AN EXPLORATION OF COUNSELLING AND SUPPORT SERVICES AS EXPERIENCED BY ADULT MALE SURVIVORS OF CHILD SEXUAL ABUSE

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Abstract

Global estimates suggest between 5% and 10% of men report that they have experienced sexual abuse as a child. However, it is thought that male childhood sexual abuse (CSA) is significantly underreported, with men being reluctant to disclose due to vulnerability, stigmatisation, homophobic responses, and loss of masculinity. Due to a lack of research and service provision targeted towards men it is suggested male survivors of CSA are marginalised. This qualitative study, using a narrative approach, has focused on four adult male survivors of CSA. The aim of the study was to explore their experiences of engaging in counselling and support services from statutory and non-statutory organisations. The participants took part in face-to-face narrative interviews, all of which were audio-recorded and transcribed verbatim. Analysis was undertaken using a two-phase approach; firstly, each narrative was analysed as a whole, rather than fragmenting the data; secondly, an across transcripts analysis was carried out to identify shared themes and divergences that emerged from the individual stories. Findings from the second phase of the analysis brought four themes to the fore; *'Trust Me, I'm a Doctor,' 'Trust me, I'm a Counsellor,' 'Counsellor or Mother?'* and *'Blocking the Memories.'* The men also described their experiences of disclosure, and the impact that CSA has had on their life. This is the first study regarding men's experience of support for CSA in the United Kingdom from a service user perspective. This study makes an original contribution to the knowledge base regarding the counselling experiences and effectiveness of therapy for male CSA survivors and will help to inform professional counselling, mental health practice, and healthcare workers per se, all of whom are likely to come into contact with male CSA survivors.

Chapter One: Introduction

Introduction

The aim of this thesis is to explore the experiences of men who were sexually abused as children and have accessed support from specialist support services or the statutory sector. The aim of the thesis was a result of my interest in the mental wellbeing of adult male survivors of child sexual abuse (CSA). Wanting to improve the quality and provision of support services, stems from my experiences of supporting this client group in a variety of contexts. These include third sector specialist counselling and support services, the National Health Services (NHS), the Criminal Justice System, and my participation in a national inquiry related to CSA in institutional settings.

Recently, there has been a dramatic increase in men that were sexually abused as a child coming forward to seek support and counselling in the organisation where, until recently, I worked. Many male survivors of CSA relay their experiences of feeling isolated and shameful, and their subsequent difficulties in accessing help and support. I have found that some male survivors, referred to the organisation I worked with by third party agencies, are often reluctant to engage with the service. Furthermore, an increasing number of clients have described how they attempted to access counselling from both private and/or counselling services for general mental health problems, but after disclosing CSA, were told that they were not equipped or experienced to deal with the issue and were subsequently referred to a specialist service. A number of male clients I have worked with have described how they felt rejected and apprehensive about accessing another service. In addition, some have relayed that they feel specialist services are overly focused on female clients. In particular, as a ‘female only’ area is often provided and the majority of the clients that they notice accessing the service are women, this message is reinforced. I was saddened to regularly hear the pain and anguish experienced by these male clients who had encountered so many barriers when it came to reaching out for help; many of whom were older and experiencing support for CSA for the first time. Quite often, they had experienced many adversities, such as homelessness, substance misuse, unemployment, offending behaviour, and mental and physical health problems, before

reaching out for help. The experiences they described had some parallels with the experiences of the women I had worked with. However, there appeared to be some notable differences when it came to the challenges of seeking support. On researching this further, it was apparent that male CSA is a misunderstood topic and this motivated me to explore this issue further. I believe that exploring the experiences and hearing the voices of male clients and what they find helpful in maintaining and improving their mental wellbeing will provide evidence as to how mental health care and specialist sexual abuse support services can better accommodate the needs of these individuals, as well as highlighting the barriers they face to accessing support from the helping professions.

Chapter one provides the background and context to this study. Firstly, the prevalence of CSA will be identified and the estimates of CSA in boys will be determined based on recent findings. A general discussion on the impact of CSA will be provided, followed by the mental health implications for males. It was determined that the topic of male CSA has been a fairly recent inclusion in the literature and a recent feature in the media. Therefore, the origins of how male CSA came to be recognised as an issue will be discussed. Finally, the current landscape of sexual abuse support services will be determined.

Before exploring the support experiences of men who were sexually abused in childhood, a review of the current evidence on male CSA was needed. Chapter two presents the published research available on CSA in males. It was evident that there are distinct themes in the research, and I have chosen to present a critical review in keeping with the themes of disclosure experiences, the long-term effects of CSA in men, and therapy and recovery from CSA in males. In addition, as the focus of this study is on the perspective of male CSA survivors' experiences of support, the limited research available on men's perspectives of support is included in the literature review. Whilst in the main it is the qualitative research that features predominately in the chapter, the chapter concludes with a review of the quantitative studies on adult male survivors of CSA.

The methodological approach for this research was carefully considered. Debate on qualitative methodologies and the rationale behind the selected approach of narrative inquiry will be discussed in chapter three.

As a data collection method was selected which encouraged storytelling in a chronological order, a process of re-storying was used when writing up the findings. Chapter four will present the findings of the narrative interviews with the four participants taking part in this research. Each story concludes with my reflexive account of the interview process.

Chapter five builds on the findings of chapter four and presents an overview of the shared themes from each of the four narratives. The discussion in chapter six situates the findings in the wider context of the literature on CSA. Finally, this thesis concludes with the implications for practice, limitations of the research study, recommendations for further research and my reflections on the research process.

Background and Context

Prevalence of child sexual abuse

Child sexual abuse (CSA) is an issue of epidemic proportions in the United Kingdom (UK) (Robey, 2021) and an international public health problem (Pereda et al., 2009). Determining the prevalence of CSA can be challenging due to varying definitions and methodological approaches in how prevalence rates are measured (Gekoski & Broome, 2019). Evidence suggests that in the UK one in twenty children have been sexually abused (Radford et al., 2011). Recent data from the Crime Survey for England and Wales reported that around 7.5% of adults aged 18 to 74 years, which is approximately 3.1 million people, disclosed that they had experienced sexual abuse before the age of 16 (ONS, 2020). In terms of disclosing these experiences, it was previously found that one in three children that had been sexually abused by an adult did not tell anyone at the time (Radford et al., 2011).

When considering what the term child sexual abuse denotes, the following definition was formulated as part of the statutory guidance for safeguarding and promoting the welfare of children in England. The guidelines state that child sexual abuse:

> *Involves forcing or enticing a child or young person to take part in sexual activities, not necessarily involving a high level of violence, whether or not the child is aware of what is happening. The activities may involve physical contact, including assault by penetration (for example, rape or oral sex) or non-penetrative acts such as masturbation, kissing, rubbing and touching outside of clothing. They may also include non-contact activities, such as involving children in looking at, or in the production of, sexual images, watching sexual activities, encouraging children to behave in sexually inappropriate ways, or grooming a child in preparation for abuse (including via the internet). Sexual abuse is not solely perpetrated by adult males. Women can also commit acts of sexual abuse, as can other children* (HM Government, 2018:107).

It is widely acknowledged that women are more likely than men to have experienced CSA. Recent statistics reported in England and Wales suggest that women are three times more likely than men to have reported that they experienced CSA (ONS, 2020). However, a study by the National Society for Prevention of Cruelty to Children (NSPCC) UK, using random sampling, found 11% of males reported that they had been sexually abused as a child, with 7% of cases involving contact sexual abuse (Cawson et al, 2000). Globally between 5% and 10% of men report that they have been victims of sexual abuse as a child (World Health Organization (WHO), 2006). There is a growing consensus amongst researchers that around one in six men have experienced sexual abuse before the age of 18 (Dube et al., 2005; Romano & De Luca, 2014; Ressel et al., 2018). Despite these relatively high estimates of sexual abuse among boys, it is likely that these figures are higher due to underreporting (Perez-Fuentes et al., 2013).

The impact of child sexual abuse

The experience of CSA is associated with a range of long-term adverse effects which has a lasting impact on the psychosocial development of children (Mullin et al. 2000; Finkelhor et al., 2007). The long-term effects are known to extend into adulthood and can impact on all areas of survivors' lives (Independent Inquiry into Child Sexual Abuse (IICSA), 2017), often manifesting as mental health problems (Mullin et al. 2000;

Finkelhor et al., 2007). Survivors can experience a range of psychological impacts as a consequence of the sexual abuse they experienced as children (Chen et al., 2010). Adults who have experienced CSA have described the ongoing daily challenges in trying to cope and come to terms with their experience of sexual abuse; this having a direct impact on their ability their day to day functioning (IICSA, 2017). The experience of CSA is correlated with the development of numerous mental health problems such as depression, anxiety, dissociative disorder, psychosis, and suicidality (Molnar et al., 2001; Warwick, 2003; Martin et al., 2004; Holm et al., 2009; Chen et al., 2010). Furthermore, it is well documented that there is a relationship between CSA and the development of post-traumatic stress disorder (PTSD) (Paolucci et al., 2001; Bruffaerts et al., 2010; Chen et al., 2010). As such, it has been suggested that those presenting to mental health services with a history of CSA should be considered to have PTSD (Read et al., 2007).

There are some notable gender differences when it comes to mental health problems associated with CSA. It is suggested that females are more likely to exhibit internalising behaviours (for example, being withdrawn or experiencing feelings of sadness, guilt and fear), whereas males are more likely to display externalising behaviours (Finkelhor et al., 1986; Lisak, 1994; Lisak et al., 1996; van Toledo & Seymour, 2013). Attributes of externalising behaviours include substance misuse, 'risky' sexual behaviours, anti-social behaviour, and offending (Nelson, 2009). In terms of children displaying externalising behaviour, this can be a significant indicator that a child is attempting to communicate that something is wrong, and they need help (Warrington et al., 2017). Indeed, it has been found that young people who have experienced CSA are up to 12 times more likely than non-abused young people to demonstrate conduct disorders (Maniglio, 2015). Furthermore, it has been found that adult survivors of CSA are 1.4 times more likely to have contact with the police. In addition, compared to those that have not experienced CSA, survivors of CSA are around five times more likely to be charged with a criminal offence (Ogloff et al., 2012).

Male child sexual abuse and mental health

There are a host of mental health problems experienced by survivors of CSA, ranging from severe difficulties in socio-emotional wellbeing to problems with day to day

functioning (Romano et al., 2019). When considering the impact of CSA on men's mental health, Mendal (1995) conducted a study of 124 adult males who had experienced CSA. All 124 participants professed that the abuse was extremely damaging to most aspects of their lives. The short-term effects reported included: anxiety, fear, shame, low self-worth, depression, suicide ideation, confusion over sexuality, homophobic reactions, anger and aggression. Most of the short-term effects are known to endure into adulthood (Hunter, 1990; Mendal, 1995). Further mental health issues associated with male survivors documented in the literature include somatic complaints, post-traumatic stress, and sexual dysfunction (Spataro et al., 2004; Andrews, et al., 2004; Dube et al., 2005; Maniglio, 2015; Easton & Kong, 2017). Substance abuse has been found to be common in men who have experienced CSA (IICSA, 2017); while a systematic review of the association between childhood physical and sexual abuse and illicit drug use established that CSA was linked to earlier onset and greater frequency of drug use (Butt et al., 2011).

As well as being susceptible to a range of mental health problems, a growing body of research has attributed CSA with subsequent suicide attempts in adolescent and adult males (O'Leary, 2009; Easton et al., 2013). Molner et al. (2001) estimated that 8-12% of suicide attempts were linked to CSA. Similarly, Brezo et al. (2008) found that young adults with a history of CSA were 5-14 times more likely to attempt suicide.

The experience of CSA in males has the potential to severely affect the gender identity of male survivors, as it violates socially constructed gender expectations; these being correlated to profound psychological distress (Mahalik et al., 2003). Moreover, male survivors abused by other males often have increased feelings of shame and internalised homophobia. As a result, male survivors often prolong disclosure for decades for fear of not being believed and feeling and being considered to be less masculine (Perez-Fuentes et al., 2013; Gagnier & Collin-Vezina, 2016). Subsequently, males that have experienced CSA often adopt hyper-masculine behaviours such as, rage and aggression. Accordingly, these characteristics can lead to male survivors coming into contact with the criminal justice system, as opposed to mental health care (Holmes et al., 1997).

Spataro et al. (2004) argue that there is a gap in the research in terms of male survivors, as the majority of research studies into the long-term effects of CSA have focused on females. As a result, male survivors continue to be marginalised and are an under researched group, who are likely to be at risk of long-term mental health problems (Easton, 2012). Although there is a paucity of research on male survivors of CSA, existing research proposes that the experiences of males tend to be severe, due to the early age of onset that the abuse occurs, the long duration of the abuse and the invasive acts often experienced by boys such as anal penetration (Dube et al., 2005; O'Leary and Barber, 2008; Ressel et al., 2018). Dube et al. (2005) argued that females are less likely to have experienced penetration during CSA than males. It has also been suggested that the psychological impact of CSA can be more complex for male survivors than female survivors (Garnefski & Diekstra, 1997; Bewaji & Rickett, 2021); mainly due to the impact of societal stereotypes (Sorsoli et al., 2008; Ressel, 2018), the negative reactions to disclosure that men often experience, and the lack of support available to men (Neslon, 2009).

The literature pertaining to the CSA of males has primarily focused on victims becoming offenders, perpetrators of abuse and users of violent behaviour (Lyle, 2006). Although these issues can be considered relevant to understanding CSA per se, it could be argued that it fails to explore the processes of recovery of men sexually abused as children and therefore has implications for treatment. In particular, men can often be reluctant to enter into, or engage with psychotherapy for fear of judgement, humiliation and stigmatisation (Gartner, 1999). Therefore, a considerable number of men reach adulthood without ever seeking support, while others often access support for issues unrelated to the abuse (Etherington, 1997; Gartner, 1999; Day et al., 2003). In a study of men exposed to CSA, participants described the experience of active or passive denial from mental health professionals when they disclosed CSA (Dorahy & Clearwater, 2012). Instead, the disclosure was attributed to psychosis or other mental illnesses. These experiences were described as increased feelings of shame, stigmatisation and hindering the likelihood of further disclosure.

The descriptions of poor responses from mental health workers outlined in Dorahy and Clearwater's (2012) study is reflected in an earlier study undertaken by Whittlemore (1990), where it was found that counsellors experienced discomfort and were less

certain how they could attend to the needs of men who presented with CSA, compared to working with female survivors. This can also be said for other mental health professionals, such as nurses, psychiatrists, and occupational therapists, all of whom have reported not feeling comfortable, competent, or supported in working with survivors of CSA (Day et al., 2003). What is more, professionals are often disinclined to routinely enquire about sexual abuse histories, for fear of opening up traumatic experiences. Lab and Feigenbaum (2000) found this to be true in their study of mental health professional's attitudes and practices towards males who had experienced CSA. They found that most mental health workers seldom enquired about a potential history of CSA in their male patients. In addition, their knowledge of male sexual abuse prevalence rates was inconsistent, and a number of professionals stated that they had no specific training on male CSA, which led them to feel incompetent in the assessment and treatment of male CSA survivors (Lab & Feigenbaum, 2000).

The emergence of male child sexual abuse

CSA and its related issues, scarcely emerges in the psychiatric literature before the mid 1980's. As well as recently coming to prominence in the academic literature, CSA has recently had increasing coverage in the media at national and international level. Recently in the UK, a number of police operations investigating CSA have been reported in the media. 'Operation Yewtree' was established in 2012 to investigate sexual abuse allegations against Jimmy Savile who died in 2011 (Gray & Watt, 2013). In 2014, 'Operation Hydrant' was set up by the National Police Chief's Council (NPCC) to investigate non recent CSA within institutional settings or involving persons of public prominence (NPCC, 2021). Following on from these enquiries, The Independent Inquiry into Child Sexual Abuse (IICSA) was established in 2014 in order to investigate concerns around institutions in England and Wales who failed, and have continued to fail, to protect children (IICSA, 2021). Since the allegations against Jimmy Savile and other prominent media figures in the UK, many voluntary specialist organisations have reported a significant increase in the number of survivors of CSA seeking therapeutic support (Sanderson, 2013). This phenomenon can be observed in a study carried out by McDevitt (1996) who investigated the relationship between CSA media exposure and CSA incident reports over a 25-year period. It was found that reports of CSA increased when there was heightened CSA news coverage (McDevitt, 1996). Whilst

media attention has led to a growth in the number of people coming forward to seek help related to CSA, stereotypical media reports have the potential to influence social judgements of CSA in a damaging way (Collings, 2002); in particular when considering the sexual abuse of males. However, exposure to media coverage may also be beneficial for some male survivors. Easton et al. (2015) described how hearing reports of male CSA via the television, newspaper, radio, or internet helped to normalise the experience of male CSA and helped the men in their study realise they were not alone in experiencing sexual abuse. Specifically, hearing the stories of men that had been sexually abused in biographies and on television has been recognised as a crucial factor in men disclosing their abuse and seeking support (Gagnier & Collin-Vezina, 2016).

Male survivors of CSA have tended to be overlooked in terms of service provision and in the academic literature (Easton, 2012). This could potentially be related to the focus on female survivors, as they are thought to be at higher risk of sexual abuse than males. This is somewhat propagated by the societal reluctance to consider men as being sexually victimised (Finkhelor, 1986). Moreover, some men are unable to consider themselves as victims, as the notion of being identified in this way can have a detrimental impact on masculinity, which is thought to be at the core of man's psychic identity (Lisak et al., 1996). With this in mind, the term sexual abuse '*survivor(s)'* will be used throughout this study to refer to those men who were sexually abused as a child. As well as being deeply imbedded in the language used by many sexual abuse support services and organisations, the term *survivor* reflects how many individuals have to find ways of surviving the emotional and physical trauma of sexual abuse (Ainscough & Toon, 2000). Additionally, the term child/childhood encompasses children and young people and is used to describe an individual below the age of 18 years.

Disclosure of child sexual abuse

It has been found that disclosure of sexual abuse per se can promote wellbeing and recovery for survivors, by moderating the feelings of isolation, shame, blame and, if met with a helpful response, relieving the burden of upholding a secret (Easton, 2014). Therefore, receiving supportive and helpful responses, both emotionally and

practically, can be beneficial for a survivor's mental wellbeing (Easton, 2014). However, Ullman and Filipas (2005) suggest negative social reactions to disclosures of CSA are related to an increase of symptoms in keeping with PTSD. When it comes to how mental health professionals describe their experiences of managing disclosures of CSA with both males and females, it has been found that they can find hearing the survivor's disclosure challenging, due to the *'horrific'* and *'disturbing'* and *'helple*ss' nature of their stories which touch them on a personal level (Chouliara et al., 2011: 144).

Non-disclosure of CSA in childhood and beyond appears to be more common in males than females (Ullman & Filipas, 2005; O'Leary & Barber, 2008; Hébert et al., 2009). It has also been proposed that boys and men are reluctant to label their experiences as sexual abuse (Artime et al., 2014) and parents and professionals are reluctant to recognise and acknowledge that sexual abuse is also experienced by boys (Day et al., 2003). The under-representation of males who have reported CSA can also be associated with masculine stereotypes, such as men not being victims, males should be able to protect themselves from abuse, and sexual activity with an older female being deemed as positive (Dorahy & Clearwater, 2012; Easton et al., 2014; Romano & De Luca, 2014). Further, the underreporting of CSA in males can also be related to their feelings of stigma, vulnerability, homophobic responses, and loss of masculinity (Perez-Fuentes et al., 2013). In addition, it has been found that boys can be reluctant to disclose abuse for fears of punishment, re-victimisation, being perceived as a perpetrator of abuse, and loss of self-esteem (Lisak, 1994; Perez-Fuentes et al., 2013).

In a study carried out by Easton et al. (2014) of 487 male survivors of sexual abuse, it was found that the average length of time between the abusive experience and disclosure was two decades. Furthermore, only one third of participants maintained that the responses to their disclosure of CSA were helpful. This raises the question as to what responses the other two thirds of adult male survivors received and what responses they consider to be a helpful and supportive when disclosing CSA. Male CSA and disclosure will be explored in greater depth in Chapter Two.

Support services for child sexual abuse survivors

As discussed above, CSA is associated with an extensive range of mental health problems later in life. Accordingly, survivors often need contact and support from various statutory and voluntary support services (Chouliara et al., 2011). The response that survivors receive from professionals and their experiences of support services serve as important protective factors which can increase resilience (Draucker & Mazurczyk, 2013).

This study explores male survivors' experiences of counselling and support from the statutory sector and from non-statutory specialist support services. For the purpose of this study, a specialist support service encompasses organisations that provide support, interventions, treatment or advice to survivors of sexual abuse. The terms counselling, therapy, and psychotherapy will be used interchangeably throughout this study. The British Association for Counselling and Psychotherapy (BACP) (Dale, 2017:1) define counselling and psychotherapy as:

> *An umbrella terms that cover a range of talking therapies. They are delivered by trained practitioners who work with people over a short or long term to help them bring about effective change and/or enhance their wellbeing.*

Adult survivors of CSA will likely present to services for an array of issues, that appear to be unconnected to a CSA experience; these may include emotional distress, relationship issues, and sexual difficulties (Cawson et al., 2000; McGee et al., 2002). Therefore, survivors of CSA can often require social services, talking therapies and medical care (Chouliara et al., 2011). As a result, help seeking and the process of receiving support can be a long, complex, and arduous process for many survivors (Gavey, 2003). It was noted above that male survivors of CSA will often take around two decades to disclose abuse for the first time. Research on survivors' engagement with support services has also found that, on average, there was a 12-year gap between their first disclosure of CSA and accessing a service for support for the first time (Smith et al., 2015; IICSA, 2020). It has also been noted that it is common for survivors of CSA to oscillate between numerous services. On average, survivors reported that, over a 10-year period between the first service accessed and the most

recent, they used between four and five services (Smith et al., 2015). A recent survey by IICSA (2020), exploring the support experiences of survivors, found that almost three quarters of the 181 respondents (82% of the sample being female) had not accessed any support services for their experience of CSA. However, across those participants who had accessed support, the most highly rated form of support was counselling delivered by charity/voluntary organisations specialising in child sexual abuse/sexual violence. It was also found that frequently used services for CSA survivors are GP, counselling, and mental health services in the first instance, followed by voluntary specialist sexual abuse and rape support services. Considering that, according to survivors, specialist voluntary services appear to be more helpful, it raises the question of why these services tend to be accessed after survivors of CSA have engaged in support from the statutory sector.

The length of time between disclosure and accessing services for help emphasises the challenges survivors encounter in talking about their experiences of abuse to support services. Additionally, it also highlights that it can be difficult to approach and access these services. Therefore, research that explores experiences and barriers in accessing support can help to illuminate how services can be better equipped to support men who have experienced CSA. Particularly when considering the additional challenges men can encounter when disclosing their experiences of CSA and accessing support. In the UK, research on CSA survivor's perspectives of accessing support services is rare (Chouliara et al., 2011; Chouliara et al., 2012; Smith et al., 2015; IICSA, 2020); particularly when it comes to exploring men's experiences.

Although there is a lack of research on support following CSA, one study on female survivors' experiences (Gekoski et al., 2013) documented that those negative experiences of support services can cause secondary re victimisation. Further, it has been reported that survivors are being consistently let down by systems such as the police, courts, and the Crown Prosecution Service (CPS) (Horvath et al., 2014). Despite survivors of CSA relaying some negative experiences of support, benefits of counselling and psychotherapy services have been documented in the research literature (Smith et al., 2015). A systematic review analysing studies on how adult survivors of CSA experienced nonspecific and trauma-focused talking therapies (Parry & Simpson, 2016) identified several helpful aspects of therapy including: supporting

them in developing choice, control and empowerment; enhancing their self-kindness and self-esteem; developing coping strategies; and improving intrapersonal skills and interpersonal relationships.

As well as the challenges faced by survivors of CSA in accessing counselling, professionals delivering these services have acknowledged the difficulties they experienced. The challenges identified include problems regarding the timing and depth of trauma focused therapy; providing contact between sessions; maintaining confidentiality; the ability to offer consistent and accessible services; managing disclosures and the impact of hearing disclosures; and handling child protection issues and the affect this has on the therapeutic relationship (Chouliara et al., 2011). Fundamentally, service providers have stressed the importance of developing a trusting therapeutic relationship with CSA survivors which can foster a sense of safety (Phillips & Daniluk, 2004; McGregor et al., 2006). Organisational and procedural factors have been found to impede the benefits of the therapeutic process. In particular, barriers in accessing services and lack of resources have been identified as issues that professionals feel hinder the client's overall service experience (Chouliara et al., 2011). Professionals providing support to CSA survivors have emphasised that there is a need to increase the resources available to clients, particularly for specific groups (Chouliara et al., 2011). Due to the known barriers, men can face in disclosing CSA and accessing specialist CSA services, it could be argued that men are a target group where there is an overwhelming need to increase service resources.

Female focused support

There exists a minority of dedicated *male only* sexual abuse support services in the UK. Some examples include: *Survivors Manchester, Survivors UK* and *Mankind.* Although many sexual abuse organisations also support male survivors, the widening of service provision to include males can be linked to increasing pressures for single sex services to extend support to men as a condition of funding (Coy et al., 2009). Furthermore, since the introduction of the Gender Equality Duty (GED) in 2007, it has been found that many women-only organisations have been asked by their local authorities to offer services to men (Coy et al., 2009). Despite this, there is no

obligation to include men, as there are specific exemptions under the Equality Act (2010) that allow single sex services when there is a need to preserve dignity and privacy, such as for survivors of violence and rape (Equal Opportunities Commission, 2006). Nevertheless, the GED has not overturned this gender exclusion in a sexual violence/abuse support service context and requests from local authorities can perhaps be attributed to a misinterpretation of the duty (Coy et al, 2009).

As mentioned above, many sexual abuse support organisations have more recently began to offer services to men. However, many of these services have an underpinning feminist perspective that supports the belief that sexual abuse is a cause and consequence of gender inequality towards women. These values are reflected in the Rape Crisis England and Wales' National Service Standards (2012). Rape Crisis England Wales (RCEW) currently has 44 affiliated member organisations across England and Wales, providing services in 54 locations, and it is the national umbrella body for services offering counselling and support to survivors of sexual abuse. However, it is also a feminist organisation (RCEW, 2018). In order to maintain service standards and membership as a Rape Crisis affiliated organisation, sexual abuse services must offer a 'women only' space and explicitly demonstrate in all promotional material that the service is female led, provides a dedicated service to women and girls, and acknowledge that sexual abuse predominantly happens to females; irrespective as to whether the organisation supports male clients or not (RCEW, 2012). Currently, just over half of all Rape Crisis England and Wales offer support to male survivors (RCEW, 2021). As a result, men living in areas where Rape Crisis centres only offer support to women will have no access to specialist sexual abuse support services. According to statistics collated from their member organisations, in 2015-2016 42% of service users were accessing support for sexual abuse that had occurred in childhood. Additionally, 95% of all service users were female (RCEW, 2018). However, as previously stated, an important issue to take into consideration is that men are less likely to seek support due to fear of stigma, vulnerability, and loss of masculinity (Perez-Fuentes et al., 2013). Moreover, this could potentially be perpetuated by the covert and overt messages from RCEW and society per se that CSA is mainly a female issue.

Aims and objectives

Aims

The aim of the study is to explore and gain an in-depth understanding of the experiences of men who were sexually abused as children and have accessed support from specialist support services or the statutory sector. In using a narrative approach, I hope to gain insights as to how services can better accommodate men that have experienced CSA.

Objectives

- To respond to a gap in the literature in terms of males who experienced CSA.
- To explore the experiences of males who have experienced CSA in terms of their mental wellbeing.
- To identify what aspects of mental health care participants found helpful in maintaining and improving their mental wellbeing.
- To identify what aspects of counselling/therapy males found helpful or unhelpful.
- To highlight any barriers participants', believe prevented them from accessing support from the helping professions.
- To provide evidence as to how mental health care and specialist sexual abuse support services can better accommodate the needs of men who have experienced CSA.
- To consider how the above evidence might be transposed to policy, guidance, and practice to benefit males who are experiencing or have experienced CSA.

In summary

It is thought that one in six men have experienced sexual abuse as a child. Men experience a range of mental health problems as a consequence of CSA, and it has

been suggested that men are more susceptible than women to substance misuse issues as a way of coping with the abuse. The process of disclosure of CSA can be more difficult for men than women due to stigmatisation, societal perceptions around men not being victims of CSA, the impact on masculinity and fear of homophobic responses or being perceived as a perpetrator of abuse. Support services for CSA tend to be targeted towards female survivors and there is a lack of service provision and research focused on the experiences of male survivors of CSA. This study aimed to respond to this gap in the literature and explore the support experiences of men who were sexually abused as children.

Chapter Two: Literature Review

Purpose of the review

A literature review is a comprehensive study, which consolidates and interprets the research literature related to a particular topic (Aveyard, 2014:2). According to Oliver (2012), the literature review is one of the most important aspects of academic writing and lays the foundations in which a research project is built. Research evidence can be used to inform professional decision-making and enhance skills in evidence-based practice (Brettle & Grant, 2004).

The purpose of this review of the literature is to develop an in depth understanding of the topic, to identify existing knowledge and to summarise the literature that is available (Brettle & Grant, 2004; Aveyard, 2014). Furthermore, in conducting this review, it is anticipated that it will highlight gaps in current knowledge that requires further exploration (Brettle & Grant, 2004). Literature reviews can also help the wider professional community to assimilate all the information that is available on a subject, particularly in health and social care settings, where professionals have an obligation to keep up to date with recent developments in research and practice knowledge. For example, counsellors are required to keep their professional knowledge and skills up to date by reading professional journals, books and/or reliable electronic resources, and are advised to keep informed of any relevant research and evidence-based guidance (BACP, 2018). As it is often not possible to read and process all information on a particular subject, literature reviews consolidate the research on a particular topic to provide a broad overview (Aveyard, 2014). The first process in undertaking a review of the literature is to identify a research question, with the aim of answering the question by analysing relevant literature using a systematic approach (Aveyard, 2012).

Search strategy

Key words

The use of carefully developed keywords optimises the potential for conducting an effective literature search (Papaioannou et al., 2010). However, Aveyard (2014) cautions that electronic searches and computerised searching tools are not always comprehensive and will not always identify the relevant research related to the topic.

Some relevant research papers might have indexing problems, or they might have been categorised using alternative keywords, which will prevent them from being retrieved when only using one particular search strategy. Despite varying the keywords to help in identifying the literature, it is still a likely possibility that research papers will remain unidentified (Aveyard, 2014). With this in mind, hand-searching and the '*snowball'* technique was implemented to identify relevant literature and citations, in addition to focused searches on electronic databases (Ridley, 2012; Sutton et al., 2016). This method was used when key articles pertinent to the research question were identified, and the reference list of each was scrutinised to identify any other potentially relevant papers (Aveyard, 2014).

To narrow the search and obtain papers that focused exclusively on males, 18 years or over that had experienced CSA, the terms 'men', 'males', 'boys', 'adult males', 'male survivors' and words synonymous with childhood sexual abuse were combined and searched. Other key words were then added to the search with the Boolean operator 'AND' being used with terms related to mental health and treatment/support. Furthermore, spelling variations and American spellings were taken into consideration and '*wildcard'* symbols were used on the root of key words that had potential variations (Ridley, 2012). For example, counsel*ing, child* sex* abuse and psychotherp* Searches were conducted using the key words alone (see Table 1), and combining them with the Boolean operators, on each database, until saturation point was reached, where the same articles were repeatedly found.

Table 1 List of key words

Child sex abuse	Males	Counselling
Childhood sexual experiences	Adult males	Mental health
Child sex coercion	Male survivors	Psychiatry
Child sex exploitation	Men	Psychoanalysis
Child ritual abuse	Boys	Gender
Child rape	Males	Psychotherapy
		Depression
		Anxiety
		Depression and Anxiety
		Internalised homophobia
		Attachment
		CBT
		Cognitive Behavioural Therapy
		Alcoholism
		Drug Misuse
		Alcohol dependency
		Substance Misuse
		Recovery
		Support Services
		Physical Health
		Post-Traumatic Stress Disorder
		PTSD
		Therapy

Databases

A variety of electronic databases and indexes were used to retrieve relevant literature in relation the research topic (see Table 2).

Table 2 Databases

Academic Search Premier	A multidisciplinary research database. Contains around 2800 full text peer reviewed journals and covers psychology and various other academic disciplines.
Child Development and Adolescent Studies	A bibliographic database with over 430,000 records related to current and historical literature on the growth and development of children up to the age of 21 years. The database is relevant to the subject areas of sociology and social work and includes books, book reviews, book chapters, dissertations, theses, journals and reports.
Cumulative Index to Nursing and Allied Health (CINAHL)	A comprehensive database with a large source of English language full text nursing and allied health professional journals. Includes journals and full text articles on healthcare, mental health and evidence-based care.
MEDLINE	A bibliographic database on biomedical and life sciences, including academic journals and articles in the field of nursing and healthcare.
PsychINFO	A resource containing peer reviewed literature in the behavioural sciences and mental health developed by the American Psychological Association.

As evidenced above, the databases were selected in order to obtain papers that would contain research on male CSA. Child Development and Adolescent Studies were included as they could potentially contain articles related to adult survivors of CSA. Although the review focused on adults, a number of the articles used for the review were from the Journal of Child Sexual Abuse, Child Abuse & Neglect and Clinical Social Work Journal.

EBSCOhost, which is an online library and academic resource system, housing full text data bases was used to run searches. EBSCOhost enabled searches to be carried on four of the above databases at the same time (Academic Search Premier, Child Development & Adolescent Studies, CINAHL & MEDLINE) using the same combination of keywords. Searches could then be saved to keep a record of the searches that were carried out.

Google Scholar was also used in an attempt to retrieve relevant research. Google Scholar has a wide range of academic resources including journal articles, books, theses, and conference papers. Another useful feature of Google Scholar is that it provides information on other articles that might be related to the topic being searched (Aveyard, 2014). Searches were also carried out using the institutional library catalogue.

Inclusion and exclusion criteria

The sexual abuse of males came to prominence in the academic literature as recently as the 1980s, and prior to this it was rare to find any reference to male CSA (Alaggia & Millington, 2008). For the purpose of this literature review relating to adult male survivors of CSA, the inclusion criteria focused on papers published in English since 1994; this being the year that male rape was first recognised as a criminal offence in England and Wales (The Criminal Justice & Public Order Act, 1994). Although CSA involves many other activities than rape per se, recognition at a judicial level can influence societal beliefs, and possibly promote the acceptance, that men, as well as women, can be victims of sexual abuse. Furthermore, as this research project focuses exclusively on the experiences of men, studies regarding female survivors or studies including female survivors were excluded from this review of the literature.

Inclusion Criteria:

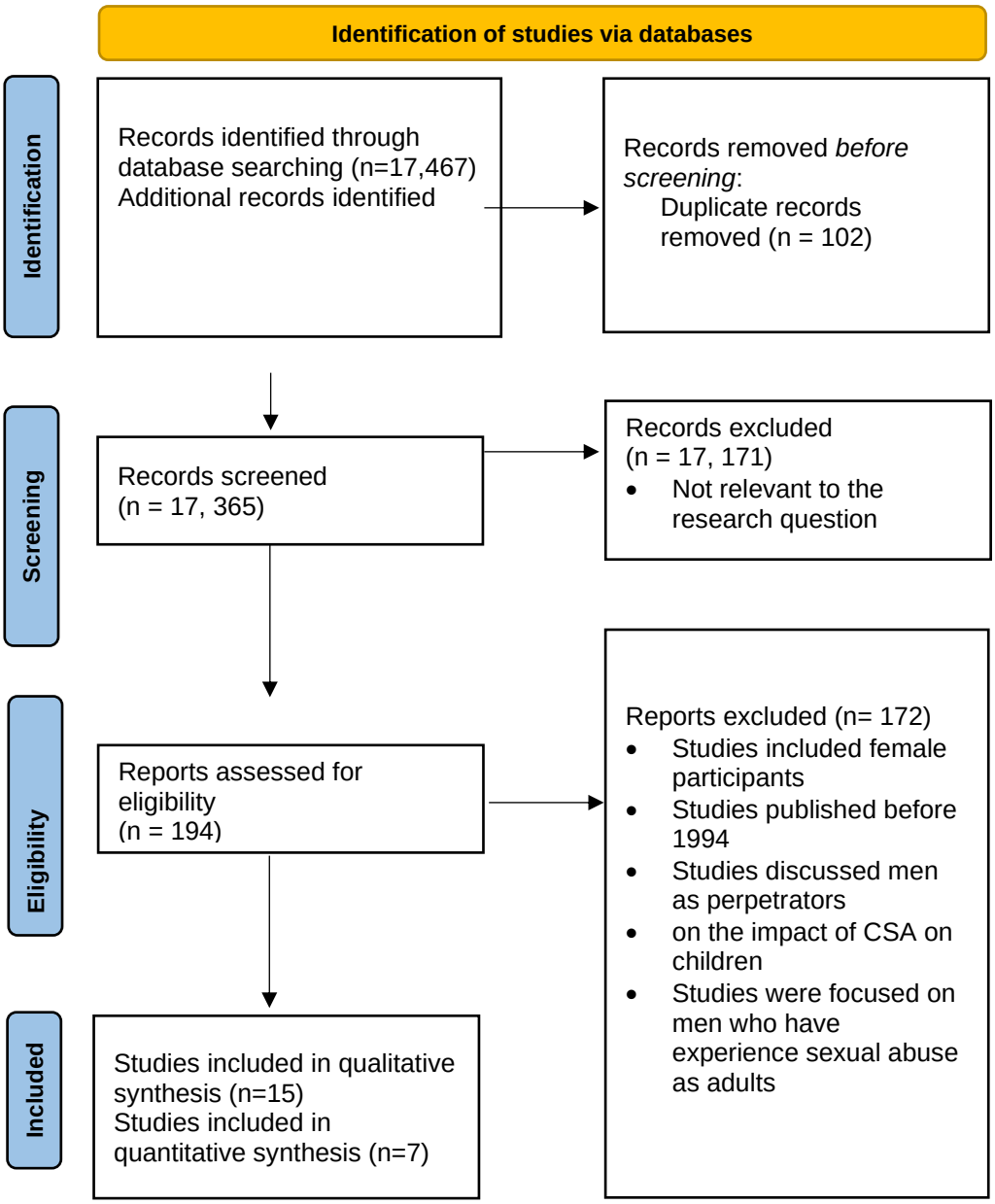
- Papers published in English.
- Papers published in 1994 onwards.
- Studies regarding the disclosure experiences and barriers to disclosure for adult male survivors, including their experiences of disclosing to professionals.
- Papers discussing the impact of sexual abuse on the emotional and mental health on adult male survivors.
- Studies focusing on the experiences of counselling/therapy for adult male survivors.
- Studies regarding therapy and recovery in relation to adult males and CSA.

Exclusion Criteria:

- Studies regarding female survivors of CSA.
- Studies that include CSA from both genders.
- Studies about men as perpetrators of sexual violence/sexual abuse of children.
- Studies regarding offending behaviour.
- Studies about males that experienced sexual abuse at the age of 18 years and over.

Database search results

A Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) flow diagram has been used to demonstrate how the research papers were retrieved using a systematic approach (Moher et al., 2009).



Selection of papers

Overall, 22 papers were obtained after reviewing the abstracts of each article and then appraising each paper to ensure its relevance for the study. Each paper was then inputted onto a spreadsheet/table and coded with a number. The table had 14 columns (article code, title, DOI, Author(s), year published, country of publication, quantitative/qualitative, method, number of participants, data collection method, data analysis method, measures used, brief summary of findings & limitations). As well as keeping a record of the articles being included in the review, the table was useful in being able to filter qualitative and quantitative papers, papers published in a particular year, the method used, the papers published in a particular country and so on. Furthermore, it was also helpful in using it as a guide to analyse how many participants were used in each study and the design of each study. A condensed version of the table is available in appendix 1.

When reviewing the literature, the included papers appeared to fall into a number of specific categories and in light of this the literature was separated into five sections, table three below indicating how many papers were obtained for each category. The review begins with qualitative research related to disclosure, as disclosure of CSA is considered to be a prerequisite to help-seeking and accessing support (Easton et al., 2014). Research papers related to the effects of male CSA will then be reviewed in order, to establish the physical and psychological effects that might lead a male survivor of CSA to seek support, as well as highlight the presenting issues that a counsellor may encounter. As this study is exploring the counselling experiences of male survivors of CSA, papers related to therapy and recovery for this group will be presented, in order to ascertain the current research available on this specific topic. This study is centred around the counselling experiences from the perspective of the client, as such a section is included related to service user perspectives of counselling. Finally, the review contains a section related to quantitative research papers to establish the scope of empirical research available on male CSA. Five of the papers included in this review were reporting on different aspects of the same study (Easton, 2013; Easton et al., 2013a; Easton et al., 2013b; Easton et al., 2014; Easton et al., 2015).

Table 3 Chapter Sections

Category	Number of Papers
Male CSA and Disclosure	3
Effects of Male CSA	5
Therapy and Recovery from CSA	4
Service User Perspectives	3
Empirical Quantitative Studies	7

Male child sexual abuse and disclosure

Although disclosure is an important aspect of CSA, there have been few studies that have exclusively examined the disclosure experiences of male survivors (Sorsoli et al., 2008). Three qualitative studies exploring this phenomenon were identified, each adopting different methodological techniques (Sorsoli et al., 2008; Easton et al., 2014; Gagnier & Vezina, 2016).

Sorsoli et al. (2008) interviewed 16 adult male survivors of CSA regarding their disclosure experiences, utilising a grounded theory approach to data collection and analysis. Two in-depth semi-structured interviews were conducted with each of the men. Interviews focused on seven areas: life history, adaption, relationships, physical abuse, sexual abuse, psychotherapy and resilience. The use of focused interview questions and topics is in keeping with the grounded theory approach (Rubin & Rubin, 1995). A key aspect of grounded theory methodology is that analysis is in keeping with data collection, which facilitates the emergence of theories (Wimpenny & Gass, 2000).

Although the interview protocol used by the researchers was supported by male CSA theory and clinical expertise, it was actually based on the researcher's prior work with

female survivors of CSA and subsequently adapted to fit with this particular study on males. Using prior work with a different group of people may assume similarity between males and females regarding their experiences of disclosure. In keeping with the analytical approach selected, the researchers endeavoured to identify commonalities, patterns, or clusters of experience within the data. It transpired that barriers to disclosure and negative disclosure experiences far outweighed positive disclosure experiences amongst the men in the study (Sorsoli et al., 2008). With regards to the sampling strategy only participants that were abused by a family member or important caregiver were selected to take part in the study. The researcher's justification for the inclusion criteria was based on the assumption of abuse being perpetrated by those who have on-going relationships with the abused are more psychologically harmful. However, this speculates that incestuous abuse or abuse by a caregiver is more damaging to a CSA survivor than sexual abuse by others.

Sorsoli et al. (2008:339) conceptualised three areas within the context of barriers to disclosure that operated: '*personal*, *relational* and *sociocultural'*. The study does not attempt to clarify at what point in the life span the men disclosed their abuse history. However, they did report that only one participant in the sample disclosed the sexual abuse experience whilst still a child. The other 15 men reported that they had not disclosed the abuse in childhood; however, some stated that they had made several indirect attempts at disclosure. In keeping with this finding, a phenomenological study regarding disclosure experiences of 17 adult men who were abused as children found that the majority of participants first disclosed the abuse experience in adulthood (Gagnier & Collin-Vezina, 2016). Similar to the study by Sorsoli et al. (2008), two of the men in Gagnier and Collin-Vezina's (2016) study made numerous attempts to disclose to someone as children, but the participants reported that they were not taken seriously.

Sorsoli et al. (2008) described distinct types of barriers to disclosure. The personal barriers included: a lack of cognitive awareness, avoidance, shame, emotional readiness, safety, and difficulty in articulating and approaching the topic. Over half of the men in their study expressed a lack of cognitive awareness, some expressing that they had '*compartmentalised'* the abuse or had completely repressed the abuse memories. As well as a lack of awareness pertaining to their abuse experience, many

of the men described how they intentionally avoided disclosure or blocked out abuse memories. This is also illustrated in Gagnier and Collin-Vezina's (2016) study, whereby nine of the participants described how they had repressed certain elements of their CSA experience, whilst others stated that they had been in denial. The sociocultural barriers to disclosure faced by the men in Sorsoli et al.'s (2008) study were reported as *'judgments,'* due to society not accepting men as victims and male CSA being a taboo subject that should not be discussed (Sorsoli et al. 2008:342). These societal stereotypes that often hinder men from disclosing earlier in life are reiterated by Gagnier and Collin-Vezina (2016). As well as the adversities they felt in being recognised as a '*victim*', the men expressed concerns about being perceived as less masculine or as homosexual if they disclosed the abuse. Another major fear was the potential of being labelled as a perpetrator of CSA (Gagnier & Collin-Vezina, 2016). The intense fears of being thought of as dangerous towards children and being labelled as homosexual were also emphasised in a study by Easton et al. (2014). However, some of the participants that were gay, or bisexual, feared that their abuse history would generate further stigmatisation, as people may assume that their sexual orientation was a result of the abuse experience (Easton et al., 2014).

Consistent with the above literature, Easton et al. (2014) identified a socio-political domain, consisting of broad social values that were deemed to be a barrier to disclosure. As CSA often violates masculine norms, many of the participants in their study felt weak, frightened, powerless, shameful, and guilty at the time of the abuse. Easton et al. (2014) argue that these rigid social gender norms pervade societal attitudes to male survivors of CSA and have a profound impact on disclosure. This is evident in the lack of resources the participants perceived were available to male survivors; specifically, they felt that rape crisis centres and counselling services for survivors of abuse were ill equipped to work with males. Furthermore, a number of men remarked on their experiences of some services, such as rape crisis centres, to be unfriendly, with some of the sample reporting that they had been refused access to certain services based on their gender (Easton et al. 2014). There were 460 men that took part in the research undertaken by Easton et al. (2014). The study on the barriers to disclosure was a secondary analysis of data obtained from a large quantitative study using a non-clinical sample of men with a history CSA who completed an online 'Health and Wellbeing' survey. Content analysis was used to analyse an open-ended item on

the survey which asked the men to consider disclosure barriers that they have encountered across the life course.

From what is described above, a parallel exists between the social attitudes, norms and values that impeded disclosure, and the interpersonal relationships of the men in the study (Easton et al., 2014). The interpersonal barriers to disclosure primarily emerged through social interactions and the potential negative consequences of future disclosures. A common theme to emerge was that many of the men were reluctant to disclose the abuse due to difficulties in trusting people, as the abuser was often the person they had trusted most as a child. Another major issue was the fear of not being believed, which resulted in profound feelings of isolation. A number of men also expressed fear that disclosure would result in negative social reactions such as; being judged, blamed, criticised and ostracised (Sorsoli et al., 2008; Easton et al. 2014). Furthermore, participants' felt that disclosure had the potential to significantly affect relationships and could result in rejection, abandonment, and loss (Easton et al., 2014). Unlike the results of the studies by Sorsoli et al. (2008) and Gagnier and Colin-Vezina (2016), Easton et al. (2014) distinguished abuser factors as being a further barrier to disclosure. Typical was the power differentials between the abuser and the child, with some participants reporting that the perpetrator threatened to harm them further if they reported the abuse. The threats made by the perpetrator initiated intense feelings of helplessness in the men that often extended into adulthood. Another unique finding in the study by Easton et al. (2014) is that most of the participants stated that protecting others was a significant barrier to disclosure. A number of the men stated that the subject of abuse was a taboo topic and believed it was uncomfortable for other people to discuss; thus, they avoided disclosure in order to protect others from discomfort (Easton et al. 2014).

Similar to that of Sorsoli et al. (2008), Easton et al., (2014) also identified a personal domain that operated as a barrier to disclosure. Although the personal domain embodies societal values and interpersonal relationships, it distinctly centres on the intra-psychic, emotional and cognitive levels of the men. The most frequently acknowledged barrier reported by more than half of the sample was the intense negative emotions they had experienced. Some of the negative emotions described by the participants included: guilt, low self-esteem, shame, humiliation, loss of control,

confusion, self-blame, and disgust. As mentioned in the other two studies, some of the men repressed memories of the abuse or attempted to block out the abuse experience (Sorsoli et al., 2008; Easton et al., 2014; Gagnier & Colin-Vezina, 2016). Another noteworthy issue around disclosure highlighted by the men in Easton's et al. (2014) study was the process and ability to name the experience as abuse. For some, the abuse experience was part of *'growing up,'* and therefore they did not necessarily recognise it as sexual abuse.

Research that focuses on the barriers to disclosure, such as Sorsoli et al. (2008) and Easton et al. (2014), has the potential to distract from positive disclosure experiences that some survivors may encounter. Gagnier and Collin-Vezina (2016) found that some of the men in their study felt at ease in disclosing and were keen to share their abuse history, making it part of their personal narratives. The vast majority of the men in their sample had experienced at least one positive disclosure experience and two of the men had not experienced any negative responses. Furthermore, the importance of being believed when disclosing CSA was found to be a contributing factor in perceiving a disclosure response as positive (Gagnier & Collin-Vezina, 2016).

The studies by Sorsoli et al. (2008) and Gagnier and Collin-Vezina (2016) used relatively small sample sizes, although this is in keeping with qualitative research studies (Holloway & Freshwater, 2007). Sorsoli et al. (2008) attributed this to the difficulty in recruiting men, as they had previously conducted a study around women's experiences of sexual abuse in which more women came forward to participate in the research. In comparison, the research by Easton et al. (2014) had a considerably larger sample for a qualitative study. However, the study was a secondary analysis, following on from an earlier quantitative study, that had a cross-sectional survey design and data from 460 men was obtained. The data presented for the qualitative aspect of the original study was based on participant's responses to a particular question in the survey, as opposed to the participants coming forward to participate in an interview. Although the study by Easton et al. (2014) had a large sample size, it was noted that around two thirds of the men were survivors of abuse by clergy members. Therefore, it could be argued that men abused in childhood by religious figures may experience different barriers to disclosure than men abused by family members, or others in a position of power or authority. Another issue relates to the

research design, as the data was collected from a single open-ended item of the 2010 Health and Wellbeing survey. This did not allow for any follow up questions to be asked by the researchers, in order to elicit further perceptions of barriers to disclosure. In Gagnier and Collin-Vezina's study semi structured interviews were conducted with participants over the phone and digitally recorded. The open-ended questions focused mainly on the process of disclosure to prompt further exploration of the participant's disclosure experiences. The three studies around disclosure mostly recruited participants that had received or were receiving support from various survivor organisations or therapists. This could potentially limit the findings of the studies, as individuals that have received support for CSA may be more inclined to communicate their experiences of disclosure than men that have never accessed therapy or support (Dorahy & Clearwater, 2012). Nevertheless, when considering the challenges in recruiting and gaining access to participants to discuss sensitive topics, such as male CSA, much of the literature identified has demonstrated that participants are recruited through similar means.

Undoubtedly, disclosure experiences in the research reviewed so far were not always easy for the men. Alternatively, non-disclosure was also found to be difficult and the burden of keeping a secret was described as being *'deeply painful and isolating'* (Gagnier & Vezina, 2016, 234). Rather than being a solitary event, the studies outlined disclosure as being a multifaceted, extended, and variable process that is often repeated across the life course.

Long term effects of male child sexual abuse

The following section reviews qualitative studies focusing on the long-term effects of CSA in males. Although there is extensive research on the psychological effects of CSA in females, only six papers were identified that specifically explored the long-term effects for male survivors (Lisak, 1994; Gill & Tutty, 1998; Gill & Tutty, 1999; Alaggia & Millington, 2008; Dorahy & Clearwater, 2012).

As it is acknowledged that men might be seeking therapeutic support for issues unrelated to abuse, Day et al. (2003) highlighted the reluctance of mental health professionals to routinely enquire about sexual abuse in males. Alaggia and Millington

(2008) maintain that therapists have an obligation to ask male clients about sexual abuse, regardless of whether CSA is the presenting issue, when they display psychological issues consistent with an abuse history. Alaggia and Millington's (2008) phenomenological study aimed to address the experiences of sexual abuse when the men in the study were boys by exploring the process of disclosure, the impact the abuse had for the men as children and adults, and the meanings they attached to those experiences. The phenomenological approach was used to develop an understanding of the lived experience of 14 participants. In-depth interviews were conducted that produced substantial narratives. Data from the interviews were produced using the 'Long-Interview Method', which is an inductive and heuristic method. *Phenomenological Reduction* or '*bracketing'* was the method of data analysis in which descriptive and interpretive analysis was carried out. The ability to bracket and suspend judgment is integral to the validity of the data (Van Manen, 1990).

Emerging from Alaggia and Millington's (2008: 258-265) study were four distinct themes that were derived from descriptive analysis of the data focusing on the men's experiences as children. The themes based on childhood experiences were '*denial*, *early sexualisation*, *confusion around their role and responsibility in the abuse,* and *specialness'*. Three additional themes were also identified through hermeneutical interpretive analysis of the participants' reflections as adults. The themes based on what the men had attributed to their abuse were '*anger and rage*, *sexual disturbance and ambivalence*, and *loss and hope'*.

Alaggia and Millington (2008) went on to discuss how denial manifests in forgotten or repressed memories of the abuse. Five of the men reported that abuse memories were recovered later in life, some experiencing flashbacks during significant life events, and also when recovering from substance misuse. Undeniably, substance misuse was a significant problem for the men and a common coping mechanism in the suppression of distressing thoughts and feelings; and dealing with the painful memories of the abuse (Alaggia & Millington, 2008). Likewise, Easton et al. (2015) found that alcohol and drug addiction was a common method of coping with traumatic abuse memories. Although their research was focused on '*turning points'* and positive changes in the healing process of CSA, Easton et al. (2015:162) indicated that the participants first had to '*hit rock bottom'* before recovery was possible. Essentially, the men felt that

they had lost all control of their lives through drug or alcohol addiction and when they believed things could not get any worse, they would then reach a '*turning point'* in which they would refocus and make positive changes. However, maintaining sobriety often bought abuse memories to conscious awareness and one participant stressed that he came to the realisation that he must '*deal with the abuse'* before substance abuse recovery was possible (Easton et al., 2015: 162).

In Alaggia and Millington's (2008) research, it was found that all 14 men in the study had been abused by males. Furthermore, the abusers had largely been older men, either in a position of power or in a parent/care-giver role. A recurring theme in Alaggia and Millington's (2008) study was the men's conflicting feelings of being complicit in the abuse. To illustrate, one man connected his involvement in the abuse with the physical sexual arousal he had experienced, whilst at the same time feeling disgust that his body had reacted in that way. Likewise, another participant described feeling pleasure from the abuse and enjoying the feeling of ejaculation; however, this was soon followed by feelings of revulsion. The confusion around the men's role, and feelings of responsibility in the abuse was found to have a profound effect on disclosure. One man described having experienced feelings of guilt that he had 'allowed' the abuse to happen multiple times, and in some cases the abusers had bribed or provided the men with material rewards. Such prizing and affection, expressed by the perpetrator, further reinforced the internalised feeling of '*specialness'* and need for approval that a number of the men attributed to the abuse. This is thought to be perpetuated by the home environment, since many of the men described neglectful and emotionally inexpressive families, where the major form of expression was anger and degradation.

Overall, Alaggia and Millington's (2008) study has numerous implications for therapeutic practice. They maintain that it is vital that the ambivalence and pain that can often surface in adults, resulting from feeling like an active participant in the abuse, is addressed in therapy. As many of the men experienced negative attitudes and minimisation from others when first disclosing sexual abuse, they stress the importance of this betrayal not being replicated in therapy, as a result of the therapist's attitude or unfamiliarity with the issues of male CSA. Although there are many similar effects related to CSA experienced by both men and women, such as, trust issues,

relationship problems, shame and anger, they advocate that there are also distinctive aspects for counseling male survivors. These are namely, offering a safe space to explore feelings of complicity, whilst helping them to recognise the coercive context in which the abuse occurred (Alaggia & Millington, 2008).

Alaggia and Millington (2008) acknowledge the limitations of their study, in that it involved a relatively small sample size, which consisted primarily of a clinical sample. Also, owing to the fact that the study had a retrospective design based on men's experiences in childhood, it is recognised that the men may have had difficulty recollecting memories, or they may have experienced memory distortions; particularly when memories had been recovered at a later stage in life due to repression. Ritchie et al. (2014) asserts that there are limits to the viability of topics that can be explored retrospectively when undertaking qualitative research, due to problems in recall, memory distortion, and post-event rationalisation. That said, the study by Alaggia and Millington (2008) centred on the interpretations and constructions of life events from the men's perceptions of how the abuse had affected them, rather than the detailed accuracy of the events that were experienced.

Feelings of shame have found to be a common theme in the literature reviewed thus far. An early study by Gill and Tutty (1999) examining the effects of CSA on ten adult males found that all the participants had experienced shame about having been abused, and they associated this with their inability to defend and protect themselves from the abuse. In-depth interviews with the men were conducted and content analysis was used to determine themes from a cognitive and emotional perspective of how the abuse had impacted their lives.

Gill and Tutty (1999) noted that feelings of shame were further reinforced by societal attitudes and a belief that men are expected to be in control and not victims. Another notable finding, relating to the emotional effects of abuse, was the belief expressed by the men that their ability to form emotional relationships had been impaired. Feelings of being different from others were profound for the men and a shared belief was that interacting with peers would inevitably result in being manipulated and abused. The men also experienced a discord between being '*sexually victimised*' (Gill & Tutty, 1999:24) and the cultural messages about masculine norms, such as being strong and

in control. There were a number of various coping mechanisms adopted by the men to disguise their reluctance to interact with others, these included; joining organisations such as Boy Scouts, participating in sporting events and joining the military. These activities helped the men to mask their perceived differences and achieve a sense of belonging (Gill & Tutty, 1999).

The participants in Gill and Tutty's (1999) study described dissociating during their sexual abuse experiences, which served as a protective mechanism. However, when applied to everyday life, problems, and stresses, this coping strategy was found to become increasingly less useful over time and hindered the formation of peer relationships for the participants (Gill & Tutty, 1999). Half of the participants described how they also dissociated during sexual activities with an intimate partner and all ten of the men described experiencing various levels of difficulties in forming and maintaining intimate relationships, which they all attributed to CSA (Gill & Tutty, 1999). Similar to Gagnier and Collin-Vezina's (2016) and Easton et al. (2014) findings, fear of being an abuser was also a factor for one of the participants, as he described fears that being homosexual meant that he could only have sex with children (Gill & Tutty, 1999).

Gill and Tutty's (1999) study highlights the issue that sexually abused men tend to enter counselling for a variety of presenting problems, often concerning relationship issues. This was evident in Gill and Tutty's (1999) study, as eight out of the ten participants accessed counselling for relationship difficulties. With regards to sexual intimacy issues, the authors recommend that therapists should help men to separate sex from violence, as men can often associate abuse with sexuality and fear that they will lose control or violate another, if erotic feelings emerge. As men can be reluctant to volunteer a history of sexual abuse, Gill and Tutty (1999) advised three noteworthy interventions based on the themes drawn from the results of their research. Firstly, it is essential that practitioners provide opportunities for men to disclose CSA, the impact of cultural stereotypes of males should be explored, and finally, emotional and sexual relationship issues should be addressed in therapy (Gill & Tutty, 1999).

An important issue to take into consideration is that all of the men in Gill and Tutty's (1999) study were sexually abused prior to the 1980's. As previously mentioned,

awareness of the problem of male CSA was substantially lacking before this time; particularly when considering the participants' beliefs about boys rarely being victims of sexual abuse and feeling different from their peers, (Gill & Tutty, 1999). Another characteristic of the sample that might have had an impact on the themes noted, is half of the sample had initially accessed counselling due to physical and/or emotional violence towards their partners.

Shame and dissociation were emotional effects identified in the above study when interviewing men based on their experiences of CSA. A study by Dorahy and Clearwater (2012) examined this in more depth by inviting seven men, who were attending a support group in a service for sexually abused males, to participate in a semi structured focus group. The men were chosen for the sample as they had showed elevated scores for shame, guilt, and dissociation on four measures known as *The Dissociative Experience Scale, The Personal Feelings Questionnaire-2, The State, Shame and Guilt Scale* and *The Childhood Trauma Questionnaire.* The focus group interview was analysed using interpretive phenomenological analysis (IPA) in order to extract themes based on the phenomenological descriptions articulated by the individual members of the group. Four superordinate themes were elicited from the transcript of the interview, underpinned by a number of subordinate themes. The superordinate themes were: *self-as-shame*, *pervasiveness and power of doubt and denial*, *uncontrollability* and *dissociation* (Dorahy & Clearwater, 2012:162).

In keeping with Sorsoli's et al. (2008) and Easton's et al. (2014) findings, feelings of shame are a significant obstacle to disclosure, the *self-as-shame* construct identified in Dorahy and Clearwater's (2012) study was found to impede the ability to disclose abuse. As well as obstructing the ability to disclose CSA, a subordinate theme deriving from shame was the fear of exposure. The intense fear that their abuse histories would become exposed were related to unpredictable judgments from others, in particular those around sexuality and being considered as homosexual were of concern. This led many of the participants to isolate themselves socially and emotionally from others. Although this was potentially a method of self-preservation, the emotional consequences, such as loneliness, were evident in the narratives. Furthermore, it was found that connecting with others had the potential to temporarily reduce feelings of shame. The term *self-as-shame* was developed, as the men appeared to embody

shame, as opposed to just living with it. These overwhelming feelings of shame manifested in the men as; feeling like a failure, unworthy, value-less, defective, and lacking in self-esteem. Such feelings often led to them viewing themselves as incompetent and inferior to others (Dorahy & Clearwater, 2012).

The second superordinate theme of *pervasiveness and power of doubt and denial* encompassed the men's self-doubt that the abuse had actually happened; and also not being heard or believed by others. Some participants described not being believed by health and mental health professionals, and having their disclosure of CSA attributed to their mental health problems. This phenomenon is common for those diagnosed with mental illness and is often referred to as '*diagnostic overshadowing'* (Jones et al., 2008). Another issue raised by the participants and related to denial by others, was how professionals often associate alcohol abuse with either genetics or learnt behaviour, rather than considering that it might be a coping strategy related to an abuse history (Dorahy & Clearwater, 2012).

The third superordinate theme of *uncontrollability* emerged based on the men's accounts of being unable to control intense anger or rage manifesting from abuse memories or more minor frustrations. Another area of concern for the men was their perceived lack of control over the residual effects of the abuse, such as shame and alcohol misuse, that continued long after disclosure and help seeking. In addition, the participants described how they felt that their abuse histories often intruded on their life and bought about intense emotional pain causing some of the men to experience suicidal ideation or self-harm, as a method of regulating the uncontrollable intrusions (Dorahy & Clearwater, 2012). Consistent with Gill and Tutty's (1999) study, dissociation was also found to be a strategy adopted by the men as a way of regulating emotions. Furthermore, they noted that one of the participants described having a dissociative experience during the focus group, as the interview content reactivated thoughts from his past (Dorahy & Clearwater, 2012).

As a consequence of social and professional denial and the overwhelming silencing effect of shame experienced by the men in Dorahy and Clearwater's (2012) study, it is acknowledged that in order to promote disclosure and exploration, considerable therapeutic engagement is required. Moreover, to reduce the feelings of shame

through therapeutic intervention, attention needs to be given to identifying the external causes and influences of shame and reducing the beliefs around negative social judgments (Dorahy & Clearwater, 2012).

There were a number of limitations in Dorahy and Clearwater's (2012) study. Although the results are not intended to be generalisable, the study was limited to a single focus group of seven men that had experienced sexual abuse as children. Similar to Gill and Tutty's (1999) research, the participants in Dorahy and Clearwater's (2012) study were support-seeking men; therefore, they are considerably more likely to be prepared to discuss their experiences of abuse. Another issue to take into consideration is that the men had been given the opportunity to reflect on their experiences and the effects of the abuse through counseling and weekly group support meetings. By virtue of shame often influencing the desire to avoid and withdraw, the use of a focus group may have prevented the participants from fully exploring and articulating their feelings of shame with others. Statements made in a group setting should not be viewed as unique individual statements. Rather, communication is rooted in the dynamics of the group setting and the authors neglected to present an analysis of the conversational components of the group and how the group was organised and developed throughout the research process (Flick, 2014). Therefore, exploring CSA and shame within the context of a one-to-one interview may have been a more appropriate method of data collection for a sensitive study such as the one undertaken by Dorahy and Clearwater (2012).

A qualitative study on male CSA by Lisak (1994), containing a larger sample size, investigated the psychological impact of sexual abuse on male survivors. Lisak (1994) interviewed 26 male survivors to establish common psychological themes using content analysis. Unlike the above studies that identified or focused on more specific issues related to CSA, Lisak (1994) provides a much broader perspective of the psychological effects related to sexual abuse. That said, a number of the themes previously noted were also found in Lisak's (1994) study. Overall, 15 psychological themes were identified: *anger, fear, homosexuality issues, helplessness, isolation, alienation, legitimacy, loss, masculinity issues, negative childhood peer relations, negative schemas about people, negative schemas about self, problems with sexuality, self-blame/guilt* and *shame/humiliation* (Lisak, 1994, 528).

The anger expressed in the participant's narratives represented many forms including interpersonal aggressiveness, homophobia, physical violence, and hypersensitivity to perceived insults or threats. As well as experiencing overwhelming feelings of rage, a number of men also described fear and confusion as to when to appropriately express anger, which led some men to suppress anger completely. However, the suppression of anger was not always helpful, as some of the men described and used the term '*snapping'* in relation to confrontations with others. In addition, 31% of the participants in the study disclosed that they had victimised others in various ways, including: sexually abusing children, rape of adult women, perpetrating domestic violence, and physical assaults on other men. Another form of anger experienced by some participants was anger directed at women, and society in relation to a woman's ease and accessibility in receiving support for sexual abuse, when they observed that there is little support available to men (Lisak, 1994).

Although the term *betrayal* was scarcely used by the participants in Lisak's (1994) study, it was classified as a psychological theme, as it signified the men's sense of having their trust or faith in another violated. The participants recurrently relayed feelings of betrayal and hurt that they had been let down by a parent or that a caregiver had failed to protect them from the abuse. The most frequently coded theme in Lisak's (1994) study was fear, which was experienced at the time of the abuse and was also an enduring effect of CSA that continued into adulthood, causing the men to isolate and confine themselves, whilst undermining their self-confidence. Although feelings of isolation and alienation were identified as being connected to fear, Lisak (1994) also ascertained that isolation was also connected to the stigma attached to the sexual abuse of boys. The most common experience of fear was the intrusive thoughts that had the potential to evoke fear reactions (Lisak, 1994). Intrusions were also later determined as an overwhelming emotional effect by Dorahy and Clearwater (2012).

With regards to the theme of *legitimacy* identified in Lisak's (1994) study, many of the participants experienced immense difficulties in acknowledging that they had been abused, and that it was abuse that was the cause of their emotional distress. Furthermore, many of the survivors battled with the notion that they may have been exaggerating or fabricating the abuse experience. This was somewhat perpetuated by

societal attitudes and their internalised views that men are not victims, which led the participants to question if they had actually been abused. Another poignant theme associated with CSA was loss. Around half of the sample established that there was a connection between CSA and the loss of childhood and their innocence. Further, some of the men relayed how they felt they had lost whole periods of their lives due to repressed memories that they were still unable to recover (Lisak, 1994).

Easton et al. (2014) highlighted that rigid gender norms are a significant barrier to disclosure for sexually abused men. Indeed, Lisak (1994) established that being victimised and exploited for the sexual gratification of another is an experience that violates male gender norms. This has the potential to result in internal conflict, as societal gender norms do not consider it to be 'appropriately masculine' to express emotional pain, vulnerability, or helplessness. This tension can impede the internal psychological processes that play a crucial role in healing from CSA. Amongst the exhaustive psychological effects of CSA that have been summarised, anger is the only emotional effect that corresponds within the conventional gender norms. Lisak (1994) suggested that men deviate between two distinctly contrasting behaviours. Characteristically, one group of men in his study acknowledged they were victimized, and thus they battled with overwhelming un-masculine feelings that left them feeling inadequate. The other group actively denied feelings related to victimization, and adopted hyper-masculine behaviours, such as rage and aggression to reinforce the denial. Additionally, the men often assumed masculine hobbies and entered masculine institutions, such as the armed forces, which is consistent with Gill and Tutty's (1999) findings.

Another pervasive effect of CSA observed in Lisak's (1994) study was issues around sexuality. Sexual problems were experienced by the majority of the sample and included: confusion around sexuality, fear of sexual intimacy, promiscuity, lack of sexual boundaries, and compulsive sexual behaviour that fixated on fantasy and masturbation. As with Sorsoli et al. (2008), Dorahy and Clearwater (2012) and Easton's et al. (2014) studies, feelings of shame and humiliation were the most permeating consequences of CSA. The feelings of shame, articulated by participants, were associated specifically with their sexuality, and contributed to their negative self-concept (Lisak, 1994).

Lisak (1994) presented a comprehensive range of psychological effects and symptoms resulting from a history of CSA in males. However, it could be argued that the sampling strategy was limited, as participants were recruited from one North American University. However, unlike Gill and Tutty's (1999) and Dorahy and Clearwater's (2012) studies, the participants were not solely recruited on the basis of being support-seeking men. Therefore, it could be suggested that some of the men in the study may not have had experience of accessing therapy or support for CSA. Another potential limitation relates to the analysis of the data. Content analysis was used to isolate the 15 psychological themes. However, only six of the 26 transcribed interviews were selected, at random, and analysed by five members of the team, whose role it was to isolate the common themes which appeared in the data and to produce a coding manual based on the results. The other 20 interviews were then analysed using a coding system that was derived from the six randomly selected transcripts, with two independent coders identifying themes within the transcripts. Therefore, there may have been unique aspects within the 20 transcripts that were not identified from the initial analysis that may have been missed from the findings.

Lisak (1994) and Easton et al. (2014) discussed how the concept of gender norms had a considerable psychological impact on male CSA survivors. Focusing on this subject in more depth, Gill and Tutty (1998) conducted a study to examine the issues that men experienced around sexual identity as a result of CSA. The data was collected from in-depth unstructured interviews using purposeful sampling to recruit ten men who were sexually abused as children, from several counselling agencies. Content analysis was employed to generate categories by coding the data. The results of the analysis were then member checked to ensure that the researchers had accurately captured the essence of the participants' experiences. Follow up interviews were then completed on eight of the ten participants the researchers were able to contact (Gill & Tutty, 1998).

In terms of the participants' biological sexual and gender identity, four out of the ten interviewees specified that they did not identify as either male or female, instead stating that they did not have a gender. Two participants felt that their gender identity was both male and female and the remaining four from the sample expressed that

they identified as male. Despite this, the participants identifying as male felt that they did not conform to the societal perception of what it meant to be male and masculine. All participants revealed that they had grown up to believe social stereotypes of what being a male signified. Mainly, these stereotypes and attitudes included the belief that men are strong, capable of looking after themselves, brave, in control and, above all: not victims. The participants indicated that their inability to measure up to the masculine ideal created by society, was a direct consequence of the sexual abuse they had experienced as children. This inability to align themselves with the societal perception that men are in control of themselves and their own experiences, led them to withdraw from family and peer relationships. Gill and Tutty (1998) speculated a theoretical explanation for this phenomenon based on Shively and DeCecco's (1977) ideas that social sex role identity is formed between the ages of three to seven. Owing to the fact that seven of the participants were first abused between the ages of three and seven, Gill and Tutty (1998) hypothesised that their social sex role identity may have been influenced by the discord between their CSA experience and societal expectations of what is culturally associated with being a male. Their argument is supported by the findings from their study, as the seven men initially abused during the ages of three and seven years old, demonstrated a greater need for self-control and were more likely to display feelings of self-blame. In addition to withdrawing from peer relationships, sexual relationships were also problematic for the men, as they described themselves as feeling soiled, damaged, and devalued. A number were unable to participate in sexual activity due to feelings of anxiety, fear, or nausea, which further reinforced their feelings that they did not measure up to the societal beliefs of a young man being enthusiastic about sexual activity (Gill & Tutty, 1998).

When questioned about their sexual orientation, it transpired that seven men identified as predominantly heterosexual, two were homosexual, and one man believed that he was bi-sexual until he attempted sexual intercourse with a male friend and was unable to become aroused. All ten of the participants expressed that they did not associate their sexual preferences with CSA. Although two participants described having occasionally questioned their sexual orientation, they did not feel that this had any connection to their past experience of sexual abuse (Gill & Tutty, 1998).

As outlined, four of the participants identified as not aligning to a specific gender. Gill and Tutty (1998) suggested that their inability to assign themselves with being male might be related to the construct of gender shame, which developed from their experience of CSA. Gender shame has the potential to compel men to distance themselves with all things male, including the oppressive and abusive behaviours that they perceive men as displaying (Gill & Tutty, 1998). One of the participants who described himself as neither male nor female was abused by a female perpetrator. However, Gill and Tutty's (1998) ideas around gender shame, as a result of CSA, may have some credence, as the four men that did distinguish themselves as male all explained and emphasised: although they were male, they were not *stereotypically* male. The authors propose that the results of the study can be applied to therapeutic practice when counselling male survivors, by using the framework around sexual identity to enquire about specific gender identity issues in order for a client to acknowledge them in a non-judgmental and non-threatening environment. They suggest that this will also help to normalize sexual identity issues and emphasize to the client that it is common for men who are sexually abused as children to experience these feelings.

Although Gill and Tutty's (1998) findings generate an argument that male CSA does not have an impact on sexual preference or cause confusion around sexual identity this directly contradicts earlier research (Myers, 1989; Dimock, 1988; Hunter, 1990b; Lew, 1990; Mendal, 1992), all of whom reported sexual orientation confusion in male survivors. Gill and Tutty (1998) attempted to address this contrast by postulating that it may be influenced by the fact that the participants were support seeking and they were all receiving therapy at the time of their research interview. Further, the findings noted by Gill and Tutty (1998) regarding the men's perceptions of social stereotypes and gender norms is supported by the theory of social sexual role identity being shaped and formed between the ages of three to seven (Shively & DeCecco, 1977). However, questionnaires were administered to all participants, alongside the interview, which included questions related to Shively and DeCecco's model of sexual identity (1977). Therefore, it could be argued this could have potentially influenced the findings regarding social sexual identity issues, as the questions were developed around the model. Finally, the research aimed to explore sexual identity problems for male survivors of CSA, which is a broad area of enquiry encompassing, biological sex

identity, gender identity, sexual orientation, and social sexual identity. Although the authors categorise each component of sexual identity, they neglected to explore each aspect of sexual identity in more depth.

Therapy and recovery from child sexual abuse

Four Papers were found that focused on recovery from male CSA through various processes, including accessing therapy, making meaning from an abuse experience, relationships and healthcare (Grossman et al., 2006; Kia-Keating et al., 2010; Hovey et al, 2011; Easton et al., 2015).

Grossman et al. (2006) specified that making sense of an abuse experience is vital in the recovery process and that resilient survivors of CSA are able to make meaning of their past abuse experience. With this in mind, they conducted a study on 16 'resilient' male survivors of CSA. Data was collected through in-depth semi-structured interviews that focused on family history, past and current functioning, abuse experiences, a self-assessment of their strengths and vulnerabilities, their engagement and experiences with psychotherapy and their perceptions of their own resilience. The interview transcripts were then analysed using content analysis, to identify themes around 'meaning making'. Overall, the interviews were coded for 40 variables, which included issues around masculinity and self-care. It can be argued that the use of the term '*variables'* is not in keeping with qualitative research. Indeed, Lareau (2012) maintains that implementing quantitative terms, such as variables, in qualitative research imposes unnecessary narrowness and limitations on qualitative work. Lareau (2012) advocates that qualitative researchers should focus on concepts and themes in the data, rather than having variables. For the purpose of their study, Grossman et al. (2006), only presented findings around meaning making and therapy. Three themes emerged from the analysis, representing styles of meaning making: *meaning making in actions, using cognitive strategies,* and *engaging in spirituality.*

The first theme identified in Grossman's et al.'s (2006) study, meaning making through action, was accomplished through altruistic activities. The majority of the men in the study defined themselves as committed to helping others; specifically, helping those that they perceived as vulnerable. It transpired that the need to help others mainly

developed in childhood and often continued into adulthood, leading a number of participants to enter the helping professions, including occupations within the mental health sector (Grossman, et al., 2006). Furthermore, some of the men made a direct connection between their abuse experience and the need to help others which could be considered an example of sublimation. Sublimation is a coping strategy identified in Freudian theory as a mature defence mechanism, whereby underlying desires are expressed in a socially acceptable way (Batemen & Holmes, 2003).

Grossman et al. (2006) also established that a fundamental aspect of meaning making involved building a cognitive framework to understand the abuse experience. A salient theme to emerge from the coded *meaning making* extracts indicated that the men attempted to find ways to understand the psychology and actions of the perpetrator. Attempting to understand the motivation of the perpetrator had the potential to reduce self-blame and was often acquired through psychotherapy. Significantly, the study revealed that all 16 participants blamed themselves for the abuse when they were children. Many of the participants stressed that reducing feelings of self-blame had required years of therapy and a number of men that had entered into trauma therapy stated that it was particularly helpful when therapists challenged their feelings of blame (Grossman et al., 2016). Another cognitive strategy adopted by the participants was: *understanding the self,* which related to how the men interpreted the abuse based on their own characteristics and behaviour (Grossman et al., 2016).

In relation to the final theme of engaging in spirituality Grossman et al. (2006) reported that a small minority of the participants turned to traditional religion. Several of the men developed their spirituality through involvement with Alcoholics Anonymous and various other support programmes. Overall, each participant employed more than one of the above meaning making strategies in order to make sense of their abuse experience. However, a commitment to helping others was a universal aspect of meaning and sense making experienced by the participants, and ultimately played a major role in building their resilience.

Grossman et al. (2006) noted that there were distinct differences in the types of meaning making that participants adopted based on a participants' ethnicity. Understanding a perpetrators' psychology was a cognitive strategy mainly discussed

by the Caucasian participants in the sample. However, when analysing this issue in more depth, the authors noted that understanding the characteristics and actions of the perpetrator is a skill often taught in trauma-focused psychotherapy in order to decrease negative feelings towards the abuser. Furthermore, it transpired that the non-Caucasian participants had minimal exposure to trauma therapy and had predominantly accessed generic counselling or the *12-step* programme, the latter often used by Alcoholics Anonymous. Overall, 11 of the participants in the study had accessed trauma therapy and the five that had not, were all non-Caucasian. Grossman et al. (2006) proposed that the African-American and Latino participants were considerably less likely to access adequate mental health treatment, due to the stigmatisation of therapy and mental illness in certain communities and cultures. Further, they stated that Latino and African Americans possess more rigid views around masculine norms than Caucasian men in American culture.

As noted, Grossman et al. (2006) selected participants for their study on meaning making was based on the men being 'resilient'. Nevertheless, their screening process for what is deemed to exemplify resiliency appears unsubstantiated, as their interpretation of resiliency was a man that has never been sexually abusive to anyone and was functioning well in at least one area of life; for example, they were employed or had at least one stable relationship. Therefore, the characteristics of a male survivor that they construe as being resilient are prejudiced in nature, as it is estimated only around one in five sexually abused boys go on to sexually abuse others (Lisak, 1996).

Easton et al. (2015) examined '*turning points'* which they equated to resiliency factors promoting positive changes in the health trajectories and healing process of adult males recovering from CSA. The study was a secondary analysis of qualitative data collected during a quantitative study using the 2010 Health and Well-Being Survey (Easton, 2014). It involved a purposive sample of men sexually abused before the age of 18 years, recruited from three survivor organisations in the United States of America (USA). The 2010 Health and Wellbeing Survey consisted of 137 items and was completed by a total of 487 men. However, for the purpose of this study, Easton et al. (2015) focused on collecting data from the 250 men that answered yes to the question regarding whether they had experienced a '*turning point'* where they decide to *'commit to healing and improving their health'* (Easton et al., 2015: 155). The men were then

asked to elaborate on their perceptions of the turning points, giving in-depth descriptions, and the data was analysed using content analysis. Content analysis was selected as it was thought to be the most appropriate method when an area of research is lacking in extensive literature and theories. However, regardless of specifying the use of content analysis they talk of the analytical process identifying seven themes and 19 subthemes. There were three distinguishing themes based on the concept of '*turning points in the healing process of CSA*: *influential relationship*s, *insights and new meanings*, and *action-orientated communication'* (Easton et al., 2015: 157).

Actively acknowledging the sexual abuse was termed a '*cognitive realisation',* and this often occurred in the context of therapy. Therefore, addressing the abuse experience, re-examining, and naming the abuse in therapy helped to recover suppressed abuse memories. For the participants that had full recollection of their childhood experiences, a turning point occurred when they came to the realisation that it was abuse, as some had not previously been aware that their early sexual experience had constituted abuse. Furthermore, for some of the men that struggled with profound guilt and self-blame, they described how the recovery process was initiated by the acknowledgment that they were faultless and not to blame for the abuse. Another important aspect of cognitive realisation was when the men gained an understanding of the effects of sexual abuse. Numerous men in the study reported that they struggled with their overall functioning due to physical, mental, and psychosocial problems, yet they had not considered that these issues might have been related to their sexual abuse experience (Easton et al., 2015).

The most recurring turning point that paved the way for the survivor's recovery was accessing professional therapeutic support, including counselling and group therapy. As well as the act of initially seeking help and accessing support, an increasing number of men described the turning point to have occurred within the therapeutic environment. As one survivor described '*the process of opening up and feeling the pain and having someone witness it, and the stories connected with that pain, were vital to healing'* (Easton et al., 2015:157). Another major turning point experienced by many of the participants was marital or relationship difficulties, sometimes occurring as a result of the men's emotional, behavioural or substance misuse problems. Some

of the men in the study experienced a turning point when faced with the breakdown of a significant relationship, while others described how the end of an important relationship proved to be the catalyst in the recovery process. That is not to say that positive relationships cannot be a factor in the turning points towards healing. An equal number of participants maintained that relationships with their spouse, friend, or child were 'transformative, uplifting and ultimately healing' (Easton et al., 2015: 159).

As the results of Easton's et al.'s (2015) study were derived from a secondary qualitative analysis of data collected from one item of an anonymised online survey, the study did not allow for any follow up questions or clarification. Thus, a more in-depth method of data collection, such as narrative interviewing could have potentially produced a richer understanding of the experiences of male survivors of CSA and their turning points towards healing and change. However, it could be argued that questionnaires allow for greater anonymity, which could potentially encourage participants to disclose more than a face-to-face interview. On the other hand, the researchers do not specify how anonymity is maintained and if any personal information, such as email addresses, are collected during the study.

A qualitative study by Kia-Keating et al. (2010) of 16 adult male survivors investigated the relational challenges and recovery processes, using a grounded theory approach. The early and ongoing relational challenges experienced by the participants were balanced with positive relational experiences the men felt were connected to their growth, healing, and recovery. These relationships developed through a variety of contexts that included safe relationships with; children, pets, adults or the shared experiences of others. In particular, participants talked about helping and relating to others that had experienced adversities, mirroring the findings of Grossman's et al.'s (2006) study. Furthermore, other recovery processes were associated with their own personal development and learning to deal with issues around anger, boundaries, trust, and intimacy. When asked about their relational challenges as children, the men described how they experienced a sense of isolation, an inability to connect with caregivers, and a lack of emotional support from others, with the majority of the men reporting they had no one to approach for support around their abuse experience. Although the participants reported that they did not feel as isolated and emotionally disconnected in adulthood, they identified barriers that hindered their ability to develop

relationships and to be emotionally expressive in intimate situations. An essential aspect of maintaining close relationships with friends, family, and intimate partners was found to be the management of interpersonal boundaries. This encompassed: respecting other people's emotional and physical space and maintaining their own boundaries by preventing others from imposing on their space. The participants maintained that they achieved enhanced skills and knowledge of maintaining boundaries and keeping safe through interventions in therapy. Kia-Keating et al. (2010) indicated the men that had established their personal boundaries in a therapeutic context were more likely to have a clear and articulate concept of what boundaries meant. Similar to the experiences of the men in Alaggia and Millington's (2008) study, most of the participants were raised in family environments where anger was a common form of emotional expression. As well as boundary and anger issues, learning to trust others was an overpowering struggle. For many of the participants, counselling or interactions with health care professionals built the foundations for their first experience of learning to trust others (Kia-Keating et al. 2010).

The research conducted by Kia-Keating et al. (2010) helps to elucidate how the men in their study navigated their way through their relational challenges such as intimacy problems, boundary issues, alienation and anger, in order to maintain and participate in supportive relationships over time. However, the study is limited due to the sampling procedure. Namely, the participants that were included in the study were selected on the basis of '*functioning well'* despite a history of CSA. It could therefore be argued that the research fails to explore the relational struggles and recovery processes that survivors who do not function as well may experience. In their discussion, the authors state that trauma focused therapy was clearly a helpful intervention in enabling the men to develop relational skills. However, the sample was recruited exclusively through trauma focused therapists and therefore biased, and it is not made clear as to whether the participants had received any other form of support or therapeutic intervention that was not trauma focused.

As previously stated in Alaggia and Millington's (2008) study, communication with counsellors and health care professionals is imperative in fostering trust of others within a male survivor. Expanding on this concept, Hovey at al. (2011) conducted research with male survivors to explore practical ways psychotherapists can support

physical healthcare experiences for males who have experienced CSA. The authors lay emphasis on the issue of psychotherapists having a duty to support clients in maintaining and improving their overall health and wellbeing. This is especially pertinent as there is evidence to suggest that there is a relationship between a history of childhood adversities, such as CSA, and physical health problems, health risk behaviours and disease in adults (Felitti et al. 1998). Hovey et al. (2011) also stressed that it is essential that psychotherapists understand the impact that CSA can have on physical health and how it can affect the client's ability to seek and access healthcare services.

Hovey et al.'s (2011) study, reporting specifically on male survivors, was the second phase of a multidisciplinary study that aimed to unite CSA survivors with healthcare professionals from a range of disciplines in order to acquire practice knowledge and improve the healthcare experiences of CSA survivors. The first phase of the original study focused on female survivors' experiences of physical therapy. The researchers then expanded on this by focusing on male survivors and a more varied range of healthcare practitioners, including: nurses, physicians, dentists, and complimentary therapy practitioners, none of whom had received training in mental health or psychotherapy.

Grounded theory and action research methods were used to gain insight into the experiences of the 49 men that were interviewed. In addition to face-to-face interviews, nine men participated in a focus group, one of these men had also been interviewed on an individual basis, the other eight men only participated in the group setting. The men were recruited through advertisements placed in counselling agencies and with individuals that provided psychotherapy and support services across Canada. The interviews consisted of open-ended questions that encouraged the participants to articulate their positive and negative experiences within a healthcare setting and they were also asked to consider what they felt would improve male CSA survivors' experiences of healthcare. In terms of the action research methods that were used within the study, the themes that were extracted from the analysed transcripts of the interviews were used to stimulate a group discussion to refine a set of principles to inform sensitive practice for healthcare practitioners. There were three action research groups: one consisting of survivors and nurses, the other of survivors and physicians,

and a final group combined survivors and nurse practitioners that participated from a different geographical area (Hovey et al., 2011).

There were a number of issues influencing healthcare interactions for CSA survivors that were amalgamated from the first phase of Hovey's et al.'s (2011) study that included both male and female survivors. These were listed as "*distrust of authority figures, anxiety about being abused by a healthcare professional, discomfort with practitioners who are the same gender as the person that abused them, experiencing of triggers and dissociation during healthcare procedures, ambivalence about their bodies, feeling unworthy of care, and the experience of physical pain"* (Hovey et al., 2011: 41). However, there were a number of issues identified that were unique to male survivors compared with women. Firstly, the male participants conveyed their concerns about being perceived as a weak or vulnerable 'victim' or not being believed if they disclosed CSA to a healthcare practitioner. Another major concern that the male participants expressed was the fear if a healthcare provider was aware that they had experienced CSA then they would then be considered as a potential perpetrator of sexual abuse towards children. This fear was embedded in cultural and societal perceptions that sexually abused men go on to abuse children (Hovey et al., 2011) and was later echoed in Easton's et al. (2014) and Gagnier and Collin-Vezina's (2016) studies around the disclosure experiences of male CSA survivors. Despite this, research evidence regarding the development of sexually abusive behaviour found that only a minority of male CSA survivors goes on to sexual abuse children (Salter et al., 2003).

When considering the debate around whether routine enquiry of CSA should be mandatory for mental health professionals, Hovey et al. (2011) support the view of Alaggia and Millington (2008) that men should be asked if they were abused when presenting with issues consistent with an abuse history. This view was based on the responses gathered from the participants, as some were unwavering in their opinion that healthcare workers should ask about an abuse history. Hovey et al. (2011) maintain that enquiry about CSA is not harmful, and when offered sensitively can result in improved health.

A further issue related to healthcare interactions was the gender of the practitioner being the same gender as their abuser (Hovey et al., 2011). Although not exclusively experienced by men, the discomfort around gender that was distinctive to the study on males was associated with homophobia. In brief, a number of participants abused by males feared that they would be presumed to be homosexual. In addition, some participants displayed negative reactions towards healthcare workers that they perceived to be homosexual. For those participants abused by females, a number professed to having experienced profound distress when being touched by, or cared for, by a female practitioner (Hovey et al., 2011).

The authors advise a number of recommendations as to how a psychotherapist can support a male survivor in accessing healthcare. They suggest that therapists enquire about the client's awareness of the relationship between CSA and physical health. Also, they stress that a therapist should evaluate the difficulties male survivors encounter with certain healthcare procedures and ascertain whether because of this a client avoids healthcare completely, in order to explore the level of self-care that a male CSA survivor undertakes. Another recommendation Hovey et al. (2011) advocate is that psychotherapists develop a plan around how to cope with abuse triggers that may arise from healthcare appointments. It emerged that some men experienced a range of emotional responses, such as flashbacks and dissociative reactions when being examined, particularly when they were touched in certain areas of the body. This could be particularly pertinent for those men experiencing symptoms of what could be prostate cancer. They also recommended that counsellors practice grounding techniques with clients in readiness for medical appointments. Similar to that of the therapeutic relationship in counselling, Hovey et al. (2011) emphasised the importance of a male feeling safe within a healthcare setting in order for trust between the patient and healthcare worker to develop. Based on the participants' responses, they advised that a counsellor should encourage a male survivor to consider what they would need to feel safe when encountering healthcare practitioners. From the results of the research Hovey et al. (2011) developed a framework for sensitive practice based on the healthcare needs articulated by the men in their study. The principles outlined included: '*respect, taking time, rapport, sharing information, sharing control, respecting boundaries, fostering mutual learning, understanding nonlinear healing,*

and *demonstrating an awareness and knowledge of interpersonal violence'* (Hovey et al. 2011:43).

Although the report by Hovey et al. (2011) suggests practical ways psychotherapy can support a male survivor, the framework and principles of sensitive practice towards male CSA survivors are clearly aimed at physical healthcare practitioners. They concluded that a psychotherapist should communicate and work alongside health professionals as a way of enriching the survivors' healthcare experiences. This multidisciplinary approach in working with a CSA survivor perhaps has some value in benefiting a client's healthcare needs. However, it may not be practical in certain settings, specifically, when CSA survivors are accessing support within the non-statutory sector.

Service user perspectives

In terms of research that focuses specifically on the narratives and experiences of male survivors who have accessed support in relation to CSA, three studies were identified (Draucker & Petrovic, 1997; Nelson, 2009; Rapsey et al., 2020). The research by Nelson (2009) is what can be termed 'grey literature' (Ridley, 2013), as the report was commissioned by an organisation for the purpose of implementing changes to government policy in Scotland. Although not academic peer reviewed research, it has been included in this review to demonstrate that there is research available that explores the experiences of therapy from the perspectives of male survivors.

Draucker and Petrovic (1997) conducted in-depth interviews with 19 male survivors, using open ended question. Participants were asked about their views of therapy, their perspectives of the helpful characteristics of the counsellor, and their healing experiences. Content analysis was used to interpret their responses and although they were not directly asked about negative experiences, the majority of participants expressed specific negative encounters they had experienced with their therapist. When asked what advice they would give to therapists working with male survivors of CSA, the participants described six basic qualities they believed were beneficial in

therapeutic work with male survivors. These counsellor traits were defined as: *'educating clients about male sexual abuse issues', 'informing clients about the therapeutic process and what they can expect from counselling', 'being 'connected' to the client and able to relate to them in a professional manner', 'respecting the client's process and their innate capacity for healing', 'going the distance with a client' and 'letting the client go at the right time'* (Draucker & Petrovic, 1997:147).

As well as identifying positive attributes of the therapist, the authors also depicted incidents of negative experiences that men had received with a counsellor. The experiences that 12 of the participants relayed included: the therapist making an inaccurate interpretation of sexual transference, counsellors were reluctant to allow a client to move on when therapy was coming to an end, female therapists who created a negative atmosphere by expressing a noticeable gender bias, and overly directive therapists who coerced clients into going over their entire abuse histories (Draucker & Petrovic, 1997). Although participants were only asked about their positive experiences of therapy, negative therapy experiences clearly emerged during the interview process, but the authors did not appear to explore this issue in more depth.

The study by Drauker and Petrovic (1997) goes some way to articulate what male survivors perceived as positive therapist characteristics and six overarching themes as outlined above were identified. However, no attempt was made to conceptualise themes based on the critical negative experiences. Rather, the negative therapy incidents, that were common amongst the men, were grouped together and referred to as being a diverse range of negative encounters. Therefore, the negative experiences relating to counsellors were merely included in the findings to provide examples of detrimental therapy encounters that were experienced by the male survivors participating in the study. Overall, 22 incidents of negative experiences were disclosed during the study and these clearly had an impact on the men, as the experiences were voiced despite not being asked about them during the interview. Therefore, it could be argued that the research is overly focused on positive experiences and does not provide the authentic voice of the men who participated.

Similar to the above, *survivor informed* research, Nelson (2009) conducted a study, commissioned by *Health in Mind,* based in Scotland, in order to disseminate a report

with recommendations for policy and practice. Life-history interviewing was carried out on a purposive sample of 24 men who had been sexually abused before the age of 16. The rationale for utilising the life history method was to reduce the risk of the researcher making pre-assumptions about the survivor's experiences or demonstrating personal bias regarding interventions they believed would have been most appropriate. Furthermore, it allowed the participants to reflect on what they considered were the most significant events throughout their life course, how the abuse impacted on them at different stages of their lives, and what particular support or intervention they perceived was helpful or would have been helpful if it had been available at that time.

Participants were asked to complete a 'life grid' in the first interview to facilitate recall and allow data collection to become more focused. The life grid documented times and dates of abuse along with specific life experiences and transitions, such as education, work, and relationships. Many of the participants conveyed frustration that the majority of support centres for victims of rape were female only, and they had often not realised that certain services were available to men as well as women. As many of the men had been unable to locate support services for a considerable time, they felt that mental health, medical and social work professionals needed to be more aware about where sexual abuse services available to men were located. The participants in the study also stressed that more male only support groups were needed. It was also found that young men in particular, who were depressed and unwell, were in urgent need of basic living skills and practical support (Nelson, 2009).

A New Zealand based study conducted by Rapsey et al. (2020) aimed to address the research gap on male survivors' experiences of treatment. Their research explored the barriers, benefits, and processes experienced by nine male participants who had engaged in *'formal therapy*.' Despite, the use of the term formal therapy, the study consisted of men who had accessed a peer support group facilitated by a male survivor of CSA, as opposed to one-to-one therapy with a qualified counsellor/therapist. Furthermore, the participants recruited were all from the same established peer support group of nine men that met on a weekly basis. It could be suggested that interviewing men from the same support group does not allow for a wide range of experiences of men who have participated in groups with varying facilitators and group

members. However, the study did explore the men's past experiences of engaging in support with professionals. All the men reported engagement with support for at least one year with a professional and most of the participants had engaged in support for five to ten years before participating in the research interview.

The study by Rapsey et al. (2020) adopted semi structured interviews to assess the men's treatment experiences. Interpretative phenomenological analysis (IPA) was utilised to analyse the data. Three superordinate themes were elicited: *'motivation to engage in treatment,' 'developing a connection with treatment providers,'* and *'changing thinking about the abuse'* (Rapsey et al., 2020: 2039). Common effects of CSA reported by the men were anxiety, anger issues, substance misuse, suicidality, hypervigilance, sleep problems, and sex and relationship difficulties. Furthermore, the majority of the nine men articulated feelings of guilt, shame, low self-esteem and low self-acceptance. Eight of the nine participants had accessed support specifically for their experience of CSA, and seven of the men had stipulated that they benefited from treatment. Only three of the participants were still actively receiving support from professionals at the point they participated in the research.

The first theme of *'motivation to engage in treatment'* related to the men's decisions to get help and how they encountered barriers in accessing support; including their experience of stigma, system processes, and the cost of treatment. Four of the men had serious concerns around being judged or stigmatised for seeking support. Despite the barriers faced, most of the men in their study described strong motivation to access support such as wanting to '*know myself'* and be *'fully present'* (Rapsey et al., 2020: 2040). In addition, the men described how they wanted to foster their ability to be more open with others and change their behaviours. In contrast to the eight men who described their determination being around improving their self-awareness and changing their behaviour, one of the participants in their study described how he engaged in therapy for his partner. As a result, this particular participant did not fully engage in treatment or relay any benefits of from his support.

The second theme in Rapsey's et al. (2020) study around *'developing a connection with their treatment provider'* encompassed the significance of the trust and connection that evolved in the therapeutic relationship. One of the participants, who did not

perceive any benefits from treatment, found that the lack of connection with professionals in the past acted as a barrier in accessing any further support for CSA. Negative encounters with professionals were found to be common for all nine participants in the study. Being able to talk about their experiences was an important aspect of the treatment and the concerns around the reactions of professionals were found to prevent honest disclosure of CSA experiences. Despite the challenges in developing connections with professionals, most of the participants could name at least one professional person whom they had experienced a connection with and felt able to fully discuss the abuse experience.

The final theme in the research by Rapsey et al. (2020) was *'changing thinking about the abuse.'* Of the seven men who reported having benefited from treatment, the support helped them to change their perspective of the sexual abuse experience. Specifically, many of the men felt responsible for their experience of CSA as children and therapy helped them to recognise and understand that what they had experienced was sexually abusive. Moreover, the participants who identified positive aspects of treatment described how they were able to change their view of themselves and gain insight of their feelings and behaviours that manifested after the abuse. It was noteworthy that it was common for group members to experience heightened symptoms, associated with the abuse, immediately following therapy and symptoms were often exacerbated by therapy.

Overall, the study by Rapsey et al. (2020) highlighted that treatment for CSA in males can be helpful and they identified some of the barriers that men encounter when trying to access support. As noted, all participants were recruited from a peer support group which suggests that the men were willing to share their experiences and were able to disclose their experiences in a group context. As a result, it could be assumed that the men were more likely to have had positive experiences with support. Indeed, the researchers acknowledge that further research with men who do not belong to a survivor's peer support group might offer further insight into the barriers and experiences of support. The fact that three of the men recruited were still engaged in therapy, also suggests that the therapy was having some benefit to the men interviewed. Finally, the study was extremely broad in its definition of '*treatment'* and the participants were asked to relay experiences of talking to a professional person

about their CSA experiences. Professionals could include psychologists, psychiatrists, counsellors, and psychotherapists. As these professions are wide ranging, further research specifically focusing on experiences of counselling could help the counselling community to better understand how their services can be adapted to accommodate the needs of male survivors.

Empirical quantitative studies

The following section will review quantitative research on male CSA. Seven quantitative studies met the inclusion criteria for this review (Steever et al., 2001; Romano & De Luca, 2006; O'Leary, 2009; Easton 2013; Easton et al., 2013a; Easton et al., 2013b; Ressel et al., 2018).

With regards to research studies focusing specifically on male CSA and disclosure, it was previously noted that three qualitative studies were identified (Sorsoli et al., 2008; Easton et al., 2014; Gagnier & Collin-Vezina, 2016). One quantitative study was also obtained (Easton, 2013) that addressed the disclosure experiences of a purposeful sample of 487 men, recruited from three survivor organisations in the USA. The participants completed a 137-item cross sectional survey that measured a comprehensive range of characteristics related to disclosure. As well as describing the processes of disclosure using a life span approach, the researcher aimed to identify any differences based on age and relationship to the abuser. In addition, Easton (2013) sought to explore the correlations between the specific attributes of disclosure and current mental health.

The results of the study by Easton (2013) exploring disclosure history were analysed using univariate analysis and indicated that the majority of participants (97%) had disclosed CSA to another person at some point in their lifetime. Of the participants that had disclosed CSA, only 26% reported the abuse for the first time in childhood. Around half of the participants' first experience of disclosure was with a partner/spouse, and 20% initially disclosed CSA to a mental health professional in adulthood. In general, 86% of men disclosed to a partner or spouse at some point in the life course. Only 15% of the participants reported the sexual abuse to the authorities, which concurs with the views of Alaggia & Millington (2008) and Perez-Fuentes et al. (2013) who

assert that male CSA is significantly under reported. It was also established that the average length of time from the CSA experience to disclosure was 21 years, with the mean age of the first disclosure being 32 years. In considering other complex aspects of disclosure, Easton (2013) sought to determine how many of the participants had experienced the opportunity to have an in-depth discussion about the sexual abuse. Approximately 77% had communicated their CSA experience in-depth and, on average it took around 28 years for the participants to have an intensive discussion about their abuse experience with another person (Easton, 2013).

Bivariate analysis was employed, to obtain information on the relationship between each disclosure variable and current mental health. The keys findings to emerge was that a number of the variables relating to response to disclosure, including: *response to fist telling, maternal support* and *overall response to telling in lifetime*, were negatively related to mental distress. Furthermore, the number of years a survivor waited before disclosing the abuse was found to be positively related to mental distress. Therefore, where there was a positive response to first disclosure and when there was maternal support available, the less likely a man was to experience mental health problems. The results indicate that the longer the time before the disclosure is made, the more likely the person is to experience mental health problems. Additionally, participants that discussed the abuse with their spouse had less mental distress than individuals who did not. Fundamentally, 42% of participants reported that therapists were their most supportive listener, and the helpfulness of a supportive listener was negatively correlated with mental distress. These results signify the vital role of the mental health professional in the recovery process for male CSA survivors. Easton (2013) promotes the idea that other professional fields, such as social work, should be encouraged to improve training and education around male survivors of CSA as a way of increasing the practitioner's skills when working with this group of people.

Recruiting participants from survivor organisations has the potential to limit the generalisability of a study such as Easton's (2013), compared with a representative sample. This is pertinent when considering the exploration of disclosure, as the likelihood of someone having disclosed CSA when they are support seeking will clearly be much greater than someone who has never pursued professional support. In addition, it was noted that 82% of participants in Easton's (2013) study were survivors

of abuse by clergy, which will likely produce sample bias, as the disclosure experiences of an individual abused by a member of the clergy will potentially be different than those abused by strangers, family members or others in a position of power. However, it is well established that recruiting male survivors of CSA to take part in research studies can be extremely difficult and, based on the number of participants that took part in the study, the sampling technique used by Easton (2013) was evidently useful in accessing such a hard to reach, stigmatised and under-researched population. Easton (2013) acknowledges that the use of retrospective self-report data poses as a limitation, due to memory distortions reducing the accuracy of participant responses. However, due to the nature of sexual abuse research and issues around confidentiality, it was not possible to extend data collection through other sources, such as therapists or spouses.

In another research paper reporting on a different aspect of the study by Easton (2013), Easton et al. (2013a) applied the same sampling technique as above to analyse the survey data of the 487 men, with the focus being to explore the relationship between abuse severity, mental health, masculine norms, and recent suicide attempts. In order to determine the links between suicide attempts and CSA, the dependent variable '*suicide attempts'* was measured using one item from the General Mental Health Distress Scale (Dennis et al., 2007) focusing on internal distress that had been experienced by the participants over the past 12 months. The item related to suicide attempts asked the participants if they had attempted suicide over the past 12 months. Further, three variables (frequency of CSA, use of force during CSA, and physical abuse) measured the characteristics of the abuse experience. Mental health variables were also measured using the nine-item Depressive Symptom Scale (Dennis et al., 2007). To determine the participants' conformity to masculine norms, Easton et al. (2013a) utilised a 22-item measure known as The Conformity to Masculine Norms Inventory developed by Mahalik et al. (2003). The results were analysed using logistic regression modelling and Easton et al. (2013a) found that five of the nine variables included in the model increased the risk of suicide attempts. The five variables positively related to suicide attempts in the last 12 months were: frequency of the sexual abuse, use of force during sexual abuse, high conformity to masculine norms, level of depressive symptoms and suicidal ideation. Essentially, men that were more frequently abused as children and men that were subjected to force during CSA were

more likely to have attempted suicide in the past year. Based on the results of the study, Easton et al. (2013a) recommend that mental health practitioners assess for the frequency with which the abuse occurred, and whether force was used during the sexual abuse experience, in order to carry out suicide assessment and prevention. As it was also found that men who presented with a higher conformity to masculine norms were more likely to attempt suicide, Easton et al. (2013a) suggest that public health initiatives should focus on the links between male CSA and suicide. In addition, they also highlighted the need for more public community awareness regarding the prevalence of CSA in boys and its influence on mental health and suicidality in male adult survivors. As previously stated Easton et al.'s (2013a) study has methodological weaknesses, in that the sample is comprised of support seeking men. This indicates that the men are more likely to discuss the topic of suicide more openly than non-support seeking men, which limits the generalisability of the results. In addition, the data was also collected through retrospective self-reports. When considering that certain aspects of the data, such as use of force and frequency of abuse may have been experienced many decades ago, it is likely that some men may experience memory distortions or experience difficulty in recollecting abuse memories. A major limitation of the study on suicide attempts is the measures that were used to determine suicidal ideation and recent suicide attempts. Although there are standardised measures that can be used to assess suicide, for example the Scale for Suicidal Ideation (Beck et al., 1988), Easton et al. (2013a) obtained the data on suicide using a single item from the General Mental Health Distress Scale (Dennis et al., 2007). The Scale for Suicidal Ideation is a 19-item measure and was designed to quantify and assess suicidal ideation. What is more, the scale has been found to have high internal consistency and correlations with clinical ratings of suicidal risk (Beck et al., 1979). As the research aimed to identify the links between CSA and suicide, the use of a measure that could attain in-depth data on suicide may have been more appropriate for this particular study.

Another study by Easton et al. (2013b) utilising the same sampling strategy as the above studies on disclosure and suicide attempts (Easton, 2013; Easton et al, 2013a), examined the factors related to posttraumatic growth amongst a non-clinical sample of male CSA survivors (Easton et al., 2013b). As with the above disclosure study, the cross-sectional survey design was used on the same purposive sample of 487 male

survivors, predominantly abused by members of the clergy. Although it was noted that a sample consisting mainly of individuals abused by clergy may generate biased data, Easton et al. (2013b) argue that abuse perpetrated by clergy may be considered more psychologically harmful and traumatic, as it has the potential to impact on an individuals' spiritual beliefs, which are often considered to be a source of strength and support. To address the research inquiry, the survey implemented measures that aimed to elicit data on posttraumatic growth and positive change. The measures included: *The Posttraumatic Growth Inventory* (PTGI) (Tedeschi & Calhoum, 1996); *Understanding of the Sexual Abuse Experience* (Easton et. 2013b)*, Perceived Disclosure Support* (Easton et. 2013b)*, The Conformity to Masculine Norms Inventory* (CMNI) (Mahalik et al., 2003), *Turning Point, and Time Since the Abuse* and *Abuse by a Clergy Member* (Easton et. 2013b).

The study by Easton et al. (2013b) was analysed using multiple linear regression and the results indicated that most of the participants had experienced positive changes in aspects of their lives such as interpersonal relationships and personal strength. Having an understanding of the abuse experience, placing responsibility of the abuse onto the perpetrator, experiencing a turning point and understanding the links between how CSA impacted on their emotions and behaviour was associated with posttraumatic growth. Additionally, ascribing to masculine norms was found to inhibit growth. Easton et al. (2013b) suggested that men abused by clergy would experience less growth than men abused by non-clergy members, due to previous research that found clergy perpetrated abuse had a destructive impact on a survivors' spirituality; however, the results of Easton et al.'s (2013b) study did not support this hypothesis. Indeed, to assume that men abused by clergy members would experience lower levels of posttraumatic growth, than those abused by other types of perpetrators, is making the presumption that clergy abuse is more psychologically damaging and violating. Furthermore, the sample selected by Easton et al. (2013b) consisted predominantly of men abused by clergy, as one of the three organisations where recruitment took place was a survivors' network for people abused by priests and 61.7% of the sample reported clergy abuse. Therefore, the author's comparisons to clergy and non-clergy perpetrated abuse appear to be tendentious.

Another limitation lies in the use of non-standardised measures (*Perceived Support Following Disclosure, Understanding of the Sexual Abuse Experience & Turning Point*), as it could be argued that the measures developed specifically for the survey lack validity. Furthermore, the authors did not indicate whether the measures had previously been tested or piloted. Although there are some issues surrounding the sampling procedure, the results indicate how posttraumatic growth can be achieved with male survivors and these findings can be applied to practice. In particular, therapeutic interventions that challenge self-blame and support a survivor in shifting blame onto the perpetrator have been reported as helpful (Easton et al., 2013b). Furthermore, helping a male survivor to explore and understand how certain emotions and behaviours, such as anger and alcohol misuse, may be connected with their earlier sexual abuse experience can promote healing and growth (Easton et al., 2013b).

Recruiting participants from CSA survivor organisations has been found to be a potential limitation in the research reviewed thus far. Steever et al. (2001) attempted to eliminate sampling bias by recruiting three groups of men to compare their perceptions of their early sexual experiences. The researchers attempted to overcome the major methodological issues that they uncovered from previous sexual abuse literature by firstly utilising a non-clinical sample and a control group. Secondly, they addressed the problem of how sexual abuse is defined and conceptualised by the participants, by splitting the sample into groups depending on how they defined their sexual abuse experience. The first group consisted of men who reported no history of childhood sexual abuse (‘Group No CSA’) or they reported consensual sexual experiences before adulthood with a peer that was close in age. The second group of men, known as ‘Group Early Sexual Experiences’, met the criteria for research definitions of CSA, as they reported a history of sexual experiences that were forceful or coercive in nature, involving someone at least five years older or involving a family member. However, the men in this particular sample did not identify themselves as sexual abuse survivors. The third group consisted of men who reported a history of early sexual experiences that they defined as CSA (‘Group CSA’). The researchers recruited 20 participants to each of the three groups and all participants were undergraduate students attending the same university. Steever et al. (2001) implemented this sampling strategy based on the suggestions of Widom and Morris

(1997) who proposed that the most effective method in the assessment of sexual abuse is to firstly investigate the participants' early sexual experiences in detail, then to ask the participants if they perceive these experiences to be CSA. A number of measures were used including: *Symptom Checklist 90-R* (DeRogatis, 1983; Cyr et al., 1985)*, Aggression Questionnaire* (Buss & Perry, 1992)*, Michigan Alcoholism Screening Test* (Selzer, 1971)*, Sexual History Interview* (Wyatt et al., 1992) and *Therapy History Questionnaire* (Steever et al., 2001). Although Steever et al. (2001) used validated measures to conduct the research, they have potentially limited the study by focusing specifically on the assessment of aggression and alcoholism, as their hypothesis was to determine if participants in the CSA group report greater levels of psychological distress. They also sought to establish whether Group CSA were more likely to have received treatment for mental health problems.

Data was collected through self-report measures and each participant also took part in a semi-structured interview. The first process of data analysis was to conduct an Analysis of Variance (ANOVA) to analyse the difference amongst the groups. The ANOVA between the three groups revealed that Group CSA reported significantly more distress that Group No CSA and Group Early Sexual Experiences. Steever et al. (2001) found that the mean scores from the Alcoholism screening test were not significantly different between the three groups. However, they did note that the scores for alcoholism in the Group CSA and Group Early Sexual Experiences were above the cut off point for the 'alcoholic' category. Despite the suggestion that these two groups have a clinical score for alcoholism, Steever et al. (2001) seemed to dismiss the significance of this finding by suggesting that this may be linked to the common 'use and abuse' of alcohol on college campuses. Nevertheless, the results indicated Group CSA and Group Early Sexual Experiences displayed similar scores for alcoholism, which was almost twice as high as the control group that reported no CSA.

In terms of the Aggression Questionnaire, the mean scores between the three groups did not demonstrate any significant differences. The researchers also conducted an analysis of covariance (ANCOVA) with some of the dependent variables. For instance, the researchers used ANCOVA to determine whether the age at which the sexual experience occurred had an impact on which group the participants classified themselves as belonging to. The participants were also asked to give a subjective

rating of the overall impact that the sexual experience had on their lives. Through ANCOVA it was found Group CSA described their experience more negatively than Group No CSA, and the scores for Group early sexual experiences did not differ significantly from Group CSA and Group No CSA; rather, the scores mediated between the other two groups. Chi-square analysis uncovered that the participants in Group CSA were two to six times more likely to have received a mental health intervention than the other two groups. When investigating the percentage of participants that had accessed psychotherapy, the results revealed that 0.5% in Group No CSA, 30% in Group early sexual experiences and 65% in Group CSA had received psychotherapy. Overall, the main presenting issues for seeking therapy were marital problems, depression, PTSD, relationship difficulties and substance misuse (Steever et al., 2001). This is consistent with previous research that found sexually abused men often seek mental health treatment and therapy for other problems that are not necessarily attributed to CSA (Gill & Tutty, 1999). Although 65% of Group CSA had engaged in psychotherapy, only three participants in the group reported that the reason for accessing therapy was specifically due to the sexual abuse (Steever at al., 2001). This could be an important consideration for counselling services and professionals that offer support to men for issues such as depression and relationship problems. It also reinforces the views of Alaggia and Millington (2008) and Hovey et al. (2011) regarding mental health professionals' use of routine enquiry of CSA, as the presenting problems, mentioned above, which led participants to seek therapy are well documented long-term effects of CSA. When assessing suicidal ideation, only one participant in the study indicated that they had attempted suicide and he belonged to Group CSA. Although Easton et al. (2013) found that CSA could be a contributing factor to suicide attempts, Steever et al. (2001) had a considerably smaller sample size of 20 men that reported CSA, as opposed to the 487 men that Easton et al. (2013) surveyed.

Overall, the study by Steever et al. (2001) established that a relationship exists between being subjected to a sexual experience that an individual labels as abusive, psychological distress, and engagement in mental health treatment. What is unclear from the study are the reasons why Group Early Sexual Experiences did not define their experience as sexual abuse when they met the requirements for most research definitions of what constitutes CSA. However, the study highlights the importance of

how sexual abuse is defined in research studies and how defining and labelling CSA for participants can have adverse consequences on research findings. Especially as research on male CSA survivors is notably challenging when it comes to participant recruitment (Sorsoli et al., 2008). Furthermore, how an individual self-defines their early experiences can be crucial in the assessment and treatment of CSA, as what can appear as abusive behaviour to a researcher or mental health professional may not be considered as CSA to the individual. The study by Steever et al. (2001) illustrates this issue, as defining the participants in Group Early Sexual Experiences as having been sexually abused may have been inappropriate. There are a number of limitations within the study to consider. Mainly, the research has a small sample size, consisting of only 20 men who reported CSA. Not only does this limit the number of variables that can be statistically measured, it also limits the generalisability of the study as 20 men self-defining as CSA survivors cannot be considered representative of all male CSA survivors. Another aspect of the sample that restricts the generalisability of the study is the use of university undergraduate students. Despite the arguments posed by Steever et al. (2001) regarding how the recruitment of participants from survivor networks can limit findings and how university students are ideal subjects for retrospective studies due to their young age enhancing the recall of childhood memories, undergraduate students are not representative of the general population.

A study focusing on the factors relating to positive growth, following male CSA, was conducted by O'Leary (2009) and consisted of a primary sample of 147 men who reported that they had been sexually abused as children. The purpose of the study was to determine whether sexually abused men would be more likely to possess higher levels of clinical psychopathology. Particular attention was paid to the coping strategies that the men displayed and their relationship to clinical psychopathology. O'Leary (2009) also sought to establish whether the time lapse since the abuse has an impact on psychological functioning, in order to determine the links between the timing of disclosure and help seeking behaviours. The study also consisted of a secondary data set of a randomised sample of 1,231 men that took part in a community survey for comparative purposes. Both samples completed the 28 item General health Questionnaire (GHQ-28) (Goldberg & Hillier, 1979) and the primary sample was administered the 60 item Coping Style Inventory (COPE) (Carver, et al., 1989) which

has previously been used in research with male and female survivors of CSA (Sigmon et al., 1996). COPE evaluates various aspects of coping processes, such as positive reinterpretation and growth, social support, acceptance, substance misuse and denial. The GHQ-28 that was utilised for the clinical and non-clinical sample is a validated measure, widely used as a psychiatric screening tool in the general population. The main area the GHQ-28 measures how a person has been feeling over the past week, paying close attention to the most recent complaints.

O'Leary (2009) undertook a number of processes in order to analyse the data. Firstly, chi square analysis was conducted to compare the two samples, followed by correlation analysis to determine the coping strategies that were linked to the scores derived for the GHQ-28. The researcher then carried out three logistic regressions to form explanatory models to analyse the variance in the GHQ-28 threshold scores, which in turn were used to formulate classification tables.

Overall, the significant findings to emerge from O'Leary's (2009) study were the distinctive coping styles that were found to be related to both positive and negative outcomes on the GHQ-28. When using coping styles to predict a clinical score on the GHQ-28, the study found that the men adopting the coping strategy 'positive reinterpretation and growth' significantly decreased the probability of obtaining a clinical score on the GHQ-28. In contrast, coping styles that predicted a clinical score included '*behavioural disengagement'* and '*acceptance*.' In terms of applying coping styles to predict PTSD within the sample, the results suggest that those who demonstrated 'positive reinterpretation and growth' and 'use of instrumental support' were increasingly less likely to attain a clinical score for PTSD. Whereas 'acceptance,' 'use of emotional support' and 'behavioural disengagement' represented an increased likelihood of a participant being classified as experiencing PTSD symptoms (O'Leary, 2009). The findings suggest that the use of emotional support as a coping strategy being linked to an increased chance of obtaining a clinical score for PTSD could justifiably be challenged. Primarily, as emotional support in the context of relationships and therapy is well documented as being a healing aspect in the recovery process of CSA. The belief that social support, from those such as friends, family members and the community, can impair the mental health of male survivors of CSA is supported by

Easton et al. (2014), who found that men often feared that they would receive negative social reactions when discussing the abusive experience.

O'Leary (2009) noted that substance misuse was the most common coping strategy adopted by the men in the study as a way of suppressing abuse memories, a finding consistent with Alaggia & Millington (2008) and Easton et al. (2015). The results from the regression analysis indicate that the length of time since the last abusive experience did not impact on current psychological functioning. O'Leary (2009) asserts that the community sample of 1,231 is relatively representative of Australian men. However, the same cannot be said for the clinical sample of sexually abused men that took part in the study. All participants in the primary sample had accessed support in relation to CSA, which is likely to affect the results of the study, as help seeking men are more likely to report psychological problems. When considering that relatively few male survivors access support, the study is unlikely to be representative of all men that have experienced CSA.

A quantitative study by Romano and De Luca (2006) consisted of a substantially smaller sample size of five participants. The aim of the research was to evaluate a treatment programme for sexually abused men. Although there are many long-term effects related to CSA, the treatment was limited to the issues of self-blame, anger and anxiety, which the authors maintain are key problem areas that warrant a structured treatment programme. They also uphold that the three behaviours they decided to focus on are independent of each other, easily measurable, and also meet the criteria for a multiple baseline design. The treatment manual developed by the researchers implemented a cognitive behavioural approach, which encouraged the participants to explore their feelings of anger, anxiety and self-blame, whilst learning strategies to reduce and manage these feelings. Simultaneously, the goal of therapy was also to identify how CSA influenced self-blame, whilst challenging these emotions. A potential limitation of the study lies in the inclusion criteria, as Romano and De Luca (2006) only selected participants that were not experiencing acute PTSD symptoms, alcohol/drug addiction, suffering from a psychotic disorder or a specific phobia. In addition, participants were required to possess a high degree of motivation to change and be stable in most aspects of their lives. This suggests that participants were required to possess high levels of functioning and low levels of emotional distress

before they commenced the treatment programme. The stringent inclusion criteria had the potential to skew the results of an intervention designed to treat sexually abused men, when the participants are presenting with low levels of psychological distress before commencing treatment.

Data was collected through daily self-ratings of abuse related self-blame, anger and anxiety. Before the intervention was delivered, a baseline measure was carried out regarding the three behaviours. The baseline results served as a control before measuring the efficacy of the treatment and drawing comparisons at the end of the intervention. In an attempt to reduce the likelihood of bias and strengthen the internal validity of the experiment, the same therapist treated all five participants. However, the number of sessions varied depending on the needs of each individual, with the average number of treatment sessions being 20. The treatment consisted of a phased approach, whereby the therapy session focused on one of the three emotional behaviours at a time. The individual's self-ratings were used to determine when the next stage of treatment could begin. Each participant had to demonstrate a decrease in levels of a particular behaviour before the next phase of treatment was introduced (Romano & De Luca, 2006). The use of self-report data can be considered unreliable, as it can be assumed that participants may underreport the extent of their psychological problems (Harrison, 1995).

In terms of treatment efficacy, Romano and De Luca (2006) reported that most participants experienced a decrease in feelings of self-blame by the end of the treatment. Although some participants demonstrated lower levels of anger and anxiety, the changes were not as extensive as the decrease in self-blame. The researchers conclude that the overall findings do not support the treatment as being effective in reducing anxiety. However, they maintain that the intervention was particularly helpful in reducing anger and self-blame. Romano and De Luca (2006) assert that some generalisations about treatment effects can be drawn from the research despite the small sample size, as they were able to continuously assess each individual and replicate the design and treatment programme across each of the participants. However, it can be argued that the ability to generalise based on the results obtained from a sample of five participants is an extremely ambitious statement, as five men cannot be representative of all adult males who have

experienced CSA. It appears that the researchers intended to isolate each of the three behaviours by implementing the three-phase approach to therapy, to determine if the intervention was effective in reducing each. However, due to the nature of the therapeutic process it could be suggested that it is difficult to evidence the effectiveness of each phase when the therapeutic relationship will potentially strengthen after each session. Another issue to take into consideration is the validity of the self-report questionnaire, as it were designed by the researchers for the purpose of the study and therefore did not objectively measure treatment effectiveness. In spite of this, Romano and De Luca (2006) stress that an individual's perception of the treatment process can demonstrate treatment effectiveness.

Research carried out by Ressel et al. (2018) was the only study to exclusively focus on young males' experiences of CSA, with their sample consisting of men between the age of 17-25 years. The participants were recruited through websites, such as 'Iin6,' aimed at men who have experienced CSA. The data for the study was extracted from a larger study on male CSA conducted by the Children's Well-Being Laboratory at the University of Ottawa. The sample included 46 men who had taken part in the larger study, and met the age criteria for inclusion in this smaller study focused on younger men. The participants responded to anonymous online questionnaires which collected detailed information regarding child maltreatment and psychological functioning. The rationale for adopting an anonymous data collection method was due to the sensitive nature of the topic. It was believed that survivors would prefer to respond to an anonymous questionnaire than attend a face-to-face interview, as the participants would feel safer, more in control, and it was assumed that they would feel that their anonymity was better protected (Simpson, 2010; Ressel et al., 2018). However, the researchers have not outlined the ethical issues associated with responding to a questionnaire of this nature and the impact of not having a researcher present during completion. Although a presumption has been made that a face-to-face interview would be more distressing, the researchers have specified that relaxation techniques and details of psychological resources were included at the bottom of each questionnaire page.

The findings of Ressel et al.'s (2018) study suggest that men's experiences of CSA tend to be severe with an earlier age of onset, invasive sexual acts such as anal

penetration and the use of perpetrator force. For 43.5% of the respondents, the perpetrator was someone outside of the family unit. However, the men reported that they were emotionally close to the perpetrator before the abuse started. More than half of the sample reported that they were threatened by the perpetrator or that the perpetrator had been physically forceful towards them during the experience of CSA. In total 78.3% of the respondents had disclosed their experience of CSA, with more than half stating that they received a negative response. The authors of the study did not report at what stage the men disclosed the abuse; specifically, whether it was at the time the abuse occurred or in adulthood. Considering that research on male CSA and disclosure indicates that men often wait around two decades before their first disclosure (Easton et al., 2014), it could be considered surprising that a large proportion of a sample aged 17-25 years had disclosed their experience of CSA to someone. It is important to consider that Ressel et al.'s (2018) sample consists of support seeking men recruited from male CSA web support pages. In addition, the fact that the men were willing to participate in a study on characteristics of male CSA suggests that they perhaps had prior experience of disclosure and discussing their experiences of abuse.

The results of Ressel et al.'s (2018) study also found that the experience of other forms of adversity were common for the men, with parental conflict, neglect, and physical and emotional abuse being the most common experience of co-occurrent maltreatment experienced by over 75% of the sample. Another important finding is that the male survivors participating in the study reported lower rates of resilience on the standardised measures, compared with adult community samples. The authors attempted to hypothesise that lower rates of resilience amongst the sample could be related to the severe nature of the CSA the men experienced, coinciding with child maltreatment and adversity. Moreover, the sample was recruited through specialist support websites, indicating that they were experiencing distress at the time they expressed an interest in the study. Despite the participants reporting lower levels of resilience, the results of the study indicated that many of the men were able to continue with their education, gain employment and maintain friendships. Overall, the study by Ressel et al. (2018) highlights some important findings related to younger male survivors, such as the severity of the abuse and the multiple incidents of maltreatment experienced by the men in the study. However, the study is limited in the richness of

the data collected, as it only reports on the characteristics from a purely quantitative perspective. In addition, the sample of 46 could be considered small for a study with a quantitative design.

Conclusions from the literature review

This literature review has identified a distinct lack of research investigating the experiences of men who have received counselling or support within mental health or specialist support services in the UK. The review identified three qualitative studies related to disclosure, two of which were conducted in the USA (Sorsoli et al., 2008; Easton et al., 2014) and one in Canada (Gagnier & Vezina, 2016). The three studies identified the barriers that men faced in disclosing their CSA experience, which included fear of societal judgement, negative stereotypes, shame, self-blame, and the inability to name the experience as being sexual abuse. The research indicated that most men waited until adulthood to disclose their experiences of CSA. One quantitative study related to disclosure (Easton, 2013) was also reviewed and it was found that the more time that passed before a man disclosed CSA equated to him being more susceptible to developing a mental health problem.

Five studies regarding the effects of male CSA were included in this review. The studies were published in the USA (Lisak, 1994), Canada (Gill & Tutty, 1998; Gill & Tutty, 1999; Alaggia & Millington, 2008) and New Zealand (Dorahy & Clearwater, 2012). The psychological effects identified included anger, betrayal, fear, shame, helplessness, isolation, and masculinity issues. It was found that societal gender norms were a barrier to disclosure, and had a significant impact on psychological functioning for men who have experienced CSA. Findings from two of the qualitative studies (Alaggia & Millington, 2008; Hovey et al., 2011) included in this review suggest that health and mental health professionals have an obligation to ask male clients about sexual abuse if their symptoms are consistent with the known psychological effects of CSA.

In terms of research papers exploring therapy and recovery from CSA, four papers were included in this review. One of these research papers was published in Canada (Hovey et al., 2011) and the other three were published in the USA (Grossman et al.,

2006; Kia-Keating et al., 2010; Easton et al., 2015). Accessing therapy or group support was found to be associated with recovery from CSA. Furthermore, engaging in supportive relationships and activities that involved helping others was correlated with posttraumatic growth.

Although the research that exists identifies long-term mental health implications and men's experiences of disclosure, intervention and methods of support that have been found to be beneficial, reports of men's interpretation of helpful responses to disclosure from professionals are scarce. When reviewing service user perspectives of counselling for male CSA survivors there were only two research studies (Draucker & Petrovic, 1997; Rapsey et al., 2020) identified, and a report produced in Scotland that was designed to inform practice and influence government policy (Nelson, 2009). The two studies on support experiences were published in the USA (Draucker & Petrovic, 1997) and New Zealand (Raspey et al., 2020) and the results of the studies identified therapist traits that the participants felt were helpful in counselling male CSA survivors, including keeping the client informed about the therapeutic process and respecting the client's process. The Scottish report found that participants reported that there is a need for male only support services for CSA survivors.

Seven quantitative studies were reviewed regarding male CSA; published in the USA (Steever et al., 2001; Easton 2013; Easton et al., 2013a; Easton et al., 2013b), Canada (Romano & De Luca, 2006; Ressel et al., 2018) and Australia (O'Leary, 2009). It was found that male CSA survivors were more likely to have accessed psychological therapies than men that did not identify as having experienced CSA. However, the main presenting issues for seeking therapy were marital problems, depression, PTSD, relationship difficulties and substance misuse. Another study found that substance misuse was the most common coping strategy as a way of repressing memories of CSA. Research around male CSA and suicide attempts found that men who were more frequently abused as children or men that were subjected to use of force during the sexual abuse experience were more likely to have attempted suicide in the past year. An overriding theme in the literature reviewed was feelings of shame. Shame was found to be a significant obstacle to disclosure, as well as a residual long-term effect of CSA often referred to in the research literature.

Reflexive Account

As a counsellor, practicing in the area of male CSA, I was aware from my initial research on this topic, that the academic literature was potentially limited. Following a deeper exploration and systematic search, I was disheartened at how limited the literature there was available on the effects of male CSA and support for men following such trauma. I anticipated I would find a higher volume of literature focused on the female experience of CSA, but I was dismayed that this group of people, who it would appear, have continually been ignored in academic literature. Personally, the experience of writing this review was informative and helped to solidify some of my practice knowledge regarding the experiences of men abused in childhood. For example, the experience of shame, sexual identity issues, the influence of societal perceptions and the process of disclosure further enhanced my knowledge. The process of writing the literature review was also emotionally demanding; often distressing and exhausting. As I work therapeutically with survivors of CSA, I am regularly listening to stories of their abuse experience. As such, at times I found it difficult to navigate my work and home environment, the latter requiring me to spend so much time saturated within the narratives and research on sexual abuse. As there was so little published research on male CSA, it felt important to include all available research on this topic which met the inclusion criteria.

A limitation of this review is the lack of a quality appraisal tool. A tool such as The Critical Appraisal Skills Programme (CASP) is a check list commonly used in health related disciplines to review qualitative evidence (Aveyard, 2014). Critical appraisal tools are not without their challenges, as qualitative methods are diverse, and the use of a checklist to appraise the quality of a paper can be problematic (Barbour, 2001). A checklist can be used as a tick box exercise, without taking accoount of the nuances associated with the research methodology. As well as there being a wide range of qualitative methods within this review, quantitative studies were also included. Although I did not use a recognised framework, such as CASP, to critically appraise the research literature, I went through a systematic process when appraising studies included in this review. As there was limited research available on male CSA, I had concerns that using a pre-constituted tool may lead to disregarding papers based on what is deemed to be poor quality. The process I adopted ensured that the papers

included met the aims of the research and used appropriate methods consistent with the methodology adopted. I assessed the included papers for the methods used to collect and analyse data and their appropriateness to the research topic. I considered the recruitment process and the nature of the sample. Furthermore, I reviewed the ethical considerations and the limitations of the research both from my own perspective and that of the researchers. I also ensured there was a level of analysis to produce findings that had utility for comparison across the sample selected. In addition to conducting a less formal approach to assessing the research papers, I established specific themes based on the findings of the 22 papers included in the review, helping me to present a more coherent story of the experiences of men who are survivors of CSA.

By capturing the lived experience of men who have had mental health problems they relate to a history of CSA, this study will make an original contribution to this vital area of work and go some way to addressing this important gap. Furthermore, as documented in this chapter, most of the studies found have been conducted in the USA and Canada, which demonstrates an apparent lack of research emanating from the UK regarding male adult survivors of CSA.

Chapter Three: Methodology

Research aim

The aim of the study is to explore and gain an in-depth understanding of the experiences of men who were sexually abused as children and have accessed support from non-statutory specialist support services or the statutory sector. In using a narrative approach, I hope to gain insights as to how services can better accommodate men that have experienced CSA.

Research objectives

- To respond to a gap in the literature in terms of males who experienced CSA.
- To explore the experiences of males who have experienced CSA in terms of their mental wellbeing.
- To identify what aspects of mental health care participants found helpful in maintaining and improving their mental wellbeing.
- To identify what aspects of counselling/therapy males found helpful or unhelpful.
- To highlight any barriers participants', believe prevented them from accessing support from the helping professions.
- To provide evidence as to how mental health care and specialist sexual abuse support services can better accommodate the needs of men who have experienced CSA.
- To consider how the above evidence might be transposed to policy, guidance, and practice to benefit males who are experiencing or have experienced CSA.

Introduction

This chapter will begin with a discussion on the qualitative and quantitative research paradigms. The philosophical assumptions related to the chosen methodology of qualitative research will then be described. As this study is informed by service user perspectives of counselling, this chapter includes a discussion on 'lay knowledge' and how knowledge is produced in relation to the epistemological position of this research. I will then describe how I position myself within the research study and outline my ontological and epistemological position. The research design will be described, including participant recruitment, the sampling procedure, and the methods of data collection and analysis. This chapter will also pay attention to the ethical considerations that have been identified in conducting a study of this nature.

Overview of methodology

Research paradigms fall into two distinct categories: qualitative and quantitative approaches. The paradigm adopted by the researcher reflects the philosophical assumptions related to the research process, including the selection of participants and the methods utilised in the research study (Denzin & Lincoln, 2018).

Quantitative research

A quantitative approach to research centres around the strict quantification of data and on the control of empirical variables (Ponterotto, 2005). The practice of quantitative research generally consists of large-scale sampling, with the use of statistical procedures and standardised measures to investigate group means and variances. Studies adopting quantitative methods address the causal or correlational relationships between variables, with the ultimate aims of prediction, control, and generalisability (Ponterotto, 2005; Denzin & Lincoln, 2018).

Positivism, post-positivism and modernism

Quantitative research is often associated with the doctrine of *positivism, post positivism and modernism* (Bryman, 2016). Positivism has also had an influence on how the social sciences and qualitative research have evolved and advanced over the last century (Ritchie et al., 2014). Mainly, as it has been argued, qualitative

researchers distinguish their approach as being in direct contrast with the principles of positivism and the scientific methods associated with it (Denzin & Lincoln, 2018).

Positivism is an epistemological position that promotes the utilisation of methods associated with the natural sciences, to obtain accurate knowledge of the world (Bryman, 2016). Positivism arose from the intellectual movement of the Enlightenment period of the 17th and 18th centuries in Europe. In challenging traditional religious views of the time, key thinkers such as Rene Descartes (1596-1650) and John Locke (1632-1704) distanced themselves from medieval practices of accepting, without question, traditional royal and religious laws and views about the nature of the world and society (Ponterotto, 2005). In 1637 Descartes wrote *Discourse on the Method*. In this text, he highlighted the importance of objectivity and evidence in the quest for knowledge. Furthermore, he believed that researchers should endeavour to detach themselves from any influences that might impact their analytical process (Ritchie et al., 2014). The philosopher Francis Bacon (1561-1626) held the view that knowledge of the world could be attained through direct observation, as opposed to knowledge being determined by abstract principles and ideas (Ritchie et al., 2014; Crotty, 2015). Overall, collecting evidence in an unbiased and objective manner, through direct observation, became a fundamental principle of empirical scientific research (Ritchie et al., 2014).

The French philosopher August Comte (1798-1857) is often associated with being the founder of positivism (Kim, 2016). However, as noted above, positivism was a concept found in the writings of eminent philosophers much earlier. Comte is credited with being the founder of sociology and popularised the term positivism (Ritchie et al., 2014; Crotty, 2015). Comte maintained that the social world should be studied by applying similar research methods used in the natural sciences, through direct observation as a way of determining universal truths of human behaviour and the social world (Ritchie et al., 2014; Holloway & Galvin, 2017). More recently, Comte's idea of universal laws has been criticised by those in the field of the natural sciences and quantitative social research, which prompted the development of *post positivism*. Karl Popper (1902-1994) rejected the positivist view that general laws could be determined through observation, as he argued that it is probable that a future observation might disprove a truth claim (Crotty, 2015). He therefore proposed a

deductive approach where a hypothesis is formulated based on theory, before being empirically tested with the aim of disproving the hypothesis. In summary, a key disparity between the two positions is that positivism holds the position of truth being determined by *theory verification,* while the post positivist stance relies on *theory falsification* (Lincoln & Guba, 1985).

Modernism emerged in the late 19th to early 20th century, as a movement born out of the enlightenment era. With this came the rejection of the myths, ignorance and superstition of the medieval period and gave rise to the use of scientific positivist methods to discover absolute knowledge and truth of reality (Crotty, 2015; Bryman, 2016).

Postmodernism

With modernism professing generalisable and valid truth of the world, post modernism was conceived as a rejection of the essentialist views of universal truth (Crotty, 2015). The basic tenet of postmodernism is that truth claims are rooted in conditions of the world and society, whilst incorporating the multiple perspectives of class, race, gender, and cultural context (Creswell, 2013). Furthermore, it is claimed that negative conditions manifest in the rise of hierarchies, power and control asserted by individuals, and the multiple meanings of language (Creswell, 2013). With the oppressive nature of the negative conditions outlined, postmodern thinking emphasises the importance of different discourses and marginalised groups (Bryman, 2016).

Qualitative research

Qualitative research is grounded in a philosophical position whereby it acknowledges that there is no one single truth, but multiple realities that are mediated by human interpretation (Denzin & Lincoln, 2018). Focusing on how people understand, experience, and interpret their world; qualitative methods seek to explore the complexities of human experience, accepting the existence of multiple realities constructed separately by each individual (Denzin & Lincoln, 2018; Mason, 2018). The findings of qualitative research are commonly presented by use of everyday prose, articulated by the research participants, and generally describe a psychological

experience or phenomena (Taylor & Bogden, 1998). Qualitative researchers espouse a person-centred and holistic approach, which assists in developing an understanding of human experiences (Holloway & Galvin, 2017). Gaining insight into human experience through the emotions, perceptions, and behaviours of the research participants, is essential for mental health professionals, such as counsellors and psychotherapists, whose work centres on communication and interaction (Holloway & Galvin, 2017). Crucially, the qualitative approach requires an empathic understanding in order to examine the feelings and experiences of the participants from their perspective, rather than the researcher imposing their own framework (Holloway & Galvin, 2017). By exploring the '*insiders' view'*, the researcher will view experiences as their participants perceive them, often termed the '*emic perspective*' (Harris, 1976). It is argued that qualitative research goes some way in helping to empower research participants; rather than responding to questions, the participant has a voice and the opportunity to guide the research study (Holloway & Galvin, 2017).

Antithetical to the emic perspective is the '*etic perspective,*' which is the outsiders' view. The etic view is associated with quantitative methods of remaining distant and uninvolved with the subject under study (Lincoln & Guba, 2018). However, the etic perspective is relevant to qualitative inquiry when it comes to the analytical and interpretive process (Harris, 1976). The researcher will oscillate between the emic perspective of the participant and their own etic view, the latter being used when developing abstract interpretations and descriptions (Holloway & Galvin, 2017).

Social constructionism/interpretivism

Constructionism is often described as interpretivism (Denzin & Lincoln, 2018) and is in direct contrast with objectivism (Crotty, 2015). Objectivism embraces the idea that truth and meaning exists in objects independently of consciousness (Bryman, 2016). Constructionism is the belief that all knowledge and subjective meaning is developed within a social context and dependent on human action and interaction with others (Crotty, 2015), hence the term *social* constructionism (Creswell, 2013). The constructionist movement holds that knowledge is actively 'constructed' by the research subject, rather than being passively received (Ritchie et al., 2014). Holloway and Galvin (2017) assert that postmodernism and social constructionism are closely

related, as both positions challenge traditional knowledge and emphasise the value of multiple perspectives, rather than a universal understanding of truth.

Qualitative research and the early ideas around constructionism/interpretivism can be found in the writing of Immanuel Kant (1724-1804), specifically his literary work the *Critique of Pure Reason*, published in 1781 (Ponterotto, 2005). Within this text, Kant proclaimed that there are ways of knowing about the world besides the reliance on direct observation and the senses. He argued that perception is associated with human interpretation, and knowledge of the world is derived from 'understanding,' which is developed from reflecting on experiences (Ritchie et al., 2014). Kant's ideas advocated that knowing and knowledge goes beyond empirical enquiry and, based on this proposition, qualitative researchers recognise the significance and value of human interpretation of the social world. In addition, the qualitative researcher places emphasis on the importance of both the participants' and the researchers' interpretations and understanding of the phenomenon under study (Ritchie et al., 2014).

Another pioneer of interpretivist thought, and qualitative research theory, was Wilhelm Dilthey (1833-1911) and his '*Verstehen'* approach. Dilthey argued that the social sciences should not aim to imitate the natural sciences; they should instead focus on empathic understanding. Dilthey stressed that understanding in the social sciences is in direct contrast with explanation that is the objective of the natural sciences (Ponterotto, 2005). The principles of Verstehen can be defined as empathic understanding of human behaviour. Within the context of the philosophy of social research, the concept of Verstehen relates to understanding something in its context and the reflective reconstruction and interpretation of the actions of others (Holloway & Galvin, 2017). Dilthey highlighted the significance of studying an individual's lived experience, which occurs within a particular historical and social context (Ritchie et al., 2014).

Influenced by Dilthey's ideas and the importance of the Verstehen approach of understanding, was the philosopher and sociologist Max Weber (1864-1920). In contrast to Dilthey's beliefs that the natural sciences and social sciences oppose each other, Weber sought to establish a relationship between interpretivist and positivist

approaches (Crotty, 2015). He suggested that there exists two categories of understanding: direct observational understanding and explanatory understanding (Ritchie et al., 2014). The explicative approach focuses on causality and found in the natural sciences is known as '*Erklären,'* meaning to explain (Crotty, 2015). Weber considered an analysis of material conditions, as would be conducted by those from a positivist position, to be important, but not essential in understanding human experience. He therefore proposed that the researcher should develop an understanding of the meaning of social actions within the context of the material conditions in which people live (Ritchie et al., 2014). Weber's view was that there are fundamental differences in the purpose of understanding between the natural and social sciences. He believed that the objective of the natural sciences is to establish law-like propositions, while the purpose of knowledge derived from the social sciences is to understand subjectively meaningful experiences (Ritchie et al., 2014; Bryman, 2016).

Social constructionism is a concept that explains the processes and influences that determine how individuals describe and account for their social reality (Daymon & Holloway, 2002). At the heart of social constructionist research, and the focus of this study, is the reconstruction of stories around experiences (Gergen & Gergen, 2003). When practicing research from a social constructionist position, the questions posed to the participant should be broad and general and as open ended as possible, to allow the individual to construct meanings of a situation or experience. Furthermore, the researcher listens carefully and addresses the processes of interaction between individuals and the social, historical, and cultural context of the participant (Creswell, 2013). The constructionist position adopts a hermeneutical approach, which is focused on uncovering hidden meaning through the process of deep reflection. The reflective process can be evoked through interaction and the researcher-participant dialogue (Ponterotto, 2005). Thus, the intention of constructionism is that the approach is both idiographic and emic (Ponterotto, 2005). An idiographic method is an approach to knowledge where the emphasis is on the unique aspects of an individual's reality (Holloway & Galvin, 2017). In contrast to the idiographic is a nomothetic approach, which establishes laws through generalisations and objective knowledge, in keeping with quantitative methodology (Holloway & Galvin, 2017). Another prominent characteristic of social constructionism is the researcher's acknowledgement that their

own background and values shape the interpretations of the findings. Therefore, the researcher '*positions self*' in the research to address how their interpretations of meaning have been influenced by their own personal, cultural and historical experiences (Creswell, 2013). Moreover, it is thought that the participant, the researcher, and the reader co-construct the research, which demonstrates how the research is produced through social interaction (Holloway & Galvin, 2017).

Philosophical assumptions of qualitative research

When undertaking this qualitative research study, the different theoretical and philosophical approaches were considered. As well as the practical consideration of the procedures of sampling, data collection and analysis, social inquiry is rooted in conflicting ideas regarding the nature of knowledge (Holloway & Galvin, 2017). There are four philosophical assumptions that influence the research process; *ontology*, *epistemology*, *axiology*, & *methodology* (Creswell, 2013).

Ontology is concerned with the nature of reality (Creswell, 2013). Positivists maintain that there is one true reality that is identifiable and measurable, and this position is referred to as *naïve realism*. Similarly, post positivists also maintain that there is one true reality. However, the post positivist position acknowledges that reality can only be measured imperfectly, which is referred to as *critical realism* (Ponterotto, 2005). The constuctivist/interpretivist stance posits that multiple and constructed realities exist, as opposed to there being one single truth, and this is known as the *relativist* position. When adopting a relativist perspective, it is acknowledged that truth is subjective and influenced by; the context of the situation, the social environment, and the experiences and perceptions of the individual. Fundamentally, relativism holds the view that truth is always relative to a particular frame of reference. Furthermore, the interactions between the researcher and the individual under study also have an impact on how knowledge is created (Ponterotto, 2005). Another ontological position to note is *critical theory,* which focuses on the nature of reality being determined by cultural, ethnic, gender, social and political values (Ponterotto, 2005). The critical approach has its roots in Marxism and addresses how power and inequality effects society (Holloway & Galvin, 2017).

Epistemology is the study of how knowledge is generated and poses questions on what counts as valid knowledge (Holloway & Galvin, 2017), whilst exploring the relationship between the researcher and the participant (Ponterotto, 2005). Within social research there are epistemological debates around how knowledge is best acquired. One perspective is that knowledge is based on induction and follows a 'bottom-up' process leading to social theories deriving from observations of the world. In contrast, the belief that valid knowledge is derived from a deductive process follows a 'top-down' approach, whereby hypotheses are tested against observations. Essentially, a deductive method uses evidence to support the conclusion of the study, by first developing a hypothesis and using the evidence to confirm or disprove it. Inductive processes involve collecting evidence first and constructing knowledge and theories from the data (Ritchie et al., 2014).

The axiological assumption inherent in qualitative research is the acknowledgment that all researchers bring their own values into the research process. By recognising and reporting on the value-laden nature of the data collected during fieldwork, the researcher positions themselves in the study and will reflect their interpretations within the findings (Creswell, 2013). This is in stark contrast with the axiological position of positivists and post positivists, as they maintain that values have no place in the research process (Ponterotto, 2005). To contain and control the influence of the researcher's values and biases, the researcher remains detached from the investigative process by use of systematic and standardised methods of collecting data (Ponterotto, 2005).

The procedures and strategies involved in carrying out research are referred to as methodology (Creswell, 2013). Qualitative research is characterised by the inductive nature of the collection and analysis of data. Therefore, qualitative researchers do not rely on a theory to inform the outcome of the study, but rather follow a path of analysing the data from the ground up, which develops detailed knowledge of the topic (Creswell, 2013). This gives way for the researcher to become immersed in the data and places centrality on the interactions between the researcher and participant. The methods underpinning qualitative research include in-depth interviewing and participant observation, which follows a naturalistic design (Lincoln & Guba, 1985; Ponterotto, 2005). Naturalistic inquiry is a method that acquires an in-depth understanding of the

social world by observing, describing, and interpreting the experiences and behaviours of a specific group of people in their societal and cultural context (Salkind, 2010). When adopting a naturalistic approach to the collection of data, methods include direct observation, case studies, in-depth interviewing, and other sources of descriptive data used to obtain rich descriptions and interpretations of the phenomenon under study (Salkind, 2010).

Lay knowledge

Inherent within the ideas of gaining knowledge and insight based on human experience is the concept of '*lay knowledge*,' which for this study encompasses male survivors of CSA and their experiences of counselling and support services. Gabe et al. (2004) define lay knowledge as "*the ideas and perspectives employed by social actors to interpret their experiences of health and illness in everyday life* (p135)." Social actor can also involve service users (Warne & McAndrew, 2007; Ward et al., 2009) of health and social care services, as with this study whereby men will be interviewed about their experiences of counselling. It is argued that involving service users in the research process stimulates empowerment, as the power relationships between the researcher and the participant shift to promote active involvement, rather than passive involvement on the part of the research participant (Ward et al., 2009), lending itself to the social constructionist position. Furthermore, lay knowledge can be considered a robust empirical approach to making sense of everyday health and illness, placing emphasis on 'experience' over 'expertise' (Gabe et al., 2004; Glasby & Beresford, 2006). However, the concept of lay knowledge is not without controversy, as it has been suggested it is primitive and unscientific (Gabe et al., 2004).

Ward et al. (2009) highlight issues around an 'epistemological dissonance' that can occur when there is a lack of acknowledgement on the part of the researcher that service users can bring valid forms of knowledge to the research process; thus, forming boundaries between lay and professional identities. Further to this, is the concept of '*epistemic violence*' which situates the researcher in the position of the 'knower' and the participant in the less powerful position of the 'docile body,' existing

to draw expert knowledge from the researcher (Lewis, 2007). When considering the value of lay knowledge, Glasby and Beresford (2006) explore what constitutes valid knowledge, arguing that the lived experience of service users and 'human testimony' in research is as effective in understanding the social world as formal objective research. Furthermore, they advocate that for certain research topics, proximity to the object under study can be more suitable than positivist views around distance and objectivity in research. Glasby and Beresford (2006:281) term this approach as '*knowledge based practice*,' rather than '*evidence based practice*'. Although they do not disregard the value of traditional objective medical research, they propose that the traditional pursuit for quantitative, objective and systematic knowledge be replaced with a more questioning approach which incorporates the voices of the service users and the practice wisdom of practitioners in order to influence and shape health and social care services. In the context of nursing practice, Warne and McAndrew (2007) highlight the value of patient '*expertience'* knowledge, which places the patient at the centre of the nurses learning, rather than pre-constructed theories being used to inform practice knowledge.

Positioning Myself

The methodological considerations discussed above were carefully examined when reflecting on the decision to conduct a qualitative study. As a counsellor, I work with a clients' subjective reality. Epistemologically, I do not hold the belief that an individual's experience can be measured and generalised to form an absolute objective truth, which is in direct contrast with the positivist paradigm. I felt that adopting a quantitative approach to this study would not be suitable, as the aim was to elicit subjectively meaningful experiences of participants' perspectives of their counselling. In conducting this qualitative study, I adopted a relativist ontological position by supporting the belief that there are no absolute truths and accepting that there are multiple realities, reporting on these through the presentation of the individuals' words and conveying the evidence of the different perspectives of the participant's experiences (Creswell, 2013).

The epistemological position I adopted in this qualitative study is that of the social constructionist position which supports the belief that knowledge is created through the subjective experiences and distinct views of the individuals under study and is

dependent on the interactions between the participant and myself as the researcher (Creswell, 2013). To attain rich data, I have immersed myself in the lived experience of the participants by adopting techniques of observation, questioning, and listening within the natural setting of the research participant (Holloway & Galvin, 2017). Holloway and Galvin (2017) stipulate that to obtain an in-depth understanding of the participant's experiences, it is essential that the researcher becomes acquainted with their world. They also acknowledge that professionals who do research are often involved, have comprehensive knowledge and are a part of the setting in which their research is conducted. However, Holloway and Galvin (2017) contend that the researcher's professional background may lead to the researcher overlooking important issues or considerations. Therefore, they advocate that to more effectively examine the lived experiences of participants, the researcher should question their own assumptions and adopt the position of a 'naïve observer', effectively divorcing themselves from their prior and existing knowledge of the phenomenon under study. However, Creswell (2013) affirms that regardless of whether the researcher is consciously aware of it or not, an individual will always bring specific beliefs and philosophical assumptions to their research. The beliefs and assumptions inherent in guiding the research process can range from deciding the specific problem that will be studied, the research questions that are selected, and the methods in which data is collected.

Reflectivity and Reflexivity

In relation to healthcare reflectivity is the process whereby a practitioner reflects upon how their own actions and assumptions influence a situation and lead to changes in future practice based on the reflective process (Argyris & Schon, 1974). Schon (1983) suggested that reflection based on practice, implicit knowledge, and the learning from direct experience enables theories to be formed. Schon (1983) distinguished between two different forms of practice based reflection: *'reflection in action'* and *'reflection on action.'* Reflection in action is when the practitioner reflects on the experience and their behaviour as it is happening; while reflection on action occurs when the practitioner reflects after the event, by analysing and evaluating the experience.

As a therapist, I am familiar with the notion of being a 'reflective practitioner,' where I reflect on my practice and the process that occurs between the client and myself. Reflective practice can be facilitated by writing notes after the session; considering the interactions between the client and myself, what was said in the session, what interventions were used and my perception of the relationship. This can be achieved on an intrapersonal and interpersonal level, the latter through clinical supervision. I will reflect later in this thesis on my clinical supervision (p110).

Reflection facilitates learning and personal and professional development by examining what is perceived to be happening in practice and how the experience was perceived by clients. Reflection also serves as a way of opening up the counsellors' practice to scrutiny (Fook, 2002). Reflective practice is not reserved for counsellors and healthcare professionals, it is a concept seen across a diverse range of professions. Fook (2002) defined reflectivity as a process of reflecting on practice, with reflexivity being a process of the researcher/practitioner locating themselves in the research process. Despite this, Fook (2002: 43) used the terms interchangeably *'assuming that reflective processes will be underpinned by a reflexive stance.'* Chriseri-Strater (1996) distinguished the difference, arguing that to be reflexive there is a need for self-scrutiny and something or someone to be reflexive about, whereas to be reflective does not need any 'other'.

However, there is a clear distinction between reflection and reflexivity. Reflection is mainly a cognitive process, whereas reflexivity pays attention to the relationship between how knowledge is created, the contextual issues that influence knowledge creation, and what the individual brings to the process (Etherington, 2004). In counselling practice, and practice, the reflexive process requires the practitioner to operate at two levels: Firstly, reflecting on the self and having an awareness of self as an active agent within the therapeutic process (Wosket, 1999). Secondly, a counsellor has awareness of how their inner story (what they think, feel, and imagine is happening in their mind and body) as they listen to a client's story (Rennie, 1998).

Reflexivity or '*critical reflexivity'* (Etherington, 2004) in research requires the researcher to be critically self-reflective on how the inter-subjective dynamics between the researcher and the participant can influence the research process and where

necessary take action to ensure findings are transparent. In particular, the researcher's gender, behaviour, assumptions, and social and cultural background can ultimately have an impact on the research findings (Holloway & Wheeler, 2002; Finlay & Gough, 2003). When it came to the research interviews, my gender seemed to play a significant role in the process. I felt that being female helped to promote trust, as the men commented on how they felt uncomfortable around men. As a counsellor, practitioner and researcher I both understand and have experience in listening and suspending judgement As such, I felt this helped the men to feel listened to, and supported in sharing their experience which was evidenced by how open they were throughout the interview. Although, my gender seemed to promote trust and openness, I felt that it influenced the behaviour of one particular participant called Tony. Tony displayed a lot of anger throughout the interview and expressed some derogatory comments about women. He also asked if I had been warned of his behaviour in advance of the interview. At times I felt a little intimidated but also curious about the root cause of his anger. During the interview, I sensed that he wanted me to feel scared or unsettled by his presence and it left me wondering whether he was testing me.

As a trained counsellor, I was able to use the skills developed in counselling training and honed during my practice, to notice my responses, thoughts, and feelings in relation to each of the study participants. To assist in recognising my own biases and assumptions, reflexive notes were taken to promote action in terms of analysing and writing up the data collected. The reflexive notes formed the basis of the critical reflection presented at the end of each narrative in Chapter Four. The importance of supervision is outlined in the BACP ethical research framework. Research supervision helped me to reflect on my work, for example analysis of my data, identifying any ethical dilemmas or conflicts of interest and then applying standards of good practice (Mitchels, 2018). Before the first interview, I was extremely nervous about the process of interviewing a participant. I feared saying the wrong thing, directing the interview away from the research aims and confusing my role as researcher with that of counsellor. One of my research supervisor suggested we role play an interview with her acting as the participant. Although it felt strange at first, I soon became comfortable with the conversation and I found that there was an ease around listening to the participant's narrative, summarising what I had heard and asking prompting questions

at specific points to encourage the participant to elaborate on certain aspects of their experience. Supervision has been an important part of the reflexive process, as I have used sessions as an opportunity to discuss my thoughts and feelings about my experience of the interview process and my experience with each participant. It can be argued that academic supervision should be *'fluid and responsive to both the supervisee's and supervisor's current circumstances* (Murphy & Wibberley, 2017:64).' After transcribing each interview, I would send my supervisors the finalised transcript and we would meet to explore our thoughts and interpretations of the data which helped me to look at '*alternate viewpoints* (Murphy & Wibberley, 2017:64). In addition, clinical supervision was used as an additional opportunity to explore my thoughts and emotional responses arising from the research interview as this helped me to explicate my biases and encouraged me to think about their influence on the data.

The approach

Case study using narrative inquiry

This qualitative research study utilised a narrative approach, as this is seen as the primary catalyst by which human experience is made meaningful (Riessman, 2008). It was anticipated that in using a narrative approach it would encourage participants to articulate their experiences, while at the same time, enabling them to make sense of events, they may have previously had difficulty in describing, by integrating them into a narrative (Frosh, 2002).

The movement towards narrative inquiry in the social sciences can be traced back to the journal *Critical Inquiry* and two issues published in 1980 and 1981, which later became a book titled *On Narrative* (Mitchell, 1981). Notably, the editor of Critical Inquiry stated: '*The study of narrative is no longer the province of literary specialists and folklorists borrowing their terms from psychology and linguistics but has now become a positive source of insight for all the branches of human and natural sciences* (Mitchell, 1981: 9).' Polkinghorne (1999) asserts that working with stories is appropriate for qualitative researchers, as a story is a linguistic method in which experiences can be expressed. Narrative as a phenomenon is valuable in understanding the multifaceted aspects of society, culture, and human behaviour by

exploring the participant's life experiences and engaging in a process of storytelling (Leavy, 2009). Furthermore, with the rise in popularity of postmodern research methods, personal storytelling is now viewed as a valid form of knowledge production (Riessman, 2008).

Before the rise in popularity of narrative research, the origins of contemporary narrative social research lay in two academic disciplines. The first being post-war humanist approaches within psychology, centering around a holistic and person centred approach that were firmly opposed to positivist empiricism (Polkinghorne, 1999; Squire, 2013). Within this movement there was a focus on the use of individual case studies, biographies and life history accounts. The second academic discipline to influence contemporary narrative research is Russian structuralist, French poststructuralist, postmodern, psychoanalytic, and deconstructionist approaches to narrative within the humanities (Squire et al., 2013). The aforementioned approaches to narrative took hold of social research from the late 1970's onwards through the work of prominent 20th century intellectuals; Louis Althusser (1918-1990), Jacques Lacan (1901-1981), and Michel Foucault (1926-1984) (Squire et al., 2013).

Along with the recent popularity in the use of narrative in contemporary social research, 'narrative' is also a term heard in modern social discourse. The term narrative is often applied to signify a deeper understanding of social issues. For example, politicians and policy makers often pay attention to people's everyday narratives. In addition, journalists describe events by discussing the underlying narratives and certain organisations use stories and 'first-hand accounts' of people affected by specific events to convey issues to the general public and achieve a better understanding of those living with adversity (Squire et al., 2013).

Narrative inquiry is a case centred research method (Reissman, 2008), used in a number of disciplines such as psychology, education, law and medicine. The turn towards narrative inquiry in the various disciplines has stemmed from the limitations

of positivist methods and the value of narrative and stories in informing and enhancing practice (Kim, 2016). However, the use of narrative case studies in counselling and psychotherapy research is scarce (McLeod, 2010). McLeod (2010) advocates the use of such an approach, as there is substantial evidence that narrative case studies can play an essential role in therapeutic practice and serve as a valuable evidence base. McLeod (2010) also believes that narratives have a central function in developing evidence-based therapy: Mainly, as the therapy narratives are produced by the clients and convey their perceptions of counselling that could have potentially been overlooked by professionals or contain insights about their experiences of counselling that members of the therapeutic community may find uncomfortable. It can be argued that the use of a narrative approach in conducting research under the auspices of counselling and psychotherapy can be therapeutic in itself, as it can often resemble the exchanges more familiar to the therapeutic alliance (Warne & McAndrew, 2010; Bamberg, 2012). Indeed, Illouz (2008) asserts that an individual in therapy is supported in seeking out the *problem* in their narrative, often reflecting on childhood experiences and memories to establish a narrative connection that has led to the problem. Therefore, encouraging the narratives of research participants can ultimately be healing by supporting the narrator in reflecting on, and making sense of their experiences. As this research study set out to explore a sensitive topic and is focused on the participants' experiences of counselling, the use of a narrative approach has the potential to further enhance the study.

Service user narratives are applied in the field of mental health to inform policy and practice around the 'recovery' movement (McLeod, 2010). Within the counselling and psychotherapy professions, former clients are often invited to act as consultants by sharing their experiences of how they overcame their mental health problems in therapy (McLeod, 2010). With this in mind, the narrative method compliments the study, as it aims to be faithful to the voices of the individuals being researched (Hollway & Jefferson, 2000). Ultimately, as Parker (2005: 82) asserts *'Narrative research does not discover what the empirical truth is, but rather how someone makes sense of an event that they may have had some difficulty in describing so that it becomes true to them'.*

Narrative is regarded as one of the four main approaches commonly applied in qualitative research (Creswell, 2013). Before embarking on this research study, the other three methods (phenomenology, ethnography and grounded theory) were carefully considered before narrative was selected as the most appropriate method of collecting and analysing the data. The objective of phenomenological research is to describe a particular phenomenon and place emphasis on direct experience by producing coherent descriptions and understandings of the constructs and ideas people use to make sense of their world (Ritchie et al., 2014). Although it is concerned with discovering meaning based on an individual's direct experience (Reid et al, 2005), the phenomenological approach strives to establish the commonalities in people's experience; thus creating a universal understanding, rather than focusing on the unique experiences of the individual (Creswell, 2013). In light of this, I felt that the phenomenological approach would not be an appropriate method for this particular study, as the research seeks to also establish the unique aspects of the participants' experiences. More recently there has been a growing rise in the number of studies adopting interpretive phenomenological analysis (IPA), whereby researcher interpretation is an added process to describing the phenomenon being studied. However, while both approaches are concerned with discovering meaning, the aim of this research study is to collect stories exploring the experiences of men in order to evoke rich descriptions, rather than how individuals make sense of a particular phenomenon which is the objective of IPA (Smith et al., 2009).

Ethnography was also excluded as a potential methodological approach, as the researcher is required to be immersed in the day-to-day lives of the participants, studying a particular group of people through observations and interviews (Creswell, 2013). Furthermore, the group under study must be a culture sharing group that have spent time interacting with each other, in order for the researcher to identify patterns in behaviours, values and social exchanges (Creswell, 2013). As the study is focused on men who have experienced sexual abuse as a child, observing the participants in a group context would not be appropriate. Furthermore, the participants in this study have been receiving individual counselling for a sensitive topic and it would therefore not be possible to observe them in a group setting. Finally, it was decided that grounded theory would not be a suitable approach, as this study seeks to unearth

stories of an individual's experience, whereas grounded theory aims to generate or discover a theory through data saturation (Creswell, 2013).

The participants

Purposive sampling was used to recruit adult males who were sexually abused before the age of 18 years and have subsequently experienced long term effects of CSA. The aim of purposive sampling is to sample participants in a strategic way, to ensure that the sample and inclusion criteria are relevant to the research question (Bryman, 2016).

The participants have also accessed counselling and/or therapeutic support from the agencies approached to recruit participants. It was intended that all participants would have finished counselling or would be coming to the end of their sessions before being recruited to the study. Generational differences were taken into consideration and the initial plan was to recruit men aged between 25-45 years to facilitate a time lapse since the abuse, perhaps enabling men to be in a better place to come forward to discuss their experiences of services. However, since advertising the project, a number of men came forward that were interested in participating, but above the stipulated age range. In addition, feedback was received from a member of the public questioning the age restrictions, as he felt that the effects of abuse were lifelong and enduring. Taking these issues into consideration, it was decided the upper age range would be extended to include older men.

Non-statutory and voluntary sector organisations, offering counselling and therapeutic support to those who have experienced sexual abuse and had subsequent mental health problems were approached to help recruit participants. Recruitment posters (see appendix 2) regarding the research were displayed at the organisational premises and/or on their websites and in newsletters. In addition, letters of invitation were made available to clients who showed an interest in the study (see appendix 3). Both the poster and letter included the researcher's contact details to enable potential participants to contact the researcher directly. Before any data was collected, potential participants were given more specific written information about the study (see appendix 4), which again provided the contact details of the researcher in order to give them the opportunity to ask and have any questions answered before deciding

whether or not to participate. Before participating, each man was asked to sign a consent form (see appendix 5).

CSA in males is significantly under reported and under disclosed. As a result, it was acknowledged that difficulties may arise in recruiting participants, and it might have an impact on the number of men that come forward to participate in this research study. Although it was recognised that difficulties may be encountered in gaining access to participants, the researcher worked in a counselling organisation for people that have experienced sexual abuse. Therefore, I had the opportunity to pass on the information regarding this study to counsellors who had clients who would be potential participants. I was careful to ensure that any participants approached with information had not had any prior contact with me and I did not attempt to recruit my own counselling clients for this study, as this could have caused a power imbalance. The study aimed to recruit between 7-10 participants, however I only managed to recruit four participants. Narrative research can be conducted with a small number of participants, as the information being collected relies on depth rather than breadth (Squire, 2013). Furthermore, the quality and richness of the data is of essence and there is no fixed sample size in narrative research, particularly, as in this research, the aim is to understand and describe a sensitive topic ideographically (Holloway & Freshwater, 2007). However, challenges did arise in participant recruitment. Mainly, some organisations approached were reluctant to advertise the study or had concerns about external researchers interviewing their clients.

Ethics

The British Association of Counselling and Psychotherapy (BACP): Ethical Guidelines for Researching Counselling and Psychotherapy (Bond, 2004), and more recently, the updated guidelines published by the BACP: Ethical Guidelines for Research in the Counselling Professions (Mitchels, 2018), which took effect on 1st July 2018, have been used as the framework throughout the research to guide the ethical decision-making process. The BACP advocates that research carried out by counselling practitioners enhances professional knowledge and provides a valuable evidence base for practice in ways that are beneficial for clients (BACP, 2018).

An ethical approval application and a risk assessment (see appendix 6) was submitted to the University of Salford's Post Graduate Research Ethics Panel in August 2016, with full ethical approval being received in September 2016 (see appendix 7).

The BACP stipulates that, in the context of research, clear communication and consent are essential in fostering a relationship of trust and respect. The ethical research framework also recommends that mutual expectations are made clear from the outset (Mitchel, 2018). In line with the framework's commitment to research integrity, clarity and provision of written information was carefully considered. The participant information sheet clearly outlined the purpose and aims of the research, what the process entails, confidentiality, participants' rights, and the complaints procedure (see appendix 4).

To ensure that participants had clear information in order to make an informed decision about taking part in the research, the counsellors working with clients who fitted the inclusion criteria were approached and I provided them with detailed written information about the study (see appendix 4) that they could pass on to their clients. I then advised the counsellors that the clients could contact me, or we could arrange a brief meeting to explain the study and what would be required of them in more detail. The first participant to express an interest advised his counsellor that I could call him to arrange a date and time for the interview. During the call, I provided the participant with details about the interview and the research project, and we subsequently arranged a date and time for the interview to take place. The other three participants all requested that I discuss the interview with them face to face prior to deciding to participate. During these meetings I outlined my motivation for researching the topic, what the interview process would entail and how their information would be used and presented.

Despite mental health service users historically having little or no voice in the research process, there has been a significant shift in contemporary research towards service users having an active role in the research process (Gillard et al., 2012). Although this study promotes the benefits of lay knowledge, service users were not actively involved in the research design or recruitment process. As a novice researcher, during the initial

design of this study, my concern was around how I would recruit participants to take part in the interviews. As this study explores a sensitive topic and an under-disclosed issue, I felt that involving male CSA survivors in the design would be an ethically challenging process. I was apprehensive about how male survivors being involved in the design of the study could have had the potential to be paternalistic towards those who might participate in the study. For example, they may be risk averse to the areas of questioning I wanted to use.

In line with the BACP ethical framework for researching counselling (Mitchels, 2018), being trustworthy is a key commitment throughout the research process. During the pre-interview discussion with each of the participants, I explored their motivation for taking part in the research, as I wanted to ensure that they had an understanding of what the process would entail and an awareness of the limitations of the research (i.e. the purpose was to explore their experiences of support with the hope of improving understanding and potentially improving the quality of support in the future). I encouraged questions and explored any concerns or uncertainties potential participants might have had about taking part. This helped to ensure that I was offering clear mutual expectations, and it promoted an openness in communication (Mitchels, 2018).

All interviews were conducted in a room at the organisation where the participants received their counselling, taking place at a mutually convenient time. The use of this location helped to promote a feeling of safety for the participant and the researcher, as interviews were conducted when there were staff members on hand if needed and they had familiarity for both parties. The use of the meeting room at the counselling service also ensured that the interviews would remain private and free from disruption.

Being a counsellor, I have experience in working with issues of confidentiality and ensuring that a client's anonymity is protected wherever possible. Similar to that of the counselling contract, that is completed when a client first engages in therapy, confidentiality was discussed in detail at the beginning of the interview before the participant signed the consent form. It was made clear to the participant that any identifying details would be removed or changed in order to preserve their anonymity.

A pseudonym would be adopted for the participant and any names they might mention throughout the research interview, including the name of their counsellor/therapist. The only individual to have knowledge of the pseudonym and the connection to the participant's real name was myself as the researcher. Prior to the interview commencing, permission was obtained from the participant to audio record the interview which I would later transcribe verbatim. The participants were informed that the recorder could be switched off at any point during the interview if they wished, and that the audio recording would be destroyed when the research study was concluded. The transcribed interviews and the audio recordings were stored on an encrypted and password protected computer.

Working as a counsellor in the sexual violence sector, I have significant experience in managing risk and safeguarding vulnerable adults and children. Due to the nature of the topic, and the fact that participants could potentially be disclosing details about mental health, risk, self-harm and incidents of CSA, close attention was paid to the following extract of the consent form to ensure that participants were clear about the circumstances when confidentiality must be broken in order to protect the participant or others:

> *I am aware that if I reveal anything related to criminal activity and/or something that is harmful to self or others, the researcher will have to share that information with the appropriate authorities* (see appendix 5*).*

It is acknowledged that qualitative research, especially interviews consisting of open-ended questions can be unpredictable (Mitchel, 2018). Therefore, in line with the BACP guidelines consent was ongoing and revisited regularly at certain points throughout the interview (Mitchel, 2018). The participants were also advised that they had the right to withdraw from the study at any time before or during the interview, and also up to one month after the interview had been conducted. They were also advised that if they chose to withdraw from the study within the given timeframe their data would be destroyed.

Prior to taking part in the research, participants were informed that if there was any indication that they were at risk of serious harm to themselves or others then the researcher would have to pass on their details to the relevant agencies in line with the

BACP ethical framework. I also explained to the participants that there was the potential for painful or traumatic material to emerge as a result of the interview dialogue (Mitchels, 2018). As set out in the BACP ethical framework for research in counselling (Mitchels, 2018: 37), I was committed to *'alleviating symptoms of distress and suffering, enhancing wellbeing and capabilities*,' and '*protecting and appreciating the variety of human experience and culture.'* As stressed in the framework (Mitchels, 2018: 37), participants can sometimes seem willing to participate *'without taking into consideration the substantial demands it might make of them, that is, traumatisation in re-living their experiences, or possible shame, guilt, and embarrassment.'* The assessment of the potential for risks and sensitivities in relation to the research topic and methods (Mitchels, 2018) was undertaken by discussing the research with each potential participant to ensure that they had a clear understanding of the potential for distress when opening up about traumatic experiences. To reduce the risk of re-traumatisation and emotional distress, the participants selected for the study had either come to the end of therapy or had been engaging in therapy for a long period of time, therefore having experience of discussing the emotional impact of the abuse. Although the focus of the study was on their experiences of counselling and support services, it was recognised that participants might discuss their experiences of CSA as an integral part of their personal narrative.

I liaised with services to ensure that any participants who experienced distress were able to access further counselling, or emotional support, immediately without being subjected to a waiting list. I made this clear to the participant before and after the interview. I discussed with them the resources that were available should they need to seek support following the interview.

A short debrief time was included at the end of each interview to allow the participant to talk about how he was feeling. This formed no part of the interview, and the audio-recorder was switched off during this time. Further, each participant was provided with a list of where they could access support in the longer term should they require this. The list of agencies appeared at the end of the participant information sheet (see appendix 4) and the researcher reiterated where they could find this at the end of the debrief period. The participants were also advised that they could use the contact number provided on the participant information sheet if they needed me to help them

access this support. I was careful to outline the boundaries of this contact; in that it was for signposting/referrals only, and not an extension of the interview or a form of ongoing professional support. All participants concluded the interviews by advising me that they found it helpful to share their experience and they expressed their desire to help others. I was mindful that it might take some time for the men to process what they had discussed during the interview, and I kept in contact with the services at regular intervals to check whether any of the participants had accessed further support or shared that they were negatively impacted by the interview process. To date, I have received no reports of the participants being retraumatised by their participation in the research.

I believed the above processes to be of the upmost importance as Hyden (2013) proposes that an event that involves a traumatic experience or socially embarrassing problems are characterised as a '*sensitive topic'* in the context of research. Hyden (2013) cautions that talking about a traumatic experience has the potential to re-traumatise an individual. However, it is also acknowledged that talking about the experience has the potential to be healing for the participant (Hyden, 2013). Renzetti and Lee (1993) argue that it is possible for any topic to be deemed as a sensitive topic, as such topics are context bound and are related to personal circumstances. However, they advise that there are particular circumstances when researching sensitive topics can become threatening to the individual participating in the research. These circumstances include situations: where research intrudes on the personal boundaries of the individual or probes at deeply personal experiences that the participants do not wish to divulge (Renzetti & Lee, 1993). With this in mind, it is evident that researching men's experiences of support in relation to CSA is a sensitive topic. Furthermore, the threatening situations when conducting research, outlined above, further reaffirms the benefits of conducting narrative interviews. Hyden (2013) discusses her own experiences of carrying out research interviews with domestic violence survivors. She acknowledges that the use of a standard interview, with pre-prepared questions and a brief answer would have been inappropriate for a sensitive topic such as domestic violence. Fundamentally, researching sensitive topics, such as domestic violence and sexual abuse through narrative interviews produce *'untold stories,'* which can often fall short during a question and answer format, as a data collection method (Hyden, 2013).

The BACP ethical framework for research in counselling (Mitchels, 2018) sets out the importance of upholding the quality and rigour of research by ensuring researcher competence through the provision of training and support both within practice and academic research. I have received extensive training on the issues associated with CSA and I have significant experience in working both practically and therapeutically with survivors. In addition, during my Doctoral journey I have received education and training regarding the research process. In the event of a participant becoming distressed, I believed that my skills as a counsellor and my experience in working with trauma and adult survivors of CSA would be beneficial in the immediate situation. However, it was also important to stress to participants that I am not in the role of a counsellor during the interview and the research interview is not a counselling session. Careful consideration was taken to be clear about ethical boundaries during the interview process (BACP, 2018), which included emphasising to participants that I am in the role of a researcher and that there would be no therapeutic agenda on my part during their participation in the study. This is in line with the ethical framework in researching counselling, which advises that the research design should pay close attention to the ethics around the limits of the relationship between the researcher and the participant (Mitchel, 2018). It was also acknowledged that certain aspects of the interview process could have an emotional impact on me as the researcher. Therefore, it was agreed that I would access my clinical supervisor during the period of data collection, ensuring researcher self-care as this is acknowledged in the ethical framework. Clinical supervision is an anonymised process in terms of clients; in this instance participants. Clinical supervision enables the practitioner/researcher to explore their thoughts and feelings during their interactions with each client/participant.

Data Collection

Whilst some demographic details were collected for example, age, ethnicity and the age of onset of abuse the main data was collected through one to one ‘narrative interviewing’. Interviews were audio recorded with the permission of the participants. The location of the interview was agreed between the participant and researcher in advance. Interviews last for around one hour, with time set aside at the end for de-briefing as outlined above. It has also been agreed with my clinical supervisor, that I contact following the interviews to debrief.

Face to face interviews

The interview consisted of a small number of topic areas (see appendix 8), with particular emphasis on the experiences of interventions for mental health problems, which manifested as a consequence of CSA. Participants were invited to share their experiences, with little interruption from the researcher, as a way of promoting the spontaneous flow of dialogue (Holloway & Freshwater, 2007). The narrative method empowers the participants to speak in their own voice (Mishler, 1995). Moreover, it encourages participants to explore specific events and situations, which can help to elicit detailed narrative accounts, rather than concise statements and answers (Hollway & Jefferson, 2000). Within the narrative interview process the researcher becomes an active participant in the interview process, collaboratively forming narrative and meaning by actively listening and subtly probing the participant to expand on a topic or by pausing at significant moments in such a way as to facilitate the participant to say more regarding what appears to be particular areas of importance (Reissman, 2011).

Careful consideration was taken to ensure that the structure of the interview, imposed by the researcher, did not suppress the telling of narratives that often manifest unconsciously as the participant relays the story of their experience (Elliot, 2005). To achieve this, I used a minimum set of prompts to ask questions that would open up a topic (see appendix 8). For example, I started the interview by saying, “tell me about your experiences of counselling” or “what made you decide to access counselling?” This encouraged the participant to start at the beginning and convey the story in a chronological sequence; thus, forming a temporal ordering of a plot within the narrative account (Reissman, 2008). This interviewing technique is also supported by Creswell (2013), who stresses interview questions should remain broad and general to allow participants to construct meaning of an experience. Creswell (2013) also emphasised the importance of ensuring questions are framed as open-ended as possible to empower the participant to tell their story.

Data analysis

It is argued that analysing narrative data is not without its challenges. Squire et al. (2013) acknowledge that unlike many qualitative frameworks, clear accounts or procedures on how to analyse data, commonly found in grounded theory or Interpretive Phenomenological Analysis, are scarce in narrative research. Despite the challenges that a narrative researcher may encounter, narrative research establishes diverse and often contradictory layers of meaning and fosters a deeper understanding of individual and social change (Squire et al., 2013). Furthermore, analysing narratives and stories allows the researcher to investigate how stories are structured, the effects that narratives have, and how narratives are silenced or accepted within society. Narratives often depict problems and fundamentally carry traces of human lives and experiences. Thus, narrative research serves to explore, describe, explain, and ultimately understand human experience and society (Squire et al., 2013).

The first phase of the analytic process starts during the interview and after the interview has been conducted. This involves hearing the stories as they are narrated and experiencing the emotions of the participant and noticing my own emotional responses (Fraser, 2004). To capture these details, I spent time immediately after the interview entering any thoughts that emerged for me during the interview in a research journal. An example of this can be found in appendix 9. The following 'questions to consider' developed by Fraser (2004: 187) were used as a guide during this process:

> *What 'sense' do you get from each interview?*
> *How are emotions experienced during and after the interview?*
> *How does each interview tend to start, unfold and end?*
> *How curious do you feel when you listen to the narrators?*
> *How open are you to developing further insights about yourself, including insights that are derived from raking over past experiences that are painful?*
> *Do you have adequate support to engage in work of this nature?*

The audio-recorded interviews were transcribed verbatim. As well as helping to preserve confidentiality, transcribing the data helped me to become immersed in it. The transcription process enabled me to become more familiar with the content and the nuances of the data. By transcribing each interview verbatim, it ensured that the participants' voices were being honoured and that the stories remained whole. Fraser (2004) advocates that there are benefits to the researcher transcribing the data, as despite being time consuming, it allows the researcher to become closer to the stories

which helps to elicit new meanings as the researcher becomes more familiar with the narrative. Appendix 10 details the process of analysis.

Narrative inquiry is a case-centred approach and as the researcher I have paid close attention to the distinctive features and characteristics of each individual case; including, how the account was generated, the way in which the participant negotiates language, and how the narrator positions themselves in the story. (Reissman, 2011). As well as the verbal communication, I also analysed the paralinguistic characteristics of the interview, such as the participants' tone of voice, pauses and laughter (Squire, 2013).

Each story was analysed as a whole, rather than fragmenting the data. Once this was achieved with each narrative, analysis across transcripts was undertaken to identify common themes that emerged. As well as the researcher analysing the transcripts, my PhD supervisory team also agreed to look at the anonymised transcripts to prompt academic discussion re where there was convergence and divergence within the four sets of analysed data. This process went some way to ensure authenticity of findings.

Presenting the narratives

For the purpose of the research study, the findings of each story will be presented individually in Chapter 4, with a running commentary narrated by the researcher. Chapter 5 presents common themes across the four narratives. This will be followed by a discussion chapter analysing the unique aspects of each story and the common themes that emerged across each narrative.

Trustworthiness, authenticity and rigour

The reliability of qualitative research findings are judged based on criteria of rigour, trustworthiness and authenticity (McLeod, 2013). Rigour is a term pertaining to the trustworthiness and authenticity of research findings. According to the BACP ethical guidelines for researching counselling, to ensure rigour the researcher should be competent to carry out the proposed research. Competency can be assessed by ascertaining that the researcher has undertaken the relevant training and that s/he has the relevant experience which is appropriate for the study being carried out.

Accountability for the researcher's competence is an expected professional value and can be assessed by the researcher. Researcher competence is also assessed in consultation with the supervisory team and other research ethics advisors (Mitchels, 2018). In terms of ensuring my competence as a researcher in this topic area, I have utilised the training that has been provided by the university to develop my knowledge and skills around research methods and ethics. Supervisory meetings have also taken place either monthly or bi-monthly and this has been a valuable opportunity to discuss all aspects of the research process, including the design, sample, methods, and analysis of findings. In addition to the above, I believed it to be important to make good use of the skills and knowledge I have developed during my professional practice when undertaking my research. Kvale (1999) suggested it would be a nonsense for a therapist undertaking research to not use the potential inherent in their own therapeutic practice. The BACP also advise that the design, methods and implementation should be consistent with the research question (Mitchels, 2018). As outlined earlier, the use of the narrative approach was carefully considered and was determined as being appropriate and complimentary to a study of this nature.

Trustworthiness is a fundamental principle in the context of qualitative research. In qualitative research, the term trustworthiness is often used to convey the quality and credibility of the research and demonstrates that the findings have relevance in other contexts (Mitchels, 2018). Trust is also an essential element of the researcher/participant relationship and, as a researcher, I had a responsibility to demonstrate trustworthiness to the participants. Throughout this study, trust was established by clear communication, accountability, transparency and gaining informed consent. Furthermore, the autonomy and dignity of the participant was respected throughout the research process by ensuring that they had detailed user-friendly information about the study with clear aims and objectives identified, and that the participant's anonymity and personal data was maintained and protected (Mitchels, 2018).

In the context of a study adopting a narrative approach, Reissman (2008) states that a researcher can ground their claims of validity by: carefully documenting the processes of data collection and how the data was interpreted, relying on detailed transcripts, and providing an interpretation of the similarities and differences among

the participant's stories (Reissman, 2008: 193). Narrative research is a case centred inquiry and studies adopting this approach focus on individuals and groups, not population-based samples (Reissman, 2008). Similarly, Babbie (1995) maintains that qualitative research is not concerned with applying research results to a wider population and therefore not conducive to generalisability, but rather focuses a small number of participants and exploring their experiences in-depth. Therefore, due to the small number of participants in a qualitative study it is not possible to conclude that the sample is representative of the larger population.

However, Flyvbjerg (2004) asserts that case studies play a crucial role in the development of both the natural and social sciences. Case studies cultivate context dependent knowledge which is vital to the development of a field or discipline, as experts often base their work on detailed case knowledge. Experiments and cases, along with reflexivity are often responsible for major developments in scientific knowledge. Further, case studies pay attention to the narrative detail which elicits important insights (Flyvbjerg, 2004). Through an in-depth analysis of each individual narrative being presented, followed by an analysis and synthesis of similarities across all the case studies, authenticity will be demonstrated. Additionally, a careful and extensive exploration of where the findings of this study achieve a 'fit' to the findings of other empirical studies will facilitate the building of a series of authentic case studies which will resonate with others working in similar areas of research. Overall, Flyvbjerg (2004) offers an argument for the importance of case studies by highlighting case-based methods are rigorous, trustworthy, and essential for the practice of science and producing knowledge about the social world.

Having discussed the research design (including data collection and analysis and the ethical considerations of this study) in detail, the following chapter will present the findings of the narrative interviews.

Chapter Four: Findings

Introduction

This chapter presents the findings of the narrative interviews conducted with David, Paul, Tony and Andrew [pseudonyms]. Each story will be presented individually, with a commentary narrated by the researcher. The stories have been presented in chronological order. Each narrative account has been structured to represent how the account was generated in a temporal ordering of the plot of their story. The themes identified signify the overarching topics present within each story. Following each story, I will offer a critical reflection of my perceptions and experiences when interviewing each participant.

David's Story: The Silence of the Child Now Speaking Loud and Clear

Introduction

David's narrative was one of abuse; physical, emotional, and sexual, by his father, mother and eventually his older sister who had a learning disability. David stated that he did not know when the abuse started, but that the abuse went on '*as far back as he can remember until he left home*'. David is white British and was 57 years old when I interviewed him. The interview took place in a counselling room at the service where he recently had therapy. David received 15 sessions of person-centred counselling at an organisation specialising in supporting people affected by rape and sexual violence. David's interview was carried out around one month after his counselling had ended. At the time of interview David was employed full time and living with his partner. He has three grown up children from a previous relationship and has been divorced twice.

David's parents died many years ago and he expressed how he does not miss them, and it appeared that he wanted to distance himself from them.

> *They are just bad people and it's happened. And they are both dead. And I don't miss them, and I don't want them. Never have done*. (p16*)*

Pulling out the thorn

In keeping with the narrative interview approach, I began by asking David to tell me about the story of his counselling and asked him to think back to when he first decided to access support in relation to his experience of CSA. David visited his general practitioner (GP) at least once a year for a check-up due to high blood pressure. On one particular occasion, around one year ago, he visited the GP for physical health problems, consisting of general aches and pains and having regular colds. When he was discussing his first disclosure to a professional, he said that he told the doctor he felt '*depressed*'. However, when I later explored this further and asked him about when he told the GP he felt depressed, he dismissed the comment about depression and said that he visited the GP due to physical ill health. David's reaction to my question could imply he was uncomfortable with the label of depression, as he appeared to become slightly defensive. Evidence suggests that men are less likely to consult a doctor about mental health issues, including emotional and physical indicators (Daines et al., 2007). Due to this mental health problems often become severe by the time they are identified by professionals (Daines et al., 2007).

The GP David saw when he first disclosed his abuse was a female doctor that he had never met before. Within his narrative he described how he '*broke down*' in front of her and he then told her that he had been abused as a child. Before this, David had not told anyone except his long-term partner about the abuse experience, and it appeared he felt safe in telling the doctor, who was not known to him. In his narrative, he considered whether her being a stranger contributed to his unexpected and spontaneous disclosure. David also described in detail how the disclosure impacted on the GP. He believed his disclosure '*upset her'*, as he had to get '*tissues out for both of them'*. Her emotional reaction clearly had a beneficial impact on David, as he said he '*felt understood'*, '*listened to*' and '*supported*' and he also stated that he was '*lucky that she was supportive and sympathetic'* towards him. Her emotional response had the potential to legitimise his feelings surrounding the abuse experience. David felt a deep sense of relief after telling the GP about his experience of CSA and he used a fitting analogy of this experience:

> *Like having a thorn in your finger and you pull it out and you go ah.* (p2)

Although David had told his partner that he had been sexually abused as a child, his encounter with the GP was his first verbal disclosure of the abuse. It was a number of years ago that he revealed he had been abused to his partner. However, he was unable to voice the abuse and instead typed it out on his phone and showed her the text. At that point in time, voicing the abuse was clearly too painful for David, which is an important consideration when working with survivors of sexual abuse in clinical practice. This is particularly important when considering the referral process, as it may be difficult for some individuals to articulate their need for support verbally, over the phone or face to face. Similar to David's experience of telling the GP, he felt relieved after his disclosure to his partner. However, prior to this the '*not knowing*' regarding how the disclosure would be received, by both the GP and his partner, made him feel increasingly apprehensive.

In terms of David's first visit to the centre where he had counselling, he felt relieved that he would finally be able to talk to someone that was *'non-biased'* and, prior to his arrival, he also believed he would '*not be judged'*. Non-judgemental communication is fundamental for abuse survivors, as a predominant reason for delaying disclosure and not seeking support is the fear of being judged (Kia-Keating et al., 2010). The positive reaction to David's disclosure from the GP made a significant impact on how he felt about seeking help for the first time in relation to CSA. After all, he had delayed disclosure for over 50 years. David described how he felt '*at ease*' immediately when he initially attended the service for the assessment and, when he met his counsellor for the first time he talked of how he just wanted to "*blurt it out"* (p1). He articulated an overwhelming feeling of relief at being able to talk about the abuse. Although at this point David had only disclosed to two people in his lifetime, he had never talked about the abuse in detail, and he felt '*surprised'* at how '*easy'* it was to disclose details of the abuse to his counsellor.

Punishment on top of punishment

David's childhood was characterised by a myriad of abusive experiences at the hands of family, school children and teachers. He described the abuse at home as consisting of physical violence, emotional abuse, and sexual abuse. He was repeatedly bullied at school and described himself as '*soiled*,' '*smelly'* and '*scruffy*' due to neglect,

resulting in punitive victimisation at the hands of his peers. He was an isolated child and had nobody to talk to, which he believes is a consequence of the generation that he grew up in. Although vehemently stating throughout the interview that things are different now, that the help for children is there and teachers are more understanding, there appeared to be an element of doubt in his narrative. Mainly, as he stated that it is now easier for children to tell; he kept reiterating how difficult telling is and he did not seem convinced by his own statement. He also relayed the experiences of not being able to talk to his teachers, as they were '*strict*' and he described how the teachers physically punished students for not doing their homework. David poignantly remarked that there was '*no safe place as a child* (p2).'

> *In a way there was home and go to school and you should feel comfort…but I didn't and there* [school] *it was just so much stricter*. (p2)

Overall, the topic of '*things being easier now'* was conveyed regularly during the interview by David when it came to disclosure. However, he repeatedly uttered that it is '*not easy to tell'*, believing it was easier for an adult to disclose abuse than for children to make a disclosure. However, after stating this David then pointed out that it is not easy for an adult as it '*took* [him] *over 50 years to disclose*.'

I'm one of them!

An important juncture in David's life, that appeared to help him feel less alone, was when media reports surfaced regarding the late Jimmy Savile committing multiple sexual offences against children. The events surrounding Jimmy Savile appeared to be a constant source of reflection for David, and he discussed how he would often talk about it in therapy. Within his narrative, David engaged in a dialogue between himself and those individuals that criticise people for coming forward to disclose historic child sex offences. His tone sounded angry, evident by raising his voice when speaking of this:

> *Why didn't they come forward before? Because it's not easy to come forward and now he's died, so it was easier. Because they thought well he can't hurt me no more, it's time to say now*. (p3)

His tone of voice when making this statement was suggestive of an act of defiance towards the critics, perhaps feeling that he needed to defend those people that he could identify with, based on their shared experience of being abused as a child and disclosing later in life. The sense of identification was apparent in how he used the words *'like me.'* He then went on to say that, like him, *'they found the courage to tell'*. Nevertheless, he quickly retracted the term '*found the courage',* insisting his disclosure did not take courage as it *"just happened, it just came out"*. This might be indicative of believing others are brave and courageous, but these attributes cannot be applied to his disclosure. Similar to the survivors abused by Jimmy Savile, David's abusers have also died, and he identified with the feeling of safety at coming forward to disclose the abuse. There was a palpable sense of anger when David talked about how there is now '*help out there'* for abused children.

> *But the help is there, and I always looked at the telly and about the abuse of these children, obviously it's horrible, but I always think…I'm one of them! I was one of those children that was abused! Where's my help? You know and in a way I was a little bit jealous I suppose*. (p3)

This fleeting outburst of anger reflected his feelings of being ignored as a child and was evidently followed with a sense of guilt that he felt jealous of other abused children. Despite the feelings of anger towards the public and feelings of jealousy towards those who are able to receive help, the cases of sexual abuse in the media gave him the confidence to talk about his own experience. He later referred back to Jimmy Savile, and also Rolf Harris, another prominent celebrity convicted of sexual offences involving children. When discussing the '*superstar*' sexual predators, David described himself as:

> *One of them children that was abused and did nothing about it*. (p3)

This statement indicates David believed he had options as a child, but he disregards living in a home that was characterised by systematic abuse at the hands of his entire family. Although he had already told me that it was not possible to tell a teacher and there were no services available to help abused children, he still believes he did *'nothing about it'*. It is also possible that the statement is not related to disclosure per se, but his feelings of vulnerability and powerlessness throughout his childhood. When

discussing the celebrity sexual abuse scandals, his description of himself and other children sounded like he was describing a subculture, consisting of a generation of children that experienced sexual abuse and did not have a voice until later in life:

> *I clap these people that have been strong enough to come forward and tell the bad things that have happened to them with these superstars and…well they don't have to be superstars, but they have had the courage to do it and I know from my experience. I don't think people understand when they see things on the telly how hard it is to come forward*. (p9)

The sense of admiration David felt towards individuals coming forward to disclose historic sexual abuse was undeniable. Regardless of this, he still believes there is a social lack of understanding in terms of how the public perceive CSA survivors. He acknowledges that CSA is now *'fairly prominent in the media'*. However, he believes there is not a sufficient emphasis on how survivors can access support for sexual abuse. Rather, the media focuses on the stories and details of sexual abuse, rather than how help can be accessed. David feels that the media has a responsibility to tackle this issue, and he reflected on his own experiences to illustrate this point:

> *When I was little there was no help there anyway so I suppose I couldn't compare, but as an adult, I can look back and say I was abused but it* [help] *wasn't there and it's not easy to…I don't know…ring* [name of organisation] *up because who are they? And it's not sort of help there if you like…in the media*. (p9)

David was told at his initial assessment that the waiting list for counselling would be around 16 weeks. However, he waited around six months for counselling, and after the 16 weeks had past, he began to think that the service had forgotten about him. This was a particularly agonising time for David, as he felt that he had got so far, and the opportunity of help was going to be taken away from him. This emphasises the significance of transparency when services are informing clients about waiting list times. The counselling service that David accessed predicted how he might be feeling, as he eventually received a phone call from them to say that he was still on the waiting list and they had '*not forgotten'* about him. David found this humorous, as they identified his anxiety about the long wait. The wait for counselling is one major problem that David would like to see changed. This could be considered an irony, as although he waited over 50 years for help in relation to CSA, the wait between his initial

disclosure and his first counselling session was incredibly arduous. A recommendation he suggested to overcome this issue was for services to call clients on the waiting list at least once a month to reassure people that the service has not forgotten about them. Despite making this recommendation and pointing out the wait being a flaw within the service, he seemed to feel bad about criticising the service and quickly maintained that it was probably just in his personal experience the wait felt long.

> *I was like oh is it this week? Because in my head it was like* (whispers): *Is it this week they are going to ring me? It never went away because I was sort of waiting for the phone to ring. It was the only hard bit. Well, I don't suppose it was hard because it didn't matter, I suppose* (laughs)*. Well the doctor…I suppose that was the biggest step I suppose. The doctor. So, I suppose the next bits were always going to be easier than the first time*. (p9)

The above extract can be considered as ambiguous. Despite feeling he had already overcome the hardest part by disclosing to the GP, he found the wait was extremely difficult at times. In contrast, David felt excited that they might be ringing him each week. The various emotions David experienced during this period is analogous to a young child being promised something, to which the child then becomes intense and excited about it happening. David displayed these behaviours when whispering "*is it this week they are going to ring me"* (p14)*.* On occasions David's inner child appeared to manifest during the research interview, exhibited in his language, his tone of voice and body language. An example was when he referred to the abuse as the '*naughty things.'*

When discussing the '*celebrity'* offenders of CSA, David articulated his anger at the rewards these men received throughout their media careers. Although one of these offenders died before allegations were made public, David feels that Rolf Harris has been brought to justice, as a result of the '*brave people who came forward'*. In turn, David feels '*justified',* as for him the conviction represents justice for all survivors of CSA:

> *But I do applaud the people who have come forward and helped to put the Rolf Harris's of this world away. Because that is where they belong. Because he was publicly a nice person, but behind walls he was a bad person.* (p10)

The above statement echoes David's isolation as a child and his anguish that everyone around him neglected to notice that he was being sexually abused by his caregivers. David feels that if he was a child in the present day, people in a position of trust would have noticed him; specifically, his '*smelly*' and '*unkempt'* appearance. Overall, there was a fervent sense that he had been failed by those around him. David believed the help was not available for him throughout his childhood and for many of his adult years, and when help did arrive it was *'far too late'*. He described this lack of support as a major regret. There was also a sense that he never really escaped the abuse throughout his teenage and adult life, despite leaving home:

> *The sexual abuse had stopped but there was always the mental abuse, that was always there.* (p4)

His abuse experience certainly shaped the way he parented his own daughters, as he reflected on his own upbringing:

> *The parents that most people have where you could talk to Mum, or you know…Dad would take you fishing. All of these lovely things that parents do. I, as a parent, make sure that my children…I have got three girls and it made me in a way a stronger person for my children*. (p4)

The above excerpt demonstrates the '*ideal'* David feels a parent should be, as he provides an archetypal image of a listening, caring mother and the father who bonds with his son over what could be considered a masculine pastime. He described himself as being an '*object'* to his parents. He feels his abuse was a bad thing, but good has come out of it, in that it made him a stronger person for his children, being able to recognise what was missing from his own childhood. When discussing how his abuse impacted on how he raised his children, he refers to the misconception that individuals' who have been sexually abused as children go on to abuse others later in life (Perez-Fuentes et al., 2013).

> *What happened to me…I don't have to do that. I have a choice.* (p4)

David's narrative echoes a common fear and reason as to why many CSA survivors do not disclose their abuse experiences. The fear of being perceived as a perpetrator of abuse has been found to be a prevailing effect of CSA, particularly in male survivors (Lisak, 1994; Perez-Fuentes et al., 2013). Despite this shared fear amongst CSA

survivors, a very small number of individuals who have experienced CSA later go on to perpetrate sexual abuse (Salter et al., 2003).

Amongst the many benefits of his counselling David expresses throughout his narrative, was how it had improved his interpersonal relationships. A major development for him was his ability to tell his three children that he had been abused, which he credits with bringing them closer together.

> *It's because of the service and my counsellor that gave me the strength to tell them, because I think it's an honest thing, coming to counselling broke down a lot of barriers for myself and gave me the confidence to tell people that I love*. (p4)

As well as giving him the confidence to disclose to his daughters, he believes his disclosure helped them to better understand him and ascribe an explanation for certain emotions he displayed throughout their childhood, including depression and low mood. Furthermore, he feels that his family are proud of his strength. He readily acknowledges the crucial event in pioneering the changes within himself and with his loved ones, was the initial encounter with his GP, when he was '*freed*' of his '*emotional baggage*', which caused a significant release for him.

> *But that comes back to the doctor that first time, that initial first time getting rid of this emotional baggage that I've got and like I said it was liking taking the thorn out, a bit of a release.* (p4)

David was extremely positive about his counselling and felt that it was hard to articulate how much it has helped him. He reflected on his initial assessment, when a counsellor asked him what he wanted to achieve from therapy and he now feels that he has accomplished his goals.

> *It just made me feel good about myself, that it wasn't my fault. That's it…we can't change that. It made me feel comfortable in myself. (p4)*

Evidently, David's counsellor helped him to challenge his feelings of self-blame that he had been harbouring since childhood. It was clear that he came to the realisation in therapy that he cannot change the past, but he can change how he deals with it, which also impacted on how he processed the abuse experience. He went on to

describe how he '*struggled immensely with any form of conflict within his relationships'* and had never had the confidence to communicate his true feelings to his partner or others for fear of upsetting people. David recognised that this was associated with his childhood, as when he upset people there would be '*serious consequences'*, which lead to physical and emotional punishment. He described how, in times of conflict during adulthood, he would keep '*everything to himself*', which was the same coping strategy that he adopted during childhood, substantiating how the past can manifest in the present. His traumatic childhood memories of being "*hit and shouted at on a daily basis*" impacted on how he raised his own children. He attempted to dissociate from his past and he feared that by shouting at his own children he would replicate his own childhood experiences for them. However, he did have to occasionally shout at his children and he clearly felt guilty, as he attempted to justify to me that "*children do cross the line, it didn't make you a bad parent just because you shout at your child"* (p5). Despite this defensive remark he laughed, which suggests that he has re-evaluated certain experiences in counselling. David stated that counselling gave him the tools to "*re-train his head, brain and thoughts on how to deal with things"* (p5)*,* which impacted on his behaviour.

David asserts that his engagement in therapy also helped his partner, as with the help of his counsellor he learnt to communicate his feelings to her in a way that felt safe for him. Before counselling, he had difficulty in trusting people, and he believed talking about the sexual abuse would lead his partner to perceive the abuse as '*part of*' him*.* Another issue with his relationships was the debilitating feeling of '*not being good enough'* which led to internalised anger. It was apparent that, before David had counselling, he did not value himself and he struggled with low self-worth.

He told his counsellor that a major problem in his life was that he *"over-thinks things."* The example he gave was when he texted a friend to invite him out to play a game of darts and the friend responded to the message with one word '*golf'.* This incident upset David and is an example of how an individual with low self-esteem might interpret the behaviour of others. I noticed that he became rather childlike when relaying this part of his story to me. Through the process of counselling, his narrative changed from one of deprecating himself for doing something wrong and upsetting his friend, to being able to rationalise that his friend was most likely busy playing golf whilst responding to

the text, and was unable to send a lengthy reply. David acknowledged that he is a sensitive person and that through counselling he has found confidence and is able to take a different outlook on life, which has led him to be a much '*happier*' person. Indeed, throughout the interview David regularly referred to how counselling led to an increase in his self-confidence.

> *I suppose it is my outlook on life. I think I have beat myself up too much all my life and I think my counsellor has just…like I don't say wave a magic wand but made me think about things, about myself and the way I overthink things, my day to day life…not overthink things. She gets an understanding of me, so she can talk to me into certain ways of thinking about my daily life and because she has listened to me, it has given me the confidence to go whatever route I like*. (p13)

The naughty things

David views himself as a "*happy person by nature*" (p6) and he has worked hard to try and remain happy in order to forget about the *'bad things'* that happened to him. However, he concedes this is '*strange*' to him because he feels that he should not be happy due to all of the *'naughty'* things that have happened to him. David's use of the words '*naughty things*' to describe the abuse sounded childlike as he expressed it to me on a number of occasions throughout the interview. It was akin to a child describing a game that they had played or something naughty that they had done that could have got them into trouble. Using the word '*naughty*' could also indicate that he perceived he had an active role in the abuse. Feeling like an active participant in sexual abuse is a common emotional effect of CSA, as the perpetrator will attempt to prevent disclosure by coercing a child into feeling like the abuse is their fault, that it is a secret, and that they will not be believed (Alaggia & Millington, 2008). David emphasises how he always tries to be happy and have a laugh, perhaps as a defence mechanism to compensate in the present, as a way of making up for his childhood. He stated that counselling has helped him to see the '*bad things'* that have happened to him. It appears that counselling has helped David to legitimise his feelings around the abuse being bad. He explained that he was able to talk about the '*naughty things'* in counselling which has been the first time in David's life that he has felt free to talk about the abuse in depth. It was also important for David to understand that he did not have to talk about the details of the abuse in his counselling if he did not want to.

Although he was eager to discuss the abuse, due to the emotional release he experienced, it was a comfort for him to know that this was optional and under his control. Indeed, during some sessions he would talk about specific things that had happened to him during the week or he would discuss difficulties he was presently having in his relationship with his partner. Despite this, he was always aware that the service was specifically for people that had experienced sexual abuse and, regardless of diversion, he did want to discuss his childhood experiences.

The process of person-centred counselling allowed David to explore his feelings at a pace that was appropriate for him. He explained that he never knew what he was going to talk about each week, but there was always an *'ease about it'*. He described himself as a '*quiet person'* yet said that he was unable to "*shut up"*" throughout his sessions. Although there was no plan or agenda set by the counsellor or David, there was one occasion in counselling when he wanted to talk about a specific event, which led to him achieving one of his main goals of therapy:

> *Well, there was sometimes an agenda I suppose. One night I wanted to talk about the explicit thing that happened to me. Err because I thought perhaps it would help, because there was never any good memories*. (p15)

Obstructed Memories

David's childhood memories were clouded by bad and abusive experiences. He was able to discuss the explicit experiences in therapy and this helped him to process the traumatic material, which he asserts has helped him to deal with the trauma of his abuse. His main goal of therapy was to recover lost memories. The way David defined his memory impairment it was clearly highly debilitating and he directly attributed his memory problems with the physical abuse he experienced at the hands of his family.

> *I know that stems from my childhood because I was always wellied*. (p12)

A profound memory that David shared within his narrative was when his mum made him go to the bathroom with her and she then did '*sexual things*' to him. He views his childhood as '*a regret'*, which implies that he perceives his childhood as something he had control over. He remembers his dad often being at the pub and absent from the

family home and he also discussed how he never had a family holiday, which undoubtedly made him feel different from his perception of the life of his peers.

> *There were no memories there because it was repressed, all the time I suppose*. (p16)

David's use of the word '*repressed*' to describe his forgotten childhood memories demonstrates how psychoanalytic language and terminology is a culturally imbedded part of the everyday lexicon of modern society (Henderson, 2012). David maintained that his memory difficulties were directly linked to his childhood. He also held the assertion that he could not remember things because he felt that he '*lacked intelligence'*. He described how he worked on these issues in therapy and now recognises that he had no self-belief and he discussed how this stemmed from his childhood and being "*downtrodden everyday*" of his life (p12). The emotional abuse had a significant impact on his self-confidence and, following two marriage breakdowns, he felt that he was to blame for all the bad things that continued to happen to him throughout his childhood and adult life.

> *I suppose that's my fault and I've always blamed myself for all these things. I was…I always thought everything was about me. That bad things have happened, and carried on happening even in my adult life*. (p12)

The feelings of self-blame and the self-doubt that eclipsed his life and relationships was something that David explored in therapy. He asserts that his counsellor helped him to normalise his feelings of being *'unintelligent'* and his frustrations around his *'obstructed memories'*, after he previously described himself as "*not the brightest button*" (p12). Throughout his life, David associated his memory loss to his perceived lack of intellect. However, the process of therapy allowed him to recognise his abilities and arrive at a conclusion that some people excel intellectually, and others excel at practical and hands-on activities. After identifying that he belongs to the latter category, he was able to list a number of his achievements, which improved his self-belief and confidence. David's experience of counselling had a dramatic effect on how he viewed himself, and he evidences how his self-beliefs and personal narrative began to change throughout the counselling process:

> *Everyone forgets things, she* [counsellor] *rationalised a lot of things for me…that I put myself down too much and I suppose she gave me…without a doubt…gave me the confidence to say well actually it's not as bad. The bad things happened, but I'm not really that thick or…and I never thought before well there is intelligent people out there, but that's the way it is. Just some people are intelligent. Most of us…the general public are alright, that we're not thick or…but I thought that because of my childhood*. (p12)

When discussing his increased confidence, David described himself as having two different parts:

> *Well surprisingly I am a sociable person, well I play darts and I go to the pub and so that side of me is alright. I have got confidence on that part of me, but when it comes to err myself, I sort of extravert that side, but I am not really. I just am a bit quiet really inside but that part of me I enjoy a laugh, so I like that part of me, but I also enjoy this part of me now and that's what counselling has done for me.* (p12)

A social friend

David often referred to '*the ease'* he experienced during counselling, and it is evident from his descriptions of his therapy sessions that his counsellor offered him the core conditions, of unconditional positive regard, empathy and congruence (Rogers, 1957) in a safe and contained space. He explained how his family and partner experienced a noticeable change in his behaviour. His partner was clearly supportive throughout his counselling experience. Although she did not ask for details about the sessions or what he had discussed, she would ask him '*how it went'* and if he had *'any homework'* that week. I asked David for a little more detail about the 'homework' he was given by his counsellor. He explained that '*it wasn't homework as such, as it was more like goals to achieve in between sessions.* 'For example, confronting his partner about incidents when he was upset and spending time rationalising and reflecting on how other people, such as his friend, communicated with him.

> *Like the texting thing, it was easy to rationalise it and think about it. So that was my homework, when I say that you have to work at it. It was about like when he* (friend) *text…I had to think…don't read too much into it*. (p7)

The counselling skills offered by his therapist undoubtedly facilitated a successful working alliance. Within his narrative he describes her as being non-judgemental and having a listening ear, demonstrating counselling skills in practice.

> *She's a counsellor so there is a certain amount of trust for me, and I knew straight away that someone is there, who doesn't know me, she's there to sit there and listen to me…not so much coax me, but let me do the talking. She probably guided me. Well, she did guide me. There is no question. Not perhaps (laughs). She did guide me to well err talking about myself, about my abuse, my…all aspects of it. I suppose I have always wanted someone there, just to say: This is my life story about my childhood, my adult life. These are the things that have happened. I just wanted somebody to listen and say: These are the naughty things that have happened to me, I am not a bad person, but I have had bad things done to me*. (p8)

The above excerpt demonstrates the impact that counselling has had for David. The counsellor guided him to talk about the abuse. David first used the word *'coax'*, which implies that the counsellor attempted to probe details from him or encouraged him to talk about the abuse experience. However, he then contemplated this word and stated that she guided him to '*talk about himself and the abuse'*. The counsellor allowed David to take control and discuss the abuse experience when he felt ready. She walked alongside him, guided him in finding his voice, and gave him permission to talk about his feelings.

> *I think just the matter of somebody sitting there and actually just letting me talk about my feelings. But also, being guided into certain areas of what's happened*. (p11)

An important aspect of the support he received being effective was that he did not feel that the counsellor was shocked by his descriptions of the sexual abuse. This potentially added to the trust he felt towards his counsellor. Experiencing a response from someone that may have indicated shock appeared to be an underlying anxiety about initially reaching out for help. A support service targeted towards sexual abuse survivors seemed to ease this concern for David. When he introduced the subject of *'shock'*, I asked David if it was a concern for him before he went for counselling.

> *I don't think it was actually because I think they are counselling people because they have heard it all before. So, in my head I thought…well they have heard it all before so I'm not going to shock this person. So straight away you feel alright about it…well I felt alright about it. Other people might struggle to release what's inside of them. I found it quite easy. I'm surprised how easy it was. I think because of that stranger, she was there because…well she was there for a*

> *reason. She was there to listen to me, my issues and what happened to me. She wasn't going to be shocked*. (p13)

This highlights the significance of professionals' knowledge of specialist support services, specifically for sexual abuse survivors. David initially presented with symptoms of depression and a referral to counselling for general mental health problems may have caused added anxiety for him around responses to his disclosure. Certainly, for David the knowledge that he would be attending a specialist sexual abuse service put him at ease when it came to the reactions he expected to receive when discussing his abuse. For David, the knowledge that the counsellors in the service were specially trained in issues related to sexual abuse potentially made the service more accessible to him. His experiences of being able to talk about explicit material or sexual abuse and his counsellor not reacting in a '*shocked way'* seemed to add to her being more trustworthy for him. In addition to his feelings around the counsellor's reaction to his dialogue about his sexual abuse experience, David also referred to the research interview interaction;

> *That listening ear is obviously important because lots of not so nice things have happened to you and she wasn't shocked…or you know you think well if I say a certain thing like…it's like you* [researcher] *are looking at me now, just listening and understanding without judging and without looking at me in a shocked manner*. (p13)

When discussing his relationship with the counsellor, David used the definition *'a social friend'* to describe her. He considered it a type of friendship, as he looked forward to his weekly sessions, and he felt that the 50 minutes passed by *'extremely quickly'*, which emphasises the ease with which he was able to share his experiences.

Finding a voice

David asserts that getting the '*nasty'* things that have happened to him out in the open has enabled him to move on. The counselling helped him to find a voice and articulate his experiences in a way that felt comfortable and therapeutic. He was surprised at how quickly a 50-minute session would be completed and he looked forward to his sessions each week.

> *The other thing is I don't normally do a lot of talking*. (p7)

The above statement demonstrates David finding his voice through counselling. He stressed that before counselling he was always '*a listener and never a talker'*. It appears that David dissociated from his feelings for most of his life, up to the time of his disclosure, as connecting with the memories and emotions related to his traumatic experiences could be deeply painful. However, the safe, supportive space facilitated in therapy has helped David to confront these painful experiences and created a definite sense of relief. As well as being able to talk about the abuse for the first time in his life, David described how he was able to *'put what he learned in therapy into practice'*, which inevitably helped him to cope more effectively with everyday life. David viewed counselling as the opportunity to think about himself, which was a unique experience for him.

> *I suppose it just makes you think about yourself, they are not all bad people out there. There is good and there is help* (p8)

A significant achievement for David was telling his daughters he had been sexually abused. He recollected how he felt that his counsellor was '*shocked*' when he told her during his session that he had told his daughters that week. It was evident that David felt proud of himself for making the disclosure to his daughters and he was eager to tell his counsellor, as he acknowledged her for giving him the confidence to tell them.

> *I think she* [counsellor] *was a bit gobsmacked really, that I had gone to that level…the next stage*. (p8)

David had previously stated that the counsellor had not been shocked by his descriptions of the sexual abuse that occurred when he was a child, and that was an important aspect of the therapy being successful. However, he appears to be accepting of the counsellor showing signs of shock regarding his disclosure to his daughters. The shock she displayed did not appear to damage their relationship and, how he conveyed this event during the interview, suggested he felt that he was pleasing the counsellor with his progress.

Your past is your past, and tomorrow is your future

As a final thought during our interview, I asked David what advise he might give to another man who has experienced CSA and is considering going to a support service for counselling. David conveyed significant confidence in counselling working for other men that have experience sexual abuse as a child. However, he did stress that it is vital for the individual to feel *'ready'* to talk to somebody.

> *If you come and talk…I just guarantee you will feel better for it and it is just a relief. Your past is your past and tomorrow is your future. Just talk about what you want, when you want, if you want. If you just want to sit there, that's fine*. (p15)

David cautioned that it is not easy for everyone to deal with their abuse and talk about it but emphasised that we live in a '*more modern world'* when it comes to an awareness of CSA, which he directly attributes to enhanced media coverage. He also feels that teachers are better placed to recognise warning signs of abuse than during his own childhood. There was an unquestionable sense of him feeling let down by his teachers. He is certain that if he were a child in today's society, a teacher would have escalated a concern based on certain behaviours, such as when he used to soil and wet himself and that he lacked personal hygiene. This then led to more abuse and isolation by his peers who would bully David. As David relays these deeply poignant experiences of abuse leading to more abuse, he then started laughing and stated that *"thankfully all that has changed"* and he does bath and shower now. It can be noted that throughout his narrative David often used humour when discussing uncomfortable and emotionally painful experiences.

Breakthrough

It was previously mentioned that David's main goal of therapy was to recover memories. As the interview was coming to a close and David had discussed in-depth about the many advantages he experienced in having counselling, I asked David if he felt there was any disadvantages about his therapy. He responded confidently that from his personal experience there were no negative aspects to the support he received. He then explained again about how he *'looked forward to the sessions'* even though he never knew what he was going to talk about. He stated that there was no agenda, then hesitated slightly, as he recalled an evening session around the tenth

week of therapy when he wanted to explore one of the '*explicit*' things that had happened to him. His rationale for wanting to talk about the explicit memory was that he had no good memories of either of his parents, particularly his mother, and he thought that exploring the specific abuse memory might help in some way to uncover any good memories that may exist from his childhood. Despite his desperate attempt to uncover a good childhood memory, the significant therapeutic movement he experienced was related to a memory he uncovered from his early adulthood.

> *It was only after about ten weeks that I actually thought of a memory of my mother. That she was actually…that I was going away for the first time, as an adult, and I was going away for two weeks. And that was the first good memory of her…when she looked like she was going to miss me. I was 18 and I couldn't remember a good memory with my mother. Certainly not of my father, but err I think it is what I wanted out of counselling. I wanted it to trigger some sort of memory*. (p16)

David's narrative concludes with the breakthrough moment of recovering a significant memory. He appears to view his mother's reaction to him going away as an expression of affection and he defines this moment as a positive memory. As a child who felt extremely unloved, acquiring this memory through counselling evidently met his needs. However, he goes on to say that the difference between himself as a parent and his own parents are that his children mean everything to him, yet he feels that he meant nothing to his parents. He explained that it is something he *'has to deal with'*, which suggests that it is still a difficult issue to work through. However, counselling has helped him to re-evaluate his own feelings towards his parents:

> *They are just bad people and it's happened…and they are both dead…and I don't miss them, and I don't want to. Never have done. My counsellor said something about it's called a sense of duty. I had never heard that phrase before and that sort of means a lot. That little phrase…sense of duty...because it doesn't mean you love somebody. You just have to do it. Well you feel like you have to*. (p16)

Throughout his narrative, David described his childhood as being defined by abuse and bullying within the home and at school, with no safe place to escape. However, the memory he recovered in therapy about his mother prompted the recollection of a childhood event that held great significance for him:

> *So, way back in my mind and I suppose I have only got certain memories and they are all bad ones. But they were memories. But saying that…there were other memories that came out about my friends in childhood that I had forgotten about. So that triggered some good memories like. Like you know about the friend I had and what we did. So there was memories there. You know…I had forgotten about them. So that in itself helped to talk about that and also trigger something. You know like one door closes and another opens in your head*. (p16)

The memory he was referring to was related to an accident that he had as a child. He explained how he tried to jump over a wood spiked fence but did not make it. Subsequently, a spike went into his leg and he remembers his mother taking him to the doctor and having to have an operation. As well as the memory of his mother seeming to care about his welfare, he remembered his friends being all around him pointing out his leg in admiration. "*I was the big hero at that time*," he remarked proudly. It can be concluded that David found the memories he was searching for in counselling, but he remained adamant that his mother was bad. There was evidence throughout his interview transcript that he yearned to find good characteristics and memories about his mother. However, David was resolute that his father was just '*bad'* and he seemed to have no expectations of a good memory of him emerging into his conscious awareness. It could be argued that his counsellor allowed David to explore his feelings in relation to his parents and gave him permission to express those feelings without feeling guilty; particularly, as he concluded the interview by discussing how he had always felt like he had to *'love his parents'*. Therefore, when his counsellor offered him the phrase '*sense of duty'* to describe how he felt obligated to love his parents, it resonated with David and appeared to give him permission that it was okay not to feel love towards them.

> *That little phrase sense of duty because it doesn't mean you have to love somebody. You just have to do it, well you feel like you have to. It has stuck with me and I have used it so many times and well like I say…counselling has helped me to understand the world out there. Well it's not nice…but the fact that you can talk about it is a good thing. It's made me feel better within myself. There are so many positives, I can't think of any negatives. I can't*. (p16 &17)

Summary

David began his story by describing how he was referred to the specialist counselling service by a GP. During his appointment with his GP, a new female doctor, he spontaneously disclosed his experience of CSA. David had disclosed to his partner in the past and he described how his CSA experience has had a profound impact on his intimate relationships. David described the issues inherent in society around people not understanding or believing that males are sexually abused as children, as well as females. An important benefit of counselling for David was being listened to, not being judged, and being able to talk to a counsellor who was not shocked by his experience. Counselling helped David to disclose his experience of CSA to family members and it has had a significant positive impact on his relationship with his partner and children. David struggled to remember his childhood experiences and described his memories as repressed. He achieved an important goal through therapy, which was to remember a positive childhood experience. Overall, he described counselling as helping him to *'feel good'* about himself and to realise that the abuse was not his fault.

Critical reflection

David was the first person that I interviewed for this study. After being contacted by David expressing an interest in taking part, we arranged to meet in a counselling room where he had previously been a client. David requested that we meet in the evening, as he was attending after work. I felt nervous about what to expect but also excited that I was conducting my first interview. I immediately warmed to David after meeting him in the reception area and walking to the room together. He looked slightly anxious and he smiled and shook my hand firmly, making small talk about his journey on the way to the room. He commented about how it felt strange to be back in the service, after ending therapy about a month ago, and he mentioned that the time he requested to meet was the same time that he used to have his counselling session (after work and after his dinner). While keeping this routine made a lot of sense to me; I instantly felt concerned that he would expect a counselling session, as opposed to a research interview. However, I soon felt reassured as David discussed his motivation to help in any way that he could by sharing his experience of therapy to help other men, and also to help make people more aware that men also experiencing sexual abuse. As this was my first interview, I was unsure what to expect. Although I was initially anxious, I felt myself instantly relax as David started to talk. Despite his large stature, he had a calming voice and I found myself captivated and deeply saddened by his

story. David's pain when discussing his mother's lack of affection and love was palpable. David was the only participant to disclose sexual abuse by a female and the fact that one of his abusers was his mother, and his anguish at his mother's lack of affection, deeply saddened me. I felt a strong urge to comfort him, as he shared his pain. Having worked with many survivors of sexual abuse in my work as a therapist, I have heard many stories of horrific incidences of violence and sexual abuse which occurs in the family home; a place that should be safe and where a child should feel loved and secure. I have often encountered the pain shared by individuals who had mothers who were implicated in the abuse; either by knowing about CSA and not protecting the child, or being actively involved in perpetrating CSA, as in David's case. Although the sexual abuse was instigated by his father, it was clear that his unresolved conflict was with his mother, as she remained at the centre of his story. As with other individuals I have worked with, I find it difficult to understand how a mother could allow their child to be harmed and I felt very protective towards David, as he shared his story.

David described himself as *'not normally a talker'* but I found an ease with the conversation between us, and the time passed extremely quickly. David's story remained at the forefront of my mind for some time, and I discussed him in my clinical supervision. I felt very relieved and excited that my first interview was complete, and I finally felt like my PhD might be achievable, after a long process in considering the ethics application and the reaction often received when telling people what my research was focused on (that of surprise and the frequent question of "how will you get ethics approval for that?"). I also felt very honoured that David chose to share his story with me. I was in awe of his courage and strength in what he had overcome. As David talked about the admiration he had for his counsellor and he discussed how counselling had helped him, I felt very proud to be part of a profession that could make such a difference in an individual's life. Overall, I enjoyed the experience of the interview and found that there was an ease in talking to David.

Paul's Story: No longer that deaf, dumb, and blind kid

Introduction

This is Paul's story; a 60 year old man at the time of interview, who experienced sexual abuse at the age of 10 years old, the perpetrator being his uncle. Paul works as a painter and decorator and has been married twice. Paul and his wife have seven children between them. The interview took place at the sexual abuse support service where he had been receiving counselling for the past 12 months. Paul's last counselling session had been arranged to take place after the research interview. The sexual abuse he experienced took place in 1967, when he was ten years old, and he described it as a '*different world'* back then. At the time of the abuse, he told his parents who are both now deceased, and he stated that he was '*never quite sure'* whether they believed him.

Closure

I began the interview by asking Paul to talk about what made him access the counselling service for the first time. Paul responded with a brief reply: *"in a few words…to find closure."* This statement echoes a desire to put an end to something that perhaps he experienced as painful. As Paul did not elaborate any further about his reasons for accessing counselling, I went on to ask him what it was like to find support, in the hope that he would start at the beginning of his counselling journey. Paul responded by telling me how finding help and support was '*very difficult'* He then went on to state;

> *I'm not one that takes tablets. I wasn't going to take tablets. That isn't me. That just blocks everything out.* (p1)

It appears that he was averse to taking medication as he felt that it '*blocks everything out.*' However, he went on to relay that he was being monitored by his GP, as he was drinking too much:

> *I was drinking too much. I know I drink too much anyway but I was drinking far too much. I knew that something had got to give…got to stop.* (p2)

Paul clearly had awareness that he was drinking too much and based on the tense of the above response, it suggests that he is still drinking what he considered to be '*too much'* at the time the interview took place. Paul described a positive relationship with his male GP, which led to him disclosing his experience of CSA to him around two years ago. In relation to the medication he mentioned, I questioned Paul as to whether medication was offered to him by the GP. Paul responded:

> *Not offered but suggested. I have got a very good GP that knows me inside out and he suggested tablets, but I told him that I wasn't taking any.* (p1)

Despite suggesting his GP knows him very well, it is contradictory that the GP suggested a course of treatment that Paul remarks '*isn't him'*. When exploring the process of disclosing he had experienced CSA to his GP, Paul stated that he told his GP around three years ago and it '*didn't really bother him'*, although the only thing that did bother him was that he was unable to '*keep it in check.'* When exploring what he meant by '*keep it in check'*, Paul explained that he thought *'it'* was dealt with, as it happened such a long time ago. This could be construed as evidence that Paul had been attempting to contain and control his emotions associated with the CSA. He also sounded disappointed with himself that he was not able to manage the effects of the sexual abuse. Paul described a '*change*' in his mental health, which prompted his GP to refer him for counselling. Paul did not articulate exactly what this '*change*' entailed, but later went on to disclose that he was drinking '*far too much*,' which could potentially be the change in his mental health he was referring to. Paul also explained that the GP was aware that his '*problems'* got worse with the '*Jimmy Savile scandal.*' His GP first referred him to a generic counselling service for mental health problems and Paul discussed how the counselling was helpful at first. He explained that the counsellor '*seemed alright*' and he had around six to nine sessions of therapy. Paul disclosed the CSA experience to the first counsellor and stated that the disclosure felt '*alright'* and '*not a problem.*' However, he then went on to explain that the counsellor told him that there would only be two sessions left due to her leaving the organisation to work at a service for survivors of domestic violence. Paul then asserted that the counsellor would "*not be very good at that*." Although Paul initially maintained that the counselling was '*alright,*' he then explained that the counselling was '*terrible'* towards the end of

the therapy sessions. I asked Paul if he could tell me more about this and he then went on to relay his account of how the therapy became '*terrible.*'

> *Well without going into too much detail. Obviously, everything is a bit raw and you dig up things that you really don't want to discuss. I said to her that I never knew if my Mum believed me. And erm, quick as a flash, she said, "perhaps your mum didn't love you". It just sent me off the scale. And I have a long-term health condition called Crohn's disease which is stressful etcetera. Then she calmly said perhaps the abuse by your uncle bought on your Crohn's disease. Then I just lost it. That was the last but one session. I ended up in a corner, just..* [pauses]. (p3)

After he '*ended up in a corner*', Paul discussed how the counsellor walked out of the room and then when she came back into the room a while later she was uttering, *"I have never seen a reaction like that."* The counsellor's response had an extremely negative impact on Paul and he then ended his therapy. It was apparent that the counsellor's words still affected him, as he referred to the incident as still being '*raw.*' The pain of the encounter with the counsellor was discernible from the tone of Paul's voice and the defeated expression on his face, as such I remarked on this when phrasing my response to Paul. I reflected to him that I could see the impact this has had on him and how hurtful it was.

> *It was because Crohn's disease is life changing and I don't want to even go down that line of if he is responsible for that. But to say perhaps your Mum didn't love you, I never would have believed it. It's a horrendous thing to say. When my mum has already passed away, you know, dementia had taken hold and that because she was 92 when she died. So not nice.* (p3).

The counsellor's suggestion that Paul's mother perhaps did not love him clearly had a significantly negative affect on him. In addition, it was apparent from his response that attributing his debilitating medical condition to the sexual abuse was too painful to consider. Paul's counselling then ended, and he returned to his GP to relay his story of the negative therapy experience. He stated that the GP's response was: "*well that's not good."* Paul did not re-enter therapy straight away following his negative experience, but he continued to see his GP regularly due to his ongoing medical condition. Paul and his GP eventually discussed accessing further counselling and his GP advised that he only knew of one other service in the area that could potentially help:

> *He did say that the only other place you can go is the rape crisis centre, which has now been renamed* [organisation's name]*. But he said that you might have problems getting in there and then I think I saw him about a month after that and he said that the only thing with going there is that you might have to go to the police. He said, "because I believe there is a big waiting list" So he said that I might have to report it* [CSA] *to the police*. (p3)

Paul explained that the GP's rationale for advising him to report the abuse to the police was to '*fast track'* him. Further, Paul explained that the GP had been talking to someone who told him that clients get through the waiting list faster when there is police involvement. Paul insisted that if it was not for the advice from his doctor, he would not have reported the abuse to the police.

> *Because he is dead now anyway now, you know? He plays cards with the devil everyday hopefully and loses. I hope so anyway.* (p3)

It could be considered that the above quotation echoes Paul's desire for the perpetrator to be suffering and experiencing punishment for his crimes. He went on to explain that he had since discovered that the perpetrator abused eight of his own children. He also stressed that the perpetrator was a '*squaddie*', quickly followed by the statement *"I'm not making excuses for him."* I then went onto explore with Paul what it felt like to come to the service for the first time.

> *Didn't have an issue with it. I mean it's not some sort of flag that you carry saying "look at me, I've been abused." But then again, I haven't disclosed to anyone that I work with like who I chose to. I haven't said to them I'm going to go for counselling. As far as I am concerned, it's none of their business. If my mate does ask me then I'll tell him…I'll just say I've got another woman [laughs], her name is* [counsellor's name] *That's what I tell my wife. I'm going to see my other woman today* [laughs]. *It was 'the other woman' because I couldn't remember her name for weeks* [laughs]*. So…I just say…my wife never asks me. Well, she says "how have you got on today." You know…I conversation…you know?* (p4)

From the above, Paul appears to contradict himself by initially stating that he '*didn't have an issue with it'* and then moving on to say that he has not disclosed to anyone that he works with and it is '*none of their business'*. However, the question posed to Paul was related to what it was like to initially seek help from the specialist counselling service. Therefore, it could be surmised that he felt more comfortable, safer and

trusting in the environment of the counselling service, rather than disclosing the abuse to colleagues and friends. He describes how he tells his work friends and wife that he has '*another woman'* in a clandestine manner, whilst noticeably finding it humorous as he relayed the story during the interview.

Pinball Wizard

As Paul was recounting how he chooses to talk about his counselling with his wife, he went on to explain how he first came to disclose the sexual abuse to her, '*many years ago*'. Paul talked about going to the local theatre to watch the rock opera *'Tommy.'*

> *You have probably heard about it and Tommy is a deaf, dumb and blind lad that was in Pinball Wizard. And in Pinball Wizard, it became a film and a show, Phil Collins was in it and Tina Turner and all these others. So, I went to see it, because I am a big music fan. And we went to see it and right before the interval there was a scene in it where Phil Collins, his character is Uncle Ernie and he abused Tommy. So, at the interval we went across to the pub, because you had to book your drinks and we went across because it's cheaper than in there. So, I was laughing and my wife said, "what are you laughing for". I said that Phil Collins, I had forgotten all about that, I had forgotten all about that he had abused Tommy. And then I thought, there you go! Dealt with! No problem! Then the Jimmy Savile thing came, and it knocked the lid off the box and I couldn't get the lid back on again. The more it was exposed, the more it hurt me. That was why I got back…that was why I got into the system. Because I knew I had to.* (p5)

From the above extract, it appeared that watching the opera empowered Paul. It could be deduced that Paul identified with the main character Tommy, who was also abused by his uncle. He described laughing to his wife in relation to the main character having been abused. He also went on to convey that his feelings about the abuse were '*dealt with'* and he used the expression '*no problem'* when articulating this. However, the scandal surrounding Jimmy Savile, and his offences towards children, disrupted the temporary euphoria he felt after watching Tommy. Paul used the metaphor that the '*lid was knocked off the box'* and that he '*couldn't get the lid back on again'*. It appears that before the news around Jimmy Savile emerged, Paul was able to contain his feelings and emotions about the abuse that he experienced. He also explained that the more exposure the Jimmy Savile scandal received, the more it '*hurt*'. This highlights how personal experience can be re-experienced by external events. One

consequence that the Jimmy Savile reports had on Paul, was his decision to arrange a meeting with his cousin, the son of the uncle who perpetrated the abuse he experienced. Paul then described how he disclosed the abuse to his cousin:

> *And I told him a story, it was basically about me, but I didn't tell him. And it turns out that he had been abused by his dad as well. But he didn't tell his wife, she didn't know. Well, I did say to him does* [your wife] *know and he went "no." You know, she didn't know anything about it, that he was a victim as well. And I didn't. He was older than me, obviously stronger than me because he coped with his* [abuse] *better.* (p5)

It was clearly difficult for Paul to articulate to his cousin that he had been abused and he chose the form of storytelling in the third person. He did not elaborate on how his cousin came to understand that the story was about Paul. However, the story enabled his cousin to disclose his own experience of CSA at the hands of his father (Paul's uncle). Unlike Paul, his cousin had not disclosed the abuse to his wife. Paul perceived that his cousin was stronger than him and he believed that his cousin was able to cope better with the abuse than he had. One explanation for these beliefs could be that Paul was aware that he had a drinking problem which he appeared to attribute to the abuse experience:

> *So, he knew that I had gone again in the system because I was drinking far, far too much. But the initial coming here didn't bother me at all. The only thing that did bother me was that I couldn't deal with it myself. But that is a bit of male pride I suppose.* (p5)

After describing the time he went to see Tommy, the period that Jimmy Savile appeared frequently in the media and the process of disclosing to his cousin, Paul returned back to my original question about how it felt to first access support from the specialist counselling service for survivors of sexual abuse. Although Paul stated that going to the service *'did not bother him'*; from his comments, it is evident that his '*male pride'* was hindered by the fact that he could not '*deal'* with the abuse himself. Paul explained that he had nowhere else to turn before going to counselling and he felt that he was constantly '*running into a wall*.' He disclosed the abuse to his closest childhood friend, who appeared shocked by the disclosure. His friend's response was that he had no idea, and questioned why Paul had not told him before. Again, Paul referred to the metaphorical '*flag*' in retort to his friend's surprise:

It's not something you wave around saying look at me. (p5)

Trust

Paul waited six months for his first counselling appointment. The way in which he described the wait, it sounded particularly agonising, and he had to keep reminding himself throughout this period: "*I have come this far. Come on!"* Paul implied that his wait was longer because he requested a female counsellor. When exploring this further, Paul explained that he does not trust men.

> *Because I don't trust men. What happened to me has affected my whole life. I got a detention in school for being late for school, for being late for cross country, for games. When it first happened, I wouldn't have a shower. Even at this age, even now, the gent's urinal…I am really, really cautious about who is around. It's just there. It has affected my entire life. And looking back, I have probably been depressed since I was 11, I would have said. Different things, when you start to delve in and unrolling and exposing the past, I would have been about 13 or 14.* (p6)

Paul highlights the impact of the sexual abuse experience in the above quotation. He stated that when *'it'* first happened he could not have a shower in school and to this day, he is wary of other males when using urinals. This demonstrates his lack of trust when it comes to men and potentially, he may harbour a fear of men. Paul was unequivocal when it came to explaining that the sexual abuse has affected his entire life, stating that he now considers he has probably been depressed since he was a young child;

> *It is only since I have been counselling and…sort of…things pop up and, not things that are tangent. Because that is how the mind works and I remember that, and I am thinking that that has got to be related to what my uncle did. Then you start looking forward from there and I start to think that yeah, I have probably been depressed all of my life I would say.* (p6)

It could be argued that counselling has helped Paul to unlock the latent connections he outlines above. Furthermore, counselling appears to have enabled him to develop his resources, enhancing his self-awareness and personal insight. Paul remarked that these insights have occurred recently:

> *I think it's only this past five or six weeks that things have just sort of slotted into place. It has affected me a lot. I say 67…1967. It is not anything like it is now. Totally different.* (p7)

Noting the above, Paul stated that after over a year of therapy, it was only around five or six weeks before his therapy was due to end that he encountered this particular positive movement towards change. Working towards ending the therapeutic relationship with his counsellor possibly triggered this therapeutic movement. Paul's comments about 1967 appeared to reflect his thoughts on how society and support has changed over the years. I explored this with Paul further and he explained that he doubted that the support he had received would have been available in 1967.

> *Probably not in its form that it is today. You would have probably seen some crusty old lady saying, "pull yourself together". Because that's what they said. That is what my Mum said. I told my Mum. Well, I told my Mum the same day to be honest. Then she asked me the following Sunday morning and I told her again, she asked me if it was true. I said of course it's true. Just the once, I never went anywhere near him. If he was walking across that car park now, I wouldn't go near him. My son wouldn't go near him either because I said that if he ever went to a family birthday party that I was at then they would never see me anywhere near it. Sorry, I got into the counselling. A lady was my preference.* (p7)

From his description, it appears Paul believed if support for CSA had existed in the 1960s, it would have been provided by a harsh, perhaps matriarchal type of 'professional.' He stated that the *'crusty old lady'* would have told him to *'pull himself together'* like his mum did. During the telling of this part of his story it was clear Paul was in pain as he recounted disclosing the abuse to his mum, as a child, and his mum's reaction. Although Paul did not state his mother's initial response, after one week of him first telling her about the abuse, she questioned him as to whether it was true. This appeared to anger Paul, as he exclaimed *"of course it's true!*" Paul also seemed to be defending himself, as he went on to talk about how he consistently tried to avoid the perpetrator after the abuse experience. This could be interpreted as a way of proving to his mother that he was telling the truth, whilst pleading for her to believe him. Avoiding his uncle could have also been a way to put distance between himself and his uncle because Paul hated what he did to him. Paul previously discussed how he did not want to work with a male counsellor, due to trust issues. It was apparent from the above statement that the thought of a '*crusty old lady'* counsellor was also

not appealing to Paul. Paul made reference to his counsellor being young and '*unfamiliar with the musical'*, when discussing her knowledge about 'Tommy.' Therefore, it can be assumed that this accounted for the therapeutic relationship being effective, as Paul's counsellor was neither male nor representative of the '*crusty old lady'* he might have encountered in the past.

The rocky road to nowhere

Having briefly explored what it felt like to initially seek support for his CSA, the direction of the interview had diverged into a discussion about the abuse. I ensured that Paul was able to discuss what he felt was important to share and when the conversation came to a natural pause, I was keen to bring the topic back to his experience of counselling. Paul reflected on his first counselling session at the specialist service:

> *Well, you are always a bit wary aren't you when you don't know someone, well the person doing the counselling. You don't know the person that you are talking to and…but yeah you do go a bit wary. I suppose you know; you are exposing things that you would probably rather not talk about, but you have to or otherwise you wouldn't be here saying I need help. So, it's just one of them things isn't it? You know, you have got to expose the nasty bits to get the cure. To put it into some sort of perspective.* (p7)

From Paul's descriptions, it appeared that the process of counselling felt uncomfortable at first, and sounded akin to an unpleasant medicine. He talked about having to '*expose'* painful material in order to get the help he needed to heal. He also describes the end result of counselling as the *'cure*'. He did not explicitly state that he felt '*cured*,' however, he did articulate that his counselling has enabled him to put his experiences into perspective. In addition, Paul explained that he made the decision to end his counselling after receiving over one year of therapy, perhaps suggesting he had achieved his overall aim and outcome. We then went on to discuss what had been the most helpful aspects of his therapy.

> *All of it really. I will say that certainly during the counselling I always thought there was something missing and there was certainly something within this interview with the police like a key. I always felt that there was something in the DVD* [the DVD made by the police when they interviewed him re the abuse]*. Not quite sure what, but I always felt that there was something within the DVD. When I went and did the DVD recording, I was 100% certain that she* [police

> officer] *said I could have it, but then when it was done she said I couldn't. Because there were two little bits in there that were a bit hair raising. When you start poking at those things it was a bit scary and I think she* [the counsellor] *was scared.* (p7)

From the above, it is evident that Paul has found his experience of counselling to be beneficial, as when questioned about the helpful aspects he responded by saying "*all of it really."* However, it was clear that there was a specific event in therapy that stands out for him. Paul previously explained that he reported the sexual abuse to the police following the advice of his GP. When reporting the abuse to the police the interview was video-recorded to gather and accurately retain the information. There was something discussed in the interview that was clearly disturbing for Paul and he was struggling to make sense of exactly what it was. Paul felt compelled to watch the police interview in order to rediscover what was said during the interview that was bothering him so much. It could be suggested that he was trying to access repressed memories.

Although Paul was eager to watch the recording of his police interview, it appeared that he felt scared to watch it alone. Despite wanting to discover the content of the interview that he believed held the key, he needed someone to support him. Subsequently, he asked his counsellor to watch it with him and, after asking permission from the counselling manager and requesting the DVD from the police, Paul and his counsellor were able to watch the video recording during one of their counselling sessions. Before watching the recording, he described specific aspects of the interview as '*hair raising'* which implies it may include details of his sexual abuse. In the process of wanting to unravel the mystery of what was on the tape, it was evident that Paul was wary about his decision to watch the interview from his comment:

> *when you start poking at those things it was a bit scary.* (p7)

As well as acknowledging that he was scared to determine the '*hair raising'* parts of the interview, he felt that the counsellor was also scared. It emerged that Paul believed that she feared his reaction to the content and the effect that it could have on him.

> *I think she* [the counsellor] *probably thought that if I did get into the system that I would ask to see that again, but I probably had more of an understanding than her. It is just that there was two little bits in there that I thought were really*

> *horrible. Anyway, I wanted my counsellor to watch it with me and she had to check with her boss that that was okay. She had never seen one before and we watched the DVD together. And I still don't know what was there or if that was the answer or even what the question was. But we left it for a couple of weeks so we could sort of…so I could digest what I had seen and I think the answer was that I can't challenge him because he isn't here, but I could challenge myself. Tell him what happened to me. It doesn't quite make sense to me but whatever was there, I think that has helped.* (p7)

Paul seemed slightly confused as he was replaying the watching of the interview and the weeks that followed. He did not go into any detail about the '*hair raising'* content, but acknowledged that there were two parts of the interview that he found '*really horrible.'* As police interviews will more likely consists of factual information about the offences being reported, it can be surmised that the parts of the interview that he found particularly distressing to listen to contained sexually graphic material. He emphasised that after watching the interview, he had to have a break from counselling for a couple of weeks to give himself time to process what he had seen. It appeared that he felt his counsellor also needed the time to process the video, as he initially stated:

> *We left it for a couple of weeks so we could sort of…so I could digest what I had seen.* (p7)

Despite Paul initially explaining that he wanted to discover the aspect of the interview which *'held the key,*' he did not share with me whether he found '*the key'* or what exactly it pertained to, and it remained unspoken.

This evidences the shared nature of the experience, and it could also be argued that he was concerned about the emotional impact it might have had on the counsellor; particularly based on his comments about her being scared about '*poking around'* at certain things. Although it was undoubtedly uncomfortable for Paul to watch the interview and listen to himself talking about the abuse, he evidently found the experience healing. Paul explained that it helped him to acknowledge that he will never be able to challenge the perpetrator about what happened to him, but he could instead challenge himself. There was a sense that Paul wanted the opportunity to have a dialogue with his uncle to make him understand the effect that the abuse has had on his life. Although Paul stipulated that he feels it does not quite make sense, he is

resolute that it [the counselling] has been a helpful experience. Paul was clear that there was something about the interview that was disturbing, and he explained that *"watching me talking about what happened and why…it freaked me out so much"* (p8).

When exploring whether Paul found it helpful to watch the interview with his counsellor, he responded by saying; *"Yeah. I haven't seen it on my own. I am not interested in seeing it on my own* (p8)*"*. It appears that there was a sense of safety and solidarity that came from watching the interview with his counsellor. Paul pointed out that his counsellor was initially sceptical about watching the DVD recording with him. Despite her initial reservations, watching the recording and resolving the riddle of the particular components of the interview that left him distressed, clearly had a beneficial effect on Paul.

> *It's been an eye opener, well that's the wrong word. I don't know what the word is. Because I have seen a change in myself since that. It's like…it doesn't matter. You know what I mean. It doesn't matter now but it does because it's part of my…part of what happened and to say it's insignificant is not the right word. It does matter. And it's not put back in the box either with the lid on. It's like it's dealt with, if it's ever dealt with*. (p8)

It appears that hearing himself recount his own story, in the safety of the counselling environment, has helped Paul. The above extract can be considered ambiguous, as he asserts that '*it doesn't matter*,' then considers this statement and goes on to emphasise that '*it does matter'*. Paul stressed that he was not stating that the abuse is insignificant, but it seems evident that he has integrated the abuse experience into his personal narrative. He described it as being '*part of me*' and '*part of what happened'.* He previously mentioned that during the Jimmy Savile media exposure, '*the lid was knocked off the box,'* he now feels that the lid is no longer on the box, as he has '*dealt with'* the impact of the experience. However, Paul went on to muse *"if it's ever dealt with."* The *'box'* felt very significant to Paul and I wanted to explore this further by posing a question to clarify how he feels that the '*box'* has been dealt with. I commented to Paul "so it wasn't about putting the lid back on, it was about dealing with what was inside the box?"

> *Yeah, it went in the box of nasty things that happened in life. Which to me has been quite full really. It's helped,* [the counsellor] *has helped, counselling has helped without a shadow of a doubt. I was going on the rocky road to nowhere.*

> *There was times when I felt that angry that I could go outside and kill the first person I saw on the pavement. That is how I felt inside. I would never do it because I am not a violent man. I stick up for myself but that's it.* (p8)

Why me?

Paul described feeling an intense anger that he believes could have easily led to violent and aggressive behaviour. Although he went on to say that it is something he would never do, as he is '*not a violent man'*, it was clear that he harboured these aggressive thoughts and feelings and worked hard to manage them. Paul explained that he felt angry during the counselling; however, as the weeks went on, Paul stated that the anger slowly '*subsided*.' It could be reasoned that the process of counselling and exploring his experiences and emotions connected with his feelings of anger. Whereas Paul had previously attempted to dampen his feeling and emotions through the use of alcohol; counselling will have required him to explore and confront these emotions. It is clear that being heard, through the process of counselling, had a calming effect on him. As Paul previously discussed, he was initially referred to counselling due to his dependence on alcohol. Paul recognised that he drank '*far too much'* and it could be argued that the use of alcohol was influential in numbing the anger he was suppressing. Although Paul explicitly stated that he felt angry during counselling, when he was later questioned on this further in order understand what made him feel angry, there was a change in his narrative:

> *I don't think any of the counselling has made me feel angry really. It's just how I felt inside. The frustration of it…The 'why me'. You know, I speak to people that have had a cold for a week and they think that they are dying. They should bloody go through what I have gone through. And if I am out with mates or whatever and someone cracks a perverted joke or something and I say, well I don't wave a flag about or anything, but I say "that isn't funny". Then they say "ah, what's up with you?" I'll tell them and they'll go "you?" Yeah. They'll say "you, are you sure?". "Yeah". Well they think because when we go out, I am the life and sole and I tell them that they shouldn't judge a book by its cover. I don't find it funny. Then they don't do it again, you know. It slipped out, oops sorry like. I tell people that I have known for years and years and something will come round and I won't shy away. I'll tell them "it's alright you laughing and thinking it's funny but it isn't funny because I am a victim of that". They literally go…*[gasps] *as if it is catching or something. I go down to* [place name] *and I like a laugh and a joke as much as the next person but not about that…it's too close to home. It's very close to home. But they don't think it of me.* (p9)

Paul's question *'why me*?' indicates his irritation at the woes of others and the insignificance he places on the experiences of those who have not been sexually abused as a child. One interpretation could be that Paul has a hierarchy with sexual abuse at the top. It was clear that Paul felt frustrated that people in his social circle were making jokes about sexual abuse and it could be argued that it reinforced the doubts he held about how he would be viewed by society as a survivor of CSA. It appeared, from his expression of amusement, that Paul found the reactions he received, when he disclosed his own experience, humorous. In the quotation above he stated he '*won't shy away*' from telling people he has known for a long time, in the instance that they make jokes about the issue. This suggests he perhaps did '*shy away'* and was reluctant to disclose the abuse in the past, which is potentially another outcome of the counselling.

A stronger person

We moved on to explore what, with hindsight, Paul might change about his counselling. Paul explained that there was nothing he can think of that he would change, except for more funding and help to be invested in specialist support services. Paul stated that, before being informed about the specialist service by his doctor, he was not aware that there was such a service available to men.

> *I had heard of the rape crisis centres, but in my mind that was only available to women*. *I can understand a change in the name.* (p9)

The above evidences how society can shape thinking. Paul was under the impression that a rape crisis centre is only accessible to women and he referred to the former title of the service; 'Rape Crisis Centre,' used before the service was widened with provision to include men and boys. Paul went on to declare:

> *I associate the name of* [the service] *like something rising up from the ashes…something good coming out of bad. Yeah, I don't know another way to describe it really because that's how I say how I feel. I don't know whether other people feel like that, but that to me just about sums it up really. It's something good that comes out of the chaos in your mind when what you have gone through and how you try to deal with it in your life. No doubt it's helped. I know it's helped me.* (p10)

It could be assumed that the above demonstrates how Paul feels about himself and his own journey since beginning his therapy. Paul went on to reflect on his feelings about the counselling coming to an end:

> *I'm a stronger person. But I'll be sad that it is ending, but obviously it has got to end sometime. I think I'm a stronger person. Although it's still there, I think it's probably because it wasn't dealt with before as well. But I say, it was a different world. Different world. I'm not the only one. It happened to lots of people. I'm not the only one. Just that, you know, people cope different. It's like my cousin, you know. He coped better with it. But then again, you know, I've gone through a really ugly divorce, Crohn's disease forever, this, that and the other. So…I have probably had more than my fair share and I can deal with most of it, I'm stuck with some of it, but this is what I'm dealing with.* (p11)

The sense of sadness that Paul was feeling about the end of his counselling was palpable. However, Paul commented on his progress and his understanding that the therapy must end eventually. Despite recognising that he is now a '*stronger person,*' there was a sense that he was seeking reassurance and had doubts about his ability to cope in the long term. He evidently felt strongly that his cousin has been able to cope better with his experience. However, this could possibly be linked to the fact that Paul did not know about his cousin's abuse experience until he disclosed his own experience. Paul also commented on it being a '*different world*' now, potentially referring back to the topic of sexual abuse being more openly discussed and there being support available. It could be argued that Paul is minimising his own experience by acknowledging sexual abuse *'has happened to lots of people'*.

Paul referred to his physical health problems throughout the interview and it was apparent that he believed there might be some connection between his experience of sexual abuse and being diagnosed with Crohn's Disease. However, when attempting to discuss this connection he stated that he would "*rather not go there to see if they are connected*." He first mentioned this possible causal link when it was suggested by his first counsellor, and from his descriptions of the experience, the topic made him very angry. It was clear that connecting his physical health issues to the abuse was too distressing to consider.

It's not all about me

Paul went on to consider what aspects of the counselling has improved his mental wellbeing.

> *All of it, I think. Just the general approach. And the help…you know. The understanding.* [The counsellor] *has seen me at my worst and she has seen me pick myself up. With her help. I don't think I could have done it on my own. It wasn't going anywhere. I couldn't take it anywhere else. It was like reaching for something and everywhere I went they had gone through the same experience. So yeah…All of it. All of it*. (p11)

He asserted that the counsellor had seen him at his worst, and, without her guidance and support, he would not have been able to overcome his issues. He went on to praise the counsellor further, asserting that she deserves '*full marks.*'

Paul conveyed that he has experienced a significant amount of loss in a short period, including a '*messy divorce*' and the deaths of his mum, stepson, brother-in-law and cousin. He explained that due to these losses, he now supports three charities that have helped him and those close to him who have been affected. He declared that the sexual abuse support service where he received his counselling is now one of the services he has chosen to support financially.

> *Got to. Got to. Not only for me, but other people. You know. Despite what these stupid judges say about women getting drunk, she is likely to get raped. Don't state the bloody obvious you know. It still shouldn't happen and if it does…well they need help. And not necessarily in six months, you know? As soon as possible. Because all it does is chew you up. 48 years, mine. Best part of 48 years. That's a long time.* (p12)

It is apparent from the above comments that Paul still views sexual abuse/violence as a women's issue. When explaining that he is donating to help others, he advocates that it is women who need the help. Paul also points out that the six months wait he was subjected to, is not conducive to helping these individuals. He described the 48 years that he did not seek help as '*chewing*' him up. Paul initially stated that there was nothing he would change about his counselling. However, I identified that the wait time was clearly an issue for him and explored this further.

> *Well, that is easier said than done. With everything that is going on with the money, with the volunteers and what they have gone through. I mean, I have been here for 12 months. How many other people have been assaulted in some shape or form that haven't been able to get a counsellor because I have been here? You know, it's not all about me, it's about other people as well. So that is about all that should change. The funding for the service should be there and to a certain degree I feel that people that have got depression or have had depression or whatever, I think it has been a taboo subject for the last 12 months, six months or so and it's only now that people realise the depth of it. You know, "oh, pull yourself together, get on with it!" If you are strong enough you can, other days you can't. Other days you just feel crushed by everything.* (p12)

Paul displayed an understanding of why there are significant waiting times before accessing specialist support services. It could be argued that he felt guilty about providing any negative feedback about the support he received from a service that clearly helped to improve his wellbeing. It also appears that he felt undeserving of the support, as he comments about taking a space for the past 12 months that someone else could have had. Paul clearly has an awareness of the shared experience of CSA and commented about depression and the *'taboo subject'* of CSA. However, he uses the term '*you*' when making the statement "*if you are strong enough you can, other days you can't. Other days you just feel crushed by everything."* It could be assumed Paul is talking about himself when making this statement, and the use of the pronoun '*you*' rather than '*I*' is related to his inability to '*own*' his own experience (Priest, 2011). When reflecting on his comments about CSA being taboo and depression, I prompted Paul to expand on this:

> *Oh yeah, because sometimes you can't just keep it between your friends and your family because you can't…it doesn't go anywhere. It is like running in a brick wall. People try to understand and care about you, but people don't know what you are going through. That is what I found. Especially in later life, you think "bloody hell! I shouldn't be going through this now, your 56/57, what's happening!" But better later than never, I suppose. But I knew I had to do something. I knew that I had to do something about it. Otherwise I would be locked up or god knows where. So…I didn't take medication. I've never had any real suicidal thoughts. I would never hurt myself. Well, apart from falling through ladders and getting wrapped around machines* [laughs]. (p12)

It appears that the metaphor of '*running in a brick wall'* relates to a dead end and Paul's vain attempts at seeking help throughout his life. His first disclosure was soon after the abuse occurred, when he told his mother, and it was apparent that Paul felt let

down by her, as she did not do anything to help and even questioned him as to whether or not he was telling the truth. Paul did not articulate who the '*people*' were that were trying to *'understand and care*,' however, it was clear that he felt that they could not fully empathise with his situation and his feelings. Paul recognised that he had an urgent need for help, before accessing counselling, and believes that he might have ended up '*locked up*.' This highlights the potential for offending behaviour if Paul had not received support to deal with his anger. He went on to stress that he has never experienced suicidal thoughts and he would not hurt himself. However, it appeared from his tone that he was trying to convince himself that this statement was true; particularly, as he ended the statement with a humorous comment about the potential hazards in his profession.

Paul went on to assert that "*someone, somewhere, has got to listen*." He acknowledged that his GP listened to him, which was arguably the catalyst for him seeking emotional support for the first time. Paul reiterated the advice given to him by his GP, regarding reporting the abuse to the police, in order to speed up the referral process. Paul professed that this was not an easy decision to make and stated

> *They are not going to dig him up and arrest him, are they? But it was something I had to do…for me.* (p3)

Although reporting to the police was prompted by the possibility it would lead to a shorter wait for counselling, it seemed that Paul was also motivated to report the abuse to the police, as it would provide an opportunity to receive justice. As well as discussing the impact CSA had on Paul as an individual, he also recognised that his emotions and behaviour have an impact on those around him.

> *How you are affects other people that are nearest and closest to you…your kids, your wife, your work mates…you know…then they go "sod off". But my first wife was aware of what happened, and my second wife knows. It's part of me. As I say you don't go round the pub saying 'look at me' on a banner. The people you are closest to you, that you trust, you tell. Because then if you are a bit fed up it might give them a reason to know as to why you feel that way.* (p13)

The above evidences how depression can affect relationships. From Paul's comments about his friends and family telling him to "*sod off*," he appears to be harbouring a fear of rejection from those close to him. Indeed, he has clearly experienced times when people have become frustrated at certain behaviours he has displayed. It is clear from his comments that trust plays a central role in his life, and it was also evident he had the ability to trust his counsellor, contributing to his therapy being effective. Paul's final comment, as the interview concluded, reflects the ongoing process he has experienced throughout his therapeutic journey:

> *I have to fight everyday but some days you just need to offload the packages.* (p13)

The metaphor of offloading *'the packages'* appears to represent his experience of the counselling process. It was not clear whether the packages are specifically referring to his experience of CSA or his emotional distress.

Summary

Paul disclosed CSA to his GP following a period where he was drinking excessively, which he attributed to the impact of repeated media reporting of CSA due to the Jimmy Savile allegations. He was initially referred to a non-specialist counsellor and he had a negative experience. He previously held the assumption that Rape Crisis services would only support females. He was eventually re-referred for support to a specialist service by his GP. However, the GP recommended that he report the CSA to the police in order to expediate his appointment. This resulted in Paul having to participate in a police video interview. He was disturbed by aspects of the interview and made the decision to request a copy of the interview to watch it with the support of his counsellor. Paul found counselling helpful and explained that the counsellor's understanding as helping to improve his wellbeing and he described himself as stronger person, as a result of his therapy.

Critical reflection

Paul attended his interview dressed in his paint covered work overalls and I wondered whether this represented his attempt to protect himself metaphorically during the

interview, as well as literally when he wears them to work. Paul regularly used the phrase *"not a problem*" and I sensed that he was often trying to convince himself of this in order to mask his pain. The beginning of the interview felt challenging, as he often responded to a question/prompt with a short response of a few words. This made me feel tense, as I wondered how long the interview would last when I only had minimal prompts. However, Paul soon appeared to open up and talk freely about his experiences. After the initial discomfort and awkwardness that I experienced, I felt relaxed in his presence and he was very funny at times. He discussed violent thoughts and times in his life when he could have become physically violent. I found it difficult to imagine his violent side, as it seemed incongruent to the kind and funny man sat in front of me.

When Paul asked me if I knew about the musical Tommy, which featured so prominently in his narrative, he found it amusing that I was not familiar with it. I felt naïve and ashamed that I was unable to understand the link between the experience he described so eloquently and the portrayal in the theatre that meant so much to him. Paul clearly sensed my reaction, as he reassured me that his counsellor was also unfamiliar with it. From the outset, I expected that the interview could potentially end prematurely. However, the conversation eventually flowed with ease and I enjoyed the experience of interviewing Paul.

Tony's Story: Fighting with the devil

Introduction

This is Tony's story. Tony was 38 years old when he was interviewed in a room at the counselling service where he had been receiving therapy. Tony had been having counselling for around nine years at a specialist charity for survivors of sexual abuse. Tony has never been in paid employment and is currently a full-time carer for a family friend. Tony has never had an intimate relationship and attributes this as an effect of the sexual abuse that he experienced as a child. From the age of 12 years, Tony experienced physical and sexual abuse, perpetrated by his stepfather.

Waiting for Mum

I initiated the interview by asking Tony to start by telling me the story of his counselling. Tony began by discussing his early years:

> *How it all started…Well I remember I was about three or four and my mother wasn't caring that much, and it was like she had given up. Then one day she had put a pan of water on the stove and it went all over her. A friend of hers came round and said that she needed to go to the hospital. So, they took her to hospital then the next day or two social workers came out and we was…I wasn't wary of this at that age and the social workers said that they were going to take us away for a couple of days. That couple of days turned into months, then four months. By the end of four months I never knew why she hadn't come back to take me in those three or four months.* (p1)

As Tony was relaying this story, his sadness was visible from his facial expression and his tone of voice. It is evident from the above that not knowing when, or if his mother would return was distressing, and it appeared that he was yearning for her to *'come back to take'* him. From the above, it could be suggested that nobody was communicating to him where his mother was and when, or if, she might return. Although Tony believes her absence was due to the scolding incident, it could be assumed there were other issues, from the length of time that she was away and his first remark about her '*not caring that much.'* He mentioned social work involvement, but also highlighted that he was not '*wary*' of this, which could indicate that he did not know that they were social workers or the implications of their involvement at the time. From his tone, it appeared that Tony felt resentful that the social workers were not

honest with him, as he remarked that they told him he would be '*taken away*' for a couple of days and this then turned into months.

Tony explained that the main impact of not seeing his mother was the effect it had on his education. He discussed how his schooling and grades began to decline and, as a result of this, he now has the reading age of a young child.

> *I didn't get high grades, can't read, can't write and I am at level one for reading and writing now and from that age…from say six, seven or eight through to me being nearly 40, it is a bit embarrassing for an old fella like me to be the same as a young kid with my reading and writing.* (p1)

Tony described his embarrassment that he struggles to read and write, and he talked about how he tries to hide this from some people. He explained; "*there is trouble with struggling*." Poignantly, Tony went on to share that he is now losing his hearing, and he stated that this is "*slowing me down again and it's all doing my head in*."

Tony's narrative then turned to discussing his first abuse experience. It was unclear what happened between the ages of three and four, when his mum was taken into hospital, to the age of 12/13 when he mentioned living with his grandparents. Tony did not articulate at what age his mother returned and, from his descriptions, it appears his mother was also living with his grandparents, as he stated, "*we were living with my grandparents."* Tony explained that at the age of around 12 or 13 he was introduced to his mum's new partner and he stated that he did not like him at first. However, Tony explained that he '*got on with him'* eventually and they were like a '*normal family'* for a while, until things changed:

> *Then I did a stupid mistake and I got a clout for it. You know in the olden days, but you can't do it now because you get in trouble for it. But then all the beatings started coming! I mean all the beatings…whips and everything else and all the beatings and I thought no no no no, my mum wasn't…she like…didn't care. It made me more worser. And after…when they got married, it went…not good…but bad, bad. Then it was before Christmas, the beatings were just carrying on and carrying on and before Christmas eve he err took me upstairs and showed me a porno book and I didn't click into this. I was that slow, I didn't know it wasn't right but then next minute he got his…you know big one out and he asked me to do something. I said "what?" and he said "yes". I said no but he said if I didn't do it then I would get a beating. And that is where it started, then*

> *next minute he asked me to do it to him and after that I thought what the hell have I just done and what has he made me do.* (p1)

Tony's comment *'what the hell have I just done?'* when describing the first incident of sexual abuse suggests that he felt complicit and, from his tone, there was a sense that he felt ashamed about this. He also appeared to blame himself for being '*slow*' and not knowing, at first, that being shown pornography as a child '*wasn't right.'* Tony appeared to believe that being beaten as a child was normal, at least he believed it was acceptable '*in the olden days.'* He then described the physical abuse escalating from a '*clout*' to severe beatings, compounded by his mother's inability to care, which was clearly very painful for Tony to acknowledge. Tony explained that he could not tell his mother, as she would not have believed him and there was a clear indication that he felt trapped. Tony then went on to describe the moment when he fought back against his abuser:

> *Then I thought to myself…if he made me do that then what else has he done to me…say at night time or whatever. And I thought to myself, 'has he or hasn't he?' Then one day I thought "I'm not having this!" He was going to punch me, so I punched him back and I thought 'yeah! That will teach you!' Then next minute I'm being chucked out at age 15. No care, no parents or fuck all. Living on me own with really no one else. I couldn't go back to my grandparents. They didn't want to know me. I got put in a hostel at aged 15 and that's where I've just lost it. Started drinking nearly every day and I've drunk a lot, a lot of beer.* (p2)

Tony appeared to be confused about whether there were any other incidents of sexual abuse that had occurred between the ages of 12 or 13, to when he *'was chucked out'* at 15 years old. It is evident, from his statement above, that Tony reached a point where he could no longer tolerate the violence he was subjected to, and he punched his stepfather. From the excited tone when narrating this part of his story, and his remark of satisfaction, "*that will teach you*," it seemed that Tony felt exhilarated by his reflections of the incident. However, this soon turned to a tone of dismay, as he described having no place to go and there being nobody else to turn to. Tony then started drinking, as a way of coping, and when questioned on roughly how long he was drinking heavily for, he responded:

> *Drinking? Err until I was about 19. That's when the other stuff started coming in me head…The madness and everything else.* (p2)

Tony described the '*madness'* as "*suicide and everything that goes with it.*" He stated that he attempted to jump off a bridge when he was 17 years old, but someone stopped him. Tony explained that he did not see a GP about his mental health problems until he was in his twenties. He felt the GP would not believe that he had been sexually abused and when he eventually did disclose CSA to his doctor, he stated that he found it '*embarrassing*.'

> *Yeah, It's not…it's maybe alright for girls and women but it's not for fellas. It is harder. It's very hard. And that's why it is hard for boys or fellas to go to anyone else to tell them what really happened. Then that's where they turn into maybe one of them* [perpetrators of sexual abuse] *or end up living on the streets.* (p2)

Tony suggests it might be easier for women and girls to disclose CSA and reach out for help. He then goes on to state that it is harder for men to tell someone about abuse and the full extent of the abuse experience. It might be assumed that his comments about turning into '*one of them*' is in reference to men becoming perpetrators of sexual abuse. Tony also indicates that he holds the belief that sexually abused men, who do not have support, are susceptible to homelessness. This assumption is possibly formed from his own experiences of having to leave the family home at 15 years old and having no place to go. During this period, Tony shared that he lived in a hostel and did not get the help he needed until he was in his twenties.

Finding help

As previously mentioned, Tony delayed seeking help from his GP for fear of not being believed and embarrassment. As feared, Tony stated that his GP did not believe him at first and it was not until he went into detail about his story of the abuse that the doctor started to realise '*that something did go on*.' Tony relayed that the first intervention offered by the GP was medication. However, he stated that it made his anger problems much worse:

> *My anger problem is not like a normal fellas. It's more harder to control.* (p3)

Tony described incidents where he has become aggressive with others when he had been drinking. He stated; "*I don't go looking for trouble, trouble comes looking for me*

when I'm in the pub." This implies that Tony does not accept responsibility for these incidents of aggression and anger. He explained that he drinks to:

> *Try and forget it all but sometimes it does come back. That's why I drink. Everyone keeps saying don't…that I'm not allowed the heavy stuff. It does send me wild.* (p3)

When exploring what he meant by '*wild*', he responded *"I could nearly end up strangling someone."* Tony discussed how he has felt protective of female friends and how them being mistreated by other men has caused him intense anger. He explained that he has tried to talk about this in therapy but stated "*most of the time I end up saying wrong words at the wrong time*." It appeared Tony believed his counsellor would chastise him for his behaviour, as there was a clear sense that he felt hesitant about discussing these events with his counsellor. When discussing the violent thoughts he had towards other men, Tony discussed how he now evaluates the consequences of violence. Tony recognised that he could be punished for violence and stated "*I'm getting old now. It's getting hard for me to try and get a Mrs."* Tony explained that a relationship is something he craves, and he believes that he has been unable to meet someone due to his *'attitude problems'*.

> *I have been told that I have got a different attitude...problems and everything else. That's why I can't understand with my attitude problems…when I'm on these tablets they are not calming me down…it's not stopping me thinking things.* (p4)

From his statements it is clear Tony is eager to confront his '*attitude problem*' and find ways to reduce his anger. It is also evident that Tony feels different. His comments above suggest he has been told that his attitude is different. However, it could be that he has internalised the views of others and now views himself in this way.

Nine years of counselling

After being given medication, which Tony felt did not help his anger issues, he was referred by his GP for counselling. Despite believing his GP did not accept he had been sexually abused as a child, his doctor referred him to a specialist counselling service for people affected by sexual abuse. Tony has been having ongoing

counselling at the service for the past nine years and has seen three different therapists during this period. I explored with Tony how it felt to access counselling for the first time:

> *It was a bit hard. I thought I would be speaking to fellas, but it was a woman.* (p5)

Tony stated that he wanted to speak to a female and that he would have become violent if he was forced to speak to a male counsellor about the abuse. He went on to explain:

> *I would just see his face. If I saw his face, then it would all…all come back to me.* (p5)

Tony discussed how he avoids speaking to men under any circumstance and it was clear that he did not want to work with a male therapist, despite going to the service and expecting to be allocated a male worker. Tony went on to elaborate on his first experiences of counselling.

> *The first couple of session really didn't do anything. It was a couple of months down the line. Well, the more I came, the more I could trust. If I don't trust I will let you know.* (p6)

Above, Tony highlights the importance of time in developing a trusting relationship between therapist and client and asserted; "*if you haven't got the trust there is nothing there"* (p6). It appears that Tony felt his counselling was not effective at first and it took a couple of months before he was able to trust his counsellor. Therefore, time limited therapy might not have been conducive to the counselling being successful. I asked Tony to expand on what helps him to be able to trust someone and he responded:

> *It's about if I say something stupid…like I do sometimes…and it's if the person takes it the wrong way.* (p6)

It could be argued that Tony measures trust, within the therapeutic relationship, based on the counsellor's responses. Tony then commented:

> *I bet the boss told you to be wary of me* [laughs]. *I bet! She must have told you I have got a nasty temper. (*p6)

From Tony's smile and laughter, it appeared that he felt proud when making this comment. I established that '*the boss*' he was referring too was the manager of the counselling service, whom Tony first had counselling with when he started his sessions at the service nine years ago. There was also a sense of Tony feeling proud of what he believed to be a notorious reputation of being an '*angry'* man with a '*nasty temper.'* From the question he posed to me and his laughter, I sensed that Tony wanted people to feel intimidated by his anger. I responded by saying I had not been forewarned by '*the boss*' and Tony laughed and sounding disappointed remarked, "*what's wrong with her then?"* Tony went on to explain that he felt calm at the moment due to his medication, but the anger was coming back slowly. It seemed that Tony was attempting to explain why he was not his usual self, a self in keeping with his infamous reputation, he believed he held within the counselling service. I also perceived that he was attempting to warn me that his anger could resurface during the interview.

Anger

Tony stated that he has been taking medication for the past eight weeks. He explained that he did not see an effect for the first couple of days:

> *Then after a week and a half they started calming my nerves down. Then everything else is just getting along and then a couple of days more my anger just sneaks back in. It only takes one thing to piss me off then the anger comes back.* (p6)

The above quotation highlights how Tony's anger can be triggered easily. From his previous question about whether I was warned about his anger before interviewing him, I explored whether he had ever become angry during a counselling session. Tony responded frankly; "*That's why I come. That's why I like coming here…to get my anger out."* With this response, Tony identified one of the aims of his therapy and it could be argued that therapy provides him with a safe space to release his anger. Indeed, Tony identified being able to '*get his anger out'* is the reason he attends therapy and also something he likes about the therapy. It could be assumed that Tony has little opportunity outside the counselling environment to express his anger safely. Tony

reinforced this assumption by explaining why the counselling situation feels safe to express anger as;

> *Sometimes I don't trust myself. I have got to be careful…I've got history of just picking something up and using it.* (Tony, p6)

It appeared that Tony was fearful of his anger, due to his lack of trust in himself. However, he explained that he is not '*scared'* for himself as he knows what he is doing, but stressed that his concern is for someone getting in the way of his anger and getting hurt. Tony also stated that he lacks remorse when it comes to expressing his anger and hurting others. Tony's anger appeared to surface during the interview, when he was discussing the reasons why he has had breaks during the nine years he has been accessing support from the service. It felt like he was addressing the counsellor directly.

> *I have had breaks in between because sometimes people say, "I'm ill! I'm sick". I'm thinking 'yeah, you've got kids'. When they say "see you next week" and don't, that does my head in…It does! It does wind me up! Then I have to wait for weeks and then sometimes I'm angry.* (p7)

Tony expressed the above quotation loudly and angrily. It appeared that he felt rejected by the counsellors who had interrupted his counselling sessions due to illness or family issues. It was evident that consistency in therapy is extremely important for Tony and he elaborated on this further explaining the reasons why he needs consistency:

> *It's the anger! I can't control it. I can't control that much. I can control it but if it comes out then I just snap. Drinking or not drinking. Drinking…it's more worse. Then I just start talking to myself. A friend of mine heard me talking and he said to me, "you know that you are nuts?" I said no and he said I was talking to myself, but I couldn't remember. Sometimes I think that memory loss just comes with old age. It's just every time I'm getting older and older…if there is something, I want I can't get. Then I think to myself "he made me do that. He really has buggered my life up so I can't find a decent woman". It's impossible. Like say…if you catch the bus and you didn't know me at all and I was looking at you and I thought "I wish I could have a date with that" you would be thinking, "I wouldn't touch that with a barge pole". That's how I feel when I get on the bus.* (p7)

Tony explains that his anger is uncontrollable and is exacerbated by alcohol. As previously mentioned, counselling facilitated a safe space to express the anger and the regular disruption in his counselling sessions clearly had a negative impact on him. Tony expresses his confusion in the above quotation, when he relays being told by someone that he talks to himself. There was a sense of sadness when he spoke of being asked whether he is '*nuts'*. Tony clearly had no recollection of having talked to himself and attributes this to possible memory loss, due to *'old age.'* However, Tony then appears to blame the perpetrator of the sexual abuse, for his anger and his inability to be in an intimate relationship. Tony went on to describe his thought process and inner dialogue when he encounters a woman. Tony explained how he feels judged by women and how he believes a woman will look at him and be thinking negatively about him. I explored with Tony whether he feels this way with all women, and he affirmed "*every time.*" I then reflected to him that he feels judged by women and society and he responded vehemently "*Yes! It pisses me off. All the time!*"

Trust me, I'm a Doctor!

When discussing what helps to reduce his feelings of anger, Tony explained that counselling sometimes helps, but then stressed sometimes it does not. Tony went on to explain that going to counselling and '*getting some things up'* and the '*old things back up'* can be very *'hard'* and he often goes home after his session to '*sit in a corner alone to forget about it'*. Tony evidenced low self-worth as he, again, described how women are thinking negatively of him when they see him. He added that women probably think he is a potential abuser. He then strongly defended himself against this assertion by having a dialogue with these women

> *Yeah, I know one thing sweety…That's one thing that I would never do anything to anyone else. Because I know how it feels. That one thing, I would never do. It would never come into my head. Sometimes I think that he has done more than that. I don't want that. That's why now, half of the days, when everyone else keeps using me and using me it turns me into more of a bad person than I am.* (p8)

Within the above dialogue he was addressing women who held those views, rather than me the interviewer. The above quotation clearly evidences Tony's pain; particularly in the way he communicated the statement about being '*used'* by people.

There was a definite sense of sadness from his tone of voice as he relayed the statement. However, when elaborating on feeling like a '*bad person,*' there was anger in his inflection.

> *I am because I am getting mad. Sometimes I just don't care. People think they can take the piss out of me. I threatened someone with a knife once. I see him every day and now he won't say boo to me because he knows I'll come back and finish the job off. But I won't finish the job off. I won't hurt a fly. I wouldn't get done for murder. I have told the doctor that I have threatened to kill people. I'm thinking why have they not put me in a nut house? I did walk in the doctors once with a blade and he said, "do that again and you will get arrested". And I'm thinking, that's what I want, you prick!* (p8)

Above, Tony appears to reveal his anguish and desperation to be heard and the lengths that he has gone to in order to seek help. Tony's narrative began by him describing a violent incident where he defended himself from those who have wronged him. Tony appeared to be proud of threatening someone with a knife, as he recounted the story enthusiastically. He seemed satisfied that the man he threatened now will not say '*boo'* to him and it could also be interpreted that he was able to exert some control. It could be surmised that Tony no longer felt vulnerable following this incident and is pleased that people are potentially scared of him. Tony then contradicted his statement about '*finishing off the job*,' as he then went on to stress that he '*wouldn't hurt a fly.'* Tony then described another incident of going into the doctor's surgery with a blade and it was clear that he was seeking a reaction from his doctor, as he questioned why they had not put him in a '*nut house.*' The use of the term '*nut house*' suggests that Tony expected to receive some form of treatment for his mental health or to be taken to a place where he might feel secure. It was apparent that Tony was disappointed and felt let down by his doctor's reaction of him giving him a warning about the blade, rather than calling the police. Tony angrily replied that he wanted the doctor to call the police. Tony went on to discuss how he does not trust his doctor and it appeared to be in relation to his own racial prejudices:

> *These days now, all these Asian doctors…half of them I don't want them to know about…You know what they are like. They can't keep anything secret. That's why I don't go into detail with them. I don't trust them.* (p8)

Due to the nature of Tony's comments, I prompted Tony to discuss trust in more general terms and he restated that trust is very important to him and he finds it difficult to trust people. However, Tony then went on to elaborate further on the ethnicity of professionals.

> *You can't trust them sort of people. It's like if you had one of them working in here…it would take me a long time to try and trust them. If one worked here and I saw her in the street, and she was speaking a different language to her people then I wouldn't know if she was saying anything about me.* (p8)

Following Tony's admission of feeling judged by others, he demonstrated judgement towards others based on their ethnicity. Although he expressed concern about there being an '*Asian'* counsellor at the service where he was having therapy, he implied that he would still work with them, it would just take '*a long time to try and trust them.'* Tony went on to articulate how feeling judged by others can impact on his self-esteem when it comes to relationships and discussed his thought process when communicating with a female.

> *Yeah. That's why I am very very wary of other people. I don't like it. You understand why when I see a nice woman, I don't know if it's worth speaking to her or anything like that. Then I'm thinking 'no, it isn't. She's not going to speak to me is she…even if she has to'. And most of them don't. If they are in a shop and working behind a counter they have got no choice. Just I would rather do it quick so I'm out and I think "yeah, you are not worth it sweety.* (p9)

Tony is again demonstrating, in the above quotation, how he becomes defensive when believing he is being judged. When making the comments about the woman '*not being worth it'* he appeared to be condescending. However, from his tone, I sensed that the comment was masking pain and rejection. Further, I sensed that the feelings he experienced as a result of the responses from women were perhaps reminiscent of his mother's rejection and he appeared to be projecting this on to other women. He went on to relay how he has struck up friendships with girls, with the hope of it developing into an intimate relationship. However, he explained that "*halfway down the line, she stops speaking to me*" and he stated that he felt '*used.'* His comment about feeling '*used'*, further evidences the hurt he appears to be experiencing and the fear of rejection he might be harbouring.

Timebomb

Discussing his negative experiences with women led to anger surfacing during the interview and Tony's tone of voice sounded agitated as he relayed the dialogue between himself and the women who had rejected him. After acknowledging to Tony that I noticed his anger, he confirmed that talking about it bought back angry feelings and he asserted that his anger is like a *'timebomb*.' I explored with Tony whether he has had any other support for his anger. He confirmed that he was previously allocated a support worker;

> *There was this one place that said they could give me a lift to hospitals and stuff like that. Then I thought…took me hospital once then another appointment came through at night time, but I can't walk back at this time at night. I'll get lost. If I catch the wrong bus I'll be buggered. So, I ended up walking home and it was miles away. That was the point, he was supposed to do things for me…give me lifts and stuff but he wasn't bothered. I let him off once, then he came back round again. He said "do you need help with your money?" I said "what money?" He said that we take it off you and give you so much a week. I thought "fuck off!* (p10)

In the above extract, Tony makes reference to his support worker being male. He was previously very clear that he would find it difficult to work with a male counsellor. It could therefore be suggested that the support worker's gender could have impacted on Tony's ability to trust the worker. Tony appeared to feel let down by the support he received, and he affirmed this by stating that the worker '*wasn't bothered'*. It was evident that the support worker was initially helpful when he drove Tony to a hospital appointment. However, from his description of walking back at night and thinking he would get lost, it appeared that Tony felt scared, and it could be surmised that it made him feel vulnerable. Tony points out that after the incident where he was left to walk home alone, he gave the worker another chance. However, it was apparent that the support worker's comments about finances prevented Tony from being able to develop trust within the support relationship. From Tony's reaction, it appeared that he felt insulted by the idea of the support service taking control of his money and budgeting for him. The suggestion that he should hand over his money to a third party clearly made him very angry, as he shouted an expletive in the research interview, in response to this comment.

> *I'm thinking, 'you don't know me that well. I don't trust you. Bye bye.' There was a couple of things that he* [support worker] *was saying, and I didn't like it. I thought I wasn't having this, it's what I say not what you want. And I'm thinking that if he doesn't like what I say then bugger off like I did with the other one here. The one that was always off* [counsellor]*. Have so much time off then I don't trust you.* (p10)

From his comment "*I wasn't having this, it's what I say not what you want*," it could be argued that Tony wants to be in control and establish the boundaries when it comes to him being supported. In the above quotation, Tony was referring to his previous counsellor who had time off. He alludes to ending the therapy with his counsellor, due to the irregularity of his sessions. Tony was unambiguous in his statement that the counsellor having time off effected his ability to trust. This emphasises the importance of consistency in establishing and maintaining trust in the therapeutic relationship. Tony evidently felt let down by his counsellor which reinforced his lack of trust in professionals, as highlighted by his comments regarding the GP and the male support worker. Furthermore, Tony has consistently demonstrated anger responses to these negative encounters with professionals.

The Devil

Tony went into further detail about the breakdown of the counselling relationship. He asserted that he "*did like her but there was something about it that wasn't doing that much."* Tony explained that his main aim in therapy was to help with his '*anger problems.'*

> *It's just…how we are now keep saying we are doing things to try and help my anger problems and work out certain things. It wasn't getting there…it wasn't building up. Then a couple of months down the line I thought that something wasn't right. You are having more time off than me…when's my counselling coming? I need to see my counsellor. I need it…I need it! Then that's why my anger problems were getting more. And my other side…say you get one good side of you and you get one bad side. My bad side is the devil. Always has to be the devil.* (p10)

There was a sense that the counselling felt '*stuck'* and Tony confirmed this. It was clear, based on his comments, that Tony felt desperate to find help to deal with his anger and counselling was undoubtedly not fulfilling his needs during this period. Tony

explained that the gap in counselling exasperated his anger. He referred to himself as having a '*good side'* and a '*bad side'* with one of those sides being '*the devil.*' As the devil is the personification of evil in many cultures and religious traditions, naming this side of himself '*the devil'* epitomises the darkness of his anger. Tony asserted that "*the devil wasn't getting worked on*" with his previous counsellor. However, he maintained that his current counsellor "*recognises something that the other one didn't.*" He explained that the current counsellor has helped him to work on the reasons why he was getting angry and from his description it could be suggested that the former counsellor avoided exploring his anger. Tony reflected on other reasons why the counselling relationship broke down:

> *Sometimes I struggle to get my words out you see. Or sometimes I say the wrong thing. That's the problem I was having*. (p10)

Tony sounded very frustrated as he articulated his struggle with the counsellor and the dialogue he had with her:

> *I'm not having this off you. You are here to do one thing for me, and you are not doing it* (p11)*.*

He eventually informed the service manager that he did not want to work with that particular counsellor anymore. As well as working on the reasons he gets angry, the current counsellor has supported Tony in discussing his anger with his doctor and being treated with medication. He then considered what he needs from a counsellor:

> *You see I just need more understanding. I need someone I can trust more. I can't just come out of it. There was more days when I was going to snap.* (p11)

Tony reiterates the importance of developing trust in the therapeutic relationship, and it was clear that feeling safe to work through the underlying causes of his anger and regular sessions were of central importance. From how he conveyed his experiences with professionals it seemed Tony did not feel '*understood'* and this frequently led to outbursts of anger. It was evident that the previous counsellor reinforced his feelings of not being understood, as he was concerned about saying '*the wrong thing'* which may have been frustrating and subsequently caused his anger to manifest.

Tony advised that his goal in therapy is now to work out why his '*anger problems*' are getting worse. He explained that he recently lost a friend in a car crash: "*I just lost it and I'm still like a timebomb. A ticking timebomb*." The analogy of the *'timebomb'* appears to represent the unpredictable nature of his anger and it could be assumed that the prefix '*ticking'* symbolises that his anger is imminent or might always be there under the surface. Tony described the feeling of his anger as being '*like a knot.*' He then added to this description:

> *I can't undo it. If you undone the knot, what is going to happen? The time bomb is going to go off. I am the time bomb.* (p13)

As Tony described the '*knot,'* it sounded like undoing the knot would be the trigger for the '*timebomb.'* Tony affirmed that the knot is the trigger to the bomb and he advised that, once triggered, the anger is uncontrollable and if he had a baseball bat in his hand he would hit everyone. It was evident that Tony felt scared to continue to take medication for fear of not being able to control the potential for rage and violence. He stated this is the reason why he wants his anger '*sorted'* and he explained that he no longer wants to take tablets because they make him worse. He added:

> *No way! I'll just end up doing something stupid. I did it once and I wouldn't do it again. That wasn't on tablets, that was normal. I have been told that I'm on the tablets now and if I go back on the old ones then they will make me nuts. That's why I can't understand why my anger problems are coming more worse. Everything else inside me is dropping. The anger problems are still up there. They do…they have calmed my nerves down a little bit…just not much though. Just if I go on the higher dose ones then my anger problems will get worse and they'll just get higher and higher. That's why I can't understand why my anger problems are still in there and I can't get rid of them.* (p13)

Tony did not articulate what he meant by '*everything else inside me is dropping*' but he may have been referring to the other issues he experienced prior to seeking support, including; the '*madness*' he described, the fear of not being believed, excessive drinking and suicide attempts. The above quotation indicates that Tony is confused about why his anger is intensifying, whilst his other symptoms are decreasing. There was a definite sense of fear regarding the loss of control when taking tablets. However, he points out that he has done '*something stupid*' in the past when he was not taking any medication at all. Tony indicated there was a sense of

desperation to get to the bottom of his anger issues and find a solution, which he expanded on further:

> *Yes. It's going to take me a long time to just try and work out why my anger problems get more and more. Like it takes something small to upset me and it stays there in my head for so long. If it comes out me head…I'll be like that…forget about it. But if another stupid thing comes in my head it just works me up inside…inside…inside. I'll either end up dead or I'll end up doing something stupid like I do all the time and sometimes I just wish I did it all that time ago and jumped off that bridge. These days now…when I'm this age…it's not easy for fellas. There is nothing out there…to say that we understand you. You know what I mean?* (p13)

Tony makes a poignant statement above about wishing he had ended his life when he was considering jumping off a bridge. His tone indicated it was deeply painful to talk about the anger *'working him up inside'* and a sense of fear about '*doing something stupid'* was palpable. It was evident that Tony feels lonely from his constant references about wanting to find someone and it could be compounded by the sense of isolation when it comes to being a man and finding support and understanding. Tony is unambiguous in his statement that it *'is not easy for men'* and he believes there is '*nothing out there'*, despite currently receiving counselling. When exploring his thoughts on this issue further, Tony expanded on why it is more difficult for men;

> *Just to women…There is more out there for women…for their problems. Not for fellas. That's why us fellas don't come forward no more. That's why there's a long long line. It's like in the church…school or church where all them kids got done and they don't want to say what happened. That's more hard for us than it is for women.* (p13)

Tony identified that there is a lack of provision and resources for men to seek support. His comments suggest that he is not referring specifically to support for sexual abuse, as he states that there is more out there for women's '*problems.'* However, he does go on to offer his perceptions on the lack of services for men being directly linked to men and boys not coming forward to disclose their experiences of sexual abuse. Tony also advocates that disclosing sexual abuse is harder for men than it is for women. Tony recommended that in order to change this situation "*there needs to be more help.*" Specifically, he believes that doctors should be more understanding when it comes to helping men who have experienced CSA. He went on to suggest that doctors

are not able to help men to cope with CSA unless they have been through sexual abuse themselves. Tony advised that it could also be a nurse who is a survivor of CSA that is allocated to support men when they feel ready to access help and support

Summary

Tony's mother went into hospital when he has was around three or four years old, and he was subsequently cared for by his grandparents. His mother's absence had a profound impact on his education. He was eventually reunited with his mother when he was around 12 or 13 years old, and she introduced him to her new partner who sexually abuse Tony. After being thrown out of his home at 15, Tony began drinking and attempted suicide. Tony has never had an intimate relationship and he attributed this to his experience of CSA and his subsequent anger.

He felt that counselling was not effective to begin with and his counsellor was repeatedly absent from sessions. Anger featured heavily throughout Tony's narrative and he found it difficult to trust his first counsellor. He started with a new therapist and explained that he sometimes finds it helpful. However, he explained that *'getting the old things back up'* can be hard. In attempting to ascertain what he meant by 'old things back up,' Tony explained that it was experiences from his childhood. Tony discussed his belief that it is much easier for women to access support for CSA, than men. He also believes that those supporting survivors should have lived experience of sexual abuse.

Critical reflection

The room we were provided with to conduct the interview, between Tony and I, had an obscure layout. The room was long and narrow and had two large sofas positioned in an L shape. As such, I was not facing Tony and had to sit on the corner of the sofa and lean to the side to make eye contact. It felt like there was a barrier between us, as the arm of the chair obscured my body. In some way, I perhaps positioned myself in this way to protect myself and hide the uncomfortableness I often felt around him. During out first introduction and throughout the whole interview I felt tense and awkward. Tony had a menacing look and regularly sneered when making comments

that he could perhaps see made me feel uncomfortable. I felt that many of his comments about females were derogatory and misogynistic and he made a number of comments which I felt were very prejudiced in nature. I sensed that Tony was trying to make me feel intimidated; particularly when he made a comment about how he thought that the boss of the counselling service must have warned me about him. He also regularly talked about his violent behaviour with pride. However, as the interview went on and I learnt more about his story, I sense a lost and vulnerable boy. Tony was the youngest participant I interviewed and despite him being older than me, I found that he was very childlike. This vulnerability would then seem to dissipate, and the angry violent man would return.

On the whole, I found Tony's story difficult to analyse, as he often became very angry and wondered into discussions about violence and his experience with women. I tried to make sense of how I could relate his narrative account into the aims of this study which was around his experience of therapy. Despite this, after listening to the transcript a number of times, I felt that I unearthed a little more about him each time. I sensed that the process he experienced with his counsellor was somehow mirrored in the process of the research interview. Particularly, how long it clearly took to establish trust with his counsellor and the difficulties I experienced in developing a rapport with him.

Trust was something that he struggled with and I sensed that he was testing me throughout the interview. Tony had an appointment after our interview so I had to wind down our discussion at a specific time to allow us time to debrief. I felt relieved and I felt like I could finally breathe when the interview had ended. I had not realised how tense I had been, during the hour, until the interview had finished and I came back to the room alone to write notes. Overall, I felt quite conflicted. I felt sad for the lost child who just wanted his mother and another part of me felt menaced by the angry, violent man who manifested throughout the interview. I thought back to his comment about his different sides of him "my bad side is the devil." Reflecting on this comment, I realised that Tony recognised that he had two conflicting parts of himself and I now feel that I was experiencing those parts in his presence.

Andrew's Story: *Alone no more*

Introduction

This is Andrew's story. Andrew was 51 years old when I interviewed him at the counselling service where he was coming to the end of his therapy. Andrew has been receiving counselling and support from a specialist sexual abuse support centre for the past two years. Andrew is currently off sick from work due to physical and mental health problems. Andrew was single at the time of interview, but previously had been in a long-term relationship. The sexual abuse that Andrew experienced occurred when he was around eight or nine years old, and was perpetrated by a stranger. Andrew was also sexually abused by a neighbour on one occasion, and he was physically and sexually abused by his brother on numerous occasions.

There is 'something' I'd like to say

I began the interview by asking Andrew to tell me the story of his counselling. Andrew explained that he had been having support for two years and he initially sought counselling because of the '*nightmares*.'

> *I have been having nightmares since after the rape. Um…it was not for repeating. I never told anybody, never went anywhere, kept myself to myself.* (p1)

It could be presumed that Andrew was referring to the rape when he asserted that '*it was not for repeating...I never told anybody',* suggesting that it was something he felt unable to disclose and this is reinforced when he talks of keeping himself isolated during this period. Although he was describing why he came to the service two years ago, the use of the present tense when he stated that he '*is having'* nightmares indicated that they are still occurring. Andrew went on to describe his first disclosure of abuse to a professional:

> *I had flashbacks and nightmares for years and years. And um…I think I was talking to my doctor once. It was on TV and I think I mentioned something, and he said, "did something happen?" and I said yes.* (p1)

Andrew had been experiencing flashbacks and nightmares for a long time. However, he suggested it was seeing something on the television that prompted him to talk to his GP. Although Andrew did not state exactly what it was on television that triggered his decision to disclose, it could be assumed it was related to CSA. During the interview it became apparent that Andrew finds it difficult to use explicit language when disclosing sexual abuse, as he refers to '*something'* which led the doctor to ask did '*something'* happen. Based on the exchange he described, Andrew's doctor employed routine questioning about sexual abuse. Asking Andrew directly whether '*something happened'* was beneficial in this circumstance as it appeared to facilitate his disclosure and led to him seeking specialist support. Andrew provided more detail regarding his dialogue with the GP:

> *Well, he must have hit on something I said or something when he said: "did something happen." Then I broke down and said yes and mentioned it and then next thing I know I was coming here* [counselling service]*. I think I waited about nine months before I could get an appointment. Then I started coming here* [counselling] *and it was the best thing I ever did.* (p1)

The above quotation highlights the significance of the dialogue between a GP and patient. It is evident that Andrew was using vague language and did not directly mention his experience of sexual abuse. However, the GP picked up on something that Andrew said, prompting him to enquire about his past experiences. It could be argued that Andrew was offering information to test the GP's response, perhaps in the hope that he would ask about the abuse directly. As evidenced above, Andrew appeared to find it difficult to articulate the abuse experience and the GP's response and tentative questioning resulted in his disclosure. Andrew did not describe what he meant by '*broke down*,' but the GP's question about whether '*something happened'* appeared to trigger an emotional response from Andrew. Andrew indicated that it was following this conversation with the GP, that he was subsequently referred for counselling, describing it as the '*best thing*' he ever did. He did however comment that there was a protracted wait of nine months, from his first disclosure to the GP until his first counselling appointment. Andrew explained in more depth what he found beneficial about the counselling:

> My counsellor *is brilliant at her job and she listens, which is the main thing. With anything like that you've got to listen to people and not judge people and*

> *believe. That's why I never went anywhere because people…even now I have spoken to people who I trust and they said, "oh well it's in the past." You know "it's one of those things…just forget* [the abuse]*." You can't. You can't forget that.* (p1)

The above extract demonstrates the counsellor's skills of listening and being non-judgemental and how Andrew identifies these as important qualities. It is evident that the counsellor fulfilled Andrew's need to be heard, believed, and not judged. From his tone of voice, Andrew conveyed frustration when describing his attempts at talking to trusted people about his experience and being met with unhelpful and dismissive responses. As Andrew relayed responses about '*forgetting'* the abuse from others, his voice became raised, and he seemed to be replying to those individuals as though they were present in the room.

Silently alone; sharing the pain

Andrew later explained that his encounter with the GP, over two years ago, was not the first time he had disclosed the sexual abuse. Andrew stated when he was '*younger,'* his sister contacted him to ask if he had heard the news that a man in their neighbourhood had died. Andrew confirmed that he had heard, as he had read it in the newspaper. His sister then disclosed to him that she had been sexual abused by this man when she was 14 years old. Following her disclosure, Andrew shared his own experience of CSA. His sister questioned why he had never told her, and he responded by saying, "*because people don't believe you*." Andrew then stated when he was a child he reached out to a doctor, who he told about the abuse he experienced. Andrew explained that the doctor responded by saying, *"don't tell lies."* The anguish in his voice was palpable, and he stated; "*that was it then. I never mentioned it again until I was older."* Andrew discussed how he has talked to people more recently who have advised him to *"just forget about it*" or have made comments such as "*it's all in the past now*." It was evident that the response of the doctor he disclosed to initially and the other comments made by people he thought he could trust had a silencing effect on Andrew. Perhaps as a legacy of these encounters, Andrew described his fear that he would also be silenced when accessing counselling:

> *Horrible. It's horrible especially when you go to a professional. That's one thing when I came here* [counselling service]*. I'll talk to them and if they don't believe me or if they say things like "it's all in the past so you should forget about it" then I'll leave. The first time I mentioned it and I wasn't believed or when I was told I should just put it in the past that just put an end to it…to ever mentioning it again.* (p2)

The above quotation demonstrates the impact of unhelpful responses to disclosures of CSA. As noted above, Andrew was *'a child'* when he first disclosed to a professional that he had been abused. Andrew spoke of how he lived with the notion that nobody would believe him, and he even expected not to be believed when accessing counselling for CSA as an adult. It was clear that he went to his first counselling session feeling prepared to walk out if he was met with a negative reaction. Indeed, Andrew later affirmed this when he stated:

> *I came* [to counselling] *expecting to walk out again. I didn't know if I was going to do the right thing or not* (p7).

Andrew added that one person who he never wanted to find out about the abuse was his mother.

> *I wouldn't have ever mentioned it to my mother though because…well it would have killed my mother*. (p2)

It appeared profoundly important to Andrew that he protect his mother from the knowledge of his abuse. His mother is now dead, and Andrew believes that she would have been '*devasted'* if she had known. It appeared that, during his childhood, he felt very alone when experiencing CSA. However, he has since discovered that sexual abuse has affected many other people he knew.

> *Over the years since I have grown up, I know it had affected dozens and dozens of children who I knew. So, I wasn't the only one. Well as far as I know the rape was the only one…Me. That was just me but other than that kids were being abused everywhere. Dozens of people…It destroys you. Especially when you have got teachers abusing you and then other adults abusing you. Especially brothers…Not nice*. (p2)

Andrew describes a community of children effected by CSA. However, he did not articulate how he came to discover the experiences of other children. He explained that there were five men who were known to be perpetrators of sexual abuse living in

his neighbourhood, and the last of these men died about two years ago. Andrew emphasises that CSA '*destroys you'* and highlights that it is particularly destructive when it is a teacher or sibling. It can be noted that Andrew uses the pronoun '*you'*, when making the statement *'it destroys you,'* as opposed to saying it destroyed *me.* The use of the pronoun '*you'* could be related to Andrew's belief that other children have also been deeply affected by having experienced CSA. In addition, it could also be suggested Andrew is unable to own his feelings of being '*destroyed*.' Andrew discussed how he is unable to remember the perpetrator of the abuse he experienced:

> *I can't remember the person that raped me. I can see the feet, I can see the flared trousers, I can see the Winklepicker shoes, the smell of Brylcreem, but I can't see the face.* (p2)

Above, Andrew describes vivid images and details of the person who raped him, memories that appear to haunt him. As he relayed these details, he became tearful and it was clearly very painful to talk about these memories. After a few moments, he exhaled deeply and whispered "*sorry.""* I acknowledged how difficult it is to see these images and he replied, "*it's a nightmare*." Again, Andrew suggests that his nightmares are still ongoing by referring to them in the present tense. He later elaborates on the nightmares:

> *I relive it every time I shut my eyes at night to go sleep. I have nightmares...Every night. I hate the dark coming. I hate going to sleep* [exhales deeply]. (p3)

Look, listen, but don't touch

The counselling that Andrew was currently receiving from a specialist sexual abuse support centre was not his first experience of therapy. Andrew explained that he received therapy from a female *'psychologist/counsellor'* who he was referred to by the hospital. Andrew stated that the counselling was for *"mental health problems, nerves, stress, OCD mainly."* Andrew described the psychologist/counsellor as "*a lady I trusted years ago."* Despite receiving therapy and trusting this particular therapist, Andrew indicated that he did not think he mentioned the sexual abuse to her. Andrew previously discussed his disclosure to a doctor when he was a child, and his disclosure to a GP two years ago, and suggested these were the only times he disclosed to a

professional. It could therefore be determined that he did not disclose to the psychologist. This highlights the potential for people who have experienced CSA to present for therapy with issues that appear to be unrelated to sexual abuse. Andrew had been diagnosed with Obsessive Compulsive Disorder (OCD) and expanded further on this:

> *I've had that since near enough the same time as the abuse. The OCD came near enough the same because I remember I was about eight or nine when that started. I can remember going to the doctors and telling him about washing my hands and things like that, checking things, and talking to things and he told me "we'll just lock you away." I thought I was going mad. I think I was 14 or 15 when I went to the doctors because later on when I was about 18 or 19, they all said the same "well if you're going mad then we'll just lock you away."* (p4)

Andrew described the impact of the above exchange as being '*horrible'* and he explained '*you don't want to go anywhere or see anybody. You don't trust anybody*.' Andrew had a '*fear of being locked away'* and the comments from the doctor led him to isolate himself from the outside world. A number of years ago, before Andrew had counselling in relation to CSA, he was offered support for symptoms of OCD by the National Health Service. During this time, he engaged in counselling with a therapist, who Andrew describes as being well known and prominent in the field. However, Andrew explained that he did not have many sessions as he felt *'very uncomfortable'* around the therapist because he was a man. Andrew went on to discuss his feelings about men in more detail:

> *Men are…if a black man come in here then I would be fine. If a white man came in here…he would go. He would either walk out or go out head first. I can't control myself…and if a man touches me…you know. I can't control myself*. (p4)

Andrew shared that he disclosed his experience of CSA to a male doctor. However, he noted that his doctor was black and, as mentioned above, he feels comfortable around a black man. It appeared that Andrew recognised the trigger for his anxiety about being around men, as he went on to explain:

> *It was a white man that raped me. And…you know…I just can't have men near me. Like yesterday I had to go up to the hospital and I went um and it was a white man and I thought "Oh gosh." But luckily there was a black girl in there*

> *and I felt a bit more comfortable with her being there. If I go in and there's a white doctor, then I normally say that I need somebody in there…a woman. I tell them "that if you touch me, I can't control my temper. I'm sorry." I tell them straight out if they say "why?" Then, I mentioned it once or twice, but other than that I just say, "I've got post traumatic and it's none of your business."* (p4)

It is evident from the above quotation that Andrew associates his fear of white men, with the perpetrator of his rape. It appeared that his fear was rooted in the potential loss of control of his temper, and having a female present was clearly a protective factor in circumstances when he was obliged to have a male doctor. Andrew also shared that this loss of temper might occur when being touched by a male doctor. It seemed that Andrew felt agitated by having to explain his reasons for wanting a woman present during appointments and consultations. Andrew also elaborated further on his preference towards working with a female counsellor:

> *I think…with being a man and having counselling…I couldn't see a man counsellor. I would have to see a woman. If they said to me tomorrow you couldn't see your counsellor and you would have to start seeing a man, then that's it…you would never see me again. No. No. I couldn't talk to a man about it. I spoke to my doctor about it but even now…I don't think I could even talk to a black man about it either. I wouldn't be comfortable…I would get upset and talk about it…but it's different when you talk to a woman. I don't know. I find women more understanding and more patient.* (p19)

The fear of therapy

Andrew discussed his experience of going for the assessment appointment at the specialist service where he went on to receive counselling:

> *Scared stiff. Like when I first came, I think I saw my counsellor and another lady, I'm not sure, I can't remember her name. I was comfortable around her but…and they were asking questions and then my nerves started to go. I was ready to go…to walk away, but there something…but there's something about how my counsellor spoke and the trust was there.* (p5)

Andrew expresses unequivocally that he found the first appointment *'scary'*. Although he seemed to relax somewhat, as he began to feel comfortable with the woman carrying out the assessment, he felt nervous when it came to her asking questions. It could be suggested that services need be mindful of the questions they ask during the assessment process, as Andrew asserted that he was almost ready to walk out of the

appointment, due to his nerves around the questioning. However, he indicated that it was the qualities and skills of the counsellor and, in particular, the way in which she communicated with him, that allowed him to trust her. Andrew described the counsellor's presence and attributes in more depth:

> *She's…she's…my counsellor. When you are talking to her she doesn't say much at first, she listens to you, but then she will jump in with something or say something and then ask questions. There is just calm around her. When I see somebody I trust…like you* [researcher]*…I just…when I first spoke to you if I couldn't have trusted you then I wouldn't have come. I sort of looked at you and I knew I trusted you.* (p5)

Andrew explained that he establishes whether he can trust someone quickly and gets a sense of trustworthiness from the way someone talks or looks at him. Therefore, first impressions are essential in his ability to form relationships with professionals. Andrew also commented on how he was only able to partake in the research interview, as he felt he could trust me as the researcher. In addition to his counselling, Andrew has also been receiving practical support from an Independent Sexual Violence Advisor (ISVA) based at the same organisation. He explained that she was supporting him with '*financial problems*' and completing paperwork in relation to his finances. Andrew explained that if he receives a letter through the post requiring him to complete forms, it can take him months, as his '*brain doesn't register properly'* and he feels '*nervous'* and '*anxious'* about sorting out paperwork. Andrew appeared to become overwhelmed in such situations and the support from the ISVA meant that paperwork that would normally take him weeks or months to complete, was sent off by the end of the day. The financial support Andrew described was practical in nature; however, he clearly describes how such support has had a positive impact on his mental health. He explained further; "*It's just like reassurance for me. It sounds quite strange but*…[pauses] *I don't like making mistakes. I'm a perfectionist*." Andrew relayed how he has completed financial paperwork in the past and has subsequently been told that he has made mistakes and would have to pay a fine. Andrew was adamant that the forms had been filled in correctly and he explained, "*they were trying to convince me it was my mistake, but this is what happens to me every time…I am so easily pushed over by people* (p6)*."* On this occasion, he eventually conceded and agreed that it was his mistake. *"I get pushed into it. I have a soft spot and I don't like it."* Despite feeling that he is easily '*manipulated'* by people, Andrew recounted a turning point since

having counselling, stating he no longer has these experiences: *"Not much though anymore. I stand up now."* From his facial expression and confident body language when relaying this statement, it was clear Andrew was proud of this change in his behaviour.

Uncomfortable conversations, difficult memories

Andrew discussed how the counselling he has been receiving for the past two years was his fist experience of support for the CSA. He portrayed some of the personal challenges counselling has posed for him:

> *I get upset. I get uncomfortable at some things but it's just one of those things. But that's about the memories for me…not what the counsellor or anyone says. No…it's things what come up in my mind as I am talking. I can't control my emotions sometimes.* (p7)

On further exploration of the consequences of not being able to control his emotions, Andrew listed the emotional and physiological effects he experiences, as a result of CSA:

> *I get irritable, anxious, arms crossed when I'm talking about this, sometimes feel sick, I get really upset very quickly, I get palpitations in my chest, I breathe deeper, I have to run to the toilet sometimes when it's that bad. But I can control that when I'm with my counsellor or with my ISVA.* (p7)

The above quotation documents how anxiety can manifest and present itself for a client during therapy. Andrew stressed that he experiences these effects when he is '*talking about this.'* It could be assumed that he is referring to talking about sexual abuse. Andrew maintains that he can control his symptoms of anxiety when he is with his counsellor and IVSA, which indicates he feels safe. Andrew stated that counselling can be '*very difficult,'* particularly as there are '*episodes and years and years'* of his life that he is unable to remember. As such, he explained that counselling can often trigger memories when he comes away from the sessions.

> *I've spoken to my counsellor many times about where I've dozed off at home and something's happened, the news has come on and it's been on the telly or something or in the paper or a word someone says. One recently…it was a*

> *plane going over the sky. It was a nice blue sky and this plane went over and the noise of that plane bought back a memory from when I was a little kid.* (p 7)

Andrew elaborated further on this particular memory, stating that it was a good memory that resurfaced when the plane flew over. However, he stressed that the good memories are scarce. He relayed a memory of:

> G*oing up to the boat yard with my mum and the kids with jam sandwiches and sitting down watching the yachts but after about eight there are no good memories. They are all bad. Nothing at all.* (p7)

It was clear that Andrew only has good childhood memories from before the sexual abuse occurred. He sounded distressed as he conveyed his experience of abuse by his brothers:

> *Even my two brothers abused me, one sexually and one physically and mentally. He used to beat me with an iron bar, me, my sister and my younger brother. We used to go to school with red marks all down my arms and legs.* (p7)

Andrew notes above that he went into school with visible injuries and it appears that the school neglected to question him about where the injuries came from. Andrew discussed how he protected his mother from the knowledge of his sexual abuse experience. He explained that his mother knew about *'the beatings'* from his brother. However, he asserted that she '*couldn't do much because he* [Andrew's brother] *had threatened her.'* Andrew commented '*I was very attached to my Mum*.' Andrew discussed how he continued to help his mother when he reached adulthood. One of his brothers had a brain tumour and he took over the role of caring for his younger siblings in the day, then working night shifts, until he was in his early thirties. It was apparent that Andrew was very protective of his mother, as he commented:

> *I was there all the time. I was very close. Nobody could say anything about my mum or go near my mum when I was there.'* It was also evident that Andrew felt proud of her, when he remarked that 's*he brought eight kids up by herself.* (p8)

Andrew stated that his father died at the age of 42 and he discussed the traumatic impact of his death.

> *So…she* [Andrew's mother] *went out to make him* [Andrew's father] *a cup of tea. She came back, and he was dead. He died in front of me, I saw him die. Chocked to death. In front of me. That's another nightmare.* (p8)

Andrew explained that he could not really remember much about his father and he thought he was around eight to ten when he died. However, he stated that there is a '*big block'* during this period, as he explained*,*

> *I know the rape happened then and other things happened then, and my dad died then, but I couldn't give specific dates. There is still a lot I don't remember between those ages.* (p9)

Something that Andrew distinctly remembers from that time, that he talked about in counselling, was his experiences of being bullied.

> *I still got bullied at school and abused. I still got bullied when I worked at the supermarket a few years ago. But I wouldn't let them get away with it. Even the bosses there used to bully me, but I wouldn't let them get away with it. Always been bullied and persecuted, victimised and intimidated. But up until I was 14 or 15, I was abused sexually by my brother and other people that lived up the street. Teachers…they used to beat me with sticks and lock me in cupboards. I have nightmares about that* [pauses]. *I remember now, grabbing me and shouting at me and locking me in a cupboard for an hour. All the other kids, I could hear them outside. It was only a small little cupboard. Locking me in there while all the other kids were laughing and shouting. For an hour. That's why I am so terrified of the dark now and small spaces with only tiny spots of slits of light to see.* (p9)

Andrew's anguish and fear, as he relayed the above experience, was palpable from his tone and body language. He described nightmares about *'The Bogey Man'* that he experienced on regular occasions until the age of 18 or 19; adding that he occasionally experiences similar dreams now. I indicated to Andrew that I had a sense that he had nowhere to escape, as he did not seem to be safe in his home, at school or in his dreams. Andrew responded by saying the only escape he had was his tree. Andrew had previously alluded to this '*tree'* at the beginning of the interview: '*You sit in a tree all day. There was a hollow in a tree and that was my get away.'* Andrew elaborated further on the significance of the tree:

> *I got raped up there, by* [pauses], *by the railway lines. I was picking blackberries and I was dragged into the shed; my clothes were removed, and I just felt pain. I didn't know nothing about it then, what had happened or nothing until a while later. But not far from there, there was a tree across the brook with a…like a big hollow in it and that was where I used to go and sit all day. If I ever wanted to get away or anything like that, I used to just sit in there.* (p10)

It can be assumed that the hollow in the tree represented a safe space and an escape from the reality of a childhood characterised by abuse and punishment. Andrew noted that the tree was close to the location where the rape happened. Andrew explained that he would sometimes go to the place he was raped with siblings or friends, but he never told them about the tree, as it was '*my place*.' Although he was able to go back there as a child after the abuse, he found revisiting it as an adult distinctly painful.

> *Oh, it was horrible. I tried to go back to where the rape happened…about halfway there…I had to go. My temper…if somebody had come or spoke to me…a bloke…I think I would have attacked him.* (p10)

Andrew again demonstrates how his anger can often be uncontrollable when it comes to being around men. He explained that he is hypervigilant when he is out, as he described his *'eyes being everywhere'* and being in a high state of anxiety. He discussed how his anger can manifest when he is alone and can lead to acts of self-harm:

> *Not when there is anyone about. It's mainly in my house. The anger…when I think about these things or when I have these nightmares…punching the wall or slicing my hands. I haven't for quite a few months now which is good but when I'm in pain or when I'm angry I do cut my arms. I can control it when I'm by myself, but if somebody touched me then the anger will come across…I am scared in case I hurt somebody*. (p10)

In the above excerpt, it is evident that harming himself is a method of controlling the '*pain'* and '*anger.'* Andrew intimated that the '*pain'* he was describing is emotional pain, rather than physical pain. Andrew feels in control when he is alone, but demonstrated his fear of losing control and hurting somebody. Despite this, he clearly recognises self-harm and cutting himself as a maladaptive coping strategy, as he pointed out that he *'hasn't harmed himself for quite a few months'* and stated that this was *'good'*. Andrew associated his fear of being around others, with his inability to trust. He firmly stated:

> *I trust nobody. I have stopped trusting people…people are…but I don't want to hurt anybody. I know if I go violent…if I attack then I can't control it* (p11).

However, from this statement, it appears that Andrew does not trust himself. Andrew associates his lack of trust, as a direct consequence of his childhood experiences.

> *Yeah. I can't control myself. This is all because of what happened to me when I was a kid. I mean I remember one day being staked out by…one of them was my brother and some other boys. They stripped all my clothes off and staked me out on a field. They covered me in ants* [pauses]. *Horrible isn't it? I see ants now and…I didn't go sleep for three days because I had ants in my flat. Until I killed them all and treated everywhere, I wouldn't go asleep in case I would sleep, and they would go over me.* (p11)

Describing the above experience noticeably evoked distress in Andrew, as he had to pause and take a breath before being able to verbalise the effects of this traumatic experience. Andrew was looking at the floor intently, as he described being '*staked out'* on the field and covered in ants. He then made eye contact and appeared to want to gauge my reaction to his story, followed by the comment '*horrible isn't it*?' Although it was a question, it felt more like a statement, as it seemed that Andrew sensed that I felt the experience was horrible from my nonverbal communication. It was evident that the above experience led to a debilitating phobia of ants. Andrew described how having ants in his house could '*destroy my life'* and trigger nightmares. When describing some of the repercussions of the abuse experience, he explained:

> *I don't think I'll ever get rid of any of it. But what* [my counsellor] *does and* [my ISVA] *and my doctor, it keeps me sane and keeps me going. I think without them I would have killed myself a long time ago.* (p11)

The above statement is a powerful example of how imperative support has been, and continues to be, in Andrew's life. Furthermore, he notes that each form of support has been essential and it's clear that an integrated approach has been the key to improving and maintaining his overall wellbeing. Andrew contemplated what exactly he has found beneficial about counselling:

> *Can't explain it…It's the person's voice. The person…they listen to you, they understand, they don't have sarcastic comments like "I don't believe that*

> *happened," like my doctors you know. They just sit and listen to you and if they want to say something then they say it. They don't talk fast or loud. They say it slowly and if I don't understand it then they will say it again. And they listen. That's the big thing with abuse…listening. Because I always tend to chatter on* [laughs] *and I'm terrible for that and I change subject so if I'm talking to you about something and I jump to something else then just tell me because it happens a lot with me. Because I'm there for counselling not to talk about…I mean she will listen to things but…she won't say "we're not talking about that." She will listen and that's the good thing about her. You know…if I'm talking about something else and she knows that it's causing me stress then she will listen and talk to me even if it's jumped from the abuse to something else. She's good.* (p11/12)

It could be concluded that Andrew regards listening as the most essential skill that the counsellor offers within therapy. He also identifies the importance of the therapist keeping the counselling sessions focused, although he points out that he is able to discuss issues unrelated to the abuse when they are causing him '*stress'.* However, he indicated that the counsellor directs the session back to the presenting issue when he changes the subject. Andrew also discussed how important it is to be given '*time*.' He explained that when you go to the doctor you are only given five or ten minutes. However, when it comes to counselling you are given one hour. He mused, '*they say time heels…don't they?'* Andrew elaborated on the problems he faces when he is not given time in relation to health issues.

> *It happens a lot with me. I'll walk out and I'll not have had a clue what they were on about. It will register maybe two or three days later. It will come to me and I'll think "oh, they said that." Then I realise then. I have got some damage to my brain. So they tell me. Something to do with the Neurotransmitters or something. It's part of the OCD anyway. I do understand things, but I can either understand there and then or two or three days later before it clicks. [Laughs] And all the years I have been told I was going mad.* (p12)

The above quotation supports the importance of time for Andrew to process what he discusses in therapy. He previously talked about how the counsellor will listen, talks slowly, calmly, and quietly, and will repeat things if he does not understand them. Andrew again mentions being told that he was going '*mad*.' It seemed that knowing he has a medical condition affecting his cognitive ability, provides some comfort and reassurance that it was not '*madness'* he was experiencing. Andrew elaborated on this further:

> *That's what the doctors told me. One psychologist told me "well, if you go insane, we will just lock you away." It's terrible. But what confidence does that give you? That makes me push away from doctors or psychologists or any help.* (p12)

Becoming altruistic; Protecting others

As discussed above, Andrew described resisting medical help, due to his earlier negative interactions and experiences with healthcare professionals. He poignantly described this further:

> *Only until a couple of years ago…one of the doctors just sits there and just gives you antidepressants. It's shocking. There are thousands of people out there…millions of people being abused in all sorts of different ways that need the help, but they're not getting it. If I can help one person by coming in here then I will do it* [becomes tearful, exhales and pauses for ten seconds]. *If I can help one person…just one…then I will do anything. Sorry…I've got tissues.* (p12)

Andrew identifies a significant issue for people who have experienced abuse, in terms of their experiences of treatment for mental health problems. Andrew expresses his frustration that doctors only offer medication, which he appears to believe does not help. Andrew evidences his altruism when he conveys his desperation to help other people. His sadness was palpable when he described how so many people have been abused and need help that he believes they cannot get. He became visibly upset and began to cry, as he paused to explain his desperation to help other people. I reflected back to Andrew that it sounded as though he does not want anyone else to experience what he has gone through.

> *I don't. I see it on TV all the time. People that have been done for abuse which happened 30 or 40 years ago. The people who are coming forward now are saying: "they didn't believe us. They thought we were lying, and they didn't believe us." It's just my story. I break my heart for them. People are being locked away now for things they did 40 years ago. They should have been locked away then and these people wouldn't be experiencing this 30 or 40 years later. It's destroyed their lives. It's destroyed mine. That's all down to the police…I don't know*. (p13)

Andrew was displaying empathy for the strangers he has seen on television who have been through similar experiences to him. The anguish in his voice was undisputable,

as he shared that his *'heart breaks'* for them. He acknowledges that what he has heard, in relation to the abuse happening 30 or 40 years ago and those abused not being believed, resembles his '*story*.' He stated emphatically that these people on the television have had their lives destroyed and he asserted that his own life has also been destroyed. He was not clear as to whether the individuals on the television had voiced this, or whether he was basing this assumption on his own experiences. The above comment was the first mention of the police, during the interview. He appears to blame the police for abusers being locked up 30 or 40 years after the abuse had taken place. Andrew discussed his urge to seek answers from his abuser:

> *I would love to stand face to face with everyone that has abused me over the years and ask them why. I would love to. I want answers, but I know I can't get the answers. The only way I would get answers is if I beat the hell out of them, but then I would just be as bad as them. I don't trust the police or anyone to do anything about it*. (p13)

It could be argued that the '*answers'* would serve as justice for the abuse he experienced. However, it appears that Andrew is resolute that he will not achieve answers through the police, appearing to have the same mistrust of them as he does for other professionals, including doctors and teachers. Andrew stated that he felt '*let down by a lot of people'* and shared another story about his experience of bullying and humiliation at the hands of a teacher.

> *A teacher is there to teach you, not to beat you, kick you, slap you, punch you or lock you in cupboards. I was a late developer. It was sports day and I used to get chinned because I was a late developer. Then I was told by the teacher to go and have a shower because I smelt…which I didn't, but then all of the lads would flick me with…even himself…would flick me with wet towels. This is a teacher. Not on is it? Because I was a late developer. I can't help being a late developer.* (p13)

Andrew relays the shame and humiliation he was subjected to by both the teacher and his peers. It could be suggested that these experiences cultivated his lack of trust in authority figures and professionals. Although Andrew had not reported the abuse to the police, he appeared to test the water more recently and approached a police officer to get more information.

> *I sort of mentioned it to a police lady when she walked past my house about the abuse and what could be done about it now when it happened so many years ago. She said that we wouldn't know until it was investigated and that wasn't good enough for me. Until we've investigated, we won't know what to believe…or something was what she said. It sounded so negative. So that was it. No.* (p13)

Andrew seemed to be seeking a definitive answer from the police officer and views the response he received as negative. As the officer explained that it would have to be investigated, and the outcome would depend on what they discovered, Andrew interpreted this statement as the police might not believe him. The policer officer's response supports the rhetoric of '*not being believed*' that Andrew discussed when commenting on television programmes depicting abuse survivors. It can also be noted that Andrew chose to approach a female police officer to make enquiries about reporting historical abuse. Based on his previous comments about the gender of professionals he encounters, it could be assumed that talking to a female felt safer than discussing the issue with a male officer.

Protecting Mum in a feuding family

Andrew described how he was met with a negative response when he tried to talk to family members about the abuse he experienced. He attempted to talk to two of his sisters and one of his brothers and they replied; '*whatever, it's in the past.'* Andrew sounded dismayed as he recounted the experience and went on to talk about the breakdown of his relationship with his family.

> *I haven't really had much to do with my family since my mother died. Big family argument and I backed my mother and stood by my mother. When she died, they all wanted her cremated at the crem but she didn't…she wanted to be buried at the church. They all wanted her cremated, but I said no and I paid for it. She was buried in the place where she spent most of her childhood. I don't speak to many of them. They all wanted off me over the years because I worked hard and saved because I knew what poor as poor could be. And all they have wanted off me over the years is money. Not last year, but the year before that, I bought all my brothers Christmas dinner and he was the one who abused me…all his food, fags and drink because he had got no money. But then when I had the nightmare about a year ago and I saw him in it when he abused me I have had nothing to do with him since. I won't. He came once to the house and I was there…but I didn't answer. I wanted to…I wanted to open the door and knock his head off. I would like to ask him why…like the teachers. Why do you*

> *beat and abuse a child…to the abusers why would you touch and rape a child? It's wrong. I just can't understand what the men see in what they are doing to children. It's like…you know…what they have done to that kid is bad enough there and then, but for the rest of his life, like me, the damage is done. It's wrong* [starts to cry and pauses]. [Inhales] *Sorry.* (p14)

Andrew had previously discussed his mother with fondness and pride in her achievements. It was clear that he was trying to protect her, even after her death, and fulfil her wishes of being buried at a church. There was a sense of sadness and disappointment, as he discussed feeling like he was being '*used'* for money. It was evident that he had tried to maintain a relationship with his siblings following his mother's death, and how their response was visibly painful for him.

Above, Andrew recounts recovering the memory of being abused by his brother, following a nightmare he had one year ago. As Andrew has been having counselling for two years, it could be argued that the process of therapy influenced the abuse memory coming into his conscious awareness. Andrew described experiencing a surge of anger, when his brother turned up at his house, following his nightmare about the abuse. He was explicit in his desire to be physically violent towards his brother; however, he did not elaborate on what stopped him from answering the door. It could be assumed that it was to protect himself from being violent. Andrew again expresses his yearning for answers from his brother and the teachers who abused him. He implied that he wants to understand the motivations of a perpetrator of CSA. He also vehemently stated that the act of abusing a child is '*bad enough'*; however, the lasting damage, for him, is the long-term impact of the abuse which he declared is '*lifelong'*. Andrew became visibly upset after making this statement and began to cry. He appeared to need time to compose himself and took a deep breath, before apologising. Andrew expressed that he wanted to continue with the interview. I reaffirmed to Andrew my understanding of it being hard for him when he reflects on his life and the harm that has been done to him. Andrew responded:

> *That's right yeah and it's the time I'll hurt myself when I get that low. But I have got a lot of support. A lot of people. A lady who used to come with me to the union…well, she worked with me and we became very good close friends. I can talk to her every day or night and I've got other people I could contact. I have a lot of support but sometimes the support doesn't even hold me up.* (p14)

Andrew acknowledges the valuable support network he has around him. However, he indicates the potential for harming himself when he becomes very low and stated that the support cannot always '*hold'* him up. This evidences the need for continued professional mental health support, regardless of an individual's social support network. Andrew had two mental health nurses, around two or three years ago when he was regularly self-harming, who used to provide home visits. Andrew described an incident which led to him refusing the support.

> *I remember one of the nurses saying to…she said to me "well, we're coming tomorrow so we will take you shopping because you haven't got much food." This was before I had my car. She says "right. You need to get some clean clothes on, get a shower and you're a bit scruffy so get a shave." I shower every day and I said the reason why I haven't had a shave is because I haven't felt like it for a couple of days. She said, "you haven't had one for four days." Then I went in my bedroom and thought "eh?" I went in my wardrobe and said, "these are what I just wear right at the back and as for saying I smell, get out and don't ever come back." They didn't. One of the other ladies came the next day because I complained, and she asked me what had gone on, so I told her. She said "well" and I told her "I don't want any of your help ever again*. (p14)

Andrew associated his reaction to the nurse's comments with his childhood experiences: *'Well, I had a problem when we were kids, we always used to be told in school that we smell.'* The nurse's comments triggered childhood memories of being bullied at school about personal hygiene, and he was undoubtedly upset as he described the incident during the interview. However, it was apparent that his emotional reaction at the time of this incident to be that of anger, as Andrew discussed telling the nurse that he '*didn't want her help again'*. His voice was raised as he relayed what he told the nurse, as if she was present in the room and he was talking to her directly. He refused further help from both mental health nurses, despite acknowledging that the support was helpful and beneficial to his wellbeing before this incident. This highlights how anger, which is a common effect of CSA, can manifest from childhood memories or perceived threat or insult (Lisak, 1994). Andrew described how the nurses had betrayed his trust.

> *I would never have them again. No, even if I need to, I wouldn't have them back again. If someone breaks their trust with me that's it. I can't be around people I don't trust. It's wrong. To say that to someone who is very low, it could have pushed me over the top that could of* [pauses]*…I don't trust a lot of people*. (p15)

Above, Andrew highlights an important issue when it comes to mental health workers maintaining trust and a positive working relationship with clients and service users by communicating sensitively and empathically. The comments made by the nurse about his appearance caused a detrimental rupture to their relationship, and it could be argued that her comments were not communicated in a trauma informed way. The suggestion for Andrew to have a shower could have been communicated tentatively and tactfully; however, Andrew was unambiguous in how the comments about not showering and looking '*scruffy'* elicited a traumatic emotional response and could have '*pushed'* him '*over the top.'*

Andrew's negative experiences of mental health support from statutory services, prompted him to share the positive aspects of the support he has been receiving from a specialist counselling service:

> *Just knowing that I am coming here really lifts my day. I know that if I have had any problems in the week or if I have had nightmares or dreams or all that, I know that coming here on that* [day of week he attends]*, I can talk to my counsellor. I know I can talk openly about it. Yes, I get upset, but I know I can talk about it. She'll talk to me and she'll just listen. That's a big thing. For her to sit there like you* [researcher] *are now and listen to me and not judge me like people have done over the years. "Oh, grow up!" You're too old now! "I don't believe you!" Don't keep lying!* (p15)

The consistency of the sessions was an important factor for Andrew. It appears that despite experiencing debilitating emotional effects, such as nightmares, knowing that he has a counselling appointment helps him to cope and function throughout the week. His comment emphasising the word '*openly*' indicates that he feels safe and comfortable in talking freely and honestly with his therapist. Andrew again highlights the importance being listened to and not being judged. He echoed the societal messages he has been subjected to throughout his life and implies that the counselling is an opportunity to talk freely, without fear of being judged. Andrew detailed the trust he has with his counsellor:

> *Trusting somebody…When you get to trust somebody, it's a big thing when you've got problems. When you get to trust somebody, and somebody will sit and listen to you, and somebody will talk to you, and somebody will help you if you need help, if you need the help, or give you advice or anything I need. If I*

> *needed to know something…Like, I mentioned to my counsellor about problems with finances if I had to pay for my own care and all that. I told her that I will have more bills if I got stuck with that. Then straight away she referred me to an ISVA, and she helped me and sorted it out. So, the help is there and for months and months I had been struggling like mad since my other support disappeared.* (p15)

Above, Andrew gives an example of how the counsellor offered a solution to problems that he has discussed during his counselling. This emphasises that it is important that clients are able to discuss general issues, such as finances in therapy, even when the counselling is focused on support for sexual abuse. As Andrew points out, the help was there all along '*for months and months*.' However, it was not until he bought it up in therapy that the counsellor was able to refer him for this support. This also highlights how the counsellor's knowledge of additional services can be beneficial for clients and how therapists can act as sign posters and information providers to wider support services. Intriguingly, Andrew used the term '*mad'* when making the comment *'I had been struggling like mad.'* As previously discussed, the term '*mad'* had negative connotations for Andrew, as he had consistently been told that he would be '*locked away'* if they thought he was mad, and he was also told that he was *'going mad'*. In particular, he described reaching out for help for OCD symptoms and behaviours and how he had been silenced for fear of being deemed to be '*mad'*. Andrew gave further insight into the struggles he experienced before receiving practical support, and the consequences of the help not being there:

> *I was getting to a point where I was ready to cancel my care and stop taking my meds and just live what time I had got left. End it. I thought about it. I told my counsellor. There is not a day that goes past that I don't think about it, but you know…my mum. I think about my mum up there and it gives me calm. Calmness because I know my mum will be mad if I kill myself. I would be happy if I was there with her, but I know I have got to keep trying. I know I have got to keep trying. I have got to push on. I don't think I would have survived this long if I hadn't been strong in a way. I mean from what…eight or nine years old and I'm 52 this year. I survived so much, and I am not about to give up. I want to bring everyone to justice to tell the truth. If I can just build up the evidence…and remember…maybe I will go to the police.* (p16)

Andrew described feeling trapped and ready to give up due to the impact of his financial problems and no longer having the funds to finance his care. He was unambiguous in his desire to '*end it,'* specifically referring to ending his life. Andrew

was able to share these feelings with his counsellor and he was subsequently offered support to help with his financial problems. Although Andrew states that he thinks about ending his life daily, he was explicit in describing his mother as the reason why he does not kill himself. Andrew's attachment to his mother is evidenced in his determination to not disappoint her, even after her death. It was apparent that he felt that he would be letting his mother down if he ended his life, despite feeling that he would be '*happy'* if he was with her again. He quoted the affirmations *'I know I have to keep trying. I have got to push on*.' Andrew recognises his inner strength and identifies himself as a '*survivor*.' It appears his ultimate goal is to bring the perpetrators to justice. However, he is clearly hesitant about this and feels that he first needs to *'build up the evidence.'* Andrew has been unequivocal about his lack of trust in the police, and it seems he feels that finding evidence is his responsibility, rather than the responsibility of the police.

Saved by an Angel

Andrew has considered writing a book about his *'life story'* and this has been encouraged by his counsellor. He advised that he had *'made an attempt'* a number of years ago, however, he would often *'get upset'* and have to stop. Writing his life story was clearly an aspiration that he wanted to achieve. However, Andrew explained the obstacles he faces:

> *Quite a lot I have written down. Maybe I should start writing a book [pauses]. Writing things down for me is good. I could sit there all day writing. Jotting things down…you know? Just writing a bit of something. Maybe I could write a bit of something. Maybe I can only remember a bit of something. I can remember a bit of what happened a certain day so I'll write that down and other bits on that day will come to me…you know? I just can't understand why I don't remember my whole life. Lots of other people have said…Dr [name] has said that this is that hard for you…that things might have been that bad that you have blocked them out. Like I say…certain things on the telly or certain words or certain things…a dog barking…it could be anything…can trigger something in me…which happened to me* [pauses]. *Strange.* (p16)

Andrew expresses a desire to chronicle his life experiences and it appears to be a cathartic process for him. Andrew conveyed concern that he is unable to remember certain experiences and it appears that writing also served the purpose of helping him to uncover lost memories. Andrew is clearly searching for some clarity and

understanding in terms of why he cannot remember his '*whole life*.' He appeared to be unsatisfied with the doctor's theory about blocking out memories due to the severity of his experiences. Andrew appeared to be perplexed by how his memories would sometimes come into conscious awareness, often triggered by unspecific events or stimuli. Andrew shared a memory which recently surfaced:

> *I can remember when I was about 14…being bullied at school and I filled my trouser pockets and my jacket pockets full of stones…ready to jump in the canal. I was 14 and I don't know where she come from…but a woman appeared with a dog called Ben. I never saw anybody coming…I never heard anyone…no one was around…she just appeared, and she put her hand on me and spoke to me and she knew what I was going to do, you know? I remember her saying "this is Ben, my dog" and she spoke to me for ages and ages. I can remember throwing the stones in the canal out of my pocket and then she had gone…she had gone. There were fields all around. She couldn't have gone that quick. She just disappeared* [tearful]. (p16)

Above, Andrew describes a desperate moment when the bullying was so intense that he could not see another solution, but to end his life at the age of 14 years. Andrew described the moment he was saved by what he now terms an '*angel'* and affirms that this incident is the reason he will always believe in ghosts, angels, and life after death. It is apparent that Andrew's beliefs have helped him to cope when he has been at his lowest points and contemplating suicide. When considering what angels represent for many people, it is clear Andrew feels protected by his spiritual beliefs. His belief in his saviour being an angel is supported by the fact that he went in search of the elusive woman who stopped him from jumping into the canal. Despite it being a small community, Andrew walked around the canal on many occasions in his search and talked to numerous local residents; none of whom knew the mystery woman with a dog called Ben. He shared the moment, telling his old doctor about his encounter with an angel and he recounted the doctor's response with a definite tone of dismay in his voice:

> *He said "oh you're dreaming, don't be daft. You're going mad." That's what he said. I never mentioned it again. I told my counsellor though. Don't be daft he said.* (p17)

The doctor's response echoes the countless negative responses he has received from healthcare professionals and was another example of a time when he has been

accused of being '*mad*.' As Andrew mentioned telling the counsellor the story of the angel, but did not elaborate on her response further, I was intrigued to hear about his experience of telling her.

> *There's something about* [my counsellor]. *I can talk to her about anything. I can sit in…the room I sit in with her…I sit down, and all my worries are gone. That doesn't happen and that doesn't happen very often. That only happens when I go to the doctor. I can talk to my GP about anything…all my worries are gone, and any problems and he'll fix' em. When I sit down with* [my counsellor] *it feels like it's a weight lifted off my shoulders and that doesn't happen a lot…like I say trust is a very big thing for me…knowing I can trust someone…Like you* [researcher]*, I know I can trust you. I know whatever I tell you…whatever you write…I won't even have to look at it. I know I can trust you. It doesn't happen very often, but it seems to be happening here [counselling service] with quite a few people…my ISVA, my counsellor.* (p17)

Above, Andrew did not directly answer the question around the counsellor's response to him talking about the '*angel'* who stopped him from killing himself. However, he provided an overall account of his feelings towards the counsellor and the therapeutic process. He cannot quite articulate what it is exactly, about the counsellor, that makes him feel at ease and he describes it as something about her presence that alleviates his '*worries.'* In the quotation above Andrew is referring to his current GP who he advocates as being caring and helpful. It seems that he has a positive relationship with a health care professional for the first time and it has undoubtedly been beneficial to his wellbeing. Andrew again refers to the overriding factor; in order for his relationships with professionals to be successful, he has to be able to trust. He discussed the trust he placed in me, as the researcher, in entrusting me to tell his story.

In for the long haul

It has previously been identified that consistency in support has been a fundamental factor in maintain Andrew's wellbeing. Another aspect that Andrew identified, during our interview, was the longevity of the support available.

> *I expected to be coming here for about three or four months and then they say the sessions ended and you will be pushed off again. Well* [the counsellor] *said to me once…she said something and I said, "does that mean the sessions will be ending soon" and she said "no, not at all Andrew." I mentioned something about how long and she said two years, so I said, "does that mean they will be ending soon" and she said "no Andrew…not at all. You can carry on for one*

> *year, two years, five years. As long as you need us…we are here." That's…that's good. You know to hear that…it made my day.* (p18)

The relief in Andrew's voice was distinct and knowing that there was no definitive end date for counselling reaffirmed the safety and consistency of the support available. Andrew's response *'it made my day'* highlights the importance of long term support for survivors of CSA. Andrew added:

> *If I need to speak to them then they are there. It's like my ISVA said that if I have any letters through or any problems then just phone me or text and we'll arrange to meet* (p18)*.*

The reassurance that in times of need the support will be there has clearly been beneficial to Andrew's mental health and wellbeing. However, it could be argued that this could lead to a dependency on the support service.

Andrew moved on to discussing the environment of the service which had recently relocated its premises:

> *I'm glad we're away from that other place though. Well…I believe in respect for everybody, but sometimes when I was parked there you had people sitting there on drugs, drinking, shouting. One time I went in…a bloke came down shouting, kicking and swearing. The police were called once or twice when I was there. People there were just being disrespectful to people. It was horrible and I don't like people drinking. If they want to drink, then they should drink in their own house…not outside causing trouble. The place there wasn't just for this service…I think it was for drugs and alcohol or something and I didn't like that place.* (p18)

Notably, Andrew uses the pronoun '*we'* when explaining that he is glad that the service recently moved location. His statement that he was glad *'we're away from that other place'* suggests Andrew considers himself as a part of the organisation. Indeed, Andrew later discusses the donations and fundraising activities he has completed to raise money for the service. On further exploration, Andrew explained that when he first went to the specialist service, it was originally located in the same building as a community drug and alcohol support service. Andrew described incidents of anti-social behaviour that he regularly encountered when attending his counselling appointments at the former building. It was apparent Andrew did not feel safe or comfortable when

accessing a service with an often volatile, client group sharing the building and common areas. This highlights a need for sexual abuse support services to be situated in a self-contained environment or, alternatively, in an environment with similar services and client populations. Andrew described the service's current surroundings:

> *It's nice here. You call in and it's easy parking and…you know it's just like this* [gestures to the room]. *You've just got the people for here that come to this place and you're not smothered by others or surrounded by people sitting about. Coming here…and it's just for people that come to counselling…it's far better.* (p18)

A man's world

Andrew had previously discussed his feelings about initially accessing a specialist sexual abuse support centre, his experience of counselling and his perceptions of the environment of the organisation. As a final thought, I asked Andrew whether he feels that there are any barriers for men in accessing support in relation to CSA.

> *I did at first. I thought…I always thought that when it comes to people being raped and abused, that they will believe the women and not the men…and men…I don't know…there's this macho thing about they don't want to talk about it and it's like they are weak if they talk about things like this or admit to something that has happened to them. I got fed up of that over the years and I don't know what happened, but I know I saw my doctor and I cracked up. The next thing I knew I was here and I'm glad I came.* (p19)

Andrew highlights the common theme he has referred to throughout the interview; not being believed about his experience of sexual abuse. Andrew conveyed the fear he had about not being believed and stipulated that it was a barrier for him when it came to accessing help and support for the first time. This is pertinent when considering that Andrew did not get any support for sexual abuse until his late forties. Andrew associated his fear of not being believed, with societal messages around masculine norms. He described these as '*talking about things'* meaning a man is not '*macho'* when disclosing their experience, as they will be seen as being *'weak.'* It can be noted that Andrew uses the term *'admit to something that has happened to them'* when referring to men disclosing their experience of sexual abuse. The word '*admit'* implies that the man is confessing to something and it could be argued that this suggests an element of responsibility. Andrew explained that he has got *'fed up of that over the*

years', which indicates that he has experienced these societal messages first-hand throughout his life. Andrew described the moment he asked for help from his doctor being the time that he '*cracked up*.' The colloquial language Andrew uses to describe his mental health has similar negative connotations as his previous comments about going '*mad.'* Andrew turned the discussion to focus on issues he feels are present in the medical profession in relation to mental health.

> *You can talk to my counsellor and she just listens. I can chat, non-stop, for hours and she just listens. Doctors…it's just ten minutes in and out and half of them just don't want to know. They really don't want to know. I feel like…I don't know…I have a problem and they don't want to deal with that problem. To me…the doctors…they don't want to listen to me. They just want an easy life. You come in and they just want to give you a tablet and send you out again. if you talk to them…some of the doctors I have spoken to…on and on and on and it's like they want to get rid of you. No, it's not me that isn't. I can't. When I came here, I knew that the trust was there, and I knew that I could talk to my counsellor.* (p20)

The above quotation is contradictory to Andrew's previous statement about his doctor. At the earlier stages of the interview, Andrew stated that he can talk to his doctor *'about anything'*, he can *'fix any problems'* and *'alleviate his worries'*. However, above Andrew expresses negative opinions about GP's per se and it could be assumed that he is describing previous experiences of doctors in various healthcare practices. Andrew indicates that a ten minute appointment is not long enough to discuss any issues. He also expressed the opinion that doctors have not been interested in his problems and have not been willing to listen to him. Andrew points out that, in his experience, doctors are more inclined to prescribe medication for mental health problems, rather than explore alternative solutions. As his current doctor clearly gives him time, listens to him, and found him alternative treatments, this might substantiate why his opinion of him presents as a marked contrast to other doctors he described above. When exploring recommendations with Andrew, he then formed his experiences of interactions with doctors into a suggestion for how healthcare services can adapt when working with male CSA survivors:

> *I think when it comes to the medical profession…I think doctors and nurses and the hospitals and that…there is not enough time to speak to people who need this help…people with mental health, who have been abused or whatever. There's not enough time.* (p20)

Andrew strongly believes in investing money into mental health services and shared his disdain about the current state of the mental health sector:

> *Well, they're cutting out all the mental health things. Even the place where I can't go myself. These places where you can have a cup of tea and talk…I can't go because of my OCD and my anxiety…but they are cutting them all. There are people on the streets with mental health problems. They shouldn't be on the streets. There should be places to go. It's wrong.* (p21)

As a final thought, as the interview drew to a close, I asked Andrew to consider what he would say to a potential male client who was thinking of attending a specialist sexual abuse support service, but felt nervous, as he described his feelings previously. Andrew responded:

> *I would love someone to come to me and say…I don't know…"I have heard you go to* [service name]"…*Anyone…I don't care who it is…If they asked me for advice then I would point them straight here* [counselling service]. (p20)

I explored with Andrew whether he would recommend the specialist counselling and support for male survivors of CSA and whether he would want to see any changes in how the support is offered:

> *Oh yes. Definitely. 100 percent. All day long. I know what they have done for me. I know I still have these problems and I still talk to my counsellor, but I know they are here for me all the time. As for this service…there is nothing different that they could do. They should just carry on doing what they are doing. (*p20)

Summary

Andrew first accessed support as an adolescent, as he thought he was going '*mad.'* After being threatened with being locked away, Andrew had accessed mental health services intermittently throughout his life. He had previously been diagnosed with OCD and had CBT in the past which he did not find helpful due to his discomfort around working with a male CBT therapist. Andrew's GP asked whether he had experienced sexual abuse and this led to his referral to a specialist counselling service. Andrew was initially concerned about having to work with a male counsellor and he found the assessment process difficult, as he felt he would not be believed because he was a

man. Andrew described counselling as a '*weight lifted off my shoulders'* and he discussed the trust he had in his counsellor. As Andrew testified if it were not for counselling, he would have killed himself a long time ago. It was clear that counselling has significantly helped to improve his mental health and wellbeing.

Critical reflection

In many ways, Andrew reminded me of David from my first interview. They had very similar features and they were both tall and well built. I met Andrew in the reception area of the building where he had counselling, he wore sunglasses (even though it was dull outside), a crisp blue shirt with the sleeves rolled up and white cotton gloves. He walked with a crutch and clearly struggled with his mobility, as he was visibly in pain from walking just a few steps. Andrew kept the gloves on throughout our interview, despite the air being warm and stuffy. We sat in an extremely small room with two bucket chairs which were fairly close in proximity. The room had no windows, and I felt a little claustrophobic being in such a confined space. I thought about what it must feel like to be a client having counselling in this space and I wondered if clients felt this way when sitting with an unfamiliar worker.

Andrew was the only participant to tell me that he had been raped and he was the only participant I interviewed that disclosed CSA perpetrated by a stranger or someone outside of the family. His first description of himself as a child was sitting alone in a hollow of a tree and I had a clear image of this lonely, eight or nine year old boy which made me feel sad and I ached at his loneliness. Andrew's descriptions of the things he remembers from the day of the rape were also very vivid in my mind, as he described the faceless men and looking down and seeing the flared trousers, Winklepicker shoes and the smell of Brylcreem. I felt that Andrew wanted me to sense the experience he had been through.

I felt that I did not have to prompt Andrew often and he had a lot to share about his experience. It was sometimes difficult to interject and ask a question or guide the questioning back to his counselling experience. Reviewing my analysis of the session, I can see that I have presented large sections of quotations from his transcript; particularly, when I compare it to the other interviews I have written up. This reflects

the interview process in many ways, as in this instance I did not always feel like an active ‘participant’ or a co constructer of the research data.

At some points in the interview, Andrew was crying, and he struggled to catch his breath. I eventually picked up a box of tissues and offered him the box. The tissues were placed on the side table next to me, out of his reach. I was mindful that they were not close to him but also conscious that I did not want him to think that the offer of a tissue symbolised me trying to stop his tears. Andrew thanked me and refused, pulling out a small packet from his chest pocket. He advised me that he brings his own tissues and his own drinks, gesturing to the bottle next to him. He also gestured to his gloved hands and told me that he does this to protect himself from the germs and he told me it is *“part of my OCD.”* I instantly felt foolish, as he had already advised me that he had OCD.

Andrew made regular comments about how he trusted me, and he had a *‘good sense about me’*. Trust is one of the ethical principles set out in the BACP framework for research in the counselling professions (Mitchels, 2018) and is noted as an important component of the researcher/participant communication and relationship. As Andrew was placing so much trust in me, I felt a weight of responsibility to honour his story. Andrew stated that he trusted me so much that he did not even have to look at what I had written. I felt very touched that he had placed so much trust in me, I also wondered if reading his story could have been extremely painful for Andrew. As well as the descriptions of his experience of being raped by a stranger having a profound impact on me, I was deeply troubled by his descriptions of torture that he experienced at the hands of other children. Andrew seemed like a kind and gentle man and I felt very nurturing towards him. At times, I sensed his innocence, and I could see the young boy sat in front of me. Andrew’s story was one of a lonely child, which made me feel deeply saddened. However, he ended the interview by sharing that he knows that the service is there for him all the time. Although it had taken a long time to get here, I sensed that he finally did not feel alone.

Chapter Five: Looking Across the Narratives

Introduction

The previous chapter presented the stories of David, Paul, Tony and Andrew and their experience of counselling for CSA. This chapter will present the analysis from across all four narratives, coalescing the individual themes identified in each, into shared themes and the unique aspects of their counselling journey. The themes presented in this chapter include: *'Trust Me, I'm a Doctor,' 'Trust me, I'm a Counsellor,' 'Counsellor or Mother?'* and *'Blocking the Memories.'*

Trust me, I'm a Doctor

David and Paul both referenced the sexual abuse scandal involving Jimmy Savile during their interviews. For Paul, the persistent reporting of Jimmy Savile, and his alleged crimes in the media, led to a decline in his mental health and his ability to cope with life. Paul referred to this as the reason he went to his doctor for help:

> *Then the Jimmy Savile thing came, and it knocked the lid off the box, and I couldn't get the lid back on again. The more it was exposed, the more it hurt me.* (Paul, p4)

David discussed Jimmy Savile in relation to his prolonged disclosure. He argued that people waited until after Jimmy Savile's death to expose his crimes, as it is easier knowing that the perpetrator can no longer hurt you. He highlighted the lack of understanding in society around why people disclose CSA later in life, and advocated that the people coming forward to disclose abuse perpetrated by *'superstars'* have *'strength'* and *'courage.'* From the admiration he expressed towards these individuals, it appeared that witnessing the courage of these people, in the media, influenced David's ability to disclose his own experience. Andrew did not specifically reference a celebrity, in relation to sexual abuse, but similar to Paul, he alluded to an increase in media activity related to CSA being the catalyst which prompted his doctor to ask him directly about whether he had been abused.

> *It was on TV and I think I mentioned something, and he* [Andrew's GP] *said, "did something happen" and I said yes.* (Andrew, p1)

In keeping with David's discussion about people waiting decades before disclosing CSA, Andrew explained that he sees, on television, perpetrators being punished and *'locked away'* 40 years later. He asserted that those coming forward in the media to disclose CSA often share their stories of not being believed or of being accused of lying. Andrew poignantly remarked *'it's just my story. I break my heart for them.'*

Andrew, Paul and David's experience of CSA in the media being the catalyst for their disclosure and help seeking, supports the theory that there is an association between CSA media exposure and an increase in incidents of CSA being reported (McDevitt, 1996). In addition, it concurs with more recent findings around the assertion that there is an increase in the uptake of disclosure and specialist CSA therapeutic support when CSA features heavily in the media (Gagnier and Collin-Vezina, 2016; Sanderson, 2013). Collings (2002) argued that media reporting of CSA can lead to negative societal judgments. David identified this when he discussed how people question why the victims of Jimmy Savile did not come forward sooner, perhaps indicating the attribution of blame. Overall, the unprecedented media attention around celebrity perpetrators of CSA was linked to three of the men seeking therapeutic support. Although Paul indicated that the news reports severely impacted his mental health, it eventually facilitated a discussion with his doctor which led to his engagement with a specialist counselling service.

Since the formation of the National Health Service (NHS) in 1948, GPs have been the first point of contact for members of the public seeking medical care. The Royal College of General Practitioners describe GPs as *'highly skilled, generalist 'gatekeepers' of the NHS who are prepared to manage risk and uncertainty'* (Royal College of General Practitioners, 2004). Cox (2004) suggested GPs can no longer contend to be the sole gatekeepers for services, as GPs working hours are constrained to nine to five, and patients no longer require a GP as the first point of contact in order to gain access to health care services. Notwithstanding, GPs acting as gatekeepers was certainly true for the four participants of this study, as they were all initially referred for specialist counselling by their doctor. David went to a GP in relation to an undisclosed illness and described *'breaking down'* in front of his doctor, disclosing to her that he felt '*depressed*' and was '*sexually abused as a child'*. The

disclosure to the doctor was the first time he had told a professional about his childhood experiences. He described the disclosure as a relief and analogous to having a '*thorn stuck in your finger that you pull out*'. David's GP reassured him that there was help available and contacted the specialist counselling service on his behalf. He described this meeting with his new GP as the first point in which he started to feel better. Similarly, Paul's GP was the only professional he had shared his experience with. Paul was unyielding in his opinion that his GP was *'very good'* and knew him *'inside out.'* However, Paul explained that the GP's initial response in helping him was to suggest medication; something which Paul was firmly opposed to, as he felt that medication *'blocked things out.'* After refusing to try medication, Paul's GP referred him for talking therapy. Despite being aware of Paul's sexual abuse experience, his doctor referred him to a generic non-specialist counselling service which proved to be inappropriate and caused him further psychological harm. When returning to the GP, following the negative counselling experience, Paul's doctor advised that there was a specialist '*Rape Crisis Centre*.' However, he advised Paul that he might have to report the abuse to the police in order to expediate the long waiting list he believed the centre had. During the research interview, Paul expressly stated that he probably would not have reported the abuse to the police if it was not for the advice given to him by the GP, as the perpetrator was deceased. It could be argued that Paul's GP caused unnecessary distress by advising him to report the abuse to the police. Tony's GP also offered him medication when he disclosed CSA, which Tony explicitly stated made his anger problems worse. Tony found talking about his experience of CSA with the doctor embarrassing, and he felt that he was not believed at first. Tony explained that, as he started to go into his story, the GP eventually believed him and referred him for specialist counselling. Unlike David and Paul, Tony expressed negative views and distrust towards his GP.

> *That's why I don't go into details with them ones. I don't trust them.* (Tony, p8)

As discussed above, David, Paul and Tony disclosed CSA to their doctor. Andrew was the was only participant who was asked directly about his experience of abuse by his GP.

> *He must have hit on something I said or something when he said, "did something happen." Then I broke down and said "yes" and mentioned it and*

> *then next thing I know I was coming here* [specialist counselling service]. (Andrew, p1)

Andrew discussed how he has a good relationship with his GP, and how he contributed towards keeping Andrew *'sane.'* Andrew had a long history of visiting his GP for issues related to mental health problems, including behaviours associated with OCD. Despite this, he had never disclosed his experience of CSA until he was questioned directly by his doctor. It could be assumed that if Andrew had not been asked about his experience of CSA then he would not have made a disclosure, which would have resulted in him not being referred for specialist sexual abuse counselling.

Based on the experiences of the men in this study, it is evident that GPs play a significant role in directing men, who have been sexually abused as children, to the appropriate therapeutic services. However, it appears, from the above, that GPs can be inclined to offer medication in the first instance as opposed to talking therapies. Notably, the four men in the study did not specifically go to the GP in relation to CSA and their disclosures occurred spontaneously during their consultations. Evidence suggests that, in the UK, men are 20% less likely to visit a GP than women (ONS, 2007). Furthermore, women are more likely to receive a mental health diagnosis. However, a mental health diagnosis may be more prevalent in women, as they are more likely to consult a doctor about all symptoms, including emotional distress and physical illness. Men are less likely to disclose mental health issues and the problem has often become severe by the time it has been identified by professionals (Daines et al., 2007). Data reported by *Increasing Access to Psychological Therapies* (IAPT) supports the debate around large numbers of men living with undiagnosed mental health problems and male under reporting of these issues, Likewise, male referrals only represented 38% of the service user population accessing psychological therapies (IAPT, 2018). This is despite over three quarters of suicides are completed by men (Health and Social Care Information Centre (HSCIC), 2014). In addition, males are three times more likely than women to become alcohol dependent and three times more likely to report frequent drug use (HSCIC, 2014). Paul explained that he was *'being monitored'* by his GP, as he was *'drinking too much.'* Tony also disclosed, during his interview, that he had issues with excessive alcohol consumption which exacerbated his anger problem. It is well established that substance misuse is a

common effect of CSA for adult men (Steever et al., 2001; Alaggia and Millington, 2008; Easton et al., 2015). From an attachment perspective, Daniel (2015:36) suggests that *'turning to drink'* is an adverse strategy for seeking security, as opposed to helpful strategies, such as seeking support from a friend. Overall, the experiences with GPs discussed by the men in this study, highlights the importance of; fostering a good relationship between doctor and patient, sensitive communication, exploration of symptoms, offering patients time to listen, and being believed when disclosing CSA histories. Crucially, GPs possessing a sound knowledge of support services available to men who have experienced CSA has proved to be fundamental in improving the men's wellbeing in this study.

Trust me, I'm a Counsellor

The alliance between the client and counsellor has been recognised as a fundamental aspect of the therapeutic process and successful outcomes in counselling across all therapeutic modalities (Bachelor, 2011). In terms of how the client views the therapist and their use of counselling skills, Bachelor (2011) suggests that the client views themselves and their counsellor as collaborators in the relationship, working as a team to achieve a shared goal; this includes, the client and therapist agreeing on the main issues to be worked through, and the therapeutic goals and tasks to achieve this. Bachelor (2011) proposes that the client's sense of a collaborative therapeutic relationship will be determined by their views on the counsellor's dedication to help clients with their problems and to achieve their goals. The client will also view the relationship based on the counsellor's perceived skills, specifically the therapist's ability in helping to foster understanding and to carry out the necessary work to achieve successful therapy (Bachelor, 2011).

From a person-centred perspective, Rogers hypothesised that by providing a *'facilitative, growth producing, psychological climate'* (Rogers, 2013: 24) a therapist will support a client in moving towards increased self-understanding, changed behaviour, a positive change in their ability to cope or a change in their self-concept. Rogers proposed that therapy outcomes would be achieved if the counsellor can provide an affirmative facilitative environment based on three essential conditions. The three essential or *core conditions* are that the therapist is *congruent* and genuine with

the client; that the therapist provides *unconditional positive regard* and cares for the client; and that the therapist feels and expresses *empathy* towards the client (Rogers, 2013; Mearns & Thorne, 2013). Roger's considered the core conditions as a way of being, rather than a set of skills utilised by the counsellor. However, treatment protocols for counselling specify that congruence, unconditional positive regard, and empathy are relational attitudes that counsellors must align themselves to (Sanders & Hill, 2014). Three of the men in this study described how the skills and attributes of the therapist such as listening, accepting, understanding, and not judging were fundamental characteristics of their therapy being helpful. It could therefore be assumed that the counsellors were successful in creating the psychological climate that Roger's described.

Congruence can also be termed *genuineness* or *realness* and is the condition in which the counsellor is accurately themselves within the therapeutic relationship (Rogers, 1957). In order to promote the growth and positive change within the client, the counsellor must be transparent and ensure that they do not convey a powerful, expert or superior façade. In a therapeutic relationship where the counsellor is congruent and transparent, the client is more likely to find internal resources to deal with their problems, rather than expecting the counsellor to provide the answers and solve their problems (Mearns & Thorne, 2013). This can be exemplified in how David decided to disclose his experience of CSA to his daughters. From his experience of working with a congruent therapist who offered him a trusting, judgement free and genuine relationship, he was able to reach his own solution when it came to making an important decision, rather than being advised or guided by the counsellor.

Empathy is a process whereby the counsellor enters the perceptual world of the client and becomes fully immersed in it. To be empathic, the counsellor must be sensitive to the changing feelings that are experienced moment to moment by the client (Mearns & Thorne, 2013). In addition, the counsellor must temporarily be living the client's life, without making judgments, and attempt to sense and uncover meaning which the client might only be vaguely aware of. However, the counsellor must be cautious not to uncover feelings which the client is completely unaware of, as this could be perceived as threatening. The counsellor communicates their sense of the client's world from an arguably more objective viewpoint. This is achieved by the counsellor

continuously checking the accuracy of their interpretations and being guided by the responses of the client (Rogers, 2013). Rogers asserted that the counsellor is a *'confident companion to the person in his or her inner world'* (Rogers, 2103: 25). To express an empathic understanding, the counsellor must momentarily relinquish their own views and values in order to enter the client's world without prejudice. Overall, Rogers (2013: 26) describes empathy as a *'complex, demanding and gentle way of being.'* The counsellor's skills in checking accuracy of their reflections and the gentle way of being was described by Andrew during his interview.

> *When you are talking to her, she doesn't say much at first, she listens to you but then she will jump in with something or say something and then ask questions. There is just calm around her.* (Andrew p5)

David evidenced Roger's descriptions of entering the client's inner world and being a companion when he portrayed his experience of counselling.

> *She's a counsellor so there is a certain amount of trust for me and I knew straight away that someone is there, who doesn't know me, she's there to sit there and listen to me…not so much coax me but let me do the talking. She probably guided me. Well she did guide me. There is no question. Not perhaps (laughs). She did guide me to well err talking about myself, about my abuse, my…all aspects of it.* (David, p8)

Unconditional positive regard is the attitude of the counsellor towards their client. A counsellor possessing this attitude deeply values the client, regardless of the client's behaviours. The attitude of unconditional positive regard is exhibited in the counsellor's consistent acceptance and the warmth they exude towards their client (Mearns & Thorne, 2013). Rogers (1957) termed unconditional positive regard as '*prizing'* and he stressed that warmly accepting a client and caring for them, in a non-possessive way, will enable the client to engage in the therapeutic process and will assist them in making profound changes in their lives. Although unconditional positive regard is associated with person centred/Rogerian theory, it is a concept which can be found in most contemporary approaches to counselling and psychotherapy (Sanders et al., 2009). A fundamental element of unconditional positive regard is that the therapist suspends judgements towards the client and offers them unconditionality within the relationship. A counsellor will strive to respond to a client's experiences,

behaviours, and feelings non-judgmentally, without leading them in a particular direction. Therapists who convey this unconditionality and accept all aspects of the client's experience, including destructive behaviours, can support a client in resolving internal conflicts (Sanders et al., 2009). David recognised this attribute with his counsellor:

> *I couldn't actually voice what had happened and so I was apprehensive and also relieved that at last I can talk to somebody that's non-biased, that's not in any way there to judge me.* (David, p1)

In addition, David, Paul, and Andrew also highlighted the importance of their counsellor's listening skills and how the counsellor's unconditional positive regard manifested during the counselling.

> *It's about them having that listening ear. That non-judgmental thing* (David, p8)

> My counsellor *is brilliant at her job and she listens, which is the main thing. With anything like that…you have got to listen to people and not judge people and believe.* (Andrew, p1)

> *All of it, I think. Just the general approach. And the help. Err you know. The understanding.* [The counsellor] *has seen me at my worst and she has seen me pick myself up.* (Paul, p11)

It could be argued that Tony's counsellor did not offer the core conditions of congruence, unconditional positive regard, and empathy. As well as a lack of consistency in the support he received, he discussed how he felt he had to be cautious about the things he talked about in therapy: *'Most of the time I end up saying wrong words at the wrong time.'* He also explained what he perceived was lacking from his counsellor, *'I just need more understanding. I need someone I can trust more. I can't just come out of it.*' Mearns and Thorne (2013) maintain that the core conditions, in particular congruence, promotes the development of trust in the counsellor and the counselling process. Further, if a client experiences the counsellor as congruent then they will know that the counsellor's responses are open and honest.

Barker (1998) applied Peplau's (1988) model of interpersonal relations in psychiatric nursing to his therapeutic work with adult male survivors of CSA. The theory centres around the use of skilled communication and the quality of the interpersonal relationship between nurse and client/patient being essential in the healing process and is closely related to Roger's (1951) person centred theory and the concept of the therapeutic alliance (Barker, 1998). Peplau determined that, to have a successful outcome, the nurse-patient relationship must transition through three distinct phases: *orientation*, *working* and *termination* (Hagerty et al., 2017). The *orientation* phase is brief and takes place when the patient is adapting to their current experiences of being hospitalised and the nurse gains information about the client's/patient's specific needs (Peplau, 1991), similar to the contracting stage between counsellor and client (BACP, 2018). During the second phase, the nurse familiarises themselves with the client and establishes the care plan. The client/patient begins to accept the nurse as a care provider and counsellor. The nurse offers non-directive listening and reflective and non-judgemental feedback to foster the patients' awareness of their feelings regarding their health (Hagerty et al., 2017). The effectiveness of the *termination* phase or *resolution* phase (Barker, 1998) is reliant on how the nurse and patient worked through the previous phases (Hagerty et al., 2017). During this final stage, the nurse offers a space to reflect on aspects of the therapeutic relationship and the work that has been achieved, which has similarities with the ending stage of therapy (Hagerty et al., 2017).

Despite criticisms of Peplau's theory (1988) lacking empirical validity (Gournay, 1995; Jones, 1996), Barker (1998) concluded that the use of Peplau's interpersonal theory when working with male CSA survivors in a therapeutic context helped him to recognise that the most essential aspect of mental health nursing is about developing a trusting, empathic and nurturing relationship centred around the client's needs, rather than using specific techniques or a *'bag of tricks'* (Barker, 1998: 151). This relationship requires gentle pacing, flexibility and for the therapist to have an astute awareness of the client's stage within the helping process. Fundamentally, Barker (1998) asserted that developing and maintaining the core conditions underpins the entire therapeutic process to effectively work with male CSA survivors and facilitate change. Undeniably, David, Paul and Andrew evidenced the effectiveness of

developing trust between counsellor and client, based on an empathic and nurturing relationship. Aside from David, who mentioned being given the occasional '*homework'* task, their counsellors did not appear to utilise specific tools or techniques.

Trust in the therapist is considered as one of the foundations of effective counselling (Sanders et al., 2009) and trust was a prominent topic for all the men in this study. The absence of trust within the therapeutic relationship would lead to a reluctance, on the part of the client, to divulge their experiences and problems. In addition, a client would be hesitant to make fundamental changes in their lives if they did not trust the counsellor supporting them (Sanders et al., 2009). David discussed how he felt free to share explicit abuse memories, without fear of shocking his therapist because he felt that *'there was a certain amount of trust there.'* Tony alluded to a lack of trust in his counsellor and subsequently described his therapy as *'not doing that much.'* However, this could be related to a lack of consistency, as his counsellor began to have a lot of time off and his sessions became erratic. He asserted that the first couple of sessions *'didn't do anything'* and it was a couple of months before it helped, suggesting *'the more I came, the more I could trust.'*. Therefore, it could be argued that it was the inconsistency which led him to believe his counselling was ineffective, rather than there being an absence of the core conditions. In addition, Tony was explicit in his therapy goals; these being to work through, and deal with, his anger. He reported that, despite consistently broaching this subject with his counsellor, his anger was not getting *'worked on.'* Tony's second counsellor was evidently more effective as he explained *'then I saw this one I am seeing now. She recognised something that the other one didn't.'* Following on from the earlier discussion around empathy, it could be reasoned that the new counsellor was able to live his experience, in order to '*recognise something'* about Tony that the other counsellor was unable to do. Additionally, the first counsellor was clearly not collaborating with him to establish and work through the goals that he was determined to achieve.

Paul explained that he would only work with a female therapist because he did not trust men. He also only disclosed his abuse experience to people he was *'closest to'* and included his counsellor as a person he could trust. Trust was a subject that

emerged regularly throughout Andrew's narrative. He described how he was expecting to not be able to go through with his first therapy session:

> *I was ready to go…to walk away but there something…but there's something about how my counsellor spoke and the trust was there.* (Andrew, p5)

Overall, Andrew discussed his lack of trust in a wide range of professionals and how this has been a barrier to accessing support. During the interview, he shared that if it was not for his GP and counsellor, and the trust he felt for them, then he would have killed himself a long time ago.

Based on a 2014 survey conducted by the British Association for Counsellors and Psychotherapists (BACP), about their members, it can be concluded that counselling is a female dominated profession. The BACP represents the largest number of registered counsellors in the UK and their findings showed that 84% of counsellors were female and 16% were male. The UK Council for Psychotherapy (UKCP) evidenced a similar female to male disparity when surveying their members in 2016; 74% of their members being female, 24% identified as male and 2% preferred not to specify their gender. The imbalance of female to male counsellors has parallels with the disparity between the increased number of females engaged in psychological therapies, compared with men (IAPT, 2018). Similar therapist gender discrepancies have been reported in Australia, with researchers trying to establish whether it had an impact on people seeking support for mental health problems (Black & Gringart, 2018). Black and Gringart (2018) determined that 43% of respondents had a gender preference for a potential therapist, and accommodating the client's preferred gender prompted people, who would otherwise be reluctant to seek help, to engage in therapy. They also established that for those that did express a gender preference, male clients were more inclined to prefer a female therapist, whereas female clients were more likely to prefer a male counsellor. In an American study, Pikus and Heavey (1996) also established that men, who expressed the need for a therapist of a particular gender, mostly preferred a female counsellor. However, in contrast to the findings of Black and Gringart (2018), Pikus & Heavey (1996) found that female clients often preferred a female therapist.

It has been suggested that regarding issues related to a client's gender preference of therapist, transference and countertransference are intrinsic in the therapeutic relationship (Moscarello, 1998). From the classic conceptualisation of '*transference,'* the client transfers feelings and unconscious attitudes, evolved from their early childhood relationships, on to the therapist (Nadelson & Notman, 1991). It is argued that this process occurs irrespective of the therapists' gender and that the client can project male or female transferred images onto a therapist of any gender (Moscarello,1998). However, Nadelson & Notman (1991) maintain that the gender of the therapist can be crucial in the development of transference in certain cases. It is suggested gender can influence the early relationship between counsellor and client, the development of transference, the pace of therapeutic issues being introduced by the client, and the length of time in which therapy progresses (Nadelson & Notman, 1991). With transference being the process whereby clients unconsciously redirect feelings for others onto the therapist, *countertransference* denotes the unconscious feelings experienced by the therapist towards their client (Reid & Westergaard, 2013).

Gender choice of therapist can be determined by conscious and unconscious influences, such as the client's gender stereotypes (Moscarello, 1998). For example, the client might perceive a female therapist to be more nurturing, caring, or empathic. Andrew expressed this perception when he discussed characteristics that differentiates a female therapist from a male therapist.

> *It's different when you talk to a woman. I don't know. I find women more understanding and more patient. I talk to her and she just listens.* (Andrew, p19)

Equally, a client might select a male therapist, as they expect the therapist to be more effective in helping them to work through their relationship with their father or they may be perceived as a successful male role model (Myers, 1991). Alongside gender choices based on the client meeting a specific need, gender preferences can be defensively rooted. To avert dealing with painful and uncomfortable material, a client might avoid working with a particular gender to protect themselves from the distressing emotions associated with their past experiences of individuals of that gender (Moscarello, 1998). This theory is supported by Tony's rationale for his preference towards a female counsellor, as he expressed fear about attending his first counselling appointment, as he presumed that he would be allocated a male worker. Tony

elaborated further, explaining that he could potentially become violent if made to work with a male therapist, as it would cause him to reconnect with images of his abuser.

> *I would just see his face. If I saw his face, then it would all…all come back to me.* (Tony, p5)

There is no empirical evidence to support the effectiveness, of the implementation of a particular gendered therapist, with any client/patient population (Moscarello, 1998). Gender preference should be fully explored in order to prevent unmet expectations on the part of the client. However, there is no justification for impeding the client's gender preference. Indeed, the literature exploring the effects of accommodating a client's preference for a particular gendered therapist is sparse (Black & Gringart, 2017).

In a summary of 'G*ender Configurations in Individual Treatment,'* Moscarello (1998) claim that the female therapist-male client dyad is the least common therapeutic dyad. They postulate that male clients might seek a female therapist in the belief that a female will be more sensitive around issues, such as sexual orientation, sexual trauma, or sexual dysfunction. They go on to warn against male client transference issues, such as dependency, developing erotic feelings towards their therapist or the need to control their therapist. Further, countertransference challenges for the therapist can include, dealing with aggression and the need for the client to be in control, managing and being aware of erotic transference, avoiding client dependency, anticipating male sexual fantasies and being mindful of boundary violations. Although now in excess of 22 years old, in their analysis of the male therapist-male client dyad, Moscarello (1998) assert that it is a common gender configuration in counselling. Notwithstanding, they assert that therapeutic issues can arise when male therapists are faced with specific client problems, such as intellectualisation, competitiveness, power struggles, discomfort, and fear of homosexuality. They also imply that male therapists can experience problems in expressing sensitivity, kindness, and compassion towards male clients, compared to their females counterparts. Although Moscarello (1998) claim that a female counsellor working with a male client is uncommon, it could be argued that they neglected to consider the gender configurations from the perspective of clients seeking therapy for CSA. Further, considering the ratio of female counsellors to male counsellors, their ascertains about

female counsellors with male client seems inaccurate. Their assumptions regarding transference issues and therapeutic challenges also lacks evidence to support their claims. Nevertheless, gender configurations in counselling is an under researched topic and little is known about how this issue impacts the therapeutic relationship, and ultimately client outcomes.

Despite the above suggestion that the male therapist and male client dyad is the most common, the four men in this study worked with females, actively choosing a female therapist and explicitly stating that they would not be able to work with a male counsellor. Paul discussed being given a choice between a male and female therapist. When exploring his counsellor gender preference further, he explained that he preferred a female counsellor, as he did not trust men. Andrew had previous experience of working with a male therapist to treat symptoms of OCD. He explained that the therapy was not effective, as a result of him feeling uncomfortable around his therapist because he was male. Similar to Tony, Andrew asserted that he would likely become violent if made to be around a man:

> *He would either walk out or go out head first. I can't control myself…and if a man touches me…you know. I can't control myself.* (Andrew, p4)

Andrew also attributed this fear of working with a male counsellor to the fact that he was abused by a man. Unlike Paul, who would not work with a male counsellor due to not trusting men, it appeared that Andrew did not trust himself around a male worker, as he stated that he would not be unable to *'control himself'*. Some studies have determined that female therapists achieve more effective therapeutic alliances and better outcomes than male therapists (Bhati, 2014; Shiner et al., 2017). The men in this study evidenced positive therapeutic alliances with their female counsellors. However, this was not explicitly attributed to the gender of their counsellor. Although, the men did express an unambiguous aversion to engaging in therapy with a male counsellor.

Counsellor or Mother?

Support from parents is consistently associated with the psychological wellbeing of sexual abused children (Elliott & Carnes, 2001; Williams & Nelson-Gardell, 2012) and there is evidence to suggest that being believed and supported by a close family member reduces the adverse effects and the legacies of CSA (Finkelhor et al., 1986). When analysing the narratives, the role of the mother was significant in all four of the men's stories for varied reasons. David's mother was complicit in the sexual abuse he experienced and did not show him affection throughout his childhood. Paul disclosed the sexual abuse to his mother, and she did not take any action, questioning him on whether he was telling the truth, which led to him feeling like he was not believed. Tony was separated from his mother, as she was unable to care for him. When Tony was reunited with her years later, she introduced the perpetrator of his abuse into the family unit. Finally, and in contrast to the other three men, Andrew idolised and protected his mother.

Throughout their narratives, David, Tony, Paul and Andrew rarely mentioned the relationship with their fathers. David was sexual abused by both parents, yet he did not go into any detail about the sexual abuse he experienced by his father. However, David often referred to his mother and he alluded to her lack of affection and care. It was apparent from the stories of David, Paul and Tony's childhood that they yearned for a mother figure. When considering the theory of attachment (Bowlby, 2008), it is clear that David's attachment with his mother was insecure and shrouded by her inability to protect him from harm. Ainsworth et al. (1978) defined the attachment figure as an individual who represents a *'secure base'* in which the individual can engage in exploration, development and gaining independence.

From David's descriptions of his counsellor and the counselling relationship it could be suggested that his therapist acted as a '*secure base'* and *'safe haven'* (Bowlby, 1969) for him. Bowlby (1988) suggested that the client-therapist relationship has parallels with the relationship between mother and child, stressing the significance of the therapist '*acting*' as a secure base. The idea of a therapist replicating the *'secure base'* of a mother figure is supported by Peplau's (1991) theory around '*surrogate roles'* in mental health nursing. Peplau posited that a nurse utilising counselling skills,

listening to patients as they express their feelings, can lead to the patient assigning the nurse into roles, such as surrogate mother. Peplau suggests that this process is outside of the patient's awareness and is dependent on their psychological needs. A nurse has the potential to symbolise a mother figure (Peplau, 1991), as in the case of David and Andrew's relationship with their counsellors. In addition, the values and feelings associated with a particular individual from the past, will shape the expectations that the client has towards the therapist who reminds him of their earlier care giver. This could be said of Tony, who expressed negative feelings of anger and rejection towards one of his earlier therapists when she had to stop working due to personal circumstances. Tony's feelings towards this counsellor could also be linked to the activation of the attachment system. According to Mikulincer and Shaver's (2007) model of the *'activation and dynamics of the attachment system,'* the attachment system is activated if an individual feels threatened or in danger. Feelings of threat or danger can be linked to loss, a relationship breakdown, or the thought of being abandoned. This is an unconscious process and has the potential to actualise an individual's entire attachment history, regardless of whether these threats or dangers are rational or not. This is particularly pertinent to counsellors, as the unconscious activation of emotions related to attachment, such as care, rejection and abandonment, has the potential to be replicated in the therapeutic relationship (Daniel, 2015), as evidenced by Tony. Furthermore, a client can often be sensitive to whether a counsellor is reliable and supportive. When an individual has been let down by an attachment figure in the past, they will be particularly cautious of being let down by their therapist (Daniel, 2015). This is demonstrated by Paul's experience of his first counsellor, and his wariness about re engaging with another service when it was suggested by his doctor. Daniel (2015) debates the appropriateness of the client-therapist/mother-child analogy due to the element of professionalism that exists in the therapeutic relationship, compared with other attachment figures. Practitioners have a distinct role and duty to carry out in relation to the client, and this takes place within an organisational environment and institutional framework. Daniel (2015) argues that achieving the level of availability and emotional support which is present in a secure attachment relationship to a parent, is not possible in a psychotherapeutic relationship. Nevertheless, Daniel (2015) neglects to consider the possibility of a therapist replicating a *'secure base'* in the circumstance of clients such as David, Paul and Tony,

who did not have a protective, supportive or emotionally available care giver during childhood.

As mentioned above, a client can re-enact certain emotions and attitudes related to early relationships and transfer these to the therapist. When it comes to familial CSA, the trauma of the sexual abuse not only exposes the child to the betrayal of the perpetrator, but they can also experience the feelings related to neglect and betrayal towards the non-abusive parents (Lahav et al., 2017). Although the emotions associated with the neglect and betrayal, such as rage and disappointment, towards the non-abusing parents can be profound, the parent is also often loved and needed by the child. As such, the therapist can re-enact the position of the '*neglectful parent'* (Lahev et al., 2017: 20). This certainly appears to be in keeping with Tony's experience of his former counsellor, as he was clearly very angry with his therapist for neglecting him. Working through this transferential and counter transferential process can be extremely valuable during the therapeutic exchange and can provide a safe place for the client to transfer their emotions onto the therapist. In turn, the therapist can support the client to overcome their emotional resistance (Kvale, 1999), as the therapist helps the client to name, form and symbolise dissociated aspects of the trauma (Lahev et al., 2017).

Blocking the memories

From a person-centred perspective, a child begins life as a unified being, with a tendency towards maintaining and enhancing their '*organism'*, towards being *'fully functioning'* (Rogers, 1959). However, to achieve a full functioning *'organismic self*,' a child needs '*unconditional positive regard'* and empathy from care givers. Punitive conditions of worth, like those expressed by the men in this study, can result in experiences being distorted or denied. Furthermore, CSA can lead to the distortion and denial being severe (Power, 2012). Blocked, denied, and repressed memories featured in all four of the men's narratives.

> *There were no memories there because it was repressed, all the time I suppose*. (David, p16)

David described his forgotten childhood memories as being '*repressed*.' In classical psychoanalytic theory, Freud observed a number of his patients had '*forgotten*' specific events and facts about their external and internal lives, but were able to recollect these memories when a particular technique was applied in therapy (Freud & Gay, 1995). The instinct for repressed material to gain consciousness determines repression as being an active process (Gomez, 2005). Freud noted that the forgotten and repressed memories exhibited by his patients were always distressing experiences that were emotionally painful, shameful, or alarming to the individual (Freud & Gay, 1995). Furthermore, the emergence of repressed material into conscious awareness had the potential to cause unwelcome emotions such as fear, guilt, or shame (Khan, 2002). Despite the uncomfortable emotional reactions experienced when repressed memories emerge into conscious awareness, Freud established that there was a relationship between the process of repression and neurosis; "*The neurotic turns away from reality because he finds either the whole or parts of it unbearable"* (Freud & Frankland, 2005:3). Although neurosis was removed from the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders in 1980, when the third edition was published, the links between repression and neurosis have contemporary relevance to therapeutic practice. Namely, symptoms of neurosis can manifest as stress, depression and anxiety (Freud, 2012), all of which can be commonly associated with CSA. When considering David's, Paul's, and Andrew's narratives, they discussed their experiences of low mood, feelings of depression and anxiety, which led to their decision to engage in therapy.

> *I was just not in a good place, not that I was going to commit suicide or anything, but I just felt depressed and down and low.* (David, p4)
>
> *I have probably been depressed all of my life I would say.* (Paul, p6)
>
> *I get irritable, anxious, arms crossed when I'm talking about this, sometimes feel sick, I get really upset very quickly, I get palpitations in my chest, I breathe deeper.* (Andrew, p7)

For some individuals who have experienced CSA, they may have a faint memory or inkling that something bad happened in their childhood; however, the memory can be extremely vague and incomprehensible. In this circumstance, the individual presenting in therapy has almost denied the abuse, and it is on the edge of their awareness (Power, 2012). Unconscious denial of the CSA experience can result in living with the

burden of distressing and uncomfortable feelings, without any knowledge of the underlying cause. Similarly, memories of CSA can sometimes be distorted; whereby, specific emotions and sensations experienced during the sexual abuse are in the individual's conscious awareness. However, they are attributed to other issues. For example, someone who is '*terrified'* during an experience of CSA can experience insomnia, digestive problems, and panic attacks in adult life (Power, 2012). These emotions and effects can often masquerade as medicalised anxiety. Likewise, an individual presenting with feelings of sadness, isolation and hopelessness can be labelled with depression. Although these diagnoses can certainly be deemed valid, it is argued that treating clients specifically for anxiety and/or depression will not be as helpful as allowing the client to explore their feelings, to facilitate the discovery of the underlying cause (Power, 2012). Abuse memories can also be completely forgotten, and an individual might have no recollection that specific events have happened or that anything untoward at all has occurred during their childhood. In these circumstances, the individual has denied awareness of their organismic experience and developed a self-concept that does not include an experience involving sexual abuse. Nevertheless, the often destructive behaviours that develop to sustain the dissociated self-concept can have a damaging effect on an individual's life (Power, 2012).

David identified recovering lost memories as one of his main goals of therapy. Specifically, he had no happy or positive memories of his childhood and, through his counselling, he achieved his aim of remembering an event in childhood when his mother expressed affection towards him. Paul similarly had a goal to recover lost memories; he was determined to watch his police interview with the support of his counsellor, in order to evoke memories of aspects of the interview which were causing him distress.

> *Because there were two little bits in there that were a bit hair raising. When you start poking at those things it was a bit scary.* (Paul, p7)

Andrew's memory issues were a recurring topic throughout his story and something that caused him anguish and confusion, '*I just can't understand why I don't remember my whole life* (Andrew, p15).' As with David and Paul, the process of counselling

appeared to bring repressed memories into conscious awareness. Andrew discussed how he recovered memories of being abused by one of his brothers, something which he was not previously aware of. He also described how, after having a counselling session, lost childhood memories could be triggered by random events. Tony referred to blocked memories less often than the other three men and his experiences were related to having no memory of incidents in adulthood, rather than childhood memories.

Although Freud suggested memories were recovered through the application of a particular technique, a possible explanation for memories resurfacing in therapy could be found in the conditions present within the therapeutic relationship. People sexual abused in childhood experience varying levels of incongruence and they require a therapeutic relationship with a counsellor who is congruent, empathic, and accepting of their whole being, including their abuse experience and its effects (Power, 2012). For some individuals, counselling might be the first time that their feelings have been validated and their frame of reference has been acknowledged as being important (Power, 2012). Power (2012) cautions that it is not a therapist's role to actively pursue the abuse memories, or change the way the client thinks, but to "*create the conditions in a relationship where a person can experience changes in their self* (Power, 2012: 52)." Ultimately, this then allows the denied material to enter conscious awareness and be symbolised.

Walker (2012) described '*recovered memory'* in CSA survivors as '*controversial*' at a societal and individual level, as there can be denial and difficulty in believing that sexual abuse can be perpetrated towards children. Further, recovered memories can raise questions as to whether the sexual abuse was real or fantasy; which in turn can reinforce the lack of acknowledgement that boys can be victims of CSA, that females can be perpetrators, and that sexual abuse occurs within the care sector and religious institutions. What makes this particularly controversial is that the term *'recovered memory'* can often be associated with '*false memory syndrome,' which* was a term conceived in the 1990's in the United States of America, following a prominent case whereby an individual named Jennifer Freyd recovered memories of CSA whilst in therapy (Walker, 2012). Jennifer Freyd's parents contested the accuracy of her memories and established the *'False Memory Syndrome Foundation,'* which argued

that families were being severely impacted by poorly trained therapists actively seeking repressed memories of abuse which the foundation claimed were false. 'False Memory Syndrome' adds to the debate that exists around whether victims can effectively repress or dissociate from the memories of CSA.

However, the stories of the men in this study support the theory around abuse memories being out of conscious awareness and resurfacing during therapy. In addition, a study by Williams (1992) found that out of 129 women, with documented histories of CSA that were proven to have occurred, a large proportion of the women did not have any recollection of the incidents of sexual abuse that they experienced. Walker (2012) advises that the counsellor should not be distracted by the controversy that surrounds recovered memories when working with abuse survivors. Similar to working with any client, counsellors should not be suggestive, should not jump to conclusions, and they should be comfortable working with uncertainty (Moscarello, 1998; Walker, 2012). The history and controversy of abuse repression has the potential to validate and deepen the denial. Therefore, working with CSA survivors requires the counsellor to be resilient, to be aware of the controversies, but not be prohibited by them. Walker (2012) warns that if a practitioner is alarmed or scared off by working with this issue, then it has the potential for the abuse survivor to become further alienated and isolated.

Throughout the four narratives, the men regularly described negative self-beliefs and expressed low self-worth. On further investigation, the beliefs they held about themselves often stemmed from external factors. Both Tony and Andrew used the term *'mad'* to describe how they have felt about themselves.

> *That's when the other stuff started coming in me head…the madness and everything else.* (Tony, p2)

Tony held the view that feeling suicidal was a symptom of '*madness*.' However, he later described an incident when he was told by a friend that he was '*nuts*.' Andrew disclosed that due to his symptoms related to OCD, he thought he was going *'mad.'* He discussed how he was told by doctors, after describing his symptoms, that if he was going mad or insane then he would be *'locked away'*.

The negative self-beliefs the men harboured and the eventual changes in their personal narratives, following therapy, can be conceptualised in the theoretical underpinnings of person-centred counselling and the ideas around '*introjects*' (Mearns & Thorne, 2000). The concept of '*introjection*' derives from psychoanalytic theory and refers to the process of '*taking in*' the external reality, including ideas and attitudes of others, thus leading the individual to internalise the beliefs and evaluations of others (Gomez, 2005). When considering the term from a person-centred perspective, an introject serves as an evaluation taken in from an external source and is then internalised and symbolised as defining a dimension of the self (Mearns & Thorne, 2000). Although introjects can represent a positive image of the self, introjects that are negative in the message they carry can define and reinforce an abused and damaged self-concept. For example, David's believed that he was '*thick'* and '*unintelligent'* (p12) and this can be attributed to the introjects he was exposed to during his formative years. Indeed, David made this connection himself during the research interview when he explained that his negative self-beliefs were related to being '*downtrodden every day*.' Introjects carry substantial power, as they can gather supporting evidence by contributing to the existential life of the person through the '*self-fulfilling prophecy effect'* (Mearns and Thorne, 2000). In David's case, he believed he was '*thick*' because he could not remember things and because he felt that his career did not require intellectual thinking. Arguably, his career choice could have been compounded by his belief that he lacked intelligence. Similarly, the self-fulfilling nature of the negative introjects he was subjected to could have had significant effects on his interpersonal relationships. David blamed himself for the breakdown of his marriages, as he felt that only bad things happened to him. Paul also had experience of a marriage breakdown and highlighted how CSA has had an impact on his relationships, as being depressed *'rubs off'* on people around you.

Summary

In summary, this chapter has discussed the themes elicited from across the narratives of David, Paul, Tony and Andrew. It has found that media reporting of CSA had a significant impact on three of the men and instigated their disclosure to the GP. The GP acted as an important gatekeeper, when it came to accessing support services for CSA, as all of the men were referred for specialist support by their doctor. The

counsellor's understanding, listening skills, and non-judgemental attitude, together with the men's ability to trust the counsellor was found to be conducive to support being experienced as helpful. Finally, the men experienced repressed memories and the relationship with their mother was a significant feature of their narrative accounts.

Chapter Six: Discussion

Introduction

As debated in the introductory chapter, male CSA is an often, neglected research topic, despite there being evidence to suggest that one in six males experience sexual abuse before the age of 18 (Dube et al., 2005; Romano & De Luca, 2014). Having presented the narratives of David, Paul, Tony, and Andrew, followed by the findings common across the four narratives noted in Chapter Five, the themes outlined in chapters five will be used as the basis of this discussion.

Based on their experiences, a major outcome of this research has been a rich and in-depth narrative account of the men's insights of receiving counselling and support for CSA. The findings in the previous chapters (four and five), presented the men's thoughts, feelings, and reflections about their experiences of therapy and the impact CSA had on their lives. Through discussion, this chapter will address the aim of the research which was to explore and gain an in-depth understanding of the support experiences of men who were sexually abused as children. The findings of this study will be discussed in detail and considered in the context of previous research on the wider topic of male adult survivors of CSA. As there has been no previous research into adult male survivors of CSA and their experiences of counselling and support in the UK, this study presents the first, and unique, findings on how men have experienced specialist counselling for CSA.

Trust me, I'm a Doctor

Trust me I'm a doctor is discussed under four separate sub-headings; *Time to tell, Reaching for help, Discomfort around men*, and *For better or worse*. Whilst there is overlap within each of these with other themes, for example 'Trust me I'm a counsellor', I have aimed to discuss each within the context of the men's experiences of their relationship with their GP, their experience of disclosing to the GP and their experience of seeking specialist support for CSA.

Time to tell

Seeking help and professional support was found to be a significant '*turning point'* for men who have experienced CSA (Easton et al., 2015). This can be said for the men in this study. It is acknowledged that disclosure to a professional is a prerequisite for seeking help (Easton et al., 2014) and all the men in this study initially disclosed to their GP. As the referral for specialist counselling services was made by their GP, this knowledge reaffirms the argument for routine enquiry regarding a history of CSA, by healthcare professionals (Hovey et al., 2011). Day et al. (2003) and Alaggia and Millington (2008) only advocated for mental health professionals questioning patients about CSA; however, as participants in this study initially accessed mental health services following disclosure to their GP, this highlights a need for questioning to be extended to a wider community of healthcare workers. It has been suggested that professionals can be reluctant to ask people about whether they have experienced sexual abuse out of concern for re-traumatisation (Lab et al., 2000). Likewise, when a survivor is not asked by a mental health professional about CSA during therapy it has the potential to reinforce a silencing message and can convey to the survivor that their experiences and distress are unimportant (Barber, 2012). Of the men in this study, who were asked directly by their doctor about CSA, the questioning was offered sensitively and was not harmful, and no re-traumatisation was reported.

> *Well, he* [GP] *must have hit on something I said or something when he said "did something happen?" Then I broke down and said "yes" and mentioned it and then next thing I know I was coming here* [counselling service]. (Andrew, p1)

Likewise, the men who offered a disclosure to their doctor, seemed to concur that the doctor's response was sensitive and was described with words such as *'sympathetic*' and *'understanding.'* However, Tony initially felt that he was not believed by his GP when making his first disclosure and he found the experience *'embarrassing.'* Fear of not being believed was found to be a barrier to disclosure in the literature (Spataro et al., 2001; Alaggia & Millington, 2008; Easton et al., 2014). Shame was also a notable theme in previous research when considering barriers to disclosure (Alaggia & Millington, 2008; Easton et al., 2014). Although Tony described feeling embarrassed, the men in this study did not explicitly refer to shame as a reason for delaying disclosure to professionals, family members or friends. Tony's experience of feeling

he was not believed by his doctor was echoed by participants in a study undertaken by Dorahy and Clearwater (2012). Men taking part in their research described how they experienced denial from mental health professionals when attempting to disclose CSA, and their disclosure was attributed to mental illness. It is notable that Tony had pre-assumptions about not being believed due to his mental health, before sharing his experience of CSA with his doctor.

> *I didn't go to the doctor till I had gone past my twenties. I couldn't. If I went to the doctors, I thought to myself that they wouldn't believe me anyway.* (Tony, p2)

His concerns were reaffirmed once disclosure was made, as he stated that his GP did not initially believe him. This is also a known issue when it comes to physical health and has been termed '*diagnostic overshadowing.'* Essentially, the individuals' diagnosis of a mental health problem prevents a physical health problem from being recognised by professionals (Jones et al., 2008). This is a concern when it comes to physical health, as epidemiological studies have indicated that there is an association between mental illness and subsequent physical health problems (Filik et al. 2006). Furthermore, individuals with serious mental health issues are predisposed to poorer physical health and premature death (Filik et al. 2006; McCabe & Leas, 2008). Overshadowing is therefore a major issue and is recognised as a barrier that impedes those with mental health problems from accessing appropriate healthcare services for other conditions (Oud *et al*. 2009). It appears that there are parallels between diagnostic overshadowing, in the context of people with diagnosed mental health problems having their physical health problems overlooked, and the experience of men having their CSA disclosure denied due to mental health issues.

It is well documented that male CSA is underreported and under disclosed, with research findings suggesting that most men do not disclose until adulthood, and on average men take two decades to disclose their experience to another person (Spataro et al., 2001; Easton et al., 2014; Romano et al., 2019). These findings are comparable to the experiences of two of the men in this study; one of which told their doctor around 20 years after experiencing CSA and the other first disclosed to his partner in his early fifties, at least 45 years after experiencing abuse. Intriguingly, the participant who shared his experience with his partner during his fifties described how

he was unable to vocalise his experience and had to write about his abuse in a text message on his phone, which he then showed to his partner. Being unable to articulate and approach the topic of CSA was also a notable theme in research focusing on barriers to disclosure for men (Sorsoli et al., 2008). The other two men participating in this study disclosed to family members when they were young and had negative responses. Paul told his parents about the abuse at the time that it occurred. His doubts about whether his parents believed him was something that he explored and questioned in his therapy, and during the research interview he described it as still '*raw*'.

> *It was a different world. I told my Mum and Dad and I was never quite sure whether they believed me, they are dead now anyway.* (Paul, p2)

Research on disclosure highlights that most men wait until adulthood before disclosing CSA (Easton et al., 2014; Gagnier & Collin-Vezina, 2016). However, as with two men in this study, research by Sorsoli et al. (2018) found that men can often make numerous attempts to disclose as a child, but might not be taken seriously. It has also been noted that survivors of CSA can often *'drop hints'* about sexual abuse to professionals if they are not questioned directly. This is thought to be a method of determining responses to establish whether the professional could cope with their disclosure of traumatic events (Barber, 2012). Supportive responses from care givers, when hearing disclosures of CSA is consistent with the psychological adjustment of sexually abused children and helps to mediate the long-term impact of CSA (Finkelhor et al.,1986; Elliott & Carnes, 2001; Williams & Nelson-Gardell, 2012). The impact of thinking he was not believed clearly had a lasting impact on Paul, and I would argue that it contributed to the physical and mental health issues he experienced throughout his life. One study investigating male CSA survivors' experiences found that men become increasingly more likely to experience mental health problems the longer the time passes before a disclosure is made (Easton, 2013). The mental health problems and long-term effects of CSA, experienced by the four men in this study, will be discussed in greater detail later within this chapter. Paul did not disclose to a professional until he was 57 years old. Before his disclosure, he had shared his experience of abuse with his wife and a cousin. Similar to Paul, Andrew mentioned the abuse to his sister when he was younger. Following this, he later told another person about his experience:

> *I was told "don't tell lies." That was it then. I never mentioned it again until I was older.* (Andrew, p2)

Being believed when disclosing CSA, is thought to be associated with men perceiving the response to the disclosure as positive (Gagnier & Collin-Vezina, 2016). Overall, this corresponds with the men's experiences. Three of the men felt believed when sharing with a healthcare professional and referred to the dialogue as being '*helpful*'. There were also two accounts of negative disclosure experiences which were both associated with not being believed by the people they told. One of the participants, David, described telling the doctor as *"the biggest step"* in terms of his journey to recovery and emphasised the significance of this exchange:

> *So, I suppose the next bits* [attending counselling] *were always going to be easier than the first time. It was 50 years basically, almost. So, for me, the doctor I suppose from that point then it made me feel better.* (David, p14)

David went on to describe the relief of sharing his abuse with his GP as being similar to *"having a thorn in your finger and you pull it out"* (David, p2). His GP had a noticeable emotional reaction when he shared his experience of CSA with her. Despite David feeling he had *'upset her,'* to the point that he gave her a tissue, he described feeling '*understood' and 'listened to.'* A recent study carried out in New Zealand, on listening to the therapeutic needs of male survivors of CSA, found that men worried about professionals not being able to cope with their stories of abuse and therefore would not be able to help them (Rapsey et al., 2020). In contrast, David's experience of the doctor being upset by his story contributed to his feelings of being understood. However, David also described how he was concerned that he would '*shock'* his therapist when it came to discussing his experience of CSA with her for the first time. This has some relevance to the findings around therapists being unable to cope with male CSA stories (Rapsey et al., 2020). Although there has been extensive discussion on barriers to disclosure and accessing support in the research literature, it is noteworthy that David described his therapy experience as a vehicle for breaking down barriers.

> *Coming to counselling broke down a lot of barriers, it broke down a lot of barriers for myself and gave me the confidence to tell the people that I love.* (David p.4)

There is an argument to suggest that support seeking is associated with attachment patterns. Securely attached individuals are more likely to approach others if they feel vulnerable, as they will have inevitably experienced receiving help and support from attachment figures in difficult or threatening situations (Wilkinson, 2003). It has been suggested that secure attachment is associated with a greater inclination to seek professional help and support, such as that of counsellors (Vogel & Wei, 2005). From the accounts of the men in this study, it is apparent that they have experienced issues around attachment, and this could go some way in explaining why it took many of them decades to access support. Attachment will be discussed in more detail later in this chapter.

Reaching out for help

It has been highlighted that fear of not being believed is significant in terms of disclosure and accessing support (Alaggia & Millington, 2008). This was notable for two of the men in this study who discussed their experiences of their first encounter with a therapist. Andrew described how his '*nerves started to go'* and he was '*ready to walk out.'* He elaborated on his concerns being related to his fear of *'not being believed'* in the first meeting at a specialist counselling service:

> *I always thought that when it comes to people being raped and abused that they will believe the women and not the men…there's this macho thing about they don't want to talk about it and it's like they are weak if they talk about things like this.* (Andrew, p19)

The above description had similarities in the responses of men who participated in research by Harvey et al. (2011). They expressed concerns that they would be perceived as a *'weak', 'vulnerable', 'a victim'*, or that they would not be believed if they disclosed the abuse to a professional. Andrew stressed that he was '*scared stiff'* when beginning therapy at the specialist service, while Tony articulated that the first session was *'hard.'*

> *It's maybe alright for girls and women but it's not for fellas. It is harder. It's very hard. And that's why it is hard for boys or fellas to go to anyone else to tell them what really happened.* (Tony, p2)

The above comment about it being easier for women was found to be a source of anger for respondents in a study by Lisak (1994). The anger was focused on the simplicity of accessing support for sexual abuse when you are female, as there are fewer services for men (Lisak, 1994). Although there is a time gap of 27 years since this situation was reported, the notion of services being more readily available for women was emphasised by Paul, when he explained that the only support services he was aware of were rape crisis centres, and he thought that these services were specifically for women. Feelings of frustration in men around sexual abuse support centres being female only, were expressed in a Scottish report on care and support needs of male CSA survivors (Nelson, 2009). Like Paul, the respondents in the commissioned report had not realised that certain services for women were also available to men (Nelson, 2009). It has been suggested that perceptions around service provision for male CSA survivors is influenced by socially constructed gender '*norms'* and societal attitudes around male CSA (Easton et al., 2014). In terms of Paul's assumptions of Rape Crisis Centres, it is also important to note that Andrew was the only participant to use the term *'rape'* to when describing his experience. It could be assumed that the other men did not associate their abuse with rape and this could also account for why they might not feel that a Rape Crisis Centre is an appropriate service for their needs. Another consideration is that the rape of males was not recognised as a crime until the Criminal Justice and Public Order Act 1994 came into being. As all the men in this research were abused before this legislation came into force, this could also influence how the men perceived these services as being female only.

It has been reported that, for male CSA survivors, motivation to engage in treatment is determined by the barriers they might face; with stigma and system processes being notable themes in the research in terms of their willingness to access support (Nelson, 2009; Rapsey et al., 2020). Comparably, all the men in this study relayed barriers which could arguably be linked to stigma and system processes. To illustrate, all the men believed that there were no services available to sexual abused men until more recently, with some perceiving that they would be judged, not believed because they

are a man, or seen as '*weak*' for discussing their issues. Similar to the previous discussion around diagnostic overshadowing, which is also firmly associated with stigmatisation (Robson & Gray, 2007), social constructs of men may inhibit individuals from accessing health services**.** In relation to system processes, one of the participants was advised to report the abuse to the police before seeking help, whilst others had to wait a long time between their assessment and first appointment. Research by Easton et al. (2014) corroborated Nelson's (2009) report, whereby male participants expressed concerns that rape crisis centres and specialist counselling services were not available to men, or that they were ill-equipped to support male survivors. Unlike the study by Easton et al. (2014), the men in this study did not relay experiences of finding rape crisis centres to be 'unfriendly' or being refused support based on their gender. That said, Paul described a negative counselling experience when he accessed therapy for the first time with a generic mental health service provider. When sharing with the therapist that he was not sure if his mother believed that he was sexually abused, she suggested that his mother '*never loved him'*. The therapist also implied that his diagnosis of Crohn's disease was caused by the sexual abuse. Despite there being some evidence to suggest that there is a relationship between a history of CSA and physical health problems such as Crohn's disease (Felitti et al., 1998), the therapist's response was clearly unhelpful and caused Paul distress. The reaction Paul had to the therapist's interpretations supports the claim by Hovey et al. (2011), that it is imperative for psychotherapists to have an understanding of how CSA can impact on physical health, but caution needs to be exercised in associating the two things. It could be argued that the therapist was lacking in sensitivity and should have approached this subject more tentatively. The negative encounter that Paul experienced with the first counsellor caused him to end his therapy and he found it difficult to access support for a considerable time after this incident. Andrew had also had previous negative encounters with other professional, and this led to intensive reservations about accessing specialist support. The experiences of Andrew and Paul is in keeping with research conducted by Rapsey et al. (2020) who noted that a lack of connection with professionals they worked with in the past was the main reason for a lack of engagement in further treatment with new providers.

The first session was described as being '*uncomfortable,'* by one participant, with another explaining *'everything is a bit raw and you dig up things that you really don't*

want to discuss.' Although stating he was *'anxious because it is the unknown,'* David conveyed that he was also *'relieved'* when it came to his first counselling session. This feeling of relief was attributed to his ability to speak about his experience of CSA for the first time. The descriptions of the uncomfortable aspects of counselling are in keeping with Easton et al. (2015), who reported '*the process of opening up and feeling the pain and having someone witness it, and the stories connected with that pain, were vital to healing'* (Easton et al., 2015:157). This description articulated by a male survivor in the research by Easton et al. (2015) mirrors the therapeutic process experienced by the men in this study, as they described how it helped being able to talk about their experiences and have someone listen and guide them. Moreover, it also manifested in the research process. Despite the aim of this research being to explore experiences of specialist counselling support, and the narrative interview being focused around this, all of the men in this study wanted to share their experience of CSA. As with the above notion of *'opening up'* about stories connected with pain and this being witnessed, the men clearly wanted their stories of abuse to be heard and documented. Phelps et al. (1997: 3) noted that *'telling stories'* and having *'somebody who listens and believes'* facilitates the development of trust on an intrapersonal and interpersonal level. Being present with the participant, I sensed the importance of their stories, not only being heard, but also being documented. The men were made aware that the focus of the research was around their counselling experiences, but it was evident that they all wanted to give a testimony of their childhood experiences.

Despite three of the men sharing that they found the process of counselling '*hard'* with some often finding it distressing, David explained that he found it '*quite easy'* and he was *'surprised'* by this. However, he did recognise that it is not easy for everyone to *'deal with their abuse.'* The difficulties associated with having counselling has been alluded to in the research literature. Male participants have described feeling worse as a result of therapy, as counselling obligated them to acknowledge their abuse experience, rather than avoid it (Rapsey et al., 2020). This could account for why Tony felt that his counselling was not working for a substantial period of time, and why he engaged in therapy for a prolonged period of nine years. It could be argued that the phenomena of feeling worse as a result of counselling, is not exclusive to men. However, it is well established that men are more prone than women to use

substances as a coping strategy in suppressing painful memories of abuse and avoiding distressing thoughts and emotions (Steever et al., 2001; Alaggia & Millington, 2008; O'Leary, 2009; Easton et al., 2015). Indeed, Tony and Paul both discussed excessive alcohol consumption in their narratives. Therefore, there is justification for the suggestion that men might feel worse when they initially have counselling. The concern around feeling worse during, or following therapy, raises the question of whether clients engaging in counselling for CSA should be educated or made aware of this issue, in order to prevent premature disengagement.

The counselling assessment process was found to be a pivotal moment for some of the men in this study. David reflected on being asked at the assessment what he wanted from the counselling and it was only after ending his therapy that he could answer the question, which was to realise that the abuse was not his fault and to improve his interpersonal relationships. David also acknowledged that the terms *'being assessed'* felt '*weird.*' Andrew explained that he was asked a lot of questions and he was unsure whether he would be able to continue the assessment session, as it made him *'anxious'*. However, Tony found the assessment process challenging as he thought he would have to talk to a male worker which he stated would remind him of the abuser. There is perhaps a need for services to consider the terms that they use when it comes to assessment. It also could alleviate anxiety if survivors are given details about who they will be talking to in advance of the session.

Discomfort around men

The concerns around working with a male counsellor was noted above in relation to fears around the assessment and allocation of a counsellor for one participant. However, the issues around working with a male therapist was significant for all the men in this study.

There is a distinct lack of research literature available around the influences of gender between a counsellor and client, particularly in the context of male CSA survivors engaging with specialist support services. The topic was briefly addressed by Hovey et al. (2011) in their study on how psychotherapists can support the healthcare experiences of male CSA survivors. They highlighted men experienced discomfort

when interreacting with a practitioner that was the same gender as their abuser. Despite alluding to this in their study, the interactions discussed were focused on healthcare practitioners, as opposed to therapists. It was noted that this issue is not unique to men. However, what they found to be exclusive to male survivors was that the discomfort around male practitioners was sometimes related to them fearing that a male professional would presume that they were homosexual, due to their abuse history (Hovey et al., 2011). Within this research study there was no indication that the men had any concerns around being perceived as homosexual. Furthermore, there is little evidence to suggest that the men in this research had an issue with male healthcare professionals, as three of the four men interviewed had male doctors and disclosed their experience of CSA to them. However, Andrew did indicate that he had a good relationship with his male doctor because he was a different race to the man that abused him. He stipulated:

> *It was a white man that raped me. I just can't have men near me. If I go in and there's a white doctor then I normally say that I need somebody in there…a woman. I tell them that if you touch me, I can't control my temper*. (Andrew, p4)

Andrew relayed a recent event when he experienced intense fear and anxiety when allocated a white doctor at a hospital appointment, which was eased slightly when he was offered a female chaperone. When exploring Paul's reasons for choosing a female counsellor, he unambiguously stated, *"I don't trust men."* As with Andrew implying that he could lose his temper around a male worker, Tony was unequivocal in his feelings around working with a male counsellor and how this would induce anger.

> *I don't want to speak to no fellas. I would end up smashing something over their heads.* (Tony p.5)

Hovey et al. (2011) also noted that participants abused by females experienced overwhelming distress when being cared for by a female practitioner. Of the participants in this study, one of the men was abused by a female, as well as a male. In contrast to the findings by Hovey et al. (2011), the participant was the only man in this study that had a female doctor and did not relay any feelings of distress around female professionals.

The relationship between the men and their counsellor was identified as one of mutual respect, with the therapists offering an approach characterised by being non-judgmental, supportive, and able to listen. One research study, focused on support for male CSA survivors, indicated that the power imbalance in an abusive relationship had parallels with the power differentials between the client and professional in the context of the therapeutic relationship (Rapsey et al., 2020). Although this was not the case for the men in this study, it is plausible that feelings of a power differential could exist in certain therapeutic modalities where the therapist is perceived as the expert (Procter, 2017). Aside from noting that the participants attended a support group, as opposed to one to one psychotherapy, the research by Rapsey et al. (2020) does not elucidate the therapeutic approach offered to the men so it difficult to ascertain whether their experience of a power differential could be linked to the model of therapy.

When it comes to how therapeutic engagement and power in the researcher-participant encounter influenced the interview process in this study, it is argued that the narrative approach challenges conventional research power relationships. The narrative approach facilitates participants to be considered as co-researchers, and counselling sessions as re-searching rather than therapy (Etherington, 2004). Indeed, as a person centred practitioner, I aim to create an equal relationship where the client is the expert in their own experience. This is something I often reinforce with my clients, particularly when establishing the boundaries in the early stages of the therapeutic process. With this in mind, it is acknowledged that the skills, qualities and principles I embody as a therapist, will have influenced the research interview process. During the interviews I listened actively and intently. I felt that I was well attuned to the participants and used skills such as summarising, paraphrasing and clarifying to ensure that I had accurately captured their narrative. I was empathic and non-judgemental when listening to their experience. This was clearly observed by David and Andrew, who commented about me not being shocked by their story and feeling that I could be trusted:

> *It's like you* [researcher] *are looking at me now, just listening and understanding without judging and without looking at me in a shocked manner*. (David, p13)

If the participants had not experienced me as empathic and non-judgemental, or if they felt they were not being listened to, then it is likely that they might not have shared as much detail about their experience as they ultimately did. Although I used counselling skills to facilitate the interviews, I made no attempt to reflect any underlying feelings that the participants might have conveyed as I would do in therapy with a client.

The participants in this study all experienced sexual abuse as a child. It is well established that perpetrators of CSA are motivated by exercising power, whilst the victims are powerless (Cossins, 2000). It was therefore imperative, that an equal relationship of mutual respect was fostered within the research encounter with clear boundaries and expectations. That said, I made it clear to the participants that the interview was not a therapy session and ongoing support with a professional would be made available following the interview if they felt it would be beneficial.

Morris and Borja (2022) caution those in the clinician-researcher role that dual-role experiences in qualitative research can cause serious ethical implications for researchers and participants if the dual role is not recognised or addressed. Some examples encompass issues around informed consent and crossing relational boundaries if the researcher or participant engages in the research encounter as a therapeutic relationship. Additionally, dual-roles can manifest if participants share sensitive information as a means of gaining support, as they believe the researcher has the knowledge and skills to support them therapeutically (Landau, 2008). Hay-Smith et al. (2016) noted two main catalysts that cause dual-role experiences among health clinicians in research: '*clinical patterns'*: times when the clinician-researcher acts as a source of clinical expertise for a research participant, and '*connection'*: times, when the relationship between researcher and participant feels more like a clinician–patient relationship. Although it has been acknowledged that my skills as a counsellor played an important role in the interview process, I feel that the boundaries were clearly conveyed to the participants throughout their involvement. I feel confident that I did not *'act as source of clinical expertise'* and I was mindful to explicitly state the aims of the interview and the research study, to ensure that the process could not be confused with a therapy session. This also extended to the de-brief period when I checked in with the participants about how they were feeling after the interview. I

explained that they might experience a delayed response of distress and I advised them how they could access ongoing support from a third party if required.

For better or worse

A common presenting problem for men accessing therapy is marital problems and relationship difficulties (Gill & Tutty, 1999; Steever et al., 2001). All the men in this study expressed difficulties in forming and maintaining relationships which was also noted in the CSA literature (Kia-Keating, et al., 2010; Tummala-Narra et al., 2012). In conflict with this, difficulties in developing and maintaining secure relationships can also contribute to the barriers CSA survivors encounter when attempting to engage in therapy (Olio & Cornell, 1993). Tony maintained that it was getting hard for him to meet a woman, as he was getting old. He yearned for a relationship and had been told by others that he was unable to have a relationship because he had an *'attitude problem.'* Tony blamed the perpetrator of his abuse for his inability to have an intimate relationship.

> *He made me do that. He really has buggered my life up so I can't find a decent woman.* (Tony, p7)

Andrew was also single at the time of his interview. However, he had been in a long-term relationship in the past and he disclosed to me that he was a victim of domestic violence perpetrated by the woman he lived with. David was in a long-term relationship and Paul was married at the time they were interviewed. They had both experienced relationship difficulties in the past, which they attributed to the impact of CSA. David had been divorced twice and Paul had been divorced on one occasion. As with all four men in this research, all 10 male participants in a study by Gill and Tutty (1999) held the belief that CSA had impacted on their ability to form and maintain intimate relationships. Further, studies have highlighted that men can have difficulties in developing relationships with peers (Lisak, 1994; Gill & Tutty, 1999), and that interacting with them would result in being manipulated or abused. This has some consistency with the reflections of the men in this study. David and Andrew both talked extensively about being bullied and victimised by peers and teachers as children. Tony discussed his difficulties in forming friendships as an adult, and he described feeling

'used' by people. David described how he blamed himself for the breakdown of his two marriages and difficulties he experienced with his current partner.

> *A couple of marriages broke down and it's like…well is that my fault? I suppose that's my fault and I've always blamed myself for all these things. I always thought everything was about me.* (David, p12)

Before engaging with counselling, David resisted any chance of conflict and was unable to express his feelings with his current partner. An inability to be emotionally expressive in intimate situations was also noted by Kia-Keating et al. (2010). However, this was in the context of forming relationships, as opposed to maintaining relationships as in David's case. However, David blamed himself for his two previous marriage breakdowns and it could be assumed that his communication problems were also present within these relationships. Through exploring, in his therapy, the underlying cause of his inability to talk about his emotions, he realised that it was due to his fear of upsetting other people. David worked on this in therapy and, with the support and guidance of his counsellor, set himself goals to be open with his partner and communicate feelings of being upset. Research by Easton et al. (2015:157) on the healing processes of men recovering from CSA, '*influential relationships,' 'insights and new meanings*,' and '*action-orientated communication'* were all identified as major themes in their findings. Being supported to improve his communication in his relationship was a key turning point for David and his descriptions of what counselling helped him to achieve concurs with the findings of Easton et al.'s (2015) study. The impact counselling had on David's relationships was clearly transformative, as he stated '*coming to counselling broke down a lot of barriers'* when he described how he was able to finally tell his adult daughters that he had been sexually abused.

Turning points have also been known to occur as a result of marital breakdowns, while relationship difficulties can be a consequence of emotional, behavioural or substance misuse problems (Easton et al., 2015). As noted above, David's turning point appeared to be linked to improving his interpersonal relationships and was one of the main outcomes of his therapy. For Paul, difficulties with interpersonal relationships and drinking excessively acted as a turning point to seek help.

> *It's alright being depressed but it rubs off on the people that are nearest and closest to you. Your kids, your wife, your work mates.* (Paul, p13)

Paul explained that he had disclosed his experience to his first wife and current partner as *'it is part of me.'* However, David had never felt able to tell his previous partners or family. David had recently told his partner, but only told his children as a result of his counselling. David's reluctance to disclose could be attributed to what Easton et al. (2014) found in their study; male CSA survivors feared that disclosing their experience of CSA could negatively impact relationships and result in rejection, abandonment, and loss. These findings highlight the significance of interpersonal relationships in the recovery and healing processes of male CSA survivors. As many men who are experiencing psychological distress, due to CSA, are likely to be presenting with issues such as marital and relationship difficulties, it is imperative that men have the opportunity to work through relationship problems in counselling. When proposing interventions to work with male CSA survivors in therapy, Gill and Tutty (1999) recommended that therapists provide opportunities for emotional and sexual relationship issues to be addressed in therapy. The findings of this study support Gill and Tutty's (1999) recommendations, as all the men conveyed relationship problems which severely impacted their lives. For David, working through his relationship with his partner and daughter led to a major shift which improved his confidence, reduced his feelings of self-blame, and had a positive impact on his family. Continuing the debate around routine questioning in health and mental health settings, there is also evidence to suggest that men presenting at counselling services specialising in relationship/martial issues could also benefit from exploration of past abuse history. It is also important that counsellors have an awareness that difficulties in forming relationships can cause challenges for CSA survivors when it comes to engaging in therapy (Olio & Cornell, 1993). Tony appeared to be a testament to this, as he found it difficult to establish a relationship with his first counsellor, which seemed to be linked to the counsellor's erratic attendance and his fear of abandonment.

Trust me I'm a Counsellor

Trust me I'm a counsellor, has only one sub-heading, 'Relationship with counsellor', as this aspect is distinctive from the previous discussion under 'Trust me I'm a doctor'.

Relationship with counsellor

In Chapter Five, attention was paid to the qualities and skills of the counsellors from the perspectives of the men. The relationship the men had with their counsellor was also a meaningful finding in this research. Male CSA survivors experiencing a positive relationship with a counsellor has been acknowledged as a fundamental benefit of therapy (Rapsey et al., 2020). The significance of healing relationships and the opportunity to revaluate abuse experiences, and find meaning in these experiences, has been recognised as a valuable process of change (Draucker et al., 2009; Easton, 2013; Willis et al., 2015). Moreover, trauma informed therapy has been identified as an environment for cultivating relationship healing and learning relationship boundaries (Kia-Keating et al., 2010). Further, a positive relationship with a counsellor can assist in supporting clients to nurture their capacity to form intimate relationships, with healthy boundaries (Muller, 2010). Although engaging in safe relationships and learning safe ways of maintaining relationships has been associated with being a mechanism for healing for men who have experienced CSA (Kia-Keating et al., 2010), the role that therapy plays in this process has previously been neglected in the male CSA literature.

For the men in this study, the key ingredient in developing the relationship with their counsellor was trust. A recent study on male survivors' experiences of group therapy found that relationships with their treatment provider was facilitated by trust and the connection they developed within the therapeutic relationship (Rapsey et al., 2020). According to the literature on male and female CSA survivors' reflections of talking therapy, being believed and not judged is an essential aspect in determining whether a counsellor is trustworthy, and worthy enough of hearing their stories (Anderson & Hiersteiner, 2008; Chouliara et al., 2011). The men in this study also testified to this. David explained that there was a *'certain amount of trust there'* due to fact that she was a counsellor and he had always wanted someone to talk to and share his *'life story'* about the abuse and his childhood. The ability to share abuse stories safely with

a therapist who demonstrates *'honesty,' 'competency'* and *'trustworthiness'* was found to cultivate relational connections and self-trust, and reduce isolation (Arias & Johnson, 2013: 832). A research study (O'Brien et al., 2007) on women's experiences of accessing services noted some similarities with David's experience of his therapist. The participant in O'Brien et al.'s study (2007: 4) stated that their therapist *'didn't judge and wasn't shocked.'* David recollected that his therapist *'wasn't shocked. She was there to listen to me, my issues, what happened to me. She wasn't going to be shocked.'* The fact that the counsellor was not shocked by his experience appeared to nurture his feelings of trust towards her. Rapsey et al. (2020) noted that a male survivors' ability to develop a trusting connection with a professional is essential for them to benefit from treatment. However, they emphasised that it is often necessary for men to change and seek alternative professionals as a way of finding the right person. This could certainly be said for Paul, Tony and Andrew, who had all described relational challenges with various health professionals and/or counsellors in the past. It is suggested that professionals who are unable to build a rapport, listen to or cope with stories of CSA, or who are reluctant to ask questions related to the sexual abuse experience, can inadvertently contribute to the barriers that prohibit engagement and support that male CSA survivors experience (Rapsey et al., 2020). These findings indicate that therapists should be sufficiently trained to develop their skills and ability to hear and cope with stories of CSA. Moreover, a therapist should be comfortable with asking direct questions about CSA. As three of the men in this study all described negative experiences with previous professionals, there is an argument to suggest that specialist sexual abuse services with staff trained in CSA, are best placed to serve the support needs of male survivors.

Andrew initially had a distrust towards professionals and counsellors, as he had a *'fear of being locked away.'* Despite initially being prepared to walk out of the counselling room he described his experience of the first session.

> *I was ready to go…to walk away but there something…but there's something about how my counsellor spoke and the trust was there. (*Andrew, p5)

Andrew's fear of being locked away stemmed from his experience of feeling like he was *'going mad'* and, when trying to share with professionals, one psychologist told

him *'well if you go insane, we will just lock you away.'* It could be suggested that Andrew's experience of counselling, at the specialist service, was his first experience of being able to share his thoughts and feelings without fear of being *'locked away.'*
A study, on women's experiences of sexual abuse counselling, by Koehn (2007: 50) documented a participant's response regarding their counsellor, '*she wasn't scared of me being mad…I learned a lot of self-trust in that.'* As Andrew thought he was going '*mad*' and feared responses from professionals, this has particular relevance to his experience of trusting his counsellor and being able to openly share his feelings. The concern around not being accepted or understood by professionals is known to be common for male CSA survivors, and being able to talk openly and honestly about their experiences is an important part of the therapeutic process (Rapsey et al., 2020). This study supports these findings, as the four men all reported fears, anxiety or negative past experiences of health and mental health professionals. It could be argued that these experiences contributed to the men accessing support for their abuse experience later in life. Andrew was around 14 when he first pursued psychological support. He explained that being told for so many years that he was going mad caused him to *'push away from doctors or psychologists or any help.'* The other men also recounted similar experiences. Similar to Rapsey et al. (2020), being able to talk openly and honestly was also a crucial factor during the therapeutic process for the men in this study. The men described how having someone to listen and understand without judgment was vital for their recovery. Andrew relayed being previously told by professionals to *'leave it in the past.'* Therefore, to have a counsellor that listened meant that counselling was the '*best thing'* that he ever did. For David, the counsellor being a *'stranger'* made it somewhat easier to talk about the *'not so nice things'* and the *'naughty things'* that had happened to him as a child. When Andrew described some of the counsellors' skills, they could be interpreted as active listening, reflection, and use of clarifying questions, all of which are often associated with the person-centred approach (Tolan & Cameron, 2016).

In the UK, there appears to be a lack of consensus and clinical guidance on effective therapeutic interventions for adult survivors of CSA. The National Institute for Health and Care excellence (NICE) have guidelines on interventions for children and young people who have experienced sexual abuse, these include offering a group or individual trauma-focused cognitive behaviour therapy (CBT) for over 12-16 sessions

(NICE, 2017). Despite comprehensive guidelines on working with children, there is a paucity of recommendations for working therapeutically with adult survivors of sexual abuse. However, there appears to be some overlap between what the men in this study described as being significant in their support, and the guidelines for children and young people. For example, the guidelines for children and young people, *'emphasises the importance of the therapeutic relationship between the child or young person and therapist'* and offering '*support tailored to the child or young person's needs including counselling'* (NICE, 2017: 40). The guidelines also address a number of skills that can be helpful when working with a child including *'being sensitive and empathetic'* and '*listen actively and use open questions'* (NICE, 2017: 12). The skills and attitudes documented in the NICE guidelines were referred to by the men in this study, as being a positive aspect of their therapy. As noted, CBT has been recommended when working with child survivors. Although research relating to both males' and females' perspectives of counselling is limited (Chouliara et al., 2012), a study by Edmond et al. (2004) found both Eye Movement Desensitisation and Reprocessing (EMDR) and eclectic therapeutic approaches to be effective according to adult survivors. There is a debate to be had that a more direct approach such as CBT and EMDR might not have been appropriate for the men in this research study; particularly, as it was reassuring for some of the men that there was no pressure to talk about their experience of CSA. Although they all wanted to talk about their experience, the fact that the therapy was client led and unstructured was a factor in the support being helpful. That said, it is difficult to make comparisons on therapeutic approaches, as only Andrew had past experience of a CBT approach when being treated for OCD. However, he was unambiguous that the CBT therapy was not helpful as he felt *'very uncomfortable around him* [CBT therapist] *because he was a man.'* Therefore, it is unclear how effective CBT could have been if it was delivered by a female therapist who he might have felt more comfortable with. Romano and De Luca (2006) found that a structured CBT treatment approach, encouraging men who have experienced CSA to explore their feelings of anger, anxiety and self-blame, whilst developing strategies to reduce and manage these feelings was particularly effective for reducing self-blame for male survivors. It appears that David's experience of therapy had a similar outcome, as what has been described by Romano and De Luca (2006), he stipulated that he no longer blamed himself, due to his counsellor helping him to *'rationalise'* his experience and the impact of the abuse.

The absence of guidelines on effective therapeutic interventions, therapeutic approaches or ways professionals can work with survivors of CSA raises the question of whether a framework or model could be developed. Chouliara et al. (2012: 159) advocated for the development of a *'survivor-friendly and sensitive framework'* to guide professionals in enquiring about CSA history, which could attend to the timing and style of questioning and guidelines on responding to disclosures. However, there is also a need for a model which goes beyond disclosure and extends to support and effective communication. The men's negative experiences with professionals, identified in this study, substantiates this need. Although a necessity for a survivor friendly framework has been proposed, due to the additional barriers and problems men often face in accessing support, there is an increasing need for a framework or model specifically targeted towards supporting male survivors. Crowder (1995) developed a four-phase treatment model for therapy with adult male survivors consisting of (1) Breaking the Silence; (2) Victim Stage; (3) Survivor Stage; (4) Thriver Stage. These phases include a myriad of interventions for both individual and group therapy; including *'Inner Child Work,' 'Drawing the Abuse,' 'Confronting the Abuser,'* and *'Body Work'* (Crowder, 1995: 71: 95). The treatment model is now fairly dated and there appears to be little evidence of its effectiveness in the wider male CSA literature. An aspect of Crowder's (1995) model which appears to have some overlap with what the men in this study described as being helpful, is how treatment by a compassionate therapist, guided by an in depth understanding of sexual abuse related trauma is imperative. This is supported by research on therapeutic engagement in mental health nursing, where it was found that trusting relationships, values and attitudes of the nurse were considered to be more important than the technical skills involved in therapy (Read, 1996). Essentially, patients regarded the nurse's ability to relate through talking, listening, and expressing empathy to be fundamental, as opposed to the therapeutic approach adopted (Rogers & Pilgrim, 1994; McAndrew et al., 2014).

Counsellor or Mother?

The discussion of this theme centres on developing and maintaining a secure base.

Securing a base

Research on the counselling relationship has determined that counsellor traits correlated with secure attachment, such as trustworthiness, openness and warmth, are associated with an effective therapeutic relationship (Ackerman & Hilsenroth, 2003). The role of attachment certainly manifested in this study. From the narratives of the men, it was evident that the counsellor's acceptance, warmth and non-judgmental attitude was conducive to allowing trust to form in the therapeutic alliance. Rothschild (2000) empathised that when working with trauma, establishing a secure base is the first priority, in order for the client to feel safe to venture and then return to the therapist for soothing if required. The counsellors, supporting the men in this study, appeared to take this approach in establishing a safe haven in the initial sessions with one of the men explaining what he found helpful in the early stages of his support.

> *I think you need someone that is quite naturally a listening person that smiles and jokes and to make you feel at ease.* (David, p13)

Another participant explained that trusting somebody is *'a big thing when you've got problems,'* and his ability to trust the counsellor was cultivated from the knowledge that she was open and willing to listen to him. Research on listening to the support needs of male survivors reported that being able to talk honestly about their experiences was an important part of treatment for men (Rapsey et al. 2020). The counsellor modelling active listing skills is arguably one of the most important factors for the men in this study. For most of the men, their encounter with the therapist was the first time they had experienced someone listening to their abuse narratives. This concurs with the findings of Easton (2013) who reported that almost half of the participants in their research, involving 487 male survivors, described their therapist as their most supportive listener. Further, the helpfulness of a supportive listener was found to reduce mental distress. Andrew shared his thoughts on essential skills and attitudes he felt a therapist should demonstrate:

> *With anything like that you've got to listen to people and not judge people and believe.* (Andrew, p1)

As discussed in Chapter Five, the counsellor can replicate the secure base or safe haven associated with secure attachment figures (Bowlby, 1969). It was also

proposed, based on Peplau's (1991) theory, that the client can assign the therapist a surrogate role and the counsellor can often symbolise a mother figure. The role of the mother was a poignant theme for the four men in this study. David was the only participant who experienced sexual abuse at the hands of his mother and the only participant to disclose being sexually abused by a female.

> *Your Mum is making you go to the bathroom and do these not so nice, sexually things to you like…and abuse.* (David, p6)

Paul shared his anguish that his mother did not believe his abuse experience and he became highly distressed when a former therapist suggested that his mother did not love him. Research by Easton (2013) found that men who had maternal support available, when first disclosing CSA, were less likely to experience mental health problems. Andrew chose not to tell his mother for fear of causing her distress. Tony did not have support from his mother, and was forced to leave the family home following his experience of CSA at the hands of his mother's partner. The fact that all the men have experienced mental health problems implies that there could be some accuracy in Easton's (2013) findings about a lack of maternal support contributing to mental health issues.

The lack of maternal support also raises the question of whether the therapeutic relationship replicating the mother-child relationship had any influence on the outcome of the men's counselling. It was clear, from the men's accounts, that the therapeutic relationship was nurturing and supportive, cultivated from the counsellor's warmth and skills in listening, unconditionally accepting and offering non-judgmental responses. Seminal work on the concept of the therapeutic alliance by Bordin (1979) distinguished the client-therapist bond to be a major aspect of the alliance. Furthermore, Bordin (1979) maintained that to develop and maintain the goals, aims and tasks necessary in therapeutic treatment to bring about change for the client, a high-quality bond between the client and therapist is crucial. The bond denotes the socio-emotional aspects of the therapeutic relationship such as trust, caring, confidence, acceptance, mutual respect, fondness, and shared understanding (Bordin, 1979). Arguably, these aspects were all present within the narratives of David, Andrew, and Paul. It is also considered that the bond refers to the rapport and collaborative effort of client and

counsellor (Hatcher, 2006; Orlinsky et al., 2004). Obegi (2008:431) aimed to uncover how this bond between client and therapist develops and argued that the therapeutic bond is *'an in-progress attachment to the therapist.'* Obegi (2008:435) conceptualised a framework of hypothetical *'attachment markers'* in the development of client therapist attachment.

There have been some notable comparisons drawn between an attachment relationship and the therapeutic relationship by researchers (Farber et al., 1995; Farber & Metzger, 2008; Obegi, 2008), which have been evidenced by the men in this study. Some examples are that an attachment relationship persists over time and in therapeutic relationships the client continues to value the relationship beyond the termination of therapy (Farber et al., 1995). This was undeniably a feature of the men's stories. Three of the men had ended their support, yet talked about the relationship with fondness, referring to the counsellor affectionately during the research interviews. Another example is in an attachment relationship, there is a joy upon reunion when an attachment figure has not been in close proximity (Obegi, 2008). Likewise, in the therapeutic relationship, a client can feel relief on seeing the therapist from week to week (Obegi, 2008). David substantiated this claim when he described how he looked forward to sessions from week to week, and became excited about being able to share his progress with his therapist. When it comes to the notion of the therapist acting as a safe haven or secure base, there are some similarities between the attachment figure and counsellor. Turning to an attachment figure for a sense of security, through contact and exploration, is mirrored in a counselling relationship when clients use the safety of sessions to explore painful feelings and experiences (Farber & Metzger, 2008). For the men in this study, it was the first time that they had been able to discuss their experience of CSA in a safe environment.

Obegi (2008) proposed that the attachment process between client and therapist is initiated before the client engages in therapy. This '*pre attachment'* (Obegi, 2008: 436) phase is when the client is seeking proximity to a stronger and wiser figure with the aim of alleviating the distress caused by their current problems. The client will be assessing the therapist's potential as a viable attachment figure and this phase encompasses searching for a therapist, making contact, and disclosing their presenting problem. The men in this study did not actively search for a therapist, as

they were all referred by a GP. However, the initial assessment process and the first session was a significant juncture when it came to determining how comfortable they were to disclose their experiences and decide whether they would continue the therapy. It has been proposed that clients evaluate the counsellor's ability to act as an attachment figure, and regulate their distress, early on in the therapy process (Vogel et al., 2006). David described being *'made to feel at ease straight away'* which led him to just want to *'blurt it out.'* Similarly, Andrew was nervous during the assessment process when he was being asked questions which caused anxiety around attending his first counselling session. However, when reflecting back on the first session he stated, *'there's something about how my counsellor spoke and the trust was there.'* For Tony, this process took a couple of months and he explained *'the more I came, the more I could trust.'*

At the end of the pre attachment phase, Obegi (2008: 437) suggested that the client will have recognised the counsellor as a potential attachment figure, and this is when the '*attachment in the making*' phase develops. Clients will tentatively start to use the therapist as a safe haven for comfort and reassurance and as a secure base for exploring deeper issues. The client will determine how safe it is to offer more detailed disclosures based on the therapist's acceptance, encouragement, and supportive responses. Having analysed the counselling experiences of David, Paul, and Andrew it is indicative that they experienced the *'attachment in the making phase'* with their therapists. They were clear about the counsellor's acceptance, supportive, and non-judgemental responses, and ability to listen being the main factors in facilitating their ability to share their stories of CSA. In Chapter Four, Tony expressed feelings of anger towards his counsellor for having time off sick.

> *It does! It does wind me up! Then I have to wait for weeks and then sometimes I'm angry.* (Tony, p7)

There is evidence to suggest that this reaction could be an adaptive response to separation (Bowlby, 1973). Therapist initiating separations, which result in disruptions to the clients' session routine, can emulate the reactions children experience when separated from a care giver (Obegi, 2008). This is particularly pertinent for Tony, as he talked poignantly about being separated from his mother as a child. Although the

literature on therapist separations is scarce, an early study by Webb (1983), who surveyed practitioners, reported that common reactions from the client included anger, anxiety, and feelings associated with fear of abandonment. Tony's quotation, documented above, substantiates these claims and highlights a need for further inquiry on the attachment between client and therapist and the impact of separation, particularly in the context of CSA.

Blocking the memories

For the purpose of this discussion 'Blocking the memories' has been sub-divided into four aspects; Helping to forget, Hurt and anger and Effects of child sexual abuse.

Helping to forget

When it comes to denial, the literature reported that alcohol and substance misuse are common coping mechanism for men in the suppression of memories and the distressing thoughts and emotions associated with their abuse experience (Alaggia & Millington; Easton et al., 2015; Rapsey et al., 2020). Paul and Tony both disclosed that they used alcohol excessively. Paul stressed that he *'was drinking too much'* and this was his main motivator when it came to approaching his GP for support. Easton et al., (2015) suggest that alcohol addiction often serves as a *'turning point'* for men who have experienced CSA and that they have to *'hit rock bottom*' and lose all control of their lives through alcohol before recovery is possible. There is no evidence to suggest that Paul had lost control or *'hit rock bottom'* due to alcohol misuse. It appeared that he recognised that his drinking was problematic and subsequently reached out for help. In terms of Tony's relationship with alcohol, it seemed that his alcohol problem was severe, as it exacerbated his anger and aggression. He also used the term '*lost it'* to describe his experience when he started drinking heavily.

> *I got put in a hostel at aged 15 and that's where I've just lost it. Started drinking nearly every day. That's when the other stuff started coming in my head…the madness and everything else.* (Tony, p2)

Denial can be two-fold and can also be communicated by professionals regarding their patients' experience of CSA (Dorohy & Clearwater, 2012). In particular, alcohol misuse

can often be regarded by health professionals as learnt behaviour, as opposed to it being considered as a coping strategy for CSA (Dorohy & Clearwater, 2012). Although Paul approached his GP about his drinking problem, Tony did not disclose this to his doctor. It could be proposed that when men present with alcohol and substance misuse issues, this might be an indicator of a history of CSA, as it has been found that substance misuse is a common presenting problem, for men who have experienced CSA, when seeking therapy (Steever et al., 2001). Gelinas (1983) used the term *'disguised presentation'* to denote the phenomenon of how adult survivors will often present to mental health professionals with issues that are commonly associated as effects of CSA, rather than for therapy specifically for their experience of CSA.

Hurt and Anger

In Chapter Five, the men's negative self-beliefs were discussed through the lens of counselling theory. Negative self-perceptions and self-concept have also been discussed in the male CSA literature (Lisak, 1994; Easton et al., 2017). Although negative self-perceptions are arguably also an issue for female survivors, the men in this study often referred to feeling that they were not believed, due to there being a perception that CSA only happens to females. In addition, some described a lack of understanding on the issue of male CSA and the overall stigmatisation rooted in societal perceptions. Research has identified that issues around trust and negative self-beliefs are associated with experiences of stigma related to masculinity and public opinion towards male victims of sexual abuse (Easton et al., 2017). A consistent theme in Tony's narrative was that of anger, and he also relayed feelings of suicidality. Research by Easton et al. (2017) investigated negative identity and psychological wellbeing in male CSA survivors and highlighted that intense anger, self-harm and suicidality are issues which are particularly pertinent for men. Of the four men in this study Tony and Andrew both shared that they contemplated suicide at some point in their lives. Andrew also shared incidents of self-harm throughout his life and described his struggle to refrain from self-injury.

Across the four interviews, anger featured most prominently throughout the exchange with Tony. However, he was not the only participant to express feelings of anger, as this manifested within all four men's narratives. David noticeably expressed anger

when his voice became raised during the research interview. The anger was aimed towards the public for their perceptions of male CSA, and regarding the fact that there was no support available to him when he was a child. He also confessed that he felt jealous towards children who are now able to access support. However, I had a sense from his expression that he felt ashamed to admit his feelings of jealousy, which was substantiated by his remark:

> *Wrong or right, I am just saying that that was my feelings like, and I felt jealous of the help that the children got.* (David, 4)

The fact that anger emerged in the participants' narratives, despite the interviews being focused on support and counselling experiences, is consistent with what has been reported in the male CSA literature (Lisak, 1994; Kia-Keating et al., 2010; Dorahy & Clearwater, 2012; Easton et al., 2013b; Rapsey et al., 2020). Although anger is also a known impact of CSA in females (Alaggia & Millington, 2008), feelings of anger or rage can be particularly severe for men and the expression of anger conforms with the conventional male gender *'norms'* and the social constructs previously mentioned (Eisler et al., 1988; Lisak, 1994; Chaplin &. Cole, 2015). Andrew described how his anger would sometimes lead to self-harm.

> *The anger…when I think about these things or when I have these nightmares…I would punch the wall or slice my hands.* (Andrew, p10)

Paul demonstrated the positive impact counselling has had on his anger issues, when he articulated the thoughts and feelings he experienced at a time in his life when he was trying to supress abuse memories and *'keep a lid on the box.'*

The comments conveyed by Tony and Andrew about their anger, mirrors the theme of *uncontrollability* which was highlighted in research findings reported by Dorahy and Clearwater's (2012). Uncontrollability manifested when men in their study were not able to control intense anger or rage stemming from abuse memories. As with three men in this study, they described heightened levels of anger, an inability to control their rage and an intense fear of losing control. This was often connected to their abuse memories; for instance, when Tony and Andrew talked about anger in the context of working with male professionals and how this connected with memories of the abuser.

> *I don't want to hurt anybody. I know if I go violent…if I attack then I can't control it.* (Andrew, p11)

Hyper-masculine behaviours such as rage and aggression are known to reinforce denial relating to feelings of victimisation (Holmes et al., 1997; Lisak, 1994). It could be debated that this presented itself in Tony's narrative, as he regularly described events where he adopted hyper-masculine and violent behaviours. Furthermore, from my perspective, his dialogue towards women had misogynistic undertones and he intimated that I should be scared of him.

> *I bet the boss* [of the counselling service] *told you to be wary of me* [laughs]. *I bet! She must have told you I have got a nasty temper.* (Tony, p6)

Effects of child sexual abuse

As discussed throughout this study, men who have experienced CSA often engage in counselling with a wide range of presenting issues (Gill & Tutty, 1999; Day et al., 2003), and CSA is known to have significant negative consequences on an individual's mental health (Hunter, 1990; Mendal, 1995). The experience of debilitating nightmares prompted Andrew to seek counselling. This appears to be unique to Andrew, as the other men did not discuss struggling with nightmares. Moreover, nightmares did not feature in the research literature. David and Paul presented to their doctors with symptoms of depression which is a known long-term impact of male CSA (Alaggia & Millington, 2008; Easton et al., 2013a). As well as depression, Paul stressed that his drinking had become problematic, and this prompted him to seek help. Excessive alcohol consumption was also an issue for Tony and precipitated aggressive and violent behaviour.

Steever et al. (2001) noted that the most common presenting problems for male CSA survivors seeking therapy are marital problems, depression, PTSD, relationship difficulties and substance misuse. The men in this study did not specify whether they had a diagnosis of PTSD. However, it is recognised that childhood abuse, whether a single or repeated event, can lead to development of PTSD (NICE, 2017). Further, symptomatology associated with PTSD includes *'re-experiencing, avoidance, hyperarousal (including hypervigilance, anger and irritability), negative alterations in mood and thinking, emotional numbing, dissociation, emotional dysregulation,*

interpersonal difficulties or problems in relationships' (NICE, 2017:49:50). Accordingly, it could be reasonably suggested that the men in this study could meet the diagnostic criteria for PTSD based on the symptoms they described in their research interviews.

Attention has previously been paid to anger. Anger issues were a notable residual effect of CSA documented in the male CSA literature (Alaggia & Millington, 2008; Lisak, Dorahy & Clearwater, 2012). Lisak (1994) found that for male CSA survivors, anger can be expressed in a multitude of ways such as interpersonal aggression, physical violence and hypersensitivity to perceived insults or threats. As previously discussed in this chapter, there were a number of examples of these manifestations of anger articulated by the men in this study. For instance, Paul stated that there were periods in his life where he could have killed the first person that he came in to contact with. Tony stated that his anger was hard to control and shared with his doctor that he had threatened to kill people. Additionally, Andrew's anger caused him to self-harm. Externalising behaviour such as aggression and substance misuse are commonly reported in men who have been sexually abused, compared with women (Crowder, 1995; Alaggia & Millington, 2008; Easton et al., 2015). Crowder (1995) suggests that the difference is likely to be due to it being culturally and socially acceptable for men to express anger, as opposed to emotions such as sadness and fear.

Dorahy and Clearwater (2012) reported that men in their research felt that their experience of abuse intruded on their life resulting in severe emotional pain, causing many men to experience suicidal ideation or self-harm. Andrew discussed self-harm and explained that when he is in *'pain'* he would cut his arms, punch walls, and slice his hands. Andrew and Tony both described their experience when they made a plan to end their life by suicide when they were adolescents; Andrew was 14 and Tony was 17. Tony experienced suicidal thoughts for a number of years as a younger man, and Andrew continued to battle suicidal thoughts throughout his adult life. Research found that there is a correlation between CSA and suicide attempts in adolescent and adult men (Molner et al., 2001; Brezo et al., 2008; Easton et al., 2013). Andrew credited counselling as something which helped him with suicidal ideation.

> *I think without them* [counsellor and ISVA] *I would have killed myself a long time ago.* (Andrew, p11)

Self-blame featured extensively throughout the literature on male CSA in the context of being a barrier to disclosure and a long-term impact of sexual abuse (Lisak, 1994; Gill & Tutty, 1999; Sorsoli et al., 2008; Easton et al. 2014; Easton et al., 2015; Grossman et al., 2016). David was the only participant to discuss self-blame. As well as blaming himself for the sexual abuse he experienced from his family, he blamed himself for his marriage breakdowns. However, David was unequivocal when explaining that therapy has helped him to no longer harbour feelings of self-blame.

> *I can't explain how much it's helped me really, it just made me feel good about myself, that it wasn't my fault.* (David, p.4)

David also articulated that he always blamed himself for the bad things that happened, and continued to happen, in his life. However, he stressed that his counsellor helped him to *'rationalise'* these feeling which led him to no longer blame himself. This was reflected in a study on men's experiences of group therapy for CSA. It was reported that the men started to understand the relationship between their childhood experience and their current issues, as opposed to thinking that they were inherently flawed or to blame for their problems (Rapsey et al., 2020).

In Chapter Five, the men's experiences of blocked and denied memories were analysed in relation to person centred and psychoanalytic theory. The research literature on male CSA reported that men experienced a lack of cognitive awareness and compartmentalised the abuse. In addition, some men reported that they had completely repressed the abuse memories (Sorsoli et al., 2008), whilst Gagnier and Collin-Vezina's (2016) found that men repressed certain elements of their CSA experience. David also used the term *'repressed'* when explaining how he had no memories of certain aspects of his childhood. As previously noted, all the men in this study described memory problems. Andrew sounded distressed as he recounted: '*I just can't understand why I don't remember my whole life.'* This was also identified in Lisak's (1994) study when men reported that they felt they had lost whole periods of their lives due to repressed memories that they were still unable to recover.

It was apparent that one of the main motivators expressed by the men, when it came to taking part in this research, was altruism. All the men stressed that they either wanted to help other men who have not yet reached out for support, or they wanted to help the services which supported male clients to better understand what helps men in their recovery. When asked what he would say to a man seeking support for sexual abuse, David urged men to '*come and talk'* and that he guaranteed that they will feel better for it. Altruistic activities, including helping vulnerable people, have been associated with *'meaning making'* and '*making sense*' of an abuse experience in resilient male survivors of CSA (Grossman et al., 2006).

Finally, men fearing that they will be perceived as a perpetrator of sexual abuse if people are aware of their abuse history appears to be a prominent fear for men, compared to women, in the research literature (Lisak, 1994; Perez-Fuentes et al., 2013; Easton, 2014; Collin Vezina, 2016). This issue was raised by Tony and David in this study. David stressed that he has *'a choice,'* and does not have to *'do that'* just because it happened to him. His concerns appeared to be perpetuated by societal myths about men going on to abuse others (Salter et al., 2003). Tony felt that women probably looked at him as a potential perpetrator and appeared to harbour some of these misconceptions when he stated that men *'turn into one of them'* because it is harder for them to share their experience of CSA.

Summary

In summary, the argument around the need for routine questioning about CSA was reinforced due to the men's experiences of disclosing to their GP. Disclosure to their GP was found to pave the way for seeking therapeutic support for CSA. The men's experiences of their first encounter with their therapist was discussed and the concerns around working with a counsellor who shared the same gender as their abuser were echoed by each of the men in the study. The helpful aspects of the therapeutic relationship were outlined, and it was found that listening and being non-judgemental facilitated trust. The role of attachment in the therapeutic relationship was significant and it was argued that a therapist can act as a secure base for the men, specifically when revisiting the pain and anguish often associated with the abuse. The

long-term effects associated with the men's experiences included depression, alcohol misuse, relationship problems, self-harm, and suicidality. Overall, the men found specialist counselling beneficial, as it allowed them to open up about their experiences for the first time.

Chapter Seven: Conclusion

Introduction

This qualitative study has used a narrative methodology to explore the counselling experiences of four men who received counselling for their experience of CSA. The study pays particular attention to the barriers that the men experienced in accessing counselling for CSA; what the men found helpful or unhelpful about their therapy; and the qualities and aspects of the counsellor which facilitated a positive therapeutic relationship. As well as addressing the aims of the study, what also emerged from the men's narratives were their accounts of how the sexual abuse has impacted their lives; physically, emotionally, and relationally. In addition, the men described their experiences of disclosure to professionals and their wider social network. Finally, another unexpected outcome of the study was that the men shared their positive and negative experiences with health and mental health professionals across the life course, and they described the impact this had on their ability to seek support for the lasting long-term effects of CSA.

This study offers a rich and in-depth analysis of each individual story, followed by an analysis and synthesis of similarities across the four narratives. Finally, this study provided a discussion on where the narratives can be situated in relation to the wider research literature on CSA. As well as strengthening the body of knowledge on the impact and disclosure experiences of men, these detailed narrative accounts have provided the first known academic study on men's experiences of counselling for child sexual abuse.

There were three notable findings across the four narratives that were uncovered in this research:

- The men's experiences with health and mental health professionals.
- The significance of the mother figure.
- The research dance: My focus of their experiences of counselling for CSA, their focus on wanting to tell their story of CSA.

Overview

It emerged that all the men in this study were referred to a specialist service for counselling for CSA by their GP. Three of the men disclosed their experience to their GP and one of the men was asked directly about his abuse history by his GP. Prior to their referrals to specialist support services being completed, the men had not known where to turn to for support or that specialist services helping men even existed. Some of the psychological and behavioural effects of CSA reported by the men included anger, depression, anxiety, violent thoughts, low self-worth, self-blame, embarrassment, problems in forming and maintaining relationships, fear of men, anger towards men, self-harm, suicidality, alcohol misuse and repressed memories. Previous to the disclosures to the GP, three of the men had been referred to mental health services and CSA had not been explored. Further, for three out of the four men, their disclosures to the GP coincided with a period of increased media coverage of high profile, non-recent, CSA cases. In the wake of allegations towards high profile celebrities, the men became increasingly distressed.

The men described the counsellor's skills in listening, unconditionally accepting and offering non-judgmental responses as being a fundamental feature of their counselling being helpful. Three of the men experienced a lack of maternal support as children. In the CSA literature the lack of such support was attributed to mental health problems experienced by men. It appeared that the therapeutic alliance with the counsellor offered a nurturing relationship, and could have been experienced by the men as a re-enactment of a more positive maternal relationship. It was important for the men to feel safe and guided in talking about their childhood, without the sessions being directed towards the CSA experience.

This study aimed to explore the counselling and support experiences of men who were sexually abused in childhood. Despite this being the focus of the research interview, all of the men directed the interview towards their childhood experiences. The men described their experiences as boys; including their experience of sexual abuse, their family life, and the bullying they experienced by peers and those in authority. Two of the men talked about their attempts at disclosure as a young person and they described the negative reactions they received, which had a subsequent impact on future disclosures of their experiences. When discussing their childhood experiences,

their mother featured heavily in their narratives. Tony had a mother who could not take care of him, and he was sent to live with grandparents. David was abused by his mother and was desperate to retrieve a good memory of his mother in counselling. Paul disclosed the abuse to his mother and was not believed and finally Andrew talked very fondly of his mother, who is now deceased, and shared that he did not tell her about his experience of CSA for fear of upsetting her.

Implications and recommendations

The experiences of the men in this study have highlighted an increasing need to improve service provision for men who experienced sexual abuse in childhood. The men in this study discussed how they felt it was easier for women to access support and how they were not aware that services were available for men. This emphasises the need for greater transparency from sexual abuse support services and for a heightened promotion of inclusivity towards male survivors of CSA. As there are limited services that offer therapeutic support exclusively to men, there is also a need for specialist male services and for policy makers to adopt a clear strategy on how to support male survivors of CSA. A notable finding of this study, was that the men did not have support as children and they struggled with the lasting effects on CSA for decades. This highlights a need for early intervention to support boys affected by CSA.

There was some debate in the research literature regarding routine questioning from healthcare professionals, and how this could help to facilitate disclosure by unburdening men of carrying the weight of a secret; particularly men who present with issues consistent with an abuse history (for example see Chapter Two). This study supports the notion of routine questioning, as each of the men told of how they were not able to access support until they were older, despite three of the four men being in contact with mental health services in the past. The main reasoning behind the delay in accessing support was due to how difficult it was to disclose and how the men were unable to attribute their emotional distress to their experience of CSA. Only one of the men was asked about their experience directly by their GP, as a result of his presenting issues. This participant has been in contact with psychiatric services for decades and described numerous negative experiences of mental health care professionals. The GP asking him about whether he had been sexual abused led to his referral to a

specialist service, which he described as being helpful and he stated that he would *'probably not be here'* if it was not for his support from the counsellor at that sexual abuse service.

As three of the men described experiences from health and mental healthcare professionals, such as negative reactions to disclosure, not being believed and being threatened with being '*locked away*,' there is a need for a framework of sensitive practice to be developed for professionals. A central theme of prior research with survivors of CSA, which has been mirrored in this study, is around the importance of helpful responses to disclosure and the significance of ongoing support following disclosure. However, the research on mental health professionals' experiences of working with CSA survivors noted that professionals are often unequipped to work with survivors of abuse, as they do not feel comfortable, competent, or supported. Further, professionals can sometimes be reluctant to recognise that boys and men are also victims of abuse. They will often not enquire about a history of sexual abuse, as they fear that they will retraumatise an individual. Such a framework could help to guide healthcare professionals in how to recognise signs that a man might have experienced CSA, how to ask questions appropriately to promote disclosure and, finally, how to respond to disclosures of male CSA survivors sensitively and professionally. A framework could help to promote awareness around male CSA being a common occurrence and support professionals in how to respond in a helpful way. There is also an argument to suggest that counsellors should have additional training on male CSA and the associated issues. As there are few specialist services available to men, it is likely that non-specialised counsellors, as well as other professionals, will come into contact with male clients who have experienced CSA; particularly as men will often present with other issues. Therefore, a competency framework which identifies the essential knowledge and skills needed to work with male survivors is needed. This could be incorporated into counselling training or continuing professional development. This study highlights the need for counsellors to have a range of core competencies to work with male CSA survivors. A similar competence framework has been developed in the context of therapeutic work with domestic abuse survivors, developed from research on a client informed domestic violence counselling model (Roddy & Gabriel, 2022).

This study has also acknowledged that healthcare professionals such as GPs, need to have comprehensive knowledge on appropriate third sector specialist services to refer or signpost men to, and they need to have knowledge around the referral processes. The latter being essential, as one of the participants recounted being advised by a GP to report the abuse to the police in order to access specialist services. As the perpetrator was deceased, and no further action could be taken by the police, the participant went through an arguably unnecessary and distressing experience of a police interview. This could have been avoided if the GP has greater knowledge of the referral pathway and had been aware that police reporting is not necessary when it comes to accessing specialist sexual abuse services.

It was identified that alcohol misuse can be a common coping mechanism for men who have experienced sexual abuse, and this was true for two of the men in this research. Routine questioning has been advocated in healthcare settings, when men present with symptoms associated with CSA. GPs should also be mindful that men presenting with substance misuse issues could be an indicator of CSA. Furthermore, it could be beneficial for alcohol and substance misuse recovery services to explore abuse histories with male service users. It could also be recommended that alcohol recovery services, health services and sexual abuse support services offer a more joined up approach when it comes to working with men affected by CSA. As alcohol is often used as a vehicle for men to deny and dissociate from abuse memories, specialist counselling could be offered in conjunction with other detox and recovery programmes. Similar to the recommendations suggested for GP and healthcare providers, alcohol recovery services should also have an in-depth knowledge of how to signpost male survivors to specialist support services.

The men discussed how they became increasingly distressed around the time that there was heightened media coverage about CSA, during the period that accusations emerged about Jimmy Savile and Rolf Harris. One of the men stated that during this period he was no longer able to '*keep the lid on the box'* and went to his GP for support, as he was drinking heavily. Another participant struggled with the societal reactions to

these events; in particular, when he heard people questioning why survivors come forward to report later in life. When gleaning recommendations from the participants who contributed to this study, one of the participants advised that support services should be publicised by media outlets when the topic is centred around sexual abuse. This particular participant raised concerns about how the act of sexual abuse is generally discussed in detail, but the support available to survivors often does not feature in the media. In light of these findings, it is essential that during periods of increased media coverage, there should be a focus on enhanced support for survivors of CSA. As well as services being supported to increase their capacity, the media outlets should highlight how men can access support and routine questioning by healthcare professionals should be encouraged.

All the men in this study discussed a preference for working with a female counsellor. The men expressed a lack of trust towards male professionals. Two of the men talked about how a male counsellor would have reminded them of their abuser and they explained that they would have walked out of their initial session if made to have a male worker. As well as experiencing this preference in the context of counselling, the men discussed their negative experiences with male health and social care workers, and the anger and anxiety that having a male worker has caused them in the past. With this in mind, it is incumbent upon counselling services to not only offer a choice in terms of gender preferences, but to also offer transparency when it comes to the gender of the therapist that they will be working with. This could potentially help to ease anxiety before men arrive at the service for their first appointment.

The findings from this study, and the wider research on male CSA, highlighted that relationship problems are common. As with the recommendations for GPs and recovery services, when men present to counselling with relationship difficulties it could be helpful to explore men's childhood experiences to gauge whether they have experienced CSA. Further, the lasting effects of CSA evidently have a wider impact on the family and those around the survivor. As such, the intimate partners and/or children of male CSA survivors should also have the opportunity to access support related to the impact of CSA. This suggests that systemic or relationship therapy could be beneficial. Particularly, as two of the participants blamed the impact of CSA on marriage breakdowns. In addition, one of the participants discussed how being able

to finally disclose and talk to his adult daughters about his CSA experience meant that they were finally able to understand the behaviours he displayed during their childhoods.

The fact that the counsellors supporting the men in this study were equipped and knowledgeable in working with CSA survivors appeared to be essential in the therapeutic exchange being helpful. Additionally, the therapist not being '*shocked'* by their disclosure was also an important aspect of the men's ability to share their experience. As two of the men had previous encounters with a non-specialist therapist, before engaging in specialist support, it could be recommended that all counsellors receive some basic training on the impact of male CSA.

In terms of how narrative re-storying influences practice, this study has evidenced that survivors often want their stories to be heard. Furthermore, by listening to these stories, practitioners can reflect on how their skills and interactions with male survivors can have a profound impact on their experiences of support. For me, as a counsellor and researcher working with male survivors, the research has reaffirmed how influential counselling can be in all aspects of an individual's life. Following the submission of this thesis, I was asked to consider how narrative re-storying influences practice outcomes. However, my personal philosophy is that counselling is a process, as opposed to a vehicle to produce outcomes. The men in this study narrated a process. This process began before support seeking was an option they had considered possible. This process then proceeded to the assessment stage of therapy, which caused them a significant amount of distress, combined with relief that they were being heard and believed. Following this, the men shared their stories of their first encounter with a therapist and the subsequent weeks as they started to build trust with their counsellor and notice changes in their everyday lives and relationships. As demonstrated by the men in this study, the process of support seeking is often a fluid and ongoing process across the life course and it might be that some of the men who found therapy to be beneficial could well re-engage with this support in the future.

Original contribution to knowledge

As this study has explored a significantly under-researched topic, the findings make several original contributions to knowledge which will be discussed in relation to research, practice implications and education.

Research

This is the first research study conducted in the UK on the experiences of counselling and support from the perspective of male survivors of CSA. As well as providing the counselling and healthcare professions with a unique insight of male survivors' experiences, it also portrays the consequences of negative experiences. As male CSA is often underreported, it is anticipated that this study will highlight the barriers that men can face when trying to disclose or access support. In turn, improvements can hopefully be made to increase awareness of male CSA and services developed that can better support men and boys.

Post-doctoral studies

From this study is evident that further research is needed. For example, more studies from the service user perspective will help to establish a substantial body of evidence of the needs of men who have experienced CSA. In addition, a more nuanced study about what specific aspects of therapy, albeit specialised or not, made a difference to men who have been abused as these initiatives and/or skills could be integrated into a framework for practice. Finally, research on gender issues relating to the therapist and client encounter when exploring sensitive topics could be useful for services providing support for those seeking help.

Practice

The findings of this study suggest that specialist counselling services for male CSA are not only effective but can have a positive impact on many aspects of their lives. Such positive aspects include reducing negative coping strategies such as alcohol misuse and self-harm; and improve interpersonal relationships and self-confidence, while reducing feelings of self-blame.

This study has demonstrated how the use of a narrative approach in research can evoke rich and in-depth descriptions of lived experience. The focus of the research was the experiences of survivors of CSA of counselling and support. However, as a

result of the unstructured nature of the interview process, this study has highlighted the importance of hearing the often complex and nuanced stories of male survivors of CSA. It is only by hearing a men's stories, their whole story, that healthcare provisions will be able to offer appropriate approaches and compassionate treatments.

This study has also identified a number of barriers faced by men when it comes to accessing support, for instance the lack of knowledge and awareness around service provision experience by survivors and professionals alike, and the men's discomfort around working with male professionals. It is anticipated that this knowledge can help to inform health services and specialist CSA support services about improvements that could be made to make services more inclusive to male survivors.

Education

As there is a dearth of research on the perspectives of male survivors' experiences of counselling, this study will help to inform therapists of men's experiences of therapy; in particular, their experience of accessing support, the process of therapy, the significance of the therapeutic relationship and the skills and attributes of the counsellor they found helpful. These insights could also help to inform the education and training provided to counsellors and other health professionals working with male CSA survivors. As well as contributing to the understanding of counselling, this study has emphasised the significant role that health professionals, such as GPs, play in promoting disclosure. It has also evidenced that professionals can be influential in male survivors accessing support.

This study has shared first-hand accounts of male survivors' experience of CSA and therapy, in an accessible way. It is hoped that male survivors, who are experiencing mental health problems and have not yet accessed support, will feel less alone by the stories of the four men presented in this thesis, and will be encouraged to reach out for help.

Limitations

As discussed at the end of Chapter Two, the lack of a qualitative appraisal tool was a limitation of the literature review, as it could have helped in assessing the quality of each of the research papers included in the review. However, during the review

process, each paper that addressed the inclusion criteria was critically appraised using the approach described in chapter two, pages 83/4.

This study was confined to a small sample size of four men. Though the number is small, this study has provided a unique insight into the support experiences of male survivors of CSA. Recruitment was challenging, as many specialist third sector services did not respond to my contact or they advised that they did not permit researchers to conduct interviews with their clients or former clients, due to the potential for re-traumatisation. I contacted a number of non-specialist counselling services. One particular national service advised that they could not advertise a research study about sexual abuse in public areas, as they often had children in these spaces, and they felt it was inappropriate. Furthermore, as highlighted in the literature review, the narratives of the four men are retrospective of their experiences.

A further limitation is the absence of service user involvement in the planning, design and recruitment stages of this study. As acknowledged throughout, male CSA is a sensitive topic and one that is significantly under disclosed and it is therefore difficult to gain access to this participant group. Consulting with men who have experienced CSA, around the design of the study may have added to the challenges of reaching this group. Further, involving male survivors in the recruitment process could have prevented potential participants coming forward to share their own stories of the counselling process due to fear of compromised confidentiality. One of the major challenges, when it came to recruiting participants from specialist services, was staff acting as gatekeepers and refusing to allow me to pass on information about the study. Therefore, the process of service user involvement may have added another layer of gatekeeping and people becoming paternalistic about what can and cannot be discussed with men who have experienced CSA. In terms of the ethical implications, exposing service users to the details of the proposed study had the potential to cause distress and re-traumatisation. The use of a narrative approach, including unstructured interviews, helped to ensure that the participants involved in this study guided the research process throughout.

Further research

One of the notable themes in this research was that the men wanted to discuss their childhood experiences of CSA. As this study has evidenced that sharing experiences can be healing, further research on men's experiences of CSA could help to elucidate an area of inquiry which is significantly underdeveloped. It was also noted that there is a lack of research on how the gender of a therapist can impact on therapeutic outcomes.

As some of the men struggled with relationship issues, it was apparent that there is a lack of research evidence on the experiences of the partners and family of male CSA survivors. The findings from research in this area could help to inform and guide relationship and systemic therapists working with male survivors of CSA and their families.

From this study, it has transpired that both men and professionals have been unclear that sexual abuse support services and rape crisis centres also support men. Therefore, there is a significant need for a national mapping exercise assessing the landscape of sexual abuse support services in the UK that will support males. A report of this nature could be a valuable resource for policy makers and health service planners, professionals and survivors alike.

Finally, I intend to disseminate the findings of this study to relevant organisations, conferences, and to submit a paper to an appropriate research journal for example 'Counselling and Psychotherapy Research,' 'International Journal of Mental health Nursing' and the 'Journal of Child Sexual Abuse.'

Reflecting on the research journey

I began this journey as a somewhat novice researcher and often felt overcome with the weight of responsibility to complete this thesis. As I navigated my way through the research language, I can now reflect on the learning and knowledge I have gained around research methods, academic writing, and critical thinking.

As a part time researcher, I felt disconnected from peers; particularly as I was the only student in my cohort working full time. Throughout my time completing this PhD, I

worked full time in sexual violence support services. Firstly, in a specialist counselling service supporting adult and child survivors of sexual abuse. I then took a full-time position working on a child sexual abuse inquiry/investigation. In this role, I supported adults sharing their experiences of sexual abuse in institutional contexts and I would often be present when individuals were sharing their experiences of child sexual abuse. As I was spending evenings and weekends working on this thesis, I found it difficult to separate work from my home life. During the earlier stages of writing, whilst immersing myself in the literature on child sexual abuse, it often felt overwhelming.

Recruitment for this study has been extremely challenging and this has mainly been due to some specialist services being paternalistic. In my experience working in third sector specialist services, I noticed a resistance towards academics and researchers. Researchers contacting the service would often be met with suspicion, and assumptions would be made about their lack of knowledge and expertise on working and communicating with their clients. Despite my reassurances that I was a qualified therapist, with extensive experience and training working with CSA survivors, I either did not receive a response or I was informed that researchers were not permitted to work with their clients in order to prevent re-traumatisation. After advertising my recruitment poster on social media, I had a number of men contact me stating that they wanted to share their experiences of CSA. Many of the men had received little or no support from services and therefore fell outside of the remit for this study, due to the aim of the research being to explore experiences of support services. Further, the ethical considerations around interviewing men that did not have support systems in place meant that I was unable to interview participants who had not received support. After reiterating the focus of the research, I signposted these men for further support. I felt disappointed that I was unable to interview the men and I started to recognise the significance of sharing stories of CSA.

Three of the men that came forward to participate in this research were slightly older than the intended age range of 25-45 years. Through discussion in supervision, and referring back to the literature on the age in which men often disclose CSA, discuss CSA in depth and access support, I determined that it was fairly unlikely that younger men would come forward to participate in the research. I felt disappointed and frustrated regarding the difficulties in recruiting participants through services.

Particularly, after talking to survivors who describe how sharing their stories and having their stories documented can be an empowering and healing process. Despite my disappointment, I feel proud that I have been able to provide rich and detailed accounts of the four narratives. The participants in this research trusted me enough to share their experiences and for this I feel very privileged, and I hope I honoured their stories.

The process of interviewing the men, who took part in this research, has been a valuable experience. I felt humbled to learn from the participants and hear about their first-hand experiences of receiving counselling and support. During the fairly early stages of the writing up process, the Coronavirus pandemic hit and this had a significant impact on my mental health. In addition, I no longer had the freedom of travelling to various locations for work and I conducted all of my therapy sessions with CSA survivors within my home environment; further blurring the boundaries between work, home and study. Despite the challenges, the 18 months spent narrating and analysing the stories of David, Paul, Tony and Andrew has been a remarkable learning experience for me. In addition, with support from my supervisors, my confidence as a researcher and writer has developed considerably. My confidence when enrolling on this PhD was fairly low. I have struggled to envisage completing this thesis, as I was battling with '*imposter syndrome'* and managing my work commitments, whilst writing this thesis. Although it has been challenging at times, I can now reflect on the progress I have made and how I have developed as a researcher and a practitioner.

Working with survivors of CSA has been a challenging yet extremely rewarding experience. I have been in awe of the courage and resilience of the men taking part in this research and of the survivors I have worked with and supported.

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Appendix 1 Table of Research Papers								
Author(s), year	**Country**	**Qualitative/Quantitative/Mixed**	**Method**	**No. Participants**	**Data Collection**	**Data Analysis**	**Findings**	**Limitations**
Lisak, 1994	USA	Qualitative	Content Analysis	26	Autobiographical interviews Questionnaires.	Content analysed to identify common psychological themes .	15 themes emerged: *Anger, Betrayal, Fear, Homosexuality issues, Helplessness, Isolation and alienation, Legitimacy, Loss, Masculinity issues, Negative childhood peer relations, Negative schemas about people, Negative schemas about self, Problems with sexuality, Self blame/guilt, Shame/humiliation.* Half of the men had at least one alcoholic or drug issues, inadequate/hypermasculine. Almost all of the men displayed problems with their sexuality. Self blame/guilt almost universal in the subjects.	Sample taken from 23 university students and 3 university employees. Only 6 interviews selected to identify themes.
Draucker & Petrovic, 1997	USA	Qualitative	Content Analysis	19	un-structured interviews with open-ended questions	Content analysed	Men described therapy as a journey and a therapist as the guide. 6 therapist traits they described as helpful were being	Overly focused on the positive experiences of therapy, participants not asked about

							informed about male sexual abuse issues, informing the client about the therapeutic process, being connected to the client, respecting the client's process, going the distance with the client, and letting the client go at the right time.	negative encounters with counsellors.
Gill & Tutty, 1998	Canada	Qualitative	Phenomenology	10	in depth interview	content analysis and member checking	male survivors struggle with disparity between sexual victimisation and social stereotypes of masculinity. Men also struggled with social sex role identity, no sexual orientation identity problems were disclosed but some found sexual contact threatening	Ideas around social sex role identity heavily influenced by Shively and DeCecco's model of social sex role identity which may have influenced findings. Each aspect of sexual identity has not been analysed in more depth
Gill, & Tutty, 1999	Canada	Qualitative	Phenomenology	10	In depth interviews	Content analysed	3 central themes 1) Society's refusal to accept the reality that men can be victims of sexual abuse 2) an impaired ability to form intimate relationships 3) an impaired ability to form intimate sexual relationships. All the	Men abused prior to 1980'S, age of men may have impact on their feelings around men and boys not being sexually abused/raped. Sample taken mainly from violent/abusive

							participants experienced shame about their abuse, connected their own failure to defend and protect themselves. 8 participants believed that they were constantly overtly and covertly told that men cannot be victims.	men towards partners.
Steever, Follette, & Naugle, 2001	USA	Quantitative	correlational	60	20 men who identified as experiencing CSA and 20 men who reported only noncoercive childhood sexual experiences by peers.	ANOVA comparing the average age between groups. ANCOVA analysis used to determine differences between groups and number of sexual partners. Chi Square analysis to determine gender of perpetrator for group CSA	men who self-identified as survivors of CSA reported nearly twice the level of psychological distress, and were twice as likely to have utilised mental health services as the 2 other groups.	Relatively small sample size, symptoms measures only focused on aggression and substance misuse. Considerable age differences between groups which may affect comparability. Subject recruitment was completed more quickly when financial rewards were given for participants time which may have influenced findings.
Grossman, Sorsoli & Kia-	USA	Qualitative	Content Analysis	16	In depth semi-	analysed using set of codes based	meaning making was established through developing a	resilient men recruited, authors interpretation of

Keating, 2006					structured interviews	on women's narratives, revised to reflect the literature around men's experiences, coded for 40 variables	framework to understand motives of the abuser. Meaning making styles established through therapy and some men made meaning through spirituality	resilient was men that have not abused others and function well in only one area of life.
Romano & De Luca, 2006	Canada	Quantitative	multiple baseline approach	5	clinical interviews, therapy sessions video taped, self-report questionnaires	Data was visually inspected to examine if clinically significant decreases in self-blame, anger and anxiety had occurred following treatment	Most participants experienced significant reduction in self blame, anger and anxiety following their involvement in a sexual abuse treatment programme. Treatment was particularly helpful in decreasing self blame and anger.	small sample size. Self report measures used rather than a more objective view of treatment effectiveness.
Alaggia, & Millington, 2008	Canada	Qualitative	Phenomenology	14	in depth interviews (data generated using Long-Interview Method which is an inductive heuristic method)	Phenomenological reduction Transcendental (descriptive) and hermeneutical (interpretive) analysis	4 themes based on the experiences as children: denial, early sexualisation, confusion around role and responsibility in the abuse, specialness. Themes around making meaning as adults included: anger and rage, loss and hope, sexual disturbance and ambivalence	small sample size, mainly clinical population, retrospective design may mean that memories and recollection are distorted.

Sorsoli, Kia-Keating & Grossman, 2008	USA	Qualitative	Grounded Theory	16	2 in depth semi structured interviews. Interview protocol was based on prior work with female survivors.	Grounded theory approach to coding and the use of conceptually clustered matrices. Checked emerging patterns across cases.	The men shared few positive experiences of disclosure. The barriers to disclosure operating were: a) personal b) relational and c) sociocultural. Several distinct types of personal obstacles to disclosure, including: lack of cognitive awareness, intentional avoidance, difficulty approaching the topic, emotional readiness and safety and shame. to experience victimisation.	Participants recruited on the basis that they are doing relatively well in at least one area of life e.g. work/relationships . Study only recruited participants abused by care givers. Pre-empts that abuse by perps that have ongoing relationships with victims is more psychologically harmful than abuse perpetrated by strangers. self-selection into a study about sexual abuse has an impact on findings about disclosure.
O'Leary, 2009	Australia	Quantitative	Community survey	147	questionnaires	Chi square analysis. Correlation analysis was conducted to identify coping strategies associated on the GHQ. 3 logistic regressions	Coping strategies associated with better functioning were positive reinterpretation and growth and seeking social support. Strategies associated with a clinical outcome were themed around	All men in the primary sample had sought help and self-defined the trauma as sexual abuse. Therefore, they may be more likely to report psychological problems.

						were conducted to construct explanatory models to examine the variance in GHQ threshold scores.	internalisation and acceptance and disengagement. Findings reinforce that the importance that practitioners being aware that men's psychiatric symptoms may be attributed to past csa.	Retrospective self-reports relied on men's recall of abuse, Accuracy of recolections may be compromised, as the abuse had happened decades earlier. It has been reported that only a small number of sexual abused adult men seek help, therefore, the study is unlikely to be representative of all men that have experienced case.
Kia-Keating, Sorsoli & Grossman, 2010	USA	Qualitative	Grounded Theory	16	semi structured interviews	coded using grounded theory approach	positive adaption mechanisms included: engaging in safe relationships, locating a community of others with shared experiences, learning healthy ways to manage relationships through setting boundaries and controlling anger, building trust, developing intimacy and achieving acceptance.	sample recruited on the basis of functioning well and only recruited through trauma focused therapists

Hovey, Stalker, Schachter & Lasiuk, 2011	Canada	Qualitative	Grounded Theory and Action Research Methods	49 (interview) 8 (group)	interviews and group discussions analysed transcripts of interviews used to stimulate group discussion of survivors and nurses and survivors, physicians and survivors and nurse practitioners.	interviews analysed for themes. Themes extracted from interviews then used to stimulate group discussion between survivors and health professionals	unique aspects of healthcare interactions specific to men included being perceived as a weak and vulnerable victim and being perceived as a perpetrator. Participants believed that routine enquiry into CSA history should take place in health care settings. Discomfort around health care worker being same gender as perpetrator and homophobia was found to be experienced by men.	recommendations for sensitive practice aimed at healthcare workers, rather than psychotherapists.
Dorahy, & Clearwater, 2012	New Zealand	Qualitative	IPA	7	Questionnaires. Semi-structured focus group interview. Focus group was audio recorded and transcribes verbatim. Participants were involved in a weekly support group.	IPA	4 superordinate themes emerged: *Self as Shame, Pervasiveness of power of doubt and denial, uncontrollability, Dissociation.*	Study limited to a single focus group of 7 men. In addition, all men were support-seeking and therefore, more willing to talk about their experiences of abuse than non-support-seeking men. Participants had had opportunities since the abuse to talk about their

								experiences in counselling and support groups. The use of focus groups may have limited the depth to which the construct of shame was fully explored due to the fact that shame often motivates the desire to avoid. Group dynamics could affect findings.
Easton, 2013	USA	Quantitative	Cross sectional survey design, Lifespan approach	487	anonymous, internet-based survey during 8 week period	SPSS 19.0	on average men delayed disclosing abuse for an until average 21.38 years and avoided discussing the abuse until average 28.23 years Most participants who told someone during childhood did not receive emotional, supportive and helpful responses across the lifespan. Several variable including timing of disclosure, discussing with spouse and response to disclosure had an	Sample bias that limits the generalisability of the results. The inclusion criteria that required participants to have internet access and be proficient in the English language

							impact on current mental health problems.	
Easton, Coohey, Rhodes & Moorthy, 2013	USA	Quantitative	multiple linear regression, Life course history	487	Online survey	Multivariate regression analysis (ordinary least squares)	men who had a better understanding of the sexual abuse experience, who ascribed to less traditional masculine norms and who experienced a turning point reported greater posttraumatic growth. Practitioners can help survivors understand the meaning and impact of CSA on their lives and deconstruct rigid gender norms.	non representative despite being a large sample size for this particular group. Self selection bias. Majority of men recruited from survivor organisations. Data collected entirely from self reports.
Easton, Renner, & O'Leary, 2013.	USA	Quantitative	cross sectional survey design	487	surveys	Logistic regression. Analysis of survey data, recent suicide attempts served as dependant variable	results from logistic regression modelling found that 5 variables (duration of sexual abuse, use of force during sexual abuse, high conformality to masculine norms, level of depressive symptoms, and suicidal ideation) increased the odds of a suicide attempt in the past 12 months. To improve mental health services for men with histories of	memory distortions may reduce accuracy due to retrospective design. Most participants were members of survivor networks/organisations. Not representative sample. 61.5% of participants were abused by clergy, men abused by clergy may have

							CSA, practitioners should incorporate sexual abuse severity, current mental health, and adherence to masculine norms into assessment and treatment planning.	different experiences than men abused by others in position of power or family members.
Easton, Saltzman, & Willis, 2014	USA	Qualitative	Content Analysis	460	data collected from a single item of the 2010 Health and Wellbeing Survey	content analysed to identify descriptive codes that captured ideas based on the research question	10 categories of barriers to disclosure identified that were categorised into 3 domains: socio-political , interpersonal, and personal	responding to survey question did not allow for follow up questions to be asked. Support seeking men
Easton, Leone-Sheehan, Sophis, & Willis, 2015	USA	Qualitative	Content Analysis	250	data collected from a single item of the 2010 Health and Wellbeing Survey	content analysed, secondary analysis of a single item that was included in the 2010 Health and Wellbeing survey	turning points identified included: professional and group support, personal relationships, cognitive realisation, and spiritual transformation	limited to one question that did not allow for further prompting or clarification
Gagnier & Collin-Vezina, 2016	Canada	Qualitative	Phenomenology ad Interpretive description	17	transcripts of telephone interviews	each transcript read separately, a preliminary coding structure was	positive and negative responses to disclosure were experienced. Majority of men waited until adulthood to disclose,	small sample size. Support seeking men and therefore more willing to disclose experiences of

						then established using a combination of descriptive and emotion coding	negative stereotype contributed to their delay in disclosure	disclosure. Member checking not used
Ressel, Lyons, &.Romano, 2018	Canada	Quantitative	Data were drawn from a larger study on male CSA conducted by the Children's Well-Being Laboratory at the University of Ottawa (Ottawa, Ontario, Canada).	46	Anonymous online survey	Descriptive statistics were calculated for all variables. Conducted correlational analyses to examine the associations among resilience (as assessed through the CD-RISC 10) and the three domains of functioning assessed through the ASR. Analyses were conducted using SPSS version 23.0.	Findings indicated that males tended to experience severe CSA, including early age of onset, invasive sexual acts and the use of perpetrator force. Males also reported the co-occurrence of other forms of childhood maltreatment and adversity, including parental conflict, neglect, physical abuse and emotional maltreatment. Finally, males reported lower rates of resilience on standardised measures, compared with adult community samples in North America.	Small sample size; purely quantitative analysis, which enabled the collection of information on a sensitive topic, but limited the richness of the collected data; the study relied on retrospective reports of childhood experiences, and thus may have been subject to recall inaccuracies.
Rapsey,., Campbell, Clearwater, &	New Zealand	Qualitative	IPA	9	3 semi structured interviews over 3 weeks	NVIVO	Seven participants reported benefiting from treatment. The interviews identified three superordinate	all participants were part of a support group for male survivors of sexual abuse and

Patterson, 2020							themes: “motivation to engage in treatment,” “developing a connection with treatment providers,” and “changing thinking about the abuse.” These themes reveal a number of obstacles that are encountered in seeking treatment including stigma, process barriers, and engagement of a skilled and empathic therapist.	therefore were actively receiving support. Furthermore, their participation in a peer support group may indicate a level of acceptance and willingness to tell their stories that many male survivors of sexual abuse are yet to experience. This group of participants were able to acknowledge their experiences as sexual abuse and disclose this is a group setting; many male survivors would find this difficult.
Nelson, 2009 (commissioned report)	UK (Scotland)	Qualitative	Life History	24	Two recorded interviews took place with 24 respondents, many using a ‘life grid’ to assist recall and aid rapport	Not reported	a quarter of survivors had been able to tell anybody about their abuse as a child. Most of these were disbelieved. Boys who reacted angrily and disruptively to abuse were usually simply punished or excluded from school. Fear of being	Commissioned report and not peer reviewed research.

							branded gay was particularly influential in silencing boys as children. Fear of being assumed an abuser often silenced them again as adults. Most struggled with confusion over issues of sexuality and masculinity. Most survivors were dissatisfied with mental health services which they felt over-medicated and ignored abuse issues. They greatly valued empathetic and knowledgeable staff.	

Appendix 2 Participant Recruitment Poster

WE NEED YOUR HELP….

Research Study

An exploration of what adult male survivors of childhood sexual abuse, who have experienced mental health problems, would have wanted from mental health services and non-statutory services to help maintain and improve their mental wellbeing.

If you are male and have received counselling from a mental health service or a specialist sexual abuse counselling organisation, we would like to hear about your experiences of accessing this support.

If you are interested in sharing your story we will invite you to participate in a 60 minute face to face interview. You will be fully anonymised and your information will remain completely confidential.

About the researcher: I am a student at the university of Salford studying PhD in counselling and Psychotherapy. I am a qualified counsellor and work with men, women, and children who have experienced sexual abuse. If you are interested in being apart of this research or would like further information before making a decision please contact:

Laura Bennett - E-mail L.A.Bennett@salford.ac.uk

Appendix 3 Participant Invitation Letter

The University of Salford
School of Nursing, Midwifery,
Social Work
and Social Sciences
Salford
Lancashire
M54WT

Dear Client,

My name is Laura and I am doing a part time PhD at the University of Salford. My full time job is in counselling and I am interested in finding out what it is like for men who have experienced childhood sexual abuse to receive support and counselling. I would also like to discover what it was like to initially access that support and if you had any difficulties in finding or accessing support.

I am interested in hearing your stories about accessing support, as I believe it is important to hear about peoples' experiences so improvements can be made. You will be invited to share your experiences of what accessing support and counselling was like and what you found beneficial and/or what you did not find helpful.

The study will also allow a better understanding, as to the difficulties you may have faced in accessing support and what aspects of counselling you found particularly helpful. The hope is that mental health care and support services will be better prepared to meet the needs of men who have experienced child sexual abuse. In addition, it is hoped that the study will help other men who may be struggling with mental health problems feel more at ease to access help and support.

If you are a male aged 25-45 years old, have experienced childhood sexual abuse before the age of 18, and have accessed counselling support due to mental health problems then it would be lovely to hear from you. I will be able to discuss the research in more detail. If you are interested I will ask you to take part in a 60 minute interview, which with your permission will be audio-recorded. The interview will then be transcribed and analysed by myself and the anonymised results will be published as part of my thesis and other academic outputs.

If you are interested in finding out more about the study please contact me (the researcher) directly for further information.

Researcher's name: Laura Bennett
E-mail: L.A.Bennett@edu.salford.ac.uk
Tel: 07432699196

Appendix 4 Participant Information Sheet

PARTICIPANT INFORMATION SHEET

Title of study: An exploration of what adult male survivors of childhood sexual abuse (CSA), who have experienced mental health problems, would have wanted from mental health services and non-statutory services to help maintain and improve their mental wellbeing.

Name of Researcher: Laura Bennett

Invitation paragraph

We are trying to find out what it is like to receive support and counselling for men who have experienced childhood sexual abuse. We also want to discover what it was like to initially access that support and if you had any difficulties in finding or accessing support.

Before deciding if you would like to participate in the study, please take time to read the information below. If you require any further information or you have any questions then please do not hesitate to contact the researcher directly on the number provided at the end of this information sheet.

What is the purpose of the study?

- To conduct face to face interviews with men, who were sexually abused as children, and have experienced mental health problems.
- The researcher aims to explore what aspects of counselling and therapeutic support were helpful and what more could have been done to help improve mental health services and specialist support organisations.
- To find out what barriers you may have faced when accessing/finding support.
- To discover how you protected your mental health.
- To use the findings to inform and improve mental health care and specialist support services locally and nationally for those who experience mental health problems as a results of sexual abuse during childhood.
- To inform policy, guidance and practice for young males who are currently experiencing childhood sexual abuse.

Why have I been invited to take part?

The research is being undertaken to hear the voices of men who have experience of accessing support in relation to childhood sexual abuse. You will be invited to share your experiences of what it was like to receive counselling and what you found helpful/not helpful.

The study will also allow us to gain a better understanding and insight, as to the difficulties you may have faced in accessing support. The hope is that mental health care and support services can better accommodate the needs of men following on from this research study. In addition, it is hoped that the study will help other men who may be struggling with mental health problems.

Do I have to take part?

You do not have to take part in the study. If you decide that you do not wish to participate in the research then it will not affect your rights to access support from any voluntary/mental health care services.

What will happen to me if I take part?

- Before participating in the research you will be asked to read and sign a consent form. If you wish, the form can be read out and explained to you to ensure that you are clear as to what you are agreeing to.
- If you agree to be interviewed, yourself and the researcher will agree on a venue to meet. This will probably be at the service where you received your counselling, as it will be a confidential space where you will be able to talk freely.
- With your permission, the interview will be recorded. The audio recording is only used for the purpose of transcription and once the researcher has written the interview up, the audio recording will be destroyed.
- During the interview you will be asked to share your experiences and talk freely about the help and support you received. The researcher will also be interested in your views and beliefs about what was most helpful and what you feel could be improved.
- The interview will last approximately 60 minutes and what is said will remain confidential between you and the researcher, unless you disclose any illegal activities that you are involved in or if the researcher feels that you pose a serious risk to yourself or others. In this circumstance, the researcher has a duty to disclose to the relevant authorities.
- At the end of the interview, the audio recorder will be turned off and there will be some time at the end for you to discuss any aspects of the interview that may have found difficult or distressing. This discussion will not be included in the research study.
- You will be free to terminate the interview at any time. If you decided that you no longer wish to take part in the interview, the information you have given will be destroyed and not used in the research.

What happens after the interview?

- Once the interviews are complete, the recordings will be transcribed by the researcher.
- The researcher will then analyse what has been said by each person participating in the research and will also look across each transcript to see what the similarities and differences are.
- Once each transcript has been analysed, the researcher will then write up the information, which will form a dissertation.

Local travel costs, that you incur to travel to the venue of the interview, will be reimbursed by the researcher. It is advisable to retain any receipts for travel costs.

What are the possible disadvantages and risks of taking part?

It is not expected that there will be any disadvantages or risks to you during the interview. It is accepted that being interviewed may at times be upsetting. However, the interview will only focus on your experiences of support and mental health care services.

The researcher will set aside some time at the end of the interview to discuss anything you found uncomfortable or upsetting during the interview. At this point, the tape recorder will be switched off and will not form part of the research. If you feel that you require further support, the researcher will signpost you to where additional support can be accessed.

What are the possible benefits of taking part?

- The interviews will provide evidence as to whether receiving counselling and support from mental health services and specialist services has had a positive effect on people's mental wellbeing.
- To highlight how services can adapt and support men more effectively.
- By hearing the experiences from a male point of view, it is hoped that it may encourage other men to seek support.

What if there is a problem?

If you have any concerns, problems of complaints regarding the research you can contact the following people:
Dr Susan McAndrew (Research Supervisor)
Dr Anthony Hickey (Research Supervisor)
And, Anish Kurien (Research Centres Manager) G.08 Joule House Acton Square, University of Salford, M5 4WT
a.kurien@salford.ac.uk 0161 295 5276

Will me being part of the study remain confidential?

Participating in the study, or contacting the researcher to show an interest in participating, will remain completely confidential between yourself and the researcher. You will not be identified as taking part in the research and all information collected will be anonymised and kept confidential.

However, if you were to disclose to the researcher any illegal activity you are involved, or suggest serious harm/risk of harm to yourself or others, or disclose any child safeguarding concerns then the researcher has a duty to report these to the relevant authorities.

What will happen if I don't carry on with the study?

What if I decide that I don't want to take part in the research?

You are welcome to withdraw from the study at any time prior to the research interview and this will not affect your rights to access support from any services. Your details would then be destroyed and would not form any part of the research.

If you have already had the interview and change your mind about being in the research, you can withdraw from the study up to one week after the face to face interview takes place. The audio recording of the interview would then be destroyed and the results of the interview will not be written up or be mentioned in any publications.

What will happen to the results of the research study?

The results of the study will be published as part of a dissertation/thesis. The results may also be published in academic journals/publications. If you decide to take part in the study, you will not be recognisable and all information in the study will be fully anonymised.

Who is organising or sponsoring the research?

The study is organised by a research student at the University of Salford and has gone through ethical clearance with the University of Salford's Ethics Panel.

Further information and contact details:

The researcher can be contacted directly by e-mail or phone.

Name of researcher: Laura Bennett
L.A.Bennett@edu.salford.ac.uk
07720232983

Appendix 5 Consent Form

CONSENT FORM

Title of study: An exploration of what adult male survivors of childhood sexual abuse (CSA), who have experienced mental health problems, would have wanted from mental health services and non-statutory services to help maintain and improve their mental wellbeing.

Name of Researcher: Laura Bennett

Please complete and sign this form **after** you have read and understood the study information sheet. Read the statements below and yes or no, as applicable in the box on the right hand side.

1.	I confirm that I have read and understand the study information sheet version 1 dated 20/06/16, for the above study. I have had opportunity to consider the information and ask questions which have been answered satisfactorily.	Yes/No
2.	I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, and without my rights being affected.	Yes/No
3.	If I do decide to withdraw I understand that the information I have given, up to the point of withdrawal, may be used in the research. The timeframe for withdrawal is one week after the interview.	Yes/No
4.	I agree to participate by being interviewed.	Yes/No
5.	I understand that my personal details will be kept confidential and not revealed to people outside the research team. [If appropriate -However, I am aware that if I reveal anything related to criminal activity and/or something that is harmful to self or other, the researcher will have to share that information with the appropriate authorities.	Yes/No
6.	I understand that my anonymised data will be used in the (researcher's thesis/ research report) other academic publications and conferences presentations.	Yes/No
7.	I agree to take part in the study:	Yes/No

_____	_____	_____
Name of participant	**Date**	**Signature**

Appendix 6 Ethics Risk Assessment

Risk Assessment Form

All projects must include a risk assessment. If this summary assessment of the risk proves insignificant: i.e. answer no to all questions, no further action is necessary. However, if you identify risks you must identify the precautions you will put in place to control these.

Please answer the following questions.

1. What is the title of the project?

An exploration of what adult male survivors of childhood sexual abuse (CSA), who have experienced mental health problems, found beneficial or what they would have wanted from statutory and non-statutory mental health services to help maintain and improve their mental wellbeing.

2. Is the project purely literature based? NO

If YES, please go to the bottom of the assessment and sign where indicated. If NO, complete question 3 and then list your proposed controls.

3. Please highlight the risk/s which applies to your study

Hazards	Risks	If yes, consider what precautions will be taken to minimise risk and discuss with your Supervisor
Use of ionising or non ionising radiation	*Exposure to radiation YES/NO*	*Obtain copy of existing risk assessment from place of research and attach a copy to this risk assessment summary.*
Use of hazardous substances	*Exposure to harmful substances YES/NO*	*Obtain copy of existing risk assessment from place of research and attach a copy to this risk assessment summary.*
Use of face-to-face interviews *Interviewees could be upset by interview and become aggressive or violent toward researcher*	*Interviewing;* *Own classmates=Low risk* ***Yes/no*** *Other University students=Medium risk* ***Yes/no***	*NB. Greater precautions are required for medium & high risk activities* *Consider:* *How will contact with participants be made - i.e. do not give out personal mobile no., home number or home email, etc.* *Location of interviews – to be held in a safe environment, e.g University building, workplace* *What support will be available, i.e. will anyone else be available to assist if you call for help, etc. e.g.*

	Non-University personnel=High risk ***Yes/no***	*colleague knows where interview to take place and telephoned when completed and safe- what action to take after certain time if not phoned* *How to deal with aggressive/violent behaviour, what precautions will be taken to prevent this from happening?*
Use of face-to-face interviews *Participants or interviewees could become upset by interview and suffer psychological effects*	*YES/NO*	*Consider:* *What initial and subsequent support will be made available for participants or interviewees?* *What to do if researcher uncovers information regarding an illegal act?* *What/who will be used to counsel distressed participants/ interviewees, what precautions will be taken to prevent this from happening?*
Sensitive data	*Exposure to data or information which may cause upset or distress to Researcher YES/NO*	*Consider:* *What initial and subsequent support will be available to the researcher*
Physical activity	*Exposure to levels of excerption unsuitable for a individuals level of fitness*	*Consider:* *Health Questionnaire/ Medical declaration form / GP clearance.* *Trained First aid personnel/ Equipment.*
Equipment	*Exposure to faulty unfamiliar equipment.*	*Consider:* *Equipment is regularly checked and maintained as manufactures instructions.* *Operators receive adequate training in use of.* *Participants receive induction training prior to use.*
Sensitive issues i.e. Gender / Cultural e.g. when observing or dealing with undressed members of the opposite sex *Children*	*Exposure to vulnerable situations/ sensitive issues that may cause distress to interviewer or interviewee*	*Consider:* *Use of chaperones/ Translators.* *What initial and subsequent support will be made available for participants or interviewees?* *Adhere;* *to local guidelines and take advice from research supervisor*

Manual Handling Activities	*Exposure to a activity that could result in injury*	*Adapt the task to reduce or eliminate risk from manual handling activities. Ensure that participants understand and are capable of the manual handling task beforehand.* *Perform health questionnaire to determine participant fitness prior to recruitment*

If you have answered yes to any of the hazards in question 3, please list the proposed precautions below:

- Support will be put in place for participants who may become distressed during the interview.
- A short debrief time will be included at the end of each interview to allow the participant to talk about how he is feeling.
- Each participant will be given a list of where they can access support in the longer term should they require this.
- Participants will be recruited from support organisations and the location of the interview will be agreed between the participant and researcher in advance. It is aimed that all interviews to take place on organisational premises where there will be staff available that can assist in case of emergency.
- Participants will be assured that the collection, storage and use of data will only be used the purpose for which the participants consent has been given. There will be no un-authorised access, use or disclosure. The only exception to this would be if the participant discloses risk to self or to other, criminal activities or child safeguarding issues. At this point, it would be necessary to breech confidentiality. However, an attempt to seek participant's permission to do this would be sought wherever possible.
- With regard to the interviewer, the lone worker policy will be adhered to and where possible interviews will take place on organisational premises where there will be privacy, other members of staff within the building and a familiar venue for the participant.
- The interviewer will have access to clinical supervision during the research. Clinical supervision is an anonymised process in terms of clients and she will be able to discuss how the interviews may have impacted on her.

Signature of student…xxx……. Date……10/07/16……..

Signature of Supervisor …… Date ……..

Appendix 7 Ethics Approval Letter

21 September 2016

Dear Laura,

RE: ETHICS APPLICATION HSCR16/96 – An exploration of what adult male survivors of childhood sexual abuse (CSA), who have experienced mental health problems, found beneficial or what they would have wanted from statutory and non-statutory mental health services to help maintain and improve their mental wellbeing.

Based on the information you provided, I am pleased to inform you that application HSCR16/96 has been approved.

If there are any changes to the project and/ or its methodology, please inform the Panel as soon as possible by contacting Health-ResearchEthics@salford.ac.uk

Yours sincerely,

A Clark

Andrew Clark

Deputy Chair of the Research Ethics Panel

Research, Innovation and Academic Engagement Ethical Approval Panel

Research Centres Support Team G0.3 Joule House
University of Salford
M5 4WT

T +44(0)161 295 2280 www.salford.ac.uk/

Appendix 8 Outline for Interview

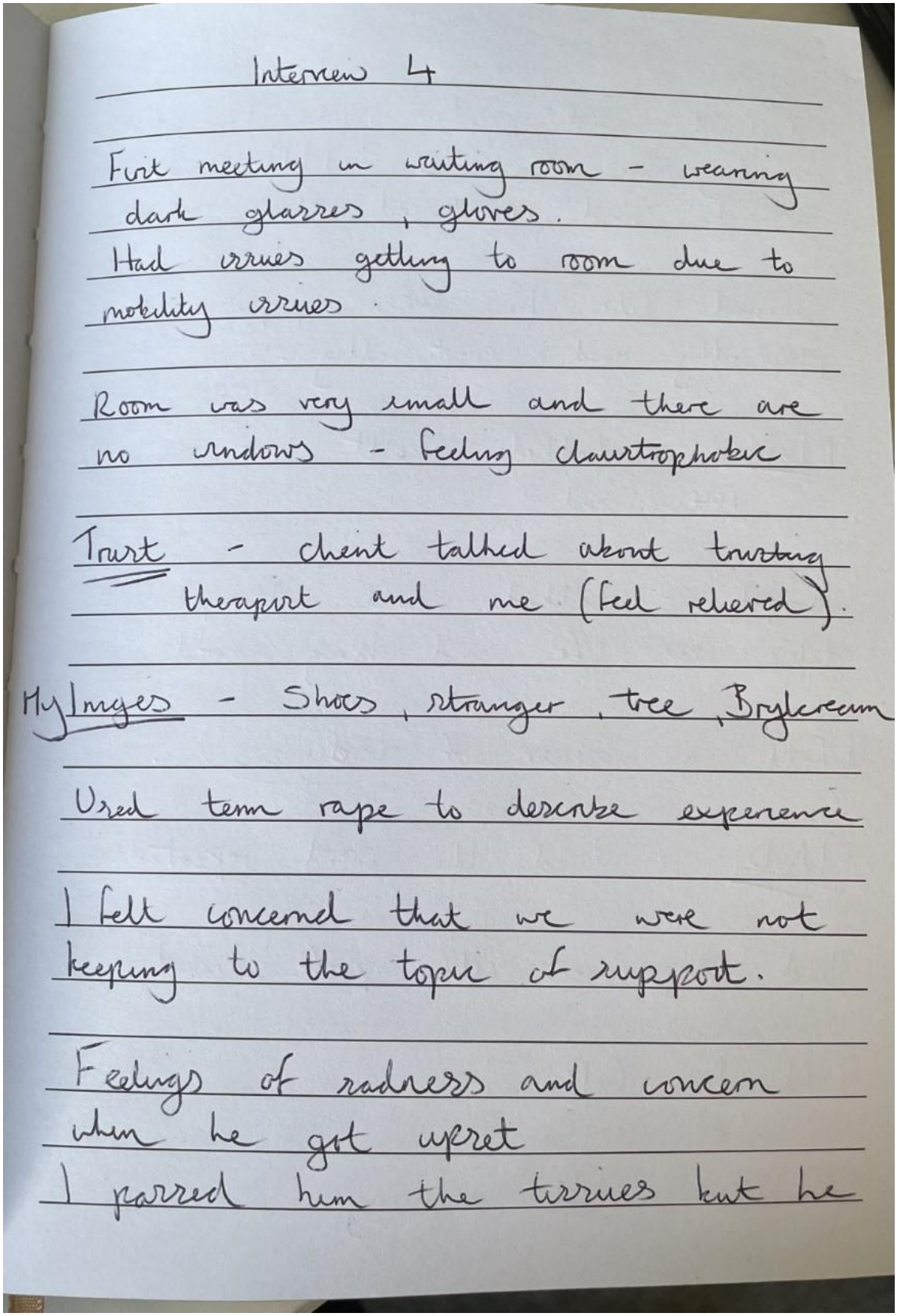
Outline for Interview

Participants will be given the topic: *What did you find most helpful when receiving counselling in relation to childhood sexual abuse?* This could be a 'starter question' or the participants can simply talk about 'the story of their counselling' from their decision to seek help to its end.

The area that the researcher will attempt to cover include:

- When were you first diagnosed with a mental health problem?
- Describe your experiences of what it was like to initially access counselling and support in relation to childhood sexual abuse.
- Your experiences of disclosing childhood sexual abuse to mental health professionals.
- Describe experiences of the counselling and support you received.
- What aspects of counselling do you think helped to improve your mental wellbeing?
- How would you describe the benefits and disadvantages of counselling?
- Has the counselling enabled you to have a better quality of life and if so, why?
- Has receiving counselling impacted other areas of your life?

Appendix 9 Extract of reflexive journal



Interview 4

First meeting in waiting room - wearing dark glasses, gloves.
Had issues getting to room due to mobility issues.

Room was very small and there are no windows - feeling claustrophobic

Trust - client talked about trusting therapist and me (feel relieved).

My Images - Shoes, stranger, tree, Brylcream

Used term rape to describe experience

I felt concerned that we were not keeping to the topic of support.

Feelings of sadness and concern when he got upset
I passed him the tissues but he

declined and pointed out the gloves reminding me of OCD - I felt embarrassed as he had mentioned this to me

Seemed like he was in pain - physically and emotionally.

Mum - talked about her a lot.
Attachment?

Angst - talked about attempt to take his life and being raped.

I felt a sense of loneliness.

MAD - Used the word repeatedly.

Bad experiences with professionals.

Told his GP.

Childlike - felt nurturing

I sense he felt heard and understood

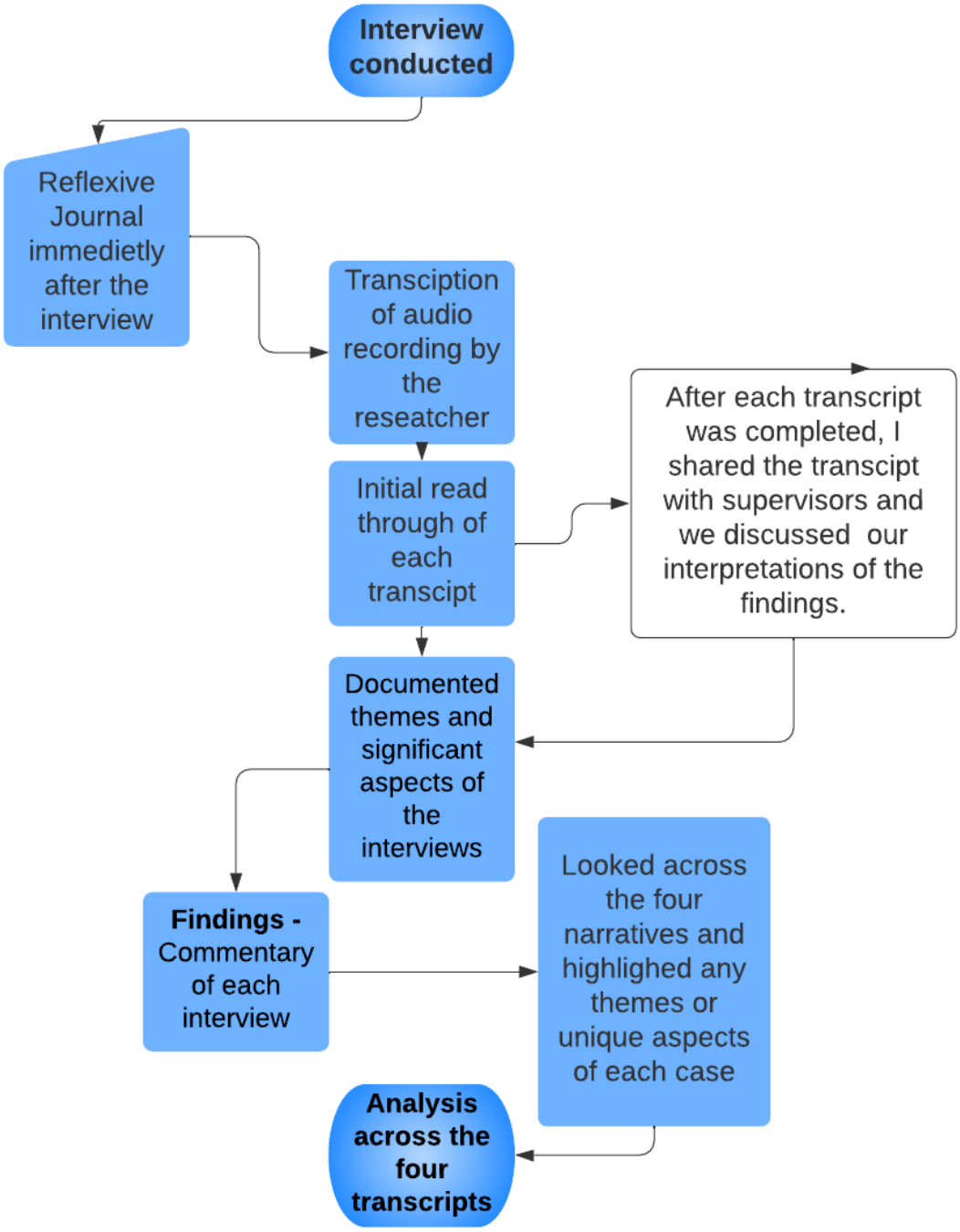
Talked about counsellor kindly - smiled

Silences - taking deep breaths

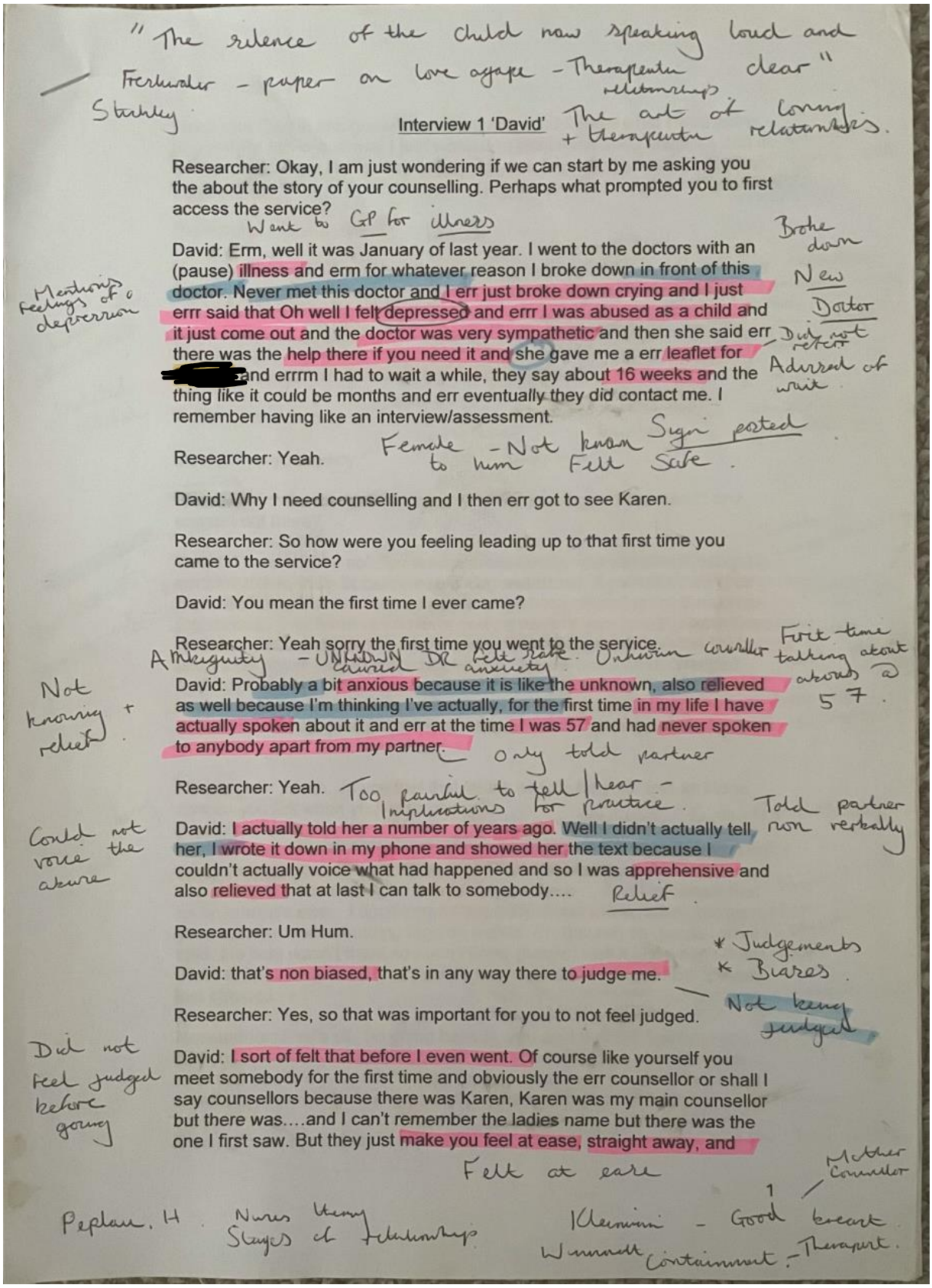
Atmosphere felt quite heavy in the room - large presence

- Still feeling this and seeing the images.

Appendix 10 Data Analysis Flow Chart



Appendix 11 Extract of Interview transcript with David and initial analysis



"The silence of the child now speaking loud and clear"

Frankl - paper on love agape - Therapeutic relationships

Stanley

Interview 1 'David'

The art of loving + therapeutic relationships.

Researcher: Okay, I am just wondering if we can start by me asking you the about the story of your counselling. Perhaps what prompted you to first access the service?

Went to GP for illness

Broke down

New Doctor

Did not refer

Advised of wait

David: Erm, well it was January of last year. I went to the doctors with an (pause) illness and erm for whatever reason I broke down in front of this doctor. Never met this doctor and I err just broke down crying and I just errr said that Oh well I felt depressed and errr I was abused as a child and it just come out and the doctor was very sympathetic and then she said err there was the help there if you need it and she gave me a err leaflet for [redacted] and errrm I had to wait a while, they say about 16 weeks and the thing like it could be months and err eventually they did contact me. I remember having like an interview/assessment.

Mentions feelings of depression

Researcher: Yeah.

Female - Not known to him

Sign posted

Felt Safe.

David: Why I need counselling and I then err got to see Karen.

Researcher: So how were you feeling leading up to that first time you came to the service?

David: You mean the first time I ever came?

Researcher: Yeah sorry the first time you went to the service.

Ambiguity - UNKNOWN DR caused anxiety

Felt safe. Unknown counsellor

First time talking about abuse @ 57.

David: Probably a bit anxious because it is like the unknown, also relieved as well because I'm thinking I've actually, for the first time in my life I have actually spoken about it and err at the time I was 57 and had never spoken to anybody apart from my partner.

Not knowing + relief

only told partner

Researcher: Yeah.

Too painful to tell / hear - Implications for practice.

Told partner non verbally

David: I actually told her a number of years ago. Well I didn't actually tell her, I wrote it down in my phone and showed her the text because I couldn't actually voice what had happened and so I was apprehensive and also relieved that at last I can talk to somebody....

Could not voice the abuse

Relief

Researcher: Um Hum.

* Judgements
* Biases

David: that's non biased, that's in any way there to judge me.

Researcher: Yes, so that was important for you to not feel judged.

Not being judged

Did not feel judged before going

David: I sort of felt that before I even went. Of course like yourself you meet somebody for the first time and obviously the err counsellor or shall I say counsellors because there was Karen, Karen was my main counsellor but there was....and I can't remember the ladies name but there was the one I first saw. But they just make you feel at ease, straight away, and

Felt at ease

Mother Counsellor

1

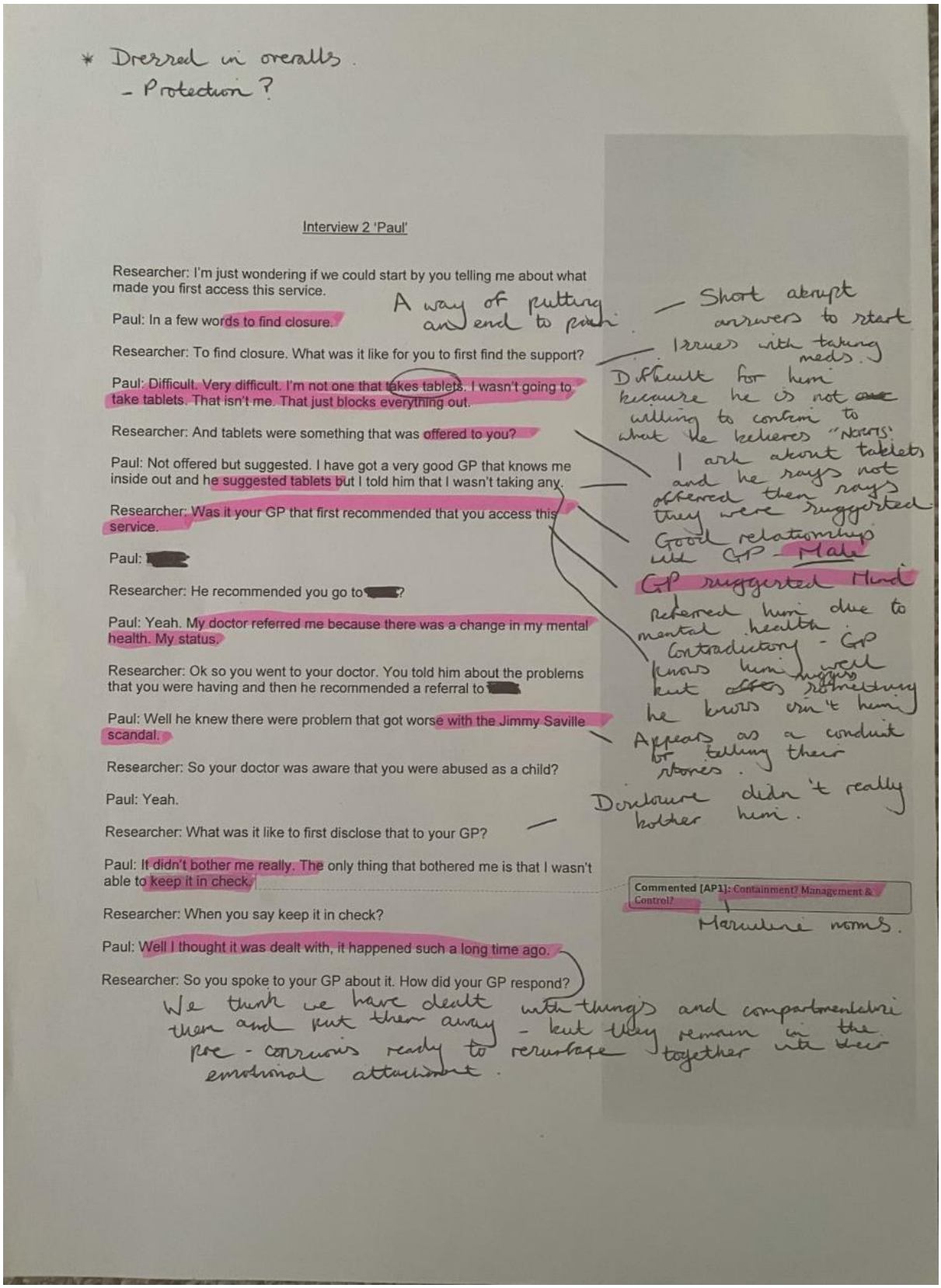
Replan. H

Nurses Using Stages of Relationships

Winnicott Containment

Klemini - Good breast - Therapist.

Appendix 12 Extract of Interview transcript with Paul and initial analysis



* Dressed in overalls.
- Protection?

Interview 2 'Paul'

Researcher: I'm just wondering if we could start by you telling me about what made you first access this service.

Paul: In a few words to find closure.

A way of putting an end to pain.

Short abrupt answers to start

Researcher: To find closure. What was it like for you to first find the support?

Issues with taking meds.

Paul: Difficult. Very difficult. I'm not one that takes tablets. I wasn't going to take tablets. That isn't me. That just blocks everything out.

Difficult for him because he is not willing to conform to what he believes "Norms"

Researcher: And tablets were something that was offered to you?

I ask about tablets and he says not offered then says they were suggested

Paul: Not offered but suggested. I have got a very good GP that knows me inside out and he suggested tablets but I told him that I wasn't taking any.

Good relationships with GP - Male

Researcher: Was it your GP that first recommended that you access this service.

GP suggested Mind

Paul: [redacted]

Researcher: He recommended you go to [redacted]?

Referred him due to mental health

Paul: Yeah. My doctor referred me because there was a change in my mental health. My status.

Contradictory - GP knows him well but also recommending he knows isn't him

Researcher: Ok so you went to your doctor. You told him about the problems that you were having and then he recommended a referral to [redacted]

Paul: Well he knew there were problem that got worse with the Jimmy Saville scandal.

Appears as a conduit for telling their stories.

Researcher: So your doctor was aware that you were abused as a child?

Paul: Yeah.

Disclosure didn't really bother him.

Researcher: What was it like to first disclose that to your GP?

Paul: It didn't bother me really. The only thing that bothered me is that I wasn't able to keep it in check.

Commented [AP1]: Containment? Management & Control?

Researcher: When you say keep it in check?

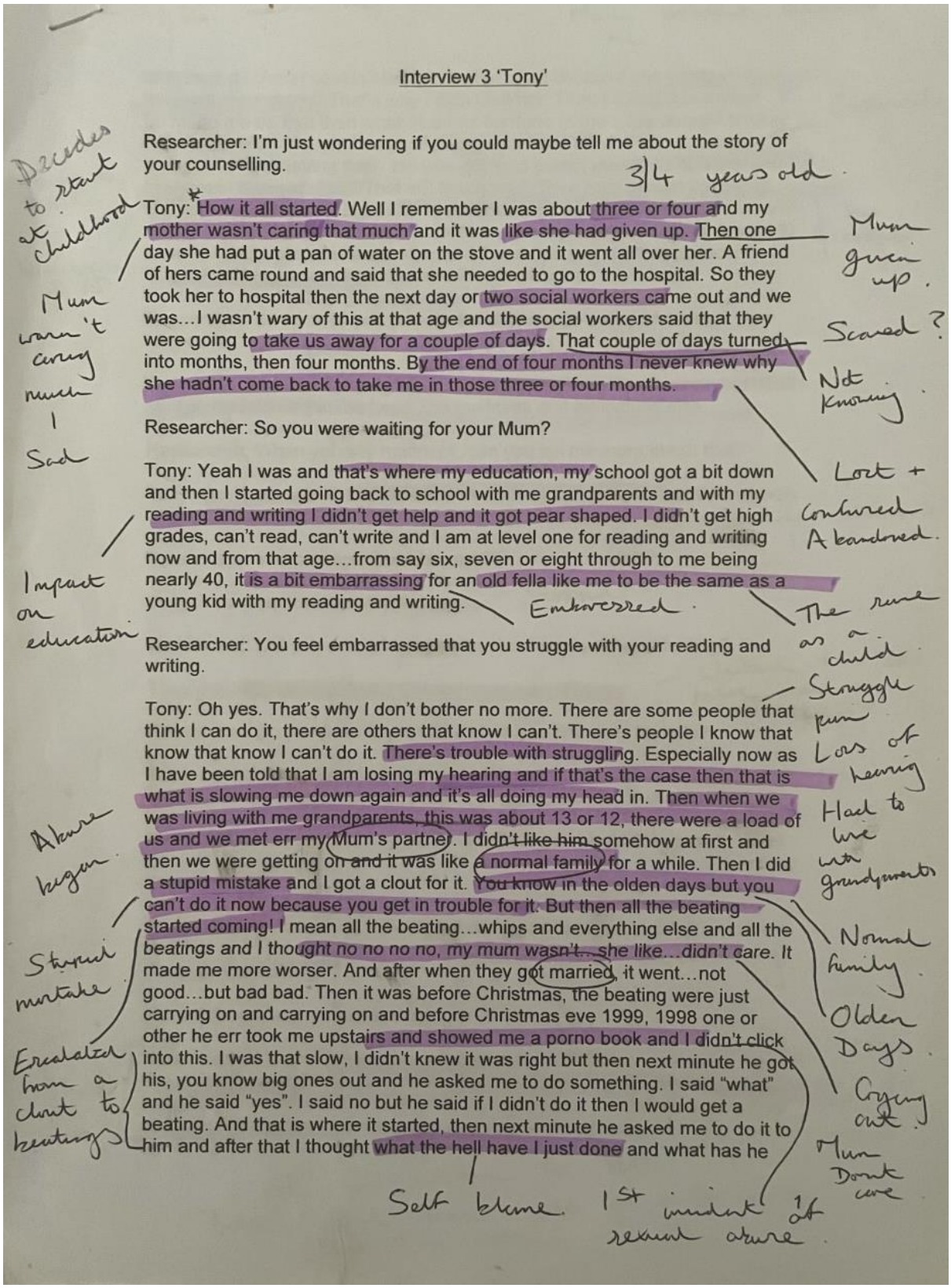
Masculine norms.

Paul: Well I thought it was dealt with, it happened such a long time ago.

Researcher: So you spoke to your GP about it. How did your GP respond?

We think we have dealt with things and compartmentalise them and put them away - but they remain in the pre-conscious ready to rerumbage together with their emotional attachment.

Appendix 13 Extract of Interview transcript with Tony and initial analysis



Interview 3 'Tony'

Researcher: I'm just wondering if you could maybe tell me about the story of your counselling.

Tony: How it all started. Well I remember I was about three or four and my mother wasn't caring that much and it was like she had given up. Then one day she had put a pan of water on the stove and it went all over her. A friend of hers came round and said that she needed to go to the hospital. So they took her to hospital then the next day or two social workers came out and we was…I wasn't wary of this at that age and the social workers said that they were going to take us away for a couple of days. That couple of days turned into months, then four months. By the end of four months I never knew why she hadn't come back to take me in those three or four months.

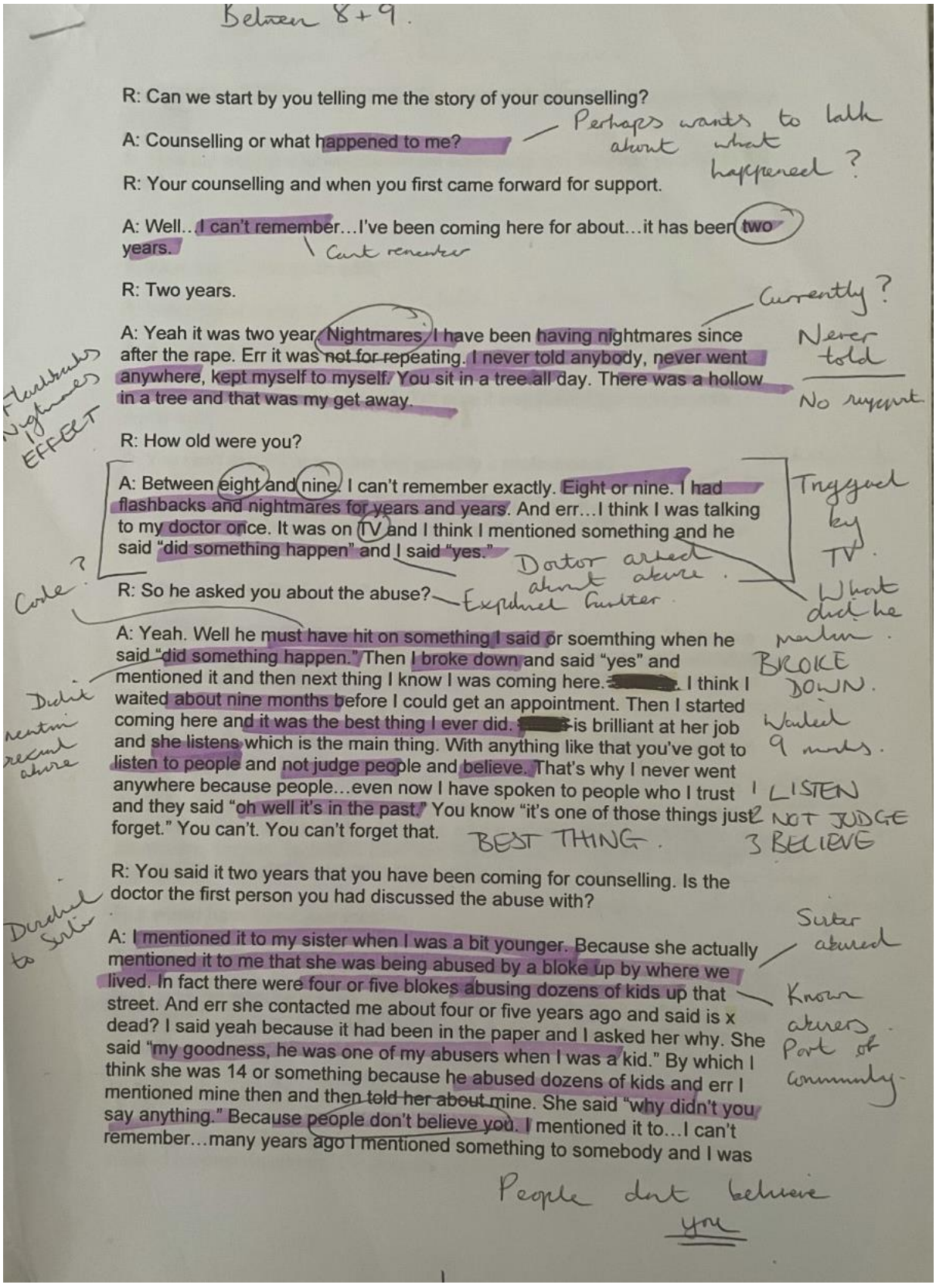
Researcher: So you were waiting for your Mum?

Tony: Yeah I was and that's where my education, my school got a bit down and then I started going back to school with me grandparents and with my reading and writing I didn't get help and it got pear shaped. I didn't get high grades, can't read, can't write and I am at level one for reading and writing now and from that age…from say six, seven or eight through to me being nearly 40, it is a bit embarrassing for an old fella like me to be the same as a young kid with my reading and writing.

Researcher: You feel embarrassed that you struggle with your reading and writing.

Tony: Oh yes. That's why I don't bother no more. There are some people that think I can do it, there are others that know I can't. There's people I know that know that know I can't do it. There's trouble with struggling. Especially now as I have been told that I am losing my hearing and if that's the case then that is what is slowing me down again and it's all doing my head in. Then when we was living with me grandparents, this was about 13 or 12, there were a load of us and we met err my Mum's partner. I didn't like him somehow at first and then we were getting on and it was like a normal family for a while. Then I did a stupid mistake and I got a clout for it. You know in the olden days but you can't do it now because you get in trouble for it. But then all the beating started coming! I mean all the beating…whips and everything else and all the beatings and I thought no no no no, my mum wasn't…she like…didn't care. It made me more worser. And after when they got married, it went…not good…but bad bad. Then it was before Christmas, the beating were just carrying on and carrying on and before Christmas eve 1999, 1998 one or other he err took me upstairs and showed me a porno book and I didn't click into this. I was that slow, I didn't knew it was right but then next minute he got his, you know big ones out and he asked me to do something. I said "what" and he said "yes". I said no but he said if I didn't do it then I would get a beating. And that is where it started, then next minute he asked me to do it to him and after that I thought what the hell have I just done and what has he

Appendix 14 Extract of Interview transcript with Andrew and initial analysis



Between 8+9.

R: Can we start by you telling me the story of your counselling?

A: Counselling or what happened to me?

Perhaps wants to talk about what happened?

R: Your counselling and when you first came forward for support.

A: Well.. I can't remember…I've been coming here for about…it has been two years.

Can't remember

R: Two years.

Currently?

A: Yeah it was two year. Nightmares I have been having nightmares since after the rape. Err it was not for repeating. I never told anybody, never went anywhere, kept myself to myself. You sit in a tree all day. There was a hollow in a tree and that was my get away.

Never told

No support

Flashbacks Nightmares PTSD EFFECT

R: How old were you?

A: Between eight and nine. I can't remember exactly. Eight or nine. I had flashbacks and nightmares for years and years. And err…I think I was talking to my doctor once. It was on TV and I think I mentioned something and he said "did something happen" and I said "yes."

Triggered by TV.

Doctor asked about abuse.

Explained further

Code?

R: So he asked you about the abuse?

What did he mention.

A: Yeah. Well he must have hit on something I said or soemthing when he said "did something happen." Then I broke down and said "yes" and mentioned it and then next thing I know I was coming here. [redacted]. I think I waited about nine months before I could get an appointment. Then I started coming here and it was the best thing I ever did. [redacted] is brilliant at her job and she listens which is the main thing. With anything like that you've got to listen to people and not judge people and believe. That's why I never went anywhere because people…even now I have spoken to people who I trust and they said "oh well it's in the past." You know "it's one of those things just forget." You can't. You can't forget that.

BROKE DOWN.

Waited 9 months.

1 LISTEN
2 NOT JUDGE
3 BELIEVE

BEST THING.

Didn't mention recent abuse

R: You said it two years that you have been coming for counselling. Is the doctor the first person you had discussed the abuse with?

Disclosed to Sister

A: I mentioned it to my sister when I was a bit younger. Because she actually mentioned it to me that she was being abused by a bloke up by where we lived. In fact there were four or five blokes abusing dozens of kids up that street. And err she contacted me about four or five years ago and said is x dead? I said yeah because it had been in the paper and I asked her why. She said "my goodness, he was one of my abusers when I was a kid." By which I think she was 14 or something because he abused dozens of kids and err I mentioned mine then and then told her about mine. She said "why didn't you say anything." Because people don't believe you. I mentioned it to…I can't remember…many years ago I mentioned something to somebody and I was

Sister abused

Known abusers. Part of community.

People don't believe you