Psychological Services
2015, Vol. 12, No. 4, 357–365

http://dx.doi.org/10.1037/ser0000049

Don't Tell: Military Culture and Male Rape

Carol O'Brien, Jessica Keith, and Lisa Shoemaker
Bay Pines Veterans Affairs Healthcare System, Bay Pines, Florida

The issue of sexual assault that occurs during military service has been a focus of attention over the past several years. Although approximately 50% of survivors of military sexual assault are men, virtually all of the literature focuses on the assault of female service members. Research has demonstrated that cultural variables are robust correlates of the sexual assault of women. This paper proposes that cultural variables are equally important when examining the rape of men, especially when this assault occurs in military contexts. We discuss male rape myths and related constructs as they are expressed within military culture. The results of data analysis from a treatment sample of veterans with military sexual trauma (MST)-related posttraumatic stress disorder (PTSD) and clinical case examples are presented to further explore the concepts. We conclude that male rape myths and related beliefs that arise from cultural norms and are further amplified and modified by military culture impact male MST survivors and delay or obstruct their recovery. Suggestions for clinical application and future research are offered to encourage further efforts in this important area of practice.

Keywords: military sexual trauma, military culture, male sexual assault, masculinity, rape myths

The issue of sexual assault that occurs during military service has been a focus of attention over the past several years. However, virtually all of this attention focuses on the assault of female soldiers, despite the data indicating that 50% of the survivors are men. Research has clearly demonstrated that cultural variables are robust correlates of the sexual assault of women. We propose that cultural variables are equally important when examining the sexual assault of men, especially when this assault occurs in military contexts, and that more attention is needed to understand the impact of military culture on male survivors of military sexual assault.

Several terms are used to describe the experience of sexual assault, and those terms vary by context (military, Department of Veterans Affairs, civilian) and focus of attention (legal proceedings, treatment, research). We will use the term "male sexual assault" in this paper to refer to experiences in which a man receives unwanted physical sexual contact without his consent or in a situation that precludes his consent. Much of the research literature with military veterans identifies the population of interest through the use of MST screening, for which a positive response can indicate a broader range of experiences, including rape, sexual assault, and/or repeated sexual harassment experienced by the veteran during military service. The term "MST" in this paper will be used when reporting results or data derived from those studies.

Research regarding adult male sexual assault is a relatively recent occurrence, with very few publications prior to 2000, even though sexual violence against men has been documented throughout history. Even with the increasing awareness of sexual assault that occurs during military service and the Veteran Administration's focus on MST for both female and male veterans, there is scant empirical work that focuses on MST in males. For example, a 2011 review (Allard, Nunnink, Gregory, Klest, & Platt, 2011) of peer reviewed articles published up to December 2009 identified 74 articles focused on MST. Of those, only two articles focused on men only, with an additional 14 reporting gender-specific data. The majority of the remaining articles focused exclusively on women, and some gave no gender-specific data.

Much of the limited MST research literature to date has focused predominantly on prevalence rates, which show that men are at risk for sexual trauma within the context of the military. Estimates of the percentage of service members sexually assaulted during military service vary widely, depending in part on the definition of MST used, the study methodology, and the setting and population studied (Morris, Smith, Farooqui, & Surís, 2014), with estimates of the yearly incidence of male MST varying from .02% to 6% and estimates of lifetime incidence of male MST varying from .03% to 12.4% (Hoyt, Klosterman Rielage, & Williams, 2011). The rates of MST reported by veterans receiving treatment at Veterans Affairs (VA), as reported through the VA's MST universal screening procedure, are fairly similar. In 2013 there were 57,800 men (1.3%) and 77,000 women (24.3%) seen at VA who had a positive MST screen (VA national screening and treatment data, 2013). Despite the discrepancy in percentages of MST between genders, the number of males and females who report MST are quite similar

Editor's Note. This is one of thirteen articles in a special issue on Military Sexual Trauma.

Carol O'Brien, Jessica Keith, and Lisa Shoemaker, Center for Sexual Trauma Services; Bay Pines Veterans Affairs Healthcare System, Bay Pines, Florida.

This material is the result of work supported with resources and the use of facilities at the Bay Pines VA Healthcare System, Department of Veterans Affairs, Bay Pines, FL. The contents of this paper do not represent the views of the Department of Veterans Affairs or the United States Government.

Correspondence concerning this article should be addressed to Jessica Keith, PTSD Programs, Bay Pines Veterans Affairs Healthcare System, 10000 Bay Pines Boulevard, Bay Pines, FL 33744. E-mail: jessica.keith@va.gov

due to the much larger proportion of men than women in the military (Hoyt et al., 2011).

Estimating the prevalence of male sexual assault is hampered not only by variations in definitions and study methodology, but also by considerable underreporting. Sexual assault is generally considered to be one of the most underreported crimes, and male sexual assault appears particularly underreported (Kimerling, Rellini, Kelly, Judson, & Learman, 2002). Though it is acknowledged that most males who are assaulted in the military do not report their assaults, the extent of underreporting is not well understood. The Department of Defense (United States Department of Justice, 2013) estimates that 67% of women and 81% of men do not report their military sexual assaults. Estimates by the Naval Inspector General (2004) are that 66% of male sexual assaults go unreported. A 2010 study by the Defense Manpower Data Center found that 85% of military men who experienced unwanted sexual contact did not report the incident (Rock, Lipari, Cook, & Hale, 2010).

Little information is available about the causes of underreporting military sexual assault. A Department of Defense report (United States Department of Defense, 2012) included summary data from the 2012 Workplace and Gender Relations Survey of Active Duty Members in which female and male active duty service members who did not report a sexual assault were asked to select from a set of reasons for their decision not to report. Males tended to endorse items related to the consequences of reporting (punishment for other violations, decreased chance for promotion, not being believed) while females endorsed items such as feelings of discomfort and wanting to keep the assault confidential. Although not included in the survey, the male service members' concerns about the career and other consequences of reporting may, in part, reflect an awareness of cultural norms related to masculinity and male sexuality and the heightened emphasis on these expectations and possible consequences in a military environment, as we will discuss.

Few studies to date have focused on the impact of military sexual assault on male survivors or on the differences in clinical presentation between male and female survivors. Research focused predominantly on female survivors suggests that the report of MST is linked to a host of detrimental outcomes, including increased rates of PTSD (Himmelfarb, Yaeger, & Mintz, 2006), physical health problems and chronic pain (Haskell, Papas, Heapy, Reid, & Kerns, 2008; Martin, Rosen, Durand, Knudson, & Stretch, 2000), difficulty readjusting to civilian life (Katz, Bloor, Cojucar, & Draper, 2007), suicide attempts (Kimerling, Gima, Smith, Street, & Frayne, 2007), a decreased quality of life (Valente & Wight, 2007), and an overall increase in mental health diagnoses (Kimerling et al., 2007). In examining mental health diagnoses of all veterans with a positive VA MST screen, Kimerling and colleagues (2007) found that women with a positive MST screen were most likely to be diagnosed with PTSD, dissociative disorders, eating disorders, and personality disorders, whereas men were most likely to be diagnosed with suicidal behavior, personality disorders, PTSD, attention deficit hyperactivity disorder and conduct problems, dissociative disorders, and bipolar disorders.

Civilian studies of male sexual assault suggest that when compared with women, men who are sexually assaulted have significantly higher rates of psychiatric hospitalization, psychiatric symptoms, and reported distress (Kimerling et al., 2002); substance abuse (Burnam et al., 1988; Ratner et al., 2003); and self-harming behavior (Coxell, King, Mezey, & Gordon, 1999). A national representation sample of 941 male and female survivors of adult sexual assault found that male survivors reported significantly higher levels of distress in areas including sexual concerns, dysfunctional sexual behavior, externalizing activities, anger, anxious arousal, impaired self-image, and defensive avoidance (Elliott, Mok, & Briere, 2004). The National Comorbidity Survey (Kessler, Sonnega, Bromet, Hughes, & Nelson, 1995) found that the probability of receiving a PTSD diagnosis following sexual assault was higher for men (65%) than women (46%).

Research within military populations has focused on the impact of sexual harassment on male and female service members. In a sample of male and female Gulf War veterans, sexual harassment was found to have a greater impact on men's mental health than on women's mental health (Vogt, Pless, King, & King, 2005). The authors hypothesize that this is likely because sexual harassment is more unexpected and has a greater stigmatizing effect for men than for women, and thus is more detrimental (Vogt et al., 2005). A study of nearly 4,000 former military reservists found that at higher reported levels of sexual harassment, males had poorer mental health than women (Street, Gradus, Stafford, & Kelly, 2007).

Despite focused attention on MST at VA facilities, including an increased awareness of the numbers of male veterans that have experienced MST, the implementation of the universal screening tool, the provision of treatment for MST without cost to the veteran, and the implementation of specialized training for clinicians to provide evidence-based treatment for MST, the rates of men coming to and staying with treatment for MST at VA are relatively low. For example, in a report from the Office of Mental Health Operations of the Department of Veterans Affairs, Office of Mental Health Services (2011), only 38% of men, compared to 54% of women, with a positive MST screen received mental health treatment in the VA. However, this data may also reflect the differences in the availability of MST-related mental health care for male and female veterans. For example, although there are several VA residential programs specializing in the treatment of MST for female veterans, there are very few similar resources for male veterans.

A qualitative study of 20 male veterans enrolled in VA who reported military sexual assault but who had not received any related mental health care identified potential barriers. All veterans interviewed identified at least one stigma-related barrier, such as a belief that sexual assault should be kept secret, fear of intense humiliation and shame if the assault was revealed to others, shame related to a perception of not fighting hard enough during the assault, fear of disbelief with disclosure, a belief that the assault should not bother them, and fear of their masculinity or sexuality being questioned (Turchik et al., 2013). A follow-up study found that men expressed a preference for gender-targeted materials in information about MST, but receipt of such information did not increase mental health treatment seeking in the six months that followed (Turchik, Rafie, Rosen, & Kimerling, 2014).

Only one peer-reviewed article identified in our review of the literature discussed a treatment specifically for males with MST. Hoyt, Rielage, and Williams (2012) describe a three-phased group therapy treatment for men with MST and noted the lack of empirical research on the efficacy of treatment for men with MST as a whole. Of note, a component of the treatment they describe is

explicitly combating male rape myths early in treatment by providing group participants with data on the rates of male MST and the severe impact of MST on males. The authors also note how they utilize group treatment to counter the sense of male MST being a rare event and to decrease the secrecy about the nature of male MST. Their treatment works to counter myths of stoic emotional avoidance by explicitly discussing "masculine" men showing emotions. Finally, they address myths related to sexual orientation and shame-based cognitions including those about peritraumatic sexual arousal.

In summary, despite some increase in research in recent years, the literature on sexual assault during military service in males is quite limited, with most research focused on prevalence rates and almost no empirical work on clinical presentation or treatment approaches. Although some information about the impact of sexual assault on adult males in civilian contexts may apply to the treatment of males with military sexual assault, the unique impact of the military context of the assault and its influence on the presentation and treatment of males is not well understood.

Rape Myths and Military Culture

Rape myths have been a focus of research on female rape, and the research literature has demonstrated a relationship between adherence to rape myths and the propensity to sexual violence (for perpetrators) and greater distress (for the survivors) (Brownmiller, 2005; Burgess & Holmstrom, 1974). In addition, much has been written about military culture and the sexual assault of female soldiers. Authors have suggested that military sexual violence toward women is related to a culture of misogyny and homophobia in the military as seen through exclusion of women from combat, the until recent exclusion of gays from the military, and misogynistic/homophobic language and jokes (Abrams, 1993; Carmody & Carrington, 2000). One example is the regular use of insult talk during boot camp, in which drill instructors put down recruits by calling them "pussies" or "sissies," teaching them to equate women and sexual minorities with degradation (Burke, 2004).

More recently, a focus on rape myths related to male rape has emerged, with the suggestion that the prevalence of these myths underlies both victim-blaming and underreporting in males (Turchik & Edwards, 2012). It is our contention that myths about male rape may be even more pervasive and impactful in the military environment which has traditionally emphasized male toughness, aggression, and emotional control, and the presence of these myths is likely to have a profound effect on men who are sexually assaulted during military service.

"Men Don't Get Raped" or at Least "Real Men/Strong Men Don't Get Raped"

Perhaps the most commonly cited male rape myths fall into the general category that posits reasons that male rape cannot and does not occur, or more simply, that men cannot be raped. Related myths are that "real" men or strong men can fight off a rapist and that no man would allow himself to be raped without at least incurring serious injury. In the military culture, there is a strong push to take control of hostile situations as the aggressor in any battle. In the sexual arena, there is the related belief that men initiate and control sexual activities and that men are too big and strong to be assaulted (Struckman-Johnson & Struckman-Johnson, 1992).

In a study of male rape myth acceptance among 412 male and female college students, Struckman-Johnson and Struckman-Johnson (1992) reported that 23% of men and 9% of women said a strong man cannot be raped by another man, and 30% of men and 18% of women said a strong man cannot be raped by a woman. This finding is likely to be even more pervasive within the military. It may have important implications for the reporting of male sexual assault within a military culture where men are expected to be strong and much of their training is focused on the acquisition of physical and mental strength. In military settings, physical strength is celebrated and rewarded and weakness or passivity is devalued: a strong soldier is a good soldier. Service members are specifically trained in hand-to-hand combat and taught that their weapon is their most valuable possession, reinforcing the idea that to be a successful member of the military, one must be able to protect oneself and others from any intentional aggression at all times. In the military setting, the concurrently held beliefs that strong men cannot be sexually assaulted and that one must be strong to be successful would be expected to result in intense feelings of shame about sexual assault and denial and secrecy as a defense against sexual assault. Historically, male service members may have internalized these beliefs. In 2004, the Office of Naval Inspector General reported that all-male crews believed that sexual assault awareness programs were not needed because "things like that do not happen in an all male crew" (Office of Naval Inspector General, 2004, p. 29). The report also indicated that military men believed that males who were sexually assaulted are weak.

"Male on Male Rape is About Homosexuality"

Another set of male rape myths are related to sexuality and sexual orientation. There is a common belief that male rape is homosexual sex and therefore, that only homosexual men get raped and only homosexual men perpetrate rape. The related myth that is identified when considering female sexual assault is that rape is about sexual attraction (Coxell & King, 1996). This set of myths has been shown to impact reporting; for example, male rape victims report fear of homophobic reactions from police and medical providers (Mezey & King, 1989).

The military culture has clearly been slow to change attitudes about homosexuality. There has been an underlying belief that homosexuality in the military would put others at risk, including the belief that gays are perpetrators and dangerous to their fellow soldiers (Knapp, 2008). A male who is sexually assaulted by another male in the military may therefore conclude that he will be viewed as homosexual. Although being labeled as gay is no longer reason for military discharge, it continues to carry a negative connotation in the military environment.

"Male Rape Is Not Serious"

Military culture reinforces the denial and/or repression of emotional distress and expects the service member willingly to subsume personal needs for the good of the unit. It is believed that this will further unit cohesion, considered essential for the success of the military mission (Greene, Buckman, Dandeker, & Greenberg, 2010). Women in the military may see themselves as minority

members and when they are sexually assaulted, typically by a male service member, because of their minority status may not as readily see unit cohesion as something that is as salient in their decision about whether to report. A male service member, who is also most likely to be sexually assaulted by a male service member, may struggle with the responsibility to maintain the cohesion of the unit and feel a great deal of internal pressure to avoid any action that may pit him against his peer group.

A related male rape myth, that men are less bothered by rape, reinforces the military cultural pressure to deny or repress emotional distress and likely contributes to underreporting. Research has supported the existence of this myth in demonstrating the frequently held belief that men are emotionally strong and stoic so that male victims are able to "tough it out" and cope with the experience of rape (Struckman-Johnson & Struckman-Johnson, 1992). This often results in less sympathy for male survivors than for female survivors because of the belief that rape is less serious for men (Burczyk & Standing, 1989).

"A Man Can't be Raped by a Woman" or "Female on Male Rape is not Serious"

Men are even less likely to gain support or sympathy when the perpetrator is female. In fact, studies have found that 47% of men believe that men who are sexually assaulted by women get sexual pleasure from the occurrence (Smith, Pine, & Hawley, 1987). As cited above, both male and female college students were much more likely to state that a man cannot be raped by a woman versus that a man cannot be raped by another man (Struckman-Johnson & Struckman-Johnson, 1992). These beliefs may be even more prevalent in the military, with fewer women present within the ranks and the exclusion of women from many combat roles, and a related tendency to view women as conquests or those needing protection, rather than as potential threats. The idea of a man being raped by someone who is supposed to be a conquest or "weak" may be especially discordant with the strong military identity.

The Impact of Military Culture on Male MST Survivors in Treatment

The impact of male rape myths and military culture as discussed above is evident in treatment with male survivors of military sexual assault at Bay Pines VA Health Care System Center for Sexual Trauma Services (CSTS). CSTS includes a 16-bed, approximately two month, residential program that provides intensive evidence-based treatment for veterans with a history of military sexual assault. Approximately 90 male and female veterans from across the U.S., roughly evenly split and in mixed cohorts, are treated in the program each year. In addition, CSTS outpatient services provide a range of psychotherapeutic services directed toward resolving issues related to sexual trauma, with approximately 500 male and female veterans currently enrolled in the program.

As part of its intake process, CSTS gathers data on the characteristics of the veterans we treat. Veterans presenting to the PTSD programs at Bay Pines VA complete a pretreatment assessment packet including demographic, treatment, military and legal history questions, symptoms measures, and a Minnesota Multiphasic Personality Inventory (MMPI)-2 personality inventory (Butcher, Dahlstrom, Graham, Tellegen, & Kaemmer, 1989). After clinical use, data is de-identified and entered into a research database through a Bay Pines Institutional Review Board-approved research study.

To expand on our understanding of the population served, we conducted post hoc descriptive and correlational analyses using this data. Veterans with a history of military sexual assault who attended the residential and outpatient CSTS programs in 2011 and 2012 were included in the sample for this analysis. Participants included 172 male survivors of sexual assault, 76 who attended the residential program and 96 who were evaluated for treatment in the outpatient program. For comparison purposes, we examined data from the same time period for the 158 female survivors of sexual assault, 66 who attended the residential program, and 92 who were evaluated for treatment in the outpatient program, as well as 680 male survivors of combat and other military-related, nonsexual traumas being evaluated for treatment in non-MST PTSD residential and outpatient programs. In addition, we cite earlier research conducted in the CSTS residential program from 2000 to 2007 and previously published (O'Brien, Gaher, Pope, & Smiley, 2008) and presented (Keith, O'Brien, & Chavez, 2012).

"Men Don't Get Raped": Secrecy and Treatment Seeking

The belief that "men don't get raped" is pervasive among the patients we treat and often lasts decades after the assault. Men report fears about not being believed, often based on past perceptions of disbelief or rejection when they revealed the sexual assault to providers or others. Many mention that they "never" heard of a man being sexually assaulted in the military, and despite their own experiences, believe it is an extremely rare phenomena in the military. On presentation to our program, men often express surprise that they are not the only man who has been assaulted, and particularly appear surprised that other men in the program who they may perceive as strong (e.g., tall or muscular men) are also in treatment for sexual assault. The impact of the belief that men do not get raped may prevent male survivors from seeking treatment as early as female survivors. For example, our data show that male survivors, on average, present for MST-related treatment later than female survivors, with a mean age of 51.1 ($SD = 8.5$) for men versus 46.1 ($SD = 10.6$; $t = 4.5$, $p < .001$) for women. The lack of treatment options for male survivors of MST compared to female survivors of MST may further compound this delay in seeking care.

Once in treatment, concerns about keeping the secret of the sexual assault continue and may intensify. For example, during interactions with combat veterans in residential mixed-trauma educational and skills groups, male sexual assault survivors almost always keep the nature of their trauma hidden, sometimes feigning a combat history or wearing paraphernalia similar to that worn by combat veterans. Men in our residential program often note that they have hidden the reason they are attending 2-month residential treatment from others by creating stories to hide the truth, such as having surgery. Men also regularly express concerns about the sexual assault being documented in their records that other providers might access.

Phil[1] presented to the outpatient CSTS program in his late 50s, the first time he had ever sought mental health treatment despite a long history of problems, including unstable relationships and a period of homelessness. He reported worsening nightmares of a gang rape that occurred while he was in Army boot camp, but which he had tried to suppress for many years. He was tentative upon presentation, asking immediately about confidentiality. When encouraged to attend an orientation group, he dropped out of treatment. Over one year later he presented again and agreed to treatment, but reported an increasing fear that now that he reported the sexual assault, others knew about it. In his view, admitting the reality of his sexual assault was akin to admitting he was a weak man, and he was certain others would perceive this and treat him in a dismissive or threatening manner. He skipped his next appointment with a medical provider who he had seen for years, and engaged in a near-physical altercation with a burly male nurse onsite, feeling certain this individual knew about his trauma and would take advantage of him as a result, despite a lack of any evidence showing this.

"Real Men/Strong Men Don't Get Raped": Shame and Hypermasculinity

The men we treat struggle to reconcile their history of military training with sexual assault. At times, they express a belief that their manhood was stolen, and that they are no longer worthy of a military identity—one they equate with strength and masculinity. Comments that veterans with combat-related PTSD are more "deserving" of treatment are common. Male survivors of military sexual assault, on average, also report less pride in their veteran status than female survivors of military sexual assault, as well as significantly less pride than male patients in treatment for nonsexual traumas. Many of the men we treat also have histories of childhood sexual abuse, and express that they joined the military to become "strong" or to "become a man" and regain what they perceived was lost or taken as a child. The reality of the military sexual assault further reinforces to them that they are fundamentally weak and shameful as men.

A common variant of guilt experienced following sexual trauma is related to the idea that one's actions during the trauma, such as not fighting back, were not justified; this is termed "insufficient justification" guilt. The catch-22 nature of sexual assault, in which one often has to choose either to risk injury or death by fighting back (assuming this is a viable choice at all, e.g., in cases of being drugged or inescapably restrained) or deal with the consequences of not fighting back, appears to heighten conflicts related to insufficient justification (Kubany & Watson, 2003). A previous analysis of our data examined the Trauma-Related Guilt Inventory (Kubany et al., 1996) Insufficient Justification subscale, which asks respondents to indicate level of agreement with statements such as "I had good reasons for doing what I did" and "If I knew today only what I knew when the event(s) occurred, I would do exactly the same thing." This analysis showed that, controlling for age, insufficient justification guilt is significantly higher for male versus female survivors of military sexual assault (Johnson, Casto, Keith, & O'Brien, 2014). In individual therapy, men often discuss not only their beliefs that they were supposed to fight back no matter what—even when this was clearly not an option—but also their redemption-focused fantasies about the violence they would unleash on a perpetrator should they be attacked again.

"A Man Can't Be Raped by a Woman": Isolation and Avoidance

Given the myths that a man cannot be sexually assaulted by a woman, or that men would not be distressed by being assaulted by a woman, shame, secrecy, and beliefs about insufficient justification for one's action may be especially great in cases in which a male was victim to one or more female perpetrators. In our clinical experience, such survivors seek treatment only rarely, and open up about the gender of their perpetrator(s) slowly. For example, one man in residential treatment spent most of the program discussing an uncomfortable, but consensual, encounter with another male soldier, and only in the last two weeks of treatment shared his much more distressing and terrifying experience of being threatened into an ongoing nonconsensual relationship with a female superior. Men appear reluctant to disclose assault by a female perpetrator to other male survivors of military sexual assault as well, since they fear that even those survivors may react with skepticism. These survivors of assault are often among the most isolated and avoidant, disconnecting from other men—especially other male veterans—due to shame, and from women due to fear and avoidance.

"Male on Male Rape Is About Homosexuality: Sexual Dysfunction and Masculine Identity

Most of our male patients acknowledge questioning their own culpability for the assault, often reflecting the internalization of cultural norms about male sexual assault. They also may be concerned because of their own physical responses during the assault. During male rape, prostate stimulation from penetration and a parasympathetic response of erection/ejaculation may be confused with sexual orientation and result in the belief that they "must have enjoyed it." In an earlier study of 175 male and female veterans in CSTS residential care, O'Brien and colleagues (2008) found that males survivors of military sexual assault reported significantly higher levels of sexual dysfunction than females ($F = 10.83$; $p = .001$) on the Trauma Symptom Checklist (Briere & Runtz, 1989). Further examination of the sexual dysfunction scale indicated that males reported higher symptoms than females on items "sexual problems," "low sex drive," "sexual over-activity," "not satisfied with sex life," "having sex that didn't enjoy," and "sexual feelings when shouldn't have them." These veterans also improved less than female veterans as a result of treatment in the area of sexual functioning as well as in overall trauma symptom severity. Studies of civilian men with adult sexual assault have found similarly high rates of sexual functioning problems (Elliott et al., 2004; Mezey & King, 1989).

Steve, a 54-year-old heterosexual male, reported questioning his sexuality and wondering if he brought on the sexual assault for 35 years. He also disclosed that his brother sexually abused him between the ages of six and nine. During the sexual assault in the military, he experienced an erection while being sodomized and then perceived himself as "letting go of the struggle and giving in." He blamed himself for "putting off some kind of vibe" as a result of being sexually abused as a child. He also believed that during the state of

[1] The names and all identifying features of patients discussed in this article have been changed to protect the identities of these veterans.

tonic immobility, he was enjoying or at least allowing himself to be assaulted. He believed that because of the erection during the assault, he must be gay. He reported decades of hypersensitivity about his sense of manhood and homophobia, leading to aggressive behaviors when he perceived that his masculinity was questioned or threatened. He also reported loss of relationships related to occurrences of sexual dysfunction and not being able to tolerate what his female partner "might be thinking about him."

The impact of sexual trauma on one's sense of self as a man is a common topic of discussion in our men's group. Men worry about being "feminized" and seek out advice from each other about what it means to be a "real man." In one emotional disclosure by a male Vietnam veteran who was invested in his masculine persona as being an "outlaw biker," he revealed that at the conclusion of his assault and for several days after the assault, he experienced rectal bleeding from which he shamefully concluded that he "bled like a woman" and therefore was no longer a man.

As a result of questioning their sexual identities and their identities as men, many men we treat take on extreme, almost caricatured, versions of masculinity as an identity. For example, a frequent disclosure by men in our men's MST group is having hypersexual behaviors by sleeping with large numbers of women to prove their manliness and their heterosexuality.

This hypermasculine presentation is also frequently reflected in a renewed and extreme emphasis on physical strength. Interest in working out at the campus gym is high among men in the residential program, and bodybuilding has become a fixation in many of the men we treat. In our men's group, male survivors often describe physical strength as proof of manhood and a way to regain the manhood taken from them by the assault. Often, when the pursuit of physical strength is not enough, males turn to violent confrontations to prove their manhood, pushing themselves to fight the fight that they believe they should have fought during the assault. Many of the men in our program attempt to use the group therapy setting to reminisce about their violent pasts and thereby loudly assert their manhood, at times sharing graphic details of past damage done to others in fights.

John presented to the treatment program in his late 20s (earlier than most), homeless and facing an assault charge. Despite being tall, in good shape, and performing well in the military, he struggled greatly with his sense of self as a man after experiencing a sexual assault in the Marines. He reported that in the years following the trauma, he became increasingly obsessed with professional boxing, in particular, the health and work-out regimens that led to the well above-average musculature of fighters. He became convinced that his perceived "flabby" physique was a sign of his inferiority as a man, and he engaged in a series of extreme body-building regimens. He reported that despite an increased muscle mass, his self-doubts about his manhood continued, and he increasingly sought conflictual situations in which he would be able to "stare down" another man, in the hopes of regaining a sense of masculine superiority; one of these situations led to an assault charge against a man twice his age.

This focus on hypermasculinity and related physical aggression is more than bravado; a large number of men in our programs have significant legal histories. Men presenting to the CSTS programs in 2010 and 2011 showed a higher percentage of legal convictions than women ($\chi^2 = 33.4$, $p < .001$) and many of these were for violent crime. Compared to 18.5% of women, 40% of men in the program reported a history of arrest for violent crime ($\chi^2 = 16.9$, $p < .001$), and 21.4%, compared to 13% of women, reported serving prison time for a violent crime ($\chi^2 = 3.7$, $p = .05$).

"Male Rape Is Not Serious": Complex Clinical Presentations and Increased Pathology

In direct contrast to the myth that men are less distressed by sexual assault than women, civilian studies by Elliott and colleagues (2004); Kessler and colleagues (1995), and others show that sexual assault is especially traumatizing to men. This pattern appears particularly pronounced for male survivors of military sexual assault, who may struggle to reconcile the experience of sexual trauma with the military acculturation to be, first and foremost, a strong warrior. The delay in treatment seeking may further compound the difficulty of addressing and working through the impact of the sexual trauma. As a result, male survivors of military sexual assault tend to present with more severe and complex clinical presentations.

Research conducted with male and female survivors in our residential MST program from 2000 to 2007 found that not only do men have higher levels of symptoms overall (O'Brien et al., 2008), but they also tend to have more severe personality pathology as measured by the MMPI-2 (Keith, O'Brien, & Chavez, 2012). Male survivors showed significantly higher mean elevations than female survivors on MMPI-2 Scales 4–Psychopathic Deviate, 6–Paranoia, 7–Psychasthenia, 8–Schizophrenia, and 9–Hypomania. Males also had significantly higher overall mean profile elevation. With the exception of the differences on Scale 9, recently analyzed data from male and female CSTS residential and outpatients from 2010 and 2011 replicated this pattern (controlling for age due to older age of males in the sample), with significant differences on Scales 4–Psychopathic Deviate ($F = 8.0$; $p = .005$), 6–Paranoia ($F = 23.1$; $p < .001$), 7–Psychasthenia ($F = 16.9$; $p < .001$), and 8–Schizophrenia ($F = 4.3$; $p = .038$). In other words, men show greater elevations on scales suggestive of pathology related to behavioral control, relationships, and distorted thinking. Not surprisingly, this pathology tends to lead to worse treatment outcomes for males (O'Brien et al., 2008).

Clinical Applications and Future Directions

Though limited by the lack of research conducted on male survivors of sexual assault to date, our review of the literature on military culture and male sexual assault combined with our clinical experiences and preliminary data analyses reveal some important clinical implications for the treatment of male survivors of military sexual assault. We believe that while cognitive distortions related to myths about male rape are an important element of treatment, without consideration of the military context, any treatment for male sexual assault survivors will fall short.

We have discussed ways in which rape myths and related beliefs that arise from cultural norms are further amplified and modified by military culture and impact male military sexual assault survivors to delay or obstruct their recovery. This knowledge can inform treatment. For example, because of the secrecy and shame associated with male military sexual assault, survivors often present with a trauma narrative that is incomplete—that is, they only share limited information about the assault in the initial stages of

therapy. With this in mind, therapists can employ a number of strategies. A supportive but constantly curious stance can help to elicit additional information. Education about the experiences of other men who report military sexual assault can begin to normalize and open the door for further sharing about what may be some of the most difficult parts of the trauma to reveal, including peritraumatic sexual arousal or freezing rather than fighting. Watching for shame-related avoidance such as nonspecific descriptions of elements of the assault can alert the therapist to focus on these areas.

The identification with military veteran status is strong within American society; most male children and adolescents are exposed to numerous media elements that glorify the role of a soldier. For those who enlist, this identification is heightened and reinforced. It is important to remember that for many male military sexual assault survivors, their constructs about masculinity and the male role are related to the image of a "warrior." For the male military veteran, the experience of military sexual assault is often associated with a larger sense of defeat and failure to win the battle, which results in shame. Assisting the veteran to identify these constructs and process their impact is an important aspect of recovery; the ability to maintain pride in one's veteran status and separate the soldier identity from the victim/survivor identity is an important part of healing. It is also important to specifically address the military context in which the assault occurred and recognize its impact on the veteran's life. In addition, treatment interventions designed to undermine the focus on hypermasculinity that may have started in the military can be important for many male veterans. This should include a careful processing of what it means to be male, review of the individual's early learning about masculinity, identification of role models (from both civilian and military settings) that express masculinity in a variety of ways, exploration of the interplay of sexuality and masculinity, and identification of values and valued life directions that are related to male roles and masculinity.

We also need to recognize the functional and psychosocial consequences of delayed treatment for male MST survivors. Our research has demonstrated that male survivors have more severe and complex pathology. Comprehensive treatment that addresses the full range of long-term behavioral and emotional consequences of untreated trauma-related problems beyond the diagnosis of PTSD is needed, and treatment needs to be based on the expectation of recovery. In our experience, a mixed gender treatment environment along with strong gender-specific interventions (both individual and group-based therapeutic strategies that explore the impact of sexual assault on sexuality, sexual identity, masculinity/femininity, and sexual attitudes and beliefs) comes closest to creating an environment that validates the possibility of recovery and a return to a normal community-based life.

Lastly, efforts to decrease the stigma associated with male sexual assault are essential to increase reporting rates, improve access to care, and further recovery. Educational materials should include examples of male sexual assault survivors. More male treatment providers are needed within the VA health care settings. We frequently attend VA conferences and training initiatives related to the treatment of mental health issues related to military sexual assault and are surprised to find that although about half of survivors are male, virtually all of the audience is female. Our male veterans need the opportunity to experience the validation and modeling that comes from a therapeutic relationship with a male therapist.

Male-specific treatment programs within the military environment are needed to provide earlier access to care, and the provision of this care would also be a clear demonstration that the problem is acknowledged. In addition, the presence of treatment resources within the military environment would demonstrate a commitment to treating the problem so that the soldier can continue to perform his duties. This might begin with focused training for leadership, not just on the scope of the problem and the reporting mechanisms, but communication and interpersonal training designed to increase their skills at educating and supporting their subordinates as they struggle with their own culturally influenced beliefs about male sexual assault.

There are several areas of research that can potentially further our understanding and treatment resources in this important area of clinical practice. The Veterans Health Administration has a national program to disseminate training in evidence-based psychotherapy for PTSD and many MST survivors have profited from this initiative. Given the evidence that treatment results in less improvement for men than for women, it is important to study evidence-based treatment outcomes for men with MST-related PTSD. In addition, there are currently several training options specific to MST for VA clinicians. It would be helpful to determine the extent to which this training offers gender-specific training, and the impact it has on the clinical practices related to MST care for men. VA Women's Clinics have typically provided a forum for advocacy for female veterans reporting MST; do we need a similar advocacy forum for male survivors?

Further research on the impact of the military environment as it relates to male military sexual assault is essential. Men and women self-select for military service, and it is believed that the rates of childhood trauma are greater for enlistees. We have not studied the manner in which prior victim status may interact with the military environment; an increased understanding of this issue may result in identification of interventions that reduce the rates of victimization, improve reporting rates, or result in better treatment outcomes. Studies of military culture might help us to identify the specific ways in which rape myths are communicated, how they might be dispelled, and the impact they have on the likelihood of reporting and help-seeking.

The increased attention to male military sexual assault reflects the important progress we have made in the areas of education and improved treatment. We still have much to accomplish.

References

Abrams, K. (1993). Gender in the military: Androcentrism and institutional reform. *Law and Contemporary Problems, 56,* 217–241. http://dx.doi.org/10.2307/1192096

Allard, C. B., Nunnink, S., Gregory, A. M., Klest, B., & Platt, M. (2011). Military sexual trauma research: A proposed agenda. *Journal of Trauma & Dissociation, 12,* 324–345. http://dx.doi.org/10.1080/15299732.2011.542609

Briere, J. N., & Runtz, M. G. (1989). The Trauma Symptom Checklist (TSC-33): Early data on a new scale. *Journal of Interpersonal Violence, 4,* 151–163. http://dx.doi.org/10.1177/088626089004002002

Brownmiller, S. (2005). Against our will: Men, women and rape (1975). In

R. Kennedy Bergen, J. L. Edleson, & C. M. Renzetti (Eds.), *Violence against women: Classic papers* (pp. 5–8). Auckland, New Zealand: Pearson Education New Zealand.

Burczyk, K., & Standing, L. (1989). Attitudes towards rape victims: Effects of victim status, sex of victim, and sex of rater. *Social Behavior and Personality, 17,* 1–8. http://dx.doi.org/10.2224/sbp.1989.17.1.1

Burgess, A. W., & Holmstrom, L. L. (1974). Rape trauma syndrome. *The American Journal of Psychiatry, 131,* 981–986.

Burke, C. (2004). *Camp All-American, Hanoi Jane, and the high-and-tight*. Boston, MA: Beacon Press.

Burnam, M. A., Stein, J. A., Golding, J. M., Siegel, J. M., Sorenson, S. B., Forsythe, A. B., & Telles, C. A. (1988). Sexual assault and mental disorders in a community population. *Journal of Consulting and Clinical Psychology, 56,* 843–850. http://dx.doi.org/10.1037/0022-006X.56.6.843

Butcher, J. N., Dahlstrom, W. G., Graham, J. R., Tellegen, A., & Kaemmer, B. (1989). *The Minnesota Multiphasic Personality Inventory-2 (MMPI-2): Manual for administration and scoring*. Minneapolis, MN: University of Minnesota Press.

Carmody, M., & Carrington, K. (2000). Preventing sexual violence? *Australian and New Zealand Journal of Criminology, 33,* 341–361.

Coxell, A. W., & King, M. B. (1996). Male victims of rape and sexual abuse. *Sexual & Marital Therapy, 11,* 297–308. http://dx.doi.org/10.1080/02674659608404443

Coxell, A., King, M., Mezey, G., & Gordon, D. (1999). Lifetime prevalence, characteristics, and associated problems of non-consensual sex in men: Cross sectional survey. *British Medical Journal, 318,* 846–850. http://dx.doi.org/10.1136/bmj.318.7187.846

Department of Veterans Affairs, Office of Mental Health Services. (2011). *Summary of military sexual trauma-related outpatient care, Fiscal year 2011*. Washington, DC: Department of Veterans Affairs, Office of Mental Health Services.

Elliott, D. M., Mok, D. S., & Briere, J. (2004). Adult sexual assault: Prevalence, symptomatology, and sex differences in the general population. *Journal of Traumatic Stress, 17,* 203–211. http://dx.doi.org/10.1023/B:JOTS.0000029263.11104.23

Greene, T., Buckman, J., Dandeker, C., & Greenberg, N. (2010). The impact of culture clash on deployed troops. *Military Medicine, 175,* 958–963. http://dx.doi.org/10.7205/MILMED-D-10-00146

Haskell, S. G., Papas, R. K., Heapy, A., Reid, M. C., & Kerns, R. D. (2008). The association of sexual trauma with persistent pain in a sample of women veterans receiving primary care. *Pain Medicine, 9,* 710–717. http://dx.doi.org/10.1111/j.1526-4637.2008.00460.x

Himmelfarb, N., Yaeger, D., & Mintz, J. (2006). Posttraumatic stress disorder in female veterans with military and civilian sexual trauma. *Journal of Traumatic Stress, 19,* 837–846. http://dx.doi.org/10.1002/jts.20163

Hoyt, T., Klosterman Rielage, J., & Williams, L. F. (2011). Military sexual trauma in men: A review of reported rates. *Journal of Trauma & Dissociation, 12,* 244–260. http://dx.doi.org/10.1080/15299732.2011.542612

Hoyt, T., Rielage, J., & Williams, L. F. (2012). Military sexual trauma in men: Exploring treatment principles. *Traumatology, 18,* 29–40. http://dx.doi.org/10.1177/1534765611430724

Johnson, E., Casto, A., Keith, J. A., O'Brien, C. (2014, July). *Gender differences in symptoms of PTSD and guilt among Veterans with military sexual trauma*. Poster session presentation at Florida Psychological Association 2014, Bonita Springs, FL.

Katz, L. S., Bloor, L. E., Cojucar, G., & Draper, T. (2007). Women who served in Iraq seeking mental health services: Relationships between military sexual trauma, symptoms, and readjustment. *Psychological Services, 4,* 239–249. http://dx.doi.org/10.1037/1541-1559.4.4.239

Keith, J. A., O'Brien, C., & Chavez, C. (2012, August). *Military sexual trauma: What about the men?* Poster session presentation at American Psychological Association 2012, Orlando, FL.

Kessler, R. C., Sonnega, A., Bromet, E., Hughes, M., & Nelson, C. B. (1995). Posttraumatic stress disorder in the National Comorbidity Survey. *Archives of General Psychiatry, 52,* 1048–1060. http://dx.doi.org/10.1001/archpsyc.1995.03950240066012

Kimerling, R., Gima, K., Smith, M. W., Street, A., & Frayne, S. (2007). The Veterans Health Administration and military sexual trauma. *American Journal of Public Health, 97,* 2160–2166. http://dx.doi.org/10.2105/AJPH.2006.092999

Kimerling, R., Rellini, A., Kelly, V., Judson, P. L., & Learman, L. A. (2002). Gender differences in victim and crime characteristics of sexual assault. *Journal of Interpersonal Violence, 17,* 526–532. http://dx.doi.org/10.1177/0886260502017005003

Knapp, D. E. (2008). Ready or not? Homosexuality, unit cohesion, and military readiness. *Employee Responsibilities and Rights Journal, 20,* 227–247. http://dx.doi.org/10.1007/s10672-008-9089-8

Kubany, E. S., Haynes, S. N., Abueg, F. R., Manke, F. P., Brennan, J. M., & Stahura, C. (1996). Development and validation of the Trauma-Related Guilt Inventory (TRGI). *Psychological Assessment, 8,* 428–444.

Kubany, E. S. & Watson, S. B. (2003). Guilt: Elaboration of a multidimensional model. *The Psychological Record, 53,* 51–90.

Martin, L., Rosen, L. N., Durand, D. B., Knudson, K. H., & Stretch, R. H. (2000). Psychological and physical health effects of sexual assaults and nonsexual traumas among male and female United States Army soldiers. *Behavioral Medicine, 26,* 23–33. http://dx.doi.org/10.1080/08964280009595750

Mezey, G., & King, M. (1989). The effects of sexual assault on men: A survey of 22 victims. *Psychological Medicine, 19,* 205–209. http://dx.doi.org/10.1017/S0033291700011168

Morris, E. E., Smith, J. C., Farooqui, S. Y., & Surís, A. M. (2014). Unseen battles: The recognition, assessment, and treatment issues of men with military sexual trauma (MST). *Trauma, Violence, & Abuse, 15,* 94–101. http://dx.doi.org/10.1177/1524838013511540

Naval Inspector General. (2004). *NAVINSGEN sexual assault study*. Washington, DC: Department of the Navy.

O'Brien, C., Gaher, R. M., Pope, C., & Smiley, P. (2008). Difficulty identifying feelings predicts the persistence of trauma symptoms in a sample of veterans who experienced military sexual trauma. *Journal of Nervous and Mental Disease, 196,* 252–255. http://dx.doi.org/10.1097/NMD.0b013e318166397d

Office of Naval Inspector General. (2004). *NAVINSGEN Sexual Assault Study Naval Inspector General Report to VCNO*. Retrieved September 9, 2014, from http://www.governmentattic.org/2docs/Navy-Sexual-Assault-Study_2004.pdf

Ratner, P. A., Johnson, J. L., Shoveller, J. A., Chan, K., Martindale, S. L., Schilder, A. J., . . . Hogg, R. S. (2003). Non-consensual sex experienced by men who have sex with men: Prevalence and association with mental health. *Patient Education and Counseling, 49,* 67–74. http://dx.doi.org/10.1016/S0738-3991(02)00055-1

Rock, L. M., Lipari, R. N., Cook, P. J., & Hale, A. D. (2011). *2010 Workplace and Gender Relations Survey of Active Duty Members: Overview Report on Sexual Assault*. Ft. Belvoir, VA: Defense Manpower Data Center.

Smith, R. E., Pine, C. J., & Hawley, M. E. (1988). Social cognitions about adult male victims of female sexual assault. *Journal of Sex Research, 24,* 101–112. http://dx.doi.org/10.1080/00224498809551401

Street, A. E., Gradus, J. L., Stafford, J., & Kelly, K. (2007). Gender differences in experiences of sexual harassment: Data from a male-dominated environment. *Journal of Consulting and Clinical Psychology, 75,* 464–474. http://dx.doi.org/10.1037/0022-006X.75.3.464

Struckman-Johnson, C., & Struckman-Johnson, D. (1992). Acceptance of male rape myths among college men and women. *Sex Roles, 27,* 85–100. http://dx.doi.org/10.1007/BF00290011

Turchik, J. A., & Edwards, K. M. (2012). Myths about male rape: A literature review. *Psychology of Men & Masculinity, 13,* 211–226. http://dx.doi.org/10.1037/a0023207

Turchik, J. A., McLean, C., Rafie, S., Hoyt, T., Rosen, C. S., & Kimerling, R. (2013). Perceived barriers to care and provider gender preferences among veteran men who have experienced military sexual trauma: A qualitative analysis. *Psychological Services, 10,* 213–222. http://dx.doi.org/10.1037/a0029959

Turchik, J. A., Rafie, S., Rosen, C. S., & Kimerling, R. (2014). Preferences for gender-targeted health information: A study of male veterans who have experienced military sexual trauma. *American Journal of Men's Health, 8,* 240–248. http://dx.doi.org/10.1177/1557988313508304

United States Department of Defense, Sexual Assault Prevention and Response Office. (2012). *Annual report on sexual assault in the military*. Retrieved from http://www.sapr.mil/public/docs/reports/FY12_DoD_SAPRO_Annual_Report_on_Sexual_Assault-volume_one.pdf

United States Department of Justice. Bureau of Justice Statistics. (2013, March). *Special report: Female victims of sexual assault 1994–2010*. Retrieved from Department of Justice, Bureau of Justice Statistics website: http://www.bjs.gov/content/pub/pdf/fvsv9410.pdf

Valente, S., & Wight, C. (2007). Military sexual trauma: Violence and sexual abuse. *Military Medicine, 172,* 259–265. http://dx.doi.org/10.7205/MILMED.172.3.259

VA national screening and treatment data. (2013). Retrieved from VA MST Resource Intranet.

Vogt, D. S., Pless, A. P., King, L. A., & King, D. W. (2005). Deployment stressors, gender, and mental health outcomes among Gulf War I veterans. *Journal of Traumatic Stress, 18,* 115–127. http://dx.doi.org/10.1002/jts.20018

Received September 15, 2014
Revision received May 19, 2015
Accepted July 4, 2015 ■