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Case Study

Him Too: A Case Report on Male Sexual Violence and Screening in Primary Care

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Males are victims of sexual violence at a rate almost as high as females; however, reports of male sexual violence are often left unscreened, unaddressed, and unacknowledged. Genitourinary complaints without an obvious cause should trigger the primary care provider to consider sexual violence as part of a differential diagnosis.

Key Words

Male victims, men, sexual violence, urinary complaint.

Mr. Q, a Caucasian male in his mid-30s, presented to his primary care office with a vague chief concern of "urinary tract infection symptoms." Although he was a new patient to this particular provider in the office, his usual provider had seen him twice within that month for the same chief complaint. At both of these encounters, the examination was unremarkable, and urinalysis was negative for blood, leukocytes, and nitrates. Both times, he was sent home with reassuring comfort measures and instructed to increase his intake of oral fluids and cranberry juice. At the current visit, Mr. Q reported his specific symptoms were feelings of burning with urination and urethral pain. He denied constipation, abdominal pain, dysuria, pressure with urination, bowel changes, bowel or bladder urgency, frequency, chills/fever, urethral discharge, hesitancy, incontinence, hematuria, and nocturia, and no suprapubic, scrotal, back, or flank pain. He reported his appetite and elimination were otherwise normal.

History

Mr. Q denied any history of urinary tract infections or other urologic problems. His past medical history was unremarkable except for hyperlipidemia. Past surgical history included only a tonsillectomy at age 7 years. Family history was non-contributory. His current medications included a daily statin for hyperlipidemia, occasional ibuprofen for backache, and a multivitamin. He reported rare alcohol use, no tobacco or marijuana use, and no use of street drugs. His last sexual activity was about one year ago, and all past partners were female. He works a full-time computer job, which was moderately stressful. Although Mr. Q is not married, has no significant other, and no children. He reported he had several good friends, bowled on a team weekly, and he walked his dog for exercise.

Lately Mr. Q had been feeling more fatigued and not sleeping well, and he had not gone bowling the past two weeks. Due to a stiff neck and back muscles from his desk job, he routinely received deep tissue massages from a reputable local massage therapist. He reported visiting the same massage therapist over the past several years and felt he had a good working relationship with this individual.

Physical Examination

Mr. Q was a well-developed, well-nourished, age-appropriate male in no apparent distress but appeared very concerned or worried. His speech was clear and articulate, but careful. He maintained eye contact. Gait was normal, and he moved freely without guarding. Abdominal, back, genital, and digital rectal examination were all performed in the presence of a chaperone, and results were all within normal limits with no pain on palpation. He had no skin

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Author's Note: Names and identifying information have been changed to protect the anonymity of the patient.

rashes or lesions. Urinalysis and urine microscopic examinations were again negative.

As the normal findings were reported to Mr. Q, it became evident that he was still worried and not at all relieved by the normalcy.

The normal findings, the repeated visits for the same concerns, and the lack of relief from the patient all prompted the provider to consider other differential diagnoses. Although Mr. Q mentioned he was not sexually active in the past year, the provider carefully asked if there was any way he could have been inappropriately touched or sexually violated. At this time, Mr. Q was silent for several seconds before stating the male massage therapist whom he trusted for years violated him during his last massage, about three weeks prior. He admitted his real concerns were the risk of sexually transmitted disease and the mental trauma of the assault. He confided that he felt very alone, embarrassed, and betrayed by a therapeutic massage provider he trusted. He also said he would never report the abuse to the police for fear of disbelief.

Sexual Violence Victimization of Males

Sexual Violence

The "Me Too" movement began in 2006 as a way to help sexual violence survivors find ways of healing (Me Too, n.d.). While it originally targeted women and girls of color and from low-wealth communities, the movement has spread globally as more and more survivors from all races, ethnicities, and socioeconomic classes have come forward to share their stories of sexual harassment and sexual assault. While the majority of "Me Too" survivors who have come forward are women, there is a quieter group of men and boys who are also survivors of sexual violence. In primary care, we need to ask ourselves if this is a case of "him too."

The Centers for Disease Control and Prevention (CDC) defines sexual violence as rape (forced penetration, attempted forced penetration, and drug- or alcohol-facilitated penetration), forcing a victim to penetrate another person, sexual coercion, unwanted sexual contact, and non-contact sexual experiences (Black et al., 2011). Mr. Q was a victim of sexual violence.

Sexual violence is a major health problem that affects our society as a whole and our patients as individuals. Many survivors of sexual violence report ongoing depression, anxiety, and other health consequences (Black et. al., 2011). Likewise, many survivors present to primary care offices with other seemingly unrelated physical symptoms, such as headaches, anxiety, depression, appetite disturbances, nightmares, stress, fatigue, and sexual dysfunction (Ray & McEneaney, 2014).

Primary care providers should be aware of the possibility of sexual violence. Ray and McEneaney (2014) noted that presence of physical complaints with no obvious cause could raise suspicion of a possible history of sexual violence and that as primary care providers; we need to be knowledgeable about screening and capable of recognizing common physical and mental sequelae of sexual violence (Ray & McEneaney, 2014). It needs to enter our minds as a differential diagnosis.

Sexual Violence Against Males

Common paradigms of sexual violence dictate a female victim and a male perpetrator, and much of what has been studied, centers on this model. Various myths contributing to this paradigm include that men cannot be raped by women, men experience less harm from sexual violence than women, men always welcome sexual advances, and real men can fend off an attacker (Depraetere et al., 2018; Stemple & Meyer, 2014). These myths are reinforced because women who are assaulted are far more likely to file a police report than men who are victims (Donne et al., 2018). When men do file a report, it tends to be labeled "unimportant," overlooked and neglected by authorities (Javaid, 2017). While men rarely report sexual violence to the authorities, they experience sexual violence in similar rates as women (men 33%, women 36%) (CDC, 2016).

When men who were victims of sexual violence were not believed, they reported feeling isolated and emotionally damaged (Javaid, 2017). The violence is often from an intimate partner or someone closely known to the victim, and the perpetrator can be male, female, or both. Men are more likely to be raped by another man, but they can also be coerced into sex or forced to penetrate by women (Black et al., 2011).

In a report on military sexual violence, Matthews and colleagues (2018) found that sexual violence was often related to hazing, and targeted victims included men who were gay, bisexual, or transgender; with a lower paygrade; under 30 years of age; white race; and often, with a history of childhood sexual abuse. The typical perpetrators were usually known to the victim, in a position of authority, and often included a group consisting of all males or of males and females (Matthews et al, 2018). It was common during the assault for the victim to be physically injured or beaten, as well as sexually violated, and took place during a 'hazing' activity. In addition, Matthews and colleagues (2018) reported that victims would often experience erections from fear, and the attackers would stimulate the victim to ejaculate. Doing such would elicit an artificial sense of 'consent' and dissuade a victim from reporting the incident (Matthews et al, 2018). Wegner and Davis (2018) also noted that sexual violence was more often aimed at "men who had sex with men and women" over "men who had sex with only women" (p. 8), yet perpetrators were both men

and women. Men were more likely to rape, and women were more likely to coerce or force penetration (Matthews et al., 2018).

Implications for Practice: Caring for Patients Who Are Victims of Sexual Violence

Mr. Q's anxiety and fears manifested into primary care visits for complaints of urinary symptoms. As primary care providers, we provide holistic care centered on biological, social, and psychological health concerns. At times, we as primary care providers may overlook subtle hints our patients give us about their real concerns.

General screening for sexual violence is not a routine recommended assessment for men, although screening for Intimate Partner Violence (IPV) is recommended for adolescents and women (U.S. Preventive Services Task Force [USPSTF], 2018). Adolescent males were less likely to receive a sexual violence screening during a routine health history than females were (Alexander et al., 2014), and when sexual violence histories were obtained, the conversation lasted only about 36 seconds (Marcell et. al., 2018).

While the screening of women is widely recommended, and many sexual violence screening tools exist to screen women, screening men for sexual violence is not routinely recommended. The USPSTF (2018) has no recommendations to screen men because they found "no valid, reliable screening tools in the primary care setting to identify IPV in men without recognized signs and symptoms of abuse."

The HITS (**H**urt, **I**nsult, **T**hreatened with harm, **S**cream) tool has been used for screening both men and women (Basile et al., 2007; Zakrison et al., 2018); however, the questions are geared toward violence from a partner, not someone else. As a provider, if you suspect sexual violence has occurred, it is imperative to ask the questions. Using the HITS tool and modifying it to be more general is one way to address it. Rather than asking if *your partner* has hurt you, ask if *anyone* has hurt you. If you are still unsure of how to broach the subject, follow the SAVE method.

The pneumonic "SAVE" guides the provider to Screen (S) all patients for sexual violence; Ask (A) direct questions in a non-judgmental way; Validate (V) your patient's response; and Evaluate (E), educate, and make referrals (Florida Council Against Sexual Violence, 2012). The study by Zakrison and colleagues (2018) included the HITS tool plus the SAVE model and found that using both was superior for screening males for sexual violence.

Implications for Urology Nursing

When assessing patients with urologic symptoms, such as unsubstantiated pelvic or bladder pain, it is important to consider that men as well as women may be victims of sexual violence. While it is recommended that women presenting with pelvic pain or bladder pain should be screened for sexual violence, so far, this has not been the case with men who present with similar symptoms. It is up to us to carefully and respectfully consider sexual violence as a differential diagnosis in patients with vague or unsupported urologic symptoms. Use of the pneumonic SAVE reaffirms the need to interview in a non-judgmental manner while validating your patient's responses.

In addition, nurses need to promote respect while interviewing and examining patients who are at risk for sexual violence. Providing privacy and reassurance of patient confidentiality during the interview and the examination are necessary to establish a caring and trustworthy environment. It is best practice to offer the patient a chaperone for sensitive examinations, regardless of the patient's gender. One way to do this is to inform the patient right away that a chaperone will be present during the examination to ensure the provision of safe and responsible patient care. Let them know the chaperone acts to protect and enhance the patient's dignity, safety, and comfort during sensitive examinations. When possible, try to offer the patient a same-sex chaperone. As the health care professional, you are extending professionalism to your patient in a very uncomfortable time.

Conclusion

Screening males at risk of sexual violence is important for primary care providers. The important take away is that sexual assault can happen to any of our patients, regardless of gender. Sexual violence often goes unreported, and even more so when it happens to men. Men are often left with physical and emotional injuries, and very little known support. When a male patient presents with risk factors for sexual violence, primary care providers need to consider "him too." ◙

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