



Sexual Assault of Men

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Dr Dave Templeton

**Staff Specialist, RPA Sexual Health, Sydney, Australia
Senior Lecturer, National Centre in HIV Epidemiology and Clinical
Research, University of New South Wales**

The vicious cycle of sexual assault...



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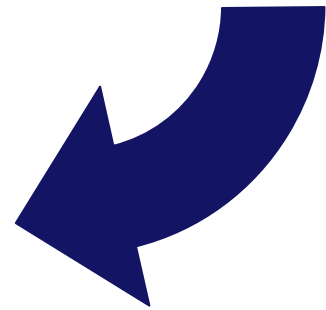
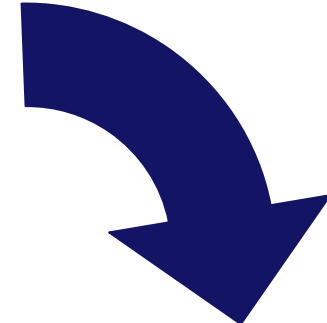
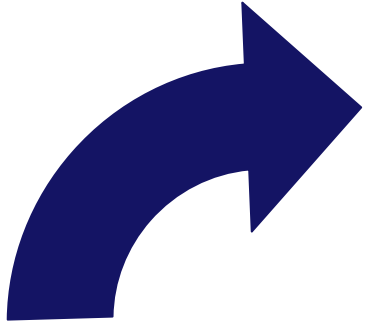
Lack of social awareness of abuse

Victims don't seek assistance/don't disclose

Limits professional ability to identify victims

Limits ability of researchers to obtain info about abuse

Especially
for men





How common is sexual assault of men?





Australian Study of Health and Relationships

Experiences of sexual coercion among
a representative sample of adults

De Visser et al. Aust NZ J Public Health
2003;27:198-203

Male SA experience in Australia



- Overall prevalence 4.8% (2% as adult)
 - Less likely than females (21/11%) to report history of SA
- Mean age SA occurred 15.7 yrs old (range 3 -57 yrs)
- Most experienced single lifetime episode
- Demographics
 - more common in MSM ($p < 0.001$) & lower income ($p < 0.001$)
 - not related to age, NESB, education, area of residence, occupation

Coerced vs. non-coerced men



- more likely to :
 - have elevated psychosocial distress scores ($p < 0.001$)
 - report lifetime history of STI ($p < 0.001$)
 - In previous year, have
 - lacked interest in sex ($p < 0.001$)
 - not found sex pleasurable ($p < 0.001$)
 - felt anxious about ability to “perform” ($p < 0.001$)
 - smoke ($p < 0.001$)
 - have ever injected drugs ($p < 0.001$)
- No more likely to report excessive alcohol consumption

Male (vs. female) sexual coercion



- Less common
 - When occurs – occurs less frequently
- Approx. one-third of both sexes talked to someone about coercion – most commonly a friend
- Males less often talked to
 - Doctor/nurse (1.4% vs 7.3%; $p=0.031$)
 - Police (2.6% vs 7.3%; $p=0.061$)
- Demographic, psychological and behavioural correlates very similar

Male presentations to UK SA services (SARCs)



- British Crime Survey 2006/2007 (n=24,000)¹
 - Annual incidence (actual/attempted) sexual assault:
 - 0.6% men
 - 3.1% women
- > 16% of British adults experiencing sexual violence each year are men
- In contrast, men account for $\leq 6\%$ presentations to UK SARCs^{2,3}
- Suggests men less likely than women to attend UK SARCs⁴

1. Homicides, Firearm Offences and Intimate Violence 2006/07. 3rd ed. Home Office Statistical Bulletin <<http://www.homeoffice.gov.uk/rds/pdfs08/hosb0308.pdf>>

2. Kerr et al. BJOG 2003;110:267–71.

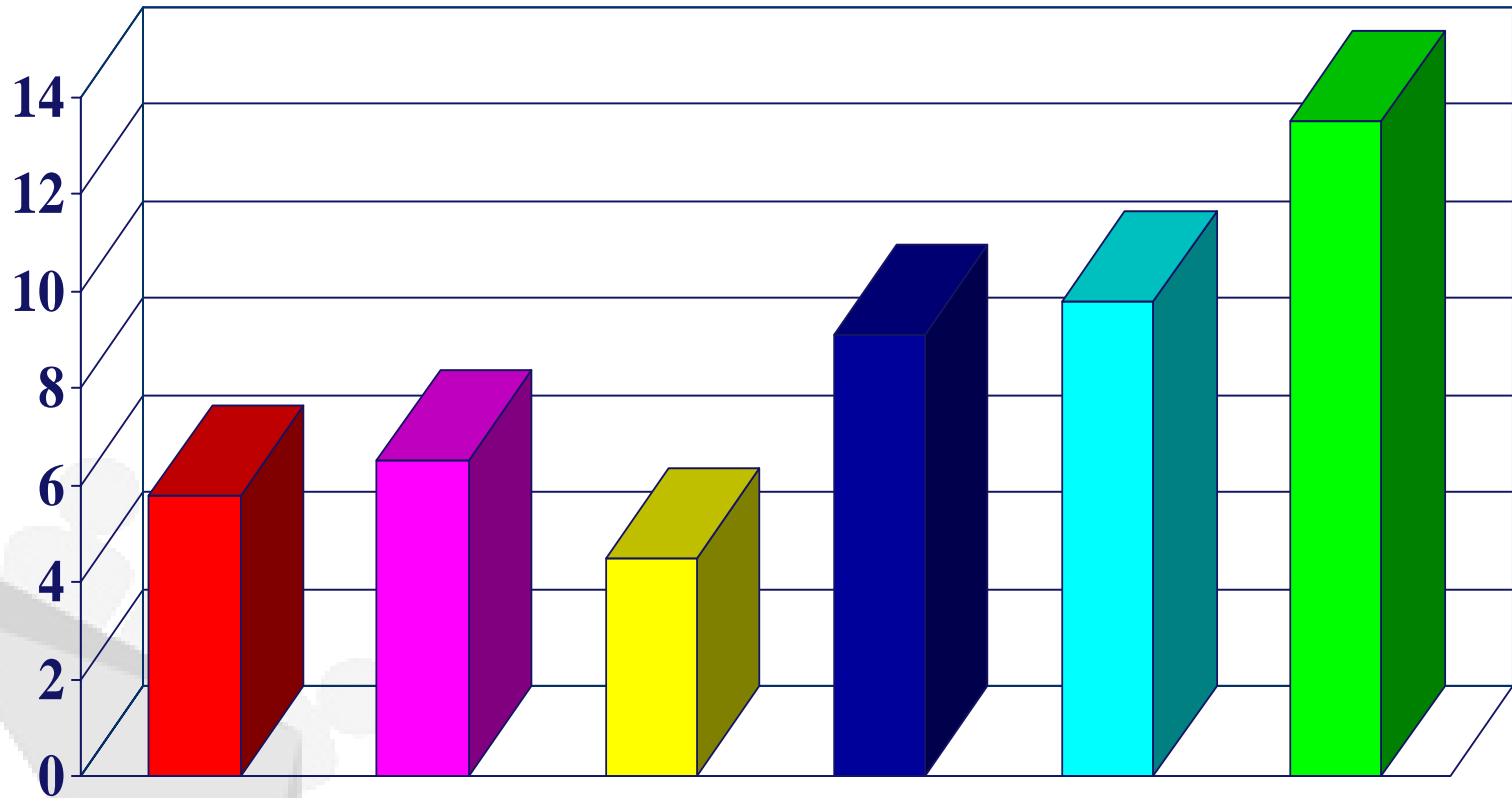
3. Chowdhury-Hawkins et al. J Forensic Legal Med 2008;15:363–7.

4. Templeton et al. J Forensic Legal Med 2009 (*in press*)

Male presentations to Australian SA Services



(% of total presentations)



■ Yarrow Place Adelaide 2001

■ Darwin 2001

■ Canberra Jul 2001 - Feb2002

■ SARC Perth 2001

■ VIFM Victoria 2001

■ ECSAS Sydney 2001

Male presentations to Australian SA services



- ASHR¹ (2001/02): Male compared with female victims
 - Five times less likely to talk to a doctor/nurse
 - Three times less likely to talk to police
- Men account for an average of 8% (range 4-14%) presentations for forensic/medical care to SA services in Australia (2001)²
- 2005 Australian Crime & Safety Survey³
 - 14% sexual assault victims in previous year were men

Suggests that adult male sexual assault victims present to SA services far less often than female victims

1. DeVisser et al. Aust NZ J Public Health 2003;27:198-203

2. Templeton DJ. Male Sexual Assault. Australasian Sexual Health Conference, Perth, 2002

3. Australian Bureau of Statistics. Crime & Safety Survey, 2005 (available online)

National Violence against women & men in the United States survey (NVAW)



- clinical samples suggest most male victims are physically injured, suffer anal penetration & threat with weapons
- NVAW - Nationally representative sample: 8000 F, 8005 M
 - 219 males – adult SA victims (2.7% prevalence)
- Adult male sexual assault characteristics
 - 11% physical injury
 - 32% anal penetration
 - 5% weapon used
 - 16% under D&A influence during assault
- 29% sought “help” after assault

Comparison of those who sought “help” in NVAW with total sample of male victims



	Whole sample (n=219) %	Help-seekers (n=62) %	p-value
Alcohol during SA	16	16	NS
Physical injuries	11	21	<0.05
Anal penetration	32	47	<0.05
Weapon present	5	5	NS
Report to police	12	19	NS
Threatened	23	31	NS

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Suggests clinical samples over-estimate % of adult male victims who suffer physical injury and anal penetration

Under-reporting of Male SA



Contributing factors

● Socio-behavioural

- Lack of awareness that it occurs
- Not being asked
- Few cultural & social supports (“woman's issue”)
- Not “man enough”; not being believed; shame
- Homosexuality (perceived / disclosed)
- “Asking for it” (homosexual)

● Physical

- Lack of injuries
- Lack of anal penetration = Lack of HIV risk???

Risk groups for adult male SA



- **Men who have sex with men**
- **Prisoners**
- **Homeless**
- **Physically and Mentally disabled**
- **Psychiatric patients**
- **Sex workers**

Vulnerability is the common factor

MSM as victims of sexual assault



- Consistently over-represented in male SA stats
- Compared with heterosexual men
 - 5X more likely in ASHR (De Visser et al 2003)
 - 6X more likely to suffer adult SA (Coxell et al 1999)
 - 4X more likely in UK Sexual Health clinic (Coxell et al 2000)
 - 3X more likely in MSM Uni students (Duncan 1990)

MSM as victims of sexual assault



Reasons for higher prevalence

- MSM more likely to be sexually assaulted
 - Higher partner numbers
 - Situations in which sex is sought
 - “Gay-bashing”
- ± More aware of / more likely to use victim services
- ± Feel less stigmatised by SA than heterosexual men

Sexual assault of prisoners



Sexual Assault of NSW male prisoners



- Lifetime sexual coercion
 - 13.7% men (*4.8% ASHR*)
 - Only 23% told someone about coercion (*33% ASHR*)
 - Police 7.2% (females 16.7%) (*2.6% ASHR*)
 - Dr/Nurse 1.2% (females 3.3%) (*1.4% ASHR*)
- Sexual coercion while incarcerated
 - Threatened sexual assault 5.7% (females 7%)
 - Actual sexual assault 2.4% (females 4%)



Clinical aspects of adult male sexual assault



Forensic Medical Aspects of Male-on-male rape and sexual assault in Greater Manchester



- Retrospective study: 376 M & 7789 F attending UK SARC
 - No difference in % of M/F having forensic exams
 - Penile-anal assaults → anal injury in 26% of 131 cases
- LESS common in male assault were:
 - Penile assaults ($p < 0.001$)
 - Genital injury ($p < 0.001$)
 - Injuries to most other body areas including neck, chest/breasts, outer/inner thighs and lower legs
- MORE common in male assault were:
 - Finger/object penetration ($p < 0.001$)
 - Anal injury ($p < 0.001$)

Anoscopy & Colposcopy in the evaluation of male sexual assault victims



- Case series of 67 adult male SA victims attending ED
- Anal injuries seen on gross examination in 63%
- Additional injuries/findings observed by
 - anoscopy in 32%
 - colposcopy in 8%
- Only 4 subjects with negative gross exams had findings observed with additional tests – all with anoscopy

Specific management issues for male victims



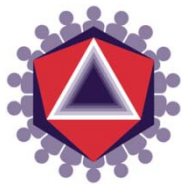
1. Psychosexual issues
2. HIV risk & post-exposure prophylaxis
3. Other STI risk & prophylaxis



Psychosexual issues for male victims



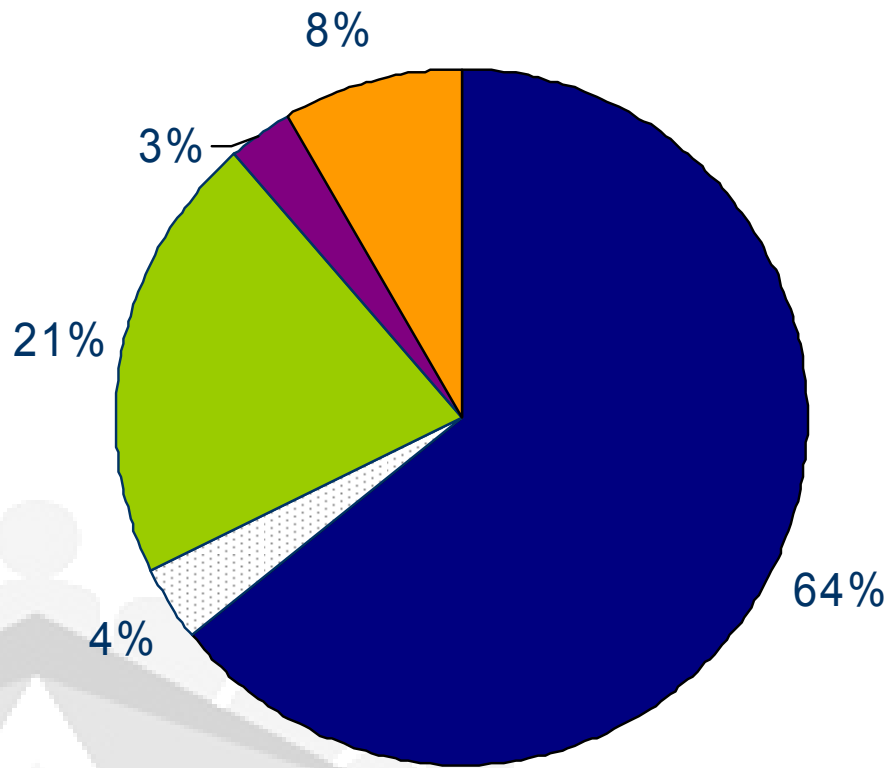
- Integrate sense of masculinity with his experience of being a SA victim
- Address issues around sexual identity & orientation
- Break down link between arousal & consent
- Address subsequent sexual dysfunction



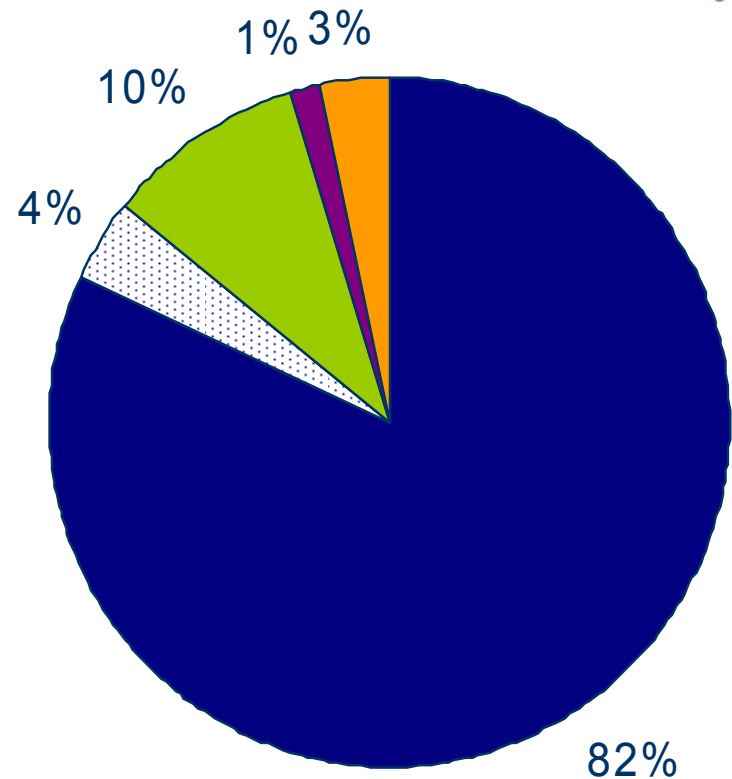
HIV Post-exposure prophylaxis



HIV in Australia* by exposure category



Newly diagnosed HIV infection



Newly acquired HIV infection

- Men who have sex with men
- Men who have sex with men, and injecting drug use
- Heterosexual contact
- Injecting drug use
- Other/undetermined

*2004-2008

Estimated risks of HIV acquisition



<i>Exposure</i>	<i>Estimated risk HIV transmission per exposure to infected source</i>
Receptive anal intercourse	1/200
Receptive penile-vaginal intercourse	1/1000
Insertive anal intercourse	≈1/1500
Insertive penile-vaginal intercourse	1/2000
Receptive penile-oral intercourse	1/10,000
Insertive penile-oral intercourse	1/20,000

CDC. Antiretroviral postexposure prophylaxis after sexual, injection-drug use or other non-occupational exposure to HIV in the United States. MMWR 2005;54:RR-2

HIV risk assessment in Male SA



**Risk of exposure \times Risk that source HIV pos
+ consideration of cofactors**

- Cofactors for male victim may include
 - anal trauma
 - concurrent STI (victim/perpetrator)
 - multiple perpetrators
- Receptive penile-anal, MSM in Sydney
 - e.g. $1/200 \times 1/7 = 1/1400$
- Receptive penile-vaginal - mod hetero HIV prevalence
 - e.g. $1/1000 \times 1/1000 = 1/1,000,000$
- Anal MSM assault by unknown perpetrator
 - Recommend 2-drug HIV PEP (e.g. Truvada ®)
 - Dr encouragement - strongest predictor of PEP acceptance^{1,2}

Other STIs in male SA victims



- High STI risk for victim of assault by MSM perpetrator
- Most will not acquired an STI from the assault
 - prevalent STI more common than incident STI
 - STI patterns in MSM victims reflect local epidemiology of STIs in MSM
- Baseline & F-U testing preferable
- STI Prophylaxis
 - Give Hep B Vaccination dose (without HBIG)
 - Consider Azithromycin (chlamydia ± incubating gono/syphilis)
 - IMI Abs not generally indicated (Ceftriaxone/Penicillin)

Conclusions



- Australian male victims of sexual assault
 - Lifetime 1/20; Adult 1/50
 - Correlates very similar to those in females
- Male-specific management issues include addressing
 - masculinity & sexual identity
 - high risk of STI/HIV
- Men appear less likely to attend SA services than women
 - Clinical male SA research unlikely representative
 - possibly even less so than female SA
 - ***Can we make SA services more “male friendly”?***

Acknowledgements



- Associate Professor Juliet Richters (UNSW)
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