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Exploring male childhood sexual abuse survivors' experiences of specialist counselling services

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Abstract

Global estimates suggest 5% to 10% of men report experience of childhood sexual abuse (CSA). However, male CSA is significantly underreported, with men being reluctant to disclose due to vulnerability, stigmatisation, homophobic responses and fearing a loss of masculinity. A lack of research and service provision targeted towards men suggests male survivors of CSA are marginalised. This qualitative study, using a narrative approach, focussed on four adult male survivors of CSA. The aim of the study was to explore their experiences of engaging in counselling and support services for CSA from nonstatutory and voluntary organisations. Face-to-face narrative interviews were audio-recorded and transcribed verbatim. Analysis was undertaken using a two-phase approach; first, each narrative was analysed as a whole; second, an across-transcripts analysis was carried out to identify shared themes and divergences that emerged from the individual stories. In this paper, findings from the second phase of the analysis are presented. Three themes regarding male survivors' experiences of specialist counselling services were identified: "*Trust Me, I'm a Doctor*," "*Trust me, I'm a Counsellor*" and "*Counsellor or Mother?*" This is the first academic study focussing specifically on men's experience of support for CSA in the UK from a service user perspective. Making an original contribution to the knowledge base regarding counselling experiences and the effectiveness of therapy for male CSA survivors, it will help to inform professional counselling services which are likely to come into contact with male survivors of CSA.

KEYWORDS
child sexual abuse, counsellor, males, narrative, survivor

1 | INTRODUCTION

Child sexual abuse (CSA) is an issue of epidemic proportions in the UK (Robey, 2021) and has been deemed an international public health problem (Jay et al., 2012; Pereda et al., 2009). Determining the prevalence of CSA is challenging due to varying definitions and methodological approaches in how prevalence rates are measured (Gekoski & Broome, 2019). Recent data from the Crime Survey for

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England and Wales reported that around 7.5% of adults aged 18 to 74 years disclosed that they had experienced sexual abuse before the age of 16 (Office for National Statistics [ONS], 2020). Regarding disclosure, previous research 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).

Whilst prevalence statistics suggest that women are more likely than men to have experienced CSA (ONS, 2020), a random sample study commissioned by the National Society for Prevention of Cruelty to Children (NSPCC), UK, found 11% of men 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 (Butchart et al., 2006), and there is a growing consensus amongst researchers that around one in six men has experienced sexual abuse, as boys, before the age of 18 (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).

1.1 | Impact of CSA on men

The experience of CSA is associated with a range of long-term adverse effects, which have a lasting impact on the psychosocial development of children (Finkelhor et al., 2007). The long-term effects are known to extend into adulthood and can impact on all areas of survivors' lives (Fisher et al., 2017), often manifesting as mental health problems (Finkelhor et al., 2007). Such problems include depression, anxiety, dissociative disorder, psychosis and suicidality (Chen et al., 2010).

The experience of CSA in men also has the potential to result in confusion around sexual orientation, as it violates socially constructed gender expectations (Mahalik et al., 2003). Moreover, male survivors abused by other men can have increased feelings of shame and internalised homophobia, often prolonging disclosure for decades for fear of not being believed and being considered less masculine (Gagnier & Collin-Vézina, 2016; Perez-Fuentes et al., 2013). Subsequently, men that have experienced CSA often adopt hypermasculine behaviours, such as rage and aggression, which can lead to male survivors coming into contact with the criminal justice system, as opposed to health services (Holmes et al., 1997).

Male survivors of CSA have tended to be overlooked in terms of service provision and research, the latter often focussing on the long-term effects of CSA on women (Easton, 2012). 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 men tend to be severe. The severity could be influenced by the early age of onset when the abuse occurs, the long duration of the abuse and the invasive acts often experienced by boys, for example anal penetration (Ressel et al., 2018). It has also been suggested that the psychological impact of CSA can be more complex for male survivors than female survivors (Bewaji & Rickett, 2020), mainly due to the impact of societal stereotypes (Ressel et al., 2018), the negative reactions to disclosure often experienced by men and the lack of support available to men (Nelson, 2009). The aim of this study was to explore male CSA survivors' experiences of specialist support services in statutory and voluntary organisations.

Implications for practice and policy

- The counsellors supporting the men in this study were equipped and knowledgeable in working with CSA survivors, and this appeared to be essential in the therapeutic exchange being helpful. 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.
- 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 men in this study did not have support as children, and they struggled with the lasting effects of CSA for decades. This highlights a need for early intervention to support boys affected by CSA.
- There is a need for specialist male services and for policymakers to adopt a clear strategy on how to support male survivors of CSA.

2 | METHODS

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 (Frosh, 2002). Narrative research as a phenomenon is valuable in providing understanding of the multifaceted aspects of society, culture and human behaviour by exploring participants' life experiences through a process of storytelling (Leavy, 2009).

Narrative inquiry is a case-centred research method (Riessman, 2008). There is substantial evidence that narrative case studies can play an essential role in therapeutic practice and can serve as a valuable evidence base (McLeod, 2010). Therapy narratives are produced by the clients and can offer insights into their experiences of counselling that members of the therapeutic community may overlook (McLeod, 2010). 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, often resembling the exchanges more familiar to the therapeutic alliance

(Warne & McAndrew, 2010). In therapy, an individual is supported in seeking out the *problem* in their narrative, often reflecting on childhood experiences and memories to establish a connection that has led to the problem (Illouz, 2008). Therefore, encouraging the narratives of research participants can ultimately be part of healing process by supporting the narrator in reflecting on, and making sense of, their experiences. As this research study set out to explore a sensitive topic, focussing on the participants' experiences of counselling, the use of a narrative approach was apt.

2.1 | Recruitment of participants

Purposive sampling was used to recruit adult males who were sexually abused before the age of 18 years, have subsequently experienced long-term effects of CSA and have accessed counselling and/or therapeutic support from the agencies approached to recruit participants. Nonstatutory and voluntary sector organisations, offering counselling and therapeutic support to those who have experienced sexual abuse, were approached to help recruit participants. Recruitment posters outlining 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. Both the poster and the letter included the first author's contact details to enable potential participants to make direct contact. Once they contacted the researcher, potential participants were given more specific written information about the study, and the opportunity to ask and have any questions answered before deciding whether to participate. Before participating, each man was asked to sign a consent form. In total, four men came forward to participate.

2.2 | Ethics

The University of Salford Post Graduate Research Ethics Panel granted full ethical approval in September 2016. As part of that process, it was stipulated that The British Association for 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), were to be used as a framework throughout the research to guide an ethical decision-making process.

To ensure that participants had clear information, in order to make an informed decision about taking part in the research, specialist services were approached to advertise the study. In addition, counsellors working in those services (with clients who fitted the inclusion criteria) were approached, and they were provided with detailed written information about the study that they could pass on to their clients. The services and counsellors were asked to advise potential participants to contact the researcher directly so that a brief meeting could be arranged to explain the study and what would be required of them in more detail. One participant discussed the study over the phone, and the other three participants chose face-to-face meetings. During these meetings, the first author outlined her motivation for researching the topic, what the interview process would entail and how their information would be used and presented. Potential participants were encouraged to explore any concerns or uncertainties they might have about taking part. This helped to ensure that the researcher was offering clear mutual expectations, and it promoted an openness in communication (Mitchels, 2018).

Once a potential participant agreed to take part, they were asked to sign a consent form, outlining what they were consenting to; how data would be used; and their rights to withdraw from the research. Completed consent forms were kept in a locked cabinet, in a locked office at the university. The transcribed interviews were anonymised, and the audio recordings were stored on an encrypted and password-protected computer. A pseudonym was adopted for each of the participants, and any names mentioned throughout the research interview were changed, including the name of their counsellor/therapist.

Talking about a traumatic experience has the potential to retraumatise an individual. However, it is also acknowledged that talking about the experience has the potential to be healing for the participant (Hyden, 2013). To reduce the risk of retraumatisation and emotional distress, 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 and thus had 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 the participants might discuss their experiences of CSA as an integral part of their personal narrative. In the event of a participant becoming distressed, the researcher's skills as a counsellor and her experience in working with trauma and adult survivors of CSA would be beneficial in the immediate situation. However, it was important for the researcher to stress to participants that she was not in the role of a counsellor during the interview, and the research interview was not a counselling session (Mitchels, 2018).

The first author, who conducted the interviews, is a practising counsellor working with child sexual abuse survivors. It was acknowledged that certain aspects of the interview process could have an emotional impact on the researcher. Therefore, it was agreed that the researcher could access clinical supervision during the period of data collection, ensuring researcher self-care, which is acknowledged in the ethical framework.

2.3 | Data collection

Face-to-face interviews consisted of a small number of topic areas, with particular emphasis on the experiences of interventions for emotional 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 spontaneity of dialogue (Holloway & Freshwater, 2007). All interviews were audio-recorded. The location of

the interview was agreed between the participant and the researcher in advance. Interviews were anticipated to last for around one hour, with time set aside at the end for debriefing.

2.4 | Analysis

Narrative research establishes diverse and often contradictory layers of meaning, fostering a deeper understanding of individual and social change (Squire et al., 2013). Analysing narratives allows the researcher to investigate how stories are structured, the effects that narratives have and how they are silenced or accepted within society.

The audio-recorded interviews were transcribed verbatim by the first author, promoting familiarity with the content and the nuances of the data, as well as ensuring that the participants' voices are respected and heard. As narrative inquiry is a case-centred approach, close attention was given to the distinctive features and characteristics of each individual case, including how the account was generated, the way in which the participant negotiated language and how the narrator positioned themself within the story (Reissman, 2011). Each story was analysed as a whole, rather than fragmenting the data. Once this was achieved, analysis across transcripts was undertaken to identify common themes that emerged. As well as the first author analysing the transcripts, the second and third authors also analysed the anonymised transcripts to prompt academic discussion relating to the four sets of analysed data. This process went some way to ensure authenticity of findings.

3 | FINDINGS

For the purpose of this paper, three of the four themes from the across transcript analysis are presented. Coalescing the individual themes identified in each narrative into shared themes and the unique aspects of their counselling journey, four themes emerged: "*Trust Me, I'm a Doctor*," "*Trust me, I'm a Counsellor*," "*Counsellor or Mother?*" and "*Blocking the Memories*." It is the former three themes that are presented in this paper. Each participant was given a pseudonym, Tony, David, Paul and Andrew, to protect their anonymity.

3.1 | Trust me, I'm a doctor

Three of the four participants identified media attention being part of the reason for their disclosure to their doctor. David and Paul both referenced the sexual abuse scandal involving Jimmy Savile during their interviews. For Paul, this led to a decline in his mental health and his ability to cope with life; however, it also prompted approaching 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)

David discussed Jimmy Savile in relation to prolonging his disclosure, arguing that people waited until after Jimmy Savile's death to expose his crimes, suggesting 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 people coming forward to disclose abuse perpetrated by *"superstars"* have *"strength"* and *"courage."* This admiration of others appeared to influence David's ability to disclose his abuse. Andrew also 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)

Andrew, Paul and David's experience of CSA in the media being the catalyst for their disclosure and help seeking concurs with findings of there being an increase in the uptake of disclosure and specialist CSA therapeutic support when there is media attention (Gagnier & Collin-Vézina, 2016). The unprecedented media attention around celebrity perpetrators of CSA was linked to three of the men seeking therapeutic support.

The four participants in this study were all initially referred for specialist counselling by their GP. David went to a GP in relation to an undisclosed illness and described *"breaking down"* in front of her, disclosing that he felt "*depressed*" and was "*sexually abused as a child.*" The disclosure 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, who was new to him, 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. Although Paul described his GP as being *"very good"* and knowing him *"inside out,"* the GP's initial response was to suggest medication, something which Paul was firmly opposed to, believing it *"blocked things out."* After refusing medication, Paul's GP referred him inappropriately to a nonspecialist counselling service, before advising him of the "Rape Crisis Centre." However, he advised Paul that he might have to report the abuse to the police 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)

Based on the experiences of the men in this study, it is evident that GPs play a significant role in directing men who have experienced CSA 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. The men in this study highlighted the importance of fostering good relationships between doctor and patient, sensitive communication, offering patients time and listening and being believed when disclosing CSA histories to be fundamental in improving their well-being.

3.2 | Trust me, I'm a counsellor

Rogers proposed that therapy outcomes are achieved if the counsellor can provide an affirmative facilitative environment based on three essential core conditions: *congruence*, *unconditional positive regard* and *empathy* (Rogers, 2013). 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.

> When you are talking to her, she doesn't say much at first, she listens to you. There is just calm around her. (Andrew)

A fundamental element of unconditional positive regard is that the therapist suspends judgement towards the client and offers them unconditionality within the relationship. 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)

The core conditions, in particular congruence, promote the development of trust within the counselling process, and trust in the therapist is considered one of the foundations of effective counselling (Sanders & Hill, 2014) and was a prominent topic for the men in this study. David discussed how he felt free to share explicit abuse memories, without fear of shocking his therapist as *"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 had a lot of time off and his sessions became erratic. 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. (Tony)

Andrew described how he was expecting to not be able to go through with his first therapy session, but the presence of trust stopped him from abandoning the sessions:

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

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

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 do not know. I find women more understanding and more patient. I talk to her, and she just listens. (Andrew)

Alongside gender choices based on the client meeting a specific need they may have, gender preferences can be defensively rooted. To avert dealing with painful and uncomfortable material, a client might avoid working with a particular gender associated with their distressing past experiences (Moscarello, 1998). This is supported by Tony's rationale for his preference for a female counsellor, as he expressed fear about attending his first counselling appointment as he presumed that he would be allocated a male worker, and this 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)

Literature exploring the effects of accommodating a client's preference for a therapist of a particular gender is sparse (Black & Gringart, 2018). The four men in this study actively chose a female therapist and explicitly stated that they would not be able to work with a male counsellor. Paul was given a choice between a male and female therapist; 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, but the therapy was not effective, as he was uncomfortable around his therapist because he was male, and Andrew had been abused by a man.

3.3 | Counsellor or mother?

Support from parents is consistently associated with the psychological well-being of sexually abused children (Williams &

Nelson-Gardell, 2012), with evidence suggesting that being believed and supported by a close family member reduces the adverse effects of CSA (Finkelhor et al., 2007). 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 thinking 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. Finally, and in contrast to the other three men, Andrew idolised and protected his mother.

It was implied from the participants' stories of childhood that they yearned for a mother figure. Bowlby (1988) suggested that the client–therapist relationship has parallels with the mother and child relationship, stressing the significance of the therapist "*acting*" as a secure base. From David's description of his counselling relationship, it could be suggested that his therapist acted as a "*secure base*" (Bowlby, 1988). 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 caregiver. Tony expressed negative feelings of anger and rejection towards one of his earlier therapists when she had to stop working due to personal circumstances. Rejection and abandonment have the potential to be replicated in the therapeutic relationship (Daniel, 2015), as evidenced in this instance by Tony. 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 with his first counsellor, and his wariness about re-engaging with another service when it was suggested by his doctor.

4 | DISCUSSION

Male CSA is a neglected research topic, despite there being evidence to suggest that one in six men experience sexual abuse before the age of 18 (Ressel et al., 2018). The themes identified above are common across the four narratives and will be used as the basis of this discussion.

4.1 | Trust me, I'm a doctor

Within the theme of *"Trust me, I'm a doctor,"* seeking help and professional support has been found to be a significant "*turning point*" for men who have experienced CSA (Easton et al., 2015). This can also be said for the men in this study. 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. This could suggest a need for routine enquiry regarding a history of CSA by healthcare professionals to ensure appropriate referral (Hovey et al., 2011). However, when questions become routine, there is a danger that they might be asked insensitively and/or become a "tick box" exercise. Additionally, when sensitive information is revealed, it is likely to be recorded in the person's medical notes with the potential to compromise the confidential nature of such a disclosure. Professionals can also be reluctant to ask people about experiences of sexual abuse out of concern for retraumatisation (Lab & Feigenbaum, 2000). Regardless of such concerns, not asking has the potential to reinforce a message of silence and convey to the survivor that their experiences and distress are unimportant (Barber, 2012). For the men in this study who were asked about CSA, the questioning was offered sensitively and was not harmful, and no retraumatisation was reported.

Similar to the extant literature, for the men in this study, fear of not being believed and shame was found to be a barrier to disclosure (Easton et al., 2014). There is documented evidence that male CSA is underreported and underdisclosed, 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 (Romano et al., 2019). These findings are comparable to the experiences of two of the men in this study: one of them told their doctor around 20 years after experiencing CSA and the other first disclosed to his partner at least 45 years after experiencing abuse. However, as with two men in this study, research by Sorsoli et al. (2008) found that men can often make numerous attempts to disclose as a child but might not be taken seriously. Supportive responses from caregivers when hearing disclosures of CSA are consistent with the psychological adjustment of sexually abused children and help to mediate the long-term impact of CSA (Williams & Nelson-Gardell, 2012). Being believed when disclosing CSA is thought to be associated with men perceiving the response to the disclosure as positive (Gagnier & Collin-Vézina, 2016). Three of the participants felt believed when sharing with a healthcare professional and referred to the dialogue as being "*helpful*." One of the participants, David, described telling his doctor as *"the biggest step"* of his journey towards recovery.

Reaching out for help can be a difficult step to take. Tony raised the issue of it being *"alright for girls and women but it's not for fellas,"* suggesting that is why it is *"hard for boys or fellas to go to anyone else to tell them what really happened*." Paul also suggested that the only support services he was aware of were Rape Crisis Centres, and he thought that these services were specifically for women. Frustration around sexual abuse support centres being female only was expressed in a Scottish report on care and support needs of male CSA survivors (Nelson, 2009). Like Paul, the respondents 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 are influenced by socially constructed gender "*norms*" and societal attitudes around male CSA (Easton et al., 2015). For example, Andrew was the only participant to use the term *"rape"* when describing his experience. It could be assumed that the other men did not associate their abuse with rape, and this could account for why they might believe a Rape Crisis Centre is not an appropriate service to meet their needs. Another consideration is that the rape of men 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 have influenced why 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 (Rapsey et al., 2020). Comparably, all the men in this study relayed barriers which could arguably be linked to stigma and system processes. For example, all the men believed that there were no services available for sexually abused men until more recently. 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. Andrew had previous negative encounters with other professionals, and this led to deep reservations about accessing specialist support. Rapsey et al. (2020) 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. 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; on average, there is a 12-year gap between their first disclosure of CSA and accessing a service for support for the first time (Gekoski et al., 2020; Smith et al., 2015). Also, oscillation between numerous services is common, with survivors reporting that, over a 10-year period, they may attend between four and five services (Smith et al., 2015).

4.2 | Trust me, I'm a counsellor

Experiencing a positive relationship with a counsellor has been acknowledged as a fundamental benefit of therapy for male CSA survivors (Rapsey et al., 2020). For the men in this study, the key to developing the relationship with their counsellor was trust. According to the literature regarding male and female CSA survivors' reflections on talking therapy, being believed and not judged are essential aspects in determining whether a counsellor is trustworthy, and worthy enough of hearing their stories (Chouliara et al., 2012). The men in this study testified to this. David explained that there was a *"certain amount of trust there"* due to the fact that she was a counsellor and he had always wanted someone to talk to and share his *"life story"* about the CSA. The ability to share abuse stories safely with a therapist who demonstrates *"honesty," "competency"* and *"trustworthiness"* has been found to cultivate relational connections and self-trust, and reduce isolation (Arias & Johnson, 2013, p. 832). Rapsey et al. (2020) noted that male survivors' ability to develop a trusting connection with a professional is essential for them to benefit from treatment. 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 (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.

The concern around not being accepted or understood by professionals is known to be common among male CSA survivors (Rapsey et al., 2020). In this study, the four men all reported fear, anxiety or negative past experiences with health professionals. It could be argued that these experiences contributed to the men delaying accessing support for their abuse experience until later in life. In the UK, there appears to be a lack of consensus and clinical guidance on effective therapeutic interventions for adult survivors of CSA. For the men in this study, it was reassuring that there was no pressure to talk about their experience of CSA and that they could do this in their own time and when they felt ready. 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 seen by them as helpful.

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. The development of a *"survivor-friendly and sensitive framework"* to guide professionals in enquiring about a CSA history, attending to the timing and style of questioning and guidelines on responding to disclosures has been proposed (Chouliara et al., 2012). However, there is also a need for a model specifically aimed at male survivors, which goes beyond disclosure and extends to support and effective communication. The men's negative experiences with professionals, identified in this study, substantiate this need.

4.3 | Counsellor or mother?

Rothschild (2000) emphasised that when working with trauma, establishing a secure base is the priority in order for the client to feel safe so that he/she will return. The counsellors supporting the men in this study appeared to have established a secure base in the initial sessions. The counsellor can replicate the secure base associated with secure attachment figures (Bowlby, 1988), and the client may assign the therapist a surrogate role whereby the counsellor can symbolise a mother figure (Peplau, 1991). 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, while Paul shared his anguish that his mother did not believe his abuse experience. When disclosing CSA, men who have maternal support are less likely to experience mental health problems (Easton et al., 2014). Andrew chose not to tell his mother for fear of causing her distress, and Tony did not have support from his mother and experienced CSA at the hands of his mother's partner, suggesting some accuracy in Easton et al.'s (2014) findings.

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 nonjudgemental responses. A major aspect of the therapeutic alliance is the client–therapist bond (Bordin, 1979). Obegi (2008, p. 431) aimed at uncovering how this bond between client and therapist develops and argued that the therapeutic bond is *"an in-progress attachment to the therapist."* Notable comparisons have been drawn between an attachment relationship and the therapeutic relationship (Obegi, 2008), which are evidenced by the men in this study. 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 an environment that felt safe for them.

4.4 | Implications for practice and policy

The counsellors supporting the men in this study were equipped and knowledgeable in working with CSA survivors, and this appeared to be essential in the therapeutic exchange being helpful. However, the participants reported negative past experiences with health and mental health professionals, and three of the men had oscillated in and out of nonspecialist services for years. The knowledge that the counsellor, and the researcher, was a specialist in this area and that they would not be "shocked" by the abuse narratives was also reported by one of the men in relation to both the counselling and the research encounter. Therefore, a competency framework identifying the essential knowledge and skills needed to work with male survivors of CSA could potentially be beneficial for those counsellors perhaps unfamiliar with this sphere of work. This could be incorporated into counselling training or continuing professional development.

The men in this study did not have support as children, and they struggled with the lasting effects of CSA for decades. This highlights the need for early intervention to support boys affected by CSA. 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 referral processes.

As men can face many barriers or be denied access to certain women-only sexual abuse services, there is a need for specialist male services across the UK and for policymakers to adopt a clear strategy on how to support male survivors of CSA. There is currently a minority of specialist male services, for example Survivors UK (www.survivorsuk.org) and Survivors Manchester (www.survivorsmanchester.org.uk). Additional funding to support these services, and a wider range of male specialist services across the country, could help to mitigate some of these barriers in accessing support. Similar to how women's services currently operate, these services could be developed and managed by individuals in the third sector who have specialist knowledge and/or lived experience of male CSA. As with women's sexual abuse services, when it comes to funding, support could come from a range of organisations such as the government, local authorities, the Police and Crime Commissioner, and trusts.

4.5 | Limitations

This study was confined to a small sample size of four men. Although 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 being contacted or they advised that they did not permit researchers to conduct interviews with their clients or former clients, as they advised that there would be the potential for retraumatisation. Although talking about a traumatic experience does have potential to retraumatise an individual, it is widely acknowledged that sharing an experience has the potential to be healing (Hyden, 2013). Furthermore, the notion that research participation will result in retraumatisation contradicts research experiences in which participants feel validated and empowered by talking about difficult life experiences (Warne & McAndrew, 2010).

5 | CONCLUSION

The research findings highlighted that men in the study delayed accessing services due to a variety of reasons, such as stigma and the fear of not being believed. Disclosure was often not planned, yet was made to a health professional (GP) who had the opportunity to refer them for specialist help. Their disclosure was probably influenced by media representations (at the time) surrounding the sexual offences committed by a high-profile celebrity.

A key emergent factor in the belief by the men of their improvement in coping was related to the counsellor's therapeutic skills and the permission granted to tell their story in their own way. In each case, the men had opted to see a female counsellor as they felt it would enable engagement and would be less challenging when disclosing due to their personal history of abuse and lack of trust in men.

The use of a narrative inquiry gave the opportunity for the men to tell their story in their own way and in their own time. Careful analysis was undertaken involving all the researchers synthesising the data collected into a series of meaningful themes that reflected the men's stories. It took great courage for the men to share their stories, and constructing the narrative within this paper to reflect their experiences was, at times, emotionally challenging. Their stories will enable readers to have the awareness to identify and explore emergent CSA in people they work with and enable them to find support when the time is right.

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AUTHOR CONTRIBUTIONS

LV Conceived the idea for the project, undertook a literature review and carried out the data collection and analysis. SM and NM, senior researchers, helped establish the design of the project and data analysis. LV, SM and NM wrote the manuscript.

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