

Psychology of Violence

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Zoë D. Peterson, Marin C. Beagley, Ethan B. McCallum, and Tiffany M. Artime

Online First Publication, April 26, 2018. <http://dx.doi.org/10.1037/vio0000187>

CITATION

Peterson, Z. D., Beagley, M. C., McCallum, E. B., & Artime, T. M. (2018, April 26). Sexual Attitudes and Behaviors Among Men Who Are Victims, Perpetrators, or Both Victims and Perpetrators of Adult Sexual Assault. *Psychology of Violence*. Advance online publication. <http://dx.doi.org/10.1037/vio0000187>

Sexual Attitudes and Behaviors Among Men Who Are Victims, Perpetrators, or Both Victims and Perpetrators of Adult Sexual Assault

Zoë D. Peterson and Marin C. Beagley
University of Missouri—St. Louis

Ethan B. McCallum
Minneapolis Veterans Administration Health Care System,
Minneapolis, Minnesota

Tiffany M. Artime
Pacific Lutheran University

Objective: Criminologists consistently find a correlation between criminal victimization and criminal offending across a variety of populations and types of crime; however, research on the relationship between adolescent and adult sexual assault (ASA) perpetration and ASA victimization is limited. Comparing the sexual attitudes of men who are both victims and perpetrators of ASA, men who are victims only, men who are perpetrators only, and men who are neither victims nor perpetrators may highlight unique sexual attitudes that create a dual vulnerability to ASA perpetration and victimization. **Method:** A convenience sample of community men ($N = 268$) completed an online survey and reported on their ASA perpetration and victimization history and their experiences of child sexual abuse. They also completed measures of traumatic sexual beliefs, dysfunctional sexual behaviors, sexual avoidance, sexual preoccupation, and distorted sexual self-concept. **Results:** Results revealed a statistically significant overlap between men's perpetration and victimization of ASA. Compared with victims-only, perpetrators-only, and men with no ASA history, men with a history of both perpetration and victimization reported the highest rates of childhood sexual abuse and the highest levels of distorted sexual self-concept. **Conclusions:** Targeting men's sexual self-concept may be an effective way to reduce their risk of both ASA victimization and ASA perpetration.

Keywords: sexual assault, child sexual abuse, sexual attitudes, sexual behaviors, men

One of the most robust empirical findings in the field of criminology is the strong and consistent correlation between criminal victimization and criminal offending (Jennings, Piquero, & Reingle, 2012). That is, those who commit criminal offenses are more likely than others to also be victims of those same criminal offenses. This is true across populations and across types of crime (Lauritsen, Sampson, & Laub, 1991; Marcum, Higgins, Freiburger, & Ricketts, 2014; Tillyer & Wright, 2014). Strangely, though, this relationship has been largely ignored in the case of one particular crime—adolescent and adult sexual assault (ASA; i.e., nonconsensual sexual acts in adolescence or adulthood that are obtained through incapacitation, physical harm, or threats of physical harm, which would qualify as criminal according

to most state laws in the United States). In this study, we aimed to compare (a) men who had no experience with ASA, (b) men who were victims but not perpetrators of ASA, (c) men who were perpetrators but not victims of ASA, and (d) men who were both victims and perpetrators of ASA in terms of their sexual attitudes and behaviors. The selection of sexual attitudes and behaviors examined in this study (i.e., traumatic sexualization, sex guilt, sexual avoidance, distorted sexual self-concept, sexual esteem, sexual depression, sexual preoccupation, and dysfunctional sexual behavior) was guided by Finkelhor and Browne's (1985) traumagenic dynamics model.

Men and ASA

The failure of researchers to examine the victim–offender overlap in the case of ASA may relate, in part, to the fact that ASA is widely recognized as a highly gendered crime—women are more likely than men to be victims (Cantor et al., 2015; Krahe & Berger, 2013), and men are more likely than women to be perpetrators (Krahe & Berger, 2013). For example, Krahe and Berger (2013) found that 13% of men and 8% of women had perpetrated ASA (defined in their study as sexual touch, attempted intercourse, completed intercourse, or other sexual acts such as oral sex obtained using verbal coercion, force, threat of force, or incapacitation); in contrast, 36% of women and 19% of men had been victims of ASA. Further, commonly held myths about male sexual victimization promote the idea that men's experiences of ASA

Zoë D. Peterson and Marin C. Beagley, Department of Psychological Sciences, University of Missouri—St. Louis; Ethan B. McCallum, Minneapolis Veterans Administration Health Care System, Minneapolis, Minnesota; Tiffany M. Artime, Department of Psychology, Pacific Lutheran University.

Ethan B. McCallum, who is now at Allina Health System, Minneapolis, Minnesota.

Correspondence concerning this article should be addressed to Zoë D. Peterson, Department of Psychological Sciences, University of Missouri—St. Louis, 1 University Boulevard, St. Louis, MO 63121. E-mail: peteronz@umsl.edu

victimization are rare and trivial (Chapleau, Oswald, & Russell, 2008; Struckman-Johnson & Struckman-Johnson, 1992); many people assume that men cannot be raped or sexually assaulted, and if men are raped or sexually assaulted, they are assumed to experience few, if any, negative effects. Unfortunately, the fact that researchers have predominantly studied women's experiences as victims and men's experiences as perpetrators of ASA does not allow for consideration of the victim-offender overlap in this particular crime.

However, there has been a steady increase in research related to the sexual victimization of men since the late 20th century, and it is clear that men do experience adult sexual assault—perpetrated by both men and women—at substantial rates (even if those rates are lower than those for women). Prevalence rates vary widely depending on the population of men studied and the definition of ASA used (see Peterson, Voller, Polusny, & Murdoch, 2011, for a review). A national telephone survey conducted in the United States in 2001–2003, for example, found that only 2% of men reported experiencing “forced sex,” defined as vaginal, oral, or anal penetration or intercourse that occurred against their will or because they were unable to give consent due to alcohol, drugs, sleep, or mental disability (Basile, Chen, Black, & Saltzman, 2007). Other studies, however, have found higher rates. For example, in two studies of German adolescent boys and community men (ages 14 and over), 8–11% of boys and men reported completed unwanted sexual contact perpetrated by a woman through physical force, and 16–22% reported completed unwanted sexual contact by a woman through exploitation of incapacitation (Krahé, Scheinberger-Olwig, & Bieneck, 2003). Across studies, rates of ASA among sexual minorities tend to be higher than among heterosexuals; for example, Balsam, Rothblum, and Beauchaine (2005) found that fewer than 2% of heterosexual men reported experiencing “completed rape” since age 14, whereas 12% of gay men and 13% of bisexual men reported experiencing completed rape. Although definitions and measurement approaches vary, making it difficult to summarize across studies, men clearly do experience ASA victimization. Further, research has demonstrated that many men who endorse ASA suffer from similar outcomes as female victims (Du Mont, Macdonald, White, & Turner, 2013; Peterson et al., 2011). In fact, in at least one study (Elliott, Mok, & Briere, 2004), men with histories of ASA reported higher symptomology on the Trauma Symptom Inventory (Briere, 1995) as compared with women with histories of ASA, including higher levels of anxious arousal ($M = 12.1$; $SD = 6.6$ vs. $M = 9.5$; $SD = 5.2$), depression ($M = 11.6$; $SD = 7.4$ vs. $M = 9.1$; $SD = 6.1$), sexual concerns ($M = 12.3$; $SD = 7.4$ vs. $M = 5.7$; $SD = 6.3$), and dysfunctional sexual behavior ($M = 8.7$; $SD = 8.3$ vs. $M = 3.4$; $SD = 5.0$).

In addition, there is no question that men perpetrate sexual assault at relatively high rates. Approximately 9% of young men self-report illegal sexual assault perpetration (Abbey & McAuslan, 2004; White & Smith, 2004). Data from victim reports substantiate these high rates of male perpetration. Both female and male sexual assault victims are more likely to report that their sexual assault was perpetrated by a man than a woman (Fleming, Gruskin, Rojo, & Dworkin, 2015; Turchik & Edwards, 2012).

Despite evidence that men are both victims and perpetrators of ASA and despite a large body of research demonstrating a victim-offender overlap in crime in general, limited research has exam-

ined the overlap between men's ASA perpetration and victimization. This is problematic because many of the established theories that are used to explain the victim-perpetrator overlap in relation to other crimes do not necessarily apply to sexual assault. For example, the victim-offender overlap in nonsexual crimes often has been explained by the “code of the street” (i.e., in some social contexts individuals are taught that they must engage in physical violence to ensure their social status, which then leaves them vulnerable to others in that social group who want to usurp their power; Anderson, 1999) and by ecological proximity to criminal activity (Sampson & Lauritsen, 1990). Neither of these explanations seems particularly relevant to the context of sexual assault, which commonly occurs not only in underprivileged, high crime neighborhoods but also, for example, on the campuses of elite private universities (Cantor et al., 2015). Thus, additional information about men who are both victims and offenders is needed to better understand factors that contribute to the victimization-perpetration overlap in sexual assault. Evaluating this overlap and identifying factors associated with it could ultimately allow for the development of prevention strategies that target both ASA victimization and perpetration.

Victim-Offender Overlap and Sexual Coercion

Although few researchers have examined victim-offender overlap specifically related to criminal sexual acts, the victim-offender overlap has been demonstrated for sexually coercive behaviors more broadly. The term *sexual coercion* is typically used to refer to a broad range of behaviors, including nonconsensual sex in adolescence or adulthood that is obtained using illegal strategies, as well as sexual acts obtained through lower severity strategies such as verbal pressure, manipulation, or nonphysical threats (which would not violate most state laws). Several researchers have examined the phenomenon of sexual coercion victim-offender overlap specifically within the context of a particular relationship. For example, in a study of mix-sex couples, Brouseau, Hébert, and Bergeron (2012) and Mathes (2015) found statistically significant correlations between experiences of sexual coercion victimization and perpetration within the current relationship for both their male and female participants.

It also is important to examine research that has looked at the overlap of sexual coercion victimization and perpetration outside of a specific relationship context. Overlap between victimization and perpetration within a relationship may best be explained by characteristics of the relationship itself (Mathes, 2015); however, overlap between victimization and perpetration at an individual level and independent of a specific relationship may be better explained by individual personality traits or attitudes. Several studies have suggested a general victim-perpetrator overlap in sexually coercive behavior among both men and women (Russell & Oswald, 2001, 2002). For example, researchers have found a statistically significant correlation between measures of adult sexual coercion perpetration and victimization (Harned, 2002; Mathes, 2015; Mathes & McCoy, 2011). In a large study ($N = 2,251$) of German college students, Krahé and Berger (2017) found a statistically significant relationship between adult sexual coercion victimization and perpetration for men and women, but the relationship was significantly stronger for men ($r = .45$) than for women ($r = .24$). Enosh (2007) also found a correlation between

sexual coercion victimization and perpetration in a sample of Israeli adolescents, and again, the relationship was stronger for boys than girls.

Although researchers have found evidence for a victim–offender overlap in sexually coercive behaviors more broadly, there are important gaps in the literature. First, it is important to evaluate whether the victim–offender overlap also exists for more severely aggressive sexual behavior. Illegal sexual acts obtained through incapacitation, force, or physical threats tend to have more severe consequences for victims than acts obtained through verbal coercion (Brown, Testa, & Messman-Moore, 2009). Second, more work is needed to identify the factors that are specifically associated with being both a victim and a perpetrator of sexual assault. Although there is a correlation between sexual coercion victimization and perpetration, it is noteworthy that many perpetrators are not victims and many victims are not perpetrators. For example, Russell and Oswald (2002) found that only 63% of men classified as perpetrators had also been victims of sexual coercion, and only 47% of men classified as victims had also been perpetrators of sexual coercion. This means that that 37% of perpetrators were not victims and 53% of victims were not perpetrators. Thus, victim–perpetrators can be considered a unique and particularly high-risk group in need of intervention. To our knowledge, no study to date has explicitly compared (a) men who have no ASA experience, (b) men with only ASA victimization experience, (c) men with only ASA perpetration experience, and (d) men with both ASA victimization and perpetration experience in terms of their sexual attitudes and behaviors. Understanding what distinguishes these four groups of individuals could be helpful in informing interventions that target specific risk factors for victimization, specific risk factors for perpetration, and, perhaps most importantly, shared risk factors for perpetration and victimization.

Who Are the ASA Victim–Perpetrators?

Generally, research has focused separately on the personality, behavioral, and attitudinal characteristics of male ASA victims and male ASA perpetrators, often revealing very distinct—even opposing—characteristics between the two groups. For the most part, the literature focuses on the *consequences* of ASA for victims and the *causes* of ASA for perpetrators, although most research is not longitudinal, so the order of causation is often assumed rather than explicitly tested. For example, based on research, male ASA victims are often described as having high levels of depression and anxiety and low self-esteem (Peterson et al., 2011; Tewksbury, 2007), presumably as a result of their victimization. In contrast, perpetrators of ASA are often described as emotionally callous and high in narcissism (Mouilso & Calhoun, 2012; Zinzow & Thompson, 2015), which is presumably the cause of their perpetration. The supposed distinctions between ASA victims and perpetrators are particularly acute when it comes to sexual attitudes and behaviors. Male victims of ASA are often said to experience sexual anxiety, sexual avoidance, and impotence (Tewksbury, 2007). In contrast, male perpetrators of ASA are often described as promiscuous sexual risk-takers (Abbey, McAuslan, Zawacki, Clinton, & Buck, 2001; Malamuth, Linz, Heavey, Barnes, & Acker, 1995; Peterson, Janssen, & Heiman, 2010). These opposing descriptions of victims and perpetrators fail to account for the overlap between the two groups.

Further, despite these contrasting portraits of male ASA victims and perpetrators, there are well-established shared correlates of ASA perpetration and victimization, including greater alcohol use (Abbey, Zawacki, Buck, Clinton, & McAuslan, 2004; Krahe & Berger, 2013) and a larger number of sexual partners (Krahe, Scheinberger-Olwig, & Schutze, 2001). One of the best established correlates of both ASA victimization and perpetration is a history of childhood sexual abuse (CSA). Individuals who were sexually abused as children are more likely to perpetrate ASA than those that were not abused. This is especially well established for men (Casey, Beadnell, & Lindhorst, 2009; Lambie, Seymour, Lee, & Adams, 2002; Peterson et al., 2017; Thomas & Fremouw, 2009). For example, Peterson et al. (2017) found a moderately strong and statistically significant correlation ($r = .25$) between perpetration of ASA and history of CSA victimization. In addition, individuals who were sexually abused as children also report higher rates of ASA victimization as compared with those without a history of CSA. This has been consistently shown in samples of both women and men (see Classen, Palesh, & Aggarwal, 2005 for a review).

The Potential Role of Traumatic Sexualization in Sexual Victimization and Perpetration

Finkelhor and Browne (1985) conceptualized the consequences of CSA as resulting from four *traumagenic dynamics* associated with the abuse—traumatic sexualization, betrayal, stigmatization, and powerlessness. According to this view, CSA leads to alterations in children’s cognitive and emotional view of the world, with the traumatic sexualization dynamic, in particular, creating distortions in the child’s sexual self-concept, sexual world view, and sexual affective capacities. The alterations associated with traumatic sexualization can result in problematic sexual attitudes and behaviors, including sexual preoccupation, sexual compulsivity, distortions in sexual identity and sexual self-esteem, sexual avoidance, sexual guilt, and depression related to sexuality. According to Finkelhor and Browne (1985), these consequences of traumatic sexualization can potentially leave CSA victims vulnerable to ASA victimization as well as to ASA perpetration.

Consistent with this idea, research has found that many of the sexual alterations theorized by Finkelhor and Browne (1985) to be associated with traumatic sexualization are also correlated with ASA victimization or perpetration. For example, dysfunctional sexual behavior (including use of sex to combat loneliness) and sexual concerns (including sexual preoccupation and sexual shame) have been shown in a prospective study to predict ASA in women (Messman-Moore, Coates, Gaffey, & Johnson, 2008). Noll, Horowitz, Bonanno, Trickett, and Putnam (2003) also found that sexual preoccupation was associated with ASA victimization among women with a history of CSA. In another study, lower sexual self-esteem and more dysfunctional sexual behaviors were shown to mediate the relationship between CSA victimization and ASA victimization among a sample of women (Van Bruggen, Runtz, & Kadlec, 2006). Thus, there is fairly robust support for a relationship between aspects of traumatic sexualization and ASA victimization—although almost exclusively among women. The relationship between traumagenic alterations in sexuality and ASA perpetration has received somewhat less research attention. However, some aspects of traumatic sexualization have been shown to be correlated with ASA perpetration. For example,

Knight and Sims-Knight (2003) found that, among men, sexual preoccupation was associated with ASA perpetration. Krahé and Berger (2017) found that, in men with a CSA history, low sexual self-esteem was associated with an increased risk of ASA perpetration.

Notably, the four traumagenic dynamics—including traumatic sexualization—are not necessarily unique to CSA (Finkelhor & Browne, 1985). This implies that individuals might hold some or all of these potentially problematic sexual attitudes even if they do not have a history of CSA. Given this, it might be expected that victims of CSA would be more likely than others to have an overlapping history of ASA victimization and perpetration; however, the problematic sexual attitudes and behaviors associated with traumatic sexualization also might be associated with an overlapping history of ASA victimization and perpetration *over and above* the effects of CSA history.

The Current Study

In this study, we examined sexual attitudes and behaviors among men who were ASA victim–perpetrators, ASA victims only, ASA perpetrators only, or neither victims nor perpetrators of ASA. The sexual attitudes and behaviors examined in this study were selected because they were theoretically consistent with the expected outcomes of traumatic sexualization as described in Finkelhor and Browne’s (1985) traumagenic model. More specifically, we predicted the following:

Hypothesis 1: We expected to replicate previous research showing that ASA perpetration and ASA victimization are correlated in a convenience sample of community men. In particular, we wanted to demonstrate this relationship using a stricter definition of ASA than in previous studies (i.e., limiting the definition of sexual assault to attempted or completed oral, anal, or vaginal sex obtained through physical force, threat, or incapacitation, all of which would be illegal in most states).

Hypothesis 2: Based on the traumagenic model and on research showing that CSA is a shared risk factor for ASA victimization and perpetration, we expected to find the highest rates of CSA among men with a history of both ASA victimization and perpetration, intermediate rates of CSA among men who were victims-only and perpetrators-only of ASA, and the lowest rates of CSA among men who were neither victims nor perpetrators of ASA.

Hypothesis 3: We hypothesized that, when compared with the other three groups, men who reported a history of both ASA victimization and perpetration would report the highest levels of sexual attitudes and behaviors associated with traumatic sexualization, including sex guilt, sexual avoidance, sexual preoccupation, distorted sexual self-concept, low sexual self-esteem, sexual depression, and dysfunctional sexual behaviors. We also expected that men who were victims-only and perpetrators-only would be intermediate in terms of these attitudes and behaviors, and we predicted that men with no ASA history would be the lowest in terms of these attitudes and behaviors.

Hypothesis 4: Although we expected CSA to be related to ASA perpetration and victimization, given that the traumagenic dynamics can exist in the absence of CSA, we did not expect that CSA alone would fully account for the group differences in traumatic sexualization attitudes and behaviors. Thus, we expected that all statistically significant results found for Hypothesis 3 would be retained even after controlling for CSA history.

Method

Participants

Participants were recruited to participate in an online survey through nation-wide web-based advertisements on Craigslist.com and on a national website that posts multiple online psychological studies. A total of 699 men provided informed consent to complete the questionnaire; however, 204 of those men discontinued participation before completing any of the measures of interest for this study. The final sample used in the current analyses consisted of 268 men who completed at least 85% of the items on the measures of sexual aggression perpetration and victimization history, as these were central to the goals of the study. All participants were male and at least 18 years of age ($M_{\text{age}} = 31.41$; $SD = 11.91$). Participants were predominantly White (76.5%), non-Hispanic (85.8%), and heterosexual (84.0%).

Procedure

Data were collected as part of a larger study (McCallum, Peterson, & Mueller, 2012). Participants were recruited through online advertisements inviting men to participate in a study of “sexual experiences and attitudes.” The advertisements included information about the length of the study (~35 min) and compensation for participation. A link to the online survey was provided within the advertisements. Participants were required to read and agree to an informed consent statement before being directed to the questionnaire. Upon completion of the questionnaire, participants were given the opportunity to enter their contact information into a separate web-form for entry into a raffle for a \$100 gift card. By separating the raffle form from the survey, we were not able to connect participants’ names with their questionnaire responses. The study was approved by the first author’s university-affiliated institutional review board.

Measures

Sexual victimization and perpetration in adulthood. To assess for participant history of ASA victimization and perpetration, this study used the short form of the Sexual Experiences Survey for victims (SES-SFV) and perpetrators (SES-SFP; Koss et al., 2007). These surveys assess an individual’s experiences of victimization and perpetration of seven nonconsensual sexual acts obtained using five types of coercion. Participants indicated whether they had experienced each type of victimization and perpetration *0, 1, 2, or 3 or more times*. For this study, participants were considered to have a history of ASA victimization if they endorsed experiencing nonconsensual attempted or completed oral or anal sex through intoxication, threats, or force since age 14, and

they were considered to have a history of ASA perpetration if they endorsed perpetrating nonconsensual attempted or completed oral, anal, or vaginal sex through intoxication, threats, or force since age 14. Notably, the SES-SFP does not specify the age of the victim that the participant has perpetrated against; however, the items were written in such a way as to describe the type of aggression that commonly occurs in perpetration against other adolescents or adults (e.g., “taking advantage when they were too drunk or out of it to stop what was happening”) rather than the type of perpetration that typically occurs against a prepubescent child. In previous studies, the SES-SFV and the SES-SFP have demonstrated evidence of reliability and convergent validity (Johnson, Murphy, & Gidycz, 2017).

Childhood sexual abuse. CSA experience was measured using an adapted version of Childhood Sexual Victimization Questionnaire (CSVQ) developed by Finkelhor (1979). The CSVQ has demonstrated good concurrent validity in a previous study of college men (Risin & Koss, 1987). The adapted measure included 11 behaviorally specific items assessing sexual contact ranging in severity from kissing and hugging to oral, anal, and penile–vaginal intercourse. Items asked about sexual acts with or without the use of force with individuals who were at least 5 years older than the participant and about coerced or forced sexual acts with perpetrators of any age. For this study, men were asked to indicate how many times they experienced each act before the age of 14. The original measure asked about behaviors occurring before age 16; we revised the measure to ask about behaviors occurring before age 14 so that the measure would be consistent with the well-established ASA victimization and perpetration measures (SES-SFV and SES-SFP), which assess adolescent and adult victimization and perpetration since age 14. This reference age is supported by literature indicating that nonconsensual sexual experiences occurring during adolescence (inclusive of ages 14 to 17) more closely resembles adult sexual assault than CSA (see, e.g., Koss et al., 2007, for a review). Responses were coded as negative for CSA if the participants endorsed zero on all items or positive if they endorsed any item occurring one or more times.

Traumagenic sexual attitudes and behaviors. A variety of different measures were used to assess sexual attitudes and behaviors theorized by Finkelhor and Browne (1985) to stem from traumatic sexualization. These measures (described in more detail in the following text) assessed trauma-related beliefs, sex guilt, sexual avoidance, sexual preoccupation, distorted sexual self-concept, low sexual self-esteem, sexual depression, and dysfunctional sexual behaviors. Based on theory and past research, these attitudes and behaviors were expected to leave individuals vulnerable to ASA perpetration and/or victimization.

The Trauma-Related Beliefs Questionnaire (TRBQ; Hazzard, 1993) was developed as a measure of trauma-related cognitions reflective of Finkelhor and Browne’s (1985) model of traumagenic dynamics. Participants in this study completed the seven-item Traumatic Sexualization subscale of this measure to assess their beliefs associated with avoidance of sex and sex-related anxiety. Participants rated items, such as “Thinking about sex upsets me,” on a 5-point scale, ranging from 0 (*absolutely untrue*) to 4 (*absolutely true*). Scores were averaged, with higher scores indicative of greater traumatic sexualization. In the current sample, $\alpha = .90$.

The Mosher Sex Guilt Scale (Mosher, 1988), a subscale of the Revised Mosher Guilt Inventory, was used to evaluate partici-

pants’ experiences of guilt related to their sexual thoughts, feelings, and behaviors. The subscale includes 50 paired items in the form of sentence completion responses. Participants rated the accuracy of each sentence completion (e.g., “When I have sexual dreams . . . I try to forget them”) on a scale from 0 (*not at all true*) to 6 (*extremely true*). Scores were summed across items to create a possible range of 0 to 300, with higher scores indicating greater guilt. In the current sample, $\alpha = .95$.

The Traumatic Sexualization Survey (TSS; Matorin & Lynn, 1998) was used to evaluate sexual avoidance, sexual preoccupation, and disrupted sexual self-concept among participants. The 38-item survey was originally validated with women and consisted of four subscales. However, in a validation study conducted with heterosexual men (McCallum et al., 2012), a three-factor solution was a better fit and included the following subscales: Sexual Avoidance (originally 16 items; e.g., “I think sex is dirty”), Sexual Preoccupation (11 items; e.g., “I can’t get my mind off sex”), and Disrupted Sexual Self-Concept (originally 10 items; e.g., “I avoid rejection by having sex”). Because the TSS–Male Version was created for heterosexual men, some of the items on the Sexual Avoidance and Disrupted Sexual Self-Concept subscales specifically reference women (e.g., “I avoid physical contact with women”); thus, those items were eliminated for these analyses, as our sample included sexual minority men, leaving 10 items on the Sexual Avoidance scale ($\alpha = .90$) and six items on the Disrupted Sexual Self-Concept scale ($\alpha = .75$). The Preoccupation scale was unchanged ($\alpha = .89$). Participants responded to items on a 5-point scale, ranging from 1 (*never true*) to 5 (*almost always true*). Scores were averaged, with higher scores indicative of more severely traumatic sexual beliefs.

The Sexuality Scale (Snell & Papini, 1989) is a 30-item scale composed of three subscales designed to measure sexual self-esteem (10 items; e.g., “I am a good sexual partner”), sexual depression (eight items; e.g., “I feel down about my sex life”), and sexual preoccupation (10 items; e.g., “I think about sex a great deal of the time”). Participants rated items on a scale from -2 (*disagree*) to $+2$ (*agree*). The Sexual Self-Esteem subscale was reversed for the analyses reported here; thus, for all subscales, scores were summed with higher scores indicative of more sexual distress. Interitem reliability for the subscales in the current sample was strong ($\alpha = .91$ for the Sexual Self-Esteem subscale; $\alpha = .91$ for the Sexual Depression subscale; $\alpha = .89$ for the Sexual Preoccupation subscale).

Dysfunctional sexual behaviors were measured using items based on the Dysfunctional Sexual Behaviors Scale (DSBS; Briere & Runtz, 1990). Participants rated seven items, such as “I have gotten into trouble because of my sexual behavior” and “I have used sex to get something I wanted or needed,” on a scale from 1 (*not at all true*) to 5 (*very true*). Scores were summed to create a possible range of 7 to 35, with higher scores suggestive of more maladaptive sexual activity. In the current sample, $\alpha = .73$.

Results

Descriptive Statistics

If participants completed less than 85% of items on a given scale or subscale, they were excluded from all analyses involving that scale or subscale. Any additional missing values on the measures

of traumagenic sexual beliefs and behaviors were replaced with mean imputation. The SES-SFV, the SES-SFP, and the CSVQ are behavioral sampling measures, so missing values were treated as nonendorsement, as this seemed to be the most conservative approach.

Based on responses to the SES-SFV and SES-SFP, 45 men (16.8%) reported one or more experience of ASA victimization (i.e., attempted or completed oral or anal sex obtained through incapacitation, threat of physical harm, or force), and 45 (16.8%) reported one or more experience of ASA perpetration (i.e., attempted or completed oral, anal, or vaginal sex obtained through incapacitation, threat of physical harm, or force). Many men reported multiple experiences of victimization and perpetration. More specifically, men reported one or more experience of completed oral or anal ASA victimization through incapacitation ($n = 32$; 11.9%), threat ($n = 16$; 6.0%), and force ($n = 16$; 6.0%), and one or more experience of attempted oral or anal ASA victimization through incapacitation ($n = 25$; 9.3%), threat ($n = 12$; 4.5%), and force ($n = 15$; 5.6%). Of the men with victimization experience, 46.7% reported that they had been victimized only by women, 31.1% had been victimized only by men, 15.6% had been victimized by both men and women, and 6.7% did not report the sex of their perpetrator(s). In relation to perpetration experiences, men reported one or more experience of completed oral, vaginal, or anal ASA perpetration through incapacitation ($n = 32$; 12.1%), threat ($n = 8$; 3.0%), and force ($n = 12$; 4.5%), and one or more experience of attempted oral, vaginal, or anal ASA perpetration through incapacitation ($n = 25$; 9.5%), threat ($n = 9$; 3.4%), and force ($n = 9$; 3.4%). Of the men with perpetration experience, 68.9% reported that they had perpetrated against only women, 17.8% had perpetrated against only men, 8.9% had perpetrated against both men and women, and 4.4% did not report the sex of their victim(s).

To test Hypotheses 2 through 4, participants were grouped into one of the following four categories: Victim-Only ($n = 23$), Perpetrator-Only ($n = 23$), Victim-Perpetrator ($n = 22$), or No History of ASA ($n = 200$). Because some groups were small, our analyses comparing across the four groups were likely underpowered; for example, calculating power for our analyses of variance (to test Hypothesis 3) based on the *smallest* group size ($n = 22$), we may have had as little as 88% power to detect a large effect size ($f = 0.4$) if $\alpha = .05$. Because of this, we report and discuss effect sizes throughout the results section—especially in cases of statistically nonsignificant findings—because our lack of power could lead to nondetection of modest effects. Further, we are careful not to draw strong conclusions about null effects given our low power.

We compared the four groups in terms of demographic variables. There was a statistically significant difference in age across the groups, $F(3, 264) = 3.58, p = .02, \eta_p^2 = .04$, such that the Perpetrator-Only group ($M = 38.5; SD = 14.11$) was significantly older than the No ASA group ($M = 30.3; SD = 11.36$); there were no other between-group differences in age. We conducted Fisher's exact tests to evaluate endorsement versus nonendorsement of each racial/ethnic identity category (participants could endorse more than one category) as a function of group membership. There were no statistically significant group differences as a function of Asian/Asian American ($n = 16$) or Black/African American ($n = 26$) identity. Identity as American Indian/Native American ($n = 12$) was statistically significant ($p = .046$), such that American Indian identity was associated with a greater likelihood of being in the Victim-Only group (33.3%) as compared with non-American

Indian identity (7.4%), $p = .002$, 95% confidence interval (CI) [6.01, 53.63]. Identity as White/European American ($n = 204$) also was statistically significant ($p = .048$), such that White identity was associated with a greater likelihood of being in the Victim-Perpetrator category (10.3%) than non-White identity (1.6%), $p = .03$, 95% CI [1.07, 13.80]. Finally, endorsement of Hispanic or Latino ethnicity ($n = 33$) was statistically significant ($p = .01$), such that non-Hispanics were more likely to fall into the No ASA group (77.4%) than Hispanics (57.6%), $p = .01$, 95% CI [3.53, 37.28], and Hispanics were more likely to fall into the Victim-Only group (24.2%) than non-Hispanics (6.5%), $p < .001$, 95% CI [5.63, 34.67]. Because of the small number of nonheterosexually identified men in the sample, the sexual identity variable was treated as dichotomous—heterosexual ($n = 225$) or sexual minority (including gay, bisexual, undecided, or "other"; $n = 43$). Sexual identity differed as function of group membership based on a Fisher's exact test, $p < .001$. Heterosexual men were more likely to fall into the No ASA group (78.2%) as compared with sexual minority men (55.8%), $p = .002$, 95% CI [7.46, 37.90]; sexual minority men (16.3%) were more likely than heterosexual men (7.1%) to fall into the Perpetrator-Only category, $p = .048$, 95% CI [0.05, 23.16]; and sexual minority men (23.3%) were more likely than heterosexual men (5.3%) to fall in the Victim-Perpetrator category, $p < .001$, 95% CI [7.21, 32.67].

Analyses of Dropout

Because our final sample consisted of only 38% of those that initially consented to participate, we wanted to evaluate whether the large number of noncompleters was likely to have resulted in a biased sample. Most of the men that dropped out did so early in the study. For example, 129 men discontinued before or immediately after completing the initial demographics questionnaire, and another 75 men discontinued before or immediately after completing a measure of general sexual history (i.e., sexual identity, number of partners, etc.) that immediately followed the demographics measure. In other words, a total of 204 men dropped out before completing *any* of the variables of interest in our study. To evaluate whether the men who dropped out following the sexual history measure differed in terms of sexual history from men who continued beyond that measure, we compared the men who dropped out during or immediately after completing the sexual history measure and men who continued beyond that point in terms of number of reported sexual partners (i.e., the number of men and women with whom they had had oral, anal, or vaginal sex). There was no statistically significant difference between those that did ($M = 17.62; SD = 32.94$) and did not ($M = 27.87; SD = 85.44$) drop out during or immediately after the sexual history measure in terms of total sexual partners, and the effect size was near zero, $F(1, 555) = 0.92, p = .34, \eta_p^2 < .01$.

We were especially concerned about dropout that may have occurred in reaction to the sexual victimization and perpetration questions, as dropout in response to those essential items might particularly bias our sample. Following the demographics and sexual history measures, participants completed some measures of traumagenic sexual attitudes and behaviors (TSS, Sex Guilt, Sexuality Survey, and DSBS). Then the measure of CSA history was the first of the victimization/perpetration measures, followed by the TRBQ, and then the adult ASA victimization measure and the

adult ASA perpetration measure. Of the men who had completed all or some of the preceding measures, only seven completely failed to complete the CSA measure, 22 completely failed to complete the ASA victimization measure, and 24 completely failed to complete the ASA perpetration measure. We compared these men ($n = 53$) who appeared to have dropped out at the point of encountering the victimization/perpetration measures with the men who did not drop out in response to these measures in terms of their scores on the three TSS subscales, the Sex Guilt scale, the three Sexuality Survey subscales, and the DSBS. There were no differences between those that dropped out at the point of encountering the victimization/perpetration measures and those that did not drop out at those points in terms of any of the sexual attitudes or behaviors ($ps \geq .11$), and all effect sizes were near zero ($\eta_p^2 \leq .007$).

Hypothesis Testing

Hypothesis 1: Victim–perpetrator overlap. We predicted that ASA victimization and perpetration would be correlated, such that men who were victims of ASA would be more likely to have perpetrated ASA than men who were not victims. We found support for that hypothesis. Specifically, 48.9% of victims had perpetrated ASA, whereas only 10.3% of nonvictims had perpetrated ASA, $\chi^2(1) = 39.88, p < .001, \Phi = .39$.

Hypothesis 2: Group differences in CSA history. Looking across our four groups, we predicted that men with a history of both ASA victimization and perpetration would report the highest rates of CSA experience. We also predicted that ASA perpetrators-only and victims-only would be intermediate in rates of CSA, and we predicted that those with no ASA history would have the lowest rates of CSA. Of the 268 men in our sample, 31.7% ($n = 85$) endorsed a history of child sexual abuse before the age of 14.¹ Rates of CSA differed across groups, $\chi^2(df = 3) = 20.79, p < .001, \Phi = .28$. Consistent with our hypothesis, men in the Victim–Perpetrator group reported higher rates of CSA (72.7%) than men in the Victim-Only (39.1%), Perpetrator-Only (34.8%), and No ASA (26.0%) groups. Contrary to our expectations, there were no statistically significant differences among the other three groups in rates of CSA victimization.

Hypothesis 3: Group differences in sexual attitudes and behaviors associated with traumatic sexualization. We predicted that the Victim–Perpetrator group would endorse the highest levels of traumagenic sexual attitudes and behaviors, the Victim-Only and Perpetrator-Only groups would be intermediate in terms of traumagenic sexual attitudes and behaviors, and the No ASA group would have the lowest levels of traumagenic sexual attitudes and behaviors. Group differences in traumagenic sexual attitudes and behaviors were examined with a series of analyses of covariance. For each analysis, the independent variable was ASA victim/perpetrator group. The covariates were the demographic variables that differed significantly as a function of group membership: age, American Indian identity, White identity, Hispanic ethnicity, and sexual identity. Descriptive statistics for all analyses are presented in Table 1.

There was no statistically significant relationship between group membership and scores on the TRBQ Traumatic Sexualization subscale, $F(3, 259) = 2.29, p = .08, \eta_p^2 = .03$, and the effect size was small. In addition, there was a small and statistically nonsig-

nificant relationship between ASA history and sexual guilt, $F(3, 258) = 2.36, p = .07, \eta_p^2 = .03$. Thus, Hypothesis 3 was not supported in relation to these two variables.

There was no statistically significant group difference on scores on the TSS Sexual Avoidance subscale, $F(3, 259) = 2.41, p = .07, \eta_p^2 = .03$, and the effect size was small. There was a small to moderate statistically significant relationship between group and scores on the TSS Sexual Preoccupation subscale, $F(3, 259) = 3.36, p = .02, \eta_p^2 = .04$, such that the Victim–Perpetrator group was higher in sexual preoccupation than the No ASA group, $p = .001$, providing partial support for our hypothesis. There was a fairly large and statistically significant relationship between group and scores on the TSS Disruptions in Sexual Self-Concept subscale, $F(3, 259) = 10.33, p < .001, \eta_p^2 = .11$. Consistent with our hypothesis, we found significantly higher disruptions in sexual self-concept among Victim–Perpetrators than among Victims-Only, $p = .02$, Perpetrators-Only, $p = .009$, and men with No ASA history, $p < .001$. There was also a statistically significant difference between the Victims-Only and the No ASA group, $p = .04$.

There was no statistically significant relationship between ASA history and scores on the Sexuality Scale Sexual Self-Esteem subscale, $F(3, 258) = 1.06, p = .37, \eta_p^2 = .01$, or the Sexual Depression subscale, $F(3, 258) = 0.67, p = .57, \eta_p^2 = .01$, and the effect sizes were near zero. However, there was a statistically significant difference on the Sexual Preoccupation subscale, $F(3, 257) = 2.88, p = .04, \eta_p^2 = .03$, although the effect size was small. The Perpetrator-Only group endorsed more sexual preoccupation than the No ASA group ($p = .03$), and the Victim–Perpetrator group endorsed more sexual preoccupation than the No ASA group ($p = .005$).

Finally, there was a large and statistically significant relationship between ASA history and scores on the DSBS², $F(3, 259) = 17.91, p < .001, \eta_p^2 = .17$. In partial support of our hypothesis, men in the Victim–Perpetrator group reported more dysfunctional sexual behaviors than men in the Victims-Only group, $p = .007$, and than men with No ASA history, $p < .001$. Men in the Perpetrator-Only group also reported more dysfunctional behaviors than men with No ASA history, $p < .001$, and men in the Victim-Only group reported more dysfunctional behaviors than men in the No ASA group, $p = .003$.

Hypothesis 4: Group differences in traumatic sexualization variables after controlling for CSA. We predicted that the group differences found in relation to Hypothesis 3 would be retained after controlling for CSA history. To test Hypothesis 4,

¹ The CSA measure included one item that represents a relatively lower level of abuse compared with all other items: “When you were 13 years old or younger, how many times did an older person (at least 5 years older than you) kiss and hug you in a sexual way?” Of the 85 men who endorsed CSA on our measure, 14 endorsed *only* that item. Thus, we ran all analyses involving the CSA measure including and excluding this item from our definition of CSA. The pattern of significant results was unchanged, so results using the entire CSA measure are reported in the results section.

² The DSBS includes one item, “I have gotten in trouble because of my sexual behavior,” that might artificially inflate the relationship between the DSBS total score and ASA perpetration if the man happened to get in trouble *because of* his perpetration behavior. Thus, we ran all analyses involving the DSBS both including and excluding that item from the total score. The pattern of significant results was unchanged, so results using all items of the DSBS are reported in the results section.

Table 1

Means and Standard Deviations for Measures of Traumagenic Attitudes and Behaviors as a Function of Men's Status as Perpetrators and/or Victims of Adult Sexual Assault

Measures	Victim-Perpetrators <i>M; SD (n)</i>	Victim-Only <i>M; SD (n)</i>	Perpetrator-Only <i>M; SD (n)</i>	No Victimization or Perpetration <i>M; SD (n)</i>
Trauma-Related Beliefs Questionnaire				
Traumatic Sexualization subscale ^a	0.71; 0.88 (22)	0.43; 0.44 (23)	0.39; 0.73 (23)	0.41; 0.49 (200)
Sex Guilt Scale	65.54; 54.30 (21)	58.58; 38.79 (23)	52.53; 30.12 (23)	74.58; 44.45 (200)
Traumatic Sexualization Survey				
Sexual Avoidance subscale ^a	1.87; 0.90 (22)	1.53; 0.60 (23)	1.34; 0.37 (23)	1.65; 0.69 (200)
Sexual Preoccupation subscale ^b	3.84; 0.97 (22) _a	3.47; 0.84 (23) _{ab}	3.43; 0.75 (23) _{ab}	3.22; 0.76 (200) _b
Distorted Sexual Self-Concept subscale ^b	3.05; 0.94 (22) _a	2.46; 0.67 (23) _b	2.38; 0.72 (23) _{bc}	2.12; 0.75 (200) _c
Sexuality Scale				
Sexual Self-Esteem subscale (reversed)	-9.53; 8.51 (22)	-12.00; 9.14 (23)	-8.52; 9.03 (23)	-8.82; 8.89 (199)
Sexual Depression subscale	-5.86; 8.39 (22)	-7.35; 6.36 (23)	-4.14; 9.14 (23)	-5.86; 8.45 (199)
Sexual Preoccupation subscale ^{b,c}	9.22; 7.36 (22) _a	6.44; 7.30 (23) _{ab}	8.05; 7.88 (23) _a	4.06; 8.17 (198) _b
Dysfunctional Sexual Behaviors Scale ^b	22.32; 6.03 (22) _a	18.17; 3.63 (23) _b	19.57; 5.77 (23) _{ab}	14.84; 5.19 (200) _c

Note. Total $N = 268$. Participants with missing data were excluded pairwise for each analysis. For all scales, higher scores indicate more negative/problematic attitudes/behaviors.

^a Result was statistically significant in at least one sensitivity analysis. ^b Statistically significant group differences were found based on an omnibus test controlling for age, American Indian racial identity, White racial identity, Hispanic ethnicity, and sexual identity. Within each row, scores with different subscripts are statistically significantly different ($p < .05$) based on follow-up pairwise comparisons. ^c Result was not statistically significant in one or more sensitivity analyses.

we reran all analyses related to Hypothesis 3 that demonstrated statistically significant results with CSA history as a covariate (along with the other demographic covariates). With the exception of the Sexuality Scale Preoccupation subscale, $F(3, 256) = 2.27$, $p = .08$, $\eta_p^2 = .03$, all group differences reported in Hypothesis 3 remained statistically significant after controlling for CSA: the TSS Preoccupation subscale, $F(3, 258) = 2.71$, $p = .046$, $\eta_p^2 = .03$, the TSS Disrupted Sexual Self-Concept subscale, $F(3, 258) = 7.72$, $p < .001$, $\eta_p^2 = .08$, and the DSBS, $F(3, 258) = 14.98$, $p < .001$, $\eta_p^2 = .15$.

Post Hoc Sensitivity Analyses

Given that this study involved small group sizes, we were aware that our results might have been unduly impacted by just a few data points (De Souza et al., 2016). Thus, even seemingly minor methodological and analytic decisions might have impacted the validity of our findings. To evaluate the robustness of our findings within this small convenience sample, we evaluated whether the findings related to our hypotheses were robust to different definitions of ASA and to different methods for handling missing data.

Robustness to different definitions of ASA. For the primary analyses reported above, we defined ASA as attempted or completed oral, anal, or vaginal sex obtained through incapacitation, threat of physical harm, or physical force. However, to evaluate the robustness of our results, we also reran all analyses reported above using (a) a broader definition of ASA, such that ASA was defined as including any sexual contact (including kissing and fondling) obtained through use of incapacitation, threat, or force, and (b) a narrower definition of ASA, such that ASA was defined as completed (but not attempted) oral, vaginal, or anal sex obtained through incapacitation, threat, or force. The patterns of statistically significant results were unchanged with two exceptions: When using the narrower definition of ASA, there was a fairly small ($p = .02$; $\eta_p^2 = .04$) but statistically significant group difference on the

TRBQ Traumatic Sexualization subscale, such that the Victim-Perpetrator group ($M = 0.83$; $SD = 1.01$) was higher than the No ASA group ($M = 0.40$; $SD = 0.48$) on traumatic sexualization, $p = .002$, and this was retained when controlling for CSA ($p = .03$; $\eta_p^2 = .03$). Also, when using the narrower definition, there was no statistically significant group difference on the Sexual Preoccupation subscale of the Sexuality Scale ($p = .10$; $\eta_p^2 = .02$). However, across all analyses, the effect sizes were similar when using the three different definitions of ASA (Φ values were within .04 of each other, and η_p^2 values were within .02 of each other).

Robustness to management of missing data. For the primary analyses reported above, we included only men who had completed at least 85% of the items on the measures of ASA perpetration and victimization. We reran all analyses including *all* men who answered at least one item on each of the ASA perpetration and victimization measures ($N = 286$) and treated any missing data on those measures as nonendorsement. The pattern of statistically significant results reported above was unchanged with two exceptions: (a) There was a fairly small but statistically significant group difference on the TSS Sexual Avoidance subscale ($p = .04$; $\eta_p^2 = .03$), and this was retained when controlling for CSA ($p = .03$; $\eta_p^2 = .03$). Specifically, the Perpetrator-Only group was lower on sexual avoidance ($M = 1.34$; $SD = 0.37$) than the No ASA group ($M = 1.64$; $SD = 0.68$), $p = .04$, and than the Victim-Perpetrator group ($M = 1.92$; $SD = 0.95$), $p = .01$. (b) There was no statistically significant group difference on the Sexual Preoccupation subscale of the Sexuality Scale ($p = .08$; $\eta_p^2 = .02$). However, across all analyses, the effect sizes (Φ and η_p^2) using this larger sample were within .02 of the primary results reported above.

For the primary analyses reported above, we used mean imputation to replace missing data on all measures of traumagenic sexual attitudes and behaviors for participants who had completed at least 85% of items on the measures. We reran all analyses

excluding those with *any* missing data on a pairwise basis (*n*s ranged from 208 to 266 across analyses). The pattern of statistically significant results was identical to what was reported above, and all effect sizes (Φ and η^2) were within .01 of the effect sizes reported above in the primary analyses.

Summary of sensitivity analyses. Generally, the statistically significant findings from our primary analyses were found to be robust to different definitions of ASA and different methods for managing missing data, and this is unsurprising given that most of the effect sizes for our primary statistically significant results were moderate to large. The only exception was related to group differences on the Sexual Preoccupation subscale of the Sexuality Scale; group differences on that subscale were nonsignificant in two different sensitivity analyses. Even in our primary analyses, for which group differences were statistically significant, the effect size related to that subscale was small, and the group differences were no longer significant after controlling for CSA. Given that the findings related to the Sexuality Scale Sexual Preoccupation subscale were weak and lacking in evidence of sensitivity, we will not interpret or discuss the significant results related to that subscale.

Discussion

In this study, we sought to examine the overlap between ASA perpetration and ASA victimization among a convenience sample of community men. We also sought to evaluate sexual attitudes and behaviors that might be associated with a dual vulnerability for ASA perpetration and victimization using the traumagenic dynamics model (Finkelhor & Browne, 1985) as a guiding theoretical approach. Our study addressed four specific hypotheses, each of which received at least partial support.

Consistent with Hypothesis 1, we found a statistically significant and robust relationship between ASA victimization and perpetration among a convenience sample of men from the community. The general relationship between violent victimization and offending (Stewart, Schreck, & Simons, 2006) is well established, and the victim–offender overlap has been previously demonstrated in relation to sexually coercive behavior broadly (Enosh, 2007; Krahe & Berger, 2017; Russell & Oswald, 2001, 2002). The current study demonstrated that this overlap also exists for men when measuring illegal sexual assault behavior.

In addition, consistent with Hypothesis 2, we found that our Victim–Perpetrator group—those men who had been both victims and perpetrators of ASA—were more likely to report a history of CSA than ASA victims-only, ASA perpetrators-only, or men with no history of ASA. In fact, we found extraordinarily high rates of CSA among our Victim–Perpetrator group, with nearly 73% of the men in that group reporting one or more experiences of CSA. However, contrary to our expectations, the Victim-Only and the Perpetrator-Only groups did not differ from men with no ASA history in terms of rates of CSA. In previous research, CSA consistently has been found to be related to ASA victimization and ASA perpetration (Casey et al., 2009; Classen et al., 2005; Lambie et al., 2002; Peterson et al., 2017); however, no study to our knowledge has compared CSA history among victims with and without a perpetration history or among perpetrators with and without a victimization history. Our results provide some preliminary evidence that CSA may represent a unique risk factor for *co-occurring* ASA victimization and perpetration. Although this is

important information, a past history of CSA cannot itself be changed through intervention; thus, it is important to identify other intervenable factors that are associated with the dual risk for victimization and perpetration.

To this end, in evaluating Hypothesis 3 of this study, we sought to shed light on the sexual attitudes and behaviors that are specifically associated with being both a victim and perpetrator of ASA. Understanding the sexual attitudes of ASA victim–perpetrators seems particularly valuable because victims and perpetrators are often portrayed in very discrepant and opposing ways in relation to their sexuality. Yet, according to Finkelhor and Brown's (1985) traumagenic dynamics model, particular sexual attitudes and behaviors should place individuals at risk for both ASA perpetration and victimization. Thus, we hypothesized that the Victim–Perpetrator group of men would be higher in traumagenic sexual attitudes and behaviors as compared with men who were only victims, who were only perpetrators, or who had no experience of ASA victimization or perpetration. We also predicted that the Victim-Only and Perpetrator-Only groups would score higher on the problematic sexual attitudes and behaviors than the men with no ASA history. We found some partial support for this hypothesis, although none of the sexual attitudes and behaviors that we examined exactly corresponded to our predicted pattern of results. For example, men with a history of both victimization and perpetration scored higher than men with no ASA history on a measure of sexual preoccupation, but they were not higher than the Victim-Only or the Perpetrator-Only groups on that measure. Similarly, the Victim–Perpetrator group scored higher than men with no ASA history and than men with a victimization only history on a measure of dysfunctional sexual behavior, but they were not higher than men with a perpetration only history.

Of all of the traumagenic attitudes and behaviors that we measured, distorted sexual self-concept was the variable that most clearly distinguished between the Victim–Perpetrator group and all other groups. Individuals with a distorted sexual self-concept tend to use sex as the primary basis for their relationships and as an important source of self-esteem; items on the measure include “I need sex to feel good about myself” and “my sexuality is what attracts people to me.” It makes sense that, if men strongly endorse items like these, then they would be vulnerable to both ASA victimization (as they might be inhibited from resisting nonconsensual sexual advances due to a fear of alienating the other person) and perpetration (as they might be so motivated to obtain sex to protect their self-image that they would be willing to ignore a partner's refusal). These cognitions associated with a distorted sexual self-concept might be a particularly useful point of intervention to reduce men's risk of both sexual victimization and perpetration.

In addition to examining the unique factors associated with both victimization and perpetration, we also were interested in attitudes and behaviors associated with only perpetration and only victimization. Looking specifically at the Perpetrator-Only group, men who had perpetrated ASA scored higher on dysfunctional sexual behavior as compared with the No ASA group. The Victim-Only group was higher in distorted sexual self-concept and dysfunctional sexual behavior than the No ASA group. However, for both of these variables—distorted sexual self-concept and dysfunctional sexual behavior—the Victim–Perpetrator group had the highest scores of all four groups, suggesting that these variables

may be associated with vulnerability for both victimization and perpetration rather than exclusively one or other. Future research could explore moderating and mediating variables that might help to explain why these sexual attitudes and behaviors are associated with ASA victimization for some men, ASA perpetration for other men, and *both* ASA victimization and perpetration for still other men.

Finally, in relation to Hypothesis 4, we predicted that these traumagenic attitudes and behaviors would be associated with risk for victimization and perpetration even after controlling for CSA. Consistent with this, the statistically significant results that we found related to Hypothesis 3 were retained even after CSA history was added as a covariate, suggesting that these problematic sexual alterations are a risk factor even in the absence of a CSA history. Finkelhor and Browne (1985) proposed the traumagenic model specifically to explain reactions following experiences of CSA; however, they acknowledged that the traumagenic dynamics—including traumatic sexualization—could potentially develop even in the absence of CSA, and our results support that claim. However, the question remains: Why do some individuals develop sexual attitudes and behaviors that are consistent with traumatic sexualization even in the absence of CSA? Speculatively, non-CSA experiences that might lead to traumatic sexualization could include shaming and punitive messages about sex and sexuality during childhood or early exposure to sexualized media content in the absence of sex education to assist the child with interpretation and meaning-making. Future research is needed to explore these and other possibilities, especially given that the findings of this study support the idea that many of the sexual alterations theorized to be associated with traumatic sexualization are also associated with ASA victimization, perpetration, or both.

Limitations

To our knowledge, this study is the first to directly examine the unique sexual attitudes and behaviors of men who have been both victims and perpetrators of ASA. There are multiple limitations associated with this study, including the fact that our Victim-Only, Perpetrator-Only, and Victim-Perpetrator groups were small, meaning that our analyses were underpowered. Given that, we may have failed to detect results that would have been statistically significant with a larger sample (although notably, effect sizes for the nonsignificant results were consistently small in both the primary analyses and the sensitivity analyses). Further, our measures of CSA victimization, ASA perpetration, and ASA victimization captured a range of different experiences, meaning that our small groups also were likely heterogeneous in terms of the type of victimization/perpetration that they experienced, their age at the time of the victimization/perpetration, the sex of their victim/perpetrator, and their relationship to the victim/perpetrator. Our sensitivity analyses helped to demonstrate the robustness of *most* of our statistically significant and nonsignificant findings within this small and heterogeneous sample. Nevertheless, these findings clearly need to be replicated in a larger sample, and future research could benefit from further examination of differences within each group related to the type and context of ASA victimization and perpetration.

Given that this study was a cross-sectional analysis of men's ASA experiences, we cannot make any claims about directionality

of relationships. Indeed, for men in our Victim-Perpetrator group, we do not even know whether their ASA victimization or perpetration experience came first. Similarly, based on the theory of traumagenic dynamics, we assumed that the sexual attitudes and behaviors measured in this study stemmed from early life experiences and thus predated experiences of ASA; however, it is possible that the attitudes and behaviors measured in the study are a consequence rather than a predictor of ASA victimization and/or perpetration.

Another important limitation of this study stems from the use of the SES-SFV to measure men's ASA victimization experiences. Although the SES-SFV assesses a variety of different sexual victimization experiences, it does not include an assessment of men's experience of attempted or completed nonconsensual penile-vaginal intercourse obtained through incapacitation, threat, or force. This is particularly problematic, as more than half (62%) of the men in our study who reported a victimization experience indicated that at least one of their perpetrators was female. It is likely that there would have been higher rates of victimization reported in our sample if experiences with nonconsensual penile-vaginal intercourse had been measured.

Despite the fact that our measure of ASA victimization excluded nonconsensual penile-vaginal intercourse, the rates of ASA reported in our sample were high (17%). Because previous studies of men's ASA victimization have relied on widely varying operational definitions of ASA (see Peterson et al., 2011), it is difficult to directly compare this rate to rates found in previous studies. Nevertheless, the rates found in this study were dramatically higher than was found in *some* previous studies of community men, in which rates of ASA victimization were ~2% (Basile et al., 2007). Similarly, rates of ASA perpetration also were high in this sample (17%) compared with some other studies of men, in which about 9% reported having perpetrated attempted or completed ASA (Abbey & McAuslan, 2004; White & Smith, 2004). The high rates of ASA victimization and perpetration within our sample raise questions about the extent to which our results are generalizable to other samples of men. Concerns about lack of generalizability are further exacerbated by the fact that only 38% of the men who consented to the electronic survey went on to complete the measures. Although this study was not advertised as being about sexual perpetration or victimization, men with a history of ASA victimization or perpetration may have been more interested in the questions' content or may have found the questions more relevant to their lives than men without such a history. On the one hand, these concerns are slightly assuaged by the fact that a large proportion of noncompleters dropped out before they had begun any of the measures that were relevant to this study and by the fact that our dropout analyses did not find differences in traumagenic sexual attitudes and behaviors between men that dropped out at the point of encountering the victimization/perpetration measures and those that did not drop out at that point. On the other hand, we cannot know why men dropped out of our study, and thus the possibility for bias remains a concern. Previous research (Dunne et al., 1997; Wiederman, 1999) has demonstrated a volunteer bias in self-report sexuality research, with volunteers reporting more sexual experience, less traditional sexual attitudes, more sexual self-esteem, and higher rates of sexual abuse than nonvolunteers; however, somewhat reassuringly, Dunne et al. (1997) did report that dropouts from sexuality surveys were more similar to volun-

teers than nonvolunteers. Nevertheless, given that greater sexual experience is associated with a greater likelihood of participation in sex research and given that a larger number of sexual partners is also associated with both ASA victimization and perpetration (Krahé et al., 2001), volunteer bias may help to explain the high rates of ASA victimization and perpetration among this convenience sample. This potential for bias within our sample also points to the need for replication of these results in other samples of men.

We cannot determine whether the victim–perpetrator overlap in this study occurred within a single relationship or whether it occurred across different relationships. If some individuals are at high risk for both victimization and perpetration across different sexual partners, then this suggests that individual-level (or possibly peer group-level) risk factors are likely contributing to that dual risk. However, if victim–perpetrator overlap primarily occurs within the context of a specific relationship, then relationship dynamics may be more important in explaining the dual risk. Future research would benefit from explicitly evaluating overlap at both the individual and the relationship level by querying experiences of both lifetime ASA victimization/perpetration and ASA victimization/perpetration within a particular relationship (e.g., the current or most recent relationship).

Finally, this study investigated sexual assault victim–perpetrator overlap only in men. Previous research has found evidence for a victim–offender overlap among women in relation to sexual coercion, although typically the strength of the relationship is smaller for women than men (Enosh, 2007; Krahé & Berger, 2017; Mathes, 2015). Nevertheless, in future research, it would be interesting to evaluate whether the traumagenic sexual attitudes and behaviors measured in this study are predictive of dual risk for ASA victimization and perpetration in women as well as in men.

Research Implications

Despite these limitations, the findings of this study evoke a number of potentially fruitful directions for future research. For example, this particular study was guided by the traumagenic model and specifically explored the association between traumatic sexualization and sexual aggression perpetration and victimization. As a result of the focus on traumatic sexualization, many of the variables that were examined in this study (e.g., sexual self-esteem, dysfunctional sexual behaviors, preoccupation with sex) have more traditionally been examined in relationship to ASA victimization (Messman-Moore et al., 2008; Noll et al., 2003; Van Bruggen, Runtz, & Kadlec, 2006) than in relationship to ASA perpetration. Importantly, this study reveals that some of these traumagenic sexual attitudes and behaviors are relevant correlates of perpetration as well as victimization. Nevertheless, there are other variables that are better established correlates of ASA perpetration, such as emotional callousness and narcissism (Mouilso & Calhoun, 2012; Zinzow & Thompson, 2015), and those variables were not examined in this study. In future research, it would be interesting to examine the extent to which those and other well-established correlates of perpetration differ among perpetrators-only, victims-only, and victim–perpetrators. Examination of commonly identified perpetrator-related variables may further contribute to an understanding of the unique characteristics of men who are both perpetrators and victims of ASA.

The findings of this study suggest that there are meaningful differences—namely, related to CSA history and sexual self-concept—between men with a history of both ASA perpetration and victimization versus men with a history of perpetration only. Researchers have theorized that there may be multiple types of sexually aggressive men (Peterson, Janssen, Goodrich, & Heiman, 2014; Ward & Beech, 2006). For example, Peterson and colleagues (Peterson et al., 2014, 2017) proposed that some men who perpetrate ASA may be motivated by high levels of negative affect—including anxiety and anger—whereas other men who perpetrate ASA may be motivated by emotional callousness and lack of empathy. It is possible that different victimization histories among ASA perpetrators may be associated with different traits and motives for sexual aggression; in other words, victim–perpetrator and perpetrator-only men may represent distinct subtypes of ASA perpetrators. Future research could explore this possibility.

Clinical and Policy Implications

This study is unique in examining the overlap between illegal ASA perpetration and victimization. Knowing that men who perpetrate illegal sexual assault are often commonly victims of the same crime may impact how we view male ASA perpetrators and victims. On the one hand, recognizing the overlap between ASA victimization and perpetration (and their shared overlap with CSA) might allow for more empathic and productive responses to ASA perpetrators. Perpetrators of ASA are sometimes explicitly characterized as “psychopaths,” “villains,” or “monsters”; such characterizations are certain to create defensiveness in men with a history of ASA perpetration, and they provide little hope of changing behavior given that rehabilitating a “monster” seems unlikely (Peterson, 2017). If, instead, one conceptualizes (at least some) ASA perpetrators as individuals with problematic sexual beliefs and attitudes that leave them vulnerable to both ASA perpetration *and* victimization, rehabilitation and behavior change seem more feasible. Further, previous research has suggested that men are often disinterested in ASA prevention programs because they view such programs as irrelevant to their lives and a waste of their time, as they typically do not conceptualize themselves as perpetrators (Rich, Utley, Janke, & Moldoveanu, 2010); in contrast, men are probably more likely to invest in a prevention program that is designed not only to reduce their risk of perpetrating ASA against others but also to reduce their personal risk of experiencing ASA victimization.

On the other hand, for crime in general, researchers have shown that perceiving a larger victim–offender overlap is associated with assigning crime victims greater blame for their own victimization (Mancini & Pickett, 2017). Thus, knowledge of the victim–offender overlap in the case of ASA may lead to more victim-blaming against men who have experienced ASA and thus may exacerbate the preexisting problem of lack of support for male ASA victims (Chapleau et al., 2008; Struckman-Johnson & Struckman-Johnson, 1992). It is important to avoid this trap. First, a victim–offender overlap certainly does not imply that all victims are also offenders. Second, given the extraordinarily high rates of child sexual abuse among our Victim–Perpetrator group, it is important to keep in mind that the majority of men who are both

victims and offenders were victims first; that is, they were victims of CSA before they ever engaged in ASA.

Most importantly, this study suggests that a history of CSA and a distorted sexual self-concept may be associated with a unique dual vulnerability to both ASA perpetration and victimization among men. Given that previous CSA history cannot be altered through a prevention intervention, cognitions associated with a distorted sexual self-concept may be the most fruitful target for intervention. Cognitions such as, "I avoid rejection by having sex" and "I need sex to feel good about myself," could be challenged through cognitive-behavioral therapy interventions combined with psychoeducation about appropriate sexual boundary-setting and the diversity of ways to achieve intimacy. Consistent with this idea, Berg, Munns, and Miner (2017) have used a sex offender treatment approach that combines components similar to these in an effort to prevent sexual offender recidivism; this approach has not been applied to primary prevention, but future clinical work and research could explore its utility. Prevention interventions that simultaneously address risk for perpetration and victimization could benefit individual men as well as the men's future sexual partners.

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Received June 25, 2017

Revision received January 16, 2018

Accepted January 30, 2018 ■