Male Victims of Sexual Assault: Phenomenology, Psychology, Physiology

Clayton M. Bullock, MD, PhD, and Mace Beckson, MD

Myths, stereotypes, and unfounded beliefs about male sexuality, in particular male homosexuality, are widespread in legal and medical communities, as well as among agencies providing services to sexual assault victims. These include perceptions that men in noninstitutionalized settings are rarely sexually assaulted, that male victims are responsible for their assaults, that male sexual assault victims are less traumatized by the experience than their female counterparts, and that ejaculation is an indicator of a positive erotic experience. As a result of the prevalence of such beliefs, there is an underreporting of sexual assaults by male victims; a lack of appropriate services for male victims; and, effectively, no legal redress for male sexual assault victims. By comparison, male sexual assault victims have fewer resources and greater stigma than do female sexual assault victims. Many male victims, either because of physiological effects of anal rape or direct stimulation by their assailants, have an erection, ejaculate, or both during the assault. This is incorrectly understood by assailant, victim, the justice system, and the medical community as signifying consent by the victim. Studies of male sexual physiology suggest that involuntary erections or ejaculations can occur in the context of nonconsensual, receptive anal sex. Erections and ejaculations are only partially under voluntary control and are known to occur during times of extreme duress in the absence of sexual pleasure. Particularly within the criminal justice system, this misconception, in addition to other unfounded beliefs, has made the courts unwilling to provide legal remedy to male victims of sexual assault, especially when the victim experienced an erection or an ejaculation during the assault. Attorneys and forensic psychiatrists must be better informed about the physiology of these phenomena to formulate evidence-based opinions.

J Am Acad Psychiatry Law 39:197–205, 2011

Although adult male sexual assault is increasingly recognized as a problem, the literature unanimously acknowledges the data on the subject to be limited, when compared with data on female victims. It is estimated that only about 20 to 25 percent of cases of sexual assault of females are reported in the United Kingdom.[1,2] It is assumed that this statistic is much lower for cases of sexual assault of males. Before 1994, the legal definition of rape in the United Kingdom was limited to cases of forced or nonconsenting vaginal penetration, thus excluding male victims.[3] Cases of forced or nonconsenting anal penetration were covered under the legal statute of buggery, which carried a much lesser penalty. In the United States, it is estimated that only 10 to 20 percent of female victims of sexual assault report the crime,[4] and the percentage of males who report their assaults is assumed to be lower. As of 1982, 39 states in the United States had gender-neutral rape statutes,[5] and currently all but three jurisdictions have such statutes, the exceptions being Georgia, Mississippi, and Idaho.[6]

The literature on the subject has grown considerably since the 1980s, suggesting that the sexual assault of men is not as rare as the earlier scarcity of literature on the phenomenon indicated. This article provides a review of the literature, including incidence and prevalence of sexual assault of adult males, the motivations of the perpetrators, and the physiology governing involuntary sexual responses of victims. Despite growing awareness of these crimes, the legal system has been unwilling to provide legal

Dr. Bullock is Staff Psychiatrist, Department of Public Health, San Francisco, CA. Dr. Beckson is Clinical Professor, Department of Psychiatry and Biobehavioral Sciences, UCLA, and Medical Director, Psychiatric Intensive Care Unit, VA Greater Los Angeles Healthcare System, Los Angeles, CA. Parts of this study were presented at the 61st annual meeting of the American Academy of Forensic Sciences, February 16–21, 2009, Denver, CO. Address correspondence to: Clayton M. Bullock, MD, PhD, South of Market Mental Health Clinic, 760 Harrison Street, San Francisco, CA 94107. E-mail: c-bullock@sbcglobal.net.

Disclosures of financial or other potential conflicts of interest: None.

Table 1 Studies of Sexual Assault of Males

Author	Study Design	% Male Victims	% Female Victims	% Orally or Anally Penetrated (Men)	Mean Age of Assault Victim	% Male Victims Identifying as Homo- or Bisexual	More Than One Assailant	% Stranger Assault
Sorenso *et al.*[7]	Randomized community study	7.2% of 1,480 total	13.5% of 1,645 total	38.8%	NA	NA	NA	NA
Elliot *et al.*[8]	Randomized community study	3.8% of 470 total	22% of 471 total	74%	20.4 (men) 24.7 (women)	NA	NA	NA
Coxell *et al.*[9]	Survey of men attending general practice clinic	2.89% of 2,474 men	NA	18% anally	20	3.1%	NA	NA
Coxell *et al.*[18]	Survey of men attending genitourinary clinic	18% of 224 men	NA	29% anally	21	22%	NA	NA
Riggs *et al.*[10]	Victims presenting to ER	3.8% of 1,076 total	96.2% of 1,076 total	42.9% orally, 66.7% anally	25 (both)	NA	NA	38.7% (both male and female)
Hillman *et al.*[11]	Male sexual assault victims contacting counseling service	100 total	NA	75% anally	14.5	61%	43%	28%
McLean *et al.*[3]	Patients presenting to a sexual assault referral center	5% of 8,165 total	95% of 8,165 total	65.6% anally	NA	NA	NA	NA
Frazier[12]	Patients presenting to a sexual assault referral center	5% of 1,445 total	95% of 1,445 total	All either orally or anally	30	NA	31% of males, 19% of females	50% (both male and female)
Stermac *et al.*[13]	Retrospective study: male stranger, male acquaintance vs female acquaintance assault	64 male stranger, 81 male acquaintance assaults	106 female acquaintance assaults	54% of stranger, 60% of acquaintance anally penetrated	27 (all)	NA	Males more likely than females	
Ernst *et al.*[14]	Victims presenting to ER	3% of 2,213 total	97% of 2,213 total	100% anally penetrated	26	NA	NA	33% of male

Table 1 Continued

Author	Study Design	% Male Victims	% Female Victims	% Orally or Anally Penetrated (Men)	Mean Age of Assault Victim	% Male Victims Identifying as Homo- or Bisexual	More Than One Assailant	% Stranger Assault
Pesola *et al.*[15]	Victims presenting to ER	27 sexual assaults of men (12% of 173)	88% of 173 assaults	23/27 or 85%	28.9	17/21 or 63%	NA	26.3% of male victims; 47.4% of male victims assaulted by someone known <24 hours; 26.7% of female victims
Lacey and Roberts[16]	Males attending a sexual assault referral center	13 total (100%)	NA	8/13 or 61.5%	21.6	3/18 or 16%	NA	5/13 or 38.4%
Kaufman *et al.*[17]	14 Male rape victims compared with 100 randomly selected female rape victims	NA	NA	All anally	NA	NA	50% of males compared with 23% of females	NA, it appears most male victims assaulted by strangers

remedy to male sexual assault victims, partly as a consequence of the belief that maintaining an erection or having an ejaculation during an assault signifies consent by the victim.[6] This review supports the idea that men often experience involuntary erections or ejaculations during a sexual assault and that these responses do not signify consent by the victim. This review also supports the idea that men can have involuntary erections or ejaculations in the context of anal rape.

Incidence and Prevalence of Sexual Assaults of Males

Thirteen studies examining the overall prevalence of the sexual assault of men were reviewed.[7–20] The data are summarized in Table 1. Although these studies vary considerably in design, several consistent trends are notable. Retrospective studies examining large populations (catchment area surveys, nationwide randomized surveys, or large clinical samples) show that between 3 and 7 percent of men report a history of sexual assault occurring during adulthood,[7–9] as compared with 13.5 to 22 percent of women. Although lower percentages of men reporting a sexual assault history are found in studies using more stringent definitions of sexual assault,[7–9] all studies report that a high percentage of assaults of men, 18 to 74 percent, involve oral or anal penetration. Data from retrospective survey studies show that females are victimized about two to five times as frequently as males. In studies from victims presenting acutely to a sexual assault referral center or emergency department, the percentage of male victims is generally around three to five percent, and the male victims in these studies had a high incidence (66%–100%) of forced anal penetration (Table 1).[3,10–17]

All studies showed that sexual assaults occur more frequently with younger victims, most in their 20s to early 30s, and the age of the victim tends not to differ with gender. A few studies[10–12,17] showed that male victims are consistently more likely to have more than one assailant than are female victims. Although the results in all studies showed that most of the perpetrators are male, women are perpetrators too.[5,7,8] Higher rates of sexual assault of males were reported in all studies enriched for men who identified as gay, bisexual, or having had consensual same-gender sexual experiences. In the 1999 study by Coxell *et al.*,[9] 3.1 percent of the men in the sample reported consensual sexual experiences with other

men, and 2.89 percent reported having experienced a sexual assault (56% male perpetrators). In the 2000 study by Coxell and King,[17] 22 percent of the men in their sample reported consensual sexual experiences with other men, and 18 percent reported having experienced a sexual assault (55% male perpetrators). Men who reported having consensual sex with other men were six times more likely to have had nonconsensual sex as an adult,[9] compared with men reporting only consensual experiences with women. Similarly, in a study by Pesola *et al.*[15] of sexual assault victims presenting to St. Vincent's Medical Center Emergency Department in the West Village area of New York City, 12 percent of all sexual assault victims were male, and 63 percent of these self-identified as gay or bisexual. In studies in which the relationship of the assailant to the male victim is examined, it appears that a majority of the sexual assaults are perpetrated by someone known less than 24 hours, or a person just met, perhaps reflecting some degree of consensual social or sexual activity taking place before the relationship becomes assaultive.[15,18]

Ignorance, Attribution of Blame, and Homophobia

Nearly all of the literature reviewed comments on the lack of recognition accorded to male victims of sexual assault as one of the most striking features of the phenomenon. This is evidenced by the legal definition of rape in the United Kingdom (see above), which before 1994 excluded males as victims. Since 1986, U.S. federal law has defined sexual abuse in gender-neutral terms as:

> . . . contact between the penis and the vulva or the penis and the anus . . . between the mouth and the penis, the mouth and the vulva, or the mouth and the anus; the penetration, however slight, of anal or genital opening of another by hand or finger or by any object, with an intent to abuse, humiliate, harass, degrade or arouse or gratify the sexual desire of any person.[19,20]

As mentioned earlier, as of 2004, all but three jurisdictions in the United States had gender-neutral rape statutes.[6] The literature on sexual assault has historically concentrated on males exclusively as perpetrators and females exclusively as victims, with the possible exception of males in all-male environments such as jails and prisons. The reasons for excluding consideration of males as victims have been manifold and include the misconceptions that men in the civilian community simply cannot be victims of sexual assault; that the incidence of sexual assault of males is so rare as not to merit attention; that male victims are more responsible for their assault than female victims; and that male victims are more likely to be homosexual and therefore actually wanted the assault.[21] Complicating these misperceptions is the status and meaning of erectile and ejaculatory behavior in men and the erroneous assumption that, when present, these physiological occurrences signify consent by the victim.[6]

Many of these phenomena are illustrated by Donnelly and Kenyon,[21] who surveyed 41 different agencies, including law enforcement agencies, hospitals, medical facilities, mental health agencies, and community crisis or rape crisis centers, all of which advertised themselves as rape crisis or sexual assault services providers in an area telephone directory in the state of Georgia. Of the 30 agencies that participated in an in-depth interview, 11 indicated they did not provide services to males; 10 were theoretically able to serve males but had never done so; 5 had dealt with at least one male in the past; and 19 were amenable to providing such services, but only 4 of them had done so in the past year. Among the facilities that either had never seen male sexual assault victims or were unable to provide services to male victims, common stereotypes abounded:

> Many believed that men couldn't be raped or that they were raped only because they "wanted to be." One law enforcement representative bluntly stated, "Honey, we don't do men. . . . What would you want to study something like that for? Men can't be raped.". . . Other respondents indicated that they did not treat men because . . . "so few get raped" [Ref. 21, p 445].

Another law enforcement representative asserted that "We don't have too many [males] that are unwontedly sodomized. If they are, they don't come to us to report it . . . [T]hat leads me to believe that there is just not a problem" (Ref. 21, p 445).

The authors note that the agencies least likely to provide services to male sexual assault victims are law enforcement officials and feminist-based rape crisis centers or hotline workers. The authors theorize that both groups tend not to believe that men can be sexual assault victims, or, in the former case, tend to believe that male victims are invariably homosexual and either actually wanted to be assaulted or that the assaults are reported in the context of a lovers' quarrel. Furthermore, the feminist-based groups tend to view rape as a product of a male-dominated society

that tacitly condones rape, are therefore ideologically at odds with the idea of males as victims, and furthermore fear that acknowledging males as victims would co-opt publicity and resources away from female victims.

Several studies have examined the blame attributed to victims as a function of the victim's gender and sexual orientation. Burt and DeMello[22] studied a sample of 168 university students in Australia (128 female with a mean age of 23.42 ± 8.14 (standard deviation, SD); and 40 male with mean age 24.63 ± 8.24). Participants were asked to complete questionnaires regarding three written rape scenarios and an Index of Attitudes toward Homosexuals (IAH). The IAH measures responses of fear, disgust, anger, discomfort, and aversion that individuals may experience in dealing with gay people. The index scores individuals on a scale of 0 to 100, with individual scores divided into four categories: 0 to 25, low-grade nonhomophobes; 25 to 50, high-grade nonhomophobes; 50 to 75, low-grade homophobes; and 75 to 100, high-grade homophobes. Males scored higher than females on the IAH (the mean for men 46.53 ± 21.99 SD versus the mean for women 36.45 ± 17.09). The participants were asked to read three rape scenarios, each consisting of a university student who is raped by a well-known acquaintance in his or her dorm room. The three scenarios are virtually identical, except for the victims who are a female, a heterosexual male, and a homosexual male. The participants were then asked to answer questions about victim responsibility for his or her assault. The male respondents tended to score higher on the IAH and to hold the homosexual male victim more responsible than did the female respondents. The homophobic respondents held the homosexual victim significantly more responsible than did the nonhomophobic respondents. Homophobic respondents tended to believe that the homosexual victim "led the offender on," more so than did the nonhomophobic respondents and also tended to blame the homosexual victim's behavior and character more so than did the nonhomophobic respondents. Men also tended to attribute more responsibility to the behavior of all victims than did women. Homophobic respondents tended to blame the offender less than nonhomophobic respondents, and male respondents tended to blame the offender in the homosexual male victim scenario significantly less than did females.

In a review of many similar studies, Davies and Rogers[23] found the same trends to be amply born out; namely, that men tend to blame victims of sexual assault more than women, that male victims of sexual assault are held more responsible than female victims, and that homosexual male victims are blamed more than heterosexual male victims. Male victims are held more accountable in scenarios where they do not offer resistance and do not fight back or appear scared, which is especially problematic, as many male and female victims react to extreme physical threats with "frozen helplessness."[24,25] Many studies reviewed also suggest the perception that gay male victims are less traumatized by an experience of rape than are heterosexual male victims.[23]

Assailants and Their Motivations

Several studies have analyzed the motivations of assailants in sexual assault. Michael B. King[25] notes that "sexual assault of men has long been recognized as a means used by conquering soldiers to humiliate opponents, as a feature of sexual torture or aggression, or as a sexual outlet in institutions where heterosexual activity is impossible" (Ref. 25, p 1345). He also noted that assailants are predominantly heterosexual and that sexual assault of males perceived to be homosexual is a form of gay bashing. In studies of accounts of both offenders and victims of sexual assault cases, Groth and Burgess[26–28] argued that assertion of power rather than sexual gratification is the motive in most rapes, including cases of males sexually assaulting other males. In their first two studies,[26,27] they analyzed accounts of 133 male offenders and 92 female victims of sexual assault, to arrive at a topology of rape. The offenders were all convicted rapists committed for clinical assessment to the Massachusetts Center for the Diagnosis and Treatment of Sexually Dangerous persons and were interviewed by the authors. Their sample of victims was derived from a one-year counseling and research study conducted at Boston City Hospital that included all persons admitted to the emergency department with a complaint of "I've been raped." Based on accounts and data collected from all the rape cases they studied, including those from interviews with both offenders and victims, the authors argue that, although a sexual motive is present, it is almost always in the service of anger and power, which are the primary motivations of the rapists. In cases where the primary motivation is power:

> . . . the aim of the assault usually is to effect sexual intercourse as evidence of conquest; to accomplish this, often the victim is kidnapped, tied up, or otherwise rendered helpless. Rape is the way in which this type of person asserts his identity, potency, mastery, strength, and dominance and denies his feelings of worthlessness, rejection, helplessness, inadequacy and vulnerability [Ref. 26, p 1240].

In anger rapes:

> The offender expresses anger, rage, contempt and hatred for his victim by beating her, sexually assaulting her, and forcing her to perform or submit to additional degrading acts. He uses more force than would be necessary simply to subdue his victim. . . . He derives his pleasure from degrading and humiliating his victim [Ref. 26, p 1241].

The authors found in their pooled sample of victims and offenders that power rapes outnumbered anger rapes and were 146 (64.9%) of the 225 offenses studied, but that anger rapes were most frequently encountered in the offender sample. The authors hypothesize that because there is more physical evidence in the anger assault category, these offenders are more easily convicted. That at least one-third of the offenders were married and engaging in regular sexual intercourse with their wives and that most of the offenders who were not married were actively involved in sexual relations with one or more women (or had access to prostitutes and other sexual outlets) is cited as further evidence that sexual fulfilment is not the primary motivation for the assaults.

In their study of 22 cases of male/male rape, Groth and Burgess[28] argued that the same basic dynamics are at work, and that for the perpetrators the sexual assault is an "act of retaliation, an expression of power and an assertion of their strength and manhood. . . . The victim may symbolize what they want to control, punish and/or destroy, something they want to conquer and defeat" (Ref. 28, p 809). In this study, the offenders (16 subjects) came from the Center for the Diagnosis and Treatment of Sexually Dangerous Persons (Bridgewater, MA); The Whiting Forensic Institute (Middletown, CT); the Harrington Hospital Forensic Mental Health Program (Southbridge, MA); and the Connecticut Correctional Institution (Somers, CT). The victims either self-referred or were referred to the authors by police or hospital personnel. The offenders ranged in age from 12 to 41 years, including three juveniles between the ages of 12 and 16. The average age among the offenders was 24. The majority (75%) of the offenders were strangers to their victims. Three of the offenders knew their victims casually, and one offender was the victim's brother. Four offenders had codefendants; the other 12 acted alone. All of the adult offenders were sexually active in consenting relationships at the time of their offenses, eight of them (four married) confined their sexual activity to women, six of them (two married) had consenting sexual encounters with both men and women, and three were extremely conflicted over their sexual encounters with other males. Two of the offenders confined their sexual encounters to other men but were not in committed relationships. Six victims were interviewed with an age range of 16 to 28 years and an average age of 17.5 years at the time of the assault. Half of these were assaulted by strangers, two by close friends, and one by a casual acquaintance; one was gang raped by three men. Three of the victims were heterosexual, one bisexual, and two homosexual, one of whom had not been sexually active before his assault.

In most of the assaults, the offender sexually penetrated his victim and in 10 of the 22 cases, the victim was anally raped, the most common sexual act overall. In over half of the cases, the offender made an effort to get his victim to ejaculate either by masturbation or fellatio or attempted to get victims to fellate each other in cases in which there were multiple victims. The authors have quotations from the offenders that support the interpretation that sexual gratification is not the primary motivation of the offenders, and the authors classify the motivations as conquest and control, revenge and retaliation, sadism and degradation, conflict and counteraction, and status and affiliation: "What was really exciting, though, was that all during the assault I felt in total control of him . . ."; "I fucked him. It wasn't for sex. I was mad and I wanted to prove who I was and what he was . . ."; "Making him suck me was more to degrade him than for my physical satisfaction . . ."; "After I came, I dragged him out of the car and punched him out and called him a punk. I told him I was going to kill him . . . I was angry at him . . . at what I was doing I guess is what I was really angry at" (Ref. 28, p 808).

Male Assault Victims and Sexual Response

Groth and Burgess[28] noted that a major strategy used by some offenders in the assault is to get the victim to ejaculate, which may symbolize to the offender his ultimate and complete control, may confirm the offender's fantasy that the victim actually

wanted the assault, may bewilder the victim and discourage the victim from reporting the assault, and may impeach the victim's credibility of his allegation of nonconsent in trial testimony. In the words of one of the victims the authors interviewed: "I always thought a guy couldn't get hard if he was scared, and when this guy took me off it really messed up my mind. I thought maybe something was wrong with me. I didn't know what it meant and this really bothered me." Other studies cite similar anecdotal evidence of involuntary arousal. Huckle[29] noted that men were particularly disgusted with themselves if they ejaculated during the rape. Mezey and King noted: "An extreme form of loss of control is demonstrated by those victims who were physiologically aroused while being terrorized. This would accord with other findings which suggest that sexual arousal may be provoked by extreme anxiety" (Ref. 30, p 208). Multiple other authors have referred to the phenomenon of involuntary arousal and ejaculation by the male victim of sexual assault.[5,31–37] Coxell and King[2] noted that the legal community has assumed that a man cannot obtain an erection involuntarily, however, King and Woollett[37] note that "just under 20 percent of the men were stimulated by their assailant until they ejaculated. This is a particularly difficult issue for victims, especially when cases are brought before the courts . . . as these events may be regarded as a form of consent by lawyers" (Ref. 37, p 587).

Indeed, as discussed by Fuchs[6] in his excellent review, the justice system has been unwilling to provide legal remedy to male victims of sexual assault. The lack of judicial concern for male victims appears strongly influenced by the idea that having an erection or ejaculating signifies consent. Fuchs cites cases of court opinions in the United States, United Kingdom, and Canada attesting to the assumption that penile erection implies consent. For example, in invalidating New Hampshire's gender-specific statutory rape statute under the Equal Protection Clause of the Fourteenth Amendment, the First Circuit Court defined sexual contact as "any penetration, however slight," thus asserting that prepubescent males are capable of being sexually assaulted in violation of the statute without obtaining a full erection. The implication is that a full erection would signify that the sexual contact was consensual: The First Circuit "sought only to protect male victims who maintain partial erections during their attacks . . . [males] who are able to maintain full erections during their sexual assaults would be left without a cognizable legal remedy" (Ref. 6, p 110). Fuchs cites instances in the United Kingdom and Canada of cases being dismissed because the victim of a sexual assault maintained an erection: one where a judge in the United Kingdom dismissed a case because the victim of a prison rape admitted that he had an erection while being raped; another U.K case, in which a judge instructed the jury to acquit a defendant charged with forcible sodomy, solely on the basis that the victim had had an erection during the assault, which the judge accepted as a "defense of submission"; and a Canadian case where a court held that maintaining an erection may be reasonably interpreted as consent (Ref. 6, pp 113–14).

Anal Stimulation and Male Sexual Response

People unfamiliar with anal sex may not appreciate that the experience can produce ejaculation, orgasm, or both in the receptive partner and that many men derive strong sexual pleasure from being anally penetrated. Electroejaculation, a procedure in which an electrical stimulus is applied intrarectally to obtain sperm samples from male mammals, takes advantage of this physiology. It is used for breeding purposes and in assisted reproduction for male humans who are anejaculatory as a consequence of disease or spinal cord injury. It is highly efficacious.[38–40] As a review of the anatomical and microanatomical basis for male ejaculatory response is not possible here, the reader is referred to several published studies on the subject that support the idea that ejaculation is essentially a spinal cord reflex with stimulatory and inhibitory influence from the brain.[41–50]

Anxiety and Male Sexual Response

Studies have show that increased anxiety is associated with premature or spontaneous ejaculation, and there is a notable body of literature, going back to Freud,[51] on the association of anxiety-provoking situations with erections and ejaculation. Men and boys have been described as having spontaneous ejaculations in response to several exciting or anxiety-provoking stimuli, including during examinations and public performances or when experiencing fear of being punished or fear of not being able to finish tasks.[51,52] Several case reports describe individuals

who have spontaneous ejaculations during times of extreme anxiety or even during panic attacks.[51,53] Premature ejaculation is a common sexual dysfunction in male socially phobic patients, and one study found that 9 of 19 patients studied retrospectively had this complaint.[54] Anxiety seems to facilitate erections in men. For example, a 1983 study of male volunteers found that the threat of contingent shock while the volunteers watched an explicitly erotic video produced the highest penile tumescence.[55] "If anything, anxiety stimulates sexual arousal" (Ref. 55, p 242). In an excellent collection of case reports, Sarrel and Masters[5] describe several cases of men forcibly sexually assaulted, who nevertheless maintained erections and ejaculated during the assault. This includes one case of a 27-year-old who was drugged, taken to a motel room, tied to a bed, and gagged. He was forced to perform coitus with four different women repeatedly over the course of more than 24 hours. At one point between coital episodes, he was threatened with castration and a knife applied to his scrotum when he experienced difficulty having an erection. He was able to have a full erection after rest periods. Kinsey[56] concluded, "The record suggests that the physiologic mechanism of any emotional response (e.g., anger, fright, and pain) may be the mechanism of sexual response."[56,57]

Conclusions

Although sexual assault of males occurs much less frequently than that of females, it is neither rare nor limited to all-male populations, such as those in jails and prisons. As with females, sexual assault of males occurs more frequently in the victim's second or third decade. The available comparisons between male and female victims show that male and female victims are assaulted by strangers at about the same rate, but that males are more likely to have more than one assailant. The studies that address the sexual orientation of male victims find higher percentages of victims who identify as gay, bisexual, or having consensual sex with men. However, these populations also tend to be more highly represented in the samples of the studies where this is shown. Many assaults of males involve anal rape.

The circumstances in which sexual assaults of men take place are varied. As with women, men are assaulted by acquaintances (including recent acquaintances), lovers, friends, family members, and total strangers. The motivations of the assailants are varied, and include demanding sexual gratification from a lover, partner, or recent acquaintance; exorcising intensely conflicted feelings about sexual orientation; humiliating the victim, sometimes as a form of gay-bashing; and exercising power and control over the victim. An extreme form of power is expressed in the victims' having an erection or ejaculating during an assault. Studies of the physiological mechanisms governing erection and ejaculation suggest that these can occur in the context of nonconsensual receptive anal sex. Erections and ejaculations are only partially under voluntary control and can take place during times of extreme stress or duress.

It is imperative that attorneys and forensic psychiatrists base their reasoning on scientific fact, both phenomenological and physiological. Otherwise, male victims of sexual assault are confronted by false assumptions by those whom they must depend on if they come forward to report such a crime. Such false assumptions can easily result in disbelief that the event even occurred, or, if it did, the assumption that it was consensual, particularly if there is evidence that the victim experienced an erection or ejaculated during the assault. The reality is that human physiology explains the involuntary aspects of both erection and ejaculation. Understanding of this reality is critical if victims of male sexual assault are to receive justice in legal settings and appropriate services in the community.

References

1. Hillman RJ, O'Mara N, Taylor-Robinson D, *et al*: Medical and social aspects of sexual assault of males: a survey of 100 victims. Br J Gen Pract 40:502–4, 1990
2. Coxell A, King M: Male victims of rape and sexual abuse. Sex Marital Ther 11:297–308, 1996
3. McLean IA, Balding V, White C: Forensic medical aspects of male-on-male rape and sexual assault in greater Manchester. Med Sci Law 44:165–9, 2004
4. Federal Bureau of Investigation: Uniform Crime Reports for the United States. U.S. Department of Justice, 1970
5. Sarrel PM, Masters WH: Sexual molestation of men by women. Arch Sex Behav 11:117–31, 1982
6. Fuchs SF: Male sexual assault: issues of arousal and consent. Clev St L Rev 51:93–121, 2004
7. Sorenson SB, Stein JA, Siegel JM, *et al*: The prevalence of adult sexual assault: the Los Angeles epidemiologic catchment area project. Am J Epidemiol 126:1154–64, 1987
8. Elliot DM, Mok DS, Briere J: Adult sexual assault: prevalence, symptomatology and sex differences in the general population. J Trauma Stress 17:208–11, 2004
9. Coxell A, King M, Mezey G, *et al*: Lifetime prevalence, characteristics, and associated problems of non-consensual sex in men: cross sectional survey. BMJ 318:846–50, 1999
10. Riggs N, Houry D, Long G, *et al*: Analysis of 1,076 cases of sexual assault. Ann Emerg Med 35:358–62, 2000

11. Hillman RJ, Tomlinson D, McMillan A: Sexual assault of men: a series. Genitourin Med 66:247–50, 1990
12. Frazier P: A comparative study of male and female rape victims seen at a hospital-based rape crisis program. J Interpers Violence 8:64–76, 1993
13. Stermac L, Del Bove G, Addison M: Stranger and acquaintance sexual assault of adult males. J Interpers Violence 19:901–15, 2004
14. Ernst AA, Green E, Ferguson MT, *et al*: The utility of anoscopy and colposcopy in the evaluation of male sexual assault victims. Ann Emerg Med 36:432–37, 2000
15. Pesola GR, Westfal RE, Kuffner CA: Emergency department characteristics of male sexual assault. Acad Emerg Med 6:792–98, 1999
16. Lacey HB, Roberts R: Sexual assault on men. Int J STD AIDS 2:258–60, 1991
17. Kaufman A, Divasto P, Jackson R, *et al*: Male rape victims: noninstitutionalized assault. Am J Psychiatry 137:221–3, 1980
18. Coxell A, King M, Mezey G, *et al*: Sexual molestation of men: interviews with 224 men attending a genitourinary medicine service. Int J STD AIDS 11:574–8, 2000
19. 18 U.S.C. § 2242 (1986)
20. Singh D: Male rape: a real crime with real victims. Acta Criminol 17:129–38, 2004
21. Donnelly DA, Kenyon S: Honey, we don't do men: gender stereotypes and the provision of services to sexually assaulted males. J Interpers Violence 11:441–8, 1996
22. Burt DL, DeMello LR. Attribution of rape blames as a function of victim gender and sexuality, and perceived similarity to the victim. J Homosex 43:39–57, 2002
23. Davies M, Rogers P: Perceptions of male victims in depicted sexual assaults: a review of the literature. Aggress Violent Behav 11: 367–77, 2006
24. Symonds M: Victims of violence. Am J Psychoanal 35:19–26, 1975
25. King MB: Male rape; victims need sensitive management. BMJ 301:1345–6, 1990
26. Groth AN, Burgess AW: Rape: a sexual deviation. Am J Orthopsychiatry 47:400–6, 1977
27. Groth AN, Burgess AW: Rape, power, anger, and sexuality. Am J Psychiatry 134:1239–43, 1977
28. Groth N, Burgess AW: Male rape: offenders and victims. Am J Psychiatry 137:806–10, 1980
29. Huckle PL: Male rape victims referred to a forensic psychiatric service. Med Sci Law 35:187–92, 1995
30. Mezey GC, King MB: The effects of sexual assault on men: a survey of 22 victims. Psychol Med 19:205–9, 1989
31. Hickson FCI, Davies PM, Hunt AJ, *et al*: Gay men as victims of nonconsensual sex. Arch Sex Behav 23:281–94, 1994
32. McMullen RJ: Male Rape: Breaking the Silence of the Last Taboo. London: Gay Men's Press, 1990
33. Rentoul L, Appleboom N: Understanding the psychological impact of rape and serious sexual assault of men: a literature review. J Psychiatr Ment Health Nurs 4:267–74, 1997
34. Propat P, Rosevear W: Sexual assault of males, in Without Consent: Confronting Adult Sexual Violence. Edited by Easteal PW. Canberra ACT, Australia: Australian Institute of Criminology, 1993, pp 219–35
35. Mezey GC, King MB: Male Victims of Sexual Assault (ed 2). Oxford: Oxford University Press, 2000
36. Scarce M: Male on Male Rape: The Hidden Toll of Stigma and Shame. Cambridge, MA: Perseus Publishing, 2001
37. King M, Woollett E: Sexually assaulted males: 115 men consulting a counseling service. Arch Sex Behav 26:579–88, 1997
38. Shieh JY, Chen SU, Wang YH: Protocol of electroejaculation and systemic assisted reproductive technology achieved high efficiency and efficacy for pregnancy for anejaculatroy men with spinal cord injury. Arch Phys Med Rehabil 84:535–9, 2003
39. Ohl DA, Wolf LJ, Menge AC, *et al*: Electroejaculation and assisted reproductive technologies in the treatment of anejaculatory infertility. Fertil Steril 76:1249–55, 2001
40. Sonksen J, Ohl DA: Penile vibratory stimulation and electroejaculation in the treatment of ejaculatory dysfunction. Int J Androl 25:324–32, 2002
41. Truitt W, Coolen L: Identification of a potential ejaculation generator in the spinal cord. Science 297:1566–69, 2002
42. Coolen LM, Allard J, Truitt WA, *et al*: Central regulation of ejaculation. Physiol Behav 83:203–15, 2004
43. Giuliano F, Clement P: Physiology of ejaculation: emphasis on serotonergic control. Eur Urol 48:408–17, 2005
44. Giuliano F, Rampin O: Neural control of erection. Physiol Behav 83:189–201, 2004
45. Holstege G, Georgiadis JR, Paans AM, *et al*: Brain activation during human male ejaculation. J Neurosci 23:9185–93, 2003
46. Holstege G: Central nervous system control of ejaculation. World J Urol 23:109–14, 2005
47. Fabbri A, Jannini EA, Gnessi L, *et al*: Endorphins in male impotence: evidence for naltrexone stimulation of erectile activity in patient therapy. Psychoneuroendocrinology 14:103–11, 1989
48. Mintz J, O'Hare K, O'Brien CP, *et al*: Sexual problems of heroin addicts. Arch Gen Psychiatry 31:700–3, 1974
49. Abdollahian E, Javanbakht A, Javidi K, *et al*: Study of the efficacy of fluoxetine and clomipramine in the treatment of premature ejaculation after opioid detoxification. Am J Addict 15:100–4, 2006
50. McIntosh TK, Vallano ML, Barfield RJ: Effects of morphine, beta-endorphin and naloxone on catecholamine levels and sexual behavior in the male rat. Pharmacol Biochem Behav 13:435–41, 1979
51. Redmond DE, Kosten TR, Reiser MF: Spontaneous ejaculation associated with anxiety: psychophysiological considerations. Am J Psychiatry 140:1163–6, 1983
52. Feldman SS: Anxiety and orgasm. Psychoanal Q 20:528–49, 1951
53. Freeman SA: Panic attacks with spontaneous ejaculation successfully treated with citalopram and clonazepam. J Clin Psychopharmacol 24:463–4, 2004
54. Figueira I, Possidente E, Marques C, *et al*: Sexual dysfunction: a neglected complication of panic disorder and social phobia. Arch Sex Behav 30:369–77, 2001
55. Van den Hout M, Barlow D: Attention, arousal and expectancies in anxiety and sexual disorder. J Affect Disord 61:241–56, 2000
56. Kinsey AC, Pomeroy WP, Martin CE: Sexual Behavior in the Human Male. Philadelphia: WB Saunders, 1948
57. Bancroft J, Mathew A: Autonomic correlates of penile erection. J Pschosomat Res 15:159–67, 1971