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ORIGINAL ARTICLE

Mental health challenges facing male survivors of child sexual abuse: Implications for mental health nurses

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ABSTRACT: *Child sexual abuse (CSA) is an issue of epidemic proportions in the United Kingdom (UK) and an international public health problem. Evidence suggests that in the UK one in 20 children have been sexually abused, with one in three not telling anyone about it at the time of the abuse. Conservative estimates suggest that around one in six men have experienced sexual abuse before the age of 18. CSA has been correlated with the development of numerous mental health problems, abused men often displaying externalizing behaviours, including substance misuse, 'risky' sexual behaviours, anti-social behaviour, and offending. This article reports on one aspect of a research study focusing specifically on male survivors of CSA and its effect on their mental health. Using narrative research, face-to-face interviews were used to collect the stories of four men who participated in the research. Interviews were audio-recorded and transcribed verbatim. Analysis used a two-phase approach; initially, each narrative was analysed as a whole, with an across transcripts analysis then being carried out identifying shared themes emerging from the individual stories. Whilst findings from the second phase of the analysis identify four themes, it is the theme of 'Blocking the Memories' that is the focus for this article. Making a valuable contribution to existent knowledge regarding the experiences of men who were sexually abused as children, this article will help to inform mental health practitioners who are likely to deliver care to male survivors of CSA.*

KEY WORDS: *child sexual abuse, males, narrative, survivors, therapy.*

INTRODUCTION

Globally, 5–10% of men report being victims of CSA (Butchart *et al*. 2006). While a recent report in England and Wales suggests that women are three times more likely than men to have reported their experience of CSA (Office for National Statistics 2020), a study by the National Society for Prevention of Cruelty to Children (NSPCC; Cawson*et al*. 2000) UK found 11% of males reported that they had been sexually abused as a child. CSA is associated with a range of short and long-term adverse effects which can have a lasting impact on the psychosocial development of children (Finkelhor *et al*. 2007). The long-term effects can extend into adulthood, impacting on all areas of survivors' lives (Fisher *et al*. 2017), and often manifesting as mental health problems (Finkelhor *et al*. 2007; Kennedy *et al*. 2021).

CSA and mental health

In terms of mental health problems depression, anxiety, dissociative disorder, psychosis, and suicidality have all been associated with CSA (Chen *et al*. 2010; Holm *et al*. 2009). A relationship between CSA and the

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development of post-traumatic stress disorder (PTSD) has also been established (Chen *et al*. 2010), and it is suggested that those presenting to mental health services with a history of CSA should be considered to have PTSD (Read *et al*. 2007). Regardless of diagnosis, for many of those who use mental health services a history of CSA is a reality (Kennedy *et al*. 2021). However, over a prolonged period, mental health professionals, such as nurses and psychiatrists, have been disinclined to routinely enquire about sexual abuse histories for numerous reasons; lack of confidence in how to ask and effectively respond, poor understanding and knowledge of CSA, and fear of re-opening traumatic experiences (Dorahy & Clearwater 2012; Walsh *et al*. 2022). Practitioners' avoidance of addressing CSA appears common throughout mental health care, including Child and Adolescent Mental Health Services (CAMHS) and male and female acute services (Kennedy *et al*. 2021; Stige *et al*. 2022; Walsh *et al*. 2022; Warne & McAndrew 2005). Such lack of professional preparedness and/or willingness to address CSA could add to the distress and compromise the recovery of those they are providing care for.

Irrespective of diagnosis, there are some notable gender differences regarding mental health problems associated with CSA, with females being more likely to exhibit internalizing behaviours, for example, being withdrawn or experiencing feelings of sadness, guilt and fear; males are more likely to display externalizing behaviours (van Toledo & Seymour 2013). Attributes of externalizing behaviours include substance misuse, 'risky' sexual behaviours, anti-social behaviour, conduct disorders, and criminal offences (Maniglio 2015; Ogloff *et al*. 2012). These behaviours are often seen out of a CSA context, as it is suggested that the average length of time for men between the abusive experience and disclosure is two decades (Easton *et al*. 2014).

When considering the impact of CSA on men's mental health, short-term effects include, anxiety, fear, shame, low self-worth, depression, suicide ideation, confusion over sexuality, homophobic reactions, anger, and aggression, most of which are known to endure into adulthood (Mendal 1995). Further mental health issues associated with male survivors of CSA include somatic complaints, post-traumatic stress, sexual dysfunction, and substance misuse (Easton & Kong 2017; Fisher *et al*. 2017). A growing body of research has also attributed CSA with subsequent suicide attempts in adolescent and adult males (Easton *et al*. 2014). Molner *et al*. (2001) estimated that 8–12% of suicide attempts were linked to CSA, while Brezo *et al*. (2008) found that young adults with a history of CSA were 5–14 times more likely to attempt suicide.

Experiencing CSA has the potential to severely affect the gender identity of male survivors, as it violates socially constructed gender expectations; these being correlated with profound psychological distress (Mahalik *et al*. 2003) and considered as less masculine (Gagnier & Collin-Vézina 2016). Male survivors abused by other males often have increased feelings of shame and internalized homophobia; often resulting in prolonged periods before disclosure (Gagnier & Collin-Vézina 2016) and the adoption of hyper-masculine behaviours such as, rage and aggression. These behaviours can lead to contact with the criminal justice system, as opposed to mental health services (Holmes *et al*. 1997).

To date, this is an under-researched group, who are likely to be at risk of long-term mental health problems (Easton *et al*. 2014). The overarching aim of this research was an exploration of men's experiences of specialist counselling and psychotherapy services; however, all the men in the study discussed how CSA had impacted their mental health and it is that aspect of the study, namely the theme of 'blocked memories', which will be reported in this article.

METHODS

Narrative case-centred research was used as a way of encouraging participants to articulate and share their experiences of services they had received for the primary reason of CSA (Reissman 2011). Narrative is valuable in understanding the multifaceted aspects of society, culture, and human behaviour through the process of storytelling (Leavy 2009). Narrative case studies can offer insights from a service user perspective about their experiences, often referred to as lay knowledge (Gabe *et al*. 2004). Involving service users in the research process stimulates empowerment; the power relationship between researcher and participant shifting to promote active, rather than passive involvement on the part of the research participant (McAndrew *et al*. 2014). Lay knowledge is considered a robust empirical approach to making sense of everyday health and illness, placing emphasis on 'experience' over 'expertise' (Gabe *et al*. 2004). Warne and McAndrew (2007) highlighted the value of service user knowledge, placing them at the centre of nurse education, rather than pre-constructed theories being used to inform practice knowledge.

Recruitment of participants

A purposive sample was used to recruit adult males who had experienced sexual abuse before the age of 18 years, and had subsequently experienced long-term effects of CSA, for which they accessed counselling and/or therapeutic support from the agencies approached to recruit participants. Non-statutory and voluntary sector organizations, offering counselling were approached to help recruit participants. Potential participants were offered further information by the first author to address any questions, then if wishing to take part in the research were asked to sign a consent form detailing all information discussed.

Ethics

The Post Graduate Research Ethics Panel at the University of Salford granted full ethical approval in September 2016. The British Association of Counselling and Psychotherapy (BACP): updated Ethical Guidelines for Researching Counselling and Psychotherapy (Mitchels 2018) was used as a guide throughout the research.

To reduce the risk of re-traumatization 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. This was to ensure they had experience of discussing the emotional impact of the abuse. Participants were also advised that they could stop the interview at any time and had the right to withdraw from the study at any time before or during the interview, and up to 1 month after the interview had been conducted. Time was also given at the end of each interview for a debrief, which did not form any part of the data collection.

Although the focus of the study was on participants' experiences of counselling and support services, it was recognized that they might discuss their experiences of CSA as an integral part of their personal narrative. A pre-arranged agreement had been made that the participant could receive more long-term support from the service they had previously accessed. Any participant who experienced distress could access further counselling, or emotional support, immediately without being subjected to a waiting list. This was clearly reiterated to each participant before and after the interview.

The first author, who conducted the interviews, is a counsellor specializing in working with children and adults affected by CSA. She has worked in a range of contexts including third-sector specialist counselling and support services, the National Health Services (NHS), the Criminal Justice System, and also participated in a national inquiry investigating historical CSA in institutional settings. In the event of a participant becoming distressed, the first author's skills as a counsellor and experience in working with trauma and adult survivors of CSA was beneficial in the immediate situation. The second and third authors are both qualified mental health nurses who have worked therapeutically with people who have experienced CSA.

It was also acknowledged that certain aspects of the interview process could have an emotional impact on the researcher. It was agreed that the researcher would access her clinical supervisor during the period of data collection, ensuring researcher self-care. Clinical supervision is an anonymized 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

The narrative interview empowers participants to speak in their own voice (Mishler 1986). Encouraging participants to explore specific events and situations can help to elicit detailed narrative accounts, rather than offer concise statements and answers (Hollway & Jefferson 2000). Participants were invited to share their experiences via face-to-face interviews, with little interruption from the researcher. Interviews took place at an agreed time and venue. All interviews were audio-recorded, and lasted for around 1 hour, with time set aside at the end for de-briefing.

Analysis

Audio-recorded interviews were transcribed verbatim by the first author, with attention being given to the distinguishing features of each individual case. This involved hearing the stories as they were narrated, and experiencing the emotions of the participant. It was also imperative that the researcher noticed her own emotional responses (Fraser 2004). To capture these details, the researcher spent time immediately after each interview entering any thoughts that emerged in a journal. Analysing narratives allows the researcher to investigate how stories are structured, the effects the retelling of them has on the participant, and how they are silenced or accepted within society (Reissman 2011). Fraser's (2004, p. 187)

'questions to consider' were used as a guide during this process (see Appendix I).

In addition to the first author analysing the transcripts, all authors reviewed the anonymized transcripts to prompt academic discussion where there was convergence and divergence within the four narratives. This process went some way to ensure authenticity of findings.

Rather than fragmenting data, narrative analysis requires each story to be analysed as a whole. 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. This ensures that the participants' voices are being honoured and their stories respected.

Findings

Blocked memories

One of four themes emerging from the cross transcript analysis was that of 'Blocked memories'; a theme demonstrating how negative consequences of CSA impact the mental health of men in adulthood. This theme is broken into five distinct sub-themes; denial and maladaptive coping, manifestations of mental illness, negative self-beliefs and self-blame, and externalized and internalized anger.

Denial and maladaptive coping

While for some survivors of CSA, memories of abuse can be completely forgotten or unconsciously denied, others may have a faint memory or inkling that something bad happened in childhood; albeit a vague and incomprehensible memory. Unconscious denial of CSA can result in living with the burden of distressing and uncomfortable feelings, without any knowledge of the underlying cause, but manifesting as mental health problems (Easton & Kong 2017).

For men in denial and living with distressing thoughts and uncomfortable feelings associated with their abuse experience, alcohol and substance misuse are reported as being used as a common coping mechanism (Rapsey *et al*. 2020). Paul and Tony both disclosed that they used alcohol excessively.

> 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. (Paul)

> Try and forget it all but sometimes it does come back. That's why I drink. (Tony)

Easton & Kong (2017) suggest that alcohol addiction often serves as a 'turning point' for men who have experienced CSA, as they have to 'hit rock bottom' before recovery is possible.

However, the emergence of repressed memories into conscious awareness has the potential to cause unwelcome emotions such as fear, guilt, or shame (Kahn *et al*. 2002). Blocked, denied, and repressed memories featured in all four of the men's narratives, with David describing his forgotten childhood memories as being 'repressed.'

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

Manifestations of mental illness

The instinct for repressed memories to gain consciousness determines repression as 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, and identified a relationship between the process of repression and neurosis (Freud & Gay 1995). Although neurosis was removed from the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM) in 1980, the links between repression and neurosis have contemporary relevance to therapeutic practice. Symptoms of neurosis can manifest as stress, depression, and anxiety, all of which are commonly associated with CSA (Chen *et al*. 2010; Holm *et al*. 2009). When considering the narratives of David, Paul, and Andrew, all discussed their experiences of low mood, and feelings of depression and anxiety.

> 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)

> I have probably been depressed all of my life I would say. (Paul)

While these experiences are valid, it is argued that treating people specifically for anxiety and/or depression will not be as helpful as allowing them to explore their feelings, as a way of facilitating the discovery of the underlying cause (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 therapy, he achieved his aim of remembering an event in

childhood when his mother expressed affection towards him.

> 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 could not remember a good memory with my mother. Certainly not of my father, but I think it is what I wanted out of counselling. I wanted it to trigger some sort of memory. (David)

Andrew's memory issues were a recurring topic throughout his narrative and something that caused him anguish and confusion, 'I just can't understand why I don't remember my whole life (Andrew, p15).' Bringing repressed memories into conscious awareness through therapy enabled Andrew to alleviate his frustration.

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

For some individuals, engagement in a therapeutic relationship might be the first time that their feelings have been validated and their frame of reference acknowledged as being important (Power 2012). However, it is not a therapist's role to actively pursue the abuse memories, or change the way the person thinks, but to "create the conditions in a relationship where a person can experience changes in their self (Power 2012, p. 52)." Ultimately, this allows the denied memories to enter conscious awareness and be symbolized in a meaningful way.

Negative self-beliefs and self-blame

Throughout the four narratives, the men regularly described negative self-beliefs and expressed low self-worth. On further exploration, the beliefs they held about themselves often stemmed from external factors. Both Tony and Andrew used the term *'mad'* to describe beliefs about themselves.

> That's when the other stuff started coming in me head…the madness and everything else. (Tony)

Tony held the view that feeling suicidal was a symptom of 'madness.' However, he later described an incident whereby he was told by a friend that he was 'nuts.' Andrew disclosed that due to his symptoms related to obsessive compulsive disorder (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'.

> 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. (Andrew)

The negative self-beliefs the men harboured and, following therapy, the eventual changes in their personal narratives can be conceptualized in the theoretical underpinnings of person-centred counselling and the notion of 'introjects' (Mearns & Thorne 2000). For example, David 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 & Thorne 2000).

In David's case, he thought he was *'thick'* because he could not remember things and believed this had negatively affected his career and relationships.

> Everyone forgets things, she [counsellor] rationalized 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. (David)

David blamed himself for the breakdown of his marriages. Paul also had experience of a marriage breakdown and highlighted how CSA had negatively impacted his relationships, as being depressed 'rubs off' on the people around you.

> 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)

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

(Easton *et al*. 2014; Easton & Kong 2017). David blamed himself for the sexual abuse he experienced from his family, and his shame appeared to be a barrier to his disclosure. 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)

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 therapist helped him to *'rationalize'* these feelings which led him to no longer blame himself. Rapsey *et al*. (2020) reported similar findings whereby 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.

Externalized and internalized anger

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 was evident for all four men. 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. Although with a sense of shame, David also spoke of feeling jealous towards children who are now able to access support.

> 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)

Anger emerged in the participants' narratives which is consistent with what has been reported in the previous literature (Easton *et al*. 2014; 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, as the expression of anger conforms with the conventional male gender 'norms' (Chaplin & Cole 2015).

Paul demonstrated the positive impact therapy 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 mirror the theme of *uncontrollability* highlighted in the research findings of Dorahy and Clearwater (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 their abusers.

> I don't want to hurt anybody. I know if I go violent. . .if I attack then I cannot control it. (Andrew)

Hyper-masculine behaviours such as rage and aggression are known to reinforce denial relating to feelings of victimization (Holmes *et al*. 1997). 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. For example, during the interview, his dialogue towards women had misogynistic undertones and he intimated that the researcher, a woman, 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)

While the anger presented above is externalized, the men in the study also talked of internalized anger. It is suggested that the experience of abuse can result in severe emotional pain, causing many men to experience suicidal ideation or self-harm (Dorahy & Clearwater 2012). Andrew discussed self-harm and explained that when he is 'in pain' he would cut his arms, punch walls, and slice his hands. 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)

Andrew and Tony both described how they had planned to end their life by suicide when they were adolescents; Andrew was 14 and Tony was 17. Tony experienced suicidal thoughts for several years as a younger man, and Andrew has continued to battle suicidal thoughts throughout his adult life. Research has found a correlation between CSA and suicide attempts in adolescent and adult men (Easton *et al*. 2014).

Andrew credited therapy as something which helped him with suicidal ideation.

> I think without them [counsellor] I would have killed myself a long time ago. (Andrew)

DISCUSSION

The men's experiences of blocked and denied memories were analysed in relation to person centred and psychoanalytic theory. Research literature on male CSA reports that men experience a lack of cognitive awareness about their abuse experience and compartmentalized their abuse (Sorsoli *et al*. 2008). Whilst some men report they completely repress memories of abuse (Sorsoli *et al*. 2008), others repress certain elements of their CSA experience (Gagnier & Collin-Vézina 2016). As previously noted, all the men in this study described memory problems; Andrew sharing his distress at not being able to 'remember his whole life.' Lisak (1994) reported a similar finding whereby men talked of losing whole periods of their lives due to repressed memories that they were still unable to recover.

Abuse memories can also be completely forgotten, and an individual might have no recollection that specific events have happened or that anything untoward has occurred during their childhood. In these circumstances, the individual has denied awareness of their experience and developed a self-concept that does not include being subjected to CSA. 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).

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 sexually abused in childhood experience varying levels of incongruence and they require a therapeutic relationship with a therapist who is congruent, empathic, and accepting of their whole being, including their abuse experience and its effects (Power 2012). These are all attributes that should be present when engaging therapeutically with those presenting with mental distress.

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 recognized that childhood abuse, whether a single or repeated event, can lead to the development of PTSD (National Institute for Health and Social Care Excellence 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' (National Institute for Health and Social Care Excellence 2017, p. 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.

Denial can be two-fold, as it can also be communicated by professionals regarding service users' experience of CSA (Dorahy & Clearwater 2012). Substance misuse is a common presenting problem for men who have experienced CSA, when seeking therapy (Steever *et al*. 2001). In particular, alcohol misuse can often be regarded by health professionals as learnt behaviour, as opposed to it being considered a coping strategy for CSA (Dorahy & Clearwater 2012). 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 with effects of CSA, rather than for therapy specific to their experience of CSA. This can be problematic for both the professional and the service user. Research suggests those who experience CSA have described not being believed by mental health and other health professionals, who often attribute their CSA disclosure to their mental health problems (Dorahy & Clearwater 2012). This phenomenon is common for those diagnosed with mental illness and is often referred to as 'diagnostic overshadowing' (Jones *et al*. 2008). Diagnostic overshadowing is a major issue and is recognized as a barrier that impedes those with mental health problems from accessing appropriate healthcare services (Oud *et al*. 2009). It appears 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.

Evidence suggests mental health practitioners are poor at addressing CSA in clinical practice (Kennedy *et al*. 2021; Walsh *et al*. 2022; Warne & McAndrew 2005). Over the past 25 years, research has identified numerous reasons as to why practitioners are reticent to address CSA in those presenting with

mental health problems. Reasons for reticence are complex, but include lack of knowledge; low level of interpersonal skills, discomfort in asking about and addressing disclosure of sexual abuse; fear of re-traumatization, time and resource constraints; adherence to the medical model, beliefs and attitudes regarding sexual abuse and its place in relation to mental health problems; believing CSA is the concern of 'other' specialists, and a practitioner's own experiences with CSA (Kennedy *et al*. 2021; Stige *et al*. 2022; Walsh *et al*. 2022; Warne & McAndrew 2005). These barriers perpetuate CSA not being addressed at all. While traditional curricula can attend to increasing knowledge, challenging attitudes, and developing skills, educational institutions and providers need to address the conflicting discourses, to ensure future mental health nurses are appropriately prepared to offer cogent, sensitive care to those in their care (Kennedy *et al*. 2021; Warne & McAndrew 2005).

Negative self-perceptions and self-concept have also been discussed in the male CSA literature (Easton & Kong 2017). Although negative self-perceptions are arguably also an issue for female survivors, the men in this study often referred to not being believed, due to a public perception that CSA only happens to females. In addition, some described a lack of understanding on the issue of male CSA and the overall stigmatization 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 & Kong 2017). Being 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 (Easton *et al*. 2014; Gagnier & Collin-Vézina 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.

Negative identity and psychological wellbeing in male CSA survivors have been associated with intense anger, self-harm, and suicidality, issues particularly pertinent for men (Easton & Kong 2017). Of the four men in this study, Andrew shared his incidents of self-harm throughout his life, and described his continued struggle to refrain from self-injury. A consistent theme in Tony's narrative was that of anger, and he also relayed his thoughts of suicidality. Whilst attention has previously been paid to anger, and this can be externalized and/or internalized; the latter is consistent with suicidality (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. Examples of these manifestations of anger were articulated by the men in this study. For example, 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. Externalizing behaviour such as aggression are more commonly reported in men who have been sexually abused, compared to women (Alaggia & Millington 2008; Easton *et al*. 2014), perhaps the difference being the cultural and social acceptability for men to express anger, as opposed to disclosing emotions such as sadness and fear.

In the UK, there is a lack of clinical guidance on effective therapeutic interventions for adult survivors of CSA. Whilst 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 group or individual trauma-focused cognitive behaviour therapy (CBT) over 12–16 sessions (National Institute for Health and Social Care Excellence 2017), nothing is offered for working with adults who have experienced CSA. 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 the importance of offering 'support tailored to the child or young person's needs including counselling' (National Institute for Health and Social Care Excellence 2017, p. 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' (National Institute for Health and Social Care Excellence 2017, p. 12). The skills and attitudes documented in the NICE guidelines were referred to by

the men in this study, as making a positive contribution to their mental wellbeing.

The absence of guidelines raises the question of whether a framework or model could be developed. Chouliara *et al*. (2012, p. 159) advocated for the development of a 'survivor-friendly and sensitive framework' to guide professionals in enquiring about CSA history, and responding to disclosures. However, there is also a need for a model which goes beyond disclosure and extends to support and effective communication. In this study, the men's negative experiences with professionals substantiate this need. 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 (i) Breaking the Silence; (ii) Victim Stage; (iii) Survivor Stage; (iv) 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, p 71: 95). This particular treatment model is now 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 care delivered by a compassionate therapist, guided by an in depth understanding of sexual abuse-related trauma is imperative. This is supported by previous research on therapeutic engagement in mental health nursing, where it was found that trusting relationships and the values and attitudes of the nurse were considered to be more important than the technical skills involved in therapy (McAndrew *et al*. 2014). Essentially, service users regarded the nurse's ability to relate through listening and expressing empathy to be fundamental, as opposed to the therapeutic approach adopted (McAndrew *et al*. 2014).

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 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'.

Limitations

This study was confined to a small sample size of four men, all discussing their retrospective experiences. However, at the time of being interviewed, each man offered their true reflections of how the sexual abuse had impacted their mental health. Though the number is small, this study has provided a unique insight into the experiences of male survivors of CSA.

CONCLUSION

This is the first research study conducted in the UK focusing on the therapeutic experiences of male survivors of CSA. The unique insight of male survivors' experiences, bring to the fore the negative consequences they have experienced. As male CSA is often underreported, this study highlights the barriers that men can face when trying to disclose or access support. For male survivors who are experiencing mental health problems and have not yet accessed support, it is hoped that the stories of the four men will encourage others to reach out for help, as well as providing mental health practitioners with insight as to how best they can provide support. Improvements can hopefully be made to increase awareness of male CSA and services developed that can better support men and boys. The findings suggest that improved knowledge and understanding of male CSA is likely to have a positive impact on many aspects of men's lives, including reducing negative coping strategies such as alcohol misuse and self-harm; and improving interpersonal relationships and self-confidence, while reducing feelings of self-blame.

RELEVANCE FOR CLINICAL PRACTICE

This study provides mental health professionals with a unique insight of male survivors' experiences. As male CSA is often underreported, this study highlights 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.

As frontline professionals, this study will help to inform mental health nurses of men's experiences of mental health services; in particular, their experience of accessing support, the significance of the therapeutic relationship, and the skills and attributes of a practitioner that they found are helpful. Compassion, sensitivity, and professionalism needed to be evident on the part of the practitioner to enable trust and disclosure.

As demonstrated, the overriding presentation can mask the underlying problem. It is imperative that mental health nurses take a full history to contextualize presenting problems, and they also acknowledge the importance of lived experience to enable accurate and realistic understanding of the impact of CSA. The long duration of untreated issues arising from CSA led to personal and social problems for the participants, and potentially the poor use of service time by engaging in less significant work. The current gaps in mental health practice coupled with the raising of self-awareness and self-conduct when being told about CSA urgently need addressing. These insights could also help to inform the education and training provided to mental health professionals working with male CSA survivors.

AUTHOR CONTRIBUTION

1 Laura Viliardos 60%; 2 Neil Murphy 20% 3 Sue McAndrew 20%.

ETHICAL APPROVAL

Ethical approval was granted from the University of Salford [HSCR16/96]. All participants gave written consent for their data to be used in academic publications.

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DATA AVAILABILITY STATEMENT

The data that support the findings of this study are available from the corresponding author upon reasonable request.

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APPENDIX I:

The following 'questions to consider' developed by Fraser (2004, p. 187) were used as a guide during the analysis 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?