

# MALE SURVIVORS OF SEXUAL ASSAULT

A Manual on Evaluation and Management  
for General Practitioners

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# INTRODUCTION

Male Survivors of sexual violence usually come to the health institutions for medical care.

The care differs from institution to institution, here the need for a manual to help health care provider's standardized, comprehensive post-rape/sexual assault care.

This manual on forensic and clinical care for sexual violence survivors is intended to contribute to the efforts by various stakeholders to address sexual violence.

The manual will aid health care providers in managing sexual violence clinically. It will provide those in health facilities with the knowledge, skills and information to ensure all male survivors of sexual violence are handled in the best and most professional manner. This manual guides health care providers to undertake forensic examination, specimen collection, analysis, and document, provide clinical management to survivors. The manual has a section on counselling, to emphasize the necessity for counselling and its implications in clinical management and to equip health care providers to provide basic counselling.

We hope this manual will contribute to the skills of health care providers in the managing male sexual violence survivors.

# 1 MALE SEXUAL ASSAULT: EVALUATION AND MANAGEMENT FOR GENERAL PRACTITIONERS

## 1.1 DEFINITION

Male sexual assault is defined as any sexual act performed on a male without his free agreement (Bates, 2012). Free agreement may be negated by many factors, including the utilization of age difference or intellectual abilities, the use of force, threats, fraud, and substances such as drugs or alcohol.

Sexual assault survivors do not “entice” their assailants; sexual assault is an act of conquest, violence, and control. It is important to make it clear that sexual assault is never the fault of the survivor.

General Practitioners may not be presented with many medical cases explicitly resulting from sexual assault, namely survivors approaching the doctor indicating that they have been sexually assaulted and clearly requesting medical attention. Instead, GPs are more likely to be approached less directly (e.g. for STI check-ups), or to address long term mental and physical consequences of the assault (e.g. post-traumatic stress, developed infections, sexual dysfunction). It is also worth noting that the assailant could be related to the survivor, as for instance it is the case with cases of domestic violence or an intimate partner, making it less likely that the survivor would clearly indicate the assault.

## 1.2 KEY MESSAGES

- Sexual assault is very common, with 1.33 men having experienced an assault in their adult lives. Among male victims of unwanted sexual

contact, about half (an estimated 51.8%) had an acquaintance as a perpetrator. Finally, among male victims of noncontact unwanted sexual violence, an estimated 39.2% had an acquaintance as a perpetrator, followed by an intimate partner (an estimated 30.9%), or a stranger (an estimated 30.9%). (CDC, 14) (Coxell et al.,1999).

- Many survivors do not report sexual assault; Therefore the effects, both physical and psychological, may go untreated.

## 1.3 BACKGROUND

Male survivors of sexual assault, like female survivors, are usually reluctant to report their assaults or present for medical evaluation; and when they do present, they are more likely to have suffered traumatic injury and forcible penetration. Societal attitudes and myths about male survivors of sexual assault discourage them from coming forward; it is altogether likely that such assaults are even more underreported in comparison to cases among females. A 'rape myth' is an inaccurate assumption about rape. For example, a commonly held rape myth about male victims is that most male rapes are perpetrated by homosexual men on homosexual men, whereas in reality we know that both victims and perpetrators tend to be heterosexual (SurvivorUK, 13) (Coxell & King, 1996).

Statistics indicate that about 3% of men will experience sexual assault during their lifetime (DeVore & Sachs, 2011). Factors underlying the failure to disclose include:

1. Lack of awareness of sexual assault against males both by health-care professionals and the general public
2. Lack of available data or supporting literature
3. Inaccurate but persistently held beliefs surrounding rape (e.g. a man can't be forced to have sex against his will etc.)
4. Fear of being discredited, defamed, discriminated against, or blamed for the assault
5. Internalized self-stigmatization
6. Reporting sexual assault is also dependent on the person's previous experience with authority figures. (Coxell & King, 1996)

**ASSESS VULNERABILITY:** Virtually, anyone can be sexually assaulted, but particular groups are at greater risk than others. Higher risk groups for sexual assault include males with:

### Associated health issue

- Alcohol users (either consumed by choice or via spiked drinks)
- Illicit drug users (taken by choice or consumed via spiked drinks), including injectable drug users (IDUs)
- Mental health issues
- Disability (including physical, learning disorders and learning difficulties). (Hurley et al., 2006). (Murray & Powell, 2008).

### Past history of abuse

- Previous experiences of sexual assault
- History of childhood sexual assault.

### Living or working conditions such as:

- Poverty
- Homelessness
- Sex industry
- Custody and incarceration
- Traveling or being an international student
- Areas of war and civil crisis
- Perceived sexual orientation and gender identity (transmales, queers)
- Trafficking
- Illegal workers/migrants

### Others:

- Being a gay
- Ethnic minorities

The sexual assailant characterization has been the focus of numerous psychological classifications. Many experts refute the concept that rape is primarily a sexual act, and take the perspective that rape is a violent act expressed sexually, rather than a sexual act expressed violently (Loncar M, et al, 2010, Lim LE, Gwee KP, Woo M et al. 2001, Ernoehazy & Murphy-Lavoie, 1998).

Regarding rape myths specific to male-on-male rape and sexual assault, research found that widely held beliefs in society that male rape is rare, partly because men should be able to resist, but when it does happen, it is usually in prisons and men should be strong enough to cope with it (Kassing LR, Beesley D & Frey LL.2005). The presence of such perceptions of rape, rapists and rape victims in society are, of course, important to understand, as they influence the way in which society and the individuals that compose it then respond to victims. Research indicated that the stronger an individual believes in stereotypes of male rape the more they will attribute blame to a male victim of such crimes while simultaneously reducing the blame attributed to the rapist (Sleath E & Bull R.2010). Perceptions of masculinity are, therefore, more influential when considering male-on-male rape than are perceptions of femininity about male on- female rape.

In a review of studies on perceptions of male-on-male rape (Davies M & Rogers P. 2006) a summary of key perceptions pertaining to male victims confirms stereotyping: males blame victims more than females; male victims are blamed more than females (Davies M, Pollard P & Archer J. 2001, Gerber GL, Cronin JM & Steigman H. 2004); homosexual victims are blamed more than heterosexual victims (Burt DL & DeMello LR. 2002) acquiescent victims are blamed more than resistant victims; and assaults on male (especially homosexual) victims are considered (especially by heterosexual males) less severe than on females.

Sexual assault's survivor may be affected by different physical and psychological injuries, up to and including life-threatening multi-organ system trauma (Ernoehazy & Murphy-Lavoie, 1998). Others might include:

- Posttraumatic stress disorder (PTSD): can cause long-term psychological impairment. (Creamer, M., Burgess, P., & McFarlane, A. C. 2001).
- Sexually transmitted infections (STIs): each stemming directly from the sexual nature of the attack, which can also be the source of subsequent morbidities and mortality.

- More likely to have higher cholesterol, stroke, heart disease, problems with their immune system, and report that they smoked or drank excessively in comparison to people who had not been raped (Smith, S. G., & Breiding, M. J. 2011).
- More likely to report mental ill health, poor life satisfaction, activity limitations, and lower emotional and social support (Choudhary, E., Coben, J., & Bossarte, R. M. 2010).

# 2

## ASSESSMENT OF THE SURVIVOR OF SEXUAL ASSAULT

It is vital to provide care to sexual assault survivors with an empathetic and understanding approach, regardless of their gender. The GP needs to understand that the survivor may be ashamed and unwilling to give a clear history of the assault, despite the fact that such information is critical for the timely treatment and/or prevention of specific infections (such as HIV), as well forensic documentation if required by the survivor. Hence it is wise to identify an experienced GP to be the initial contact in the event of a male survivor of sexual assault presenting to the clinic.

There is no evidence to suggest that the gender of the physician is important but it is of good practice to offer a choice. Tomlinson & Harrison, 1998).

The survivor's privacy and confidentiality shall be secured at all times; they should be seen in a private, well soundproofed, and pleasant room, where the survivor is provided with a safe space to get ready for the medical examination, in which they feel safe to answer sensitive questions. The interview and examination must be unhurried and without interruptions or judgmental attitudes. In other words, the survivor should not be rushed to provide information of receive medical examination, they should also not be subjected to behavior or statements from the GP indicating judgement from the latter, regardless of gender identity, sexual orientation, age, social status and work conditions, nationality, or any other factor. Also, the other personnel should not interrupt or intrude into the room. It is also important to remember that the survivor will be in contact with nurses, receptionists, administrative managers and assistants, as well as other personnel, the survivor may be in position where they need, or want, to provide information to any or some of them, it is therefore important for any potentially involved staff be trained on effective communication,

empathy, positive and negative discrimination, as well the sensitivity of the case in terms of administering prophylaxis.

## 2.1 INITIAL PRESENTATION

Building a relationship of trust with the survivor during the first minutes of the interview is essential to help the survivor feel comfortable and more willing to answer sensitive questions. Such a relationship is built by adopting a non-judgemental attitude towards the survivor and their experience, using reassuring and empathetic statements, such as “everyone takes time to deal with an assault”. For more examples and recommendations on this point, Tomlinson & Harrison, 1998).

Please refer to Table 1.

If there is difficulty forming a good rapport, some of the more intimate questions can be covered at the follow-up visits. However, it is not advisable to rely on follow-up visits for crucial information because survivors rarely ever come back for a follow-up, and even if they do, their recollection of details and events is less efficient.

**REMEMBER** the legal aspects: If the survivor does want to seek legal compensation, medical evidence may well be used in court and the history should be as clear, comprehensive and legible as possible given the constraints of what the survivor might feel able to deal with at that time.

According to article 400 of the Lebanese Penal Code, if during health care provision the health care provider identifies an act of harassment or violence inflicted on the patient/victim that necessitates persecution (without claim), and the health care taker did not notify the proper authorities, then she/he can be penalized.

Regarding adolescents and under age subjects, article 26 of the Adolescent Protection Law indicates that informing the proper authority about vulnerability of the adolescent to danger is not considered a violation of the medical secrets. This was echoed in

a dispatch number 58 from the Minister of Public Health (12/6/26) urging physicians and nurses and other health professionals to inform the proper authorities about cases who might be victims of violence, especially if they were adolescents or children.

In cases of rape, article 7, item 14, indicated that if the victim of rape is adult, the physician must inform the Attorney General after the victim consent (consent is mandatory so not to penalize the physician for violating medical secrecy under article 579 of the Penal Code). If the victim is an adolescent or under age, the physician must inform the proper authorities about the case in hand without getting the consent of the victim (Article 7, item 15). It is permissible for the physician to seek the Juvenile judge if the juvenile (adolescent/underage) is vulnerable or under threat. Even in situation where the legal guardian of the juvenile is refusing consent, which may threaten the juvenile, the physician can still seek the juvenile judge.

**Table 1: Examples of good practice in the assessment of male victims of sexual assault**

<b>Practice</b>	<b>Rationale</b>
Choose a private room and ensure that there will be no interruptions.	Facilitates disclosure and builds up victim's sense of trust and provides a safe containing environment.
Make clear how much time you have available, the structure of the consultation and who will be available for follow-up.	Avoids finishing an interview abruptly and sets the framework of the consultation.
Don't make notes during the initial description of the assault but listen to the story first. Check back with him that you have got the details correct as you then write it down.	Gains patient's trust and belief that he is being heard by the clinician.
Listen for indications that he assumes that he is being judged or criticized and reassure appropriately.	Acknowledges the trauma of the event and minimize self-blame.
Beware of asking "why did you . . ." type questions.	Avoids interpretation of the clinician as blaming or critical of the man.
Do not express your own attitudes, judgement or feelings unless necessary for reassurance and do not get drawn into speculation on motivation of assailant etc. e.g. Why did he do it? Why me?	Avoids collusion and maintains professional boundaries.

## 2.2 PRESENTATION

### History

Initial history and evaluation are intended to establish the presence of any potentially serious injury or illness and stabilize any life-threatening or emergent conditions.

#### History taking needs to be:

1. Accurate
2. Contemporaneous
3. Comprehensive
4. Objective
5. Respectful and sensitive
6. Paced at the survivor's rate not the clinician's rate
7. Intelligent and tailored to the circumstances and to the findings

#### The physician must be aware of the following issues:

1. Legal importance of both the questions asked, and their answers, but also the questions not asked and the answers not given; here the clinician wears two hats, therapeutic and forensic
2. Survivor's situation: they may be tired, in pain, and frightened, and this might affect recall
3. Questions and statements to be avoided: leading questions, judgmental questions, questions stemming from preconceived ideas, as well as victim-shaming and victim-blaming statements.

It is important to elicit as much detailed information, detailed information here refers to those impacting the medical and mental state of the survivor, it is important to avoid questioning the survivor regarding the identity of assailant, the survivor's attire, and what they were doing at the location when the assault took place. The survivor should be encouraged, as much as that is possible, to talk using non-verbal signals as appropriate, such as maintaining eye contact and a listening attitude. Ask the survivor to narrate the events of the assault, assure them that they may take as much time as needed to recall and talk about it. Additional questions need to be oriented to gather more information regarding the nature of the sexual activities forced upon the survivor (whether achieved or only attempted), and it advised to ask questions with a "Yes/No" answer.

For more information and recommendations on this point, please refer to Table 2. [Agrees with acts oriented questions]

<b>Table 2: Questions to ask about the nature of the assault that invite Yes/No answers</b>				
	<b>By the penis</b>	<b>By a finger</b>	<b>By an object</b>	<b>To him</b>
<b>Oral Penetration</b>	Did he put his penis in your mouth?	Did he put his finger inside your mouth?	Did he put an object of any sort inside your mouth?	Did he put your penis in his mouth?
<b>Anal Penetration</b>	Did he put his penis inside your anus?	Did he put his finger inside your anus?	Did he put an object of any sort inside your anus?	Did he put your penis in his anus?
<b>Other sexual practices</b>		Did he masturbate you?		Did he make you masturbate him?
<b>Other information</b>	Did he bite you?	Did he threaten you with violence?	Did he threaten you with an object, such as a knife?	

# 3

## WORKUP OF SURVIVORS CASES

### 3.1 PAST MEDICAL HISTORY

- Has the survivor had any past ano-genital surgery?
- History of previous sexual infections or diseases prior to assault (i.e. history of sexually transmitted infections and vaccination, HIV risk behaviors, last consensual sexual contact, sexual practices (oral, anal, vaginal)
- Any previous episodes of sexual assault
- Current medications/allergies
- Past psychological or psychiatric history

### 3.2 ASSESSMENT OF CURRENT MEDICAL STATE

- Does the survivor have any particular symptom or concern at the moment?
- Location, date and time of the assault.
- Personal details relevant to the medical record (sociodemographics)
- The use of physical force, weapons, or foreign bodies.
- Injuries sustained by survivor/assailant.
- Whether or not alcohol or drugs were used by the assailant(s) and/or survivor before, during, or after the assault.
- Use of a condom.
- The specifics of the rape, including anal and oral penetration (by penis, finger, object) sucking, licking, biting (where) and fondling.
- Whether or not the survivor has changed clothes, showered or practiced other hygienic practices after the assault.
- Last urination, defecation.
- Support networks: Has the rape survivor been able to tell anyone, their reactions, who he wants to tell etc.
- Police involvement (refer to the legal section above)

An additional note to be considered is that many assailants are known to the survivor (Jennifer S. McCall-Hosenfeld, 2009); in such a scenario, information regarding assailant's health status such as the assailant's hepatitis B status, HIV status, and risk factors for HIV may be obtained and documented in order to support medical assessment and decisions. However, regardless of the knowledge we have of the assailant's status, the survivor should be advised to receive the necessary prophylaxis for HIV, hepatitis B, tetanus, and other STIs according to the timeline of the assault.

### 3.3 PHYSICAL EXAMINATION AND INJURY DETECTION

The examination must be thorough and accurately documented

1. Start with attention to the ABCs of the potential trauma survivor
2. Attention should also be given the emotional state of the survivor, and the exam should be preceded by a complete explanation of the procedures and examinations to follow.
3. As with any survivor, informed consent should be obtained for the forensic rape examination if the survivor decides to proceed with it.
4. It is helpful to explain that some of the tests may bring back disturbing memories of the assault, particularly the proctoscopy.
5. Evidence of the use of force and/or lack of consent (e.g., presence of blood and/or sperm, contusions, lacerations, other injuries consistent with resistance) should be sought
6. Evidence of other injuries and diseases should be sought during the examination and treated where present.

After that, a complete inspection of the fully unclothed survivor should then follow with consideration given to the details of the assault. Search for and precisely document:

- a. Foreign bodies
- b. Fingernail scrapings
- c. Dried semen stains, or vaginal fluids in cases where the assailant is female
- d. Abrasions, lacerations, contusions, incisions, suction injuries, and bites
- e. Swabs of bite and suction marks and semen stains are obtained as per usual protocol, and consider obtaining oropharyngeal and anorectal swabs for gonorrhea and chlamydia if indicated.

Signs of trauma in the oropharyngeal examination may include:

- a. Laceration of the labial or lingual frenulum
- b. Mucosal abrasions, and contusions following forced receptive oral sex
- c. Additionally, posterior pharyngeal wall and soft palate petechiae may develop days after the assault, and it should be noted that spermatozoa have been found in the oropharynx as many as 12 hours after the assault despite brushing or oral intake.

Genital examination shall inspect external genitalia and perineal area for injury, foreign materials, and other findings; areas included are:

- a. Buttocks, thighs, foreskin, urethral meatus, shaft, scrotum, perineum, glans and testes
- b. The Status of circumcision of the survivor should be documented.
- c. History of the survivor will advise the areas that should be closely inspected, as it shall also include areas reported being grabbed contacted or other body parts where the assailant may have ejaculated
- d. If dried semen is present on the survivor's pubic hair, a clipping of the survivor's hair may be obtained
- e. Penile swabs should also be obtained the glans, shaft, corona, and base of the penis, as they may contain dried secretions or saliva
- f. Additionally, swabs should be taken of the anterior scrotum around the base of the penis, as they can be a potentially rich source of DNA evidence in cases of oral copulation of the survivor by the assailant.

Anorectal exam: Be prepared to pace the examination as required to the survivors comfort. The region must be inspected for:

- a. Gross injury, including tears, abrasions, bleeding, erythema, hematoma, discoloration, tenderness, fissures, foreign bodies, engorgement, and friability; active bleeding is rare
- b. Swabs should be obtained by inserting them approximately 2 cm into the rectum and gently moving in a circular motion
- c. Proctoscopy is not routine but should be strongly considered in cases in which there is attempted or successful anal penetration or in which the survivor had a lapse of consciousness. Proctoscopy may identify additional findings in survivors with and without findings on gross examination. As such, consider the survivor's narrative of events and gross findings when considering the utility of proctoscopy.

Significant pain and inability to tolerate the exam may warrant admission for surgical consultation and exam under anesthesia.

There are also the extreme cases in which significant injuries are present, including large and expanding rectal hematomas and perforation, which will necessitate emergent surgical consultation and admission. However, body injuries could also be found ranging from mild lacerations/abrasions to major bleeding (internal or visible), as well as fractures and tissue trauma.

### Practice points

- It is not the norm for survivors of sexual assault to have body injuries or genital injuries.
- The clinician examining the survivor undertakes a therapeutic as well as a forensic role.
- Care should be taken to give back power and control to the survivor and not further 'objectify' him.
- The clinician must consider differential diagnoses objectively, based on the history and examination findings.
- Reporting rates are very low for male survivors. Survivors may present to clinicians with a variety of signs and symptoms, but no direct disclosure.

## 3.4 DIFFERENTIAL DIAGNOSES

- Abdominal Trauma, Blunt
- Abdominal Trauma, Penetrating
- Acute Coronary Syndrome
- Alcohol and Substance Abuse Evaluation
- Ankle Injury, Soft Tissue
- Anxiety
- Asthma
- Back Pain, Mechanical
- Bite, Human
- Burns, Thermal
- Candidiasis
- Cellulitis
- Cervical Strain
- Chancroid
- Compartment Syndrome, Extremity
- Corneal Abrasion
- Corneal Laceration
- Costochondritis
- Depression and Suicide
- Diaphragmatic Injuries
- Dislocations, Ankle
- Dislocations, Elbow
- Dislocations, Foot
- Dislocations, Hand
- Dislocations, Hip
- Dislocations, Interphalangeal

## 3.5 LABORATORY STUDIES

A Baseline screening for STIs shall be advised and done if approved by the survivor depending on the nature and circumstances of the assault. Survivors shall be offered antibiotic prophylaxis regardless of results from the preliminary screening.

Screening recommendations following a recent sexual assault are outlined in Table 3.

Investigations include:

- Serologic tests for syphilis, hepatitis B, and HIV shall be considered unless the survivor declines; (HIV testing requires counseling and follow-up care).
- Cultures of exposed body sites (e.g. oral, throat, rectal) as appropriate.

**Table 3: Baseline screening recommendations for sexually transmitted infections**

Infection	Test	Site (take according to history)
HIV	HIV antibody	Blood
Hepatitis B	Hepatitis B surface antigen (HbsAg). Core antibody (anti-HBc) anti surface antibody (anti-HBs)	Blood
Syphilis	Rapid plasma regain (RPR) + treponema pallidum haemagglutination assay (TPHA)	Blood
Chlamydia	Polymerase chain reaction	First-void urine or high vaginal swab
Gonorrhea	Polymerase chain reaction or microscopy, culture and sensitivity (M,C&S)	First-void urine, rectal swab* or throat swab*
Trichomonas	Microscopy, culture and sensitivity (M,C&S)	First-void urine, only if the assailant is a female

*\*M,C&S only, as PCR is not validated for these sites*

## 3.6 IMAGING STUDIES

- Imaging studies are only indicated for evaluation of co-morbid trauma.

## 3.7 OTHER TESTS

- To collect evidence, hospitals and concerned health centers must have a prepackaged rape kit with the necessary equipment and detailed instructions.
- However, if the sexual assault survivor presents 72 hours after the event, the evidence collection kit is no longer needed for legal documentation of the case.

# 4 TREATMENT AND MANAGEMENT

## 4.1 MANAGEMENT

Management will vary depending on the assault's circumstances. It is important to listen to the survivor, believe their story, and be non-judgmental and supportive.

It is advised to prepare the survivor to common responses to trauma like flashbacks of the assault and/or nightmare.

Also, feelings of increased irritability and anger, low mood and changes in sexual function might be experienced. These symptoms are essentially normal reactions and mostly resolve over a few months.

Medication is focused on prevention of STIs. If an STI is diagnosed, then it must be treated in the usual way with attention to contact tracing of consensual partners (if appropriate) and follow-up for test of cure (TOC) in 3-2 weeks. Comprehensive discussion about the potential transmission of hepatitis B, C and HIV attempts to allay the survivor's fears and explain about the 'window period' of sero-conversion.

Suggested prophylaxis is outlined in Table 4. Offer prophylactic vaccination for hepatitis B to all survivors. The vaccine should be administered intramuscularly to survivors not previously immunized. The first dose is given in the emergency department, the second dose at 2–1 months and the third dose at 6–4 months. If the survivor has not been immunized and the assailant is known to have acute or active hepatitis B, the addition of hepatitis B immune globulin (HBIG) should be considered.

HIV post-exposure prophylaxis is discussed but very rarely given, unless there is evidence that the assailant was, or was highly likely to have been, HIV positive and the survivor presents within 72 h of the assault.

### Management should include:

- Being aware of treatment options.
- Allowing the survivor to accept or decline treatment options using shared decision making.
- Being aware of local resources – for example, sexual assault counseling services or group support.
- STIs and what needs to be offered on spot.
- Forensic examination if a recent assault – to be performed by an appropriately trained personnel, with the consent of the survivor and preferably within 72 hours.
- Follow-up– survivors may need to return for follow-up at 6 ,2, and 12 weeks following STI checks.
- Continuing your involvement as the survivor’s physician.

**Table 4: Suggested prophylaxis to be considered for STIs**

STI	Treatment
Chlamydia	Azithromycin (1g orally)
Hepatitis B	Hepatitis B vaccine (1mL intramuscularly IM)
Gonorrhea (only if considered high risk)	Ceftriaxone (250 mg IM) OR Where local gonococcal sensitivities permit: Ciprofloxacin (500 mg orally) OR Amoxicillin (3g orally) and probenecid (1g orally)
Syphilis (if high risk)	Benzathine penicillin (1.8g IM)
HIV (If high risk)	Telephone local infectious diseases or sexual health physician urgently; initial dose must be given with 72 hours, sooner is better
Other STIs	Consult local infectious diseases or sexual health physician

**MANAGING MISBELIEVES:** The clinician should try to address some of the myths surrounding male rape as this has an important impact on the recovery from sexual assault.

1. A widely held belief that sexual assault is not something that can happen to a man since a man can't be forced to have sex against his will. This includes the idea that a man cannot attain an erection, or ejaculate, if he doesn't want to or if he is not sexually aroused. It is well described that non-specific physiological arousal, as a result of being involved in a fearful or threatening situation, may facilitate involuntary arousal responses to sexual stimuli.
2. The faulty expectation that men should be able to defend themselves in situations of physical assault; whereas studies shows that men who believed their lives to be in danger at the time of the assault, demonstrated a 'helplessness and passive submission responses
3. A man who is sexually assaulted by another man must be gay or have been acting in a gay manner. Whilst this is not true, survivors are frequently concerned that they have been perceived as such, either by the assailant(s) or others in their social network. Even if the survivor is gay, cross-dresser, or trans\*; the survivor should be reminded that their behavior and/or identity were in no shape or form a "provocation" for assault, there is considerable evidence that the prime motivation for a sexual assault is not sexual satisfaction, but an expression of power or dominance over the survivor, as mentioned before.
4. Men are less affected by sexual assault than women and whilst there is limited evidence, it appears that %54 of men suffer post-assault symptomatology presenting with psychological problems that include confusion about sexual orientation, sexual dysfunction, post-traumatic stress disorder, mistrust of other men in all situations, depression and suicide. [Ilian McLean Best Practice & Research Clinical Obstetrics and Gynaecology 46–39 (2013) 27]

## 4.2 FOLLOW UP:

Given the long-term emotional and psychosocial impact of sexual assault on the survivor, aftercare is vital. Multiple follow up visits are recommended to check for the STI's status as long as to provide the vital aftercare component of recovery.

A suggested follow up program is outlined in Table 5.

Table 5: Follow up program
<b>2-3 days</b> Assess injury healing if relevant
<b>2 weeks</b> Test results, healing, coping Follow-up testing: HIV Chlamydia, gonorrhea, (depending on local prevalence and practice)
<b>3 months</b> Follow-up serological tests for HIV, hepatitis B virus, syphilis
<b>6 months (if hepatitis C was considered a risk)</b> Follow-up serological test for hepatitis C virus if a test was performed initially Examine and swab, as appropriate, all sites that as a result of the assault are at risk of infection

## 5

REFERRAL  
GUIDELINES

Every effort must be made to provide the survivor with adequate referral to available resources. Survivors with coexisting injuries or psychiatric symptoms may require referral to psychologists or insurvivor care, with admission to the appropriate service. It is therefore important to assess, and reassess the survivor's psychological adjustment to the assault, table 6 offers a devised series of questions that although not formally standardized and evaluated, seems to work in practice.

Referral to a clinical psychologist is recommended for appropriate support and intervention if the survivor scores 4 or more of the responses suggesting that he is not coping with the aftermath of the assault.

**Table 6: Suggested ways of looking at the degree of coping following an assault**

<b>1 Behaviour</b> Available support/extent of acknowledgment	Have you been able to tell anyone?
<b>2 Feelings</b> Sense of isolation	Do you feel any closer or less close to family or friends? Have you experienced changes in intimacy? Have you felt isolated?
<b>3 Behaviour</b> Restriction due to fear, depression, lack of trust	Has there been any change in your work? Has there been any change in your social life?
<b>4 Behaviour</b> Social withdrawal, low self-esteem	Has there been any change in the way you get to know new people?
<b>5 Behaviour</b> Any unreasonable avoidance behaviour	Are you able to go out alone or to places that you would normally visit? (if any difficulty expressed, elicit context)
<b>6 Feelings</b> Homophobia, reduce sense of safety or control	Do you think that your feelings about man have changed?

<b>7 Behaviour</b> Any unreasonable avoidance behaviour	When was the last time you felt comfortable with a man socially? Or at work?
<b>8 Behaviour</b> Erectile difficulties, promiscuity	Has there been any change in your sexual relationships?
<b>9 Feelings</b> Dislike of body, uncertainty about sexuality	Has there been any change about how you feel about your appearance? Has there been any change in your sexual relationships?
<b>10 Feelings</b> Low self-esteem, avoidance of interaction	Do you ever feel that people can tell that you've been assaulted?
<b>11 Other</b> Degree of insight, avoidance	Is there anything else that has changed for you since assault happened?

Severe injuries may mandate transfer to regional trauma centers following surgical consultation.

## 5.1 COMPLICATIONS

- STIs, including HIV
- Posttraumatic stress reactions and disorders
- Sexual dysfunctions (hypoactive sexual disorder, erectile dysfunction)
- Morbidity and mortality (arising from physical injuries incurred during the sexual assault)

## 5.2 PROGNOSIS

- The prognosis for sexual assault survivors is generally favorable if adequate aftercare is available to assist the survivor in recovery.

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