

MEN & HEALING: Theory, Research, and Practice in Working with Male Survivors of Childhood Sexual Abuse



Prepared for the Cornwall Public Inquiry

by

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www.themensproject.ca

**Men & Healing:
Theory, Research, and Practice
in Working with
Male Survivors of Childhood Sexual Abuse**

A Guidebook

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TABLE OF CONTENTS

| | |
|--|-----|
| FOREWORD | i |
| INTRODUCTION..... | 1 |
| PART I - CONCEPTUAL AND RESEARCH FOUNDATIONS | |
| CHAPTER 1 - A BACKDROP TO MALE SURVIVOR SERVICE DEVELOPMENT | 13 |
| 1.1 A Male-Centred Approach To The Healing Of Male Sexual Trauma..... | 13 |
| 1.2 Cultural Context, Part One: The Socialization Of Men..... | 16 |
| 1.3 The Prevalence And Nature Of Male Childhood Sexual Abuse: A Research Primer..... | 27 |
| 1.4 Cultural Context, Part Two: “Myths” Or Cultural Delusions About Male Childhood Sexual Abuse | 55 |
| 1.5 The Aftermath Of Abuse: Male Sexual Trauma | 67 |
| CHAPTER 2 - SPECIAL FOCUS ON MALE INTIMATE PARTNER VIOLENCE IN LIGHT OF CHILDHOOD TRAUMA..... | 105 |
| 2.1 Why A Special Focus?..... | 105 |
| 2.2 Research Evidence Linking Trauma And Intimate Partner Violence | 112 |
| 2.3 Emotion Theory: The Shame-Rage Link..... | 116 |
| 2.4 Attachment Theory: Understanding The “Intimate” In Intimate Partner Violence | 128 |
| 2.5 Treatment Implications..... | 138 |
| PART II - GROUP PROGRAMMING | |
| CHAPTER 3 - INTAKE AND ASSESSMENT | 152 |
| 3.1 Conducting The Intake Interview | 152 |
| 3.2 Developing A Framework For Assessment And Evaluation | 162 |
| 3.3 Considerations For Serving Diverse Client Populations | 177 |
| CHAPTER 4 - GROUP THERAPY FOR MALE SEXUAL TRAUMA..... | 184 |
| 4.1 The Advantages Of Group Therapy For Male Survivors..... | 184 |
| 4.2 Role Of Individual Therapy And Partner Groups In Relation To Men & Healing Groups..... | 198 |
| 4.3 Structural Elements Of Men & Healing Groups | 199 |
| 4.4 Session Practice Principles | 203 |
| 4.5 The Men And Healing Group Therapist | 214 |
| CHAPTER 5 - MEN & HEALING PROGRAM CONTENT | 221 |
| 5.1 Group Themes..... | 222 |
| 5.2 Remembrance And Mourning..... | 252 |
| 5.3 Reconnection And Moving On..... | 264 |
| 5.4 Men & Healing: A Living Program | 267 |

| | |
|------------------------------|-----|
| ANNOTATED BIBLIOGRAPHY | 269 |
| REFERENCES | 272 |
| APPENDIX A | 272 |
| APPENDIX B | 272 |

FOREWORD

“Our echoes roll from soul to soul and grow forever and forever.”

The words above are from a poem by Alfred Lord Tennyson. In their simplicity and elegance, they provide a reminder about the responsibility we bear toward one another—especially toward our children. Our actions create echoes which, in myriad ways we cannot even imagine, affect countless lives around us.

During every second we are in the company of a child our actions send a ripple into our collective future. Our acts of kindness lead a child to thoughtfulness and caring concern for others. Acts of withholding love create feelings of isolation and despair. Acts that set firm but fair boundaries and limits create a foundation for respect and peaceful coexistence. Acts of neglect teach a child to feel shame. Acts that reveal warm affection inspire feelings of connection, intimacy and belonging. Acts of cruelty or abuse isolate and wither a child's sense of self.

It is humbling to realize that the quality of life we create in our society depends so very much on the way we treat our young. Whether it is against one child or a group of children, the consequences of harm we cause becomes reflected in the social fabric of the larger community. In one way or another, through the taxes we pay, our strained health care system, our child protection services, and the lasting damage done to our everyday social relationships, we all ultimately bear the cost.

We have an obligation to be mindful of our interdependence and the responsibility we bear for one another. This obligation is all the more important when it comes to supporting and assisting people whose lives have been touched by violence and abuse. Victims need to know they are seen, that

we believe them, and that we will act in their interest to prevent further harm. And yet - despite over 30 years of advocacy—we are still uncomfortable acknowledging that children experience unimaginable levels of violence at the hands of their caregivers.

This is especially true for male victims. Men and boys still struggle to find true welcome when they bring forward their accounts of being harmed through abuse, violence and aggression. Despite a growing body of literature documenting the prevalence of male victimization, male survivors are still largely excluded from the national conversation on interpersonal violence. This cannot continue. It is time for us as a society to evolve past narrow interests and gender stereotypes and embrace the fact that unless all victims are welcome at the table then nothing will substantially change in our quest for real and inclusive social justice and peace.

The challenge of supporting male victims is not a project solely for the survivors themselves—it is a responsibility that belongs to us all. Men and boys struggling to cope with the consequences of violence and abuse do not live apart from us and on the margins of society. They number in the millions in this country and look like any men we may encounter. The way we treat male survivors, honour their stories, and support them in their healing contributes directly to the quality of life in our communities. There is no way we can ignore their plight without diminishing our own lives.

Men & Healing represents a clarion call to support male survivors in their struggle to reclaim their dignity and self-respect. The insight, analysis, and intervention strategies contained in its pages provide a foundation upon which to take action and, through action, to create hope for male survivors. The authors have left a legacy that will echo through the lives of countless men and boys. The men and women at The Men's Project have developed extraordinary insight into the male experience of trauma and recovery. They deserve to be

lauded for the kindness and compassion they extend to male victims and the invaluable contribution they have made to our collective well being.

*Dr. Fred Mathews
Author of The Invisible Boy
Central Toronto Youth Services
October, 2008*

INTRODUCTION

It gives me great pride to present *Men & Healing* to you, the reader. *Men & Healing* has been an ambitious project, meant to serve a dual role: a resource compendium aimed at presenting a research-based understanding of male sexual victimization* and its sequelae; and a model of a successful community-based treatment strategy for male survivors. This guidebook is a product of a Phase II Action Research initiative funded by the *Cornwall Public Inquiry*, and it is based on a decade of delivering clinical counselling services for male survivors† operating out of *The Men's Project (TMP)*, one of the few men's sexual abuse/assault treatment centres in Canada.

The past generation of feminist research and advocacy has informed us that childhood sexual victimization creates a myriad of lifelong consequences for female survivors. By the late 1970s, this awareness of the plight of abused women and girls began to inform emerging services and advocacy organizations, particularly through the establishment of sexual assault centres, transitional shelters, and the like. Although the resultant framework of services was dedicated to serving female victims, our understanding of and intervention with male survivors has benefited significantly from this pioneering work.

However, research on men's experience of sexual trauma has trailed feminist research. The acknowledgment that boys and men can be victims of such experiences has only recently been recognized; the psycho-social impact of sexual trauma on men is not well understood; and clinical services for male

* This is a resource for understanding and treating adult male survivors of childhood sexual abuse. Male sexual assault is the term generally used to describe sexual violence against an adult male. The needs of sexually assaulted men are not addressed in this sourcebook.

† A "survivor" is the term that is generally used to refer to those who have been sexually victimized, and is seen as the preferred term for both male and female abuse victims.

survivors are underdeveloped. It could be said that our society's knowledge of male sexual trauma is a generation behind its consciousness of women's experience of trauma.

Addressing this knowledge gap is one of the objectives of this document. Before support and specialized treatment[†] strategies can be created for male survivors, we need to recognize that the sexual abuse of boys and male youth is "common, underreported, underrecognized, and undertreated" (Holmes and Slap, 1998). *Men & Healing* has been developed to address this situation by providing helping professionals with the conceptual and practical orientation needed to assist male survivors in their recovery.

Sexual trauma is typically accompanied by silence. Whether on the level of cultural denial and amnesia, or that of the individual victim's denial and shame, this silence needs to be broken—a prerequisite for healing. Survivors and their helping professionals must enter an intensely personal dialogue that involves safety, trust, and the willingness to explore the depths of the survivors' hellish experiences. And throughout this process a message of hope must be instilled. It is only with hope that we can dare to suggest to victims that their pain can be relieved, and a full life realized. This book then is about hope. It offers a hopeful message to those men whose lives have been irrevocably shaped by "the abuse;" and a hopeful passageway for those service providers who bear witness to their clients and subsequently become the fire keepers of survivors' strength, resilience, and courage.

We must match the hope and dreams of those wounded by offering them not only a route to emotional restoration but also to a sense of meaning in their suffering. The words of the psychiatrist and Holocaust survivor Viktor Frankl come to mind: "what is to give light must endure burning." Part of this

[†] The terms "counselling," "psychotherapy" and "treatment" are used interchangeably in this book.



meaning-making process for the survivor is to develop a sense of self that goes beyond simply having repaired the damage done by trauma. Our collective experience suggests that the journey of healing for a survivor must redefine his manhood within this re-found self. As *Men & Healing* demonstrates, refashioning masculinity offers a route not only for *recovery* but also for *discovery*. By unearthing and reconstructing one's manhood, less hindered by the events of the past as well as the ongoing constraints of the traditional male code, a survivor can truly heal in the fullest sense.

A Brief History of The Men's Project

When Larry Gauthier and I created *TMP* in the mid 1990s, we had little in the way to guide us. While we knew there were incredible gaps in community services for men, there was a dearth of information on how to establish a healing place for men. Furthermore, there was scant literature on how to best deliver these services. We faced a monumental challenge, but over the years we were able to evolve our services with the help of seasoned clinicians along with astute coaching on organizational development. Having cut the cake a year ago to celebrate our tenth anniversary, we can say with confidence that we are true to our tag line: *We help men and their families build better lives.*

Our early social theory at *TMP* could be best defined as "pro-feminist." Our prior work with assaultive men was what connected Larry and me as social work colleagues in the 1980s. The key populations we wanted to serve were male survivors, men who were in need of "aggression containment," and men who wanted greater emotional integrity. However, we were propelled into developing broader service areas than just these. Men who were assaulted in their relationships, men wrestling with compulsive sexual behaviours, homeless men, and other struggling males often came to our doors unannounced, hoping that we could serve their needs as well. Larry and I were preoccupied with



finding an overarching philosophy for *TMP* that would accommodate the experiences of all these men.

We were quite taken by new approaches in therapy emerging out of “the new psychology of men”—a field that says the lives of men are shaped by a conflict between their biological, emotional, and social nature and the rigid, socially recognized “ideal” of masculinity. We found this viewpoint on the social construction of gender to be congruent with feminism, while allowing for a male-specific approach. As such, it helped us think about how to formulate our services. The migration from a pro-feminist ideology to an approach anchored by the new psychology of men is reflected in our mission statement, which includes our goal of providing “innovative counselling and educational services through a *male-centred* approach that honours and respects the experiences of men.”

We came to believe that a male-centred approach to therapy was necessary in order to address the nature of the trauma experienced by sexually and physically victimized men. We recognized, however, that this approach does not, by itself, tell us *how* to do male-centred trauma work. Some of the questions that emerged from struggling with core philosophical and theoretical issues became clear:

- What are the essential challenges in providing a therapeutic service for men, as well as an instrument for broad social change?
- What are the linkages between male survivors of abuse and men who are currently abusive in their adult intimate relationships?
- What are the best strategies for supporting men in their healing journey?

In order to fulfill our mandate of providing treatment to male survivors, Larry and I explored various approaches to trauma recovery over the years to find out what works best. We started with a model of facilitated support-style



programs and evolved to our current integration of psychodynamic and experiential psychotherapeutic approaches. Underpinning this evolution of our services has been a deep awareness of the influence of male socialization in the lived experience of male survivors.

Over the past ten years, our collective clinical capacities grew exponentially, and many of our dilemmas sorted themselves out. We began to understand that trauma has both universal *and* gender-specific features for men and women, and that treatment must be fashioned accordingly. As service providers, we saw that strategies of engagement with male survivors require *both* clinical therapy *and* community intervention. We also recognized that male survivors *and* men who are abusive with their partners often have much in common. In retrospect, our organizational and clinical breakthroughs were actualized only when we were able to break through these either/or dichotomies. Such convergences are expressed throughout this guidebook, in its articulation of both theory about male sexual trauma *and* practical intervention. We have learned much through this struggle.

How to Read Men & Healing

In writing *Men & Healing*, we envisioned a broad readership. While we thought that professional service providers would constitute the majority of readers, we wanted to specifically address counsellors who would be able to take on this work either by creating an initiative specifically for male survivors (such as *TMP*) or by establishing a designated program as part of a larger organization (such as a group run out of a health centre). We have endeavoured to make this document applicable to as many contexts of human services as possible. We hope we have been successful in this regard.



We had four main objectives in creating *Men & Healing*:

- Articulate a male-centred approach to therapeutic engagement with male survivors.
- Provide a thorough and up to date review of the research literature concerning male childhood sexual abuse.
- Explore the linkages between childhood trauma in boys and the expression of male violence in intimate relationships.
- Present a model of therapeutic group engagement with male survivors that is informed by both research and our 10 years of clinical service provision.

The dialectic of theory and practice is reflected in the creation of this guidebook. Readers who have scanned the table of contents, or glanced at the text, will have noticed that *Men & Healing* has two separate yet hinged parts—one on theory and research, and the other on practical aspects of programming. Readers are encouraged to read both parts, as it is by digesting all of the material that the service provider will best utilize this resource.

This approach to theory and practice is also evident in this book's authorship. Andy Fisher is the principal researcher and writer, and the sole author of the first two chapters. In Part 1, Andy has summarized the relevant theoretical concepts and state of the art research as it pertains to male survivors. It is an important, research-intense read. Mark Patton wrote the first draft of the chapters on program formulation and delivery which make up Part 2, drawing on his practical experience with the clinical team at *TMP*. Mark's work was expanded by Andy and me to fully reflect the structure and process of the Men & Healing program. Through this collective approach to the writing of the text, we believe that theory and practice have been merged to give you this unified guidebook.



The Limits of This Guidebook

Despite its breadth and depth, this guidebook on its own is not sufficient to teach service providers how to engage male survivors in either individual or group psychotherapy.[§] If this is the reader's first time venturing into trauma literature or counselling with males, *Men & Healing* will be useful but not sufficient. The reader is strongly encouraged to pursue many of the resources referenced in this text, as well as explore training opportunities regarding trauma and therapy with men. This guidebook is also not intended as an exact manual for delivering male survivor services, but rather as a guide to the reader in establishing services within their own contexts. We have endeavoured to share what we have found valuable in our Men & Healing program, but recognize that this material may need to be adapted to specific settings and complemented by other approaches.

Another critical caveat for the reader who is a service provider is the need to attend to his or her own unresolved issues stemming from childhood wounds. Working with trauma is akin to swimming in the deep end, and is not a casual encounter for either client or counsellor. We believe that personal psychotherapy on the part of the counsellor is a prerequisite for taking on trauma work. In a similar vein, clinical supervision should be seen as a co-requisite for sustaining this work. Vicarious trauma, a chronic occupational hazard of trauma work, needs to be guarded against. In the wise words of Mr. T (an infamous television character from the 1980s): "I can't teach what I don't know. I can't lead where I don't go."

[§] It should be noted that this service model does not address the needs of those men who have been sexually victimized *and* who have consequently offended sexually as adults. The service needs of this population (sometimes referred to as "victims/perpetrators") are unique, profound, and essentially unaddressed by funders and communities alike. It is our experience that "victim/perpetrators" cannot be incorporated into conventional survivor services, and thus dedicated treatment programs are required to serve these individuals and their communities.



A subject matter that is not included in this guidebook is the inherent tensions that exist in the gulf between established women survivor services and fledgling parallel services for males. Newcomers to this field are at times surprised by the gender politics within victim services. Differences of opinion invariably occur regarding priorities, the focus of funding and public education, and engagement strategies. Accusations of bias and discrimination are not uncommon. These tensions frequently mar the relationships between service sectors and invariably retard effective community engagement and dialogue. While a mediation of these interests is no doubt required, the task of finding this philosophical and operational common ground is well beyond the scope of this guidebook.

In conclusion, the authors hope that this resource may provide the inspiration, knowledge, and guidance to fuel initiatives for male survivors in communities across Ontario and beyond. Healing does not take place in a vacuum nor in an atmosphere of indifference. Healthy and vibrant communities require vital services, and vital services must include places of healing for all survivors, regardless of gender. The opportunity to build resiliency is essential for us all—for our children, and for the men and women they become. May we all share in the necessary courage to build the foundations that will sustain us.

Credits

It takes a community to raise a child, and it certainly took a community to write this guidebook.

For co-founding *TMP* with me in 1997, my first kudos goes to my friend and colleague Larry Gauthier, MSW. Another co-founder was the National Capital Region YMCA-YWCA, which believed in *TMP*'s organizational goals and



incubated this initiative to its fruition. Their motto says it all: “We build strong kids, strong families, and strong communities.”

The viability and growth of this agency is attributed to innumerable folks: volunteers, staff, referral agents, sponsors, and donors—all have believed in this agency. One particularly dedicated crew has been our Board of Directors, which guides the vision of this small yet mighty ship. This guidebook originated under the presidency of Peter Gahlinger, was researched under the reign of Bill Staubi, and will be published under Mark Feldstein’s leadership. My blessings go to these three men for the determination they have shown while at our helm.

In many ways, this guidebook is based on the collective direction of its clinical team, whose strength and depth humbles me. Particular thanks go out to Dr. Roy Salole, who has been our Clinical Supervisor since the early days. Roy has provided the safe container for the clinical staff to deepen and sustain its challenging mission. Particular acknowledgement and appreciation goes to Monica Forst, Clinical Associate of *TMP*, who has lent much to the therapeutic depth of the agency, both in terms of direct service as well as through our training services. I am grateful that both Roy and Monica agreed to review this document.

Big kudos also go to Lucinda Thum in her role as project manager for this book. She is truly the proverbial herder of the cats, and kept this project (and the writers!) on track, despite it all.

Particular thanks and praise to my coauthors of this guidebook: Andy Fisher and Mark Patton. Andy had first contact with the agency back in 2001, and it was a fortuitous match. Andy has worked with us as a facilitator of Men & Healing, staff trainer, and staff guide on wilderness retreats. He is now a senior trainer in *TMP*’s training services. Andy’s academic rigour has helped not only to gel our thoughts and theories, but to anchor them in research to boot. We shine in



his brilliance. Mark Patton is a *TMP* clinical staffer who has facilitated our services both in Ottawa and in Cornwall, and is the co-originator of our Phase 1 program. We have benefited from Mark's hand in creating some guiding documents at the agency, and his contribution to *Men & Healing* is a fine addition. He lent his voice to the presentation of not only our model of service but its interior narrative as well. Thank you both.

Much appreciation goes out to two gentlemen external to *TMP*. First of all, big thanks to Fred Mathews, PhD, who kindly wrote our Foreword. Fred is the author of the seminal study *The Invisible Boy*, the first Canadian publication on male sexual victimization. His track record as a psychologist, trainer and consultant is staggering; we owe him much. We are also indebted to Richard Gartner, PhD, who was our external reviewer for *Men & Healing*. Richard, a New York based psychologist, is recognized as one of the leading thinkers in the field of male sexual victimization. He is author of *Betrayed as Boys: Psychodynamic Treatment of Sexual Abused Men* (1999) and *Beyond Betrayal: Taking Charge of Your Life after Boyhood Sexual Abuse* (2005). He is also a past president of MaleSurvivor USA. Richard's review of *Men & Healing* helped to sharpen its clinical focus. Thank you Richard.

Finally, the last credit goes to the hundreds of men throughout the years who entrusted us to help guide their journey from trauma to recovery. The role of witnessing their journey is ever humbling and ever lasting. Many of these men were not aware of their role in pioneering this agency, and this sector of specialized victim treatment services in Ontario. Each came to *TMP* for the same reasons: to be a better father, a better partner, a better person. I hope we never forget these essential tasks.



I remember a participant in a public session commenting that as a society we have “forgotten to look after our boys.” This poignant remark summarizes so much of what this guidebook (and this agency) is about. And so, let us all make a proclamation to never forget these boys again. No victim should ever be forgotten. In so doing, we will all be helping men and their families build better lives.

*Rick Goodwin
Ottawa, Ontario
December, 2008*



PART I

CONCEPTUAL AND RESEARCH FOUNDATIONS



CHAPTER ONE

A BACKDROP TO MALE SURVIVOR SERVICE DEVELOPMENT

1.1 A MALE-CENTRED APPROACH TO THE HEALING OF MALE SEXUAL TRAUMA

The sexual abuse of boys and male youth is both a human experience in general and a male experience in particular. It is human in that childhood sexual abuse is in many respects genderless. Men and women sexually abused in childhood have much in common and there is significant overlap in the psychological and social aftermath they typically go through. It is important not to forget this commonality. At the same time, there are significant differences in the experience of sexual abuse for males. These differences include the nature of the abuse itself and the way that the victimization of males intersects with their gender socialization. Men abused in childhood face a number of harmful “myths,” or as we will call them here *cultural delusions*, that act to amplify their trauma, limit the services available to them, and block their entry into a healing process. For many male survivors getting help is inconceivable.

Bearing these realities in mind, this guidebook adopts a male-centred approach to the healing of sexual trauma. Our approach draws on three sets of literature. The first is that of the “new psychology of men.” This is a body of research and theory that aims to give a truer picture of the actual shape of men’s inner lives than is suggested by traditional stereotypes. The second set of literature concerns the nature of trauma and the trauma- recovery process. Until recently it was generally believed that the sexual abuse of males is rare and in any case not of much consequence. To the contrary, in order to understand the experience of men sexually abused in childhood one must



understand the nature of trauma. Finally, this book draws on the small but growing body of research literature dedicated specifically to the sexual abuse of males. While there are many gaps in the research on male sexual victimization, the findings to date do provide significant data for the understanding and healing of sexually traumatized men. Combined, these three sets of literature provide a realistic, compassionate, and clinically useful account of the lives of male survivors.

This approach parallels and is indebted to efforts made by feminists such as Judith Herman (1992) and Lenore Walker (1994) that combine feminist theory, trauma theory, and research on the abuse of females. The women's movement introduced the idea of gender analysis in psychological research and theory, and gender awareness in therapeutic practice. A male-centred approach applies a similarly gendered perspective to males (Lisak, 1995). In doing so, moreover, it continues the conversation started by feminist scholars and activists by addressing the so-called "feminization of victimization" (Sepler, 1995, cited in Lab et al., 2000) and "masculinization of oppression" (Mendel, 1995). This tendency to associate victimization solely with females and perpetration solely with males was probably an inevitable, and so in a sense necessary, development in the process of bringing the phenomenon of sexual victimization to light. At the same time, the belief that only females are victims and only males are abusers has not served male victims well. The time has thus come to include a male perspective in the discourse on abuse and victimization and in so doing to "combine the voices" of men and women in offering recognition and services to both (Mathews, 1995).

Figure 1.1, The Intersection of Male Socialization with Male Sexual Victimization, indicates the topics that will be covered in the various sections of this chapter. What we will emphasize throughout is that when a boy or male youth is being sexually abused he is at the same time being socialized as a male. These two experiences are very much at odds with one another, setting

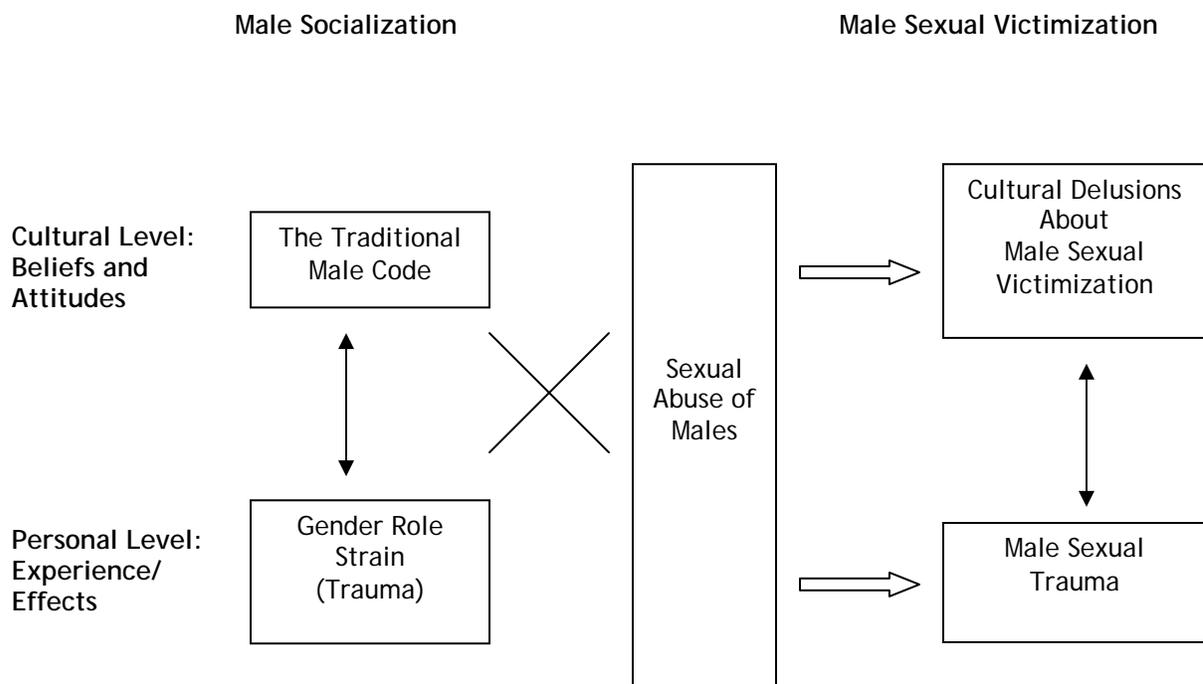


up powerful and damaging conflicts within the abused male—conflicts that clinicians working with male survivors must understand.

Figure 1.1

THE INTERSECTION OF MALE SOCIALIZATION WITH MALE SEXUAL VICTIMIZATION

Prepared by Andy Fisher, PhD



The left side of Figure 1.1 represents the process of male socialization, as formulated by the new psychology of men literature. This topic is covered in Section 1.2. Male socialization is depicted here as the internalizing or cultural inscribing of certain gender role norms that together make up the traditional “male code.” “Gender role strain” (Pleck, 1981) refers in turn to the harmful outcomes for males on a personal level from being socialized according to this code. The concept of gender role strain highlights that, whether sexually

abused or not, being socialized as a male is in itself a wounding experience for most.

The middle of Figure 1.1 indicates that for males sexually abused in childhood the strain of being socialized as a male intersects with their abuse experience. Section 1.3 provides a research primer on the nature and prevalence of the sexual abuse of young males. Section 1.4 then discusses how the intersection of the traditional male code with the phenomenon of male sexual abuse generates that set of myths or cultural delusions (shown on the right side of Figure 1.1) that is harmful to male victims, and instrumental in obstructing the development of services for them. Section 1.5, finally, outlines some of the typical traumatic aftermath that follows this process of being both socialized as a male and sexually abused as a male: male sexual trauma.

We believe that the theory and research presented in this chapter provides a crucial backdrop to service providers working with male survivors. We have therefore placed it ahead of the chapters on programming and service delivery in Part 2 of this guidebook, where the practical significance of the material covered here will be more evident.

1.2 CULTURAL CONTEXT, PART ONE: THE SOCIALIZATION OF MEN

1.2.1 The Traditional Male Code

As discussed above, childhood sexual abuse takes place within a gendered cultural context. In order to understand male sexual victimization we must therefore first understand the *traditional male code*. This refers to the historical rules or standards about the socially approved ways of being male. When men in a group are asked about how they should or shouldn't behave as men they easily come up with versions of this code. The version in Figure 1.2 is



put together from a number of sources, principally David and Brannon (1976). Although the male code varies from culture to culture and place to place, the core elements of self-reliance, toughness, status, aggressiveness, and non-femininity are nearly universal. In his anthropological study of codes of masculinity around the world, Gilmore (1990) concluded that “Man-the-Impregnator-Protector-Provider” is a globally ubiquitous figure (even if some cultures are more “macho” than others). Gilmore offers the simple explanation that in most places life has been a demanding and dangerous business and that hardiness has been required of men as a matter of a society’s survival (see also Levant, 1995).

Figure 1.2

THE TRADITIONAL MALE CODE

| | |
|-------------------------------|---|
| The Rugged Individual: | Men should be emotionally stoic and hide their inner lives. They should be tough and deny their pain (“suck it up”). They should be independent and self-reliant—“rugged individuals.” |
| The Big Man: | Men should be preoccupied with status, work, achievement, conquest, and success. They should be number one, the boss. They should be competent and never fail. They should maintain power and control, especially over women (who are inferior). They should be sexually magnificent, and are sexually eager by nature. They should not be victims. |
| Give ‘em hell: | Men should be active, forceful, aggressive, and fearless. They should see life as a competitive battlefield. They should be physically strong. “Winning isn’t the main thing, it’s the only thing.” |
| No sissy stuff: | Men should reject everything traditionally associated with femininity, including vulnerability, emotion, dependency, passivity, and intimate conversation. Sex should be a purely physical act, not an emotional, relational, or spiritual one. Men should especially reject homosexuality. |



But times are changing. With the rise of the women's movement and reforms in the workplace, the dysfunctional or "dark side" of masculinity has become increasingly apparent (Brooks, 1998). The expectations women have of men have changed, and with more women in the workforce men can no longer rest comfortably in the provider role. There are also fewer "manly" jobs available, as the economy shifts away from manufacturing toward service and information. One positive aspect of this so-called "crisis of masculinity," however, is that the male gender code is widely being questioned rather than taken for granted.

Indeed, both the traditional male code and female code are now being seen as oppressive and damaging, and they are increasingly being linked to traumatic processes. For example, Howell (2002) suggests that in a society pervaded by childhood abuse and neglect, the traumatic effects of these experiences are commonly channeled along gender lines, so that these effects appear as normal features of masculinity or femininity rather than as signs of trauma. Stereotypical male aggressiveness and emotional disconnection, for example, can be seen in this light. Wheeler and Jones (1996) suggest, further, that gender is a "codification or vehicle for shame in our culture," in that internalized shame acts to inhibit each gender from accepting certain modes of experience and behaviour for males and females, which in turn maintains unhealthy social patterns and power relationships.

Finally, it only takes a quick glance at the traditional male code to realize how utterly at odds it is with the experience of being sexually victimized. If our society is to truly address the sexual abuse of males then the traditional male code will have to undergo close examination. This will be a regular theme in the discussions below.

The traditional male code presented in Figure 1.2 is the male code at its most stereotypical or extreme. It may look somewhat absurd when written down,



but men—including, crucially, male survivors currently seeking help—have in fact traditionally been subject to these gender role expectations. Recent research (Levant, 1995) has found that men are generally in a process of redefining this code, sorting out which elements need to be rejected and which are worth preserving. For example, many men still value such traditional male qualities as withstanding hardship and pain to protect loved ones and staying calm in the face of danger. Research has also revealed, however, that many harmful elements of the traditional male code persist (Levant, 1995; Levant and Pollack, 1995). The injunction against having vulnerable feelings is demonstrated, for example, in the common attitude among men of “sucking up” their pain when it would be more functional to express it and take emotional support from others.

Perhaps most in need of comment here is the “No Sissy Stuff” dimension of the traditional male code. “Don’t be a girly man,” says Arnold Schwarzenegger. Indeed, in order to be a traditional man a male has to prove constantly that he is not a woman, in the process of which he projects his rejected “feminine” qualities onto the opposite gender. This then engenders hostility to women and most things typically regarded as feminine, such as emotional expression. It also sets up hostility toward homo/bi/trans-sexuality. As Schwarzberg and Rosenberg (1998) note, men have historically been raised in a culture that is sexist (devaluing of women), heterosexist (heterosexually biased), and homophobic (fearful/hating of homosexuality). Regarding homophobia, they observe:

...fear and hatred of gay men have at its core a terror regarding homosexuality’s unconscious equation with femaleness and femininity. Male homosexuality, as epitomized by anal penetration, can stir a man’s deep fear of emasculation and “getting fucked.” As such it elicits a much sharper phobic response than female homosexuality (p. 270).

Sexism, heterosexism, and homophobia/transphobia thus all converge in the injunction against the feminine. We note this point here because of its obvious



relevance to the experience of being sexually abused as a young male, whether one later identifies as heterosexual, gay, bisexual, or transgendered.

1.2.2 Gender Role Strain

The notion of gender role strain has emerged to conceptualize the psychological and interpersonal trouble caused by traditional gender codes. *Gender role* refers to the set of characteristics and behaviours that are stereotypical for each gender in playing prescribed societal roles. *Gender role strain* refers to the negative effects of this traditional gender socialization. Pleck (1981, 1995) introduced this term in the early 1980s as a way to help overturn the previous model of gender (which he called “gender role identity”) that rooted the male code in the biological needs of men rather than in the dictates of culture. The shift, in other words, is toward the view that males and females share the same basic humanity but that cultures obscure this sameness through their enforcement of gender codes. Ironically, then, one of the aims of the male-centred approach we are presenting here is to say that, apart from their socialization, males and females are really not so different. Pleck identified three categories of gender role strain.

Discrepancy Strain

For a male, discrepancy strain refers to the distress he feels when he fails to live up to his internalized ideal of manhood, i.e., when he experiences a discrepancy between his ideal male self and his actual self. The effect here is that a feeling of failure haunts most men to some extent. Indeed, a chronic sense of personal inadequacy has been described as the birthright of all American males (Woolfolk and Richardson, 1978, cited in Pleck, 1981).



The emotional consequence is that many men feel to some degree lacking or ashamed of themselves as men because of the impossibility of living up to unrealistic gender role expectations. Shame is the emotion we experience when we don't measure up to an ideal sense of self. Thus, the more psychologically invested a man is in traditional gender concepts the more shame he will experience, even if only implicitly, when his actual self falls short of the ideal. He may then develop characterological defenses against having his shameful inadequacies revealed, such as "macho" attitudes and poses (Krugman, 1998).

One example of discrepancy strain that shows the persistence of the traditional male code is the trend toward increasingly muscular images of men in mass culture. Pope et al. (1999) suggest that this indicates a harmful evolution in American cultural ideals of the male body image. They tracked changes over the last few decades in popular male action toys—GI Joe and Luke Skywalker—as an index of this evolution. As they note, "the contemporary GI Joe dwarfs his earlier counterparts with dramatically greater musculature and has an expression of rage which contrasts sharply with the bland faces of his predecessors" (p. 68). This trend toward increased muscularity in images of ideal men is not unrelated, they suggest, to the body image disturbances now commonly found among men. These disturbances include "muscle dysmorphia," where the individual develops an obsessive preoccupation with their muscularity. Body image problems have well-documented links to a sense of inadequacy, low self-esteem, or shame.



Trauma Strain

Trauma strain refers to the traumatic effects widely experienced by males in the normal processes of male socialization.** This is a particularly important area of strain to identify given the close relationship suggested above between gender and trauma. We will touch here on some of the main areas of normal male trauma recognized to date.

The first is trauma experienced through the binding of emotional expression in infancy and early childhood. Numerous studies (see, e.g., Bronstein, 1984; Levant, 1998; Pollack, 1998) have revealed that parents and peers actively discourage male infants and children from expressing vulnerable or caring emotions through a variety of processes such as ignoring them when they are upset, directly shaming them for being a weakling, and teaching them that “big boys don’t cry.” Most males thus learn to cut themselves off from or neutralize their “feminine” emotions at a very early age, and this is now considered to be a highly traumatic experience for them (with this trauma becoming largely invisible precisely because the emotions that would express it are eventually extinguished).

While it is common to laugh at men for being emotional dolts, studies have shown that male infants are actually *more* emotionally expressive in general than females. The “crossover in emotional expression” (Haviland and Malatesta, 1981; cited in Levant, 1998) that occurs in early childhood, then, is accomplished through traumatic socialization. One of the consequences of this is that many men subsequently feel empty inside, their emotions gone, as if

** This is not to say that all boys experience trauma through their socialization that is severe enough or of a nature to develop a posttraumatic stress syndrome or disorder (PTSD). According to its Greek origins, the word trauma simply means “wound.” In this context, then, we are saying that traditional male socialization wounds males—by cutting them off from significant portions of their inner lives, isolating them emotionally from others, and so on. Generally speaking, trauma may be defined as an “inescapably stressful event that overwhelms people’s existing coping mechanisms” (Van der Kolk, 1996d, p. 279).



their core self has just been hollowed out. Another consequence is that because they have learned early to go to war with their own emotional needs most men have difficulty putting words to emotions, a condition known as “alexithymia” (“a” meaning *without*, “lexus” meaning *words*, and “thymos” meaning *emotions*) (Levant, 1998).

A second area of trauma that has been studied is the early separation of boys from their mothers. Girls have traditionally been encouraged to maintain their closeness to their mothers while boys have been pushed to make a break. Pollack (1995) calls this the “traumatic abrogation of the early holding environment” (p. 41), in that the boy experiences a deep sense of loss and abandonment from being prematurely forced into independence. In disidentifying from his mother and denying any dependency on her, the boy learns to devalue not only her but intimacy and connection in general. This rupturing sets up for the male a lifetime of feeling insecure and cut off from the world and of being dissociated from his dependency longings that are now bound in shame. It is easy from this to see why masculine identity development has been described as involving a “successive unfolding of loss,” as opposed to a genuine development or growth process (Real, 1997, p. 130).

A third area of trauma for males is the pervasive violence within male culture. This violence is so omnipresent and unquestioned that it appears natural. A large scale study of children and adolescents found that about half of the boys had experienced some form of violent victimization (Boney-McCoy and Finkelhor, 1995; cited in Howell, 2002). Indeed, a sizable portion of male childhood experience involves being on the receiving end of a fist in the schoolyard, a humiliating initiation on a sports team, or some other anti-social act. The “boys will be boys” attitude minimizes the actual trauma many boys are experiencing.



The violence males experience is not always physical but is often emotional. Here is the voice of one participant in a study of sexual abuse speaking of his experience as a male *independent of* his experience of sexual abuse: “I was a very thin child with very curly light brown hair and I was called a f— [*sic*], a girl, um. A sissy, um...And that just destroyed myself, my sense of self, just I mean brutal [trails off]” (Alaggia, 2005, p. 462)

Finally, it has been observed that for certain populations of males the socialization process is particularly severe and traumatic. This includes professional athletes, men in the military, men of colour, and gay/bisexual men. Regarding the gay male, for example, Cassesse (2000) notes: “Psychological trauma is a relentless, chronic reality in the life of the gay child” (p. 6). Subject to constant rejection, ridicule, violence, and stigmatization for traditional male code violations, the gay child may accept his culture’s view of him as a deviant without gender status among his male peers. Unable to find support for the emotional pain and humiliation of this experience, and typically lacking a secure emotional base within his own family, the gay child’s identity is thus “*forged* in a traumatic context” (p. 8).

Dysfunction Strain

The third category of gender role strain, dysfunction strain, is where the crisis of masculinity is most evident. This refers to the negative consequences for men, and for those around them, when men successfully fulfill gender role standards that prescribe dysfunctional or harmful behaviours. Whereas discrepancy strain refers to a failure to live up to the traditional male code, dysfunction strain occurs when a man actually does meet the standards or over-conforms to them. Because other people are then harmed by the man’s actions, this area of strain highlights the so-called “collateral damage” of male socialization.



Drawing principally on the work of Brooks (1998), we present below a list of significant categories of dysfunction.

Physical violence. Unsurprisingly, research indicates a strong link between masculine identity and aggression, violence, and conduct problems in men (Cohn and Zeichner, 2006).

Sexual Aggression. Rape, sexual assault, and sexual harassment have similarly been linked to masculine attitudes. Rates of sexual harassment, for example, are highest in those work environments where women have traditionally been underrepresented (Brooks, 1998).

Nonrelational Sexuality. Male socialization tends to foster a fear of emotional closeness with women and an objectification of them, both of which make for sex lives that are lacking in genuine intimacy. This contributes to men's involvement in the sex industry, including the consumption of pornography that degrades women. Nonrelational or impersonal sex is not confined to heterosexual men, however, but is also common among gay men (Scrivner, 1997).

Substance Abuse. Though not restricted to men, drug and alcohol abuse has been described as a "male" problem because of the much higher rates of substance abuse among men compared to women (studies indicating rates ranging from 4 to 6 times higher for men than women) (Brooks, 1998). There are several factors in traditional male socialization that contribute to substance abuse, but perhaps the most significant is the use of emotional numbing as a coping style.

High-Risk Behaviour. High-risk behaviours—extreme sports, high-speed driving, ignoring workplace safety precautions, gun play, etc.—fit into the social



demand that men be fearless. Socialized to numb themselves, such behaviour also help them feel alive.

Suicidality. In Canada, the rate of completed suicides for males is about four times higher than that for females (Statistics Canada, 2005). Krugman (1995) links suicide in men to a bypassing of shame: “As in other situations, males, when faced with unbearable shame, move into action to discharge the tension and escape the profound sense of despair. Suicide, like domestic violence and assaults on peers, is an attempt to transform the helpless passivity that threatens their core identification as males” (p. 120).

Absent Fathering. Traditional men are often uninvolved with and emotionally distant from their children. This leaves children hungering for a father who was never there. This is an especially common theme among men, where the absence of a father constitutes another major hole in their lives.

Inadequate Partners. Verbal closeness, emotional intimacy, and a housework ethic are not traditional male qualities. This tends to make for inadequate partnering. Men often exhibit “defensive autonomy” (Pollack, 1995), where they deny their yearning for closeness by exaggerating their sense of independence, all the while relying on their female partners to take care of their emotional lives. Many men also possess what has been called “destructive entitlement” (Boszormenyi-Nagi and Ulrich, 1981, cited in Levant, 1995), which refers to an unconscious belief that one can exploit or take from others more than one gives, in order to compensate for one’s childhood emotional losses. Socialized to be providers, finally, men commonly become absent workaholics.

Health Problems. Taught to be invincible and to deny their vulnerability, traditional men are much less likely than women to get a medical check-up or practice preventive medicine. They tend to ignore warning signs of sickness



because the sick role is unmasculine and because they are uncomfortable with passivity and dependence. The traditional Western male diet has often been bad for their health, as has much traditional male behaviour, such as high-speed driving and drinking contests.

We have provided this overview of male socialization—through the lenses of the traditional male code and gender role strain—in order to set up discussions below about how the sexual abuse of young males intersects with their experiences within a gendered cultural context. We turn, next, to the research on male sexual victimization itself.

1.3 THE PREVALENCE AND NATURE OF MALE CHILDHOOD SEXUAL ABUSE: A RESEARCH PRIMER

1.3.1 Research Problems and Problems with the Research

The Need for Research

It is sad that we need a fleet of social scientists to help us perceive the phenomenon of male sexual victimization. Hopefully, however, this research will ultimately provide a more detailed and realistic picture of males and male sexual victimization than we have to date. The issue of male childhood sexual abuse seems to present two broad research problems. The first concerns the hiddenness of the phenomenon and the challenge of bringing it to light. The second concerns the need to test and/or challenge certain widely held beliefs about male sexual victimization that contribute to this concealment, and which in most cases turn out to be false.

Regarding the first general area of research, it has been observed that the abuse of male children has been less recognized and often taken less seriously



than the abuse of female children. One reason for this under-recognition is that the mandate of child protection agencies directs attention primarily toward abuse occurring within the family, whereas most cases of male childhood sexual abuse appear to take place outside the immediate family system (Crowder, 1993).

It may also be the case that male victims are perceived as being less vulnerable and in need of less care than female victims. In one study, for instance, it was found that male victims of sexual abuse were five times less likely to be removed from their homes than female victims (4% versus 20%) despite evidence that the male subjects had been subject to more severe abuse (Pierce and Pierce, 1985). In a literature review of male sexual abuse research, Holmes and Slap (1998) found other studies that likewise reported poor management with respect to the recognition, reporting, evaluation, and treatment of boyhood sexual abuse.

Lisak (1993) notes that although studies on the abuse and neglect of children have acknowledged the existence of male victims when they are still children, these males have until recently disappeared in the research literature after they became men (i.e., fully gendered males). In other words, at a certain age male victims crossed an “invisible gender line” and were no longer recognized as victims. Thus there has been a research “blind spot” (Lisak and Luster, 1994) in need of correction.

Studies by Holmes et al. (1997) and Lab et al. (2000) on attitudes and practices in mental health settings also reveal that mental health professionals routinely fail to recognize a history of sexual abuse in men. Mental health professionals are less likely with a male (as compared to a female) to: hypothesize a sexual abuse etiology; ask about a possible history of abuse; and believe their accounts. The way such professionals respond to disclosures by males of childhood sexual victimization is also more likely to contribute to the denial of



the experience as being abusive. This is especially the case when the abuser is female (Ford, 2006).

Watkins and Bentovim (1992) list a host of factors contributing to the under-reporting of male sexual victimization, from the victim's own fear of being viewed as homosexual to a wide range of familial factors (e.g., victim blame) and cultural factors (e.g., denial of female, father-son, and child-child abuse). In sum, mental health professionals, families, and victims themselves are all subject to the same harmful attitudes and false beliefs about the sexual abuse of males. Hence the need for that second general area of research, on cultural delusions, as discussed in more detail in section 1.4.

Problems with the Research Literature

As Hopper (2007) suggests, it is important for clinicians to have some grasp on the research literature on male sexual abuse—so that they can be knowledgeable with clients, bring a critical eye to various research reports, and challenge widespread misconceptions about male sexual victimization. Social science research is, however, a tricky business at the best of times, dealing as it does with the elusive inner meaning of things. In the arena of human psychology, moreover, things are often not what they seem. This is especially the case with the sexual abuse of males, a phenomenon made hazy by cultural blindness, denial, secrecy, self-deception, dissociation, and amnesia. The question arises as to whether the research process itself has sufficient psychological power to see through to the hidden reality of male sexual victimization.

The best way forward seems to be to take a critical approach to the research and then draw conclusions carefully. Goldman & Padayachi (2000) discuss the problems with incidence and prevalence research for childhood sexual abuse in



general; while Violato & Genuis (1993), Dhaliwal et al. (1996), Holmes and Slap (1998), and Hopper (2007) discuss the problems with male sexual abuse research in particular. In our reading of this literature, four problematic areas with the research stand out.

Defining Sexual Abuse

The definition of sexual abuse is the most important factor in research outcomes, yet there is little agreement on, or consistency in, the definitions used. In their extensive review of the research literature, Holmes and Slap (1998) categorized the definitions used in studies in three ways: subjective, where the person is simply asked if they were abused; objective, where specific acts are identified or exemplified; and non-existent, where no method of asking about the abuse is indicated, e.g., child protection records. Additional criteria used in determining abuse included an age differential (where the age difference may be unspecified, e.g., adult/child; fixed; or graded depending on the age of the victim), use of coercion, a negative reaction to the abuse by the victim, perpetrator as an authority figure, physical contact, and penetration.

Debate exists as to how broadly to define abuse, some limiting the term to only the most severe forms involving physical contact, others arguing that even non-contact forms of abuse (such as exposure of genitals, sexual threats, or repeated exposure to or involvement in the making of pornography) are still exploitative and can have negative long-term psychological and interpersonal effects (Hopper, 2007).

Discussion has also recently emerged over how to define abuse by females, as this abuse can be disguised as affection or childcare (e.g., bathing a male beyond an appropriate age) (Ford, 2006).



Finally, some disagree with the definition of abuse as an “unwanted” sexual act, as many males will rationalize that they wanted or enjoyed the experience. This may be explained by the fact that they have difficulty perceiving themselves as victims, were “groomed” into the experience, had visible physiological reactions such as an erection or ejaculation, or were abused by a female or, if growing up gay, a male. Holmes and Slap (1998) thus recommend giving consideration to defining sexual acts as abusive even when the victim perceives them as non-abusive or normative.

Data Collection

How data are collected also affects the outcome. For example, when multiple questions are asked about a possible abuse history, higher prevalence rates are generally found compared to when fewer questions are asked. Questions about specific concrete sexual acts similarly result in higher prevalence rates than vague questions. Qualitative studies with extensive interviewing of subjects reveal more information and depth of meaning than quantitative studies, though because of the typically small sample sizes provide weaker generalizations.

Also of concern to the collection of data is the manner in which the data are collected. Holmes and Slap (1998) report a study in which a prevalence rate of 6% was determined from chart reviews of a sample of male psychiatric inpatients, whereas face-to-face interviews with the same population resulted in a rate of 26%. This latter number may still be an underestimation, however, given the fact that, for men, face-to-face interviews generally result in lower prevalence rate estimates than do more anonymous methods—whereas face-to-face interviews with women tend to yield higher rates (Hopper, 2007). This may be because in face-to-face situations men more easily “lose face” for having been abused. In a study of Canadian university students, Bagley et al.



(1991) found the prevalence rate to vary depending on whether the questioning was done via computer (14%) or paper (8%).

Another significant data collection issue is whether the study is retrospective or prospective, as the former relies on the (often unreliable) memory of adults.^{††}

The Populations Studied

Populations studied by researchers of male sexual victimization include college students, clinical populations (hospital records, psychiatric inpatients or outpatients, men in therapy), the “general community” (which nonetheless excludes certain segments of society, such as the homeless), sex offenders in prison, children found in child protection records/case studies, “convenience” samples such as men found at a Gay Pride event, and so on. Depending on which population researchers choose, the findings will be skewed one way or another. Samples of college students, for example, will usually have a higher socioeconomic status and lower ethnic diversity than a general population sample. Each study must be read, therefore, in light of the particular population and sample size.

Persistent Under-Recognition and Concealment of Male Sexual Victimization

The under-recognition of male sexual victimization is what has prompted research on this topic in the first place. Overcoming the concealment of the sexual abuse of males is, however, a significant research challenge. Consistent with their cultural training, males are more likely than females to minimize or deny their abuse experience due to fears of stigmatization. The victim may also

^{††} Retrospective studies gather data by looking backwards, discovering what has already happened. Prospective studies, by contrast, gather data by looking forward, seeing what outcomes follow from a known initial event. Thus retrospective studies of childhood sexual abuse typically ask adult subjects to recall childhood events; while prospective studies study the aftermath for subjects with documented histories of childhood sexual abuse.



simply not see the event as being abusive, especially when the abuser was female, despite clear evidence of harm. Holmes et al. (1997) quote a British study by Boyd and Beail (1994) that demonstrates how the sexual abuse of males is often labeled by victims as harmless “experimentation.” “In one such instance, they outlined the case of a man with a 39-year history of severe psychological problems, which dated back to his being repeatedly anally raped and orally penetrated by older boys. He described these incidents to his therapist as ‘horseplay’” (Holmes et al., 1997, p. 76). In another study, a recovering male sex addict told the interviewer when asked if he had been sexually abused in childhood that he was one of the “lucky ones” who was spared. When asked later in the interview about his first sexual experience he said “That was when my uncle started masturbating me at age five” (Carnes, 1991, p. 109).

A study by Lawson (1993, cited in Holmes et al., 1997) suggests that long-term therapy may be required for a man to feel enough trust with his therapist to disclose that he was abused by a female. If this is so, we can speculate that research may fail to fully detect such abuse.

Finally, psychological defenses such as dissociation and repression may simply remove the abuse from the explicit consciousness. Cassesse (2002) suggests along these lines that dissociation among survivors at the very time of the research interview or questionnaire may contribute to underreporting.

While these research problems need not stop us from drawing on the literature, they do need to be kept in mind. The wide range in reported prevalence rates, for example, has in all likelihood more to do with methodological factors than with differences in actual prevalence between population samples. Hopper (2007) argues that there are in general more reasons to suspect underestimation of prevalence than overestimation. Research reporting



prevalence rates on the low end of the range should therefore, he suggests, be viewed cautiously.

1.3.2 Prevalence of Male Childhood Sexual Abuse

Canadian Studies that Sampled Community Populations

We first consider noteworthy Canadian studies that sampled community populations, as researchers often consider these to be the most representative kind of sample. We discuss the studies in some detail in order to indicate the complexity of the research and to stress that unqualified quoting of prevalence rates can be misleading.

The Badgley Report (Badgley et al., 1984)

The Badgley Commission (Badgley et al., 1984) was a landmark study on sexual abuse that included a survey drawing from 210 communities across Canada. The survey had a relatively large sample size: 2,135 men and women, aged 18 to 85. It questioned respondents about their recollections of four forms of “unwanted” sexual experiences: sexual exposure without touching; threats to have sex; sexual touching without penetration; and sexual penetration, attempted or achieved through force. Using these four categories, 31% of men and 54% of women were determined to have histories of unwanted sexual experiences, with approximately 4 out of 5 of these experiences occurring before the age of 21.

Bagley (1988) reanalyzed the data from the Badgley Commission due to perceived weaknesses in the study.^{††} He restricted the definition of abuse to the two categories involving physical contact (regarding these as the “more

^{††} Note: despite the close resemblance in their names, these are two separate researchers.



serious aspects of sexual assault”), as well as to incidents occurring prior to the age of seventeen. Following these changes, as well as some data pruning (reducing the sample of men to 935) he determined a prevalence rate for males of 8.2% (17.6% for females).

Having determined these lower prevalence rates, however, Bagley then emphasized that, for a large number of significant methodological reasons, he believed that the revised rates “are almost certainly an underestimate of the amount of abuse.” For example, because the survey questionnaire had a relatively complex/flawed structure and no supervision was provided for completing it, a certain percentage of severe incidents of abuse were likely not reported and functionally illiterate respondents likely under-reported their abuse histories. From Bagley’s reanalysis, then, it can be concluded that the prevalence of childhood contact sexual abuse of males in Canada is greater than 8.2%, though it is not possible to say by how much.

Bagley also highlighted the fact that respondents who were between 18 and 23 years old at the time of the Bagley survey reported a much higher prevalence of childhood contact abuse than the older male respondents: 25.3% (using Bagley’s criteria). Bagley cited a number of other studies that also discovered a much higher prevalence rate of childhood sexual abuse among young adult versus older subjects. He noted that these higher prevalence rates could be due to more accurate reporting; a sampling error; or an actual historical increase in prevalence due to changes in family structure and other factors. He favoured the idea that prevalence rates were actually increasing, concluding therefore that “repeated surveys of random samples of young adults are by far the most valuable research technique.”

Bagley also reported the “surprising finding” that 18% of the perpetrators against males were female, including both teenagers and adults.



Bagley, Wood, and Young, 1994

Following Bagley's recommendation for sampling young adults, Bagley, Wood, and Young (1994) completed a community study in Calgary of 750 men aged 18 to 27 years old about unwanted sexual contact under the age of 17. This revealed a prevalence rate of 15.6% (versus 32% in a parallel sample of women), with 6.9% of respondents having experienced multiple episodes (versus 6.8% in the female sample). As discussed above, defining sexual acts as "unwanted," as was done here, may lead to an underestimation of prevalence.

Ontario Health Supplement (MacMillan et al., 1997)

The Ontario Health Supplement was a study that re-interviewed a random subsample of respondents from a general health survey, the Ontario Health Survey. The sample was very large (9,953). The study determined a prevalence estimate of childhood sexual abuse of 4.3% for males and 12.8% for females. MacMillan et al. (1997) recognized that these numbers are on the low end of the range for both males and females, and offered that this is "most likely because the period of abuse was restricted to 'while the person was growing up' and perpetrators were restricted to adults only" (i.e., versus children and adolescents as well). They comment that the survey's vague wording regarding age at the time of the abuse (i.e., "when you were growing up") may have caused the survey to miss those abused as adolescents. We may speculate about other factors contributing to a low prevalence estimate (such as a lack of detailed questioning and a low overall response rate, where non-responders were more often male than female), but the comments by MacMillan et al. themselves suffice to introduce a note of caution regarding their findings.



Literature Reviews

Research findings are often contradictory and difficult to compare due to methodological differences. Literature reviews attempt to sort out some of the confusion. We discuss a few literature reviews here with respect to prevalence rates, and return to them below when discussing further aspects of male sexual victimization.

Holmes and Slap, 1998

Holmes and Slap (1998) reviewed 166 studies, representing 149 samples. They found prevalence rates for male sexual victimization ranging from 4% to 76% depending on the definition used and population studied, though they also stressed the poor quality of most of the studies. Their discussion of the gender of the abuser suggests further the variability of findings:

Large-sample studies reported that 53% to 94% of perpetrators were men, with up to half of female perpetrators being adolescent-aged baby-sitters. Small-sample studies revealed a similar predominance of male perpetrators. [...] Studies of children and young adolescents reported that more than 90% of the perpetrators were male. Studies of older adolescents and young adults reported lower rates of male perpetrator abuse (22% to 73%), and rates of female perpetrator abuse from 27% to 78%. Studies of adult samples reported intermediate male perpetrator rates of 63% to 90% [10-37% female] (p. 1857).

The authors recommended that definitions of abuse incorporate perpetration by females more carefully, especially when the coercion is passive and thus not as obviously abusive.

Mendel, 1995

Mendel (1995) provides a lengthy discussion on the under recognition of male childhood sexual abuse. For example, he cites a study (Tobias and Gordon,



1977) in which a survey of schoolchildren (grades 4 to 9) revealed approximately equal rates among male and female children of sexual activity with an older child or adult. Male children, however, constituted only 17% of the total sexual abuse cases reported to police in the same year.

As with Holmes and Slap (1998), Mendel stresses that the rate of female perpetration is likely much higher than generally believed, and suggests that prevalence studies will underestimate it unless questions are specifically designed to identify female-perpetrated abuse. In his own study of 124 men in therapy, 60% reported childhood sexual activity with a female (46% with both males and females and 14% with females only).

Finally, because only the most severe forms of sexual abuse of males generally tend to get recognized, Mendel stresses that the rates for noncontact and milder forms of contact abuse are likely much higher than is generally believed. Considering these and other factors, he concludes that “somewhere in the range of one in five to one in eight men appears to be a reasonable approximation” (p. 47) for the prevalence of male childhood sexual abuse.

Ford, 2006

Ford (2006) conducted a review of literature on women who sexually abuse children. Until the mid-nineties it was commonly believed, even among researchers, that female perpetration is exceedingly rare and committed primarily by women with serious mental illnesses or coerced by a male partner. With more accurate data emerging, this view is changing. Ford found that while many studies report that a low percentage of perpetrators of sexual abuse against males are female, a certain number do indicate relatively high percentages. For example, she cites Finkelhor’s (1986) conclusion that females account for 20% of the sexual abuse of boys (and 5% of the abuse of females). She also reports her own finding that 35% of boys calling a British children’s



phone helpline about sexual abuse were calling about female abusers, 17% of which were mothers.

These studies notwithstanding, Ford stresses the uncertainty surrounding research on female perpetration, given both the ease with which abuse by females can be disguised and the resistance by society to recognize female perpetrators. The traditional female gender role includes the care and nurturing of children, and so does not make much cognitive space for the possibility of women child abusers. Female perpetration likewise does not square with feminist explanations of sexual abuse that directly link it with patriarchy or male domination.

Noting that criminality has traditionally been viewed as a masculine trait, Ford refers to Worrall's (1990) observation that in order to consider women as abusers they must be seen as either "not women" or "not criminals." She notes that the latter route is often taken. One judge, for example, justified the dropping of charges against a woman who admitted to sexually abusing her children with the following statement: "Women don't do those kinds of things, especially in this community. Besides, the children need their mother" (Allen, 1990, cited in Ford, 2006, p. 18).

Ford also cites research indicating that even when there is clear evidence of sexual abuse by females; police officers tend to "reconstruct" events into images consistent with gender stereotypes. Thus the abuse is minimized, the female offender is portrayed as harmless, and male victims are viewed as being more to blame. Furthermore, because men are socialized to view almost any sexual contact as a good thing, sexual abuse by women is easily reframed as sexual initiation.



Other Noteworthy Studies

A number of other studies are noteworthy for either their method or large sample size.

Lisak, Hopper, and Song (1996)

Lisak and his associates put considerable effort into designing their research so as to minimize the factors known to result in underestimations of abuse prevalence, while also not biasing their research toward overestimation. Using a sample of 595 male college students they determined a prevalence rate of 17% for contact sexual abuse and of 28% when noncontact abuse was included. Sixty-one percent of victims were abused by a male, 28% by a female, and 11% by both males and females.

Dube et al. (2005)

Dube et al. (2005) conducted a survey using a very large community sample (17,337) of men and women members of a health management organization (HMO) in San Diego, California. Their data revealed a prevalence rate for contact abuse of 16% for males (25% for females). They also found that male victims reported abuse by a female 40% of the time.

The LA Times Poll (Finkelhor, 1990; Gordon, 1990)

As reported by Finkelhor et al. (1990) and Gordon (1990), the LA Times Poll is the largest national general population survey on childhood sexual abuse conducted in the U.S.A.: 2,626 men and women 18 years of age and older (1,145 men). A survey conducted by phone, it revealed a prevalence rate of 14.4 % for males for contact abuse and 16% when noncontact abuse was included (27% for females). Contrary to Bagley's hypothesis regarding a recent



rise in prevalence rates, there was no evidence of a change in prevalence with the age of the respondent. Female perpetrators accounted for 17% of the abuse of males. A number of factors associated with underestimation of prevalence were present in this study, including vague questioning and the respondent's having to view the sexual activity as being abusive.

Whitfield et al. (2003)

Whitfield et al. conducted another recent survey via a San Diego HMO, using a sample of 8,629 men and women (3,955 men). Data revealed a prevalence rate for men of 17.1% for contact abuse (24.3% for women). The survey involved no detailed questioning about the abuse experience, which may have resulted in some underestimation.

Summary

What, then, is a realistic estimate for the prevalence of male sexual victimization? The current conventional wisdom among a number of researchers and clinicians (e.g., Briere, 1996; Gartner, 1999; Hopper, 2007) is that approximately 1 in 6 males are sexually abused in childhood. When noncontact abuse is included the prevalence is higher still (e.g., about 1 in 4 in the study by Lisak, Hopper, and Song [1996]). We believe the 1-in-6 rate is a fair estimate using existing data, but have included the foregoing discussions so that the basis for this view is clear. In any event, the sexual abuse of male children is without doubt a common occurrence.

There does not yet appear to be a convergence of opinion on what percentage of men sexually abused in childhood had female abusers (whether abused by females alone or by both males and females). However, roughly 20% does not seem an excessive working number, especially given the much higher



percentages found in some studies and the widely held belief that female perpetration is underestimated. If female perpetration is under-detected in current research findings, then the overall estimate of abuse prevalence will rise as additional cases of female perpetration are included in the data.

Specific Sub-Populations

Prevalence estimates of abuse for the general population of men obviously may not reflect the prevalence among particular sub-populations. Research is generally weak here, though we mention below some of the populations where the prevalence rate for childhood sexual abuse is likely higher than that for the general population. Other sub-populations at high risk undoubtedly exist. As with the case of female perpetration against males, the inclusion of data from these populations (where normally missed) would therefore raise overall prevalence rates. In Chapter 3, we discuss further the importance of being thoughtful about the needs and reality of different sub-populations entering counselling services.

Gay and Bisexual Men, or Men Who Have Sex With Men^{§§}

Having reviewed data from North America and elsewhere, Dorais (2004) concluded that approximately 20% to 40% of gay or bisexual men have histories of childhood sexual abuse. Noteworthy is a study by Paul et al. (2001) which surveyed a large (2,881) community sample of men who have sex with men. Using multiple questions and a definition of sexual abuse that required the use of coercion and physical contact, the authors found a prevalence rate of 20.6%. In their study of 1,001 gay and bisexual men attending STD clinics, Doll et al.

^{§§} The term “men who have sex with men” is sometimes used instead of “gay” and “bisexual” because it refers to same sex activity rather than to sexual orientation. It would include men who identify as heterosexual but who as part of the aftermath of their sexual abuse have sex with other men. When citing research literature, we use the terms adopted by the researchers themselves in each case.



(1992) found that 37% had been “encouraged or forced to have sexual contact before age 19 with an older or more powerful partner.”

Aboriginal Men

The rate of sexual abuse among Aboriginals is widely held to be higher than in non-Aboriginal populations. Many commentators trace this to the history of colonialism, including deliberate policies to assimilate Aboriginals to European society through undermining traditional values, practices, and beliefs. In particular, the reserve system and residential school system are seen as playing a central role in breaking down traditional norms, standards, and mechanisms of social enforcement. This created the conditions for sexual violence and other social problems to escalate (Hylton, 2002).

Large numbers of Aboriginals are known to have been sexually victimized at residential schools, notably by priests and nuns. Hidden away from the eyes of society, many of these schools were scenes of horrific abuses against Aboriginal children (Hylton, 2002). The nature and degree of sexual, physical, and other forms of abuse at specific residential schools varied widely. Some reports suggest that all the children at some schools were sexually abused (Canadian Psychological Association, 1990, cited in Hylton, 2002). Thousands of civil cases are currently before the courts.

Despite the recognition of epidemic levels of sexual abuse in Aboriginal communities, there has been little systematic study of incidence rates. One estimate, however, is that approximately one third of Aboriginal males and one half of females have been sexually victimized (Bopp and Bopp, 1998, cited in Hylton, 2002). Research on more specific populations has yielded some very high numbers. A study in the Northwest Territories, for example, found that half of the boys under the age of eight (and 80% of girls the same age) had



been sexually abused (Royal Commission on Aboriginal Peoples, 1996, cited in Hylton, 2002). This is clearly an area of research that needs further attention.

Men with Histories of Marginalization

Samples for general population surveys tend to miss certain marginalized members of society who likely have higher rates of childhood sexual abuse, such as sex trade workers, runaways, and the homeless. McCormack et al. (1986, cited in Mendel, 1995) found that 38% of adolescent male runaways had histories of childhood sexual abuse. Watkins and Bentovim (1992) state that male and female sex trade workers are “very likely to have experienced preceding sexual abuse.”

In what may be the largest study of sexual exploitation among youth in Canada, Saewyc et al. (2008) surveyed 1,845 youth in communities across British Columbia who were either street-involved^{***} or in custody. The study found that roughly one-third of male street-involved youth had been sexually exploited (given money, drugs, shelter, or other consideration in exchange for sexual activities). The rate of sexual exploitation among male youth in custody ranged from 12% to 18%. Of the male youth in the survey who identified the sex of their exploiter, 44% had been exploited by a male, while 79% had been exploited by a female. The authors note that these numbers challenge the stereotype that the sexual exploiters of youth (both male and female) are overwhelmingly male.

Disabled/Challenged Males

Physically and/or developmentally disabled males represent another vulnerable population. One study (Sobsey et al., 1997; cited in Holmes and Slap, 1998)

^{***} Saewyc et al. (2008) define street-involved youth as “Marginalized youth who may be homeless or in precarious living situations, such a couch-surfing or living on the street, or who may be involved in street-based activities, such as buying or selling drugs, panhandling, etc.” (p. 16).



found that disabled boys were sexually abused more frequently than non-disabled boys. A number of studies have found that people with developmental disabilities have higher childhood sexual abuse rates than non-disabled individuals—somewhere in the range of 1 in 3 for males, and even higher for females (Passmore and Fresco, 2006).

Male Psychiatric Patients

Studies on the prevalence of sexual abuse in male psychiatric patients yield rates ranging from 4% to 39% (Lab and Moore, 2005). Lab and Moore (2005) have criticized a number of these studies on methodological grounds. They accordingly undertook their own study with a male in-patient psychiatric population that used a method specifically designed for assessing prevalence of *male* sexual abuse. Approximately one third (31%) of the study sample met the definition for contact sexual abuse by the age of 13. Half of the men had not disclosed their abuse to anyone prior to the study, and only 1 in 5 had the abuse documented in their medical records.

Men Who Attended Residential Institutions

Watkins and Bentovim (1992) note the widespread anecdotal reporting of sexual exploitation occurring within male-dominated residential institutions. These include residential schools, juvenile offender contexts, training schools, children's homes, etc. The authors were, however, unable to find any studies that determined incidence or prevalence data for this population.

Newcomer (Immigrant and Refugee) Men

Immigrants and refugees have been identified as being at higher risk for childhood sexual abuse due to the vulnerabilities inherent in their situation (e.g., having no legal immigrant status, having been traumatized in their



country of origin, having a sponsor who is abusive, etc.) (Babcock, 2006). There do not appear to be any prevalence data here.

1.3.3 The Nature of Male Childhood Sexual Abuse

We consider, next, the nature of male sexual victimization: the types and severity of the abusive acts, the victim's relationship with the perpetrator, the family context, and other demographic factors.

Types and Severity of Sexually Abusive Behaviour

Holmes and Slap (1998) summarize the forms of abuse against males as follows:

Male victims typically described 3 or more types of sexually abusive acts, including forced anal penetration of the victim or perpetrator, vaginal penetration of the perpetrator, orogenital contact of or by the perpetrator, manual-genital contact of or by the perpetrator, and exhibitionism. Anal penetration was reported by 37% to 70% of victims in 13 studies, but by less than a third in 9 other studies. Anal penetrative abuse was more likely to be repeated than other types of sexual abuse. It was reported by less than 10% of subjects victimized prior to age 2 years compared with 71% victimized at ages 9 to 11 years. Rhynard et al. [1997] reported that 5% of male high school students had been forced to have intercourse while on a date (date rape) (pp. 1857-1858).

Fondling, either of or by the perpetrator, was the most frequently reported type of abuse, while exhibitionism was the least, though the authors comment that both of these types of abuse may be underreported because subjects are often asked to describe only the most severe or disturbing acts. Fifteen percent to 38% of abused subjects were fellated, while 12% to 35% were forced to perform fellatio or cunnilingus. Other forms of abuse include having a child be sexual with animals or engaging a child in prostitution (Hunter, 1990).

Holmes and Slap (1998) found that physical force was involved in 10% to 25% of cases in many studies, though some studies reported even higher rates. Threats of physical violence were found to increase with the victim's age and with male perpetration. Seven studies reported that 36% to 68% of male victims were also physically abused. The risk of concurrent physical abuse was greatest when the abuser was a family member.

Findings on the age of onset for childhood sexual abuse show considerable variation. Holmes and Slap (1998) determined a mean and median age of first sexual abuse for males of 9.8 years and 10 years respectively. Fifty-eight percent were younger than 11 years. This age profile is generally similar to that for females, with some studies finding a lower onset age for males and others a lower age for females.

Regarding the duration of the abuse, Holmes and Slap (1998) again found a wide variation in the research literature. "Several studies reported that abuse was a 1-time occurrence in 46% to 93% of cases. [...] Many boys (17%-53%), however, reported chronic abuse. Duration of abuse ranged from less than 6 months to 18 to 48 months" (p. 1857).

Regarding gender differences in types of abuse experienced, Watkins and Bentovim (1992) conclude in their literature review that the strongest evidence for a difference is that male victims are more likely than females to experience anal abuse. In a separate literature review, Dhaliwal et al. (1996) likewise note this general finding, but point at the same time to studies indicating low rates of anal intercourse. They also note research indicating that male and female child victims experience about the same percentage of oral sexual abuse. Females were reported to experience more fondling, though a very high percentage of both male and female victims may experience this (Kendall-Tackett and Simon, 1992). As noted above, milder forms of abuse may be underreported in males. Watkins and Bentovim (1992) also found evidence that



males are less often abused solo (i.e., with a single victim present) than females and are subject to more forceful abuse and concurrent physical abuse. There was some limited evidence (Pierce and Pierce, 1985; Cupoli and Sewell, 1988) that males experience more masturbatory abuse.

We have discussed above the difference between contact and noncontact forms of abuse. Contact abuse is more obvious and usually of a criminal nature. Noncontact abuse, often excluded from prevalence data, includes a wide variety of behaviours. Gartner (1999) lists the following examples:

Masturbating or otherwise being sexual in front of a child; exposing genitals to a child for sexual gratification; encouraging a child to be sexual with others; practicing voyeurism; photographing a child for sexual purposes; showing a child pornography or making it available to him; engaging in sexualized talk with a child or confiding in him about sexual issues; ridiculing a child's sexual development, preferences, or organs; forcing a child to dress in an over revealing manner; stripping oneself and/or a child in order to hit or spank him, or getting sexual pleasure from spanking; employing sexually charged verbal or emotional abuse; having a child witness the sexual abuse of others; using sexual punishments; manifesting unusual interest in and asking questions about sexuality; taking too much interest in baths at an inappropriate age; applying medication on genitals or cleaning genitals when a child is old enough to do it himself (this does include contact, of course, but is considered too subtle to be considered contact abuse); and employing seductive looks or talk to a child that violates generational or personal boundaries (pp. 25-26).

As Gartner observes, many of these noncontact forms of abuse are subtle and covert, and are unlikely to be detected by researchers. They nonetheless form a significant category of abuse experienced by boys and male youth. Gartner emphasizes that, in interpersonal terms, covert abuse has the same essential meaning as overt abuse in that it constitutes a betrayal of the victim. In an intrafamilial context, covert abuse may be described as "psychological incest," as it involves parents' gratifying their own sexual interests and violating or eroticizing sexual boundaries at the expense of the young male.



Regarding sexual abuse by women, Carlson (1990, cited in Ford, 2006) has described four levels of types of abuse:

- Chargeable offences such as oral sex, intercourse or masturbation.
- Offences such as voyeurism, exposure, seductive touching, sexualized hugging or kissing, extended nursing or flirting.
- Invasions of privacy including enemas, bathing together, washing the child beyond a reasonable age, excessive cleansing of the foreskin or asking intrusive questions about bodily functions.
- Inappropriate relationships created by the adult such as substituting the child for an absent parent, sleeping with the child, unloading emotional problems on the child or using them as a confidant for personal or sexual matters (p. 14).^{†††}

Many of these acts are recognizable as covert forms of abuse.

Despite Holmes' and Slap's (1998) finding that up to half of female perpetrators are adolescent-aged babysitters, most of the research on female abuse appears to focus on mother-son incest. As we have stressed, the research here is slim, so findings are to some degree tentative. Ford (2006) cites a number of studies indicating that the abuse committed by female perpetrators is just as severe as that of males, if not more so, while Mendel (1995) cites research suggesting that female abuse is less severe. (The research cited by Ford may again reflect a reporting bias toward severe abuse.) Allen (1991, cited in Ford, 2006) describes female abusers engaging in more sexual acts at both ends of the severity spectrum, i.e., from voyeurism to penetrative abuse. This is supported by other studies cited by Ford (2006) that found less oral-genital abuse, genital fondling, and masturbatory abuse among female versus

^{†††} We have included this typology because of its usefulness in identifying different levels of female perpetrated sexual abuse. However, we do not view unloading emotional problems on a child or using them as a confidant for personal matters as sexual abuse but rather as psychological abuse.



male perpetrators. Kaufman et al. (cited in Ford, 2006) also found that female abusers were significantly more likely to engage in penetrative acts using a foreign object.

Regarding the severity of the abusive acts, the discussions above indicate a continuum used by researchers from mild to severe. One-time fondling by a stranger would lie at the mild end while chronic, violent penetrative abuse by a parent would lie near the severe end. Saying this, however, is not to imply a direct correlation between the severity of the abuse and the severity of the trauma experienced by the victim, as there are a number of factors (discussed below) other than the abuse severity that influence the actual impact of the experience. It is thus possible for mild abuse to be highly traumatic and for severe abuse to be relatively non-traumatic.

Where there appears to be some controversy is over whether males experience more or less severe abuse than females. The findings here are contradictory. Mendel (1995) cites numerous case study reports that indicate a higher rate of severe sexual abuse among males than females, with higher rates of concurrent physical abuse as well. He does not conclude from this, however, that males are indeed more severely abused than females, as he notes that it is only the most severe and obvious cases of sexual abuse of males that generally get reported. In the LA Times Poll, it was found that males were the victims of more serious abuse, being more likely than females to have experienced attempted or achieved sexual intercourse (Gordon, 1990). The study by Dube et al. (2005) likewise found a considerably higher percentage of sexual intercourse for male versus female victims. Ullman and Filipas (2005), however, found more severe abuse for females than males in their sample of college students. Holmes et al. (1997) take a different approach, stating that “it is not possible to characterize one gender as having an overall profile of more severe abuse, since the direction of severity is a product of the characteristic investigated. For example, boys suffer more frequent,



penetrative acts, while girls are more often abused by relatives” (p. 76). We note, finally, that in their study of men who have sex with men, Paul et al. (2001) found that initial sexual abuse experiences involved a high level of force (43% involved physical force/weapons) and penetrative sex (78%).

Further Characteristics of Male Sexual Victimization

Who perpetrates sexual abuse against young males? Lisak and Luster (1994) note that the evidence suggests the following characterization: “compared to females, males are more at risk from extra-familial perpetrators, equally at risk from non-immediate family members and less at risk from immediate family members” (pp. 509-510). Indeed, in their literature review Holmes and Slap (1998) note the following findings:

Large-sample studies reported that 54% to 89% of perpetrators were extrafamilial, and that 21% to 40% of these perpetrators were not known to victims. Small-sample studies also reported that more than half of perpetrators were extrafamilial, but noted that less than 6% were strangers. Boys younger than 6 years were at greatest risk for abuse by family and acquaintances; boys older than 12 years faced an increasing risk of extrafamilial abuse by strangers (p. 1857).

Extrafamilial perpetrators include coaches, clergy, teachers, babysitters, neighbours, family friends, peers, Scoutmasters, club leaders, camp counselors, employers, strangers, members of pedophile rings, and authority figures in general. One-time occurrences of sexual abuse tend to be by strangers (Bagley, 1988). When the abuse goes beyond a single incident or is chronic, it is more likely to be perpetrated by acquaintances and peers, and to involve anal contact and anal penetration (Bagley, 1988; Bagley et al., 1994).

The LA Times Poll study found that when a male is abused within his family context, the abuser is more likely to be someone close in age, such as a cousin, sibling, or young uncle, versus when a female is abused, where the abuser is



more likely a (step-)parent, grandparent, or uncle. (Gordon, 1990) Thus, while females are typically abused by an older relative, males are typically abused by a stranger, acquaintance, or a relative close in age to themselves.

Despite that these findings match our own impression of typical perpetrator relationships; it is worth noting a contradictory finding from a Quebec-based study by Dorais (2002). In this study of 30 men sexually abused in childhood by a male, Dorais typified the abuse by whether it was extrafamilial or intrafamilial, and also by whether it was intergenerational or intragenerational (i.e., perpetrator close in age to victim). This resulted in 4 categories or quadrants of abuse. The most common category, it turned out, was intrafamilial and intergenerational, i.e., abuse by an older relative within the family such as a (step-)father or uncle, followed distantly by extrafamilial/intergenerational (e.g., an older neighbour) and intrafamilial/intergenerational (e.g., an older brother or cousin). Mendel (1995) similarly found a high rate of intrafamilial abuse in a study of American men in therapy. Seventy-seven percent reported childhood sexual activity with an immediate family member, 29% with a non-immediate family member, and 67% with a non-relative. While these findings do not match the general trend, they do alert us to the possibility of other patterns of perpetrator relationships.

So-called “grooming” is a method commonly used by perpetrators, where there is a progressive luring and entrapping of the victim through initial actions that seem innocent or kind. The Badgley Commission found that while adolescent perpetrators tend to use force during the abuse, adult perpetrators tend to use persuasion, gifts, emotional manipulation, bribery, and so on (Bagley, 1988). Holmes and Slap (1998) found that female perpetrators are much more likely to use persuasion than physical force, and 26% promised special favors. Pornography is often used as part of the grooming process. A study by Itzen (1997, cited in Simons et al., 2002) found that pornography is used by abusers



to: normalize the abuse, blackmail their victims into not disclosing the abuse, get themselves and their victims sexually aroused, and persuade the child to participate in the abuse.

In his study of sexually abused men, Dorais (1997) observed that the groomed child forms an emotional attachment with the abuser through the initially friendly contact. When the relationship turns sexual “he does not even grasp the portent of the gestures he is expected to submit to. Above all, he does not perceive that it is only the beginning and that, if the relationship continues, the aggressor will in time make additional demands. Inevitably he will be swept along on a tide of deception, disenchantment, and trauma.” Dorais quotes the testimony of one survivor abused by a cousin: “At the beginning he only pawed me, he was nice to me in return, [...] but afterwards he always asked me to go further. I hesitate; I know it isn’t right, but he threatens me: ‘If you don’t want to, if you tell, my friends will break your neck’” (pp. 45-46).

The rate for males’ disclosing their sexual abuse was found by Holmes and Slap (1998) to range from 10-33% in the studies they reviewed. Reasons given for non-disclosure included wanting to forget about the abuse, wanting to protect the perpetrator, and a fear of the reactions they would receive. In their follow-up study of youth who had disclosed their sexual abuse, Burgess et al. (1987, cited in Holmes and Slap, 1998) report that after making the disclosure most of the youth experienced pressure, rejection and threats, and parental blame and punishment. They regretted telling. Holmes and Slap (1998) also found that when a boy or male youth was known to have been abused, he received little care or acknowledgement in the way of counseling, medical attention, or criminal investigation.

Disclosure rates are low for both males and females, but overall it appears that males are less likely to reveal their abuse. For non-clinical samples, studies indicate similar rates of disclosure for men and women (Holmes et al. 1997).



The Badgley Commission, for example, found a rate of around 20% for both genders. For a clinical population, however, Roestler & McKenzie (1994) reported a significant difference: 61% of women had told someone about the abuse as a child whereas this was true for only 31% of men. In another study, it was found that in a cohort of males and females with documented sexual abuse histories, only 16% of the men had told anyone about their abuse 20 years later, compared to 64% of the women (Widom and Morris, 1997, cited in Fondacaro and Holt, 1999). As these numbers would suggest, it is common for male survivors entering therapy to have told no one about their abuse history, or to have disclosed it only recently.

What kind of family environments put young males most at risk for sexual victimization? In their literature review, Holmes and Slap (1998) found the following:

Family factors that increased a boy's risk for sexual abuse included living with only 1 or neither parent; parental divorce, separation, or remarriage; parental alcohol abuse; and parental criminal behavior. Sexually abused boys were 15 times more likely than nonabused boys to have family members who had also been sexually abused (p. 1857).

In a comparison of male and female child victims of sexual abuse, Pierce and Pierce (1985) found that 38% of the males had no father figure in the home while this was true for only 12% of the females. In the same vein, 58% of the female victims lived with their natural fathers, whereas this was true for only 24% of the males. They suggest, as is commonly believed, that the lack of a father figure makes young males more vulnerable to predation/grooming outside the family because of their need and desire for a male role model. Similarly, in Lisak, Hopper, and Song's (1996) study, 60% of the men sexually abused in childhood were also physically abused. The authors suggest that because the majority of physical abuse was intrafamilial and the majority of sexual abuse was extrafamilial, physical abuse at home may be a risk factor for subsequent sexual abuse outside the home.



Gartner (1999) observes that because a large percentage of males are abused outside the family, it is difficult to identify composite family patterns for male sexual abuse that compare to the family patterns commonly found among female incest victims. He does, however, offer some generalities present in a number of cases. These include strained parental relationships with deficient communication, boundary difficulties or violations, and either an avoidance of sexuality in conversation or a preoccupation with it. Bolton et al. (1989) have also identified various categories of home environment based on the attitudes they take toward sexuality. These range from “ideal,” where there is little risk of abuse, to “overtly sexual,” where there is overt sexual contact.

While it is often stressed that childhood sexual abuse cuts across all types and classes of family, Holmes and Slap (1998) do report a number of studies correlating male sexual abuse with low socioeconomic status. Associations were found between male sexual abuse and paternal unemployment, unskilled labour, mothers receiving social assistance, and so on. It is suggested that such families tend to offer less supervision and protection, and so leave children more at risk. Offering a caution about such findings, however, Bagley (1994) notes that while “the risk in economically poor and socially disorganized families is somewhat greater, the risk in ‘normal,’ middle-class families is not negligible” (p. 694).

1.4 CULTURAL CONTEXT, PART TWO: “MYTHS” OR CULTURAL DELUSIONS ABOUT MALE CHILDHOOD SEXUAL ABUSE

Male childhood sexual abuse, then, is common and serious yet not well recognized or articulated. As trauma theorists inform us, societies are often reluctant to face horrifying and taboo-breaking events occurring in their midst. Disturbing phenomena like childhood sexual abuse are vigorously denied access



to consciousness (Herman, 1992). One of the main ways this “social amnesia” (Jacoby, 1975) is maintained is through certain false beliefs or “myths” embedded in culture. For example, the sexual abuse of females has historically been denied through such beliefs as: girls are not abused, females’ memories of sexual abuse are actually fantasies, girls are only abused by strangers not by their fathers, abused females are sexually promiscuous “tramps,” and so on (Holmes et al., 1997). While these beliefs have not entirely died, they have in recent decades been actively challenged. A similar set of “myths” has been used to deny the reality of male sexual abuse, and these must now also be challenged. This challenging of false beliefs about male childhood sexual abuse forms a significant component of the healing process for male survivors.

We prefer the term *cultural delusion* to myth for three reasons. First, it seems to us a more accurate term, given that a delusion is a false belief or a belief out of contact with reality. Secondly, using the term “myth” in this context itself supports the erroneous belief that all myths are false. A myth is a story, whether true or false. Thirdly, in many cultures myths have an explicitly inspirational or practical function. *Cultural delusion* thus seems to us a more precise and sensitive term. Nevertheless, given that the term myth is commonly used in the abuse and trauma literature, we do make reference to certain “myths” that have been identified.

Referring back to Figure 1.1, cultural delusions about male sexual victimization are generated in the intersection between the traditional male code and the reality of male sexual victimization. Because the latter is utterly incompatible with the former, the delusions act either to deny or minimize the abuse, or else portray it as a failure of masculinity. Or as Crowder (1995, cited in Gartner, 1999) puts it: “Our culture has no mythology to identify the process of male victimization and boy victims are emasculated by this bias. They are seen as either like a woman and therefore feminized, as being powerless and



therefore flawed, or as being interested in sex with men and therefore homosexual.”

We discuss below ten cultural delusions about male sexual victimization (drawing for their titles on Gartner, 1999), including how they connect to the traditional male code and research that exposes them as delusions. This exercise is part of the cultural therapy that must accompany the individual and group therapy for male sexual abuse. As deVries (1996) emphasizes, the interaction between an individual and his cultural environment plays a “key role” in how that individual copes with potentially traumatizing experiences, including whether the person develops a posttraumatic stress syndrome or not. Until the cultural delusions regarding male sexual victimization are more widely identified and challenged we can anticipate that large numbers of abused men will continue to suffer their traumatic consequences.

Cultural Delusion #1: Males cannot be sexually abused or victimized.

This is the master delusion. Within the terms of the traditional male code there is no way to make sense out of male sexual victimization. The only resolution is either to deny the abuse or regard the victim as not a male. As discussed below, the result is that the male survivor often struggles with the sense of being some kind of genderless freak. Many survivors also struggle to legitimize to themselves that they were in fact abused, and harmed by the experience. In the words of one survivor: “It’s like, men aren’t abused? You know, who ever heard of that? Who talks about that? If men aren’t abused how could I have been abused?” In the words of another: “...well, I’m the victim and I’m a guy, but guys are bad [i.e., stereotypical abusers]. So I can’t even be a victim, right?” (Lisak, 1994, p. 536). Because of the non-recognition of male sexual victimization, it is not uncommon for a male survivor to believe that he is the only person to have ever had the experience (Gill and Tutty, 1999). It is worth



emphasizing that the lack of services available to sexually abused men not only follows from this delusion but also circularly reinforces it.

Cultural Delusion #2: If a male has allowed abuse, then he is a sissy or weakling.

The logic here is simple. If a man cannot be a victim, and if he was sexually abused, then he is not a man. He is a sissy. Gill and Tutty (1999) found that a common theme in the lives of male survivors is shame over failing to defend and protect themselves, i.e., for failing as males, even as vulnerable boys, to “give ‘em Hell.” The shame over being a failed male is reinforced by the responses that victims often receive when the abuse is disclosed. For example, when the father of a young adolescent male abused in a northern Ontario town by a teacher found out about the abuse, he declared that his son “must be gay” and called him to his face a “homo” and a “faggot” (Macklem, 2003, p. 34).

Cultural Delusion #3: Boys/youth can always say no to abuse if violence is not used. If they don't, then they must have wanted the abuse to occur.

This delusion has been called the “myth of complicity.” The same father mentioned just above, tormented and blamed his son, asking “Why didn't you stop it, why didn't you kill him?” (Macklem, 2003, p. 34). As we have already noted, abused males sometimes do convince themselves that they wanted the abuse to occur, or should have stopped it. Here's the voice of a victim of a church choirmaster: “I never could speak about what Gallienne did; we were all silent for so long. I guess we felt we were implicated, we were somehow to blame, we must have asked for it, we let him do it” (Steed, 1995, p. 1). This self-blaming does not, however, reflect the truth of the situation, namely, that victims are exploited and betrayed, either through force or manipulation.



Cultural Delusion #4: If a male becomes sexually aroused, then he is an equal participant in the abuse.

This is another version of “myth of complicity.” As Hunter (1990) writes:

One widely held myth about the sexual abuse of males is that it is not possible for a male, boy or man, to obtain or maintain an erection when threatened or attacked. [...] Many people, including victims, falsely believe that an erection means enjoyment and willing participation. However, research shows that just as women who are being sexually assaulted sometimes lubricate and even are orgasmic, men who are forced to have humiliating and frightening sexual experiences can and do maintain erections (p.37).

Given the delusion that sexual arousal means complicity, many male victims feel deep shame for the automatic physiological reactions and even pleasant or exciting sensations they experienced at the time of the abuse. Their abuser may also reinforce this delusion by telling the victim that he enjoyed the sexual experience, so it couldn't possibly have been abusive (Lew, 2004).

Cultural Delusion #5: Most sexual abuse of males is perpetrated by homosexual men.

In a study to determine whether children are at risk for abuse by homosexuals, Jenny et al. (1994) found that the answer is no, they are not. They evaluated the sexual orientation (gay, lesbian, or bisexual) of the alleged offender in 352 cases of reported child sexual abuse. Based on their findings, they determined that the odds of an alleged offender being a “recognizably homosexual adult” was no greater than the percentage of homosexuals in the general population.

In reviewing the literature on the sexual orientation and psychology of male pedophiles and sex offenders, Gartner (1999) concluded that:

While some pedophiles may consider themselves gay, it is far more often true that boys are abused by men who consider themselves heterosexual. Some of these men do not really



differentiate between boys and girls, choosing whoever is most vulnerable and/or available. [...] Pedophiles preying on boy victims often report that they are uninterested or repulsed by adult homosexual relationships and are attracted to young boys' feminine characteristics and absence of secondary sexual characteristics as body hair. This supports the accepted clinical picture of sexual offenders and pedophiles as people who are psychosexually immature and who therefore in some way identify as psychological and psychosexual peers of the children they molest (p. 99).

Following this discussion, Gartner notes that it is misleading to speak of "homosexual victimization," as this implies that sexual abuse is a homosexual act when sexual orientation is not in fact the issue. He thus suggests using the term "same-sex abuse" instead.

Cultural Delusion #6: Sexual abuse turns a boy/youth gay.

The fact that childhood sexual abuse histories are more common in gay/bisexual men than in heterosexual men appears to support the belief that the sexual abuse is responsible for their sexual orientation. This is an area of some controversy, including among clinicians and researchers. There are, however, good grounds for questioning this belief and for providing alternative explanations for the high prevalence rates among gay/bisexual men. First, Gartner (1999) observes that most sex researchers believe that predominant sexual orientation is established before latency (middle childhood), while most sexual abuse of males occurs after this period. He also cites Simari and Baskin's (1982) finding that most of the gay men they studied had a clear sense of homosexual orientation *prior* to their being sexually abused.

If sexual abuse is not responsible for the development of a gay sexual orientation then what accounts for the high rates of sexual abuse among gay males? It is likely that young gay males are simply more vulnerable to abuse, as they are a marginalized and oppressed population. Young gay males exploring their sexual and cultural identity may frequent environments where they are



more at risk for abuse. Sexual predators are also likely able to detect and exploit the vulnerability and incipient sexual interests of the gay boy/youth. An isolated and distressed young gay male may in fact welcome some aspects of the abuse, as the attention and interest they receive overcomes their aloneness. Gartner (1999) quotes a client for whom this was true: "I felt such joy at discovering that I wasn't the only one who was aroused by men that I didn't care who showed me or how. [...] I was no longer alone in the world. [...] At the time, I hardly realized how horribly he was treating me—I didn't care about anything but my relief at not feeling like a total freak any more" (p. 106).

While primary sexual orientation appears to develop early, the fluidity of human sexuality does allow for a range of expressions. It is true, in this respect, that childhood sexual abuse can and does affect a survivor's sexual feelings and behaviour. For example, some men abused in childhood have sex with men as part of the aftermath of their abuse, often in a compulsive or fixated manner, while nonetheless identifying as heterosexual. The quality of a man's sexual relatedness may also be affected by abuse, as in the development of sadomasochistic fantasies or activities, various erotic obsessions and compulsions, or fear of intimacy (Gartner, 1999). As we discuss below in more detail, moreover, many men abused in childhood go through a period of being confused about their sexual orientation that may extend over a lifetime.

Finally, we may ask why the question of the relationship between sexual abuse and a gay/bisexual orientation arises with such force in the first place. This no doubt reflects to some degree our culture's anxieties over homosexuality, and a desire to identify a source of the sexual corruption so that it can then be contained or "fixed."



Cultural Delusion # 7: Sexually abused boys/youth inevitably become sexually abusive men

This delusion creates a brutal stigma for survivors, as the message it gives is that the masculinity of sexually abused males has been completely corrupted. This delusion has been called the “myth of contact contamination” (Crowder, 1993). It has been explored in the research literature under the title of the “abuse-to-abuser,” “victim-to-victimizer,” or “cycle of violence” hypothesis. This is a highly charged topic, so we will discuss it at some length. We offer three main points.

The first point to note is the repeated finding that the majority of males sexually abused in childhood do not become men who perpetrate. For example, in what Mendel (1995) calls the “most thorough examination of this topic,” Kaufman and Zigler (1987, cited in Mendel, 1995) found that about 70% of families in which a parent had experienced some form of child maltreatment (including neglect, physical abuse, and sexual abuse) did not “transmit” the abuse to their children. Lisak, Hopper, and Song (1996) similarly found in their study that about four-fifths of men sexually and/or physically abused in childhood had not perpetrated any kind of abuse against children (the rate was about two-thirds with perpetration against adults included). In short, there is no “inevitability” about the link between childhood sexual abuse and becoming a sexually abusive man.

At the same time, studies indicate that among sex offenders a large percentage do have histories of childhood sexual abuse, ranging anywhere from 25% to 90%. (See Dutton and Hart [1992], Simons et al. [2002], and the literature review in Mendel [1995].) What this indicates, however, is that a certain percentage of sex offenders do *not* have histories of childhood sexual abuse.

What can be concluded from these data, then, is that although research findings offer partial support for the cycle of violence hypothesis, the



experience of childhood sexual abuse is neither a necessary nor a sufficient condition for becoming a sexually abusive man (Simons et al., 2002).

This leads to the second point that needs to be made, namely, that sexual perpetration is multiply determined, involving numerous variables. Although being sexually abused in childhood is one factor, many commentators caution against adopting any single-factor theory to explain sexual perpetration. It is not the purpose of this guidebook to detail the research on sex offending. However, we will discuss here some of the variables that have been identified because of the relevance of this material to men with sexual abuse histories, many of whom worry that they may indeed become abusers themselves.

Sexual abuse is only one form of abuse found in the background of sex offenders. Simons et al. (2002) indicate that childhood sexual abuse and physical abuse are both factors. Citing studies reporting rates of physical abuse of around 50% in sex offenders, they note that men from physically violent households are more likely to develop patterns of sexual interest that involve coercion or force. In their own study, 32% of convicted rapists had been sexually abused while the rate was 70% for having been physically abused. Widom and Ames (1994) similarly found that although men with histories of sexual abuse, physical abuse, or neglect were all more likely than men without such histories to commit a sex crime, the men in the physically abused group had an even greater likelihood of committing a violent sex crime (rape/sodomy).

Simons et al. (2002) also identify childhood exposure to hard-core pornography in particular as an important factor in later sex offending. Ford and Linney (1995, cited in Simons et al., 2002) found that a large percentage of adolescent sex offenders were exposed to hard-core sex magazines at an early age, with those who offended against children being most frequently exposed to pornography at the youngest ages (5 to 8 years old).



In a study of men sexually abused in childhood, Briggs and Hawkins (1996) found that those who became child molesters tended to normalize their own experience of abuse and to report fewer negative effects from it. Having been groomed to view sexual abuse as a normal act, they were then more likely to abuse others. These authors cite Ryan's (1989) suggestion that acceptance of the pleasurable aspects of an abusive sexual experience while defending against the traumatic aspects through denial, repression, and dissociation, may lead a victim to minimize the harmfulness of his own subsequent perpetration.

Marshall (1990) highlights the emotional loneliness and social isolation that is ubiquitous among sex offenders, originating in disturbed childhood attachments. Unable as an adult to meet his needs for emotional intimacy through healthy relationships, such a man feels chronically alienated, powerless, and enraged. He is then vulnerable to cultural messages that depict others as objects that can be taken by force. Bagley, Wood, and Young (1994) found that "those who report sexual interest and/or activities involving children tend to be more depressed and anxious and have more suicidal feelings and behaviors than those without such interests" (p. 690).

Sex offender literature also frequently identifies lack of empathy as a key factor in the etiology and maintenance of sexual offending. Simons et al. (2002) note that the development of sensitivity toward others may become blocked in victims of child abuse because they were shown such little empathy by their own abusers. These authors determined that empathic disconnection was in fact a mediating variable between physical/sexual victimization and hard-core pornography exposure, and sexual offending. Lisak, Hopper, and Song (1996) and Lisak (1997) similarly link childhood maltreatment to perpetration of sexual/physical abuse through the variable of empathic disconnection. Significantly, however, they additionally tie this empathy deficit to the victims' adoption of a hypermasculine defense offered to them by traditional male socialization. We discuss this finding further in Chapter 2.



The third point we wish to make about this delusion is to highlight the existence of certain protective or resiliency factors. In their study on this topic, Lambie et al. (2002) conclude that “friendship and social support may play a significant role in acting as a buffering factor to the victim-offender cycle.” Resilient survivors (i.e., those who did not perpetrate sexually) typically received greater levels of emotional support, provided by parents, relatives, and other adults. They also received more verbal and physical displays of affection and greater support during times of crisis, and had higher levels of education than the victim-offender group. Rather than maintain the belief that sexually abused boys inevitably become sexually abusive men, then, it would be more productive to institute interventions that help maximize these resiliency factors.

Cultural Delusion #8: Males are less traumatized by sexual victimization than are females.

According to the traditional male code, men are strong and can “take it.” If they were abused they should therefore be able to tough it out and not suffer much ill-effect. In a direct refutation of this belief, Dube et al. (2005) report the following finding from their general population study.

It was found that the magnitude of increased risk of alcohol problems, illicit drug use, suicide attempts, marrying an alcoholic, and current marital and family problems associated with CSA [childhood sexual abuse], was similar for both male and female respondents. Furthermore, severity of the CSA consistently showed that intercourse CSA was associated with an elevated risk for the outcomes among both genders. Thus, the data provide strong evidence that exposure to CSA among both genders is common, and acts as a strong risk factor for multiple types of mental health, behavioral, and social outcomes similarly for adult men and women (p. 434).

Other studies have found similar results, as will be discussed further when we consider the aftermath of male sexual abuse in the next section. At this point,



it is perhaps enough to say that for sexually abused men who enter therapy the abuse experience is typically shattering, having negatively affected almost every area of their lives.

Cultural Delusion #9: Perpetration by females is rare.

The belief that males are only rarely abused by females has been called the “myth of female innocence” (Crowder, 1993). As discussed above, research reveals that a significant percentage of sexual abuse against males is perpetrated by females.

Cultural Delusion #10: Perpetration by a female is less harmful than by males. In fact, if the perpetrator is female then the boy/youth got lucky. He is fortunate to have been initiated into heterosexual activity.

The idea here is that abuse by females is a form of initiation or sexual education, and is non-traumatic—the “myth of sexual initiation” (Crowder, 1993). Male survivors who were abused by a female often adopt this belief themselves as a way to counter their shame over being so-victimized. However, the myth of initiation can be challenged not only due to its heterosexist bias, but also because a number of studies have reported significant negative consequences of being abused by a female. For example, Dube et al. (2005) conclude that among “male victims of CSA, the risk of negative outcomes was similar when the gender of the perpetrator was compared. Thus, perpetration of CSA by a female appears to exert negative effects that are similar in magnitude to CSA perpetrated by males” (p. 434).

In a study of clinic-referred men with histories of childhood sexual abuse, Kelly et al. (2002) found that the men who had been abused by their mothers had higher levels of trauma symptoms than did other sexually abused men, including more interpersonal and sexual problems, and more symptoms of



aggression and dissociation. They conclude that (among clinic-referred men) mother-son incest is a risk factor for severe psychosocial adjustment. "In therapy, these men often expressed rage, shame, and profound sadness that they were abused by the person who was supposed to teach them how to love, trust, and feel safe in the world." One survivor described it as "the essence of chaos" (p. 435). The authors found, as well, that an initial positive perception of mother-son incest actually leads to more severe psychosocial adjustment problems than a negative perception at the time of the abuse.

Finally, in a qualitative study using a clinical sample of men and women sexually abused in childhood by female perpetrators, Denov (2004) found that all 7 participants who were abused by both men and women said the abuse by women was more traumatic due to a greater sense of betrayal. Both male and female victims reported similar aftereffects: substance abuse, self-injury, suicidal ideation and suicide attempts, depression, rage, rage toward the abuser, mistrust of women and fear of their sexuality, a desire to retaliate against women, self-concept and identity issues, discomfort with sex, fear of abusing children, and reported sexual abuse of children. Denov observed, as well, that sexually abused men experience an additional layer of trauma when they encounter mental health professionals who themselves hold false beliefs about female perpetration.

1.5 THE AFTERMATH OF ABUSE: MALE SEXUAL TRAUMA

The previous two sections have already indicated some of the typical aftermath of male sexual victimization. In this section we present this aftermath more systematically. In doing so, however, we do not mean to imply that each survivor will present for therapy with all of the difficulties we list. As we discuss in Part 2, we believe strongly in the uniqueness of each man's experience and in the necessity of hearing his particular story. Certainly, not everything a man may have gone through will be covered here. Nor does every



man with a sexual abuse history develop negative symptoms from it (Dallam et al., 2001). At the same time, it is important to understand some of the common difficulties experienced by male survivors in order to provide a safe and compassionate therapy environment for them and to help normalize and validate their experience.

Compared to research findings on prevalence rates, the findings on long-term effects of male sexual abuse have been more consistent (Hopper, 2007). While we can therefore be relatively confident in these findings, a note of caution is still in order as they do contain some degree of variation and contradiction.^{†††} We cannot reproduce here the long lists of qualifiers and limitations that accompany each study, but have attempted to present the research findings that seem to us most reliable or that indicate a particular question mark. We begin by returning to the discussion on gender role strain, this time to consider some of the aspects of abuse aftermath that are particular to having been socialized as a male. We then discuss some of the co-factors of abuse that affect the severity of the aftermath. Finally, we discuss the suffering that arises in the wake of childhood sexual abuse more broadly, while still noting those facets most significant to or characteristic of men. Many of the topics discussed here will be revisited in Chapter 5, where they are considered in context of group therapy for male survivors.

^{†††} Perhaps the most extreme case of contradiction surrounds an article by Rind, Tromovitch, and Bauserman (1998). After conducting a meta-analysis of 59 studies on childhood sexual abuse (CSA) among male and female college students, these authors concluded that “Self-reported reactions to and effects from CSA indicated that negative effects were neither pervasive nor typically intense, and that men reacted much less negatively than women” (p. 22). This article and its conclusions set off a major controversy that included denouncement of the article by the U.S. House of Representatives and U.S. Senate, and refutation of its findings by a number of other researchers (summarized at www.leadershipcouncil.org/1/rind/1.html; see especially, Dallam et al., 2001). See Rind et al. (2000) for their response to the controversy. We have chosen in this book to draw on the bulk of literature which, in contrast to Rind et al., has concluded that “sexual abuse is likely to have significant long-term effects” for both men and women (Briere and Elliot, 2003, p. 1220).



1.5.1 On Being Male and Being Sexually Traumatized

Male survivors of sexual abuse typically experience a “toxic amplification” (Lisak, 1998) of the normal gender role strain accompanying male socialization. In discussing a kind of discrepancy strain, for example, Gill and Tutty (1999) refer to the extreme “cognitive dissonance” men experience due to the conflict between their internalized ideals about masculinity and the reality of their victimization. A sexually victimized male knows that he “can never truly embody the masculinity that his culture has made him believe is the true measure of his worth” (Lisak, 1995, p. 261). This is by now a familiar theme. What we would stress here, however, is the profound degree of gender shame that survivors experience due to this particular discrepancy, over and above the normative levels of shame experienced by men. Denov (2004) speaks, for example, about men who have been abused by a female. To have been victimized by the “weaker gender” indicates all the more to these men that they are utter failures as men, which then marks them with a crippling sense of inadequacy.

A further struggle for male victims, beyond the shameful fact of having been victimized, involves being flooded by vulnerable emotions culturally defined as non-masculine (Lisak et al., 1996). To be sexually traumatized is to be overwhelmed by feelings such as terror, helplessness, humiliation, disgust, sadness, and so on. As a male, however, these feelings are traditionally off-limits. The abused man is thus “forced to repress tidal waves of emotion” (Lisak, 1995, p. 262). The effect is a compounding of his trauma, for the path of healing goes directly through the emotional territory he is disallowed from entering.

Lisak (1995, 1997, 1998) has identified a number of paths that survivors then take in attempting to resolve this conflict between masculinity and emotion.



The first is that of “hypermasculine compensation,” a sort of reaction formation in which the survivor adopts a rigid persona that is aggressive, homophobic, and hypersensitive to insult because of a relentless need to defend against a sense of inferiority. The second path goes in the exact opposite direction, in which the survivor rejects the traditional male code outright and adopts a counter-cultural identity. This may be easier for gay-identified survivors who can find support for such a path within the gay community. Kia-Keating et al. (2005) note, in this regard, that publicly identifying oneself as gay or bisexual itself usually involves critically evaluating masculinity. In their research on resilient survivors they found that a high proportion of their sample (7 of 16) was gay; learning to “resist” masculinity increased their resilience. The third path involves surrendering to society’s perception of oneself as non-masculine. Unable to play the role of the Big Man, this survivor leads a small, passive life largely invisible to the world. The fourth path, finally, is one that psychotherapy often supports. It takes the form of an active struggle with one’s masculinity in order to find a middle ground. The evidence suggests that this may lead to a more flexible gender adjustment than is normal for non-abused men, as men on this path demonstrate less gender role stress, homophobia, emotional constriction, etc. Regardless of which path (or combination of them) a survivor may take, the very existence of these paths demonstrates that a defining characteristic of sexually abused men is that they must find some way to resolve the “conflicting legacies” of their abuse and their socialization as males.

As Gartner (1999) suggests, another aspect of being sexually abused that is unique to males concerns the way traditional men feel about being penetrated. The “no sissy stuff” injunction requires men to form their identities, their sense of self, through disidentifying from qualities culturally defined as feminine. To be a man is to be *impenetrable*. Men are penetrators; they are not penetrated. To sexually penetrate a male is therefore not only to violate a bodily boundary but to wipe out a self.



As noted above, male socialization in general involves a series of subtractions. Men commonly live with a hole in the centre of their being where a self should be. Traumatic experience in general “punctures” the self, in that it leaves zones within that are blank, speechless, unsymbolized (Howell, 2002). Van der Kolk (1996a) describes trauma as a “black hole.” The combined effect, then, of normal trauma strain, psychological trauma from sexual abuse, and the accompanying masculine identity extinction, is that many survivors fight on a daily basis just to exist, to have a self at all. As we will see in Chapter 2, this struggle against the annihilation of selfhood sometimes takes the form of a rage that is expressed in violence against an intimate partner.

Although gay men may have some advantage in ultimately resisting the traditional male code, this is not to suggest that they are any less traumatized by sexual abuse. To the contrary, given “the trauma inherent in a cultural context which stigmatizes, devalues, pathologizes and punishes homosexuality, the added trauma of childhood sexual abuse in effect exponentially intensifies the trauma and the task of healing” (King, 2000). Having learned to keep secret both their sexual orientation and abuse history, many gay male survivors routinely function in a dissociated state (Cassese, 2000). Subject, moreover, to a cultural delusion that equates male sexual abuse with homosexuality, gay survivors may view their sexual orientation as indelibly connected to their sexual victimization, as in: “The abuse caused me to be gay;” “I hate my homosexuality;” “I deserved to be abused because I’m gay;” and so on (King, 2000).

It is worth emphasizing, as well, the “second assault” (Washington, 1999) male survivors often experience when they are met with negative, indifferent, or insensitive responses from the people and social institutions they turn to for help. They may be met by any combination of disbelief, denial, non-comprehension, blame, and inaction. It is hard to underestimate the levels of despair, isolation, and rage that a survivor may experience when this happens.



In addition to the kinds of amplified discrepancy strain and trauma strain discussed here, male survivors of sexual abuse are prone to amplified forms of dysfunction strain. For instance, in a study of differences in how males and females attribute the blame for their sexual abuse, Hunter et al. (1992) found that males are less able to make a clear distinction between blaming themselves and blaming their abuser. They are more likely to blame themselves while *simultaneously* blaming the abuser (whereas for women there is more of an inverse relationship between self-blame and abuser-blame). The authors found, in particular, that the level of force used by the abuser correlated with both greater self blame *and* abuser blame. The authors speculate that the male victim blames himself for being weak and vulnerable while also blaming and resenting the abuser for having emasculated him. This may furthermore mean that men are more prone to confuse the perpetrator-victim boundary and so identify with the aggressor to a greater extent than women—thus making them more prone to victimizing others. (More areas of dysfunctional aftermath will be discussed in section 1.5.4.)

One other area of sexual victimization particular to males is the relatively low percentage of abused males who view the experience negatively. Holmes and Slap (1998) found rates of victims' perceiving their abuse negatively ranging from 15% to 68%. A certain percentage of male victims therefore have neutral and/or positive perceptions of their abuse. Positive perceptions were associated with physical pleasure, older age of the victim, longer duration, and female perpetration. Holmes and Slap comment that these positive perceptions are perplexing given the long list of adverse clinical outcomes in the wake of the abuse. They speculate that men minimize the abusiveness of their experience as a way of defending against acknowledging their victimhood. Cassesse (2001b) has likewise shared his clinical impression that:

[Gay] clients who fondly remember sexual encounters with adults when they were children have similar symptomatology to those who remember them negatively. The clinical difference, however,



is in the configuration of the defensive structure. Often, the person who remembers it fondly relies on greater extremes of defense, combining, for example, a primitive denial with a sophisticated level of intellectualization (p. 191).

Clearly, this is an area that needs further study.

In sum, our intention in this discussion of the intersection of male socialization and sexual victimization has simply been to illustrate some of the areas of aftermath that a male-centred lens brings to light. Additional areas will no doubt be identified as this topic receives further attention from researchers and as survivors of all kinds are themselves given more opportunity to voice their experiences. The main point, for now, is to recognize that for male survivors their socialization will in one way or another play a compounding or intensifying role in the trauma they experience. Our presentation of male socialization in section 1.2 is meant to provide a general background to consider the many ways that a male survivor's gender training might contribute to his abuse aftermath.

1.5.2 Co-Factors Affecting the Severity of Trauma

There are a number of factors or variables associated with sexual abuse that affect the severity of the aftermath for survivors. While it is common for authors to list these factors one at a time, as if they each make their separate contribution to the abuse outcome, research suggests that the interaction among them is complex (some having a more direct relationship with abuse after-effects than others, some moderating others, some being linked to specific kinds of outcome but not others, and some being recognized as a factor in one study but not another). For example, Kelly et al. (2002) found that a greater number of perpetrators, earlier age of onset, physical abuse, and parent with alcoholism all significantly correlated with greater trauma symptoms and psychosocial problems; while the intrusiveness, frequency, and



duration of the abuse did not. Meanwhile, Steel et al. (2004) found that the number of abusers and the duration of the abuse were directly associated with psychological distress in adulthood. However, whether or not other factors (relation with perpetrator, force, resistance offered, age of onset, participation in the abuse, and frequency) led to greater distress was found to depend on the victim's coping strategy and attribution style. As these two studies suggest, human reality does not always cooperate with the search for precise and straightforward links between variables. As Gartner (1999) cautions, a male abused once or twice may not be distinguishable from a male who experienced chronic abuse. Keeping this complexity and inconclusiveness in mind, we will discuss a number of factors that may or may not play a role in the degree of aftermath a male survivor experiences (noting, as well, that much of the discussion is not specific to males but also applies to females). We draw here largely on Crowder (1993) who provides a good treatment of this topic.

Age at which the abuse began. A relatively early age of onset may have a more traumatic effect because of the psychological vulnerability of young people and the impact on subsequent psychological development. Young children are more likely to use primitive defenses such as dissociation, which become highly problematic later in life. Disruptions in early relationships also tend to make for insecure attachment styles, which in turn have a host of consequences for adult functioning.

Duration and frequency of the abuse. The more chronic the abuse the more it becomes the psychological "air" that the child breathes (Crowder, 1993). The abuse may become the child victim's defining reality, leading to the development of abuse-related schemas that organize his perception of himself and others.



Severity (coercion, threats, penetration, violence). Not surprisingly, more severe and deviant sexually abusive activity may lead to more severe aftermath (Hunter, 1990).

Nature of the relationship with the perpetrator. The Badgley Commission found that sexual abuse when groomed by an adult is more traumatic than when abused by force by an adolescent (Bagley, 1988). As Gartner (1999) and others have stressed, sexual abuse is essentially an act of interpersonal betrayal; the greater the perceived betrayal the greater the traumatic impact. Abuse by a parent introduces a high level of danger and insecurity in the child's home environment, and therefore is usually experienced as a severe betrayal. This does not mean, however, that extrafamilial abuse will always have less effect. As Dorais (2002) observes, a boy who has a badly strained relationship with his father and is then abused by a perpetrator outside the family home may have no place in the world where he feels safe, having been doubly betrayed.

The number and gender of perpetrators. This factor is related to the frequency and duration of the abuse in that it affects the victim's view of self (e.g. as "dirty") and the world (e.g. as populated only by dangerous people). Ritual abuse or abuse within a pedophile ring can completely shape a child's world in a highly traumatic fashion. Being victimized by both male and female perpetrators can likewise lead a child to believe that neither gender is safe. Whether the gender of the abuser is different than or the same as that of the survivor's predominant choice in a sexual partner is also a factor. As Gartner (1999) notes, a gay man sexually abused in childhood by an uncle or a heterosexual man abused by an older sister may not encode the experience as abuse, though may nonetheless evidence signs of trauma.

The manner in which the abuse was disclosed. Generally speaking, if a child is able to disclose the abuse to a safe and supportive person shortly after the



abuse occurs, he is going to be less affected than if he keeps the abuse secret. He may stay silent out of a fear of telling, or if he does tell he may experience a negative response or “second assault.” Hunter (1990) and Violato and Genuis (1993) identify this as the most significant factor in determining the short and long-term impact of the abuse.

Coping Style. Research has generally found that the psychological aftermath of abuse is more severe when the victim adopts an “emotion-focused” coping style, i.e., one that aims to avoid or escape distressful emotion through drugs/alcohol or dissociation, and that views problems as permanent. Less distressful outcomes are associated with coping styles that involve social supports and problem solving that expands the survivor’s resources for dealing with their situation (Steel et al., 2004). We would also refer back to Lisak’s (1995) identification of four different adjustments that male survivors make in attempting to resolve inner conflicts around their masculinity. The hypermasculine adjustment, for example, would involve a great amount of dysfunctional behaviour and a low level of integration of the trauma. The survivor who finds a more flexible gender adjustment, by contrast, would be expected to experience less distress because he is more able to face and process his trauma.

Cognitive appraisal (interpretation of the abuse). In a population of inmates with sexual abuse histories, Fondacaro, Holt, and Powell (1999) found that those who perceived themselves as having been abused had higher rates of posttraumatic stress disorder and obsessive-compulsive disorder than those who did not see themselves as victims. Meanwhile, those who did not consider themselves to have been abused had higher rates of alcohol abuse/dependence. Similarly, children who perceive themselves as being to blame for the abuse (i.e., who have a “negative attributional style”) have worse outcomes than do children who see the abuser as being at fault (Steel et al., 2004).



Other risk factors and protective factors. All these co-factors are related to the severity of the abuse, the relational context of the abuse, or the child's reactions (Hopper, 2007). The last two—the relational context and the child's reactions—can act as either risk factors or protective factors. We have already seen the risk associated with certain family factors. By contrast, positive family characteristics such as support and harmony, as well as extrafamilial support, are protective factors. Finally, in addition to the survivor's coping style and cognitive appraisals, certain personality factors such as self-esteem, social skills, and autonomy have been identified in the resiliency literature as protective factors, for the child with such personality features is more able to cope with the abuse than a child without them (Lambie et al., 2002).

1.5.3 Aftermath as Psychopathology

The aftermath of childhood sexual abuse is usually discussed in the language of psychopathology and diagnostics. If we are going to talk in terms of psychopathology, however, we believe it is important to recognize the root meaning of the word, namely, as a giving of voice (“logos”) to the suffering (“pathos”) of the soul (“psyche”). We note, in this regard, that diagnostic labels have unfortunately often done more to stigmatize people than give voice to their suffering souls. We have nonetheless chosen to use diagnostic categories here in order to reflect the findings in the research literature. By emphasizing that these various forms of suffering originate in childhood victimization we are aiming to counteract the stigma associated with these diagnoses. Indeed, the abuse and trauma field is praiseworthy for its efforts to connect the suffering in the soul of survivors to traumatic experiences, and we intend to maintain that spirit here.

At the same time, it is important not to attribute all the distress a sexually abused male may be experiencing to his having been abused, for suffering is



inherent in the human condition, and there are countless factors that shape a person (Hopper, 2007). That said, in a general population study that controlled for a number of variables other than the sexual abuse—including sex, age, race, family income, subsequent interpersonal victimization as an adult, and physical abuse in childhood—Briere and Elliott (2003) found that respondents with histories of childhood sexual abuse still had elevated scores on all 10 scales of a trauma inventory. In other words, the sexual abuse was revealed as a significant determinant of trauma and psychological suffering in its own right. Similarly, in a follow-up study of 56 young adults who were removed from their homes as children because of abuse and neglect, Bagley and MacDonald (1984; cited in Bagley, 1988) found that “sexual abuse victims had much poorer psychiatric profiles than all other groups, except victims of combined physical and sexual abuse, who had the poorest outcomes of all” (p. 70).

The traumatic impact of childhood sexual abuse is borne out by the vast range of negative clinical sequelae reported in the literature. Holmes and Slap (1998) noted the following outcomes for males: posttraumatic stress disorder (PTSD), major depression, anxiety disorders, borderline personality disorder, antisocial personality disorder, paranoia, dissociation, somatization, bulimia, anger, aggressive behavior, poor self-image, poor school performance, running away from home, and conflict with the law. The rate of major depression among sexually abused men was 65%; for PTSD it was 25% to 30%.

Regarding PTSD, while not all sexually traumatized men will qualify for this diagnosis, it is common to see men in therapy whose lives become profoundly disorganized and fractured following their abuse. For others, their trauma reaction may not take the exact form of PTSD but rather some other configuration of suffering, such as depression or a dissociative condition. In addition to “classic” or “simple” PTSD, the abuse and trauma field has distinguished a “complex” posttraumatic stress disorder that arises from prolonged, repeated trauma, frequently of an interpersonal nature. As a



diagnostic category, it is meant to give voice to the suffering at the extreme end of the posttraumatic spectrum.

Although not an official DSM-IV category, Herman (1992) has proposed diagnostic criteria for complex PTSD, the first of which is a history of “subjection to totalitarian control over a prolonged period (months to years)” that includes childhood sexual abuse and “organized sexual exploitation.” We reproduce the remaining criteria here in full because they indicate the extensiveness and severity of impacts found among men with sexual abuse histories in therapeutic settings, and also because this diagnosis is itself under-recognized.

Alterations in affect regulation, including:

- persistent dysphoria
- chronic suicidal preoccupation
- self-injury
- explosive or extremely inhibited anger (may alternate)
- compulsive or extremely inhibited sexuality (may alternate)

Alterations in consciousness, including:

- amnesia or hypermnesia for traumatic events
- transient dissociative episodes
- depersonalization/derealization
- reliving experiences, either in the form of intrusive posttraumatic stress disorder symptoms or in the form of ruminative preoccupation

Alterations in self-perception, including:

- sense of helplessness or paralysis of initiative
- shame, guilt, and self-blame
- sense of defilement or stigma



- sense of complete difference from others (may include sense of specialness, utter aloneness, belief no other person can understand, or nonhuman identity)

Alterations in perception of perpetrator, including:

- preoccupation with relationship with perpetrator (includes preoccupation with revenge)
- unrealistic attribution of total power to perpetrator (caution: victim's assessment of power realities may be more realistic than clinician's)
- idealization or paradoxical gratitude
- sense of special or supernatural relationship
- acceptance of belief system or rationalizations of perpetrator

Alterations in relations with others, including:

- isolation and withdrawal
- disruption in intimate relationships
- repeated search for rescuer (may alternate with isolation and withdrawal)
- persistent distrust
- repeated failures of self-protection

Alterations in systems of meaning, including:

- loss of sustaining faith
- sense of hopelessness and despair

In a related discussion on the assessment of complex posttraumatic states, Briere and Spinazzola (2005) also identify as characteristic of this syndrome a wide range of activities that act to reduce tension, such as substance abuse and bingeing and purging of food (as well as those identified by Herman, such as compulsive sexual behaviour, self-mutilation, and suicidality).



Another reason why complex PTSD is a helpful diagnosis is because it makes sense of such a wide range of pathology. As van der Kolk (1996c) has noted, “PTSD has a high rate of psychiatric comorbidity with mood, dissociative, and anxiety disorders; substance abuse; and character pathology” (p. 16). To locate personality disorders, substance abuse, eating disorders and so on within the context of a complex posttraumatic state is to unify or connect the dots among these various forms of suffering and “depathologize” those with abuse histories by understanding their distress-filled expressions as the creative adjustments of traumatized individuals. Recognition of this diagnosis may also help clinicians identify a history of childhood sexual abuse in men, as such men often come with a “disguised presentation,” such as anxiety, suicidality, hostility, rage or hypermasculine behaviour (Johanek, 1988; cited in Holmes et al., 1997), that fits into the complex PTSD profile.

Although there are a number of differences between males and females with respect to childhood sexual abuse and its aftermath, a difference in general levels of psychopathology does not appear to be one of them. This fact gives compelling testimony to the basic humanity shared by males and females and helps put lie to the traditional male code.

Holmes et al. (1997) cite studies that found the profile and levels of psychopathology for male and female victims to be “relatively similar across the genders.” Dube et al. (2005) found “strong evidence that exposure to CSA among both genders is common, and acts as a strong risk factor for multiple types of mental health, behavioral, and social outcomes similarly for adult men and women” (p. 434). In a study by Roesler and McKenzie (1994), a greater degree of sexual dysfunction (e.g., low sex drive, sexual over-activity) was the only finding that differentiated men from women with equivalent levels of sexual abuse.



On this note, Holmes et al. (1997) observe that although men and women have equally poor outcomes from childhood sexual abuse overall, there are some areas where symptoms do tend to differ. Males, for example, are more likely to develop substance abuse problems while females manifest more anxiety and depression. They comment, however, that such differences are not surprising, for they map onto the distribution of clinical problems between males and females within the general population.

Gold et al. (1999) likewise give importance to considering aftermath data for male and female survivors in light of data for each of the genders in the general population—but they draw a different conclusion. In their study of a clinical sample of men and women with sexual abuse histories they compared their findings to respective findings for men and women in normative (general population) samples. By doing so, they discovered that although the raw psychological/psychiatric symptomatology was similar for men and women, when compared to the normative samples for each gender, men had significantly higher scores on a range of measures (interpersonal sensitivity, depression, anxiety, and phobic anxiety) relative to their normative sample than women had to theirs. The authors concluded, then, that male survivors in therapy generally feel more inadequate, nervous, fearful, and depressed compared to the general population of males than female survivors do compared to the general population of females.

This study may say more about how bad it has to get before a typical man will enter therapy than it does about differences in how men and women are affected by sexual abuse. We believe it is also important not to turn the comparison of male and female trauma outcomes into a contest of suffering. What these data do indicate is that both genders experience a significant range and a significant degree of psychopathology as a consequence of their childhood sexual abuse.



1.5.4 Common Difficulties for Survivors

In this final subsection we discuss in more detail common difficulties found among male survivors. While male and female survivors may suffer about equally, we attempt here to bring out some of the places where this suffering takes on a meaning more characteristic of or unique to men. The various difficulties of course overlap and intertwine in the lives of survivors, so there will be some repetition in our discussion. As already noted, many are recognizable within the unifying framework of complex PTSD. There are numerous ways of categorizing these difficulties. We have chosen the following: emotional/mood difficulties; gender, sexuality, and intimacy difficulties; interpersonal, behavioural, and social problems; and physical problems. While these categories cover a fair bit of ground, we make no claim to having exhausted this subject.

Emotional/Mood Difficulties

Anger and Rage

In her survey of clinicians working with male and female survivors, Crowder (1993) found that the common idea that men “act out” while women “act in” was indeed accurate. Her respondents observed more depression and self-harming in their female clients and more anger, aggression, and generalized anti-social behaviour in their male clients.

Bruckner and Johnson (1987, cited in Mendel, 1995) came to the same finding when they compared the characteristics of participants from male and female survivor groups. In a sample of psychiatric patients, Carmen et al. (1984, cited in Dutton and Hart, 1992) similarly found that 2/3 of female survivors of child abuse had an internalizing coping style, where anger is directed inward, leading to depression, suicidal intent, self-hatred, and self-mutilation. By



contrast, only 20% of male survivors had internalizing coping styles, while 43% had externalizing coping styles, where anger is directed outward, leading at times to physical assaults and threats. The remainder of men had a mixed coping style.

In another study that found a gender difference in anger styles, Denov (2004) found in her small sample of men and women sexually abused in childhood by a female that it was much more common for the men to express rage at their perpetrators, some of them sharing graphic violent fantasies.

In his qualitative study of dominant themes in the lives of male survivors, Lisak (1994) noted a range of ways in which anger was discussed by his subjects, including “feeling overwhelmed with rage, of being afraid of anger, of suppressing it, and of discovering its existence.” Men commonly direct their anger at themselves for allowing the abuse to occur; at the perpetrator (including violent revenge fantasies); and at those who should have protected them or known about the abuse (Dahliwal et al., 1996). It is also common for male survivors to be angry at a world that seems to ignore or dismiss their experience as victims, and that offers few resources for men.

While many survivors express their anger outwardly, it is also true that a certain percentage is very constricted emotionally, sometimes out of a fear of their potential for violence. A high percentage of survivors do experience depression, though depressed men are often both outwardly and inwardly angry. In many cases, anger is used as a defense against acknowledging vulnerable (non-masculine) feelings such as sadness, shame, and loss (this use of anger as a defense is discussed further in Chapter 2).



Depression and Suicidality

As reported by Holmes and Slap (1998) rates of depression are extremely high among male survivors of sexual abuse. This corresponds to the near-universal theme of guilt and self-blame among these men (Lisak, 1994). Highlighting the role of male socialization in this finding, Lisak (1995) notes that in a “culture in which gender identity forms the core of an individual’s basic identity, to be insecure about one’s adequacy as a member of a certain gender is to be insecure about one’s adequacy as a person. This leads to a basic feeling of inadequacy, of negative self-worth, and of low self-evaluation” (p. 261). The sense of self-blame sometimes translates into a general sense of “hyper-responsibility,” where the man believes he is at fault for virtually anything that goes wrong and responsible for making everything right. He believes he has to somehow atone for his perceived wrong-doing.

Once again showing the variability in findings, Bagley, Wood, and Young (1994) found that male victims of long-term or multiple events of childhood sexual abuse were more likely than female victims of such abuse to manifest psychological problems, especially depression and suicidal behaviour. Research generally shows male and female survivors to have either equal rates of depression or for females to have higher rates (Dhaliwal et al., 1996).

Related to the experience of depression is the theme of loss (Lisak, 1994; Lew, 2004). Childhood sexual abuse involves countless losses, and healing must in part take the form of a grieving process. The list of losses is long: loss of childhood, loss of innocence, loss of whole pieces of one’s life, loss of opportunities, loss of control over one’s body, loss of a sense of the world being safe or “there” for you, loss of basic human experiences and capacities, loss of human connection and faith in the world, a loss of spirituality, and so on. For males, the list would include the loss of a sense of membership in the ranks of men. It is not uncommon to hear survivors talk of being “robbed” of



their lives. The sense of loss, defeat, guilt, unworthiness, emotional deadness, social exclusion, self-alienation, inner conflict, and so on are all commonly combined in the life of the depressed survivor.

In their literature review, Holmes and Slap (1998) found that the suicide attempt rate among male survivors ranged from being 1.5 to 14 times greater than that for nonabused males. In a study on sexual abuse and suicidality among adolescents, Martin et al. (2004) found that sexually abused males were 15 times more at risk than nonabused males for attempting suicide. Fifty-five percent of the abused young males had attempted suicide, compared to 29% of the abused females.

As noted earlier, men in the general population are about 4 times more likely than women to complete a suicide. It is not possible to say what portion of these suicides is related to a history of childhood victimization, including sexual victimization. Recall, however, Krugman's (1995) suggestion that for males suicide may be a way to actively escape certain feeling states—such as shame, despair, and helplessness—that are incompatible with a traditional masculine identity. Such feeling states are common among male survivors.

Shame and Isolation

We have already discussed the shame male survivors experience because of their extreme sense of “gender inadequacy” (Lisak, 1994). Real men do not get abused. Gay and bisexual men may feel ashamed of their sexual orientation, attributing it to their abuse (Dorais, 2004). Krugman (1995, 1998) discusses shame as a central organizing force in the lives of men, especially men with abuse histories. Sexually abused males typically feel damaged, dirty, and different from the rest of humanity. This can reach the point of feeling “infected” or irremediably bad. As one survivor comments: “It’s like when I have sex with a girl, as soon as I have an orgasm the guilt and shame is



incredible. Then I feel like the minute I ejaculate then I feel I should be killed. I should be shot for what I just did. The shame that comes out is incredible” (Lisak, 1994).

In a study on mother-son incest, Kelly et al. (2002) found that men who felt some degree of initial positive feelings about the abuse (e.g., sexual pleasure or nurturance) reported more subsequent aggression, self-destructive behaviour, and trauma symptoms than did men who had an entirely negative initial perception. Men in their study talked about being “especially” deviant for having experienced pleasure during sex with their mothers. As one participant commented: “I am now associated with something that is disgusting that I liked. I have incest tendencies. I am part of the incest. I am as screwed up as my mother. I am as tainted, I am as damaged, I am as dirty as she is....The incest has cheapened and dirtied my manhood” (p. 437).

Taught not to ask for help but rather to be self-reliant, tough, non-feminine and so on, many male survivors lead lives of profound isolation. The abuse experience typically sets the victim up for an immediate sense of separateness from his peers and of being isolated or alienated from others in general. The young male keeps himself apart from others in order to guard his secret (Lisak, 1994). Many male survivors talk of having lived a lie their whole lives, hiding behind a mask of normalcy, feeling utterly alone. This then sets up a vicious cycle of shame and isolation for the survivor. His shame feeds his isolation; his isolation feeds his shame. The loving human contact that could break this cycle and heal his shame is excluded from the dynamic.

Fear and Anxiety

Given that PTSD is an anxiety disorder, it only makes sense that the lives of many male survivors would be pervaded by fear and anxiety. Indeed, Lisak (1994) found that fear was his most frequently coded theme in his qualitative



study of male survivors. This included fear of intrusive traumatic experiences such as flashbacks and out-of-the-blue panic. Not uncommonly, men also dread having their abuse and/or their badness “discovered,” and spend much energy maneuvering their lives and the lives of others so as to minimize the risk. Any genuine relating with others is a cause for anxiety. Male survivors often have a basic revulsion and fear of other men (Gartner, 1999). This might manifest as discomfort with such activities as undressing in locker rooms, urinating in public washrooms, participating in traditional male activities, or even being alone with other men in a room (Dimock, n.d.; cited in Gartner, 1999).

Gender, Sexuality, and Intimacy Difficulties

Not surprisingly, sexual trauma leads to sexual problems. This is an area of some gender difference given physiological differences and the different ways males and females are socialized as sexual beings. Males are taught, for instance, to believe that they should be sexually adventurous and ready to go at any minute. How, then, to make sense of sexual experiences that are abusive?

Sexual Identity Confusion

When discussing sexual identity it is important to clarify terms. Shively and DeCecco (1977, cited in Gill and Tutty, 1997) differentiate four components to sexual identity. *Biological* identity refers to the sex assigned by medical examination at birth. *Gender* identity refers to an individual’s belief about being male or female. *Social sex role* identity refers to identification with characteristics culturally associated with men or women (what we would call *gender* role). (Money and Ehrhardt [1972; cited in Gartner, 1999] define gender identity as the private experience of gender role, and gender role as the public



expression of gender identity.) *Sexual orientation* identity is based on the sex of one's preferred love object or one's erotic and affectional attachments.

With respect to biological and gender identity, Gill and Tutty (1997) found that 4 out of the 10 male survivors in their study on this topic did not identify themselves as either male or female. They were "beings" or "humans" or "persons," with no gender.

With respect to gender role, Richardson et al. (1993, cited in Rosen and Martin, 1998) studied four sex-role types—masculine, feminine, androgynous, and undifferentiated—in a sample of college men. They found men with histories of childhood sexual abuse were more often identified as undifferentiated in their sex-role type than nonabused men, who were more often identified as masculine. Holmes and Slap (1998) found numerous studies indicating that male survivors experience more gender role confusion than non-abused men.

With respect to sexual orientation identity, finally, Lisak (1994) found a pervasive concern about sexual orientation among the male survivors in his study. This included the fear of being gay, or having the potential to be gay. As one participant said: "And it's like am I gay? And then the homophobia comes in, being afraid of gay people. And I'm like paranoid to death because maybe inside I am." A fear of being gay leads some survivors into a counter-phobic posture where they express hostility toward homosexuality. As already noted, a gay man may experience distress over his sexual orientation, linking it to his abuse. Gilgun and Reiser (1990) quote a bisexual survivor saying that his sexual orientation "feels crazy, and I don't know what to do with it." He became depressed in his late twenties, and said that "If I had a gun I would have shot myself" (p. 520). The sexual permissiveness in the gay community can, furthermore, be confusing for a gay-identified survivor, for it is hard to separate his abuse experiences from some of the sexual practices in the gay



community (e.g., multiple sexual partners) that are seen as liberated (King, 2000).

Summarizing the extent of sexual identity confusion that is possible for a male survivor, one respondent in a study on HIV-positive men is quoted as saying: "I am not a man, or a woman, or a homosexual or a heterosexual. I am nothing" (Dorais , 2004, p. 118).

Sexual Problems, Compulsions/Addictions, or Dysfunctions

Holmes and Slap (1989) found that sexually-related problems were five times more common for sexually abused males than for nonabused. Sexual problems were most associated with an early age of abuse onset and with chronic abuse. Dahilwal et al. (1996) found reports of the following problems in men sexually abused as children: sexual identity confusion/confusion of being homosexual or bisexual; sexual aggressivity; sexual adjustment problems; lower sexual self-esteem; avoidance of sexual activity; fear of negative emotions that resemble those associated with the abuse when having acceptable sexual experiences with a partner; specific sexual problems such as premature ejaculation, erectile dysfunction, retarded ejaculation, exhibitionism, sexual masochism, fetishism, sexual sadism, and frotteurism; lack of sex education; sexually compulsive behaviour; and multiple concurrent sexual partners. The authors report that the extent of these problems is not well-established empirically, but they do cite some suggestive studies. In one, for example, 75% of men with childhood sexual abuse histories in a mental health clinic sample had problems with compulsive sexual behaviour, compared to 20% for nonabused men in the same sample (Olsen, 1990). Identifying another area believed to be unique to male survivors, Urquiza and Crowley (1986, cited in Widom and Ames, 1994) found that 25% of male survivors reported some kind of sexual fantasies involving children (versus 9% for nonabused males) and 13% admitted to a desire to fondle or engage in sexual activities with children (versus 7% for



nonabused males). No connection was made, however, to rates of actual sexual abuse perpetration.

Sexual addiction or compulsiveness is a well-recognized outcome of sexual abuse. Gold and Seifer (2002) conservatively estimate that as many as 70% of male survivors in therapy acknowledge periods of engaging in sexually addictive/compulsive behaviour. Paul et al. (2002) cite studies reporting that male versus female survivors have higher levels of eroticism, lower levels of sexual anxiety, and more sexualized behaviours. Males are indeed considered to be the majority of sex addicts, though female sexual addiction is likely under-detected due to conflicts with the "female code."

In one survey of 932 sex addicts, 82% of respondents were male (Carnes, 1991). This research has identified the following areas of compulsive behaviour: fantasy sex (e.g., compulsive masturbation), seductive role sex (e.g., many relationships at the same time), anonymous sex (e.g., "cruising," one-night stands), paying for sex, trading sex (e.g., receiving drugs for sex), voyeuristic sex, exhibitionist sex, intrusive sex (contact and noncontact sexual abuse), pain exchange (e.g., receiving pain to heighten sexual pleasure, acting out the victim role), object sex (e.g., fetishes), and sex with children. The Internet has become a common vehicle for sexually compulsive behaviour, including the use of pornography and online dating, where men can make easy anonymous hook ups, especially with other men.

In a study of 233 men and 57 women in advanced stages of recovery from sexual addiction, Carnes (1991) found very high rates of childhood abuse: 81% for sexual abuse, 97% for emotional abuse, and 72% for physical abuse. That sexual addiction does not appear to be an exclusive product of childhood sexual abuse confirms that it has more to do with attempting to cope with feelings of shame, powerlessness, loneliness, and so on.



A certain percentage of men, by contrast, are sexually “anorexic” or “hyposexual,” i.e., fearfully avoidant of sex. Survivors may also alternate between periods of hypersexuality and hyposexuality as part of the posttraumatic swings that they go through. Schwartz and Galperin (2002) note a common pattern of hyposexuality with close intimate partners and hypersexuality with new partners, the latter often being a reenactment or repetition of the original abuse.

A common theme for men in Lisak’s (1994) study was that of viewing male sexuality as dangerous and bad. As one survivor commented: “I figured I was too much of a mutant for anybody to love me and any kind of sexual feelings would probably be unappreciated by a woman so I’d hide them, I tried not to show them at all.” Another theme was fear of sex: “I’m sexually attracted to her and she’s sexually attracted to me. So we went back to her house. And we started fooling around. And somehow intercourse came up. And I said not tonight. I was scared. I was scared because she wasn’t scared. That scared me.” Other men, needing to prove their self-worth, engage in compulsive philandering—an avenue congruent with the traditional male code. Finally, because the male code traditionally includes being sexually magnificent, and because many male survivors have sexual dysfunctions, these men may feel an additional layer of shame around their masculinity.

High-Risk Sexual Behaviours, HIV-Risk Behaviours

Holmes and Slap (1998) found that compared to nonabused males, abused males have higher rates of high-risk sexual behaviours. This includes prostitution and unprotected anal intercourse. It also includes more lifetime sexual partners, less frequent condom use, and higher rates of sexually transmitted diseases and partner pregnancy.



A number of studies have found up to a two-fold increase in HIV infection in sexually abused men (Holmes and Slap, 1998). Using a general population-based telephone survey of men, Bensley et al. (2000) found that childhood sexual abuse was associated with an 8-fold increase in HIV-risk behaviors. In a study of men who have sex with men, Kalichman et al. (2004) found that the men with childhood histories of sexual abuse reported more HIV-risk behaviours, specifically unprotected anal receptive intercourse and unprotected oral receptive acts. They were also more likely to have traded sex for drugs, money, or a place to stay, which is also considered an HIV-risk behaviour. (See also Brennan, 2007.)

A variety of complexly-interrelated factors are believed to account for HIV-risk behaviours, including motivational factors (e.g., wish for social acceptance, attempt to regulate painful emotions), escape-avoidance coping strategies (e.g., dissociation, substance use), poor risk appraisal processes (e.g., inattention to danger cues), weak interpersonal skills (e.g., lack of sexual assertiveness), and risky sexual scripts (e.g., learned patterns of sexual passivity or aggression) (Paul et al., 2001). Sexual scripts that reenact abusive childhood episodes may bias men toward partners who are insensitive to their safety, such as those who are dominating, over-controlling, or violent.

Holmes et al. (2005) found that childhood sexual abuse was linked to a high number of lifetime sexual partners via the variables of depression, PTSD, and comorbid depression and PTSD. They suggest that an explanation for survivors' choosing risky partners, then, is that the depression and PTSD incline the survivor toward riskier social networks, with higher levels of psychopathology. An impaired ability to form long-term relationships also leads to a risky pattern of short-term sexual relationships or one-night stands. The presence of PTSD/depression provides an explanation here as well, in that the survivor may be avoiding emotionally intimate relationships because they trigger anxieties from their abuse. Gore-Felton and Koopman (2002) have similarly found an



association between moderate to severe trauma symptoms and HIV-risk behaviours.

Numerous studies have found substance abuse to be both an outcome of childhood sexual abuse and a correlate of sexual risk taking (e.g., Paul et al., 2001). Drug and alcohol use affect sexual risk taking by impairing judgment, disinhibiting oneself, and make one less sensitive to the concerns of a partner (Strunin and Hingson, 1992, cited in Gore-Felton and Koopman, 2002). Higher lifetime intravenous drug use and rates of needle-sharing are also associated with histories of male sexual abuse (Bartholow et al., 1994; Lodic and Diclemente, 1994, cited in Goodwin, 2001).

In a qualitative study of 40 HIV-positive men, Dorais (2002) identified four patterns of HIV risk taking. The “Zombie” pattern is characterized by “an unquenchable thirst to be desired or loved for an instant” that overrides an awareness of risk in erotic situations. This survivor has poor sexual boundaries and self-destructive tendencies, and learned in childhood to see extreme risk as a normal part of life. Men who fit the “Disoriented” pattern are confused about their sexual orientation and take risks not so much because of a lack of knowledge about protective measures but rather because of the “clandestine, uncomfortable, and often quick nature” of their sexual contacts. The “Rebel” pattern defines a survivor who mistrusts authority, which he associates with his abuser, and who lives by his own rules. He accordingly views AIDS prevention messages from medical or institutional authorities with suspicion, seeing them as one more way of having his sex life controlled. The “Reconciled” pattern, finally, characterizes the survivor who has been through one of the previous three patterns but found a way via therapy or major events to examine himself and take control of his sexual risk-taking.



Emotional Intimacy Problems

Issues around sexual identity, sexual dysfunctions, and risky sexual behaviour all converge on this final area of difficulty, namely, an impaired ability to form satisfying emotionally intimate relationships with romantic or sexual partners. Holmes and Slap (1998) found numerous studies indicating that male survivors experience more fears than non-abused men regarding intimate relationships with both men and women. Nuttall and Jackson (1994, cited in Holmes and Slap, 1998) found that sexually abused men are twice as likely to be unmarried as nonabused men. Similarly, Lisak and Luster (1994) found that the intimate relationships of men with sexual abuse histories “ended more frequently because of affairs or abuses committed by one of the partners, or because of repeated conflicts” (p. 519). (In chapter 2, we discuss the topic of intimate partner violence.)

Survivors may either avoid sexual contact with their partners or engage in sex in a purely physical and dissociated manner, with no emotional component. As one survivor describes his non-relational sex life: “It was like masturbating, only you had to talk when you were done.” Or as another said: “If I’m performing the other person is an object and you can’t feel anything for an object” (Gill and Tutty, 1999, pp. 25-26).

Genuine intimacy is generally avoided out of a fear of bringing up painful feelings associated with the sexual abuse, including terror, nausea, etc. The survivor may hunger for emotional intimacy yet recoil from it; may be needy and demanding then suddenly withdraw. To be intimate is to make oneself vulnerable and surrender control, which is something that many survivors have vowed never to do again. Survivors may also act out of a general feeling of unworthiness. As one survivor shared: “I could not see anybody loving me, I could not see anybody liking me or wanting to be with me, I could not see



myself as significant to the point where I would actually be in a relationship with someone else" (Lisak, 1994, p. 542).

Introduced to sex in an exploitative context, a survivor may have difficulty differentiating among sex, love, nurturance, affection, and abuse. One outcome is for the sexually abused man to continue engaging in violent or abusive relationships as a dysfunctional way to experience a sense of love. Another is for him to view sexuality and seduction as a form of interpersonal currency, where almost all relationships are sexualized (Gartner, 1999).

What if the abuser was female? Kelly et al. (2002) note the repeated finding that female perpetration against males is associated with more interpersonal problems in intimate heterosexual relationships than is male perpetration. In Denov's (2004) study of men and women sexually abused in childhood by females, all 14 participants (male and female) reported a strong distrust of women. One man shared the following comments:

The sexual abuse has damaged me in that I cannot fully trust a woman. It's a contradiction because I'm married to a woman, but I don't fully trust her. Something inside me tells me she's going to leave me, and she's going to take my kids. I feel a sense of doom (p. 147).

Kelly et al. (2002) suggest that being abused by a female may be particularly humiliating for a male. Female-abused survivors may therefore be more prone to directing feelings of rage at a female intimate partner in adulthood.

Interpersonal, Behavioural, and Social Problems

Interpersonal Problems

In addition to problems in forming a satisfying relationship with an intimate partner, male survivors tend to have interpersonal problems in general. Lisak



and Luster (1994) found that such troubles run through the histories of male survivors as a common thread. "As children, sexually abused men got into more trouble at school, felt more rejected by their peers and also had more difficulty with academic achievement" (p. 519). The young male victim may experience a vicious cycle, where he gets rejected because of his insecurity and alienation, which only deepens his sense of separateness. A common theme is an inability to trust others or expect them to offer any help; a sense that people will hurt you if you give them a chance; a belief in having to rely completely on yourself. As one survivor comments about his abuse: "It made me not trust people at all. Really not liking people to a big extent. Because I feel like they'll abuse that trust. I just get the feeling that everyone wants something from me. There's always an ulterior motive to everyone" (Lisak, 1994, p. 540). (See also Gill and Tutty, 1997.) In a study of a large sample of adult men with sexual abuse histories, Morrell et al. (2001) found that mistrust in relationships and problems with intimacy correlated with the severity, frequency, and duration of the abuse.

Childhood abuse by a female appears not only to impair a heterosexual man's relationship with an intimate female partner but also his social relationships with women in general. Denov (2004) reports some of her participants expressing a fear of female sexuality, quoting one survivor who was "paranoid about women getting at me [sexually]." In order to maintain friendships with women, this survivor had to consciously imagine separating the sexual component of the woman away from the rest of her. If he were to reintegrate the sexual aspect in his mind he would feel threatened. We mentioned above, as well, the difficulties that male survivors commonly have in trusting other men, and the hypervigilance around men they will often maintain (Gartner, 1999). Because of this, male survivors sometimes keep only to female friends. Morell et al. (2001) found that having both female and male abuser(s) was the strongest predictor of "social incompetence," suggesting an inability to trust



basically anybody. (This can also be the case when a bystander or authority figure of the opposite sex to the abuser took no action or abandoned the male.)

Substance Abuse or Avoidance, Compulsive Behaviours

A number of studies have found a significant link between childhood sexual and physical abuse and illicit drug use in adulthood (Kalichman et al., 2004). Holmes and Slap (1998) found studies connecting sexual abuse and substance abuse among boys and male youth, indicating that drugs and alcohol offer an immediate coping strategy. In one study among high school age males, for example, the current use of alcohol, marijuana, and cocaine were two, four, and ten times higher respectively for abused versus nonabused males (Nelson et al., 1994, cited in Holmes and Slap, 1998). In a study of men who have sex with men, Kalichman et al. (2004) found that the men with childhood histories of sexual abuse were more likely than nonabused men to report using tobacco, crack cocaine, and methamphetamine in the previous six months. They were also more likely to have been in treatment for substance abuse (28% versus 9%). *Avoidance* of drugs and alcohol has also been noted as an aftereffect of abuse due to a fear of losing control (Denov, 2004).

In addition to substance abuse/dependence, we have already mentioned sex addiction as a form of compulsiveness subsequent to childhood abuse. Other areas of compulsiveness include gambling, working, eating, exercising, and shopping. Whatever form the compulsive behaviour takes, it can be seen as a dissociative solution to the problem of managing overwhelming negative feeling states (Gartner, 1999).

Self-Injury

King et al. (2002) found that men with sexual abuse histories were significantly more likely than nonabused men to score positively for each of the



psychological/behavioural disturbances that they surveyed for: psychological disturbance, sexual problems, substance abuse, and self-harm. Self-harm was defined as “any episode in which the man deliberately tried to harm himself or take his own life.” Examples of self harm include cutting or burning oneself, banging or punching ones head, or punching a wall. The authors emphasized their finding that having sexual experiences under the age of 16 that were perceived by the victim as “consensual” (i.e., viewed positively) was still a significant predictor of subsequent self-harm. Reasons for self-harming include attempting to regulate painful emotion or punishing oneself.

High Risk Behaviours and Revictimization

As has been noted, hypermasculinity is one possible pathway for men sexually abused in childhood. Although a rigid gender adaptation is noted in the literature on male sexual victimization, we are not aware of studies measuring specifically for traditional male high risk behaviours. We are certainly familiar, however, with male survivors who have lived their lives “on the edge,” with bodies worn out from motor vehicle accidents, bar fights, extreme sports, and other high impact, “masculine” activities.

It has also been observed that both male and female survivors are at greater risk than the general population for additional victimization. This is due to a number of factors, such as traumatic reenactment, poor sexual boundaries, learned helplessness, becoming a sex trade worker, drug use, and other vulnerabilities. In a study of men who have sex with men, Kalichman et al. (2004) found that the men with childhood histories of sexual abuse were more likely than nonabused respondents to have been hit by an intimate partner (54% versus 25%). In another study of men who have sex with men, Kalichman et al. (2001) found that one third of the men who had experienced sexual coercion as adults had been sexually abused in childhood.



Conflict with the Law and Victimization of Others

According to Rogers and Terry (1984, cited in Watkins and Bentovim, 1992), the most common behavioural reaction of boy victims of sexual abuse is to inappropriately attempt to reassert their masculinity through marked disobedience, fights, destructiveness, hostile or aggressive attitudes, and recapitulating their abuse by victimizing others. Chandy et al. (1996) confirmed this finding, saying that compared to female adolescent victims, male adolescents use more externalizing defenses and are thus prone to more behavioural and social problems. In a prospective study of 34 sexually molested boys a link was made to drug abuse, juvenile delinquency, and criminal behaviour within a few years following detection of the abuse (Burgess et al, 1987; cited in Van der kolk, 1996a).

For a certain percentage of male survivors, antisocial activity and trouble with authority continue into adulthood. Holmes et al. (1997) cite a number of studies reporting higher rates of childhood sexual victimization in male prisoners than in the general population. Fondacaro et al. (1999), for example, found a rate of contact childhood sexual abuse of 40% in a randomly-selected sample of inmates. It has also been found that a very high percentage of rapists, sex offenders, and sexually aggressive men have histories of being sexually abused by females (Mathews [1996] cites studies reporting rates from 59% to 80%). Similarly, almost a third of the 26 men in Lisak's (1994) qualitative study of male survivors had victimized others. This included "sexual abuse of children; rape of adult women; battery of female intimate partners; and sadistic, physical assaults on adult men" (p. 530). While these reports are significant and need to be borne in mind, it is also important to remember that the majority of men sexually abused in childhood do not commit these acts, and that antisocial behaviour is a possible aftereffect of childhood abuse and neglect in general, rather than sexual abuse in particular.



Educational and Occupational Problems

Lisak and Luster (1994) found that academic problems among male victims of sexual abuse typically persist through high school and college. At college, male survivors are more likely to perform poorly, drop out, and switch majors. Similarly, in the workplace male survivors report conflicts with coworkers and supervisors and frequently changing jobs for such reasons as feeling bored, making too little money, being injured or becoming ill. The Badgley Commission found that both male and female survivors “were significantly more likely to have achieved fewer years of education, be in lower status occupations, and to have lower income than non-victims” (Bagley, 1989, p. 295).

Difficulty Disclosing the Abuse

Disclosing or not disclosing sexual abuse is an area of distress in itself, fraught with risk either way. As noted above, rates of disclosure at the time of sexual victimization are low for both males and females, though they appear to be lower still for males. In a Canadian study on the disclosure of sexual abuse among male and female victims, Alaggia (2005) notes that it seems to be more common than not for victims of both genders to delay disclosing their abuse. She describes disclosure not so much as a one time event but as a process where there is often an initial testing of the waters, with the first attempt being indirect, behavioural, or nonverbal, where the victim drops hints. Disclosure for both genders was often precipitated later in life by an emotional collapse or even a hospital admission.

While delay of disclosure was the norm for both genders, Alaggia did identify three aspects of this delay that differentiated men. First, men feared being viewed as homosexual and being “bashed.” Second, they felt “profound stigmatization or isolation because of the belief that boys are rarely victimized.” Third, they feared sexually abusing a child themselves. This fear



was at first an inhibitor to disclosure but later becomes a precipitant, as the man wishes to seek help before possibly committing an offence.

Many men feel extreme guilt for not having disclosed sooner. They feel a responsibility as men to tell and protect other potential victims, but live with all the forces that as men inhibit them from doing so. Lew (2004) discusses this guilt and (as a way to help men relieve it) lists additional reasons why men delay disclosure, including not having yet defined the experience as abuse, still being under the spell of the perpetrator, and not realizing that there were any options.

Physical Problems

Physical problems derive from the physical violation at the time of the abuse, from trauma symptoms that play out somatically, from developing a negative (distrustful or hateful) relationship with one's body, and from injuries and illnesses sustained in the course of acting out the abuse experience.

Holmes and Slap (1998) found that 24% to 90% of males who experienced repeated abuse had a number of physical signs and symptoms at the time of the abuse, including: encopresis (loss of bowel control), enuresis (bed-wetting; incontinence), or dysuria (difficult or painful urination); rectal patulosity (expansion) or impaction; anal erythema (inflammation), fissures, tears, or hyperpigmentation. Boys sexually abused when less than two years old, whether once or multiply, were most likely to have physical problems. Constipation and encopresis are reported in adult survivors (Gartner, 1999).

Somatic complaints are common among trauma survivors of all kinds. Trauma gets held and expressed through the body when it has yet to be symbolized otherwise. When the trauma is "somatized" in this way, the victim may



experience such effects as chronic pain (e.g., headaches, heart pain, painful joints, pelvic pain), hypertension, immunity problems (e.g., allergies, asthma, skin problems), heavy limbs, numb or tingling body parts, dizziness, exhaustion, and gastrointestinal disturbances (e.g., irritable bowel syndrome) (Schiraldi, 2000).

The male survivor often learns to hate and/or mistrust his body (Hunter, 1990). It reminds him of his humiliation and victimization. It betrayed him by its physiological reactions and sensations at the time of the abuse. He may view it as ugly, yet wonder what it is about his body that invited the abuse. Or he may make himself less attractive, through bad grooming, overeating, or other means, as a way to insure that he is not an object of desire. He may still not trust his body, feeling he is not in control of it. He may have learned to dissociate or split off from it, which can itself be a scary experience when this takes the form of a dissociative episode involving disorienting or surreal perceptions. Some survivors also develop body image disturbances, such as compulsive body-building, and eating disorders, such as anorexia and bulimia.

Van der Kolk (1996b) has eloquently observed that when traumatized, “the body keeps score.” He has compiled an extensive list of “psychobiological abnormalities” or mind/body effects associated with PTSD. These include *psychophysiological effects*, such as hyperarousal to intense but neutral stimuli; *neurohormonal effects*, such as decreased serotonin levels and heightened opioid responses to triggers; *neuroanatomical effects*, such as a decrease in volume of the hippocampus (the structure in the brain associated with the integration of memory); and *immunological effects*, including abnormalities in cells related to immunity. While an in-depth discussion of these effects is beyond the scope of this guidebook, some familiarity with them is important in working with sexually traumatized males, as this knowledge enables the clinician to explain and normalize much aftermath (such as depression or amnesia) that has a psychobiological component.



As already discussed, male survivors may develop sexually transmitted diseases, physical injuries, or other illnesses as part of the aftermath of their abuse. This may range from minor injuries caused by accident proneness to death due to AIDS, suicide, substance abuse, or a major accident.

Finally, the traditional male neglect of medical self-care is often amplified in survivors. They may fear talking about their bodies or being examined by a medical professional, especially for a prostate exam. Survivors often avoid going to the dentist. They may also be so dissociated from their bodies that they are simply unaware of being in pain or having a physical problem.

Having reviewed a number of long-term effects of male childhood sexual abuse, we would like as a final note to mention the findings of a literature review on the effects of childhood sexual abuse for women. Neumann et al. (1996) compared 38 studies that met rigorous research criteria. They found that anxiety, anger, depression, revictimization, self-mutilation, sexual problems, substance abuse, suicidality, impairment of self-concept, interpersonal problems, obsessions and compulsions, dissociation, posttraumatic stress responses and somatization are all significantly associated with female childhood sexual abuse. We conclude with this reminder of the common ground shared by male and female survivors, even if their aftermath and gender role journeys may differ in other respects.



CHAPTER 2

SPECIAL FOCUS ON MALE INTIMATE PARTNER VIOLENCE IN LIGHT OF CHILDHOOD TRAUMA

2.1 WHY A SPECIAL FOCUS?

Much debate currently exists about the causes of intimate partner violence and the best practices for treating domestically violent men. The dominant treatment model today is feminist-based group re-education, exemplified by the Domestic Abuse Intervention Project, also known as the Duluth Model (Pence and Paymar, 1993). According to this model, domestic abuse consists of sexual and physical violence and a number of interpersonal tactics that abusive men use to maintain power and control over women. Treatment then involves holding these men accountable for their actions, challenging the sexist or patriarchal beliefs that they use to justify their behaviour, and encouraging them to see their intimate partners as equals. The Government of Ontario mandates such a re-education and re-socialization approach for its Partner Assault Response programs, as do many other provinces and states for their own programming.

In Chapter 1, we noted that anger, rage, and intimate violence are part of the aftermath of male childhood sexual abuse for some survivors. In Lisak's (1994) study of sexually abused men, for example, almost a third of the survivors reported victimizing others, including battery of female intimate partners. In a similar qualitative study on the effects of childhood sexual abuse on men, it was discovered that 5 out of 10 of the participants had entered counselling because their partners had complained about their abusive behaviour, both verbal and physical (Gill and Tutty, 1999). Such findings imply that something



other than, or in addition to, patriarchal attitudes is going on for a certain portion of domestically violent men.

We have therefore included this special focus to draw attention to the role of male sexual trauma, and also trauma experience more generally, in the generation of intimate partner violence. Our intention is to heighten awareness of this topic for therapists working with male survivors of sexual abuse, as well as to promote a wider dialogue on the place of trauma and childhood victimization in the etiology of domestic violence. We present this material not to prescribe an exact model of practice but rather to highlight significant research and theory in this area, and to suggest certain practice principles for the reader's consideration, regardless of their treatment setting.

A psychological analysis of male intimate partner violence puts into doubt some of the tenets of the feminist sociopolitical analysis. We do not propose, however, that the feminist approach be entirely replaced. What we are aiming at, rather, is conversation that broadens our understanding of domestic violence, where patriarchy is seen as one factor among others. Like any good conversation, positions must shift as new perspectives are brought to bear on the subject matter. For our part, we again wish to stress that the issue is not only patriarchy and male socialization, but also how this socialization strains men and intersects with their own experiences of victimization. We believe that including such a male-centred viewpoint in the conceptualization of intimate partner violence will ultimately result in more effective treatments for men and a safer society for women. Mauricio and Gormley (2001) write, in this respect, that "using the feminist hypothesis to collaborate with rather than compete with individual-level psychological explanations of violence may be instrumental in decreasing recidivism among batterers" (p. 1068).

As in the case of sex offending, intimate partner violence is an area where researchers are today arguing against any single-factor theory in favour of a



multi-factoral approach. It is by now well-known that most domestically violent men have histories of childhood maltreatment, and present with a range of psychiatric difficulties, including affective disorders, personality disorders, neurological disorders, and psychoactive substance use disorders (Sonkin and Liebert, 2003). Boyle and Vivian (1996) found that severely violent men have higher levels of depressive symptomatology compared to nonviolent men. Dutton and Starzomski (1997) have determined that about 80% to 90% of wife assaulters have demonstrable personality dysfunctions. The research of White and Gondolf (2000) likewise indicates that if there are 20 men in a group for domestically violent men, about 3 will exhibit severe personality pathology, a further 6 will have moderate personality disorders, and the remaining 11 will have some degree of milder personality dysfunction.

Despite the seeming relevance of these striking findings, the authors of the Duluth model downplay the role of psychological/psychiatric factors in domestic abuse. Duluth model proponents argue that taking a therapeutic approach dodges the real issue—namely, men’s belief in their superiority over women—and allows assaultive men to avoid taking responsibility for their violent actions by pleading the “abuse excuse.” One of these authors, Michael Paymar, presents his own view on why men assault their partners as follows.

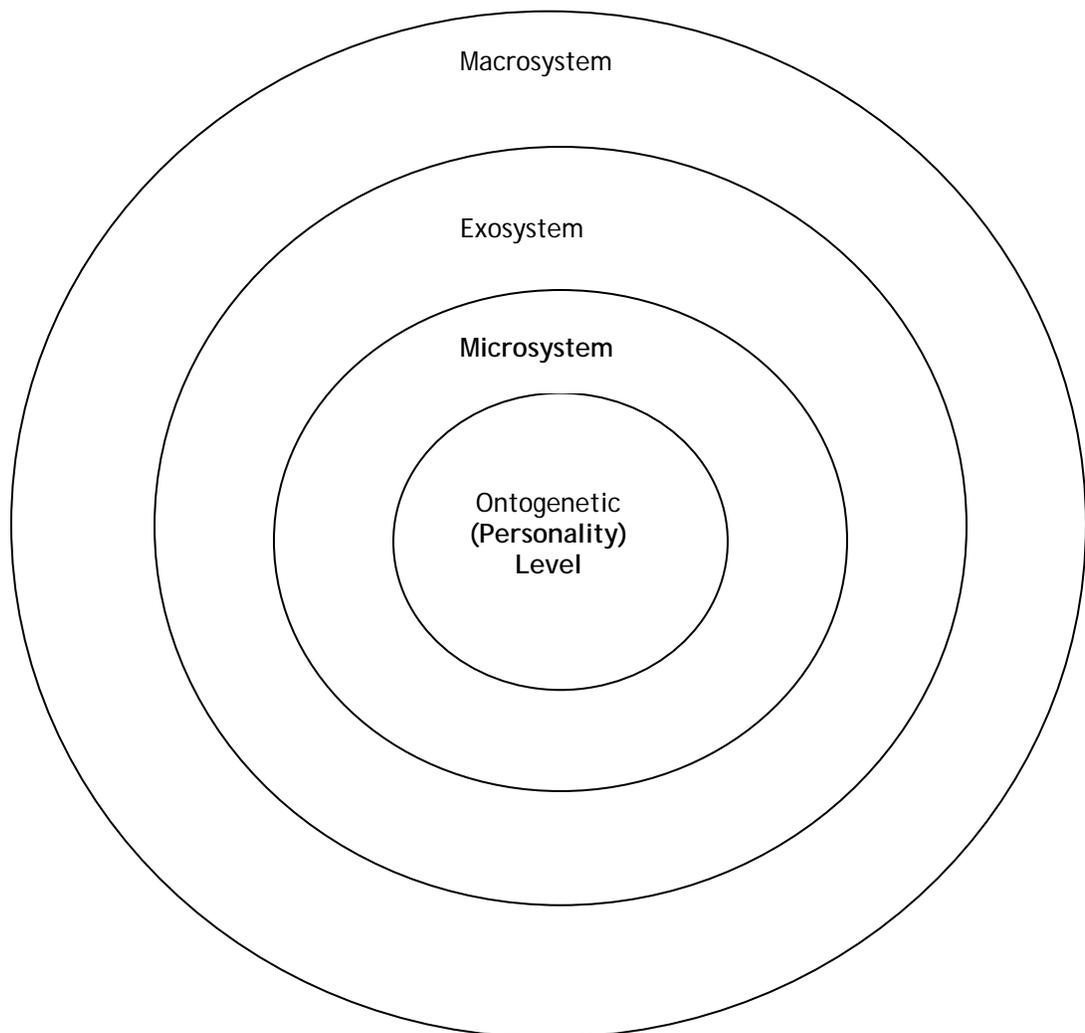
When I think about the hundreds of men I’ve worked with over the years, men batter (1) to get their partners to stop doing something they disapprove of, (2) to stop their partners from saying things or to end an argument, (3) to punish their partners for something they’ve done. It really is that simple (Paymar, 2000, p. 232).

The research suggests, however, that it is not in fact that simple.

Part of the problem with the “Male Beliefs of Women” theory that Paymar advocates is that it does not provide an adequate account of the motivation for abusive behaviour. To say that abusive men are controlling because they want to be in control explains very little. It tells us nothing about the origins or

nature of this desire to control, the conditions under which abuse occurs, or other purposes that violent behaviour might be serving for the assaultive man. We find Dutton's (1995) adoption of a "nested ecological theory" more satisfying in these respects, as it makes room for interaction among a number of levels of causation and for a more complex understanding of intimate partner violence.

Figure 2.1 **A NESTED ECOLOGICAL THEORY OF WIFE ASSAULT**
(Dutton, 1995)



As shown in Figure 2.1, a nested ecological approach identifies four levels of analysis: the macrosystem, exosystem, microsystem, and ontogenetic levels. The macrosystem consists of broad cultural values and belief systems, such as the traditional male code. This is the level of patriarchal ideology, so is the one that Duluth-type feminist analysis focuses on. The exosystem consists of certain social structures such as work, friendship, and support groups. Examples here of risk factors for intimate violence include job stress and social isolation. The microsystem consists of the immediate context or family unit in which the violence occurs. Marital conflict is highly associated with the occurrence of intimate violence (Langhinrichsen-Rohling, 2005), and particular marital characteristics (e.g., poor communication, patterns of negative interaction) are known to distinguish relationships that include intimate violence from those that don't (Vivian and Malone, 1997). The ontogenetic level, finally, refers to factors having to do with the abusive man's developmental history, including childhood abuse and exposure to violence, and certain personality features such as empathy and verbal skills. What Dutton emphasizes is that a man's risk for partner abuse depends on the interaction between this ontogenetic level and the three-level social context.

For example, wife assault would be viewed as likely when a male has strong needs to dominate women (ontogenetic), has exaggerated anxiety about intimate relationships (ontogenetic), has had violent role models (ontogenetic), has poorly developed conflict resolution skills (ontogenetic), is currently experiencing job stress or unemployment (exosystem), is isolated from support groups (exosystem), is experiencing relationship stress in terms of communication difficulties (microsystem) and power struggles (microsystem), and exists in a culture in which maleness is defined by one's ability to respond aggressively to conflict (macrosystem) (p. 50).

Using this ecological framework, Dutton has identified a number of flaws with the Duluth-type feminist model. The most obvious of these is the fact that the vast majority of men are not assaultive, yet all are exposed to patriarchal values and socialized as men. This illustrates the point that aggregate social



categories such as patriarchy are inadequate by themselves for explaining individual behaviour. Attempts to do so commit what Dooley and Catalano (1984; cited in Dutton, 1994) have termed the “ecological fallacy.” Dutton (1994) notes, moreover, that “only a minority of batterers are misogynistic, and few are violent to nonintimate women; a much larger group experiences extreme anger about intimacy” (p. 174). He argues, accordingly, that deeper personality factors and traumatic childhood experiences need to be part of the picture (Dutton, 1998).

Because the focus of this book is the treatment of men sexually abused in childhood, our interest also lies primarily with the ontogenetic or developmental level of explanation. We stress this level only to maintain our focus on sexual abuse and its aftermath, not to discount other levels or factors. Indeed, we could additionally note certain exosystem and microsystem factors common among male survivors, such as social isolation, marital and interpersonal difficulties, and employment problems. In order not to commit a kind of ecological fallacy ourselves, we will also discuss how the macrosystem factor of patriarchal beliefs and attitudes does in fact interact with personality factors for a number of abusive men maltreated in childhood.^{§§§}

One last reason to introduce a male-centred trauma perspective on domestic violence is provided by outcome studies on the treatment of domestically violent men. Most of this treatment uses a group format that combines a

^{§§§} In questioning a single-factor approach, it also bears mentioning that intimate partner violence is not limited to male-on-female violence. Using data from Statistics Canada’s 2004 General Social Survey, Beauchamp (2008) found that 15% of gays or lesbians and 28% of bisexuals reported being victims of spousal abuse in comparison to 7% of heterosexuals. Researchers further recognize the phenomenon of so-called “husband abuse,” where men are abused by women partners. The prevalence, severity, and meaning of husband abuse are much debated, and few would dispute that woman abuse is the more serious and widespread issue (Tutty, 1999). The battery of men by female partners nonetheless needs to be explained—as does violence among gays, lesbians, and bisexuals. Although we do not pursue these topics directly in this chapter, our discussion of the psychological factors in intimate violence likely has relevance to them.



Duluth-type model with some cognitive-behavioural therapy. Babcock et al. (2004) undertook a major meta-analysis on batterers' treatment outcome studies and concluded that "current interventions have a minimal impact on reducing recidivism [repeat offending] beyond the effect of being arrested" (p. 1023). Based on partner reports, men who completed a Duluth-type and/or cognitive-behavioural program had a 40% chance of being successfully nonviolent, while this was true for 35% of the men who received no treatment at all. These types of treatment thus accounts for a 5% increase in success.

Babcock et al. did allow that assaultive men are a difficult population to treat, especially because their attendance is often mandated rather than volunteer and because they tend to use externalizing defenses. Better outcomes are typically reported, however, for other difficult-to-treat populations (e.g., aggressive children and adolescents, adult prisoners). The authors also found that the two types of partner assault groups that had the highest success rates used interventions that distinguish them from Duluth/CBT groups. One used "retention techniques," such as writing supportive handwritten notes to group members that improve the therapeutic alliance between members and the group leaders. The other aimed at helping the men enhance their intimate relationships, using methods such as role-plays, and homework aimed at improving expressiveness, empathy, intimate communication, and identification and management of emotion. Based on the successfulness of the latter group model, Babcock et al. (2004) note that "emotion-focused, rather than cognitively focused, interventions may increase the effect size [successfulness] of batterers treatment" (p. 1046). They further conclude:

Given what we know about the overall small effect size of batterers' treatment the energies of treatment providers, advocates, and researchers alike may best be directed at ways to improve batterers' treatment. [...] Battering intervention agencies are more likely to improve their services by adding components or tailoring their treatments to specific clientele, than by rigidly adhering to any one curriculum in the absence of empirical evidence of its superior efficacy. Different types of batterers may



preferentially benefit from specific forms of interventions, yet no controlled treatment matching studies have been concluded to date (p. 1048).

In sum, we believe that knowledge gained from trauma research, theory, and therapy has a role in the comprehension and treatment of intimate partner violence. In the remainder of this chapter we examine some of the research evidence linking trauma and intimate partner violence; consider some of the theoretical options—emotion theory and attachment theory, in particular—for explaining this linkage; and conclude by discussing some of the clinical implications of incorporating a male-centred trauma perspective in the treatment of intimate partner violence.

2.2 RESEARCH EVIDENCE LINKING TRAUMA AND INTIMATE PARTNER VIOLENCE

As we have already noted, childhood emotional trauma is not the only factor in the causation of intimate partner violence. Assaultive men have much higher rates of previous significant head injury, and lower test scores for cognitive flexibility and executive functioning than non-assaultive men (research cited in Sonkin and Liebert, 2003). These findings suggest that neurological impairment may also be an important factor.

It is noteworthy, as well, that some of the first links between trauma and intimate violence were made not for victims of child abuse but adult war veterans. Even if this research on combat veterans does not make a link to child abuse, it is still significant for the strong association it has made between PTSD and intimate partner violence. Riggs (1997), for example, discovered that combat veterans with trauma-related symptoms such as PTSD are much more at risk for domestic violence than veterans without such symptoms. There are many overlapping characteristics of veterans with PTSD and those who perpetrate domestic violence, including high rates of comorbid depression and



substance abuse, relationship distress, increased day-to-day stress, poor problem-solving skills, and responding to perceived threats with intense fear and anger. In their review of the literature on PTSD and intimate partner violence among combat veterans, Sherman et al. (2006) note that the severity of PTSD correlates with the risk of perpetrating domestic violence. In their own study, they found that assaultive veterans' anger was associated with PTSD, not with combat experience. They propose that a complex interplay among anger, hostility, and hyperarousal may put PTSD-veterans at increased risk for being violent with an intimate partner (see also Savarese et al., 2001).

While the research on combat veterans connects trauma to domestic violence, clinicians and researchers have consistently found that for many perpetrators of intimate violence the source of trauma was childhood maltreatment (Langhinrichsen-Rohling, 2005). As Simoneti et al. (2000) note: "previous theoretical and empirical work indicates an association between traumatic childhood experiences, difficulties in modulating affect and aggression, serious personality disturbances, and high degrees of violence exhibited by partner-assaultive men" (p. 1265). Van der Kolk (1996) cites a number of studies that "found a direct relationship between the severity of childhood abuse and later tendencies to victimize others" (p. 199). Lisak (2007) likewise observes that "scores of studies" have confirmed the relationships among childhood abuse and chaos, PTSD and depression, school problems and substance abuse, a derailed transition to adulthood, and perpetration of violence as an adult. He has defined eight risk factors for the perpetuation of a cycle of violence: sexual abuse, physical abuse, substance abuse, physical neglect, witnessing violence, family history of abuse, family history of substance abuse, and family history of mental illness. Even the authors of the Duluth model, while opposing psychological explanations for partner assault, note that:

The history of a man who batters is often a history of childhood abuse; exposure to male role models who have shown hostile attitudes toward women; exposure to women-hating



environments; alcoholism; racial and class oppression; and the denial of love and nurturing as a child. Clearly many men who we work with need to find ways to heal from the sexual and physical abuse they experienced as children. [...] Their collective history is filled with violence (Pence and Paymar, 1993, pp. 4, 15).

In their *Relating Without Violence* program at Ontario Correctional Institute, Bierman and Cheston (1996) likewise found that most men in their groups reported violence in their childhood families of origin, being abused themselves or witnessing others being abused. Sources of trauma included physical abuse (sometimes extreme), being raised in an alcoholic family, emotional abuse, sexual abuse, abandonment, parental neglect or rejection, and losses due to divorce, death, etc. It was very common for the assaultive man to have experienced multiple abuses. Murphy et al. (1993) have found that partner assaultive men with histories of severe childhood physical abuse could be differentiated from other partner assaultive men by the presence of more personality disorders and other psychopathology, and by higher levels of psychological and physical aggression directed toward an intimate partner (see also Caesar, 1988; and Holmes and Sammel, 2005). As one last example of research evidence linking trauma and intimate partner violence, Dutton (1995) has found a significant degree of similarity among the clinical profiles of men with histories of childhood trauma, men with borderline personality organization, and men who assault their partners.

As for childhood sexual abuse in particular, it is likely that this abuse is underdetected in assaultive men because it is underdetected in general. There is, however, some important evidence we can point to. Using a very large general population sample, Whitfield et al. (2003) discovered that physical abuse, sexual abuse, and growing up with a battered mother each increased the risk of men perpetrating physical violence with an intimate partner by a factor of approximately 2 compared to men without such histories. Men who had experienced all three of these forms of violence had a 3.8-fold increased risk for partner abuse. Contact sexual abuse by the age of twelve was itself



associated with a 3.3-fold increase in risk for perpetrating intimate violence (1.8-fold when sexually abused after the age of 12). The authors noted that these numbers are likely on the low side due to a lack of detailed questioning.

In another noteworthy study, Simoneti et al. (2000) based their research on the fact that severe wife abusers are sometimes unable to recall their assaultive episodes, tend to black out during these episodes, and exhibit altered states of consciousness. These dissociative processes have been traced to traumatic childhood experiences. The authors state that a dissociative coping style is a significant factor in severe partner assault, as it creates the detachment from emotion necessary to engage in violence. They found that male sexual abuse survivors had significantly higher scores on measures of depersonalization and amnesia than assaultive men without such histories, and that they had higher dissociation scores than men who were physically abused or who witnessed their mothers being abused. They also found that domestic violence is more frequent and severe when the perpetrator has dissociative symptoms or reports dissociating specifically when violent. This suggests that defenses adopted by trauma survivors, such as dissociation, can themselves be associated with abusive behaviour.

Although 11 out of the 47 men in their study (all of whom were undergoing counselling for domestic violence) had histories of childhood sexual abuse, the authors observe that sexual abuse in the histories of domestically violent men has “been only rarely studied and may warrant further investigation.” They discuss their own findings in this respect as follows.

With only a couple of exceptions, the sexual abuse in the current study involved intercourse during preadolescence or early adolescence with women who were more than 5 years older than the respondent (the women’s age ranged from 24 to 47 years). Study participants did not generally report being disturbed by these experiences. For adolescent males, having sex with an older woman may be congruent with a sense of rebelliousness and may be taken as evidence of one’s ability to achieve sexual conquests



or form a manly identity. These sexual experiences, however, may create discontinuities in the child's social and emotional development. Suppressed guilt and rage, along with subsequent devaluation of women, may accompany the exploitative component of these early sexual experiences. Such experiences may contribute to a dissociative style of coping, a complex distancing from oneself and intimate others, and a tendency toward abuse of females in adulthood (pp. 1277-1278).

Kelly et al. (2002) cite several studies that likewise found that male survivors had more problems in intimate relationships (particularly sexual aggression) when the perpetrator was female than when male. Like Simoneti et al., they offer an explanation based on the intersection between male sexual trauma and male socialization: "Being victimized by females, who, according to masculine stereotype, are weaker than males, may be especially hard to tolerate for boys and men. Consequent feelings of shame and rage may be directed toward the women with whom they are intimately involved in adulthood" (p. 435). Further male-centred research may throw even more light on this topic.

Having surveyed some of the research linking intimate partner violence with trauma in general, and childhood sexual trauma in particular, we consider in the next two sections some of the theoretical bases for further explaining this connection.

2.3 EMOTION THEORY: THE SHAME-RAGE LINK

Anger Is a Factor in Intimate Partner Violence

One of the tenets of the Duluth/feminist model is that domestic violence is not an anger problem but rather a problem of men's beliefs about women. This does not fit, however, with the research by Dutton and others that has consistently found a correlation between anger and assaultiveness in abusive men, with anger significantly predicting violence. Highlighting the importance



of emotional factors in domestic violence, Dutton et al. (1995) note that “men who assault their wives experience high levels of chronic anger, high levels of chronic trauma symptoms, a tendency to externalize the cause of their violence and an admixture of shame and guilt about their violence” (p. 121). Harper et al. (2005) cite extensive research literature that connects anger with intimate partner violence, including anger that is specifically directed toward the man’s partner (“spouse-specific anger”); while Lafontaine and Lussier (2005) found strong evidence that anger mediates and moderates**** the relationship between romantic attachment and intimate violence. The research on combat veterans also makes this link. From a slightly different angle, Kia-Keating et al. (2005) found in a study of resilient male sexual abuse survivors that most of these men were aware of their rage and potential for violence in their intimate relationships. Such men reported having to actively work on containing their anger in order not to perpetuate a cycle of violence, with one participant stating that he deliberately limited intimacy in order not to trigger his rage.

What, then, accounts for the difference between the position of the Duluth/feminist model and the position of those researchers cited here who have found anger to be a significant factor in domestic violence? The Duluth/feminist model holds that partner assault is an act of *instrumental* violence, where the man deliberately chooses to use violence in a systematic and calculated way to maintain power over his partner. This view accordingly downplays the idea that the man just can’t control his anger. Sonkin and Liebert (2003) disagree with such a view, emphasizing the role of impulsiveness:

The idea that all patients are in complete control of their behavior stems from the socio-political perspective that emphasizes power and control, self-will, and accountability.

**** A mediating variable (e.g., anger) is one that explains the connection between two others (e.g., romantic attachment and intimate violence), while a moderating variable is one that creates conditions for the connection to occur.



Although research suggests that a certain percentage of perpetrators may use violence instrumentally, the vast majority of batterers use violence impulsively and therefore are needing more than the message “use violence, go to jail.”

The difference, then, between these two stances is that the former sees intimate violence primarily as an instrumental act while the latter sees it primarily as an *expressive* act. In contrast to instrumental violence, expressive violence involves high levels of emotional arousal, is poorly controlled, and aims both to hurt the other person and relieve one’s own anxiety or distress. It is committed with little insight or forethought and functions as part of the individual’s emotional defense system. It is also characteristic of an emotionally dysregulated state, where the individual has difficulty modulating their emotional life. Recall that one of the diagnostic criteria proposed by Herman (1992) for complex PTSD is “Alterations in affect regulation, including [...] explosive or extremely inhibited anger.”

Unsurprisingly, a number of researchers are now commenting that dysregulation of anger is definitive both of trauma survivors and of many men who batter. This would seem to be borne out by Rosenberg’s (2003) study in which male and female perpetrators of domestic violence who completed a partner assault program were asked to share what was helpful for them in reducing their abusiveness. (The programs they attended were all 52-weeks long and included process-oriented clinical approaches, cognitive behavioural approaches, and educational approaches, though much of the content was consistent across the programs because dictated by state law. Eighty one percent of the study participants were male, 19% were female.) Eighty one percent of respondents said that learning anger management tools was helpful, while 84% said they continued to use these tools after the program was completed. As Rosenberg remarks, “This study suggests that, in the eyes of the program participants themselves, improving emotion regulation is critical to effective domestic violence treatment” (p. 315). Given these findings, the



challenge is to provide additional theoretical avenues for understanding the nature and function of dysregulated anger in expressive violence.

The Shame-Rage Connection

One important avenue that has been pursued by a number of theorists and clinicians for comprehending abusive men's anger is that of the close relationship between shame and rage. Bierman (1996/1997) comments, for example, that the tough and rageful exterior of assaultive men he has worked with acts to hide their "shamed" identities formed through childhood abuse and neglect. Although anger is often used as a term to include rage (as we have been doing above), it is important in this context to distinguish the two as separate emotions. While anger arises in response to a blocked goal or hurtful interaction, rage arises in response to a humiliating or shaming attack against the self, whether the attack has an internal or external origin.

The emotion theorist Helen Block Lewis coined the term "humiliated fury" to indicate the simultaneity of shame and rage. She spoke of shame as an "'implosion' or a momentary 'destruction' of the self" (Lewis, 1987a, p. 95). To experience shame is to feel inadequate, exposed, dirty, defective. In shame, a sense of badness or rejection radically separates us from the rest of the world, and in this truncation from the love of others we feel ourselves disappearing or dying as a self—what has been called "idiocide" (Dutton, 1998). (This differs from the experience of guilt, where the sense of wrongness or badness attaches to our actions rather than our very self.) Rage, then, is an attempt to preserve the self; an explosion that reverses a shame implosion. In order to overcome the shaming attack against the self, one must turn the tables and attack the other; to defend against personal annihilation one must rage against the perceived source of humiliation.



In a series of interviews with assaultive men, Solomon (2001) discovered precisely this relationship between shame and intimate violence. He consistently discovered symptoms of depression among these men, one of whom stated that he felt “so worthless on this earth I might never do nothing again if I don’t fire out or punch something.” A sufferer of depression himself, Solomon offers his own honest and revealing testimony regarding an episode of intimate violence:

I had a serious falling-out with a man whom I loved very much and by whom I felt profoundly and cruelly betrayed. I was already in a somewhat depressed state, and I became enraged. I attacked him with a ferocity unlike any I had experienced before, threw him against a wall, and socked him repeatedly, breaking both his jaw and his nose. He was later hospitalized for loss of blood. I will never forget the feeling of his face crumpling under my blows. [...] When people expressed horror at my attack I told them almost what the batterer told me: I felt as though I were disappearing, and somewhere deep in the most primitive part of my brain, I felt that violence was the only way I could keep my self and my mind in the world (pp. 179-180).

Solomon describes his rage as “totally impulsive.” His account conveys the function of rage as a primordial self-preserver, as a way to ward off psychological disintegration by discharging humiliated fury.

We may experience a milder version of this phenomenon when someone gets into our personal “space.” Our self-boundary feels somewhat impinged; we lose a bit of our sense of autonomy, get irritated, and ask the person to “back off.” For an abuse survivor whose very identity is shame-based, this process is profoundly magnified. If shame and rage function to guard the boundaries of the self (Nathanson, 1987), then staying angry or rageful in those places where the self is most vulnerable or fragile, as in intimate relationships, may seem the only way to have a self or to exist at all. Inward destruction through shame is defended against by means of outward destruction through rage.

This view of shame and rage is consistent with the finding by researchers that abusive men score high on measures of shame. Dutton et al. (1995), for instance, found in a study of abusive men that there were significant relationships between recollections of shaming experiences in childhood and subsequent adult anger/rage and intimate violence (as well as personality dysfunction). They discovered, in fact, that there was no correlation between being physically abused in childhood and becoming an assaultive adult unless the childhood experience was accompanied by shame and guilt. Without the emotional engine of internalized shame the childhood violence did not appear to cycle from one generation to the next. Dutton (1998) similarly found that shame is strongly related to borderline personality organization, anger, and trauma symptoms, which are core elements of what he calls the “abusive personality.”

As another example of research on shame and rage in assaultive men, Harper et al. (2005) found in their study of dating violence that levels of shame correlated with levels of anger/rage, and anger/rage was found in turn to correlate with psychological abuse with dating partners. As they note, “anger appears to serve as a pathway through which shame is expressed as psychological abuse” (p. 1658).

Rage and expressive violence, then, can be seen as functioning to ward off unbearable feelings of internalized shame and self-annihilation by putting one on the offensive. The shame-prone individual easily feels attacked and reacts with a “preconscious rush from embarrassment to humiliation to rage” (Krugman, 1998, p. 171). The aggression serves to restore a sense of personal power, autonomy, or agency by making the other person bad or wrong. This often involves a defense mechanism known as projective identification, where the abusive man projects his sense of inferiority or powerlessness onto his partner who then identifies with or is induced into feeling what is in reality the man’s shame. As is well recognized in the domestic violence field, the



partner's self-esteem may then steadily erode as she carries the abusive man's sense of badness.

In more social terms, this defensive dynamic has been referred to as "altering the interpersonal field" (Wallace and Nosko, 1993). To experience shame is to feel excluded from the circle of society. Displays of shame (hung head, expressions of remorse, etc.) then function as a signal that one wishes to be readmitted into this circle. When, however, an abusive male is defended against feeling his shame, he may adjust by creating his own small social circle or micro-society and then making his partner the bad one who has to be readmitted. He tightly controls or restricts her friendships, finances, and movements as a way to maintain this altered and shrunken relational field, one that spares him from contacting the well of shame at the core of his own fragile self. The "power and control" tactics identified in the Duluth model can thus be seen as having a basis not only in patriarchy but also in a defense against internalized shame.

The workings of shame can be seen as well in the "cycle of violence" originally described by Lenore Walker. This particular cycle refers not to the intergenerational transmission of violence but rather to the phases that some abusive men go through in any given cycle of intimate violence. The first phase consists of a period of tension and moodiness where there is a build-up of anger and the partner "walks on eggshells" in order to avoid setting the man off, or where she deliberately provokes him just to get the violence over with. In this phase the man fears his partner will leave, and escalates his controlling behaviour, possessiveness, and jealousy. The second phase is an explosion of acute battering, where the tension peaks and is discharged uncontrollably in a rage. The assaultive man can form a sort of addiction to this behaviour because of the sense of release that it brings. The third phase is that of contrition, where the man demonstrates remorse, apologizes profusely, brings flowers, and promises not to do it again, or to get help. Paymar (2000) downplays this

three-phase formulation of partner abuse because it gives a place to anger and because not all abusive men go through these phases. It is nonetheless true that this cycle is commonly seen in cases of domestic violence and that Walker's description of it was empirically based (Walker, 1979, cited in Dutton, 1995). What is more, it clearly indicates that psychological processes are involved in partner abuse, not just social and cultural ones.

Dutton (1995, 1998) sought to provide an explanation for Walker's cycle of violence by means of personality types. What he discovered is that "cyclical wife assaulters" frequently demonstrate borderline personality organization. In fact, borderline personality is a later term for what was originally termed "cyclical personality." Dutton came to see the cycle of abuse as a playing-out of the extreme instability of the borderline personality.

Dutton notes that in the tension phase the abusive man's anger and rage build-up because his fragile self is disintegrating and he is viewing his partner as "all bad" (using the defenses of projection and blame). Socialized as a male to submerge his feelings of terror about being abandoned, the abusive man in this phase is typically only aware of a diffuse tension he cannot put into words but which he expresses in complaints about his partner. When this tension phase gives way to contrition, however, he switches into viewing his partner as "all good" and himself as "all bad," the interpersonal field now altered so that he is the one who must plead to be readmitted into the circle of loving relations. As Dutton comments, these two phases represent two distinct selves, a tension self and a contrition self, both of which are shame-based and separated within the abusive man by a process of primitive splitting or dissociation. The explosive phase of acute battering represents a transition between the two selves. The borderline personality construct thus provides a good explanation for the behaviour of assaultive men in terms of the interplay of shame and rage.



As a final note here, we would stress that so-called borderline personality is one of the common outcomes of child abuse, including male sexual abuse, and may therefore be located more satisfactorily within the context of complex PTSD in many cases. We say this because being labeled “borderline” ironically often produces another layer of shame for the abuse survivor. While agreeing with Dutton’s analysis, and seeing its relevance for our work with male survivors, we are thus cautious about the use of this terminology.

Shame, Rage, and Male Socialization

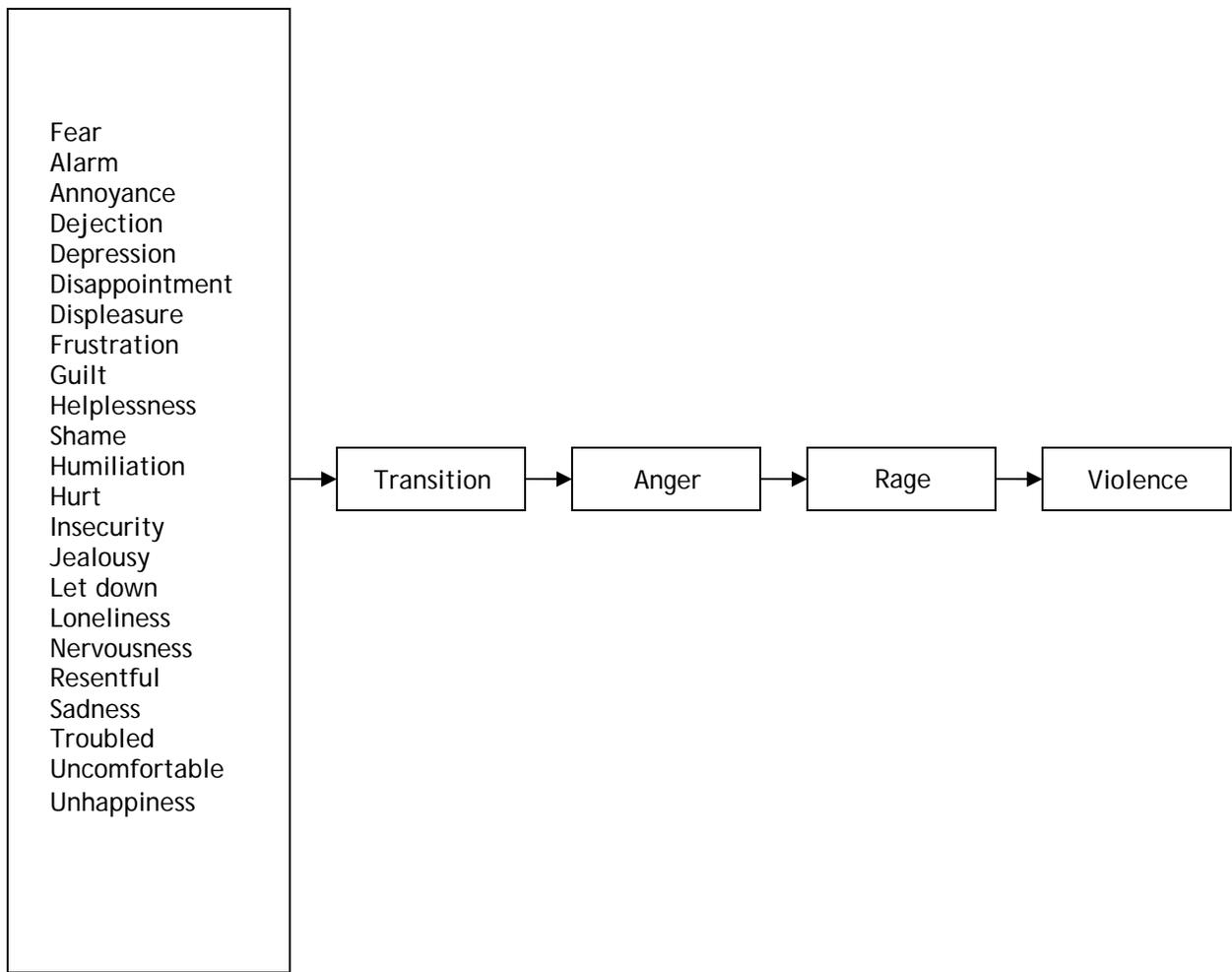
Significantly, the avoidance of shame and the violent acting out of rage by men who batter is fueled and catalyzed by traditional male socialization. It is fueled in that men have traditionally been disallowed from experiencing vulnerable feelings such as shame—and to feel ashamed if they do. When vulnerable feelings such as helplessness, powerlessness, fear, or shame arise for a traditional male he does what he has learned to do: he either finds a way to numb himself or else redirects the high arousal from these feelings into anger or rage. Gondolf (1985, cited in Dutton, 1995) has described this latter option as a funneling process because of the way that a wide range of “non-masculine” feelings get reduced down to the narrow point of anger and rage (Figure 2.2). Male socialization thus tends to insure that shame and other vulnerable feelings will remain unrecognized, unarticulated, and unhealed. It then catalyzes the expression of these dammed up feelings as anger and rage by providing a patriarchal code that promotes male aggression, control, and authority. The more shame and other vulnerable feelings a man may harbour the more prone he may be to anger, rage, and hostility. Supporting this idea, Jakupcak et al. (2005) found that fear of emotions was a significant predictor of overt hostility, anger expression and diminished anger control in a sample of college men. Shame-proneness also predicted hostility and aggression.



Figure 2.2

THE MALE EMOTIONAL FUNNEL SYSTEM

(Gondolf, 1985)



Lisak et al. (1996) discovered this relationship between vulnerable emotions and violence in a sub-set of men abused in childhood who adopted a hypermasculine defense. They note two significant reasons why such a defense puts men with abuse histories at risk for violent behaviour. First, the constriction or funneling of emotional expression rules out the possibility of the trauma experience being integrated, because it cannot be explicitly felt. The hypermasculine survivor will then be intolerant of expressions of emotional distress in others or behaviours that trigger his own unhealed trauma because

these evoke his vulnerable, shame-bound feelings, and threaten him with an emotional overarousal he cannot regulate. As we have seen above, in order to terminate or relieve himself from this aversive experience, he may then act abusively toward the person he perceives as the source of his discomfort. His violence against his partner is thus essentially an attempt to relieve his own anxiety.

The second reason why the hypermasculine survivor is at risk for violence is because in his emotionally cut off state he has an impaired ability to empathize with others. He is thus largely unable to imagine the fear and other distresses that his partner is experiencing as a result of his abusive actions. Missing the crucial inhibition against violence provided by empathy, he is more likely to act out his own shame-bound emotion through abusive tactics. (Recall, as well, Simoneti et al.'s [2000] finding that dissociation following trauma also creates a detachment from feelings that if consciously present would inhibit violence.)

A related finding of the Lisak et al. (1996) study was that the abused men who did *not* perpetrate violence were less rigid and less stereotyped in their gender identity, and more capable of full emotional expression, than nonabusive men who had no history of child abuse at all. This finding was particularly true for nonabusive men with histories of sexual abuse.

Lisak et al. (1996) caution that linking abuse, gender rigidity, empathy deficits, and violence is to account for only one subtype of perpetrator of interpersonal violence. What these authors did observe, however, is that the empathically disconnected survivor is particularly open to sexist cultural messages because they fit into his defensive structure. Hypermasculinity provides an ideological home for the traumatized and emotionally constricted male. Lisak's (1998) remarks suggest the importance of these findings:

Among the factors that have been associated with the perpetration of interpersonal violence, few if any come close to



the predictive power of childhood abuse, and few have been as consistently documented as hypermasculine ideologies (p. 235).

Compared to abused men who *do not* perpetrate, abused perpetrators are more rigidly masculine, more emotionally constricted, and less empathic. Thus the masculinization process, early trauma, and the intertwined and interacting emotional legacies of both appear to be important and relatively common factors in men who commit violence (p. 220).

These conclusions again put into question the Duluth model's single-factor theory, as Lisak's findings indicate that intimate violence takes place in the interaction between the traditional male code and certain abuse-related personality factors for at least a portion of assaultive men. As Dutton (1994) notes, "patriarchy does not elicit violence against women in any direct fashion. Rather, it may provide the values and attitudes that personality-disordered men can exploit to justify their abuse of women" (p. 176).

Another challenge to the Duluth model comes from the finding that it is not simply men's traditional values that are associated with intimate violence, but also their gender role strain. As would be expected, there is some degree of correlation between traditional masculinity or hypermasculinity and intimate partner violence (Mahalik et al., 2005; Moore and Stuart, 2005; Parrott and Zeichner, 2003). However, recent studies indicate that the correlation between masculinity and intimate violence may to some significant degree be due to male discrepancy strain (what in the research literature is being called gender role *stress*) (Mahalik et al., 2005; Moore and Stuart, 2005). Research by Eisler and his colleagues (cited in Mahalik et al., 2005) has found that men with higher levels of gender role stress (discrepancy strain) have more negative intentions, feelings of irritation, and anger toward women who threaten their control than do men with lower levels of gender role stress. These men are also more frequently verbally and physically abusive. In other words, a significant factor in intimate violence is not just the adoption of traditional male values but the feeling of not measuring up to these values, of feeling inadequate,



ashamed, or insecure in one's masculinity. As we have seen, this is a feeling prevalent among male survivors of sexual abuse.

Interestingly, Jacupcak et al. (2002) found that masculine ideology on its own did not in fact predict relationship violence but it did when the experiential factor of gender role stress was also present. Even in this case, however, the interaction of these two factors only accounted for 12% of the variance in reported intimate violence (Cohn and Zeichner [2006] report a similar finding.) Given these relatively small numbers, the authors concluded that while masculine ideology and gender role stress are significant factors in domestic violence they are not the *primary* factors. In speculating about other factors not measured by their study they comment that perhaps a "history of abuse is the critical factor to understanding men's violence, and masculine gender role stress is only indirectly related" (p. 104). The study by Lisak et al. (1996) discussed above would certainly lend some weight to this possibility.

In sum, while traditional masculinity plays a role in intimate violence it seems to do so largely in interaction with other variables, especially personality factors having to do with shame internalized from abusive experiences in childhood.

2.4 ATTACHMENT THEORY: UNDERSTANDING THE "INTIMATE" IN INTIMATE PARTNER VIOLENCE

The Relevance of Attachment Theory

If we are to understand domestic violence we must understand the nature of intimacy, for the violence occurs precisely within the context of an intimate relationship. As Dutton (1994) states, for many abusive men "intimate relationships are a source of great fear. [...] It is not a question of 'anger versus



control' as Gondolf and Russell (1986) put it; anger and control stem from the same origin: terror of intimacy." Hence, "intimacy rather than gender politics seems to be the most crucial factor in such violence" (p. 177).

Intimacy-related themes such as dependency, abandonment, engulfment, and spouse-specific anger and hostility have indeed been found to be central to abusive behaviour (Boyle and Vivian, 1996; Langhinrichsen-Rohling, 2005; Murphy et al., 1994). Given the tremendous discomfort that male survivors of sexual abuse commonly experience in their intimate relationships it is easy to speculate about a link between child abuse and partner abuse. Recall, in this regard, the finding from the Simoneti et al. (2000) study that of the assaultive men in their sample with histories of childhood sexual abuse most had female perpetrators, and likely harboured a rage at women that got triggered in their intimate relationships.

Distress that arises specifically within intimate relationships, then, may well be a key factor in domestic violence. Our discussion of emotion theory has already begun to map out this territory. In this section we go one step further by turning to a school of empirically-based theory that deals precisely with the emotional landscape of intimate relationships: attachment theory.

As with emotion theory, attachment theory provides ground for some disagreement with the Duluth model. The fact that most partner abusive men are violent only in their intimate relationships is presented by the Duluth authors as proof that the violence is instrumental. They argue that because the assaultive male (when not of the generally violent type) seems to be able to control his anger at work and other social settings his violence at home must be a deliberate, conscious choice. Attachment theory provides an alternative interpretation: intimate or romantic relationships are always *attachment relationships*, while work and social relationships typically are not. For an attachment theorist, this makes all the difference.

What, then, is an attachment relationship? The original model is the relationship between an infant and a caregiver or “attachment figure” (usually, but not necessarily, the mother and/or father). For the infant, the attachment figure is a source of security, love, and soothing. The founder of attachment theory, John Bowlby, postulated that whenever an infant feels alarm (whether of internal or external origin) this activates what he termed “the attachment behavioural system.” At this point the infant engages in “attachment behaviours,” such as crying or crawling toward a parent, the purpose of which is to bring about soothing physical contact with the attachment figure. In other words, these behaviours are such as to keep the attachment figure close to the infant, in the role of the infant’s secure base and safe haven.

One attachment behaviour noteworthy for our purposes is the display of anger. When alarmed due to separation from a caregiver the first response of the infant is to protest with angry crying, clinging, and screaming. Bowlby accordingly called anger an emotion born of fear of loss of an attachment figure. This fits the view of emotion theorists that humiliated fury is “rage at the threat of lost love” (Lewis, 1987a, p. 26). Because infants depend on their attachment figures for the latter’s power to soothe their tension and anxiety, they experience emotions such as terror, grief, and rage when the figure is felt to be absent or otherwise not providing the needed comfort and security. The power that nature gives to infants at these moments of distress, then, is to engage in angry and demanding behaviours aimed at controlling the proximity and nurturing attention of caregivers, to overcome the sense of rejection and shame through expressions of rage. When, however, displays of anger do not meet with success and as a result become chronic, the anger becomes dysfunctional. The now intense and/or persistent anger backfires and actually alienates the attachment figure instead of bringing them closer.



Although attachment theorists such as Bowlby originally studied infants and children, later theorists found that attachment patterns from childhood tend to be reproduced in adulthood in romantic relationships. What they discovered is that while romantic relationships are not identical to parent-child relationships, adult intimate partners do in fact play the role of attachment figure for one another. One of the consequences of this is that any dysfunctional anger or rage from childhood attachment experiences that has been lying dormant within the person gets reactivated when they form an adult attachment relationship (Dutton, 1998). According to Dutton (1998), this triggering of attachment-rage left over from childhood provides a compelling account of the developmental origins of intimate violence:

Loud crying and shaking of the cot are prototypical forms of later physical acts we would call aggressive. The first and primary function of anger is to reestablish soothing contact with the attachment figure. By adulthood the male has learned and reshaped these actions over a lifetime so that crying is replaced by shouting, shaking the cot by throwing or smashing objects. Control over the woman's emotional distance becomes a preemptive strike precluding the need to display rage for her return, except when the control breaks and she leaves. At these junctures the suppressed dependency explodes in a pyrotechnic display of rage and desperation. But the motive is the same even if the behaviors have changed: an attempt to regain control through physical actions (p. 118).

As this passage suggests, much intimate violence may be seen as a dysfunctional, adult version of childhood attachment behaviours. The difference between the adult and the child is that the adult male's power to rage and control has grown tremendously.

From a trauma perspective, it is crucial to see an assaultive man's abusiveness in this light, namely, as a dysfunctional attempt to establish contact with an attachment figure who will soothe his emotional pain and insecurity. Attachment relationships by their nature are used to regulate emotion by providing an attuned figure who mirrors and calms the distressed person. For



infants this “dyadic regulation” is crucial, for they are not at that age able to soothe themselves. One of the functions of secure attachments, then, is to provide the opportunity for the child to internalize the caregiver’s calming abilities so that the child can then self-soothe. Secure attachments are also the antidote to emotional trauma in that they act to restore a sense of calm and safety. Conversely, when children lack a secure attachment figure and are traumatized they experience a “double whammy” (Allen, 1995). They are thrown into a state of emotional arousal beyond normal bounds (because of the overwhelming nature of the experience) while utterly lacking resources for calming down and feeling safe again. They will therefore continue throughout their life to feel the need for a person to play the role of soother.

This appears to be the case for many abusive men. Given, however, the dysfunctionality of the man’s rage, his lack of insight into it, and his anxiety about the very intimacy and dependency he insists on, his partner will inevitably be perceived as failing him in this role—which then creates more anger, rage, and violence (Dutton, 1998). Consider, in this respect, the findings from a study on assaultive men by Holzworth-Munroe et al. (1997):

Violent-distressed men reported having a high need for nurturance from their wives and a narrow focus on their wives; yet, they also reported tending to avoid dependency, having discomfort with closeness, and being fearful of closeness. [...] in particular, they reported being anxious about abandonment (in general and with their wives), being preoccupied with their relationships (both past relationships with parents and current romantic relationships), being jealous of other men, and not trusting their wives. As a result, they are at risk for a general breakdown in attachment strategy (p. 327).

The interpretation of intimate violence provided by attachment theory thus again offers a powerful psychological or ontogenetic explanation for abusiveness. When a person lacks the ability to form a positive and loving attachment to another who can be their secure base, they experience a terrible aloneness and a deep discomfort with themselves. This makes them



prone to a host of problems, from addiction to depression to psychosomatic illness—to violence. Violence, then, can be seen as one outcome of a failure of intimacy, as the behaviour of an individual who feels painfully detached. In short, through all the man’s controlling and terrorizing behaviour it is possible to glimpse an anxious and insecure boy attempting desperately to meet his basic needs for love and security.

Adult Attachment Styles and Intimate Violence

Following Bowlby’s original formulation of attachment theory, much research has gone into assessing individual differences in attachment status. This research has resulted in the identification of four prototypical attachment patterns or styles observed in both children and adults. Different theorists use different terms and criteria, but the four basic styles can be briefly summarized as follows (descriptions here are drawn largely from Karen [1998] and Bartholomew [2007]):

Secure. Securely attached infants readily explore their environments using the attachment figure as their secure base. As children, they have good self-esteem, are resilient, and make friends easily. As adults, securely attached individuals are comfortable with emotional expression and are basically sociable, having positive internal “working models” of themselves and others. Their romantic relationships involve relatively high levels of closeness, sharing, mutual respect, and a general ability to resolve conflicts constructively. The three remaining attachment styles are all categorized as “insecure.”

Anxious, Preoccupied. The attachment system of anxiously attached infants is hyperactivated due to the unpredictable, inconsistent, or chaotic nature of their care. Anxious babies cry and scream, are clingy and demanding, and often angry or furious with their primary caregivers. They are upset by brief



separations and make limited explorations of their environments. As children they are immature, fretful, easily overwhelmed by anxiety, and may be victimized by bullies at school. Being uncertain about their caregivers' love, they both seek the latter's attention and act hostilely toward them. For adults, the anxious attachment style is termed *preoccupied*. Preoccupied adults are emotionally "up-regulated," being emotionally reactive, sensitive, and incoherent. They lack confidence, having a negative working model of themselves and a positive working model of others. They therefore tend to be highly dependent on others for their self-esteem. They are overly demanding of closeness and place a high priority on their romantic relationships, with a constant background worry about their desirability or lovability. Anger, passion, jealousy, fear of abandonment, and possessiveness are hallmarks of the preoccupied style in intimate relationships.

Avoidant, Dismissing. The attachment system of avoidant infants is deactivated. They have defensively suppressed their attachment needs due to experiencing the unavailability or rejection of their primary caregivers. They give up on seeking physical contact with the caregivers and take on an air of self-reliance, becoming neutral and unenthusiastic in their exchanges. They bypass their feeling of shame over being rejected, so do not express humiliated fury. They instead quietly turn the tables and reject the caregiver (Lewis, 1987c). At school, these children are often aggressive and defiant, and may be disliked or isolated, with few friends. For adults, the avoidant style is termed *dismissing*. These emotionally "down-regulated" and non-introspective individuals appear cool, rational, and aloof or arrogant. Having a positive working model of themselves and a negative working model of others, they actively avoid turning to others for support, often being critical of or cynical about the world. In romantic relationships they keep their distance, avoiding self-disclosure, interpersonal conflict, and displays of emotion or affection. Although these individuals present as having high self-esteem, this is more



accurately seen as masking their core anxiety and negative feelings about themselves.

Disorganized, Fearful. The disorganized attachment style is characterized by the absence of a consistent attachment strategy (such as the clinging of the anxious baby or aloofness of the avoidant). The caregivers for disorganized children are frankly abusive or else fearful themselves. These children thus live in a state of high anxiety where the caregivers are the source of fear. Placed in an impossible situation, disorganized children both approach their caregivers for protection and avoid them because of their dangerousness, often behaving in a seemingly bizarre manner such as reaching out while backing away or approaching the parent then falling on the floor. Disorganized children often display a violent imagination, thinking that they or their parents will be severely hurt or killed. They may speak in contradictory, strangely repetitive or nonsensical language, accompanied by aggression. For adults, the disorganized attachment style is termed *fearful*, and is characterized by the same “erratic dependency and distancing” (Sonkin and Dutton, 2003), where their attachment system alternates between hyperactivation and deactivation. Fearful adults are highly self-conscious, hesitant, vulnerable, and lacking in confidence. Because they have negative working models of both themselves and others, they are easily distressed yet reluctant to show it or go to others for support. They demonstrate dependency, jealousy, and separation anxiety, while at the same time being fearful and mistrusting of intimacy because of their trauma histories. They are profoundly insecure in romantic relationships, dreading that their partners will discover their unworthiness and leave them, and caught between the fear of aloneness and the fear of engulfment by the other. When the disorganizing forces become very strong in these individuals the result can be “a breakdown in cognition and affect resulting in uncontrollable rage and dissociation” (Sonkin, 2007, p. 13).



Some researchers currently stress that a person's attachment style can be assessed not only according to a single category but also by the degree to which it matches each of the four prototypes. This gives a more complex or composite picture, especially for those who don't fall as obviously into one category. The four prototypes are nonetheless still used as the framework for assessment, and many researchers do characterize a person according to the attachment style that appears to describe the person best overall.

With regard to research on intimate violence, the distinction between a secure and an insecure attachment style is considered to be highly informative. Insecure children are commonly low in self-esteem, impulse control, and stress tolerance; have a decreased capacity for genuine trust, intimacy, and affection; lack empathy, compassion, and remorse; and, significantly, demonstrate antisocial attitudes and aggressive behaviour. The emotional dysregulation that is virtually definitive of assaultive men, moreover, is characteristic in one way or another of all three insecure attachment styles. Numerous studies indicate that adults with secure attachment styles have more satisfying and trusting relationships than people with insecure attachments, the latter being more prone to anxiety, anger, and frustration (Lafontaine and Lussier, 2005; Mahalik et al., 2005). Research also consistently links intimate violence with insecure attachment styles, especially preoccupied and fearful styles (Mahalik et al., 2005). A significant link has been found, in this regard, between insecure attachment styles and the need for dominance and frequency of violence (Mauricio and Gormley, 2001). As we would anticipate from the findings of attachment theorists, then, research reveals high rates of attachment insecurity among abusive men.

When insecure attachment styles are themselves traced to child abuse the links are made from childhood victimization to attachment insecurity to adult abusiveness. Dutton (1998) has done this through the construct of the borderline personality, tracing the origin of this personality to child abuse,



shaming experiences, and the formation of insecure attachment styles. The connection is most evident with fearful attachment, but is also significant with preoccupied. He notes that “the correlation of fearful attachment to borderline personality organization is so strong that one could argue that the latter is a representation of this particular attachment style” (1995, p. 157). For Dutton, the angry, assaultive man with a borderline personality, trauma history, and fearful attachment style is the “pure” form of batterer because of the powerful dynamics around intimacy and the confinement of the violence to the romantic relationship. It would be a mistake, however, to say that all abusive men fit this typology. Lafontaine and Lussier (2005) report that although men with dismissive attachment styles are more often passively aggressive, they can on some occasions cross a certain threshold and become overtly violent. As will be discussed in the next section, moreover, there is a range of types of batterers with different diagnoses and severities of abusiveness. The research of Dutton and others nonetheless does illustrate the value of looking at intimate violence through the lens of attachment strategies and behaviours, which in turn places an emphasis on childhood experiences including abuse and trauma.

What about the role of traditional male socialization in the development of attachment patterns? While noting that males are no more likely than are females to develop insecure attachment styles, Mahalik et al. (2005) note that attachment style formation and gender role socialization are interrelated developmental processes, and that traditional male socialization can foster a fear of dependency. With respect to men who batter, their research reveals that both fearful attachment and gender role stress (discrepancy strain) significantly predict controlling behaviours, with the gender role stress accounting in part for the link between fearful attachment and controlling behaviour. As we have seen in other areas of research, these authors therefore call for a gendered perspective on partner abuse.



We note, finally, that although attachment theory has obvious relevance for the domestic violence field, we are not aware of research that has specifically studied attachment styles in assaultive men who were sexually abused in childhood. We do know that personality disorders, including borderline, are part of the aftermath of male sexual abuse and that, following Dutton, borderline personality organization correlates with fearful and (to a lesser extent) preoccupied attachment styles. It is noteworthy as well that many sexually abused boys were vulnerable to extrafamilial predation precisely because their home environments were insecure. Having been betrayed both inside and outside the home, where can such a male feel safe? We also know that difficulties with intimacy are common among male survivors. In a study of object relations in sexually abused men, Morrell et al. (2001) concluded that male survivors “tend to experience a basic lack of trust in relationships and difficulty with intimacy” (p. 861). The survivors in their study had significantly elevated scores on scales of insecure attachment, alienation, social incompetence, and egocentricity. Being sexually abused by a male was the strongest relative predictor of insecure attachment (though severity, duration, and frequency of abuse were all predictive of elevated scores). Such findings are certainly suggestive. In the absence of attachment research aimed directly at abusive male survivors, however, our discussions here must be considered exploratory.

2.5 TREATMENT IMPLICATIONS

The research and theory discussed in this chapter have identified a number of overlapping psychological factors that connect trauma and adult perpetration of intimate violence. These include PTSD (hyperarousal); emotional dysregulation; depression; personality disorders; substance abuse/dependence; suppressed rage (at women); humiliated fury; defense mechanisms such as projective identification, altering the interpersonal field, and dissociation; emotional constriction; empathy deficits; hypermasculine adjustment; intimacy



anxiety; and insecure attachment strategies. The existence of these numerous ontogenetic level factors suggests that the successful treatment of assaultive men may in many cases require more than group re-education. Dutton and Sonkin (2003) argue, in this light, that “acknowledgement of attachment, shaming and trauma precursors to battering should become an integral part of treatment” (p. 4).

In this final section, we consider four general implications of adopting a trauma lens for the treatment of men who are abusive in their intimate relationships. We do so, however, not to prescribe a precise model but rather to identify those areas where researchers and theorists are currently calling for exploration and innovation in the treatment of assaultive men, whatever the treatment setting may be.

Screening and Assessment

Given the relationship we have been exploring between trauma and intimate violence, it follows that trauma therapists need to screen for intimate violence and that partner assault programs need to screen for trauma. Intake questionnaires can easily be designed to incorporate themes related to trauma and intimate violence, and many screening and assessment tools can be used (including those for the related factors of substance abuse, depression, etc.). For instance, Sonkin and Dutton (2003) discuss assessing for attachment styles, using tools such as self-report scales that are readily available and relatively straightforward to interpret (see the web links in Sonkin, 2005).

The Importance of the Therapeutic Alliance



Despite that Duluth-type groups are described as re-education, in practice they have a largely *therapeutic* intent: they focus on behavior change not just knowledge acquisition; require disclosure of personal information (such as feelings, attitudes, and relationship problems); and employ cognitive behavioural techniques (such as self-monitoring and cognitive restructuring) (Murphy and Baxter, 1997). A childhood trauma perspective on intimate violence, moreover, explicitly calls for a therapeutic approach. It follows that everything known about therapy and the therapeutic process will be relevant for the treatment of intimate violence. More specifically, research has consistently revealed that the therapeutic alliance, or working relationship between therapist and client, is the most important variable in treatment outcomes. As Taft and Murphy (2007) note with concern, however, “many in the partner violence field downplay the importance of a collaborative therapeutic relationship, empathic listening, group cohesion, and related processes shown to promote success in other areas of psychotherapy” (p. 11). Such authors are now saying that the domestic violence field needs to pay more attention to the topic of the therapeutic alliance, and that better outcomes may result from doing so.

The therapeutic alliance refers to the bond between therapist and client and to their agreement on the goals and tasks of the therapy (Bordin, 1979, cited in Taft and Murphy, 2007). Carl Rogers’ original formulation of the necessary and sufficient conditions for therapeutic change—therapist empathy, prizing of the client, and genuineness—is also invoked in this context. In terms of attachment theory, we could say that the therapist needs to be a secure base for the client, creating a kind of safe holding environment where the client can be mirrored and otherwise assisted in a process of healing and growing. When a good therapeutic alliance is missing treatment outcomes are generally poor. In group therapy, the formation of a therapeutic alliance among group members (including identification with others, group cohesion, trust in others, etc.) has



also been identified as a crucial ingredient of successful therapy (Courtois, 1988).

With respect to the therapeutic alliance and intimate violence treatment, two recent studies (cited in Taft and Murphy, 2007) have indeed found that alliance development improves treatment compliance and is associated with less psychological and physical abuse recidivism. In addition, Rosenberg's (2003) study on those aspects of the group experience that group members themselves found most helpful in reducing their violence, the two highest rated items were related to therapeutic alliance. Ninety-six percent said that "group support/feedback/other's stories" was helpful, while 86% said this was true for the "connection with group leader/role model." A "strong sense of rapport between group members, and the ability of the group leader to facilitate individual and group expression each played a significant role in change for many men and women" (p. 309). As Rosenberg comments, "there is more to changing violent behavior than imparting information" (p. 314).

It is common for men in partner assault groups to initially resist the group leaders but then to feel sad when the group is ending because of the bonds they have formed. Not surprisingly, then, Rosenberg found that most (60%) of the participants in their study strongly supported having programs that were 52 weeks long rather than shorter. They commented that the process of loosening their defenses and building trust was a gradual one. Specifically, the men mentioned that it took between three and six months for them to develop a sufficient therapeutic alliance with the leaders and the group to start taking advantage of what the program had to offer. The women in the groups, by contrast, did not mention time as a factor in their ability to connect with others. Although they did mention a process of building trust and loosening defenses, the women were more able to share immediately their feelings and personal information. As Rosenberg notes, the majority of men, unlike the women, had never shared their inner lives with a group of other people. If the



sharing of emotions and development of a therapeutic alliance are considered crucial to the change process, then Rosenberg's findings would seem to argue for relatively lengthy programs for men.

As further evidence here, Taft and Murphy (2007) point to the research finding that the use of supportive and empathic methods in the treatment of substance abusers leads to less resistance and better outcomes than confrontational methods. The authors suggest that a parallel can be drawn with assaultive men, as they are similarly regarded as a treatment-resistant population.

While research has shown that a good therapeutic alliance is crucial for positive outcomes, there are a number of reasons why it may be particularly important for the treatment of men who are violent in their intimate relationships. As we have seen, first of all, many of these men are shame-prone. They are accordingly resistant to confrontation because they perceive it as one more shaming attack. Therapy for them may represent the threat of vulnerability and dependence. Research suggests that a good therapeutic alliance may be all the more important for clients who use externalizing or blaming defenses, as they will not relax these defenses until they feel safe enough to do so (Taft and Murphy, 2007). Violent men who have only known abusive and neglectful caregivers do not easily trust others or let their guard down. Similarly, if many assaultive men are empathically disconnected then it is especially important that therapists and group leaders themselves demonstrate empathy, as the abusive men are otherwise unlikely to soften or repair their disconnection. From an attachment perspective, finally, we would repeat the point that therapy clients learn to tolerate and regulate their painful emotions only when they have a good enough relationship with the therapist that they can risk making contact with their vulnerable feelings.

In light of these points, a number of concerns have been expressed about the Duluth model. Mankowski et al. (2002) suggest that when intimate violence is



viewed as purely instrumental, interventions are more likely to take on a punitive character. Empathy is not considered necessary; only confrontation. These authors also argue that, ironically, the Duluth model is traditionally masculine in its avoidance of the “unsettling ‘feminine’ aspects” of the assaultive man’s experience (p. 176). In maintaining an “emotional distance from male suffering,” such an approach may actually reinforce anxieties about male power rather than help see through to the human being inside the violent man.

Concerns have also been expressed about the potential for destructive countertransference reactions in treatment providers. In a room full of assaultive men powerful emotions get projected onto the group leaders. Scalia (1994) notes that the leaders’ confrontations can then become hostile or abusive, as their own anger and aggressive states get triggered. Mankowski et al. (2002) similarly caution that countertransference reactions under confrontational conditions can result in leaders’ controlling, degrading, or belittling the group members. In order to underscore such concerns, Murphy and Baxter (1997) cite research (by Henry, Schacht, and Strupp) indicating that even subtle and/or infrequent forms of therapist criticism and blame are sufficient to produce negative treatment outcomes because they act to reinforce the client’s low self-esteem and their self-criticism. It is crucial, these authors say, for therapists to “pass their clients’ ‘tests’ by consistently disconfirming the client’s expectation of rejection” (p. 612). This is as true for a man with a history of intimate violence as it is for any other client.

To express these concerns about the use of a confrontational method is not to say that all or most Duluth-type facilitators act unempathically or aggressively in their groups. It is rather to highlight that the Duluth model places them more at risk for doing so than if it were to give more attention to the development of a strong therapeutic alliance.



A few words, then, about the task of building a therapeutic alliance with abusive men. First, there is no question that assaultive men need a resocialization experience that is challenging to them. From what we have said in this chapter, however, it is crucial that the context for this resocialization be empathic. What needs to be challenged, moreover, is not just sexist beliefs about women but also (and perhaps more importantly) the belief that men have no inner lives. Our experience has been that by explicitly drawing attention to the kind of psychological topics discussed here, many abusive men with trauma histories finally feel understood and recognized. They are relieved to have an opportunity to discuss their emotional lives—which then becomes central to their change process.

Sonkin (2003) makes a related point when he suggests that confrontation will do less to build a therapeutic alliance with an abusive man than offering him *interpretations* of why he behaves the way he does, helping him to understand the emotional meaning of his violence and the gendered cultural context in which it occurs. He promotes empathy as the “primary means of engaging the client” (p. 12).

A number of authors have also identified various techniques for working with abusive men that are deliberately designed to avoid reshaming them (e.g., Dutton, 2003; Sonkin and Dutton, 2003). The work of Wallace and Nosko (2003) is noteworthy here, as they have designed a therapy program for abusive men that keeps the relationship between shame and rage continually in the foreground. Their methods for resolving the men’s shame (and hence abusive behaviour) include the following: using the group as a container for learning to tolerate the feeling of shame and to “detoxify” it through safe exposure in a supportive interpersonal context; presenting didactics on emotion theory and shame dynamics; using visualizations to contact vulnerable emotions, and group support for expressing them; offering training in ego states, including the “inner child;” reframing the men’s statements in a positive light, e.g., framing



the change process as courageous; and using the co-leaders as role models for directly countering the traditional male code, thus showing possibilities for masculine identity that involve less gender stress and more equalitarian values.

As a final note, the more secure that treatment providers feel within themselves the less likely they are to engage in destructive countertransference and the more able they will be to respond to clients with the kind of genuineness that builds a therapeutic alliance. We include a segment of a therapy transcript provided by Lisak (1998) in order to illustrate this point:

THERAPIST: Your voice is matter-of-fact but in your face I see fear.

PATIENT: (Face tensing, eyes narrowing in anger.) If there's anyone afraid in the room it should be you.

THERAPIST: You know, trying to make me feel your fear won't do you any good. How about I feel my fear and you feel yours?

Differential Treatment Based On Batterer Typologies

Over the years, various typologies have been proposed for assaultive men. These appear to converge on three main types. The following summaries draw primarily on the work of Cavanaugh and Gelles (2005) and Saunders (1996).

Low Risk (low severity and frequency). This category has been referred to as "common couple violence," where the violence is often mutual. The low risk abusive male has poor communication skills and is variously described as over-controlled (unexpressive), avoidant, narcissistic, or depressive. Of the three types, he has experienced the least severe childhood trauma. He is also the least likely to be using the power and control tactics identified in the Duluth model. (Dutton has determined that about 2/3 of men in court-mandated treatment for domestic violence do not engage in the patterns of abusive



behaviour described in the Duluth model [Dutton, in press; Dutton and Nichols, 2005; cited in Dutton and Corvo, 2006].)

Moderate Risk (moderate severity and frequency). The man in this category has been described as “dysphoric-borderline,” and appears to correspond to Dutton’s “abusive personality.” This man is volatile, under-controlled (impulsive), and the most emotionally abusive of the three types, commonly having a fearful or preoccupied attachment style. His history usually involves traumatic childhood experiences, including parental rejection.

High Risk (high severity and frequency). This category is for the generally violent man with an antisocial or psychopathic personality. This man is rigidly masculine, frequently has a criminal history, endorses pro-violence norms, and abuses drugs and alcohol. His violence is under-controlled and instrumental (Dutton, 1998). He has experienced severe childhood abuse, and can be theorized as having a dismissing attachment style.

Given these differences in type, a number of authors are questioning the “one size fits all” approach to domestic violence treatment. A study by Saunders (1996) illustrates the need to tailor treatment to the personality style of the particular man. He rated the outcomes from two types of groups: a conventional feminist-cognitive-behavioural therapy (FCBT) group and a process-psychodynamic therapy (PPT) group which assumes a childhood trauma etiology. Those men with dependent (borderline) traits had lower recidivism rates following a PPT group than following a FCBT group. The findings were almost exactly reversed for those with antisocial traits, who had lower recidivism rates following a FCBT group than a PPT group.

Saunders suggests that those with dependent/borderline traits do less well with confrontation than with support and the development of insight, while those with antisocial traits are not open to the development of insight so they do



better with being held accountable and with knowing the consequences of their actions. These findings are consistent with Wallace and Nosko's (2003) screening practices for their therapy groups, where dependent-type assaultive men who have some awareness of their shame are included, while antisocial-type men who would not benefit from an emotion-focused approach are excluded.

The research of Saunders and the practice of Wallace and Nosko are significant for our purposes because they suggest that a man with a history of abuse and trauma who has some openness to an emotion-focused model of treatment will likely benefit more from that approach than a strictly Duluth-type program. Indeed, there is some consensus that assaultive men with dysphoric-borderline personalities require therapy to address their childhood trauma, and may need a treatment sequence that starts with some individual work (Langhinrichsen-Rohling, 2005; Sonkin and Liebert, 2003). Low risk assaultive men, on the other hand, may need help with identifying and communicating emotion, and benefit from couples therapy. Severely violent men may only respond to the legal system. We do note, however, that the psychopathic tendencies of some severely assaultive men will have originated in extreme childhood trauma that deactivated or dissociated them from their emotions and capacity to empathize (Porter, 1996). For this subgroup, some degree of therapeutic intervention may be possible (Langhinrichsen-Rohling, 2005).

Finally, while the three-fold typology discussed here is not sufficient to guide all possible treatment differentiations a provider might make, and may require further refinement, it does at least alert providers to the need to make such differentiations.

Therapy with a Trauma and Emotion Focus



Sonkin and Dutton (2003) comment that if the treatment of an assaultive man does not attend to his childhood trauma and attachment disturbances he will typically continue to be violent in his intimate relationships. Riggs (1997) suggests, along these lines, that for an abusive man with PTSD, trauma treatment and domestic violence treatment must be coordinated or perhaps handled entirely within the context of trauma treatment, though with an incorporation of a domestic violence lens. Simoneti et al. (2000) similarly argue that assaultive men with dissociative symptoms need to be regarded first as chronic abuse victims.

Recall, as well, Babcock et al.'s (2004) finding that outcomes for abusive men who completed a group with an emotion-focus were better than outcomes for men in conventional cognitive, re-education groups. Murphy et al. (1994) raise a significant concern in this light, namely, that a man may halt his physical violence in response to legal or psychosocial interventions while nonetheless remaining psychologically abusive. These authors therefore call for interventions that better address the assaultive man's "emotional insecurities."

Even for low risk men (and women) engaged in common couple violence, Lafontaine and Lussier (2005) recommend that—following group or individual therapy to manage their anger and violence—the couple undergoes Emotionally Focused Therapy. Such therapy, they note "should place special emphasis on the significance of anger in the relationship and how this anger is related to past or present frustrated attachment needs" (p. 359). The goal of the couples therapy would be to restructure their attachment, thereby reducing fears around intimacy, worries about abandonment, frustrations around a partner's unavailability, etc.

We would also mention again Kia-Keating et al.'s (2005) study of resilient male survivors of childhood sexual abuse, most of whom had to make deliberate



efforts (some via therapy) not to be violent in their intimate relationships. These men refused the pull of the traditional male code and instead made contact with their vulnerable emotions and developed their capacity for empathy.

In short, these numerous studies and commentaries lend significant support for developing therapeutic approaches to domestic violence treatment that adopt a trauma and/or emotion-focused orientation.

One case study that illustrates the merit of a trauma and emotion focus is that of the *Relating Without Violence (RWV)* program delivered at Ontario Correctional Institute (OCI). OCI is a correctional facility that offers treatment to incarcerated men, including violent offenders, sex offenders, and property offenders. *RWV* is a program for domestic violence offenders who have already been through programming in which they took responsibility for their actions. It uses experiential therapy and relationship enhancement training in order to help men face their childhood trauma, undergo personality change, and learn to resolve conflict nonviolently. Unlike conventional re-education approaches, the men undergo deep emotional processing aimed at resolving shame and integrating child abuse/neglect. Outcome studies indicate significant additional gains (beyond the re-education program) in the areas of power and control, aggression, anger, and defensiveness (Bierman, 1996; 1996/1997). While *RWV*'s treatment setting is unique and perhaps not exactly replicable in the community, the results it achieves do provide powerful testimony as to the value of employing a trauma lens for treating intimate violence.

In presenting these treatment implications we are mindful of the fact that the current climate for domestic violence treatment does not support this exercise. In calling for new strategies to enhance treatment effectiveness, Langhinrichsen-Rohling (2005) comments that such strategies “will need community and institutional support for their development, implementation,



and evaluation” (p.112). In the meantime, Sonkin (2007) suggests that treatment providers find ways to incorporate attachment theory principles as best they can rather than try to completely overhaul their models, while also spreading the word about a trauma/attachment approach and advocating for change in the way partner assault programs are mandated. We would likewise comment that the evidence for adopting a trauma perspective on domestic violence seems stronger every day, and urge both practitioners and policy makers to creatively incorporate the kind of understandings presented in this chapter into their treatment practices and programming.



PART II

GROUP PROGRAMMING



CHAPTER 3

INTAKE AND ASSESSMENT

Part II of this guidebook, starting with the present chapter, is based on our experience at *TMP* in formulating and delivering the Men & Healing program. This program consists of three phases. Phase I is a brief psycho-educational group; Phase II is a process-oriented psychotherapy group; and Phase III consists of groups and resources for moving beyond one's trauma history. The nature and workings of the Men & Healing groups are discussed in Chapters 4 and 5. In the current chapter we cover topics concerning the "front end" of the program: intake and initial encounter, assessment and evaluation tools, and considerations for working with diverse client populations. We will not address topics such as service promotion, phone contact, agency location, and so on, so that we may concentrate instead on matters of more specific relevance to serving male survivors.

3.1 CONDUCTING THE INTAKE INTERVIEW

Men seeking entry into any clinical program at *TMP* must complete an interview with an intake counsellor that typically lasts one to two sessions. An effective intake and assessment process gathers key information, builds connection, and plays a triage role in linking people with appropriate service, whether within or outside the program or agency. In the intake process, we aim to demonstrate to clients the program's competence and professionalism, establish a vision of the recovery process for them, and normalize any trauma symptoms they may have. This section discusses some of the key aspects of conducting the intake interview, including creating a welcoming environment and dealing with trauma symptoms in the intake sessions.



3.1.1 Creating a Welcoming Environment

Clinical engagement with male survivors begins from the moment of first contact. Creating a welcoming intake process is a critical aspect of program formulation, not only because intake sets the tone of treatment but also because entry into counselling services can be a particularly charged experience for men—especially men sexually abused in childhood. Consider the case of Jamal.

Jamal

Jamal recalls feeling very uncomfortable during his first encounter at The Men's Project. At the time he wasn't sure what he was feeling, but he realizes now that it was a lot of fear and shame. He had previously only talked to his girlfriend about his abuse. How could he now talk to a stranger about it? He thought to himself: "Maybe I'm okay and don't need counselling; I am strong enough to handle this on my own. Do I really want to open up this can of worms? What if I go crazy or start crying and never stop? What if the counsellor tells me that I'm crazy and I am making this up? I don't want to go back to those dark and depressing times in my life. Like my brothers always said when we got hurt as kids, I just need to suck it up and act like a man."

Jamal's experience is similar to that of many male survivors who seek help. Having been traumatized in childhood by interpersonal violations, they may be highly wary of opening themselves up in a new interpersonal setting. They often enter social services reluctantly, fearing they will be judged, disbelieved, or shamed. Many have previously had their abuse experience minimized by professionals, received ineffective treatment, or been denied services because they are male. They may have been told that "males do not get abused" or admonished to "get over it." It is thus especially important that male survivors experience a friendly and understanding environment at the moment of first contact. We offer the following suggestions for creating such an environment.

Address the cultural delusions about male sexual abuse.

Having a working understanding of and an ability to recognize cultural delusions about male victimization (see Section 1.4) is crucial in working with male survivors. For example, professionals who do not acknowledge that males can be sexually abused/assaulted will not pick up on clients' intimations that they want to talk about something they have long kept hidden.

Hugh

"The first time I talked with my doctor about my abuse, I thought that maybe I was talking about something not relevant. She asked me during my physical whether I had ever been abused, sexually, physically, or emotionally. I told her about having some memories about my female babysitter making me touch her and feeling like I couldn't breathe. The memories didn't make complete sense to me, but she took the time to listen to me and allowed me to cry. She was the first person to name what happened to me as abuse."

Hugh was fortunate to have a helping professional who provided openings for him to disclose his abuse and supported him in a way that countered traditional male socialization. Waiting for men to identify their abuse history without providing openings does not create a welcoming environment for those who are survivors. Other cultural delusions, such as the belief that all male sexual abuse victims become perpetrators, also need to be addressed as they arise during the intake process. Doing so offers male survivors a healing interaction right at the start of their treatment and helps establish a therapeutic alliance.

Recognize male survivors' struggles around masculinity.

The struggle that many male survivors face around their masculinity often surfaces in the assessment process. For example, bravado and humour may be

used to avoid disclosing their “unmanly” emotional pain and so keep their sense of personal integrity intact. Male survivors may also simply be less able than females to articulate what is going on for them internally. Just as it is necessary for intake counsellors to provide openings for men to talk about an abuse history, they must also provide verbal or non-verbal messages that encourage men to step out of the constraints of their traditional male socialization.

Social services are more commonly accessed by females than males and so tend to be oriented primarily toward women. As Brooks (1998) notes, “in the past, most therapists have accepted referrals for new male clients with resignation instead of enthusiasm. Their male clients in turn, have often done little more than go through the motions” (p. 69). Men often have to be pushed or encouraged to enter counseling, and may do so only when their problems have reached an advanced or crisis stage. Traditional men often dread the counselling arena because they see it as a foreign culture where they are bound to fail and experience humiliation. Indeed, Brooks (1998) suggests that therapy with traditional men has to be conceptualized as a form of cross-cultural counselling, bridging the divide between the culture of therapy and the culture of men and masculinity. Given the typical male survivor’s extreme sense of gender shame, male survivor services must actively engage in such bridge-building.

Be aware that many survivors are seeking hope and recognition of courage.

Male survivors often experience tremendous apprehension about the prospect of addressing their trauma. Having struggled alone for many years with the sequelae of abuse, they commonly present with a deep sense of hopelessness. Providing a picture of recovery to them can help alleviate such fears and doubts, and inspire hope. This means offering information in a realistic and



compassionate way, using statements like “Many guys who come here do get better.” The intake counsellor’s own comfort with men’s issues and sexual abuse recovery is key. Having a knowledgeable and trustworthy individual encouraging them to disclose their abuse history represents a significant departure from the isolated way that many of them have previously dealt with their trauma.

Recognizing and appreciating the courage it has taken for survivors to come forward is also an important gesture. Men generally welcome acknowledgement and congratulations in the initial sessions. It can be supportive, furthermore, to inquire about their experience coming into the agency for the first time. Making statements like “You did great work today,” or “I bet it took a lot of courage to talk about that,” offers validation and again acts to build a therapeutic alliance.

Be attuned to what is hidden or not disclosed.

Many male survivors seeking services do not have an initial interest in trauma recovery. They often enter helping systems because of addiction or relationship problems, or because they think they are “going crazy.” They may be unaware, or only vaguely aware, of links between their present issues and past abuse, despite the fact that these links may be quite visible to others. For example, some men seem very intense or highly needy, while others seem difficult to connect with or oddly problem-free. As we discuss in Section 3.1.3, these are normal post-trauma adaptations. When the intake counsellor notices such signs it is welcoming to clients to inquire about a possible trauma history. At the same time, it is important to understand that men often do not open up or disclose hidden vulnerabilities until a therapeutic alliance has been built. In this case, the task for counsellors is simply to remain confidently open and



optimistic in the assessment process rather than to make any specific intervention.

Arrange pre-group meetings.

Clients who are assessed by the intake counsellor as appropriate for the Men & Healing program are scheduled for a pre-group meeting with the group therapist. This meeting assists with creating connection between survivor and facilitator, and provides an opportunity for men to ask questions and clarify expectations about group participation. To lower anxieties, pre-group meetings often take place in the room used for group sessions. The men tend to have questions about the group structure and format, including safety parameters and group rules. Toward the end of the pre-group meeting the client contract and confidentiality agreements are signed. Although this meeting typically lasts only about half an hour, it does much to help transition survivors from the intake process to the group.

3.1.2 Working with Trauma Symptoms in the Initial Intake Session

Classic trauma symptoms fall into the three categories of hyperarousal, intrusive recollections, and numbing/avoidance, as detailed in the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV). Male survivors commonly exhibit such symptoms during the intake process, whether they have been formally diagnosed with posttraumatic stress disorder (PTSD) or not. Noticing trauma symptoms allows the intake counsellor to tailor the interview according to the particular symptom category. Ideally, the assessment process neither overwhelms the survivor nor leads him to disconnect and withdraw. In this section we discuss the three categories of trauma symptoms with the idea of maintaining this balance between states of overwhelm and withdrawal.



Hyperarousal Symptoms

The first hallmark of posttraumatic stress is extreme psychological and physiological arousal, whether experienced generally or in response to particular triggers. For the hyperaroused person danger never seems far away. The DSM-IV lists the following hyperarousal symptoms.

- Difficulty falling or staying asleep
- Irritability or outbursts of anger
- Difficulty concentrating
- Hypervigilance
- Exaggerated startle response

Panic attacks and certain physiological conditions (e.g., elevated heart rate and blood pressure, lightheadedness) are also considered to indicate hyperarousal.

In the intake session survivors exhibiting hyperarousal may appear highly anxious, agitated, or tense and unable to settle down. The intake interview may itself be a trigger.

Generally speaking, survivors typically feel threatened by unfamiliar situations, where they anticipate having their (perceived) badness exposed, doing something wrong, or having some uncontrollable painful experience. Interpersonal situations *per se* can be anxiety-provoking for survivors, let alone one where they are asked to talk about their childhood abuse.

It is helpful for the intake counsellor to acknowledge any hyperarousal the client may be experiencing and, again, to comment on the courage he has shown in coming in for an assessment. This also allows for a discussion of the fact that emotional and physical discomfort is an unavoidable part of recovery



work, and that healing involves learning to tolerate and stay present with it. It is important to remember, as well, the sensitivity that the abuse survivor often has to nonverbal cues. Any gesture, hesitation, or look may be interpreted as a sign of judgment or rejection. Intake counsellors must therefore ensure that their communication style is welcoming, clear, and congruent.

Intrusive Recollection Symptoms

Intrusive experiences that bear the imprint of the trauma are the second hallmark of posttraumatic stress. Extreme physiological arousal from trauma is believed to prime the victim's brain to etch the traumatic experience deeply into memory (Allen, 1995). However, unlike normal memories which can be recalled whole and free from severe distress, traumatic memories take the form of experiential fragments that intrude into consciousness in a highly disturbing way. The DSM-IV lists the following intrusive symptoms.

- Repeated intrusive memories of the trauma, including images, thoughts, and perceptions
- Nightmares related to the trauma
- Acting or feeling as if the trauma were recurring—including a sense of reliving the experience, illusions, hallucinations, and dissociative flashbacks
- Intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the trauma
- Physiological reactivity on exposure to internal or external cues that symbolize or resemble an aspect of the trauma

Reenactments of the trauma are also considered to be a form of traumatic memory, where some aspect of the trauma that has not been symbolized verbally is communicated via behavioural repetitions (Gartner, 1999). For



example, abuse survivors often repeat certain trauma-based roles in interaction with others, such as the victim, bystander, or seducer.

The intake questions or even the assessment process itself can cue or trigger intrusive experiences. The survivor may experience a sudden burst of strong emotion or demonstrate a relentless preoccupation with his abuse. This can be an indication that the survivor is experiencing an intrusive episode.

Working with intrusive symptoms can involve giving the survivor permission to slow down: “You are talking about very powerful and important things, so please take your time.” It can also involve walking him through simple grounding exercises such as deep breathing, especially if he is experiencing flashbacks, shame, or rage. When the survivor is having intrusive experiences, it is advisable to move on to less intense or triggering questions and then return to the skipped questions later in the session. This approach models regulation of emotion without avoidance. By helping the survivor to contain intrusive symptoms through grounding, pacing, and other strategies, a sense of safety can be established.

Numbing and Avoidance Symptoms (Constriction)

Hyperarousal and intrusive experiences are painful and overwhelming. Together they also generate a vicious cycle, where hyperarousal leads to intrusion and intrusion leads to hyperarousal. As a way to defend against these intense symptoms, trauma survivors develop patterns for numbing themselves and avoiding reminders of the trauma. This numbing and avoidance strategy, also referred to as “constriction” (Herman, 1997), defines the third category of trauma symptoms. The DSM-IV lists the following numbing/avoidance symptoms:



- Efforts to avoid thoughts, feelings, or conversations associated with the trauma
- Efforts to avoid activities, places, or people that arouse recollections of the trauma
- Inability to recall an important aspect of the trauma
- Markedly diminished interest or participation in significant activities
- Feeling of detachment or estrangement from others
- Restricted range of affect (e.g., unable to have loving feelings)
- Sense of a foreshortened future

As this list suggests, PTSD symptoms overlaps with the symptoms of numerous other diagnoses. Dissociative disorders, depression, and substance abuse all involve these sorts of constrictive reactions.

Numbing/avoidance symptoms are less readily recognized than the other two categories because they lack the visibility of intrusive and hyperarousal symptoms, and are easily mistaken for normal features of an individual's personality (Herman, 1997). In the intake session, evidence of constriction includes highly intellectual conversation with little or no discussion or demonstration of emotion. Survivors may joke or minimize the impact of their abuse, or present as passive and withdrawn. They may also appear dissociated, having difficulty focusing or recalling information.

Ken

In his intake session for a Men & Healing group, Ken said that he wanted to join the group to help out other members. When asked about his own abuse, he said, "You know, it hasn't affected me that much. You just have to try to forget about it or it'll drive you crazy."



In the initial sessions it is advisable to be respectful of numbing/avoidance symptoms, as these serve a protective function for survivors. They can, however, make it difficult to gather relevant information for deciding on appropriate treatment planning. Ken's talking in the second person (using the word "you" to refer to himself) helps him keep his trauma at a distance, but doesn't directly reveal much about his inner feelings and needs. The intake counsellor can nonetheless recognize that men like Ken are presenting in a constricted manner, and see this as an adaptation to their trauma, rather than try to force them to express some emotion. The counsellor may also wonder about and investigate levels of dissociation, use of substances, and other related themes. When working with withdrawn survivors, the task is to find a way to engage their interest or empathically make contact with them, so that they can sense some benefit in facing their trauma history rather than avoiding it.

3.2 DEVELOPING A FRAMEWORK FOR ASSESSMENT AND EVALUATION

The assessment process is used to determine the clients' clinical needs and decide which services would be appropriate for them. In this section we first discuss the general criteria we use to exclude potential group members from entering the Men & Healing program when they would be better served elsewhere. We then present an overview of the specific tools or measures that we have found helpful in completing our assessments, as well as evaluating the program.

3.2.1 Exclusion Criteria

Not all survivors seeking entry into the Men & Healing program are accepted. If the intake counsellor has doubts about the appropriateness of this program for the individual, then they consult with the Executive Director in making a



decision. When necessary, the client case is presented in clinical supervision. If a client is not accepted, he is informed of the reason and referred to appropriate supports or services within *TMP* or outside the agency.

Generally speaking, all men with histories of childhood sexual abuse are included in the Men & Healing program unless they meet criteria for exclusion. These exclusion criteria can be organized into three categories.

The client is insufficiently stable. Men who have very active addictions or non-stabilized mental health problems (psychosis, severe depression or personality disorder, etc.) are referred to more appropriate services. This includes referrals out for addiction, psychiatric, and case management services, but also internal referrals for individual counselling and specialized anger management treatment. Obviously, if clients are homeless, have no supports, or are unable to meet their basic needs, then these challenges become the priority and must be attended to outside of the group program.

The client has perpetrated sexual abuse as an adult. Clients who have perpetrated sexual abuse when over the age of 18 are excluded from Men & Healing groups both for safety reasons and clinical reasons. Having survivor-perpetrators in the group can be highly triggering for the other, non-abusing survivors, some of whom bear significant hatred and fantasies of revenge toward sexually abusive people. The group would be safe for neither the survivor-perpetrator nor the other group members. Beyond these safety concerns, the clinical priority for survivor-perpetrators who have not addressed their own history of abusiveness is to take responsibility for and gain insight into their behaviour (Dimock, n.d.). Clients who have been sexually abusive as children or adolescents are not automatically excluded for that reason, so long as abusive behaviour has not carried over into adulthood.

The client would not benefit from the program or would disrupt the group.

Men who would not benefit from the program include those who are insufficiently motivated, currently in a life crisis, or actively assaultive. Furthermore, certain subpopulations of survivors need to be excluded due to the inevitable service limitations that prevent a program from being able to benefit all survivors (as discussed in Section 3.3). Those who could not benefit from an insight-oriented group (e.g., because of a severe brain injury or sociopathic personality) are also excluded and referred to more appropriate services. Clients who would be disruptive to the group include those with a hostile interpersonal style or low ability to be supportive or tolerant of other group members. These clients would be candidates for individual counselling.

3.2.2 Assessment and Evaluation Tools

The Men's Project is one of few agencies in North America that dedicates most of its programming for male survivors. Over the last decade we have refined our assessment and evaluation process, though still consider it a work in progress. As male survivor services become more widespread we anticipate that a variety of tools and perspectives on the assessment of sexually abused men will be developed and employed. In the meantime, we share here what we have found most effective.

Assessment and evaluation tools or measures are used with the intention of benefiting one or more of the following four parties.

Clinicians. Assessments and evaluations help clinicians make case formulations that lead to constructive treatment planning. They determine the type of service to provide for a client, and give feedback on whether interventions have been effective. They also help maintain the consistency of treatment.

Clients. Ensuring that clients benefit directly from the use of assessment tools is considered integral to the use of these measures. At the very least, such use should not interfere with the client's needs. Assessments and evaluations are increasingly being seen as a feedback mechanism for clients rather than simply an esoteric scientific procedure. Receiving feedback helps clients construct meaning about their change, or lack thereof, over time.

Organizations. An organization's frontline staff, managers, and members of its board of directors, all have a uniform interest in ensuring that they are providing high quality services.

Funders. Funders have an interest in ensuring that money is well spent.

The following are the assessment and evaluation tools routinely used in the Men & Healing program for meeting the needs of these four parties.

- Standard Assessment Questionnaire (SAQ)
- Beck Depression Inventory (BDI)
- Impact of Event Scale - Revised (IES-R)
- Dissociative Experience Scale (DES)
- Partner Abuse Index
- Men & Healing Group Evaluation (Appendix B)

Standard Assessment Questionnaire

The most important assessment tool used in the Men & Healing program is the Standard Assessment Questionnaire (SAQ). A broad questionnaire, it was developed by staff at *TMP* because other standard assessments were not adequately responsive to the clinical issues relevant to working with male survivors. The main areas explored in the SAQ are as follows.



Previous and Current Therapy/Counselling. Understanding the individual's previous or current therapy/counselling experience helps determine the sort of service he might now benefit from and whether he is/was able to commit to a treatment program. It also allows exploration of possible service duplication.

Employment Status and History. An employment history helps assess the degree to which childhood abuse and other issues have been disabling for the man, as well as his current ability to commit to and follow-through with group therapy. It also provides a baseline in evaluating recovery and functioning. If an individual has not been able to hold a job for more than brief periods of time, it may be unrealistic to set full-time work as a benchmark for recovery.

Legal History. Asking about current and past legal problems may provide valuable information about acting-out behaviours, aggression, and possible sociopathy. Exploring a client's pattern of conflict with the law often allows him to provide information about the impact of his abuse that he would not have mentioned otherwise. It is advisable to assess whether men currently involved in a civil or criminal proceedings are seeking therapy chiefly for non-clinical purposes (e.g., to impress the court that they are taking steps to deal with their problems).

Relationship History and Status. Information about a survivor's relationship history and status can illuminate his patterns of connection and the quality of supports he has in his life.

History of Intimate Partner Violence. Asking about abuse in current and previous relationships—both as aggressor and/or victim—inquires directly about recent abuse experiences, which may otherwise get lost in discussions about past abuse. Questions pertaining to intimate violence can lead to more formal assessment measures, and informs the service provider about whether referral

to an anger management or partner assault program, and/or focused individual counselling, may be warranted.

Children. Information about the ages, gender, and custody of children is used to assess how past abuse might be playing out for the survivor as a parent. If child protection services are involved due to abusive behaviour by the client, then this information may be vital in providing appropriate services.

Family of Origin. The composition of a survivor's family of origin, and the atmosphere that was in it, is a critical piece of his trauma history. Any abuse or neglect he experienced in his family is obviously of great significance to understanding his experience. Understanding the survivor's relationships with parents and siblings can also be important for anticipating his transference reactions in the group.

Childhood Abuse History. Asking survivors about their abuse histories allows the intake counsellor to assess the clients' ability to talk about the abuse. Because men often will not discuss or name their abuse history unless asked, clients are prompted separately about childhood emotional, physical, and sexual abuse. Men are sometimes unaware that being shamed and demeaned by a parent is abuse. We also ask them who they first disclosed their abuse to and how it was received. Men who told and were not believed, or who were shamed or punished for telling, are often reluctant to participate in groups and may become very anxious when talking about why they came in for an assessment. Asking the men directly about how they think the abuse has affected them also assists greatly in identifying their present difficulties.

Specific Symptoms. Exploring specific symptoms, both current and historical, helps access issues the survivor does not feel comfortable talking about (e.g. sexual problems) or link to his abuse. The Men & Healing SAQ asks about the following:



- Depression
- Anxiety
- Thoughts of suicide
- Fear of people, places
- Difficulty falling or staying asleep
- Sexual problems
- Compulsive behaviours
- Angry outbursts
- Irritability/impatience
- Disturbing dreams
- Disturbing thoughts
- Job related problems
- Other

Alcohol and Drug History. Because substance abuse is common among male survivors, it is necessary to ask about current and past problems with drugs and alcohol. Asking about consumption levels, prior addiction treatment, and membership in peer-support and/or twelve-step groups (e.g., Alcoholics Anonymous) helps understand the problems the individual is facing, the type of supports that might be appropriate, and the coping mechanisms he has come to rely on.

Medical/Mental Health History. Information about medications, suicidality (past and present), and mental health diagnoses supplement depression measures. This information is relevant in assessing readiness and capacity for group work or therapy.

History of Sexual Abuse Offences. Given that men who have perpetrated sexual abuse as adults are excluded from the Men & Healing program, we ask directly whether the individual has ever sexually abused another. This is



essential in assessing appropriateness for group and possible triage to other services.

Concerns Regarding Participation in a Group. Men who are being assessed for a group program are asked how they think they will feel being in a group with other men. This helps assess their level of apprehension and their frame of reference for group work with men. They are also asked about how they think they will feel attending a group with:

- both co-facilitators being male;
- a female facilitator;
- men who have a different sexual orientation than he;
- facilitators who have a different sexual orientation than he;
- men of other cultures or races;
- men familiar to the individual.

Many of these questions are used to anticipate sexism, racism, and homophobia. The questioning and exploration is not aimed at promoting choice but rather informing the potential group member about possible scenarios and preparing him to handle them. An overtly sexist, racist, or homophobic survivor may have to be declined admission to a group.

Survivors do sometimes encounter men in groups who they have met in previous situations. This is particularly common in small communities, groups geared to a particular sub-population (e.g., gay men), and groups where several members also participate in twelve-step programs (e.g., Alcoholic's Anonymous). Discussing this possibility in advance instead of waiting for an awkward moment to arise prevents unnecessary discomfort. When men do recognize each other, we ask them whether they need to say or discuss anything in order for them both to be comfortable. Often, men find it



necessary to reassure one another of their commitment to confidentiality. In rare instances, men may need to be assigned to separate groups.

Motivation and Goals. Applicants are asked to identify their three main goals for attending group and to rate how committed they are to using the group to meet them. This indicates their motivation for joining the group, fosters discussion about whether the goals are realistic, and provides a space to attend to any ambivalence or apprehension they might be experiencing. We also ask whether there is anything that might prevent them from attending the group regularly. While inconsistent attendance can present practical challenges to the functioning of any group, it is particularly disruptive for a survivor group, as many survivors have experienced inconsistency in their relationships. Consistent attendance, on the other hand, helps create a corrective emotional experience.

Assessment & Admission to the Program. Having completed the questionnaire with the applicant, the intake counsellor fills out a section on his or her clinical observations and recommendations. They may comment, for example, on their impression of the applicant's internal safety (how he handles his own thoughts and emotions) and external safety (risk-taking, dysfunctional and/or abusive relationships, etc.). Concerns such as suicide risk and active substance use are rated. Decisions about admission (e.g., recommending entry to a program or requesting completion of a consent form) are also documented.

Beck Depression Inventory

We use the Beck Depression Inventory (BDI) at *TMP* because of its well-documented norms and psychometric properties. A drawback of the BDI is that it only provides a single value. Other depression scales such as the Burns Depression Checklist provide more information because of the use of subscales, but the norms are not as well validated.



The BDI can sometimes be used to help assess if people are ready for psychotherapy or how difficult it will be for them. Clients with high scores on the BDI generally find individual or group therapy very challenging and make relatively slow progress. High scores may also indicate the need for medical intervention or a course of individual therapy prior to group therapy. This is especially true for those with elevated scores on items such as suicidality and hopelessness. We recommend sharing the clients' BDI scores with them and exploring their own interpretation of how they are doing, or their ability to participate in a group therapy program. This transparency communicates to survivors a respectful and collaborative ethic.

Impact of Events Scale - Revised

The Impact of Events Scale - Revised (IES-R) is used to measure the impact of trauma through people's self-perception of their distress. This scale helps gain further information about hyperarousal, intrusion, and numbing/avoidant symptoms. It measures the reported presence of each of the three symptom categories in the past week. Scores indicate both the level of distress related to a trauma history and the difficulty in coping with this distress, though people with a numb/avoidant style may under-report their distress compared to people who tend to operate more from intrusive or hyperarousal positions. This scale does not currently have validated norms. (The previous version of the scale does have norms but does not measure hyperarousal symptoms.) A drawback with this measure is that calculating the subscales and total is somewhat labour intensive.

Survivors who have multiple abusers or types of traumas can fill this assessment out specific to a particular trauma. That is, a client who, say, experienced sexual abuse and witnessed domestic violence can fill out an IES-R for each one of these if, in the clinician's opinion, this would be a valuable exercise. In our



experience it is useful for survivors and clinicians alike to differentiate impacts from multiple traumatic events.

Dissociative Experiences Scale

The Dissociative Experiences Scale (DES) measures dissociation, a prevalent symptom among male survivors. In Men & Healing groups, dissociation is a topic that survivors often want to discuss and learn about. Some of them experience high levels of dissociation but do not have a name for it. These men often think they are “crazy.” Conversely, some survivors are unaware that there is anything unusual about their high level of dissociation, assuming that what they experience is normal. Like many of the other measures that we use, the DES is educational for survivors. It helps provide examples of the different ways a person may dissociate. It is not uncommon for clients’ DES scores to increase after group discussions about dissociation, particularly for those who begin their treatment primarily from an emotionally constricted position.

The DES score provides an indication of people’s ability to remain focused and attentive during individual or group session. High scores may indicate the need for a formal assessment for a dissociative disorder, and need to be considered when constructing a treatment plan.

Partner Abuse Index

The Partner Abuse Index was created by *TMP* to identify abusive behaviour toward and from an intimate partner. While this is an important assessment tool if domestic violence is suspected, results should be viewed in light of other information gathered in the assessment. Male survivors may under-report abusive behaviours for fear of experiencing shame or negative consequences such as being denied service or being reported to the police. They may also under-report intimate abuse when they are themselves the victim.



Evaluation of the Group Therapy Program

Evaluation of the group therapy program is conducted in two ways. Clinical progress made by clients is assessed using the IES-R and the BDI scales. These measures are completed in the assessment interview and at the end of each 10-week group cycle. An evaluation of the program (content, structure, and facilitators) by the clients is completed in the last week of each cycle. These evaluation tools are reviewed on a regular basis to ensure their effectiveness.

3.2.3 Additional Considerations for Assessment and Evaluation

Assessment Measures are Useful but Have Limitations

Assessment measures are essential tools for professionals, but they do have their limitations. We have noticed that survivors sometimes appear to be enjoying improved coping, interpersonal relationships, and emotional expression, yet their assessment scores suggest the opposite (e.g., they show an increase in symptoms of depression or dissociation). This phenomenon may be related in part to a shift in the men's connectedness that creates a greater awareness of emotions, sensations, thoughts, and behaviours. Clinical judgment is vital in this case. Similarly, if clients score very low on the DES (mild to no dissociation) but seem to experience a lot of difficulty concentrating and staying present, clinical observation should probably receive greater weighting than the DES measure.

Being Attentive to Stages and Phases



We make it a practice to evaluate the applicant's stage of recovery in assessing his group readiness and conceptualizing his treatment. Recognizing his stage of recovery at the intake stage assists in tracking his progress and thinking about his needs relative to other men in a group.

Numerous authors have proposed models of post-trauma treatment that involve a sequence of stages (as discussed by Herman, 1997; and Courtois, 1999; see also Kepner, 1995). Although the various models use different terms, there is considerable consensus among them about the nature of the stages and the corresponding therapeutic tasks. We use the three-stage model articulated by Judith Herman (1997).

Stage 1: Safety. The task of Stage 1 is to achieve safety and stability. This includes learning to regulate emotion, reducing suicide risk, using psychiatric medication, and establishing a safe environment and support system.

Stage 2: Remembrance & Mourning. In Stage 2, survivors reconstruct the story of their abuse, integrate their traumatic memories, and mourn their traumatic losses. Through these deep emotional processes, they are gradually able to release their bond to the traumatic past.

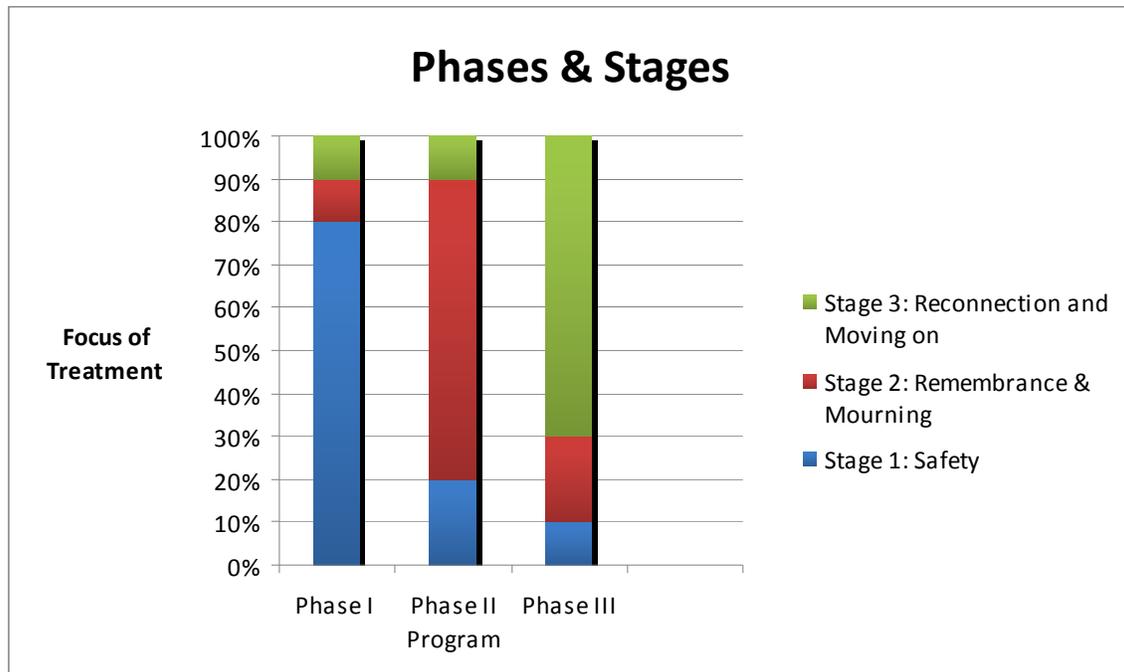
Stage 3: Reconnection. With the past no longer gripping the trauma survivor, the task of Stage 3 is to build a future. This involves developing new relationships, interests, activities, and sustaining beliefs that are not defined by the trauma. In this stage the survivor creates a self based on their re-empowerment and reconnection with the world.

The three phases of the Men & Healing program correspond roughly to these three stages of recovery. Most survivors do not, however, move smoothly from one stage to the next in an upward arc of recovery but rather move in and out of stages, their progression describing something more like a spiral. All three



phases of the program must therefore deal with each of the stages of recovery to some degree, especially because the work in any one stage supports additional gains on themes from the other two. Figure 3.1 depicts the relative attention given to the three stages within each phase.

Figure 3.1



Thus, while in Phase II of the program group members are generally able to discuss their abuse issues openly (i.e., remembrance and mourning stage), roughly one-fifth of the time is still spent on safety matters, such as grounding skills and managing suicidality. Some degree of attention is likewise given to the third stage of recovery as members turn toward a life beyond the limitations and dysfunctions associated with their trauma.

The three phases of the Men & Healing program will be discussed in great depth in the following two chapters.



Personalized Assessments

Using assessments as a feedback tool can benefit clients; taking a litany of tests, however, is rarely therapeutic. Assessment should not interfere unduly with making the agency a place where male survivors can connect. Building a therapeutic alliance takes priority. It may be more effective at times to space the assessment measures over two sessions than to try accomplishing them all in one.

Many male survivors experienced problems in school, and some have been diagnosed with learning disabilities or literacy problems. They often report a history of daydreaming or dissociating in class, and of expressing their emotional pain through behavioural problems. Some survivors were initially targeted for sexual abuse precisely because of troubles in school or with the law. For men with histories of school problems, it is best to limit the number of assessment measures or make extra effort to ensure that they do not experience the assessment as a test that reinforces their sense of failure and incompetence. Not all survivors will have difficulty in these areas; it is nonetheless good practice to be open to cues, and to adjust the assessment process to meet the needs of the client as best as possible.

While it is advisable to limit the use of formal assessment tools, it is necessary to *add* specific measures when the routine measures fail to capture a specific assessment concern. For instance, if a client indicates a presenting problem of anxiety, self-esteem, or anger, it may be useful to incorporate a measure that is tagged to the particular problem. Using a tailored measure in this way ensures that the measurement process is in fact giving feedback on issues that are relevant to the client and the delivery of service.



3.3 CONSIDERATIONS FOR SERVING DIVERSE CLIENT POPULATIONS

Despite the fact that male survivors have the experience of childhood sexual abuse in common, the diversity among survivors needs to be considered during the intake and assessment process. Counsellors must be alert to critical issues regarding specific subpopulations, knowing that these issues present particular challenges in the treatment process. In this section we make a number of suggestions for addressing client diversity and helping ensure that male survivors from all walks of life receive quality service.

Explore concurrent disorders knowledgeably.

Stephane

"I tried to get help for my problems but ran into many roadblocks. I was sexually assaulted while coming home late from a party. I took a shortcut through a park and was raped. If I hadn't been so high on marijuana I probably could have fought him off. When I sought help, the mental health counsellor said I had to get my alcohol addiction under control first, and the addiction counsellors told me that I didn't qualify for their program because of my high anxiety. My AA sponsor told me that I have a drinking problem because I am an alcoholic not because of the assault. He said that I am just making excuses rather than dealing with my drinking if I talked about the assault. Finally, I found a counsellor who looked at the assault, alcohol, and anxiety together."

Our experience has been that a very high percentage of men who seek entry into a trauma recovery group also struggle with substance abuse. This fits with the research finding that a large number of substance abusers have histories of childhood sexual abuse (Briere, 1996). Significantly, people with co-occurring

PTSD and substance abuse typically have more severe clinical profiles than those with one of these alone (Najavits, 2002).

A high percentage of clients in our Men & Healing program have also been diagnosed with a mental illness and/or involved with the mental health system. Indeed, the abuse and trauma field has revealed that a large degree of what we call psychopathology originates in childhood trauma (Briere, 1992, 1996). Being part of a mental health system or service can lead to positive experience and better management of symptoms. It can, however, also lead to certain problems, such as seeing oneself as powerless, feeling stigmatized (which may compound the shame and isolation of being a survivor), or believing that the adaptive symptoms of trauma are actually a reflection of genetics, chemical imbalances, character flaws, or illness. For survivors who have such histories it is advisable for intake counsellors to raise these topics.

In completing the intake, the counsellor must be knowledgeable about and comfortable with mental health and addiction problems. Many of the clients who present with persistent and severe mental health and/or addiction problems may have to be jointly case managed with other health care practitioners. We have found, furthermore, that using a phased model provides a way to work with trauma survivors even when addiction or mental health symptoms are active. Phase I groups allow the survivor to focus on stabilization, safety, and replacing unhealthy coping strategies with healthier and more functional ones. Phase II-level explorations of underlying traumatic material is generally inadvisable in the early going of addiction recovery because of the risk of relapse. It is better to examine instead the function or role that the addiction serves. This approach to concurrent disorders is consistent with the one proposed by Najavits (2002), where trauma recovery and addiction recovery are integrated because the initial stage for both focuses on safety and stability. The same principle of integrated treatment, with a focus on safety and stability, applies to mental health recovery as well.



Be sensitive to the culture and clinical needs of gay and bisexual men.

Because the sexual abuse of males raises so many issues related to sexual orientation, intake counsellors may inadvertently demonstrate insensitivity in this area. For example, their word choice may be heterosexist (e.g., referring to a client's partner with a female pronoun) and interpreted by clients (whether identified as gay or not) as exclusionary. It is therefore important that program staff be sensitive to this issue of inclusion, as well as to the many facets of gay male culture.

Some gay and bisexual clients may request the services of a therapist who shares their sexual orientation. Some may also request programming dedicated to gay and bisexual men. Whether or not a program can meet these requests, it is essential that counsellors understand the cultural and sexual mores within a gay male context. Particular attention needs be given to: the clients' relative openness about being gay or bisexual; the shame they may attach to their sexual orientation; risky sexual practices (which may both relate to their abuse *and* reflect gay male sexual expression and norms), including the minimization or denial of these practices; and the relative isolation of gay and bisexual men, particularly those who are reticent about disclosing their sexual identity to their health care practitioners. Gay and bisexual men may also express concerns about the possible homophobia of fellow group members. Exploring such topics of concern can help intake counsellors begin to establish a sense of safety and trust with gay and bisexual clients. (Cassese [2002] offers many helpful discussions on the experience of gay and bisexual survivors in this regard.)

Contextualize the experiences of men who have been in conflict with the law.



Gerry

“When I was a kid, I was the class clown. Looking back, I wanted somebody to recognize the hurt and pain I was going through at home. In my teenage years it escalated into destroying property. I was so full of anger. Eventually, I was arrested and charged for a string of B&E’s. In some ways it was a relief being in jail because I felt safe. Being out is really hard and I still feel angry a lot even when I am not thinking about what my father did to me.”

Many men who have been sexually victimized have been in conflict with the law. Intake counsellors must be careful not only to avoid judging past criminal behaviour but also to convey an understanding of the many interconnections between being both a victim and an offender. As discussed in Chapter 1, criminal behaviour (often including alcohol and drug abuse, intimate partner violence, and anti-authoritarianism) is part of the aftermath of abuse for some male survivors. Conflict with the law can represent misplaced rage, avoidance of shame, or a cry for help. The experience of imprisonment may itself have been traumatic; it is thus important to be aware that sexual coercion and sexual assault while incarcerated could also be part of the clients’ stories. Some men were targeted as boys by sexual perpetrators because they were already having problems at home, school, or with the law; they were therefore less likely to be believed if they disclosed their abuse. While making these various links known to clients is more of a treatment than an assessment task, intake counsellors do need to be able to empathize with these men in order to engage them and help them feel welcome in the program.

Be mindful of safety and confidentiality concerns specific to particular subpopulations.

While the issues of safety and trust are relevant to working with all male survivors, they are particularly figural for certain subpopulations. For example,

men who are in treatment in small or rural communities face unique challenges regarding confidentiality. They are likely to be seen going to a counselling centre by people they know, and may fear being perceived by others as gay or as perpetrators themselves. Men in small communities also fear that they will know other men in the group or be related to them. There are no easy answers to these fears, but addressing them directly with the men during intake is always a good idea. We share with them, for example, that survivors in small communities often do in fact have a pre-existing connection with other men in the group, sometimes even having the same abuser, but that once the fear of encounter has been faced a strong sense of alliance can form between them. Some survivors prefer to travel out of the community to access services in a larger centre where anonymity is more likely—although practical problems, such as transportation and scheduling difficulties, can be present barriers to doing so.

Various subpopulations of survivors in large urban centres face parallel safety and confidentiality concerns. Men who identify with the gay community, men in twelve-step programs (AA/NA), and particular ethno/cultural minorities may all fear meeting up with people they know. As mentioned above, discussing with all new clients the possibility of knowing someone in the group helps them prepare for this occurrence.

Be clear about the limitations of service.

Some survivors will inevitably present issues that are beyond the program's existing capabilities, especially because programs for male survivors presently tend to be modestly resourced. To engage survivors in a service when their clinical needs cannot realistically be met risks providing ineffective treatment and revictimizing the men. The Hippocratic principle of "first we do no harm" cannot be underscored enough.



While the following list is in no way meant to be exhaustive, it does suggest the kind of program limitations that intake counsellors need to bear in mind as they complete their assessments.

- Aboriginal men are often ambivalent about entering mainstream survivor services. Some may prefer a service dedicated to residential school survivors or one with an Aboriginal counsellor who works with traditional healing methods. Of course, the reverse can be true: some Aboriginal survivors may prefer to be served by counsellors outside of their communities.
- Many New Canadians are not familiar or comfortable with the cultural specificity of the counselling process. Frames of reference with respect to stigma, gender socialization, sexuality, and the recovery process are largely culture-bound. It is necessary to explore these frames of reference before a treatment plan can be formulated with these clients.
- Men who are visibly or culturally different may feel misunderstood in group or individual counselling. It is critical for therapists to help forge a sense of belonging and bridge cultural gaps between themselves and their clients, as well as between group members. Where possible, it is helpful to have more than one visible minority man in a group.
- Men with significant physical and intellectual disabilities are generally served best in individual counselling. The funding and capacity of the program may further limit service engagement. The requirements of particular high-needs individuals cannot be allowed to supersede the needs of the group. Alternative service provision may best be arranged in collaboration with a specialized service provider that focuses on the disability presented.



- Men who have been sexually victimized as adults but not as children should not be accepted into a program for childhood sexual abuse survivors.
- The needs of transgendered men who were sexually victimized as children cannot easily be addressed in a general group program for male survivors. Transgendered survivors may require specialized individual treatment with clinicians trained in working with this population.
- Survivors in small or rural communities may periodically encounter their abusers or find it difficult to avoid reminders of their abuse. The actions of a single pedophile can touch many or most people in a small/rural community, and cause deep, painful divisions among the populace. Survivors in this situation may be retraumatized frequently, especially if their abusers have never been held accountable and/or are still perceived as dangerous. Because it is difficult to establish a sense of safety under such conditions, some men in rural/small communities make slow progress and are not able to get beyond the first stage of recovery. These men may be best served in individual therapy that focuses on creating distance from the trauma.



CHAPTER 4

GROUP THERAPY FOR MALE SEXUAL TRAUMA

Trauma-oriented group therapy is the primary form of service delivery for male survivors at *TMP*. For those survivors who are ready for group therapy, this mode offers a unique and powerful healing experience, and an effective complement to individual therapy. In this chapter, we discuss the advantages of group therapy for male survivors; the role of individual therapy and partner groups in relation to the Men & Healing program; structural elements of the Men & Healing groups; practice principles for effective trauma group work with male survivors; and the gender, training, and supervision of Men & Healing group therapists. Our discussion is limited to Phase I and II of the program because Phase III can take a variety of forms; we reserve the discussion on Phase III programming to Chapter 5. The current chapter also deals mostly with subject areas that are specific to delivering our Men & Healing program, leaving the topic of group therapy in general to other texts (e.g., Yalom, 2005). In the next chapter we outline the specific curriculum used in the Men & Healing program.

4.1 THE ADVANTAGES OF GROUP THERAPY FOR MALE SURVIVORS

It has long been recognized that group therapy offers particular benefits to child abuse survivors that individual therapy cannot (Courtois, 1988). More recently, group therapy has also been recognized as having particular value for men (Andronico, 1996). The advantages of group therapy for these two populations—abuse survivors and men—combine powerfully in group interventions for male survivors of childhood sexual abuse. In this section we



identify a number of these advantages. We also include a discussion of group therapeutic factors that are particularly significant for male survivor groups.

4.1.1 Advantages of Groups for Child Abuse Survivors in General

In his article on psychodynamic group therapy for male survivors of sexual abuse, Friedman (1994) discusses the benefits of abuse-oriented group therapy relative to individual therapy as follows.

Individual treatment provides a safe environment to explore the childhood trauma and begin working through the persisting symptoms. Certain aspects of sexual abuse, however, respond best to a group approach. Having suffered a lifetime of feeling isolated and powerless, abuse survivors perceive themselves as social oddities and benefit enormously from group support and validation. The profound shame and guilt caused by sexual abuse are much reduced by telling one's stories to other survivors and being helped to accept devalued parts of the self. The group setting also provides a matrix for the reworking of disturbed childhood relationships and the correction of distorted self-images (p. 226).

As a form of interpersonal betrayal, sexual abuse impairs a survivor's ability to be in close relationships. Group therapy offers a unique laboratory for developing the capacity to form and maintain interpersonal connections (Gartner, 1999). Van der Kolk (1987) warns, moreover, that individual therapy can foster a sense of inequality and dependence for the client in their relationship with the therapist. Group work, on the other hand, creates a sense of membership, inclusion, and equality that many trauma survivors have missed in their lives.

To recognize the relative advantages of group therapy is not to privilege it exclusively over individual therapy. Indeed, for many male survivors the



thought of joining a group of other survivors is terrifying, and being in a group would in fact be overwhelming for them. There is no substitute for the sense of initial safety and depth of work that can be gained with an individual therapist. Membership in a group can then act to widen the survivor's "circle of trust and intimacy" (Lew, p. 265). As Parker (1990; cited in Gartner, 1999) observes, "What individual work provides in depth and particulars, group work provides in breadth and enhanced power" (p. 295). The widening of the circle of trust and intimacy also overcomes the residual sense of secrecy and isolation inherent in the confidentiality-bound dyadic structure of individual therapy. Individual and group therapy, then, are best seen as complementary treatment modalities for abuse survivors, with each offering particular benefits based on the survivor's needs of the moment.

4.1.2 Advantages of Groups for Men

In one of the rare books on group therapy for men, Michael Andronico (1996) contends that men benefit much more from a group than an individual setting because groups are more able to counter the negative effects of male socialization that would otherwise impede therapeutic progress. Brooks (1998) writes, in this respect, that "Men learn to be men in front of other men. Therefore it is in front of other men that men can *unlearn* some of the more unproductive lessons about manhood and *relearn* and *reinforce* some of the more positive lessons" (p. 104). Far too many men either lose touch with male pro-social communities that offer bonding and healing or else "function in male collectives laden with hierarchical rituals, hostile competition and emotional distance or alienation" (Brooks, 1998b, p. 95). According to Isely (1992), male psychotherapy is "grounded in the belief that the 'male role' creates enormous constrictions for men," and that the task of therapy is to help foster a capacity for genuine intimacy (p. 236). Properly facilitated group therapy provides an environment that challenges negative and inauthentic socialization and



requires authentic, positive, and intimate connections with other men. In offering respite from the traditional “male chorus,” then, a male-centred model of group therapy is invaluable for men in search of healing.

Paradoxically, men may both long for emotional connection with other men and fear it. Groups for men immediately contradict the isolation and rugged individualism of traditional male socialization. This can be a relief for many men but it also forces them to confront their vulnerable feelings and discomfort within an all-male setting. An advantage of male-only groups over mixed-sex groups is that the men are more clearly required to develop emotional capacities stereotypically restricted to women. The male group members are forced to nurture other men because they are unable to relegate this task to female group members (Brooks, 1998). Male groups thus not only provide shelter from the harmful aspects of male socialization, they also create an ideal environment for men to grow new capacities and so expand and deepen their humanity. Men thus learn that they can care and feel warm for one another without losing their identities as “men” (Isely, 1992).

4.1.3 Advantages of Groups for Male Sexual Abuse Survivors

Knowing that group therapy offers particular benefits both to abuse survivors and to men, it follows that group therapy would be a preferred treatment modality for male survivors. As shown in Figure 4.1, the healing or integration of male sexual trauma requires a male-centred approach that challenges the “myths” or cultural delusions about male sexual victimization and allows men to redefine their masculinity (this figure carries on from Figure 1.1 in Chapter 1). We have found that survivor groups for men create a micro-society that counters the shaming beliefs about male sexual abuse found in larger society. This feature has been essential to the workings of the Men & Healing program.

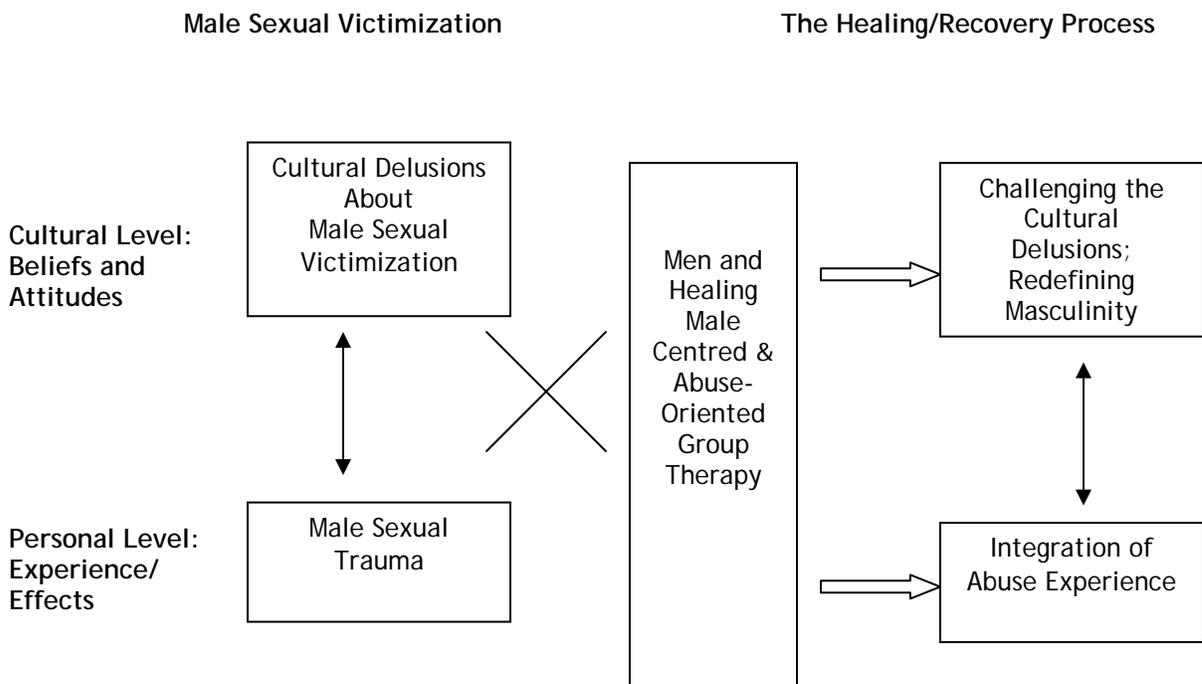


Dimock (n.d.) lists a number of ways in which groups support male survivors to face the issues underlying their gender shame and to take pride in their masculinity, including: providing a safe environment to explore sexual orientation and preferences; receiving validation from other men who can play a “fathering” role; providing a welcoming space to express their anger and rage (in a contained manner); giving permission to discuss a variety of difficult sexual issues and experiences; countering stereotypes about men and male survivors; and redefining their masculinity through such processes as developing intimacy with other men, learning interdependence, and valuing process over end-product.

Figure 4.1

THE MEN AND HEALING PROGRAM

Prepared by Andy Fisher, PhD



Other authors likewise discuss the positive value of group therapy for male survivors (Lew, 1988; Bolton et al., 1989; Crowder, 1993; Friedman, 1995; Gartner, 1999). Little research has, however, been done on these groups. The findings of a survey by Horsley (1997; cited in Gartner, 1999) are noteworthy for this reason. Horsley's goal was to survey a large number of group therapists from across the United States working with sexually abused men. As a sign of just how few groups exist for male survivors, she was able to locate only nine therapists for her research sample. From these therapists she determined the following.

- Issues typically dealt with in the groups included interpersonal relationships (especially with men), sexualization of friendships, problems with power and control, vulnerability related to intimacy and trust, shame and guilt, expressions of anger, and fear of becoming perpetrators of abuse themselves.
- Five main factors were thought to make the groups therapeutic: rebuilding identity, reducing isolation, reworking family dysfunction, regaining power and control, recognizing defenses.
- Men learned to identify unhelpful defenses such as numbing and isolation; and to confront shame, self-blame, and self-hate.
- Other therapeutic factors included: discovering that their abuse experience is universal, gaining new hope, testing self-degrading beliefs, learning to express a wider range of emotions, understanding the limits of gender socialization, allowing men to tell their stories for the first time, and providing a place for men to confront their fear and expectation that other men will judge them.



- The group supported men in incorporating their abuse history into their self-perception, thus allowing it to become more “ordinary” and less dominating of their functioning.

The following section on group therapeutic factors identifies additional advantages of groups for male survivors.

4.1.4 Therapeutic Factors for Male Survivor Groups

In his classic text on group therapy, Irving Yalom (2005) lists thirteen^{††††} empirically-validated factors that account for the therapeutic value of groups. When starting any new group, Yalom recommends identifying the therapeutic factors that are most relevant to the nature and goals of the particular group. This helps ensure that the facilitators are emphasizing the factors most important to the group members themselves, and shaping their interventions to match group expectations.

Following Yalom, we identify here a number of therapeutic factors from his text that seem particularly relevant to male survivor groups. Our intention is to highlight what makes these groups so therapeutic, as well as to provide commentary that can help guide facilitator interventions.

Universality

Having experienced both male socialization and childhood sexual abuse, male survivors typically live in extreme isolation. The realization in group that their experience is not unique and that they are not in fact alone is, then, profoundly therapeutic; the sense of relief can be enormous. This is the factor

^{††††} Yalom identifies eleven primary factors but then expands these to thirteen for his research project.



of universality. Whereas sexual abuse isolates and shames the men, the group acts to give them a sense of connection and pride by validating their experience, recognizing their humanity, and honouring their story. Not surprising, Isley (1992) found that universality was considered the most important factor by members of the short-term psychoeducational groups he studied. Yalom (1995) himself notes that members of sexual abuse survivor groups “profit enormously from the experience of universality” (p. 7).

Richard

“When I joined the group I felt very alone. I thought I was just about the only guy who had ever been sexually abused. As the other group members talked, I realized that I was not in fact alone. They were just like me. I had finally found people who understood me.”

One of the most beneficial aspects of a group program is the opportunity to connect with other survivors. Male survivors rarely get the chance to speak openly and in detail with other men who have been through the same experience. Most of them find great value in hearing from other survivors and receiving feedback and support from men who share their experience. In developing compassion for other survivors, group members develop compassion for themselves. While there is a certain spontaneity to the experience of universality, facilitators play a role by highlighting commonalities in the group and by shaping the group culture so that it enables healthy connections between group members.

Group Cohesiveness

Group cohesiveness refers to the “condition of members feeling warmth and comfort in the group, feeling they belong, valuing the group and feeling, in turn, that they are valued and unconditionally accepted and supported by

other members" (Yalom, 1995, p. 48). For male survivors, this condition is closely related to the factor of universality, the shared experience of sexual trauma providing a strong initial basis for group cohesion. More than the sense of commonality, however, cohesion refers to an attachment to and cherishing of the group. This can deepen over time as members go through powerful experiences together. Cohesiveness is particularly significant in supporting male survivors to self-disclose, this being one of the main tasks of a survivor group. The non-judgmental acceptance and sense of inclusion within the group allows them to take ever greater risks in exploring their inner worlds.

Group cohesion helps create the therapeutic alliance essential to trauma work. The alliance with an individual therapist simply cannot create the same effect as the cohesion among an entire group of survivors. The role of the facilitator is to create conditions needed for cohesion to develop by maintaining the group as a stable base for its members and by shaping the group culture to include norms of caring and acceptance. The group must be a place where differences are respected. This includes differences not only in obvious areas such as race, class, and sexual orientation, but also with respect to how the sexual abuse has affected members differently and the various ways they have managed to cope. Many survivors have been scapegoated for being "different." Many are highly wary of other men. The task of the facilitator is to help members reach across their fears and sense of difference so that the group becomes a place where they genuinely feel they belong.

As Friedman (1994) notes, the cohesion in a male survivor group can have a superficial or adolescent quality based solely on an initial sense of solidarity. The group avoids any conflict that might disturb the sense of sameness, and so does not reach that stage of mature intimacy that comes from resolving such conflict. Any moves toward genuine contact or scrutiny stir up anxieties and create an urge to flee. Survivors may become dissociated or withdrawn in the group, or start making excuses to leave the program. The facilitator in this



case must address the avoidance and resistance of group members while at the same time offering sufficient support and empathy so that the intervention does not exacerbate any negative transference toward the facilitator (Friedman, 1994). This can be a delicate balancing act when group members are highly defended and multiple needs must be addressed.

Family Re-enactment

Because groups resemble families, they are environments where clients tend to relive conflicts and negative attachment dynamics from their childhoods. In time, members start interacting with one another and with the facilitators in ways that resemble their relationships with siblings and parents. Group therapy turns this phenomenon to its advantage by bringing these re-enactments to the members' awareness and replacing them with emotionally corrective experiences. In other words, transference reactions that repeat childhood dynamics are made conscious so that the underlying issues can be resolved rather than continue to be acted out.

As with other groups, group therapy for male survivors recreates family of origin dynamics, including violence experienced in the home. The factor of family re-enactment may be expanded, moreover, to include dynamics from abuse experiences that occurred *outside* the family. Generally speaking, this sort of group recapitulation involves clients' enacting trauma-based roles such as victim, rescuer, bystander, and persecutor—such that the intrapersonal structure of the abuse gets recreated within the interpersonal field of the group. As discussed further in Section 5.1, naming these roles allows survivors to step out of them and find new ones that are more empowering.

The factor of family re-enactment must also be broadened to include the repetition of dynamics from childhood experiences in male groups and boy-to-



boy relationships. As noted above, all-male therapy groups are environments where men can go “back to the scene” where they learned destructive ways of relating to other males and then have corrective experiences with a new group of males. As Brooks (1998) observes: “An all-male group can help a man passionately re-experience past stresses and failures with the male chorus and nostalgically rediscover the more therapeutic aspects of male bonding groups” (p. 104).

Vicarious Learning

Bogdan

“I have tried to push away so many feelings about my abuse, fearing that showing them would only prove my weakness. One evening, a man in my Men & Healing group sobbed and sobbed. Other men in the group and the facilitator listened and congratulated him for his courage. I realized that showing emotions is a sign of strength, not weakness.”

Vicarious learning is a variation on Yalom’s (2005) therapeutic factor of imitative behaviour. It includes not only the imitation of other group members’ positive qualities but also the learning or insight gained from witnessing other members’ experiences and from observing the facilitators’ interventions (Isely, 1992; citing Block and Crouch, 1985). For example, hearing other men talk about their abuse history and its aftermath makes it very difficult to ignore or deny one’s own history. As Hunter (1990) notes, male survivor groups can thus be highly effective in dissolving denial and repression.

In Isely’s (1992) male survivor groups, vicarious learning was considered the second most important therapeutic factor after universality. It was particularly relevant for survivors in learning how to handle the deep emotional experiences in the group.

Usually the first member to begin sharing his abuse story provided an important role model for the other group participants. They were able to learn both how to share their stories and how to respond to this telling by observation of the therapist. The men originally remained quiet after someone disclosed a piece of their abuse history. They expressed fears about not knowing what to say or how to act. The therapists as role models, provided examples of how to listen and respond to the struggling member. The men were later able to work emotional issues in the group without the assistance of the facilitators (p. 241).

Vicarious learning also includes group members' acting as role models for one another when they demonstrate qualities such as vulnerability, intimacy, and honesty. This is particularly relevant for traditional men who have experienced little such role modelling in their lives and who need to be shown alternatives to the restrictive male code. Role modelling likewise helps demonstrate alternatives to certain compensatory or acting-out behaviours such as substance abuse and controlling or abusive behaviour that men often engage in when feeling distressed or powerless (Andronico, 1996).

Imparting Information

This therapeutic factor refers to information imparted both didactically and through the suggestions and guidance given by facilitators and group members. A necessary component of any trauma therapy is the provision of information about the impacts of trauma and the recovery process. This topic is discussed at length in Chapter 5.

Emotional Expression^{††††}

^{††††} Yalom uses the term "catharsis" for this factor. We have used the term "emotional expression" instead because "catharsis" is today commonly understood as a process of emotional ventilation that lacks the crucial element of insight or meaning-making.



Male survivors have in general had little opportunity in their lives to express emotion in a therapeutic manner. Those who are emotionally constricted have poor access to their emotional selves, while those who are emotionally impulsive or under-controlled often repeat emotions such as anger or rage unconstructively. An important role for facilitators is therefore to provide coaching and exercises to help clients express their emotions in a way that is not just a process of empty ventilation. The emotional release must be accompanied by a process of cognitive reflection, re-evaluation, and integration. In other words, head and heart need to come together if the expression is to be of lasting benefit. This is an important lesson for most men.

Emotional expression is facilitated not only by the therapist but also by the powerful witnessing environment created by the group itself. The caring, nonjudgmental attention of other members helps liberate blocked emotions by giving these emotions a strong welcome signal. Members are sometimes surprised to suddenly find themselves crying as they work on an issue while sensing the group's support. The group environment also supports self-disclosure and emotional expression through a "chaining effect" (Courtois, 1988). Having one group member share some aspect of his abuse experience helps others get in touch with their own memories and feelings. Facilitators need to monitor this chaining effect and invite members to share how one member's disclosure or expression has affected the others.

In order for emotional expression to be beneficial, especially if it is a new experience, it generally requires interpersonal contact. Facilitators need to interrupt the group process if they see a client lowering his head, withdrawing, or otherwise avoiding contact with others after expressing a vulnerable emotion. These moments are decisive. If left unattended, the man's emotional expression will simply add another layer of shame to his inner world. If, on the other hand, the facilitator draws the member out and invites him to notice the other men's respect and compassion for him, then he may internalize this care



and access his own self-compassion. It is good practice, then, to always check in with a member after he has expressed some painful feeling to see if this violation of the traditional male code has created any shaming self-criticism.

Instillation of Hope

As previously noted, male survivors typically live with a sense of hopelessness or pessimism about getting help or freeing themselves from the aftermath of their abuse. The very fact of participating in a male survivor group can therefore go a long way toward instilling hope, as it offers the survivor recognition and the prospect of change. Isely (1992) shares his impressions on this topic based on his experience of facilitating male survivor groups.

The men felt the group experience was hopeful because they had searched so long for such a group of men. For many, it was important that male sexual abuse was being addressed and openly acknowledged by professionals. The men felt that they were “pioneers” in the field who were opening a path that other men would be able to follow. The men’s greatest hope, the tearing away of the isolation and secrecy involved in their abuse, was realized in the group experience. Many were able to carry this learning into their friendships, love relationships, and family by finally sharing the secret of their sexual abuse (p. 242).

Many survivors look toward “society” for signs of recognition and service development. They may feel hope or despair to the extent that they find it. The men need to hear that their clinical progress is not only beneficial for themselves but for all survivors, as well as their families and communities. Most of the hope will come in the end from the concrete experience of witnessing other men making therapeutic progress and from making their own internal gains.



4.2 ROLE OF INDIVIDUAL THERAPY AND PARTNER GROUPS IN RELATION TO MEN & HEALING GROUPS

Individual Therapy

Individual psychotherapy is strongly recommended as a corollary to participation in the Men & Healing program. Men & Healing policy was previously firmer in this regard, with individual therapy being a prerequisite or corequisite to group work. This policy has since been terminated, however, due to the inaccessibility for low income men of counselling services that speak to the needs of male survivors. Certainly, men who do not have an individual counsellor are referred to one during the intake process.^{§§§§} Individual therapy provides focused attention to the clients' needs, including stabilization around disturbing thoughts and memories that arise in group. Individual counselling is both a container for processing material arising in group, as well as a setting for developing insights and questions to take back to the group. The individual therapist might, for example, suggest to the client that he disclose to the group something about himself that he is withholding out of a sense of shame, knowing that the group experience can detoxify such shame more effectively than an individual therapist can. We have observed that survivors in the Men & Healing program who work with an individual therapist generally make more rapid progress than those who do not have this resource.

Partner Groups

The impact of sexual trauma is not limited to the survivors alone; rather, sexual trauma affects intimate partners, families, and communities. Partners, in particular, benefit from support, information, and the opportunity to ask

^{§§§§} *The Men's Project's* primary funder, The Ontario Ministry of the Attorney General, does not, however, allocate funding resources for individual therapy.



difficult questions. *TMP* runs six-session long groups for partners (both male and female) of Men & Healing clients. Partners are often relieved to find that the symptoms of trauma are normal, and that the partners are not to blame for them. Sometimes they need permission to stop taking responsibility for the thoughts, feelings, and behaviours of survivors, and instead to take care of themselves.

One of the greatest benefits of such a group is providing the opportunity for partners to ask questions they are not comfortable asking the survivors themselves. Questions about sexuality and intimacy problems are common in partner groups. Mutual support can be invaluable for partners, as many believe that they are the only person struggling with these problems. They learn to distinguish between supporting their partners and trying to “rescue” them. When partners are supported in these ways, they can become strong allies for survivors as they attempt recovery in therapy.

4.3 STRUCTURAL ELEMENTS OF MEN & HEALING GROUPS

In this section we discuss various structural elements of the Men & Healing groups: group composition, co-leadership, size, and duration. The topic of group agreements is left for Chapter 5.

Composition

Yalom (1995) suggests that cohesiveness be made the primary guideline in composing a group because of its central role as a therapeutic factor. In practice this means aiming for a relatively homogeneous composition. While some believe that homogeneity makes for groups that are too comfortable, being spared the human diversity and conflict that spark the therapeutic process, Yalom disagrees. Rather, he says the conflict and discomfort needed



for members to grow and gain insight will always emerge because no group is completely homogeneous and because each member has to confront the tasks of the group itself—self-disclosure, developing intimacy, self-examination, and so on—so long as the facilitators are doing their job of focusing members on these tasks.

Men & Healing groups are homogenous in the sense that all of the members are men and abuse survivors. Homogeneity is also promoted by our phased approach, such that all members progress roughly from one stage of healing to the next. This helps ensure that members have a comparable level of tolerance for the depth of work the group is designed to facilitate (recognizing, of course, that new members to Phase II will in general be less advanced in their healing than those who have been through a number of cycles in the group). Creating groups for specific subpopulations is another way that homogeneous group compositions can be achieved.

As Yalom suggests, elements of heterogeneity are unavoidable. Men & Healing groups are diverse in terms of types of abuse experienced,^{*****} gender of abuser(s), symptomatology, length of membership in the program (when open-ended), age, culture, race, sexual orientation, and so on. Some group members will present as very intrusive, extroverted, or talkative while others are constricted, shy, or withdrawn. Group members also vary in the amount of contact they have had with individual psychotherapy, and involvement with other services and peer-support groups (e.g., AA or NA). These differences generally create positive tensions in the group—all “grist for the mill,” and all serving as avenues for developing mature group cohesiveness.

^{*****} Survivors of childhood physical abuse alone are admitted into Men & Healing services, being assessed on a case-by-case basis.



Co-leadership

Men & Healing policy regards co-facilitation of groups as preferable to solo facilitation, although co-facilitation is not always possible due to funding limitations. The merits of co-facilitation are numerous. First of all, having two leaders, particularly a male and female team, invites a greater variety of transference reactions or symbolic reenactments of childhood dynamics. As discussed further in Section 4.5, this makes for rich therapeutic material and allows facilitators to focus on the therapeutic factor of family reenactment. Second, two leaders make a stronger container for trauma work than one. This is especially true during experiential exercises, where one leader can direct the exercise while the other monitors the group for emotional flooding, dissociation, and so on. Thirdly, two leaders allow for more thorough session preparation and clinical debriefing; this improves the quality of the therapeutic work and reduces the risk of a leader becoming vicariously traumatized.

Size

Group size varies by program phase. Men & Healing Phase I groups can be larger than Phase II groups because the emphasis is on information and stabilization. Relatively large groups create greater anonymity while also enhancing the factor of universality. Our practice principle is generally to limit Phase I groups to twelve members. However, groups with larger numbers have in fact worked well, given the psychoeducational format. With Phase II, the group size is capped at eight members, which we regard as the ideal size for maintaining the energy of the group while allowing each member to have some space.



Duration

The Phase I group program is eight sessions long. This duration was for chosen for a number of reasons. First, it is short enough to keep drop-out rates low. A brief program also gives survivors the opportunity to have a concrete experience of accomplishment and completion in their recovery process (Isely, 1992). At the same time, eight sessions is sufficiently long to provide enough psychoeducational material and group experience for the participants to become interested in Phase II of the program. Our observation has been that many survivors in the early stages of recovery are reluctant to make a commitment to a long-term healing process before they have had a chance to assess the possible benefits of this work and their comfort with it. Phase I of the program thus provides this opportunity to “test the waters.”

In contrast to the situation in Phase I of the program, the remembrance, mourning, and integration work of Phase II requires a long-term approach. Survivors in Phase II generally do not feel safe enough to undergo a deep emotional journey unless they know the group is going to be “there” for them for the long term (Gartner, 1999). Mennen and Meadow (1992), writing about women’s survivor groups, argue for long-term groups because of the time require to build trust and cohesiveness, allow interpersonal patterns to develop, and work though deep-seated emotional issues. In Friedman’s (1994) male survivor groups most members remain in the group for around one-and-a-half to two years. This duration allows him to focus on the goals of personality change and the reworking of relationship problems rather than mere symptom removal.

Phase II of the Men & Healing program is structured by 10-session cycles. At the end of each 10-session “cycle of commitment,” men are given the opportunity to commit to another 10-session cycle or achieve closure with the group. This



decision is based on the client's interest, the results of evaluation measures, and the clinical judgment of the facilitator. Current Men & Healing policy allows for men to attend a maximum of five 10-week cycles in Phase II (approximately one year), with extensions beyond this length allowed on a case-by-case basis. This enables them to engage in this healing strategy over a significant period of time with manageable commitment expectations. This also allows men at different levels of recovery to be in a group together, creating a functional heterogeneity.

4.4 SESSION PRACTICE PRINCIPLES

In this section we discuss practice principles for running male survivor groups under two broad headings: structuring the session and directing the session.

4.4.1 Structuring the Session

Pre- and Post-Session Contact with Group Members

It is important to maintain a clear boundary between the time spent in group work and the time of informal contact before and after a group session. Facilitators need to keep pre- and post-session discussions with group members light in content. In the Men & Healing program, facilitators usually stay out of the group room or keep busy with making coffee or setting up the room. This helps guard against establishing a special relationship with a select member or sub-group during this time, thus preserving the sense of equality that Yalom (1995) calls the cement of the group.



Frank

Frank, a member of a Phase II Men & Healing group, approached his facilitator after group and said that he was bothered by George, another client, because he “took too much time talking about his problems.” The facilitator encouraged Frank to bring his concerns about the group process to the next session. Frank needed some assistance and coaching from the facilitator to convey his thoughts and feelings to George in a caring and effective way.

As in the case of Frank (above), we encourage group members who have a complaint about another member to bring up their concern as a topic for discussion during the session. Facilitators do not commit to holding back information obtained outside the group that is relevant to group. Such secrecy can create a confusing group environment and thwart connection between group members.^{††††}

The Check-In

We use check-ins as a way to establish brief contact with each group member and to hear about his present emotional condition and life circumstances. Members are encouraged to focus inwardly and identify their current feelings, as well as their insight into them. Check-ins should not be simply a recounting of the weeks activities, as this can become a disconnected activity of little substance (although some mention of the week’s events can, of course, provide context for the client’s emotional state). Members are asked to use check-in time responsibly. If a member is talking at length about superficial issues or speaking in the second person then we refocus him on sharing his inner world and speaking in the first person. We use a talking stone in order to emphasize

^{††††} This is particularly relevant for facilitators who also provide individual counselling to group members. In this case, the fact that the member is in individual therapy with the facilitator must be disclosed to the group. The practice of having group members in individual counselling with facilitators is, however, actively discouraged in the Men & Healing program.

the sacredness of each individual's speaking time and to ward off questions and advice ("cross-talk"). In this way men can disclose information or ask questions without committing to any additional group process. Following these guidelines fosters a climate of authenticity at the beginning of each session.

If the group as a whole is checking-in in a superficial or detached way, then it can be fruitful to facilitate a second check-in. Here men are asked to name a basic emotion they are feeling—whether anger, happiness, shame, sadness, or fear—and to share the context of this emotion. This exercise often brings the group to a deeper level of connection. Men are socialized to avoid emotional expression in groups with other men, so this check-in process, while often foreign to them, can therapeutically bring men out of their comfort zone.

Superficial check-ins may indicate that an issue or situation exists in the group that has led the men to guard their vulnerability. These include threats to confidentiality, "heavy" discussion in the previous week, and new members joining at the start of a new 10-week cycle. It is useful for facilitators to share their observations in this case and ask how members are feeling about being in the group at this moment.

Material introduced in check-in that raises safety concerns—such as suicidality, addiction relapse, or high-risk behaviours—should be addressed quickly. This is one area where it is constructive for facilitators to intervene during check-in to express concern or ask clarifying questions. A group member who is highly distressed or dealing with an upsetting situation (such as major medical problems or death of a loved one) can be asked what he needs from the group. This reinforces the validity of being nurtured by group members and gives the member permission to do what he needs to do (sit back, ask for help, cry, etc.) to benefit from the session; he learns that he does not have to struggle alone with his thoughts and feelings.



The check-in format for Phase I and Phase II groups is generally the same, although in Phase I we limit the depth of emotional exploration. In Phase I groups, material from the check-in can be woven into the theme for the week as a way to maintain the psychoeducational focus. When possible, it is worthwhile to change the week's focus if a more relevant educational theme has been identified in the check-in. Group members are not asked to do a check-in in the first session of a new Phase I group, as the objective is for them to acclimatize to the group at a gentle pace without needing to talk if they are not comfortable doing so.

With Phase II, check-ins are beneficial for establishing the agenda and context for the session at the start of the group, as well as for providing a ritual for men to transition into the psychological space of the group. Group members are encouraged to "ask for time" if they want to initiate work on a particular issue.

Announcements and Unfinished Business

After check-in, announcements are made by the facilitators about housekeeping issues or about group members who called to say that they are sick or unable to attend. Following this, group members are encouraged to raise any unfinished business in the group. This may be unresolved conflict with or feelings toward other group members; a question sparked in an earlier session that has stayed with a group member; or a member reporting back to the group about a new behaviour or coping mechanism he said he was going to try.

In Phase I, unfinished business is handled within the context of Stage 1 recovery work, where the focus is on safety and support. In practice, this means limiting the degree of interpersonal encounter and instead working with



men on their individual situations and on clarifying educational topics. In Phase II, on the other hand, members are encouraged to air conflicts, projections, or difficult feelings about other group members. Making a space for unfinished business provides opportunity for group members to work through interpersonal issues and conflicts in an open and therapeutic way. For both Phase I and II groups, the unfinished business segment also provides opportunities to discuss matters related to the functioning of the group, such as violations of the group agreement or inconsistent attendance.

The Middle of the Session

The middle of the session differs considerably between Phase I and Phase II. In Phase I, the middle of the session generally takes on one of three forms.

Discussion Questions. Asking the group members questions facilitates group discussion. How have they coped? What stopped them from accessing treatment in the past? What is motivating them to continue? What are the links between anger and shame? Such questions are useful in unpacking various themes, without having all the material presented by the facilitators. This approach respects the fact that group members have relevant knowledge. Asking questions that are easy to grasp invites greater responsiveness, as do questions that may evoke controversy (e.g., how do male and female survivors differ?). Discussion prompted in this way not only gets members engaged but also allows cultural delusions and other misinformation to be addressed.

Presentation of Information. Presenting information didactically helps fulfill the educational function of the Phase I program. We keep didactic pieces short (e.g., a half hour) and interactive. Because group members tend not to retain the information well, interactive discussions and experiential exercises (as discussed in Chapter 5) are often where the learning and remembering



happens. The information presented provides a basis for the interactions and gives purpose and direction to the group process.

Group members typically apply the presented material to their lives and explore the fit of the information to their lived experience. They sometimes become emotionally overwhelmed because they are triggered by the information or because they begin talking about details of their abuse experience related to it. Facilitation involves monitoring the pacing of disclosures and supporting emotional containment while not leaving group members with the sense that they have been shut down or silenced.

Experiential Exercises. Experiential exercises in Phase I of the program generally involve grounding, relaxation, or visualization. We avoid doing such exercises at the beginning of sessions, as late arrivers can be disruptive. Grounding exercises are particularly valuable following triggering presentations or discussion; using them at the end of a session models emotional safety when leaving the group. Permission is always given not to participate.

The middle portion of Phase II group sessions largely depends on issues identified in the check-in. It is important, however, to prioritize matters as discussed below in Section 4.3.2. Facilitators need to use probing questions to clarify the issue presented by a member and what he hopes to achieve by bringing it forward. This helps ensure that the support given is as constructive as possible and that the therapeutic contract is clear. The member who raised the issue is furthermore asked what type of support he would like. The other group members are discouraged from offering advice unless given permission, and when they ask probing questions the member being questioned has the option of not answering. Once the issue has been worked on with the individual, he is asked if it is okay to have the discussion opened up to the rest of the group. Members are encouraged to share what the issue brought up for them—their feelings, thoughts, sensations, fantasies, memories, and so on.



Asking group members what they hope to achieve by bringing the issues to the group, what kind of support they would like, and whether they would like their issues opened up for discussion with the rest of the group gives them the experience of healthy and clear negotiation of boundaries. This offers an important corrective to the experience of sexual abuse, which by definition is characterized by the absence of boundary negotiation.

The Check-Out

At its most basic level, the check-out helps facilitators assess whether group members feel grounded or safe enough to leave group. It may also reveal unfinished business that needs to be addressed at the next session. For group members, the check-out provides a ritual for leaving the group in a grounded and connected way, in touch with their bodies and minds. Members are often asked to review and describe what they learned in the session, as this helps them transfer skills and insights gained in the group to their personal lives.

4.4.2 Directing the Session

Using the same structure for each session, from check-in to check-out, creates a consistent and familiar framework. Facilitators and group members alike can rely on it. In any given session, however, facilitators must make decisions about how to direct the session: what themes to pursue or draw out, how to allocate time and prioritize issues, and how to find a balance between curriculum content and interactive group processes. This is the topic for the present section.



Phase I

In Phase I of the program, the eight sessions are organized by information themes or modules (discussed in depth in the next chapter). Given that Phase I is geared toward Stage 1 of recovery, the theme of safety carries over into most weeks and experiential grounding techniques are used in all sessions. Relationships are also discussed as a major theme in two or more sessions due to the relevance of the material to the experience of group members. If time permits, the links between addiction and trauma often warrant a full session.

Due to the levels of dissociation and concentration difficulties among group members, it is realistic to assume that some or most members are going to miss substantial amounts of information along the way. Sometimes it is worth letting go of the psychoeducational agenda to allow room for discussion and to assess whether group members are experiencing information overload. It is helpful to emphasize with the group that the information is simply a brief overview that will provide the groundwork for greater explorations in Phase II or with an individual counsellor. We tell group members that it is normal and acceptable not to understand all of the material presented, and that it is sufficient to absorb some key bits of information about the material or themselves. A facilitator might say something like: "I am conscious that I have given you a lot of information. I think it's important to take some time to unpack some of the ideas discussed so far." Or: "It's okay if you are not processing all of the material we are covering. This is intended as an introduction. If you take away a key idea or two each week, that's great."

Phase II

In Phase II, the programming shifts from psychoeducation to process-oriented group work. The men have a common vocabulary from Phase I, but the focus is now on insight and integration. Thus, session material is generated primarily from the issues that group members bring to the session. The role of the facilitator is to distil these issues and select where to place emphasis. Generally, it is best to prioritize as follows:

1. Safety issues
2. Group maintenance issues
3. Here-and-now issues
4. Working through trauma (there-and-then issues)
5. Other issues

These priorities replicate the stages of healing, and thus offer a way of handling group members' being at different stages.^{****} If, for example, one group member has safety issues or is in crisis, it is advisable to attend to this first and foremost—and then move on to other issues in the group. Problems pertaining to group structure or group maintenance should likewise be addressed without delay. It is difficult for survivors to work on a personal matter if they don't trust others to maintain confidentiality, think another group member is going to kill himself, or believe that the group is going to disband any day due to erratic attendance.

Regarding these first two priorities, facilitators need to deal quickly and effectively with abusive, shaming, misogynistic, homophobic, cruel, exhibitionistic, or antisocial behavior so as to maintain the sense of safety in

^{****} This prioritization scheme comes from the clinical supervisor at *The Men's Project*, Roy Salole.



the group. It may seem counter-intuitive or undemocratic to be forceful with survivors of abuse, but this is in fact particularly appropriate because a protective authority figure was often absent at the time of the abuse. When group leaders are authoritative (versus authoritarian), it gives members the message that the leaders care enough to protect them. This also ensures that the therapy space does not become a men's social club but rather remains an environment to foster new ways of relating and gain therapeutic insight. For example, examining homophobic beliefs sometimes reveals fears about being weak or powerless, uncertainties about sexual orientation, and confusion between homosexuality and pedophilia. Similarly, misogynistic statements may stem from having had a female abuser or a mother who was unprotective, or from feelings of insecurity as a male.

Here-and-now issues are the next priority. One category of here-and-now issues involves difficulties in the relationships between group members or between one or more group members and a facilitator. Resolving these issues fosters awareness of how trauma has affected the members' object relations,^{§§§§§} teaches healthy interpersonal relating, and helps maintain group cohesion. The second category of here-and-now issues involves difficulties that a group member is having in his life outside of the group. These issues are worked on by helping members develop certain skills or capacities such as assertiveness, managing bodily and sexual boundaries, affect regulation, distinguishing the past from the present, respectful communication, cognitive restructuring, self-care, and so on. These are often capacities that were impaired or underdeveloped as a result of the sexual abuse. Developing them in group and practicing them between sessions increases the survivor's ability to then handle the deep emotional process of working through their trauma, i.e., the fourth level of priority. Finally, any other matters, such as educational topics, are

^{§§§§§} This phrase refers to the inner or intrapsychic representations of relationships from early in life which affect how one interacts with others in the present. It points to the way that current interpersonal patterns are shaped by past relationships.



best dealt with in the absence of more pressing issues, as the fifth priority level.

As Phase II membership matures it increasingly spends its time on here-and-now issues and on the working through of traumatic material, moving from the content-orientation of Phase I curriculum to more of a process-orientation. It is worth noting, at this point, that the emphasis in process-oriented trauma work is on the impact of the trauma on the self-organization and personality structure of the individual survivor (Hudgins, 2002). In other words, even when working on group conflicts and other interactive processes, the therapist's interventions are designed primarily to link the individual's current experience to the effects of the past trauma on his inner world or intrapsychic functioning. This is not to downplay the importance of the bonding, cohesiveness, and genuine contact experienced in the group; rather, it is to recognize that the main target of change is the internal legacy of the sexual abuse. All interpersonal group processes are in service, then, of illuminating and transforming this inner reality shaped by trauma. By explicitly holding an intrapsychic focus the facilitator encourages members to maintain an inward attitude toward what they experience in the group. A member who is feeling attacked, for example, can be helped to discern if this as a re-enactment of childhood patterns or simply a real-time insult (which it could be). Such interventions help minimize confusion and distress about group relationships, for they direct members back to their own issues and therapeutic goals.

Although each of the three phases of the Men & Healing program corresponds roughly to Herman's three stages of recovery, it is worth keeping the cyclical relationship between these stages in mind when directing a session. While therapeutic gains made at earlier stages support the work at later stages, it is also true that gains made during later stage work supports additional work on earlier stage themes. Thus, if a Phase II group seems stuck in Stage I work, it may be beneficial to introduce Stage III themes like wellness, strength, positive



identity, and fun. This tends to build connection and self-esteem, and open up an exploration of what motivates change and recovery. The positive energy gained from visiting Stage III themes also instills hope. Without hope, people are less likely to get out of bed, embark on processing traumatic memories, enter into an addiction treatment program, or take psychiatric medications.

When attending to group process it is also valuable to keep in mind how the effects of male socialization are playing out in the room. Group members in male survivor groups are more likely to act-out the effects of their male socialization (e.g., suppressing emotional expression) than to discuss them directly. It is the role of group facilitators to bring gender issues to the fore when members do not, both by sharing observations of gender-related behaviours in the group and by introducing questions related to the traditional male code. As noted above, one of the advantages of a male survivor group is that it provides opportunities for men to question gender stereotypes, challenge the cultural delusions about male sexual abuse, and redefine their masculinity.

4.5 THE MEN AND HEALING GROUP THERAPIST

Trauma therapy is characterized by healing that takes place in the context of the relationship between client and therapist, as well as between group members. The therapeutic relationship is an intense interactive field in which therapists must allow themselves to be tested and to serve as a source of corrective experiences. The self of the therapist is thus unavoidably a central factor in doing trauma therapy (Dalenberg, 2000; Pearlman and Saakvitne, 1995). Given this situation, a practice principle for trauma therapy—including therapy for male sexual trauma—is to give careful attention to the gender/sex, training, supervision, and well-being of the therapist.



4.5.1 Therapist Gender/Sex

Recall from Chapter 1 that the biological sex of a person can be distinguished from their gender, the latter referring to the psychological and social meanings associated with their sex (i.e., gender identity and gender role). For survivors of childhood sexual abuse, the sex/gender of the therapist strongly influences their experience of the therapist. As Gartner (1999) notes:

...whatever the sex of the therapist, gender issues are likely to figure prominently and problematically in the treatment of a sexually abused man (or woman), especially in relation to transference and countertransference. This is true whether he chooses a therapist whom he feels is different from or like his abuser or himself. It is true no matter how rational or distorted his reasons for choosing a male or female therapist (p. 266).

There is no simple formula for predicting how any given male survivor will react to a male or female therapist—based, for example, solely on the sex of his abuser(s). As Crowder (1993) notes, “Clients’ fears, conscious or unconscious, about revictimization, and their sense of who they feel safe with, are very idiosyncratic” (p. 91). One male survivor may be highly uncomfortable admitting to his victimization with a female therapist, while another may feel exactly the same with a male therapist (for a fuller discussion on this topic, see Gartner, 1999). Survivors of child abuse often feel more comfortable working with either a male or female therapist at first, but may come to a point where they realize a need to work with a therapist of the other sex in order to further their healing.

The practice principle at *TMP* is to make no preference regarding the therapist’s sex; both males and females can be group facilitators. This is consistent with Brooks’ (1998) remark that the “therapist’s gender awareness and gender sensitivity are far more critical than the therapist’s gender” (p. 205), as well as Crowder’s (1993) view that “the gender of the therapist is a minor issue compared to his or her competence” (p. 90). It is also crucial that



both male and female facilitators demonstrate gender role flexibility and examine their own gender stereotypy, so that they do not treat men in the program according to unaware biases, e.g., that men cannot be as emotionally expressive or insightful about personal concerns as women (Gartner, 1999).

A Men & Healing practice principle is to prefer female-male co-facilitation teams (as mentioned earlier, however, funding limitations generally prevent co-facilitation). This creates a rich ground for working with object relations, projections, transference, and counter-transference (Gartner, 1999). Facilitators will be tested, accepted, or rejected based largely on whether they are male or female, and they must make themselves available for clients to work through the trauma-based feelings they have for each gender (Webb and Leehan, 1996). Male-female co-facilitation also allows the facilitators to model mutually respectful and constructive relating between the two genders, as opposed to the harmful or dysfunctional relating that groups members may have come to expect.

For male facilitators, it is crucial to understand the struggle that male survivors typically have regarding their identity as men, and how this can play out in their relationship to figures of male authority. As Gartner (1999) notes, the survivor may perceive the male therapist as an aggressive, predatory figure; may envy him for (seemingly) being a “real man;” or may hold him in contempt for being a feminized male interested in emotions and interpersonal relationships. He may dread the male therapist, long for him, or hate him. What is most important, then, is that the facilitator be attuned to whatever the particular gender-based transference reaction is, and to courageously meet the survivor there.

Female professionals who work with male survivors face unique challenges of their own. Many men lack a model for an intimate relationship with a female that does not involve physical intimacy. They will at times sexualize their



relationship with a female therapist with compliments or flirtation when they are feeling most vulnerable (Potash, 1998; Shapiro in Gartner, 1999). Female facilitators may be treated as a nurturing object or sex object. At the same time, they may be perceived as invasive, “phallic,” and harsh, while male facilitators are seen as nurturing, feminine, and maternal. Female leaders are likely to evoke issues that group members have had with their mothers or female care givers, just as male facilitators are likely to raise issues related to their fathers. Knowing the sex of the perpetrators or bystanders and the nature of group members’ relationships (past and present) with significant female authority figures can be helpful in this regard. This involves open discussion about interpersonal patterns between the client and females in his life.

One Phase II group at *TMP* was being facilitated by a male when it was announced that a female facilitator would start co-leading the group. At the time, group members expressed intense anger and fear. They were concerned that they might become sexually aroused in group, have to watch their profanity, stop sharing, or become highly emotional. While there was initial concern that the group might dissolve if members dropped out because of their fears, the change in facilitation did not cause a flight from the group and ultimately allowed for discussion of topics that had remained dormant with only male facilitation. This episode illustrates both the significance of gender to the male survivor and the value in dealing with this topic directly.

4.5.2 Training, Supervision, and Vicarious Trauma Management

Good training and supervision is required not only to competently assist abuse survivors in their recovery but also to minimize the risk of their being re-traumatized in the course of treatment. This is well known in the abuse and trauma field. Less well recognized is the role that training and supervision plays in minimizing the therapist’s experience of vicarious trauma. A relatively



new construct, vicarious trauma refers to the trauma that clinicians experience secondary to their empathic engagement and countertransferential struggles with trauma survivors. It is not our intention to elaborate the topic of vicarious trauma here (on this, see Pearlman and Saakvitne, 1995; and Saakvitne, Pearlman, et al., 1996). We do, however, wish to share some of our experience with using group clinical supervision as a forum for ongoing training and vicarious trauma management.

Saakvitne et al. (1999) assert that:

...the single most important factor in the success or failure of trauma work is the attention paid to the experience and needs of the helper. That is not to say that the clients' needs are less important, but rather that we cannot meet the needs of clients when we are overriding those of the helpers (p. 157).

Clinical supervision is in our view one of the main arenas where the needs of the helper can be addressed. At *TMP*, supervision is conducted in group format in a monthly three hour session under the guidance of a senior clinical consultant who is external to the organization. Group supervision has some distinct benefits for facilitators of male survivor groups. Perhaps most critically, the group structure helps to break the isolation inherent in work with trauma survivors. Mann (2006) notes that:

... therapists can often work in contexts of isolation themselves. Therapeutic conversations often occur between two individuals. Therapists are often physically separated from each other in the workplace. And some organizational practices, such as individual supervision, tend to support an individualized approach to therapeutic work (p. 12).

These remarks suggest the value of developing workplace conversations and processes that foster collaboration among therapists. Group supervision provides opportunities, in this respect, for facilitators to connect and feel like a team.



We have found it of particular value to treat group supervision as a safe environment for sharing personal difficulties or countertransference reactions experienced in facilitating Men & Healing services. While it is risky to put uncertainties, mistakes, painful feelings, over identifications, gender conflicts, erotic attractions, and gut reactions into a room of peers, this is generally more effective than depersonalized case discussions or individual supervision. Group supervision performed with a willingness to self-disclose is often experienced as more relevant by clinical team members than a dry and technical discussion about a problematic behaviour of a client. Such an approach not only acts to increase the clinician's skillfulness, but also helps resolve personal issues and thus reduce the risk of vicarious trauma. This is particularly true for facilitators who are themselves sexual abuse survivors or whose lives feel pervaded by trauma. Supervision ideally provides the clinician experiencing vicarious trauma a place to consider their self-care and own therapeutic needs. For interns who are able to witness more seasoned professionals working through difficult issues and stuck places in this way, group supervision can be a rich learning experience.

Group supervision provides the opportunity, furthermore, to work through interpersonal issues present within the supervision group itself. The role modeling of the supervisor in facilitating the group dynamics provides experiential learnings about facilitating groups in general.

Finally, a group format allows opportunities to share diverse knowledge and experience when working with difficult issues in groups. One facilitator is likely to have worked on the same or similar issue presented by another, and can therefore share their knowledge and observations. Group supervision allows for experiential learning such as role plays and grounding exercises, as well as more formal didactic training. It is not uncommon at *TMP* for therapists to present information in supervision about current models, intervention



strategies, or material from workshops that they have attended, thus providing opportunities for integrating new material into clinical practice.



CHAPTER 5

MEN & HEALING PROGRAM CONTENT

This chapter presents an overview of the content of *The Men's Project's* Men & Healing program. We begin by discussing eight main themes: setting the stage; the aftermath of trauma; handling stress & crises; dissociation & grounding; trauma & relationships; trauma & identity; emotions & trauma; and closure & looking ahead. These themes are presented to clients most formally in Phase I of the program, where they are covered as educational topics. This educational material then gives the men a foundation for progressing to Phases II and III of the program, where the themes are returned to or brought to the foreground as needed. In the second section of this chapter, we discuss the content of Phase II groups. Although these groups are process-oriented and so do not have a set curriculum, they have two aspects that deserve mention: the use of experiential exercises and formal testimonies. In the final section of the chapter we provide a brief discussion of the "reconnection and moving on" stage of recovery, particularly with respect to formulating content for Phase III programming.

We remind the reader that our intention here is not to provide a detailed manual for delivering the Men & Healing program. It is rather to share some of our experience and knowledge as an aid to others in designing their own programs, based on their particular circumstances and theoretical leanings. *TMP* has, for example, shared much of the material presented in this guidebook with an Aboriginal healing community. This community has, in turn, adapted the material to fit with and complement Aboriginal teachings. We repeat, as well, that delivering a program for male survivors of sexual abuse requires professional training in facilitating trauma work (as discussed in Chapter 4).



5.1 GROUP THEMES

Psychoeducational material is best delivered by taking a dialogical and collaborative approach. This keeps the information relevant and lively for the group members and allows facilitators to remain flexible with the curriculum, adapting it to the concerns that clients bring to sessions. Although we have identified eight themes and there are eight Phase I sessions, the themes do not correspond in an exact one-to-one manner with the sessions. Indeed, we rarely stick to one theme per session because there is much overlap among them; we also give extra time to those themes that seem particularly relevant or weighty. Although presented most methodically in Phase I of the program, the eight themes are relevant to all stages of recovery and thus reappear naturally in Phases II and III of the program.

Theme 1: Setting the Stage

Just as it is important to provide a welcoming environment to clients during the intake process, so too the first few sessions of Phase I of the program are critical for establishing an inviting and healing space. The first theme, “setting the stage,” is about acknowledging feelings of anxiety and ambivalence, building connection, giving the men a picture of what to expect, establishing the structure of the group, and introducing some initial skills for containment and grounding.

In the opening session of Phase I of the program we invite men to share their feelings of nervousness and ambivalence, giving them room to discuss their resistance. This helps normalize the fact that many survivors are apprehensive about therapy, question whether recovery is possible, and feel stigmatized for having been victimized as males. We help men clarify their own reasons for pursuing recovery. Many fear passing their issues and problems on to their



children or are alarmed about the possible grave consequences of their trauma-related behaviours. Others have reached a moment of reckoning from feeling so distressed all the time, or want to solve chronic problems in their intimate relationships. We highlight with clients the success of other men who have entered the program, noting that although most begin Phase I with a lot of ambivalence they do go on to the other phases, eventually graduating from the program.

In order to forge an initial sense of connection between men, we highlight commonalities in the group and downplay or normalize differences. With Phase I groups, we avoid exercises such as “icebreakers,” as the men may have tremendous fear about having to talk. Sitting in a group with other male survivors is often stressful enough. Interactive opening exercises are more appropriate for longer-term (Phase II or III) groups, where they help generate familiarity and mutuality.

In the early sessions of Phase I, the psychoeducational format is instrumental in taking the pressure to talk off the men, allowing them to listen rather than perform. We typically use a number of handouts. Figure 5.1, for example, is an agenda for the eight sessions. It helps clarify the mandate and parameters of the group, and prompts facilitators to ask clients what they wish to accomplish over the course of the 8-week group. We also provide a handout on the stages of recovery. This helps give the men a picture of the path ahead, and situates the tasks of the group within the overall context of recovery. Seeing a path that is well-worn by others helps instil hope at this early stage.



Figure 5.1 INTRODUCTION TO MEN & HEALING: PHASE 1

Session 1: Understanding Trauma and Recovery

In this session you will be introduced to the topics of the group. Many survivors of trauma wonder whether there is any point in talking about abuse and about how it has affected them. This common question will be explored. Paths to recovery will also be discussed.

Session 2: The Aftermath of Trauma

The impact of abuse on people's lives will be discussed in this session, as will the impact of trauma on the brain. We will discuss how people survive abuse. This is important for understanding where difficult emotions, thoughts, and old coping patterns come from.

Session 3: Handling Stress & Crises

In this session we will discuss how to handle difficult emotions and thoughts, including "flashbacks." We also will explore creating safety when coming to terms with old patterns of coping. We will look particularly at dealing with addictions. We will introduce "grounding" techniques, and look at self-care and building a support base.

Session 4: Trauma & Relationships

In this session we will examine some of the ways that abuse impacts relationships. We will explore dynamics of healthy and healing relationships.

Session 5: Trauma & Identity

Abuse often affects how people see themselves. In this session we will explore the impact of abuse on identity in general and male identity in particular. We will also discuss myths about male victimization.

Session 6: Trauma & Relationships II

In this session we will continue to examine the ways that abuse impacts relationships and to explore healthy vs. unhealthy relationship dynamics.

Session 7: Emotions & Trauma

In this session we will examine the relationships between trauma and emotions. In particular, we will look at anger and shame; loss, forgiveness, and letting go; and emotions and the brain.

Session 8: What to Expect in Men & Healing Phase II

In this session we will review previous sessions, and look ahead to the next steps of recovery.

We will hear a guest speaker from a Men & Healing Phase II group.

The topic of group agreements is likewise covered using a handout. We prefer the term “group agreements” to “group rules” because the former implies an agreed-on contract rather than something that is imposed on the men by the facilitators. We emphasize that the group agreements are there to support containment and safety. The following group agreements have particular importance for male survivor groups.

Confidentiality

Confidentiality has great significance for survivors because of their history of betrayal and because of the highly secretive and stigmatizing nature of many abuse events. Confidentiality is particularly crucial within small communities and any group limited to a specific sub-population where anonymity is less assured. Of course, the limits to confidentiality placed on facilitators must be explained.

Arriving and ending on time and committing to attend consistently

Uneven group attendance or consistently late arrival impairs the development of trust, especially because many survivors have had inconsistent and undependable relationships in their lives. Such behaviour also reinforces dysfunctional patterns that clients have themselves developed as part of the aftermath of their abuse. Explaining that this agreement is not to benefit the facilitators but rather to create a corrective experience for the men helps to foster compliance. Exploring the issues underlying attendance problems is also often helpful. These problems frequently reflect low self-esteem (lack of self-structuring or self-nurturing), feeling unsafe in group, or ambivalence about recovery and change. It is policy at *TMP* to review the membership of clients



who miss 2 out of 8 sessions in a Phase I group, or 3 out of 10 in a Phase II group. These conditions are made explicit when the group agreements are made. Clients are also required to call ahead and inform the facilitator when they cannot attend, giving reasons for this.

Sobriety

We do not require that clients be abstinent; however, we do require that group members attend sober. This is defined as not using on the entire day of group. We explain to clients that they will not benefit from group when intoxicated. We also explain that the desire to use might be quite strong after attending group and that such post-session use is counter-productive. We encourage members to find healthier ways to soothe painful feelings, so that they do not undo their therapeutic gains.

Honouring each other's process

Group members are expected to respect one another's pace of learning and to use talk time responsibly. This teaches awareness of other people's needs and a certain discipline of give-and-take (it also fosters the therapeutic factor of "development of socializing techniques" [Yalom, 2005]).

Touch

Members agree not to make physical contact without permission. Many survivors are sensitive to touch because of body boundary violations they have experienced. It is not uncommon for them to be triggered by or react strongly to physical contact. On the other hand, physical contact—a friendly hand on the shoulder or a hug when feeling sad or vulnerable—can be nurturing and therapeutic for abuse survivors. The agreement is therefore that all touching be done consciously and with consent.



John

In a Phase II group session, John disclosed his HIV-positive status. He was convinced that he would be rejected by the other men, who would ask him to leave the group. Instead, one of the men asked if he could give John a hug (thus respecting the group agreements). After some discussion in the group, John indicated that he was comfortable receiving hugs from group members. The facilitators made it clear that everyone had the right to pass on this activity. During check-out the men shared that this was a very powerful session. A number of them discussed how this experience differed from other times in their lives where boundary changes were not discussed and/or made optional.

Contact outside of group. Restricting and/or negotiating contact outside of group reduces the risk of dual relationships and sub-grouping. Of particular concern are sexual relationships or financial relationships. One group member might find employment for another group member with good intentions and then find that this interferes with comfort discussing difficult issues in group. The disallowing of sex between group members needs to be discussed overtly, as this can be very harmful to individual members and the group. Breaking this agreement invariably leads to both men exiting the group due to the difficulties it causes. Also, when group members know that the other men have agreed not to pursue sexual relationships, they are less likely to misconstrue a friendly approach.

It is important to be realistic about the agreement about extra-group contact. Members inevitably do meet outside of group, and in small towns avoiding some contact is often impossible. This being the case, it is crucial to encourage discussion within the group about the contact. It is better to create a group climate where extra-group contact can be discussed openly than one where members fear saying anything and so hold the information secret. Lew (1988) and Gartner (1999) allow contact outside of group (so long as the contact is mentioned in group) because they believe that extra-group socializing helps

overcome the extreme isolation that many survivors experience. Gartner notes that he is willing to deal with any complications in group that might develop as a result of relaxing the normal no-contact rule because of the benefits he perceives in doing so.

It is a good idea to develop consensus about unplanned extra-group contact, as clients do run into each other from time to time or may see each other in places such as peer-support groups (e.g., 12-step groups). Groups often decide that in the event of such meetings members will say hello to one another and perhaps have a brief conversation, but will avoid discussing the group or how they know one another. Clients always have the prerogative not to participate in any contact outside of group.

The right to pass.

Some men join Phase I groups only on the condition that that they will not have to talk about their abuse history. Having the right to pass is vital to these men. In any group, moreover, the right to pass is about respecting another man's pace of healing.

When doing eyes-closed experiential exercises, members of all Men & Healing groups are given one of three options:

1. Pass.
2. Do the exercise with eyes open with a soft unfocussed gaze.
3. Do the exercise with eyes closed.

Giving explicit permission to pass on an experiential exercise generally results in greater participation in the exercise, an increase in self-efficacy among group members (many of whom may have difficulty saying "no" or trusting their internal sense and judgment), and fewer power struggles.



Constructive Feedback.

This agreement is about responding from one's own experience using "I statements" and not giving advice. This teaches good communication and increases the level of authenticity, respect, and connection in the group. The facilitator must often provide guidance here because men are generally socialized to fix problems rather than just listen and share how they identify with or relate to another person's situation.

Sometimes clients want to talk in detail about their abuse experience before the group agreements and mandate of the program have been clarified. Gentle boundary setting with such clients, or helping them to contain their emotions in a non-shaming way, creates a climate where group members are more likely to feel safe and to leave the first session with a sense of success.

At the end of the first session in the Phase I program we often introduce a grounding exercise. Initial experiential work is kept short and simple, as some men have apprehensions about grounding exercises, meditation, and visualizations. They wonder whether it will be "weird," embarrassing, or difficult. Generally, however, the men find that ending the session with a straightforward exercise that brings awareness to their breathing helps calm strong emotions from the session. They thus learn at this early stage the value of experiential work.

Theme 2: The Aftermath of Trauma

The second theme is about heightening awareness and understanding of the aftermath of trauma. Two main topics are introduced here: typical trauma sequelae and the impact of trauma on the brain.



The Hangover of Trauma

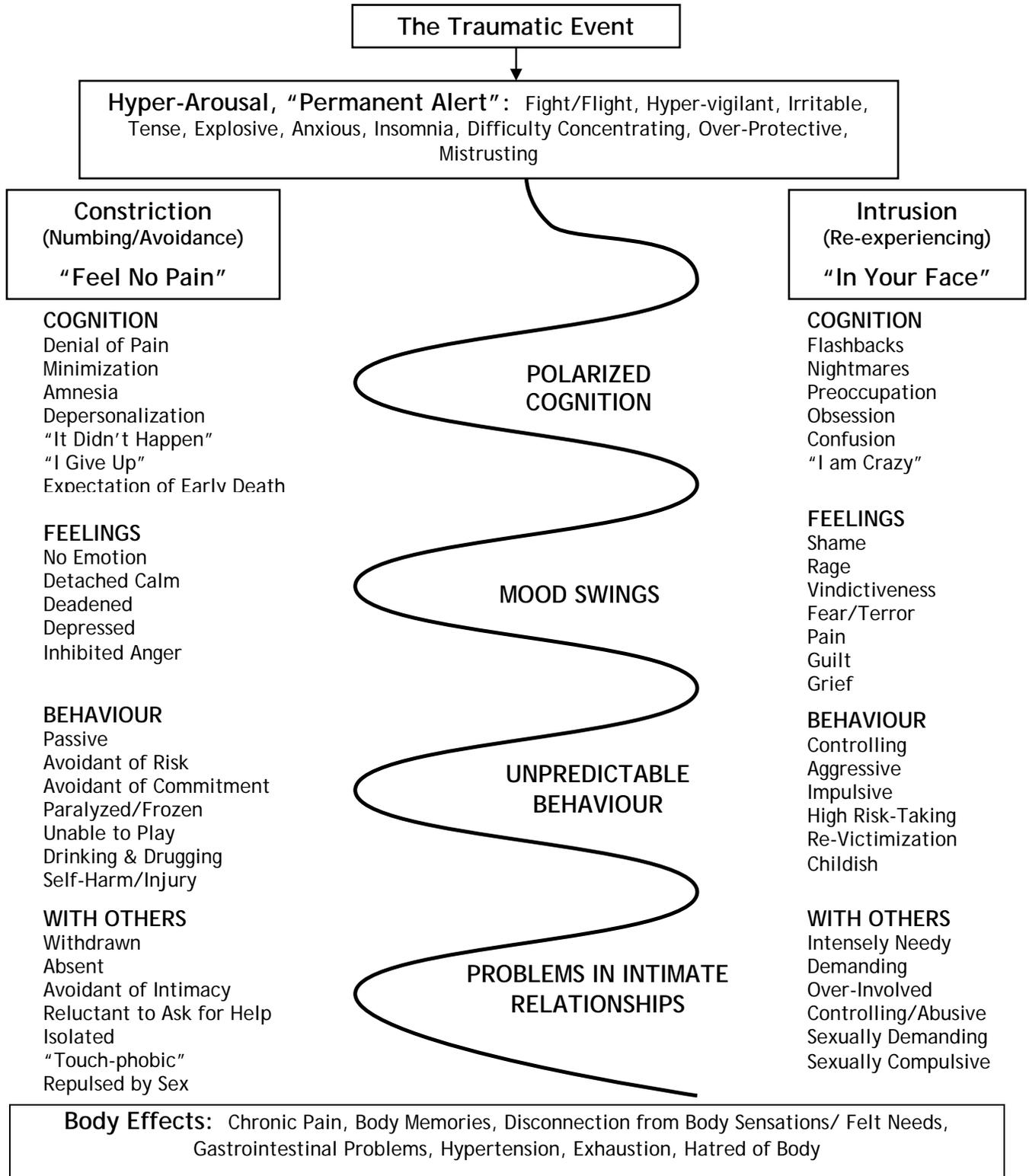
Rather than provide the men with extensive lists of sequelae from childhood sexual abuse, we use a single handout depicting posttraumatic reactions. Called “The Hangover of Trauma” (Figure 5.2), it shows the hyperarousal that follows trauma, as well as the characteristic oscillation between intrusive and constrictive symptoms (what Herman [1997] calls the “dialectic of trauma”). The handout has come to be known as “The Wobble” because it illustrates the shifts or swings that trauma survivors typically experience between intrusive and constricted states. We note, however, that we have taken a broad interpretation of intrusion, going beyond the classic PTSD definition. In the category of “Problems in Intimate Relationships,” for example, the intrusive symptoms listed do not strictly speaking come from a re-experiencing of trauma but rather of attachment needs that were unmet in conjunction with trauma. Similarly, certain behaviours, such as being aggressive or childish, while not always an exact reliving of trauma, can be seen as an acting-out of internalized trauma-based roles (as discussed below). We choose to use this broad interpretation of intrusion because it has allowed us to map out the aftermath of sexual trauma in a way that is helpful for our clients, even if this approach deviates in some respects from conventional usage.

While not all male survivors qualify for a PTSD diagnosis, most Men & Healing clients are able to recognize themselves in the “Hangover of Trauma” handout. Indeed, clients often express great relief at knowing their experience is both recognized and normal for trauma survivors. They commonly look at the handout and marvel at how closely it represents their lives. They now have a way to connect their lived experience to their abuse history, whereas they may not have previously made any links. Discussing each symptom cluster in detail often creates “aha!” moments. We also explain that the oscillations or “wobbles” are generated through the conflict between, on the one hand, the

Figure 5.2

THE HANGOVER OF TRAUMA

(Prepared by Rick Goodwin, drawing on J. Herman, *Trauma and Recovery* [Basic Books, 1997].)



need to complete, heal from, or go back to their trauma (intrusion) and, on the other, the need to protect themselves from unbearable pain or retraumatization (constriction). This explanation helps make sense of the often chaotic nature of their lives, where they may be raging one moment and “shut down” or “zoned out” the next. Finally, the handout is used to identify and explain features associated with PTSD (seen especially in complex PTSD), such as depression, problems in intimate relationships, drinking and drugging, the use of tension-relieving strategies such as self-injury or sexual compulsivity, and certain effects related to the body such as chronic pain and body memories.

For some men, heightening awareness of the aftermath of their sexual trauma brings up feelings of grief. They may feel despair from recognizing the extensiveness of the impacts. Or they may want to know immediately what to do about it all. We address these feelings by noting the value of building self-awareness as an important initial task, and of not rushing the healing process. Creating a neutral space from which to observe and name trauma symptoms is itself an important step in recovery, especially for men socialized to try to fix things right away. We also lead the men through a grounding exercise at the end of each session, emphasizing that learning to ground themselves is likewise an important healing step.

Another useful direction when discussing “The Wobble” is to get curious with clients about how the aftermath of trauma is playing out in group. One exercise we use is to ask clients to identify with a show of hands which of the three symptom clusters (hyperarousal, intrusion, constriction) comes closest to being their “home base” position in life. This provides a visual for how the men in the room have adjusted to their trauma. It also helps illuminate interactions in the group. Men who are constricted may find group members with intrusive symptoms irritating or frustrating—and vice versa. Naming this tendency supports the men in shifting their perceptions of other group members. The



relatively constricted clients can now see the “annoying” and “disruptive” group members as people with intrusive cognitions, feelings, behaviours, or relational patterns. Conversely, the clients dealing primarily with intrusive or hyperarousal symptoms can now see those in the group who seem uninterested, disconnected, arrogant, hopeless, or overly intellectual as people who are protecting themselves from highly painful emotions and memories.

Finally, many men find it very helpful to have a name for the oscillations they experience between symptom clusters. They will sometimes check-in at the start of a session by saying “I had a lot of wobbles this week.” Furthermore, knowing that the partners of male survivors often find the men’s shifting among hyperaroused, intrusive, and constricted states to be confusing and distressing helps motivate them to make changes.

Trauma and the Brain

Teaching clients about the impact of trauma on the brain gives them a useful explanation for experiences such as flashbacks, nightmares, and dissociation, and for the process of integrating traumatic memories. While it is not necessary for the men to learn all the scientific names for regions of the brain (amygdala, hippocampus, etc.), having some knowledge of how the brain is affected by traumatic events gives them an important perspective on their struggles. They see that they cannot just “get over it”—because their posttraumatic experience has a basis in the structure and activity of their brains. They become more able to let go of self-blame and develop some self-compassion, knowing now how their abuse history has affected their mental functioning.

We are not able here to discuss the topic of trauma and the brain in detail (for fuller discussions see van der Kolk et al., 1996; Rothschild, 2000; Heim and



Nemeroff, 2001; Solomon and Siegel, 2003; and Weber and Reynolds, 2004). We do, however, suggest a number of points to consider for group discussion.

- Memories of traumatic events are stored differently than normal, autobiographical memories. Traumatic memories get broken up into dissociated pieces and exist implicitly in emotional, sensory, and behavioural form (e.g., emotional flooding, visual flashes, re-enactments). Knowing that traumatic memory differs from non-traumatic memory helps clients normalize gaps in memory, partial memories, flashbacks, sudden surges of intense emotion, and so on.
- The part of the brain (amygdala) that stores emotional memories produces rapid “fight or flight” reactions to perceived dangers. These emotional memories lack sensory detail and language, so they do not operate like normal, autobiographical memories. This point is used with the men to explain what is going on in their brains when they get triggered by symbolic reminders of their abuse, often without knowing why.
- There is compelling research suggesting that memories are stored in various parts of our bodies, not just our brains. The working of such “body memories” explains in part why musicians can play their instruments without thinking about it—and why physical touch can bring forth unsolicited memories and sensations, including those from past traumas.
- Memories of traumatic events are often incomplete and stored with significant contextual information missing. As traumatic memories are integrated they are converted to normal memories where some of the dissociated or missing context is restored. This knowledge helps the men understand that as they go through the “remembrance and mourning” stage of therapy and form a coherent narrative of their abuse history, their posttraumatic symptoms will diminish.



Theme 3: Safety

In introducing this third theme, we return clients to the discussion from Theme 1 on the stages of recovery, noting that the first stage is to establish safety. A foundational and recurrent theme in trauma work (Najavits, 2002), safety can be defined in both internal and external senses. Internally, safety is about being able to regulate painful emotions, contain difficult thoughts and memories, abstain from self-harm, and engage in healthy self-care. Externally, it is about reducing risky outward behaviours (e.g., bar fights), addressing or removing oneself from dangerous situations (e.g., intimate violence, unsafe sex), and increasing healthy, trustworthy supports. The psychoeducation provided in Phase I of the program helps create safety in both senses by providing information and road maps for the men to orient themselves and think about how to create a stable base for their healing.

As discussed in Chapter 1, males are socialized to be fearless and so to engage in dangerous activity as a way to confirm their masculinity. This phenomenon is often exaggerated in male survivors. Indeed, many clients in Men & Healing groups readily recount episodes of fast and hazardous driving, dangerous substance use, and risky sex. We frame such unsafe practices or behaviours as coping strategies the men have been using to deal with the incomprehensible abuse they experienced in childhood. This takes the shame out of their behaviours, frees them to talk openly about their unsafe practices, and opens the door to discuss more empowering ways of coping.

The “Hangover of Trauma” handout (Figure 5.2) makes a useful visual reference for the discussion of safety, as it illustrates the lack of safety on both sides of “the wobble.” On the intrusion side, for example, flashbacks can retraumatize clients unless they are able to recognize them as such and ground themselves. On the constriction side, withdrawn or isolated behaviour puts clients into an unsafe place because they can deteriorate emotionally when

disconnected from healthy supports and may turn to self-destructive practices such as drinking and drugging. Having opened up the discussion of unsafe practices, we then engage the men in devising concrete strategies for increasing safety, e.g., making an inventory of supports, establishing a healthy eating and sleeping routine, recognizing warning signs for addictive behaviour, setting boundaries with harmful people, taking psychiatric medication, identifying safe places, using deep belly breathing to calm anxieties, or making a suicide prevention plan.

Because of the frequent comorbidity of PTSD and substance abuse problems in male survivors, this topic often warrants special discussion or even a session of its own. As part of this discussion, we highlight some of the links between childhood sexual abuse and adult substance abuse. Substances may have been used to lower the young male's ability to resist abuse and also to forge a secret bond. Some abusers threaten to disclose the illegal substance use if the boy talks. Substance use may bring youth into contact with abusers and thus make them targets or lower their ability to defend themselves. Finally, substances are commonly used to cope with or find escape from the emotional aftermath of trauma. Making these sorts of links helps motivate the men with substance abuse problems to seek help.

A good experiential exercise to introduce under the theme of safety is the visualization of a safe place.

Theme 4: Dissociation & Grounding

Dissociation is discussed relatively early on in Phase I of the program, often in conjunction with the theme of the aftermath of trauma. We do this because dissociation is a common source of difficulty among sexual abuse survivors,^{*****}

^{*****} See Gartner (1999) for a lengthy treatment of this topic with respect to male survivors.



and because they often dissociate in learning environments, possibly feeling shame for “spacing out” or having gaps in their knowledge about what has been presented. Many clients have struggled with schooling and learning as a result of their trauma, in part because of high levels of dissociation. By openly discussing dissociation and recognizing the original role it played in surviving the abuse, the men are given a space to directly address this very troubling aspect of their functioning. On a practical level, making dissociation a theme provides an opportunity to teach the important skills of grounding.

In introducing this topic, it can be illuminating to share that military personnel are sometimes actually trained to dissociate as a way of coping with torture or other painful experiences. This shows the value of dissociation as a defense against unbearable pain, and provides clients the image of a war hero. By presenting dissociation as an adaptive behaviour, those who struggle with dissociation can be congratulated for having used it in order to survive their abuse. The problem is that they continue to use it automatically and unconsciously, without control or awareness, when the situation usually no longer warrants it. Chronic dissociation also makes the walled-off aspects of the abuse experience unavailable for assimilation, so condemns the survivor to a life of unresolved trauma. Recognizing these facts leads to a discussion of finding healthier ways of coping.

When given space to discuss dissociation in their lives, group members often mention having lost jobs and important relationships because of their dissociative behaviour. They talk about living in a fog, being emotionally distant, having difficulties concentrating, being overwhelmed by images of their abuse, losing time, acting compulsively in trance states, and so on. There is usually a diversity of dissociative experience in the room, with some clients readily identifying how they dissociate, others not realizing just how disconnected they really are, and still others experiencing relatively little dissociation. Some survivors are unable to dissociate sufficiently to defend



themselves against becoming overwhelmed by hyperarousal and intrusive experiences. Whatever the particular case may be, clients find it helpful to have accurate labels for their experience.

Grounding is a coping strategy that is offered to the men as a replacement for dissociation. As noted above, we do grounding exercises in each session of the Phase I program. Grounding is a process where emotional difficulties are managed not by narrowing consciousness but rather by actively making contact with a safe, supportive, or soothing reality. Providing group members with a list of grounding strategies allows them to try out different approaches. Najavits (2002), for example, offers a number of techniques under the three headings of mental, physical, and soothing grounding. The strategies that are grounding for one survivor are not necessarily so for another. Facilitators must guide the clients, then, in experimenting with different approaches and discovering experientially what works best for each of them. One note of caution, however: some eyes-closed methods of grounding, such as visualizations or body-scan meditations can actually raise a survivor's anxiety because of the traumatic material they encounter when they turn their attention inward. This can trigger a dissociative episode, sometimes leading to an unfortunate encounter with traumatic imagery. We instruct clients to be mindful of this possibility and stress the importance of maintaining contact with the facilitator's voice. Permission to pass on an exercise or do it with eyes open is also important here.

Theme 5: Trauma & Relationships

As previously noted, one of the main areas impacted by sexual abuse is the ability to form and maintain healthy relationships. Many clients enter the Men & Healing program precisely because of problems in their intimate



relationships. Due to this central importance of the theme of trauma and relationships it is given two full sessions in Phase I programming.

We use two approaches in addressing trauma and relationships. The first is to employ the theory of Transactional Analysis (TA), specifically the theory of ego states and the drama triangle. The advantage of TA theory is that clients readily connect with it and find it immediately helpful in making changes in their relationships. The second approach we take is to open up a space for the discussion of sexuality. Although sexuality is an aspect of intimate relating highly impacted by sexual trauma, the men generally do not raise this subject on their own. When the facilitators do so the clients nonetheless find it a rewarding topic of exploration.

Transactional Analysis Theory

In Phase I of the program, TA theory is generally presented didactically, while in Phase II it is used further to examine specific patterns in the clients' intimate relationships, as well as the relationship dynamics within the group itself. As discussed in Section 5.2, we also use the drama triangle as the basis for a Phase II experiential exercise. The presentation that follows is intended simply as a sketch or outline of the TA theory we use; we refer the interested reader to additional source materials (Berne, 1964; Steiner, 1971; Stewart and Joines, 1989).

Ego States

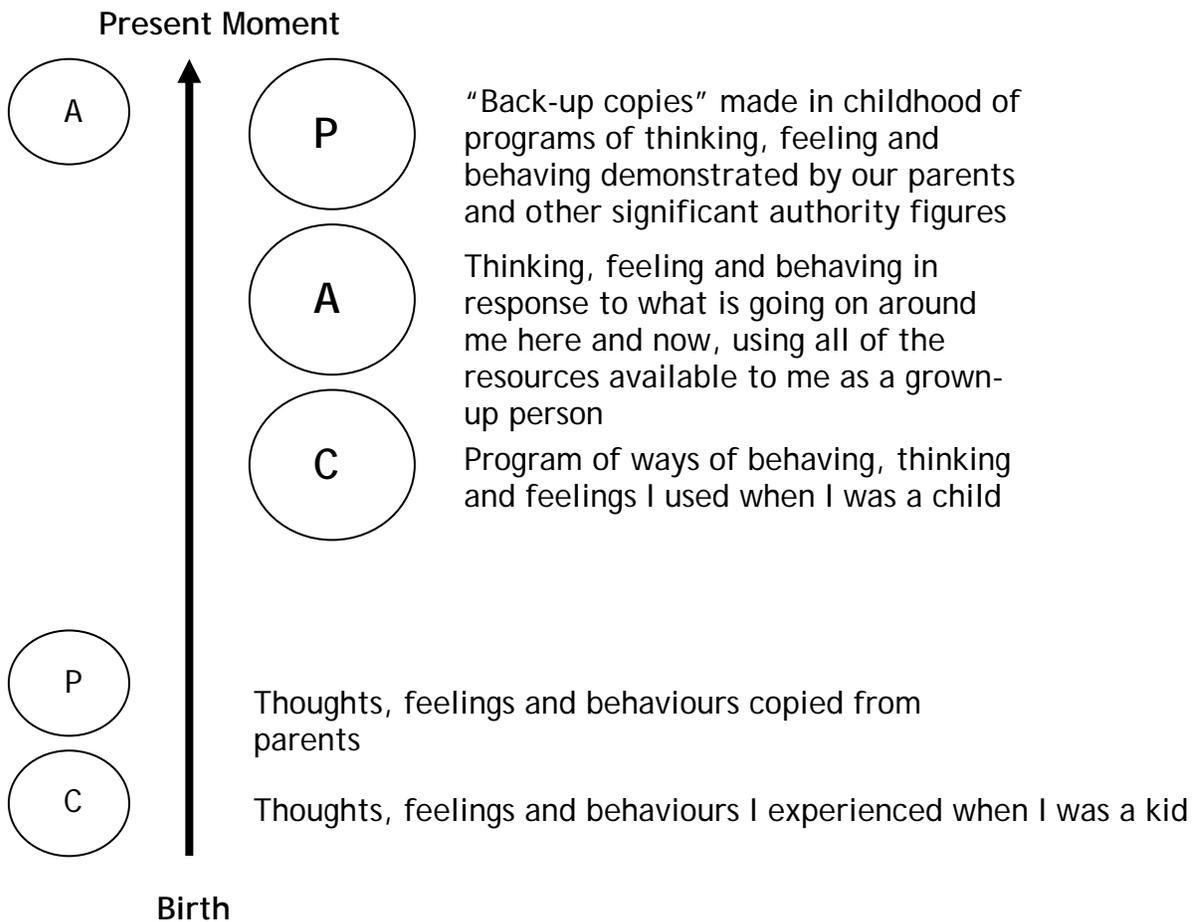
In TA's structural model of ego states, an ego state is defined as a consistent pattern of feelings, thoughts, and behaviours that is active at any given moment. The three categories of ego states are designated as Child, Parent, and Adult. As shown in Figure 5.3, the Child ego state is characterized by



Figure 5.3

STRUCTURAL MODEL OF EGO STATES

Prepared by Roy Salole, MBBS, CTA



feelings, thoughts, and behaviours experienced and exhibited in childhood; the Parent ego state consists of feelings, thoughts, and behaviours copied from parents and other authority figures through the processes of introjection and identification; and the Adult ego state is composed of feelings, thoughts, and behaviours congruent with one's current age, drawing on adult resources or capacities in response to present reality. Figure 5.3 places the ego states on a time line in order to indicate how the Child and Parent ego states originate in early childhood and continue to function today in the modes of being adopted

at that time. The Adult ego state, by contrast, is located at the moving top of the time arrow, always functioning in relation to here and now reality.

The value of ego state theory is that the men learn to recognize and differentiate among these three basic states of mind. For survivors of childhood sexual trauma, the Child is typically wounded and vulnerable, while the Parent is critical and hateful. Thus when clients experience themselves as, say, young, terrified, and powerless, facilitators can help them understand that they are in a Child ego state and that their experience is being relayed to them from the past. Similarly, when they are experiencing an attack of shame they can identify their self-punitive, shaming thoughts as coming from a Parent ego state (directed inward) that is likewise frozen in the past. Clients learn, in other words, that their Child and Parent ego states carry a legacy from their abuse that they continue to play out in the present. It is through becoming aware of ego state shifts and strengthening their ability to operate from an Adult ego state that clients develop the capacity to accurately tell the difference between their past and present realities, and thereby to transform the inner legacy of their abuse.

In Transactional Analysis, TA concepts are used to analyze interpersonal communication and relationship patterns. In a workplace situation, for example, a transaction between a supervisor and worker may look like an adult-to-adult encounter when in reality the supervisor is in a Parent state, using authoritarian attitudes copied from parental figures, and the worker is in a Child state, feeling like a young boy afraid of getting in trouble. In the Men & Healing program, we use the same approach when working with clients in examining their relationships. They come to see that the bulk of their relationship difficulties stem from the operation of Child and Parent ego states. The withdrawn behaviour, angry outbursts, hurt feelings, obsessions, fears of intimacy, mistrust, controlling behaviour, harsh judgments, misperceptions, and so on, all become comprehensible as feelings, thoughts, and behaviours



that are largely inappropriate to the present, being reflective of past abuse and trauma.

There are two general outcomes from using this approach. First of all, the clients become more able to “own” their contributions to their relationship problems by recognizing how they switch into Child and Parent ego states, especially in intimate contexts. They gradually learn to step back from conflicts and other problems and to view these from an Adult perspective. Secondly, as the men become more aware over time of how they carry the legacy of their abuse in Child and Parent ego states they become more willing to establish healing relationships in their lives. We stress with them the importance of getting support from others rather than trying to work through their trauma symptoms on their own (which their Parental introjects may be telling them to do). It is useful, in this regard, to discuss the nature of healthy social networks, as well as how to deal with the challenges associated with unhealthy ones. We also discuss the value of building relationships with intimate partners where both partners are committed as Adults to the recovery process. In this case, clients can use their relationships as testing grounds for building trust, fostering connection, learning to share and heal vulnerable emotions, and acting responsibly. This is challenging work that takes time, but it is a very real possibility that we hold out to the men.

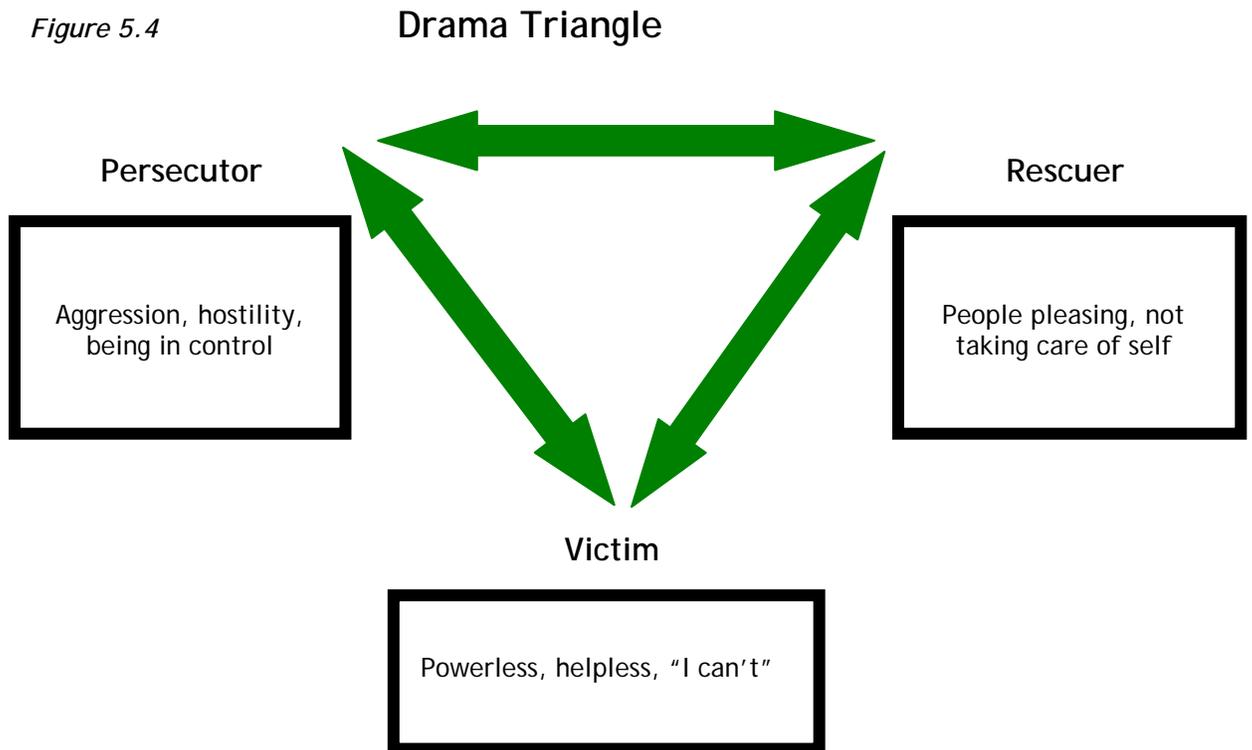
The Drama Triangle

The “Drama Triangle” or “Karpman’s Triangle” (Karpman, 1968) is a TA construct that we use to illustrate the trauma-based roles survivors commonly play-out in dysfunctional relationships.^{†††††} As shown in Figure 5.4, the three

^{†††††} The drama triangle is used in TA to analyze the nature of “games” in general. Games are repetitive sequences of dysfunctional transactions that result in the same bad feelings over and over again. They come in three levels of severity. The first is the mild, openly social kind, the second is more hidden and shame-filled, and the third results in severe outcomes such as divorce, suicide, and homicide. Childhood sexual abuse and trauma involve second and third



points of the drama triangle are defined by the roles of Persecutor, Victim, and Rescuer. These three roles are originally adopted as a result of harmful transactions in childhood and then continue to be used in adulthood.



When in the Persecutor role, people act aggressively, criticizing, judging, or abusing others. Persecutors operate either from a critical Parent ego state (directed outward) or an angry Child. They disown their wounded Child, projecting it onto their victims, who then bear the Persecutors' vulnerability and shame. The Persecutor's mission in this sense is to maintain control over others and avoid being revictimized by staying on the offensive. When operating in this manner, Persecutors may be re-enacting some behaviours learned from their own abusers, now copied into their critical Parent ego state.

degree games. Our discussion of the drama triangle in this section is geared toward these more serious levels of "games."

This role plays a big part in situations of intimate violence, as discussed in Chapter 2.

The Victim role is characterized by a sense of helplessness and powerlessness. Victims of abuse are by definition powerless relative to their abusers. In adulthood, however, a belief in one's helplessness persists in what is now a Victim *stance*. In other words, the victim of abuse has become bonded to their victim status, operating from a powerless, wounded Child ego state. Victims expect others to rescue them, and maintain their role through allowing or inviting others to continue to persecute them, and through refusing to develop their natural powers as adults.

Rescuing is defined by compulsive care-taking or assisting of others at the expense of one's own self-care. Being in a Rescuer role involves putting more effort into a relationship than the other person; doing something one does not want to do; attempting to do something one is not capable of doing; "helping" when it is not called for; and doing something without explicit agreement (Steiner, 1971). Rescuers project their wounded Child onto Victims, who they can then attempt to save while avoiding their own history of victimization. Rescuers get a superficial sense of worth by being valuable to others, and avoid feelings of guilt (generated by a critical Parent ego state) by constantly trying to undo the pain of others.

As a variation on the drama triangle, we also use Hudgins' (2002, 2004) construct of the trauma triangle. Defined by the roles of Perpetrator, Victim, and Abandoning Authority, the trauma triangle illustrates that victims of child abuse did not have an authority figure to genuinely care for or rescue them at the time of the trauma. The Abandoning Authority role is based on an internalization of this abandonment, with trauma survivors now abandoning themselves (e.g., through poor self-care) and failing to accept their authority as parents, teachers, and so on. We find the trauma triangle most useful as a



template for what happened at the time of the child abuse. We then highlight with the men the connection between the original trauma triangle they experienced in the past and how they play it out now in the form of the drama triangle. The contrast between these two triangles helps us to again emphasize the difference between the past and the present, and encourage clients to choose healthier roles in their current relationships.

In working with clients on building healthier relationships we first of all discuss the inherent unsatisfactoriness of the trauma-based roles. All four roles involve a deficit of self-worth, ongoing boundary failures, an attachment to one's abuse history, and a lack of genuine needs fulfillment (Carnes, 1997). As discussed further in Section 5.2.1, the roles are also inherently unstable, such that one may suddenly switch from, say, the Rescuer role into the Persecutor role when feeling resentful of the person in the Victim role. These role switches are a core feature of the relational dramas that survivors commonly find themselves in, where there is a great deal of intensity but no real intimacy (because they simply repeat old trauma-based roles).

Having established the dysfunctional nature of these roles, we then work with clients on various strategies for getting off the drama triangle, all of which require operating from an Adult ego state. Shedding the Rescuer role involves such things as paying attention to one's own needs, setting "contracts" with others, and learning to tolerate the discomfort that arises from breaking the pattern of automatically helping others in distress. Overcoming the Victim role is a process of empowerment that includes paying attention to and building one's strengths, resources, and personal agency. Indeed, the trauma recovery process is described as moving from "victim" to "survivor." Stepping out of the Persecutor role, finally, entails learning to heal the wounded and shamed part inside oneself, recognize how one has identified with one's own abuser, and make amends for one's harmful behaviour.



Sexuality

The topic of sexuality is easy to bypass but it is important for facilitators not to avoid it. Many male survivors in our groups experience difficulties in the area of sexuality. For example, they may get triggered by sexual activity, be experiencing sexual side effects from psychiatric medications, or feeling confused about their sexual orientation. Many struggle with sexual addictions or problematic sexual phobias or fetishes that are directly linked to their abuse experience. Failure to make a space for discussing such problems simply adds to the shame the men likely already feel about their sexuality. By contrast, being frank and open about such problems offers them a rare opportunity to share their struggles, gain insight into them, and think about their sexual healing.

Theme 6: Trauma & Identity

This theme is about the impact of sexual trauma on identity, especially male gender identity. It also involves the barriers that restrictive gender roles place on recovery and on access to services and support. Discussing male identity is crucial for many survivors due to the amplified gender role strain that typically stems from sexual abuse. Examining the intersection between male socialization and sexual abuse opens up avenues for clients to reflect on their gender identities and to experiment with different ideas about being a man.

In Phase I of the program we hand out the version of the traditional male code discussed in Chapter 1 (Figure 1.2). Knowing that this is the male code at its most stereotypical, clients are given an opportunity to discuss how their own gender socialization compares to the material in the handout. We also present a list of the “myths” about male sexual victimization, noting the connections between the myths and the male code. (Despite our preference for the term “cultural delusions,” we tend to use the conventional term “myths” because



we want to avoid giving clients the message that they are delusional; many already think of themselves as “crazy” or have been labeled as such.)

Reviewing the traditional male code and the myths about male sexual victimization sets the stage for discussing the impact of male socialization on male survivors and on their identities as men. There is often a wide range of opinions on the topic. Some believe that the male code has in many ways served them well, e.g., by pushing them to succeed in life. Others believe that the male code has only caused them problems, and want to discard it completely. One way of generating additional discussion is to ask clients how they perceive the differences between male survivors and female survivors. It is common for clients to remark on the fact that males are seen as gay or as perpetrators of abuse, not its victims. They also talk about their isolation and their dread of being “discovered” as victims because the sexual abuse of men is not recognized in our society or is considered shameful in the extreme.

With both Phase I and II groups, discussing how the effects of gender socialization are visible within the group also helps bring this material to life. Topics such as the difficulty of being in an all-male group, use of bravado in the room, and fear of getting emotional in front of other men present opportunities for exploring the issue of being both a man and a sexual abuse survivor. This can, however, be a challenging exercise because of the range of views in the group about manhood. It is not uncommon, for example, for there to be very traditional men who are suspicious or fearful of gay men at the same time that there are self-identified gay men in the group. We discuss the importance of respecting differences prior to this discussion in order to avoid having to backtrack to restore a sense of safety. The task of facilitators is to provide a nonjudgmental space for clients to critically examine their gender role training and identity construction, defining for themselves an image of masculinity that allows them to both feel good about being a man and integrate their sexual abuse history.



Because a man's identity is not limited to his gender we also introduce the topic of identity or self-definition more generally. We note that complex PTSD and dissociative problems characteristically involve identity confusion due to the attendant lack of personality integration, regardless of gender. We likewise mention the idea that much identity confusion, including confusion over sexual orientation, comes from having one's identity development interfered with by child abuse. Trauma recovery therefore includes developmental repair in this area, where survivors define who they are separate from the effects of abuse. For example, healing from the effects on one's sexuality (e.g., hating one's body, feeling out of control sexually) involves deciding to reclaim one's sexuality and discovering one's "real sexual self" (Maltz, 1991). More broadly, we take this theme as an opportunity to work with the men on their strengths, talents, and interests, as part of the overall process of coming "home" to themselves.

Theme 7: Emotions and Trauma

Survivors of sexual abuse are inundated by distressful emotions. Due to the combined effects of impaired emotional self-regulation and male socialization, however, male survivors typically have little awareness of their emotional lives. The theme of emotion and trauma is therefore not only about understanding the emotional aftermath of trauma but also developing the emotional intelligence needed to heal emotional wounds.

A key message in Phase I of the program is that awareness is power. We work with the clients, then, on learning to recognize, name, and tolerate their feelings of anger, shame, anxiety, and so forth. We use a simple list of basic emotions—glad, sad, mad, scared, ashamed—to help them identify what they are feeling. Naming and simply "being with" emotions is not something that



comes easily to most men, and is particularly challenging to male survivors experiencing intense emotional reactions from their trauma. In addition, we explore the relationships between emotion, thoughts, and behaviours. In a typical Men & Healing group, facilitators can be heard saying “You feel that because you think what?” This is an ongoing way we coach the men to be aware of the thought processes associated with their emotions. We furthermore discuss certain behaviours that generate emotions, as well as the behaviours that certain emotions call for (e.g., anger calls for an assertive action to solve a problem or set a boundary). These explorations help the men to witness and remain curious about their emotions, managing and containing them rather than acting them out. Finally, men who present as highly constricted need to be introduced to processes that help them overcome emotional numbness (Levant, 1995).

We give particular attention to the emotions of shame and rage. In Phase I of the program we might simply ask the men why shame and rage are so commonly experienced by male survivors and what the connection is between the two. In Phase II groups, the focus is more on deep emotional processing. Men experiencing intense anger or rage are directed to explore underlying vulnerable feelings such as shame, fear, sadness, and so on. It can be a startling experience for some men to discover the shame and other “non-masculine” feelings they harbour. This work overlaps, then, with that of redefining one’s identity as a man—in this case, to include the full range of human emotion.

A question that often comes up in Phase I groups is whether it is necessary to forgive one’s abuser(s) in order to recover from sexual trauma. We handle this by saying there is no one right answer, and stress that the question is best answered by each man himself as he reaches the later stages of recovery. Lew (2004) warns that in the early going of recovery survivors risk “falling prey to confusion, denial, pretense, wishful thinking, or other people’s agendas” (p.



199) when it comes to this topic. Indeed, some survivors hope that they can heal or make their pain go away simply by forgiving their abuser(s).

In Phase II groups, the question of forgiveness again arises naturally, this time as part of the deep emotional processing. Forgiveness can be handled at this stage using psychodramatic or Gestalt-style exercises, in which group members rehearse forgiving or confronting their abusers in a supportive setting. Delivering a testimony (discussed in Section 5.2) is also an important exercise for reaching a decision point about forgiveness.

Theme 8: Closure and Looking Ahead

Giving time to the theme of closure is important in both Phase I and II of the program because it allows for discussion of feelings associated with losses or endings, and gives necessary attention to review and next steps.

Many men, especially male survivors, have had little sense of belonging in their lives. Having now had the experience of belonging to a Men & Healing group, clients are often reluctant to terminate their participation. They have developed an attachment to the group and are anxious about releasing it. This is true even in Phase I of the program, despite its brevity and psychoeducational focus. There are a number of possible factors here: the experience of having a positive connection with other men and countering the traditional male code together; the affiliative power of breaking the bonds of shame and secrecy; and the tremendous sense of relief and satisfaction that comes from having completed the group without anything disastrous happening. Men who have little social network or support outside the group can also feel they are losing something invaluable.

As a result of their socialization, many men approach closure and goodbyes by avoiding them, believing that they need to be tough, unemotional, or



superficial. Men often try to leave the group quietly. A closely related factor here is that the group experience itself heightens awareness of losses related to the clients' childhood traumas. Phase II of the program is precisely about mourning these losses. The end of participation in a Men & Healing group is now another loss they must mourn. Few men, however, allow themselves to experience the raw pain of their grief (Brooks, 1998). For all these reasons, it is important that closures carry a significant and meaningful quality, the process of separation or ending being fully acknowledged. We also require, in this respect, that men who wish to leave the group attend at least one final session in order to process their leaving the group.

The theme of closure also includes looking ahead, so that the loss of membership in a given group does not strand clients in a void but rather marks the beginning of the next stage of their healing or moving-on process. One of the explicit goals of Phase I of the program is to prepare men for Phase II. In support of this, a Phase II graduate is normally brought in for the final session as a guest speaker. This session is typically one of the most powerful, as group members meet a role model who has been down the road ahead of them. Dialogue with the guest speaker brings clarity about the healing process, instills hope, and provides answers to concrete questions. By hearing about the journey of another survivor, the men engage in vicarious learning and come to imagine their own path of recovery more vividly.

Finally, Phase III of the program plays the same role for Phase II as Phase II plays for Phase I. Having participated in a long-term group therapy process, some of the graduates of Phase II feel the need to maintain a connection to the program as they work at setting up their lives beyond their survivor identities. We discuss Phase III programming below, in Section 5.3.



5.2 REMEMBRANCE AND MOURNING

While the tasks of remembrance and mourning are a minor aspect of Phase I group work, they are the main focus of Phase II of the Men & Healing program. Remembrance and Mourning, the second stage in Herman's (1997) scheme of the trauma recovery, involves recalling the abuse experience within a therapeutic context, deep emotional processing, mourning losses, and consolidating gains. By working through the details of their trauma history in depth and reevaluating their past abuse experiences from the safe distance of the present, trauma survivors gradually integrate and transform their traumatic memory, finding release from its painful grip.

Because each Phase II group is preceded by a Phase I group there is greater opportunity to move into issues brought forward by the men themselves. Psychoeducation continues to play a role but it is not the main form of group work, the educational themes having largely been incorporated into the working memory of the group. In the Remembrance and Mourning stage of recovery it is time to start the deep working-through process that comes from thoroughly facing the abuse experience and its aftereffects, and from having emotionally corrective experiences in the group. Rather than repeat the discussion from Chapter 4 on group process, we focus in this section on two activities that distinguish our Phase II programming. The first is the use of experiential exercises, which we regard as invaluable for teaching self-regulation, shifting trauma-based schemes, and reprocessing traumatic memory. The second is the use of testimonies, which provides the men with a powerful opportunity to form their story of abuse and recovery into a coherent narrative, and to have this story witnessed in a respectful and compassionate way.



5.2.1 Phase II Experiential Exercises

Experiential methods are increasingly recognized as an important component of trauma therapy. One of the leading researchers in the psychobiology of trauma, Bessel van der Kolk, has been notably outspoken in his support of experiential and somatic therapies, pointing out that conventional talk therapy does not adequately access the nonverbal, emotional regions of the right-brain where traumatic experiences are stored (van der Kolk, 2004). By fostering deep-level experiences and having clients symbolize and reflect on those experiences, the various experiential therapies (Greenberg et al., 1998) are able to activate traumatic memory while also providing interventions to transform it. Not only is experiential therapy valuable for trauma work in general, it is also well-suited to men in particular. Males are socialized to be action-oriented rather than verbally-oriented. They therefore benefit from experiential action-methods that involve “doing,” not just talking.

We have incorporated experiential methods into the Men & Healing program from the schools of psychodrama (Kellerman and Hudgins, 2000; Hudgins, 2002), Focusing-oriented psychotherapy (Gendlin, 1996), and Gestalt therapy (manualized in the process-experiential therapy of Greenberg, Rice, and Elliot, 1993). Unlike Phase I of the program, where simple experiential exercises are routinely used to promote grounding and relaxation, Phase II has no set agenda for experiential work. It is introduced, rather, at appropriate points in the group process, tailored to the need of the moment.

We obviously cannot provide a thorough account of experiential methods, nor reproduce here the training necessary to use them. In this section we do, however, offer several examples of the kind of experiential work we have found helpful, commenting along the way on the particular benefits of these exercises for men.



In Phase I of the program we discuss the idea of the working zone within the context of finding concrete strategies for safely managing intrusive, hyperaroused, and constrictive states. In Phase II of the program we go further by offering the men an experiential exercise where they can experiment directly with how this zone feels in their bodies. The exercise is a variation on one commonly used in therapeutic circles, where one person approaches another in order to feel and define the boundary between them. In the version we offer to the men, however, they are required to pay close attention to the felt sense in their bodies as they are approached by the person they are partnered with, and to notice when they have entered that zone where their feelings are uncomfortable yet bearable.^{§§§§§§} We monitor their experience closely in order to ensure that they find the felt place where they are aware of trauma-based emotions and cognitions while at the same time not losing contact with a sense of groundedness in present reality. We then ask them to describe their experience—what they are perceiving, remembering, thinking, imagining, needing, wanting to do, and so on, as they hold themselves in this zone. They are thus given a concrete experience of the contained emotional territory where therapy takes place, and can subsequently use the memory of it as a touchstone in their trauma recovery work.

This is an exercise best done with two facilitators in the room, as it requires careful monitoring and typically produces strong feelings. Some men enter an intrusive state as soon as they come face to face with the man they are partnered with (e.g., sensing the other as their abuser and feeling enraged). In this case, the facilitator works with the client to find a working zone right where he is standing, by making sufficient contact with present reality to provide a balance to the flashing back to his past trauma. In other cases, the men have an intense emotional experience—trembling in fear, for example—while nonetheless remaining sufficiently grounded that they can remain in

^{§§§§§§} This aspect of the exercise comes from the Focusing community—specifically, in this case, from the *Centre for Focusing* in Toronto.



charge of the experience, instructing the other person to move closer or farther away from them. In yet other cases, men opt not to participate in the approach exercise itself but are still able to find a working zone simply by sensing the optimal distance from which to watch the others and imagine themselves in the participants' shoes.

In all cases, the men tend to find the working zone exercise highly illuminating. They learn that they do not have to fear their feelings but can regulate them by finding ways to move toward and away from them. The literal experience of closeness and distance from the other person in the exercise becomes a metaphor for other ways of moving in and out of one's feelings. They come to understand, as well, that they can articulate or put words to their experience when in an uncomfortable place rather than having to flee it or act it out. Finally, the exercise teaches them that emotional experience does not have to be an either/or business, where one either has vulnerable feelings and is a "sissy" or has no such feelings and is a man. The men realize that it is possible to have an emotional life without being emasculated. Indeed, by allowing clients to experience their vulnerable emotions while at the same time retaining a sense of strength and agency, the exercise can even enhance their identity as men.

Psychodrama Exercises

Psychodrama is a school of psychotherapy that uses enactments of dramatic situations as an avenue for therapeutic change, drawing on the healing potential of creativity, physical action, spontaneity, self-expression, and so on (Blatner, 1996). Staff at *TMP* trained in psychodrama use this approach to offer experiential exercises to the Phase II groups (as well as to other groups at the agency).



One such exercise involves enacting the drama triangle. This is done by first marking the three corners of a large triangle in the centre of the floor. Volunteers are then chosen to play each of the roles of Persecutor, Victim, and Rescuer. They take up their places on the respective corners of the triangle designated for the three roles and are directed to get into character, each person using his spontaneity and imagination to play his chosen role. The three volunteers interact with each other from their roles, but after a period of time they invariably find themselves switching into one of the other roles. The Victim, for example, may tire of being in the one-down position and become angry with either the Rescuer or Persecutor; the Victim then switches into the Persecutor role himself. When the facilitator notices these switches starting to happen they direct the clients to move to the corner of the triangle that represents the role they are now shifting into. The three participants thus all wind up moving around the triangle as they switch from one role to the next. Once this pattern is evident, the volunteers are encouraged to experiment with how they could respond differently, finding a more powerful and direct way to interact. The man in the Rescuer role, for example, may shed the role by offering to help the Victim, but only if the Victim also makes some effort; when the Victim persists in saying he is completely helpless, the former Rescuer responds by saying he is unwilling to do all the work, and steps off the triangle.

As with the working zone exercise, the benefit of the drama triangle exercise is that the clients gain insight from their first-hand experience. From their own journeys around the drama triangle they come to sense the “stuckness” of the roles and the futility of endlessly switching from one to the next. In playing the three roles, they come to recognize their own relational dramas with new awareness; and in finding ways to step off the triangle, they develop a bodily felt sense of new ways of being in relationship to others. Men who have disowned the Persecutor part of themselves may at first be reluctant to play this hostile role, but the exercise demonstrates to them that the roles are all



interrelated and that it is normal to have Persecutor energy inside them. They may even find a sense of relief in enacting the role. Despite the seriousness of the exercise, it draws out humour from the men as they play the roles, and offers them an enjoyable activity.

Empty Chair Exercises

Empty chair exercises are a form of psychodramatic work made popular in Gestalt therapy. The client interacts with another person or some part of themselves that they imagine sitting opposite them in the empty chair. These exercises are particularly valuable for completing unfinished business with people from the past, as well as for building a relationship with various parts of oneself.

When men wish to confront an abuser or abandoning authority figure with the truth, using an empty chair provides a way to live out a highly emotional encounter within a safe setting. This is particularly valuable for men who struggle with anger, whether it is over-controlled, under-controlled, or both. This is because the exercise forces the men to direct their anger toward the imagined individual in a measured way, with well-chosen words. Men whose anger is inhibited experience the satisfaction of finally releasing it and getting a flush of self-respect and healthy entitlement. Men who are prone to rage benefit from having to focus their anger on an appropriate figure so that it may find some completion, as well as from connecting with tender feelings underneath their anger.

We also use empty chair exercises to help the men make nurturing and compassionate contact with the hurt Child inside themselves. When a client has gained some awareness of his Child ego state and is experiencing feelings related to his abuse, a facilitator might in the moment invite the client to imagine his child part in an empty chair and express some loving or protective



remarks. This enacting of healthy adult authority sends the kind of caring messages inward that the client never received as a child, and so functions as a form of re-parenting. For the rest of the men in the group, watching this man connect with his emotions and wounded self can be a moving and pivotal moment in their own self-transformations.

5.2.2 Testimony

Testimonies (Appendix A) are an essential feature of the Men & Healing program, typically delivered by clients as they approach the end of their participation in Phase II. Testimonies were first reported as a therapeutic method by two Chilean psychologists working with victims of torture, and are now widely recognized as an effective avenue for treating trauma (Herman, 1997). Testimonies have also been used internationally to uncover truth and support healing on a political and community level, perhaps most notably in South Africa following Apartheid. The heart of a testimony is the telling of a detailed story of the traumatic event to an audience that bears witness to its truth. The encounter between teller and witness brings the traumatic event out into the open, affirms the reality of the survivor's experience, and proclaims the universality of our humanity. Testimonies are important vehicles, in this respect, for restoring hope about humanity, the world, and the future (Lustig, 2004).

Why Testimony Is Important

At *TMP*, testimony takes the form of a ritual that culminates the clients' involvement in Phase II of the program. Throughout their time in the group clients disclose memories of their abuse history, sometimes arriving at sessions with a sense of urgency about telling a particular facet. These disclosures help desensitize the clients' memories, removing the arousal and aura of distress from them. This desensitization process proceeds in a step-wise manner, with



clients gradually becoming able to face more and more of their past abuse experiences (Briere, 1992). The testimony caps off this process, the abuse story being told in full from an emotionally grounded or centred place.

The testimony itself acts as the coherent narrative required in trauma therapy for making sense of the victimization experience. This involves not only putting all the pieces of the story together but also doing so in such a way that clients no longer blame themselves or feel shame for what they experienced. Clients recount the facts as accurately as possible while sharing the new meanings and understandings of the facts they have developed.

The testimony process thus aids with the cognitive restructuring or narrative reframing of the abuse: by thinking differently about it they feel differently about it; by telling the story in a new way they let go of the old story. For example, self-shaming thoughts about the abuse and subsequent harmful behaviours are replaced by compassionate ones that recognize the vulnerability of children and the persistence of trauma-based ego states into adulthood. Similarly, the old story of being a defective person doomed to self-destruction is retold from the perspective of overcoming, surviving through courage, resourcefulness, and being resilient. Testimonies thus allow clients to see the abuse in a new light and so gain distance from the trauma (Lustig et al., 2004). Traumatic memory becomes normal memory; while hyperarousal, intrusion, and constriction give way to integration.

Another important aspect of testimony is the role it plays as a ritual in the survivor's healing journey. Delivering a testimony ritually marks an important accomplishment for clients, honouring the very human effort it has taken for them to get to that point. Having that accomplishment respectfully witnessed by peers is a powerful symbolic exercise that helps consolidate the reality of being in a new place with oneself and the world. It is a moment for appropriate pride.



In addition to the role that testimonies play in sense making, desensitization, integration, and the ritual marking of a stage in healing, they serve several practical functions. First of all, they establish purpose, structure, and content for the Phase II groups. Lacking the psychoeducational structure of Phase I groups, Phase II groups benefit from having a goal toward which all group members can work. Testimonies clarify that the healing task of remembrance and mourning is to gain mastery over the abuse experience rather than remain its victim, and to rework the past in light of present knowledge and awareness. Asking the men about their progress in accomplishing this task, or what lies between them and delivering a testimony, is thus a consistent way to generate content for group sessions.

A second practical role played by testimonies is in assessing a client's readiness to leave the group. If a member seems relatively disconnected or flooded during his testimony, this suggests that he is not ready to leave, or that he is leaving with unfinished work or significantly unintegrated trauma. In order to reduce the likelihood of clients' delivering their testimonies prematurely, we ask them first to share various parts of their abuse histories in the group. These sharings act as a prelude to the formal testimony and help "test the waters."

Finally, testimony can also serve an altruistic function. At *TMP*, graduates sometimes return to a Phase I group to talk about their healing journey. Although these talks are tailored to a Phase I audience, lacking the depth and detail of a testimony, it is largely because they have already delivered a testimony that Phase II graduates can now speak comfortably with others about their recovery process. Doing so provides them with a compelling reminder of their success, as well as a powerful means of giving back, by helping other survivors. (Yalom [2005] has identified altruism as one of his therapeutic factors for this very reason.) This exercise reaffirms the purpose of the group, provides a role model for recovery, and reduces anxiety for group members



about giving a testimony themselves. It is remarkable to watch a relatively new Phase II group member witness a testimony and say that he will never be able to do this and then, months later, deliver a testimony with confidence and tenderness.

Preparation and Delivery of the Testimony

Preparing a testimony involves creating an integrated narrative of the abuse experience as the survivor understands it. Clients are given a lengthy handout that offers guidelines for:

- clarifying who they wish to share their testimony with;
- recounting the details of the abuse, its impacts at the time, and subsequent aftermath;
- identifying any parts of the story that have yet to be told;
- recognizing how surviving the abuse has made them stronger;
- naming where they now stand and what they have accomplished in their group work; and
- acknowledging what remains unfinished.

This handout can be intimidating at first, when it is still alarming to think about talking about the abuse in detail in front of the other men. We do, however, encourage clients to keep approaching the exercise and to work away at it throughout their involvement in the Phase II program. We suggest making a first draft that can be revised or added to as they proceed through their group experience. They are also encouraged to work on it with an individual therapist. However they do it, they are asked to keep building their story until they feel it is complete.

Testimonies are usually created as a written record. They can take a number of forms, however, depending on the client's preferred mode of expression. They



may be presented almost purely orally, with just a few notes. They may also be expressed through artistic media such as painting or drama. Group members with literacy barriers may tape record or find some other means to document their experiences. We invite all clients to share photos or other objects from their lives that add concreteness to their story.

When a client announces that he feels ready to deliver his testimony, we set aside an entire group session specifically for that purpose. We also dedicate some time in the session prior to the testimony for letting the group know what to expect and for asking the client what he would like from the group or the facilitator(s). This sets the stage and emphasizes the control that clients themselves have over the telling of their experience.

After a testimony is shared, facilitators conduct a go-around so that all men can speak to what has been shared. If the person giving the testimony wants particular feedback on some part of his narrative, then this is made clear before opening it up to the group. We remind the group, though, that this go-around is primarily a time for the other men to share how they have been touched by the testimony, not to pose questions. This sharing helps the client who delivered the testimony to feel witnessed, validated, and connected to the other men.

Following completion of a testimony, the client's group work shifts to the theme of closure. It is a mistake to believe that a survivor who has reached a stage of relative integration will no longer struggle with the aftermath of his abuse history. He has, however, reached the point of graduating from Phase II of the Men & Healing program. Naming how he will maintain and continue to work on his recovery after his testimony experience underscores that healing is often a lifelong process. Phase III of the program offers him some options in this respect.



5.3 RECONNECTION AND MOVING ON

Oscar

“Looking back on my time in Phase II, I am aware of how far I have come. When I started in the group, it was difficult just being here and I didn’t want to talk. Now I can talk about my abuse and I’m okay. The challenge for me now is I don’t really know how to get on with my life and manage without my group when I leave it.”

Reconnection, the third stage in Herman’s (1997) scheme of recovery, is the primary focus for Phase III of the Men & Healing program. In this final stage of healing, the survivor experiences himself as larger than the abuse, no longer beholden to his survivor identity. What remains is to face the world more directly and actively than in the previous stages. While maintaining a focus on his personal growth and emotional integrity, the work of reconnection involves revising his old hopes and dreams, taking initiative in building his life, and deepening his identity as a partner, father, or community member. As the work of reconnection proceeds, moreover, the man at this stage often encounters or becomes more able to address pieces of his recovery work left over from earlier stages.

This stage of recovery is marked, then, by a growing sense of competence, purpose, and joy as he creates a life not circumscribed by trauma.

Because the task in Stage 3 of recovery is to shift away from a direct focus on the trauma, we have designed Phase III of the Men & Healing program to include several options or themes:

Maintenance and Transition. The first option is a group centred on maintaining the clients’ progress and helping them make the transition out of active trauma treatment into lives of their own making. This group operates

according to a “step down” philosophy, offering clients a reduced level of support. Facilitators play a more limited role than in Phase II groups, with group members being expected to take more of a lead in problem solving and re-engaging healthy coping skills. The group provides a setting for continued mutual aid, skills maintenance, and support in applying the learnings from the program to the clients’ lives outside the group. The men also work with each other on pursuing healthy interests and activities that allow them to flourish simply as human beings. Given the intention to step down the degree of support to the men, our current Phase III group operates monthly, facilitated by a clinical staff member at the agency.

Identity and Role Expansion. Another theme for Phase III programming is the task of identity and role development outside the defining parameters of trauma survivorship. The options here include group, couple, and individual therapeutic activities that are not geared specifically to trauma survivors but are still free from dysfunctional forms of traditional male camaraderie. Phase II graduates who participate in the Phase III group options come to expand their knowledge base and sense of self, and strengthen their interpersonal abilities—all through participating alongside other men who do not necessarily have a backdrop of victimization. Our current Phase III program menu is as follows:

Emotional Intelligence. This is a 10-week renewable group program for men who wish to work on the areas of emotional sensitivity, expression, and interpersonal conflict resolution.

Fathering. This 10-week group program is offered to men who wish to explore how parenting can be more rewarding, effective, and fun. Founded on the premise that “all fathers are sons,” it is specifically designed to explore the experience of being both a son and a father, and to strengthen the attachment between men and their children of any age.



Anger Management. This 10-week group therapy program is offered for men who wish to resolve problems either at work or at home due to problems associated with anger and rage.

Individual and Couple Counselling. This option allows men who have been through a Phase II group to examine areas of their lives and intimate relationships that could not be productively addressed until now.

In addition to these Phase III options offered in-house at *TMP*, we recommend and refer men to other options in the community that speak to their need for identity and role expansion. A space is made in our monthly Phase III meetings for considering these other possibilities.

Mentoring and Giving Back. A final theme of Phase III programming is mentorship, committee work, and activism. Some survivors view giving back as an essential part of their recovery work. Lending their experience to a worthwhile cause gives them a sense of purpose and helps them find meaning in their history of personal misfortune. Whether offering their service to fellow survivors, community members, or policy makers, their altruism is a “win-win” for all involved.

Some of the examples of mentoring and giving back evident in our program include guest speaking to participants in Phase I, providing abridged testimonies as part of the agency’s training services, and participating in public education events concerning sexual trauma, the recovery process, or broader community safety events. Perhaps the most impressive example of mentoring and giving back is when Men & Healing graduates become involved as members of our Board of Directors or one of its sub-committees. Here the circle comes complete, the recipients of the service becoming in a sense the providers of the service.



5.4 MEN & HEALING: A LIVING PROGRAM

We believe the Men & Healing program has made lasting change in the lives of hundreds of men. This guidebook has been written on the conviction that the structured approach to trauma treatment we have developed is now worthy of export. At the same time, we recognize that Men & Healing is a living program: it will continue to grow and evolve. Certainly, it has undergone many transformations since its inception in 1997; no doubt, there are more to come. Some programming shifts will be influenced by the evolution of therapeutic modalities in trauma treatment, such as the turn toward experiential methods. Other changes will depend on the resources available for delivering the program. For example, we recently decided to cancel a planned yoga initiative due to a lack of financial resources. Through all the anticipated changes, what will remain is our commitment to overcome the multiple barriers men encounter in their efforts to heal from sexual trauma. Resilience, integrity, courage—these are qualities not only for recovering survivors but for their healing programs as well.

Men & Healing is a living program in a second sense: it has to be adapted to its particular clientele. When we ran a Men & Healing program for gay and bisexual men the essential program model did not change, but the facilitation team did introduce certain emphases and supplemental material. Our collaborative program with the *Canadian Mental Health Association (Ottawa)* for male survivors with concurrent disorders has likewise been adapted for its clientele. In yet another example, the program for the *Hearing, Healing, Hope* initiative out of the *M'Wikwedong Native Cultural Resource Centre* (Owen Sound, Ontario) blends Men & Healing and traditional healing methods so that it may speak to Aboriginal and Non-Aboriginal participants alike. As this guidebook finds its audience, we encourage and anticipate many more such adaptations.



Indeed, we hope that *Men and Healing* will provide impetus for the development and delivery of trauma treatment for male survivors in many quarters. As healing services for men expand, we can look forward to the day when as a society we have freed ourselves from the shame of having “forgotten to look after our boys.” At that time, we will all be helping men and their families build better lives.



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APPENDIX A

CREATING A TESTIMONY

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 your self and/or your healing journey.



After you share your story with the group, we will conduct a go-around 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 counsellor)?
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., who 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 Men & Healing? (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 Men & Healing?
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]



APPENDIX B

PROGRAM EVALUATION

Date: _____ Group/Time Slot: _____ Facilitator(s): _____

MEN & HEALING PROGRAM EVALUATION

Please circle the appropriate number based on your involvement over the past group/cycle:

1 not satisfied 2 somewhat satisfied 3 satisfied 4 very satisfied 5 excellent

Phone Service, Information & Support: (i.e., your first contact with us)

1 2 3 4 5

Assessment Interview (i.e., your first meeting with our Intake Services Coordinator)

1 2 3 4 5

Content of the program (i.e., what you learned))

1 2 3 4 5

Process of the program (i.e., how you learned)

1 2 3 4 5

Structure of the program (i.e., 8 weeks in Phase I, repeating 10 week cycles in Phase II)

1 2 3 4 5

Facilitation (i.e., the role of your counsellor(s) in the group sessions)

1 2 3 4 5

Meeting Space (e.g., room, chairs, air quality)

1 2 3 4 5

What comments do you have on the above?

1. _____
2. _____
3. _____

What can you suggest that might improve our services?

1. _____
2. _____
3. _____

Please add any additional comments on the back of this page. All comments kept in confidence.

