous / current suicide attempts, appears suicidal, describes wanting to take their own life, harm self, die.
Intrusive Thoughts	Having thoughts entering their mind relating to the sexual violence experiences, present with difficulty staying in the present and difficulty concentrating.
Avoidance of Thought	Presents with desire to avoid certain thoughts.
Sexual Difficulties	Sexual dissatisfaction, dysfunctional sexual behaviours, loss of masculinity, sexual orientation concerns / difficulties, sexual difficulties with other s/ partners /s.
Dissociation	Detaches from present, separates self.
Sleep Difficulties	Presents as tired due to lack of sleep, report sleep difficulties.
Self-Harm	Observing physical markings / harm caused e.g. superficial cuts, bites, burn marks etc. Reports of controlling behaviour and managing emotions via harming one's self.
Eating Disorders	Observable build / size / stature problems due to food restrictions / intakes, descriptions of concerning eating habits, overly concerned by bodily appearance,

	desire to significantly control appearance / food.
Body Problems	Signs of body dysmorphia, distorted perceptions of self / body, desire to alter or change own body.
Parenting Problems	Problems with managing child's behaviours, maintaining boundaries, routines, confidence in parenting abilities impacted, feeling over protective, feeling inadequate as a parent, feeling unable to provide for the child physically, financially or emotionally, lacking in patience, overall sense that parenting of child is hindered due to impacts of sexual violence experiences.
Loss of Home	Require assistance with housing due to loss of home / problems with home.
Restrictions to Movements	Safety issues or concerns, hypervigilant, issues with freely moving as one would hope / expect, concerns with planning movements etc.
Loss of Employment	Requires assistance with employment, sign posting etc due to loss of job following sexual violence.
OCD	Presents with OCD type behaviours e.g. presents with compulsions or repetitive behaviours.

Appendix 10: Example of a chaining Dendrogram:

