

# Listening to the Therapeutic Needs of Male Survivors of Childhood Sexual Abuse

Journal of Interpersonal Violence

1–22

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DOI: 10.1177/0886260517701453

journals.sagepub.com/home/jiv



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## **Abstract**

Childhood sexual abuse of males is not uncommon with estimated prevalence rates across countries and different studies indicating that 8% of boys experience sexual abuse before age 18. A number of adverse outcomes are recognized in terms of mental health, behavioral, and relational difficulties. However, research also indicates that there is potential for healing. The present study explores the barriers, benefits, and processes involved in engagement in formal therapy for adult survivors of CSA from the male survivor's point of view. Nine men spoke of their treatment experiences in response to semistructured interviews. Participants were all members of a group for male survivors of sexual abuse. Seven participants reported benefiting from treatment. Interpretative phenomenological analysis (IPA) of the interviews identified three superordinate themes: "motivation to engage in treatment," "developing a connection with treatment providers," and "changing thinking about the abuse." These themes reveal a number of obstacles that are encountered in seeking treatment including stigma, process barriers, and engagement of a skilled and empathic therapist. For the men who were able to take part in therapy despite these barriers, improved quality of life were noted through the two primary mechanisms

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of relationship and changed thinking. Key changes in thinking included developing an awareness that they were not responsible for the abuse, understanding the effects of abuse, and developing an identity distinct from the experience of abuse. These changes in thinking occurred within the context of a robust therapeutic relationship.

**Keywords**

child sexual abuse, male, treatment, therapy

Childhood sexual abuse (CSA) has been associated with a range of negative sequelae including increased risk of mental disorder (Easton & Kong, 2017; Fergusson, McLeod, & Horwood, 2013; Molnar, Buka, & Kessler, 2001; Nelson et al., 2002), interpersonal difficulties (Easton, 2012), and increased risk of poor physical health outcomes (Maniglio, 2009; Scott et al., 2011). While the experience of sexual abuse can increase the risk of a range of negative outcomes, alongside the effects of trauma, male survivors also describe healing, transformation, posttraumatic growth, and contribution to the lives of others (Draucker et al., 2009; Easton, Coohy, Rhodes, & Moorthy, 2013; Easton, Leone-Sheehan, Sophis, & Willis, 2015; Grossman, Sorsoli, & Kia-Keating, 2006; Willis, DeSanto-Madeya, & Fawcett, 2015). Thus, it is important to understand the elements associated with addressing trauma and its effects and the move toward healing.

The sexual abuse of boys is not uncommon. In two systematic reviews including data from 24 different countries in one study (Barth, Bermetz, Heim, Trelle, & Tonia, 2013) and 9,911,748 participants in the other (Stoltenborgh, van Ijzendoorn, Euser, & Bakermans-Kranenburg, 2011), meta-analyses were conducted to estimate the international prevalence rates for the sexual abuse of boys. Despite variation between 3% and 17% across studies, within each review, the findings of the meta-analyses were consistent. Lifetime prevalence rates up until the age of 18 were estimated to be approximately 8% using a wide definition of sexual abuse and 3% for forced intercourse.

Prevalence of the sexual abuse of boys may be higher than is reported. Potentially influencing prevalence rates is the finding that boys are less likely than girls to disclose sexual abuse at the time (O'Leary & Barber, 2008), boys and men may be less likely to label their experiences as sexual abuse (Artime, McCallum, & Peterson, 2014), and parents and clinicians may be less likely to acknowledge the sexual abuse of boys (Day, Thurlow, & Woolliscroft, 2003; Holmes & Slap, 1998; Lab, Feigenbaum, & De Silva, 2000). Furthermore,

men report significant barriers to disclosure with similar themes reflected across several studies (Gill & Tutty, 1999; Sorsoli, Kia-Keating, & Grossman, 2008) and discussed by Easton, Saltzman, and Willis (2014) as relating to three categories: sociopolitical (e.g., cultural constructions of masculinity and lack of male sensitive services), interpersonal (e.g., stigma, distrust of others), and personal (e.g., shame, concerns about sexual orientation). Barriers to disclosure act as barriers to treatment access and also to engagement with a therapist whereby therapist confidence and competence can result in “don’t ask, don’t tell” care (Gill & Tutty, 1999).

The clash between the experience and impact of sexual abuse with culturally formed concepts of Western masculinity is a substantive barrier to disclosure and treatment engagement (Kia-Keating, Grossman, Sorsoli, & Epstein, 2005). Hegemonic constructions of masculinity may include the importance of power and control, being unemotional, and sexual virility—assertively pursuing sex with women (Mahalik, Good, & Englar-Carlson, 2003). Such internalized masculine norms and expectations can come under direct threat through the experience of sexual violation (Gill & Tutty, 1997, 1999; Willis et al., 2014). The fear that others will view one as emasculated enables and perpetuates the shame and secrecy associated with male sexual abuse (Easton et al., 2014; Gagnier & Collin-Vézina, 2016; Lab et al., 2000; Sorsoli et al., 2008). One study found that holding beliefs that conform to masculine norms significantly reduced posttraumatic growth in male survivors (Easton et al., 2013) and another study found that conformity to masculine norms was associated with higher mental distress (Easton, 2014). Alternatively, one element of healing from the effects of abuse as described by resilient survivors is the capacity to reappraise the meaning of masculine norms and associated implications of sexual abuse (Kia-Keating et al., 2005; Willis, Rhodes, Dionne-Odom, Lee, & Terreri, 2015).

The need to take account of masculine norms suggests one process whereby male survivors of sexual abuse may have unique treatment needs. However, mirroring a cultural denial of the vulnerability of boys, research attention has focused on female survivors with a paucity of research focused on the treatment outcomes of male survivors (Gill & Tutty, 1999; Taylor & Harvey, 2010; Trask, Walsh, & DiLillo, 2011). In their meta-analysis of the effects of psychotherapy with adults sexually abused in childhood, Taylor and Harvey found only six out of 44 studies included male participants; within those six studies, the majority of participants were female. Only one study, including participants with HIV and a history of CSA, compared outcomes by gender, finding no differences in outcomes (Sikkema et al., 2007). In another review of outcomes related to the treatment of posttraumatic stress disorder (PTSD), males with PTSD who had experienced a range of trauma

experiences, including but not limited to sexual abuse (e.g., combat trauma and motor vehicle trauma), responded more poorly to treatment than did women with PTSD (Wade et al., 2016). Thus, the effect of gender on treatment outcomes is not clear.

Although there is not sufficient research to draw clear conclusions about the effect of gender on treatment outcomes, male survivors have reported that treatment can be beneficial (Easton et al., 2015). Receiving treatment or professional support was the most frequently mentioned “turning point” in the life trajectory of men recovering from CSA; for some men, the act of seeking help was in and of itself the crucial step with additional turning points experienced in therapy (Easton et al., 2015). In another study, trauma-informed therapy was noted as a valuable context for relationship healing and learning relationship boundaries (Kia-Keating, Sorsoli, & Grossman, 2010).

There is also research that indicates potential mechanisms whereby men are able to experience healing. The value of healing relationships and reappraisal of the meaning of abuse have been consistently identified as important mechanisms of change (Draucker et al., 2009; Easton, 2013; Willis, Rhodes, et al., 2015). Drawing on a large survey of men with sexual abuse histories, Easton (2013) reported that men who were in the process of working through their abuse experiences and who had greater understanding about their abuse, associated emotions and behaviors, and the responsibility of the abuser reported lower symptoms of mental distress. In another study, mechanisms associated with healing were identified as engagement in safe relationships, gaining a sense of belonging, and learning safe ways to manage relationships (Kia-Keating et al., 2010). However, the role of formal therapy in helping participants develop mechanisms for healing was not specifically addressed in these studies.

In sum, there is some evidence that engagement in formal therapy can be beneficial although barriers to engagement in therapy may be common. There is also evidence that specific processes aid healing, but the role of these mechanisms within the formal therapy settings is less clear. Therefore, in the current study, we aim to understand the mechanisms that work to assist, or act as a barrier to, healing from histories of sexual abuse within the context of formal therapy. We seek to explore this question phenomenologically from the perspective of men with a history of sexual abuse who are members of a support group for male survivors.

## **Method**

### *Study Design*

The University of Otago Ethics Committee gave approval for this study. A qualitative method was chosen as a valuable method for exploring complex

questions inherent in sexual abuse research (Gibson & Morgan, 2013). As part of a broader project, participants took part in three 60- to 90-min, semi-structured interviews over the course of 3 weeks. A female, clinical psychologist with experience working with survivors of sexual abuse conducted the interviews. The interviews explored sexual abuse experiences, responses to it, impact on puberty and sexuality, and experiences of treatment. "Treatment" is used to refer to participants talking to any professional person about their abuse experiences. Professional people included psychologists, psychiatrists, counselors, and psychotherapists.

### *Recruitment*

All participants attending a peer support group for male survivors of sexual abuse were invited to take part in the study. There were no exclusion criteria and all group members agreed to participate. The peer support group was well established, met regularly, and was facilitated by a male survivor of sexual abuse. It was located in a New Zealand city.

### *Sample Characteristics*

Nine adult males, between 42 and 67 years of age, took part. Seven of the men were New Zealand European and two were other, European. All men reported experiencing penetrative acts of abuse. Two participants reported penetrative acts and no other acts. In addition to penetrative acts, seven of the men reported genital touch, four men reported oral sex, and one reported exposure to pornography. Three men reported experiencing one to five abusive events and six of the men described experiencing multiple events. The men who reported multiple events experienced this abuse across a period of 12 months through to several years. At the time of the abuse, the boys were between 5 and 15 years old. For most of the men, their first experiences of abuse were between 5 and 7 years of age or at 11 years of age. A broad range of perpetrators were implicated and included family (brother, sister, uncle, father), peer group (school boys, boys home), strangers, individuals known to family (neighbor), and persons in authority (teachers, doctor/nurses). All of the men experienced sexual abuse by a male and five also had female perpetrators.

All participants described engaging in therapy with a professional for at least 1 year with most participants reporting engaging in therapy for between 5 and 10 years. Difficulties commonly reported by participants included anxiety, anger, alcohol and drug addiction, sex and relationship difficulties, hypervigilance, poor sleep, and suicidality. Most participants described low self-esteem and low self-acceptance along with strong feelings of guilt and shame.

Eight participants had engaged in therapy specifically related to sexual abuse. Seven participants described benefiting from their treatment. Of the two participants who reported they had not benefited from treatment, Mark had engaged in treatment in the past but did not report any change due to this treatment and Andrew had not engaged in treatment specifically for sexual abuse. Three participants were still actively engaged with professional people.

### *Data Coding and Analysis*

The interviews were recorded and transcribed verbatim. NVivo, a qualitative data analysis software package, was used to assist with the identification and classification of themes. Interpretative phenomenological analysis (IPA) was used to explore participants' experiences. IPA is a bottom-up method and thus is not used to test hypotheses but to understand the meaning that individuals in a particular context make from their experience (Smith & Osborn, 2015). It is an iterative process that involves multiple readings and immersion in the text to confirm that the emergent themes and interpretations are supported by the data. The process of analysis is not a discrete step but continues throughout the analysis and write-up phases. In IPA, it is assumed that a participant's account during the interview is an attempt to make sense of their personal and social experience and world (Larkin, Watts, & Clifton, 2006). It is also acknowledged that the interviewer interprets the participant's account through the lens of their own attitudes and experiences (Smith & Osborn, 2015).

To ensure the quality of the emerging themes that were identified, the team (two clinical psychologists and an intern psychologist) read the transcripts and had regular meetings to discuss the identified themes, possible gaps, coherence, credibility, and significance of the content.

## **Results**

Three superordinate themes were identified in the interviews: "motivation to engage in treatment," "developing a connection with treatment providers," and "changing thinking about the abuse."

### *Motivation to Engage in Treatment*

This superordinate theme incorporated participants' experiences of deciding to get treatment and encountering barriers to accessing that treatment. Barriers to treatment included stigma, system processes, and the cost of treatment. The relationship with the treatment provider was also identified as a barrier but is considered under the theme "developing a connection with treatment

providers.” Most participants did engage in treatment despite, sometimes substantial, barriers. Participants’ reasons for engaging in treatment and their expectations appeared to influence how well they were able to engage in the treatment.

Four of the participants discussed stigma about treatment as a barrier to seeking help. They thought they would be judged or ridiculed for needing treatment. Simon explained this idea:

Yea I think it’s that shame, that weak, you know, if I need help I’m weak, those were the things that would have stopped me years ago getting help, even though people told me I needed help, I avoided it. . . . Yea, and also people wouldn’t understand me and stuff like that. And didn’t want to get judged, that was a huge one. That’s the same as the forms and that, it’s as if you’re getting judged, you know, and things like that. And the fear that someone might not believe me was awful.

Simon described delaying accessing treatment because of a general stigma about what it means about a person if they need to seek psychological help—that they are “weak.” He also introduced the fear that he would not be believed or understood by the people he was seeking help from. This fear was common among these participants and is described more fully in the next theme, “developing a connection with treatment providers.”

In addition to stigma, Ray identified a parallel between the power differential in an abusive relationship and the inevitable power differential that occurs between a professional person and their client in a therapy relationship. This aspect of treatment could make it difficult for the participants to engage in treatment and be open about their experiences.

Initially it was a nervousness about the process, it’s a little bit daunting in a way when I think back now, that you go into a room with someone and the door is shut, there’s a parallel immediately with abuse, it’s usually in isolation with the abuser and victim sort of thing, so I guess there’s a little bit of that come into it.

Many of the participants mentioned the cost of treatment as a barrier to seeking help. Some participants were able to overcome this barrier by having government-provided assistance through the Accident Compensation Cooperation (ACC). ACC is a New Zealand crown entity that provides funding for treatment as compensation for mental and physical injury resulting from sexual assault. However, many described the process of accessing this funding to be difficult in several ways. Thus, the cost of treatment was prohibitive but the process of accessing ACC-funded treatment was also prohibitive. To gain access to funding, disclosure of abuse is required on the first

meeting with the professional person. Mark, who did not describe benefiting from his previous treatment, said, "I would hate to go back now. From the stories I have heard, it just seems to be so complex now instead of making it easier." Kim said,

I had more than ACC would pay for so that was expensive. It was some years ago now, I can't remember how many more but two or three times what ACC would pay for treatment. . . . It was ACC funded so I had to spend a whole lot of time talking about the actual event so she could, which is an awful thing ACC does, you have to disclose first up so that your therapist can apply for funding, and that was really hard, it was physically hard.

While participants described encountering a number of stigma and process related barriers, most participants also described strong internal motivations for seeking treatment. In discussing these issues, most participants talked about wanting to "know myself" and to be "fully present." Peter said,

I wanted to understand myself more, so that I could accept why I was like that. It's a difficult thing to explain, don't know who you are sort of thing. . . . I wanted to be me, not something that I felt was manufactured by events sort of. I just felt that everything I did was influenced by my past and shaped by those events and I wanted to become my own person so to speak.

Peter implied that his abuse had become a part of him and his personality because of the influence it had over his behaviors. He was motivated to be open about his experiences so that he could create a future for himself that he controlled and was more true to the person he wanted to be. Jason also described internal motivation to change his behaviors as a reason for engaging in treatment:

I don't want to be that person wearing my armor anymore, I don't think I'm tough and staunch, I just think I'm screwed up. I just want to have a bit of a, I don't want to say normal because I don't know what it is, I just want to have a better life . . . I've just had enough of the anger and, I've just had enough of it and I can't go deal with it in the wrong way because of the obvious results and I just don't want to live like that anymore, simple as that.

Jason realized that this way of coping was not effective, and to deal with his issues in the right way, he was motivated to remove his armor and discover who he really was. Again, he indicated that he was motivated to be open and honest during treatment. Lex explained that he was able to use his own experiences in his psychodrama training, and this gave him the opportunity and the motivation to engage with treatment:

And that was a journey I was on as part of my training and so the abuse just became part of that journey, so it wasn't that I particularly wanted to deal with it, I was just committed to knowing myself and being more fully in the world and my training didn't progress for about 5 or 6 years while I dealt with it.

A contrast was noted between Mark's reason for seeking treatment and the reasons of the other participants who described benefiting from treatment. Mark described external motivation to receive treatment:

I hoped that they would take away my issues, because I was always under the impression that counselors and psychologists fixed you, you know like glue, and that certainly, now that I work in the field I can certainly see the advantages of it, but at the time I was just doing it to keep my partner quiet.

Mark described his main reason for engaging in treatment to be the motivation of somebody else, whereas all other participants described internally motivated reasons for seeking treatment. Furthermore, Mark's expectations about treatment were that his issues would be taken away, whereas other participants indicated that they expected treatment to help them to change in some way. Mark's external motivation to engage in treatment for his partner did not appear to allow him to engage fully and benefit from treatment.

### *Developing a Connection With Treatment Providers*

This superordinate theme addresses participants' relationships with their treatment providers and emphasizes the importance of trust and connection within the therapeutic relationship. Mark, who did not benefit from treatment, did not describe having a strong connection with his therapist. For Andrew, who had not received treatment for his sexual abuse, his lack of connection with professionals in relation to past treatment was his main reason for not wishing to engage in further treatment:

I'd seen a couple of psychologists through CADS but I didn't really connect with too many people that I could open up to around my addictions, let alone my abuse. . . . My treatment for my addictions wasn't that helpful sometimes as far as professional people were concerned, so I disclose it to friends, more than I would any professional person. So it's about the person's own ability as opposed to the qualifications they've got. . . . For me, I haven't met very many people who can listen to what I have to say. And I've had bad experiences.

Andrew did not feel comfortable disclosing his abuse to professional people, although he mentioned that he does get support from his friends who he feels

able to speak to openly. He appeared to have little confidence in professionals to be able to understand and help him, and his negative experience of past treatment prevented him from seeking treatment for sexual abuse.

Many participants described negative experiences with professionals before they were able to find a connection with one particular professional. For example, Peter said,

Yea, so with the psychiatrists, and psychologists, and counselors and all that I only connected with my last counsellor, I guess because I never discussed things properly with them, I don't know whether they would have accepted me or. . . . I got that feeling from a couple of counselors so I didn't go any further and the biggest thing for me in all of it is just being honest and saying how it was and the results of it.

Peter described being unable to open up and connect with previous professionals he had worked with due to a fear that they would not accept him. He recognized that being able to talk honestly about his experiences was an important part of treatment, but considered the reactions of professionals sometimes prevented honest disclosure.

The fear of not being accepted or understood by professional people was common with all the participants. Participants talked about a need to feel as though professional people were hearing them accurately. Some participants described worrying that professionals they talked to would not be capable of coping with their stories and so would not be able to help them. Others had not been able to develop rapport with professionals they had seen because the professionals avoided actually discussing the abuse. Jason's experience of not being asked about his abuse, despite this being the reason for his appointment, added to his fears that professional people did not truly listen to him:

Didn't ask the right questions and I was in there for half an hour and didn't ask me one question that focused around abuse. I left there feeling worse than I went in, even my partner commented what the hell are you doing out here already? I don't want to judge the man because there's not many people out there bar people who have lived through the experience that can actually help, so getting the help, like I said I'm very lucky and blessed to have the help that I have now because it just wasn't there before, at all in any way shape or form.

He implied that those who do not have personal experience of being abused have difficulty helping others, making seeking help harder. Ray also described a situation where he did not appear to be listened to or understood, in that the professional person he talked to did not understand his abuse experience. Ray said about his assessment (necessary for government-funded therapy):

I only ever had one assessment, which was, it was kind of disappointing in a way, I mean it was about three pages of report I got, but I don't think that the psychologist really could separate homosexuality and abuse, he said I was embroiled in a homosexual situation at the school, but did concede that it affected me.

Andrew's experiences with professionals prevented him from engaging in treatment for his sexual abuse specifically. He described,

Being talked to like I was just something out of the textbook. One regret I have had is that I made a clinical psychologist very uncomfortable because of how I was and I was just sick of her talking to me like, I call them desktop generals, there was no rapport, there was no connection, there was no real understanding, there was someone behind a desk and someone they had to see.

These types of experiences with professional people reinforce participants' fears that they will not be understood and stop them from being able to engage fully in treatment. Despite these difficulties in developing a relationship with a professional person, most participants described one professional person with whom they felt a connection and with whom they were able to fully discuss their abuse experiences and go on to benefit from therapy. However, usually these connections only came after seeing a number of professionals.

In addition to professional support, most participants reported that ongoing support from friends, support groups, or other people that they were able to talk to was important. There was a sense from many participants that they had someone they could call if they needed to, and this safety net appeared to be very important to them. Lex illustrated this:

Yea I can go back when I need to and the work I do with other men reinforces my journey all the time, so seeing in them things that I have dealt with and reminds me what my struggles are and helps me be clear about those, so I think you always learn about yourself when you are working with others.

Overall, contained within this theme is the imperative for the survivor to be enabled to develop a trusting connection within the therapeutic relationship. The survivor's ability to develop a connection with a professional person, which at times required changing and seeking other professionals to find the right one, was essential for participants to benefit from treatment. It also indicates that professionals who are unable to develop rapport, listen to, cope with stories of abuse, or ask questions directly related to abuse can create barriers to treatment engagement.

### *Changing Thinking About the Abuse*

This superordinate theme incorporates participants' views on what they have gained through treatment. It includes the way participants have changed their thoughts and behaviors because of their treatment. The seven participants who benefited from treatment reported that they changed their perspective of their abuse, or of themselves, through the course of their treatment. For some, this involved recognizing and understanding that they had been abused. As children, most of the participants believed that they were responsible for the fact that they were abused. Most participants described changing their perspective from believing that they were responsible for what happened to them to realize that someone else had taken advantage of them, they were not deviant, and it was not their fault. James said,

I guess it's more just talking about it and I guess the more I talk about it the more I understand it as being abuse, because I've been going to this group for a year and five months and hear other people's stories or bits of their stories and I always kind of feel like a fake, like a phony sitting there because I feel I haven't been abused, because I enjoyed it and I kind of feel like I don't belong there sometimes. And I think that's what I'm learning with the counsellor, even though I enjoyed it, doesn't mean it wasn't abuse.

James had to shift his feelings of being responsible for his abuse occurring and change his thinking to realize that he experienced abuse. He appeared to be beginning to understand that he did deserve help and that a negative thing had happened to him that had affected his life. His perspective that he is wrong was being changed to the perspective that he was wronged by somebody else. This allowed him to enter a space where he could accept that he had been abused and accept that he could receive treatment for this.

Associated with letting go of feelings of responsibility about the abuse, participants also described changing their view of their abusers.

I think I came to understand it a lot differently. I think that's where I got the, also realized that both those people who did that to me have issues and I was able to come to terms with that. That was a huge step. (Simon)

Simon described that his change in thinking about his abusers helped him understand why his abuse occurred so that he could start to explain it and cope with it.

Mark received treatment for his sexual abuse experiences but did not benefit from this treatment or change his thinking. He then identifies that he was not engaged in treatment for himself, which may have contributed to his lack of change in thinking or feeling:

Interviewer: So then after talking to this professional person, did things change?

Participant: Not obviously.

Interviewer: Did you think or feel differently about the abuse after talking to the counsellor?

Participant: I don't recall feeling any better.

Interviewer: What about thinking differently about it, did it change the way you thought?

Participant: Nothing snapped to me about it, I think a lot of it might have been me though because I wasn't really doing it for me, so maybe that's got something to do with it. (Mark)

All of the participants who benefited from treatment described changing their view of themselves and gaining insight about their own behavior or feelings through treatment. Some of the participants went into treatment wanting to understand themselves better as a person, but most of the participants achieved this after treatment. Most participants gained insight about their behaviors after the abuse and their reactions to the abuse. They started to understand the relationship between the abuse they experienced in their childhood and the issues they were currently experiencing rather than continuing to think that they were inherently flawed or bad. They were able to understand their current reactions to situations in which they feel threatened or vulnerable, and relate these reactions to what happened to them in the past, to understand them better and take control over them. They learned about themselves and about their own emotions, which lead to increased self-acceptance. Ray described his change in thinking about himself:

A lot more understanding and acceptance of myself and what had happened and that it wasn't my fault, and the things I had done where just simply to try to balance up the inequality of the power situation in it, that helped.

Ray described gaining understanding that the behaviors he engaged in after being abused were a response to the abuse experience, rather than something about him. He identified the power imbalance that comes from being abused and that his behaviors related to changing this balance to make him feel more powerful. Once he understood these behaviors and where they originated from, he was able to accept himself and reduce his feelings of responsibility related to the abuse. Lex was able to make sense of his world and his needs through treatment:

Once I had identified it I could then make more sense of my world. Over a period of a couple of years the black holes where I couldn't speak got less and less and they don't happen at all now. I'd spent my whole life trying to be

lovable and now I love myself so instead of getting unconditional love from everyone in the world except me, I now love myself, which means I need less unconditional love from others.

Kim also gained insight about his reactions:

Initially it was that I could see, I could know what was happening in me, so if I went down to [the pub] on a Friday night and began to feel really uncomfortable I would know why, instead of just wanting to get the hell out of there. The nightmares got worse and the flashbacks got worse during the therapy, but they certainly, I mean I stopped therapy when they were at a manageable level, I was sleeping better, people who know me were sort of seeing me as more settled and also I just wasn't feeling this overwhelming shame, like whenever a cop pulled me over or someone told me off at work or my partner went quiet for the day, I wasn't reacting to that by feeling, oh I'm a piece of shit, I'm an awful person.

Kim's insight that his symptoms became worse during therapy was a phenomenon that was common in this group of participants, because therapy forced them to engage with the abuse rather than avoiding it. He described experiencing shame, especially when it appeared he had done something wrong, indicating that he believed he had done wrong in terms of the abuse. He was beginning to change his opinion of himself and gain understanding of where these thoughts had come from, allowing him to change them.

Overall, within this theme, participants who had benefited from therapy identified that to benefit, they need to first understand that they were abused and deserve to be getting help. As they changed their thinking about the abuse and themselves, the cycle of shame, guilt, and destructive behaviors was interrupted. The participants described the importance of understanding their reactions and thoughts as they gained a new sense of identity and control over their behavior.

## **Discussion**

The goal of this study was to provide a phenomenological perspective on the barriers, benefits, and mechanisms associated with engagement in formal therapy for a group of resilient men with a history of CSA. Consistent with prior qualitative research, the present study indicates that engagement in formal therapy can be beneficial (Easton et al., 2015) but that there are multiple barriers to therapeutic engagement (Alaggia & Mishna, 2014; Easton et al., 2014; Gagnier & Collin-Vézina, 2016; Willis et al., 2014). The majority of participants in this study described strong motivation to change that therefore

enabled them to persevere with seeking therapy despite multiple barriers. It was identified that formal therapy can prompt mechanisms of change previously identified as important aspects of the healing process, that is, through relationship and changed thinking (Draucker et al., 2009; Easton, 2013; Grossman et al., 2006; Kia-Keating et al., 2010).

Consistent with prior research, this study found multiple barriers to treatment engagement (Alaggia & Millington, 2008; Easton et al., 2014). The most commonly noted barriers to engaging in treatment were internal factors such as shame, fear of being disbelieved, and fear of not being understood. In addition to internal barriers, several structural barriers were identified that had the potential to reinforce internal barriers. Structural barriers ranged from navigating complex systems—knowing where to access treatment, the process of getting help (filling out forms, completing an assessment, sitting in a waiting room), cost of treatment—through to the client engaging with an appropriately skilled therapist.

Most participants described persevering to find a therapist despite substantive internal and structural barriers due to their strong motivation to change. The men reported this motivation was connected to strong feelings about wanting to break away from the effects of abuse in their lives and to live different lives. This theme has been noted in prior research where male and female survivors have discussed “getting tired of living with the effects of violence” (Draucker et al., 2009). The majority of the men in this study reported that they wanted to understand their abuse and themselves, rather than just having the effects taken away or fixed by a professional. This helped them to engage with the sometimes challenging therapeutic process and enabled them to address prior strategies of avoidance, which they recognized as not having helped with their symptoms of anxiety, hypervigilance, and relationship issues. The men described recognizing that understanding and controlling their anxiety or anger was more helpful than avoiding it.

The process of therapy was ongoing over a period of years for most men, with the majority looking back and summarizing a long period of therapeutic engagement. The process of therapy as being nonlinear and taking place over a long period has been described by others (Easton, 2013), with some reporting that “the process of healing is never complete” (Draucker et al., 2009). Part of this long journey of therapeutic engagement also included experiencing negative clinical experiences prior to forming an alliance with a therapist. This possibly partly reflects the nature of the therapeutic process whereby two factors, client readiness for treatment and therapist skill, coincide. However, it is also likely to reflect a structural barrier whereby a lack of comfort and competence by many therapist in working with sexual abuse trauma results in, at best, delayed treatment (Day et al., 2003).

Therapists who did not ask about abuse or who appeared to show discomfort with the discussion had the potential to do further harm to their clients due to several processes. First, avoidance of sexual abuse by a therapist has the potential to reinforce secrecy and shame through the message that this is not something that should be talked about and talking about it may be dangerous. In this study, a significant obstacle to engaging in treatment was a negative experience with a treatment provider in the past. Second, feeling rejected by a therapist can also be seen in light of attachment processes and thus work to reinforce beliefs about the danger of vulnerability and the necessity to avoid intimacy (Allen, 2001). Sexual abuse can result in a disruption of the capacity to form intimate relationships with boundaries (Allen, 2001) whereas a positive relationship with a therapist can work toward repairing this fundamental disruption (Muller, 2010).

In addition to enabling therapeutic engagement, a positive relationship with the therapist was identified as an overarching benefit of therapy. Prior research has indicated the importance of supportive relationships for healing and we observed this mechanism to be an essential element of formal therapy (Kia-Keating et al., 2010). Despite setbacks, most participants in this study eventually found a therapist that they were able to develop a therapeutic relationship with and then they were able to tell their story. Having their story heard, believed, and accepted without judgment was a key element in treatment and interacted with the second superordinate theme and mechanism of change identified in this study.

Participants identified that changed thinking about themselves and their abuse was a significant benefit of therapy and that this was only possible within a supportive, accepting therapeutic relationship. As the men in this study were able to be honest in their therapeutic relationships, they were able to understand how their thoughts and behaviors were influenced by their abuse experience. This allowed them to question the belief that their behaviors reflected their inherent inadequacy—that there was something wrong with them, for which they should feel shame or guilt. Participants reported that through increased understanding of their abuse, their feelings of responsibility for the abuse were reduced, which reduced their feelings of shame. Participants identified that disclosure of current behaviors enabled them to understand the reason for their behaviors and to develop compassion toward themselves as they worked to learn new patterns. With a framework to understand their behaviors, thoughts, and feelings, they developed a greater degree of control over their behavior and a lessening of the shame they had felt. They were able to challenge their appraisals of the meaning of abuse, beliefs that others would not believe them, and beliefs about themselves. Furthermore, as they gained greater awareness, they were able to address prior strategies of

coping through avoidance such as through the use of alcohol or avoidance of triggers and reminders. The importance of changed thinking has been a key finding in other studies of healing from sexual abuse trauma (Easton, 2013; Grossman et al., 2006; Willis, Rhodes, et al., 2015).

### *Limitations and Future Research*

This study explored the experiences of a specific group of individuals; future research is necessary to ask similar questions about the barriers, benefits, and mechanisms of treatment with men who may have had different experiences. In the present study, all participants were part of a support group for male survivors of sexual abuse and therefore were actively receiving support. Furthermore, their participation in a peer support group may indicate a level of acceptance and willingness to tell their stories that many male survivors of sexual abuse are yet to experience. This group of participants were able to acknowledge their experiences as sexual abuse and disclose this in a group setting; many male survivors would find this difficult.

In this study, most participants had persevered to find a therapist who was able to demonstrate compassionate presence in the midst of disclosure. The majority of participants had specifically sought treatment for sexual abuse as the presenting issue and sought treatment despite having encountered previous negative clinical experiences. Thus, the participants in this study showed resilience in persisting with accessing treatment. There are likely to be a number of men who engage with mental health services without reporting a sexual abuse history, a number of men who do not try again after encountering a nonsupportive clinician, and men who have never sought therapy. A negative experience with therapy has the potential to confirm the beliefs that sexual abuse is unmentionable, overwhelming, and that they are alone. These stories also need to be heard. In addition, research with men who do not belong to a survivors' group may provide different insights into barriers to treatment.

The participants in this study reported that strong motivation to change helped them to persevere with seeking treatment. It is also likely that they were able to be supported by the survivors group to find a therapist that met their needs or they may have personal or social resources that enabled them to both engage with a survivors group and those factors may also have helped them to engage with therapy. It would be valuable for future research to explore more fully the nature of the mechanisms that enable men to overcome structural barriers. Furthermore, the participants in this study comprise a group of men who have engaged in therapy over a long period of time; men at the beginning of the treatment journey may offer a different perspective on the nature of the challenges in initial therapeutic engagement.

In addition, all of the men identified as European, predominately from New Zealand, and therefore do not represent the experiences of sexual abuse within other cultures. Prior research indicates that ethnicity can have significant implications for the outcomes of male survivors of sexual abuse (Payne et al., 2014), but we were unable to explore these implications in the current study. We also did not explore sexual orientation as a potential factor that may have interacted with the experience of therapy. Furthermore, the participants in this study all identified as men. A future study that examines the role of gender could be valuable for several reasons, for example, the experience of transgender people, the interaction between client and therapist gender, or a study that examines differences in the therapy experiences of men, women, and gender queer individuals.

Another factor that was not explored in the study was the effect of different types of therapy such as group therapy compared with individual treatment with one professional person. The similarity between the therapy session and the abuse context was mentioned by one participant. It may be that group settings reduce the power differential of the usual therapeutic relationships along with increasing the expectation that others will be able to understand their experiences because they have also had them happen. It would be valuable to explore this in a future study. Fouché and Walker-Williams (2016) have outlined key theoretical approaches used for interventions with survivors of CSA; the degree to which gender influences outcomes has yet to be explored when considering the success of these treatment modalities.

## **Conclusion**

The themes identified in this study (“developing a connection with treatment providers,” and “changing thinking about the abuse”) indicate what men require when they talk about their abuse experiences in formal therapy. They need to be listened to, believed, and understood. Men described changes in their coping skills, sense of identity, and reduced emotional distress when they were able to work alongside a skilled and empathic therapist. The men in this study reported being strongly motivated to persevere with therapy, despite structural and internal barriers, due to a strong desire to heal and live a different way. Therapists must acknowledge and respond sensitively to this desire for change alongside offering hope that change is possible.

## **Declaration of Conflicting Interests**

The author(s) declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

## Funding

The author(s) disclosed receipt of the following financial support for the research, authorship, and/or publication of this article: The study was funded by the James Hume Trust Fund.

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