Sexual Assault Among Male Veterans

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Sexual assault is a serious problem associated with significant human suffering and long-term health costs. Since the widely publicized incident at the Tailhook Symposium in 1991, which included Navy personnel, disturbingly high rates of adult sexual assault have been documented among women serving in the military (Table).

The prevalence of adult sexual assault among female veterans, for example, has been estimated as high as 41% (Coyle et al., 1996; Sadler et al., 2000; Skinner et al., 2000) and is considerably higher than rates of lifetime sexual assault among civilian women (Resnick et al., 1993). Among women, sexual assault is a significant risk factor for posttraumatic stress disorder, anxiety, depression and suicidal ideation, and alcohol and drug abuse (Koss et al., 1994). Other long-term sequelae identified among female adult sexual assault survivors include sexual dysfunction (van Berlo and Ensink, 2000), impaired social functioning and employment difficulties (Sadler et al., 2000; Schwartz, 1991), and physical health complaints, as well as increased health care utilization (Frayne et al., 2003; Ullman and Brecklin, 2003).

In comparison to the burgeoning literature on the prevalence and impact of adult sexual assault on women, there is a dearth of published literature on male adult sexual assault victims. In this article, we provide an overview of the existent literature on male sexual assault and highlight recent findings on the prevalence of adult sexual assault in a large sample of male veterans applying for PTSD disability benefits from the U.S. Department of Veterans Affairs. The treatment implications of these recent data for psychiatrists and other mental health care professionals are discussed.

Male Sexual Assault and Rape Myths

Despite early epidemiological data estimating that as many as 7% of men have experienced adult sexual assault (Sorenson et al., 1987), the scientific and clinical communities have largely ignored men who have experienced sexual violence. The lack of data on male sexual assault may reflect the fact that women are more likely than men to experience adult sexual assault and that the majority of perpetrators of sexual assaults are men.

Cultural stereotypes and myths about male rape that fail to recognize men as potential targets of sexual violence and minimize the consequences of adult sexual assault for men may also influence research in this area. Examples include beliefs that (Coxell and King, 1996):

- males cannot be raped;
- sexual assaults against males are committed only within prisons;
- male adult sexual assault victims must be homosexual;
- heterosexual males do not sexually assault other males;
- males are less affected by sexual assault than females.

While extensive research on adult sexual assault among women has helped dispel many cultural myths supportive of violence against women (e.g., only bad girls get raped, women ask for it and healthy women can resist rape), male rape myths continue to pervade our society including the disciplines of medicine, psychiatry and psychology.

Psychiatric Sequelae of Adult Sexual Assault in Men

While previous data on male adult sexual assault were largely limited to anecdotal clinical case reports and small samples, researchers have recently begun to give more serious empirical attention to questions regarding sexual assault among men in the general population (Elliot et al., 2004). Preliminary data suggest that sexually victimized men experience similar adverse outcomes to those widely documented for women. For example, in the Los Angeles Epidemiological Catchment Area Study, the impact of sexual assault on men's and women's mental health status was similar, except that sexually assaulted men were more likely than assaulted women to report

subsequent alcohol abuse or dependence (Burnam et al., 1988). Similarly, Ratner and colleagues (2003) found that sexually assaulted men were 2.9 times more likely than nonvictimized men to abuse alcohol. Coxell and colleagues (1999) found that nonconsensual sexual experiences among men were associated with increased self-harm, alcohol abuse and general psychological problems.

Similar to the phenomenon of sexual revictimization documented in women, high rates of childhood sexual abuse have been found among men reporting adult sexual assault. Elliott and colleagues (2004) found that men who had experienced adult sexual assault were five times more likely to report a history of childhood sexual abuse than men with no adult sexual assault history. Sexually revictimized men also report more severe psychiatric consequences than those men with a history of childhood sexual abuse only or adult sexual assault only (Coxell et al., 1999). For example, Ratner and colleagues (2003) found sexually revictimized men were 3.3 times more likely to have attempted suicide than nonvictims. Other data suggest that sexual victimization may be an especially potent traumatic stressor for men. In a study of male and female patients seen at a rape treatment center, Kimerling and colleagues (2002) found that men had significantly higher rates of current psychiatric symptoms, lifetime history of psychiatric disorders (54.8% versus 28.5%) and a greater history of psychiatric hospitalization (51.7% versus 17.9%) than did women. Elliott and colleagues (2004) found that sexually victimized men reported greater difficulties with sense of self and engaged in more dysfunctional sexual behavior than female adult sexual assault victims.

Adult Sexual Assault in the Military

The existing empirical literature on male adult sexual assault has focused predominantly on community samples, and understanding the scope and nature of sexual assault among male active duty soldiers or combat veterans remains in its infancy. Recent research in this area has investigated the prevalence and incidence of male adult sexual assault (Table). For example, Martin and colleagues (1998) reported that 6.7% of male Army soldiers had experienced sexual assault during their lifetimes and 3% since entering the military. Smith and colleagues (1999) reported a lifetime prevalence of sexual assault of 12% among 129 combat veterans consecutively referred for PTSD. However, 92% of these assaults occurred prior to combat exposure, so it remains unclear whether these assaults actually occurred during or before military service. In general, the past-year incidence of sexual assault among enlisted men ranges from 0.4% to 3.7% (Bastian et al., 1996; Culbertson et al., 1992; Culbertson et al., 1993; Martin et al., 1998; Martindale, 1991), a figure comparable to the lifetime prevalence of sexual assault reported for civilian men in some studies (Kessler et al., 1995; Norris, 1992).

In a recent survey examining a nationally representative sample of 3,337 male and female veterans applying for VA disability benefits for PTSD, we found that 4.2% of men reported experiencing sexual assault while in the military (Murdoch et al., 2004). However, in-service sexual assault rates in our sample varied substantially according to veterans' service era and combat-exposure status. Across wartime eras, 1.7% of male World War II veterans reported a history of in-service sexual assault compared to 13.3% of male Gulf War veterans. Almost 4% of male combat veterans reported in-service sexual assault, compared to 12.6% of noncombatant male veterans. These findings suggest considerably higher rates of sexual assault among male veterans seeking VA disability benefits for PTSD than among men in the general population. For example, rates of adult sexual assault among male combat veterans in our study were approximately five to nine times higher than that reported by men in the general population (Kessler et al., 1995; Norris, 1992). For noncombatant male veterans, the prevalence of adult sexual assault was 13 to 24 times higher.

Clinical Implications for Treatment

Following U.S. Senate hearings on military sexual trauma in 1992, the U.S. Congress mandated the VA provide health care services for women veterans who experienced sexual assault while serving in the military. Later the mandate was extended to male veterans sexually assaulted in the military. However, without routine screening for sexual assault, many victims of adult sexual assault may be unrecognized; consequently, veterans suffering sexual assault-related sequelae may go untreated by their health care providers. In 1999, the VA was mandated to screen all veteran enrollees, regardless of gender, for military sexual trauma experiences. Since 2002, 33,212 male veterans and 28,850 female veterans have been identified as reporting military sexual trauma (Department of Veterans Affairs, 2003, 2002). However, a number of intervening factors, including time constraints and stereotypical beliefs about victims of sexual assault, may influence whether health care professionals routinely screen all patients for a history of sexual trauma.

Nowhere are society's expectations of men as being strong, aggressive and avoidant of sexual contact with other men more pronounced than in the military. Combat veterans are stereotypically viewed as heroic, strong and hypermasculine. Such attributes are antithetical to stereotypical characteristics of adult sexual assault victims (e.g., weak, ineffectual, female) (Howard, 1984; Madriz, 1997; Sattem et al., 1984). Thus, common (but erroneous) clinician beliefs about who is and is not likely to be a sexual assault victim in combination with male victims' gender socialization (e.g., stigma against vulnerability, weakness and homosexuality) could lead to situations where male veterans "aren't asked and don't tell" about sexual assault (Whealin, 2004). Data highlighted above suggest that male gender and veterans' combat status should not dissuade psychiatrists from screening for adult sexual assault.

Despite growing constraints on psychiatrists' clinical time, screening for sexual trauma and consequent psychiatric sequelae among men should be routine. Screening for sexual trauma does not generally require a great deal of time and may greatly enhance clinical outcomes by leading to appropriate assessment of sexual trauma's role in a particular patient's psychiatric difficulties. Effective sexual assault screening incorporates evidenced-based screening methods and may be accomplished through the use of written, self-administered intake forms containing behaviorally specific items asking about unwanted sexual experiences. Several instruments designed to assess a wide range of potentially traumatic events, including sexual assault, are available for use by clinicians. For example, the Life Stressor Checklist-Revised (LSCL-R) (Wolfe and Kimerling, 1997) assesses for sexual trauma, high-magnitude events and broader developmental experiences (e.g., permanent separation from a child) that may be linked to psychosocial disruptions. The Post-traumatic Stress Diagnostic Scale (PDS) contains a 12-item checklist of potentially traumatic events (Foa et al., 1997). Those who screen positive for exposure to potentially traumatic events are then instructed to provide ratings of the frequency of PTSD symptoms corresponding with DSM-IV criteria.

In addition to administering brief questionnaires, questions about trauma exposure-including sexual assault-may be incorporated into the psychiatric evaluation. For health care and mental health care professionals with less experience in assessing and treating sexual assault, the VA Employee Education System has developed a military sexual trauma self-study guide that offers guidelines for successful screening strategies, potential barriers to screening and follow-up treatment strategies (Employee Education System, 2004). A Web-based version is available at <www.va.gov/vhi>.

When men disclose a history of sexual victimization, it is critical that health care professionals respond in an empathetic, nonjudgmental and affirming manner. Disclosure of sexual assault by men provides psychiatrists and other mental health care professionals with an important opportunity to dispel male rape myths for victims, offer accurate information and education about the impact of sexual assault, and discuss the availability of effective treatments, including psychotherapy, for post-assault sequelae. By routinely asking about sexual assault, psychiatrists can play an important role in identification of trauma-related psychopathology, which, if undetected and untreated, could contribute to psychiatric treatment failures. Increased awareness and understanding of male sexual assault as well as routine screening of all patients, regardless of gender, for exposure to sexual victimization or other potentially traumatic experiences, will enhance the recovery of sexual trauma survivors.

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