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THE PSYCHOSOCIAL EFFECTS OF RAPE ON HETEROSEXUAL AND  
HOMOSEXUAL MEN

by  
Alison Heather Litvack

A Thesis

Submitted in partial fulfillment of the requirements of the  
Master of Arts Degree  
of  
The Graduate School  
at  
Rowan University  
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Approved by \_\_\_\_\_

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## ABSTRACT

Alison Heather Litvack  
THE PSYCHOSOCIAL EFFECTS OF RAPE ON HETEROSEXUAL AND  
HOMOSEXUAL MEN

2008/2009

Dr. DJ Angelone

Master of Arts in Mental Health Counseling and Applied Psychology

The present study evaluated the psychosocial effects of rape on heterosexual and homosexual men. It was hypothesized that 1) non-closeted homosexual men would have less symptomology and more resilience than closeted homosexual men and heterosexual men; 2) the more protective factors a man had, the less symptomology he would display and the more likely he would exhibit posttraumatic growth; 3) there would be an interaction between sexual orientation of the perpetrator and sexual orientation of the victim on symptomology. One-way ANOVAs revealed that homosexual men and bisexual men reported significantly less PTSD symptomology than heterosexual men. Further, homosexual men endorsed more male rape myths than heterosexual men. A univariate-ANOVA revealed a significant interaction between victim orientation and perpetrator orientation on depression. Clinical implications and social issues surrounding male rape are reviewed.

## ACKNOWLEDGEMENTS

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## CHAPTER 1

### Introduction

American laws governing rape have undergone drastic changes in the past century. A man can no longer legally force his wife to have sex and a woman can revoke consent at any point during sexual activity (Martin, Taft, & Resick, 2007). It may be of little consolation, but women can seek some comfort in the laws designed to protect them. Despite such laws, 248,300 rapes were reported to police in 2007 (USDJ, 2008). Though this number may seem striking, it only accounts for an estimated 38.5% of rapes that were actually committed (USDJ, 2008). It is suspected that 644,935 rapes were actually committed, though the majority are likely unreported.

While it may be widely assumed that all rape victims are female, 11,300 men reported being raped in 2007 (USDJ, 2008). Agencies that report rape statistics may not separate female and male rape victims, thereby increasing the invisibility of male rape (FBI, 2008). The estimated number of men who do not report being raped may be even greater as men tend to report rape far less frequently than women (Calderwood, 1987; Pino & Meier, 1999; Chapleau, Oswald, & Russell, 2008). Therefore, these estimates of male rape are probably quite low. Underreporting is problematic because male rape can have negative effects on men, such as depression or posttraumatic stress disorder (Groth & Burgess, 1980; Goyer & Eddleman, 1984; Mezey & King, 1989; Garnets, Herek, & Levy, 1990; Isely & Gehrenbeck-Shim, 1997; Scarce, 1997; Ratner, Johnson, Shoveller, Chan, Martindale, Schilder, Botnick, & Hogg, 2003; Walker, Archer, & Davies, 2005; Tewksbury, 2007). If men are not reporting rape, it follows that they are not obtaining

the mental health treatment they likely need. Educating practitioners about male rape victims is necessary to help treat those who are raped. Through an open exchange of knowledge, an environment can be fostered wherein men can report being raped without fear of further victimization.

In psychosocial research, rape has a broad definition and refers to the non-consented penetration of one person's bodily orifices by another person's penis or other object (Scarce, 1997). The term "male rape" is another phrase used in psychosocial literature to differentiate male victims from female victims. Male rape is defined as the act of one adult male raping (as defined above) another adult male (Scarce, 1997). From a legal perspective, the United States Department of Justice (2008) defines rape as sexual intercourse that is attained through psychological coercion or physical force where penetration by one or more offenders occurs or is attempted. The victim can be male or female, heterosexual or homosexual.

We can establish that male rape has negative effects on men, yet some states do not even recognize that male rape can occur. For example, Georgia's legal definition of rape is "carnal knowledge of a female forcibly and against her will" (The State of Georgia, 2008). This definition implies that men cannot be raped and are not protected by the laws governing men who rape women.

Given the underreporting of male rape and the legal drawback that male rape is disregarded by some states, it is understandable that the public may hold false perceptions about men who are raped. However, male and female rape victims generally experience similar psychosocial reactions (Groth & Burgess, 1980; Goyer & Eddleman, 1984; Mezey & King 1989; Garnets, et al., 1990; Isely & Gehrenbeck-Shim, 1997; Scarce,



1997). Posttraumatic stress disorder, depression, suicidal ideation, anger, decreased self-esteem, homophobia, and questioning one's sexuality are typical responses to male rape (Groth & Burgess, 1980; Goyer & Eddleman, 1984; Mezey & King, 1989; Garnets, et al., 1990; Isely & Gehrenbeck-Shim, 1997; Scarce, 1997; Ratner, et al., 2003; Walker, et al., 2005; Tewksbury, 2007). Men may also experience functional changes following a rape including increased drug and alcohol use, sexual dysfunction, suicide attempts, and interpersonal problems (Goyer & Eddleman, 1984; Mezey & King, 1989; Garnets, et al., 1990; Isely & Gehrenbeck-Shim, 1997; Scarce, 1997; Ratner, et al., 2003; Tewksbury, 2007).

A number of the previously mentioned misconceptions about male rape that are maintained by the public are known as male rape myths. Rape myths are false statements about rape that are taken as truisms by a society (Stuckman-Johnson & Struckman-Johnson, 1992; Chapleau, et al., 2008). Male rape myths include the beliefs that a man cannot be raped, a man is to blame for being raped, and a man is not traumatized by being raped (Stuckman-Johnson & Struckman-Johnson, 1992). Such beliefs can unjustly influence the perception of male rape victims. For example, research consistently indicates people believe a male rape victim is responsible for being raped and experiences more pleasure during rape when compared to a female rape victim (Stuckman-Johnson & Struckman-Johnson, 1992; Mitchell, Hirschman, & Hall, 1999). Further, people attribute the most responsibility, the most pleasure, and the least amount of trauma to homosexual male rape victims when compared to heterosexual men, heterosexual women, and homosexual women (Stuckman-Johnson & Struckman-Johnson, 1992; Mitchell, et al., 1999).

Heterosexual men appear to be the least sympathetic group toward male rape victims. They frequently endorse more male rape myths compared to homosexual men and attribute more pleasure, responsibility, and blame on a male victim than do heterosexual females or homosexual individuals (Davies & McCartney, 2003; Chapleau, et al., 2008). Male rape myths endorsed by heterosexual men are augmented by homophobic beliefs. Homophobic men accept male rape myths more readily than non-homophobic heterosexual men (Kerr Melanson, 1999; Kassing, 2003; Anderson, 2004; Kassing, Beesley, & Frey, 2005). Interestingly, endorsement of rape myths is unaffected by an individual's past experience with sexual assault or rape (Struckman-Johnson & Struckman-Johnson, 1992). However, the acceptance of male rape myths creates a heterosexist environment, which can result in negative self-perceptions in homosexual men. Internalized homophobia (i.e., fear and hatred of homosexual impulses in the self) is fostered in societies where homosexuality is marginalized (Garnets, et al., 1990).

Despite misguided and erroneous perceptions of male rape, research has begun to examine the similarities between male and female rape victims to dispute some of these stereotypes. This comparison serves an important role in understanding the basic framework of male rape symptomology. Currently, one of the only differences between male and female rape appears to be in the physical nature of the rape. Male rape victims tend to incur more physical injuries than female rape victims (Kaufman et al., 1980; Calderwood, 1987; Scarce, 1997; Hodge & Canter, 1998; Tewksbury, 2007). Knowledge regarding differences between the male and female rape experience is valuable. However, it is crucial to know if differences exist within diverse male rape victim populations, such as the differences between homosexual and heterosexual male rape

victims.

As the majority of rape research is devoted to women, little information exists to differentiate heterosexual and homosexual male rape victims' experiences. However, it does appear that women of different sexual orientations vary widely in their psychological response to rape. For example, lesbian rape victims may exhibit varying abilities to develop positive sexual identities and to form intimate relationships following a rape experience (Warwick, 1996). Further, lesbian women may also be confronted with feelings of discrimination in response to being raped (Orzek, 1989). As previously mentioned, the physical nature of rape differentiates the male and female rape experience such that male rape victims sustain more physical injuries than female rape victims (Garnets, et al., 1990; Scarce, 1997). Therefore, men of differing sexual orientations may respond to rape in diverse psychological ways similarly to female homosexual rape victims.

In sum, it appears that homosexual male rape victims tend to sustain more injuries than heterosexual male rape victims (Kaufman, 1980; Hodge & Canter, 1998). In addition, homosexual men are raped more often than heterosexual men (Mezey & King, 1989; Scarce, 1997). Interestingly, the male rape perpetrator is more often heterosexual than homosexual (Groth & Burgess, 1980; Scarce, 1997; Hodge & Canter, 1998). When a homosexual man is raped by a heterosexual man, the homosexual man may experience a victimization that goes beyond the violations of rape. Therefore, the sexual orientation of the perpetrator may also make a difference in the psychological consequences following a rape, particularly in situations where men feel they were targeted because of their sexuality (Garnets, et al., 1990). While this information is valuable to

understanding the male rape experience, the current literature on male rape fails to indicate how the psychological consequences of rape may differentially affect heterosexual versus homosexual male victims.

Although in comparison to heterosexual men, homosexual men sustain more physical harm, disclosure of homosexuality may play a role as a protective factor to psychosocial harm. That is, homosexual men who have come out of the closet may have better coping skills than closeted homosexual men because they have dealt with threats to their self-esteem and mental health and succeeded in forming an integrated identity (Garnets, et al., 1990; Scarce, 1997). Further, homosexual men who are committed to their homosexual identity and do not hide their sexual orientation from the public seem to have better psychological adjustment (Garnets, et al., 1990). It appears that the degree to which a homosexual male is out of the closet will have an impact on his ability to cope with being raped. Homosexual male rape victims, who have not disclosed their sexual orientation (non-out), may be more vulnerable to psychological harm. These men may experience internalized homophobia, a hatred of the homosexual feelings within them, as well as self-blame if they believe they were raped because of their sexual orientation (Garnets, et al., 1990; Scare 1997).

Another protective factor to psychosocial harm is resiliency. Resilience is a term that encompasses a variety of constructs and meanings. Broadly, resilience is the ability to cope with and fully recover from challenging and stressful situations. Resilience can be considered a personality variable that has the ability to moderate outcomes (Wilson, 2004; Abaigi & Wilson, 2005). That is, if a man displays resilient characteristics, he may be less likely to develop psychological symptoms, such as PTSD, following a rape.

Resilient individuals may even experience growth or positive change, known as posttraumatic growth, following traumatic events.

A third protective factor to psychosocial harm is social support. According to Barrera (1986), perceived social support, the perception that people would be available should an individual need them, can influence a person's ability to cope and maintain psychological well-being following trauma. Perceived social support includes the perceived availability and the perceived satisfaction of the support. The amount of social support, both received and perceived, and the level of satisfaction with such support can affect the amount of symptomology a person experiences following a rape (Barrera, 1986; Garnets, et al., 1990; Shriner, 1999). Social support has been shown to serve as a protective factor in children and adolescents who face difficult life experiences and potentially protect them from future stresses (Anderson, 1998). In the case of female rape, fewer social supports tend to be associated with greater psychological symptoms (Shriner, 1999). Given that male rape victims respond similarly to female victims, it can be assumed that men with fewer perceived social supports will also exhibit more psychological symptomology following a rape experience.

For those rape victims who have one or more protective factors, including disclosure of homosexuality, resiliency, and high levels of social support, it may be possible for an individual to emerge more psychologically sound than before the trauma. Not all victims demonstrate adverse effects following a trauma, such as rape. This concept of positive growth following trauma is known as Posttraumatic Growth (PTG). PTG is the ability to grow and make positive changes in one's life following a tragedy or a traumatic event (Snape 1997; Pat-Horenczyk & Brom, 2007). If male rape victims have

one or more protective factors, which are known to help rape victims overcome trauma, they may have an increased likelihood of experiencing PTG rather than psychological symptomology.

Despite the fact that 10% of rape victims are male, the laws in some parts of the United States do not protect them as they would a female rape victim (USDJ, 2008). Further, the public, particularly those with homophobic beliefs, often blame the male rape victim and assume he will experience less trauma than his female counterpart (Struckman-Johnson & Struckman-Johnson, 1992; Mitchell, et al., 1999; Ker Melanson, 1999; Kassing, 2003; Kassing, et al., 2005). However, research has shown that male and female rape victims are equally harmed by the trauma of rape (Mezey & King, 1989; Garnets, et al., 1990; Isely & Gehrenbeck-Shim, 1997; Scarce, 1997). What is not known is how different populations of men are psychologically and behaviorally affected by male rape. These important distinctions are essential in the treatment and recovery of male rape victims and should be addressed.

The purpose of this study is threefold: 1) to develop a better understanding of the psychological effects rape has on heterosexual men as well as homosexual men with varying levels of outness, 2) to determine the role that protective factors, such as resilience, social support, and outness, play in the protection from psychological harm and the development of posttraumatic growth following a rape, and 3) to examine the significance of the perpetrator's and victim's sexual orientations on the victim's psychological harm.

First, it is hypothesized that non-closeted homosexual men will have less symptomology and more resilience than closeted homosexual men and heterosexual men

(hypothesis 1). Consistent with previous research with heterosexual women, it is hypothesized that the more protective factors men have, the less symptomology they will display (hypothesis 2a) (Barrera, 1986; Garnets, et al., 1990; Shriner, 1999). Further, it is hypothesized that the more protective factors men have, the more likely he will be to experience posttraumatic growth (hypothesis 2b). Third, it is hypothesized that there will be an interaction between sexual orientation of the perpetrator and sexual orientation of the victim such that homosexual male rape victims who are raped by heterosexual males will have more severe symptomology than homosexual male rape victims who are raped by another homosexual male (hypothesis 3) (Garnets, et al., 1990).

## CHAPTER 2

### Method

#### *Participants*

Of the 102 website hits, only 67 individuals qualified for the study based on the inclusion criteria questions. Of those 67 individuals, only 48 participated in the study, of which 33 completed some of the questionnaires, and only 15 completed all the questionnaires. All participants were male (100%) and a majority Caucasian (85.7%), followed by African American (6.1%), Multiracial (4.2%), Asian (2%), and Hispanic/Latino (2%). The mean age was 21.3 years old with a range of 18 to 72 years. Many participants had completed some college (39.6%), obtained a graduate degree (20.8%), or graduated from a 4-year college/university (18.8%). A large number of participants were married/civil union (40.8%), followed by single/dating (36.7%), divorced (14.3%), unmarried but living with partner (6.1%), and separated (2%). Most participants self-identified as middle class (44.9%), followed by lower-middle class (24.5%), middle-upper class (22.4%), lower class (4.1%), and upper class (4.1%).

#### *Measures*

A general demographics questionnaire was developed to assess for gender (male, female), age (in years), ethnicity (Caucasian, African American, Asian or Asian American, Hispanic or Latino, Hawaiian or other Pacific Islander, Native American or Alaska Native, Multiracial), education (grade school, high school/GED, some college, graduated 2-year college or university, graduated 4-year college or university, some graduate school, graduate school) marital status (single/dating, unmarried but living with



partner, married/civil union, divorced, separated, widowed), and socioeconomic status (lower class, lower-middle class, middle class, middle-upper class, upper class).

*The Marlowe-Crowne Social Desirability Scale-2(10)* (M-C 2(10); Strahan & Gerbasi, 1972). The M-C 2(10) is a self-report measure that assesses an individual's ability to answer questions honestly rather than in a socially desirable fashion. The M-C 2(10) consists of 10 true-false items. Scores range from 0-10, where 10 indicates socially desirable responding. Questions include, "I never hesitate to go out of my way to help someone in trouble," and "I am always courteous, even to people who are disagreeable." The M-C 2(10) scales correlate highly (.80-.90) with the full measure, The Marlowe-Crown Social Desirability Scale (M-C SDS).

#### *Psychological Constructs*

*The Connor-Davidson Resilience Scale* (CD-RISC; Connor & Davidson, 2003). The CD-RISC is a self-report measure that assesses levels of resilience. The CD-RISC is comprised of 25 items, rated on a 5-point Likert scale, where 0 is "not at all true" and 4 is "true nearly all of the time." Scores range from 0-100, where higher scores indicate greater amounts of resilience. The CD-RISC measures personal competence, tolerance of negative affect, and social support. Sample items include, "Things happen for a reason," and "Sometimes fate or God can help." The CD-RISC demonstrates good reliability, (Cronbach's alpha = 0.89). The CD-RISC also exhibits good convergent validity using the Kobasa hardiness measure,  $r = .083$ ,  $P < 0.0001$ .

*PostTraumatic Growth Inventory* (PTGI; Tedeschi & Calhoun, 1996). The PTGI was used to measure the amount of positive changes participants may have made in their lives following a traumatic event. The PTGI is a 21-item self-report measure, rated on a

6-point Likert scale, 0-5, where 0 means “I did not experience this change as a result of my rape,” and 5 means “I experienced this change to a very great degree as a result of my rape.” The PTGI assesses the five factors of New Possibilities, Relating to Others, Personal Strength, Spiritual Change, and Appreciation of Life. Sample items include, “I have a greater sense of closeness with others,” “I am more likely to try to change things which need changing,” and “I discovered that I'm stronger than I thought I was.” Internal consistency was observed to be strong, alpha values were reported at 0.90 for the whole scale, and alpha values range from 0.67 to 0.85 for the five factors (Tedeschi & Calhoun, 1996).

*The Posttraumatic Stress Disorder Checklist-Civilian Version (PCL-C; Weathers, Huska, & Keane, 1991).* The PCL-C was used to assess posttraumatic stress disorder (PTSD) symptomology directly related to the rape. The PCL-C is a 17-item self-report measure, rated on a 5-point Likert scale, 1-5, where 1 is “not at all” and 5 is “extremely.” The PCL-C corresponds to diagnostic criteria B, C, and D for PTSD of the fourth edition of the Diagnostic and Statistical Manual of Mental Disorders (American Psychiatric Association, 2000). Participants were instructed to answer each question in relation to how much they experienced that symptom over the last month. Questions include “Feeling very upset when something reminded you of a stressful experience?” and “Feeling distant or cut off from other people?” The PCL-C exhibits high internal consistency between the full scale, re-experiencing scale, avoidance scale, and hyperarousal scale, (Cronbach’s alpha = 0.94, 0.85, 0.85, 0.87), respectively (Ruggiero, Del Ben, Scotti, & Rabalais, 2003).

*Beck Depression Inventory (BDI; Beck, Ward, Mendelson, Mock, & Erbaugh,*

1961). The BDI was used to assess severity of depression during the past week. The BDI is a 21-item self-report measure that is scored on a 4-point Likert scale from 0 to 3, where 0 is the absence of depression and 3 is extreme depression. Total scores range from 0 to 63. Four statements are grouped together in increasing intensity of depression. The participant chooses the statement that represents their feelings that week. For example, 0: I do not feel sad; 1: I feel sad; 2: I am sad all the time and I can't snap out of it; 3: I am so sad or unhappy that I can't stand it. A score of 0-10 indicates no depression; 10-18 indicates mild to moderate depression; 19-29 indicates moderate to severe depression; and 30-63 indicates severe depression. Based on a meta-analysis, the BDI has good internal consistency for non-psychiatric individuals with coefficient alphas ranging from 0.78 to 0.95.

*Beck Anxiety Inventory* (BAI; Beck & Steer, 1990). The BAI was used to assess participants' severity of anxiety during the past week. The BAI is a 21-item self-report measure that is scored on a 4-point Likert scale from 0 to 3, where 0 is "not at all," and 3 is "severely; I could barely stand it." Total scores range from 0 to 63, with higher scores indicating more severe anxiety. Specifically, 0-21 indicates low anxiety, 22-35 indicates moderate anxiety, and 36-63 indicates persistent and high anxiety. Sample items include, feeling hot, fear of worse happening, and nervousness. The BAI displays good internal consistency with a Cronbach alpha of 0.90 (Osman, Kopper, Barrios, Osman, & Wade, 1997).

*The Social Support Questionnaire-6* (SSQ6; Sarason, Sarason, Shearin, & Pierce, 1987). The SSQ6 was used to assess participant's social supports. The SSQ6 is a 6-item self-report measure, where the odd items indicate the number of people available to a

person and the even items indicate the degree of satisfaction the person has with those supports. The SSQ6 provides two scales, one of which accounts for the number of people available to a person, SSQN, and a second of which accounts for the satisfaction a person feels in their relationships, SSQS. Sample questions include, “Whom can you really count on to distract you from your worries when you feel under stress?” and “How satisfied?” Internal reliabilities (coefficient alphas) range from 0.90 to 0.93 for the SSQN and SSQS scales of the SSQ6.

*The Cut Down, Annoyed, Guilty, Eye-Opener Questionnaire (CAGE; Ewing, 1984).* The CAGE is a 4-item self-report measure that assesses alcohol use. Participants are asked to rate their alcohol use in the past year. The CAGE uses yes or no responses and is scored 1 or 0, respectively. Higher scores imply greater drinking problems, where scores of two or more are considered clinically significant. A sample CAGE question includes, “Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover (eye-opener)?” The CAGE’s reliability has produced reliability coefficients up to 0.90 (Shields & Caruso, 2004). Validity also appears sound, with sensitivity ranging from 43% to 94% and specificity ranging from 70% to 97% (Fiellin, Reid, & O’Connor, 2000).

*The Cut Down, Annoyed, Guilty, Eye-Opener Questionnaire Adopted to Include Drugs (CAGE-AID; Brown, & Rounds, 1995).* The CAGE-AID is a 4-item self-report measure that assesses drug use. Participants are asked to rate their drug use in the past year. The CAGE-AID is scored the same as the CAGE, where yes or no responses are scored 1 or 0, respectively and scores of two or more indicate clinical significance.

When respondents answered yes to one or more questions, the CAGE-AID demonstrated

good sensitivity and specificity, 0.79 and 0.77, respectively. When respondents answered yes to two or more questions, the CAGE-AID also displayed good sensitivity and specificity, 0.70 and 0.85, respectively. A sample CAGE-AID question includes, “Have you ever done drugs first thing in the morning to steady your nerves or get rid of a hangover (eye-opener)?” (Brown & Rounds, 1995).

### *Sexuality Constructs*

Three dimensions of sexual orientation were assessed: self-identification, desire, and behavior. The self-identification (heterosexual, homosexual, bisexual) and desire (attracted to men, women, or both) dimensions were adapted from Lippa (2000). The third dimension, desire, asked participants, “Have you ever engaged in consensual oral (anal) sex with a man?” (yes, no); “How often do you engage in oral (anal) sex with men?” (frequently, occasionally, one time, never); How much of your sexual activity is comprised of oral (anal) sex with men? (all, most, some, none).

*The Homosexual Orientation Measure of Outness (HOMO)*. The HOMO is a 20-question self-report measure that was developed for the purposes of this study to measure homosexual outness. The HOMO was piloted tested on homosexual and bisexual men and women. The HOMO assess the percentage of people who know about a person’s homosexuality in the areas of family, straight friends, LGBT friends, coworkers, and religious community members. Answers range from 0%, 1-25%, 26-50%, 51-75%, and 76-100%. The HOMO also assesses how much a homosexual individual believes they are “out” in general. Questions include, “Approximately what percentage of your coworkers know you are homosexual/bisexual?” Pilot data suggests that the HOMO exhibited good reliability with coefficients ranging up to 0.89. For the current sample, the

HOMO also demonstrates good reliability ( $\alpha = .881$ ).

*Rape Myth Measure* (RMM; Struckman-Johnson & Struckman-Johnson, 1992).

Endorsement of male rape myths were assessed through the RMM. Three dimensions of rape myths are assessed: cannot happen, victim blame, and victim trauma. Two questions were developed for each dimension. For example, “It is impossible for a man (woman) to rape a man,” and “Even a big, strong man can be raped by another man (woman)” make up the “cannot happen” category. For each category, the words “man” are replaced with “woman” such that the questions were asked from the perspective of a man raping another man and a woman raping a man. The RMM uses a 6-point Likert scale, from 1 to 6, where 1 is “strongly disagree” and 6 is “strongly agree.” Total scores range from 12-72, where higher scores indicate greater acceptance of male rape myths.

*Internalized Homophobia Scale* (IHP; Herek, Cogan, Gillis, & Glunt, 1998). The IHP is a 9-item self-report measure that assesses an individual’s level of ego-dystonic homosexuality. Items are rated on a 5-point Likert scale, from 1-5, where 1 is “strongly disagree” and 5 is “strongly agree.” For example, “I wish I weren’t gay/bisexual” and “I wish that I could develop more erotic feelings about women.” Total scores range from 9 to 45, where higher scores indicate greater psychological distress with one’s sexual orientation. The IHP demonstrates good reliability, Cronbach’s alpha = 0.71 (women) and 0.83 (men) (Herek, Cogan, Gillis, Glunt, 1999).

*Index of Attitudes Towards Homosexuals* (IAH; Ricketts, & Hudson, 1990). The IAH is a 25-item self-report measure that assesses an individual’s comfort with close proximity to homosexual individuals. Items are rated on a 5-point Likert scale, from 0-4, where 0 is “strongly agree” and 4 is “strongly disagree.” Example items include, “I

would feel comfortable working closely with a male homosexual,” and “It would not bother me to walk through a predominantly gay section of town.” Scores range from 0 to 100, where higher scores indicate greater discomfort with close proximity to homosexuals. Scores below 50 indicate increasingly less discomfort with close proximity to homosexuals. The IAH demonstrates good reliability, Cronbach’s alpha = .90 (Ricketts & Hudson, 1990). The IAH has content, construct, and factorial validity correlations over 0.60 (Fischer & Corcoran, 2006).

### *Procedure*

Fliers and handouts advertising a “Male Sexual Experiences Survey” were distributed to 803 rape centers, 46 colleges, and 62 gay community centers. A Facebook.com group and LinkedIn.com group were created devoted to the advertisement of the survey. Further, the survey was posted several times on Craig’s List. Finally, online forums were contacted in regard to survey advertisement, including MaleSurvivor.org, RAINN.org, and various others. Grassroots methods were also used to encourage individuals to pass along the survey information to as many people as possible.

Participants who were interested visited a SurveyMonkey.com website to access the questionnaires at their convenience. The first screen welcomed participants to the study and ensured that they met the inclusion criteria before beginning (i.e. male, over 18 years old, experienced sexual assault after the age of 15). Participants who did not meet the inclusion criteria were thanked for visiting the website. If participants did meet the criteria, they were directed to an informed consent page. Following the informed consent, all of the above questionnaires followed. At the end of the questionnaires,

participants were given the option of leaving their email address for an entry into a drawing for one of two \$50 gift cards. When the participants were finished, a debriefing form appeared.



## CHAPTER 3

### Results

Initial descriptive analyses revealed several interesting relationships (see Table 1 & Table 2). BDI scores were positively associated with scores on the PCL,  $r(17) = 0.563, p = 0.019$ . That is, high levels of depression were associated with high levels of PTSD symptomology. In addition, the BDI and BAI were both negatively associated with the PTGI ( $r(18) = -0.589, p = 0.01$ ), ( $r(19) = -0.386, p = 0.10$ ). That is, high levels of depression and anxiety were associated with lower levels of post-traumatic growth. Finally, an independent samples t-test revealed a relationship between male rape myths and sexual orientation such that homosexual men endorsed male rape myths significantly more frequently than heterosexual men ( $t(13) = -2.07, p = 0.059$ ).

Hypothesis 1 stated that non-closeted homosexual men would have less symptomology and more resilience than closeted homosexual men and heterosexual men. To test hypothesis 1, a series of one-way analyses of variance (ANOVAs) were conducted to evaluate the relationship between non-closeted (out) males, closeted (non-out) males, and heterosexual males on symptomology and resilience. The independent variable was outness and included three levels: non-closeted (or out), closeted (non-out), and heterosexual. The dependent variables were the amount of symptomology and resilience. Symptomology included measures of depression, anxiety, posttraumatic stress disorder, and drug or alcohol use. The ANOVAs were not significant. Groups were then redefined by sexual orientation (homosexual, bisexual, and heterosexual) rather than outness (non-closeted, closeted, and heterosexual) and the ANOVAs were reassessed.

An ANOVA revealed a relationship that approached significance between homosexual and bisexual males ( $M = 59.40$ ,  $SD = 8.85$ ) to heterosexual males ( $M = 46.90$ ,  $SD = 18.16$ ) on PTSD symptomology,  $F(1,18) = 3.83$ ,  $p = 0.066$ . The results of the one-way ANOVA partially contradicts the hypothesis that non-closeted homosexual men will have less symptomology and more resilience than closeted homosexual men and heterosexual men.

Hypothesis 2a stated that the more protective factors men had, the less symptomology they would display. To test hypothesis 2a, a series of independent sample t-tests were performed to evaluate the relationship between protective factors and symptomology. The independent variable was protective factors and included two levels: low and high protective factors. The dependent variables were the amount of symptomology. Symptomology included measures of depression, anxiety, posttraumatic stress disorder (PTSD), drug use, and alcohol use. A t-test revealed a trend between high and low protective factors and alcohol use,  $t(12) = 1.93$ ,  $p = .078$ . Males with high protective factors had lower CAGE scores ( $M = 1.57$ ,  $SD = 1.81$ ) than males with low protective factors ( $M = 3.29$ ,  $SD = 1.50$ ). T-tests were not significant for depression, anxiety, PTSD, or drug use.

Hypothesis 2b stated that the more protective factors men had, the more likely they would be to experience posttraumatic growth (hypothesis 2b). To test hypothesis 2b, a series of independent sample t-tests were performed to evaluate the relationship between protective factors and posttraumatic growth. The independent variable was protective factors and included two levels: low and high protective factors. The dependent variable was the amount of posttraumatic growth. The t-tests were not

significant.

Hypothesis 3 stated that there would be an interaction between sexual orientation of the perpetrator and sexual orientation of the victim such that homosexual male rape victims who were raped by heterosexual males would have more severe symptomology than homosexual male rape victims who were raped by another homosexual male. To test hypothesis 3, a 3 (victim sexual orientation) x 4 (perpetrator sexual orientation) ANOVA was conducted to evaluate the effects of the sexual orientation of the victim and the sexual orientation of the perpetrator on symptomology. The independent variable, sexual orientation of the victim, included three levels: homosexual, bisexual, and heterosexual. The independent variable, sexual orientation of the perpetrator, included four levels: homosexual, bisexual, heterosexual, and unknown. Symptomology included measures of depression, anxiety, posttraumatic stress disorder (PTSD), and drug or alcohol use. A covariate of social desirability was included. The ANOVA indicated a significant interaction between victim orientation and perpetrator orientation on depression,  $F(1,3) = 6.23, p = .038$ . The results of the 3 x 4 ANOVA partially support the hypothesis that there will be an interaction between sexual orientation of the perpetrator and sexual orientation of the victim on symptomology.

## CHAPTER 4

### Discussion

Results indicate that men of different sexual orientations experience variable levels of symptomology that can be influenced by the sexual orientation of the perpetrator, sexual orientation of the victims, and quantity of protective factors. Hypothesis 1 was generally unsupported when groups were defined by outness. However, when groups were redefined according to sexual orientation, a trend indicated that homosexual and bisexual males experienced greater PTSD symptomology than heterosexual males. Hypothesis 2a was partially supported such that males with greater protective factors (i.e. disclosure of homosexuality, resilience, and social support) were less likely to endorse problematic drinking behaviors than males with fewer protective factors. Hypothesis 2b was unsupported indicating that greater protective factors did not necessarily indicate less symptomology or lead to increased posttraumatic growth. Lastly, hypothesis 3 was partially supported, such that depressive symptomology was impacted by the interaction of the perpetrator's and victim's sexual orientation. This is the first known study to address symptomatic differences between homosexual and heterosexual male victims of rape. While more differences were expected between groups, findings that indicate similarities are equally important in the development of effective treatments for male rape victims.

A notable procedural setback was encountered when communicating with many of the sexual assault centers. Numerous centers were unwilling to allow the male rape victim clients to participate in research due to the sensitive nature of their problem. To

highlight this point, the following quote was excerpted from a letter received by one of the centers, stating, “It is imperative that we know what questions are going to be asked before we survey the people who have entrusted us with their care.” Aside from the fact that the ability to make an informed consent was taken away from these individuals, the overprotective reaction to such research is of great concern. The male rape community appears to be closed off to outsiders, even to those with the desire and ability to help. This protectiveness may be a byproduct of the secondary victimization too often experienced by male rape victims, but is potentially just as damaging. The therapeutic use of the survey was not even considered despite research indicating exposure therapy as an efficacious treatment for posttraumatic stress disorder (Cahill & Foa, 2007). Furthermore, research has shown that participation in sexual assault surveys can actually improve the mood of sexual assault victims and non-victims. A recent study on female sexual assault revealed that female sexual assault victims reported personal benefits from survey participation (Edwards, Kearns, Calhoun, & Gidycz, 2009). Therefore, male rape victims’ mood may also improve through participating in sexual assault surveys, despite the common belief that participation may be harmful.

In context of this setback, several limitations are to be considered when interpreting the outcomes of the present study. First, a selection bias may be reflected in the kinds of people that would be willing to take this survey. A man who was raped but has never sought help or denies the experience may have been less likely to participate than a man who was raped and had received counseling for this experience. Those who have been raped but do not define their experience as rape may have excluded themselves from participation as well. Another possible limitation is a demand characteristic, which

may have influenced participants to respond according to what they think the researcher may want to find. For example, a man might have exaggerated his psychological and behavioral responses to being raped because the survey was designed to assess male rape experiences. A third limitation was the online format of the questionnaire. This format may have affected participants' willingness to participate or willingness to complete the questionnaires once begun. The online format was originally designed to protect participants' identity as a male rape victim. However, this format may have had a negative impact on the number of participants that completed the questionnaires because there was no motivation or obligation to finish the survey.

The final, and most notable, limitation of the current study was the limited sample size. It is important to recognize the small sample size of this study so as not to over-generalize the findings. However, this is the first known study to assess behavioral and psychological consequences of male rape on men of differing sexual orientations. While the findings will require replication with a greater sample size before treatment implications can accurately be made, this project represents a useful step in the right direction.

One possible explanation for the minimal sample size is high attrition rates found in internet studies. Jain and Ross (2008) report an attrition rate of 47.5% when utilizing the internet to study men who have sex with men. Another possible explanation for the small sample size may be related to male help-seeking behaviors. Men, across cultures, ages, nationalities, ethnicities, and diagnoses seek mental health services less frequently than women (Husaini, Moore, & Cain, 1994; Neighbors & Howard, 1987; D'Arcy & Schmitz, 1979). Since men seek psychological help at decreased rates, this may indicate

less impetus to engage in research related to their mental health problems. Further, men who do not seek help after being raped would be less likely to encounter advertisements for the study. Men who do not receive help for rape-related issues may also be less likely to engage in a study designed to assess sexual experiences. In addition to being less likely to seek psychological help than women, men who are raped may experience additional barriers to seeking psychological help, which may influence their willingness to participate in research.

One barrier to seeking psychological help after a rape may be secondary victimization. Secondary victimization, also referred to as “the second rape,” occurs when rape victims are mistreated, typically by the use of victim-blaming attitudes and behaviors, by professionals who are supposed to help the victim (Campbell, 2008; Campbell, Wasco, Ahrens, Sefl, & Barnes, 2001). These professionals can include, but not limited to, law enforcement professionals, crisis workers, medical professionals, and mental health professionals. Qualitative data indicates that a majority of men are met with negative, victim-blaming reactions when in fact they report being raped (Rumney, 2008; Scarce, 1997) Other research indicates that negative contacts with community professionals are associated with worse victim outcomes (Campbell, et al., 2001). Although most men do not report being raped or get the psychological help they may need, those who do report are often victimized a second time and still do not receive the help they deserve. Men who experienced secondary victimization may have been unwilling to participate in a “sexual experiences survey” for fear of further victimization.

Another barrier to seeking psychological help after a rape may be an individual’s endorsement of male rape myths. If a man believes that men cannot be raped, he may not

label the experience as rape and deny that he needs help. Alternately, if he labels the experience a rape, he may have to cope with the embarrassment of admitting he was raped, traditionally a female problem, before he is willing to seek help. Other facets of male rape myths may lead men to blame themselves for being raped; perhaps feeling like he should have tried harder to fight the man off. The third male rape myth, male rape victims experience pleasure, may bring to the surface feelings of homophobia for heterosexual men or internalized homophobia for homosexual men. Heterosexual men may also begin to question their sexuality and masculinity, particularly if they experienced an erection or ejaculated while being raped (King & Woollett, 1997; Scarce, 1997). In the present study, homosexual males endorsed rape myths more frequently and displayed more PTSD symptomology than heterosexual males. A man's endorsement of male rape myths may influence his ability to pursue psychological services as well as his proclivity to engage in research related to his rape experience.

A third barrier to seeking psychological help after a rape may be masculinity. Masculinity can be classified by the restricting of emotions other than anger, avoiding associations with femininity or homosexuality, being sexually promiscuous, competitive, successful, and independent (Mahalik, Good, & Englar-Carlson, 2003). Men who endorse more masculine ideals have more negative attitudes towards seeking psychological services and therefore seek psychological services less frequently than men who endorse less masculine ideals (Mahalik, Good, & Englar-Carlson, 2003). Therefore, masculinity may have also contributed to participation problems in a survey that assesses emotions, traditionally feminine problems, and raises issues of homosexuality or homophobia.



A fourth barrier to seeking psychological help after a rape may be gender role conflict. Gender role conflict occurs when societal norms about gender roles are internalized and cause distress (Hayes & Mahalik, 2000; Simonsen, Blazina, & Watkins, 2000). Such gender role ideals are frequently incongruous, incompatible, and unachievable and when adhered to have the ability to predict psychological distress (Good, Robertson, Fitzgerald, Stevens, DeBord, & Bartels, 1996; Hayes & Mahalik, 2000). Greater gender role conflict has been shown to inhibit men from seeking psychological services (Mahalik, Good, & Englar-Carlson, 2003). Thus, if a heterosexual man who endorses masculinity is raped, it is likely he is also experiencing gender role conflict as well as psychological distress. Unfortunately, both masculinity and gender role conflict greatly diminish a man's likelihood of seeking psychological services and inclination to engage in this type of research. Research regarding homosexual men indicates they experience gender role conflict in similar ways as heterosexual males (Szymanski & Carr, 2008; Simonsen, Blazina, & Watkins, 2000). Homosexual men with greater degrees of gender role conflict are more likely to experience psychological distress, specifically internalized homophobia (Szymanski & Carr, 2008). Paradoxically, homosexual men with greater gender role conflict appear to seek psychological services less frequently than homosexual men with less gender role conflict (Simonsen, Blazina, & Watkins, 2000).

Secondary victimization, male rape myths, masculinity, and gender role conflict are all constructs that indicate society's influence in understanding of the male rape victim and are deserving of future research. Societal norms and beliefs have not only negatively influenced men's willingness to seek mental health services but have also

negatively impacted the outcome of the help male rape victims receive. In order for the misperceptions of male rape victims to change, education and outreach is essential if male victims are to be able to receive the help they deserve. Though a daunting task, educating society about male rape may help undo male rape myths and their detrimental effects. Further, educating professionals who may be the first contact a male rape victim has after being raped will help prevent secondary victimization. Outreach is another essential component if male rape is to be fully understood. Male rape victims often remain invisible due to many of the aforementioned issues. Through education and outreach, male rape victims may be more willing to report being raped, seek psychological services, and engage in research to help further the understanding of their experience.

There is a clear demand for future research on behalf of male rape victims. Based on the current study, it appears male rape victims and those who treat them are unwilling to participate in research. One area of research that would be beneficial is the development of effective methods of recruiting male rape victim participants and fostering cooperation with those who treat them. Not surprisingly, research on treatment approaches for males is another underdeveloped area of research, likely due to the lack of male rape victim research in general. At present, it is unclear what services male rape victims receive when they do get help. The treatments male rape victims receive are not always evidence-based treatments and even then, it is uncertain if the evidence-based treatments are effective for male victims (Campbell, 2008). Further research is necessary to determine the most effective and efficacious treatment modalities for male rape victims.

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Table 1

## Correlation Matrix: Psychosocial Symptomology

		Victim Sexual Orientation	Perpetrator Sexual Orientation	Depression	Anxiety	PTSD	Alcohol Use	Drug Use	Male Rape Myths	Homophobia	Internalized Homophobia	Resilience	PTG
Victim Sexual Orientation	Pearson Correlation	1.000											
Perpetrator Sexual Orientation	Pearson Correlation	-.011	1.000										
Depression	Pearson Correlation	-.030	.495**	1.000									
Anxiety	Pearson Correlation	-.231	.348	.472**	1.000								
PTSD	Pearson Correlation	.367	.331	.563**	.475**	1.000							
Alcohol Use	Pearson Correlation	-.373	.037	.076	.208	.151	1.000						
Drug Use	Pearson Correlation	-.197	-.332	-.389	.154	.009	.490*	1.000					
Male Rape Myths	Pearson Correlation	.211	-.399*	-.146	-.338	.080	.114	.092	1.000				
Homophobia	Pearson Correlation	-.160	.118	.332	.152	.250	.023	-.061	-.253	1.000			
Internalized Homophobia	Pearson Correlation	.725***	.017	.313	.068	.417*	-.284	-.123	.332	-.008	1.000		
Resilience	Pearson Correlation	-.063	-.006	-.541**	-.254	.519**	-.037	.094	.038	.039	-.004	1.000	
PTG	Pearson Correlation	-.006	-.352	-.589**	-.386*	-.267	-.267	.173	-.312	.000	-.213	.291	1.000

\*\*\* Correlation is significant at the 0.01 level (2-tailed).

\*\* Correlation is significant at the 0.05 level (2-tailed).

\* Correlation is significant at the 0.10 level (2-tailed).

Table 2

Correlation Matrix: Psychosocial Symptomology, Descriptive Statistics

	Mean	Std. Deviation	N
orient1	1.7297	.87078	37
sprf13	2.8750	1.15392	24
bdi_full	20.1667	12.43926	18
bai_full	2.1579	1.21395	19
pcl_full	53.1500	15.30832	20
cage_full	2.2667	1.86956	15
cageaid_full	.9286	1.68543	14
rmm_full	17.3636	4.33749	22
iah_full	61.1667	19.40664	18
ihp_full	18.9048	17.41237	21
cd risc_full	86.0588	21.17308	34
ptgi_full	36.5455	24.87823	22

