SEXUAL EXPERIENCES AND MENTAL HEALTH IN MEN: THE GANYMEDE STUDY

Presented by Seena Ounsinegad

in partial fulfillment of the requirements for completion of the
Health Science Scholars honors program in the College of Natural Sciences at
The University of Texas at Austin

Spring 2019

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I intend to submit a copy of my Health Science Scholars thesis to the Texas ScholarWorks Repository. For more information on the TSW, please visit https://repositories.lib.utexas.edu/.

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Acknowledgements

I would like to thank Chelsea Kilimnik and Dr. Cindy Meston for their tireless efforts guiding me through this project and providing me with endless resources in our lab. Chelsea has dedicated many hours to sending me examples, helping with recruitment and data analysis, and proofreading my writing and tearing it apart so that I could build it back up. I also have special gratitude for Dr. Rebecca Wilcox, Kevin Nguyen, and all of my peers writing theses who gave me invaluable feedback. Without these people to keep me on track, I do not know where I would be now. By meeting with this group weekly, I have been able to use their input to shape my writing experience continuously. Finally, I cannot thank enough all of my family and friends who have supported me unconditionally and lifted me up when I needed it. You know who you are.

Abstract

Sexual violence is a prominent issue in the U.S. and worldwide. Although the majority of research has focused on women, 1 in 6 men in the U.S. have experienced sexual violence, and this statistic is likely an underestimate due to markedly low rates of men identifying and reporting these experiences as sexual assault, rape, or sexual abuse. The current study investigates the ways in which nonconsensual sexual experiences (NSEs) affect men's subjective mental health and attitudes toward help-seeking behaviors later in life, while considering the roles of hegemonic masculinity, patriarchal social roles, and minority group membership (e.g., sexual orientation). An online survey was administered to both community (U.S.; n = 108) and undergraduate (University of Texas at Austin; n = 49) samples. A series of multivariate regression analyses were used to assess the amount of variation in outcome variables that could be explained by NSEs and minority status. Findings support predictions that NSEs have a negative impact on subjective mental health and attitudes toward physical health help-seeking behaviors, and that there is a combined effect of NSEs and minority status on support preferences, such that NSEs are detrimental to inclinations to seek support in this relationship. However, the relationships between NSEs and mental health help-seeking behaviors, and the effects of minority status on the other outcomes, should be studied in more detail in replications. These results suggest the need for treatment providers to address the intersectionality of sexual violence and sexual minority status of men as barriers to treatment, and the necessity of considering this in the application and development of treatment options for this population.

Keywords: sexual violence; nonconsensual sexual experience; socialization; hegemonic masculinity; minority; stigma; treatment

Introduction

Purpose

Sexual violence, which can be defined as any instance of coerced or nonconsensual sexual activity between individuals, is a prominent issue in the U.S. and worldwide. Due to the higher prevalence rates in women, the majority of the research has been conducted on women's experiences of sexual violence. Yet, 1 in 6 men in the U.S. have experienced sexual violence (Dube et al., 2005), and this statistic is likely an underestimate due to markedly low rates of men reporting and identifying these experiences as sexual assault, rape, or sexual abuse (Lisak, Hopper, & Song, 1996; Stander, Olson, & Merrill, 2002). Additionally, research suggests that a significant proportion of men in America experience sexual violence in childhood, which is often experienced again in adulthood and even with the same offenders (Zinzow & Thompson, 2014). There is a dearth of research examining men's nonconsensual sexual experiences (NSEs), as well as the unique post-NSE psychosexual outcomes and their specific treatment needs. Since social scripts of masculinity suggest that men should always be ready for sex (Muehlenhard & Cook, 1988) and deal with mental and physical concerns without complaint (Hong, 2000; Kia-Keating, Grossman, Sorsoli, & Epstein, 2005), there are significant barriers to the reporting of sexual violence experiences that are unique to men. Furthermore, many sexual violence social movements, such as the Me Too and Time's Up movements, are not inclusive to men with these experiences. Men are only acknowledged in the Me Too discourse as allies or secondary to women (Miller, 2017; Freischlag & Faria, 2018). This may further alienate men from the support they need and invalidate their traumas.

The research that has been done suggests multiple psychosexual correlates to men's NSEs (e.g., Ahmad, 2006). For instance, Bartholow et al. (1994) conducted a landmark study

that consisted of interviews with over a thousand homosexual and bisexual men who were seeking treatment at STI clinics. Through these interviews, they discovered that men with histories of sexually abusive experiences in childhood and/or adolescence had increased psychiatric diagnoses (e.g., anxiety and depression), substance abuse, suicidal ideation, altered sexual identity formation, and heightened predisposition for HIV risk behaviors. It has been demonstrated that gay and bisexual men who have earlier psychosexual development, meaning earlier realization and disclosure of their sexual orientation, are more likely to have experienced NSEs earlier in life, discrimination and bullying for their sexual orientation, intimate partner violence, depression, and HIV seropositive status (Friedman, Marshal, Stall, Cheong, & Wright, 2008). Evidently, NSEs can contribute to many different negative consequences in men's psychosexual health. Yet, many men do not seek treatment or support due to sociocultural stigma of help-seeking within the dominant discourse of masculinity.

Current Study

The name "Ganymede Study" is given for a very specific reason. In Ancient Greek mythology, Ganymede was the name of a Trojan prince who was renowned for his beauty. This magnificent pulchritude attracted the attention of Zeus, the king of the Olympian gods and the god of the sky and thunder (Atsma, 2017). Zeus has a track record in Greek mythology of sleeping with or raping multitudes of mortal women, which is how he sired so many demigods. In this case, Zeus appeared to Ganymede in the form of an eagle and seized him to carry him to Mount Olympus. There, Ganymede became deified as the cupbearer of the gods, and he spent eternity serving the Olympians in this capacity. Ganymede was also made into the constellation Aquarius, and his sphere of godly power included homosexuality, which led him to be portrayed

alongside love gods such as Eros and Hymenaeus (Atsma, 2017). This myth can be interpreted as a story of how nonconsensual sexual experiences can take on many forms and have multifaceted repercussions, particularly for men who are survivors. Because of its important deeper meaning, the myth of Ganymede has been chosen for the name of this study.

The current study examines the intersectionality of NSE history and minority group membership on mental health symptoms and attitudes toward help-seeking behaviors. We consider two main hypotheses in this study. The first hypothesis is that it is expected that men with NSEs will have higher symptom scores on measures of mental health. The second hypothesis is that belonging to a marginalized group (e.g., ethnic minority, sexual minority) will predict for more negative help-seeking attitudes, due to societal barriers to access and healthcare disparities that have historically prevented minority individuals from seeking help. We also consider in the following literature review the indicators of stereotypical gender roles and masculinity, and whether these mediate the relationships between NSE history and help-seeking behaviors and attitudes. The long-term goals of this study are to engage more scholarly research around the outcomes experienced by men with NSEs, to reduce the sociocultural and academic stigmas associated with these experiences, and to inform treatment development to address the intersectional needs of this population.

The below figure shows the relationships that we investigate between our primary variables of interest. Nonconsensual sexual experiences are positioned as the primary explanatory variable for the outcomes of subjective mental health and attitudes toward help-seeking behaviors. We also consider minority status (primarily race/ethnicity and sexual orientation) and socialization into hegemonic masculine roles as covariates mediating this

primary relationship. However, only the former of these was explicitly investigated in our original study.

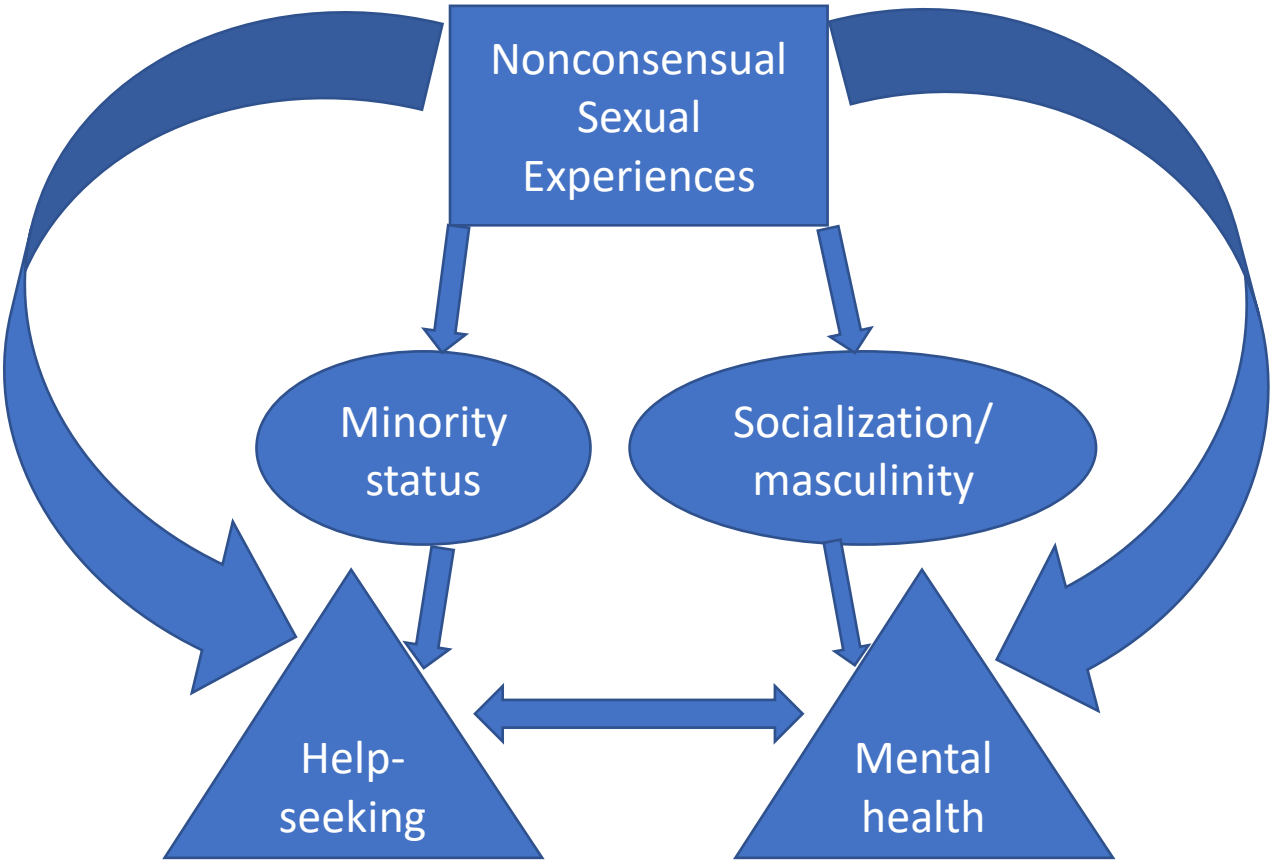

Figure 1. The relationships of the variables being investigated.

Background

Socialization and Hegemonic Masculinity

Hegemony is defined as the standards that are reinforced by power structures as "normal" or "natural," which inform individuals to act in a way that keeps those structures in place (Donaldson, 1993). Applied to masculinity, these hegemonic standards are learned by boys during the socialization process to teach them the traditional roles that are assigned to males in our society. Hegemonic masculinity appears to be the basis of many social issues encountered by men, which is why it has garnered the title of "toxic" masculinity. As hegemonic masculinity is

an unattainable standard, men typically fall outside of it in some capacity. Many men struggle with mental health issues and have trouble seeking help when they need it, due to the fact that they were socialized to be independent and not to express vulnerable emotions (Mansfield, Addis, & Courtenay, 2005). Toxic masculinity and its contribution to men's health have been explored in multiple studies, and researchers agree that hegemonic standards of masculinity in Western societies teach men to internalize emotions and stay rational, be sexually assertive, and maintain strictly heterosexual relationships (Donaldson, 1993).

Hegemonic masculinity has been associated with aversion to help-seeking behaviors because of deeply ingrained social roles (Messerschmidt, 2018). A study of 400 undergraduate men found that acceptance of traditional male gender roles and negativity toward expressing emotions and expressing affection for other males were all associated with negative attitudes toward help-seeking in a psychological context (Good, Dell, & Mintz, 1989). Comparative studies between men and women have also been used to give context to this issue in male populations. A landmark study by Möller-Leimküller (2002) examines help-seeking in men and women with depression, finding that men consistently have worse help-seeking patterns than women. Evidence does not suggest that men are overall in a better state of health than women, so this finding is likely attributed to perceptions of the need for seeking help and the social consequences of doing so. Due to lethargic depression symptoms (e.g., low motivation/interest, anhedonia) and toxic masculinity, men with depression likely have further obstacles preventing them from engaging in help-seeking behaviors. Overall, it is apparent from these studies that the effects of hegemony on masculine roles in our society results in reduced help-seeking behaviors.

It is important also to investigate the influences of hegemony on male perpetrators of sexual violence. In addition to preventing help-seeking in men, unhealthy forms of masculinity

can also interact dynamically with occurrences of sexual violence, especially where the perpetrators and victims are both men. Whitehead (2005) studies the dynamic presence of masculinity in instances of violence between men. Interestingly, while Whitehead acknowledges the presence and validity of multiple masculinities such as marginalized and subordinate subtypes, he argues that the singular, unifying concept of masculinity between all men is what either motivates or discourages sexual violence between them. According to this research, the dynamic use of masculinity by men can either designate other men as "worthy" of violence, in which case it is initiated, or as "unworthy" of the effort. I would argue that this conception of an all-encompassing masculinity is Whitehead's version of the hegemonic masculinity that has been discussed in so many other studies of sexual violence. Men who perpetrate sexual violence, especially domestic abuse, tend to use hegemonic standards to reinforce the gender binary so as to justify their own actions (Anderson & Umberson, 2001). Although this binaric reasoning only applies to opposite-sex sexual violence, it is important to evaluate how men compare their own form of violence as "effective" as compared to what women practice. In fact, these same men also tend to self-victimize by blaming an unjust system for criminalizing them when they do not perceive themselves to be at fault for being violent toward their partners. Anderson and Umberson (2001) use this evidence to advance the notion that hegemonic standards allow men who perpetrate sexual violence to perceive themselves as simultaneously self-righteous and justified in their actions, no matter how extreme or egregious.

Masculinity is an important part of the discussion of sexual violence as it is integral to men's responses to their NSEs. Many survivors find themselves positioned incongruently between the societal standards of masculinity and the reality of being victimized (e.g., not being able to fight back, having a sexual experience they did not want) (Kia-Keating, Grossman,

Sorsoli, & Epstein, 2005). In addition to these considerations, most societies perpetuate the misconception that women are the only victims of sexual violence, and this puts men in a uniquely difficult position with further barriers to addressing their NSEs because it is not socially acceptable to do so (Stander, Olson, & Merrill, 2002). One study by Onyango and Hampanada (2011) investigates this issue in the context of wartime survivors, who experience heightened psychosocial consequences of sexual violence, including posttraumatic stress disorder and physical injuries. The men who undergo NSEs during wartime have diminished access to health resources and are effectively removed from discourse regarding survivors and their treatment needs, which severely negatively impacts their recovery.

Less privileged forms of masculinity, such as marginalized and subordinate subtypes, may be further discouraged from help-seeking due to their lack of conformity to the central hegemonic standard. Men in oppressed groups, however, such as ethnic and sexual minorities, practice alternative forms of masculinity by their very nature, which thus could relate to the predisposition of these marginalized groups to experiencing NSEs (Messerschmidt, 2018). Messerschmidt's theory states that these less privileged masculinities in minority men could result in an intersectional form of marginalization, which would then lead to disproportionate targeting for sexual violence. Ethnic minority men experience discrimination for their marginalized masculinity as well as their race, which creates an intersectional experience of oppression. For instance, one study investigated the experiences of black men who had and had not experienced racial discrimination and a comparison group of white men (Goff, Di Leone, & Kahn, 2012). Results demonstrated higher levels of endorsement for hegemonic masculine norms among the black men with discrimination experiences. Additionally, these men also practiced high numbers of masculine-typed behaviors to compensate for their marginalized status

compared to white men. The researchers attribute this to compensatory attitudes and behaviors to negate their discrimination experiences. Researchers have explained the division between hegemonic and alternative masculinities with the analogy of a mixed martial arts competition in which one opponent strikes (i.e., hegemonic) and the other submits (i.e., alternative), creating a hierarchical dichotomy (Hirose & Pih, 2010). These researchers proposed that racially marginalized masculinities, particularly in East Asian men, are emasculated in Western cultures and positioned as legitimate only as a counterpart to white masculinity.

Subordinate masculinity is often observed in LGBTQ+ men and those who practice queer behaviors. These masculinities are left out of theoretical discourses on masculinity because homosexuality is socially positioned as opposite hegemonic masculinity, which is heteronormative by nature. For instance, much of the research describing queer masculinities is in reference to how cisgender heterosexual men display queer behaviors, especially in the context of media and other performance outlets (e.g., Becker, 2008). Consistent with this theme, Heasley (2005) disrupts the hegemonic norms present in society by categorizing straight men he observed through their display of queer behaviors. He discusses five archetypes of subordinate masculinity practiced by straight men: *straight sissy boys*, who are perceived by others as queer and may be discriminated against for it; *social-justice straight-queers*, who choose to be outspoken advocates despite not being queer themselves and are often perceived as queer for these actions; *elective straight-queers*, who make use of queer masculinity and spaces to liberate themselves from heteronormative standards and elect to expand their horizons by flirting with queerness; *committed straight-queers*, who integrate queerness into their personalities by exploring the intricacies of queer sexuality and dedicating themselves to learning about it; and *men living in the shadow of masculinity*, who understand and support queer rights and expression

but avoid making this public. It is apparent that queer masculinities are far more prevalent and integrated into our society than dominant power structures would have us believe (Heasley, 2005). Through this research, Heasley demonstrates the social risks associated with performing these masculinities, where there is far greater risk for queer men who express these alternative forms of masculinity. While non-queer men have the privilege to choose how they embrace queerness, actual queer men have limited options for expressing their true identities. Because of this, discrimination becomes unavoidable, and tropes like the "sissy boy" category could function as excuses for people to take advantage of queer men (Heasley, 2005).

Minority Group Membership

Belonging to a minority has powerful repercussions for individuals in terms of access to healthcare and other important considerations. It is clear that patients with psychiatric diagnoses have trouble accessing care in the U.S. in general, but research shows an even larger disparity in treatment seeking among those who belong to ethnic minorities (Alegría et al., 2008). Even when holding all other factors constant, these patients experience inadequate or no treatment due to a number of socioeconomic factors. Public policies, such as the Americans with Disabilities Act and the Earned Income Tax Credit, have assisted in addressing this disparity, but there is still a long way to go to equalize healthcare access (Alegría, Perez, & Williams, 2003). Even outside of healthcare, racial and ethnic minorities have a long history of being denied equality in professional environments in the U.S., and this will continue unless certain cultural competency practices are implemented into public spaces and services nationwide (Betancourt, Green, Carrillo, & Owusu, 2003). This inequality is also perpetuated by geographical discrimination, usually in the form of segregation of racial minority groups through gentrification to the outskirts

of cities (e.g., Morello-Frosch & Lopez, 2006). Individuals affected by segregation and gentrification are subjected to physical conditions and material deprivation that contribute to poor health and various illnesses. This relates directly to our later analysis of the effects of minority status on health outcomes.

Similarly, belonging to a sexual minority can be very frustrating in a heteronormative society where individuals are conditioned to perceive otherness as wrong. This frustration has been shown to often reach a state of chronic stress when queer individuals must address these heteronormative standards during their daily lives, causing sustained hypervigilance (Mink, Lindley, & Weinstein, 2014). The stress that results from living in a society that opposes one's existence can lead to a variety of other complications for LGBTQ+ people. For example, bullying is a common experience of LGBTQ+ oppression starting in childhood, and this discriminatory practice is perpetuated in schools because of the fact that systematic laws and regulations in place allow its continuation, and counselors do not receive proper ethics training to address the issue and create a safe space for queer students (Abreu, Black, Mosley, & Fedewa, 2016). Furthermore, Robinson and Espelage (2012) discovered in their study that, when controlling for bullying, queer and non-queer children have significantly different rates of self-destructive behavior. Additionally, the researchers found that queer students are about 3 times more likely to think about or attempt suicide and about 1.4 more times more likely to skip school than non-queer students who underwent the same degree of bullying. In these situations, the issue of cultural consciousness becomes paramount to successfully reducing professional discrimination, and LGBTQ+ focus groups are also necessary to close these gaps in order to better address instances of discrimination and violence against this community (Rounds, Mcgrath, & Walsh, 2013).

While it is imperative to understand the systematic factors that lead to oppression for minority populations, it is equally crucial to investigate how these groups deal with trauma such as NSEs differently than more privileged groups. For example, intimate partner violence (IPV) is a prominent issue among all demographics, but same-sex couples have added "sexual minority stressors" that make this issue even more difficult to deal with (Carvalho, Lewis, Derlega, Winstead, & Viggiano, 2011). These stressors include internalized homophobia, higher expectations of discrimination, and heightened stigma consciousness. All of these factors were found to be related to both victimization to and perpetration of IPV in same-sex couples, which is why it is important to investigate the effects of stigma on sexual-minority individuals who experience sexual violence. When investigating ethnic minorities, there is also a wealth of research that suggests that these populations also undergo multiple forms of trauma from the experience of sexual violence. One such study investigates childhood sexual abuse in ethnic-minority children, finding their minority status to have an additional effect on their traumatization because of the subjugation of these populations to institutional racism and other oppressive systematic processes (Wyatt, 1990). The combined impact of these different forms of victimization is determined by the researcher to be significant through a multiple traumagenics model, and these results urge a larger national discussion of the ways in which institutional stigma further harms already marginalized groups.

In addition to all of these factors, the intersection of minority identities must also be investigated to determine the effects on individuals who have more than just one minority social affiliation. To this end, Balsam, Molina, Beadnell, Simoni, and Walters (2011) created the LGBT People of Color Microaggressions Scale, which measures this intersection of racism in LGBTQ+ communities, heterosexism in people-of-color (POC) communities, and racism in dating/close

relationships. They found that women scored higher than men, homosexual people scored higher on this scale than bisexual people, and Asian Americans scored higher than other racial minorities, implying that each of the former experiences more marginalized statuses than the latter. However, these interpretations should be made with caution as it may invalidate the stress of other minorities.

Method

Procedure

This study recruited men from the community, which consists of men in the United States who find survey advertisements and complete it online, and undergraduates, who are students in residence at the University of Texas at Austin (UT) and enrolled in the introductory psychology course. Inclusion criteria for the study require all participants to self-identify as male, be at least 18 years of age, and proficiently read and write in the English language. This study was approved by the UT Institutional Review Board (IRB) with exempt status on November 29, 2018.

A brief study description was posted on the Sona online research system to recruit students from UT. Sona is a research portal used specifically for introductory psychology (PSY 301) classes at the University of Texas at Austin, in order for students to complete research participation requirements for the class. Individuals who were interested in participating were directed via a hyperlink in Sona to UT Qualtrics in order to take part in the online study. In order to recruit a community sample, descriptive posts for the study were placed in relevant research forum list servers via email (e.g., the Society for the Scientific Study of Sexuality listserv), on websites (e.g., Meston Lab website), by word of mouth, through flyers posted around the Austin

area, and on social media (e.g., Facebook, Twitter, Reddit). Community organizations such as the Gender and Sexuality Center at UT were also contacted to enlist their help in advertising the study. Community participants were directed via a hyperlink in the study ad to UT Qualtrics in order to take part in the online study.

At the beginning of the study individuals are provided with an informed consent form that details information about the sensitive nature of the study (i.e., sexuality), the study goals, and participation expectations (including length of time to complete the study and compensation requirements). The consent form also details the risks and benefits to participation, the anonymous nature of the study, the confidentiality of the data, and the researchers' intent for dissemination of results. Additionally, participants are informed of their right to withdraw from the study at any point by exiting the survey and their option to leave questions blank (i.e., skip a question) if they do not feel comfortable responding without forfeiting their compensation. The consent form also contains the study IRB approval information and contact information for the investigator regarding questions or concerns about the study. Participants are not able to continue to the study unless they consent to participation. Participants are prompted to print a copy of the consent form for their records. A waiver of documentation of informed consent was receieved from the IRB as the research presents no more than minimal risk of harm to subjects and involves no procedures for which written consent is normally required outside of the research context. Participants consent to participation by clicking a button that reads, "I have read the above information and give my consent to participate in the described study."

Those who consented to participate were then directed to fill out the demographics form to assess relevant personal history, including: age, location, gender identity, sexual orientation, ethnicity, religion, socioeconomic status, education level, parents'/guardians' education level,

age of pubescence, age of first sexual experiences, relationship status, and psychiatric history. Following the demographics, participants completed the self-report measures in the order presented in the Measures section. The entire study took approximately 45 minutes to complete. Following completion of the study measures, participants were presented with a debriefing form that further detailed the purpose of the current study, thanked the individuals for their participation, and offered resources. Participants from UT were compensated for up to one hour of research credit for completing the study. Participants from the community were able to enter a drawing to win a $30 prepaid Visa e-gift card.

The main outcome measures of the study are participants' responses to the mental health and help-seeking attitude scales. The independent variable is the sexual violence history reported on the sexual violence scale. A secondary predictor variable was minority group membership which was created through the use of the demographic information pertaining to ethnicity and sexual orientation. Multivariate linear regression analyses have been used to determine the best models for predicting the mental health and attitude to help-seeking variables.

Measures

The following self-report questionnaires were used to determine participants' demographic information, sexual violence history, subjective mental health, and attitudes toward help-seeking behaviors.

Demographics Questionnaire collects information on age, gender identity, sexual orientation, ethnicity, exposure to previous sex education, pubertal timing, age of first consensual sex, relationship status, and psychological history.

Nonconsensual Sexual Experiences Interview-Revised (*NSEI-R*; modified from Kilimnik, Boyd, Stanton, & Meston, 2018). The NSEI-R is a comprehensive measure of NSEs that uses activity-specific language to assess the types of NSEs (e.g., "*Has anyone ever inserted fingers, objects, or genitals into your anus against your will?*"). The original NSEI was modified for this study by including a question that asked about forced penetration of another individual. Follow-up questions are also used to gather information about the characteristics of the NSE (e.g., perpetrator, age of onset, force/violence, etc.).

Outcome Questionnaire 45.2 (*OQ-45.2*; Wells, Burlingame, Lambert, Hoag, & Hope, 1996). The OQ-45.2 is a 45-item self-report mental health inventory that assesses symptoms of psychological disorders on three subscales: symptom distress (25 items, e.g., "*I feel no interest in things*"), interpersonal relationships (11 items, e.g., "*I feel unhappy in my marriage/significant relationship*"), and social role performance (# of items, e.g., "*I feel stressed at work/school*"). Participants rate the items on a five-point Likert scale from *Never* to *Always* (either from 0-4 or from 4-0 depending on the valence of the question).

Inventory of Attitudes Toward Seeking Mental Health Services (*IASMHS*; Mackenzie, Knox, Gekoski, & Macaulay, 2004). The IASMHS is a 24-item self-report inventory assessing attitudes toward help-seeking behaviors for mental health concerns across three factors: psychological openness (8 items, e.g., "*There are certain problems which should not be discussed outside of one's immediate family* "), help-seeking propensity (8 items, e.g., "*If good friends asked my advice about a psychological problem, I might recommend that they see a professional*"), and indifference to stigma (8 items, e.g, "*Having been mentally ill carries with it a burden of shame*"). Participants rate the items on a five-point Likert scale from *Disagree* to *Agree* (0-4).

Barriers to Help-Seeking Scale (*BHSS*; Mansfield, Addis, & Courtenay, 2005). The BHSS is a 31-item scale assessing reasons that an individual would not want to seek help, across five factors: need for control and self-reliance (10 items, e.g., "*I would think less of myself for needing help*"), minimizing problem and resignation (6 items, e.g., "*The problem wouldn't seem worth getting help for*"), concrete barriers and distrust of caregivers (6 items, e.g., "*People typically expect something in return when they provide help*"), privacy (5 items, e.g., "*This problem is embarrassing*"), and emotional control (4 items, e.g., "*I don't like to get emotional about things*"). Participants rate the items on a five-point Likert scale from *Not at all* to *Very much* (0-4).

Support Preferences Questionnaire (SPQ). The SPQ was constructed by the primary researcher for the purpose of this study. It is a 9-item inventory of preferences for forms of support when coping with mental health concerns. These items are grouped into two domains: clinical support (4 items, e.g., "*General family doctor*") and social support (5 items, e.g., "*Romantic or dating partner*"). Participants rate items on a five-point Likert scale ranging from 0 ("*I would never prefer this option*") to 4 ("*I would always prefer this option*").

Risks

While there are no direct risks to participants that exceed the risks that they might encounter on a daily basis, there is potential for some of the NSEI-R to bring up memories of traumatic sexual experiences. In order to mitigate these risks, the consent form fully details the expectations of participants to complete measures of both consensual and nonconsensual sexual experiences. Additionally, the consent form details the participant's right to withdraw from the study at any point and/or decline to answer questions that they do not want to respond to.

Since data is collected online, there is a slight risk of breach of confidentiality because of limitations of the technology. For this reason, there is no identifying information requested from participants at any point during the data collection. Anonymous identification numbers are assigned to all response sets. Therefore, the study is entirely voluntary, confidential, and anonymous, which also helps to reduce some of the risk. In order to facilitate the anonymous data collection, the Qualtrics Anonymized Response feature has been used to ensure IP addresses and locations are not collected.

It has been demonstrated that surveys with sexual or trauma-related content are not distressing to participants and that participants generally rate the experience as positive (DePrince & Chu, 2008; Yeater, Miller, Rinehart, & Nason, 2012). In fact, the latter article found in an experimental study that participants who filled out trauma and sex questionnaires (containing over 300 items on "casual sex, sexual fantasies, child abuse, rape, masturbation, and trauma symptoms" [p.784]) reported significantly greater post-study positive affect and greater benefits than those that filled out a cognitive measure on vocabulary. There was also no relationship found between previous sexual victimization and reported negative emotions (Yeater, Miller, Rinehart, & Nason, 2012). In the chance that individuals do have an aversive experience in the completion of the study, resources for counseling and support of trauma and sexual assault/rape/abuse survivors have been provided along with the contact information of the investigator on a debriefing form. If the investigator is informed of an aversive experience, this will be promptly reported to the IRB at the University of Texas at Austin.

Privacy and Confidentiality

The data remains completely anonymous and de-identified at all times. Participants' randomly assigned ID numbers were matched to their responses within the final data set downloaded from Qualtrics after completion of data collection. Data was collected with UT's version of Qualtrics in order to ensure the security of the online data collection. Qualtrics uses Transport Layer Security (TLS) encryption for all data, so there is no concern regarding participants being identified based on their answers or the data confidentiality being violated. In order to facilitate the anonymous data collection, the Qualtrics Anonymized Response feature has been used to ensure IP addresses and locations are not collected. Data was stored on UT Qualtrics for security until completion of data collection. After data collection, the data was downloaded from Qualtrics into an encrypted comma separated values document (.csv file), at which point it was saved on the University of Texas at Austin's secure network within a password-protected server and then deleted from Qualtrics.

Emails from the participants wishing to enter the draw were kept only until the draw was complete and participants were contacted with the results. These email addresses were stored directly within the study email account. All data is completely de-identified and anonymous at all times with no identifying information ever being collected. Participants were assigned a random subject number at the beginning of the study by Qualtrics and only this number was associated with the participants' responses. The researchers at no point have access to identifying information of the participants. Data will not be shared with any other research teams except upon dissemination of results at which point data will be presented in aggregate form. In order to facilitate the anonymous data collection, the Qualtrics Anonymized Response feature has been used to ensure IP addresses and locations are not collected.

Participants had to email the researchers in order to enter the draw for the compensation; however, participant email addresses were only associated with the fact that they participated and not with their data or responses. The email addresses were only housed in a folder within the study email account (i.e., they were stored separately from responses) so as to keep them completely anonymous, and they were deleted immediately after the draw was complete. Participants who did not want to enter the draw did not need to email the researcher after study completion and were therefore not associated with study completion. Emails containing the draw entry email addresses were deleted from the email account immediately after the draw had taken place and the entered participants had been contacted. No further correspondence took place with participants after the draw was complete.

Compensation

UT student participants who completed the study in full were compensated through Sona with one hour of research credit. Participants who respond fully to the questionnaires but miss three or more of the six check items placed within the surveys (i.e., questions asking for a specific answer selection to ensure participants are not answering at random) received a half-hour of research credit. Participants who did not complete the study in full (i.e., miss the check items AND the majority of their data) received no compensation, and their data was deleted. Students who did not wish to complete the research credits for PSY 301 were given the option to submit a research paper instead. The requirements for this research paper were outlined in their syllabus and facilitated by the research coordinator for the psychology department.

Community participants who completed the study were provided with a code ("GANYMEDE3102") and a prompt to email the researcher at

GanymedeStudyUTexas@Gmail.com to enter the draw. The email only indicates the participant completed the study and was not associated with their data in any way. After completion of data collection, the researchers selected an email address at random as the winner of the draw. The selected email address was then contacted to issue them their Visa e-gift card. The email addresses used draw purposes were then discarded. There was only one draw and one Visa e-gift card (of $30.00 USD) given away. The Visa card was an "e-gift card" sent to the individual at the email address provided. All emails were deleted after the draw took place. Researchers only used the email addresses to contact the winner of the draw.

Data Analysis

The data was analyzed using a number of different statistical methods. First, the demographic data for all of the participants was compared using proportions to show the composition of the sample being investigated. Next, linear regressions were performed to analyze the amount of variation in the outcome variables that could be predicted by the independent variables. The effects of NSEs and minority status were all evaluated separately for their contributions to both subjective mental health and attitudes toward help-seeking behaviors. This was accomplished through 8 different simple linear regression models. The effects of NSEs and minority status were then evaluated in the same model for their additive contributions to both subjective mental health and attitudes toward help-seeking behaviors. This was accomplished through 4 different multiple linear regression models.

Survey responses were scored using a different template for each measure. Most of the scoring was done in Excel after exporting the data from Qualtrics, and some was done in RStudio before conducting analyses.

Minority status was scored only for participant responses to the race/ethnicity and sexual orientation questions on the demographics questionnaire. This was done on a binary scale of "0" or "1" with one variable for both race/ethnicity and sexual orientation. A score of "0" indicated majority status (white and heterosexual) and a score of "1" indicated minority status (any other combination). NSE history status was scored based on responses to the NSEI-R. This was done on a binary scale of "0" or "1." For those who had any NSEs, the variable was assigned a value of "1" and those with no NSEs were assigned a value of "0."

The OQ-45.2 was scored using the such that each item was included in one of three domains: symptom distress (SD), interpersonal relationships (IR), and social role performance (SR). For each of these domains, the individual item response scores (on a scale from 0-4) were summed to make a domain score. The domain scores were then summed to make a total score, with a larger value indicating more psychological distress and mental health symptoms.

The IASMHS was scored such that each item was included in one of three domains: psychological openness (PO), help-seeking propensity (HS), and indifference to stigma (IS). For each of these domains, the individual item response scores (on a scale from 0-4) were summed to make a domain score. The domain scores were then summed to make a total score, with a larger value indicating higher psychological openness, help-seeking propensity, and indifference to stigma.

The BHSS was scored wherein each item was included in one of five factors: need for control and self-reliance (NCSR), minimizing problem and resignation (MPR), concrete barriers and distrust of caregivers (CBDC), privacy (P), and emotional control (EC). For each of these factors, the individual item response scores (on a scale from 0-4) were summed to make a factor score. The factor scores were then summed to make a total score, with higher scores indicating a

greater need for control and self-reliance, a greater tendency to minimize problems and resign oneself to them, more concrete barriers and distrust of caregivers, more value placed on privacy, and/or more emotional control. All of these factor scores correlate negatively with healthy attitudes toward help-seeking behaviors.

The SPQ was scored with each item included in one of two domains: clinical support (CS) and social support (SS). For each of these domains, the individual item response scores (on a scale from 0-4) were averaged to make a domain score. The domain scores were then averaged to make a total score, with a larger value indicating a higher preference for social and/or clinical support.

After the scoring of these measures, the regression analyses were conducted in RStudio by using either the binary NSE variable or the binary variable for minority status as the independent variable in the model. The outcome variable for each simple linear regression was the final score for each of the outcome measures (OQ-45.2, IASMHS, BHSS, and SPQ). For each multiple linear regression, both binary explanatory variables were used with one of the four final outcome scores (OQ-45.2, IASMHS, BHSS, and SPQ). This yielded a total of 12 regression equations.

Results

Participants

The community and undergraduate samples were evaluated separately for demographic data of the participants. A total of 135 survey responses were submitted in the community sample, and 53 responses were submitted in the undergraduate sample, making a grand total of 188 responses. However, several of these were removed from analysis during data cleaning: 8

were removed for meeting exclusion criteria (e.g., the participant identified as a woman), and 23 were removed for insufficient responding (more than one-third of the survey left blank). After this filtration process, a total of 157 responses remain: 108 from the community sample and 49 from the undergraduate sample. Participants in the community sample had a mean age of 30.53 years, with a standard deviation of 12.38 years; those in the undergraduate sample had a mean age of 19.94 years, with a standard deviation of 2.66 years. All other demographic information for these respondents is included in the Tables 1 and 2 below.

Table 1

Demographics for the Community Sample

Variable	Category	*n (%)*
Gender	Man	100 (93)
	Trans man	5 (5)
	Trans non-binary	2 (2)
	Non-binary	1 (1)
Race/Ethnicity	African American/Black	1 (1)
	Asian	7 (6)
	Caucasian/White	84 (78)
	Hispanic/Latin American	3 (3)
	Middle Eastern	2 (2)
	Mixed	9 (8)
	Other	2 (2)
Education Level	Advanced degree	19 (18)

	College diploma/university degree	34 (31)
	Some college/university	41 (38)
	High school graduate/GED	9 (8)
	Some high school or less	5 (5)
Income	Less than $15,000	27 (25)
	$15,000 to $25,000	17 (16)
	$25,000 to $50,000	16 (15)
	$50,000 to $75,000	14 (13)
	$75,000 or more	30 (28)
Sexual Orientation	Asexual	2 (2)
	Bisexual	19 (18)
	Heterosexual/straight	46 (43)
	Homosexual/gay/lesbian	20 (19)
	Pansexual	6 (6)
	Queer	5 (5)
	No label	6 (6)
	Other	3 (3)
	Blank	1 (1)
Religion	Agnostic	15 (14)
	Atheist	13 (12)
	Buddhist	2 (2)
	Catholic	12 (11)
	Christian	19 (18)

	First Nations/Native American beliefs	1 (1)
	Muslim	2 (2)
	Jewish	4 (4)
	Pagan	2 (2)
	Spiritual/New Age	4 (4)
	Taoist	1 (1)
	Wicca	1 (1)
	Not religious	17 (16)
	Other	9 (8)
	Blank	6 (6)

Table 2

Demographics for the Undergraduate Sample

Variable	Category	*n (%)*
Gender	Man	49 (100)
Race/Ethnicity	African American/Black	4 (8)
	Asian	13 (27)
	Caucasian/White	15 (31)
	Hispanic/Latin American	12 (24)
	Mixed	3 (6)
	Other	2 (4)
Education Level	College diploma/university degree	1 (2)

	Some college/university	34 (69)
	High school graduate/GED	14 (29)
Income	Less than $15,000	16 (33)
	$15,000 to $25,000	3 (6)
	$25,000 to $50,000	3 (6)
	$50,000 to $75,000	8 (16)
	$75,000 or more	19 (39)
Sexual Orientation	Bisexual	2 (4)
	Heterosexual/straight	40 (82)
	Homosexual/gay/lesbian	6 (12)
	No label	1 (2)
Religion	Agnostic	7 (14)
	Atheist	1 (2)
	Buddhist	1 (2)
	Catholic	10 (20)
	Christian	11 (22)
	Hindu	3 (6)
	Muslim	1 (2)
	Jewish	3 (6)
	Spiritual/New Age	1 (2)
	Wicca	1 (2)
	Not religious	6 (12)
	Other	2 (4)

Blank	2 (4)

It is clear that both samples show diversity in certain demographic areas while being limited in others. For example, the community sample has a large age range, some representation of transgender and non-binary participants, and a wide array of education levels, income, and sexual orientations. However, this sample lacks diversity in racial and ethnic representation. Conversely, the undergraduate sample has a much more even racial spread, but being that this sample consists entirely of college students, there is less variation in age and education level, and even sexual orientation. The correlation of these variations in demographics with the outcome variables as covariates is further explored in the analysis below.

Analyses

Descriptive information for each of the outcome variables across the total sample is reported in Table 3. The mean score for each subscale is compared to the highest possible score.

Table 3

Mean Scores for Each Outcome Measure Across the Whole Sample

Scale	Subscale [Highest Possible Score]	*M (SD)*
OQ-45.2	Symptom Distress [100]	34.22 (23.19)
	Interpersonal Relationships [44]	13.92 (9.66)
	Social Role Performance [36]	12.25 (6.14)
	TOTAL [180]	60.39 (37.05)
IASMHS	Psychological Openness [32]	10.73 (7.00)

	Help-Seeking Propensity [32]	18.69 (9.65)
	Indifference to Stigma [32]	11.17 (7.52)
	TOTAL [96]	40.59 (18.30)
BHSS	Need for Control and Self-Reliance [40]	17.1 (11.45)
	Minimizing Problem and Resignation [24]	10.75 (6.94)
	Concrete Barriers and Distrust of Caregivers [24]	6.55 (5.46)
	Privacy [20]	7.61 (5.87)
	Emotional Control [16]	6.68 (5.27)
	TOTAL [124]	48.69 (28.78)
SPQ	Clinical Support [16]	5.92 (3.81)
	Social Support [20]	7.08 (4.83)
	TOTAL [36]	12.99 (7.81)

Our analyses reveal that the only significant relationships are those of NSEs and subjective mental health ($OQ = 32.2NSE + 42.35$; $F(1, 155) = 35.7$, $p < 0.001$), such that those with NSE histories were more likely to report more symptoms of psychological distress levels of mental health. Additionally, the relationship between NSE status and attitudes toward physical health help-seeking was also significant ($BHSS = 10.38NSE + 42.87$; $F(1, 155) = 5.16$, $p = 0.02$), such that those with NSE histories were less willing to seek help for physical health concerns. There was also a trend observed in both relationships with support preferences, where NSEs correlated with a lower inclination to seek support ($SPQ = -2.36NSE + 14.32$; $F(1, 155) = 3.61$, $p = 0.06$).

Given these relationships, we can also investigate the interactive relationships of minority status and NSE history through multiple linear regression models with the outcome measures. Most of these models did not appreciably change the significance of either of the explanatory variables in predicting the outcomes, except for the multiple linear regression for support preferences ($SPQ = -2.56NSE + 2.22minority + 12.87$; $F(2, 154) = 3.19$, $p = 0.04$). In this relationship, the analysis of both explanatory variables together made the effects of NSEs on support preferences significant, as well as the effects of both NSEs and minority status together on support preferences.

These results support some of our predictions, but not others. Our hypotheses that men with NSEs would have more psychological diagnoses and that men with NSEs would feel less inclined to seek help were both supported by the data. However, our hypotheses that men belonging to ethnic and/or sexual minorities would have more psychological diagnoses due to the chronic stress of being marginalized within society, and that these men would feel more disenfranchised from help-seeking due to societal barriers to access and health disparities that have historically prevented them from doing so, were not at all supported by our findings. In fact, the observed trends seem to show that men belonging to ethnic/sexual minorities could actually be more likely to seek help, which requires further investigation.

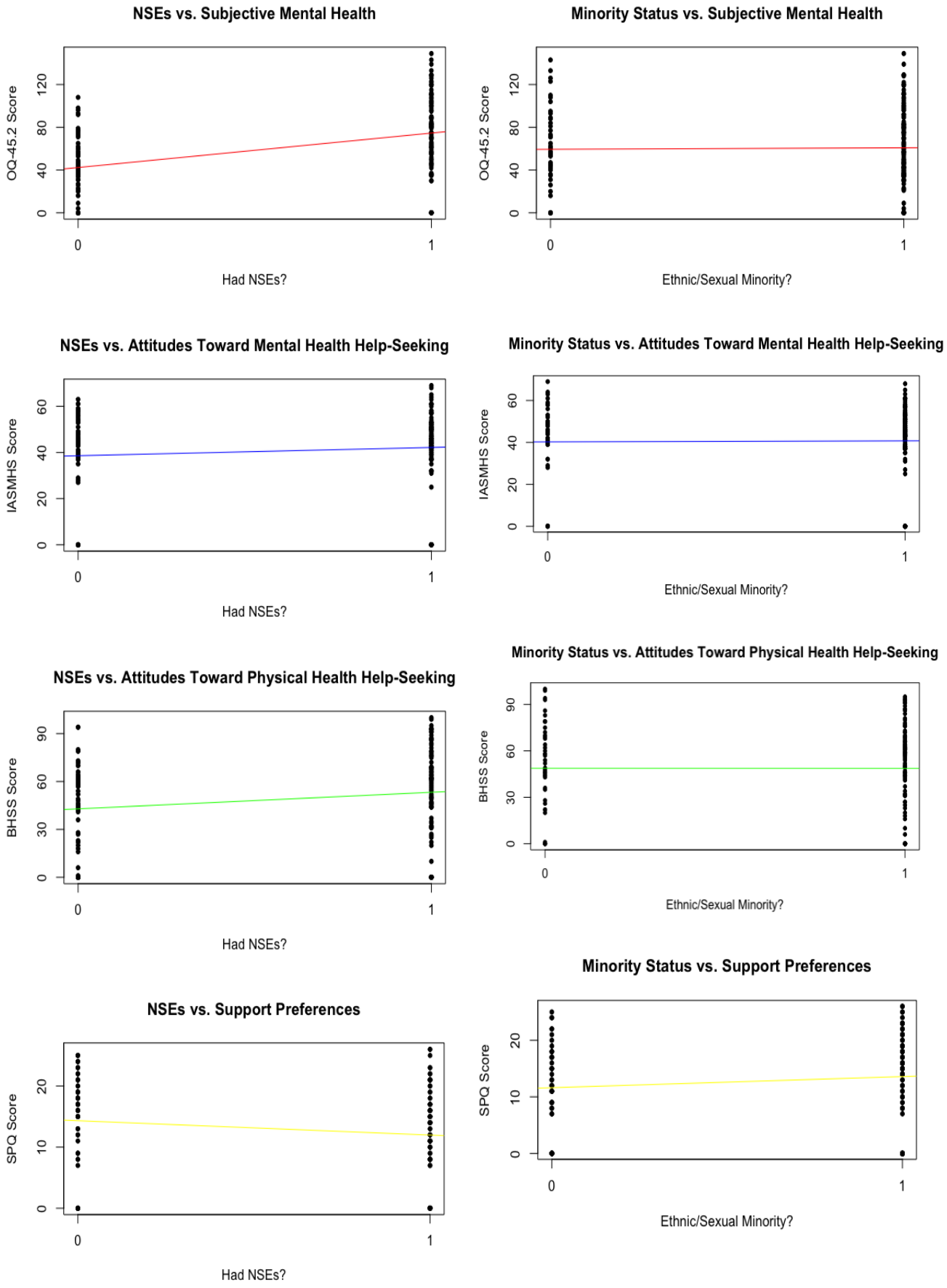

Figure 2. Scatterplots for the simple linear regression models with lines of best fit.

With definitive results from this study, we can now compare our findings to some of the research investigated in the literature review. Although we examine novel relationships between variables, there are other findings that we can compare our own with. For example, our finding that minority status has no significant effect on subjective mental health or attitudes toward help-seeking on its own directly opposes the arguments made by multiple researchers that minorities experience heightened psychological distress (Alegría et al., 2008; Mink, Lindley, & Weinstein, 2014; Wyatt, 1990), and that they should feel disenfranchised from seeking help in a society that systematically denies them proper treatment or care (Rounds, Mcgrath, & Walsh, 2013; Carvalho, Lewis, Derlega, Winstead, & Viggiano, 2011). However, our finding of NSEs contributing significantly to negative mental health outcomes is overwhelmingly supported by other research in the field that has found psychosexual detriments associated with sexual violence experiences (Ahmad, 2006; Bartholow et al., 1994; Friedman, Marshal, Stall, Cheong, & Wright, 2008). All of these studies agree on the myriad negative psychological repercussions of nonconsensual sexual experiences, especially childhood sexual abuse.

Discussion

Strengths

This study bridges an important gap in the literature. We were able collect data from a considerable number of participants. While this study is very field-specific, the experiences and struggles that it brings to light are applicable to a wider audience through the interdisciplinary approach (e.g., clinical, sexual, social). Overall, this is a well-executed study that serves its purpose as a basic proof of concept, and a stepping stone for future research.

Limitations

Despite its strengths, the current study is limited in multiple ways, most notably through sampling methods. We made use of convenience sampling, particularly with Facebook and Reddit. These social media platforms were ideal for access to a large number of people who would be interested in completing the study for multiple reasons. Most of the individuals reached on Facebook had personal connections to one of the researchers, and Reddit posts were only within subreddits for sexual violence survivors. This could have made the study more biased toward treatment seekers through their own self-inclusion as participants. Because of these factors, the sample investigated is not truly random or representative of the population of men in the U.S. We also posted flyers advertising the study around the Austin area, which further served to concentrate the sample to one region of the country. While most of the recruitment for this study was done online, the flyers we posted were mostly concentrated in West Austin, which is historically segregated from East Austin. The residents of East Austin tend to be more heavily POC and belong to lower socioeconomic status, so posting more flyers in this area would also have diversified the sample. A portion of the sample came from introductory psychology undergraduate students, who are already a very specialized subsection of the U.S. population, with different average demographics than U.S. men as a whole. Additionally, the sample was relatively small, consisting of only 157 respondents total, which may not be enough to accurately represent the population being studied. This was also due to the lack of funding for the study, which meant a lack of monetary incentive for the individuals we recruited to participate.

Because of the limited sampling style, there was limited representation within the sample, especially of transgender men. The majority of respondents were cisgender men, and there were only 8 trans and/or non-binary individuals in total who participated through the community

sample. With only 8 out of 157 respondents being transgender, our results are not readily generalizable to the trans-community. Because of this, it is imperative to replicate this study with more significant trans representation. Additionally, POC representation was limited in the study, especially in the community sample. Particularly, African American and Middle Eastern participants were extremely low in number, and future studies should focus more on the holistic recruitment of ethnic minorities for more generalizable results.

Finally, the study measures were also limited. Although the investigation of socialization into hegemonic masculinity was an integral component of the background for the current study, we did not include any questionnaires for the direct measurement of this, which limited our data analysis and did not allow us to assess our hypotheses for the relationship between socialization into masculine roles and the outcome variables. This study also did not include any measures that would allow respondents to freely express their thoughts, aside from a handful of short-answer follow-up questions in the NSEI-R. By excluding a space for participants to articulate their feelings regarding their experiences, the current study did not allow them to give a full sense of how their experiences affected them. This would have been a valuable addition to the survey.

Implications

The background and findings of this study pose important repercussions for the future of this field. Notably, the research demonstrates a relationship between NSEs and negative attitudes toward help-seeking in men. There is an imperative need for future research to expand upon this crucial link. As was discussed previously, there is currently a large gap in the literature between investigations of men who have NSEs and men's subjective mental health and attitudes toward

help-seeking. The current study has successfully bridged some of that gap, but there is still more research that needs to be conducted to explore this relationship thoroughly.

In order for this study to be meaningful in the wider context of sex research and therapy, our results must be positioned under a broader lens. It is important to evaluate this study alongside other research in the field that evaluates similar variables with women, which will allow for us to compare and contrast our findings and determine the differences between women and men who undergo these experiences. A 2006 study by Evans-Campbell, Lindhorst, Huang, and Walters found that American Indian and Alaska Native (AIAN) women who had experienced interpersonal violence tended to display more psychiatric diagnoses and emotional trauma, as well as more help-seeking behaviors. This final result is directly in opposition to our findings with men, which is why it is so imperative to study social and cultural influences on help-seeking and other behaviors in survivors. Men are socialized differently than women in our society, and individuals may belong to multiple intersectional cultural identities, bringing a need for research to be specific to people's experiences.

The two long-term goals of this proof-of-concept study are stigma reduction and alternative treatment outcomes for male survivors. In order to reduce sociocultural and academic stigmas associated with men who have NSE histories, we must implement education, advocacy, and survivor focus groups. These efforts will not only help male survivors push past hegemonic masculine norms and seek help when they need it, but also improve public awareness of the issue and spur researchers and clinicians to focus on this important population. It is clear from the findings of this study and the background in existing literature that male survivors are highly discriminated against, not only for reporting and seeking help for sexual violence experiences, but for being victimized against their will in the first place. This discrimination is exacerbated for

survivors who have minority status, particularly LGBTQ+ and POC individuals (Alegría et al., 2008; Mink, Lindley, & Weinstein, 2014). With hegemonic masculine norms preventing men from reporting their experiences and simultaneously influencing the general population to disregard these experiences, it is more crucial now than ever to focus on eliminating these restrictive and toxic gender roles so that individuals can express themselves freely.

Finally, the results of this study should be used to develop feasible, alternative treatment options for male survivors. As discussed above, men are socialized very differently than women and taught to internalize their emotions and always be prepared for sex (Kia-Keating, Grossman, Sorsoli, & Epstein, 2005; Muehlenhard & Cook, 1998). Men also come from many different backgrounds and walks of life, and these intersectional identities must be considered for treatment. Men who belong to minorities often need culturally conscious treatments, which is especially prominent for ethnic minorities and immigrants, but which also applies equally to minority status in sexual orientation, gender identity, physical ability, and more (Alegría, Perez, & Williams, 2003). The recent flourishing of treatment outcomes available to women is exciting and innovative, but it would be careless to blindly apply these same treatments to male survivors as well. With all of the differences in the ways that men and women handle their experiences in a sociocultural climate, we must also tailor psychological treatments accordingly so that men can cope and heal in the best way possible.

Conclusion

The current study investigated the relationship between nonconsensual sexual experiences, subjective mental health, and attitudes toward help-seeking experiences in men. We also examined ethnic and sexual minority status as covariates to mediate this relationship. The

online study was conducted with community and undergraduate samples, and our findings supported the predictions that we made about the negative effects of NSEs on subjective mental health and attitudes toward physical health help-seeking behaviors, as well as the combined effects of NSEs and minority status on support preferences. However, the results did not support our hypotheses on the effects of NSEs on mental health help-seeking behaviors, or the effects of minority status on any of the other outcomes. These relationships specifically should be studied in more detail in replications.

Future studies should focus on expanding the scope to more thoroughly focus on covariates, including immigrant status, which was not investigated here. Immigrants may experience perhaps the greatest barriers to access in our country, especially with the current political era. It is very important to study this significant portion of the U.S. population specifically, in order to determine their experiences and how treatments can also be tailored to them. There should also be a greater emphasis on more random and representative sampling, recruiting a larger participant sample, and equalizing the proportion of trans and POC men represented in the study. To build off this proof-of-concept study, future research should incorporate our recommendations to implement culturally conscious treatments for survivors. Treatment studies will be the ultimate translational link between our basic science research and actual clinical applications.

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Author Biography

I was born in the DC area and moved to Austin when I was very young, so this city has been my home for my entire life. My parents and my brother Aurod are tremendous forces within my life, and I would not be where I am now without their constant love and support. My hobbies include reading, playing video games, finding new restaurants to eat at, and exploring museums. I am graduating from the University of Texas at Austin in the Class of 2019 with a major in Neuroscience and minors in Psychology and Women's & Gender Studies. In the fall, I will be attending medical school in either Houston or Dallas, and I plan to continue this line of research while I am there. My professional passions include mental healthcare, survivors of sexual violence, immigrant health, and addressing healthcare disparities, barriers to access, and overall stigma for minority populations in general. I hope to pursue these passions through a specialized career in psychiatry or a similar profession within the field of medicine.