

**A First Step in the Development of a Program Model
for Male Survivors of Childhood Sexual Abuse:
Report of Relevant Issues**

By

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For

**The Men's Resource Centre
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Introduction

History and Background

In 1985, The Laurel Centre (then known as the Women's Post Treatment Centre) was founded to provide therapy to women who were dealing with a history of childhood sexual abuse as well as compulsive coping behaviours, particularly addictions. The first agency to treat both of these issues simultaneously, The Laurel Centre has demonstrated innovativeness since its inception. Its purpose is to

- a. enable the provision of counselling services for women and youth who have experienced childhood or adolescent sexual victimization and want to resolve long term effects of abuse, recognizing that challenges to mental health as well as addictions are among the long term consequences related to unresolved trauma;
- b. enable the provision of counselling services for men who have experienced trauma and stressors in their lives and want to resolve related issues, recognizing that challenges to mental health as well as addictions are among the long term consequences related to unresolved trauma and stressors;
- c. to address the issue of societal denial of the seriousness and prevalence of the problem of child sexual abuse, and the detrimental long term effects (including challenges to mental health and addictions).

Given this purpose, The Laurel Centre provides counselling which allows women, men, and youth to understand their experiences, to put their experiences in context and to make the link between mental health, their compulsive coping behaviours and the trauma experienced in their childhood. **This understanding empowers them to make life affirming choices and to resolve the impact of trauma by integrating physical, emotional, intellectual, social, and spiritual aspects of self in context.** The purpose and the services are supported by the following perspectives:

- a. that women, men, and youth have a right to social, political, and economic equality and power;
- b. that childhood sexual abuse has a long term damaging effect over one's wellbeing (physical, emotional, social, spiritual, intellectual), and may result in challenges to mental health and the adoption of compulsive coping behaviours;
- c. that problematic adaptation is a consequence of inadequate resources and supports rather than a reflection of deficiencies within the women, men, and youth; and
- d. that women, men, and youth have the right to choose the course of their healing process.

With an established reputation for quality services and a well developed system for tracking service utilization and outcomes, The Laurel Centre was in an ideal position to take on the administration of the Men's Resource Centre (MRC), which it did in 2010. The Men's Resource Centre, established in 2001 as part of a joint project between the Province of Manitoba and the School of Social Work at the University of Manitoba, was the first male specific agency in Manitoba. Since becoming a program of The Laurel

Centre, the MRC has provided drop-in, individual and group counselling related to a variety of trauma and stressors experienced by men.

The current goal is to develop a childhood sexual abuse (CSA) program at the MRC comparable to that at The Laurel Centre. In recognition that men who experienced CSA may have different concerns and issues than women and that the program model for women may not be applicable to men, the need to develop a model specific to men was identified. This report represents a comprehensive review of issues relevant to CSA programming for men. It is intended to guide decisions as to the best approach and content for a men's CSA program. Suggestions and recommendations are included at the end of the document.

Methodology

With the intent of facilitating the development of a program model for men who experienced childhood sexual abuse (CSA), this report outlines issues relevant to impact and therapeutic approaches. The information is based on two sources of information:

1. A literature review on the sexual abuse of males, its impact in adulthood, and therapeutic approaches with adult males who experienced CSA.
2. Focus groups and interviews with men who experienced CSA, therapists providing services to men, and therapists providing services to women who experienced CSA.

The literature review focused on more recent research and reports, however older sources are also represented where appropriate. Overall, early and recent research reports similar issues and findings. A bibliography is included at the end of the report. It consists of references used in the report as well as other literature that presents information related to the topic areas but not used for the report. The sources are categorized into the topics areas presented in the report. A complete non-sectioned bibliography is also available upon request: Jocelyn.Proulx@ad.umanitoba.ca.

Men attending programming at the MRC were invited to attend one of two focus groups or to take part in individual interviews, according to their preference. Men were provided with an honorarium as compensation for their time and input. Focus groups took place at the MRC and emergency counselling was made available to anyone who became distressed during or after the focus group/interview. Men were provided with a list of Winnipeg based resources for men, including counselling and crisis lines. A total of 14 males participated in interviews or focus groups.

Focus groups were also conducted with staff at the MRC who were able to provide information based on their work with men in general and with men who have experienced CSA. The staff of The Laurel Centre, who provide therapy to women who experienced CSA were also invited to participate in a focus group to share information about working with survivors (for example, the development of similar mental health issues and compulsive coping behaviours). Given that the literature reports some similar impacts for

both males and females, their information was helpful to the process of model development for men's programming. As with the men, individual interviews were given as an option for staff from both agencies. A total of 14 staff from the Laurel Centre and the MRC took part in either focus groups or individual interviews.

To protect the privacy of the participants and the confidentiality of the information provided, no names were recorded and no distinction was made between individuals who participated in focus groups or interviews. Although the information from the literature and from the focus groups/interviews often coincided, the report makes note of these different sources of information. Where relevant, distinctions are made between men's and staff responses.

A Trauma Informed Perspective of Childhood Sexual Abuse

The Laurel Centre was among the first service provider agencies in Manitoba to become trauma informed. This approach has been applied to all of its services and extends to its programming at the MRC. For all clients, including men who have experienced CSA, this means an approach that is respectful, nonjudgmental, individualized, empowering, and collaborative.

A trauma informed approach recognizes the link between a person's past, present and future and helps them understand these links (Proulx, Barkas, Messina, 2011). This leads to a more defined perspective on how the initial trauma has led to subsequent traumas. **In the case of CSA, it can lead to incarceration, experiences of violence and rejection, the break up of valued relationships, and loss of jobs. The approach also acknowledges the role of culture and social environments on the trauma and its effects** (Klinic Community Health Centre, 2008). For CSA in males this would include recognizing the role that male socialization has on attitudes, beliefs, disclosures, and responses to disclosures. Understanding these experiences and their connections helps to clarify that although past experiences are always part of the person's life, they don't have to dominate the present or dictate the future. It is the person's current choices and behaviour that will impact their future and therefore they are actively involved in shaping the future they desire.

Because being trauma informed means understanding the complexity of trauma and its effects, in the case of CSA it leads to the recognition that abuse is linked to other forms of trauma and to the development of substance use and mental health issues. Due to the interconnection of these experiences, it is acknowledged that these have to be dealt with simultaneously in therapy. Men have to be able to talk about these issues and the links between them as they come to process their thoughts, emotions and behaviours related to the abuse. Separating them would make recovery fragmented and less successful.

Trauma informed services take a holistic view of individuals and treat them as more than just victims (Proulx, et al., 2011). Individuals are not seen as damaged, maladapted, and pathological, but rather as having been injured. Evidence of the neurobiological effects of trauma supports this perspective, as it demonstrates that these experiences affect brain structures and functioning, much as an experience of physical harm injures muscle and bone. Recovery addresses these injuries and their effects. Because trauma such as CSA affects individuals' identity, it often becomes the focal point of their self concept. They can also become the means by which others identify them, as an "abused person" or a "victim" which only confirms this unidimensional view of self. The trauma informed approach encourages the person to see themselves within a broader perspective thereby promoting the development of other aspects of identity and defining themselves with multiple abilities and qualities rather than just by their abuse.

Being trauma informed also encompasses a strength and resilience based approach to therapy (Klinic Community Health Centre, 2008). Identifying the person's strengths and abilities is empowering for them and builds their sense of self efficacy or confidence in being able to talk about and move beyond their experiences of abuse. Respect for the

person's capacity to cope and survive from their experiences rather than disqualifying their strategies as harmful and maladaptive is an essential part of a strength based approach. Change then becomes a matter of selecting other types of coping strategies that are more adaptive in their current circumstances and the efficacy built will encourage pursuit of these alternate choices.

Another empowering component of the trauma informed approach is that it promotes a partnership between therapists and clients (Klinik Community Health Centre, 2008). Abuse takes control away from the individual. A collaborative approach gives them back control over their lives and the course of their therapy. Having the therapist listen to what is important to them and being given a voice in their own therapy validates their being an effective agent in their lives and in the world; this in turn enhances self efficacy and the confidence to implement change. Because the therapeutic relationship is a partnership it means that individuals do not have to go through the process of change alone.

Incidence and Prevalence Rates

Recent estimates of prevalence rates of CSA in Canadian males are between 14% (Briere & Elliot, 2003) and 37% (Trocme, Fallon, MacLaurin, Daciuk, Felstiner, et al., 2005), with the most frequent estimates being one in six or 16% (Dorais, 2009; Dube, Anda, Whitfield, Brown, Felitti, Dong, & Giles, 2005; Hopper, 2010). Research indicates that incidence are higher among gay/bisexual men, Aboriginal men, sex trade workers, homeless men, runaways, disabled/challenged men, addicts, psychiatric and incarcerated populations (Amos, Peters, Williams, Johnson, Martin, & Yacoubian, 2008; Bernstein, Ahluvalia, Pogge, & Handelsman, 1997; Butt, Chou, & Browne, 2011; Dorais, 2009; Fisher, Goodwin, with Patton, 2009; Henny, Kidder, Stall, & Wolitski, 2007; Johnson, Ross, Taylor, Williams, Carvajal, & Peters, 2006; McCormack, Rokous, Hazelwood, & Burgess, 1992; Ryan, Miyoshi, Metzner, Krugman, & Fryer, 1996).

Despite fairly consistent findings about prevalence rates, it is believed that these represent underestimates because of underreporting and males being left out of CSA research (Crowder, 1995; Violato & Genius, 1993; Kohn Maikovich-Fong & Jaffee, 2010). Underreporting occurs for a variety of reasons including males' fears of the social and personal repercussions of disclosure, male socialization to be tough and stoic about experiences, social expectations that males are more sexual and more prone to sexual exploration, and males' belief that that they are alone in their experience (Durham, 2003; Hunter, 2009; 2010; Sorsoli, Kia-Keating, & Grossman, 2008; Romano & DeLuca, 2001). (A more in-depth look at disclosure issues can be found in the section on Manifestations of CSA Impact). Because research into child abuse grew with the increased attention to violence against women, investigations of CSA focused on girls as victims. With this focus and the subsequent knowledge and research came more reporting by girls and this led to yet greater attention and more services for females. The lower reporting rates and the lack of attention in the research to male CSA have contributed to a lack of social awareness of male CSA and consequently the lack of services devoted to males (Kia-Keating, Grossman, Sorsoli, & Epstein, 2005). The lack of awareness reinforces men's belief in the uniqueness of their experience and increases their reluctance to report, thereby establishing a negative feedback loop where less awareness and services leads to less disclosure which in turn contributes to less awareness and services.

The research indicates that there are greater similarities than differences in the characteristics of CSA experienced by boys and girls. The differences that are most consistently reported are that for boys abuse begins at younger ages, is mostly extrafamilial, and involves more threats and/or physical force or abuse (Fisher, et al., 2009). As with girls, in cases of extrafamilial abuse, the perpetrators are more often known to male victims. The lack of a father figure and dysfunction in the family appear to be common risk factors for the sexual abuse of boys (Lyle, 2008). Many of the men who took part in the focus groups/interviews reported problematic or nonexistent

relationships with their fathers. Their need for affection makes them more vulnerable to the attention of abusive adults (Garrett, 2010; Gartner, 1999; Leung, Curtis & Mapp, 2010; Martsof & Draucker, 2008). Gay children and youth also appear to be more vulnerable, possibly due to their lack of closeness or comfort with peers, fears related to their sexual orientation, or as mentioned by a few men in the focus groups/interviews, their more feminine characteristics.

Female Perpetrators

It has been and continues to be difficult to determine the rate of CSA perpetrated by females due to under-reporting by victims and social reluctance to identify women as perpetrators. Most rates have been derived by case reports to social services or the justice system, but when compared to self reports of victims the two rates are very discrepant, with self reports being significantly higher than case reports (Denov, 2003a). This discrepancy is larger for male victims than for female victims. It has been suggested that part of the issue is the social perception of females being nurturing, caring, maternal, less concerned with sex, not sexually aggressive, and sexually harmless (Bornstein, Kaplan, & Perry, 2007; Crowder, 1995; Denov, 2001; 2003a), leading to the myth that women do not sexually abuse children (Gartner, 1999).

Both professionals and laypersons minimize women's culpability in cases of CSA. Studies using vignettes that alter the sex of the victim and the perpetrator of CSA have found that people believe that sexual abuse perpetrated by females is less harmful to the victim than abuse perpetrated by males (Bornstein, et al., 2007; Broussard, Wagner, & Kazelskis, 1991). Some of these studies have created vignettes about teachers and students with the same results, situations where female teachers sexually abuse male students were seen as the least harmful and often not recognized as abusive (Dollar, Perry, Fromuth, & Holt, 2004; Smith, Fromuth, & Morris, 1997). In each of these cases, male perpetrators with male victims are perceived as the most harmful scenario. Further, the effect was stronger for male respondents.

These beliefs are also common among professionals and therefore affect their actions in cases of female perpetrated CSA. Denov (2001) found that for both Canadian police officers and psychiatrists women were not officially considered as perpetrators. The term perpetrator was always made in reference to a male and the term victim to a female. This perception was included in the formal training for these professions as well as their informal culture; it had become ingrained in the language of these occupations. With all sources of information validating each other the perception was never challenged. They did not believe that women had the ability to commit sexual assault nor that women were capable of being sexually interested in children. Acts of sexual perpetration were explained as being unintentional (i.e. sexually educating the child or the victim was not reliable or sought the sexual attention) or nonthreatening to the community (i.e. nonviolent, nonaggressive, not harmful).

The lack of recognition of female perpetrated abuse often means that action is less likely to be taken and sentencing lighter (Denov, 2001; 2004). Hetherington and Bearsall (1998) found that both social workers and police officers felt in cases of female perpetrated sexual abuse, investigations were less necessary. This lack of concern leaves both victims and perpetrators without helpful intervention (Denov, 2001; 2004). With the prevailing social and systemic attitudes that male victims of female abusers actually enjoyed the encounter, that they initiated the encounter or that they were lucky to have received this female attention (Denov 2001; Crowder, 1995; Hunter 1990; 2010; Romano & DeLuca, 2001; Schachter, Stalker, Teram, Lasiuk, & Danilkewich, 2009), male victims' disclosures will be less likely to be believed and more likely to be ridiculed or minimized. This potential revictimization by the system maybe contributing to men's lack of disclosure and service seeking (Denov, 2001; 2004). Research has found that CSA victims find it more traumatizing to be abused by a female (Denov, 2004) and more difficult to disclose abuse by females rather than by males, stating that it is particularly shameful to be abused by a woman. They were fearful that disclosures would elicit hostile responses, disbelief, and minimization (Denov, 2003a). Male victims in particular were embarrassed at admitting that they were not masculine enough to fend off a woman (Denov, 2004; Gartner, 1999). These fears are realistic as victims were more likely to be believed if the perpetrator was a male rather than a female (Bornstein et al., 2007), this is especially so if the person the victim disclosed to was male (Golding, Sego, Sanchez, & Hasemann, 1995; MCCauley & Parker, 2001). The response of professionals has been associated with the wellbeing of survivors, with supportive responses such as acknowledging and validating the abuse mitigating negative consequences and nonsupportive responses such as minimization and disbelief exacerbating negative effects (Denov, 2003b). Revictimization by the system thus prolongs the effects of the abuse (Denov, 2001).

The effects of abuse by a female appears to be similar to abuse by a male with some exceptions. For men especially, there are often problematic relationships with women, based on mistrust of women and discomfort with women's sexuality (Denov, 2004). Men are often angry and embarrassed at having been abused by a female and sometimes act in hypermasculine ways to reconfirm their damaged sense of masculinity. Female victims report a sense of confusion and discomfort with femininity and their own sexuality. Glasser, and colleagues (2001) found that males who had been sexually abused by a female, especially a mother or a sister, were more likely to become sexual offenders than males who had been sexually abused by a male. Other effects such as addictions, self injury, depression, fear of abusing their own or other children, and choosing not to have children because of this fear are common in all male survivors and are discussed more in detail below. Interestingly, Denov (2004) found that of the four survivors she interviewed who had sexually abused a child themselves, the two men had been convicted of the crime but the abuse perpetrated by the two women was not even reported.

The Impact of Childhood Sexual Abuse Trauma

Physiological Impact

When a person experiences a stressor, information about the nature of the stressor is sent to the thalamus (brain area that receives information from the senses and relays this information to other brain areas), which then sends the information to the amygdala. The amygdala responds automatically by sending messages to the brain stem and this generates a sympathetic system response that prepares the body for flight or fight (increased heart rate, change in muscle tone, rapid breathing, constricting arteries in the digestive system). In addition to generating a physiological arousal response the amygdala sends messages to the hypothalamus (brain area linked to biologically based behaviours such as eating and regulation of hormones) which triggers a hormonal system response.

1. The HPA axis

The hypothalamus releases corticotrophin releasing hormone that then triggers the pituitary gland to release beta-endorphins which act to suppress pain (van der Kolk, 2003). The hypothalamus also releases adrenocorticotropin hormone which stimulate the adrenal gland to release cortisol (Yehuda, 2002). Stress leads to a dysregulation of this system. In the case of posttraumatic stress (PTSD), flashbacks and intrusive memories lead to the continued release of beta-endorphins, which has been associated with other PTSD symptoms such as avoiding situations or thoughts reminiscent of the trauma, emotional numbing, lost of interest in life, and detachment from others.

Problems with the release of cortisol also occurs (Pfeffer, Altemus, Heo, & Jing, 2009). Cortisol impacts learning, memory and emotions. It plays a role in metabolism by regulating the storage of glucose and effects the immune system by determining the length and strength of the inflammatory response to injury and by promoting the development of immune system cells. In nonstressed individuals cortisol is produced in higher levels in the morning and these levels gradually decrease during the day. With stress comes an increase in the production of cortisol and this increases the sensitivity of the thalamus. This increased sensitivity means individuals will be better able to focus on dangerous or threatening stimuli, remember information relevant to the stressor, and stabilize information about the stressor in long term memory, thus improving their response to stressors (van der Kolk, 2003).

An overproduction of cortisol eventually leads to a reduction the secretion of corticotrophin releasing hormone and adrenocorticotropin hormone. Since adrenocorticotropin hormone promotes the release of cortisol, over time there is a subsequent decrease in the release of cortisol (Miller, Chen, & Zhou, 2007). This negative feedback loop likely accounts for research findings that individuals with PTSD have lower levels of cortisol in their system (Delahanty, Raimonde, & Spoonster, 2000;

Marshall, Blanen, Printz, Liebowitz, Klein, & Coplan, 2002; Miller, et al., 2007; Olf, Guzelean, de Vries, Assies, & Gersons, 2006; Shalev, Videlok, Peleg, Segman, Pitman, & Yehuda, 2007; Witteveen, Huizink, Slottje, Bramsen, Smid, & Van der Ploeg, 2010; Yehuda, Morris, Lebinsky, Zelman, & Schmeidler, 2007). Individuals with depression and who are under current conditions of stress tend to have higher than normal levels of cortisol in their system. Even individuals with PTSD and generally lower levels of cortisol may have temporarily elevated levels in response to current stressors (de Kloet, Vermetten, Geuze, Kavelaars, Heijnen, & Westenberg, 2006; Handwerker, 2009; Marshall, et al., 2002). It is not yet clear from the research whether PTSD causes lower levels of cortisol or if it is individuals with a genetic predisposition to having lower levels of cortisol that tend to develop PTSD. Both higher and lower than normal levels of cortisol in the system create problems. It is suggested that lower levels may negatively affect a person's ability to process the event into long term memory and therefore the memory remains as intense as when it first occurred. This may account for the flashbacks, intrusive memories, nightmares, and fears characteristic of PTSD (Delahanty, et al., 2000). Higher levels of cortisol result in kindling, a process where the nervous system becomes sensitive to psychologically threatening stimuli, thereby generating an exaggerated response to even weak and nonharmful stimuli. Memories of the event and negative thoughts can enhance this sensitivity and therefore the details of the event and the sensory associations (sights, smells, tastes) remain vivid (Abercrombie, Kalin, Thurow, Rosenkrantz, & Davidson, 2003).

2. The Hippocampus

This hippocampus is a brain structure involved in the formation of memories and in the regulation of stress. Stress inhibits the hippocampus's ability to develop new neurons and establish new memories (Karl, Schaefer, Malta, Dorfel, Rohleder, & Werenner, 2006). In individuals with PTSD have less hippocampal activity during learning and memory tasks and there is a significant amount of research indicating that people with PTSD have a smaller hippocampus (Freeman, Kimbrell, Booe, Myers, Cardwell, Lindquist, Hart, & Komoroski, 2006), including individuals who experienced sexual and physical abuse (Bremner, Randall, Vermetten, Staib, Bronen, Mazure et al., 1997; Stein, Koverola, Hanna, & Torchia, 1997). Other studies however, have not found a smaller hippocampal volume for individuals with PTSD (Bonne, Brandes, Gilboa, Gomeri, Shenton, Pitman, & Shalev, 2001; Pederson, Maurer, Kaminski, Zander, Peters, Stokes-Crowe, et al., 2004; Yehuda, et al., 2007). It has been suggested that rather than PTSD causing a reduction in the hippocampal size it may be individuals with a genetically smaller hippocampus that may be more vulnerable to developing PTSD or that it is only in cases of chronic PTSD that the hippocampal volume is affected. In either case, a degeneration of the hippocampus may lead to problems in learning and remembering new information, failure to remember general or detailed information about the trauma, incomplete or no memory of the trauma and dissociative episodes (Vermetten & Bremner, 2002). This may account for reports of autobiographical memory loss in both men and women who experienced CSA, with higher rates of loss associated with more traumatic experiences (Edwards, Fivush, Anda, Felitti, & Nordenberg, 2001).

3. Medial Prefrontal Cortex

The medial prefrontal cortex lies just behind the forehead and is the brain structure involved in decision making, reasoning, and judgment. It is also involved in emotion regulation by suppressing or modifying the systemic arousal generated by the amygdala. It can send messages that the situation is safe and therefore curtail the flight or fight response or it can generate a calmer, more strategic response to threatening stimuli (Zubieta, Chinitz, Lombardi, Fig, Cameron, & Liberzon, 1999). The medial prefrontal cortex filters out irrelevant information allowing the person to focus on what is important in the environment, what requires a response, and what an appropriate response would entail in that given environment.

Trauma can impair the functioning of the medial prefrontal cortex, therefore individuals will be less able to generate effective coping strategies, self sooth and calm themselves. With less regulation of the amygdala response, the person may have an intense emotional response to fearful stimuli and may respond to a broader range of stimuli (Jatzko, Schmitt, Demirakea, Weimer, & Braus, 2006; Liberzon, Britton, & Phan, 2003; Shin, Orr, Carson, Raugh, Macklin et al., 2004; Shin, Wright, Cannistraro, Wedig, McMillin et al., 2005; Weinberg, Johnson, Bhatt, & Spencer, 2010). This may be linked to symptoms of hyperarousal, exaggerated startle response, irritability, outbursts of anger, hypervigilence, flashbacks, intrusive memories, and misinterpretation of harmless stimuli as threatening, typically found in PTSD. Reduced ability to discriminate between relevant and irrelevant information may occur and will interfere with attention, concentration, capacity to follow instructions, reasoning, judgement, and decision making. Less activity in the medial prefrontal cortex has been linked to a decreased ability to process positive emotions, perhaps because, unchecked the amygdala focuses on negative emotions such as fear (Armony, Corbo, Cliement, & Brunet, 2005; Brunetti, Sepede, Mingoia, Catani, Ferrett, Merla, Del Gratta, Romani, & Babiloni, 2010; New, Fan, Morrough, Liu, Liebman, Guise, et al., 2009).

Some of the staff that participated in the focus groups felt it was important to make the men aware of their body's response to their trauma. **Helping them understand trauma's effect on the brain and body would help them normalize their own inner state and trauma reactions. Making them aware of their physiological response would also help them change from a highly active state to a calmer one, thereby building self-soothing skills.**

Emotional Impact

Male CSA results in a number of emotions, with the most prominent ones being:

- Shame, guilt, and self blame (Crowder, 1995; Grubman-Black, 1990; Romano & DeLuca, 2001; Wilken, 2003);
- Feelings of violation and being damaged (Hunter 2009);
- Anger (Alaggia & Millington, 2008; Durham, 2003; Hopper, 2010);
- Fear (Hopper, 2010);

- A sense of powerlessness, hopelessness, lack of control (Grubman-Black, 1990; Hopper, 2010; Hornor, 2010; Spokas, Wenzel, Stirmann, Brown, & Beck, 2009);
- A sense of betrayal, especially when the abuser was a trusted individual (Hunter 2009; Isely, Isely, Freiburger, & McMackin, 2008);
- Feelings of loss and grief (Hopper, 2010).

These emotions were also identified by male and staff focus group/interview participants.

1. Self Blame, Guilt and Shame

Several circumstances can result in self-blame, guilt and shame, including: if the abuser made them feel responsible for the abuse; experiencing blame from others upon disclosure; becoming aroused and/or feeling pleasure during the sexual contact; feeling special or good because they received gifts or affection from the abuser; not meeting the norms of masculinity by not being able to stop the abuse or protect themselves; and for not disclosing the abuse (Alaggia & Millington, 2008; Dorais, 2009; Durham, 2003; Romano & DeLuca, 2001; 2006; Schachter, et al., 2009). Shame and guilt can also arise when men have sexualized thoughts about children or if they behave in a sexually abusive way towards others (Alaggia & Millington, 2008; Crowder, 1995). In focus groups/interviews staff also indicated that some men who had behaved abusively felt shame and were reluctant to discuss this behaviour. Some men generally feel guilty during any form of sexual activity, as the emotions linked to their abuse resurface at these times (Easton, Coohy, O'Leary, Zhang, & Lei, 2011). Men who participated in focus groups/interviews stated that sexual activity or intimacy often brought back memories of the abuse.

Related to shame are feelings of being violated and damaged (Fisher, et al., 2009). In Hunter's (2009) study of men and women's narratives of their CSA, both genders expressed feelings of being damaged by the abuse and carrying that damage with them. Low levels of confidence and self-esteem often accompany these feelings (Romano & DeLuca, 2001). For some, this sense of being "dirty" results in feeling unworthy of love and in fear of abandonment should others find out about the abuse (Anderson & Veach, 2005). These feelings were also reported by some of the men who participated in the focus groups/interviews.

2. Anger

Anger is another common emotion in men who have experienced CSA. Often more vulnerable emotions such as shame, humiliation, and fear get converted to anger because anger generates a sense of power rather than vulnerability (Crowder, 1995; Fisher et al., 2009; Isley et al., 2008; Wilken, 2003). Staff participating in focus groups/interviews identified this sense of power generated through anger. Anger is also more in line with the masculine norm, whereas more vulnerable emotions are most often associated with

the feminine norm. The experience of CSA, however, has many aspects that can lead to feelings of anger, including: anger at themselves for not stopping the abuse; anger at their abuser for taking advantage of them; anger against those whom they feel should have protected them; and anger at a system that ignores their experience and provides no services for them (Fisher et al., 2009; Romano & DeLuca, 2001; 2006; Wilken, 2003). These targets of anger were common among the men who participated in the focus groups/interviews. Partners, family members, and therapists are sometimes the targets of direct or displaced anger (Anderson & Veach, 2005). While anger is an understandable response to personal violation, it can become a destructive force in men's lives. Mathews (1996) distinguishes between toxic anger that is misunderstood, harmful, and misdirected and righteous anger that is part of a normative response that is acknowledged and managed in a healthy way.

3. Fear

Fear is a frequent and pervasive emotion resulting from CSA. Some men fear others finding out about their abuse and then seeing them and treating them differently (Fisher et al., 2009). Men in focus groups/interviews expressed a fear of even showing any emotions, lest others use these against them. They also feared talking about the abuse because they thought others would not believe them. Fear of being homosexual or being perceived to be homosexual and the negative repercussions from others is common (Durham, 2003; Hovey, Stalker, Schachter, Teram, & Lasiuk, 2011; Hunter, 2010; Isely, et al., 2008; Romano & DeLuca, 2001). A few men in the focus groups/interviews revealed a fear of men, particularly homosexual men. For others, fear centers around becoming an abuser or being perceived as one (Crowder, 1995; Romano & DeLuca, 2001), or of taking out their anger on others through violent actions. Staff in the focus groups reported that men felt a great deal of fear about being perceived as an offender by others and so became fearful about revealing their abuse. They stated that men often had fears about parenting and caring for their children, with some fearing becoming abusive and others fearing being perceived as being abusive or inappropriate. In many cases fear is constant and generalized to all parts of life.

4. Loss and Grief

Feelings of loss are common. They can center around loss of self, of childhood, of trust, of faith, of safety, or of family. Some men who took part in the focus groups/interviews talked about the loss of their youth and not knowing what a "normal" adolescence was like. The staff mentioned a loss of faith or religion, particularly for individuals who had been abused by clergy.

5. Emotion Regulation

Despite the broad range of emotions that can result from experiences of CSA, most men have difficulty correctly labeling their emotions and expressing them in a healthy way (Schachter et al., 2009). Problems in managing emotions may result in feelings of being overwhelmed by these emotions, and subsequent feelings of being out of control (Wilken, 2003). This perceived lack of control can lead to further fear, guilt, and anger. Although some men have difficulty in regulating their emotions, others have learned to suppress and/or maintain very strict control over them (Crowder, 1995; Wilken, 2003). After years of suppression, these men may become dissociated from their emotions and thus have even greater difficulty in identifying and expressing them. Both men and staff who participated in focus groups/interviews talked about numbing of emotions and suppressing vulnerable emotions such as shame. For some men this avoidance becomes a coping mechanism leading to a disconnect between themselves and their emotions. Establishing a strict routine with a tight schedule of activities can become part of this emotional suppression, as their schedule leaves no time for dwelling on the abuse or their emotions. Chronic avoidance of traumatic information is common in CSA survivors and leads to increased distress symptoms (Rosenthal, Rasmussen, Hall, Palm, Batten, & Follette, 2005). Some may come to fear expressing their emotions and feel shame when they do finally talk about them (Fisher et al., 2009). Staff who participated in focus groups/interviews stated that some men may try to rush through therapy in order to avoid dwelling on their emotions.

Cognitive Impact

1. Self Concept

Self-concept is developed throughout childhood and is affected by other's perceptions of the person. Messages related to abuse can impact a child's self-concept and these impacts can last well into adulthood, affecting not only their view of themselves but how they interact with others (Lyn & Burton, 2004). Children who were told or made to feel they were liars, "bad" or "dirty", worthless, someone to be used, weak or stupid, will incorporate these ideas into their sense of self. Hopper (2010) reports that men who have been abused often have negative beliefs about themselves or others. Blaming themselves for the abuse is common and can contribute to these negative self-concepts. In addition to taking responsibility for the abuse, some men deny or minimize the effects of the abuse (Andersen & Veach, 2005; Fisher et al., 2009; Wilken, 2003). Although this may be done to avoid the stigma of having been abuse, it can also lead to perceptions that what happened to them did not matter and that they are not worthy of care and empathy (Isley et al., 2008). Staff in the focus groups/interviews indicated that men often feel that they are unacceptable to others, that they don't have any rights, or that others don't care about their needs. Disbelief or disregard of disclosures of abuse can exacerbate these perceptions, as can a lack of public awareness about and a lack of services for male CSA.

2. Identity

Because identity becomes a prominent issue in adolescence, some men experience identity diffusion (Dorais, 2009), a lack of sense of who they are and what they want or believe. Erikson identifies six tasks of identity achievement in adolescence (Sokal, 2009):

- Experimenting with different roles and potential occupations.
- Gaining future perspective and managing one's time.
- Making decisions about sexual orientation and a sense of comfort with their own sexuality.
- Self-confidence.
- Determining legitimate from non-legitimate authority and knowing when to take a leadership or follower role.
- Finding a philosophy of life that provides meaning and direction.

Each of these is negatively affected by CSA. As reported by staff and the literature, the role of abuse victim may become the focal point of self-definition (Dorais, 2009; Wilken, 2003). Johnson, Rew, and Sternglanz (2006) found that sexually abused homeless youth had a decreased future perspective. Some men lack self-confidence as others' disbeliefs about the abuse and their own fears can negatively affect their confidence. Men's ability to discriminate healthy and legitimate forms of authority is often impaired through the abuser's betrayal of his or her authority. Sexuality is an area fraught with problems such as confusion about sexual orientation, sexual acting out, risky sexual behaviours, and discomfort with sex and sexuality. In focus groups/interviews both staff and men identified these issues with sexuality. Some men also revealed their loss of faith and spirituality or sense that life has meaning.

3. Legacy of Abuse

The 88 male and female participants of Martsolf & Draucker's (2008) study of experiences of CSA reported a sense of having inherited a life filled with abuse and adversity. Some felt they were stuck in a family legacy of abuse that was characterized by negative life events including addictions, physical health problems, involvement with the legal system, violence, and instability. Others felt they continued to suffer the repercussions of a family legacy of abuse in the form of mental health issues, negative views of self and of others. A certain portion of individuals actively rejected their family legacy of abuse, opting to create a new, healthier legacy for themselves and their families. Some of these participants felt they were part of a process of passing on a destructive legacy to others, including their children, while others were trying to break the cycle and still others were trying to pass on a new legacy. Some studies also report mixed cognitions, with some men reporting that they had lost part of their lives to the abuse and others feeling that it had given them insight into other injustices in the world (Alaggia & Millington, 2008).

Other cognitive effects mentioned by the staff who participated in the focus groups/interviews included a loss of inner sense of knowing what is healthy from that

which is unhealthy or harmful. Extremes of thought, or polarized thinking without moderate positions or multidimensional views were reported by staff and men. These types of cognitions can also lead to extremes in behaviour. Some men reported creating a false idealized childhood that they would tell others about, thus denying their real self.

Behavioural Impact

1. Addictions

CSA is strongly associated with compulsive coping behaviours, most notably alcohol and drug abuse and addiction (Alaggia & Millington, 2008; Heim, Shugart, Craighead, & Nemeroff, 2010; Hornor, 2010; Johnson, Rew & Sternglanz, 2006; Lew, 1999; O'Leary, 2009; Romano & DeLuca, 2001). A study of African American males found that those who had experienced CSA were more likely to use substances such as tobacco, alcohol, marijuana, cocaine, and hallucinogens (Amos et al., 2008). Experiences of CSA have also been associated with substance use at an earlier age, use of illicit drugs, frequency of drug use, multiple drug use, severity of drug use, and beliefs in the benefits of using drugs. Risk for drug use at an early age and supportive beliefs for drug use was particularly high for those who experienced both sexual and physical abuse (Butt et al., 2011; Schraufnagel, Cue Davis, George, & Norris, 2010). Mallow (2000) found that severity, duration and frequency of abuse were positively related to severity of alcohol addiction. Substances are often used to escape memories and emotions related to the abuse, thus when the person becomes sober they are often overwhelmed with thoughts of the abuse (Alaggia & Millington, 2008), making them more vulnerable to return to their addiction. Agency staff who took part in focus groups/interviews indicated that substance use was extremely common, particularly alcohol and marijuana, but with illicit and prescription drug use also appearing. The majority of the men who took part in focus groups/interviews reported problems with addictions and substance use throughout their lives. Workaholism, internet addiction, creating and living a fantasy life, sexually compulsive behaviour, gambling and spending sprees are other forms of compulsive coping identified in the literature (Anderson & Veach, 2005; Grubman-Black, 1990) and by both staff and men in the focus groups/interviews. Workaholism has the added reinforcement from society in terms of meeting the male gender role of being hardworking, successful, and a good provider.

2. Aggression and Violence

Aggressive and violent behaviour has frequently been reported in men and boys who were sexually abused in childhood (Gartner, 1999; Hornor, 2010). Violence and exploitation of others are sometimes forms of revenge for their abuse (Dorais, 2009). A number of studies have found that men who were sexually abused in childhood, have a higher risk of being violent in their intimate relationships (Bassuck, Dawson, & Huntington, 2006; Welles, Corbin, Rich, Reed, & Raj, 2010; Whitfield, Anda, Dube, & Felitti, 2003). Given that anger is a common emotional response, aggression may be an

easy outlet for that anger. Further, if violence is normalized in the lives of these men from the time they were children, then it becomes part of the expected and acceptable way of dealing with emotions and conflict (Fisher et al., 2009).

3. Risky and Aggressive Sexual Behaviour

Compulsive behaviour and aggression are often manifested sexually. Sexual promiscuity, compulsive masturbation, infidelity, and sexual risk taking have frequently been reported in the literature (Alaggia & Millington, 2008; Anderson & Veach, 2005; Catania, Paul, Osmond, Folkman, Pollack, Canchola, Chang, & Neilands, 2008; Fisher et al., 2009; Hornor, 2010; Isley, et al., 2008; Johnson, Ross et al., 2006; Schraufnagel et al., 2010) and were reported by men who took part in focus groups/interviews. High risk sexual behaviours are significantly corrected with substance use (Gore-Felton, Kalichman, Brondino, Benotsch, Cage, & DiFonzo, 2006). In focus groups/interviews staff also indicated that the use of or addiction to pornography was observed in men who experienced CSA. Men who are in the sex trade often have histories of CSA (Gore-Felton, et al., 2006; Henny et al., 2006; Martsof & Draucker, 2008), and addictions and sex trade involvement are positively correlated, with each contributing to the other.

Although most sexually abused men do not become offenders and in fact fear becoming offenders (Kia-Keating et al., 2005; Romano & DeLuca, 2001), a proportion of men who experienced CSA manifest sexual thoughts and fantasies about male children and adolescents (Bramblett & Darling, 1997) and aggression and abuse towards others (Alaggia & Millington, 2008; Gartner, 1999; Romano & DeLuca, 2001). Catania and colleagues (2008) found that men who experienced CSA manifested more anger and more aggressive sexual scripts than men who did not experience CSA. Some studies report that 39% (Ryan et al., 1996) to 80% (Burton, Miller, & Shill, 2000) of juvenile male sex offenders and 76% of serial rapists (McCormack et al., 1992) experienced childhood sexual abuse. Adult male child sex offenders were more likely to have experienced CSA (Felson & Lane, 2009; Haapaslo & Kankkonen, 1997; Marshall, Serran, & Cortoni, 2000). Felson and Lane (2009) found that male inmates who were sexually abused as a child were eight times more likely to have sexually abuse a child. Male sex offenders were also found to have had the perpetrator use more force and to find the abuse more upsetting than a group of nonoffenders (Marshall, et al., 2000). They did not differ from nonsexual offenders, however, perhaps indicating that CSA is related to aggressive and criminal behaviour in general.

4. Involvement with the Justice System

Addictions, aggressive and violent behaviour, sex trade involvement, and sexual offending increase men's likelihood of incarceration, thus men who have been involved with the justice system have often experienced CSA (Alaggia & Millington, 2008; Darby, Allan, & Kashani, 1998; Felson & Lane, 2009; Gartner, 1999; Gover, 2004). Johnson, Ross et al. (2006) reported that 59% of incarcerated males had experienced CSA and

Fisher, et al. (2009) also report that more inmates than non-incarcerated men have experienced CSA. Statistics from Correctional Services Canada (2008) indicate that 12% of men in federal prisons have experienced childhood sexual abuse; 39.6% experienced both sexual and physical abuse in childhood; and 11.8% had witnessed sexual abuse as a child. Hornor (2010) and Fisher and colleagues (2009) state that CSA of males tends to be accompanied by physical and emotional abuse and witnessing of abuse, rather than in isolation, corroborating the above statistics. Out of those who had experienced both sexual and physical abuse 42.5% had been violent towards family members; 38.8% had been violent against their female partners; and 22.2% had been violent towards a child (Correctional Services Canada, 2008). These as well as other criminal behaviours had brought them into the criminal justice system. Because of underreporting of experiences of childhood abuse by males, it is likely that the actual percentages are higher than reported by Correctional Service Canada. A few of the men who participated in focus groups/interviews had been in prison.

Manifestations of Childhood Sexual Abuse Impact

The above mentioned effects can impact on all aspects of men's lives. The nature of these impacts may change with time and age, but the areas of impact remain fairly consistent. It is important to note, however, that the nature and extent of impact varies across men. Below are presented some of the more commonly sited areas of CSA trauma impact.

Disclosure

As compared to girls, fewer boys disclose their experiences of CSA, and although more disclose in adulthood, they don't often talk about it with others or seek help in dealing with these experiences (Dorais, 2009; Hunter 2009; O'Leary & Gould, 2009; Romano & DeLuca, 2001; Schachter et al., 2009; Sorsoli et al., 2008). Partners, parents and therapists are the individuals men disclose most to in adulthood, and even with these support systems, disclosure and discussion is difficult (Sorsoli et al., 2008; Wilken, 2003). In focus groups/interviews some men revealed that it took a lot of time before they could tell their partners and their parents about the abuse, with some still unable to take this step. Even talking about it with a therapist was difficult for some. Numerous barriers to disclosure exist for men. Sorsoli, Kia-Keating and Grossman (2008) categorize these barriers as: personal, relational, and sociocultural. These categories are used below to summarize the obstacles identified in the literature and described in the focus groups/interviews.

1. Personal Barriers

a. Lack of Cognitive Awareness

Some men have suppressed the experience of abuse to the point where they no longer have a clear memory of it and thus have no reference for disclosure (Sorsoli et al. 2008). A few of the men in the focus groups/interviews reported only vague memories of the abuse and sometimes doubted whether or not it happened. Others have an awareness of the experience but do not define it as abuse and therefore do not disclose it as such (Isely et al., 2008). If they physically responded to the sexual contact or if it was with someone only a few years older than themselves males may see it more as sexual play or exploration rather than abuse (Romano & Deluca, 2001).

b. Intentional Avoidance

For some men the lack of disclosure is part of a conscious effort not to dwell on the abuse (Sorsoli, et al., 2008). By avoiding thoughts of the abuse they can work on leading a "normal" life (Hunter, 2010). Some will even avoid discussing the topic of abuse, even in general terms, as a means of stoically trying to ensure it does not interfere with their lives.

c. Lack of Language

The lack of appropriate language or words to clearly talk about their abuse may discourage men from disclosure (Sorsoli, et al., 2008). Hunter (2010) indicates that men sometimes feel the language of abuse implies a female victim. For example the word "rape" connotes a man having forced sexual intercourse with a woman and so does not always seem to fit or explain their experience. In some cases men may feel they do not have the right words to describe what happened to them and how they felt about it because their socialization has not included extensive verbal discourse (Mathews, 1996).

d. Emotional Safety

When men have kept silent for so long, it may be frightening to finally talk about the abuse out loud. They may fear being overcome by negative emotions, anxiety and depression (Sorsoli, et al., 2008). In the focus groups/interviews men stated that sometimes they wanted to tell their story in hopes of finally getting rid of it and its effects, but when it came time to talk about it they became extremely fearful and hesitant. They worried that once they told the therapist about their abuse they still would not feel better and the therapist would not be able to help them.

e. Shame

As mentioned, shame and feelings of guilt and responsibility are prevalent and they can create an obstacle to disclosure in both childhood and adulthood. Boys who received special attention or gifts in exchange for their cooperation, and liked these rewards, may have felt that they were responsible for perpetuating the abuse (Hunter, 2009; 2010; Sorsoli, et al., 2008). The shame of being abused by a mother or other female, because it goes against social norms and reflects poorly on their masculinity, may lead boys and men to deny the abuse or not disclose it to others (Denov, 2001; 2004). Responding physically or feeling pleasure in the sexual contact with their abuser may also be interpreted by boys and men as their having played an active role in their own abuse (Dorais, 2009). Further, as adults, men may feel shame at not reporting the abuse sooner (Sorsoli, et al., 2008).

2. Relational Barriers

a. Fear of Negative Repercussions

Believing that disclosing the abuse will lead to negative responses from others is a barrier frequently mentioned in the literature. Among the anticipated negative responses are disbelief, minimization, having their disclosure ignored, or being blamed for the abuse (Durham, 2003; Fisher, et al., 2009; Sorsoli, et al., 2008; Wilken, 2003). Not having disclosed the abuse at the time it occurred may exacerbate these fears in adulthood.

These concerns are not unfounded, as men who disclosed have reported that others did not believe them, did not take the disclosure seriously, got angry at them, and in some cases physically assaulted them (Dorais, 2009; Rubin & Thelen, 1996; Sorsoli, et al., 2008). Due to the social perception of males being more sexual, others may be more likely to see the sex as consensual, particularly if the boy responded to the stimulation (Crowder, 1995), and thus not define it as abuse. Being abused by a woman has also

been found to be particularly shameful and males anticipate and receive negative reactions to these disclosures (Bornstein et al., 2007; Denov, 2003a). Men who participated in the focus groups/interviews also indicated that when they tried to tell someone what had happened to them, they were not believed or the abuse was dismissed as inconsequential. These reactions were especially likely if the abuser was an esteemed or trusted member of the community or if the man was perceived to have willingly participated in the abuse. This and the ridicule faced by others who disclosed their victimization (such as women who disclosed rape) discouraged further attempts to tell others about their experiences.

The fear of being perceived as homosexual, of others believing they were selected by their abuser because they were homosexual or feminine in some way or of being perceived as someone who will now become an abuser have been well documented as barriers to disclosure (Cermak & Molidor, 1996; Crowder, 1995; Durham, 2003; Fisher, et al., 2009; Hunter, 2010; Romano & DeLuca, 2001; Sorsoli, et al., 2008; Valente, 2005). The social stigma and verbal and physical violence that often accompanies being identified as a homosexual or an offender were part of this fear. Some men acted in a hypermasculine manner to deflect potential perceptions of homosexuality (Durham, 2003).

Boys may have been threatened by their abuser not to tell anyone (Dorais, 2009). Some may have feared the nature of parental or systemic response such as parents becoming over-protective, leading to a loss of their freedom and independence (Romano & DeLuca, 2001), being removed from their family, having a family member taken away or incarcerated (in the case of incest) or having their experience made public through the courts. Durham (2003) reports that men who did disclose found the examinations they underwent to validate the abuse as well as their involvement in the legal system distressing. Further, sexual abuse of males is less likely to be substantiated than sexual abuse of females (Dersch & Munsch, 1999), thus for males the distress of bringing the abuse to the attention of the legal system may have few or no positive outcomes.

The anticipation of negative responses to disclosures of male childhood sexual abuse may represent an awareness of social reality. Ullman and Filipas (2005) state that women in their study were more likely to have reported their abuse and although both men and women did report negative social responses to their abuse, women received more positive reactions than men. Negative social reactions were more likely if men blamed themselves for the abuse, if they disclosed a lot of information about the abuse, and if they knew their offender. Negative social and professional responses to disclosure have been associated with greater distress and more negative outcomes, whereas positive social and professional responses have been linked to less negative outcomes (Crowder, 1995; Denov, 2003b; Fisher et al., 2009).

b. Isolation

The isolation of feeling that this has not happened to anyone else or the lack of support or care from family and other support systems may hinder disclosures (Sorsoli, et al., 2008). A family that is not supportive, does not believe the child's disclosure, minimizes or

ignores the abuse, rejects the child, or blames the child, does not encourage open discussion of experiences and feelings. These nonsupportive family responses are not unusual, particularly if the abuse was intrafamilial (Dorais, 2009). Both males and their families are likely to minimize the effects of abuse as compared to females and their families (Public Health Agency of Canada, 2009). Several men who took part in the focus groups/interviews stated that their parents were not supportive, ignored the abuse or told them to forget it. In a few cases the parents showed greater support to the abusive family member than to the male victim. These types of family responses are associated with more negative outcomes for abused males (Hornor, 2010). The sense of isolation and nonsupport reaches beyond the family, as male survivors have stated that health care professionals are prone to disbelieving and minimizing the effects of men's experiences of CSA compared to women's experiences (Schachter, et al., 2009).

c. Protecting Others

Some men do not disclose because they want to protect their family, their partner, and sometimes the perpetrator (Martsolf & Draucker, 2008; Sorsoli, et al., 2008). Focus group/interviews participants talked about being reluctant to tell their elderly parents about their childhood experiences of sexual abuse for fear they would not be able to handle it and that it would generate a sense of guilt at not having protected their child. Shielding loved ones from the pain and guilt of not having known about the abuse or even of hearing what was done to their child, sibling or partner is often part of a pattern of looking after others needs before their own. Focus groups/interviews with staff revealed that protectiveness of their culture can make some men reluctant to disclose, because they fear that abusive behaviour will become part of the racist perceptions of their culture or group by the larger society. As Dorais (2009) indicates, nondisclosure may be a way of protecting their abuser, who they have come to care for or love. They may make excuses for the person's abusive behaviour thus allowing them to resolve ambivalent feelings of fear and anger with those of love. Boys may also see the sexual contact as payment for the affection, gifts, and other preferential treatment that they received. The need to protect the abuser may be especially strong if he is a family member.

d. Perceived Knowledge of the Abuse

In some cases, men believe that others knew about the abuse or cannot conceive how they could not know about the abuse (Sorsoli, et al., 2008). For example, if the abuse occurred while they were in close proximity. Thus, for them there was no point in telling people if they were already aware of it. This belief may lead to feelings of not being supported or that the abuse was not something to be discussed. Unfortunately, adults ignoring the abuse or the clues that something was not right is not uncommon (Dorais, 2009; Hunter, 2010; Martsolf & Draucker, 2008; Romano & DeLuca, 2001).

3. Sociocultural Barriers

Sociocultural barriers refer to social rules, norms, and expectations about gender role behaviours that work to keep male CSA hidden (Sorsoli, et al., 2008). The norm for

masculine behaviour is to be stoical, tough, strong, dominant, and able to defend themselves. Any situation that places males in a position of vulnerability would lead to shame and embarrassment at not meeting this masculine ideal, and thus something to keep hidden (Alaggia, 2005; Dorais, 2009; Hunter, 2009; 2010; Kia-Keating et al., 2005). Boys may believe that they were victimized because they did not fit into the typical masculine standard, thus compounding their shame at being abused (Romano & DeLuca, 2001). Some boys may see the abuse as a manifestation of dominance and anger and thus part of the male gender role (Dorais, 2009). This belief may contribute to their own abusive behaviour, as they play out the more dominant and aggressive masculine role rather than the passive victim role they played when they were younger. Because male victimization goes against social and cultural norms, others may be more likely to minimize its severity or its effects (Alaggia, 2005).

For abused males as well as for others, the abuse may be perceived as a sexual initiation rather than assault. The perpetrator may have couched the abuse as a rite of passage into manhood, thereby portraying it as a normal and positive event (Dorais, 2009). The staff who participated in the focus groups also mentioned this social perception of early sexual experience as an initiation rite and thus a positive experience that would enhance rather than detract from the boys' sense of masculinity. Part of the social perception is that men have a stronger sex drive than women (Bornstein et al., 2007; Denov, 2001; 203a). This contributes to the false belief that females cannot be abusers and that if a boy has a sexual encounter with an older female it is not harmful (Bornstein et al., 2007; Broussard, et al., 1991) and is often considered a sexual initiation he should feel lucky and proud that it happened (Crowder, 1995; Hunter 1991; 2010; Romano & DeLuca, 2001; Schachter et al., 2009). As one staff member indicated, a recent news story about sexual behaviour between a male teacher and a 17 year old female student was referred to as "abuse", whereas another story about sexual behaviour between a female teacher and a 12 year old male student was referred to as an "affair" and a "relationship". This perception is supported by the research (Dollar et al., 2004; Smith et al., 1997). The social perception of females being less sexually oriented and more nurturing than males also leads to the denial of mothers being abusers (Crowder, 1995; Denov, 2001; 2003a; Gartner, 1999). Staff who participated in the focus groups recognized the prevalence of this belief and stated that in their experience as therapists in the area of CSA, female perpetrators are more frequent than is commonly believed. Corroborating this view is the research of Denov (2003a) and the statistics from Correctional Services Canada (2008) that report 12.23% of incarcerated males who were abused were abused by their fathers and 9.2% were abused by their mothers.

Because of the many barriers to disclosure, men are less likely to seek either formal or informal help and the effects of the abuse are less likely to be ameliorated (Hunter 2010; Sorsoli, et al., 2008). Fewer disclosures and the lack of recognizing male CSA experiences as abuse leads to the social perception that men are not frequently abused and thus there is less of a need for services for male CSA survivors (Schachter et al., 2009; Wilken, 2003). The lack of services reinforces the myth that few men have experienced CSA and this can lead men to doubt their experiences or feel isolated in their experiences (Fisher, et al., 2009). Hooper and Warwick (2006) state that social services are often

poorly informed about and lacking in concern for male CSA. It is not surprising then that men feel like "invisible survivors" (Schachter et al., 2009).

The staff and men who participated in the focus groups/interviews also talked about the invisibility of sexual abuse of males. Many believed that this invisibility and the reasons behind it need to be brought to light in order to affect needed social and community change. Part of the impetus for change is the presence of visible role models, men who come forward and speak out against CSA. Their public disclosures increase awareness of male CSA and making it more acceptable for others to come forward. Public awareness efforts would help to educate others about male CSA and generate greater social concerns and support. The presence of services specific for males and increased awareness of these services will also facilitate disclosure and help seeking.

Gartner (1999; pg. 19) outlines 10 myths about victimization that contribute to nondisclosure of sexual abuse in males:

- Men cannot be sexually abused.
- Women do not sexually abuse others.
- Abuse is always overt. This myth ignores nonphysical sexual behaviour such as inappropriate seductiveness, flirtations and sexualized talk as forms of abuse.
- Sexual abuse turns a boy gay.
- Almost all sexually abused boys become abusers.
- Abusers are always aware of when their behaviour is abusive.
- Most abusers are homosexual.
- Abused boys are weak and feminine.
- If boys don't say "no" to the abuse or fight back then they must have wanted the abuse to occur.
- If a boy is sexually aroused then he is an equal participant in the abuse.

These myths reflect many of the issues discussed above. Dispelling these false perceptions will work to increase awareness about sexual abuse of males and create a social climate that is more open to responding appropriately to disclosures.

Masculinity and Identity

The cultural masculine ideal includes being stoic, dominant, powerful, virile, aggressive, independent, heterosexual, financially successful, a provider and a protector. This gender role is conveyed through family, peers, and social systems such as media and policy.

Many aspects of CSA are discrepant with this gender role ideal (Wilken, 2003).

Victimization is associated with being weak and vulnerable and sexual victimization by a man is associated with homosexuality and being sexually submissive. Boys often worry that they were selected as victims because they were weak, feminine or otherwise failed to meet the male gender role norm (Dorais, 2009; Romano & DeLuca, 2001). They feel shame at not having protected themselves more effectively (Schachter, et al., 2009). **The more value men place on the traditional male gender role**, the more shame they feel at their victimization and the more focused they are on the perceived gap between their ideal self and their real self, something Fisher, Goodwin and Patton (2009) call

discrepancy strain. Thus, many men who have experienced CSA report gender identity, sexual orientation, and masculine identity confusion and concerns (Anderson & Veach, 2005; Grubman-Black, 1990; Hopper, 2010; Isely, et al., 2008). Staff and men in focus groups/interviews identified these as areas of concern that should be addressed in therapy, a view shared by therapists and researchers (Romano & DeLuca, 2005; Sorsoli, et al., 2008).

Since CSA brings their masculinity into questions, many boys and men try to reassert or confirm their masculinity. Suppressing vulnerable emotions (Anderson & Veach, 2005; Gartner, 1999; Hunter 2008; 2010; Wilken, 2003), denying their victimization and its effects (Kia-Keating et al., 2005), and taking responsibility for the abuse (Gartner, 1999) are ways of maintaining a masculine sense of stoicism, power and control and because these are social ideals for men they are rewarded for this behaviour through social acceptance and retaining their sense of manhood in the eyes of others. Grubman-Black (1990) found that the more rigid men's gender role ideal was, the more difficult it was for them to disclose their abuse. Adhering to the masculine norm has also been associated with isolation and denial of self (Fisher, et al., 2009; Grubman-Black, 1990; Kia-Keating et al., 2005; Wilken, 2003), both of which contribute to disowning their experience.

Another way of maintaining a sense of masculinity is through exerting power and control, often through aggressiveness. There is a social expectation that males will be aggressive or violent and therefore this behaviour is often condoned (Fisher, et al., 2009). The men in Kia-Keating et al.'s (2005) study reported that as children they were expected and encouraged, by male family members, to stoically conceal their emotions and act tough or even violent. Experiences of CSA can generate a lot of anger and because this is the one emotion that is sanctioned by the male gender role, more vulnerable emotions are often converted into anger and subsequently into aggressive behaviour (Gartner, 1999). **For some men there is shame in not being able to control their anger and aggressive behaviour and this shame then causes more anger.** Fears about their masculinity may also result in anger directed at women who serve as reminders of this perceived failing (Fisher et al., 2009).

Occupation is closely tied with individuals' sense of identity. For men, it is also part of the male gender role of being a provider, successful, and independent. Loss of employment then would not only cause financial concerns but directly attack their sense of masculinity. Although loss of employment is upsetting to most men for these reasons, for men sexually abused in childhood it may be particularly devastating because their sense of masculinity has already undergone a significant assault. In some cases abused men lose their job because of behaviours that directly stem from their abuse such as mental health issues and anger and aggression. Staff participating in focus groups/interviews stated that this was particularly shameful for these men. They indicated that there was sometimes a push to accelerate therapy in order to get their job back or to get and keep another job. This further doubt placed on their masculinity may also compound anger, guilt, fear, aggression, low self esteem and other negative emotions, thoughts, and behaviours associated with their abuse. Many of the men who

participated in the focus groups/interviews had sporadic employment histories or were unemployed and many directly related their employment problems to the effects of CSA.

One of the most significant issues for men whose abusers were male, is that of sexual orientation. Homosexuality is inconsistent with the cultural ideal of masculinity, and the cultural ideal of heterosexuality is especially strong in some cultures. Many sexually abused men wonder if they are homosexual, especially if they responded physically to the sexual stimulation (Romano & DeLuca, 2001). Men who participated in the focus groups/interviews indicated that they questioned their sexual orientation, with most feeling that they were the only ones facing these questions about their sexuality. McGuffey (2008) found that parents of sexually abused boys also feared that their children would now become gay. To counteract this possibility they promoted athletic activities and emotional detachment, both typical of the male gender role. This type of parental reinforcement of masculine ideals strengthens boys resolve to behave in hypermasculine ways. In adulthood their fear of being or being perceived as homosexual may lead men to avoid friendships with men, engage in non-intimate sexual activity with many women, speak derogatorily towards homosexuals and/or act aggressively towards them (Dorais, 2009; Fisher et al., 2009; Isely, et al., 2008; Romano & DeLuca, 2001). The staff who took part in the focus groups/interviews indicated that confusion around sexuality and sexual orientation was common and they recognized that some homophobic behaviours and thinking were in response to this confusion and fear of having their masculinity questioned. Gay men may see their sexual orientation as a being a result of their abuse, thus increasing any difficulties they may have had in coming to terms with their homosexuality (Fisher et al., 2009). For some men, their view of masculinity becomes polarized into rigid categories, coinciding with the all-or-nothing thinking previously mentioned (Gartner, 1999).

Attachment

Although different attachment categories have been proposed and researched by Ainsworth (1979) and Bartholomew (1990), these categories are similar in their manifestations (information below is derived from Ainsworth, 1973; 1979; Bartholomew, 1990; Bartholomew & Shaver, 1998; Collins & Feeney, 2004; Shaver & Mikulincer, 2002). It is important to note that people are not stringently in one category or another, but rather have a general sense of attachment within a category; they may sometimes manifest some characteristics from another category.

- **Secure Attachment.** This attachment style is characterized by low anxiety and low avoidance of others. These individuals seek others for comfort, safety and support. They trust that the people who love them will care for them and protect them. Securely attached children will use parents as a secure base from which to explore their world. As adults they form stable relationships, regard themselves as worthy of the love and respect of others, tend to be responsible and reliable in their relationships and are comfortable with emotional and sexual intimacy.
- **Anxious/Ambivalent/Preoccupied Attachment.** This style is characterized by high anxiety and low avoidance of others and is often the result of inconsistent parenting

and caregiving. Individuals with this form of attachment seek the approval of others and have a high desire for emotional intimacy. As children they often alternate between being needy and clingy to being rejecting and angry at their parents. As adults they tend to believe they are unworthy of love and respect and thus are vigilant in their efforts to obtain or retain the affection of others. Because they fear abandonment and rejection they are often jealous of partners, believing that they will leave them. They feel threatened by any perceived sign of abandonment, resulting in high levels of emotional distress.

- **Avoidant/Dismissing Attachment.** Characterized by low anxiety but high avoidance, these individuals do not seek support and comfort from others. This attachment style is often the result of neglect of emotional and/or physical needs by parents. As children they do not use their parent as a secure base and often treat their parent much the same as they would a stranger, with unemotional disregard. As adults they see relationships as unimportant and value personal independence. They see themselves as unworthy of respect or love and although they sometimes seek relationships with others, they do not trust others, are often suspicious and jealous, and see others as unreliable and uncaring.
- **Avoidant/Disorganized/Fearful Attachment.** This attachment style is characterized by high anxiety and high avoidance. As children their responses to others are confused and often contradictory. They have problems regulating their emotions, and their emotions often appear blunted or do not correspond to the situation. They have difficulty connecting with others emotionally. As adults their problems with emotional connection and emotion regulation lead to discomfort in social and interpersonal situations, especially intimate situations. This discomfort can lead them to avoid intimate relationships. Avoidance is their way of reducing the anxiety and fear that results from intimacy. Their behaviour also tends to create discomfort in others who then avoid developing relationships with them.

Research has found a relationship between insecure attachments and CSA. First, childhood trauma and particularly multiple forms of abuse are related to a reduction in oxytocin, a hormone associated with the formation of attachment (Heim, Young, Newport, Mletzko, Miller, & Nemeroff, 2009). There is evidence that insecure attachment to parents, particularly to fathers, may leave boys vulnerable to the affection and ultimately abuse from other men (Dorais, 2009; Fisher, et al., 2009; Gartner, 1999; Limke, Showers, Zeigler-Hill, 2010; Lyle, 2008). One study found that men who had experienced CSA reported more insecure attachments (anxious/ambivalent/preoccupied and avoidant/dismissing) to their fathers than their mothers (Marshall et al., 2000). Many men who were sexually abused came from violent and/or dysfunctional homes (Avery, Hutchinson, & Whitaker, 2002; Garrett, 2010; Martsolf & Draucker, 2008; Sorsoli et al., 2008), were living with neither or only one parent, came from a separated or divorced family, or had parents who were involved with substance abuse or criminal activity (Avery, et al., 2002; Gartner, 1999).

Second, both males and females who experienced CSA have been found to show patterns characteristic of the three insecure attachment styles (Aspelmeier, Elliot, & Smith, 2007; Sypeck, 2005; Twaite & Rodriguez-Srednicki, 2004). Altman (2007) found that insecure

attachments were more likely when the victim and the perpetrator were male, the perpetrator was a family member, the abuse was long lasting, frequent and severe, the child was abused at an early age, and there was little perceived support from family. Incest may have particularly strong links to the avoidant/disorganized/fearful attachment style (Alexander, 1993). CSA has been linked to less trust and attachment to and greater alienation from parents (Aspelmeier, et al., 2007).

Third, there is some evidence that attachment to parents and peers (Aspelmeier et al., 2007; Sypeck, 2005; Whiffen, Judd, & Aube, 1999) and adults (Twaite & Rodriguez-Srednicki, 2004; Whiffen, et al., 1999) may moderate the effects of CSA. Specifically secure attachments were related to more adaptive coping strategies (Marshall et al., 2000). Thus, CSA survivors with secure attachments in their lives appear to have fewer CSA related symptoms such as depression, anxiety, and dissociation and more confidence and a sense of personal control (Sypeck, 2005; Whiffen et al., 1999). Personality disorders and PTSD symptoms have also been linked to insecure attachment (Alexander, 1993). In addition, sexual behavior may be related to attachment. Lyle (2008) found that men who had experienced CSA had more insecure attachments, were more likely to use sex as a coping strategy and had poorer mental health. Insecure attachment to their mothers were related to increased masturbation and decreased interest in consensual sex.

There are inconsistent findings about specific forms of attachment and attachment with either fathers or mothers being related to mental health. For example, one study found that mental health was strongly associated with the anxious/ambivalent/preoccupied attachment style (Limke et al., 2010); another study found that the anxious/ambivalent/preoccupied and the avoidant/disorganized/fearful attachment styles were related to greater symptoms (Whiffen, et al., 1999). Some studies have found that insecure attachment to either mother or father was associated with poorer psychological functioning (Alexander, Anderson, Brand, Schaeffer, Grelling, & Kretz, 1998; Romans, Martin, Anderson, O'Shea, & Mullen, 1995), while another study found that insecure attachment to the father rather than the mother was associated with mental health (Schreiber & Lyddon, 1998). Inconsistent findings are in part due to the use of different attachment scales and examination of different psychological symptoms. More systematic research is required to understand the moderating effect that attachment may have on coping with CSA, and the importance of attachment to mothers and fathers.

One of the prevailing beliefs in attachment theory is that attachment patterns developed in childhood tend to form the basis for adult relationships and thus are often replayed in adulthood (Bartholomew, 1990; Collins & Read, 1994; Kenny & Barton, 2003; Treboux, Crowell, & Waters, 2004). Securely attached children value themselves and generally trust others. As they move into adulthood, relationships with people that prove untrustworthy or who are disrespectful to them are ended and healthy relationships are retained. Children with an anxious/ambivalent/preoccupied attachment are clingy and anxious to please, yet often react with anger towards others. As they grow up these behaviours often manifest as jealousy, overdependence, and anger, behaviours that often cause others to end relationships with them, making them even more anxious about

subsequent relationships. Children with avoidant/dismissing attachments generally convey to others their lack of interest in relationships, thereby leading to the discomfort and avoidance by others. Avoidant/disorganized/fearful attachments can lead to a lack of emotional connection and a lack of emotional regulation that creates discomfort in others who then avoid these individuals.

Whatever the nature of the attachment pattern, it will affect the person's friendships, intimate relationships and parenting. Insecure attachments can make some people feel fearful about their relationships, either fearful of losing them or of even having them. This has led some men to remain emotionally distant in their relationships despite wanting intimacy (Kia-Keating et al., 2005). Grubman-Black (1990) found that fear of abandonment led to later relationship problems in men who experienced CSA. Men who participated in the focus group/interviews often indicated that they chose not to have relationships or not to have emotionally intimate relationships because they were either because sexual intimacy reminded them of the abuse, because they could not share information about themselves with others, because they could not emotionally connect with others, or because they distrusted others.

Insecure attachments can make individuals vulnerable to further victimization or to victimizing others (Dutton & Holtsworth-Munroe, 1997). Victimized or fear of victimizing others sexually is often reported by men (Crowder, 1995; Romano & DeLuca, 2001). Some of the men who took part in the focus groups/interviews had been revictimized by others either in childhood or adulthood, some had victimized others, and some feared that they would victimize others.

Impaired attachments often leave individuals without the ability to emotionally connect with others, to manage their own emotions, or the knowledge and skills to build intimacy or to parent their children, creating the opportunity for fear and/or inappropriate behaviour. Research with mothers who had experienced CSA, found that they were less able to focus on the needs of their children and mental health issues related to CSA made them less available to their children (Hornor, 2010). Despite wanting to protect their children from abuse and harm, some sexually abused men found that some of their own behaviours, such as an inability to effectively discipline their children was in fact harmful to them (Martsof & Draucker, 2008). In focus groups/interviews men talked about how destructive their experience of CSA had been to their adult relationships and in some cases to their relationships with their children. They expressed the need for programs for men and their partners to create greater understanding of each other and the effects of CSA, to improve communication, and to build healthier relationships. A few also stated the need for parenting programs to reduce men's fear of being physically close to their children and to develop better parenting skills.

Although there is a tendency for attachment patterns to be fairly stable through mutual person/environment interactions, these patterns can change. At any point in time a relationship can change the attachment pattern, either making it more secure or more insecure depending on the nature of the relationship. This can be a relationship with a friend, a partner, or even a therapist.

Relationships

Men's relationships are significantly affected by experiences of CSA. Many of the emotions that are triggered by the abuse serve to create problems in relating to others. For example, the abuse may instill an expectation of betrayal or fear of abandonment which then leads to anxiety, particularly in relationships with authority figures (Gartner, 1999; Grubman-Black, 1990; Wilken, 2003). This may make power and control a prominent issue in the relationship. Anger resulting from experiences of abuse, can be directed towards partners (Anderson & Veach, 2005), parents and friends. In focus groups/interviews, staff indicated that survivors sometimes direct their anger at mothers or fathers for not protecting or believing them.

For some time childhood abuse and trauma has been associated with victimization and perpetration of intimate partner violence. In their studies of men who act violently against their partners, Dutton and Holtzworth-Munroe (1997) outlined how early childhood abuse results in a variety of psychological problems such as poor self concept, insecure attachment, problems processing social information, mental health issues, and problems with emotion regulation. These in turn create interpersonal problems that interfere with establishing and maintaining healthy intimate relationships, including being violent with partners. While some studies have linked childhood physical abuse with psychologically controlling behaviours and CSA with sexual violence against partners (Rangul, Evang, & Heir, 2011), others have made a more direct link between CSA and intimate partner violence in general (Bassuck, et al., 2006), including violence and victimization in homosexual relationships (Welles, et al., 2011). Whitfield and colleagues (2003) found that experiencing CSA, physical abuse and having a mother who was battered by her partner increased the risk of perpetrating intimate partner violence in males and being a victim of intimate partner violence in females, with the number of violence experiences in childhood being positively related to increased risk of perpetration and victimization. Men who experienced all three risk factors were found to be 3.8 times more likely to abuse their partners; women who experienced all three were 3.5 times more likely to be victims of intimate partner violence. Other researchers have also found that men who were both sexually abused in childhood and who witnessed violence as children were likely to commit severe forms of intimate partner violence (Downs, Smyth, & Miller, 1996; Murrell, Christoff, & Henning, 2007), and to abuse their own children (Murrell, et al., 2007).

Impaired attachments and negative emotions associated with the abuse and/or the lack of support and protection by caregivers and authority figures, can lead to problems with intimacy and trust (Durham, 2003; Fisher et al., 2009; Hopper, 2010; Hunter, 2009; Kia-Keating, Sorsoli, & Grossman, 2010). Feelings of shame, being unworthy of love, and expectations of betrayal and abandonment make men uncomfortable with emotional closeness (Anderson & Veach, 2005; Wilken, 2003). Many feel that they don't fit in or belong with others due to their childhood experiences of abuse. Their distrust can lead to suspicions about the motives of others, particularly those that are nice to them (Dorais,

2009). Because the abuser is often male, relationships with men are frequently characterized by fear and distrust and thus are avoided or are dysfunctional (Gartner, 1999; Grubman-Black, 1990; Hovey et al., 2011; Hunter, 2010), something reported by some of the men in the focus groups/interviews. Although many would like to form close relationships, emotional intimacy is so fearful and uncomfortable that they isolate themselves from others rather than face the potential for more harm (Durham, 2003; Gartner, 1999; Kia-Keating et al., 2010; O'Leary & Gould, 2009). Many of the men who were part of the focus groups/interviews made deliberate efforts to isolate themselves from others to prevent further harm and abuse, to keep their abuse hidden, or because of fear of or actual negative reactions by others. Some felt they could not be a good enough friend, son, brother or partner and so avoided these relationships and others avoided relationships because emotional and physical closeness to others brought back painful memories of the abuse and fears of further betrayal. Even developing trust with a therapist can be difficult (Isely et al., 2008). In some cases, extreme formality and lack of affect in interpersonal interactions serves to maintain this emotional distance (Gartner, 1999). Adhering to the male gender role would facilitate this emotional distancing. Isolation from others can result in poor interpersonal skills, which in turn creates more social discomfort and avoidance of relationships (Martsolf & Draucker, 2008). Men who participated in focus groups/interviews identified problems communicating with others and with being in touch with relational emotions such as love. For some of these men it was easier to not have partners and children than to face and deal with their fear of intimacy. Most of these men, however, wanted a family and what they termed a "normal" life. Some men isolated themselves physically as well as emotionally by moving away from family and friends. In some cases the city in which the abuse occurred became a trigger for memories and men moved in an effort to escape these environmental reminders.

Another pattern witnessed in men who have been sexually abused in childhood is a focus on others rather than on themselves. They take on the responsibility for others feelings, happiness and for meeting their needs, placing these needs above their own (Gartner, 1999; Grubman-Black, 1990; Wilken, 2003). If this focus on others dominates their relationships, they may begin to define themselves through others rather than relying on their own self perceptions (Hunter, 2009). A prime motivation for these men may involve seeking the approval of others (Anderson & Veach, 2005). Some of the men in the focus groups/interviews reported caring for others more than themselves, stating that they always put themselves last. Staff also identified this pattern in men, saying that survivors of CSA often bow to the pressure others place on them because they put their own needs and concerns last. Having been overly attentive to their abuser can be the catalyst for the focus on others (Crowder, 1995). Some men may see relationships as opportunities to re-enact the relationship pattern they have learned, thus either leaving them open to boundary violations and re-victimization (Dorais, 2009; Gartner, 1999) or to themselves violating boundaries by exploiting others to meet their own needs (Dorais, 2009; Gartner, 1999).

Because the abuse was sexual in nature and affected men's sense of masculinity and sexual orientation, sexuality and sexual relationships are especially affected. For many

there is a disconnection between intimacy and sex (Crowder, 1995; Hunter, 2009). Staff and men who participated in focus groups/interviews also reported this separation of sex from relationships. Easton and colleagues (2011) found that this may be particularly so for men whose abuse occurred later in childhood. This disconnection may contribute to the frequent reports of promiscuity, infidelity, use of pornography, risky sexual behaviour, and violent and exploitive sexual behaviour that is reported in male survivors of CSA (Alaggia & Millington, 2008; Anderson & Veach, 2005; Crowder, 1995; Fisher et al., 2009; Gartner, 1999; Isely et al., 2008; Schraufnagel et al., 2010). Divorcing sex from relationships may serve to reduce the shame and guilt associated with exploiting or betraying partners and loved ones.

Conversely, some men are so uncomfortable with sex that they disengage from it completely. This discomfort may have come from associating sex with abuse and thus fear and shame (Crowder, 1995; Fisher et al., 2009; Romano & DeLuca, 2001). Sexual thoughts or behaviours can bring back memories of the abuse and therefore are avoided (Dorais, 2009). In focus groups/interviews men stated that memories of the abuse affected their sexuality, with some avoiding or having lost interest in sex. The staff stated that beyond the abuse, some of the messages about sex they received as children may be part of men's aversion to sex in adulthood. Men who cope with their fear and guilt about sexual behaviour by avoiding it tend to have poorer sexual skills, which then generates more fear and anxiety and further avoidance (Cantania et al., 2008). Feelings of guilt and fear of sex were found to be more likely when the abuse occurred later in childhood, there were multiple abusers, and disclosures occurred soon after the abuse. Further, men who were injured during the abuse, who had multiple abusers, whose abuser was a family member, and who disclosed at the time of the abuse generally had more sexual problems (Easton et al., 2011). Findings related to the negative impact of disclosure in childhood are likely due to nonsupportive responses to the disclosure. Some men's feelings are more ambivalent, as they enjoy the pleasure of sex, but still feel guilty or ashamed afterward (Gartner, 1999).

Children represent significant relationships in the lives of men and as with other relationships parenting is affected by CSA. While for a few this means they either think about or carry out sexual interactions with children, for most it means they fear that their parenting behaviours or interactions with children will be interpreted as abusive because of their own abuse history. In focus groups/interviews the staff discussed these parenting fears. Regular parenting behaviours such as bathing, changing, dressing, hugging and kissing their children cause anxiety and are often avoided. Some men feel they don't have proper parenting skills and many don't have the support of their family or a good family model of parenting. Single fathers are especially vulnerable. Most men want to protect their children and fear passing on the legacy of abuse onto them, however behaviours meant to protect their children such as their leaving the family, not disciplining their children or leaving their children in care either make them more vulnerable to abuse or to other harms, thus fulfilling the legacy. Deciding not to have children is one way some men resolve this dilemma (Martsolf & Draucker, 2008), and as mentioned, this option was selected by some of the men who took part in the focus groups/interviews.

A study by Anderson and Veach (2005) found that the partners of men sexually abused in childhood shared many of the emotions, thoughts and behaviours manifested by the men. They too feared their partner would abuse their children. They were angry and resentful about their partner's behaviour and the slowness of the recovery process and some felt guilt and shame at not being able to help him recover from his experience or at being impatient with the process. Like their partner they felt isolated and lonely because in order to respect his privacy they could not talk about his abuse with others. This led to feelings of powerlessness and depression. Some minimized or denied the impact the abuse had on them and their family. Low self esteem, compulsive coping and psychological problems were reported. A number of these women became emotionally disconnected from others, including their partner, while some tried to take a more enabling approach such as taking on the role of caretaker, provider, and protector, enabling their partner to continue his maladaptive behaviours. This sometimes entailed sabotaging his recovery efforts and discouraging him from disclosing the abuse to others. Some even regularly followed or spied on their partner if they did not trust his fidelity. As indicated by these researchers, this evidence of trauma contagion suggests the need for couples or family programming to augment men's programming. This need was also voiced by a number of men in the focus groups/interviews. The bibliography at the end of this report includes resources specifically intended for partners of men who were sexually abused in childhood. Unfortunately these resources are few and somewhat dated.

Health

1. Physical Health

While any aspect of health can be affected by CSA, some are of more prominent concern. In terms of physical health, men often turn to a variety of addictive behaviours as a means of coping with their experiences of abuse and numbing their emotions (Lew, 1999). Drug and alcohol use can lead to a variety of health problems including brain damage, liver damage, increased risk of cancer and heart disease. Social costs of high levels of substance use are incurred by the health care system (hospital care and medication), the welfare system (social assistance and child and family services), the workforce (reduced paid workforce, absenteeism, reduced on the job productivity), justice system (police, courts, jail, violence, property damage), road accidents (productivity, health care, justice system, vehicle damage and insurance costs), and social services (addictions programs) (Collins, Lapsley, Brochu, Easton, Perez-Gomez, Rehm, & Single, 2006). Most of the men who participated in the focus groups/interviews had addictions to substances like alcohol and cocaine for which they had attended or were attending treatment. Several were unemployed and on social assistance; some had been incarcerated.

Risky sexual behaviours are also frequently reported by men who experienced CSA. These behaviours can directly lead to STIs and HIV (Cantania et al., 2008; Gore-Felton,

et al., 2006; Schacter et al., 2009; Schraufnagel et al., 2010; Welles, Baker, Miner, Brennan, Jacoby, & Rosser, 2009). As with addictions, contracting these infections can result in considerable social system costs, particularly in the health care systems, the welfare system, and the workforce. Substance use can indirectly increase risk of contracting STIs by contributing to risky sexual behaviours such as involvement in the sex trade and reduced condom use (Schraufnagel et al., 2010; Stall & Purcell, 2000).

In combination with physical abuse, CSA has been linked with multiple health concerns, pain and disabilities. These have resulted in more frequent use of emergency health services and healthcare professionals (Chartier, Walker, & Naimark, 2007). Further, any type of stress negatively affects the immune system (Schachter et al., 2009), leaving men more open to diseases and infections. Thus, behaviours that are often triggered by CSA not only create health problems on their own, but they frequently co-occur and thus compound these health concerns.

Given that many men affected by CSA present with health care issues, it is important that these systems are aware of male's experiences CSA and its effects. This knowledge would not only increase sensitivity but would contribute to more effective and appropriate health care measures. Unfortunately men have indicated that they often do not disclose their abuse to health care professionals. Hovey and colleagues (2011) conducted interviews with 49 male CSA survivors who had accessed health services. Most did not feel comfortable enough to disclose that they had been sexually abused. Fears about disclosure were similar to fears they had with other people including fear of being seen as weak, an abuser, and homosexual. Some were especially uncomfortable with a physician who was the same sex as their abuser, particularly during examinations that involved touching. Not knowing what would be done to them contributed to these fears. Schachter et al., (2009) report that some men felt health care professionals did not believe their disclosures of CSA and did not take them as seriously as they did women's disclosures. In addition to fears related to health care practices, some men felt they did not deserve health care or special health services. This may stem from feeling unworthy of being cared for and/or of always putting others needs before their own. These fears and low level of self care or self worth led many men to avoid accessing health care, cancel appointments, and not maintaining recommended health care activities such as taking medications. In focus groups/interviews, staff indicated that some men did not attend to basic health care and that part of introducing ideas of self care involved regular visits to physicians, dentists, and other health care professionals. They stated that often health care concerns are not mentioned in therapy, as they are seen as a private issue, however they do need to be addressed as they are part of the pattern of CSA effects.

As staff suggested, promoting self worth and self care may increase men's focus on their own health and their accessing of health care services. It has also been suggested that greater sensitivity within the health care system could alleviate men's fears of the system and make them more likely to access various health related services such as physicians and dentists (Hovey et al., 2011). In order to increase men's sense of comfort and safety with health care professionals the following conditions must exist within the health care system and with physicians: rapport, respect, open and mutual sharing of information,

patient control over procedures and decisions, respecting boundaries and understanding boundary issues, a general understanding of CSA and its effects by physicians, and understanding that healing from CSA is a nonlinear process (Hovey et al., 2011).

2. Mental Health

Mental health disorders and symptoms are commonly reported in men who experience CSA and unless addressed they tend not to diminish over time (O'Leary, 2009).

Frequency, severity, multiple abuses and longer duration of abuse have been associated with more negative outcomes (Heim, et al., 2010). For example, an Australian study found that men who had been penetrated during CSA had impairments in mental health 5.93 times greater than the general rate; this was also greater than the rate found in women who had been penetrated during CSA, which was 3.15 times greater than the general rate (Najman, Nguyen, & Boyle, 2007). Some studies suggest that men who experienced CSA are at greater risk of re-victimization in adulthood and re-victimization exacerbates incidence of mental health problems such as PTSD, hostility, depression and overall distress (Aosved, Long, & Voller, 2011; Hornor, 2010; Wolff, Shi, & Siegel, 2009).

Among the most prominent mental health problems in men who experienced CSA are depression and suicide (Alaggia & Millington, 2008; Anderson & Veach, 2005; Dorais, 2009; Hopper, 2010; Hornor, 2010; Hunter, 2009; Isely et al., 2008; Romano & DeLuca, 2001; Schachter et al., 2009). Depression brings with it a number of negative beliefs about self and others. A sense of loss and feeling that they are not meeting the masculine ideal contribute to this depression (Fisher, et al., 2009; Hopper, 2010). Men who participated in the focus groups/interviews talked about a sense of loss of youth, of family, of self, and of a normal life. Those who had been incarcerated talked about losing part of their life to the prison system. Some also spoke about feeling bad about themselves and having an inner sense that something was wrong with them. A few of these men had been diagnosed and were taking medication for their depression.

It is important to note that although there is an increased risk of depression, not all men who experience CSA develop depression. A history of abuse has been associated with memory problems and difficulties in organization and decision making (Minzenberg, Poole, & Vinogradov, 2008). Family environments characterized by dysfunction and nonsupportive interactions have been associated with a greater risk of developing depression (Maniglio, 2010). Persistent negative thoughts and emotions such as shame and self denigration, placing other's needs above their own, and a lack of emotion regulation have also been associated with depression (Heim et al., 2010; Maniglio, 2010).

Further, Kendall-Tackett (2009) links depression to health concerns such as coronary heart disease. Depression increases artery blockages and inflammation of tissues. The hostility that often accompanies depression and is frequently part of the effects of CSA also constricts coronary arteries and increases inflammation. Insufficient sleep, another symptom of depression further spreads inflammatory substances which then act to impair

the quality of sleep. Lack of sleep also suppresses the immune system leaving the person vulnerable to infections. Some of the men who took part in the focus groups/interviews suffered from insomnia or deliberately tried not to sleep to avoid abuse related nightmares. The likelihood of substance abuse, risky behaviours, and suicide also escalates with depression. Natural counteractive measures include ingesting omega 3 fatty acids found in fish and fish oil which alleviates the stress response, decreases inflammation and decreases depression, and exercise which also decreases inflammation and promotes physical healing (Kendall-Tackett, 2009).

Suicide often is part of depression. Boys and men who have experienced CSA are at higher risk for suicide than nonexperiential males (Andover, Zlotnick, & Miller, 2007; Dube, Anda, Felitti, Chapman, Williamson, & Giles, 2001; Martin, Bergen, Richardson, Roeger, & Allison, 2004; Molnar, Berkman, & Buka, 2001; Najman, Nguyen, et al., 2007; Sapp & Vandeven, 2005; Schachter et al., 2009; Spokas, et al., 2009). Joiner, Sachs-Ericsson, Wingate, Brown, Anestis and Selby (2007) report that sexually abused men were up to ten times more likely to have thoughts of suicide than nonabused men. These results were found for men with and without other psychological disorders and therefore may be independent of psychiatric conditions. The more severe, painful and injurious the abuse, the more suicidal thoughts were present. Both staff and men who participated in focus groups/interviews indicated that suicide, suicidal thoughts, and self-harming behaviours commonly occurred in male CSA survivors. Feelings of isolation, self-blame, anger and aggressive behavior (Joiner et al., 2007), and hopelessness (Spokas, et al., 2009) were highly predictive of suicide ideation. For many CSA survivors suicide is their means of coping with the fears and anxieties that results from their abuse (Joiner, et al., 2007).

Another prominent mental health issue among men who experienced CSA is anxiety, which can manifest in a number of different symptoms and disorders. Multiple abuses or abusers are linked to reduced levels of oxytocin, a hormone related to formation of attachment. Low levels of this hormone are associated with increased risk of anxiety and attachment problems (Heim, et al., 2009). This may account for some of the relationship problems reported by men who have experienced CSA, as may the reported social anxiety disorders (Rojas & Kinder, 2009). Many men also report PTSD symptoms, including hypervigilance, a preoccupation with control, interpreting harmless situations as threatening, flashback, nightmares, emotional numbing and distancing, hypervigilance, exaggerated startle response, and sleep problems (Alaggia & Millington, 2008; Crowder, 1995; Gartner, 1999; Hornor, 2010; Leahy, Pretty, & Tennenbaum, 2008; Romano & DeLuca, 2001; 2006; Schachter et al., 2009). Anxiety can lead to sexual dysfunctions through fear of sexual contact and avoiding sexual contact or content because it is reminiscent of the abuse (Romano & DeLuca, 2001). Anxiety can also lead to substance use as a means of suppressing fear and worry (O'Leary, 2009; Romano & DeLuca, 2001).

Dissociative symptoms have been reported in men who have survived CSA (Crowder, 1995; Hopper, 2010; Leahy et al., 2008). These symptoms may accompany depression or PTSD or they may occur independently of these disorders. Dissociation may develop as a means to survive experiences of sexual abuse (Dorais, 2009) and then may become a

method of coping with other life stresses. Grubman-Black (1990) reports that some men believe in and live a fantasy life, which would involve a dissociation from reality. Compulsive behaviours such as sexual compulsions and gambling may be a way of dissociating from the sexual abuse trauma. In extreme cases, dissociative identity disorder may occur (Putman, 2003). Gartner (1999) warns that when men stop dissociating and the experiences are allowed into their consciousness they are often as intense as when they first occurred. Without the dissociative methods of coping, self-destructive coping behaviours may then arise.

Personality disorders such as antisocial personality disorders (Alaggia & Millington, 2008) and borderline personality disorders (Agrawal, Gunderson, Holmes, & Lyons-Ruth, 2004; Gunderson, 1996; Levy, 2005; Putman, 2003; Spokas, et al., 2009; Zanarini, 2000) are associated with abuse and attachment problems in childhood and have been reported in some men who have experienced CSA. Although depression is the more frequently manifested mood disorder, bipolar disorder has also been reported (Anderson & Veach, 2005). Somatoforms disorders where the primary manifestation of anxiety is in a variety of physical symptoms have developed in some men (Romano & DeLuca, 2001). Eating disorders and pain disorders also have been related to experiences of CSA (Putman, 2003; Sapp & Vandeven, 2005). Given the broad range of potential mental health issues evident in male CSA survivors, therapists should be prepared to deal with them either directly or through helping men access other mental health services.

Outcome Related Elements

There are a number of elements related to outcomes for men who have experienced CSA, with some being related to more positive outcomes and some increasing the risk of negative outcomes. These elements are discussed below. Please note that the presentation of these elements is not in order of importance or contribution to outcomes.

Elements Related to Positive Outcomes

1. Trust and Safety

Discussions of abuse and vulnerable emotions require a great deal of trust and safety (Durham, 2003) and providing a safe place and a trusted person with whom to talk about emotions have been associated with more positive therapeutic outcomes (Alaggia & Millington, 2008; Chouliara, Karatzias, Scott-Brien, Macdonald, MacArthur, & Frazer et al., 2011; Crowder, 1995). Both men and staff in focus groups/interviews identified trust and safety as issues of paramount importance in having men openly talk about their abuse. However, because male survivors' basic sense of trust and safety have been negatively affected by the abuse, it may take a while to establish these elements. It will also likely require a good therapist/client match. This match may be based on therapists' gender, client issues with therapist gender and interpersonal comfort with the therapist. Some men will prefer a male therapist, some will prefer a female, while for others gender will not be a significant factor in developing a sense of trust and safety. The preference for a therapist of a particular gender may be based on the gender of the abuser, with one gender being perceived as either aggressive and predatory or seductive and the other gender then being perceived as safer and more nurturing. Some men may prefer a female therapist believing that she would better be able to understand what it is like to be victimized and vulnerable (Gartner, 1999). Unfortunately, with few services, choice of therapist and the matching of client to therapist may not always be available. The key, according to Gartner (1999) is not forcing a client to work with a therapist with whom he does not feel safe. Men in the focus groups/interviews reported that the therapist's gender was more of an individual issue for men. They felt that it was important to let the therapist know if they were not feeling safe with them and to deal with these issues directly. Some men talked about the benefits of working with both males and females and needing to learn to be comfortable with both in order to function in the world.

2. The Therapeutic Relationship

Research has found that survivors of CSA emphasize the importance of the therapeutic relationship whereas non-CSA clients focus more on the process and methods of therapy (Chouliara et al., 2011). A good therapeutic alliance is built on feelings of trust and safety and maintaining confidentiality, good judgement, openness and honesty, and flexibility are skills associated with men feeling that their therapist is trustworthy (Heim et al., 2010; Lew, 1999). Characteristics such as being nonjudgmental, compassionate,

honest, empathic, and respectful were all mentioned by the staff and the men in the focus groups/interviews as essential in a therapist working with CSA clients. Some therapists have stated that being responsive to client needs, being empathic, accepting, supportive, honest and genuine are more important in a therapist than presenting as perfect and/or emotionally distant (Crowder, 1995; Lew, 1999). These beliefs were echoed by the staff participating in the focus groups/interviews. Staff also believed that humour generated a more positive therapeutic atmosphere. The men in the focus groups/interviews also wanted a therapist that had life experience as well as well as knowledge of CSA based on education, training, and/or professional development.

Recovery is not a linear process and there may be periods when progress is minimal or even where men will revert to previous thinking or behaviour (Wilken, 2003). Therapists have to let the men know that this is a normal process and they have to be patient with this pattern of progress (Crowder, 1995). Men who took part in focus groups/interviews said that they would want a therapist who was patient and would allow them to work at their own pace so they would not feel rushed through the process. Being non-directive was seen as important to empowering men and helping them make their own choices by both staff and men. Crowder (1995) and Wilken (2003) stated that being client focused and working collaboratively with the client was beneficial to therapy, because having the therapist take a position of authority recreates the abusive relationship. For men in the focus groups/interviews being down to earth and not taking a power or status position was important to creating a sense of comfort with the therapist.

The therapist must be also able to comfortably and calmly discuss sexual abuse and all its aspects in a manner that is nonshaming and nonjudgemental (Alaggia & Millington, 2008; Sorsoli et al., 2008). Men in the focus groups/interviews mentioned how important it was that therapists remain calm and understanding. Abused men are keenly aware of negative responses, disbelief and discomfort in others around the issue of abuse, thus a good therapist will have evaluated and dealt with their attitudes, values and beliefs about CSA before doing therapy. In the focus groups/interviews with staff the issue of therapists being aware of their responses, both verbal and nonverbal was stressed. Staff stated that it was important that clients be allowed to say what they wanted without concern about the therapist's reaction. Remaining calm and open to whatever the clients needed to talk about was recommended. This may become a particularly salient issue when men reveal sexual feelings and behaviour towards children. The staff indicated that some therapists fear dealing with clients who become offenders. Therapeutic supervision can help therapists come to terms with their issues around CSA so these do not interfere with the therapeutic relationship (Crowder, 1995). Staff recognized that supervision and consultation were important to maintaining awareness of therapeutic response and dealing with personal issues and feelings about clients.

Validating men's experiences is a critical part of the therapeutic process. Men have indicated the importance of having their experiences and perceptions heard and believed (Chouliara et al., 2011). Acknowledging men's strengths and survival methods rather than focusing on the negative aspects of their behaviour is an important part of building a safe and caring environment (Gartner, 1999). The staff who participated in the focus

groups/interviews indicated that being present and really hearing what the men were saying was part of building rapport and helping clients. Further, honouring clients' ideas and identifying the way they creatively coped with a traumatic situation was a key part of therapy.

Therapists should be prepared for transference of men's emotions on to them as part of the therapeutic process (Crowder, 1995). Gartner (1999) reports the following potential forms of transference:

- The therapist is placed in the more aggressive role of abuser and the man re-enacts being the victim.
- The therapist is placed in a more seductive role as abuser and the man takes on the role of the person being seduced.
- The therapist is placed in the role of idealized rescuer and the man in the role of the child demanding to be rescued.
- The therapist is placed in the role of the non-abusing but distant parent and the man takes the role of the neglected child.
- The roles of the doubter who disbelieves and the believer who trusts fluctuate between the therapist and the man.

Therapists who are aware that these roles may be part of the client's response repertoire can work with these forms of transference to allow men to work through these issues and progress through therapy. Counter-transference where therapists take on the role assigned to them by the client and respond to the client's transference in a personal way can be detrimental to therapeutic progress.

3. Dealing with Emotions

Understanding and dealing with emotions such as fear, anger and grief are essential to recovery (Crowder, 1995; Gartner, 1999; Grubman-Black, 1990; Kia-Keating et al., 2005; Little & Hamby, 1999; Wilken, 2003). Gartner (1999) suggests having therapy session topics on expressing and managing emotions; fear of becoming abusive; vulnerability related to intimacy, trust, shame and guilt; and expressing anger. Resilience in men has been associated with finding safe ways of expressing anger and developing empathy (Kia-Keating et al., 2005).

Therapy may result in the reappearance of a variety of emotions that men were previously suppressing or thought they had resolved. Talking about abuse experiences and/or listening to other men talk about their experiences can bring emotions to the surface once more. When these emotions re-surface men may once again feel vulnerable, confused, and out of control. The loss of part of themselves and their lives may become a focal part of their thoughts and emotions and may lead to depression and suicide ideation. Thus, therapy must be prepared to help men process and cope with emotions more than once in the recovery process (Isley, et al., 2008). In focus groups/interviews men and staff stated that talking about, confronting and becoming more knowledgeable about emotions was a helpful component of therapy, particularly because so many men avoid their emotions. Addressing self blame was reported as important, coinciding with Fisher and colleagues'

(2009) finding that men who blamed themselves had poorer outcomes. Fears about what others are thinking about them and self hatred were identified by men in the focus groups/interviews as other emotions needing to be dealt with in therapy. These men believed that discussing suicidal thoughts and a therapist who was comfortable talking about suicide was important to recovery for many men.

4. Talking About the Abuse and Abusive Behaviour

The literature and the men who took part in the focus groups/interviews stated that talking about abuse and its effects and allowing men to tell their stories is important. **Disclosing their stories and hearing other men's stories may help men realize the commonalities of these events and their affect on their lives.** In the focus groups/interviews men talked about how helpful it was to read other men's stories in books such as Grubman-Black's *Broken Boys/Mending Men*. The reference for this and other books men found helpful are listed in the bibliography attached to this report. Further, as some of the men stated, they were silenced about their abuse for so long that finally being able to talk about was validating. It is believed that providing information about abuse and its effects will help to normalize their experience, reduce distress and further their recovery (Dimock, 2007; Isley, et al., 2008).

Because sexual abuse is often accompanied by other forms of abuse such as physical or psychological abuse, these need to be discussed as well (Leahy et al., 2008). Men's definition of abuse can be explored, as some may be unsure about whether certain experiences were abusive or not, particularly more subtle forms such as sexual innuendos and suggestive body language. Placing the abuse within a historical or family context may help provide a clearer understanding of the abuse (Gartner, 1999). This may include men's feelings about having participated in the abuse and how their need for affection affected their vulnerability to the abuse (Alaggia & Millington, 2008).

One of the issues that men want to talk about is their fear of becoming abusers themselves. Men have indicated that some interventions do not allow them to talk about their sexualized thoughts about children (Alaggia & Millington, 2008). Kia-Keating et al. (2005) found that resilient men developed cognitive strategies to help them stop being abusive including being knowledgeable about their feelings and learning to manage their feelings of anger. These would be enhanced by the therapeutic process. However, as the staff in the focus groups/interviews stated, there may be some discomfort with this issue among therapists.

5. Cognitive Restructuring

The cognitive approach to therapy proposes that by changing thoughts, emotional and behaviour changes will follow. Ascertaining men's perceptions often facilitate the understanding of their behaviour. For men, talking about the effects of their abuse may help them connect their past with their present and understand how their thoughts,

emotions and behaviour affect each other (Chouliara, et al., 2011; Dimock, 2007). O'Leary (2009) found that improved functioning was associated with men's reinterpretation of their abuse experiences, and more positive thoughts and greater self understanding have been associated with recovery (Grossman, Cook, Kepke, & Koenen, 1999) and better emotional regulation (Wolin & Wolin, 1993).

Providing men with information about abuse and its effects would be part of the cognitive change (Chouliara, et al., 2011; Crowder, 1995; Gartner, 1999). Men in the focus groups/interviews stated that learning about the effects of abuse on all aspects of life both as a child and as an adult (for example the link between abuse and involvement with the criminal justice system), would help them understand that these behaviours were normal given the circumstances. Many said they felt that their problems with addictions and relationships were because there was something inherently wrong with them. Understanding the link between their abuse and these problems would lessen their self blame. The staff reflected these statements, saying that explanations of the trauma's effect on the body and the mind had to be explored to encourage understanding of life choices and to normalize men's reactions to the abuse. By teaching men the triggers to their emotional responses and negative thoughts they can learn to better respond to these triggers. Focusing on the present and monitoring their functioning in everyday life will encourage men to move forward rather than dwelling on the past. The staff also believed that it was important to challenge the myths of abuse. Research suggests that dispelling myths of male childhood sexual abuse, addressing social and cultural expectations and confronting cognitive distortions and unrealistic goals and expectations may lead to a normalization of men's behaviour and more positive perceptions of themselves and how they dealt with the abuse (Crowder, 1995; Fisher, et al., 2009).

Teaching coping and stress management skills is an important part of changing cognitions and reactions. These coping skills can include reinterpretation of events, focusing on positive elements of a situation rather than negative aspects, and managing emotions. Stress management skills have been linked to improved immune system functioning, less cognitive avoidance, problem solving capacity and positive appraisals (Wilson, 2010). The men in the focus groups/interviews said they wanted a program that would help them develop ways of coping with the information they would be discussing in therapy, otherwise it might be too overwhelming and aversive. Because men who experience CSA sometimes develop polarized thinking, cognitive restructuring may involve helping them see events and people as combinations of positive and negative qualities. It may also entail expanding men's view of their choices. Men in the focus groups/interviews stated that helping them see the many choices that they have would benefit their lives and help them move beyond their narrow and negative view of life.

The staff who participated in the focus groups talked about providing men with feedback on their progress and how this would help them realize the changes they were making. This may include a continued evaluation of goals and progress in meeting these goals or the development of new and different goals. Frequent and informative feedback contributes to the cognitive changes that are being encouraged where men come to focus on positives and think more constructively of how to deal with difficulties.

6. Support and Resources/ Interpersonal Skill Building

As with most stressors, social support is associated with resilience in dealing with CSA (Fisher et al., 2009). Because social support is so important to resilience and recovery, building support networks and helping men access support is recommended as part of therapeutic intervention. Support can be in the form of affection, emotional support and instrumental support. As mentioned, CSA disrupts the development of interpersonal trusts and leads to withdrawal, emotional distancing, and isolation (Isley, et al., 2008; Kia-Keating et al., 2010). Therapy should work to reduce isolation and reconnect men to sources of support (Crowder, 1995; Gartner, 1999). Men who took part in the focus groups/interviews stated that because of the abuse and its impact they lost their family, their partner and/or their friends, therefore they needed help in building other sources of support.

Part of building support involves improving interpersonal skills (Isley, et al., 2008). The men in Kia-Keating, Sorsoli and Grossman's (2010) study recovered from their CSA through relationships with pets, children and understanding adults. Some spoke about achieving a sense of belonging and reducing isolation through sharing experiences with other men who had been abused or who had trauma in their lives and through helping others. This speaks to the value of group work with men, where there is mutual validation (Chouliara, et al., 2011; Gartner, 1999; Wilken, 2003). Group work also helps men deal with other men and develop male friendships, something that has often been difficult for male victims of male abusers (Gartner, 1999). Developing interpersonal skills such as setting boundaries, emotional regulation, and becoming more comfortable with intimacy contribute to the development of healthy and supportive relationships (Wilken, 2003). For some men, their therapist was the first person they trusted since the abuse occurred. Addressing specific relationship problems and family dysfunctions can help men better identify healthy from unhealthy relationships and develop ways to improve existing relationships (Kia-Keating et al., 2010). Men in the focus groups/interviews spoke about the need to learn communications skills and how to set and maintain healthy boundaries.

7. Finding Meaning/Helping Others

Men finding meaning in their experience is an indicator of resilience and recovery. Grossman, Sorsoli and Kia-Keating (2006) outline three ways that men find meaning in their experiences. The first is through direct actions such as helping others, especially vulnerable others, and creative activities like art, music and writing. Several men in the focus groups/interviews talked about wanting to help others who had experienced abuse or trauma, be involved in teaching children what to do if they are being abused, and educating others and building awareness about male sexual abuse. Helping others allows men to connect with others and reduce their isolation (Anderson & Veach, 2005; Grossman, et al., 2006; Wilken, 2003). Related to this is the conviction of some men not

to be defined by their abuse or perceived as victims (Hunter, 2009; Wilken, 2003). In focus groups/interviews men and staff talked about not being defined by the abuse as a significant step towards recovery.

The second way that men find meaning is through thinking and reasoning about the abuse such as finding explanations for why their abuser behaved the way he did; understanding their own behaviour (for example seeking affection); understanding the social contributors to abuse; and adopting a philosophical perspective of abuse. Gaining knowledge about abuse in general will help in this process. Men and staff in the focus groups/interviews talked about forgiveness as a way of understanding the abuse, releasing negative feelings and moving on to focusing on more positive aspects of life. Men stated that it could be achieved in a variety of ways sometimes involving talking with the abuser (in the case of a family member) or through an internal sense of forgiveness of the abuser or of themselves.

The third form of meaning making is gaining a sense of spirituality or finding a larger purpose in the abuse (Grossman, et al., 2006; Hunter, 2009; Wilken, 2003). Both men and staff who took part in focus groups/interviews talked about the importance of talking about spirituality in a CSA program. Discussions on how the abuse affected their spirituality and faith and help in reconnecting with this part of themselves was reported as essential by almost all of the men. The men felt that introducing different types of spirituality, such as Aboriginal spirituality as well as spiritual perspectives and practices from different cultures would provide choice in how they could rebuild this part of their lives. Some felt that this connection to a higher power would make them feel less alone. A number of men also saw spirituality as a way to reach forgiveness of self and perhaps those who had harmed them, and as a way to let go of hostility and resentments.

8. Self Awareness and Self Acceptance

Self awareness and self acceptance are a large part of recovery (Anderson & Veach, 2005). The men in Chouliara and colleagues' (2011) study stated that therapy helped them increase their self esteem and self acceptance, helped them feel better about themselves, and encouraged self care. Self acceptance involves letting go of self blame, having an awareness of personal limits, differentiating between others expectations and ones own expectations, and becoming aware of the benefits and limits of current relationships (Grossman et al., 2006; Kia-Keating, et al., 2010). Self care activities are strong indicators of increased self worth and recovery (Chouliara, et al., 2011; Lew, 1999; Wilken, 2003). This includes attending to physical and mental health issues. In focus groups/interviews staff indicated that when people started to feel better about themselves they displayed more attention to their health and wellbeing. Both staff and men reported that for men, self care is often ignored, as part of the masculine role is caring for others and putting others needs above their own. Therefore, when men begin to demonstrate self care it is indicative of recognizing their needs and worth.

9. Empowerment/Control

Because men who have been abused have had their control over their own body taken away and felt powerless to stop the abuse, regaining their sense of power and control over themselves and their lives is an important part of therapy and has been associated with recovery (Chouliara, et al., 2011; Gartner, 1999). Therapy that is client centered and strength based empowers men by placing them in control of the course of their therapy (Alaggia & Millington, 2008; O'Leary, 2009). In focus groups/interviews the staff stated how important it was to have a client centered, strength based approach and to be prepared to follow the presenting needs, interests and concerns of the client. This reinforces the idea that their life belongs to them. Men who participated in the focus groups/interviews said that sometimes what they need is for the therapist to help them see all the choices they have, because they have been made to feel that they have no choices and they have to follow the wishes of others. Focusing on strengths rather than weaknesses gives men a greater sense of self efficacy and greater self efficacy encourages men to try more challenging tasks thereby contributing to a sense of personal success, growth and recovery (Dorais, 2009). In focus groups/interviews staff stated that providing men with frequent and positive feedback on their progress and achievements provides a sense of pride and confidence in their capacity to successfully deal with difficult issues.

10. Sexuality and Masculinity

Experiences of CSA often lead men to question their sexuality and their masculinity, therefore these issues need to be discussed in therapy. Discussions around sexual orientation and homophobia have been suggested as a way to openly deal with these issues (Alaggia & Millington, 2008; Fisher et al., 2009). The following topics for discussion have been suggested (Crowder, 1995; Dimock, 2007; Gartner, 1999):

- Male stereotypes, **cultural norms** and media messages about masculinity and their impact.
- Dealing with anger and power.
- Healthy male role models.
- Intimacy issues.
- Pride and value in being male and in masculinity.
- Interdependence vs dependence.
- Gender role confusion.
- Sexuality, sexual relationships, discomfort with sexuality or sexualizing relationships.
- Sexuality and vulnerability.

The staff and men who took part in focus groups/interviews identified these same issues as needing to be discussed in terms of the effects of CSA and within the context of healthy behaviour. Crowder (1995) suggests emphasizing the strength and courage it takes to face the difficult issues related to CSA as a way of using the masculine ideal in a

positive way. Recovery from CSA is marked by these men defining masculinity for themselves rather than trying to meet a culturally imposed ideal (Crowder, 1995; Kia-Keating, et al., 2005; Wilken, 2003). Because this is linked with self acceptance and self determination it is a particularly strong indicator of healing and moving on from the abuse. In focus groups/interviews staff also felt that men needed to establish their own norms for masculine behaviour to feel comfortable with themselves and move on from the effects of the abuse on this aspect of their identity.

11. Parenting Issues

Although not a frequently mentioned topic of discussion in the literature, parenting and parenting issues were mentioned by staff and men who participated in the focus groups/interviews as either an area for discussion or perhaps a separate group for men who have children. Because men may have concerns about becoming abusive or being perceived as being abusive they may not want to become physically close to their children. Further, men who have lost their family and/or their partner because of the abuse may be parenting with very little support. Other men may be dealing with having children who are not in their custody. The men stated that they needed to learn about healthy parenting either by themselves or with a partner.

12. Partners

Men from the focus groups/interviews said that because their experiences of abuse have affected their relationships either through sexuality, intimacy, communication, emotional distancing or other interpersonal factors, that there should be a **group program specifically for partners of men who were sexually abused in childhood, similar to AI Anon for family members of alcoholics**. This group could help partners understand what the men in their lives are going through and give them coping skills to deal with their partner and his issues. Couples or family counselling were discussed as possibilities as well. The men saw these additional programs as helping them build a healthier family life.

Elements Related to Risk of Negative Outcomes

There are a number of concerns that can interfere with the therapeutic process and thus should be considered as part of program planning and development. These are outlined below. Please note they are not presented in order of importance or level of concern.

1. Accessing Services

Because men will experience crises outside of therapeutic sessions it is important that therapists prepare them for these inevitabilities. Some programs offer men the option of

contacting the therapist or emergency counselling outside of scheduled sessions. These options are typically appreciated and utilized (Chouliara et al., 2011). Men who took part in the focus groups/interviews also talked about needing a service option between counselling sessions and some reported that extra counselling, specific exercises (writing, taking a walk), or an opportunity to just sit, **have coffee and calm down after sessions when they are feeling upset would also be beneficial.**

2. Service Availability

There are few resources available to men dealing with issues of CSA and therefore men often have few options, particularly if the cost of therapy is an issue. Therapists in private practice may be more plentiful, however many men lack the financial resources to access these services. Services that are culturally sensitive and services for men in remote areas may have limited availability and in some cases may not be available at all (Chouliara, et al., 2011). Staff who took part in the focus groups/interviews felt it was important to talk about the lack of services with the men and to explore what this meant to them and how they dealt with it. Certainly men were vocal about their dissatisfaction with the lack of services for men and the social disregard of CSA in men. This may be couched within a discussion of the need for social and community change and a need to make the issue of male CSA more visible.

3. Continuity of Services/Therapists

Due to the difficulty men often have building trust with a therapist it is important that there is consistency in who is counselling them (Chouliara et al., 2011). Therapeutic progress will be delayed with each new therapists as case information must be re-explored, stories re-told, details re-explained and trust rebuilt. As much as possible therapist turn over should be minimized.

4. Unrealistic Goals of Therapy

Men may have unrealistic expectations of therapy. Some will expect the process to be very quick. This is often a manifestation of men's eagerness to have a healthy and "normal" life. In focus groups/interviews staff identified this as a common expectation among CSA clients. Discussing the trajectory of recovery with men early on in the therapeutic process can address some of these false expectations. Men should be informed that bringing painful, previously suppressed or avoided memories to the forefront may lead to a worsening of trauma symptoms. Hearing the stories of other men in a group setting may also have this effect. Men may become frustrated when they realize the length of the recovery process (Crowder, 1995). Explaining the breadth of effect of CSA trauma and the length of time those effects have been part of their lives may give them insight into the length of the recovery process.

Some men may also fear relinquishing patterns of behaviour and thinking that they have manifested for the majority of their lives (Crowder, 1995). Giving up familiar patterns, even if they are maladaptive, can be frightening. Part of the therapeutic process will be acknowledging how these patterns may have served them well, but have become a hindrance to a healthier life. Replacing these patterns with ones that are more adaptive at this point in their life can be emphasized.

Both staff and men who took part in focus groups/interviews talked about problems with clients getting off topic during therapy sessions. At times these may be attempts to avoid dealing with a particularly sensitive or traumatic issue or it may be tangential thinking and a problem focusing on a particular topic. Men reported that in a group setting this could lead to some individuals dominating the conversation. They indicated the importance of allowing all group participants equal time to speak. On the other hand, some warned that there are times when men shut down and do not talk. Although they stated the need to respect this within the short term, they also recognized that this could not go on throughout an entire group program. As stated by a number of men, a therapist who knew how to get these men to open up by asking the right questions and addressing their fears would be essential in having them get the most out of therapy.

Staff reported that some men may transfer their sense of dependence onto the therapist, and thus have difficulty progressing to recovery. This may be particularly so for those men who have not built trust or attachment with anyone previous to the therapeutic relationship. Supervision and consultation with other therapists would provide a venue for exploring these issues and how to deal with them.

5. Vicarious Trauma

Because therapists will be exposed to a number of stories from men, there is a chance of vicarious trauma (Chouliara, et al., 2011). Due to the traumatic nature of the men's stories, some therapists may hurry the process to a point where they do not have to dwell on the information about the abuse. Some therapists may feel irritated, angry or may blame the victim as a way of dealing with vicarious trauma (Gartner, 1999). There is also the chance that therapists will take on the responsibility for clients and their behaviours (Crowder, 1995), which can lead to further frustration and anger when there is a lack of progress or a regression to maladaptive behaviours. Although most therapists are prepared for this likelihood through training, accessing therapy themselves, supervision, and debriefing sessions with other therapists in the field may prove beneficial in reducing vicarious trauma (Crowder, 1995; Gartner, 1999). Support among therapeutic staff help to circumvent many problems that would otherwise negatively affect therapy. Self care measures such as establishing a balance between work and personal life is essential to avoiding over-involvement with the trauma they deal with daily.

6. Therapeutic Misconduct

Therapeutic misconduct can occur within any type of therapy and addressing any type of issue. Among the most harmful ones are the therapist expressing and acting on a sexual interest in their client (Chouliara et al., 2011). For men who have experienced CSA where a person with power and authority took advantage of them sexually, this would be particularly devastating because it represents yet another betrayal by a person with whom he has trusted his vulnerability. Sexual misconduct may be a counter-transference response to clients' sexualized behaviour. A few of the men in the focus groups/interviews feared having sexual feelings for their therapist or for other men in groups therapy sessions. It is the responsibility of the therapist to not let the therapeutic situation become sexual.

Boundary issues and violations are part of sexual victimization by a therapist, but may arise without any intent toward sexual impropriety. For example, Harper (2006) reports that some men said they did not feel comfortable if their therapist revealed information about their past or touched them to provide comfort or support. Although they felt uncomfortable and in some cases violated, the men felt they could not say anything. On the other hand, some men felt hurt and rejected if their therapist did not share any personal information with them. These contradictory findings are likely related to men's issues with authority figures. While some therapists feel that relaxing the boundaries around revealing personal information is beneficial, others feel that it is detrimental. Many do not know how to handle requests for boundary violations about personal information from the client. As Harper (2006) suggests, this makes it clear that boundaries must be clearly discussed and outlined prior to therapy and must be agreed upon by both client and therapist. If the client is distressed, therapists should ask before offering a comforting touch, as sometimes this will be a welcome form of support and sometimes it will create discomfort.

Avoiding or ignoring problems or mistakes made in therapy or being uninvolved or unresponsive to clients can also be detrimental to the therapeutic alliance and hinder the progress of therapy. Applying a new form of therapy or intervention method without consulting the client may replicate taking control away from him and infantilizing him (Chouliara et al., 2011). This may lead to a damaged sense of trust in the therapist, a reduction in self esteem, and a sense of helplessness. Crowder (1995) warns therapists about their own cultural and personal ideas interfering with the therapeutic process. Personal issues with sexual abuse and perhaps their own experiences of abuse should also be addressed before helping others.

7. Child Protection

There may be times when therapists may struggle between supporting their clients and issues of child safety and protection. Research has indicated that these dilemmas also create concern for the male CSA survivors. Generally men understand the legal

obligations of therapists to protect children, but want procedures explained more thoroughly and to be involved in the process rather than having the situation being taken completely out of their control (Chouliara, et.al., 2011).

Therapeutic Approaches

Cognitive Behaviour Therapy

The therapeutic approach that is most often applied with CSA survivors is cognitive-behaviour therapy (CBT). The basis of CBT is that thoughts, emotions and behaviours are mutually influential and changing one will incur changes in the others. Interventions are cognitive or behavioural in nature, goal oriented and present focused (Rachman, 1997). Distortions and inaccuracies in thinking and beliefs are replaced with more reality based cognitions. Memories and perceptions are relabelled and reorganized to help the client regain a sense of meaning and control (see Robertson, Humphries & Ray, 2004). In Rieckert and Moller's (2000) application of rational emotive therapy with female CSA survivors, irrational beliefs around issues of safety, trust, power and control, self esteem and intimacy were targeted. Experiences of abuse and their effects were discussed to produce an understanding of the link between these experiences, the women's perceptions of the events and their subsequent behaviours and emotions. The underlying dysfunctional cognitions that led to maladaptive emotions and behaviours were identified, challenged, and replaced with more rational beliefs and thoughts. Cognitive and behavioural skills were developed. Homework and reading assignments were given to help women analyze their irrational beliefs and images. Compared to a control group, significant improvements were found on measures of depression, anxiety, anger, guilt, self esteem and sexual problems after therapy and at the six month follow up.

In the therapy model described by Romano and DeLuca (2005) (see section on therapeutic models below), male survivors of CSA evaluate the origin, accuracy and impact of the beliefs and behaviours that have resulted from the abuse including self blame, anger, depression, anxiety, coping and learning strategies. In talking to staff and men in the focus groups/interviews, CBT appears to meet many of their identified therapeutic needs including: obtaining knowledge and information about abuse and its effects, learning coping, emotion management and relationship skills, changing negative thoughts and feelings to positive ones, learning relaxation and self soothing skills, and being present focused.

CBT has been the most researched therapeutic approach in trauma intervention and it has been found to be an effective approach for PTSD and trauma in general (Bisson, Ehlers, Matthews, Pilling, Richards, & Turner, 2007; Kornor, Winje, Ekeberg, Weisaeth, Kirkehei, Johansen, & Steiro, 2002; Mendes, Mello, Ventura, Passarela, & Mari, 2008), and PTSD related to experiences of CSA (Chard, 2005; McDonagh, Friedman, McHugo, Ford, Sengupta, et al., 2005; Wolfsdorf & Zlotnick, 2001). This is perhaps why the approach dominates the field of CSA and other types of trauma. For more information on CBT application in cases of trauma including trauma with co-morbid substance abuse, revictimization, grief and acute stress, see *Cognitive Behavior Therapies for Trauma* (2nd ed.) by Follette and Ruzek (2006). This book provides a description of CBT methods of engaging clients, teaching coping skills to deal with emotions and memories, confronting

feared situations, cognitive reconstruction, self care practices, goal establishment, and overcoming trust and intimacy issues. *Surviving Sexual Violence: A Guide to Recovery and Empowerment* by Gerbarg and Brown (2011) is another helpful resource.

A number of different methods within the CBT approach have been applied or suggested as means of addressing CSA and trauma. These are described below. Please note they are not presented in order of importance or applicability. Each of the therapeutic methods mentioned have been used and have merit. Research indicates that different methods may be differentially beneficial depending on the particular individual and on his state of recovery (Chouliara, et al., 2011). Most therapists take an eclectic approach, selecting methods, exercises and activities that work with a particular client or group. Staff who participated in focus groups/interviews indicated that it was important to follow the lead of the clients and use methods that are applicable and helpful at a particular time.

Exposure Therapy

Exposure therapy is based on a behavioural approach and the principle of extinction. Avoiding thinking about or talking about a traumatic event maybe reinforcing in that the person does not have to face the feared event, but it does nothing to resolve the trauma. Thus, the trauma continues to exert its power and effect over the person's life. Facing the traumatic event dissipates the fear by showing the person that it no longer is a threat to them. In dealing with trauma such as CSA it is best if exposure therapy is done gradually and in combination with relaxation training. The gradual exposure allows the person to face their fears at their own pace and the relaxation exercises help keep them from being re-traumatized by the information and emotions they are confronting. For example, Cloitre and colleagues (2002) in their treatment of PTSD related to childhood abuse began with an initial phase of eight weekly sessions of emotional and interpersonal skills management training that built the therapeutic alliance and then went into a second phase of eight sessions of exposure. They found this combination to be effective in reducing PTSD both immediately and in a three and nine month follow ups.

Many men avoid memories of the abuse and situations that remind them of the abuse. Because these memories are not processed they continue to exert their influence, often with the same intensity as they did when they first occurred. Facing these memories dispel their power to induce fear and helps men move the experience into the past (Robertson et al., 2004). The event is not forgotten, but it's meaning and place in their life is explored and then moved to long term memory. The fear arousal generated by these memories must be reduced before introducing new ways of coping and new thought and behaviour patterns, otherwise it interferes with the cognitive processes needed to apply these more adaptive behaviours (Bryant, Felmingham, Kemp, Das, Hughes, Peduto, & Williams, 2007).

Exposure therapy has shown evidence of effectiveness in the treatment of PTSD and other trauma related distress (see Jaeger, Echiverri, Zoellner, Post, & Feeny, 2009) and

seen in the work of Cloitre et al. (2002) it has also been successfully applied in treating PTSD in childhood abuse survivors. A form of exposure therapy termed imagery rescripting has been effective in reducing PTSD symptoms in sexual assault (Krakow, Hollifield, Johnston, Koss, Schrader, et al., 2001) and CSA survivors (Smucker, Dancu, Foa, & Niederee, 1995; Smucker & Niederee, 1995). Traumatic images and intrusive memories of the abuse characteristic of PTSD cause additional stress and trauma in survivors. In imagery rescripting the traumatic images are confronted and changed to less threatening images or new positive images are developed to replace the traumatic ones (Holmes, Arntz, & Smucker, 2007). Rescripting can generate new perspectives, new emotions, previously unrecognized needs, and new realities. For some survivors this is the beginning of the mourning of loss and moving forward from that loss. Changes in anger, guilt and shame have been noted (Arntz, Kindt, & Tiesema, 2007). For a more detailed description of exposure therapy and its use please see Abromowitz, Deacon, and Whiteside (2010).

Despite the considerable evidence of the effectiveness of exposure therapy for dealing with trauma, there are some studies that have failed to support the effectiveness of their form of therapy, finding, rather, that fear responses naturally diminish over time (e.g. Protopopescu, Pan, Tuescher, Cloitre, Goldstein, et al., 2005). There has also been some concern that exposure therapy may re-traumatize individuals, however, research has found that given a choice among different types of therapeutic interventions, individuals chose cognitive therapy followed by exposure therapy (Tarrier, Liversidge, & Gregg, 2006). Further, disclosures of traumatic experiences, particularly verbal disclosures and re-telling of stories has long been found to be beneficial and although negative emotions may increase immediately after the disclosure, significant long term effects have been evidenced in both physical and mental health (Cole, Kemeny, Taylor, & Visscher, 1996; Donnelly & Murray, 1991; Easterling, Antoni, Kumar, & Scheiderman, 1990; Easterling, L'Abate, Murray, & Pennebaker, 1999; Greenberg & Stone, 1992; Pennebaker, 1993; Pennebaker & Graybeal, 2001). Benefits to survivors of CSA have specifically been reported (Alaggia & Millington, 2008; Kendall-Tackett, 2009). Research has found that traumatized individuals believe in the benefits of talking about their problems and trauma as part of the therapeutic process (Angelo, Miller, Zoellner, & Feeny, 2008; Cochran, Pruitt, Fukuda, Zoellner, & Feeny, 2007) and these beliefs may keep them attending therapy through the difficult first disclosures and telling of their story.

Speaking with men in the focus groups suggested that for many men traumatic CSA based fear responses do not always diminish or disappear over time. It was also apparent that it was the men who had confronted their fears and began to process the experience who were ready to learn new information and skills and to move on with their lives. Both men and staff reported the need to talk about the abuse, confront and process the various emotions and effects of CSA, and the importance of establishing safety, coping and relaxation skills before delving into the more emotional aspects of CSA. The staff recognized how difficult it was to introduce behaviour change when clients were in a highly aroused state.

Stress Inoculation Therapy

Stress inoculation therapy has been used to help individuals cope with current stressful events and future stressors by addressing both cognitive and emotional factors. It consists of three phases (Michenbaum, 1996):

a. Education Phase or Conceptualization Phase – where there is a collaborative exchange of information between the therapist and the client. Information about the trauma and its effects, including how clients may have unintentionally behaved in ways that increased the stress, are explored. Clients are helped to evaluate what they want to and can change about their life and then to apply either problem-focused (active efforts to change) or emotion-focused (change how one views or feels about the situation) coping methods. Short term, intermediate and long term goal establishment turns large seemingly insurmountable problems into manageable and specific plans of action. Clients prepare, build up to, confront and reflect on how they respond to the distress or trauma they experienced with specific focus on their personal issues such as anger, self blame, anxiety, depression and withdrawal. Men and staff who participated in the focus groups/interviews indicated that learning about CSA and its impact and exploring men's reactions to this experience, including compulsive coping behaviours, was an important component of therapy. They also mentioned the importance of setting goals to help change behaviours. Staff felt that intervention needed to be specific to each individual client and their presenting issues.

b. Skill Building and Rehearsal Phase – allows individuals to learn and practice cognitive and behavioural strategies within a safe environment. The skills and strategies are specific a particular issue like CSA and might include emotion regulation, self acceptance and self care, relaxation training, adaptive problem and emotion focused strategies, life skills, relationship and interpersonal skills, and accessing support systems. Learning these types of coping skills were suggested by men and staff in focus groups/interviews as beneficial in overcoming the effects of CSA.

c. Implementation and Follow Through Phase – where clients apply the skills learned in the second phase in their real life and monitor their effectiveness, making adjustments where needed. They may begin by role-playing and in this endeavour group programs may be helpful. Helping others with comparable problems, preparing for potential relapses (identifying warning signs and coping with reversions to previous behaviour), ownership of change, and refresher sessions can be part of this final phase. In focus groups/interviews the staff indicated the importance of not only practicing new skills in session, but of applying these skills in everyday life and having the men monitor their daily functioning.

This form of therapy helps individuals manage their environments and at times to change those environments and the stressors within them. In some cases this may include community based change. In focus groups/interviews, staff and men stated that their needed to be community and social change to increase recognition of the prevalence of CSA in men, a clear message that it was not acceptable, and more resources to help men. Men wanted to help others affected by CSA by speaking out and being involved in education and prevention efforts and building community and government awareness

through community events and public service announcements similar to the ones done for substance abuse, drinking and driving, and bullying.

Stress inoculation can be done with individuals, in groups and with couples. Typically it consists of eight to 15 sessions with the addition of follow up or refresher sessions over three months to a year. Thus it is amenable to a variety of issues and time structures. This therapeutic approach has been shown to be effective in reducing distress and trauma symptoms (Michenbaum, 1993), particularly when combined with exposure therapy (Robertson et al., 2004). Exposure therapy should precede stress inoculation, allowing men to reduce arousal levels to the point where they can focus on the more cognitive and behaviour processes of the therapy.

Narrative Therapy

Narrative therapy is based on the premise that a person's subjective reality will determine their behaviour and emotions. The stories people tell about their lives represents their subjective view of reality. A person's life contains many stories and each story has many different components or aspects. People will focus on different aspects of a story depending on the context and audience and what they don't talk about is often just as revealing as what they do talk about. Over time a particular perspective can come to dominate a narrative, for example a narrative of self blame may be replayed and these dominant themes will come to negatively affect the person's view of themselves and/or the world (Etchison & Kleist, 2000). Sometimes these narratives take on a very narrow focus. All experiences are then filtered through this limited perspective and the negative focus such as self blame becomes magnified to insurmountable and unrealistic proportions (Morgan, 2000). These narratives not only affect perspectives of the past and the present, but also of the future.

Narrative therapy utilizes people's natural tendency to tell the story of their lives as a mechanism of change. The initial telling of their experiences to the therapist may reveal a particular narrative and dominant theme. In therapy individuals are asked to reconceptualize and retell their story with a different focus, different possible reactions, perspectives or contexts, or how they wish they and their lives were in reality (Augusta-Scott & Dankwort, 2002). Expanding narratives to include more detail and complexity is encouraged. By developing these different narratives individuals come to realize that reality is a matter of personal perspective and that they have the capacity to construct alternative views of reality, some of which will help them achieve more desirable outcomes (White & Epston, 1990).

This form of therapy has been applied with CSA survivors. The life stories of survivors often contain problem based themes such as shame and self blame (Bhuvanewar & Shafer, 2004). Because therapeutic processes sometime focus on presenting problems, these themes may be perpetuated. However, with a more strength based focus and the realization that they can structure their life stories as they choose, survivors feel more confident in organizing past events, changing the meaning of these events, altering their

view of the effects of the events, and considering future paths and choices (Gasker, 2001; Harvey, Mischler, Koenen, & Harney, 2001). In their study of the narratives of male and female survivors of CSA, Anderson and Hiersteiner (2008) found that over time narratives changed from being dominated by themes of vulnerability, defeat, difficulty, and hopelessness to themes of strength and recovery. Recovery was facilitated by disclosing the abuse, finding meaning in the experience and developing support systems. It was characterized not by eradicating the abuse from their memory, but by incorporating it into their memories of past experiences and no longer letting it defining their entire selves. Some survivors kept journals as a way to tell and track their own stories. The authors suggest that keeping the focus on the dynamic rather than static aspect of a person's life may encourage clients to progress towards a change in story themes.

This therapeutic method works well with strength based, client centered, and solution based approaches (Morgan, 2000; Saleebey, 2005), all of which were recommended by the staff who took part in the focus groups/interviews. Narrative therapy places the person as the expert in their own life and separates their problems from their personal qualities and capacities so that their problems do not define them. Thus, it is respectful and non-blaming (Morgan, 2000). Wilken (2003) states the importance to the recovery process of men no longer defining themselves based on the abuse, a position reiterated in focus groups/interviews with staff.

Narrative therapy is best applied for individuals who are more verbal as it involves written and verbal exercises. Because it is a slower reflective process that develops with time and may contain regression to previous negative themes, it is more appropriate with longer term therapy (Milner & Jessop, 2003). A caution for therapists is that with this type of guided process there is a greater chance that the therapist will influence the client's narratives through their prompts and suggestions as to what could be included in the narrative, the focus of the narrative and where detail could be added.

A more detailed explanation of the application of narrative therapy with male survivors of CSA, is presented in Tim Harker's (1997) book: *Narrative Therapy in Practice: The Archaeology of Hope* and specifically his chapter entitled: *Therapy with Male Sexual Abuse Survivors: Contesting Oppressive Life Stories*. Training in narrative therapy is available through a) Winnipeg Narrative Therapy (www.winnipegnarrativetherapy.com) b) The Vancouver School for Narrative Therapy (<http://therapeuticconversations.com>); and c) The Institute of Narrative Therapy in the UK (www.theinstituteofnarrativetherapy.com).

Emotion Focused Therapy

The basic premise of emotion focused therapy is that emotions are integral to the development of self. Individuals form emotional schemas or systems of knowledge which they use to interpret and respond to their environments and relationships. The schema contains information about how the emotion feels physically, when it occurs, what it signals, and what thoughts and behaviours go along with it (Greenberg, 2004).

Because emotions can generate different thoughts and behaviours they can lead to adaptive or maladaptive responses (Greenberg, 2004). Some emotional schemas that may have been adaptive in a threatening environment become maladaptive in a nonthreatening setting.

Negative emotions such as fear indicate the presence of a problem that needs to be addressed and therefore have adaptive value for survival. However, when the negative emotion is prolonged beyond the existence of the threat it can become maladaptive (Greenberg, 2004). Emotional responses then need to be adjusted so they better match environmental demands. For some individuals negative emotions and memories become so intense that they block them out, this too is maladaptive since emotions are part of an adaptive response system when utilized effectively.

Therapy is a process of emotional awareness and acceptance and emotional transformation. Emotional awareness and acceptance begins with helping clients become cognisant of their emotions with a focus on the physical experience of the emotion rather than on the cognitive processing of the emotion. Because this involves facing emotions and related schemas, it is similar to exposure therapy. Clients are then guided through the description and labelling of these emotions, including identifying emotions as primary (the original or underlying emotions such as fear) or secondary emotions (those that mask primary emotions such as anger). Increased emotional awareness has been associated with developing a more positive mood and decreasing negative ruminations on a negative event (Salovey, Mayer, Golman, Turvey, & Palfai, 1995). Both men and staff in focus groups/interviews indicated the importance of CSA survivors gaining an awareness and greater comfort with their emotions including the physical sensations that accompany emotions and how they are triggered.

Emotion transformation involves identifying if the primary emotion is adaptive or maladaptive, with adaptive emotions being used to guide behaviour and maladaptive emotions being targeted for change. Change of maladaptive emotions consist of modifying emotional schemas (cognitive systems of knowledge and information). This is accomplished by helping people change the narratives of their life, thus this therapy combines well with narrative therapy. Changing their narratives can change the thoughts and emotions that are part of the maladaptive schema that drives the narrative (Greenberg & Angus, 2004). This schematic change can include an increased focus on positive emotions. Positive emotions are related to resilience in terms of more flexible, creative thinking and counteracting the effects of negative emotions (Fredrickson, 2001; Davidson, 2000). Due to mood congruent recall, emotions will lead to thoughts that are commensurate with either positive or negative emotions and these thoughts then intensify the emotion which then leads to more thoughts associated with the emotion. This forms a self perpetuating loop that feeds into either positive or negative emotional valence. Developing positive emotions can then work to reduce negative emotions. Applying more positive imagery scripts can also negate negative imagery scripts, thus this therapy works well with imagery scripting.

Other forms of emotion regulation include accepting and tolerating emotions through emotion focused coping (changing how events are perceived for example through reappraisal and finding meaning), being able to create a working distance from overwhelming maladaptive emotions, decreasing susceptibility to negative emotions, self-soothing and distraction (Greenberg, 2004). A functional or working distance can be maintained through meditation and self-soothing can be achieved through self talk, relaxation and self compassion. In focus groups/interviews staff identified the need to address negative self talk and use methods such as mindfulness meditation for relaxation. Music can also be used to change mood in order to self sooth, relax, feel energized or feel empowered (Russell, 1992). Role playing is sometimes used to help individuals become more aware of their emotions and emotional responses. It can also help them change their thoughts about their emotions and their responses.

A collaborative relationship is formed between the therapist and client and therefore the client is an active agent in his therapy (Greenberg, 2004). The therapist does not suggest what the focus of therapy should be or interpret the clients' perspective, rather they guide the process of emotional exploration and schematic change. This fits well with the client centered, strength based approach supported by the staff who participated in the focus groups/interviews.

Emotion focused therapy has been found effective in improving symptoms of distress related to all forms of CSA in the time immediately after therapy and at the nine month follow up (Macintosh, 2006; Paivio, Jarry, Chagigiorgis, Hall, & Ralston, 2010; Paivio & Nieuwenhuis, 2001). It has also been associated with forgiveness in survivors of childhood abuse (Chagigiorgis & Paivio, 2008), and Wilken (2003) reported on the benefits of forgiveness to the recovery process for male CSA survivors. Both men and staff in focus groups/interviews talked about the importance of forgiveness with men, stating that it would help stop the resentment, anger and hurt they felt and provide closure and inner peace. Most felt it was more of an internal personal process rather than an outwardly expressed sentiment.

Some have found that emotion focused therapy enhances CBT by improving emotion regulation before initiating exposure therapy and increasing healthy relationship strategies and skills (Cohen, 2008; Greenberg & Goldman, 2008; Gurman & Jacobson, 2002; Johnson, 2002; 2004; Johnson, Bradley, Furrow, Lee, & Palmer, 2005). This therapeutic approach has also been used extensively with couples and there is evidence that it increases relationship satisfaction (Macintosh, 2006). It has also been used as a form of family therapy (Palmer & Efron, 2007). More information on the use of emotion focused therapy and training can be found in Johnson et al.'s (2005) workbook as well as the following Canadian websites: International Centre for Excellence in Emotionally Focused Therapy (www.iceeft.com) in Ottawa; the Emotion Focused Clinic in Toronto (www.emotionfocusedclinic.org) at York University; and the Burnaby Counselling Group (<http://counsellinggroup.org/emotion-focused-therapy>) in British Columbia.

Solution Focused Therapy

Solution focused therapy is often a brief therapy lasting from one to eight sessions. It is practical and goal oriented with a focus on the present and future rather than on the past. It takes a strength based approach as clients' skills and resources rather than the presenting problems play a central role in therapy. The assumption is that everyone has the capacity to envision a better life and to make that vision a reality through the application of existing skills and strengths (Institute for Solution-Focused Therapy, n.d.). Success would then be at least partially defined as setting, pursuing and achieving self directed goals. Part of developing a sense of empowerment is in accomplishing goals and feeling in control of their lives. Therapy can help by keeping them focused on the present, as many become stuck in the past, and by point out successful goal attainment, especially small accomplishments that can be overlooked. This approach would fit as part of a strength based, goal oriented, client centered approach recommended by staff.

The therapeutic process is guided by a series of questions meant to help clients recognize their existing skills and strengths and applying them in a broader range of situations. The types of questions posed by the therapist include (Institute for Solution-Focused Therapy, n. d.):

- **The Miracle Question.** This question helps the person to articulate what the future would look like if the problem no longer existed. Typically the question is the nature of: if during the night while you slept (the problem) vanished as if it never existed, when you awoke how would you know (the problem) was gone? What would be the signs that it was not there? Through this question clients can establish specific future goals associated with a better life.
- **Scaling Questions.** Clients are asked to assess their current situation, their progress, their resources, their level of motivation, sense of hope, confidence, depression and other topics and issues related to their progress on a scale of one to ten. This helps clients orient where they are currently in relation to where they want to be or their ideal situation.
- **Exception Seeking Question.** There are times when the problem is less severe. This type of question asks clients to find what was different about situations where the problem was less severe. Identifying these factors can lead to repeating behaviours associated with decreased problem severity. An example of an exception seeking question would be: "What was different between the times (the problem) was less of a problem and more of a problem?"
- **Previous Solution Questions.** This question is intended to help clients focus on their capacity to solve problems and to apply previously successful solutions to their current problems. An example of this type of question would be: "What did you do in the past that proved helpful?"
- **Present and Future Focused Questions.** Clients may want to talk about the past and the origin of the problem rather than on the future. These questions are meant to direct them towards what they want their life to be like and what they are doing that is working towards improving their life, thus they tend to be goal focused. "What will you be doing within the next week that will be helping you work towards your goal?"

- **Coping Questions.** These questions will help clients realize the internal and external resources they have to assist them achieve their desired future. Resources utilized for self care and relaxation can be identified and encouraged, particularly since the importance of these resources are sometimes overlooked. Questions such as: "How did you keep things from getting out of control?" and "How were you able to able to continue doing what needed to be done?" can focus on current coping skills and encourage their future use.
- **Complimentary Questions.** Compliments will help validate clients' skills and progress. They can also be used to acknowledge the difficulty of certain tasks or of the hard work already implemented. Questions such as "How did you do that?" will help clients recognize their strengths, confidence, and motivation.

A consultation break can be inserted half way into the session. During this break clients can be asked to reflect on what has occurred during the first half of the session. They can add information they felt was important or to explore behaviours that are helping them achieve their goals and how these can be applied more broadly.

Solution focused therapy has been applied alone or with other forms of therapy in a variety of areas including adolescent child sexual abuse survivors (Kruczek & Vitanza, 1999), adult sexual abuse survivors (Dolan, 1991; McConkey, 1992), criminal justice populations (Lindforss & Magnusson, 1997), end of life grief counselling (Simon, 2009), and mental health issues (Simon & Nelson, 2007). It was found to be effective in reducing symptoms of PTSD in adult survivors of CSA, and although it was not as effective as CBT it led to lower dropout rates (McDonagh et al., 2005). Although the therapy may help clients define and work towards personal goals, researchers like McConkey (1992) found that it did not increase the capacity to think about larger systemic problems. This may present problems in helping CSA clients to consider social and systemic issues related to CSA and recovery, something that both staff and men in focus groups felt were important. For more information on solution focus therapy please see De Shazer and Dolan with Korman, Trepper, McCollom, and Berg (2007); Guterman (2006); O'Connell (1998); and the Institute for Solution-Focused Therapy (www.solutionfocused.net).

Mindfulness

Mindfulness is intended to help individuals reduce stress by being fully in the present and attending to current sensations without imposing interpretation or judgement (Coffey & Hartman, 2008; Kabat-Zinn, 1990). Physical sensations, internal states and action/environment interactions become the focal point and therefore individuals become aware of multiple sensory experiences and the contexts in which they occur (Chatzisarantis & Hagger, 2007). By maintaining awareness of present sensations individuals not only slow down their systemic arousal, but they break past patterns of perceiving the world and begin to experience their world differently. It diverges thoughts from the automatic, habitual perceptions to develop new awareness. The following changes can result from mindfulness (Follet, Palm, & Pearson, 2006):

- Increased sensitivity to one's current environment.
- Increased openness to new information.
- Increased capacity to formulate new ways of categorizing or structuring perceptions.
- Increased capacity to consider multiple dimension and perspectives when problem solving.

Mindfulness uses a variety of techniques or exercises including meditation, yoga, deep breathing, listening to music, and self monitoring of thoughts. It combines well with other therapeutic approaches such as CBT. It can be used as an emotion regulation technique (Gerburg & Brown, 2011; Heim, et al., 2010; Wolfsdorf & Zlotnick, 2001) and therefore would combine well with exposure therapy and emotion-focused therapy.

Within the past few years mindfulness has increased in use and popularity. Branches of this approach have developed to deal with specific issues such as depression (Finucan & Mercer, 2006; Germer, Siegal, & Fulton, 2005; Segal, Teasdale, & Williams, 2002; Owens, Walter, Chard, & Davis, 2011), anxiety (Finucan & Mercer, 2006), PTSD (Batten, Orsillo, & Walser, 2005; Owens, et al., 2011), chronic pain and stress (Kabat-Zinn, 1990; 2005), and to align behaviour with personal values (Hayes, Luoma, Bond, Masuda, & Lillis, 2006). It has also helped individuals end or reduce smoking, binge eating, and alcohol and substance use (Greeson, 2009). Its application has been effective in reducing mindless automatic patterns of behaviour (Langer, 2000), psychological distress (Coffey & Hartman, 2008), improving capacity to identify and manage emotions, increasing self awareness, and increasing capacity to cope with problems and stresses. Researchers like Lutz, Stager, Dunne, and Davidson (2008) found that open monitoring, a meditation process similar to mindfulness, led to better monitoring of internal states and reduced stress related arousal. They suggest it may also reduce traumatized individual's tendency to get stuck in a particular pattern of thought or focus, such as on the traumatic event. In Manitoba, the Evolve program at Klinik Community Health Centre uses mindfulness based stress reduction in their therapeutic interventions with men who behave abusively and individuals affected by trauma and have extensive information about the use of this method of therapy.

Mindfulness has been used in intervention with CSA survivors and has been effective in regulating emotions (Wolfsdorf & Zlotnick, 2001), decreasing depression and anxiety (Kimbrough, Magyari, Langenberg, Chesney, & Berman, 2010), and decreasing PTSD symptoms, particularly symptoms of avoidance and numbing (Kimbrough et al., 2010). Further, it's use has been suggested as part of intervention for survivors with depersonalization, a dissociative symptom where individuals feel detached from their thoughts and body, because mindfulness brings sensations into immediate focus (Matthias, Beutal, Jochen, Zimmerman, Wolters, & Heidenreich, 2007). It is important to note that although mindfulness based stress reduction has proven helpful in the reduction of many distress symptoms, a recent study found that it is no more effective than an alternate but similar form of intervention where individuals focused on music rather than their own thoughts and sensations (MacCoon, Imel, Rosenkranz, Sheftel, Weng, et al., 2012). Thus, the benefit may come from focusing on current sensory

information regardless of the nature of the sensation or its relation to the person. The mere act of focusing attention may be enough to reduce the systemic arousal that fuels stress. Focused attention meditation, where the individual focuses on one stimuli and filters out all other distractions, has been associated with increased cortical connections, capacity to concentrate, block out negative thoughts, and reduce systemic stress based arousal. With practice this ability becomes easier and requires less mental energy to accomplish (Brefczynski-Lewis, Lutz, Schaefer, Levinson, & Davidson, 2007; Lutz, et al., 2008).

Somatic Therapies

Since the 1970s, a number of somatic therapies have been developed. These therapies include somatic experiencing; self regulation therapy; and sensorimotor psychotherapy. The premise of these therapies is that like all animals, when faced with trauma humans have a physiological arousal response that prepares the system for flight, fight or freeze. This response is due to the release of stress hormones such as adrenaline. Typically, after the trauma has passed, animals discharge this built up arousal by shaking, trembling and twitching. This dissipates sympathetic system arousal and allows the parasympathetic system to bring the system back to a balanced state.

Humans, on the other hand, tend to suppress these types of physical releases of arousal by telling themselves or being encouraged by others to “calm down”, “get a hold of themselves”, or “pull themselves together”. Thus, the body retains the sympathetic system arousal which then exerts negative effects in the form of trauma symptoms. Some of these symptoms involve “kindling” where the thalamus becomes very reactive to stimuli, even nonharmful stimuli, leading to hypervigilance and exaggerated fear responses. For some, the trauma response is suppressed until something in the environment triggers a memory and then the individual responds as if the trauma were happening again, as in a flashback. Symptoms such as addictions, aggression, self destructive behaviours, sleep disturbances, and pain have been associated with dysregulation of the autonomic nervous system (LaCombe, n.d.).

Based on the belief that the unreleased sympathetic system arousal has to be discharged before the individual can focus on more cognitive forms of coping, somatic therapies use techniques that help achieve this discharge. Although similar in many ways, these different therapies have slightly different intents or approaches.

1. Somatic Experiencing Therapy

First introduced in Peter Levine and Ann Frederick’s book *Waking the Tiger: Healing Trauma in 1997*, somatic therapy guides clients through the process of regulating their autonomic nervous system by helping them release the arousal that remains in the system after trauma. Because the focus is on systemic arousal and body sensations, individuals are not required to revisit traumatic memories. Rather, they learn to identify and release

undischarged arousal and to apply these new capacities in taking control of their maladaptive responses and moving on from past, current and future distress, thus helping them lead happier more productive lives (Levine & Frederick, 1997).

It has been suggested that securely attached individuals are better able to identify and communicate their physical sensations, since their parents responded to their communication of these sensations in childhood. Through tone of voice, eye contact, facial expressions, and touch securely attached parents and children learned to communicate emotions and sensations. Through parents soothing behaviours such as rocking, singing, holding etc, individuals learn to self sooth and move from a state of negative sensations to a state of positive sensation (Cohen, 2011). In addition, the sensory stimulation that comes from secure and frequent physical contact between parent and child helps to develop neural structures related to sensory awareness (Cohen, 2011). Without these connections insecurely attached individuals have greater difficulty with sensory awareness and self regulation.

A variety of methods are used to help the person navigate the regulation process. First, clients learn to attend to the physical sensations in their bodies. Mindfulness is used to focus on physical sensations and leads to more accurate perceptions of the environment and of internal responses to the environment. Second, a technique call “titration”, where clients are exposed to a small amount of distress at a time, helps them to gradually to tolerate and cope with higher levels of distress over time. Third, rather than progressing through a hierarchy of distress, a process called “pendulation” is employed, where clients are exposed to distress and then helped to move from the dysregulation of the distressed state to a more regulated state. Because this is done gradually, clients do not get overwhelmed by the distress, rather they come to feel that they have control over it. Pendulation can also be applied to move clients from a focus on past events and trauma to the reality of the present. Fourth, “resourcing” involves clients utilizing various capacities, skills, or supports to help them move from a dysregulated to a regulated state. These can include images of a safe place, positive memories, support from family and friends, strengths, passions, humour, and grounding and orienting exercises. Fifth, touch is sometimes applied to focus attention on a particular part of the body that his holding a lot of undischarged tension and arousal and the sensations, cognitions and emotions related to that arousal. The application of this technique is based on client’s comfort level with being touched; CSA survivors may experience a great deal of discomfort with being touched. Sixth, calming and relaxation techniques are frequently applied to help clients tolerate distress and move to a more regulated autonomic state. Breath work involves the use of regulated breathing patterns to produce a calming effect that can open clients to more positive physiological and emotional experiences. Progressive relaxation, meditation, and guided imagery are used to facilitate relaxation and to help clients become aware of what relaxation feels like both physically and mentally.

Cohen (2011) suggests that somatic experiencing therapy can be used in groups as well as in individual therapy. Awareness of undischarged physical arousal would be achieved through describing sensations, emotions and cognitions and attending to body language and breathing (Ogden, Minton, & Pain, 2006). These descriptions would help group

members to differentiate and integrate these different components of experience. It would also help further their understanding of self and others. Working in groups would help clients with anxious attachments to regulate the negative arousal generated by intimate relationships and clients with avoidant attachments to gain comfort with self disclosure and intimacy. This type of group therapy approach would work well with CSA survivors (Cohen, 2011), however therapists need to be vigilant for group members reliving the trauma of abuse as they become more aware of physiological arousal and body sensations (Adams, 2006).

A number of skills and capacities are potentially developed through somatic experiencing therapy. Among these are:

- The capacity to experience distress without overwhelming negative sensations or reactions.
- The ability to establish, maintain and respect healthy boundaries.
- The ability to recognize and change negative, inaccurate or distorted thoughts into more positive and adaptive cognitions.
- The ability to connect with others in healthy ways.
- Increased connection between physical, cognitive and emotional self to establish a more coherent sense of self.
- Reduced physical and mental health symptoms.

Extensive training is required for practitioners of this therapy. Training is available through the Somatic Experiencing Trauma Institute in Boulder, Colorado (<http://www.traumahealing.com/training-schedule/intlCanada.html>). The Institute often provides training within Canada. The above website provides training sites and events.

Although somatic experiencing has been suggested for use with a variety of types of trauma, including CSA, little evaluative research has been conducted on its effectiveness. Statements about effectiveness tend to be anecdotal in nature. Based on participant self report measures, Parker, Doctor, and Selvam (2008) found that somatic therapy treatment reduced PTSD symptoms of arousal (measured by degree of jumpiness and watchfulness), intrusion (measured by sleep difficulties and reoccurring thoughts), and avoidance in tsunami survivors. Results were significant at the four week and eight month period after the tsunami. More empirically based research is needed before the effectiveness of this form of therapy has been clearly established.

2. Self Regulation Therapy

Developed by Josephs and Zetl (2001), self regulation therapy works to help the individual release the build up of energy and more effectively manage arousal levels, giving them control over their arousal and response. Rather than suppressing physical release of energy, it helps the individual work through it gradually through the process of titration (CFTR, n.d.; LaCombe, n.d.). Too much exposure to a large amount of arousal at one time can result in flashbacks, which would be detrimental, as it is this type of heightened systemic arousal that interferes with cognitive and emotional processes.

Clients are encouraged to monitor physical sensations, learn internal signals to arousal, and regulate the release of arousal in a safe manner. During this process individuals may feel sensations of heat, trembling, or tingling, as the sympathetic system arousal is released. They may feel restless and have the urge to flee or twist and fidget. Allowing them to follow through with these urges through imagined or actual behaviours, activate the sympathetic nervous systems and allow the energy to be released. It is believed that once this energy is released the nervous system becomes balanced once more and the individual can form more positive neural pathways associated with contentment and happiness.

As individuals work through discharging this energy they are able to integrate the trauma into their life experience and move on to more positive physiological responses, leading to a dissipation in trauma symptoms. Resources such as memories and sensations that help clients feel secure are used to help them formulate new neural responses to daily stressors. It is believed that capacity to self sooth, manage fear and anger, and emotional wellbeing is increased with this form of therapy (LaCombe, n.d.). Compared with somatic experiencing, self regulation therapy is more focused on the release of built up arousal, believing that symptoms will naturally dissipate after the regulation of the autonomic nervous system. However, as with somatic experiencing, it is believed that self regulation therapy will help individuals establish healthy boundaries, increase feelings of safety, have more control over emotional and behavioural responses, and increase their capacity to self sooth (LaCombe, n.d.).

There is very little research on self regulation therapy and thus little evidence of its effectiveness. Two studies have examined the effectiveness of trauma affect regulation, a form of self-regulation therapy used with youth. Evidence was found for the effectiveness of trauma affect regulation in reducing PTSD symptoms such as flashbacks, avoidance, anxiety, intrusive thoughts and increasing emotion regulation in delinquent girls (Ford, Steinberg, Hawke, Levine, & Zhang, 2012). When this therapy was given within seven days of delinquent youth receiving detention, there was a decrease in the number of disciplinary events and shorter subsequent detention times (Ford & Hawke, 2012). There is a need for more empirical evidence of the effectiveness and applicability of this form of therapy with CSA survivors and other trauma survivors.

3. Sensorimotor Psychotherapy

Sensorimotor psychotherapy was developed by Pat Ogden in the 1970s. This therapy differs from somatic experiencing in that it works towards the reintegration of physical sensations with emotions and cognitions, for a more holistic form of therapy. It proposes that processing of physical sensations and arousal is insufficient to bring about healthier functioning. Rather, each of the hierarchical levels of processing (autonomic or more primitive level; emotional or intermediary level; and higher cortical level) and the mutual influence they exert upon one another must be considered in therapy. Clients learn to regulate arousal levels and to discriminate between cognitions and emotions that result

from dysregulated arousal and those that are based on genuine issues, with the goal of developing a more functional system of information processing (Ogden & Kekuni, 2000).

Trauma can lead to both overarousal or underarousal of the sympathetic system, with the former causing exaggerated responses such as rage, hypervigilance, and memories of trauma that further heighten arousal and the latter leading to a depletion of normal response such as passivity, an inability to set and maintain boundaries and helplessness. In either case, the primary intent of the sympathetic response to accurately signal danger is impaired and thus it is not accurately connected to the upper levels of processing represented by thoughts and emotions (Siegal, 1999). Therapy is intended to reconnect these three levels of processing and create a balance among them (Ogden, Pain, & Fisher, 2006).

Addressing undischarged arousal is important, as it often interferes with clients' ability to accurately judge emotions and cognitions. In turn, cognitions and emotions condition somatic arousal, as when fear can cause sympathetic response to increase. Most adult activities utilize top down processing where thoughts are given precedence over emotions and sensations. However, for individuals who have experienced trauma, emotions and sensations often dominate over cognitions. Most therapy takes a top down approach, encouraging the client to have his thoughts once more control his response system. Sensorimotor processing therapy suggests that this will not work while clients are overwhelmed by undischarged arousal (Ogden & Kekuni, 2000).

Therefore, after a safe environment has been established, the therapeutic process begins with helping clients becoming aware of physical states and bodily sensations such as muscle tension, agitated movements, posture, breathing, shaking, and getting flushed or hot, through the use of mindfulness. Initially they are asked to focus on physical sensations related to current situations or sensations associated with the trauma. This provides a more concrete description such as breathing rapidly and increased heart rate rather than the more vague 'panic'. At first the therapist provides guidance through this sensory awareness, but gradually clients become capable of doing this for themselves. By focusing on sensory arousal, clients learn how much information they can tolerate at a given time and to self regulate emotional responses. Although with these first steps clients are asked to put aside the emotions and cognitions that occur until physical sensations and arousal are regulated, later in therapy cognitions become helpful in the process of self regulation (Ogden & Kekuni, 2000). Gradually clients become aware of thoughts and emotions that are linked to and reflected in physical sensations and arousal (Ogden, et al., 2006). In this way they begin to integrate these three components of self and gain a sense of power over distressing situations that occurred in the past and those that will occur in the future. This sense of power then dissipates the fear of negative or unpleasant future events, making individuals more functional in their daily lives. Further, the skills learned in this therapy can be transferred to other therapeutic approaches such as CBT.

Because of its gentle approach, this form of therapy, is appropriate for use with CSA survivors (Ogden et al., 2006). Recently, it was applied to a group of 10 women who had

experienced CSA. Preprogram, postprogram and six month follow up evaluations found that these women had improved body awareness, decreased dissociation, and were more open to methods of self soothing (Longmuir, Kirsh, & Classen, 2012). Although this is the first attempt at testing potential changes resulting from sensorimotor therapy and the sample size was small, it provides preliminary evidence of effectiveness beyond the anecdotal evidence typically cited.

Training in sensorimotor therapy is extensive in nature. It is available through the Sensorimotor Psychotherapy Institute in Colorado. After completion of the training, therapists can be certified in sensorimotor psychotherapy (<http://www.sensorimotorpsychotherapy.org/psychotherapists.html>). Training is held in Canada at selected times and locations that can be found by contacting the Institute.

Approaches Based on the Process of Change

Some models of change began as approaches to ending substance abuse, but were then applied in a wide range of other types of behaviours such as changing health behaviours, eating patterns, and aggressive behaviour. Three of the most popular models are described below. These models are similar in process, philosophy and techniques and some have suggested using all three to guide treatment. For example Carey (1996) used all three of these models to develop an approach for intervention with individuals who have the dual diagnosis of substance abuse and psychological disorders.

1. The Transtheoretical Model of Change

Developed in 1982, the Transtheoretical Model of Change, otherwise known as the Stages of Change Model (DiClemente & Prochaska, 1982) was initially intended to be used to help people stop smoking, but has since been applied in a variety of treatment areas including alcohol and drug use, medication compliance, weight loss and exercise programs and changing abusive behaviour. The model proposes five progressively more committed stages of change (Prochaska, DiClemente, & Norcross, 1992):

- 1) Pre-contemplative Stage – The person has not yet acknowledged that they have a problem.
- 2) Contemplative Stage – The person acknowledges that they have a problem.
- 3) Preparation Stage – The person gets ready to make a change, often by setting up a plan of action.
- 4) Action Stage – The person implements their plan of action; this often involves beginning a treatment program.
- 5) Maintenance Stage – The person has made changes and now works to keep up with the changes.

Change is perceived as a gradually process consisting of explicit and implicit activities and experiences within each stage. The processes of change include cognitive, emotional and behavioural processes, with cognitive and emotional changes occurring before

behavioural changes. Being able to see and articulate the advantages and disadvantages of old and new behaviour patterns and increased confidence in the ability to change behaviour patterns are signs of progress. Individuals are encouraged to consider all of the areas of their lives affected by their addictive behaviour and to address each of these specifically in therapy sessions (De Biaze Vilela, Jungerman, Laranjeira, & Callaghan, 2009).

Large scale changes are not recommended nor are they likely to be successful as they may push the person beyond their capacities, leading them to feel overwhelmed and to make the change process aversive. Rather, interventions need to match individual's stage of change to be maximally effective. Each stage requires different techniques and approaches to best respond to individuals' differing perspectives and cognitive and emotional capacities (Prochaska, et al., 1992). When interventions match individuals' level of readiness for change, clients feel in control of the process and build a sense of self efficacy that encourages them to progress from one stage to the other. Progression through the changes, however, is not linear. The momentum and support often gained in the preparation and action stages is difficult to maintain and thus the maintenance stage is often the most likely stage for relapses to occur. Planning for these relapses is an important part of intervention as is a support network and the potential for follow-up programs. For a more detailed look at the application of the transtheoretical model see "The Transtheoretical Model of Behavior Change" in the Handbook of Health and Behavior Change (3rd ed.) by Prochaska, Johnson, and Lee (2009).

Despite positive research results for the application of this model in the 1990s, more recent investigations have had mixed findings. Some studies have found the model helpful in predicting alcohol consumption in undergraduate students (Ward & Schielke, 2011), and at least some of the scales (contemplation and maintenance) predictive of recovery from alcohol and drug use and social conflict (Fontan, 2010). Farley (2008) found that higher levels of readiness to change alcohol and drug use were matched with higher stages of change. On the other hand, a lack of support for the model's applicability for substance abuse has been reported in a variety of studies (Callaghan, 2004; Sutton, 2001). One study found that the stages of change did not correspond strongly or consistently with clients' motivational or change related language (Hallgren, 2011).

The explanation of some of these inconsistent results may lie with the change processes in different areas of change. Research has suggested that cognitive processes were applied in earlier stages of change than behavioural processes for smoking cessation, while cognitive and behavioural processes were applied simultaneously for diet and exercise change. In areas of substance abuse and psychotherapy, no consistent pattern of cognitive or behavioural processes were found (Rosen, 2000). Other researchers believe the problem may reside with the scales, principally the URICA, used to measure the stages of change (Callaghan, Taylor, Moore, Jungerman, De Biaze, et al., 2008), particularly in the case of substance abuse. Sutton (2001) reported that the stages of change were not clearly defined and that the scales of the URICA were not representative of the specific stages of change.

Given that readiness for change has been associated with recovery from CSA (Hewes, Black, & Haggis, 2010), the transtheoretical model would seem to apply well to predicting recovery and providing useful approach to therapy with individuals at different stages of readiness. The model has been applied with adult survivors of CSA with some success. For example, as predicted by the transtheoretical model of change, Koraleski and Larson (1997) found that survivors progressed from using more cognitive and emotional processes of change to using more behavioural processes, and that these behavioural process were more often evidenced in the action stage of change. However, there was no correspondence between earlier stages and cognitive or emotional processes. These researchers used the Stages of Change Questionnaire, rather than the URICA, possibly accounting for some of their more positive results. With this limited and contradictory evidence of the model's applicability with various populations, more research is needed to fully understand its usefulness for CSA or substance abuse.

2. Motivational Interviewing

Motivational interviewing is a nonconfrontational, client-centred, strength based, semi directive therapeutic approach to help individuals implement behaviour change. As with the transtheoretical model, it was originally developed to help individuals with substance abuse issues, but has been utilized within other realms of behaviour change (Houck, 2012; Miller & Rollnick, 2002). The approach is collaborative in nature and supports the need and direction of change identified by clients rather than change imposed by the therapist. It brings out clients' own motivations and helps them develop a plan or set of goals that will lead them towards the desired change. Thus, it is present focused and goal directed. It is believed that if the motivation comes from within the person they will have a greater commitment to behaviour change. The responsibility for change lies within the clients themselves and therefore progressive change is an empowering experience. Because motivational interviewing is individualized, there is an understanding that people seeking therapy will approach change in different ways, be differentially prepared for change, and will progress at different rates (Miller & Rollnick, 2002).

The first stage of therapy includes building a rapport and sense of trust with the client and this is facilitated through the use of reflective listening, expressing empathy, and nonjudgmental acceptance. When the therapist works to clarify their understanding of clients' experience and perspective, it makes clients feel heard and validated and helps the therapist to determine in what areas clients need support and when this support is required (Bundy, 2004; Miller & Rollnick, 2002). As discourse progresses, the therapist helps clients to resolve their ambivalent feelings about change. Having mixed feelings about making changes is regarded as normal, and in fact is experienced by most people. Discussions on the positive and negative aspects of changing and of not changing, often helps reinforce the necessity for change if desired goals are to be reached. Part of this is noting the discrepancy between the clients' current situation and their desired future and values. Working on the same principle as cognitive dissonance, this discrepancy encourages change in behaviour and cognitions. Establishing future goals is important to

developing a focal point for change and motivation to make change. These goals, however, need to be specific so the client will know when they are reached and realistic so that they can be reached. Goals should also be small or larger goals broken into smaller one so that they are achievable, reinforcement occurs fairly frequently, and self efficacy can build as small incremental changes are made. Further, small changes are less threatening than large ones. All of these will build motivation and persistence in the pursuit of goals (Bundy, 2004; Milling & Rollnick, 2002).

Therapy also includes efficacy building. Therapists focus on clients' strengths, often reinterpreting perceived failures in order to point out some of the skills or capacities exemplified by the behaviour. Polarized thinking is reduced by helping clients understand that there is more than one way to achieve a goal and if one strategy does not work, it does not signal failure, but rather that a change in strategy may be needed. This type of strength based approach helps clients feel confident about themselves and encourages further attempts at changing their behaviour (Bundy, 2004; Miller & Rollnick, 2002).

The term "rolling with resistance" is used to describe the therapists' lack of confrontation of clients' argumentativeness or oppositional stance in regard to change. When change becomes too aversive or threatening, clients may resist it by finding ways to support their maladaptive behaviour patterns. If the therapist was more confrontational the focus of discourse would be on the argument. With no confrontation, the client faces no argument and thus is likely to refocus on ambivalent feelings and how to resolve these feelings (Bundy, 2004; Miller & Rollnick, 2002). Rather than being seen as a failure, relapse to previous behaviours is an expected part of the process, and the success lies with how relapses are dealt with and not that they occur. Renewing commitment to change in the face of a relapse and continuing with that change is seen as an adaptive response (Miller & Rollnick, 2002).

Several techniques are outlined that are intended to facilitate the processes of motivational interviewing and thus advance progress towards change. These include asking open ended questions that encourage more thorough and detailed thought and providing clients with affirmation statements that magnify their strengths. Affirmation statements must be based on honest, realistic and relevant observations and perceptions; clients will recognize statements that do not reflect them or their capacities and this will impair the therapeutic relationship (Miller & Rollnick, 2002). Summarizing accomplishments at the end of each session will help clients see the progress they are making, highlight key aspects of what they discussed, and clarify pertinent information.

One of the markers of change is change talk. Therapists need to pay close attention to the language clients use when discussing change. This language will reveal their motivation for change and their level of commitment to change. Initially they may do more preparatory change talk about their wanting to change, their reasons for wanting to change and how they plan to change. Later action change talk reflects their level of commitment to change, the strategies they have used and the effectiveness of these strategies, and future plans for change (Miller & Rollnick, 2002). It is believed that the

more clients talk about change the more they will change. Opposite to change talk is sustain talk which reflects the clients desire to stay as they are and not change (Houck, 2012).

Several studies have supported the effectiveness of motivational interviewing or components of it. Lundahl and Burke (2009) found that it was more effective than no treatment for substance abuse and risky behaviours and as effective as other methods of treatment. They also found that motivational interviewing applied in individual therapy was more effective than when applied in a group setting. Motivational interviewing that included feedback on progress and areas of difficulty was found to be more effective than motivational interviewing alone. A short motivational interviewing program administered to soon to be released inmates with a high risk to reoffend was successful in effecting positive change both immediately after the program and 12 months after the program (Austin, Williams, Kilgour, 2011). A two session intake using motivation interviewing with men who were abusive in their intimate relationships was effective in reducing resistance to intervention and ambivalence about behaviour change and increased the use of change related language (Musser & Murphy, 2009).

The change talk technique has specifically received support (Amrhein, Miller, Yahne, Palmer, & Fulcher, 2003; Houck, 2012; Miller & Rose, 2009) and the neurological mechanisms involved in change talk have been identified as occurring in the right hemisphere and are consistent with brain activity related to cognitive dissonance (Houck, 2012). Positive results have been found for changing substance abuse patterns, physical and mental health behaviour management and gambling (Amrhein, et al., 2003; Brodie, Inoue, & Shaw, 2008; Cummings, Cooper & Cassie, 2009; Miller & Rose, 2009), with effect sizes being larger and longer lasting with motivational interviewing was combined when other effective treatments (Burke, Arkowitz, & Menchola, 2003; Hetteima, Steele, & Miller, 2005). For example, combined with CBT, motivational interviewing was found to be effective in changing problem gambling (Oei, Raylu, & Cassie, 2010).

On the other hand, a number of studies, as summarized in Miller and Rose (2009) have found motivational interviewing to be ineffective in developing immediate or long term change. It has been suggested that these varying results may be due to the approach not being appropriate for all people and/or due to the skill and training of the therapist (Forsberg, Ernst, Sundqvist, & Farbring, 2011). In fact some studies have found that increased skill and training of therapists improves outcomes for motivational interviewing. This approach appears to be more effective with populations that are not Caucasian (Hetteima, et al., 2005; Villanueva, Tonigan & Miller, 2007; Winhusen, Kropp, Babcock, Hague, Erickson, Renz, Rau, et al., 2008). Motivational interviewing's applicability to CSA has not yet been tested. The following books provide more detailed information about the application of motivational interviewing: *Motivational Interviewing in Treating Psychological Problems* (Arkowitz, Westra, Miller, & Rollnick, 2008); *Motivational Interviewing: Preparing People for Change* (Miller & Rollnick, 2002); *Changing Behavior: Using Motivation Interviewing Techniques* (Bundy, 2004).

3. Harm Reduction

The harm reduction approach has a long history, being initially introduced, but not implemented, in 1920s UK (McMaster, 2004) and resurfacing again in the 1980s as an alternative response to the AIDS epidemic (Lushin & Anastas, 2011). The focus of the approach has been on substance use and HIV/AIDS prevention, particularly through needle exchange programs for the latter. More recently, it has been applied to reducing the harm related to other issues such as safe sex, healthier eating, exercise and self harm (Logan & Marlatt, 2010).

In contrast to the abstinence model which requires complete cessation of the problematic behaviour, and as in the 12 step program, often involves confrontation of clients by service providers, the harm reduction model is nonjudgmental and encourages gradual reductions in harmful behaviour (Logan & Marlatt, 2010; McMaster, 2004). It is less extreme than the abstinence model in its demands and thus may be less intimidating for clients who are not ready to completely and suddenly give up their established coping mechanisms such as substance use, gambling, and other compulsive coping behaviours (Logan & Marlatt, 2010). Harm reduction operates on the following perspectives (McMaster, 2004):

- Substance use exists and will continue to exist in society.
- There are many approaches to addressing problematic behaviour, abstinence is only one approach.
- Problematic behaviours have both direct and indirect harmful effects.
- Available services must be applicable to a broad range of people.
- Problematic behaviours such as substance abuse is not only an individual issue, but a systemic issue as well.

Given these premises, abstinence may only be applicable to a proportion of individuals and harm reduction may reach another portion of the population. McMaster (2004) suggests that individuals for whom abstinence works may be at the action stage of the transtheoretical model, whereas individuals at the earlier stages of change such as contemplation and preparation may be better served by a harm reduction approach. Thus, this approach is more responsive to the person's level of readiness for change. Compared to the abstinence model it does not apply the same intervention methods to individuals with the same problematic behaviour, rather it responds to the contexts within which individuals exist and their own personal goals (Marlatt, 2002; Tuchman, 2010). This makes the model very client centred.

Clients establish goals for change based on their capacity and comfort level. Therapists help in the process by having discussions with the clients about the negative impact of their behaviour and how some of these impacts can be avoided or minimized. Changes towards reducing harm are recognized and reinforced, thus encouraging clients to maintain these changes and implement new ones. The therapist also assists clients by identifying potential ways to deal with behaviours that are particularly difficult to change. Coping skills are developed as part of the collaborative therapeutic process and their use is reinforced (Logan & Marlatt, 2010).

The harm reduction approach has received a significant amount of research support. Its original use as a means of reducing HIV infection through needle exchange programs have been successful (Des Jarlais, Marmor, Paone, Titus, Shi, Perlis, Jose, & Friedman, 1996; Hurley, Jolly & Kaldor, 1997; Strathdee & Pollini, 2007). Programs based on the harm reduction approach have been found to reduce alcohol related problems in college populations in the form of setting limits on drinking, monitoring drinking, and refusal of drinks (Fromme, Marlatt, Baer, & Kivlahan, 1994; Marlatt, Baer, Kivlahan, Dimeff, Larmer, Quigley, Somers, & Williams, 1998). More recent studies have found that the model is associated with decreased use of substances, improved interpersonal skills, and eventual abstinence (Hartzler, Cotton, Calsyn, Guerra, & Gignoux, 2009; Marsden, Eastwood, Bradbury, Dale-Perera, Farrell, Hammond, & Wright, 2009; Tuchman, 2010). Success has also been reported in terms of reduced drinking in the workplace (Matano, Koopman, Wanat, Winzelberg, Whitsell, Westrup, et al., 2007; Osilla, Zellmer, Larimer, Nighbors, & Marlatt, 2008), increased stress management (Kline & Snow, 1994), reduced substance use and PTSD symptoms and improved family and social interactions (Najavits, Schmitz, Gotthardt, & Weiss, 2005). Although the harm reduction model has not been used with CSA, recently researchers are suggesting its use and developing models for its use with victims of intimate partner violence who are not ready to leave the relationship (Friend, Shlonsky, & Lambert, 2008; Shlonsky, Friend, & Lambert, 2007).

Harm reduction appears to combine well with the transtheoretical model (McMaster, 2004) and motivational interviewing (Baer, Kivlahan, Blume, McKnight, & Marlatt, 2001; Borsari & Carey, 2000; Larimer & Crouce, 2002; Larimer, Turner, Anderson, Fader, Kilmer, Palmer, et al., 2001; Murphy, Duchnick, Vuchinich, Davison, Karg, Olson, et al., 2001). There have also been web-based and computerized programs utilizing the harm reduction approach that have been effective in reducing alcohol use and alcohol related harmful behaviours (Kypri, Saunders, Williams, McGee, Langley, Cashell-Smith et al., 2004; Lewis & Neighbors, 2007; Walters, Vader & Harris, 2007; Neighbors, Larimer & Lewis, 2004). Further, some service providers have shown overwhelming support for its use. For example, staff at an Ontario addiction treatment facility supported the use of harm reduction in the form of needle exchange and short term nonabstinence goals for substance use problems. They were however less inclined to support prescription methadone and heroin as a means of harm reduction (Ogborne & Birchmore-Timney, 1998).

Harm reduction is a practical approach, as it is applicable to individuals who may not be ready for complete abstinence. It proposes that some change is preferable to no change and that initiating any form of change may lead to more long term and broader ranging changes (Logan & Marlatt, 2010; Lushin & Anastas, 2011; McMaster, 2004). Achieving abstinence may be even more likely with harm reduction since fewer individuals drop out of harm reduction programs than abstinence programs (Hartzler, et al., 2009; Marsden et al., 2009; Toumbourou, Stockwell, Neighbors, Marlatt, Sturge, & Rehm, 2007). Further, needle exchange programs and substance use programs have been associated with eventual enrollment in addictions treatment programs, which are typically abstinence based (Brooner, Kidorf, King, Beilson, Svikis, & Vlahov, 1998; Heimer, 1998; Vlahov,

Junge, Brokkmeyer, Cohn, Riley, Armenian, & Beilenson, 1997; Wood, Tyndall, Zhang, Montaner, & Kerr, 2007).

Suggested Exercises

This section contains exercises used in therapy with men who experienced CSA. Exercises should be selected based on the client's qualities, comfort level with the exercise, presenting problems, and therapeutic needs. The list of exercises is not exhaustive and therefore others may prove equally or more effective. Therapists are encouraged to explore others that they have found to be effective.

1. Emotional Expression Exercises

a. Handouts and Homework

CBT often uses reading assignments and homework assignments. These keep the information fresh and available to the client between sessions and gives them more information on some topics. They help clients apply the information and skills they learned in therapy on their own. Men in the focus groups/interviews felt that homework was helpful but they cautioned about not reviewing the assignments in therapy, stating that without going over the assignments the exercise is pointless and not helpful. Another caution with handouts and homework is that they may not be appropriate with men who have literacy or language problems.

b. Writing Activities

i) Feelings Worksheet

Wilken (2003) outlines a feelings worksheet that can be used to help men become more aware of their emotions in different situations. For each of the emotions listed, he suggests having men write out times or situations when they experienced these feelings. This list can be found in Appendix A.

ii) Emotion Reaction Assessment Exercise

This exercise has men select a situation in their life that has made them feel stressed. The men are then asked to list their emotions about the event. The feelings list mentioned above can be used to explore these emotions. After they have listed their emotions, the men are asked to write down how they responded to these emotions. They are then asked to make note of which behavioural responses were healthy and which were unhealthy. The exercise ends with having the men list what type of new coping skills they would like to learn (Wilken, 2003).

iii) Letter Writing

Letter writing is recommended as a means of exploring emotions about events and people (Crowder, 1995; Grubman-Black, 1990; Lew, 1999). Letters can be personal and not intended to share with anyone, they can be given to the therapist to help explain or tell the story of their abuse, or they can be letters to people in their lives such as parents and the abuser, as a means of expressing how the behaviour of these people affected them. This is helpful if clients want to confront these individuals but cannot do so personally. Letter writing can validate men's experience (Crowder, 1995) and make problems clear and concrete, thus putting the men in the role of external problem solver. Kress, Hoffman,

and Thomas (2008) have used this method with CSA survivors, asking them to write to themselves from the future. Some letters are written as:

- The older and wiser self from the future.
- A friend of a person who was sexually abused.
- A future self that is having a good day written to the present self on a bad day.
- A future self who has completed therapy.
- A future self who has had a personal accomplishment.
- A future self who understands how their experiences have created the person they are currently.

These letters help the individual gain a more hopeful perspective of the future, set goals, problem solve, and gain strength, motivation, inspiration and self compassion. This method works well with narrative therapy. However, it may not be appropriate for individuals with language difficulties, are actively suicidal, have severe substance use problems, have narcissistic or borderline personality disorders, have dissociative disorders or have uncontrolled intense anxiety (see Kress, et al., 2008).

ii) Journaling and Life Book

Have clients buy a journal or give them one. Have them assign a page to each year of their life (or a number of pages per year). Then have them write notes or stories about their life for each year. Writing about events that happened to others is acceptable, but the focus should be on how these events affected them. Space should be left for each year for comments made later in the therapeutic process (Crowder, 1995). Reviewing what they have written will be helpful in evaluating their perceptions and may be a step in changing those perceptions. Staff as well as men who took part in focus groups indicated that exercises like journaling can be helpful in telling their stories, letting their emotions out and processing information. Men stated that self affirmations were important to generating positive emotions and self perspectives. If these self affirmations are written down in a journal, they can be revisited when needed.

iii) Anger Journal

Because men who have been sexually abused in childhood often feel anger but either feel they cannot express their anger or cannot control their anger, Wilken (2003) suggests journaling as a way to become more in touch with the aspects of their anger and to have them respond in a more planned and thoughtful way rather than reacting automatically. This type of exercise engages parts of the brain (medial prefrontal cortex) that mediate the automatic responses to fear and anger. The following information would be included in the journal (from Wilken, 2003, pg 163):

Date:

Situation that sparked the anger:

Intensity level of anger from 1 to 10:

What was the person experiencing physically and emotionally?

What were the triggers to the anger?

How did he respond to the triggers?

How could you have or would he respond differently if the situation arose once again?

c. Art Activities

i) Draw the Abuse

There are times when drawing may be more expressive than a verbal description of the abuse. Have the client draw a picture of himself, family, home, before the abuse occurred and then scenes from the abuse or after the abuse. Dialogue bubbles or captions can be used to explain what is happening in the picture (Crowder, 1995).

ii) Drawing Your House of Self Respect

On a piece of paper have the men draw a blue print of a house. They should think of themselves as the person building this house. Each room will represent part of their lives that is important to them. This could include their family, their work, therapy, leisure activity or any other component of their life that has meaning for them. The size of each room should be proportionate to their need for that component or the time and activities devoted to it. The activities they use to maintain these areas of their lives can be written down in each room. This house can be revisited throughout therapy, for example if they feel their life is out of balance they can review which room may need to be renovated. Further as men's needs change over time, the rooms may need to be changed. Some men may need a dramatic change in their house and may want to draw or build a new house over time, either taking out or adding rooms or making some rooms smaller or larger. These houses can be used by men as a source of explaining what is happening in their lives to their therapist or to other group members. Men can be encouraged to make their drawing as simple and elaborate as they want. Some like to add landscaping and house details (Wilken, 2003, pg 167).

iii) Construct a Collage

Clippings from magazines and other sources can be used to demonstrate what it feels like to be abused. The collage could then be used to guide a verbal description of the abuse (Crowder, 1995).

iv) Playing Music

Clients who play an instrument could be encouraged to use their music to tell their story. Some may choose to sing a song that represents their feelings (Crowder, 1995). Music can be used to describe particular feelings about different issues such as relationship problems or empowerment. Thus, this can be used throughout therapy to represent different emotions. Drumming groups from the Aboriginal community may be invited to group therapy sessions, with follow up discussions about how the music made the men feel physically and experientially. This may be a beneficial activity for emotion focused therapy as it emphasizes a physiological experiencing of an emotion.

v) Crafting

Any form of crafting can be used as an activity in group sessions, while discussing the abuse or another topic. This provides an activity that can draw visual attention without removing auditory attention. It also makes the men feel less "on stage" as they talk about their abuse.

d. Role Playing

Role playing can be used to express emotions or to practice skills. In group therapy, different group members can role play with each other or with the therapist. They can explore different roles and express their feelings towards the people represented in these different roles. The empty chair exercise can be used in group or individual therapy. In this form of role play, the men imagine different people in an empty chair and express their emotions to them (Crowder, 1995). This would provide the same benefit as letter writing. In focus groups/interviews, men and staff mentioned role play as an exercise that might prove helpful in therapy.

2. Emotional Regulation Exercises

a. Visualization Exercises

i) Container for Bad Memories

This exercise has clients imagine a container that they can put intrusive memories in when they do not want them to surface. The exercise begins with progressive muscle relaxation, followed by imagining a container only they can access. They then mentally practice putting a memory into the container and taking it out until they can generate this vision quickly. This provides a sense of control over these memories. The memories can then be taken out and dealt with in a safe environment such as a therapy session (Crowder, 1995).

ii) Place of Safety

This exercise begins with progressive muscle relaxation followed by visualizing a place where men feel completely safe and peaceful. Time should be spent fully exploring the place so that it can be brought to mind easily and in detail. A hand gesture or item they can keep with them such as a small stone can be used as a cue to the safe place. When anxiety threatens to become overwhelming they can touch the item or do the hand gesture and go to the safe place where they can retain a sense of calm. Men in groups can eventually share information about their safe place with the other men if they so choose (Crowder, 1995).

b. Breathing Exercises

Conscious regulated breathing forces a person to focus on something other than their anxiety as well as bringing down arousal associated with anxiety. In some forms of the exercise clients are asked to imagine that they are breathing in positive thoughts and feelings and breathing out negative thoughts and feelings (Crowder, 1995). Staff and men in focus groups/interviews reported that breathing exercises would help create a greater sense of calm.

c. Self Soothing Exercises

There are many ways that men can self sooth and these may differ from person to person. Because this may be a new process for them, have men describe what they enjoy doing

that brings them positive feelings such as happiness, calm and contentment. These could include favourite leisure activities, physical activities, visualizations, spirituality and spiritual support (i.e. elder), or quiet time alone (Gartner, 1999). Men in the focus groups/interviews talked about the importance of physical activity for men and how it would help connect them to their physicality. Staff as well as men emphasized the necessity of self care as part of nurturing self and learning to self sooth. These could then prove a healthy outlet when they are feeling overwhelmed with negative thoughts or images. As mentioned, men often don't do much self care, as part of the masculine role is putting others first, therefore time may need to be spent exploring possible self care activities that would be beneficial and rewarding for them.

d. Meditation

Meditation can be used to bring arousal levels down by slowing heart rate and breathing, increasing muscle relaxation, and modifying stress arousal by engaging the more cognitive areas of the brain (medial prefrontal cortex). There are several different forms of meditation with some involving focusing on current sensations and events as they impact on the system and some focusing on one stimulus and filtering out all other sensations. Mindfulness, described above is a form of meditation. Some meditations are spiritual in nature, while others are not. Although the research evidence on the effects of meditation are varied, there are some indications that it can benefit mental health by alleviating stress, negative emotional arousal, depression, anxiety, and increasing concentration, attention, performance, self esteem, forgiveness and self control (Brefczynski-Lewis, et al., 2007; Chu, 2009; Lutz, et al., 2008; Oman, Shapiro, Thoresen, Plante, & Flinders, 2008), and physical health by improving immune system response and lowering blood pressure (Cahn & Polich, 2006; Davidson, Kabat-Zinn, Schumacher, Rosenkrantz, Muller, et al., 2003; Newberg & Iversen, 2003). In focus groups/interviews men stated they were interested in mediation as a way of relaxing and gaining awareness. For a review of the different types of meditation and the research on effects see Ospina, Bond, Karkhaneh, Tjosvold, Vandermeer, et al., 2007).

e. Self Affirmations

Have men list ten positive things about themselves. They may find this a difficult task, particularly early on in therapy, and they may try to interject some negative aspects along with positive qualities, such as "I am concerned about others, but I never act on it." The therapist can list positive qualities he has noticed, asking the client what he thinks of a person with these positive qualities (Wilken, 2003). Positive affirmations can also be obtained from other men in groups and can be kept in a journal for later review. This list can be added to as recovery progresses.

3. Orienting/Grounding Exercises

a. Physical Sensations

Have men focus on the physical sensations they are experiencing either during or after discussing the abuse. Detailed exploration of these sensations (pounding heart, tightening of muscles) can help them link their physical body to their mental and

psychological processes (Crowder, 1995). Linking physical sensations to any emotions can help them make this connection.

b. Mirror Exercise

Having men look at themselves in a mirror can help them focus on themselves as an adult rather than the powerless child they often feel like inside. Viewing themselves physically makes them conscious of their adulthood and capacity to control their own lives. Having them keep symbols of their adult identity with them can help orient to the adult self when they do not have access to a mirror (Crowder, 1995). These items may also be triggers for the image of themselves in the mirror.

c. Seated Grounded Posture

Sitting up straight with both feet on the ground, focus on your body and its connection to the ground. Do not cross your legs so energy can move freely through your body. Rest your hands on your thighs or the arms of the chair. Hold your head straight. Become aware of how your body feels sitting in the chair, of how your feet feel touching the ground. This posture can increase a sense of calm and of strength at the same time (Pandora's Project, n.d.).

d. Mindful Walking

This can also be used as a mindfulness exercise. Walk mindfully around the room, being in the moment with each step. This can be done either slowly or more quickly. Focus on the sensation of walking; how the heel and then the ball of your foot touches the floor. Notice how your knees bend, your toes flex, and how you shift your weight with each step. Count ten steps and then another ten, another ten, another ten, until you feel calm and relaxed (Pandora's Project, n.d.).

e. Writing and Saying Grounding Statements

Develop a number of grounding statements that are associated with a sense of safety and that bring you comfort. You can write these down on small pieces of paper and keep them with you in your wallet or you can write them on a larger piece of paper that you can put up in your home. Write the statements in a color that makes you feel safe and strong. You can say these statements out loud or just think them. Examples would be:

- You are not a child anymore. You are an adult and you are safe.
- You are safe and strong.
- This feeling is not permanent, it will pass

f. Grounding Through Breathing

Think of your breath as an anchor that keeps you tied to the present and guides you back to the present when your thoughts wander to the past. Shifting your awareness to your breathing brings you back to the here and now. Focus on what it feels like and sounds like to breathe in and to breathe out. Think about the air moving in and out of your nostrils or on your abdomen expanding and contracting. Breathe slowly and count ten breaths. Keep counting groups of ten breaths until you feel calm. You can combine breathing with calming statements such as:

- I am breathing in calm, I am breathing out anxiety

- I am breathing in good energy, I am breathing out bad energy
- I am safe, I am strong

(Pandora`s Project, n.d.)

g. Visual Grounding Exercise

Take a deep breath and begin to take note of the things in your environment. Take in even trivial details such as the color of the switch plate (Salters-Pedneault, 2009).

h. Auditory Grounding Exercise

Listen to the sounds in your environment. Notice the loud and quiet sounds, the obvious sounds, and the background sounds. Pay attention to the layers of sound. Take note of the pitch and the rise and fall of the sounds (Salters-Pedneault, 2009).

i. Tactile Grounding Exercise

Hold an ice cube until you start to feel some discomfort. Let the discomfort reconnect you to the present. Do not hold on to the ice cube until it is painful. Taking a cool shower or snapping a rubber band on your wrist can also quickly ground you back to the present (Salters-Pedneault, 2009).

j. Other Grounding Techniques (from Pandora`s Project, n.d.)

- Dance to or sing a song that makes you feel good.
- Stamp your feet and feel the strength in your legs.
- Make eye contact with a safe person.
- Scan the room to remind yourself that you are here in the present.
- Direct your gaze outward; look around and not down at the ground.
- Hold, look at, listen to or smell a grounding object. This can be any object that provides comfort and grounds you to the present. Examples would be a stone, a bell with a soothing sound, a favored picture, a vial of fragrance, a piece of jewelry. If the grounding object is small enough you can carry it with you and access it whenever you need.
- You may want to use your grounding object while doing one of the other grounding exercises in order to increase your grounding.

Intake and Preparation

Intake

Intake is a time to give and gather information. Gathered information will allow for the assessment of men's **appropriateness for therapy** and to enable therapy to respond their individual needs. Information given will let men know what they can expect from the therapeutic process, appease their fears, and answer their questions. It will often be men's first impression of therapy and they may be fearful of the reaction to their revelation of abuse and of what therapy will involve and require of them.

1. Information Gathered

A variety of information can be obtained from men seeking therapy. This information will be useful in maintaining contact with men, tracking current issues and crises, tracking what they may require from therapy and noting what strengths and skills they are bringing into therapy. These will all maximize responsiveness to men's individual circumstances. Below is a list of some of the information that has been gathered at intake into CSA therapy for men (Crowder, 1995; Fisher, et al., 2009):

a. Basic Information

- Contact Information.
- Referral source.
- Previous and current therapy.
- Concerns about therapy, individual or group.

b. Personal Information

- Employment status and history.
- Relationship history and status.
- Children and parenting roles.
- Family of origin.

c. Abuse Information

- CSA history – at intake this can be very general information about the nature of the abuse.
- Compulsive coping behaviours such as addictions, gambling, involvement with the justice system.
- Mental health concerns.
- Physical health concerns.
- Intimate partner violence and CSA offending history.

d. Motivation

- Motivation for accessing therapy.
- Goals – making note of whether goals are realistic and achievable.

It is recommended that questions about these issues are asked in a specific, straightforward, and nonjudgmental manner to minimize defensiveness and other negative responses (Crowder, 1995). Explaining the reasons for gathering this information will clarify how this knowledge will benefit the therapeutic process. Beyond asking questions making note of behaviours such as hypervigilance, numbing, avoidance and withdrawal may help to identify issues that will need to be addressed in therapy.

2. Information Given

It is important to acknowledge the courage it took for men to come and seek therapy. Recognition of all of the barriers to coming forward and seeking help, including dealing with messages about masculinity and victimization and talking about some the myths of CSA may be used to impart an understanding of this manifested courage (Fisher, et al. 2009). Providing basic grounding techniques may help men deal with stress and anxiety before beginning therapy.

Giving men information about the agency and the program such as the nature of the program, program goals, and what participation involves, will be an important part of the intake process. This allows the men to decide if they are ready to attend therapy and if this is the appropriate program for them. Any fees and basic expectations about attending programming such as being on time, signing in, and confidentiality policies can be provided. Allowing men to ask questions will set the stage for more open exchange of information and provide clues as to some of their key concerns.

Exclusionary Criteria

There are certain criteria that have been identified as indicative of men not being ready for therapy and/or **not being prepared for group therapy.**

1. Exclusionary Criteria for Therapy

Personal crisis. Men who are dealing with immediate crises will be focused on this event rather than the concentration and commitment required in therapy. Therapy may be appropriate after the crisis has been resolved to the point it no longer demands all of their attention (Crowder, 1995; Gartner, 1999).

Severe mental health issues. When mental health problems such as being actively psychotic, severely paranoid, acutely suicidal and self destructive, severely dissociative, and having poor impulse control interfere with the ability to participate in therapy fully then other forms of therapy addressing these issues may be more beneficial to the client (Crowder, 1995; Gartner, 1999).

Severe violence. Violence to the extent that it is brought into the therapeutic situation will interfere with therapeutic process and create situation dangerous to the

therapist and the agency and other individuals working at or accessing the agency (Crowder, 1995; Gartner, 1999).

Addictions that interfere with therapy. Addictions that preclude active and consistent participation in therapy will negate any positive effects of therapy (Crowder, 1995; Gartner, 1999). However, having an addiction should not automatically exclude men from therapy. Because so many men who have experienced CSA have turned to substances as coping mechanisms, therapy that excludes all men with addictions will be turning away the majority of men affected by CSA. Ideally a therapeutic program can help men deal with both CSA effects and addictive behaviours, as is done with women CSA survivors at The Laurel Centre.

Lack of motivation to change. Men who are highly resistant to the therapeutic process and are not ready to deal with their issues related to CSA will not benefit from going into therapy (Crowder, 1995).

Inability to maintain rules of therapy. Men who have no regard for therapeutic rules of confidentiality, boundaries, and attendance requirements will not reap the benefits of therapy (Crowder, 1995). This lack of respect for the process and/or therapist works against bringing a sense of self respect and respect for others.

2. Exclusionary Criteria for Group Therapy

Instability. Individuals who are unstable may be disruptive in group settings. These individuals may benefit from individual therapy or **other programs** (Fisher, et al., 2009).

Perpetration of CSA as an adult. Someone who has sexually abused children may create too much discomfort and anger in a group setting where the men are victims (Fisher et al., 2009). Individual therapy would be more appropriate for these men. In accordance with Gartner (1999) staff who participated in focus groups/interviews indicated that men who have perpetrated CSA as adults should be provided with individual therapy but not be included in survivor groups even if they themselves are survivors. Men who acted abusively but in childhood and youth could however be considered for acceptance as members of a survivor group.

Preparing for Programming

Preparation for either individual or group therapy can involve a pre-therapy meeting with each client and going over the therapeutic process with him. He can be given written information providing a general overview of what to expect while in therapy and the issues and topics that may be discussed. The pattern of each session can be discussed (It is recommended that sessions, especially group sessions, have predictable beginning, middle and end activities) (Crowder, 1999). He can be given a tour of the agency and the counselling room to allow him to build a familiarity with the location and facility. He can also meet with the therapist or therapists that he will be working with and ask them questions (Fisher et al., 2009).

Going over the ground rules of therapy and the consequences of violating those rules will be important in preparation for programming. Some basic rules have been suggested from therapists who have provided CSA programming for men. Most of these are equally applicable in either individual or group settings. Although these are common rules developed in a variety of CSA therapies, it is also advised that rules be developed in collaboration between clients and therapists and within each therapeutic group (Crowder, 1995). Both men and staff in focus groups/interviews stated that developing group or individual therapy rules together was important in getting men involved and having ownership of the therapy from the beginning and to creating clear boundaries and a sense of safety within the program. Therapists could make sure that important rules and guidelines were included. It is believed that men will be more likely to adhere to rules they helped establish and it is a way of getting them involved in the therapeutic process from the beginning. Some of the rules that are common to therapy are (Crowder, 1995; Gartner, 1999):

- **Confidentiality** – In individual counselling therapist will not reveal anything that is discussed in therapy or anything in client files. Exceptions to this include being subpoenaed by the courts and clients reporting plans to harm another person. In group therapy it involves not talking about information shared by other group members outside of the group.
- **Boundaries** – In individual therapy, boundaries refer to maintaining a professional therapeutic relationship. A sexual relationship with the therapist, touching without permission, and a social relationship with the therapist outside of therapy are violations of these boundaries. In group therapy these rules apply to group members. The exception is that some groups do not see social relationships between men outside of the group as boundary violations. In these cases it is expected that men be open about these friendships in the group and that there be no secrets in the group.
- **Threats** – Nonthreatening behaviour to either the therapist or other group members is a common rule established to maintain safety.
- **Equal Participation** – Active participation in therapy is part of the process and although there may be times when a person feels less like talking, there are certain expectations about some degree of interaction. In group this also means that group members will not dominate the discussion and will respect the contribution of others.
- **Attendance** – Attendance is also a form of respect for the therapists' time and the time of the other groups members. Many programs have a particular number of sessions that clients are required to attend, with the exact number depending on the individual program and the length of the program. Missing sessions also delays the progress, and in group, places individuals at a different level than other groups members. Some groups also expect men to give notice before leaving therapy or the group.
- **Sobriety** – Intoxication to the point of not being able to fully participate in the therapeutic session or at the point of causing disruptions in the session is detrimental to progress of the client and of others in the case of group therapy and can negatively affect group members' sense of safety.

- **Pass** – Clients appreciate the option of passing on a certain activity, with the recognition that they cannot do this with every activity and in every session. This rule recognizes that there will be days or activities in which a client may feel unable or uncomfortable participating.

Some of these rules are placed into a therapeutic agreement that is signed by clients before they begin therapy. An example of this type of agreement can be found in Wilken (2003) and is replicated in Appendix B. Rules and limits of confidentiality, structure of sessions, and boundaries about touch are among the rules often included in these agreements. Support outside of therapy and emergency plans for crisis management outside of therapy may also be included. Finally if fees are being charged the agreement to pay the fee and the method and process of payment would be clearly stated.

Certain preparation will be specific to group therapy. This will include:

- Preparing each man for the possibility of knowing someone in the group (Fisher, et al., 2009). This will be particularly relevant in a smaller city or town. If this generates too much discomfort, **group therapy may not be appropriate for the person.**
- Preparing men for hearing stories that may be both similar and different from their own. Hearing these stories may trigger emotional responses. Even the appearance or mannerisms of some group members may remind men of their abusers.
- Preparing men for the likelihood of there being both homosexual and heterosexual men in the group.
- Preparing men for the likelihood of their being men from cultures and religious or spiritual beliefs different from their own.

Methods of Intervention

The two basic forms of intervention are individual and group therapy. The choice of one over the other will depend on each client, their preference, presenting issues, and level of recovery. In their investigation of the effectiveness of group or individual psychotherapy for females survivors of CSA, Ryan, Nitsun, Gilbert, and Mason (2005) report that both are equally effective and state the importance of accommodating the preference of clients. Most therapists for male sexual abuse survivors see a combination of individual and group formats as ideal, allowing clients to reap the benefits of both of these formats (Crowder, 1995; Dimock, 2007). Men in the focus groups/interviews also wanted the option of having both of these therapeutic approaches. In addition to in-person therapy, men in the focus groups/interviews along with therapists such as Lew (1999) suggest that on-line therapeutic resources be made available for men who fear coming to therapy. These resources may also be helpful to men in remote areas with no in-person therapy.

Individual Therapy

Individual therapy is often a good starting point for therapy (Lew, 1999), particularly for men who have not previously disclosed their abuse or processed the experience in any way. The one-on-one relationship with a therapist allows trust and rapport to build more quickly. This rapport will facilitate disclosures about the abuse and help them gain comfort and confidence in openly discussing abuse related issues. Because it is individualized, this therapy allows clients to proceed at their own pace, take any direction they choose and focus on highly personalized issues. When combined with group therapy, individual therapy provides a venue for further exploration of issues brought up in group. Sometimes individuals begin with individual counselling, going through disclosure of their abuse and gaining a level of comfort where they can then access group therapy as well as individual therapy. Others only ever feel comfortable with individual therapy. Individual therapy may be the preferred approach for men who have issues that make group therapy inappropriate such as mental health problems, are extremely uncomfortable with other men or gay men, or have themselves sexually abused children.

Group Therapy

Group therapy plays a large role in mid and late recovery where there is less focus on a need for a close relationship with the therapist, a greater focus on self, a greater comfort with emotions and other men, and less of a focus on abuse related activities (Lew, 1999). As indicated, group therapy may not be helpful to all men and some may become prepared for group therapy only after a period of time in individual therapy. In order to participate and benefit from group therapy client should be able to (Crowder, 1995; Wilken, 2003):

- Be able to openly talk about their abuse.
- Have social supports outside of the group.
- Be able to discuss goals.

- Have good social skills.
- Have self care and coping strategies for dealing what they will hear in group (this is where individual therapy can be helpful).
- Not be homophobic.

Group programs for men who have experienced CSA have been found to be effective in the recovery process (Heim et al., 2010) and many benefits of group therapy have been reported. First, being in a group with other CSA survivors reduces isolation (Chouliara et al., 2011; Crowder, 1995; Dimock, 2007; Dorais, 2009; Fisher et al., 2009; Gartner, 1999). Because men do not often disclose or talk about their experiences of sexual abuse, they often feel like they are the only ones this has happened to or who are experiencing resulting emotions and behaviours. When they meet other men in the group with similar experiences, emotions and behavioural effects they are often relieved at not having to go through the process alone and at having their feelings validated. In focus groups/interviews men talked about reading the stories of other men making them feel like they were not alone in their experiences and that groups should include a sharing of stories. Even within the focus groups, men would identify with each other's concerns and emotions. A few men who said they were uncomfortable with other men said they would feel comfortable in a group program because the other men would have shared similar experiences. Generally, men recognized the value of group therapy in helping them feel less alone with their experiences.

Another benefit of therapy groups for men is the sense of mutual support, acceptance and validation (Chouliara, et al., 2011; Dimock, 2007; Fisher et al., 2009). Showing compassion and respect for each other helps to build relationship skills that can be transferred outside of the therapeutic environment. Men come to understand that they can have positive relationships with other men (Gartner, 1999). Through mutual acceptance men can learn to redefine masculinity, learn to build social support resources and gain pride in being a man (Dimock, 2007; Gartner, 1999). Some men may form support networks with each other that they can access outside of therapy, thus helping them deal with difficult issues between therapeutic sessions. Men in focus groups/interviews stated that in a group setting the men could find support with each other thereby feeling less alone and more understood. For men who got no support from their family, this was a very attractive feature of group therapy. The staff felt there was a benefit in men making connections with other men and seeing that survival is possible.

Some therapists feel that men are more open to expressing emotions with other men, particularly anger and rage (Dimock, 2007). However, some warn that after expressing emotions, particularly of vulnerable emotions, some men may feel shame (Fisher et al., 2009). This is when the support and validation of other men will be helpful in working through these emotions. Another concern is that hearing other men's stories and observing their emotions may trigger emotional reactions for some men (Crowder, 1995). Preparing men for this possibility, providing them with coping skills, individual therapy, and group support will serve to help them effectively deal with emotions that surface following the disclosure of others. Gartner (1999) believes that group therapy can help

men confront their fears of being judged by others and therefore provides a form of exposure therapy when those fears are unfounded.

Group therapy provides an ideal venue for learning from others (Dorais, 2009; Fisher et al., 2009). Conflict resolution skills and being nurturing and affectionate without being sexual are among the forms of socialization provided in a group setting (Crowder, 1995). Men can also learn to express anger and power in appropriate ways. They can learn to compete in ways that do not harm or belittle others. Through helping each other men can become interdependent rather than dependent (Gartner, 1999). They can obtain information from each other and practice new skills with each other in group interactions and/or through the use of role play. Feedback from other men can be both informative and supportive. Men can serve as models of recovery for each other and encourage growth in each other (Crowder, 1995; Gartner, 1999). In focus groups/interviews men stated that in group programs men can relate to each other's experiences, provide each other with positive nonjudgmental feedback, and share ideas about coping strategies. Men tend to seek help a) if they can normalize the problem and know that other men share this problem; b) if they feel they can help others as well as receive help; c) other men are supportive of their seeking help; and d) the problem does not impact on their self concept (Addis & Mahalik, 2003). Group therapy for men who experienced CSA addresses the first three of these conditions.

a. Group Composition

Groups can be varied in age, culture, sexual orientation and experiences, however it is advised that members be at the same level of recovery so they can deal with the same types of issues and information (Gartner, 1999). This will lead to less frustration and greater progress. Single gender groups are also suggested (Crowder, 1995; Sharpe, Selley, Low & Hall, 2001).

b. Open and Closed Groups

Because of the limited amount of research on programs for male CSA survivors, some of the following advantages and disadvantages of open and closed groups have been borrowed from the literature on men who have used abuse in their relationships, which is more extensive. Although the men represent very different concerns, both represent sensitive topics and the information about the nature of the group is equally relevant to men seeking help for sensitive issues in their lives.

i) Closed Groups

Closed groups refer to a series of program sessions that are delivered to the same group members over a specified amount of time. Closed groups have a clear beginning and end date and therefore are more structured. Because the same people are in the group together over a series of weeks or months, it is believed that closed groups foster a greater sense of trust and safety that will then lead to more comfort and openness in disclosure and emotion work (Baker & Sheldon, 2007). Thus, closed groups may be preferred for more intense therapy. With group members getting to know each other well and going through difficult issues together, closed groups may generate a greater sense of cohesion and more caring and support among members. Men work through the program

at the same pace and therefore are at the same level of recovery as the group progresses, allowing sessions to build upon each other (Pandya & Gingerich, 2002). The men will also experience the ending of the group together, possibly making this termination point easier (Baker & Sheldon, 2007). There will be more predictability in terms of group dynamics and interactions making it easier for therapists to select topics and activities that will work with a specific group of men. Finally, although evaluations of open groups have been done (Sharpe, et al., 2001), closed groups facilitate the evaluation process as pre- and post- program measures can be gathered from the same men with the knowledge that they have experienced the same information and the same number of sessions. Staff who took part in focus groups/interviews believed that closed group would make men feel safer.

In addition to the advantages of closed groups there are some disadvantages. If the group is being used for intense emotional work, as would one for male CSA survivors, too many members would curtail the amount of time each person has to process and discuss issues of concern to them. However, beginning with a smaller group may mean that if some men drop out, the group could be very small at the end of therapy. Further, in sparsely populated areas it may be difficult to get a sufficient number of men to commit to attending a specific number of session over a number of weeks (Rosenbaum & Leisring, 2001). In focus groups/interviews staff expressed concern that a closed group presents such a unique context that it does not translate into real life. An open group that may include interactions with both familiar and unfamiliar people would be closer to real life.

ii) Open Groups

Open groups have fluctuating memberships with some accepting new members in at specified times and others operating on a drop-in basis. Some of these groups present a cycle of sessions on specific topics, but some let the group concerns dictate the topic of discussion. Men attending open groups will be at different points in their recovery and those more advanced in the process can help men who are beginning their recovery process (Pandya & Gingerich, 2002). Some men in the focus groups/interviews felt that open groups would allow them to see and be encouraged by the progress of men at a more advanced level of recovery and to help those just starting the group. Experiences with the group will vary with some men attending many sessions and some only attending a few. Drop-out will have less of an effect than in closed groups, but numbers of men per session can vary greatly with either large groups or very small groups of only one or two men, making it difficult to plan activities. Open groups allow men to tailor the program to their schedule and this is ideal for those who are unable to commit to a regular or long term program schedule (Rosenbaum & Leisring, 2001). Because these groups place men in charge of their own attendance, they may feel greater responsibility and empowerment about their recovery.

The staff who took part in this research recommend that therapeutic groups be closed, cautioning against the use of open groups based on the following concerns:

- Discussing highly personal and sensitive issues related to sexual abuse requires feelings of safety and trust in groups members. With ever-changing

membership, open groups would hinder the development of safety and trust, thereby interfering with the therapeutic process.

- Because men are often fearful of disclosing their experiences of abuse, it takes a lot for them to come forward to obtain therapy. Being able to assure them confidentiality builds their sense of safety. In closed groups, there is comfort in sharing sensitive information with a small, specific, and known group of men and greater confidence that they will maintain the rules of confidentiality. With new men coming into an open groups and others leaving, it may create more concerns about breaches of confidentiality.
- Trust and safety and detailed therapeutic work requires a certain degree of cohesiveness among groups members. Attending groups with the same members works to build this sense of cohesiveness as members get to know each other, share details of their abuse, and work through the therapeutic process together. Open groups, because of their variable composition would make it difficult to build cohesiveness.

Sharpe et al. (2001) report that lack of trust, boundary issues, late arrivals, leaving early, among other problems were common in their open group for male survivors of CSA. These problems did diminish as the group progressed, but still caused disruptions and concerns for facilitators throughout the process. In speaking about other therapy groups they had attended, some men in the focus groups/interviews expressed frustration when others did not show up for group. Predicting group dynamics will be more difficult and therefore facilitators will need to be more flexible in their approach. For all of these reasons open groups may be preferable for less intense therapeutic work, for men further along in their recovery, or for follow up groups (see below).

c. Preparation Groups

In treatment programs for men who behave abusively, preparation groups have been introduced with some success (Evolve Program at Klinik Community Health Centre, n.d.; Rosenbaum & Leisring, 2001). Given the similar sensitive nature of CSA these groups may work with this client population as well. Preparation groups are introduced prior to the process group and can be closed or open. These groups can be provided to men as they wait for space in the program group. Preparation groups can provide information about abuse and its effects and/or offer the opportunity to learn communication and coping skills that can then be applied to deal with more intensive and emotional issues in the program group. If these groups are closed and contain the same group of men that will progress together into the program group they can serve to build familiarity and trust with each other and with the therapist. Even if these groups are open, men can build coping and interaction skills they can use in the program group and in their lives. They become more comfortable with the group process, making beginning the program group less frightening. Men in the focus groups/interviews stated that the first three sessions of a group program should include methods of coping with the intense emotions they will be revealing in the program, learning safety skills and grounding exercises. Staff also thought that the first three sessions should be about building trust and could be more educational in nature. These are the very things that preparation groups do to facilitate program group process.

d. Follow up groups

Some programs offer follow up groups as a continuation of the process of change. Some of the changes men want to implement in their lives will not be automatically achieved after the program groups ends, particularly if the program group is short term. Follow-up groups provide men with the opportunity to continue meeting, talking about issues they are facing in their lives, and obtaining advice and support as they work to apply the new skills they have learned. These groups may be led or guided by a facilitator/therapist or may be more in the nature of a support group led and organized by the men themselves. Often the most difficult part of any type of change is maintaining it after the momentum of programming is gone (Prochaska, DiClemente, & Norcross, 1992). Follow up groups can help men stay motivated to apply what they have learned in group in their lives. The men who took part in the focus groups/interviews indicated that they would like to have a long term follow up group with a facilitator to ensure that the group retains a therapeutic quality rather than merely becoming a socializing resource, at least in the first few sessions. Some also suggested having specified topics for discussion for follow up group sessions. A few men saw these groups as offering support and reducing isolation in the long term. Follow up groups are often open and would provide the more real life experience of talking with both familiar and unknown men, as suggested by the staff.

e. Group size

Between five and 12 members are recommended for a closed therapeutic group (Crowder, 1995; Dimock, 2007; Fisher, et al., 2009; Gartner, 1999) and both men and staff who participated in the focus groups/interviews reported their preference for this group size. A few men suggested larger groups because they would bring more diverse experiences and perspectives and offer a wider range of support, however they also were concerned that everyone have a chance to speak and be heard. Smaller numbers will allow the men to more easily build trust and cohesion and offer sufficient and equal opportunity to have their needs and questions addressed in the group and for therapists to get through information and exercises with the entire group. This time will be needed due to the intensity of the work done in the group (Dimock, 2007). Some dropouts should be expected and therefore this needs to be taken into consideration when deciding the number of men allowed into the group at the beginning. Larger groups may be more appropriate for follow-up or even preparation groups. Open groups will vary in the number of participants attending from one session to another. If open groups are consistently too large separating the group into two smaller groups may be an alternative to trying to manage a large group.

f. Session Format

Group sessions typically have a particular format and despite slight variations they tend to include a check in session, group discussion and activities, and check out (Fisher et al. 2009). Check in allows men to talk about events in their lives and how they are feeling (Gartner, 1999). Check out can be used to assess feelings of safety, general feelings about what was discussed in group and issues that men may want to revisit at the next session (Fisher et al., 2009; Gartner, 1999). Everyone should be given a chance to speak in both check in and check out. In focus groups/interviews staff indicated the need for a

check in and grounding exercises at the beginning of each session. Men stated that they would need a chance to calm down from the intense emotion work at the end of each session or to have the opportunity to talk to an individual therapist if there is no time to deal with residual emotions at the end of the session. They felt it was important that men not go home when in a high emotional state.

Session lengths can also vary from one hour to two and a half hours. Therapists like Gartner (1999) state that longer sessions allow for more in depth exploration of issues. They also allow all group members a chance to speak and process the information and sufficient time for checking in and checking out and dealing with end of session issues before the men leave.

Staff who took part in the focus group/interviews stated that there should be a plan for evidence based topics and activities for group sessions and men should be told about what to expect in group sessions. Men also stated that they would like an outline of planned topics for group sessions. This would give them a chance to prepare for what would be discussed and to alleviate fears and uncertainty about what was going to happen. The preference for men and staff was for longer group sessions of two to two and a half hours.

Program Length

Individual therapy can proceed for as long as required however, groups, and particularly closed groups, have a finite point. Although a number of researchers and therapists recommend long term group therapy (Heim, et al., 2010), many are short to moderate in length. Long term group therapy is believed to bring about more lasting and significant changes (Crowder, 1995; Mennen & Meadow, 1993). Supporting this belief are the findings of Valerio and Lepper's (2010) research with female CSA survivors which indicated that although there are significant changes after a short term group program of eight sessions, there were larger and more broad ranging improvements with longer term group programming lasting a year. One of the potential problems with long term group therapy is that men will not be able to commit to the program. Fisher and colleagues (2009) addressed this by developing a two phase program. The first phase consisted of eight sessions that served as a preparation group. Phase two consisted of 10 session cycles of programming with up to five cycles for a program that ran for a year in total. Men committed to each cycle they were able to attend.

In focus groups/interviews, men stated their support for longer term individual and group therapy. They indicated that it often took at least three group sessions to feel comfortable with the other men in the group and with short term therapy, those first three sessions may represent a third or more of the group. It takes time to build enough trust to be vulnerable with other men, particularly since many of their abusers were men. Most said that if a group ran for a year they would attend and that the length would not be a deterrent. However, a few were concerned that because commitment was problematic for some men who experienced CSA, regular attendance for a long term program would be

difficult. Staff suggested either having a number of short term programs focusing on different areas of change or having a longer term program. They recognize that long term groups create waiting lists, but felt that they are more comprehensive in providing men with what they need.

Therapists

There have been debates about the number and gender of the therapist for men who experienced CSA. The issue is that for men whose abusers were men, male therapists may present a source of fear and distrust and for men whose abusers were women, female therapists may generate this type of response. A few therapists suggest that if there is only one therapist as in individual therapy, it should be a male (Gartner, 1999). The preference for a male therapist is to encourage open discussions about gender based shame and issues around masculinity. However there are indications that men can be just as comfortable with a female as a male therapist.

In the case of group therapy most therapists recommend having two therapists and that they be a male and a female, although there is recognition that this may not always be possible. Co-therapists can support each other, provide different perspectives of the group interactions, and help each other with group planning and group activities (Gartner, 1999). Male and female co-therapists can model gender interactions and can recreate the parental dynamic (Baker & Sheldon, 2007; Ganzarain & Buchele, 1993; Gartner, 1999). Having both genders also helps men learn to deal with males and females, both of which they will encounter in their daily lives (Sharpe, et al., 2001). Staff from MRC and TLC added that having two therapists meant that one could take one of the men out of the room for more individual attention if he became upset by group discussion. They also felt that two therapists could support each other in dealing with problems; would create a greater safety for each other and for the men; could debrief with each other; could divide group related tasks; and could model healthy relationships. Further, having two therapists would provide a more balanced approach, male and female role models, and emphasize that male CSA is not solely a male issue, but rather a social issue.

Most men who participated in focus groups/interviews stated that they would be comfortable with either a male or female therapists, stating that gender was much less important than the caring, compassion, genuineness and understanding of the therapist. As indicated by the research, men indicated that they needed to learn to feel comfortable interacting with both genders in order to move beyond the abuse and function in the world. It is important to note that high levels of discomfort with either gender should be taken into account when planning therapy for a particular individual. Further, over time men's comfort level with either gender may change.

Stages of Recovery

Men who come for therapy will be in different stages of recovery and their varying experiences and personality will mean that their recovery process will differ. However, the Public Health Agency of Canada (2009) and Wilken (2003) have described some general stages of recovery. These stages are as follows:

- **Denial.** This may include denial of the abuse or its impact. Denial means that issues do not get resolved. Addictive behaviours and other compulsive coping behaviours can develop and will be maintained through denial.
- **Confused Awareness.** Men become aware that they have to deal with the abuse, often following an event like a divorce, the death of the perpetrator, or their incarceration. As men stop denying the abuse they often begin to experience a new set of negative emotions.
- **Reaching Out.** Disclosures and seeking help, including therapy, characterize this stage. The response to their disclosures will affect their feelings and reactions.
- **Redefining Masculinity.** Myths of masculinity can create barriers to recovery. Dispelling these myths and men exploring their own and new ideas of masculinity are part of recovery.
- **Anger.** As men begin to confront their experience they often become angry at the abuser, at the reaction of others, at the losses they have experienced and the situations in which they now find themselves. Men may have revenge fantasies that are detailed and violent.
- **Depression.** Sexually abused men often feel powerless to protect themselves, others or to make changes in their lives. Some grieve for the loss of their childhood, family or other valued aspects of self. The negative opinions and reactions of others may become a part of their self focus. Recognizing the maladaptive nature of their behaviour and giving up old behaviour patterns can lead to feelings of guilt, remorse, helplessness, despair, sadness and emptiness. These can all lead to depression.
- **Clarity of Emotions.** With support men begin to talk about their feelings and sometimes to tell their stories or part of their stories. They grieve their losses and work through their depression.
- **Regrouping.** Men develop a new found trust in others and themselves. They explore more of their past and their abuse and gain a new understanding of themselves. This will lead to new healthier behaviour patterns and becoming more positive and future focused.
- **Spirituality.** This can include men's sense of personal power and of a power greater than themselves. For some it consists of a sense of inner peace, of never being alone in the world, unconditional love, and acceptance. Forgiveness of self and sometimes of the perpetrator may be part of this stage. It is important to note that men do not have to be spiritual to heal, but it is part of the healing of many men.
- **Moving On.** There is a shift in focus from the past to the future and painful emotions about the past are released. The past becomes viewed more objectively. Adaptive coping strategies are learned and predominantly applied. Grieving current loss and distress no longer devastates the man's personal coping capacity.

Self acceptance, self care and personal growth are achieved. Men develop and access a support system. They gain a sense of stability in themselves and their lives.

Programming Models

Individual Therapy Models

Romano and DeLuca (2005) Model

This individual counselling program was developed for adult male survivors of CSA by Romano and DeLuca (2005) in Winnipeg Manitoba. This therapy takes a CBT approach where men explore the basis, validity and impact of their self blame, anger and anxiety. They also learn strategies to better manage their feelings, cognitions and behaviours. Self blame, anger and anxiety are addressed in this order to allow the information and skills learned within each component to build upon each other. These also allow for greater trust and comfort with the therapist as the components get progressively more intense.

Format

Therapy consisted of 20 sessions with attendance either once or twice a week, as preferred by each man. Progress is individualized in terms of the pace that is comfortable for the men and their motivation in achieving each task.

1. Introduction to the Program

The first session included:

- Providing information about the scheduling of the therapy sessions.
- Reviewing confidentiality policies and the rules for therapy.
- Assigning reading material on males who have experienced CSA.

2. Self-Blame

Men will often take responsibility for the abuse, either because the abuser told them they were responsible, because of their physical response to the sexual stimulation, or because they liked the special attention or rewards given to them by the abuser. Briere (1996) also suggests that for some men self blame may be a way of their maintaining a sense of control and avoiding feelings of powerlessness. This component is intended to educate men about childhood sexual abuse and help them place responsibility for the abuse with the abuser. Tasks include:

- Examining coercive techniques used by the abuser and methods he may have used to make the person feel responsible.
- Looking into the origins of self blame and issues of responsibility and power related to CSA.
- Examining physical response to sexual stimulation and its meaning in the context of abuse.

- Challenging perceptions of self blame and distorted beliefs about blame and encouraging more accurate cognitions about where the responsibility for the abuse lies.
- Exploring and addressing myths of CSA, with an emphasis on the ones related to the effects of abuse on sexuality and concerns about sexual orientation.
- Factors involved in failure to disclose the abuse.

3. Anger

Many men feel anger and use anger to mask more vulnerable emotions. This component of therapy helps men understand and cope with anger. Developing adaptive ways of addressing abuse-related emotional, cognitive, and behavioural problems is a large part of this component. Tasks include:

- Helping the person recognize the cause of his anger and at whom his anger is directed.
- Expressing suppressed emotions in socially acceptable ways.
- Examining fantasies about revenge.
- Preparing for future interaction or confrontation of the abuser. Confrontation should be based on the client's desire for it and on his psychological preparedness for it. There are several concerns and benefits to confrontation (see Freshwater, Ainscough, & Toon, 2002).

Activities included:

- Writing letters to the abuser to express their anger at what he has done.
- Writing letters to express vulnerable emotions such as loss, grief, and powerlessness.
- Role playing to express anger and other emotions and to further explore their experiences.

4. Anxiety

Anxiety symptoms are common in individuals who have experienced CSA. In this part of therapy men connect their experiences of abuse with their current anxiety symptoms.

Tasks include:

- Discussing the link between abuse and current anxiety based thoughts and behaviors.
- Challenging the validity of thoughts and beliefs that induce or increase anxiety.
- Learning cognitive and behavioural strategies that will reduce anxiety and help individuals deal with anxiety provoking situations.

Activities included:

- Relaxation training.
- Thought stopping.
- Guided self talk.
- Grounding techniques to focus on the present.

5. Termination

Termination of therapy may be difficult for men. The following components should be included as part of the termination process:

- Explore feelings about the ending of the therapy.
- A review of the progress made and goals accomplished.
- Discussion of the importance of the therapy and the therapeutic relationship to both the man and the therapist.

Research conducted by the authors (Romano & DeLuca, 2006) found that the majority of participants had reduced their level of self blame, anger and anxiety both after therapy and at a six month follow up. Exploring ways the abuser made the individual feel responsible and examining the myths of CSA were particularly helpful in effecting decreases in self blame and thought stopping and progressive muscle relaxation were most effective in controlling anxiety related thoughts. Men experienced the least amount of change in their level of anxiety. The authors suggest that because anxiety may generalize to many areas of functioning it may be more difficult to link it to CSA. However, they did state the importance of addressing anxiety because of its prevalence in CSA survivors.

Important Note: The authors recommended the addition of a fourth phase covering issues of sexuality.

Crowder's (1995) Model

Crowder describes a four phase model for individual therapy and combines it with group therapy (see below for model).

Phase 1

Breaking the silence of abuse through disclosure and acknowledgment of the experience is the primary task of the first phase. Because men often deny, suppress and fail to disclose or talk about the abuse, doing so is the first part of confronting this event in their lives. It also means that revealing the abuse is done in a safe environment with the support of the therapist. Being able to talk about the abuse prepares for understanding its impact which is part of phase two.

Phase 2

Called the victim stage, this phase is focused on promoting a cognitive understanding of the abuse, means of managing distress, and ending self blame for the abuse. In fact, men are not considered prepared to move on to phase three until they see the abuser and not themselves as responsible for the abuse. Among the tasks in this phase are:

- Building a safe therapeutic environment.
- Validating the client's abuse history.

- Providing the client with information about the effects of abuse.
- Teaching stress management techniques to help clients deal with the intense emotions and sensitive information they will be dealing with in this and the next phase. This will circumvent their need to revert to compulsive coping behaviours such as addictions to deal with the emotions that will surface due to disclosing and facing their abuse.
- Helping the clients establish support systems that can help them cope with the emotions and memories that will increase in this early phase of the therapeutic process.

Phase 3

This phase, known as the survivor phase is focused on developing adaptive coping skills, cognitions, behaviours and emotion regulation. There is a danger in this phase that clients will become discouraged and dropout of therapy. Their willingness to symbolically confront their abuser indicates that they are prepared to move on to the next phase. During this phase the following tasks may be achieved:

- Discussing revenge fantasies or any fantasies that involve the abuser.
- Discussing fantasies and/or fears about becoming an abuser. Replaying the abuse scenario and conditioned sexual responses may be part of this discussion.
- Understanding the role that addictions and compulsive coping behaviours play.
- Learning new coping strategies.
- Learning strategies to safely express emotions. Because this can make men feel vulnerable this task should progress at the client's pace. Ensure that they know that ambivalent feelings are acceptable and common.
- Discussing how culture contributed to the clients' fears of expressing emotions. It sometimes helps to have them speak about emotions as if they belonged to another person.

Phase 4

This thriver phase is characterized by the abuse no longer being the central theme or focus in the client's life. Men need to be assured that they can re-access therapy if needed (this is the value of a follow up group). In this phase, therapy shifts its focus to other life issues such as relationships, sexual difficulties and self care. Some men may want to confront their abuser in reality or symbolically or family members, but they need to have realistic expectations of the outcome of these confrontations and be prepared for the reaction of the people they confront (see Freshwater et al., 2002). The last part of this phase is a planned termination where progress, successes, and strengths are reviewed and celebrated.

Group Therapy Models

Crowder's (1995) Group Therapy Model

Crowder cautions that group therapy may not be appropriate for all men. He proposes a two stage group therapy model, each of which corresponds to different phases of individual therapy. He recommends that men who access group therapy also attend individual therapy. His model for individual therapy is presented above.

Stage 1

This stage is psychoeducational in nature and is intended to build skills that will prepare men to deal with the more emotion related and functional tasks of stage two. It consists of a closed group that runs for eight to ten weeks. It corresponds to the victim phase of individual therapy. The closed group provides safety and increased trust as the same people will be in each session. Having a structured information based set of sessions **provides predictability** in terms of what will be discussed. The beginning session should cover group rules and procedures. The remaining sessions can then cover abuse related topics and utilize handouts and exercises to facilitate understanding of the information provided. Time should be devoted towards the end of this stage for a celebration of growth. Topics covered in this phase have included:

- Legal and criminal aspects of sexual abuse.
- Typical roles in abusive families.
- Types of offenders.
- Healthy sexual development.
- Sexual and nonsexual intimacy.
- Assertiveness.
- Relationship styles.
- Conflict resolution.
- Domestic violence.
- Child development.
- Parenting skills.
- Self esteem.
- Self care and stress reduction methods.
- Self defeating behaviours.

Stage 2

Resolving the abuse and developing effective life skills are the primary intent of the second stage. It is associated with the survivor phase of individual therapy. This stage is comprised of an open group that is unstructured in nature. Emotions and issues that arise make up the session topics, thus the group follows the concerns of the men in the group as they present themselves. Because it is an open group some men will have more experience in the group than others and interactions and group direction will be affected by these differing experiences.

Herman's Three Stage Model As Used By Fisher et al. (2009).

This therapeutic model consists of two phases and it is suggested that each group have between eight and 12 members. Sessions in both phases begin with a check in followed by announcements, discussion of unfinished business, presentations of session module, and ends with a check out that assesses feelings of safety and outlines unfinished business to be dealt with in the next session.

Phase 1

This phases consists of eight sessions that are psychoeducational in nature. The modules are kept brief and engaging. The first sessions may be for any of the following:

- Establishing group rules. Confidentiality, beginning and ending on time, no relationships between groups members outside of the groups, no sexual relationship with anyone in the group, how to deal with encountering group members outside of the group, and the right to pass on talking or exercises are among the rules that can be discussed.
- Acknowledging emotions.
- Building connections among men.
- Giving men an idea of what to expect from the program.
- Establishing the structure of the group program.
- Building grounding skills.
- Discussing commonalities.
- Outlining means of developing safety and healthy behaviours for self and others.
- Visualizing a safe place.

In the first couple of sessions therapists can do most of the talking and provide men with handouts in order to take the pressure off of men to talk before they feel comfortable enough with each other to share information.

The following content for phase one modules are suggested:

- Understanding trauma and recovery.
- The aftermath of trauma.
- Handling stress and crisis.
- Trauma and relationships (two sessions, not necessarily presented consecutively).
- Trauma and identity, including the male gender role.
- Emotions and trauma, including how emotions, thoughts and behaviours are connected.

Phase 2

Phase 2 consists of up to five ten session cycles per year. Men commit separately to each ten session cycle. Issues brought up at check in are used to guide discussions. If men do not bring up any issues the therapist should be prepared to introduce relevant topics such as gender issues. The sessions are intended for deep emotional processing, re-evaluating and integrating the trauma with other past experiences. A variety of exercises such as

role playing are recommended. Testimonies about experiences are part of the integrative process and cognitive restructuring and are usually done towards the end of phase two. A guideline for developing a testimony is included in Appendix C. It is strongly suggested that the end of the program include covering feelings of loss and anticipation of the future.

Phase 3

A third phase is suggested and would involve men accessing other groups or follow up groups. The intention is to help men maintain positive changes, make successful transitions, expand their roles and identities, find mentoring opportunities and give back.

Wilken's (2003) Group Model

Wilken (2003) recommends combining individual and group therapy, realizing that for some men, only one of these will be appropriate. The group program typically occurs after a number of individual therapy sessions. His approach is client centered, with therapists and clients forming a cooperative partnership but with the client determining the course of their own healing process. In group, the therapist provides motivation and support and otherwise does not structure the conversations into a rigid schedule.

Sessions are approximately two hours long. They begin with a check in, where men discuss how they have been since the last session and issues they would like to discuss before the end of the session. After check in the session module is discussed and activities and questions related to the topic are used to enhance understanding. Check out started about 20 minutes before the end of the session. Men talk about how they feel about the session and if they have any overwhelming emotions they need to be addressed. Check out is meant to keep men grounded in the present.

Wilken (2003) suggests a series of short term closed groups, believing that closed groups are beneficial in creating consistency in interactions and trust among members. He does not propose that healing will occur completely after ten weeks of group therapy, but his program offers a number of these short term groups and men can attend more than one. At the beginning of each group men determine which topics they want to discuss in the group and therefore topics vary from group to group, although many are the same because the same issues are of concern to many men. Part of the therapist's job is to ensure that these goals are met by the end of the ten week group.

An example of the group topics for a ten week program include (Wilken, 2003, pg 155):

- Members tell their stories.
- Masculinity and stereotypes.
- Relationship issues with family and partners.
- Grieving and healing.
- Finding a voice.
- Dealing with anger.

- Depression, awareness.
- Spirituality.
- Self-respect.
- Review/Moving on.

Recommendations and Suggestions

Recommendations

Based on overwhelming evidence three recommendations were made:

1. Establish and Maintain A Men's Childhood Sexual Abuse Program

The magnitude of the incidence and effects of CSA in men and the fact that it has been relatively unrecognized and unaddressed emphasize the need for a well developed and permanent program for men. Although the current incidence rate is one in six men, it is believed that, due to underreporting, the numbers are actually higher. Even at 16% of half of the 224,365 men 20 years and over living in Winnipeg (Census, 2006), this would mean that about 36,000 of Winnipeg men experienced sexual abuse as children. These numbers alone warrant a permanent therapy program for men. When one considers that men from outside of Winnipeg will also have been abused and will likely come to Winnipeg to seek services, this programming becomes even more necessary. Staff at the Men's Resource Centre report that there is one man who travels from northern Ontario to access the current therapy being offered to men affected by CSA, thus the program would potentially serve men from outside of Manitoba.

Childhood sexual abuse has a variety of effects that are detrimental not only to the lives of the men but to the community in which they live. Mental and physical health issues are common long term effects of CSA that place significant demands on the health care system. Beyond the stress related to the abuse, there are health care costs associated with the negative impact of stress on the immune system, pain and disabilities, risky sexual practices, and emergency care. Addictions are very common in men who experienced CSA and with addictions come added health care costs such as hospital care, residential treatment programming and medication. Due to addictions, aggressive behaviour and sexual offending, many men become involved with the justice system, thereby incurring costs related to police service, courts, jail, and property damage. Road accidents related to addictions lead to added costs in terms of loss of productivity, health care costs, justice system costs, vehicle damage and insurance costs. Workforce related costs such as a reduction in the paid workforce, absenteeism, and reduced productivity occur due to stress, mental health issues, addictions and incarceration. Finally welfare costs, like social assistance and child and family services, may be added to any of the above costs. Without programs to help men make positive life changes these costs will continue to escalate with current and future generations of abused men.

A permanent CSA program for men would clearly send the message that this is a recognized problem in our society, that the wellbeing of victims and survivors matters, and that the community in which they live cares enough to reach out and help them address the problems in their lives. Besides some individual therapy offered by private practice therapists for a considerable fee, there are no CSA programs specifically for men

in Manitoba. Because of difficult life circumstances many men affected by CSA do not have the financial resources to access private practice services. Part of the problem has been the visibility of the issue of childhood sexual abuse in men. Boys and men tend not to disclose their experiences of abuse, which leads others to believe it is rare and thus not requiring special services. With no services available and the issue not being discussed or addressed, men are more reluctant to come forward about their abuse, which contributes to the perceived rarity of the problem and thus the lack of services. Reports from the staff at the MRC and from the men who came forward to participate in focus groups and interviews, it is men in their middle years that are prepared to address their issues of abuse. Clear messages about the prevalence and unacceptability of this abuse and the availability of a safe place where services are available free of charge to men will likely encourage men at younger ages to come for therapy. This may curtail negative effects and the subsequent costs to the system by several years. As awareness builds about the issue of CSA in men the stigma about disclosing and dealing with the abuse will lessen and the demand for programming will grow.

2. Childhood Sexual Abuse, Addictions, and Mental Health Need to be Addressed Together

Although men turn to a number of compulsive coping behaviours such as gambling, the most prevalent one is substance abuse. Mallow (2000) found that severity, duration and frequency of sexual abuse were positively related to the severity of alcohol abuse and Johnson and colleagues (2005) found that among incarcerated men, those with histories of CSA had a 30% higher rate of substance abuse than those without CSA histories. Substance use resulting from the abuse is associated with risky sexual behaviour, illegal behaviour, relationship problems, vehicle accidents and injuries, employment problems and violence, all of which incur significant costs to the system.

Over half of the men who participated in focus groups and interviews had substance use problems at some point since their abuse and a number of them were currently in treatment for alcoholism or the abuse of other substances. Because their substance use is so intimately connected to their experiences of abuse, these men would ideally be able to talk about their experiences of abuse as part of their drug and alcohol treatment. However, existing treatment programs do not offer a safe venue for disclosing childhood abuse. All of the fears around disclosure such as being stigmatized, labelled as homosexual or a sexual predator, and disbelieved, exist within these treatment programs. Further, with the focus on substance use, disclosing sexual abuse would be opening up issues and emotions that could not be explored sufficiently and the surfacing of painful memories and emotions may lead to a relapse or intensification of substance use. In addition, not dealing with the underlying cause of their substance use often means that they revert back to their addictions or substitute another compulsive coping behaviour for their addiction. This incurs great costs to the system providing addictions treatment and does little to permanently resolve the problem.

A more effective, efficient, and long lasting approach would be to offer a CSA program that would also address compulsive coping behaviors such as addictions. In this safe environment with men who have similar issues, clients could explore the link between their abuse and their addictions. As they find more adaptive ways to cope with their experiences of abuse they will have less need to use substances to numb their pain. They can also find ways to cope with letting go of their addictions by replacing them with healthier means of coping. This needs to happen within the context of having experienced abuse, because for these men the two are so closely related.

Further, both CSA and addictions are linked to mental health issues such as depression, anxieties, PTSD, suicide, and dissociation. Some men use substances to cope with the CSA, but these substances can increase mental health symptoms such as anxiety, dissociation or depression. These symptoms can then lead them to self medicate with more substances, both legal and illegal, which can lead to overdoses, accidents, incarceration, loss of employment and other problems with daily functioning. In order to effectively deal with many of these mental health symptoms, CSA and the resulting addictions need to be addressed and in order to effectively deal with CSA, the resulting mental health issues and the use of substances to cope with these symptoms need to be addressed. Thus, because these issues do not occur in isolation, they cannot be treated in isolation from each other.

3. Efforts Towards Public Awareness

The overwhelming majority of the men who took part in interviews and focus groups strongly stated the need for greater public awareness of the issue of CSA in men including: general awareness in all individuals; increased awareness in governments and policy makers; and awareness in schools and with children. The men clearly stated the need to make children aware that these events can occur and what to do if they have experienced this type of abuse. For many, not knowing what to do and feeling like they were alone contributed to their silence and not receiving appropriate intervention. This recommendation comes with a realization that the silence that continues into adulthood needs to end in order to better address this issue. Studies have found, and the men who participated in the focus groups/interviews confirmed, that men's disclosures of abuse often receive negative responses. Greater public awareness may then lead to more positive responses and increased help for men affected by CSA. This recommendation is made with the realization that public awareness efforts may be more of a future endeavor requiring special funding and time.

4. Increased Research

Writing the report on CSA in men and the issues of concern for therapeutic intervention, it became apparent that there are many areas where more research is required. First, there is not only a need to develop a program model for men who experienced CSA, but also a need to empirically test this model. Few intervention programs or even therapeutic

approaches have been evaluated. Evidence of the model's effectiveness would give funders, program developers and therapists, confidence that their resources are being well spent. It would also provide a foundation for potential modifications and enhancements to the model. Further, testing the therapeutic approaches would add considerably to the literature on programming for men who experienced CSA.

In addition to the need to evaluate the model and the therapeutic approaches used, other research needs were identified. First, expanding the current knowledge about the effects of male vs female perpetrators on boys and men is required as there is very little research in this area. Second, further explorations into CSA experiences and subsequent involvement with the justice system are needed to provide a clearer picture of the trajectory between these two events. Current Canadian justice statistics indicate that CSA occurs at a high rate in men within the prison system, but these statistics are limited by availability of information and there is little research examining the path between abuse and incarceration. Third, research into family and couple's therapy and developing programs that fit with the CSA program model would prove helpful to the men, particularly since many of them reported problems in their relationships with partners. The work of Anderson & Veach (2005) who found that over time partners often manifest symptoms similar to the men with CSA experiences supports the need for programs involving partners. Family therapy could include a parenting program, as both the literature and the men who took part in the focus groups/interviews reported feelings of discomfort in caring for their children due to fears about becoming abusive, being perceived as abusive, or an inability to build attachments and emotionally connect with others.

Suggestions

The following are suggestions for therapy based on prevalent findings from the literature and in talking to men with experiences of CSA. The ultimate choice of a program model will depend on therapists' preference, resources, and specific client needs.

1. Suggested Discussion Topics

These topics are based on the identified issues related to recovery in the literature.

The Impact of CSA. Many men feel that they are alone in their experience and its effect on their lives. Discussion of CSA and its effects has been associated with normalizing men's experiences and thus reducing their sense of isolation.

Telling Their Story of Abuse. The literature identifies benefits for men telling their story and the story provides a basis for addressing abuse related issues. It also provides the basis for cognitive restructuring of the story through narrative therapy and helps in the processing of the information into long term memory. In focus groups and interviews men talked about the importance of getting to tell their story in order to feel validated.

Part of telling their story then may be about previous disclosures that were not validated and the need to have their story acknowledged.

Emotional Awareness and Emotion Management. Guilt, shame, self blame, anger, and fear are among the most prevalent emotions in CSA survivors. The literature indicates that many men either suppress or cannot control their emotions. Emotional awareness and management is part of emotional intelligence and adaptive personal and social functioning.

Masculinity and Sexuality. The experience of abuse impacts on men's sense of masculinity because the victim role contradicts the tradition masculine gender role. Their sense of sexuality is also affected as some men question their sexual orientation, develop homophobia, become disinterested in sex, or engage in risky or compulsive sexual behaviour. These sexual issues can further impact their sense of masculinity and their relationships with both men and women. Masculinity and sexuality are important components of men's identity and therefore affect their self perceptions and their interactions with others.

Cognitive Restructuring. Addressing inaccurate and irrational thoughts and encouraging a more positive focus will change thinking patterns and encourage better judgment and decision making. It will also reduce negative self thoughts and negative self talk.

Trust and Intimacy. Because the abuse represents a betrayal, often of a trust based relationship, men's sense of trust and intimacy are significantly affected. This impacts their friendships, partner relationships, and even casual relationships. It can lead to withdrawal from others and subsequent isolation which can ultimately negatively affect relationship and communication skills and deplete their social support systems.

Social Support and Interpersonal Skills. Building interpersonal skills such as communication skills will improve relationships and comfort in social situations. Enhancing relationships will increase social support systems which facilitate the recovery process.

Spirituality and Finding Meaning. Although not frequently included as part of therapeutic models or the literature on CSA in males, the men who participated in focus groups and interviews saw spirituality as an important component of therapy. Both for those like Wilken (2003) who do address this issue in therapy and for the men who provided information for this report, spirituality meant different things. Finding meaning in the experience or in life, gaining a sense of purpose, connecting with an inner self or a higher power, gaining a sense of inner peace and awareness, or self acceptance were listed as potential aspects of spirituality. Thus although it is individualized and personal it is important to men.

Self Awareness and Self Acceptance. These are associated with more positive emotions about self and life. They are linked to self esteem and self care. With these comes a sense of worthiness of respect and regard by others and by themselves.

Empowerment. Sexual abuse and the subsequent effects often make men's lives feel out of control. Helping them regain a sense of control will build confidence and self efficacy which in turn will help them implement positive changes in their lives and persevere in the face of adversity.

Parenting. Parenting is not an issue covered extensively in the literature nor is it a topic of most therapies, however, there are significant concerns around this issue voiced by men. Some men worry about replaying the abuse with their own children and consequently fear physical closeness with their children. Others fear imposing any of their own abuse effects on their children. Thus, parenting concerns may be a topic to consider as a session module or a separate short term program.

2. Suggestions for Therapeutic Process

Combined Individual and Group Therapy. The benefits of both of these approaches complement each other and will likely facilitate the recovery process. The combination may not be appropriate for or preferred by all men, thus each clients' circumstances and need should be considered.

Longer Term Programming. The research indicates that long term programming, usually at least a year, is associated with greater improvements in a variety of areas. Because the abuse has had an impact on emotions, cognitions and behaviours for several years, it will take time to formulate and consistently apply new patterns. An alternative to one long term program is offering a series of shorter term programs based on abuse relevant issues with men participating in a number of these programs.

Include a Follow Up Group. Men who participated in focus groups and interviews stated their interest in having a follow up group that would be less structured than the therapeutic group but would allow them to continue their recovery process. The literature is also supportive of follow up groups for longer term change and additional support through difficult events and issues when old patterns may reappear.

Provide Resources for Men and Staff. One of the concerns voiced by men in focus groups/interviews was the lack of reading material for men. Many of the resources they listed (these are included above) as helpful were dated, but still provided the best information available, and only a few men had access to these resources. Having a lending library would make these resources available to all men. A similar resource library, containing more information on research and therapeutic approaches could be established for use by the staff at the MRC.

Appendix A
Feelings Worksheet
(from Wilken 2003, pg.159-160)

List the times or situations when you felt these feelings.

Angry Feelings

Angry
Annoyed
Bitter
Frustrated
Furious
Hateful
Mad
Peeved
Rage

Worry Feelings

Bothered
Restless
Uneasy
Unsettled

Wanting Feelings

Empty
Gypped
Jealous
Lonely
Longing
Lustful
Rejected

Satisfied Feelings

Adequate
Blissful
Calm
Glad
Grateful
Peaceful
Satisfied

Pain Feelings

Agony
Grief
Guilt
Hurt
Remorse
Shame

Disoriented Feelings

Ambivalent
Confused
Disoriented
Flustered
Sceptical
Suspicious
Zany

Unmotivated Feelings

Apathy
Exhausted
Hopeless
Lazy
Lethargic
Powerless

Confidence Feelings

Bold
Confident
Eager
Energetic
Helpful
Inspired
Keen
Powerful
Sure
Strong
Trusting

Sad Feelings

- Low
- Melancholy
- Miserable
- Sad
- Sorrowful
- Weepy

Fear Feelings

- Anxious
- Fear
- Frightened
- Hysterical
- Nervous
- Petrified
- Scared
- Terrified
- Threatened
- Vulnerable

Pleasurable Feelings

- Affection
- Blissful
- Cheerful
- Delighted
- Elated
- High
- Joy
- Pleased
- Loving
- Sexy

Other Feelings

Appendix B

Sample Men's Group Agreement

(from Wilken 2003, pg.154)

In order that I have a safe place for personal growth for myself, and that I help to create one for others, I agree to abide by the following:

1. Confidentiality: Who I see and what I hear stays in the group. There are four conditions under which I waive confidentiality. These are:
 - a. If I threaten to kill myself.
 - b. If I threaten to kill someone else.
 - c. If I am abusing a minor.
If I divulge plans to do any of the above, I would be encouraged to change my mind, however, if I did not change my mind, I understand that the appropriate authorities will be contacted.
 - d. If I have signed a release of information form, I agree that it is in my interest to have my progress discussed with the parties indicated.
2. I agree not to use recreational drugs or alcohol before the meeting, and if I do take something, I will tell the group leader before the group begins.
3. Once I decide to join the group, I will call if I am going to be late or miss a session. I understand this to take responsibility for my actions in my relationships with others.
4. I understand that this group has “crosstalk” – participants make comments and questions about what others say. My input is welcome, although I agree that only one person will talk at a time, and that negative crosstalk about a person's race, origins, religion, social or financial position, physical appearance, political or sexual orientation is unacceptable.
5. I understand that it is up to me to assert myself so that I get the time I need in the meetings, and in my life to maintain my commitments to the group. I understand that the coaching of the facilitator is intended to assist me.
6. When referring to another person, I will refer to him by his first name. By doing this, I make it clearer that I am talking about a human being and not an object. By doing so, I am seeking healthier perspectives and choices on relationships in my life.
7. I will speak about myself and my experiences. To help me do this, I will use “I”, “me”, “my”, etc. rather than “we”, “you”, “you know”, etc. I intend to own my opinions and speak from my experience, not to project these on others.
8. I will mark “no” on the information sheet if I do not want my name on the phone list. If I do not mark “no”, I understand that my name will be on the phone list and people may call me to talk.
9. I agree that violence is unacceptable in the group.

Appendix C

Creating a Testimony

(from Fisher, et al;., 2009, pg. 294-296)

A testimony is a detailed, extensive statement you make about the abuse you experienced. Testimony is usually created by writing it down as a record. You may, however, wish to just use point form notes. This record is for your use – it is your story, for you to share or not. Time will be made for you to share your testimony with the group, but this is not mandatory. The choice is yours.

You may want to create a “first draft” of your testimony, and then add to it at later dates. If you have a computer, you may want to create an ongoing journal. Keep adding to it until you feel your story is complete. You may want your individual therapist to assist you with this. However you do it, you need to prepare for when you share your story with others.

The following questions have been created to help you form your testimony. Each one has a specific purpose. Feel free to add any questions that would be helpful for you. When you plan to present this, bring these notes as a guide. You may want to read what you have written out loud, or respond to questions using these notes as a guide. If possible, bring some pictures of yourself when you were a child to share with your group. You may also want to bring any other representations of yourself and/or your healing journey.

After you share your story with the group, we will conduct a go-round so that all men can speak to what you have shared. If you want particular feedback on an issue, make it clear to the others.

The Questions:

1. Who do you wish to share your testimony with (e.g., just group members, certain friends or family, your individual therapist)?
2. Who do you not wish to share this with?
3. What do you want people to do as you tell them your testimony (e.g., just listen, provide feedback to certain questions, give you affirmations)?
4. What do you need to tell us about the background to your testimony (e.g., what was in your family when you were growing up; where you lived; how old you were; where the abuse took place)?
5. Who do you identify as your abuser(s)?
6. Were there other victims of the abuse? Who were they?
7. What happened to you? (Focus on your experience – with as much detail as necessary to tell your story completely and fully).
8. Is there a part to your story that you have not told to anyone else? (This is the time to disclose any part to your story that you have been keeping to yourself. If you choose not to tell part of your story, share your reasoning with the group members.)

9. How did the abuse affect you? (What did you experience at the time? What was the aftermath?) Categorize your answer: thoughts, feelings, behaviour, relationships, physical health, relationship to spirituality, other.
10. How has your life changed as a result of your participation in (the name of the group) (What are your thoughts, feelings, behaviour, and relationships now? How do you view the abuse? How do you view yourself? Your abuser(s))?
11. What are three major accomplishments in your work with (group name)?
12. What “unfinished business” are you still carrying?
13. What else do you want to say, now that you’ve shared your testimony?

[signature, date, witness signatures]

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Suggested Exercises

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Suggested Resources for Men Sexually Abused in Childhood

This section contains resources that have either been suggested by men who have experienced childhood sexual abuse or by therapists and researchers in the field.

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Suggested Resources for Partners of Men Sexually Abused in Childhood

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Murphy, C. (2010). *When a man you love was abused: A woman's guide to helping him overcome childhood sexual molestation*. Grand Rapids, MI: Kregel Publications.