

Male County Correctional Facility Inmates' Attitudes Towards Male Sexual Assault and
Sexual Assault Services

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Abstract

Male rape is a topic that has been neglected both in society and in research. When male rape is researched it focuses on male to male prison rape while neglecting treatment options for the male rape victims. An anonymous survey was distributed to 85 male inmates in a northeast correctional facility. Quantitative data was collected and analyzed from 51 male inmates. This research examined male inmates' attitudes towards male rape and the rape crisis services provided. The findings of this research helped to identify barriers that prohibit male victims from seeking rape crisis services.

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Rape affects both male and female unfortunately male rape has been a topic that has been neglected both in society and in research. The limited research or outdated research on male rape suggests that males are uncomfortable reaching out to emergency rooms, mental health services and rape crisis centers to receive treatment both physically and psychologically because of the stigma that is associated with male rape (Perrott & Webber, 1996; Rumney, 2008; Veranals & Campbell, 2001). When research is conducted most of the literature focuses on prison rape. According to the U.S. Department of Justice's National Inmates survey estimated that 64,500 of inmates self-reported being a victim of sexual assault (U.S. Department of Justice, 2010). One of the highlight of The National Inmates survey states that "among inmates who reported inmate-on-inmate sexual victimization, 13% of male prison inmates and 19% of male jail inmates said they were victimized within the first 24 hours after admission, compared to 4% of female inmates in prison and jail" (U.S. Department of Justice, 2010). That is why on September 4, 2003, former President George W. Bush signed into law the Prison Rape Elimination Act and Congress passed the law (Peretti, 2007; U.S. Department of Justice, 2009). The purpose for the Prison Rape Elimination Act is to acknowledge and understand the magnitude of prison rape so that the amount of prison rape can be eliminated within correctional facilities (U.S. Department of Justice, 2009). In the meantime, rape is still occurring in prisons and civilian population. What can be done to help this neglected population if they do not report the crime to law enforcement and seek mental health services? The answer is unknown, and this is exactly why there is a need for further empirical studies to improve the reporting rate and provide treatment providers with

researches for males who are affected physically, psychologically and/or interpersonally by rape.

The purpose for conducting this research is to help with the understanding of male attitudes toward male rape and the rape crisis services available to men. The focus of this research is understanding rape that occurs in prisons, males reporting their victimization, support services available for male victims and the effects on survivors' physical, psychological and interpersonal functioning. The purpose and findings of the research will educate the reader, researchers and counselors about barriers affecting male's attitudes about male rape and treatment. This research also provides suggestions for professional treating male sexual assault victims and future research.

Literature Review

Sexual assault is viewed as a severe social problem in The United States of America and worldwide (Smith, Pine & Hawley, 1988). It is typically assumed that females are the victims of rape while males are the perpetrators (Graham 2006; Scarce, 1997; Vearnals & Campbell, 2001) and most rape literature focuses on female victims (Adams-Curtis & Forbes, 2004; Bondurant, 2001; Cowan, 2000) and male perpetrators. The Federal Bureau of Investigation's Uniform Crime Report defines rape as "the carnal knowledge of female forcible and against her will" (Federal Bureau of Investigation, 2008, para.1). For more than 30 years, rape has been in the spotlight as a safety concern for women (Weiss, 2010). Young girls are educated to be aware of sexual assault, to avoid dark places, and dress in conservative ways in hopes of reducing the risk of becoming victims of sexual assault (Scarce, 1997; Sivakumaran, 2005). Conversely, "in

our culture, the definition of masculinity does not allow for male rape victims" (Eigenberg, 2000, p. 437).

In reality, men are indeed victims of rape at an alarming rate; according to the U.S. Department of Justice's National Crime Victimization Survey, a total of 39, 590 men were victims of rape/sexual assault in 2008 (U.S. Department of Justice, 2009). There may be more incidences of male rape, however, as men are apprehensive about reporting because of the social stigma and the risk of not being seen as "real men" (Eigenberg, 2000; Knowles, 1999; Perrott & Webber 1996). Males are taught to demonstrate masculine behaviors; they are socialized to be aggressive, dominant, violent, and powerful, and to be in control (Eigenberg, 2000; Scarce, 1997; Sivakumaran, 2005; Weiss, 2010). If men do not possess these aforementioned characteristics they risk being labeled as homosexual or *womanly* (Weiss, 2010, p.277).

Prejudices about male rape are not limited to the United States. In fact, prior to 1994, the category of male rape did not even exist under English Law (King & Woollett, 1997; Mulkey, 2004; Veranale & Campbell, 2001). Rape was strictly defined as "vaginal penetration by a penis" (Mulkey, 2004; Vearnals & Campbell, 2001). Adjustments were made to the Public Order, Sexual Offenses and Criminal Justice Acts in 1994 to include "anal penetration with a penis" as a type of rape (Graham, 2006; King & Woollett, 1997; Vearnals & Campbell, 2001). Despite the evolving definition of rape, there is still little attention being paid to conducting research and publishing literature that addresses male rape and how rape alters a person's life (Mulkey, 2004; Vearnals & Campbell, 2001; Washington, 1999).

According to Peretti (2007), rape is a “destructive, catastrophic, life-changing event” for both male and female victims in and outside of prison institutions (p.766) When looking at today’s literature, the female perspective on the effects and treatment of rape is heavily emphasized in comparison to the male’s perspective which is “20 years behind” female rape literature (Davies & Rogers, 2006). Despite the lack of emphasis on male rape (Graham, 2006; King & Woollett, 1997; Vearnals & Campbell, 2001; Willis, 2009), there are scholars that have researched male sexual assault, and part of the research focuses on rape in prison institutions (Davies, 2002, Davies & Rogers, 2006; Eigenberg, 2000a, 2000b; King & Woollett, 1997; Mezey & King, 1989; Struckman-Johnson & Struckman-Johnson, 2000, 2006, 1996; Tewksbury, 2007).

Prison Rape

Prison rape has been one of the “oldest and darkest secrets” (Peretti, 2007, p.759) in prisons, local jails and juvenile detention centers (Peretti, 2007). There are bodies of literature related to prison male victims of sexual assault that were focused on the prevalence of inmate sexual coercions (Struckman-Johnson & Struckman-Johnson, 2000, 2004, in press), effects of sexual assault on male victims (Mezey & King, 1989; Tewksbury, 2005) and characteristic of male victims of sexual assault (Hensley, Kosheski & Tewksbury, 2005; Hensley, Tewksbury & Castle, 2003). Sexual assault in prisons, however, appears to be normalized as an expectation among prison inmates (Wyatt, 2006).

Rapes among inmates are described as common events (Wyatt, 2006) in such a way that inmates have a universal labeling system (Knowles, 1999; Robertson, 2003). The labeling system identifies which inmates are the masculine, *real men*, and which

inmates are the *feminine, weak homosexuals* who will be the targets of sexual assaults (Knowles, 1999; Robertson, 2003). Femininity is described as “*physically weak*” (Weiss, 2010, p.277) and “*inferior to men*” (Eigenberg, 2000, p.437). *Punks* or *kids* are men (Knowles, 1999) who must “provide sexual services” (Scarce, 1997, p.38) to their aggressors. *Jockers* or *pitchers* are *real men* who forcibly or coercively copulate or prostitute another man (Knowles, 1999; Scarce, 1997). Perpetrators are believed to be “sexually deprived” (Eigenberg, 2000, p.418), and will uncontrollably (Eigenberg, 2000) copulate with other men. It is important to note that jockers/pitchers identify themselves as heterosexual men, not homosexuals who engaging in homosexual acts; they are strong physically, psychologically (Knowles, 1999; Fowler et al. 2010; Sivakumaran, 2005) and “sexually deprived” (Eigenberg, 2000, p.418). Jockers demonstrate their strength through physical aggression such as hitting or holding down a victim; they are psychologically aggressive by threatening, pressuring or coercing a victim into copulation or fellatio. Male inmate victims of sexual assault are raped because they are “unable to protect themselves” (Eigenberg, 2000, p.419) from being “severely beaten”, raped (Wyatt, 2006, p. 587) and/or gang raped.

Punks/kids (victims) are labeled as homosexual, even if their sexual orientation is heterosexual or bisexual, because they appear weak and feminine (Knowles, 1999; Weiss, 2010). In addition to male victims of sexual assault displaying feminine characteristics, there is an assumption that “real men” cannot be raped (Eigenberg, 2000; Knowles, 1999). The labeling system allows perpetrators to escape stigmatization and maintain their masculinity (Eigenberg, 2000a, 2000b). Instead of victims receiving treatment, they are brutally stigmatized or “tainted” (Sivakumaran, 2005, p.1290) as homosexuals; they

are blamed for their victimization because they appear feminine Eigenberg, 2000). In a sense, male victims are “stripped” (Sivakumaran, 2005, p.1298) of their masculinity and power (Knowles, 1999; Sivakumaran, 2005). The prison labeling system clearly shifts the blame from perpetrators to victims.

Target Victims

Researchers have tried to focus their attention on identifying which inmates are targeted in an attempt to stop potential victimizations (Hensley, et al. 2005; Peretti, 2007; Struckman-Johnson & Struckman-Johnson, 2000). Hensley et al. (2003) conducted a face-to face interview with male inmates in minimum, medium and maximum-security correctional facilities in Oklahoma to identify target men of sexual assault. Demographic information, type of offense committed, and prison security-level were evaluated in this study. There were a total of 174 inmates that participated in this study. Results revealed that 58% of white men were targets of sexual assault, and 29% of African Americans were targeted. The average age of targeted men of sexual assault was 20.5 years old. The average incarceration duration of men targeted for sexual assault was 143 days before targets’ first sexual encounter. This study, in addition to other literature (Eigenberg, 2000; Hensley et al. 2005; Peretti, 2007; Struckman-Johnson & Struckman-Johnson, Ruchker, Bumby & Donaldson, 1996), supports that inmates who are targets of sexual assault tend to be young, white, small body frame, perceived as weak, and are first-time offenders.

Researchers have tried to provide recommendations for reducing incidences of sexual assault to correctional officers and target victims, such as segregation of target inmates and rapists (Hensley et al. 2003). They also recommended providing sexual

assault resistance training for correctional officers and target inmates, and providing them with sexual assault support services (Hensley et al. 2003). For a period of time, prisons tried to segregate sexual assault target inmates from the other prisoners, but segregation was abandoned because the target inmates were essentially punished, as their privileges were taken away in an effort to keep them safe (Hensley et al. 2003). The target inmates were placed in lockdowns and were prohibited from participating in general prison activities such as church, work and classes (Hensley et al. 2003). Segregation of target prisoners was also abandoned due to overcrowding in prisons and staff shortages (Wyatt, 2006).

Another recommendation for reducing rapes in prison was to provide men with single cells, but that was considered too costly; single cells cost “\$20,000 a year” and cell sharing “reduces housing cost” (Wyatt, 2006, p.593). A final recommendation was to allow conjugal visits, allowing married inmates to copulate with their wives (Wyatt, 2006). Critics argued that rape is not about sex, it is about power and control, (Knowles,1999; Wyatt, 2006) and therefore conjugal visits would not necessarily reduce sexual assaults (Wyatt, 2006). Most of the above recommendations focused on how to prevent future sexual assaults of inmates. Preventing sexual assault is essential because many male victims experience severe physical, psychological and interpersonal trauma (Bull & Sleath 2009; Tewksbury, 2007; Walker, Archer & Davies, 2005; Wyatt, 2006).

Effects of Sexual Assault

Physical Effects

It is assumed that male victims of rape sustain more physical injuries than females (Graham, 2006; Tewksbury, 2007). While in most cases this is true, not all men

experience physical injuries (Tewksbury, 2007). Some men do not experience anal penetration, because they are forced or coerced into engaging in masturbation and/or oral sex (Eigenberg, 2000; Mezey & King, 1989; Peretti, 2007; Tewksbury, 2007; Struckman-Johnson & Struckman- Johnson, 2000, 2006; Wyatt, 2006; Vearnals & Campbell, 2001). Lipscomb, Muram, Speck and Mercer (1992) conducted a study comparing incarcerated men's and community men's sexual assault experiences and consequences (Tewksbury, 2007). This study found that 62.5% of community men and 52.6% of incarcerated men experienced forced oral sex. This study also found that 75% of community men and 58% of incarcerated men did not sustain physical injuries during their sexual assault.

Struckman-Johnson & Struckman-Johnson (2000) conducted a survey examining sexual coercion rate in seven Midwestern male prisons. Surveys were distributed to a total of 7,032 male inmates. Results revealed 21% of inmates had been coerced or forced into having sex during their state incarceration. Statewide rates varied from 16% to 26% of male inmates who had been coerced or forced into having sex. Whereas 16% of male inmates had been coerced or forced into having sex in their local facilities. The seven facilities collective rates ranged from 4% to 21%, which was lower than the statewide total "because some inmates experienced sexual coercion in prison or jails other than their current facility" (Struckman-Johnson & Struckman-Johnson, 2000, p. 383). While the research study focused on male victims' experience with sexual coercion, this research did not address male inmates' sexual assault recovery process after their victimization.

Although physical injuries do not always accompany male rape, there are some cases where men have been significantly injured (Tewksbury, 2007). It is important to

point out that most men who experience physical injuries are more likely to have bodily injuries as opposed to genital or rectal injuries (Peretti, 2007; Tewksbury, 2007).

Examples of physical injuries that can be sustained from a sexual assault include “abrasions to the throat and abdomen” (Tewksbury, 2007, p. 27) as a result of victims resisting being held down by their abuser (Tewksbury, 2007). Other physical injuries include ‘bruises, black eyes” (Tewksbury, 2007, p.27) “concussions, hemorrhoids, lost teeth” (Peretti, 2007, p.765-767) and broken bones (Peretti, 2007; Tewksbury, 2007).

These injuries above are normally an indication that the perpetrator wanted to restrain their victims quickly by striking them (Tewksbury, 2007). When sexual assault victims experience genital injuries, these tend to be “tears of the anus, abrasions” (Tewksbury, 2007, p.27), ulcers, erythema (abnormal redness), hematoma (Tewksbury, 2007) and bleeding from the rectum (Peretti, 2007; Tewksbury, 2007). In addition, some male victims may experience headaches, constipation, abdominal pain, as well as nausea and vomiting (Tewksbury, 2007).

Aside from physical and genital injuries acquired during the sexual assault, some men may experience involuntary erections and ejaculate during the assault (King & Woollett, 1997; Mezey & King, 1989; Tewksbury, 2007; Rogers, 1997). Erections and ejaculation are common reactions for men when they experience intense pain, fear, panic and anxiety from sexual assault (King & Woollett, 1997; Tewksbury, 2007). In addition to involuntary erections, victims are being exposed to sexually transmitted diseases, including human immunodeficiency virus (HIV), acquired immune deficiency syndrome (AIDS), and hepatitis (Knowles, 1999; Peretti, 2007; Robertson, 2003; Wyatt, 2006).

HIV and AIDS Effects

Sexually assaulted male victims are being affected in many areas of their life. They are physically affected and perhaps contracting sexually transmitted diseases, perhaps as debilitating as HIV/AIDS. Contracting HIV/AIDS can significantly impact on someone's physical, psychological and interpersonal state.

Some inmates who are sentenced to a year in prison are in a sense coming out with a "death sentence" (Peretti, 2007, p.767) when they are exposed to HIV/AIDS (Peretti, 2007). HIV/AIDS diagnoses are high in the prison population because many inmates were intravenous drug users prior to their incarceration (Peretti, 2007; Scarce, 1997; Wyatt, 2006). The U.S. Department of Justice Bureau of Justice Statistics estimated that 21, 987 state or federal inmates were confirmed to have HIV/AIDS in 2008. Male inmates accounted for 20,075 of that total number (U.S. Department of Justice Bureau of Justice, 2008).

Preventing sexual assault is essential this is why service providers and researches are urged to discover what would help make services more appealing to these male sexual assault victims. Service providers and researchers should then take a look at the additional psychological and interpersonal effect these male sexual assault victims face in addition to their physical and health issues.

Psychological Effects

Male victims of sexual assault are more likely to display long-lasting psychological disturbances (King & Woodllett, 1997; Tewksbury, 2007; Walker et al 2005; Wyatt, 2006). Another name for psychological disturbance as a result of sexual assault is rape trauma syndrome (RTS) (Robertson, 2003; Scarce, 1997; Sivakumaran, 2005). Originally, in 1974, rape trauma syndrome was only a condition that applied to

female rape victims (Scarce, 1997). Since male victims of sexual assault experience similar trauma as female rape victims, researchers have confirmed that males also experience post-sexual assault victimization and displays some RTS conditions (Scarce, 1997; Sivakumaran, 2005).

Sexual assault victims with RTS experience short term (acute) (Scarce, 1997, p. 20) and long term (chronic) physical and psychological disturbances (Scarce, 1997; Sivakumaran, 2005). Some of the short term physical disturbances of sexual assault are listed previously, but may also include skeletal muscle tension, gastrointestinal irritability, genitourinary disturbance” (Scarce, 1997, p. 20). Some long term psychological effects of sexual assault include depression, anxiety, excess fear, shame, self-blame, guilt, anger, low self-worth, suicidal ideation, sexual identity and for men masculinity confusion and post-traumatic stress disorder (PTSD) (Davies & Rogers, 2006; Mulkey, 2004; Peretti, 2007; Robertson, 2003; Rogers, 1997; Sivakumaran, 2005; Tewksbury, 2007; Vearnals & Campbell, 2001; Walker et al. 2005).

Walker et al. (2005) conducted a psychological function study comparing 40 British male rape survivors to 40 British males who never experienced rape at The University of Central Lancashire (UK). British newspapers and magazines were utilized to recruit participants that were sexually assaulted. The control group was selected by convenience sampling (Walker et al. 2005). The two groups completed a series of questionnaires that measured their psychological functioning, assumptions about the world and self-esteem (Walker et al. 2005). Results indicated that male rape survivors’ self-worth and self-esteem were considerably lower than the control group, which is consistent with literature (Scarce, 1997). Male rape survivors suffered intrusive thoughts

and avoidance (58%), social dysfunction (28%), anxiety (42%) and depression (35%)

The research supported the literature (Davies & Rogers, 2006; Mulkey, 2004; Peretti, 2007; Robertson, 2003; Rogers, 1997; Sivakumaran, 2005; Tewksbury, 2007; Vearnals & Campbell, 2001) that male victims of sexual assault suffer a great deal of psychological and social dysfunctions. Since the sample population consisted of community male sexual assaulted victims, the results may not be reflective of male inmates that are affected as victims of sexual assault.

Interpersonal Effects

Some male victims of sexual assault experience sexual dysfunction which can affect these men's ability to form relationships (Mezey & King, 1989; Tewksbury, 2007; Vearnals & Campbell, 2001). It is common for male victims to experience a variety of sexual dysfunctions, such as erectile dysfunction, premature ejaculations, pain, and loss of sexual interest (De Silva, 2001; Mezey & King, 1989; Scarce, 1997; Tewksbury, 2007; Vearnals & Campbell, 2001). In addition to sexual dysfunctions, victims may experience "irritability, inability to trust" (De Silva, 2001, p. 270) and fear of forming close relationships (De Silva, 2001). Male sexual assault victims oftentimes feel like their bodies are damaged goods resulting in victims developing low self-esteem and self-worth (Scarce, 1997). Male sexual assault victims may also experience feelings of vulnerability and become extremely hyperconscious about potential rape (Scarce, 1997). These sexual dysfunctions and feelings can make it hard for men to form close relationships or maintain their relationships, resulting in these victims becoming isolated and emotionally distant (De Silva, 2001; Mezey & King, 1989; Mulkey, 2004; Vearnals & Campbell, 2001; Willis, 2009).

It is also common for male victims to question their sexual identity and masculinity, especially if victims involuntarily ejaculate during the assault (Scarce, 1997; Tewksbury, 2007; King & Woollett, 1997). Ejaculation during an assault is a common physiological response to a sexual act (Scarce, 1996; Tewksbury, 2007). Male inmate sexual assault victims may also fear being beaten or gang raped and, therefore will often agree to the sexual acts with another man (Wyatt, 2006). Some heterosexual victims may perceive themselves as homosexual or think people perceive them as homosexual (Scarce, 1996; Tewksbury, 2007). While some homosexual victims may think their sexual orientation was the primary reason for their victimization, resulting in them hiding or denying their sexual orientation (Scarce, 1999; Washington, 1999).

Mezey & King (1989) studied the effects of sexual assault on men. A total of 22 participants were selected. These participants were given an extensive questionnaire to complete. The researchers found that 11 participants were experiencing sexual dysfunctions, which was consistent with the literature (De Silva, 2001; Scarce, 1997; Tewksbury, 2007; Vearnals & Campbell, 2001). One participant informed the researchers that he feared becoming an “unintentional rapist if he had sex” (Mezey & King, 1989, p.207). In conclusion, the authors found that sexual dysfunctions for male rape victims were almost a universal theme (Mezey & King, 1989).

Reporting Sexual Assault

Males are typically reluctant to report sexual assault to police and are less likely to seek mental health services (Eigenberg, 2000; King & Woodllett, 1997; Tewksbury, 2007; Vearnals & Campbell, 2001). Male victims of sexual assault would rather indulge in drugs and alcohol (Mezey & King, 1989) or engage in risky sexual behaviors with

frequent male and female sexual partners (Tewksbury, 2007) instead of reporting their victimization or seeking treatment.

Fowler, Blackburn, Marquart & Mulling, (2010) conducted a study of male and female inmates in minimum, medium and maximum security Southern prison. This research examined male and female inmate's perceptions about self-reporting their sexual assault, and encouraging other inmates to report their sexual assault. In total, there were 935 inmates participating, 499 men and 436 women. However the sample size was reduced to 912 because of missing data. Fowler, et al. (2010) found that inmates who identified being raped inside or outside of prison were unlikely (52.7%) to report their sexual victimization. Male inmates were unlikely (81%) to encourage other inmates to report their sexual assaults. Only 4.1% inmates indicated that they would report their sexual assault, and would encourage other inmates to report their sexual assault.

In addition to not reporting victimization, male sexual assault victims are reluctant to seek medical attention (Kupers, 2005; Tewksbury, 2007) if injuries acquired during the assault were not physically significant (Tewksbury, 2007). If sexually assaulted male inmates decide to seek medical attention, they are not treated with the same quality of care as sexually assaulted victims in the community settings because of security concerns (Scarce, 1996). Some male inmate victims of sexual assault have shackles around their feet and hands during their medical examination. Being in shackles can remind victims of how "powerless" (Scarce, 1996, p. 173) they felt during the attack. If victims decide to seek mental health therapy, some male victims are forced to talk to the therapist from within their cell while the therapist stands outside of the cells (Kupers, 2005); this provides no security of confidentiality. Inmates share cells and cells are next to each

other (Kupers, 2005), which could then lead to men being identified as kids or punks (Knowles, 1999) or as snitches (Fowler et al. 2010; Peretti, 2007; Wyatt, 2006); this oftentimes leads to repetitive sexual victimizations, or severe beatings, and perhaps death of the victims by perpetrators or other inmates (Brittan, 1989).

In addition to the environmental structure of prison, seeking mental health treatment goes against the traditional masculine role which tells men that they cannot express physical weakness and emotions other than anger (Eigenberg, 2000; Hammer & Vogel, 2010; Kupers, 2005; Weiss, 2010).

There are additional reasons why men do not report the crime, seek medical attention and/or seek mental health services. Blame is one reason why men rape victims refuse to seek services. Blaming victims is essentially attributing the responsibility of the rape to the victim (Fowler et al. 2010; Washington, 1999). Another reason why male sexual assault victims do not report their victimizations or seek treatment include social stigmas, judgments, fears, lack of support services, ignorance of support services and the prison environmental structure (Fowler et al. 2010; Kupers, 2005; Perrott & Webber, 1996; Rumney, 2008; Vearnals & Campbell, 2001). One social stigma that stops males from reporting being raped is being labeled as homosexual, because society views male rape as homosexual rape (Graham, 2006; Mulkey, 2004; Scarce, 1997; Sivakumaran, 2005). Another stigma is that society views that a man should be in control of their feelings (Hammer & Vogel, 2010), and seeking help is a sign of weakness. Male sexual assault victims, regardless of their sexual orientation, are stripped of their masculinity in society (Sivakumaran, 2005) because the belief that men should be able to physically fight off their attacker (Eigenberg, 2000; Knowles, 1999; Perrott & Webber 1996).

Other reasons for underreporting male sexual assault is fear of being humiliated (Tewksbury, 2007; Willis, 2009). Male sexual assault inmates also fear retaliations and developing a reputation of being a snitch (Fowler et al. 2010; Peretti, 2007; Wyatt, 2006). Snitching is unfavorable and represents disloyalty (Fowler et al. 2010). Another fear male sexual assault victims' face is disbelief by friends, family members, medical professionals, mental health professionals and law enforcement (Fowler et al. 2010; Tewksbury, 2007; Willis, 2009).

In prison settings, not being believed by correctional officers is a major problem for male inmates of sexual assault (Peretti, 2007). Correctional officers frequently will not believe male inmates of sexual assault if victims do not exhibit physical injuries, refuse medical treatment, refuse police services and display feminine characteristics (Eigenberg, 2000; Peretti, 2007). Some correction officers will intentionally not report a rape (Wyatt, 2006) possibly because of their own homophobic feelings. Other correctional officers will ignore victims being raped because they cannot distinguish rape from consensual sex (Eigenberg, 2000; Wyatt, 2006).

Eigenberg, (2000) conducted a survey examining all officers in a mid-western rural correctional facilities, perceptions of rape in prison. A total of 391 surveys and cover letters were administered through inter-department mail, 209 surveys were returned resulting in a 53% responses rate. Results showed that 95% to 96% of officers believed inmates, who were overpowered or threatened body harm, were raped, which was consistent with the literature (Fowler et al. 2010; Peretti, 2007). Officers identified that being labeled as snitch (74%) and paying off debts (73%) were other reasons that inmates were raped. About 6.9% of officers refused to blame sexual assault victims for their

victimization; however, 12% of officers believed that some inmates deserved to be raped. Officers believed that inmates deserved to be raped if they accepted money and/or cigarettes for consensual sex prior to their rape (23-24%), if they were homosexual (16%), or appeared feminine (17%).

Support Services

Mental health services are limited for male victims of rape (Sivakumaran, 2005). Most of the support services, such as rape crisis centers, were founded on the “women-helping-women perspective” (Perrott & Webber, 1996). The women-helping-women perspective puts men in a situation to experience stereotypical beliefs, and insensitivity in counseling needs and denial of services (Perrott & Webber, 1996; Tewksbury, 2007). Washington (1999) examined how many support services were available for male sexual assault victims (as cited in Tewksbury, 2007). Results suggested that only 5% of programs serve male sexual assault victims with specific programs designed for male sexual assault victims.

In prison settings, resources such as counselors and crisis centers are of little help (Scarce, 1996). Many counselors and crisis centers are reluctant to give out their phone number for fear of male inmates abusing hotlines (Scarce, 1996). Also most crisis centers are not prepared or equipped to assist incarcerated sexual assault victims (Scarce, 1996). Most groups in prison are dedicated to substance abuse problems, sex offenders and anger management because it is part of inmates’ mandated sentencing (Kupers, 2005). Mandated inmates have to wait or not attend mandate group treatment because of shortage of staff (Kupers, 2005). Therefore, sexual assault inmates who decide to seek

treatment maybe waiting long periods of time to report assaults or to receive treatment (King & Woodllett, 1997; Tewksbury, 2007).

King & Woodllett (1997) conducted a survey on 115 sexually assaulted men in the community who sought mental health services. Results indicated 60% of men who were sexually assaulted before the age of 16, waited 16.4 years, post-rape, to seek mental health services, whereas, 36% of men who were raped after age 16 waited 7.3 years post-rape to seek mental health services.

With high numbers of underreporting, and a low number of support services available for male rape victims (Sivakumaran, 2005) in and outside of prisons, survivors are experiencing long-lasting psychological disturbances (Tewksbury, 2007; Walker et al. 2005; Sleath & Bull, 2009) as well as physical and interpersonal disturbances (Sleath and Bull, 2009; Tewksbury, 2007; Walker, Archer & Vacies, 2005; Wyatt, 2006). Services for men are severely lacking in and outside of prisons (Sivakumaran, 2005). Research is still needed to address specific treatment needs of male sexual assault victims (Davies, 2002) in and outside of institution.

Research Questions

Psychological distress effects both male and female victims' experience. Unfortunately, male sexual assault victims in and outside of prisons are lacking supportive services (Sivakumaran, 2005). In addition to the lack of services, sexually assaulted male victims suffering from psychological agony also suffer interpersonally. This is why it is necessary to find out what would help male sexual assault victims feel comfortable reaching out to supportive services. This research will examine:

1. What are male county correctional facility inmates' attitudes toward male rape?

2. What are male county correctional facility inmates' attitudes toward male rape crisis services?
3. What are male county correctional facility inmates' attitudes toward mental health services?

Method

The purpose for conducting this research is to help with the understanding of male attitudes toward male rape and the rape crisis services available to men. A survey was distributed to 85 male inmates at an inner city correctional facility in the northeast United States. The intent of the survey is to measure males' attitudes toward male rape and how attitudes can influence and affect men seeking rape crisis treatment.

Setting

The setting consists of three correctional facilities: the downtown jail located in the inner city, the correctional facility and the psychiatric center located in the urban suburban area. The jail is a maximum security facility designed to house approximately 1,100 inmates that are classified as high risk inmates and these inmates are awaiting trials or court decisions (Monroe County Sheriff's Office). Once these inmates are sentenced, they are usually transported to the correctional facility or another jail in a separate county/state. The correctional facility is a medium security institution designed to hold approximately 400 sentenced inmates that are classified as low risk inmates (Monroe County Sheriff's Office). High risk typically includes murder and sexual assault while low risk crimes include driving while intoxicated (DWI), driving while under the influence (DUI), property crime, theft, burglary and prostitution. The correctional facility also houses inmates only sentenced to weekend incarceration. In addition, within the

correctional facility there is a Chemical Dependency Re-Entry Program that focuses on rehabilitation and training, preparing inmates for re-entry into society with goals of reducing recidivism (Monroe County Sheriff's Office).

Sample and Participants

There are a total of 85 men in Chemical Dependency Re-Entry Program. All men, 19 years of age and older, were invited to participate in this study. This study was conducted by distributing surveys to 85 inmates who were participating in the Chemical Dependency Re-entry Program. The surveys were either fully or partially completed by only 51 out of the 85 inmates. Inmates in the Chemical Dependency Re-entry Program were the focus of this study because the researcher believed that these inmates could provide key elements to understanding males' perspectives on male rape and how rape crisis services could be more sensitive to male victims. They were 51% of males who participated in this study. The mean age was 23-34 years old. About 43% identified themselves as being Black or African American, 35% were Caucasian, 8% were Hispanics or Latino, 4% were Native American and 6% were other. A total of 55% identified themselves as being single, 18% were married, 14% were divorced and 8% were legally separated (see Table 2). About 88% identified themselves as heterosexual and 2% were either homosexual or unsure. The highest level of education completed was either high school or GED with 49%, 2% elementary, 8% middle school, 26% some college, 6% associate degree and 4% undergraduate degree (see Table 1).

Table 1: Demographics

| Demographics | Responses | Percentage |
|---------------------|------------------|-------------------|
| Age | | |
| 19-21 | 4 | 8 |
| 23-34 | 17 | 33 |
| 35-44 | 8 | 16 |
| 45-54 | 13 | 26 |

| | | |
|--|-----------|-----------|
| 55-64 | 6 | 12 |
| 64 and over | 1 | 2 |
| No Response | 2 | 4 |
| Ethnicity | | |
| Black/African American | 22 | 43 |
| White/Caucasian | 18 | 35 |
| Hispanic/Latino | 4 | 8 |
| Native American | 2 | 4 |
| Other | 3 | 6 |
| No Response | 2 | 4 |
| Marital Statues | | |
| Single | 28 | 55 |
| Married | 9 | 18 |
| Divorced | 7 | 14 |
| No Response | 3 | 6 |
| Sexual Orientation | | |
| Heterosexual | 45 | 88 |
| Homosexual | 1 | 2 |
| Unsure | 1 | 2 |
| No Response | 4 | 8 |
| Highest Education Level Completed | | |
| High School Diploma/GED | 25 | 49 |
| Elementary | 1 | 2 |
| Middle School | 4 | 8 |
| Some College | 14 | 28 |
| Associate Degree | 3 | 6 |
| Undergraduate Degree | 2 | 4 |
| No Response | 2 | 4 |

Percentage was round to the tenth place value.

Materials/Instrument

The survey instrument has 35-items, 5 demographic questions, and was developed by the researcher (See Appendix A). These questions were original and generated from male sexual assault literature and professional experiences. The survey was answered using a Likert-type scale. A pilot study was not conducted with this instrument, and they are no existing reliability or validity data for this survey.

Procedure

The day before the surveys were distributed participants were informed that the following day a research study would be conducted for the purpose of understanding their viewpoints and attitudes about male sexual assault and sexual assault services. The following announcement was made to the potential participants:

The purpose for conducting this research project is to understand your viewpoints and attitudes about male rape/sexual assault and rape crisis services. This research project is also being conducted in order for me to complete my Master's thesis for the Department of Counselor Education at the College at Brockport, State University of New York.

Participation is completely voluntary and confidential. There are no anticipated benefits from participating in this study. There are consent forms, cover letters, envelopes and surveys face down on each bed. The survey has 40 questions (35 items and 5 background questions) and should take about 15-20 minutes to complete. If you are interested in voluntarily participating please do not include your name and/or any identification on the survey. If you would prefer me to read the consent form, cover letter, and survey to you please let me know, and assistance will be provided.

If you choose to complete the survey, please place it in the survey envelope and place the survey envelope in the survey drop box located on the table.

If you choose not to participate, please place your incomplete survey in the survey envelope and place it in the survey drop box located on the table.

Thank you!

The following morning, the researcher placed one prepared envelope with a consent form, cover letter and survey on each participant's bed (see Appendices B, and C). Participants were informed that they all had an envelope on their beds that were separated from one another by 3 ½ feet to ensure privacy. Participants were informed that participation was completely voluntary and anonymous. They were instructed not to place any identification, including names, on the survey instrument. The inmates were instructed to submit surveys, whether or not they were completed, into the envelope and into the drop box located on a table. This procedure helped to maintain the confidentiality and anonymity of those who participated in the study.

The researcher offered to read the consent form and survey in a private room to individuals with learning disabilities, those who were illiterate, or those who requested a reader. The process took about 20 to 30 minutes. Upon completing, participants were instructed to place surveys in its designated box as stated above.

Results

Inmates were asked to indicate their level of agreement with 35 survey questions associated with male sexual assault and sexual assault services. The level of agreement ranged from 1=strongly agree, 2= agree, 3= neutral, 4 =disagree and 5 = strongly disagree. The author collapsed strongly agrees with agree and strongly disagrees with disagree to make the responses stronger.

As indicated in Table 2 about 47% of male inmates would not know where to get sexual assault services if they were a victim of sexual assault, while 35% would know where to get sexual assault services and 16% were neutral. About 63% of male inmates agreed that they would go to a mental health service provider for sexual assault services,

20% disagreed with this statement and 16% were neutral. Slightly over a half of the male inmates agreed that they would go to a rape crisis service provider for sexual assault services 51%, while 26% disagreed and 24% were neutral. The overwhelming majority of male inmates agreed to go to the hospital for sexual assault services 77%, while 19% disagreed to go to the hospital and 14% were neutral. Likewise, more than half of the inmates agreed to go to the police about the sexual assault 68% while 18% disagreed to go to the police and 10% were neutral. Almost half of the inmates disagreed that they would question their masculinity if they were a victim of sexual assault 43%, while 28% were neutral and 26% agreed that they would question their masculinity. Inmates were 35% less likely to tell a family member that they were sexually assaulted and 39% agreed that they would tell a family member, while 24% were neutral. Inmates were 37% more likely to tell their significant other, while 31% disagreed with telling their significant other and 29% were neutral. Slightly over half of the inmates agreed that they would feel ashamed if they were a victim of sexual assault 59%, while 24% were neutral and 16% disagreed that they would feel ashamed. Likewise, over half of the inmates disagreed that they would blame themselves for being a victim of sexual assault 59%, while 22% agreed that they would blame themselves for the assault and 10% were neutral. Nearly half of the inmates agreed that they would feel comfortable with a professional of their ethnicity providing sexual assault services 47%, 39% were neutral and 12% disagreed. Slightly over half of the inmates were neutral about feeling comfortable with a professional of another ethnicity providing sexual assault services 53%, 26% agreed that they would feel comfortable with a professional of another ethnicity while 20% disagreed with this statement. Likewise, almost all of the inmates were neutral about feeling comfortable

with a male professional 47%, while 29% agreed that they would feel comfortable seeing a male professional regarding their sexual assault and 22% disagreed with seeing a male professional regarding their victimization. Almost half of the inmates agreed that they would feel comfortable seeing a female professional regarding their victimization 43%, while 37% were neutral and 18% disagreed. The overwhelming majority of inmates agreed that they would feel comfort talking to a counselor face-to-face about their sexual assault 73%, while 14% were neutral and 19% disagreed with this statement. About 35% of inmates reported neutral regarding feeling comfortable with using hotline services for counseling, while 33% agreed that they would feel comfortable using a hotline service for counseling and 28% disagreed with feeling comfortable using a hotline service for counseling. Slightly over half of inmates agreed that they would feel comfortable receiving rape crisis services at a substance abuse agency 51%, 29% were neutral and 14% disagreed with being comfortable receiving rape crisis services at substance abuse agencies. Likewise, 67% of inmates agreed that they would feel comfortable receiving rape crisis services at a mental health agency, 20% were neutral while a small percentage disagreed with this statement 8%. About 39% of male inmates disagreed and were neutral with being comfortable with rape crises services that have males on their brochure covers, while 18% agreed that they would feel comfortable. An overwhelming majority disagreed that they would be concern that the helping professional would think they agreed to the act 65%, while 24% agreed that they would be concern that the helping professional would think they agreed to the sexual act and 10% were neutral. Likewise, most inmates disagreed that they would be concern with the helping professional would thing they were a homosexual 61%, while 24% had concerns that they would be labeled

as homosexual and 14% were neutral with this statement. About 35% of inmates agreed that they would have concerns that the helping professional would think they were heterosexual, while 29% of inmates both disagreed and were neutral with this statement. An overwhelming majority of inmates disagreed that they would be concern that the helping professional would think they were unable to handle their own problems 61%, while 20% of inmates agreed that they would be concern that the helping professional would think they were unable to handle their problems and 16% were neutral. About 37% of inmates agreed that they would be concern that the helping profession would provide them with medication as a treatment for being a victim of sexual assault, 33% disagreed and 28% were neutral. Nearly half of inmates disagreed that they would be concern with the helping professional not being comfortable providing rape crisis counseling to a male 49%, while 28% were neutral and 22% agreed that they would be concern. Male inmates were 37% neutral that men who were sexually assaulted by another man are heterosexual, 31.4% disagreed and 18% agreed. Male inmate disagreed that men who are sexually assaulted by another male are homosexual 33%, while 31% agreed and 26% were neutral. Likewise, 33% of male inmates disagreed that men who are sexually assaulted by another man is weak, while 43% agreed and 16% were neutral. About 39% of inmates disagreed that when they hear the word sexual assault they believe the man is the victim, while 33% were neutral and 24% agreed. Slightly over half of inmates believe that the man is the perpetrator when they hear the words sexually assault 55%, 28% was neutral and 12% disagreed. The overwhelming majority of inmates, about 78% disagreed that male sexual assault only occurs in jails and prisons, 14% agreed, while 4% were neutral. An overwhelming majority of inmates agreed that male sexual assault only occurs in

childhood 84%, a small percentage were neutral 6% and a small percentage disagreed 4%. Likewise, 63% of male inmates agreed that male sexual assault only occurs in adulthood, 22% were neutral and 12% disagreed. Likewise, most of the inmates agreed that male sexual assault can be carried out by a woman 65%, 18% were neutral and 12% disagreed. Over half of inmates agreed that male sexual assault is threatening to the male identity 57%, while 26% were neutral and 12% disagreed.

Table 2: Survey with Results

| Survey Questions | N | Agree Percentage | Neutral Percentage | Disagree Percentage |
|--|----|------------------|--------------------|---------------------|
| If I were a victim of sexual assault, I would know where to get sexual assault services. | 50 | 35 | 16 | 47 |
| If I were a victim of sexual assault, I would go to a mental health service. | 50 | 63 | 16 | 20 |
| If I were a victim of sexual assault, I would go to a rape crisis service. | 51 | 51 | 24 | 26 |
| If I were a victim of sexual assault, I would go to a the hospital | 51 | 77 | 14 | 10 |
| If I were a victim of sexual assault, I would go to the police. | 49 | 69 | 10 | 18 |
| If I were a victim of sexual assault, I would question my masculinity | 49 | 26 | 28 | 43 |
| If I were a victim of sexual assault, I would tell a family member | 50 | 39 | 24 | 35 |
| If I were a victim of sexual assault, I would tell my significant other | 50 | 37 | 29 | 31 |
| If I were a victim of sexual assault, I would feel ashamed | 50 | 59 | 24 | 16 |
| If I were a victim of sexual assault, I would blame myself | 46 | 22 | 10 | 59 |
| If I were to seek sexual assault services, I would feel comfortable with a professional of my ethnicity | 50 | 47 | 39 | 12 |
| If I were to seek sexual assault services, I would feel comfortable with a professional of another ethnicity | 50 | 26 | 53 | 20 |
| If I were to seek sexual assault services, I would feel comfortable with a male professional | 50 | 29 | 47 | 22 |
| If I were to seek sexual assault services, I would feel comfortable with a female professional | 50 | 43 | 37 | 18 |
| If I were to seek sexual assault services, I would feel comfortable with face-to-face counseling | 49 | 73 | 14 | 10 |
| If I were to seek sexual assault services, I would feel comfortable with Hotline counseling | 49 | 33 | 35 | 28 |

| | | | | |
|--|----|----|----|----|
| If I were to seek sexual assault services, I would feel comfortable with an agency that provides substance abuse services, in addition to, rape crisis services | 48 | 51 | 30 | 14 |
| If I were to seek sexual assault services, I would feel comfortable with an agency that provides mental health and rape crisis services | 48 | 67 | 20 | 8 |
| If I were to seek sexual assault services, I would feel comfortable with rape crisis services that have pictures of males on their brochure covers | 49 | 18 | 39 | 39 |
| If I was a victim of sexual assault, I would be concerned that the helping professional would think I agreed to the act | 50 | 24 | 10 | 65 |
| If I was a victim of sexual assault, I would be concerned that the helping professional would think I am homosexual | 50 | 24 | 14 | 61 |
| If I was a victim of sexual assault, I would be concerned that the helping professional would think I am heterosexual | 48 | 35 | 29 | 29 |
| If I was a victim of sexual assault, I would be concerned that the helping professional would think that I am unable to handle my own problems | 49 | 20 | 16 | 61 |
| If I was a victim of sexual assault, I would be concerned that the helping professional would provide me medications/ drugs as my treatment | 50 | 37 | 28 | 33 |
| If I was a victim of sexual assault, I would be concerned that the helping professional would not be comfortable providing rape crisis counseling to a male | 50 | 22 | 28 | 49 |
| I think men who are sexually assaulted by another man are heterosexual | 44 | 18 | 37 | 31 |
| I think men who are sexually assaulted by another man are homosexual | 46 | 31 | 26 | 33 |
| I think men who are sexually assaulted by another man are weak | 47 | 43 | 16 | 33 |
| When I hear the words “sexual assault”, I believe the man is the victim | 49 | 24 | 33 | 39 |
| When I hear the words “sexual assault”, I believe the man is the perpetrator | 48 | 55 | 28 | 12 |
| I think that male sexual assault only occurs in jails and prisons | 49 | 14 | 4 | 78 |
| I think that male sexual assault can occur in childhood | 48 | 84 | 6 | 4 |
| I think that male sexual assault can occur in adulthood | 49 | 63 | 22 | 12 |
| I think that male sexual assault can be carried out by a woman | 48 | 68 | 18 | 12 |
| I think that male sexual assault is threatening to the male identity | 48 | 57 | 26 | 12 |

Percentage was rounded to the tenth place value.

Discussion

For the most part, the findings in this study revealed male inmates' attitudes towards male rape, rape crisis services and mental health services. Most participants in this study reported neutral on several sensitive questions, which could be an indicator that some of the questions were too sensitive and possibly triggered their own sexual trauma and were a safer response. It is also possible that some of the sensitive questions were confusing or too ambiguous so reporting neutral was a comfortable response than agreeing or disagreeing.

Base on the results revealed, male inmates reported that they do not know where to receive treatment for sexual assault but would still seek treatment if they were a victim of sexual assault. The majority of male inmates indicated that they would reach out to the police professionals, medical professionals, mental health professionals and rape crisis professionals. This finding is inconsistent with the literature in this study, which indicates that male victims typically are reluctant to report sexual assault to police and are less likely to seek mental health services (Eigenberg, 2000; King & Woodllett, 1997; Tewksbury, 2007; Vearnals & Campbell, 2001). This finding is significant because this could be an indicator that there are shifts in the way males' view male rape or a decrease in societal stigma towards men who seek treatment.

In addition to seeking treatment, male inmates reported that they would tell family members and/or a significant other. This could be because participants may have a strong supportive relationship with their family or they were once victims who were believed by their family and/or significant other when they reported their sexual assault. Although some male inmates indicated that they would report their victimization, scores were close

in regards to how many inmates would refuse to tell their family and/or significant others about their assault. Also, when telling family members and/or significant others, could potentially generate uncontrollable uncomfortable emotions for men and society says men should be in control of their feelings (Graham, 2006; Mulkey, 2004; Scarce, 1997; Sivakumaran, 2005). Interestingly, the majority of male inmates said that they would seek treatment from police professionals, medical professionals, mental health professionals and rape crisis professionals, which could indicate that males are more comfortable talking with a stranger than family and/or a significant other. Perhaps, some participants were victims of sexual assault and reported the incident but were not believed. An alternative explanation is that societal stigmas regarding male rape are still prevalent that victims could risk being labeled as homosexual, because society continues to views male rape as homosexual rape as the literature review indicates in this study (Graham, 2006; Mulkey, 2004; Scarce, 1997; Sivakumaran, 2005). By reporting, male victims are susceptible to being viewed as weak, blamed for their victimization and humiliated. Fowler et al. (2010) and Washington (1999) support the idea that blaming victims are essentially shifting the responsibility for the rape to victims instead of perpetrators, which is a problem and another contributing factor to why men do not report their victimization.

As discussed in the literature review, the relationship between male victims blaming themselves for their victimization and feeling ashamed and/or questioning their masculinity is consistent within this research. Close to 60% of respondents reported that they would feel ashamed and blame themselves if they were victims of sexual assault. Almost half of the inmates responded that they would not question their masculinity;

however, close to 30% reported that they would question their masculinity and 30% reported neutral. This is still significantly high. In addition to question their masculinity, over half of male inmates indicated that male rape is a threat to the male identity. It has already been indicated that when victims blame themselves, question their masculinity and are ashamed, it is unlikely that they will report their victimization or seek support services which may result in victims experiencing long-lasting psychological disturbances (Tewksbury, 2007; Walker et al. 2005; Sleath & Bull, 2009). In other words, self-blame, self-shame and confusion with masculinity are barriers for men reporting, which prolong the healing process from psychological disturbances.

Data were similar in this study regarding male inmates who would and would not feel comfortable with a professional of their own ethnicity and gender when seeking sexual assault treatment. Likewise data were similar with regard to male inmates feeling comfortable with other ethnicities and genders providing them sexual assault treatment. Male inmates who are suffering would work with professionals that are of a different gender and ethnicity, but they would prefer someone of their own ethnicity and opposite sex. This can be problematic because in most cases, service providers who are available may not be the same ethnicity or gender as the victim or may not be available, and depending on the funding of the organizations, hiring the same ethnicity and gender as the victim may not be feasible. Also, in most cases when a crisis or emergency occurs, the main objective is to provide mental, medical and/or support services not provide victims with service providers similar to the victims' ethnicity and gender.

It is important to note, that an overwhelming proportion of male inmates in this study would want treatment if they were sexually assaulted. Likewise, male inmates said

they would feel comfortable with face-to-face and hotline counseling. This study suggests that the location where services are available makes an enormous difference as to whether services will be sought. Because in this study, male inmates are comfortable with receiving sexual assault services from chemical dependency mental health and rape crisis organizations. But this still does not answer why men do not seek treatment. One possibility is that male victims are unaware and uninformed of community rape crisis treatment services. Another possibility is that most chemical dependency and mental health organizations' governmental funds are tailored specifically to chemical dependency and mental health treatment, not sexual assault treatment and perhaps staffs are not trained to treat sexual assault clients.

Surprisingly, male inmates were comfortable with receiving treatment from a male provider but were not comfortable with receiving treatment services from an organization advertising male sexual assault victims on their brochure covers. Perhaps having a male on the brochure cover are interpreted to men as a physical weakness, which is consistent with the literature review, that explains that receiving treatment goes against the traditional masculine role, telling men that they cannot express physical weakness and emotions other than anger (Eigenberg, 2000; Hammer & Vogel, 2010; Kupers, 2005; Weiss, 2010). After all, males are taught to demonstrate masculine behaviors; they are socialized to be aggressive, dominant, violent, powerful, and in control, (Eigenberg, 2000; Scarce, 1997; Sivakumaran, 2005; Weiss, 2010) anything less than masculine behaviors, men risk being labeled as homosexual or womanly (Weiss, 2010, p.277).

Based on the results, male inmates were confident in service providers' knowledge of sexual assault and their ability to work with men. Male inmates were confident that service providers will not blame them for the assault or judge them by thinking they were homosexual or unable to handle their problems, but they were concerned that service providers would provide them only with pharmaceutical treatment. This is concerning because it has been established, in this study that these men would reach out to service providers despite gender and ethnicity differences have a false belief and fear that service providers will only treat them with medication instead of talk therapy.

Unexpectedly in this study, male inmates were not concerned that the service providers would judge them, blame them or think they were homosexual. However, they were concerned that service providers would think they were heterosexual. These responses could cause one to assume that maybe this question was confusing to the inmates and caused a false truth to become evident in their responses. Is it possible that these men are really concerned with their sexuality being questioned? Scarce (1996); and Tewksbury (2007) believe that some heterosexual victims may perceive themselves as homosexual or think people perceive them as homosexual. Or perhaps, they internally have conflict with their masculinity, which parallels the literature review that male sexual assault victims, regardless of their sexual orientation, are stripped of their masculinity in society (Sivakumaran, 2005).

It is clear when examining this study, that the societal stigma that men who are raped are considered weak and homosexual, are contributing factors in how society views male rape. When the question was posed to judge other males' sexual orientation that were sexually assaulted as opposed to viewing their own sexual orientation, most

participants responded at a high rate of neutral, which can indicate that they did not want to honestly answer this question and neutral was a safer response. When the same question was posed and heterosexual was changed to homosexual, surprisingly the participants' answers were relatively close to each other. This can also indicate that there are still serious societal stigmas and judgment about men who are raped. As stated in the literature, society views male rape as homosexual rape (Graham, 2006; Mulkey, 2004; Scarce, 1997; Sivakumaran, 2005).

Based on the results revealed, it is clear that societal stigma still influences male's attitudes towards male sexual assault because when male inmates hear the words sexual assault they believe the victim is a not a male but the perpetrator. This is troublesome because if men do not believe male could be victims of sexual assault as the literature point out, in a sense, male victims are "stripped" (Sivakumaran, 2005, p.1298) of their masculinity and power (Knowles, 1999; Sivakumaran, 2005). Perhaps this is another reason why men suffer in silence because if society and males do not believe men could be victims of sexual assault only perpetrators this may be why men do not report at a rapid rate as female victims of sexual assault.

Although these findings strongly suggest that societal stigma is a major contributing factor as to whether men will report their sexual victimization or seek treatment, there may be a shift as to how men are viewing where sexual assault can occur, according to these findings. The results indicated that male inmates do not believe rape only occurs in jail; however, the majority of male inmates believed male rape can occur during childhood and/or adulthood. This suggests that these male inmates probably were not exposed to males being victims of sexual assault during their incarceration. Perhaps

male sexual assault is not as prevalent in a local jail as it is in a high level maximum security prisons. It is also possible that if these male inmates were victims of sexual assault their victimization occurred outside of jail during their childhood or adulthood. Whether rape occurs in prisons, jails, during childhood or adulthood, the reality is that men indeed can be victims of rape. This present study has established the important of how attitudes about male rape can significantly impact treatment. This study has established that males' attitude towards sexual assault and mental health and rap crises services are positive, but because men are paralyzed by societal stigma they would rather silently suffer than seek treatment services.

Limitations

There were myriad limitations to this study. Although the researcher wanted the participants to anonymously complete the surveys, the environment was a dormitory setting and the beds were separated 3 ½ feet. The participants potentially were aware of who were participating in this research, which could have resulted in some participants not fully completing the survey or not honestly answering the questions. Because of the dormitory setting, some of the inmates questioned the researching method as being a homophobic study, which could have significantly influenced some of the data collected, which was evident in one participant's survey that was incomplete and the words, "this is gay," was written on the survey. Also, participants were not allowed to identify themselves as being victims of sexual assault, so the data may have been based on assumptions and not representative of the true attitude of male rape victims.

Prior to conducting this research, the researcher established a professional working relationship, as mental health counselor intern, with some of the participants and

it is possible that the inmates felt obligated to participate in this study which could have also impacted the data.

The researcher created the survey and it appeared to have a few flaws. The wording of the questions could have been more precise and sensitive to the inmates' vocabulary and literacy in order to accumulate more accurate data. Some of the questions appeared vague and possibly confusing for the participants. The surveys were in English which could have excluded non-English speaking participants who wanted to participate but did not. Also, the survey was based on a Likert-type scale; however, the researcher included neutral as one of the responses instead of forcing participants to answering questions that they felt uncomfortable with or uncertain about. This could have been alleviated if a pilot study was conducted prior to this study.

Implications for Counseling

As stated previously, this present study established the important of how attitudes about male rape can significantly impact treatment. Males' attitude towards male sexual assault and rape crisis services in this study has revealed that men would receive treatment from a chemical dependency, mental health and/or rape crisis service providers. Likewise, male inmates would receive treatment from service providers of a different gender and ethnicity as their own, but because men are paralyzed by societal stigmas which are shaped in peoples' attitudes, they would rather silently suffer than seek treatment services. The literature in this study supports that male victims of sexual assault suffer a great deal of psychological and social dysfunctions (Davies & Rogers, 2006; Mulkey, 2004; Peretti, 2007; Robertson, 2003; Rogers, 1997; Sivakumaran, 2005; Tewksbury, 2007; Vearnals & Campbell, 2001). Thus, counselors in any discipline

should be prepared to provide sexual assault services to male victims. When counselors are formulating male rape victims' treatment plans, counselor should be sensitive to the symptoms that victims exhibit because they are potentially being misdiagnosed. When counselors are conducting groups, counselors should be prepared that some group members were victims of sexual assault, and their nonparticipation and/or isolation are common characteristics exhibited from male victims. Likewise, counselors in correctional settings should be aware of male victims' release date before doing intensive trauma therapy, because the clients could be transferred to another correctional facility or in a private cell designated to inmates who demonstrate unacceptable behaviors, such as, getting into fights with other inmates. Counselor should be properly trained in trauma therapy to prevent re-traumatizing victims. Counselors could collectively ask their employers to provide sexual assault workshops and/or training. Most local rape crisis centers are willing to provide free trains to educate people about sexual assault and how it affects both males and females.

Implications for Future Research

According to Peretti (2007), rape is a "destructive, catastrophic, life-changing event" for both male and female victims in and outside of prison institutions (p.766). Rape is also a life-changing event for victims' family. If men are isolating themselves and are emotionally disconnected from people, relationships are definitely affected. Not only are family members alone due to the isolation that victims exhibit, but family members and victims do not have updated literature about male rape and its impact to refer to for support. Most of the literature focused on the female perspective and the effects and treatments of rape in comparison to the male perspective which is "20 years

behind” female rape literature (Davies & Rogers, 2006). This is why further research is needed to broaden the understanding of male rape and how men and their families can be educated on community services that will assist male rape victims. Researchers, who are interested in a study like this, should perform a pilot study before conducting their study. Other researches should look at this study’s limitations to eliminate repeated errors. Researches’ priority might be to look at self-identified male rape victims’ attitudes towards male rape and rape crisis services which may reveal that men are not comfortable seeking treatment for their victimization. Future research should include the physical, psychological and interpersonal effects on male rape victims’ immediate family. Understanding what family members are experiencing could educate family members as to why their loved ones’ behaviors have changed. Understanding what family members are experiencing could reduce family members from blaming victims for their victimization. Understanding and educating family members about male rape could help reduce the societal stigma regarding male rape and encourage more male victims to report their abuse.

Conclusion

Male rape is a health concern both in prisons and in civilians’ environments because men can potentially contract HIV/AIDS. They are being affected physically, psychologically and interpersonally. This study has provided hypothetical evidence that if these male inmates were victims of sexual assault they would want treatment regardless of the provider’s gender and ethnicity. Male inmates would seek sexual assault treatment from chemical dependency, mental health and rape crisis providers. However, societal

stigma still influences males' attitudes about rape which also influences how realistic male victims would report their abuse and seek treatment.

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Appendix A

**Survey on Attitudes Towards
Male Sexual Assault and Sexual Assault Services**

Please fill in one circle for each question that best describes your attitude or belief.

| If I were a victim of sexual assault, I would: | Strongly Disagree | Disagree | Neutral | Agree | Strongly Agree |
|---|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|
| 1) Know where to get sexual assault services | <input type="radio"/> |
| 2) Go to a mental health service | <input type="radio"/> |
| 3) Go to a rape crisis service | <input type="radio"/> |
| 4) Go to the hospital | <input type="radio"/> |
| 5) Go to the police | <input type="radio"/> |
| 6) Question my masculinity | <input type="radio"/> |
| 7) Tell a family member | <input type="radio"/> |
| 8) Tell my significant other | <input type="radio"/> |
| 9) Feel ashamed | <input type="radio"/> |
| 10) Blame myself | <input type="radio"/> |
| If I were to seek sexual assault services, I would feel comfortable with: | Strongly Disagree | Disagree | Neutral | Agree | Strongly Agree |
| 11) A professional of my ethnicity | <input type="radio"/> |
| 12) A professional of another ethnicity | <input type="radio"/> |
| 13) A male professional | <input type="radio"/> |
| 14) A female professional | <input type="radio"/> |
| 15) Face-to-face counseling | <input type="radio"/> |
| 16) Hotline counseling | <input type="radio"/> |
| 17) An agency that provides substance abuse services, in addition to, rape crisis services | <input type="radio"/> |
| 18) An agency that provides mental health and rape crisis services | <input type="radio"/> |
| 19) Rape crisis services that have pictures of males on their brochure covers | <input type="radio"/> |
| If I was a victim of sexual assault, I would be concerned that the helping professional would: | Strongly Disagree | Disagree | Neutral | Agree | Strongly Agree |
| 20) Think I agreed to the act | <input type="radio"/> |
| 21) Think I am homosexual | <input type="radio"/> |
| 22) Think I am heterosexual | <input type="radio"/> |
| 23) Think that I am unable to handle my own problems | <input type="radio"/> |
| 24) Provide me medications/ drugs as my treatment | <input type="radio"/> |
| 25) Not be comfortable providing rape crisis counseling to a male | <input type="radio"/> |
| I think men who are sexually assaulted by another man are: | Strongly Disagree | Disagree | Neutral | Agree | Strongly Agree |

Appendix B

Cover letter/Instructions

Dear Participant:

The purpose for conducting this research project is not intended to identify individuals of sexual assault, but to understand your viewpoints and attitudes about male sexual assault. This research project is also being conducted in order for me to complete my Masters thesis for the Department of Counselor Education at the College at Brockport, State University of New York.

This study involves completing a 40 item survey (35 items and 5 demographic questions) that will take approximately 15 to 20 minutes to complete. Your completion of this survey is important to help broaden the research and services available to male victims of sexual assault. You are being asked to voluntarily participate in this study, doing so signifies that you consent to participate. Participating in this study signifies that you are at least 19 years or older. Your participation is completely voluntarily and you are not obligated to participate in this study. You may exercise your right to not complete and/or return the survey without penalty at any point of the study.

There will be no personal benefits from participating in this study. Due to the sensitivity of this research topic and survey questions, there is the potential for psychological stress/trauma as a result of completing this survey. To minimize this risk, the Monroe County Office of the Sheriff Chemical Dependency Re-Entry Program's counselors have a list of resources and information about sexual assault. Therefore, if you are experiencing any uncomfortable feelings and/or thoughts as a result of participating in this study, please see your counselor.

To ensure your anonymity and confidentiality please do not write your name and/or any identifying information on this survey. Once again, at any time you have the right not to answer any questions and/or not complete the survey. The survey will be shredded when the research has been completed.

If you choose to participate, please place your survey into the envelope and then into the drop box. If you are not participating in the study, please place your uncompleted survey into the envelope and drop box. Returning all completed and incomplete surveys to the drop box ensures participants' anonymity. If you have any questions regarding this study you may contact:

April Aycock
Primary Researcher

Craig Johnson LMHC, CASAC
Director of Chemical
Re-Entry Program
Phone: (585) 753-3080
Email: cjohnson@monroecounty.gov

Summer Reiner PhD
Clinical Coordinator

Thank You!

Appendix C

STATEMENT OF INFORMED CONSENT

The purpose for conducting this research project is to understand your viewpoints and attitudes about male rape/sexual assault and rape crisis services. This research project is also being conducted in order for me to complete my Masters thesis for the Department of Counselor Education at the College at Brockport, State University of New York.

In order to participate in this study, your informed consent is required. You are being asked to make a decision whether or not to participate in this project. If you want to participate in this project, and agree with the statements below, please place your survey into the envelope and ballot box. You may change your mind at any time and leave the study without penalty, even after the study has begun. If you are not participating, please place your uncompleted survey into the appropriate envelope and ballot box

I understand that:

1. My participation is voluntary and I have the right to refuse to answer any questions.
2. My confidentiality is guaranteed. My name will not be written on the survey. There will be no way to connect me to my written survey. If any publication results from this research, I would not be identified by name.
3. There will be no anticipated benefits because of my participation in this project. There may be psychological risk due to the sensitive topic (male rape). Counselors will be available on the unit during and after the administration of the survey.
4. My participation involves reading a written survey of 40 questions (35 items and 5 background questions) and answering those questions in writing. It is estimated that it will take 15-20 minutes to complete the survey.
5. Approximately 85 people will take part in this study. The results will be used for the completion of a master’s thesis by the primary researcher.
6. Data will be kept in a locked filing cabinet by the investigator. Data will be destroyed by shredding when the research has been accepted and approved.

I am 19 years of age or older. I have read and understand the above statements. All my questions about my participation in this study have been answered to my satisfaction. I agree to participate in the study realizing I may withdraw without penalty at any time during the survey process. Returning a completed survey indicates my consent to participate. If you have any questions you may contact:

| | |
|--------------------|---|
| Primary researcher | Director |
| April Aycock | Craig Johnson Director of Chemical Dependency Re-Entry Program |

| | |
|--|---|
| | Phone: (585)753-3080 Email: cjohnson@monroecounty.gov |
|--|---|