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

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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, frequen-

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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.

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 (Hurt, Insult, Threatened with harm, Scream) 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), edu-