Original Article

Male Help-Seeking After Sexual Assault: A Series of Case Studies Informing Sexual Assault Nurse Examiner Practice

Carolyn M. Porta, PhD, MPH, RN, SANE-A[1], Ellen Johnson, BA, RN, SANE-A, CEN[2], and Cris Finn, PhD, NP, FACFEI, FNE[3]

Background: A series of three composite case studies of cisgender men who presented to an emergency department for care after experiencing a sexual assault are presented. These cases show common assault characteristics including substance use, force, and multiple perpetrators.
Methods: We describe the sexual assault nurse examiner (SANE) findings and treatment and provide legal details of specific cases when available.
Results: These case reports highlight common challenges to help-seeking and the primary reasons these male victims overcame the barriers to seek care.
Discussion: SANEs are encouraged to provide consistent care to all sexual assault patients, regardless of gender. SANEs have an obligation to educate peers and broader society about sexual assault prevention and to advocate for policies that encourage help-seeking when a sexual assault has occurred.

KEY WORDS:
Case study; forensic nursing; male; male victims; sexual assault; sexual assault nurse examiner (SANE)

One of every 10 sexual assault victims is male (Department of Justice, 2013), and in the United States, one in 71 men will be sexually assaulted in their lifetime (Black et al., 2011). This risk increases 10 times for men who enter the military (Government Accountability Office [GAO], 2015), yet few military men will disclose a sexual assault incident and even fewer will seek health care. When they do seek care, care is often delayed an average of at least 6 months and sometimes years after the incident (Campbell, 2008; Donne et al., 2017; Monroe et al., 2005; Rape, Abuse & Incest National Network, 2016). When there is a delay (beyond 72 hours for HIV prophylaxis; beyond a week for prophylaxis of chlamydia, for example), the window of opportunity for prophylactic medications has passed. Delay in care also results in missed opportunities for immediate emotional and psychosocial support that can benefit the patient (i.e., sexual assault nurse examiner [SANE] examination and trauma informed care benefits/support; advocacy support for safety) as well as midterm and long-term benefits (Dworkin & Schumacher, 2016). Encouraging timely help- seeking after a sexual assault is paramount to improving the health outcomes for victims of sexual violence. SANEs are in a unique position to advocate for gender-inclusive conceptualization of sexual violence that informs prevention and intervention efforts for all victims (Turchik, Hebenstreit, & Judson, 2016).

There are numerous reasons individuals chose not to seek care after a sexual assault. These include fear of people finding out, disbelief or shock that the assault took place, shame, guilt, reliving childhood trauma, relationship to the offender, and past negative experiences with the healthcare system (Chu, DePrince, & Mauss, 2014; Du Mont, Macdonald, White, & Turner, 2013; Kilpatrick, Resnick, Ruggiero, Conoscenti, & McCauley, 2007; Masho & Alvanzo, 2010; Masho & Anderson, 2009; Patterson,

Author Affiliations: *[1]School of Nursing, University of Minnesota; [2]Regions Hospital; and [3]Loretto Heights School of Nursing, Regis University.*

The authors declare no conflict of interest.

Correspondence: *Carolyn M. Porta, PhD, MPH, RN, SANE-A, School of Nursing, University of Minnesota, 5-160 Weaver Densford Hall, 308 Harvard Street SE, Minneapolis, MN 55455. E-mail: porta@umn.edu.*

Received December 10, 2017; accepted for publication March 24, 2018.

DOI: 10.1097/JFN.0000000000000204

Greeson, & Campbell, 2009; Simmons, Bruggemann, & Swahnberg, 2016). Additional factors that might discourage help-seeking include the nature of the community (i.e., rural, urban), availability of healthcare services, relationships or support available, and community attitudes toward sexual violence. Furthermore, broader influences on help-seeking could include overarching views, myths, and stereotypes regarding men and women, victims and perpetrators, and violence (Campbell, Dworkin, & Cabral, 2009; Ellis, 2002; Hayes, Abbott, & Cook, 2016). General stereotypes about men and masculinity commonly held in North America are outlined in Table 1, whereas specific reasons male victims of sexual assault choose not to seek care are compared with universal reasons for not seeking care, and are highlighted in Table 2.

TABLE 1. Common stereotypes about men and masculinity

• "Men don't cry"—Showing emotions (other than anger) is not masculine.
• "Marlboro Man"—Men are rough, tough, and silent and aren't allowed to be vulnerable.
• "Men can't be raped"—Men are strong and can fight someone off.
• "Men have sex"—Men want sex all the time with anyone.

TABLE 2. Male-specific and universal reasons victims of sexual assault might not seek care

Male-specific reasons for not seeking care	Universal reasons for not seeking care
• Embarrassment, especially if there was erection/ejaculation associated with the assault	• Embarrassment
• Feel emasculated	• Feel shame
• Believe others will think they are gay because of it	• Worry about perceptions of others, including the healthcare providers
• Believe they will appear weak if they seek care or report sexual assault	• Believe they should have been able to stop the assault
	• Believe law enforcement won't take it seriously, or fear of law enforcement's response
	• Fear of finding out they have HIV/AIDS
	• Fear of spouse or friends/peers/coworkers finding out
	• Fear they won't be believed

Case Studies

In this article, we present three composite case studies (i.e., the case details have been altered where necessary to ensure anonymity) of cisgender men (i.e., personal identity and gender correspond with sex assigned at birth) who have overcome help-seeking barriers and sought care after a sexual assault. These cases show (a) diverse situations in which men have been sexually assaulted, (b) common reactions to sexual assault, and (c) unique, challenging factors the SANE had to address in their care and treatment of these men.

Case 1

Description of Case

A 23-year-old man was brought by ambulance to an upper Midwest trauma center. He reported being "choked from behind" 4 days prior, where he woke up blindfolded with his wrists tied to his feet. He stated that he was "maced when he tried to get the blindfold off, and that he was rectally assaulted twice a day." He described being held captive, blindfolded, bound by the neck and wrists, and chained to a wall. He stated that he was forced to smoke marijuana, which he felt had helped with the pain to his legs from being shackled together. He said that he was able to escape by pulling the bar that his handcuffs were attached to off of the wall. His feet were still handcuffed so he hopped up the stairs and escaped through a window. He went from house to house until he found someone who would call 911.

Summary of Key Examination Findings

The patient had bilateral subconjunctival hemorrhages covering the entire sclera and complained of pain in his eyes. The emergency department (ED) physician assistant performed a slit lamp examination and found bilateral corneal abrasions. Moreover, the patient had circumferential scabbed abrasions to his neck, wrists, and ankles, which were consistent with his history of being bound and handcuffed. The patient declined an anoscopy stating, "there's been enough in my ass, I can't take this any longer." The trauma surgeon was consulted because of the patient's physical findings and report of strangulation. He had a computed tomography/angiograph of his neck with intravenous contrast per national guidelines (Training Institute on Strangulation Prevention, 2016), which showed no evidence of dissection or pseudo aneurysm. The trauma surgeon wanted to admit the patient for observation, psychosocial support, and pain management, but he adamantly refused.

The Centers for Disease Control and Prevention (2016) recommend starting patients on HIV nonoccupational post-exposure prophylaxis (nPEP) within 72 hours of exposure. In this case, rectal assaults occurred repeatedly over the 4 days the patient was held captive. It was not certain when the possibility of transmission of HIV would have occurred during this time frame, so in consideration of the risk factors and the time frame range, the decision was made to provide

28 days of two recommended medications: emtricitabine/tenofovir disoproxil fumarate and raltegravir. The patient was strongly encouraged to make a follow-up appointment to get both baseline HIV testing plus kidney and liver function tests as soon as possible because he had refused the laboratory draw in the ED. He was subsequently discharged 14 hours after admission to the ED, to the care of his girlfriend, with pain medications, trimethoprim-polymyxin B eye drops, and the HIV nPEP medications.

Discussion of Case

The patient's words were reminiscent of statements we hear often from both female and male rape victims. He said, "The days kept going by. I did not know if he was going to rape me again or kill me. I was raped and I had no control. I feel violated. I don't know if he gave me a disease. I can't believe this is happening to me." Fear for personal safety and possible negative health outcomes during sexual assault are not gender specific. The SANE is well prepared to address these commonly voiced concerns and, indeed, expected to do so (U.S. Department of Justice, 2013).

Case Conclusion, Including Investigator Follow-Up

Care for this patient was challenging because of his refusal of anoscopy and baseline laboratory testing; as a result, the SANE was unable to determine if he had a rectal injury or if his labs were normal before placing him on HIV nPEP. Furthermore, his refusal of hospital admission after a potentially life-threatening strangulation injury was disconcerting. Caring for this patient, however, reinforced the importance of appreciating patients' preferences in healthcare treatment and, ultimately, respecting their autonomy. Although the patient had significant injuries, he was autonomous and able to make his own healthcare decisions, including refusing recommended care. His expression of autonomy also occurred in his interaction with the criminal justice system; notably, he did not wish to continue to engage in the criminal justice process and stopped communicating with investigators. Subsequently, the case was not pursued by the authorities although there was general consensus by law enforcement that a crime had occurred.

Case 2

Description of Case

An active duty 21-year-old man sought care while home on leave as a "self-pay" patient because he did not want a military trackable record for his health issue. He stated to the provider, "Just want to be sure I'm ok down there…it was six months ago and still hurts." "At night they would pull the covers over me and beat me with a bar of soap in a sock. They would push me out of my bunk onto the floor. They would mess up my locker during inspection. They left the bar of soap in my ass." In response to a question about reporting to law enforcement, the patient stated, "Hell no, I didn't report this. Who was I going to report it to?" He shared that he still had 3 years left to serve. "My girlfriend and family don't know about this and I don't want them to [know]."

Summary of Key Examination Findings

The patient presented for an examination 6 months after the incident; at the time of the examination, he had no physical injuries.

Discussion of Case

Government service can be a confounding barrier to help-seeking after an assault. The moment a man enters the U.S. Armed Forces, his chance of being sexually assaulted increases tenfold (GAO, 2015). Military culture is built on a tenuous balance of aggression and obedience (Garamone, 2016), so it is not surprising that approximately only 10% of assaulted men in the military will report the incident (GAO, 2015). The patient's love of country and desire to serve were in direct conflict with seeking self-care after the assaults. "I can't blame the whole military for what they did. I like the structure—having a sense of I know what I am doing, what my job is. I will go back at the end of leave even after everything that has happened. I am in a different unit now." His personal safety was adequately addressed, and during the discussion, he brought up emotions and reflections about his healing journey. "In order to heal, I'm supposed to forgive; I've been told that many times by the Chaplain. But how do you forgive somebody that's done that to you for not measuring up during training? How do I do that?" "I want to beat them to a pulp or worse, but I know I can't."

Case Conclusion, Including Investigator Follow-Up

Lessons learned from this case include the importance of conducting a thorough history, demonstrating compassion, and sharing community and related resources, as essential components of a SANE examination. The barriers to reporting in the military, although similar to the civilian world with respect to embarrassment, manliness, and fear of repercussions (see Table 2), are potentially stronger for men in the military because of the close proximity in which they live with one another, including the perpetrators of the violence. They eat, sleep, and work alongside each other; with preparations focused on going to war, being side by side, or having each other's "back," these men literally hold each other's lives in their hands when they deploy. Although a significant loss of trust occurs when someone has been assaulted, there is fear of substantial retaliation if the assault is reported (with the potential risk of losing one's life). Beyond these factors, there is the military reporting structure that is designed for top-down orders to facilitate fighting a war, not for up-the-chain complaints. Complaints of any kind are viewed as a barrier to a unit's readiness to wage

war and reflect poorly on all members of the unit. The best solution for this man who had been assaulted, and who had overcome barriers to at least seek care outside the military setting, was to request a transfer and start over with a new group of servicemen; this type of action is viewed as a career-neutral event with fewer potentially negative implications. This serviceman returned to active duty with a new unit and became a part of the military sexual assault prevention and response program aimed at helping other survivors.

Case 3

Description of Case

A 22-year-old college student was transported to an upper Midwest trauma center by local police. He stated that he went to a professor's house for dinner. The professor's partner and a female friend of the patient were also there. A lot of alcohol was ingested, and marijuana was smoked. After everyone else fell asleep, the professor suggested that they go upstairs so they could drink some more. The patient took another sip but then stopped drinking because he did not want to get sick. The professor said, "You can sleep on the couch."

The patient stated, "He stood up from his end of the couch and set up some pillows on his end. Then he said 'take your shorts off.' I unbuckled my belt and undid the button and he pulled my pants off. I pulled the blanket over me and tucked myself in. He sat on the floor in front of the couch and I could feel him touching me, going up my thighs. Then I remember feeling him touch me on my crotch area. I turned on my back to turn away. He kept touching me and I was getting an erection. I was trying to turn further towards the couch. I was acting like I was asleep because I didn't want to have the conversation. Then he was positioning me and I knew I could not keep pretending to be asleep. I was wondering how much I could fight back while pretending to be asleep. I wondered if he had done this before. I thought it would be safer to just keep pretending to be asleep. I didn't know if he would hit me over my head or if he was experienced at this. He started to suck on my dick and I started to lose my erection. I remember him tucking my penis back in my boxers at one point. I must have dozed off and then I woke up and I opened my eyelids a little bit and he was asleep in the chair. I got dressed and then I picked up the glass on the end table in case I needed to hit him over the head. Then I went down both flights of stairs and then I was not sure if I should grab my friend but I thought she was not in immediate danger. I was not sure of the procedure for calling the cops. I went to the intersection and flagged down someone and called 911. I had set my glass at the intersection because I did not know if I needed to have some other proof that I was at the scene."

Summary of Key Examination Findings

The patient had no physical injuries.

Discussion of Case

Many of the thoughts the patient expressed were typical of many victims and are not gender specific. With the large amount of alcohol ingested, along with marijuana, the patient was confused and unsure of what to do. He made statements such as "I wasn't sure what was happening," "Should I ignore it and maybe he will stop?", and "I wasn't sure how to get myself out of this situation." He tried to use avoidance techniques like rolling over and pretending he was asleep. He was not sure if he was in danger and did not know if the professor had done this to anyone else before. Many patients seeking care after a sexual assault often voice these same thoughts.

Case Conclusion, Including Investigator Follow-Up

A key lesson learned in this case is that men can also experience fear and feelings of vulnerability, which can lead to confusion about how to get out of a situation when they are being assaulted. In addition, this case reinforced the importance of providing compassionate care and affirming that an assault is never the victim's fault. The SANE acknowledged his courage in reporting to law enforcement and presenting for a medical forensic examination. The case was presented to the prosecutor who declined to lay charges in the case. However, the patient also reported to his university, and as a result of the Title IX investigation, the professor was fired.

Overall Conclusions

Victims of sexual violence, regardless of gender, show commonalities in their victimization experiences and hesitancies in reporting or seeking health care (Hines, Armstrong, Reed, & Cameron, 2012; McLean, 2013). There is an obligation for SANEs to provide excellent evidence-based health and legal care to all victims of sexual violence with an accepting and nonjudgmental stance, including offering comprehensive follow-up services such as counseling (Du Mont et al., 2013). This consistent care is welcomed by all genders, and the SANE should have confidence that a trauma-informed approach (Graham, Yaros, Lowe, & McDaniel, 2017) delivered in a healing environment will be well received. Offering choices at every step in the process and respecting patients when they make choices contrary to what is recommended or requested are ways to gently come alongside the patients and support their efforts to regain control.

An important part of the process toward identifying solutions is recognizing the intersectionality of factors that influence help-seeking (e.g., gender, race, socioeconomic status, geographic residence; Campbell et al., 2009; Patterson et al., 2009; Ullman, 2007). In recent years, theoretical advancements have been made regarding postassault help-seeking primarily grounded in the experiences of female survivors (e.g., Campbell et al., 2009; Campbell, Greeson, Fehler-Cabral,

& Kennedy, 2015; DeLoveh & Cattaneo, 2017). There remains, however, a need for future research to examine decision making by male survivors of sexual violence. For example, insights around disclosure to formal (e.g., healthcare providers, law enforcement) or informal (e.g., friends, family members) resources might inform strategies to encourage disclosure and healing processes among men. Recognition of the critical questions survivors often face immediately after an assault (e.g., Do I need help? What can I do? Where do I turn?; see DeLovey & Cattaneo, 2017) and how these influence help-seeking and disclosure is necessary to strengthening interventions aimed at increasing help-seeking among male survivors.

SANEs are at the forefront of sexual violence prevention and response and are in a unique position to bring attention to victims of sexual violence who have historically been invisible—i.e. men (Donne et al., 2017; Ellis, 2002; Gorris, 2015; Stemple & Meyer, 2014). Finally, SANEs have responsibility to educate and contribute to the advancement of policies within healthcare and governmental institutions to prevent sexual assault and to respond to and protect victims of sexual violence. On college campuses, for example, SANEs have the opportunity to work with health services and administrative officials to ensure that responsive services are available to male and female victims of sexual violence, including confidential one-stop services that are offered in a "culture of caring" (Munro-Kramer, Dulin, & Gaither, 2017). Forensic nurses can provide education to colleagues in health care, law enforcement, the military, and community-based organizations (e.g., shelters, afterschool programs, religious institutions) to increase awareness of sexual violence, including prevention and response that encourages disclosure and help-seeking after an assault. These efforts are critical to ensuring that all victims of sexual violence have the support and care they need for healing and recovery.

Acknowledgments

We offer gratitude to the men who have trusted our care after an assault. We thank Liz Fine Weinfurter for literature research support that informed this article.

References

Black, M. C., Basile, K. C., Breiding, M. J., Smith, S. G., Walters, M. L., Merrick, M. T., … Stevens, M. R. (2011). *The National Intimate Partner and Sexual Violence Survey (NISVS): 2010 summary report.* Atlanta, GA: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention. Retrieved from https://www.cdc.gov/violenceprevention/pdf/nisvs_report2010-a.pdf

Campbell, R. (2008). The psychological impact of rape victims. *American Psychologist*, *63*, 702–717.

Campbell, R., Dworkin, E., & Cabral, G. (2009). An ecological model of the impact of sexual assault on women's mental health. *Trauma, Violence, and Abuse*, *10*, 225–246.

Campbell, R., Greeson, M. R., Fehler-Cabral, G., & Kennedy, A. C. (2015). Pathways to help: Adolescent sexual assault victims' disclosure and help-seeking experiences. *Violence Against Women*, *21*(7), 824–847. doi:10.1177/1077801215584071

Centers for Disease Control and Prevention. (2016). *Updated guidelines for antiretroviral postexposure prophylaxis after sexual, injection drug use, or other nonoccupational exposure to HIV—United States, 2016.* Retrieved from http://www.cdc.gov/hiv/pdf/programresources/cdc-hiv-npep-guidelines.pdf

Chu, A. T., DePrince, A. P., & Mauss, I. B. (2014). Exploring revictimization risk in a community sample of sexual assault survivors. *Journal of Trauma and Dissociation*, *15*, 319–331.

DeLoveh, H. L., & Cattaneo, L. B. (2017). Deciding where to turn: A qualitative investigation of college students' helpseeking decisions after sexual assault. *American Journal of Community Psychology*, *59*(1–2), 65–79.

Department of Justice. (2013). *Office of Justice Programs, Bureau of Justice Statistics. Female victims of sexual violence, 1994–2010.* Retrieved from https://www.bjs.gov/content/pub/pdf/fvsv9410.pdf

Donne, M. D., DeLuca, J., Pleskach, P., Bromson, C., Mosley, M. P., Perez, E. T., … Frye, V. (2017). Barriers to and facilitators of help-seeking behavior among men who experience sexual violence. *American Journal of Men's Health*, *12*(2), 189–201. doi:10.1177/1557988317740665

Du Mont, J., Macdonald, S., White, M., & Turner, L. (2013). Male victims of adult sexual assault: A descriptive study of survivors' use of sexual assault treatment services. *Journal of Interpersonal Violence*, *28*(13), 2676–2694.

Dworkin, E. R., & Schumacher, J. A. (2016). Preventing posttraumatic stress related to sexual assault through early intervention: A systematic review. *Trauma, Violence & Abuse*, 1–14. doi:10.1177/1524838016669518

Ellis, C. D. (2002). Male rape—The silent victims. *Collegian*, *9*(4), 34–39.

Garamone, J. (2016). Experts: Males also are victims of sexual assault. *DOD news, defense media activity*. Retrieved from http://www.defense.gov/news/article/article/604140/exoerts-males-also-victiums-of-sexual-assault

Gorris, E. A. (2015). Invisible victims? Where are male victims of conflict-related sexual violence in international law and policy? *European Journal of Women's Studies*, *22*(4), 412–427.

Government Accountability Office. (2015). *Actions needed to address sexual assaults of male service members, GAO-15-284.* Retrieved from https://www.gao.gov/products/GAO-15-284

Graham, P. W., Yaros, A., Lowe, A., & McDaniel, M. S. (2017). Nurturing environments for boys and men of color with trauma exposure. *Clinical Child and Family Psychology Review*, *20*(2), 105–116.

Hayes, R. M., Abbott, R. L., & Cook, S. (2016). It's her fault: Student acceptance of rape myths on two college campuses. *Violence Against Women*, *22*, 1540–1555.

Hines, D. A., Armstrong, J. L., Reed, K. P., & Cameron, A. Y. (2012). Gender differences in sexual assault victimization among college students. *Violence and Victims*, *27*(6), 922–940.

Kilpatrick, D. G., Resnick, H. S., Ruggiero, K. J., Conoscenti, L. M., & McCauley, J. (2007). *Drug-facilitated, incapacitated, and forcible rape: A national study (final report, NIJ Grant #2005-WG-BX-0006).* Charleston, SC: National Crime Victims Research and Treatment Center, Medical University of South Carolina.

Masho, S. W., & Alvanzo, A. (2010). Help-seeking behaviors of men sexual assault survivors. *American Journal of Men's Health*, *4*(3), 237–242. doi:10.1177/1557988309336365

Masho, S. W., & Anderson, L. (2009). Sexual assault in men: A population-based study of Virginia. *Violence and Victims*, *24*(1), 98–110.

McLean, I. (2013). The male victim of sexual assault. *Best Practice & Research in Clinical Obstetrics and Gynaecology*, *27*, 39–46.

Monroe, L. M., Kinney, L. M., Weist, W. D., Dafeamekpor, D. S., Dantzler, J., & Reynolds, M. W. (2005). The experience of sexual assault: Findings from a statewide victim needs assessment. *Journal of Interpersonal Violence*, *20*(7), 767–776.

Munro-Kramer, M. L., Dulin, A. C., & Gaither, C. (2017). What survivors want: Understanding the needs of sexual assault survivors. *Journal of American College Health*, *65*(5), 297–305. doi: 10.1080/07448481.2017.1312409

Patterson, D., Greeson, M., & Campbell, R. (2009). Understanding rape survivors' decisions not to seek help from formal social systems. *Health and Social Work*, *34*, 127–136.

Rape, Abuse & Incest National Network. (2016). *Victims of sexual violence: Statistics*. Retrieved from https://www.rainn.org/statistics/victims-sexual-violence

Simmons, J., Bruggemann, A. J., & Swahnberg, K. (2016). Disclosing victimization to healthcare professionals in Sweden: A constructivist grounded theory study of experiences among men exposed to interpersonal violence. *British Medical Journal Open*, *6*(6), e010847.

Stemple, L., & Meyer, I. H. (2014). The sexual victimization of men in America: New data challenge old assumptions. *American Journal of Public Health*, *104*(6), e19–e26.

Training Institute on Strangulation Prevention. (2016). *Recommendations for the medical/radiographic evaluation of acute adult, non-fatal strangulation*. Retrieved from https://www.strangulationtraininginstitute.com/wp-content/uploads/2015/07/Recommendations-for-Medical-Radiological-Eval-of-Non-Fatal-Strangulation-v17.9.pdf

Turchik, J. A., Hebenstreit, C. L., & Judson, S. S. (2016). An examination of the gender inclusiveness of current theories of sexual violence in adulthood: Recognizing male victims, female perpetrators, and same-sex violence. *Trauma, Violence & Abuse*, *17*(2), 133–148.

Ullman, S. E. (2007). Mental health services seeking in sexual assault victims. *Women and Therapy, 30*, 61–84.

U.S. Department of Justice. (2013). *A national protocol for sexual assault medical forensic examinations, adults/adolescents* (2nd ed.). Retrieved from https://www.ncjrs.gov/pdffiles1/ovw/241903.pdf