MALE SEXUAL ASSAULT: AN
EXPLORATION OF MEN SEXUALLY
ASSAULTED IN THE OPEN COMMUNITY
AND THE INFLUENCE OF HEGEMONIC
MASCULINITY

By

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A thesis submitted
to the Faculty of Graduate Studies and Research
in partial fulfillment of
the requirements for the degree of

Masters of Arts

Department of Sociology and Anthropology
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Department of Sociology and Anthropology

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CARLETON UNIVERSITY

ABSTRACT

MALE SEXUAL ASSAULT: AN EXPLORATION OF MEN SEXUALLY ASSAULTED IN THE OPEN COMMUNITY AND THE INFLUENCE OF HEGEMONIC MASCULINITY

by Mark D. Jarvis

Chairperson of the Supervisory Committee:
Professor Katharine Kelly,
Department of Sociology and Anthropology

This study examined the sexual assault of adult men (males 16 years of age and older) in the community; it is the second study to examine this issue in a Canadian context. The main goals of this study were to identify: (a) traits of survivors and of sexual assaults of adult males in the community, (b) the influence of common understandings of masculinity in the sexual assault of adult men. Specifically, this study examined how hegemonic masculinity impacts MSA survivors' understanding of themselves as men and of their assault and influences their post-assault responses and behaviours. Part of this objective will be to identify the special needs that this creates for MSA survivors, who seek counseling as part of their recovery process. Twenty counsellors from Ontario, Alberta, and British Columbia, identified via snowball sampling, were interviewed. They provided data on 156 survivors. This study indicates that: (a) the survivors ranged from 16-71 years of age and the majority of counsellors identified that the majority of survivors that they worked with self-identified as being homosexual or bisexual, having been sexually abused in childhood, and having been assaulted by a known attacker. Known attackers were most likely to be partners, dates, employers, and family members. (b) that the traits associated with hegemonic constructions of masculinity strongly influence the understandings, responses and behaviours of male survivors of sexual assault, regardless of sexual orientation, including conceiving themselves to be less of a "man", questioning their sexual orientation (heterosexual survivors), minimizing emotions, blaming themselves for failure to be "in control" and high levels of stigma and shame and homophobia. A key finding of this study was the role that survivors' understandings and orientations towards dominant ideologies of masculinity play in hindering the survivor's ability to disclose their sexual assault experience. Reluctance to disclose begets difficulty seeking and maintaining formal and informal mechanisms of help and willingly communicating their feelings and needs. Given the diversity of experiences that men assaulted as adults have, attempts to provide survivors with appropriate help is difficult. Programmes should be sensitive of this diversity in planning. Adult male survivors of

sexual assaults in the community share some common programming needs with survivors of other kinds of trauma, including adult females who survive sexual assaults. However, they also have additional distinct needs. Ignoring these distinctions is problematic. In conclusion, in addition to highlighting significant findings and concerns, this study raises questions that need be addressed in forthcoming research to further facilitate access to, and efficiency of, all forms of help. The most pressing of which is to engage survivors in creating and implementing appropriate measures of outreach and help.

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Introduction

Most of us think of rape as something done to women by men. We sometimes allow the fact of prison rape to enter into our conscious minds, but we rarely delve deeply into the implications and complexities of even this scenario wherein men rape men. We are even less likely to think about male-on-male rape in the military, religious communities, sports organizations, college fraternities, or between warring armies. We certainly do not give a lot of thought to male-on-male rape in our neighborhoods, among people "like us". Nor do most of us think about the possibility of date rape between two gay men and certainly not about the possibility of a heterosexual man raping another man (King, 1990, 710).

Hegemonic constructions of masculinity perpetuate an understanding of men that suggests that being a 'real man' is to be invulnerable and not victimisable. Hegemonic constructions are powerful social forces in the day-to-day lives of men. They serve as beacons from which men navigate their social existence. The experience of male sexual assault (MSA) is irreconcilable with these standards – MSA survivors transcend traditional understandings that construct men as invulnerable and impenetrable. In the absence of a mainstream discussion of MSA, men who are sexually assaulted are left in a state of abandon – they are unable to meet the standards that establish their masculinity and are unable to socially locate themselves among a general population of 'survivors.'

Traditional studies of rape and/or sexual assault¹ have examined female and/or children as survivors. This has narrowly focused the way that we think about sexual assault.

Historically children and women have, and to varying degrees, continue to be regarded as

¹ General definitions of rape and sexual assault refer to forced or non-consensual sexual acts perpetrated against a person. More specific definitions of these terms are ground in law and as such vary by jurisdiction. The Criminal Code of Canada now uses the term sexual assault rather than rape. The term rape is used, more specifically, to refer to forced sexual

being vulnerable to sexual assault. Vulnerability to sexual assault has traditionally been calculated as a complex interaction between understandings of gender, behaviour and physiological differences. In the case of children, in addition to being considered to be physically vulnerable, they are also regarded as being naïve and innocent. This is generally rooted in the belief that children are considered to be intellectually immature and therefore more susceptible to being manipulated by a potential perpetrator (Scarce, 1997a: 20)².

Much of our understanding of how and why women have been constructed as vulnerable to sexual assault has resulted from research and analysis based in the feminist tradition. Early works on sexual assault often dealt with sexual assault as an unavoidable circumstance of women's lives (Marcus, 1992: 387). Although this perspective continues to be espoused in some more contemporary works, more recent work has focused on fighting to extinguish sexual assault from the lives of women.

For instance, according to Sharon Marcus' (1992:389) work "Fighting Bodies, Fighting Words: A Theory and Politics of Rape Prevention", the vulnerability of women to sexual assault results from women limiting themselves to acting within the confines of traditional feminine characteristics³. Marcus (1992: 388) realizes that many of the standard interventions related to sexual assault either prescribe post-assault actions or rely on

penetration. Whereas, the term sexual assault is a more encompassing term, used to refer to any form of sexual contact without voluntary consent. This will be further discussed in the next chapter.

² The research that differentiates the sexual assault of an adult from the sexual abuse of a child generally uses a range of age of 16 to 18 to differentiate childhood from adulthood (Isely and Gehrenbeck-Shim, 1997; Stermac et al., 1996; Mezey and King, 1989).

³ Vulnerability is certainly not to be confused with responsibility. Neither Marcus' argument, nor this interpretation of it, is meant to infer that victims are responsible for sexual assault.

attempting to “persuade men not to rape”. These interventions withhold the power of self-determination from women. For Marcus (1992: 388), one of the keys for women to protect themselves from being raped is to physically escape feminine restrictions on behaviour – “to intervene, overpower and deflect the threatened action”.

The same interactions of gender understandings, behaviour, and physiological differences that withhold power from women also contribute to empowering men. Where traditional feminine qualities contribute to the vulnerability of women, traditional masculine qualities contribute to an ideal of male invincibility. For Marcus’ (1992, 389) understanding of rape, it is this power - expressed in sexuality - that women need to overcome to end rape.

Although Marcus’ (1992) understandings of sexual assault may adequately represent the experiences of women, when one considers men who are sexually assaulted, Marcus’ interpretations appear to be inadequate. As a result, interpretations of sexual assault, such as that of Marcus’ (1992), which fail to consider MSA, need to be re-examined and re-questioned to discover if and how they can be reconciled with the experiences of survivors of MSA.

Isely and Gehrenbeck-Shim (1997: 160) define MSA as “any non-consensual sexual acts perpetrated against a man, 16 years of age or older, by a male or female.” Adopting this definition, this thesis focuses on MSA in open-society as opposed to closed, single-sex populations such as prisons. As a review of the past literature will demonstrate, only a small body of research has been conducted to investigate MSA – only 20 research studies

have collected any data on MSA, and only one book has been published. Like most social phenomena, MSA is very complex, interwoven with many different themes, issues and patterns. The small amount of analyzable data that is available restricts our ability to gain a precise body of knowledge of MSA. MSA is an important and relevant topic of sociological investigation for a number of reasons.

First, there is a need to address the lack of understanding of this phenomenon. Feminist research and theoretical perspectives have provided an important theoretical framework of sexual assault that can be extended to the study of MSA. An improved understanding of MSA can also help us to improve our understandings in other areas, including our general understanding of sexual assault and our understandings of gender and gender relations, in particular. Understandings of MSA move us to rethink narrowly focused theoretical perspectives and social constructions. More detailed knowledge of MSA will support and reinforce some aspects of our current understandings of gender and sexual assault, and challenge others – these are important aspects of knowledge production. Second, through a greater understanding of this issue we can also increase and improve the techniques available to assist MSA survivors in their healing process.

Although MSA is an understudied social phenomenon, there has been a clear increase in research in recent years. This existing body of published research has provided us with a strong foundational understanding of MSA from which to launch further research, including a number of emerging patterns and trends in the findings of prior research (see Literature Review).

The original objective of this study was to study MSA survivors directly. However, this was not logistically possible and the decision was made to focus on interviewing Canadian counsellors who had experience working with MSA survivors. The switch from interviewing MSA survivors to counsellors reflected the difficulty faced in gaining access to a sample of appropriate size to participate in the study.

The present study has two objectives. The first is to present an exploratory examination of the characteristics of MSA and MSA survivors. The second goal is to examine the role that common understandings of masculinity play in MSA. Specifically, the study will explore how hegemonic masculinity impacts MSA survivors' understanding of themselves as men and of their assault. This will include an examination of how hegemonic masculinity influences their post-assault responses and behaviours. Part of this objective will be to identify the special needs that this creates for MSA survivors who seek counselling in their recovery process.

In order to meet these goals, the body of this paper is divided into four chapters. Chapter One of this work is a review of the literature relevant to this study. This chapter will review past and current literature on sexual assault, gender, masculinity and MSA (including the focus and findings of previous research).

Chapter Two will present a detailed examination of the methodology used in this study. This will include an examination of the sampling technique, the interviews and their

structure, as well as characteristics of the individuals who participated in the interviews and the ethical safeguards used in the study.

Chapters Three and Four of this paper will present the core findings of the study. Chapter Three will summarise, in the experiences of the 20 interviewed counsellors, characteristics of MSA. Given the limitations of this study, these findings are not meant to provide a definitive description of MSA. Rather, it looks to highlight some of the more important factors that characterise MSA. Chapter Four will then present an exploration of the responses of MSA survivors to being sexually assaulted. This section will specifically examine the effects that hegemonic masculinity has on the understandings, responses and behaviours of MSA survivors. This includes the decisions of survivors to seek “help”, in a variety of forms, and their orientation to, and expectations of, counselling as told to the counsellors. This chapter will, in this process, look to highlight some of the special needs of MSA survivors that counsellors identified.

The Conclusion will present an understanding of MSA based on the literature review and the findings of this study. The Conclusion will also identify questions/issues that have arisen in the context of the research and provide suggestions for the type of research that will move our understanding of MSA forward.

Chapter One

REVIEW OF PAST LITERATURE

A theoretical understanding of MSA currently remains in the early stages of development. In the absence of a discussion of male victimisation within the theoretical literature, we rely heavily on feminist theoretical understandings of sexual assault and victimization as they relate to women. MSA could conceivably be located within a feminist discussion of power, inequality and subordination. However, currently MSA remains outside the boundaries of the mainstream feminist discussion of sexual assault. The following chapter will review the pertinent research and theoretical literature in an attempt to further our understanding of MSA.

This chapter will begin by defining MSA and then turn to an examination of the current body of published research, its findings and its limitations. It will then shift to an examination of our understandings of sexual assault and rape and their implications for understanding MSA. The third section of this literature review will examine our discursive understandings of gender and their implications for how we understand sexual assault and vulnerability to sexual assault. This will include a feminist analysis of power dynamics and inequality as they relate to an understanding of male victimisation in the context of patriarchal social structures.

Defining Male Sexual Assault

MSA encompasses the sexual victimization of adult men in any location by any perpetrator(s). Although existing research on MSA has been focused primarily on the sexual assault of men in prison or other single sex populations, it is important for us to note that MSA is not limited to these settings. Indeed, MSA happens to men who live in the open community. The definition of MSA used in this study, “any non-consensual sexual acts perpetrated against a man, 16 years of age or older, by a male or female” (Isely and Gehrenbeck-Shim, 1997: 160) is widely used throughout the sociological literature on the topic. A small number of studies have used a variation of this definition that limits MSA to those 18 years of age or older. This is an inclusive definition that recognises that any man, regardless of their sexual orientation, can be the target of sexual victimization (Lipscomb, 1992: 3064). It also recognises that a wide range of possible perpetrators – both gay and heterosexual men and women – commit MSA. Further, this definition is also inclusive in terms of the range of sexual acts, such as sexual touching, and oral and anal rape, that MSA encompasses.

The Current State of Research on Male Sexual Assault

It is impossible to provide a valid estimate of the prevalence of MSA in the community. First, the fragmented body of research that has been conducted and the lack of any large-scale representative sample studies do not provide a suitable foundation from which to make a valid or reliable estimate.

Second, even if a large-scale study with a representative sample had been conducted, it would rely on MSA survivors to come forward to participate. Numerous studies have shown that female survivors are often reluctant to come forward to report their sexual assault (Kaufman et al., 1980: 223). Although some of the reasoning may be different, the current literature suggests that MSA survivors may be even more reluctant to do so (Donnelly and Kenyon, 1996: 447; Kaufman et al., 1980: 223; Brochman, 1991: 41). This reflects hegemonic constructions of masculinity that position 'real' men to be invulnerable and rarely in need of emotional or physical assistance. Hegemonic conceptualizations are powerful social forces. A man who openly admits that he has been sexually assaulted is admitting that he does not meet these rigorous standards and consequently is not a "real" man.

In the context of patriarchal society, it is also difficult to paint an accurate picture of what MSA "looks like". MSA is undoubtedly a complex phenomenon laden with numerous themes, issues and patterns, and the lack of research restricts the ability to adequately analyse each of these. However, the literature allows us to conceive at least a foundational understanding of the nature of MSA.

An in-depth review of the literature found 20 studies that have collected at least some data on the sexual assault of adult men in the open community. However, of these, two provided a glimpse of information on MSA in the context of a study of sexual assault more generally. Unfortunately in these studies only very small amounts of information were

broken out specifically on MSA. In addition, three more of these studies focused exclusively on the sexual assault of either gay (two) or heterosexual (one) men.

The remaining 15 studies that examine MSA directly have serious limitations that hinder our ability to generalise their findings. These studies provide varying depth in their analysis, are all plagued by either a very small sample size and/or by their methodology (i.e. many recruited a narrowly focused sample of MSA survivors). These studies have primarily been conducted in England and the United States, with one study having been conducted in Canada. Ten of these studies were undertaken since 1987.

Within the same time frame a number of other studies attempted to gain a perspective on the prevalence and/or nature of sexual assault – ‘generally’ – disregarding the existence of MSA by not inquiring about it. For instance, Koss’ 1988 study of sexual assault in higher education institutions, though innovative in the context of its examination of sexual assault, inquired of men only about their sexually aggressive behaviour and failed to ask about the possibility that men are also victims of sexual assault.

The sociological research offers a varied perspective on MSA through the use a number of respondent-recruitment methodologies. Eight studies recruited participants through medical-based (hospital and non-hospital, mental and physical programs) services. Three studies recruited participants from sexual assault (non-medical based) counselling services. Two studies recruited participants from law enforcement agencies and one, each, recruited

through newspaper advertisements and private counselling practice. This variance in sampling methods also creates difficulty in comparing findings among the studies.

The existing literature on MSA has focused on a number of key variables in the analysis of this phenomenon. With the exception of only a few, the majority of these variables are the same as those at the heart of the analysis of “traditional” sexual assault. These variables include the number of perpetrators; survivor/perpetrator relationship; survivor/perpetrator demographics such as age; nature of the assault; the use of physical violence (including a weapon); physical injuries suffered by the survivor; location of assault; disabilities at the time of attack; and intoxication. Other variables, namely, survivor/perpetrator sexual orientation and the sex of the perpetrator, have also become prominent in the analysis of MSA.

The use of very different samples and recruitment methods (e.g., clerical versus newspaper) have resulted in conflicting, as well as, similar results. Further, particular studies, such as Isely and Gehrenbeck-Shim, have been able to present findings based on much larger samples of survivors, and as a result are relied on more heavily herein. These studies are almost exclusively non-random and as a result are not likely to be representative. Further, the results of those studies with particularly small samples must be generalized with caution. In those instances where similar results have been achieved, particularly across sample and methodological differences, we are able to be more confident in these findings. Some of these patterns and trends are discussed below. For more information regarding the findings of the existing body of research on MSA refer to Appendix A.

Findings in the Literature: Patterns and Trends

An analysis of the past literature devoted to MSA suggests the emergence of two distinct patterns. The first pattern depicts MSA in a fashion that is reconcilable with more “traditional” accounts of sexual assault. In this pattern or ‘typology’, a homosexual individual is assaulted by a ‘pick-up’, date or partner of the survivor. Although some differences may be noted, this pattern of MSA can seemingly be understood in similar terms as the sexual assault of a woman by a known man, commonly referred to as “date rape” (Stermac et al., 1996; Mezey and King, 1998; Isely and Gehrenbeck-Shim, 1997). The reconciliation of this pattern of MSA with understandings of “date rape” is made easier given that homosexual men are often socially constructed as having many of the same characteristics as women – “flighty, nervous and neurotic” (Adams, 1993:174).

A variation in this pattern, one that is less commonly discussed in the literature, is the sexual assault of a heterosexual adult male by a female “pick-up”, date, partner or spouse. Struckman-Johnson and Struckman-Johnson (1994), in a study of forced and coerced sexual experience among college males in the United States, found 69 out of 204 males in this survey reported a range of forced or coerced sexual experiences such as forced or pressured sexual touch or intercourse. Among those 69 males, 49 reported that the incident in question was committed by a lone female, 90 percent of whom were known to the survivor. In the cases that included intercourse, more than half were the intimate partner or a casual acquaintance, including dates or “pick-ups”, of the respondent. In another 12

incidences the assault was committed by female and male perpetrators (Struckman-Johnson and Struckman-Johnson, 1994: 95).

Struckman-Johnson and Struckman-Johnson's study stands as the only study that has identified a higher rate of female than male perpetrators⁴. This may reflect either an increased likelihood of female perpetrators among the narrow sample of male college students or increased openness to discussing this particular pattern of MSA among this sample, or both. This pattern of MSA would appear to be similar to "date rape" in the heterosexual context. However, given the reversal of roles – a female assailant and a male victim – hegemonic constructions of femininity and masculinity would be challenged here.

The second pattern of MSA is the assault of typically young, heterosexual, white males by other young, heterosexual, white males (Hodge and Canter, 1998; Isely and Gehrenbeck-Shim, 1997). As noted above, with the exception of Struckman-Johnson and Struckman-Johnson, all other studies have found that heterosexual men are more likely to be assaulted by a male perpetrator. This pattern of sexual assault is also more likely to involve multiple assailants and be physically violent or involve physical violence (Hodge and Canter, 1998: 236; Isely and Gehrenbeck-Shim, 1997: 163). This pattern of MSA is clearly not parallel to any other patterns of "traditional" sexual assault.

⁴ Of those studies that examine MSA in a general manner i.e. that do not limit their study to examine solely the MSA of heterosexual men such as Busby and Compton (1997) who examined patterns of sexual coercion of adult men in heterosexual relationships.

Stermac, Sheridan, Davidson and Dunn (1996) conducted the only Canadian study to date. Their study compiled a database of the survivors' description of themselves, their assailants and their assaults at the time that the survivors presented to a sexual assault trauma centre at a Toronto hospital. At the time of the publication of the findings, the database contained information on the assault of 29 men between the ages of 18 and 65. These men all presented themselves to the unit in a 16-month period between January of 1992 and April 1993 where they were able to attain short-term professional counselling if they wished. It is important to note that what may appear to be a very low prevalence of MSA may more accurately reflect underreporting.

Rape and Sexual Assault

The existing literature on MSA has generally not been situated within the larger body of research and literature on sexual assault. Further, the lack of recognition of MSA within the mainstream literature on sexual assault has contributed to the current lack of awareness of MSA. Our understanding of MSA is certainly influenced by the understandings of sexual assault expressed in the mainstream literature on sexual assault. It is, therefore, important to examine our current understandings of sexual assault and rape and the development/evolution of these social understandings, to gain a better comprehension of how MSA is understood.

Generally, the terms rape and sexual assault are used interchangeably to refer to forced or non-consensual sexual acts perpetrated against a person. More specific definitions of these

terms are grounded in law and as such, vary by legal jurisdiction. Rape is generally used to refer to forced vaginal penetration. Feminist literature in the mid-1970s shifted the discussion which concentrated on rape to a more encompassing recognition of a stream of offences, referred to as sexual assault, which included any unwanted form of sexual contact.

Statutes in almost all legal jurisdictions have, until recently, focused on rape as opposed to the more encompassing sexual assault. Laws focused on rape do not embody the experience of MSA survivors. Keane et al. (1995) examined the consequences that these narrowly focused laws held for MSA survivors in the United Kingdom. Prior to 1994, sexual assault statutes in the United Kingdom concentrated solely on vaginal penetration.

Similarly, Canada in 1983, through Bill C-127, changed the Canadian Criminal Code statutes shifting the focus from rape to sexual assault, defining three categories of sexual assault. This change opened the door to recognizing a broader range of victimization. Schissel (1996: 124) accounts for changes to the Criminal Code as arising from successful lobbying efforts by women's groups to improve the status of women while seeking gender equality across Canadian laws. Bill C-127 also removed the gender specific language of the former law allowing for men to be considered as sexual assault victims (Schissel, 1996: 123). However, it is important to note that these changes were not likely made to be more responsive or sensitive to men who were sexually assaulted.

The focus of historical sexual assault laws on vaginal penetration marginalises the experiences of men who have been sexually assaulted. Their experiences are located outside of the boundaries that limit sexual assault solely to the experiences of women. If a man was interested in pursuing criminal action against an assailant, such action could only have possibly been pursued on the charge of either "non-consensual or consensual buggery", a law used to criminalize homosexual activity rather than sexual assault (Keane et al., 1995: 95). By not allowing male survivors to access the same legal remedies as female sexual assault survivors, male victims were discounted as actual victims of sexual assault – men were unable to meet the criteria for having been sexually assaulted. These laws implied that any man who claims to have been attacked is not a 'straight or 'real' man but a homosexual, effectively defining MSA as a homosexual activity (i.e. anal-penetrative intercourse) and shifted the focus from the assault to the supposed 'unnatural' or 'sinful' act (Keane et al., 1995: 95). Although the shift to new legislation has allowed males to access the legal remedies for sexual assault, they still are located in a cultural context that denies their vulnerability and does not recognize them as 'at risk'.

Discursive Understandings of Gender

In order to improve our understanding of MSA it is important to examine discursive understandings of gender as they relate to our understanding of men and women. A predominant aspect of this is to examine the attribution of characteristics and traits that stipulate what behaviors and actions are appropriate for each gender. These constructions

are communicated through dominant conceptualizations of femininity and masculinity (Poon, 1993: 254).

Table 1 summarizes some of the stereotypical characteristics and traits traditionally attached to gendered understandings of women and men in western culture. According to the feminist theoretical perspective, the subordination of women has developed throughout history via a complex arrangement of societal institutions, social structures and commonly held myths and beliefs systems that divide power along the lines of gender (Scully, 1991: 49). Hegemonic construction often positions these traits as innate differences between the sexes rather than the gendered constructions that are socially attached to men and women (Scully, 1991: 49). When the characteristics traditionally associated with masculinity and

Table 1: Common Gender Traits Assigned Within Western Patriarchal Cultures⁵

Men	Women
Masculine	Feminine
Logical & rational	Illogical & irrational
Knowledgeable/Objective	Intuitive/Subjective
Reasonable	Hysterical
Strong/Powerful	Weak/Frail
Emotionally obscure	Emotionally vulnerable
Dominant	Castrating
Mature/Adult-like	Immature/Child-like
Possessive	Controlling
Autonomous/Independent	Needy/Dependent
Leader	Follower
Active	Passive
Able to overcome obstacles	Thwarted by obstacles
Competitive	Non-competitive
Goal-directed/productive	Process-oriented/less productive
Requesting help = unmanly	Requesting help = being a woman
Denial of fear	Acceptance of fear
Dignity in the face of tragedy	Strain/weariness in face of tragedy

⁵ Taken from Struve, Jim "Socialization and its Impact on Male Survivors of Sexual Abuse." Available at <http://www.nomsv.org/articles/social.html>.

femininity are laid out side-by-side, as they are in Table 1, it is apparent that these characteristics are dichotomously polarized. These stereotypical characteristics clearly construct an ideal of women as subordinate and men as superordinate. Although not all women possess the characteristics that are associated with femininity – they are a social creation of gender, not a trait of sex – these characteristics nevertheless impact strongly on the lives of those women who do not meet the ideal standards. Instead of being subordinated by aligning themselves with the actual characteristics, women are often marginalised for being “different”, and their experiences are discounted as unrepresentative, unattractive, and not normal.

The powerful and aggressive characteristics attributed to masculinity are positioned to take advantage of the constructed feminine weakness. In addition to the characteristics listed above, men are believed to be heterosexually insatiable. Women, on the other hand, are constructed as naturally sexual beings that provoke masculine sexual urge and are charged with the responsibility of fulfilling these needs. While seemingly out-dated in some regards, these dichotomous, polar-opposite characteristics continue to influence behaviour and understandings and remain useful for understanding gender dynamics.

Although the hegemonic ideals of femininity and masculinity are powerful, influencing the perceptions and expectations of individuals, they represent a social location that is impossible to arrive at. Further, hegemonic constructions of gender are not static; they are formed and re-formed through continuous social interaction (Connell, 1995: 35). Connell

(1995: 3) is to-the-point in his observation that these concepts are often incoherent, intangible and lacking precision. As such, they are irresolute and “politically fraught”.

Masculinity

Although the benefits of masculine privilege are still readily evident today, not all men share equally in these benefits (Haddad, 1993: xii). Past research has documented that variables such as economic class, race and sexuality have resulted in different experiences of ‘what it is to be a man’, and that differently located men experience and live different masculinities (Connell, 1995: 36). The formation of different masculinities is not limited to visible differences in attributes. Differing masculinities can emerge even in relatively homogenous cultural and institutional settings such as public and private schools (Connell, 1995: 36-37). Thus, not even all white heterosexual men experience male privilege in the same manner.

Connell (1995: 37) calls for the need to understand that a number of different ‘masculinities’ exist and interact with each other. These interactions serve to align, subordinate and marginalise differing forms of masculinity depending on their relationship to the hegemonic construction existing in the space and time in question (Connell, 1995: 37). The form of masculinity that assumes a dominant position in a certain social location is quite often physically and emotionally unachievable by those individuals who attempt to meet its standards (Connell, 1995: 78).

The dominant form of masculinity is able to attain a privileged position within that space, often based on its alignment with the power structures in a certain locale (Connell, 1995: 77). The ability of a particular form of masculinity to establish legitimacy and power to influence other forms of masculinity is tied to its ability to create a wide ranging network of human and non-human allies that attempt to provide a uniform image of what it is to be a 'man' (Connell, 1995: 77). The standards of the hegemonic construct are often portrayed in the media through characters as representing the "norm", such as both advertising and the entertainment attractions that deliver an audience for the advertising. These 'standards' are examples of the non-human allies used to reinforce hegemonic constructs, that support the imbalances in power that they create, and thereby generate consent to the status quo.

Connell (1995: 77) recognises that the dominance of any one form of masculinity, in a particular space and time, is conditional on its ability to maintain its alignment of power and ward off challenges that attempt to reshape what the dominantly held understanding of masculinity encompasses. The characteristics associated with a dominant form of masculinity constantly evolve as a consequence of internal challenges from the different competing masculinities that exist, as well as, external challenges, such as femininity (Connell, 1995: 77).

According to Connell (1985: 77), the majority of dominant forms of masculinity from the recent past have been formed as a response to challenges to patriarchal power and attempts to legitimise the ability of men to be dominant figures. As a result, the dominant forms of masculinity woven into the fabric of western society foster traditional societal attitudes that

"real men" are impenetrable. Although the standards of dominant masculinity have become increasingly flexible, they nevertheless continue to dictate that to be a "man" is to be brawny, muscular, strong, brave, courageous, and powerful. In addition, hegemonic standards of masculinity continue to be tied to heterosexuality (Kinsman, 1993: 5).

It is important to recognise that Connell (1995) does not assume that all men will subscribe to, or attempt to meet, the dominant form of masculinity. Rather, Connell (1995: 37) argues that even those individuals who completely absolve themselves from attempting to reach the dominant standards do not escape the power of these standards. Those who reject the dominant standards must either establish an alternative programme from which they can substantiate themselves as masculine or they risk being classified as not meeting the standards of what it is to be a "man" (Connell, 1995: 37). The consequences of this with respect to sexual assault are explored below.

Implications of Discursive Understandings for Sexual Assault

Sexual assault has traditionally been understood to capitalise on the imbalances of power constructed by hegemonic conceptualisations of femininity and masculinity and acts as a tool to maintain and perpetuate the subordination of women in society. However, this understanding does not take into account how MSA is used to create and reinforce imbalances within masculinity. This is reflected in our social and academic understandings of vulnerability to sexual assault, the ways in which sexual assault is used as a form of social control over women, and the traumatic impact of sexual assault.

Vulnerability to Sexual Assault

Hegemonic constructions of gender have influenced the way that we think about who is vulnerable to sexual assault. In their examination of the gender differences in perceived vulnerability to sexual assault, Burt and Estep (1981: 511) found that “adult women report much higher levels of both warnings and fear of sexual assault than either their adult male counterparts, or than they themselves felt as children”. They reported that the fear and threat of sexual assault is instilled in women, as they become young adults, compared to men who were found to not have an entrenched sense of sexual vulnerability (Burt and Estep, 1981: 520). Men were found to have received virtually no warning of sexual victimization through their childhood, adolescence and adulthood⁶ (Burt and Estep, 1981: 512).

Fear of sexual assault restricts women from being fully active citizens in their communities (Donat and D’Emilio, 1998: 41). Burt and Estep (1981: 511) concluded that messages of vulnerability are strongly reinforced among women “to control their behaviour either keeping them passive, dependent and restricted or blaming and punishing them if they become victims”.

In addition to acting as a mechanism of social control over women, the denial of the existence of male vulnerability has consequences for men and the way that we understand

sexual assault. First, as men receive limited messaging that they could be sexually victimized, they are unlikely to take any precautions to protect themselves (Laurent, 1993: 19). Second, hegemonic constructions of gender have shaped an understanding of sexual assault that excludes men as potential victims by denying that they are vulnerable to sexual assault. Men who claim that they have been sexually assaulted risk being marginalized as less manly. As a result, MSA survivors are forced to socially locate themselves outside of the boundaries that define what it is to be a man.

Sexual Assault and the Social Control of Women

Hegemonic masculinity has shaped an understanding of sexual assault as a “woman’s problem”, by constructing men as invulnerable to sexual assault. In addition, hegemonic conceptualizations of gender also define the way that men and women interact. The feminist movement has focused on how the perpetuation of an image of women as vulnerable grounds what is believed to be the appropriate manner for women to act and be acted towards.

Violence against women has been one of the central issues of the feminist movement since the late 1960s. The women’s movement provided help to survivors and waged public education campaigns focused on gaining rights for women who were survivors of sexual assault (Scully, 1991: 34). The need to mobilize around sexual assault education and

⁶ There is some reason to believe that this has likely changed somewhat given our heightened awareness of the sexual abuse of boys in recent years. In Canada this awareness has been particularly focused around organised sports, religion, and residential

survivor support reflected the treatment of sexual assault as a “woman’s issue”, given the complete absence of thinking that men might also be victims of sexual assault.

The work of the feminist movement spawned changes to contemporary understandings of sexual assault and to the way society responded to sexual violence (Donat and D’Emilio, 1998: 35). The emergence of the feminist perspective provided an alternative to understanding sexual assault strictly as a “woman’s issue”. The feminist perspective sought to uncover the cultural and social dynamics of sexual assault (Scully, 1991: 47). The feminist theoretical perspective marked a shift in focus to sexual assault as a social problem that needed to be confronted and stopped. However, this shift did not change how we think about who is sexually assaulted – it did not recognize that men are also sexually assaulted.

The feminist literature of the 1970s narrowly examined sexual assault from the perspective of female survivors, in an attempt to provide a more precise understanding of the phenomenon (Donat and D’Emilio, 1998: 41). Through this perspective, sexual assault was not examined in and of itself as an act of sex, but as an act of interpersonal power that facilitated male control over women (Scully, 1991: 48; Donat and D’Emilio, 1998: 41).

The feminist scholars understood sexual assault as both resulting from and reinforcing the hegemonic constructs of masculinity and femininity that subordinate women. Women,

schools with the exposing of a number of high profile cases.

constructed as innately sexually provocative creatures, were to dutifully provide sexual service to “normal” heterosexually insatiable men (Scully, 1991: 48-49). Feminist scholars further argued that men are socialised to have expectations that reflect these understandings, expectations that have entrenched an understanding of sexual assault as a justifiable acquisition of these services (Scully, 1991: 49-50).

Feminist political activism and research have contributed, to some extent, to the myth that men cannot be sexually victimized. This arose out of a lack of focus on men as possible victims and a narrow focus on women as the only credible victims of sexual assault. Where Keane (1995) argues that laws have in the past restricted our understanding of sexual assault to the anatomy of women, early feminist understandings eliminated the possibility of understanding “real” men as potential victims by narrowly focusing on constructed gendered traits. Rather than focusing on sexual assault as an act of power by one individual who subordinates another, the feminist perspective reinforces the notion of male sexual impenetrability by failing to recognize that “normal” men are sexually assaulted. Like the admission of vulnerability, the consequences for men in admitting that they have been sexually assaulted is an admission that they are “less of a man” than other “normal” men.

For Brownmiller (1976: 6) the fear of sexual assault was the biggest factor in the continuing of a subjugating domestic relationship – “protective mating”. Rather than the often quoted “natural inclination towards monogamy, motherhood or love”, Brownmiller (1976: 7) argued that the basis of women surrendering their “title” to a man was a desire to

achieve a level of protection from sexual assault that women were convinced that they could not afford themselves. In the same breath Brownmiller (1976: 7) recognized that these relationships served as “convenient sexual arrangements” for men and that for many women these relationships did not protect them from sexual assault, but rather limited the number of attackers to one – the domestic partner. Although Brownmiller’s (1976) analysis may uncover a “solution” for women, it fails to address how men experience sexual assault.

More recent work in the feminist tradition continues to focus on men primarily as perpetrators. They regard male sexual aggression as existing on a continuum where sexual assault may be seen as worse than or the equivalent to death (Scully, 1991: 50; Marcus, 1992: 387). Although they may not be considered as severe as sexual assault, sexual harassment, wife battery, “less severe” forms of sexual assault (i.e. sexual touching/non-penetrative sexual acts), and sexually coercive behaviour are all mechanisms that perpetuate the social control of women (Scully, 1991: 50). Early feminist works argued that the benefit of maintaining the social dominance over women through sexual assault, and the fear and sense of vulnerability that it perpetuates, extends to all men, not only those who actually commit sexual assault (Scully, 1991: 49).

The understandings and theoretical frameworks of sexual assault generated in the work of early feminist scholars provided a strong foundation from which more contemporary feminist scholars have been able to advance an understanding of sexual assault. Gendered vulnerability, as a tool of the marginalisation of women, continues to be a major concern

for more contemporary feminist scholars, including Marcus (1992). In her work "Fighting Bodies, Fighting Words: A Theory of Politics and Rape Prevention", Marcus (1992) attempts to explain the consequences of the standards that we have attached to being female within the framework of rape. Marcus (1992: 389) argues that the way we have defined what it is to be "womanly" has translated into an understanding of women as unable to fend off an attacker.

In an analytical look at the dynamics of "traditional" rape – male attacker on female victim – Marcus (1992: 390) states that the construction of women as vulnerable makes the rape inevitable once the attack has begun. Marcus (1992: 390) argues that women are left with an inability to fend off an attacker due to the linguistic difference that positions women as the weak object of the power granted to men, rather than a lack of physical strength.

However, the experiences of MSA survivors challenge this analysis. Male survivors embody the gender that Marcus (1992) argues dominates women by its construction. MSA survivors demonstrate that men can be just as vulnerable as women, which challenges both the construction of men as purely dominating and women as purely vulnerable.

Marcus (1992) further argues that the best way to empower women to fight rape is by urging them to break away from the rigid traditional understandings of masculinity and femininity. Marcus (1992) argues that if women do not exist and behave in-line with traditional understandings of femininity – that if they step outside of those boundaries – that they will challenge and increasingly alter the script. They will not be forced to play the role of victim in the "rape script" (Marcus, 1992: 392). However, although Marcus' (1992)

“rape script” recognizes that the ability of men to be dominant can be interrupted, she does not take this far enough to recognize that men can also be victims.

When we recognise the existence of men who are supposed to be physically stronger, powerful and emotionally invulnerable (see Table 1) as survivors, it would appear that Marcus' (1992) argument is unsustainable as a holistic explanation of sexual assault. Marcus' argument is challenged by the fact that healthy, heterosexual white males, who are generally most empowered by hegemonic masculinity, are sexually assaulted. MSA demonstrates that it is not simply what is constructed as appropriate or inappropriate behaviour that makes women unable to defend themselves from rape or be more vulnerable to it in the first place. The experiences of men who are sexually assaulted suggest that sexual assault is not a tool that is used to solely dominate and control women.

A lack of recognition of MSA continues to marginalise MSA survivors. These understandings exclude men from being portrayed in any role other than that of a perpetrator and shape the way that people respond to MSA survivors. The few exceptions that exist have done little to dispel the view of men that is entrenched in our cultural understandings of sexual assault and masculinity. The two exceptions are childhood sexual abuse and the sexual assault of adult males in sex-segregated populations. However, neither of these types of sexual assault directly challenges our traditional understandings of masculinity or sexual assault.

As noted earlier, we have a fundamentally different culturally-based understanding of male children than the understandings that we attach to men. Further, our stereotypical understanding of those men who are assaulted in a sex-segregated population is that those men are victims at least in part due to a lack of potential female victims (King, 1998: 710). This exception was even noted by Brownmiller (1976: 258), who noted that within sex-segregated populations of men exist hierarchal arrangements of power, similar to those among men and women in open society. In Brownmiller's (1975, 258) estimation, sexual assault is used in prison to enforce these relations. Further, MSA has been a well documented and long-standing practice used in the military as a mechanism of ultimate humiliation often inflicted by multiple assailants upon a defeated male enemy (Donaldson, 1990).

It should be noted however, that while feminist analysis of sexual assault has largely not recognized MSA, feminist researchers and writers have created a space that allows us to challenge hegemonic norms – enabling a discussion of the harmful consequences of hegemonic masculinity, not only for women but also for men.

In addition to the reasons that men have not been considered potential sexual assault victims, homosexual men have also been discounted as potential victims of sexual assault. Male homosexual sexual activity has been both criminalised and medicalised, largely based on socially accepted stereotypical understandings of high risk sexual activity and sexually

transmitted diseases (especially HIV/AIDS) among gay men⁷ (Kinsman, 1993: 23).

Homosexual men are regarded as universally partaking in promiscuous, rough sex, with high levels of drug use. Where heterosexual men are thought to be sexually insatiable, homosexual men are thought to be even more so.

Traumatic Impact of Sexual Assault

An important area of analysis in the study of sexual assault has been the response of survivors to the trauma of being sexually assaulted. The response of survivors to sexual assault is multifaceted and includes, but is not limited to, post-assault symptomology and the emotional response to the assault. These reactions are often intertwined. Both Kaufman et al. (1980) and Isely and Gehrenbeck-Shim (1997) observe the response of MSA survivors is generally similar to those women have been documented to experience. There are, however, some differences that seem to reflect differences in gendered socialisation.

A considerable portion of the study of the reaction of women to being sexually assaulted has focused on particular medicalised psychological symptomology, referred to as Post-traumatic Stress Disorder (PTSD). These symptoms include depression, suicidal ideation and nightmares and/or flashbacks. It is widely accepted that most female survivors of sexual assault experience a range of this symptomology in reaction to their victimization.

⁷ Social understandings of homosexuality is worthy of and has been the subject of valuable examination in its own right. For fuller discussion see Kinsman (1993).

Isely and Gehrenbeck-Shim (1997) acknowledge that the ability to generalize or conduct precise comparisons of the timing and nature of the symptomological responses of MSA survivors in their study was quite limited. However, they conclude that MSA survivors experience many of the same post-traumatic stress symptoms that female sexual assault survivors have been documented to exhibit (Isely and Gehrenbeck-Shim, 1997: 162).

In addition to symptomology, researchers have also examined the emotional responses that survivors experience after being sexually assaulted. In their study of female sexual assault survivors, Burgess and Holmstrom (1974: 982) classified the emotional reaction of women to sexual assault into two categories: “expressive” and “controlled” reactions.

“Expressive” reactions include emotion-demonstrating behaviours such as crying or smiling which they contrasted with “controlled” reactions, such as emotion-concealing behaviours (i.e. being placid or subdued) (Burgess and Holmstrom, 1974: 982). Burgess and Holmstrom found that the female sexual assault survivors that participated in their study were evenly distributed between the two types of reactions.

Using Burgess and Holmstrom’s conceptualizations of “expressive” and “controlled” emotional reactions, Kaufman et al. (1980) later extended this examination to the emotional reactions of MSA survivors. Kaufman et al. found that 79 percent of the MSA survivors that participated in their study demonstrated a “controlled” as opposed to an “expressive” emotional response (Kaufman et al., 1980: 223). The study cited the differing gender-based socialisation – towards the expression of emotions that men and women receive – as the grounds for the difference in their findings. Men are often taught from an early age to

minimize their negative emotions or channel them “into anger, aggression and violence” (Poon, 1993: 255).

Stermac et al. (1996: 60) echoed these findings, suggesting that while all men showed signs of traumatic emotional response, few actually sought attention for their emotional response. Further, the administration of tranquilizers was the most common treatment administered at the hospital where the data was gathered (Stermac et al., 1996: 60). Tranquilizers further repress emotional reaction; however, tranquilizers may well have been dispensed to female survivors that reported to that hospital as well.

The hegemonic construction of masculinity is challenged by the experiences of MSA survivors. MSA survivors experience a range of symptoms and painful emotions that are irreconcilable with socially constructed gender traits. As a result MSA survivors are left to abandon their manhood and marginalise themselves or deny the reality of their experiences and feelings.

Implications for MSA

The lack of recognition of MSA survivors and their experiences has had a number of consequences both for survivors and our social understanding of MSA. When male “victims” of sexual assault are recognised, they are not understood in the same light as female survivors. In surveying social judgments of male and female sexual assault survivors, Smith et al. (1998: 113) demonstrated that MSA survivors who are assaulted by

women, are perceived as more likely than female survivors (who are assaulted by men) to have “initiated the episode, to have derived pleasure from it and to have experienced less stress”. This trend is generally found to be more pronounced among male respondents suggesting the acceptance of stereotypical attitudes that men cannot be truly victimized, especially by a female and that men are sexually insatiable creatures (Smith et al., 1998: 128). The acceptance of these and other stereotypical attitudes are at the basis of our misunderstandings of gender and sexual assault. One respondent summarized this in writing at the bottom of his survey, “Some guys have all the luck” (Smith et al., 1998: 128).

A second consequence of narrow understandings of gender and sexual assault is that little help has been made available to MSA survivors. As we have not effectively allowed ourselves to believe that men are victimisable, we have not provided adequately to ensure that men who have been assaulted can come forward to seek post-assault help. This is reflected in the amount of actual counselling services offered for MSA survivors.

In their article, “Honey, We Don't Do Men,” Donnelly and Kenyon (1996: 441) examined how such narrow understandings of men have translated into a lack of available sexual assault crisis and post-assault services for MSA survivors. The authors reported that many of the services that already exist for women either refuse services to, or are ill prepared to provide assistance to MSA survivors (Donnelly and Kenyon., 1996: 447)⁸.

Donnelly and Kenyon (1996: 441), undertook in-depth interviews with providers of sexual assault crisis services and attributed the difficulty of MSA survivors in accessing appropriate help to “traditional gender role stereotypes, lack of responsiveness to male victims and gaps in service provision” (Donnelly and Kenyon, 1996: 441). They recognised that providers who held less stereotypical attitudes were more likely to accept that MSA survivors exist and to respond sympathetically to them (Donnelly and Kenyon, 1996: 446). Those who held more stereotypical perspectives of men, including that men are “always in control sexually”, discounted the notion of MSA as “inconsequential” (Donnelly and Kenyon, 1996: 447). Donnelly and Kenyon (1996: 448) argue that until mythical notions of masculine invulnerability and narrow conceptualisations of sexual assault are redefined and homophobia is addressed, MSA survivors will continue to be under served.

In addition Scarce (1997b: 172) notes that campus sexual assault education and prevention programs generally lack awareness of MSA. Scarce (1997b: 172) attributes this lack of responsiveness to the situation of social and academic discussion of sexual assault within the context of violence against women. Further Scarce (1997b: 172) notes that MSA survivors may be reluctant to seek help at sexual assault care centres or hotlines as they may interpret them as being established to serve solely women.

⁸ In earnest it must be noted that some establishments will turn away men in an attempt to secure a feeling of safety for female clientele who have been assaulted by men. However, many establishments have developed alternative scheduling programs and other alternative procedures to attempt to provide both programming for men and a secure environment for women.

Another "social" consequence is the lack of preparedness and willingness of law enforcement personnel to deal with MSA (Donnelly and Kenyon, 1996: 447; Lauren, 1993: 19). Other authors have also noted that reporting such crimes to the police can be quite problematic. Scarce (1997a: 216) cites "disbelief, mockery, homophobia" as well as, at times, a general combination of all three of these as attitudes that often leave survivors more traumatised than when they arrive to report the instance to police. In her discussion of the fears that survivors must face in approaching law enforcement, Laurent cites the same attitudes (Laurent, 1993: 19). Scarce (1997a: 217) does not posit that this is, in general, a deliberate attempt to maim or hurt, but rather a product of a lack of awareness and necessary training on the part of law enforcement personnel.

Donnelly and Kenyon's (1996) characterisation of law enforcement's application of stereotypical attitudes was far less lenient. They observed that the masculine world of law enforcement used stereotypical understandings of masculinity to deny the possibility of "real" men being sexually assaulted, categorising those who come forward derogatorily as homosexual (Donnelly and Kenyon, 1996: 447). They reaffirm their own "invulnerability" by marginalising those men who do come forward as less than "real" men, homosexual or "like woman" (Donnelly and Kenyon, 1996: 447).

Donnelly and Kenyon's (1996: 447) research suggested "Feminist-based" crisis support service workers were also resistant to acknowledging MSA survivors. The women that Donnelly and Kenyon (1996: 447) interviewed who provided these services saw domestic and sexual violence solely as actions perpetrated against them by men. Some of the

women acknowledged a fear that resources would be directed away from women and felt that “the small number of men who were victimised did not justify risking resources that could be used to assist women” (Donnelly and Kenyon, 1996: 447).

Narrowly defined expectations of masculinity also hinder survivors from coming forward, contributing to the underreporting of MSA (Donnelly and Kenyon, 1996: 447). Groth and Burgess (1980), in their study “Male rape: Offenders and Victims,” recognise how difficult it is for men to come forward and report assaults or to seek help. Groth and Burgess (1980: 810) call on clinicians who work with men for other counselling needs to be very alert to signs that men may have been sexually assaulted in order to detect MSA.

As discussed earlier, women have also faced a number of mechanisms that by design or not, have hindered them from coming forward. Some of these are similar and some different than those that men face. For both, coming forward has consequences that are again in some instances similar and in some instances different. By coming forward women signal – according to narrow understandings of femininity and sexual assault – that they cannot simultaneously achieve rigorous feminine standards to avoid marginalisation, and aspects of traditional masculine qualities, that would diminish their vulnerability. By not denying their victimisation and coming forward to ‘speak’ of their assault, MSA survivors admit that they are vulnerable and penetrable and by asking for help signal that they can no longer even aspire to meet the standards of masculinity (Donnelly and Kenyon, 1996: 447).

Unrealistic notions of masculine invulnerability, a lack of resources for MSA survivors, and shaming by law enforcement are only a partial list of factors which interact to reinforce understandings that to be a man is to be impenetrable. By deterring men from coming forward, and delegitimising those who do, a convincing body of evidence that would suggest that men are indeed vulnerable and penetrable – evidence that would challenge narrow understandings of masculinity and sexual assault – fails to materialise. This climate discourages men from speaking of their assault – or seeking help – and limits our ability to gain a precise understanding of the nature of MSA.

What we know about Male Sexual Assault, Sexual Assault and Masculinity

Our review of the literature pertinent to MSA leads us to highlight a number of patterns and trends. We know that:

1. hegemonic constructions of masculinity suggest that men are impenetrable and invulnerable to sexual assault.
2. historically men have been excluded from being considered sexual assault victims through laws that hinged sexual assault on female anatomy.
3. men continue to be unrecognized as potential victims of sexual assault by narrowly developed understandings of sexual assault focused on hegemonic constructions of gender.
4. exclusion from being considered a potential victim of sexual assault marginalises those men who are sexually assaulted and discounts their experiences.

5. social and academic ignorance of MSA has led to a climate that inhibits men from coming forward and reporting their experiences or from seeking the necessary forms of help.
6. men of all sexual orientations are sexually assaulted.
7. current published research reports that homosexual men tend to be sexually assaulted by someone who they know in a manner akin to “date-rape”; whereas, heterosexual men have a greater likelihood of being sexually assaulted by a stranger and there is a greater chance that it would involve physical violence and/or multiple assailants.
8. all survivors of sexual assault, regardless of their sex, sexual orientation or the location where the assault took place, can be defined as victims and experience and respond to sexual assault in similar manners.
9. male survivors do seem to exhibit some differences related to their social location as influenced by constructions of gender.
10. sexual assault needs to be understood in the context of history, power and culture.
11. MSA is more prevalent than assumed and more prevalent than the literature reports.
12. all survivors require help and access to educated and respectful assistance.

These are integral elements to an informed analysis of MSA. In the case of this thesis, they are central to the analysis of interviews conducted with counsellors of MSA survivors.

Chapter Two

METHODOLOGY

The present study is based on interviews with 20 counsellors who have experience working with MSA survivors. The counsellors have varying degrees of counselling experience, in general and with MSA survivors in particular. All the counsellors who participated in this study provide service in Canada: 17 in Ontario, two in Alberta and one in British Columbia. As there has only been one study of MSA conducted in Canada prior to this, a deliberate effort was made to maintain this study as a "Canadian study" by collecting data only from Canadian counsellors.

The counsellors were identified for participation in this study through snowball sampling. The identification of potential participants for this study posed a considerable challenge. There is a lack of counsellors who have substantial experience working with MSA survivors. This could be the result of, as Donnelly and Kenyon (1996: 444-446) concluded, both a small number of survivors seeking help and a lack of agencies that are available to MSA survivors. It would be impossible to produce a representative sample of counsellors who work with MSA survivors as there is no Canadian record of how many or which counsellors work with MSA survivors. As a result, a snowball sample was considered to be the most appropriate means of identifying potential respondents.

Snowball sampling relies on the known social networks of participants (and non-participants who are part of the social network) to identify potential participants (Thomson, 1997: 299). As this study is exploratory in nature, the fact that snowball sampling does not allow a representative sample is not considered to be of primary concern. The potential participants are seen as being connected by their common work and interests that are invaluable to this research (Atkinson and Flint, 2001). This is especially true in attempting to study individuals who are difficult to access or hidden, such as MSA survivors or counsellors who have worked with MSA survivors (Atkinson and Flint, 2001; Faugier and Sargent, 1997). Further, it is unlikely that this study achieved data saturation. Again, as an exploratory study this work was not looking to achieve saturation but rather to identify emerging themes/issues.

In order to participate in this study, a potential participant had to meet the following criteria: be a Canadian counsellor and have experience counselling MSA survivors (either for the assault directly or for another issue related to the assault). The original contact for the sample was a counsellor from a local agency that provides a variety of counselling services to men. This original contact identified a number of the counselling agencies that provide services to men and a contact person within these agencies. The Internet was also used to identify additional agencies. The majority of the agencies identified through the Internet were regional sexual assault counselling agencies.

Agencies were contacted and the research was explained to the contact at each agency. They were then asked if the agency provided services to MSA survivors, and if they or

someone else at the agency would be willing to participate. The contact was also asked if they could identify other counsellors or agencies that provided services to MSA survivors.

In those cases where a potential agency was identified, but where there was no contact identified, the research was explained to the individual who answered the phone and she or he was asked to direct the researcher to the most appropriate individual at the agency. This person was usually either the director of the agency or the coordinator/counsellor responsible for a special program (e.g. for men, for sexual assault, etc.).

If the organization provided the appropriate services, the participation of the organization was then sought. Interviews were requested of all counsellors at the organization who were currently, or had in the past, provided services to MSA survivors. In most cases, there was only one individual at each agency who had worked with anyone who was an MSA survivor.

Once the appropriate respondents were identified, each was contacted individually⁹. The research was explained and they were asked to participate in the study. If they agreed, they were then sent a copy of the interview structure and the "Informed Consent Form" by email or fax. They were asked, based on the interview structure they received, to review their files to prepare for the interview. Finally, an interview was scheduled at a time convenient to them.

⁹ If the appropriate individual was the initial contact then the following procedure was used during the first conversation.

Only two counsellors who had met the criteria declined to participate in the research. In both cases these potential participants cited time constraints as the barrier to participation.

The consent form was reviewed with participants prior to the start of their interview (see Appendix B). The participant was then given an opportunity to ask any questions relating to the research and when they were satisfied, they were asked to sign the consent form. The consent forms were then returned to the researcher by mail.

This research used a structured interview with a mix of open and close-ended questions (see Appendix C). The interview was based on an earlier questionnaire and interview schedule designed to interview MSA survivors themselves (see Introduction). The re-designed interview was developed to gather information on all the subject matters that the original research tools sought to gather from the men themselves. The mainly qualitative interviews were, like the snowball sample, well suited to this study. Interviews serve as an effective research tool, especially suited to inform qualitative and descriptive research of complex phenomena such as MSA (McCracken, 1988: 17).

Close-ended questions were used to gather information concerning the counsellors' professional histories; some demographic and historic details of the survivors; and characteristics of the MSA experiences of the survivors.

Open-ended questions with probes were used to gain the counsellors' understandings of MSA in relation to other forms of sexual victimisation and related consequences, their

experiences working with MSA survivors and any patterns that they observed in the men's understandings of their victimization and other experiences. Such open-ended questions permitted the interviews to gather data on a wide range of subject matters including, but not limited to: what counsellors considered to be the biggest impediments to men accessing and attaining help; differences and similarities between MSA survivors and survivors of childhood sexual abuse or women who have survived sexual assaults; what the counsellors thought to be effective intervention strategies for MSA survivors; patterns in presenting problems and symptomology; and survivors' understandings of themselves.

The interviews consisted of 26 questions containing varying numbers of sub-questions and/or probes. The questions were broken down into four sections: Counsellors' Histories, MSA Counselling Service Provision, MSA Characteristics and Impacts and Survivor Responses to MSA. Each interview was conducted in one sitting and ranged in length from approximately 45 minutes to two hours and 45 minutes, with most interviews taking approximately one hour and 15 minutes¹⁰. All of these interviews were conducted by phone, with the exception of one¹¹, and tape recorded.

It would have been preferable to interview the counsellors in person. In-person interviews are thought to facilitate the personal connection between the interviewer and participant,

¹⁰ It should be noted that during some of the interviews and especially during some of the shorter interviews that time constraints on the participant affected the length of time that they were available and as a result how much they were able to elaborate upon their answers. Given the nature of funding for social service programming in Ontario under the current Harris government agencies operate on what tends to be a shoestring budget meaning that counsellors maintain maximum workloads and have very little time for "extras" like research participation.

¹¹ In this case although the participant was able to set aside enough time to conduct the interview they were unable to tie up the organization's phone line as it was also used as part of the organization's crisis hotline.

and potentially induce more elaborate responses from participants. However, both the time and fiscal demands of traveling from city to city to perform the interviews constrained this researcher's ability to do this.

After all the interviews were completed, they were transcribed and the taped recordings were destroyed. During the transcription the interviews were coded to allow only the researcher to identify each interview to avoid any possible identification of survivors who were discussed during the interviews. A general thematic approach to analyses was undertaken. The transcribed interviews were reviewed for mistakes and re-read. As themes and patterns emerged, text was culled thematically into summative text, with specific quotations interspersed. Quotations that were representative of the patterns and themes in the research were selected to be used in the text. Quotations from certain counsellors were more widely used as they were more articulate. Those not quoted are similar to those who were.

At all times, whether on tape or in transcribed form, all interview-related materials are stored in a locked filing cabinet to which only the researcher had access. All steps were taken throughout this research process to strictly adhere to all applicable ethical considerations and ensure the confidentiality and anonymity of the MSA survivors discussed.

This study does not escape limitations. First, while interviewing counsellors enabled the study to capture information based on a larger population of survivors; the information

loses some degree of detail due to recall effects and is further susceptible to error depending on the strength of the counsellors' record keeping.

Second, although the counsellors who participated in this study provide a range of counselling services, MSA survivors who receive counselling are in all likelihood not a representative sample of the population of survivors. Due to the nature of sexual assault – a very personal, shame inducing experience – it is impossible to arrive at a completely accurate account of the prevalence and behaviors associated with it. Past research on women who have been sexually assaulted suggests that a significant proportion do not seek help after being assaulted (Kaufman et al., 1980: 220). It is assumed, largely based on understandings of masculine behaviours and a lack of readily available help, that even fewer men would be likely to seek help (Donnelly and Kenyon, 1996: 448).

Chapter Three

CHARACTERISTICS OF SURVIVORS AND THEIR ASSAULTS

This chapter describes the perceptions of counsellors on victims of MSA and their assaults. These counsellors had worked with 156 MSA survivors. Some counsellors were able to provide more precise "numbers" in response to questions relating to the demographic characteristics of the survivors they had counselled. Other counsellors used more general terms, such as "all", "the majority", "a minority", "some", "rarely" or "none", to convey their experiences.

A variety of reasons were given for the inability to provide more specific information on each of the cases that they had worked on. One important reason was the way that records were kept at a given organization. Some organizations kept very detailed records, while others kept less specific files on counselling sessions. Moreover, some agencies stored files only in hard copy format, while others stored files on computers that made them more accessible in the course of an interview. Further, the varying numbers of clients that a counsellor had worked with, and the duration of time over which these cases occurred, had an effect on the counsellor's ability to give specific details.

The Counsellors

Table 1 summarizes the general counselling experience, abuse/assault counselling

experience, and the number of cases of MSA that each of the interviewed counsellors had worked with. The table also includes the year that each counsellor first worked with a case of MSA. The counsellors' general counselling experience ranged from one year to 30 years, with a mean of 16.4 years of counselling work. On average, the counsellors had worked with abuse/assault survivors for 79.4 percent of their career. The counsellors interviewed had worked with a range of from one to 30 MSA survivors. Cumulatively the counsellors had worked with 156 MSA survivors, a median of 5 survivors per counsellor¹². Approximately 75 percent of the counsellors stated that they had first worked with a MSA survivor in 1990 or more recently and almost 50 percent indicated 1995 or more recently.

All of the counsellors who participated in this study have significant counselling experience, both generally and with survivors of abuse and assault. With the exception of only one counsellor, all of the counsellors interviewed had five or more years of counselling experience with abuse/assault survivors. This level of experience made the respondents very competent and qualified to participate in this study. The past literature has presented evidence suggesting that only a small number of MSA survivors actually access counselling services from a small pool of available sources/service providers (Donnelly and Kenyon, 1996, 447). Although we are unable to ascertain the actual prevalence of MSA, the fact that these counsellors, in 249.5 years of cumulative counselling experience, with survivors of abuse/assault, had only worked with 156 cases of

¹² In this instance the use of the median provided a more representative depiction of the counsellor's experience than the mean (approximately 7.8 survivors/counsellor).

MSA should be seen as reinforcing the notion that few survivors actually report being assaulted.

Table 2: Respondents' Counselling Experience (General and MSA)

Counsellor	Years of Counselling Experience	Years Of Counselling Abuse/ Assault Survivors	Approximate Number of MSA Survivors Worked With	Approximate Year First Counselling a MSA Survivor
1	5.5	5.5	15	1992
2	25	21	3	1990
3	22	9	3	1995
4	11	11	12	1992
5	16	8	15	1987
6	15	15	5	2000
7	10	10	10	1992
8	20	20	5	1997
9	12	12	4	1999
10	11	11	20	1995
11	33	33	3	1985
12	15	10	5	1996
13	30	11	30	1996
14	15	5	5	1997
15	6	6	4	2000
16	10	10	3	1993
17	12	12	2	1989
18	3	3	2	1999
19	25	25	5	1985
20	12	12	5	1986

The counsellors have significant experience practicing with a diverse range of counselling services. These distinctions are reflected in the variation in the characteristics and demographics of the clientele who will access their services. As a result, this sample of counsellors has experience working with a more diverse population of survivors than

would be the case if the counsellors had been concentrated within one type of service provision. Figure 1 summarizes the types of counselling services provided by each counsellors to the MSA survivors they had worked with.

Figure 1: Type of Counselling Service Provided by Respondents

The majority of counsellors, 80 percent (16), were evenly distributed among four types of counselling services. Four counsellors each represented sexual assault care centres, counselling services for men, homosexual/bisexual oriented counselling services, and private practices. The sexual assault care centres were regional services that provided counselling services to survivors, generally women who had been sexually assaulted. The sexual assault care centres from which counsellors participated in this study had extended

their services to men who been sexually assaulted. It is important to note that not all sexual assault care centres have extended their services to MSA survivors. In the course of generating this sample a few centres that had not extended their services were contacted¹³. Their policy was to refer MSA survivors to another organisation or local private practitioner¹⁴.

Homosexual/bisexual and male oriented counselling services provided a diverse range of counselling services (e.g. relational, HIV/AIDS, addiction and individual counselling) to their respective targeted client group. In all cases this included being equipped to work with traumatic experience survivors, predominantly childhood sexual abuse, which was extended to provide services to MSA survivors. However, in no cases did MSA survivors account for a large percentage of the organization's caseload.

Of the private practitioners who ran their own counselling programs, two had a clinical psychological focus and two had a social/social psychological orientation. Two of the remaining counsellors provided counselling to survivors through services for victims of crime. One counsellor provided counselling help through a residential addiction treatment program and one through a religious-based counselling organization.

¹³ Snowball sample techniques led to an avoidance of such organizations as those individuals who referred other potential participants were quite aware of the specific intention of the research as well as the professional capacities of their colleagues.

¹⁴ It should be noted that the organizations that lacked the appropriate experience to participate in this study nevertheless made substantial contributions to the research by referring other potential participants in nearly all cases. Universally, the referred party worked where the organization would direct any men who sought counselling from their organization.

Survivor Characteristics

Age

The MSA survivors ranged from 16 to 71 years of age at the time that they received counselling services. Counsellors were asked to identify the age category of the majority of survivors to whom they had provided services. Figure 2 demonstrates that 11 of the 20 counsellors (55 percent) indicated that the majority of the men were between 26 and 35 years of age. These 11 counsellors worked with approximately 54 percent of the 156 survivors who were clients of the 20 counsellors. Six counsellors reported that the majority of survivors they had worked with were 36 years of age or older and the remaining three counsellors identified that the majority of survivors they had worked with were 16 to 25 years old. These counsellors worked with approximately 22 and 24 percent, respectively, of the 156 survivors who the 20 counsellors collectively worked with.

These findings suggest that the experiences of the counsellors who participated in this study were with a slightly older group of survivors compared to the survivors that have participated in past research. Isely and Gehrenbeck-Shim found that of the 1,962 client records that they were able to draw information from, 49 percent were under age 21 and 86 percent were under age 30 (Isely and Gehrenbeck-Shim, 1997, 162). The 29 men that Stermac et al. collected data from ranged in age from 18 to 65 with a mean age of 26.86.

Figure 2: Counsellors' Response to Question: "What is the age category of the majority of your MSA clients?"

Further, 55 percent of the survivors were between the ages of 18 and 25 and 97 percent were aged 35 and under (Stermac et al., 1996, 57)¹⁵.

Sexual Orientation

Counsellors were next asked about the sexual orientation of the survivors that they had worked with based upon the survivors' self-identification. One of the challenges of the data collected on sexual orientation results from differences in the terminology used to discuss

¹⁵ One significant difference between this study and the study undertaken by Stermac et al. (1996) was that the survivors in Stermac et al. reported to a hospital, the site of data collection, at the time of their assault. In this study, with few exceptions, survivors did not present to the counsellor who participated in this study until some time after the attack. At times these delays accounted for up to a number of years after the actual assault occurred. However, in even the most extreme cases recalled by the counsellors, these delays were not likely to have accounted for the seemingly large differences in findings, in regards to survivor age, between this study and Stermac et al.'s (1996).

sexual orientation. The term “Men who have Sex with Men (MSM)” is often used by counsellors to avoid the judgment or discriminatory myths that are associated with other sexual orientation denoting terms to survivors, while still capturing their self-disclosed behaviour. For instance, many negative stereotypes have been attached to gay men surrounding sexual promiscuity and other high-risk sexual behaviour.

However, other counsellors intentionally avoid the use of “MSM”, explaining that although there may be negative stereotypical understandings affiliated with the term gay, the term nevertheless encapsulates an element of identity that should not be sacrificed. The result of the use of different terminology by different counsellors is that data representing the same characteristics is at times categorized under competing terms. As a result, the data has been presented in Figure 3 in the generalised categories “heterosexual” and “homosexual/bisexual/MSM”.

The majority of counsellors, 55 percent (11), reported that the majority of survivors that they had worked with self-identified in the “homosexual/bisexual/MSM” category. The remaining 45 percent (9) of counsellors identified that the majority of survivors self-identified as heterosexual. The two groups of counsellors each worked with one half of the 156 survivors that these 20 counsellors had worked with. As stated earlier, this study has achieved a balance of types of counsellors in this sample. As a result, it is less likely that the current findings have been skewed by a concentration of one counselling type that would have increased the prevalence of one categorization of sexual orientation over the other.

Figure 3: Counsellors' Response to Question: "What is the sexual orientation of the majority of your MSA clients?"

The published literature has concentrated heavily on the sexual orientation of both survivors and assailants. Hillman et al. (1991), Mezey and King (1989) and Stermac (1996) et al. have all found that the majority of the survivors in their respective studies self-identified as homosexual or bisexual. Isely and Gehrenbeck-Shim (1997) and Hodge and Canter (1998) found that the majority of survivors on whom they collected data identified as heterosexual. Given that we know that a considerable majority of men in society in general identify as heterosexual, we may be able to speculate that MSA is more prevalent in the lives of homosexual and bisexual men.

In addition, Stermac et al. (1996) noted that the majority of studies have documented a higher prevalence of homosexual and bisexual survivors of MSA than heterosexual (Stermac et al., 1996, 61). However, Stermac et al. (1996) warn that we should be cautious

in this analysis, as we need to determine whether these findings reflect a greater awareness of and/or use of counselling services among gay and bisexual men, or that gay or bisexual men may “feel less stigmatized by sexual assault than heterosexual men” (Stermac et al., 1996, 61). Our understanding of masculinity as well as other research has pointed to higher prevalence rates of sexual abuse and assault among homosexual and bisexual men throughout their lifetime,¹⁶ which lends support to such a conclusion.

It should be noted that in addition to the groupings used in the chart that several counsellors also identified that they have worked with one or two cases of survivors who identified as either transgendered or cross-dressing. Although these terms are used to identify aspects of an individual's sexuality, they do not necessary identify their sexual orientation. Thus, in a manner consistent with the other cases that they had work with, the counsellors identified these survivors according to the sexual orientation that the survivors self-identified.

Previous Sexual Assault/Abuse

As presented in Figure 4 the majority of counsellors, 70 percent (14), reported that only a minority or none of the survivors they had provided service to had previously experienced sexual assault in their adult life. These counsellors worked with approximately 80 percent of the total number of survivors that these 20 counsellors had worked with. Fifteen percent (3) of the counsellors, who worked with approximately four percent of the 156 survivors,

¹⁶ Duncan, 1990, suggests that homosexual and bisexual men report a significantly higher rate of sexual victimization throughout life than heterosexual men. However, many of the same issues regarding the underreporting that are explored in this study must be considered in reviewing Duncan's results.

identified that a majority of the survivors they had worked with had experienced a prior sexual assault in their adult life. The remaining three counsellors were unable to identify whether or not any of the survivors they worked with had been sexually assaulted in their adult lives.

As Figure 5 shows, 60 percent (12) of counsellors reported that all or the majority of the survivors had experienced childhood sexual abuse. However, 5 counsellors, who worked with 30 survivors, were unable to identify whether their clients had been victims of childhood sexual abuse. When these five counsellors are dropped from the analysis as missing data, then 80 percent (12 of 15) of the remaining counsellors indicated that all or the majority of the survivors they had worked with had experienced sexual abuse as a child, as presented in Figure 6. These counsellors worked with 87 percent of the 126 survivors that remain a part of the analysis after the five counsellors are dropped.

Figure 4: Counsellors' Response to Question: "What proportion of your MSA clients reported previous adult sexual assault?"

Figure 5: Counsellors' Response to Question: "What proportion of your MSA clients reported childhood sexual abuse?"

Figure 6: Counsellors' Response to Question: "What proportion of your MSA clients reported childhood sexual abuse?" with "Unknown" Respondents extracted

These findings are consistent with the findings of previous research, although they potentially suggest a stronger relationship between experiences of childhood sexual abuse

and MSA. This underscores the urgency to fully understand the nature of the connection between childhood sexual abuse and MSA. Stermac et al. indicate in their findings that approximately 34 percent of the survivors in their sample report they had been sexually abused as children and 14 percent had been previously sexually assaulted as adults (Stermac et al., 1996, 57).

The ability to capture the prevalence of previous sexual assault/abuse experiences of survivors relies on survivors coming forward with this information. As will be further discussed in the next chapter, the counsellors suggested that the survivors they had worked with often were more comfortable disclosing an experience of childhood sexual abuse than a more recent MSA experience. This often led counsellors to use probing questions or other techniques to initiate a survivor's revelation that they had also been sexually assaulted as an adult. This may mask many more instances of men coming forward to seek help after having been sexually assaulted and would have implications for determining the prevalence of MSA. We might also expect that some individuals who do seek help for MSA may not disclose historical childhood sexual abuse. Thus, even those counsellors who identified that either the majority or a minority of the survivors that they had worked with had been sexually abused during childhood, may not be aware of the full extent of this phenomenon among their clients.

Counsellors reported that individuals who have survived multiple assaults often perceive themselves as projecting the image of a victim to others and consider their victimization as a central characteristic of their identity. In discussing why the survivors that she had worked with perceived that they had been victimized, one counsellor responded:

“I’m a survivor of childhood sexual abuse, so therefore it’s almost that people know that I’m a person that they could use”, is often one that I hear. I have them sit in front of me and say, or sit in group and say, “do I have sucker written on my head or do I have sexual abuse survivor written on my head” where it just invites people to say, “fuck it, they’ve been violated before, they can do it again” (Interview 1).

This response strongly suggests that those survivors who had multiple abuse/assault experiences that this counsellor had worked with had constructed an understanding of themselves, based on their experiences, as subordinate to other “normal” men. Noting that for men normalcy is often closely aligned with hegemonic masculinity, her observation suggests that these survivors felt that they were individuals, who other, more “empowered” individuals could manipulate or “use” at will.

The counsellors whose clients had experience with previous sexual abuse/assault indicated that multiple abuse/assault experiences merited specific additional attention, in the context of compounded trauma. In addition, counsellors indicated that childhood sexual abuse created a need to work with survivors to help them develop improved boundary setting skills and a sense of self-worth. Although this may be seen as blaming the victim, counsellors indicated that they were attempting to help survivors to develop an ability to protect themselves from further assault experiences. Similar to Marcus’ advice that women

need to act outside of the boundaries of traditional conceptualizations of femininity; these counsellors are urging MSA survivors to take actions outside of limitations of the subordinated location where they understand their lives to exist. The same counsellor later added:

First off, it's a continuation of the symptomology that they experienced from their childhood abuse, only it becomes fresh and new and maybe a little stronger at this point in time. But the symptoms like low self esteem that I spoke of before seem to be far more prevalent or have escalated to a crisis as opposed to something that they're trying to work through. Maybe not necessarily at a crisis level... I say that in the fact that some people have got so, unfortunately have got so caught into the idea that they are nothing. That a recent assault has really played itself out as, why does it matter, this is what my life has been like anyhow. This is what apparently my role is supposed to be because it started when I was 3. And so what's the difference between being assaulted then and assaulted now? That's the role I play. And that's a hard one to get through, when you're ambivalent (Interview 1).

This work should begin as early as possible with individuals who have been sexually abused or assaulted and ingrained in any counselling program to reduce the risk of further assaults. The effects of multiple abuse/assault experiences on the way that survivors understand themselves are further discussed in the following chapter.

Characteristics of MSA

Survivor-Perpetrator Relationship

As stated in the literature review, previous research has focused the study of MSA on an

examination of some specific variables. Primary among these key variables is the relationship between the survivor and perpetrator.

Figure 7 depicts the counsellors' identification of the prevalence of known and stranger attackers. The counsellors' responses were coded into three categories "Known", "Stranger" and "Half of Cases". The "Half of Cases" category captures those counsellors who identified that the number of survivors was approximately evenly distributed between known and stranger attackers. As Figure 7 depicts, 75 percent (15) of the counsellors indicated that the majority of clientele to have been assaulted by a known attacker. These 15 counsellors had worked with approximately 63 percent of the 156 MSA survivors who were clients of the 20 interviewed counsellors. Only 15 percent (3) of the counsellors, who worked with approximately 28 percent of the 156 survivors, identified as having worked with more survivors who were victimised by stranger than known attackers. The most common types of relationships between survivors and known attackers that counsellors identified were intimate partners, dates or pick-ups and employers/supervisors. In a small number of cases, family members or a medical care provider was identified as the attacker.

This is consistent with past research that found that the majority of MSA survivors are assaulted by a known attacker (Isely and Gehrenbeck-Shim, 1997; Mezey and King, 1989). In addition, homosexual and bisexual men are more likely to be sexually assaulted by a intimate partner or date, consistent with traditional "date rape" where a woman is sexually assaulted by a an acquaintance in the context of a date or being "picked-up" in a bar or

other setting (Stermac et al., 1996, 58). This is also consistent with the findings of Hillman et al., 1991 and Mezey and King, 1989.

Figure 7: Counsellors' Response to Question: "Were the majority of your MSA client attacked by 'known' or 'stranger' perpetrator?"

Of the 11 counsellors who stated that the majority of the survivors they worked with identified in the "homosexual/bisexual/MSM" category, nine stated that the majority of the survivors had been attacked by a known perpetrator. Another counsellor stated that approximately half of the survivors were attacked by a known individual. Whereas, two out of the nine counsellors who stated that the majority of the survivors that they had worked with identified as heterosexual, also reported that the majority of assailants were strangers to the survivors. In addition, one identified that approximately half of the survivors that they had worked with were attacked by a stranger.

Physical Assault as Part of the Sexual Assault

Figure 8 shows that 50 percent (10), of the counsellors who worked with approximately 71

percent of the 156 survivors, indicated that only a minority of the men stated they had been physically assaulted at the time they had been sexually assaulted. In those cases where men had been physically assaulted at the same time that they were sexually assaulted, nearly all counsellors reported that the nature of these physical assaults was battering assaults. Punching, kicking, and choking were the most commonly identified forms of physical violence. Counsellors identified that a weapon had been used in only about eight of the 156 cases of MSA.

The weapons that were used were most commonly objects that the individuals were struck with, and in one case a survivor was stabbed with a knife. In addition to the eight cases where a weapon was used, two other counsellors identified that in a small minority of cases the threat of a weapon was used. In addition to the weapons that were actually used, the three weapons that were threatened to be used, in one case each, were a knife, a gun, and an AIDS tainted needle. Hillman et al. reported the threat of infection of HIV/AIDS as one of the most common uses of force to achieve MSA in their study (Hillman et al., 1991: 22).

Figure 8: Counsellors' Response to Question: "What proportion of your MSA clients reported being physically assaulted during the sexual assault?"

Data was not formally collected on the number of assailants per survivor. However, it was noted that in those cases where there was more than one attacker and especially when there was a group of more than two assailants there seemed to be a greater propensity for physical violence as part of the sexual assault. Only three counsellors indicated that either all or the majority of the clients that they worked with reported fearing for their lives at the time of the attack. Nearly half of the counsellors reported being unaware of whether or not their clients had feared for their lives at the time of the sexual assault. It is of interest that this was unknown to so many of the counsellors. It remains unclear as to why most counsellors did not inquire about whether survivors experienced such fear. This could be one area that further research may wish to examine.

Survivor Injuries

Figures 9 to 11 indicate the counsellors' identification of the types of injuries survivors accrued during their most recent sexual assault. Seventy percent (14) of the counsellors, who worked with approximately 69 percent of the 156 survivors, reported that only a minority of the survivors that they had worked with suffered non-sexual assault-related, physical injuries. Non-sexual assault related injuries ranged in severity and included broken bones (jaw, nose, and arm), soft-tissue damage (bruising of ribs, torso, and neck), and in one case each a concussion and a stab wound.

Coker et al. (1998: 609) reported that risk factors for physical assault related injuries during sexual assault, among both female and male victims, include: multiple assailants, sodomy, use of a weapon, being assaulted by a stranger, and the use of alcohol and drugs.

Where most counsellors reported that non-sexual assault related injuries were in the minority among the survivors, a higher percentage of the counsellors reported that the majority of clientele they had worked with suffered sexual assault-related injuries. In Figure 10 it is demonstrated that 20 percent (4) of all counsellors reported that the majority of the clients had received a sexual assault related injury. When this is recalculated in Figure 11 (dropping those six counsellors who were unable to provide this information

Figure 9: Counsellors' Response to Question: "What proportion of your MSA clients reported sustaining a physical assault-related injury during the sexual assault?"

for the analysis) the 4 counsellors who reported that the majority of their clients suffered a sexual assault-related injury amounts to approximately 30 percent of the remaining counsellors. These 4 counsellors worked with approximately 26 percent of the 108

survivors that remained after the five cases of missing information were dropped.

Although this certainly does not push counsellors who indicated that such an injury occurred among most of their clientele into the majority, it does indicate that these injuries were more common than non-sexual assault-related injuries. Given the stigma and shame associated with discussing sexual anatomy and “problems” with sexual anatomy, it could be assumed that sexual assault related injuries would be underreported.

Figure 10: Counsellors’ Response to Question: “What proportion of your MSA clients reported sustaining a sexual assault-related injury during the sexual assault?”

The most commonly identified sexual assault-related injury was anal tearing. This reflects the earlier findings that suggest the most common form of MSA is forced anal penetration (Hillman et al., 1991; Stermac et al., 1996; Isely and Gehrenbeck-Shim, 1997). As a result, MSA survivors face a high risk of HIV/AIDS infection, as anal penetrative intercourse is categorized among the highest risk activities for transmission. This risk is enhanced in MSA given the likelihood of higher rates of anal tearing resulting from the probable absence of risk reducing behaviours (e.g. use of a condom; use of proper lubrication).

Figure 11: Counsellors' Response to Question: "What proportion of your MSA clients reported sustaining a physical assault-related injury during the sexual assault?" with "Unknown" Respondents Extracted

Although data was not formally collected on the transference of STDs in this study, one counsellor noted that in at least two cases the survivors felt that they had contracted HIV/AIDS due to their sexual assault.

Hillman et al. found through their examination of the case records of 28 males that reported to a counselling agency in the United Kingdom, that 71 percent of those who sought medical service tested positive for sexually transmitted diseases that they attributed to their sexual assault (Hillman et al., 1991, 24). Although the results of the Hillman study cannot be upheld through corroborating evidence (i.e. a pre-assault test result), there is a need to improve the awareness of the importance of medical services and their discreet availability in our attempts to assist MSA survivors. Survivors may also require additional counselling support around HIV/AIDS testing, test results and potential necessary lifestyle adjustments.

Intoxication

Figure 12 summarises the percentage of counsellors who reported that the survivor was intoxicated at the time of sexual assault. The degree of intoxication varied from case to case and could not be examined through the current data collection. Forty percent (8) of the counsellors stated that none or only a minority of the survivors who they worked with were intoxicated whether, by drugs or alcohol, by choice or by force, at the time of the sexual assault. These counsellors worked with approximately 31 percent of the 156 survivors who the 20 counsellors had worked with. Twenty-five percent (5) of the counsellors, who had worked with approximately 25 percent of the total number of survivors worked with by all counsellors, identified that the majority of survivors that they worked with were intoxicated at the time of the assault. An additional five counsellors, who worked with approximately 23 percent of the 156 survivors, reported that approximately half of the survivors who they worked with were intoxicated when they were assaulted. Out of the entire group of 20 counsellors, only 3 out of the entire 149 cases discussed involved the use of “date-rape” drug (e.g. Rophynol) had been used to sedate and then victimise a survivor, a currently popular point of interest in the general examination of sexual assault. Isely and Gehrenbeck-Shim found that near 40 percent of the survivors that they gathered information on had been sexually assaulted while intoxicated.

Figure 12: Counsellors' Response to Question: "What proportion of your MSA clients reported being intoxicated at the time of sexual assault?"

Stermac et al. reported that 46 percent of the survivors in their study were under the influence of alcohol and 18 percent were under the influence of drugs at the time that they were sexually assaulted (Stermac et al., 1996, 59). Their study also reported that five survivors were unconscious at the time of the assault as a result of intoxication; however, in none of these cases did this condition seem to be a part of a premeditated assault (Stermac et al., 1996, 59).

Patterns and Trends in Characteristics of MSA

As demonstrated in the literature review, MSA has been divided into two "typologies". The first is a pattern of known or acquainted homosexual men sexually assaulting other homosexual men. This pattern of MSA closely follows patterns of traditional "date rape".

The second pattern identified is the increased likelihood of heterosexual men being sexually assaulted by a stranger assailant and an increased likelihood of increased physical violence and injury.

In this study only three counsellors reported that the majority of the cases that they had worked with reported being assaulted by a stranger assailant. Table 2 presents how these counsellors stated the sexual orientation and the prevalence of physical assault in the majority of cases that worked with. Two out of the three counsellors identified that the majority of survivors they worked with self-identified as heterosexual. These two counsellors worked with approximately 92 percent of the 44 counsellors that these three survivors had worked with. In comparison in Table 3, of the 12 counsellors who identified that the majority of the survivors they had worked with had been assaulted by a known attacker, nine identified that the majority of the survivors self-identified as either homosexual, bisexual or MSM. These nine counsellors worked with 73 percent of the 98 survivors that these fifteen counsellors had worked with.

Table 3: Summary of Identified Sexual Orientation and Prevalence of Physical Assault by Respondents who Identified Majority Category of Prevalence of Stranger Perpetrators

Number of Survivors Worked With	Counsellor Number	Self-Identified Sexual Orientation	Physical Assault at Time Of Sexual Assault
12	4	Majority Heterosexual	Half
30	13	Majority Heterosexual	Minority
2	18	Minority Heterosexual	Half

Among the three counsellors who reported that the majority of the cases who they had worked with reported being assaulted by a stranger assailant, two counsellors report that half of the survivors also report being physically assaulted at the time that they were sexually assaulted. When one isolates, as in Table 4, the five cases where a counsellor identified that the majority of the MSA survivors they worked with reported a physical assault, only two of the five counsellors identified that the majority of the survivors who they had worked with self-identified as heterosexual. Further, these two counsellors worked with only a minority of the 21 survivors who these five counsellors worked with. This seems to indicate that a clear pattern of physical violence does not emerge among the sexual assaults of heterosexual survivors, as suggested by the past research.

This chapter provides a glimpse of some of the characteristics of the MSA survivors, and their sexual assaults. Although due to the discussed limitations of the data collection these findings should not be considered precise information that we can generalise to all MSA survivors, this information does provide us with some patterns and trends, as well as support for some of the published research, that we can consider in defining the next steps in research. In addition, this data can provide a general sense of what MSA “looks like”.

This thesis found that although the MSA survivors that were clients of these counsellors were slightly older than previous research reported, that, like earlier studies, the majority of counsellors reported that the majority of survivors they had worked with self-identified as

Table 4: Summary of Identified Sexual Orientation by Respondents who Identified Majority Category of Prevalence of Known Perpetrators

Number of Survivors Worked With	Counsellor Number	Survivor Self-Identified Homo-/ Bisexual/MSM
15	1	Majority
3	2	Majority
3	3	Minority
15	5	Majority
5	6	Minority
5	8	Majority
20	10	Majority
3	11	Minority
5	12	Minority
5	14	Majority
4	15	Majority
3	16	Majority
2	17	Majority
5	19	Minority
5	20	Minority

Table 5: Summary of Identified the Sexual Orientation by Respondents who Identified Majority Category of Prevalence of Physical Assault

Number of Survivors Worked With	Counsellor Number	Survivor Self-Identified Heterosexual
3	2	Minority
5	6	Majority
5	8	Minority
5	12	Majority
3	16	Minority

homosexual, bisexual or MSM. The majority of counsellors also stated that majority of survivors that they worked with reported having experienced historical childhood sexual

abuse and that some experienced one or more previous MSA incidences. Regardless of the type of previous abuse/assault, counsellors stated that previous victimisation often results in compounded trauma and magnified vulnerability. This research seems to indicate that there may be some sort of connection with childhood sexual abuse. Counsellors reported low levels of the use of tools, such as weapons or drugs or alcohol, to induce the vulnerability of these survivors. Finally, the accounts of these counsellors support the suggestion of published literature that the majority of survivors are assaulted by a known attacker, though heterosexual men seem to be at greater risk than homosexual or bisexual men to be assaulted by a stranger.

The characteristics of both survivors and their sexual assaults influence the way that men understand themselves and their attack and respond and act after they have been assaulted. The next chapter of this thesis will examine some of the post-assault understandings, responses and behaviour as observed by these counsellors and will, at times, discuss the influence of the characteristics of the survivors and their assaults as discussed in this chapter.

Chapter Four

SURVIVOR RESPONSE TO MSA

The previous chapter examined the way that men experience sexual assault in the open community, from the perspective of counsellors who had experience working with MSA survivors. This chapter will build on those findings by examining how survivors respond to the trauma of MSA. The chapter will begin by examining patterns and trends in the responses of counsellors in reporting how the survivors with whom they had worked understand themselves and their assaults in the context of hegemonic constructions of masculinity. This will include an examination of the understandings that survivors formulate about their own identity, vulnerability and sexual orientation. The chapter will then examine the emotional and physiological responses that the survivors exhibited. This will include an examination of how survivors dealt with their emotions, the emotions expressed by survivors and the post-traumatic stress symptomology that they presented. This will lead the chapter into an examination of the post-assault behaviour exhibited by MSA survivors, including the coping mechanisms that MSA survivors employ and patterns and trends in their attainment of formal and informal help. The final section of this chapter considers some of the special needs of MSA survivors that emerged in this research.

The responses of MSA survivors to being sexually assaulted are complex and multidimensional with many interconnected aspects that, at various points, overlap with

one another. Survivors' responses are not a linear set of emotions, thoughts or actions. Rather, their responses are fluid, dynamic and at times dialectical. Although there is no single "normal" response to MSA, patterns emerged in the data gathered through the interviews conducted in this study with respect to the type and nature of the responses of MSA survivors. Many aspects of the responses MSA survivors experience and express are quite similar to or are shared with women who have been sexually assaulted.

This chapter pays particular attention to the influence of masculinity on the responses of MSA survivors, from the perceptions and interpretations of professionals working with survivors. The influences of hegemonic constructions of masculinity on survivors' responses to sexual assault are perhaps the principal differences between male and female survivors. As Scarce (1997a: 19) points out, although survivors demonstrate varied reactions, these reactions are most often mitigated by the individuals "own identity, culture and background". As established in the literature review, hegemonic conceptualizations of masculinities are among the strongest of western cultural influences on the lives of men. This is substantiated in the findings presented in this chapter.

Archaic expectations of men created by the constructions of hegemonic masculinity impede the post-assault health of MSA survivors. The literature review has documented how sexual assault continues to be formulated as a "woman's problem", with exceptions being the sexual abuse/assault of males who are particularly vulnerable – male children and men in sex-segregated populations (e.g. in prison). This has had consequences for the way that men understand and interpret their experience and themselves in light of their

experience as well as their emotional and physiological responses and their post-assault behaviour.

Understanding Themselves and their Assault

One of the issues that MSA survivors face in the wake of their sexual assault experience is the challenge to their understanding of themselves and their assault. As discussed in the literature review, hegemonic conceptualizations of masculinity dictate that to be a man is to be powerful and not vulnerable to sexual assault or any other mechanism of subordination. Although most men are subordinated in any number of the power relationships that exist in their day to day lives, the majority of men still strive to meet these inaccessible standards. It is probable that if the majority of men did not strive towards these, then the dominant conceptualization would have evolved in different directions. For men, the experience of being sexually assaulted is not reconcilable with their supposed invulnerability. Sexual assault, indeed, exposes the vulnerability of an individual in being dominated by another person. This study sought to examine the influence of being sexually assaulted on how MSA survivors understand their own identity as a “man” – an act that compromises the standards of that identity.

One of the dominant themes that ran through the counsellors’ experiences was that the MSA survivors that they had worked with felt a shifted or problematised sense of identity after being sexually assaulted. This included confusion over their ability to be a “man” and

a heightened sense of their own vulnerability. For some, this also included uncertainty over their sexual identity.

Problematised Sense of Identity

Of the 20 counsellors interviewed in this study, 17, these counsellors had worked with 81 percent of the 156 survivors, signalled that the survivors with whom they had worked struggled with their identity as a man after having been sexually assaulted. These 17 counsellors' responses, based on their experience working with MSA survivors, suggested that the survivors had internalized an understanding of what it is to be a man that reflected the hegemonic constructions of masculinity. Survivors were intellectually challenged by an inability to rationally reconcile their identity with these internalized understandings. For instance, this was articulated in Interview 4 in the context of differences that the counsellor saw between the way that men and women respond to being sexually assaulted:

...whereas a woman, there's so much, ah you know, this may not be quite the right word, but rhetoric around female oppression. You know, after the women's movement, that a woman who's sexually assaulted doesn't really take it as a flaw in her personality, but more evidence of male oppression of women...I think generally speaking the woman isn't going to feel like somehow her character has been diminished, or her, "womanness", if you will, has been diminished by being assaulted (Interview 4).

Another counsellor identified this challenged sense of masculine identity that MSA survivors experience by expressing the need of male survivors to demonstrate that they still meet the characteristics associated with hegemonic masculine norms:

[A major concern] was for them to be, to remain, a real man, not to talk about it, just to go on and work, and say “You know, I’m a good provider, I work hard, I have a partner. You know, I’m seen as normal in the world” (Interview 13).

By attempting to demonstrate their ability to align their actions with hegemonic norms, MSA survivors attempt to minimize an appearance that they may be less than a “real man”. Given the high level of secrecy surrounding MSA it is likely that the portrayal of a masculine image is also used to assuage their own fears of not meeting hegemonic norms.

Hegemonic masculine norms do not only problematise heterosexual men’s sense of identity. Although sexual activity between men remains a violation of the norms of hegemonic masculinity and homosexual men continue to be stereotypically understood as feminine, MSA also confounds the masculine identity of homosexual men. For example, one counsellor stated:

There is quite a continuum...for some whom it’s more I guess similar to the heterosexual men in terms of the internalization of sexual expectations, and for some that’s not an issue; but, even for flamboyantly effeminate men they can still be getting caught in that thing about ‘I am still a man and I should still be in charge of life’. I think that sexual stereotyping really gets ingrained in us...I think that all men, or that’s my impression as a female anyway, sort of believe that they’re supposed to be sexually assertive or sexually aggressive - supposed to be on top - so anytime you’re not on top is really a blow to masculinity... (Interview 2)

The counsellor who participated in Interview 4, who was quoted earlier differentiating the responses of men and women to sexual assault, also alluded to this in the same pattern of response:

Well I mean the difference between men and women would be the idea of, you know, real men don't get victimised, and I think gay and straight men most, may both have that thought, that you know, I shouldn't have had this happen to me, it's just that, uh, gay men, have had a lifetime of feelings that somehow they don't make the grade, because they're gay, they're not, you know, all American macho, American heterosexual males, and so as soon as they begin to identify their sexual orientation, they're already feeling that they're less by comparison to the, you know, the accepted norm for male behaviour, and, um, male characteristics. Um, but I think the fact that they've been victimised is a problem for both gay and straight men if they're assaulted as adults... (Interview 4)

The findings of this study suggest that men, regardless of their sexuality, internalize hegemonic masculine norms and tie their identity as a man to aligning themselves with these norms. The norms call for men to be impenetrable and in control sexually at all times, as part of their identity. As a violation of these norms, MSA forces survivors to at least question their identity as a man – if they do not feel it is irreparably damaged. The findings of this study suggest that even when survivors feel that they are unable to maintain their identity as a man, they often still struggle to find ways to reconcile themselves with this identity. Among the ways that they attempt do so are the emotions and post-assault behaviours that they exhibit. This will be discussed in detail in later sections of this chapter.

Similar patterns of response between heterosexual and homosexual men are reconcilable with Connell's understanding of masculinity. Although socially homosexual men have been stereotyped as effeminate, and thereby considered less masculine than heterosexual men, they are not excused from hegemonic masculine expectations. Rather, as suggested by Connell, individual men, including homosexual men, are socially located differently and

they relate to the dominant ideals in different ways (Connell, 1995, 37). In particular, not all men in what appears or are considered to be homogenous populations, relate to the ideals of dominant conceptualizations of masculinity in the same way (Connell, 1995, 36-37). Homosexual men are no further removed from the vast network of people, symbols and messaging that advertises and reinforces the hegemonic norm. Rather, their sexual identity is one characteristic – among many that they either share or do not share with many other men who are or aren't also homosexual – that influences how they relate to these norms. The one item that all men share is that they all live in the context of hegemonic standards that are impossible to meet.

The assault experience of MSA survivors further subordinates the lives of men as it contravenes these standards. By being dominated by another person, MSA survivors demonstrate that they are vulnerable, that they can be weak, that they are not always in control, that they are penetrable, that they feel emotion, and that they may need help. MSA survivors demonstrate that they cannot achieve internalised masculine norms that dictate what it is to be a man. As a result, many MSA survivors feel like they are less of or perhaps no longer a man:

...but I think and certainly some cases where a child has been sexually abused, they haven't really formulated a masculine identity, and so the identity that they formulate is one that is formulated as least in part by the abuse, whereas someone that's assaulted as an abuse, if that was their first experience, have formulated an identity that encompasses more of a traditional view of masculinity. So when they are assaulted, it is, it actually feels like it's been taken away, whereas as a child they may not have had it in the first place (Interview 4).

Heightened Sense of Vulnerability

Another common challenge of MSA is that it increases survivors' sense of vulnerability.

All of the counsellors suggested that the survivors who they had worked with perceived themselves to be more vulnerable after being assaulted. One counsellor described MSA as the "rug of social safety being pulled from beneath [the survivors'] feet (Interview 12)".

Another counsellor described this process:

Everyone has disbelief that it could happen to them, "I can't believe it's happened to me". But for men it's even that much more so. "You know I'm a man, these things don't happen to men." So a heightened sense of vulnerability (Interview 12).

Survivors often required help to understand that the reasons that they were vulnerable were more elaborate than just physical strength. Given the prevalence with which counsellors reported that the survivors had also been the victims of historical childhood sexual abuse, this was a common source of vulnerability identified by counsellors:

And, so yeah, so a lot of them weren't quite aware of their blind spots. Only later, when we kind of reconstructed all therapeutically, and tied in to their previous victimizations and patterns of use of alcohol and drugs do they make the association, only then are they able to understand, 'ah, okay here's the context in which it happened'. It kind of makes sense to them in a more integrated way (Interview 14).

As men have little or no warning that they could potentially be the victims of a sexual assault, the heightened sense of vulnerability should be of little surprise. Counsellors were able to identify other factors that added to the vulnerability of the clients that they had seen – for example previous abuse or assault, high risk behaviour, addiction, poverty, self-

esteem, power relationships (e.g. employee-employer), disabilities, and homophobia – and help survivors develop the boundary-setting skills necessary to protect themselves. This was often a difficult process as it often required men to critically reflect on what at times were emotionally difficult or painful aspects of their lives.

Questioning Sexual Orientation

Questioning one's sexual orientation is an extreme instance of the reflexivity that some men experience after having been sexually assaulted; however, this seems to be a more common reaction to MSA for particular groups of MSA survivors. As the majority of MSA survivors identify as homosexual – as found in this and other studies (Hillman et al., 1991; Mezey and King, 1989; Stermac et al., 1996) – it follows that only a minority of MSA survivors are likely to question their heterosexual sexual orientation. Further, the counsellors who participated in this study suggested that the questioning of sexual identity was less prevalent than among men abused as children. The counsellors indicated that most MSA survivors had already forged a sexual identity, whereas men who were sexually abused as children experienced this trauma while they were in the midst of developing their sexual identity. This study found that 15 of the 16 counsellors¹⁷ who worked with heterosexual survivors indicated that at least some of the survivors who they had worked with questioned their sexual orientation in response to being sexually assaulted. The 15

¹⁷ It should be noted that four of the counsellors worked exclusively with homosexual survivors.

counsellors worked with 96 percent of the 124 survivors who these 16 counsellors worked with.

Counsellors also identified that the characteristics and context of MSA also influence the likelihood that a survivor might question their sexual orientation. For instance, prevalence or an absence of overt sexual messaging and the immediate physiological response experienced by the survivor during the assault were both characteristics that the counsellors associated with influencing whether or not a survivor might question his sexual identity.

Counsellors suggested that men who were the victims of assaults that included overt sexual messaging, such as a perpetrator expressing explicit 'sexual interest' in a survivor, suggesting that a survivor is homosexual or suggesting that a survivor is 'good' at performing 'homosexual sexual acts', may be more likely to question their sexual orientation. Counsellors suggested that assault incidences that lacked the sexual messaging that exists in other MSA incidences – that were equally about degradation and the creation and/or reinforcement of subordination – were less likely to instigate the questioning of sexual orientation. For instance it was suggested that men who were the victims of violent multiple-assailant assaults, that centred more on the sexual assault as an act of violence than as a sexual act, would be less likely to question their sexual orientation.

The counsellors suggested that a survivor's immediate physiological response could also influence the likelihood that a survivor might question his sexuality. For instance, if a survivor ejaculated or became erect during the assault then they may misinterpret these as

physiological signs that they intrinsically enjoyed the experience. One counsellor who worked exclusively with gay survivors, almost all of whom had been assaulted by their partner, explained:

Or it could be that the offender is really going out of his way to stimulate his victim. Or just that spontaneously that happens. That's always a nightmare for people. Because the body responds it doesn't mean you like it. I think that's one of the worst pieces to all of this for people. And I think that's what makes people not talk about it too, because then it doesn't get categorized as a sexual assault: 'Well, I really didn't like it, but I must have liked it because I responded' so it gets put into the category of "I liked that" as opposed to "I didn't like that" (Interview 2).

Physical stimulation on its own does not constitute sexual pleasure or a need to re-examine one's sexual identity. However, confusion over the message of physiological responses can, in addition to causing confusion over sexual identity, influence survivors of all sexual orientations to believe that they consented to the sexual assault. Some survivors are groomed by their attacker(s) to believe that their physiological response suggests that they enjoyed the experience and as a result consented to what had occurred.

The masculine norms of Canadian and western society remain firmly tied to heterosexuality. Homosexual activity is a clear violation of the norms and raises concerns paramount to the heterosexual identity of survivors. A survivor's questioning of their sexual identity in the wake of sexual assault is often tied to their feeling of being "less than" or no longer a "real man", stereotypes also associated with homosexuality. By being sexually assaulted men breach the hegemonic standard through their (unwilling) participation in a "homosexual act", and their inability to maintain in control – sexual or

otherwise – be impenetrable and be powerful. In addition to the influence that masculine socialisation has on the way that survivor's understand themselves, their internalised sense of masculinity also influences how survivors respond emotionally to MSA.

Emotional Responses to MSA

Sexual assault is clearly an emotionally charged incident for survivors and generates cumulative emotional reactions over time. It produces feelings of sadness, embarrassment, anger, worthlessness, dirtiness and pain. The way that survivors express these feelings varies. The emotional response of an individual to their sexual assault, including to the assailant, is particularly influenced by an individual's socialization.

In addition to problematising MSA survivor's sense of their identity in relation to the standards of hegemonic masculine norms, the expression of emotion is also a gendered issue. Normatively, men are restricted in the emotions they are "allowed" to express and under the relatively few circumstances they are allowed to express them in. As discussed in the review of past literature, dominant masculine norms dictate that men are to be stoic, where the expression of painful emotions is a threat to a man's ability to be powerful. This presents problems for counsellors and survivors, in terms of the ability of men to express their feelings as an aspect of healthy recovery.

This section of the chapter will examine the three aspects of emotional expression that the counsellors who participated in this study identified as being the most common among the survivors who they worked with: emotional minimization, shame and anger.

Emotional Minimisation

Research has shown that the emotional responses of women – who are expected to be “overly” emotional - to their sexual assault range from being quite expressive to quite minimalistic (Burgess and Holmstrom, 1974, 982). In furthering the work that Burgess and Holmstrom conducted with female survivors, Kaufman et al. found that MSA survivors have a greater tendency to exhibit a “controlled” emotional response where female survivors were more likely to have “expressive” emotional responses (Kaufman et al., 1980, 223). Kaufman et al. suggested that the emotional minimization displayed by MSA survivors may be a product of the gender expectation that men are to be constantly in control of their emotional state (Kaufman et al., 1980, 223).

Sixteen of the 20 counsellors interviewed suggested that there was a tendency for MSA survivors to minimise their own emotional responses. The 16 counsellors worked with 74 percent of the 156 MSA survivors. As Kaufman et al. (1980, 223) noted, this was often reflected in survivors’ attempts to avoid discussing their emotions or how they “felt” about their assault. One counsellor described this when describing the differences between MSA survivors and female survivors:

Usually, for example, women when they come in, by the time...they're kind of brimming to the top with [emotions] and it just kind of builds out. With men they seem to try and attempt to contain it more and they go a little bit more into the facts and have more of a difficult time when they're approached with you know the [emotional] impact on them (Interview 12).

Such responses by MSA survivors reflect normative masculine standards of behaviour that direct men to attempt to make sense of their experiences through rational or analytical reasoning rather than introspective examination of their emotions. The counsellors in this study suggested that MSA survivors are also hindered in expressing themselves by the confusion that they feel over the emotions or the severity of those emotions that they experience and those that they expect to experience. One counsellor explained this pattern in the following way:

...What you're socialised to believe is "masculine" is completely contradictory to what a lot of these men feel when they do feel vulnerable, when they do feel victimised, they do feel wounded, they do feel pain, they do feel hurt. There are a lot of feelings and emotions that they've been told they're not supposed to have. But yet they're having them, so absolutely there's a question of their socialised masculinity, if you will (Interview 1).

The unexpected nature of the emotions that MSA survivors experience also causes them to misconstrue their severity. Schneider et al. (1994: 805) reported that male participants in their study viewed the psychological traumatic effects of MSA with less severity than other impacts of the assault. Schneider et al. (1994: 805) attributed this finding to the inability of male participants to relate to the "psychological aspects of victimization" due to an emotional socialisation that suggests that men are not to 'feel' painful emotions and that those who do are weak or less of a man.

This is not to suggest that MSA survivors will not talk about or express their emotions. Rather, the counsellors interviewed in the study felt MSA survivors required time and coaching to understand that the expression of emotion was an important and natural element of a healthy recovery process:

...I find that there's a fair amount of emotional containment at the beginning with the adult assault survivors because once again that's part of the male image, you know I'm supposed to be tough, I'm supposed to be in control, I'm not supposed to let out my vulnerability. I can talk about this, but you know in a very academic sort of way. I can describe what happened but I can't have feelings about it... I'll say to men...sometime in the next week or two...you'll feel a lot of feelings just coming up, just, you know, in spite of your efforts, and that's a normal part of the process so don't be shocked when that happens...When it does happen they feel a lot easier about letting it happen and they'll come back to me and say: "You know, what you said about the emotional upheaval was right. That's happened to me and I start, I just start breaking down and I cried for half a day". So, once again, saying that that's a normal part of the process I think helps them (interview 4).

Counsellors indicated that coaching men to become more comfortable with discussing or expressing their emotions was one of the biggest challenges in working with MSA survivors. However, unfortunately few MSA survivors remain engaged in a counselling regime long enough to successfully overcome hindrances to discussing their emotional responses to sexual assault (refer to subsection of this chapter: Orientation to Counselling). The counsellors indicated that developing their ability to discuss and openly express their emotions was an important step for MSA survivors in overcoming unhealthy internalised understandings of masculinity:

The greatest challenges about men is defining healthy masculinity. And discerning their definition of what is a healthy man and healthy men, or assisting them with, um, to express a wide range of feelings and emotions.

Both to acknowledge them and to identify them, and express them. So, with men, it can be difficult to get them to express or acknowledge what they're feeling and what they're going through and how that relates to views on masculinity. Kind of – 'men aren't victims, so victims aren't men' (Interview 7).

The counsellor later added:

Men and women are socialized differently, brought up differently so the recovering process is somewhat different – they are much the same, but somewhat different at the same time. Men often need to work hard on their views of masculinity – what is healthy masculinity, how does that affect the healing process. But part of that process would be, um, working with feelings and emotions and education of feelings and emotions. Men often identify with anger and, uh, connect a lot of feelings and emotions to anger, so a lot of the work is, uh, identifying and working through the feelings and emotions connected to that anger. And the acceptance of this being a healthy process instead of an unhealthy process attacking the masculinity (interview 7).

Men often manifest many of their negative emotions through anger. Rather than being able to self-examine their emotions and accept feelings of hurt or pain, men are socialised to channel negative emotions through anger and aggressive behaviour that is flavoured with retribution (Poon, 1993, 255). This may lead many MSA survivors to other interrelated responses such as homophobia and unhealthy post assault behaviours such as hyper-masculine coping mechanisms as vehicles to relieve their post-assault emotional response.

Anger

Anger is one of the few emotional reactions that hegemonic masculinity supports. As stated, men are socialized to be without emotions and when they express emotions such as

sadness or hurt, men are regarded as weak and 'feminine' (Poon, 1992: 255). Poon (1992: 255) suggests that rather than expressing negative or painful emotions, men are brought up to learn to channel these into anger and aggression. Through the expression of anger men are supposed to be able to "deal with" whatever difficult circumstances arise and return to a controlled, emotionless and "sturdy" state (Poon, 1992: 255).

Scarce (1997a: 23) recognizes that, although anger can be a healthy emotional response in some instances, it is often detrimental to the post-assault health of MSA survivors. MSA survivors may direct their anger at a range of individuals including their assailant, individuals who they perceive to share characteristics with their assailant(s), individuals who react negatively to their disclosure, ill- equipped professional service providers, society in general and/or themselves.

All of the counsellors who participated in this study indicated that the majority of the survivors that they worked with expressed anger as part of their emotional response to MSA. This section discusses the two forms of anger most commonly discussed by the counsellors who participated in this study: self blame and homophobia.

Self Blame

One of the most common responses to sexual assault by both women and men is self-blame. The majority of counsellors who participated in this study suggested that MSA survivors blame themselves along a number of dimensions for their victimisation. The

counsellors identified that, although some of the reasons that MSA survivors may blame themselves are similar to those of female survivors, other reasons are fundamentally different. Some reasons women tend to blame themselves for being assaulted are being provocatively dressed, being intoxicated and/or being in a place that puts them at risk. These reasons tend to be oriented towards blaming themselves for attracting an attacker to their seemingly “natural” vulnerability.

All but one of the 20 counsellors who participated in this study identified that the majority of the MSA survivors who they worked with blamed themselves for being sexually assaulted. The 19 counsellors had worked with 99 percent of the total number of survivors. The counsellors’ responses suggested that the survivors who they had worked with predominantly blamed themselves for allowing themselves to be vulnerable and not being able to stop the assault:

...my experience is that [self blame] is a more typical response for a victim, but males tend to, to take it harder in some ways, like, it’s almost women can eventually see, but the men continue to, you know, hush it up, If I had done this, if I had done that, and it’s a constant...Yeah, oh even after session it seems to come back to that. And...a real upset around having been vulnerable (Interview 12).

This provides more evidence of the pervasiveness of hegemonic standards of masculinity among survivors of MSA. This quote suggests that the survivors that this counsellor worked with engage in a process of intellectual analyses of the events of the sexual assault, attempting to identify “mistakes” in their own actions that could have prevented its occurrence. Survivors assume that they were in control and that by identifying their

“mistake” that they can return to the hegemonic norm and figure out how to be more “in control” in their lives. In effect, they are rejecting attempts to problematise masculinity and to think critically about it.

Another counsellor stated:

I think a lot of them have so much self blame and judgment that they were not able to stop it that they struggle with more than any thing not explaining to us but to themselves "why didn't I?" (Interview 3)

A third counsellor's response also attested to the strong need by MSA survivors to be able to explain what has occurred:

Even with people who seem to have a little more clarity around “it’s not my fault”, often that’s a front, that’s an intellectual front and underneath there may very well be very strong feelings about ‘that’s my fault and I should have done something, I should have been able to prevent it...I was born rotten there, there must be something about me, I shouldn’t have gone there, I was too stupid.’ It’s quite remarkable how oppressors in situations across the globe manage to transfer responsibility to the victims. It’s uncanny...sexual assault cuts to some of the most vulnerable aspects of people, and to leave them to field the blame. It’s like brainwashing of some sort (Interview 2).

The counsellors indicated that this tendency for men to blame themselves for allowing themselves to be vulnerable or for not stopping the assault was closely linked to a need to be able to explain why they were a victim in the first place. One counsellor described the case of one survivor who was assaulted by an assailant who was a great deal larger and more physically powerful than himself. Even though the survivor was at the complete

mercy of his attacker, the survivor was still unable to cease blaming himself for what happened:

I said well...If you had tried to resist, you probably would have been seriously injured. And he was in a group, and the group reinforced that, and said pretty much the same thing, and although that helped a bit, he still really couldn't let go of some sense of, well I should have been able to stop it. Where he might not have been able to physically prevent it I guess he still condemned himself for not seeing through the manipulations (Interview 4).

Counsellors also identified additional areas of self blame among the men that they had worked with. They considered these additional reasons for self blame to be more comparable with the reasons for which women tend to blame themselves. The counsellors identified that this included the appearance that the men thought they might have given off. Rather than focusing on not stopping the assault from occurring, in these instances men seemed to be more concerned that they may have signalled that they were gay or weak – that they were not masculine or not masculine enough:

Men won't say it's something that I wore, men will say is it something that I did or the way that I looked that gave them the idea that they could do that to me so, that they think I'm weak. It's more like that, because women will tend to say "Was I provocative in any way, did I flirt, did I wear the wrong clothing, bit of a different twist (Interview 3).

Another counsellor also commented on this concern:

Yeah, I'm just trying to differentiate between the childhood and the adult, because certainly the child does that, and carries it with them for a long time. Um, certainly, no, and I would say that's an adult concern too. What did I do to cause this to happen? What should I have done to avoid it? Um, am I homosexual? You know. Are these men attracted to me

because I uh, because I am somewhat of a homosexual and don't know it? Um, yeah, so men would go through very much a lot of the similar things a woman would go through (Interview 7).

Scarce (1997a: 24) recognizes that a significant difference between MSA survivors and childhood sexual abuse survivors and female sexual assault survivors is that MSA survivors face greater difficulty in avoiding self-blame for allowing someone else to dominate them. One counsellor articulated this in the following way:

Dealing with the shame of being sexually abused as an adult male, you know, that may be one of the differences of being an abused or assaulted adult male compared to a child. A child still feels responsible but can often work through that as not being their fault, where possibly the adult male views it as well, I'm an adult male, I should have been able to stop this, I should have been able to do something. A child is vulnerable, but I am an adult, I should have been able to do something (Interview 7).

Counsellors indicated that gay and bisexual men's experience of self-blame might encompass some different complexities. As discussed earlier, some heterosexual men question their sexual orientation or heterosexual masculinity as a result of the attack and may require assistance to realise that being sexually assaulted does not change this. However, for gay or bisexual men the act used to assault them is an act that, at a different time, place, circumstance, and/or with a different person(s), may be enjoyable. As with women who experience date rape, gay men may experience a heightened sense of self blame if they feel that they may have initiated some form of intimacy:

And certainly in the case of gay men some instances have been a date, date rape, and so they don't feel, they felt like they really are responsible. They went with a person, they consented to a certain degree of intimacy, or implied intimacy was all right. So when they ended up to have been a victim of date rape, they don't feel comfortable reporting it to the police,

and uh they are, they may find it a little bit more difficult to let go of any sense of responsibility (Interview 4).

This may increase the feelings of self blame and intensify the difficulty in ending the sense of self blame that survivors experience. They may interpret their actions or core sexual desires as being the cause of the sexual assault. As gay men are at high risk to be assaulted by a partner or date this may further complicate matters. Another potential complication, discussed earlier, is physical stimulation.

For those individuals who do reveal their assault to friends, family or others (e.g. police), the way that these individual(s) react to the disclosure has a strong influence on the degree and nature of self blame that a survivor experiences (Scarce, 1997, 20). Any negative reactions that suggest the individual was to blame or had done something to bring about the assault serves to intensify the feelings that a survivor experiences. As discussed in the previous section of this chapter, the counsellors who participated in this study indicated that the MSA survivors that they had worked with experienced considerable anxiety around how others will perceive them as well as worrying that others will feel that they had done something 'wrong'.

Homophobia

The second most common form of anger that the counsellors who participated in this study identified among the MSA survivors who they had worked with was homophobia.

Fourteen of the 20 counsellors, who worked with 83 percent of the survivors, identified that

the survivors expressed homophobia towards their assailant, the homosexual community, or at themselves. According to Scarce (1997: 57), “no bigger factor is responsible for the stigma” of MSA than homophobia.

Homophobia, as related to MSA, is grounded in traditional understandings of sexual assault, masculinity and homosexuality. Homophobic understandings of sexual assault are similar to understandings that suggest that sexual assault is a “woman’s problem”.

Homophobic understandings of MSA are premised on perceptions that men are victims only because they are the object of uncontrolled homosexual sexual desire and that is fulfilled through MSA. As one counsellor reported:

And it’s really interesting at that time to be able to see the commonalities and the differences between male and female survivors together in the same group, and I would say that there’s more similarity than differences. They all have a lot of pain, they all have a lot of shame, they all have a lot of anger, they all have sexual issues. They may look somewhat different, but they share so much that the differences seem to be once again more about the individual, not really about one gender as opposed to the other. With the exception of the homophobia. That is an issue that seems to be pretty much absent with female survivors, and very much present for male survivors (Interview 4).

Stereotypes of homosexuality are largely based on historical beliefs that homosexual men are a “sexual danger”, especially prone to molesting children and responsible for “social decay” (Kinsman, 1993, 21). Although these convictions have been somewhat moderated over time, homosexuality continues to be understood as “deviant” to the heterosexual norm in Canada today (Kinsman, 1993, 23). Kinsman suggests that this has fostered the

continued existence of notions of homosexuality as “criminal” and “ill”, and other myths about homosexual sexual behaviour (Kinsman, 1993, 23).

This continues today in the context of societal perceptions of the “causes” of HIV/AIDS. Homosexual men and their behaviour have been “remedicalised” – associating sex between men with illness and death (Kinsman, 1993, 25). According to Kinsman, until the dominant standards of heterosexual masculinity are displaced, these notions that act to marginalize homosexuality will continue to exist (Kinsman, 1993, 23).

Homophobic understandings of MSA expressed in the reaction of survivors are usually manifested either in anger directed towards their assumed gay perpetrator or fear of being perceived as gay or having willingly had a homosexual experience:

It’s also because of the homophobia issue, they don’t want me to think that they’re gay, so they have to make it real clear to me real quickly that they had no interest in this [MSA] happening whatsoever (Interview 4).

This quote, again, highlights the degree to which survivors look to demonstrate their ability to maintain the standards of the masculine norms. As discussed in the section of this chapter devoted to shame, MSA survivors place a great deal of emphasis on ensuring that others do not perceive them as having taken on weaker or more “feminine” qualities, such as those often affiliated with homosexuality.

These understandings ignore the fact that sexual assault is more precisely about power and subordination, though it is manifested in a sexual act. Indeed past literature has even

suggested that this is unfounded as the majority of research conducted to date has suggested that most MSA perpetrators are in fact heterosexual (Stermac et al., 1996; Mezey and King, 1989; Groth and Burgess; Scarce, 1997).

Homophobic reactions are also internalized among many gay MSA survivors. Counsellors referred to gay survivors who directed anger and self-blame at themselves because they were gay:

Within, let me see if I can put it this way (pause) I think (pause) the way that my limited experience tends to play out with gay men is the question that comes up for them as follows: "I was assaulted because I am gay? Right?"...In other words, "does my being gay mean that I am intrinsically weak and vulnerable the way a woman would be?"...Right but just to take it back to the issue at hand here, I think that kind of homophobia in terms of fear of one's own gayness and what might it might mean and the other face of that being the kind of misogyny that's built into it and it's built around: that needs to be addressed (Interview 17).

Another counsellor believed that the effects of homophobia are far reaching among the gay clientele that they had worked with:

I would say that the differences are really more individual than they are one group as compared to another. Although, um, the, between gay and straight men there are certainly some differences, the whole issue of homophobia they all share but the way it's manifest is going to be different because gay men are going to feel the burden of socialized homophobia in a different kind of way, it's really more about their entire identity (Interview 4).

This reinforces the degree to which homosexual activity remains stigmatized in Canada and much of western society.

Shame

Another emotional response that counsellors identified among the MSA survivors that they had worked with is shame. All of the counsellors who participated in this study indicated that the majority of survivors who they worked with experienced shame after being sexually assaulted. Counsellors indicated that the potential embarrassment that would be incurred if others were to find out about the sexual assault and the fear of how others will react to this are core aspects of the shame that MSA survivors feel:

I think one difference I noticed with the men as compared to the females is that shame and embarrassment was experienced, or a key issue, to a much greater degree. So there was much more concern around others knowing, the public knowing. I think that's a big difference. So greater degrees of shame (Interview 15).

This shame associated with MSA is deeply rooted in hegemonic understandings of masculinity and homosexuality. As stated earlier in this chapter, homosexual activity, whether consensual or not, remains among the most stigmatized forms of sexual activity in western society and irreconcilable with dominant masculine norms. Scarce (1997a: 20) cites the fear of being perceived as homosexual as being the foremost cause of the potential embarrassment of stigma and shame for MSA survivors. The counsellors' responses supported this and also suggested that the fear of being perceived as gay is not limited to heterosexual men:

It's also about them feeling like, you know, maybe they're not a real man, maybe they'll think I'm gay, um, all the stigmas that goes with that. "Maybe I've made this up, maybe it isn't as big as I thought it was", um, and feeling very much ashamed of it. And having uh, not much of an

access to their anger or their sadness because they're ridden with guilt and fear, and shame (Interview 13).

Even for those survivors who do come forward publicly, the fear of the reactions of others is paramount. For example, despite the exceptional behaviour of the clients of one counsellor (who provided services only to survivors who were proceeding through the justice system) in that all of these clients reported their victimization to the police, they were intensely concerned with how others viewed them. Ultimately, their own shame may have been the most difficult to come to grips with:

They were telling people... but it created huge issues...in terms of not getting appropriate responses, or them having lots of mixed feeling about telling others. It was the key presenting issue for them, their own mixed reactions to what had happened, and then telling others. Whereas, usually the historical ones had disclosed to somebody else before hand and that had kind of subsided a bit. The new issue for them was the court system, and facing the perpetrator. Facing the perpetrator wasn't as significant for the [survivors of adult sexual assault], compared to dealing with their own reaction (Interview 15).

This suggests that, in addition to fearing the reactions of others, a great deal of the shame that MSA survivors experience derives from their own fears of not being able to meet internalized standards of "manhood". The fear of public reaction is paramount to the post-assault behaviour of survivors. The result is that the majority of the survivors refrain from telling anyone else, including intimate partners, family members or close friends, about their experience for fear of their reaction.

Physiological Response

In addition to the upheaval that individuals experience in regard to their understanding of themselves and their emotional responses, an interrelated aspect of their response to MSA is their physiological response to the sexual assault. This response is largely manifested in post-traumatic stress symptomology.

In this study, 17 of the counsellors suggested that the majority of the MSA survivors that they had worked with presented symptoms consistent with Post-Traumatic Stress Disorder (PTSD). These 17 counsellors worked with 92 percent of the MSA survivors. Many of the counsellors stated this directly:

For [MSA survivors] it's usually just Post-Traumatic Stress Disorder symptomology. You know: 'I can't sleep', 'I've got kind of flashbacks, can't sleep', anxiety, can't leave their house. You know, that kind of stuff. Or acute difficulties in their current relationships (Interview 14).

Others described symptoms consistent with this diagnosis:

Okay the biggest difference was that these men [MSA survivors] were in what I would call acute distress. They were highly anxious, experiencing very intrusive and distressing flashbacks. That's how I would describe them in a nutshell (Interview 17).

Often, counsellors identified these symptoms as being comparable with those experienced by female survivors of sexual assault whom they had worked with:

Interference with sexual functioning, like ability to be intimate, triggers interfering with sex, those kinds of things, I think are fairly common...with men and women (Interview 2).

Other symptoms that counsellors who participated in this study identified included inability to concentrate, phobias related to aspects of their assaults and suicidal ideation or attempts. The counsellors noted that MSA survivors rarely seek assistance immediately following the assault incident and that most did not come forward until months, and for some, years after the sexual assault. This meant that the symptomology presented by many of the MSA survivors showed some variation based on the length of time between the assault and reporting.

The results of the interviews with counsellors for this study support the findings in the existing literature. Burgess and Holmstrom documented Rape Trauma Syndrome (RTS) in 1974 as a form of PTSD in women who had been sexually assaulted. Their conceptualization included immediate and long-term symptomology resulting from sexual assault (Burgess and Holmstrom, 1974, 985). In addition to the symptoms cited in the quotes taken from the interviews conducted for this study, additional symptoms of RTS and PTSD include: physical trauma, skeletal muscle tension, gastrointestinal irritability, sexual dysfunction and an array of interrelated emotional reactions including heightened levels of fear – often related to characteristics of the sexual assault (Scarce, 1997a: 20-21).

Kaufman et al. found that the male survivors that they studied exhibited similar post-assault symptomology as Burgess and Holmstrom documented among female survivors (Kaufman et al., 1980, 223). Symptoms included shock, disbelief, disruption in family or personal life or work, and social dysfunction. The findings of this thesis and other studies suggest that PTSD, and more specifically Rape Trauma Syndrome, is a “human”, as opposed to

gendered, response to the trauma of sexual assault, although it is likely that gendered socialisation may influence the texture of this response.

Post-Assault Behaviour

The three previous sections of this chapter examined how dominant understandings of masculinity and sexual assault influence how MSA survivors perceive themselves and their emotional and physiological responses to being assaulted. In addition, these understandings also influence the behaviours of survivors following their assaults. This study looked at two types of post-assault behaviours: the use of coping mechanisms and the attainment of help in addressing the trauma impacts of being sexually assaulted.

Coping Mechanisms

The counsellors indicated that the majority of MSA survivors they had worked with engaged in coping mechanisms as part of their post-assault behaviour. The counsellors suggested that these coping mechanisms were used by survivors to alleviate the intense stresses of their perceived loss of masculine identity, the emotional and physiological trauma and the shame they felt. Coping strategies are a particularly important crutch for individuals, often utilized by survivors who are unable or unwilling to address these stresses directly, to circumvent or dull the pain that a survivors experiences. It is common for individuals to employ multiple coping mechanisms at one time. Although they may be seen as at least temporarily relieving the pain of sexual assault, they are often detrimental to the health of survivors in the short and long term. In addition to allowing survivors to

avoid addressing many issues that are important aspects of a healthy recovery process, they often bring about further physical and psychological health impediments.

The two most commonly identified coping mechanisms in this study were social isolation and substance (alcohol or drug) abuse. Nineteen and 17 counsellors, respectively, identified that the majority of the survivors whom they had worked with utilised these coping mechanisms. The counsellors worked with 99 percent and 94 percent of the 156 survivors, respectively. One counsellor articulated the use of social isolation by the survivors that they worked with:

...they will avoid social contact much more so than normal, than they would otherwise, because they're experiencing a struggle with their feelings and wanting not to let their emotional vulnerability or volatility be seen. They choose to avoid social contact more likely because they don't want any of that stuff to be seen, they don't want any of it to leak out. And so until they feel that they've got it under control, there's an unlikelihood that they would, because they stay home and stay more isolated. (Interview 4)

As suggested by this counsellor, social isolation allows survivors to minimize the chances that anyone else would find out about their experience. The stigma and shame of MSA preys on the fear that others will respond negatively to a survivor's experience.

The other coping mechanism that almost all counsellors reported was substance abuse. Counsellors suggested that the use of substance abuse as a coping mechanism was far more common among MSA survivors than female survivors:

With adult men there is more evidence of substance abuse as one of the symptoms that accompanies it. I haven't seen much of that with women. There are lots of matching levels of depression, things like that. I don't actually think I see a great deal of difference [between the reaction to sexual assault by men and women], but substance abuse might be one of those areas (Interview 8).

Alcohol and drugs are commonly thought to "take the edge off" or "dull" painful emotions, commonly referred to as "self-medicating" (Scarce, 1997a: 25). Traditionally, alcohol has been considered to be a "masculine" coping mechanism for its ability to mask emotions that were considered inappropriate for men. This distinction is becoming blurred, however, as alcohol and substance abuse among women is becoming more common. The use of alcohol and drugs as a coping mechanism often leads to alcoholism or addiction that brings about additional difficulties in the lives of survivors.

In addition to social isolation and substance use, counsellors also indicated that a minority of survivors that they had worked with also utilised coping mechanisms that were aimed at bolstering their own sense of masculinity or masculine image. Thirteen counsellors reported that at least some of the survivors with whom they had worked used coping mechanisms that they identified as attempting to demonstrate their ability to remain a "real man". These 13 counsellors worked with 63 percent of the 156 survivors. These were often hyper-masculine activities or behaviours were geared to clearly establishing a traditional heterosexual masculine image. Hyper-masculine activity is also consistent with Poon's suggestion that men are socialised to channel negative emotions through anger and aggressive behaviour that is flavoured with retribution (Poon, 1993, 255). One counsellor

described one client who felt that he would only be able to regain his masculinity through extreme aggressive actions:

Um, getting drunk, getting stoned, something engaging in high-risk or aggressive sport and recreational activities. For two reasons: One trying to suppress their vulnerable feelings, and also to intensify the image that they're portraying to anyone that happens to be observing. Because that that's been undermined so they need to reassert that (Interview 4).

The counsellor later added:

...it seems to me like very often men who've been abused as an adult or in their late teen years are more likely to fantasize about, or think about acting out violently towards their offenders. And as one man expressed it to me, he said that his masculinity was taken away and that he has to hurt or kill his offender in order to regain that (interview 4).

The aggressive behaviour that a survivor may employ does not necessarily have to be directed at his assailant(s) or another person. One counsellor described the aggressive behaviour of one of the survivors they had worked with in demolition derbies:

...I mean, you know the young man, he'd become completely socially isolated...he was, eventually he was saying "Well, I don't have any social life. All I did was you know, try and build these cars and wreck them in the demolition derby". That was his whole life (Interview 11).

Another coping mechanisms that counsellors identified and could be considered to be hyper-masculine is sexual promiscuity. Survivors were able to use sexual activity to

demonstrate their masculinity as well as to channel or suppress their emotions through what some counsellors described as addictive sexual behaviour:

And my impression was that he certainly had not had much in the way of healthy sexual intimacy or healthy sexual activity...were in a setting that allowed me to do this I would immediately, or very soon probe for - I'd do a detailed sexual history - and probe for suspected addictive sexual behaviour... I include not only speaking out or acting out behaviour but the flip side of that, which is aversion or avoidance...I would agree strongly that his sexual behaviour was very much [a coping mechanism] affected by having been abused (Interview 17).

As well as social isolation, substance abuse and hyper-masculine behaviour, other coping mechanisms that these counsellors identified included self-mutilation, changing jobs, dropping out of school, compulsive/obsessive behaviours (including cleaning, working, gambling, and exercise) and moving. All of these coping mechanisms are used by survivors to address the challenges that being a MSA survivor presents. The coping mechanisms that the counsellors identified are consistent in nature with other aspects of these survivors' post-assault responses and behaviours. These behaviours sought or did limit the shame and potential stigma of being an adult male sexual assault survivor, channelled or negated difficult emotional responses that most men are not socialised to experience and mask potential signals of their MSA experience and new found vulnerability. There was a consensus among counsellors that these mechanisms are detrimental to the health of the survivors who employed them. Few counsellors reported that the survivors that they worked with engaged in any positive coping mechanisms outside of counselling, such as using self-help materials.

Getting Help

One alternative to the use of unhealthy coping mechanisms used to address the trauma of MSA is accessing “help”. It is important to understand that help can be available in a variety of formal and informal mechanisms. Formal mechanisms of help include services such as medical or police services, in addition to counselling services. Informal mechanisms of help include the assistance of family and friends. It should not be forgotten that the data collected in this study is based solely on MSA survivors who chose to access formal counselling help. This is likely to have skewed the findings presented in this thesis, as evidence suggests that most MSA survivors do not access any form of help. While the findings of this study are generally consistent with the little research that has been done on the responses of MSA survivors, this problem is an issue that runs through almost all of the research conducted to date on MSA. Counselling organizations are one of the few mechanisms that allow researchers access to data on MSA survivors or to the survivors themselves. The counsellors suggested that the stigma and shame of MSA also inhibits MSA survivors from accessing help after being assaulted. The counsellors who participated in this study indicated that, even though the survivors they worked with had accessed their service, few had sought out additional formal or informal mechanisms of help.

The majority of counsellors reported that the majority of survivors did not access any other 'formal' mechanism of help. With only one exception¹⁸, the counsellors uniformly reported that the majority of survivors did not access help from the police. Several researchers, including Donnelly and Kenyon (1996) and Scarce (1997a), have documented overtly negative reactions by police, including shaming, disbelief and mockery. The anticipation of this sort of reaction or the fear of being perceived as homosexual has resulted in reluctance to turn to police for help or to report their assault. One counsellor identified that it was almost "impossible" for MSA survivors to go to the police:

...because with the police there is potential for police to belittle a man who has been assaulted, because there are so many power dynamics. We know it happens with gay men, with women, with cultural minorities (Interview 2).

Similarly, counsellors reported that with few exceptions only those in the most serious medical need sought out medical attention and rarely did these survivors identify that they had been sexually assaulted. Only five counsellors, who worked with 40 percent of the 156 survivors, reported that the majority of survivors accessed help from medical services. Survivors are generally less worried that they would be shamed or mocked by medical personnel. Rather than fearing being mocked, survivors' fears seem to be more tied to general shame of the stigma of admitting that they are the victims of MSA.

¹⁸ One of the counsellors who worked in an organization that provided services to victims of crime reported that all of the individuals that she worked with had reported to the police – it was only through reporting to the police that the survivors were offered the counselling services.

Counsellors identified similar patterns of disclosure in regard to “informal help”. The counsellors identified that for the majority of survivors the stigma and shame that they felt, often due to the fear of a negative reaction from someone close to them, inhibited them from speaking out. Negative reactions included disbelief, blame, mockery and/or shunning. Only eight counsellors identified that the majority of the survivors whom they worked with sought help from friends. Six counsellors identified that the majority of the survivors whom they worked with sought help from partners, regardless of sexual orientation. Finally, only one counsellor identified that the majority of the survivors who they worked with sought help from family members. These counsellors worked with 50 percent, 49 percent and 6 percent, respectively, of the total number of survivors that the 20 counsellors worked with.

Compared to other groups that usually may have one person that they’ve told or they’ve hinted. they tend not to tell at all. Because they’re, they believe that no one’s going to believe them. Part of this is they cannot really believe that it’s happened to them (Interview 12).

Many of the counsellors reported that in the cases they were aware of where a survivor did reveal the assault, it was usually to a partner or close friend and often, the experience of “opening up” went poorly and the survivor did not tell anyone else:

The one person I’m working with right now ... they had reported and were told that it couldn’t have been, it couldn’t possibly happen to a man. And um, so it was very difficult to come forward thinking that most likely other people wouldn’t believe it either (Interview 12).

The responses of these counsellors reinforce the intensity of hegemonic norms, experienced by survivors through the stigma and shame of MSA. For many survivors the need to ensure secrecy around their assault is so important that it impedes access to any form of help available to them, regardless of the severity of the trauma or pain that they are experiencing. It should also be noted that many survivors are also unaware of much of the formal mechanisms of help that are available to them (Donnelly and Kenyon, 1996: 447).

Orientation to Counselling

In addition to influencing whether or not a survivor accesses counselling, hegemonic norms also influence why survivors seek help, what they expect to gain from it and the commitment they are willing to make to counselling. Even though counselling services constituted the one mechanism of formal help sought by all of the survivors discussed in this study, their orientation to counselling was consistent with their other responses and post-assault behaviours:

Well, I think that probably the most challenging thing is to, to find a way to make it comfortable for them to seek, ah, recovery options. It's very difficult for them to even admit that they've been victimized, and then for them to follow through and actually get therapy (Interview 4).

Survivors often seek help only when they are in extreme need or feel that they cannot function otherwise. Even when survivors do access counselling help, the counsellors

identified that the survivors they worked with arrived at counselling sessions with a variety of presenting problems – usually PTSD symptomology – rather than the actual sexual assault. This included symptoms such as the inability to concentrate or the inability to sleep and other symptoms that disrupted the day-to-day functioning of survivors. The counsellors reported that initially survivors orientated themselves to rationally solving a problem (i.e. “Why didn’t I stop it? Why can’t I function?”) – even when their understanding was irrational – and avoided discussing or admitting that they were sexually assaulted or openly discussing their emotions. One counsellor commented:

I think back to the early days of working with women around sexual assault and how it was so necessary to observe reactions or potential symptoms and then be able to ask more directly “Have you been assaulted?” And so my guess is that it’s probably going to be more true with men (Interview 2).

Another stated:

Some of the differences of male childhood abuse survivors and recent assault survivors...generally speaking, with childhood abuse survivors their issues are more entrenched, they’re closer to core identity issues than men who have been recently sexually assaulted. Often, men who have been recently assaulted in my experience have been wanting their symptoms to go away...I’ve got nightmares, I’m claustrophobic and I don’t know if I can go on another day (Interview 5).

The counsellors who worked primarily with homosexual survivors suggested that their orientation to counselling was quite similar to heterosexual men. For example, one of the counsellors who worked exclusively with gay survivors indicated that the survivors she had worked with came in seeking assistance for a full range of symptoms, including trouble

with a partner, wanting to understand self, trouble at work, trouble sleeping, depression and anxiety, rather than the actual assault:

But I don't know if they themselves would necessary identify that it had to do with the assault or it might be from the consult...I'm not sure if we have ever had someone come in because they had been assaulted as an adult. I know people have come forth because of childhood abuse, and because of a current assault or gay bashing, but I don't know we have ever had someone – a gay man - presenting exclusively because of a sexual assault. It's more something that we'd hear about in the course of determining why the person is here and what issues they're dealing with. And because we are a short term service we don't do a full assessment by sitting down and going over everyone's history and teasing out everything that's happened to them (Interview 2).

This suggests as has been raised in earlier sections of this chapter that despite stereotypical understandings, homosexual men feel the need to meet many of the same traditional masculine expectations that heterosexual men do.

Although the presenting problems of MSA survivors seem to be similar, one difference is survivors who presented to a counselling service specific to sexual assault/abuse. The four counsellors who provided services through a sexual assault counselling organization identified that the survivors they worked with did not present for particular symptomological issues. Rather, they generally presented directly for their sexual assault experience.

Many of the counsellors also identified that at times the survivors presented historical childhood sexual abuse rather than presenting their more recent sexual assault:

...some men may be a bit more open to talking about having experienced victimization in childhood than in adulthood because of the socialised expectations of, you know – “a man’s got to be able to defend himself”. Whereas, the man who was abused as a child there is less of a stigma than having been abused as an adult male (Interview 14).

Although very little research has been done specifically on the process underlying the ways MSA survivors seek counselling help, these findings seem to be consistent with Kaufman et al. Kaufman et al. found that MSA survivors who sought medical attention for either “secondary physical” or “emotional trauma” were less likely than female survivors to disclose the sexual assault (Kaufman et al., 1980, 223).

The resistance of survivors to discuss their MSA experience is also evident in the short time that the majority of survivors actually spend in counselling. Of the counsellors who participated in this study, 16 suggested that most survivors who they worked with remain engaged in counselling for two months or less. These counsellors worked with 74 percent of the total number of survivors that these 20 counsellors worked with. Only a few exceptional cases remained attached to a counselling program for long term care. One counsellor who attempted to reach out to a survivor who had prematurely left counselling was told by the survivor not to attempt contact again. Although this was the only counsellor who spoke about such an experience, generally this survivor’s resistance to counselling was consistent with other survivors who left counselling after a short period and didn’t return. Counsellors suggested that many of the men who left did so because they wanted to avoid discussing their experiences or the emotions that they attached to

them or in the absence of doing so felt that they were not accruing any benefits from remaining in a counselling program. At times this even occurred with survivors leaving in the middle of sessions.

Special Counselling Needs of MSA Survivors

Throughout the findings presented in this study, issues specific to MSA survivors emerged as requiring particular counselling attention. These almost exclusively are attached to the need of MSA survivors to navigate the norms of hegemonic masculinities as a part of their recovery process. In addition to influencing how survivors understand themselves and how they respond and react to being assaulted, the counsellors also suggested that internalised masculine norms also influence their needs for recovery and the effects that counselling may achieve.

Generally, the most pressing special counselling need of MSA survivors is the need for counsellors to be vigilante in their attentiveness to signals that an individual may be a survivor. As evidence presented in this thesis suggests the majority of MSA do not actually present their assault in accessing help and require survivors to identify it for them. Kaufman et al. (1980: 223) also recognizes this. In the absence of the suspicions of counsellors, many survivors may never disclose their assault or initiate the full recovery process that they likely require to achieve post-assault health.

The internalization of hegemonic masculinity that suggests that men cannot be victims of sexual assault creates enormous challenges for men in formulating a positive understanding of themselves after being sexually assaulted:

I would say that there is a real difficulty for men to see themselves as victims of abuse. With some, how they see themselves - as the world sees them - [is] as weak and not being able to protect themselves just that whole idea that they might be a victim of sexual abuse what does that mean for them that somehow women seem to know how to do that how to be a victim in the world and men have a harder time with that (Interview 3).

This seems to be one area that counsellors can provide particular assistance to MSA survivors. The counsellors reported that it was important for them to help survivors realise that, while being sexually assault may prompt them to reconsider some of their understandings, values and actions, being sexually assaulted has not changed “who they are” or what they can accomplish. One way that counsellors can do this is by demonstrating that expectations of dominant forms of masculinity are unhealthy conceptualizations that present unattainable standards as norms. Counsellors can discuss the ill-effects that attempting to reach such standards have and help survivors to understand themselves in terms of healthier conceptualizations of what it is to be a man.

This need is especially evident in those MSA survivors who had experienced historical childhood sexual abuse in addition to being sexually assaulted:

So where there have been multiple offenders, either over a period of time, or a shorter period of time, there seems to be a greater damage to a person or to a person's boundaries and subsequently the sense of identity is

somewhat more shaken. Many clients have talked about having, or not having a core sense of self because it had been so badly undermined through the abuse that they just don't even know where they are, who they are, what they are, whereas someone who's had an isolated incident does have a stronger sense of core self, and of course that means that progress and therapy is going to be a little bit more rapid because, or noticeably more rapid because they have a core sense of self to, to, to sort of hold on to and to maintain throughout the process (Interview 4).

As indicated above the ability of counsellors to help survivors realize that having been sexually assaulted does change who their identity is critical to a healthy recovery.

Although none of the survivors had run a group of exclusively MSA survivors – none of the counsellors had enough MSA survivors engaged in counselling for a suitable length of time concurrently to form a MSA group – many had one or multiple MSA survivor(s) participate in a group with men who had been abused in their childhood. The counsellors generally indicated that this was an area that group counselling seemed to be of considerable value. Group counselling allowed the survivors to see that they are not alone and that other men shared common or similar experiences. This helps to provide a sense of normalcy around an experience that most individuals feels isolates them. However some of the counsellors were also quick to warn that this is not for all survivors. First, most survivors will need some time until they are ready for the group setting to develop a sense that they can talk openly.

Second, the effectiveness of group counselling relies on all members of the group. The inclusion of a particularly “unhealthy” member may limit the effectiveness of the sessions or risk negative consequences for all the other members. For instance, one counsellor

discussed group sessions that were over run with homophobic reactions to the survivors abuse and assault histories. This proved quite detrimental to an undisclosed homosexual survivor who was also in the group. As discussed earlier in this chapter, homophobic reactions are one of the ways that survivors channel their negative or painful emotions in response to MSA.

Homophobic reactions to MSA perpetuate the subordination of homosexual men. In addition to using anger, expressed through homophobia, survivors also attempt to normalize what's happened to them by vilifying further a group that is already vilified (gay man) and making the problem that group's behaviours. By shifting the blame to a specific group some survivors may be able to remove the blame from themselves. However, homophobia is not a healthy alternative. Given that this is a common response to MSA, much care is needed around the exposure of homosexual survivors, who may already be struggling with internalized homophobia, to these responses where rapists are defined as gay and in homophobic terms. This necessitates education among survivors about who commits MSA and that sexual assault, including MSA, although a sexual act is an act of domination that does not necessarily denote sexual desire.

Conclusion: Understanding Sexual Assault

Currently, our understanding of sexual assault is incomplete. Most past literature has narrowly defined sexual assault to only include the assault of women. In some instances, exceptions have been made to include the experiences of men, usually assaulted in prison or in other sex-segregated populations. Few studies, outside of the small number conducted on MSA specifically, have taken into account the experiences of men who are sexually assaulted in the open community. Ultimately little is known academically about the sexual assault of adult men, even within the noted exceptions. Socially, our knowledge of male sexual victimisation is even more limited with almost no recognition of men assaulted as adults in the open community.

A full understanding of sexual assault must take into account the experience of MSA survivors. It is essential that our understanding of sexual assault be thorough and based on the experience of all sexual assault survivors – not just a select group. Only through a thorough knowledge will we fully understand the actual nature of, and the reason for, the occurrence of sexual assault. It is only through such a body of knowledge that we will be able to limit or hopefully end sexual assault and assist all survivors.

By not fully taking into account the experiences of MSA survivors we risk stigmatising or isolating a group of survivors as “lesser” or “different” and position them to compete for the services that all survivors should have available to them. This also risks not attracting the appropriate attention to MSA. The feminist movement of the early 1970s worked with

particular vigour to ensure that 'all' victims could come forward, seek help and be understood. Such a climate is derived from shared knowledge and education and requires incessant effort to maintain. MSA survivors require that same climate.

To arrive at a complete knowledge of sexual assault we will have to vastly expand our research of MSA. As stated, the current body of literature on MSA has provided us with a strong foundation from which we can identify many of the key concepts and traits that will be at the core of a more expansive body of knowledge. However, it also has serious limitations to its generalisability and provides a limited examination. By expanding our knowledge of MSA we will substantiate some previous understandings of sexual assault and challenge other ideas.

This study certainly does not escape the limitations that previous research has faced. This study collects indirect data on MSA survivors, obtained through counsellors and only on a sub-population of those survivors – i.e., those who sought counselling. Regardless, this study in attempting to meet its modest goal – to explore the characteristics of MSA and survivors' responses to MSA – does make a significant contribution to the existing body of knowledge. It provides support for the findings of existing research, and raises some additional ideas that require further exploration.

Interviews were conducted with 20 counsellors, from a variety of counselling backgrounds, who had cumulatively worked with a total of 156 MSA survivors. The findings of this study support many of the findings of earlier research in regard to how men experience

sexual assault. These findings indicate that the majority of survivors self-identify as homosexual or bisexual. Further, the majority of MSA survivors had been sexually abused in childhood, and a minority had a previous MSA experience. Multiple abuse/assault experiences often lead to a “victim mentality” that includes feelings of worthlessness and ambivalence towards their future. This study also suggests that, like women, men are more likely to be assaulted by someone whom they know and this often occurs in the form of ‘date rape’. In addition, heterosexual survivors seem to have a greater likelihood than homosexual or bisexual survivors to be assaulted by a stranger.

Further, the findings of this study indicate that a number of reactions and responses are central to the post-assault experiences of both men and women. These include questioning their identity in the face of being sexually assaulted; emotional response; PTSD symptomology; self blame; and patterns of stigma and shame. However, at times, men seem to experience some differences in the manifestation and nature of these and other reactions. These differences seem to be driven by the influence of hegemonic constructions of masculinity flavoured by the social location of the survivor.

The findings of this study substantiate the need to develop the most precise knowledge possible on social understandings of gender. The counsellors’ experiences that are presented herein demonstrate, at the same time, the archaic nature of the dominant understanding of masculinity and the power of these understandings. The traits associated with hegemonic masculinity are challenged in the experiences of MSA survivors. As suggested by the experience of counsellors, men do feel emotions; men are not always

rational; men are not always in control; men are vulnerable and penetrable; and men can be victims. Yet at the same time it is evident in the counsellors' experiences that these dominant understandings of masculinity strongly influence the understandings, responses and behaviours of MSA survivors.

The power relations of gender have been at the core of the understanding of sexual assault since the work of the early feminist movement beginning in the early 1970s. An understanding of MSA demonstrates the need to expand on current understandings of sexual assault. Considering MSA survivors as a part of a complete body of knowledge of sexual assault, and more generally sexual victimization, adds to our understanding of how sexual assault is used as one tool of power stratification. Whereas in the past, the examination of sexual assault has focused on how sexual assault has been used by men to subordinate women, a comprehensive examination of MSA demonstrates that sexual assault is also used by men of all sexual orientations, and even by women to subordinate men.

This reality demonstrates the relevance of Connell's suggestion that men occupy different social locations and, as a result, experience masculinity in different manners (Connell, 1995, 37). While the counsellors' indicated that men very much feel the need to meet the expectations of dominant social understandings of masculinity, the experience of MSA survivors provides an example of how men are subordinated and do not live their lives in a world of masculine privilege. These dominant social understandings create social

expectations posed by others and internalized by individuals that influence their thoughts and actions.

The engrained need to meet masculine expectations impedes MSA survivors from accessing the help they may require for a healthy recovery. The counsellors suggested that not only do social understandings of gender impede healthy recovery, but they can also lead to additional harm for MSA survivors. In the absence of appropriate help, survivors often rely on detrimental coping strategies such as social isolation, substance abuse, and in some cases, hyper-masculine responses that build on the damage of the trauma caused by sexual assault.

For Marcus, sexual assault capitalises on the perpetuation of dominating images of women as vulnerable individuals in the way that women act and are acted towards. In Marcus' analytical look at the dynamics of what is considered to be a more "traditional" rape, male attacker on female victim, Marcus understands this vulnerable image of women as making the rape inevitable once the attack has begun (Marcus, 1992: 390). Marcus argues that women are left with an inability to fend off an attacker, not due to a lack of physical ability, but rather due to the differences that position women as the weak object of the power granted to men (Marcus, 1992: 390).

Marcus suggests that by encouraging women to act outside of the rigid traditional understandings of masculinity and femininity we can empower women to fight rape.

Marcus argues that if women do not exist solely in-line with traditional understandings of

femininity and act outside of these boundaries, they will then have the ability to alter the 'rape script' that forces them to be a victim (Marcus, 1992: 392).

When one considers MSA survivors within Marcus' argument we see that we need to carry Marcus' suggestions further. The experiences of MSA survivors demonstrate that we do not simply have to encourage women to act outside the traditional understandings of femininity, but rather, we need to expand our understanding of vulnerability and demonstrate the inability of dominant understandings of masculinity and femininity to embody the actual lives of individuals or groups. Not only do women have to act outside of the boundaries of femininity at the time of the attack, but men and women have to demonstrate, daily, the mythical nature of dominant understandings and their negative effects.

Only by the eradication of an ideology of masculinity that expects individuals to demonstrate their dominance over other individuals will we escape the need for tools such as sexual assault to demonstrate and reinforce subordination. As Kinsman suggests, the breakdown of the current dominant form would allow for less oppressive and more egalitarian "ways of doing masculinity" for both men and women (Kinsman 1993: 24). As dominant forms of masculinity and femininity have been shaped in contrast to one another, reshaping hegemonic masculinity would also spin-off changes to the way we understand femininity and sexual assault. As suggested by one counsellor, the experiences of MSA survivors offer an opportunity to transform hegemonic masculinity by socially demonstrating its inadequacies and unrepresentativeness:

...the one thing that I would say, one of my biggest observations is that if we can't look at leaving the status quo behind, and the status quo in terms of what roles and what titles we place on people, and the expectations that come along with those titles, right now we will do a very good job at band-aiding the problem as opposed to addressing it. There's far too many expectations placed on victims, solely based on body parts and who they identify themselves as. And therefore this is how you heal and you're allowed to heal and you're not. I'd love to be able to get to a place where we don't actually have female survivor groups and male survivor groups, we have survivor groups...Why are we breaking this down? Why are we specifically saying that, you know I understand that there are some issues that are triggering there are some things that are this and there are some things that are that. But part of me is feeling are we feeding into that or perpetuating that belief that all men are offenders so therefore we won't put a male facilitator in a female survivor group. Wouldn't it be a much better opportunity to have a male see a positive female role model or to see that there are females that can relate to their feelings, and that they're not so different...So I think that until we start to get rid of the titles, get rid of the expectations around how to respond as a victim and start acknowledging that people are being victimised is when we'll actually start putting a dent into dealing with the whole issue of sexual assault (Interview 1).

MSA demonstrates that the perpetrators of MSA capitalize on a breadth of vulnerability not usually considered when one thinks about the sexual assault of women. The counsellors identified that MSA survivors are targeted for an expansive array of vulnerabilities including addiction, poverty and cultural expectations of impenetrability. The interviews identified that historical sexual abuse, especially when repetitive, created high levels of vulnerability.

Nearly 80 percent of the counsellors who knew the abuse/assault history of the MSA clients they worked with identified that the majority or all had been sexually abused as children prior to being sexually assaulted as an adult. As demonstrated in the counsellors'

discussion of historical sexual abuse, survivors who had repeated sexual assault/abuse experiences developed chronic feelings of self-worthlessness and often came to understand themselves as intrinsically a victim. These understandings, at times, created ambivalence to protecting themselves from future sexual assaults.

In demonstrating the inadequacy of dominant conceptualisations of masculinity, MSA recasts many of our basic assumptions of sexual assault. Understanding MSA commands that we realise that regardless of their sex, anyone can be a victim of sexual assault or can perpetrate sexual assault. MSA also demonstrates that vulnerability encompasses more than just physical strength and that men and women experience many similar reactions to being sexually assaulted. Understanding MSA also reinforces, with particular emphasis, that sexual assault is an act of domination.

Given the developing nature of our academic knowledge and our lack of social awareness of MSA, we are generally unprepared to fully assist male survivors of sexual assault and have done little to develop a comfortable environment for them to come forward to seek help or report their assault. Much more research is needed to fully comprehend MSA and the reactions, responses and behaviours of MSA survivors. The challenge for this area of research will be to extend our inquiry beyond the boundaries that limit the research that has been conducted to date. Few studies have recruited samples beyond men who self-identified their experiences in a very narrow manner (i.e. medical, legal or counselling context) and almost all studies have relied on a small sample of survivors. Past research has demonstrated that only a small proportion of women survivors come forward and

identify their assault and it has been suggested that we ought to expect an even smaller proportion of male survivors to come forward (Donnelly and Kenyon, 1996: 447; Kaufman et al., 1980: 223 Brochman, 1991:41). Depending on those men who do come forward, to fully appreciate the dimensions of MSA, may skew the findings of our research.

Improving our knowledge of, and ability to respond to, MSA will require a cooperative effort in key areas. A large-scale, comprehensive study is required to gain a full and advanced knowledge of MSA. Such research will require an appropriate and flexible timetable, proper funding, diverse instruments of data collection and varied sites of information.

The biggest general research need is to perform research that draws data from a larger sample of survivors that includes men that have not yet utilised traditional reporting mechanisms for MSA survivors (i.e. counselling and medical services). Random dial digit sampling has been shown to be effective in formulating a random sample of survivors of historical childhood sexual abuse in large American cities (Holmes, 2001). Although this may be premature for the study of MSA, due to the evident inhibitions that survivors indicate limit their willingness to come forward, this technology, though expensive, may be quite valuable. This will hopefully allow us to determine if the trends, patterns and themes that have been identified in the current body of literature are expandable to a more encompassing population of MSA survivors.

Future research needs to re-examine some of the trends that have surfaced in the current body of research. For example, additional study is required to develop a more precise understanding of the influence of masculinity. Research seeking detailed accounts of how survivors interpreted the influence of masculinity on their thoughts and actions is needed. Perhaps the most pressing research need identified in this study is the need to more fully understand and expose the vulnerability created by historical childhood sexual abuse and its link to MSA. Given that nearly 80 percent of the counsellors identified that the majority of survivors had experienced childhood sexual abuse, it would seem that our foremost challenges are to prevent child abuse and to protect childhood survivors from encountering further abuses/assaults.

Researchers will have to work with survivors and counsellors to ensure that the information needed to develop services for MSA survivors is gained and disseminated in a safe and ethical manner. This includes making services available to survivors at their will after their participation. Survivors' participation is essential in informing research, in the development of appropriate programming and in ensuring that programming is delivered in a relevant and "safe" manner. This must include the development of effective strategies for survivors of sexual abuse and assault to protect them from further assaults.

More comprehensive research will be able to inform professional development and education around MSA to increase the effectiveness of counselling services for MSA survivors. Survivors, counsellors and researchers must network with one another to share both "best practices" and what they have found to be ineffective, as well as to support MSA

survivors in becoming active in speaking out about their experiences and ensuring that they receive the resources and services that they feel they need. By working together researchers, counsellors and survivors must create an environment where MSA survivors feel they can speak out about their experiences and come forward to seek the help that they require without being caused further damage.

Our understanding of MSA suggests that, like the feminist literature has suggested regarding the sexual assault of women, the sexual assault of men in the open community is a tool of power used to subordinate and degrade another human being. This reinforces an existing or establishes a new power relationship between the assailant and the perpetrator. However, the subordination that one experiences from having been sexually assaulted is not limited to the survivor-perpetrator relationship. The subordination that an individual experiences as a result of being sexually assaulted transcends his or her relationship to society, and in the case of male survivors, is reinforced by the hegemonic construction of what it is to be a man.

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Appendix A

Summary of Past Research

Authors	Year	No. of Subjects	Recruited From	Survivor Sexual Orientation	Survivor/Perpetrator Relationship	Multiple Assailants
Groth and Burgess	1980	6	Outpatient Psychiatric Clinic	Half Heterosexual	Half Known	Minority
Kaufman et al.	1980	14	Hospital Emergency Room	Majority Heterosexual	Not Reported	Half
Forman	1982	12	Law Enforcement	Not Reported	Majority Stranger	Minority
Sorenson et al.	1987	107	Random Community Sample	Not Reported	Majority Known	Not Reported
Mezey and King	1989	22	Newspaper	Majority Homosexual	Majority Known	Not Reported
Hillman et al.	1991	28	Rape Crisis Centre	Majority Homosexual	Not Reported	Not Reported ¹⁹
Lipscomb et al.	1992	19 ²⁰	Non-hospital Clinic	Not Reported	Not Reported	Majority
Struckman-Johnson et al.	1994	69	Undergraduate Classes	Not Reported	Majority Known	Minority
Hickson et al.	1994	212	Newspaper	Majority Homosexual ²¹	Majority Known	Minority
Huckle	1995	22	Forensic Psychiatric Service	Majority Heterosexual	Majority Stranger	Minority
Keane et al.	1995	10	Hospital	Half Heterosexual	Half Known	Minority
Stermac et al.	1996	29	Hospital Sexual Assault Crisis Centre	Half Heterosexual	Majority Known	Minority
Wisely and Gehrenbeck-Shim	1997	3,635 ²²	Sexual Assault Counselling Agencies	Majority Heterosexual	Majority Known	Minority
Hodge and Canter	1998	119	Newspaper, Counselling Groups and Police Reports	Majority Heterosexual	Majority Known	Minority

¹⁹ Reported as mean 2.8 with a range from 1-8.

²⁰ Lipscomb also presented data on an additional 80 survivors who were sexually assaulted while incarcerated.

²¹ The data that Hickson et al. collected was part of a study of sexual victimization in homosexual men's lives

²² Note: Isely and Gehrenbeck-Shim collected data based on 3,635 survivors through 336 agencies over a 19 year period – 1,159 of these survivors reported a sexual assault.

Appendix B

INTERVIEW CONSENT FORM

AN EXPLORATION OF THE IMPLICATIONS OF HEGEMONIC MASCULINITY FOR SURVIVOR RESPONSES AMONG ADULT MALE SURVIVORS OF SEXUAL ASSAULT IN THE COMMUNITY

Mark D. Jarvis

This consent form is part of the process of gaining informed consent for participation in this research. This form should provide you with a basic understanding of the research and what your willingness to participate entails. If you have any questions or would like more information about any aspects of the research you should feel free to ask. Please take the necessary time to read all aspects of this form carefully.

1. The purpose of this research is to expand the very limited base of knowledge that has been accumulated on the topic of the recent sexual assault of adult males in the community.
2. The collection of data will require only one interview and will last approximately 1 to 1.5 hours.
3. The interview will involve the discussion of what are possibly highly emotional subjects.
4. The main possible benefit from your participation in this research is that you can help form an understanding of how we may be able to help more survivors to get the help that they need.
5. You have the right to end your participation at any time. You also have the option of not answering any of the questions in the interview.
6. Your identity, and that of any individual of whom you speak, is guaranteed to remain completely confidential. By conducting all interviews myself and maintaining personal control of access to the data I am able to give an assurance that your anonymity will be maintained.
7. The data collected from this study will be used as the basis of my thesis requirement as part of the Masters of Arts degree in Sociology at Carleton University. This data might also be used as the foundation of articles or information packages concerning the recent sexual assault of adult males. At the time of the interview you will be given an opportunity to provide a mailing

address whereby I can anonymously mail you the findings generated from the current research project.

Your signature on this form indicates that you have understood to a level of your satisfaction the information regarding participation in the research project and agree to participate as a subject. In no way does this waive any of your legal rights nor release the investigator from his legal and professional responsibilities. You are free to withdraw from the study at any time. You should feel free to ask for clarification or new information at any stage in your participation. If you have further questions as to your participation in this research, please contact me:

Mark Jarvis
(613) 293-9686

If you have any questions concerning your rights as a possible participant in this research please contact:

Katharine Kelly
(613) 520-2600 ex. 2624

Participant's Name

Signature

Date

Investigator's Name

Signature

Date

**A copy of this consent form has been given to you to keep
for your records and reference.**

Appendix C

COUNSELLOR INTERVIEW GUIDE

Section I - Initiation

1. Personal Introduction
2. Review of Informed Consent Matters
3. Acquisition of Informed Written Consent
4. Verbal Acknowledgement of Start of Interview

Section II – Therapist's Background

I want to begin by asking you a bit about your background working as a counsellor generally and with sexual abuse survivors in particular.

1. How long have you worked as a counsellor? How long have you worked with abuse survivors (include work within child abuse survivors, female survivors and male survivors)? Probe what year did you first see a survivor of a recent sexual assault of adult men? Approximately how many survivors of recent sexual assault of adult men have you worked with thus far in your career?
2. If counsellor has dealt with female and/or child abuse survivors - ask what differences, if any, s/he sees in the type of clients, the presenting problems/issue/symptomology, the response to the assault, reporting and/or telling friends, family, and seeking "professional" help. If they see these patterns ask them what they see and why they think these differences exist.
3. Profile of Agency:
 - (a) Location - downtown, suburbs, etc.
 - (b) Client base - who do they see - full range of socio-economic groups, socio-cultural groups, fully range of ages.
 - (c) Agency mission - do they provide short-term support (such as Employee Assistance Programs) or long-term care; where does the funding for these services come from?

Section III - Helping Survivors

1. Could you tell me what you found to be the greatest challenges of working with adult male survivors of sexual assault?

Probes:

- (a) The absence of male directed support programs/guidelines.
 - (b) Problems associated with willingness to disclose, ability to discuss feelings about the assault
 - (c) Availability of support/help that is male specific.
 - (d) Ease of access to services - waiting lists, availability of support persons/counsellors, availability of support groups, male counsellors.
 - (e) Funding restrictions that impact on service delivery.
 - (f) What are the three most common reasons survivors have given to you on why they accessed "professional" help (specific symptomology, or more general)?
 - (g) On average, what is the duration of your involvement with clients?
 - (h) How long after their assaults do most survivors seek help?
2. Could you tell me about the ways that you have developed to meet the challenges of working specifically male survivors?

Probes:

- (a) Have they developed gender-appropriate approaches/ intervention strategies?
- (b) Have they found that specific types of programs work for different survivors or different types of survivors (i.e. gay men vs. heterosexual men, women vs. men etc.) (probe for the patterns they report).

Section IV - Abuse Events and Impact of Assault:

Based on your experiences with working with male survivors of adult sexual assault - can you please answer the following questions:

1. Approximately how many clients have you seen in the past X years.
2. Can you tell me what proportion of your clients have been in the following age groups:
 - (a) between 16 and 25
 - (b) 25 to 34
 - (c) 35 and above

3. Can you tell me what proportion of your clients have been:
 - (a) heterosexual
 - (b) MSM (men who have sex with men)
 - (c) bisexual
 - (d) transgendered
 - (e) other (please specify) _____
4. Can you tell me what proportion of your clients had been assaulted more than once as an adult? What proportion were assaulted as children? Do survivors with multiple abuse experiences present with different needs than other survivors? (Probe for how they are different and how this impacts on what the counsellor does esp. between those with a history of childhood and those without). Do survivors of childhood abuse present differently than adult survivors? (Probe for how they are different and how this impacts on what the counsellor does).
5. Can you tell me what proportion of your clients reported that in addition to the sexual assault they were physically assaulted (probe for threatened with a weapon, use of weapons, threatened assault, actual assault)
6. Can you tell me what proportion of your clients suffered physical injury in addition to the emotional/psychological harm - (Probe for nature of injury - e.g. anal tearing, injury due to assault, stabbed/shot/struck with weapon.) What proportion feared for their life?
7. Can you tell me what proportion of your clients report that the assaults took place when they were intoxicated and/or high? Did this impact on how they viewed the assault (e.g. did they use this to account for their inability to stop the assault)
8. Can you tell me what proportion of your clients reported being assaulted by (i) a known attacker or by (ii) a stranger? Of the known attackers could you tell me what proportion of the attackers were an intimate partner of the survivor? Of the stranger attacker cases could you tell me what proportion of the survivors indicated that they felt "gay-bashing" to be a cause of the attack?
9. What proportion of survivors offered an explanation as to why they were unable to physically stop the assault? Examples. How do you see these explanations - do they suggest that these men thought they should have been able to stop the assault, do they suggest that their physical ability to defend themselves was impaired).
10. What proportion of survivors offered explanations as to why they became victims of these assaults? What kinds of explanations did they offer? (Probe for explanations similar to those offered by women - e.g. should not have been drunk, etc.)

11. Can you tell me whom your clients indicate they have told about the assault (probe for police (did they file a report, was there an investigation/trial/conviction), partner, co-workers, boss/supervisor, friends (male friends/female friends - long-term friends/more recent friends), help lines, physician, or no one. Probe also is individuals in committed relationships were more or less likely to tell their partners.)
12. How long after the assault did clients make their first VOLUNTARY report to another person? (Probe for information on why they told the other person - e.g. were they concerned that another person was at risk).
13. What impact(s), if any, did clients report the assault had on their intimate/ relationships? [probe for changes in sexual behaviour (increase, decrease, dysfunction), increased or decreased conflict within the interpersonal relationship, leaving partners or ending non-cohabiting relationships]
14. What impact(s), if any, did clients report the assault had on their friendships? (Probe for whether they told their friends, time spent with their peers - how does clinician see this?)
15. What impact(s), if any, did clients report the assault had on their recreational activities? (Probe for decreased social activities, changes in recreational activities. Probe specifically for activities to increase strength or fighting ability (self defence, weight lifting, martial arts. Probe for how the clinician sees these changes and whether they varied for different clients - what patterns, if any, do they see?)
16. What impact(s), if any, did clients report the assault had on their employment? (Probe for different impacts depending on job type (e.g. jobs with disability benefits etc.)- also try to ascertain if they only saw clients in particular socio-economic range).
17. Did any of the clients have concerns about having been sexually aroused during the assault or having enjoyed any aspect of the assault? (Probe for whether this led, among heterosexual survivors, to questioning their own sexual identity or orientation).

Section V - Response to Assault

I would now like to ask you how your clients coped with their assaults:

1. What types of coping mechanisms did your clients use, prior to therapy, to cope with the assault (Probe for the use of drugs and alcohol, probe for seeking social/medical/legal support, probe for changing behaviour as a mechanism to increase their control of risk, [changing lock/living arrangements/activities/locations they went to etc.]
2. Do survivors commonly (probe for how common this is - proportion of cases) blame themselves for the assault? (Probe for what they blame themselves for - e.g., being out alone after dark, being drunk, taking a ride or going home with someone they did not know). Do you have a sense whether different kinds (probe for assaults with weapons/

use of "date rape drugs"/ drunk and-or high/known vs. unknown assailant) of assaults are more or less likely to lead victims to consider themselves at fault?

3. Do you believe that being assaulted effects how client think about what it means to be man or what a man should be? (Probes - do they report feeling less of a man, do they report questioning their ability to perform the social role of a man (strong/the protector), do they report a concern or experiences with others that question their "masculinity"?)

Section VI - Conclusion

1. Offer participant chance to ask any questions or make any suggestions.
2. Thank participant for their co-operation.
3. Ask participant for a mailing address to send a copy of the results.