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Clinical Work with Adult Male Incest Survivors: Therapeutic Themes and Perspectives

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CLINICAL WORK WITH ADULT MALE INCEST SURVIVORS: THERAPEUTIC THEMES AND PERSPECTIVES

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Abstract

For psychotherapists, encountering clients who have experienced sexual trauma or abuse is inevitable, whether or not the abuse is disclosed to the therapist; however, mental health professionals receive extremely limited (if any) training on how to identify or effectively support adult clients who are survivors of childhood sexual abuse (CSA). Many people who experienced CSA, especially those who identify as male, remain isolated and invisible in their suffering as adults even within therapeutic spaces, facing what feel like insurmountable barriers – both internal and external – to getting help. When sexual abuse is intrafamilial, these barriers are both amplified and multiplied; and for reasons that this dissertation explores in depth, the same is true when the victim is a male. This study aimed to explore and qualitatively analyze the experience of psychotherapists with clinical expertise in providing mental health treatment to men with a history of CSA, using interpretative phenomenological analysis as a methodological framework. The author interviewed six licensed therapists about their perceptions of therapy with these clients, issues related to the abuse, particular challenges for male survivors, and how they experienced the therapeutic relationship with these clients. Through intensive analysis of interview transcripts, phenomenological clustering of data and inclusion of direct quotations from participants, the study's findings illustrate a tragically unrecognized reality about the plight of male survivors, their critically unmet mental health needs, and parallel challenges faced by the providers who treat them.

Keywords: child sexual abuse/incest, male survivors, therapist experience, interpretative phenomenological analysis

PsyD Program Signature Page

This dissertation, written under the direction of the candidate's dissertation committee and approved by members of the committee, has been presented to and accepted by the faculty of the PsyD Program in Clinical Psychology in partial fulfillment of the requirements for the degree of Doctor of Psychology. The content and research methodologies presented in this work represent the work of the candidate alone.

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When I first started asking the questions that eventually became the basis for this dissertation, I found myself at a loss for where to find answers or even begin to look for them. The process of imagining, designing, proposing, implementing, processing, and documenting the results of this study has been incredibly humbling, and has contributed to my personal (and professional) growth in more ways than I probably realize. I am profoundly and perpetually grateful for the support I've received from loved ones along the way, and for the abundance of smart, thoughtful, open-minded, caring, diverse, emotionally engaged people whose voices and stories keep me in a constant state of learning.

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Lastly, I want to acknowledge the endless patience, kindness, encouragement and guidance of Dr. Rick Ferm, who has been my rock (aka academic advisor, professor, mentor, and dissertation chair) since the program's inception – thank you for believing in me.

Dedication

This study would not have been possible without the immense courage of the person who initially brought this issue into my awareness, whose capacity for deep reflection and painful honesty will forever inspire me.

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CHAPTER I

Introduction to the Study

Statement of the Problem

The purpose of this study is to explore and qualitatively analyze the clinical presentations of adult men who as children were sexually abused by a family member, in addition to treatment approaches that are being utilized with this population and specific clinical considerations. Even within existing research and emerging professional discourse acknowledging the problem of child sexual abuse (CSA) and its prevalence, male survivors (particularly of incest) constitute a substantial group of individuals that remains remarkably under-represented in both of these spheres. Research indicates undeniable negative effects of childhood sexual abuse on children's psychological wellbeing and their development into adulthood; however, there has been a significant gap in the literature in the understanding of incest and other forms of sexual abuse from the perspectives of male survivors.

Additionally, the majority of treatment studies do not distinguish between individuals abused within the family or by someone outside the family, despite research suggesting certain disparities between these two groups (including increased guilt and/or reluctance to disclose abuse among those abused by a relative, as well as decreased improvement following therapy). This lack of specificity within research creates challenges in teasing out the differences between the impacts of CSA within or outside of a family, and as has been previously documented in various literature, the secrecy and stigma surrounding sexual abuse is exacerbated in situations where incest has occurred, and even further exaggerated when the victim is a male. Grappling with and trying to navigate the complexities of holding these painful intersecting identities (male survivor, incest survivor) is a burden that no child or adult is equipped to face, or should have to cope with alone. Mental health professionals have a responsibility to create space for these critically important conversations to happen – both on a micro (individual/within the context of therapy) and macro (advocacy and education in the public sphere) level.

Purpose of the Present Study

As previously described, the purpose of this study is to explore and qualitatively analyze the subjective experience of mental health professionals who have had substantial clinical experience in providing psychotherapeutic treatment to adult male incest survivors. There is limited research on this subject, which presents specific challenges for both individuals affected by this form of abuse and for the clinicians trying to support them and provide effective mental health treatment. In determining common themes identified by clinicians working with male CSA survivors, a qualitative method to data collection and analysis was utilized due to the inherently unique experience and resulting subjective narrative of each clinician. More specifically, a phenomenological approach was employed to ascertain themes, observations and specific therapeutic considerations in a sample of mental health professionals who have significant clinical experience working with male survivors of incest. This approach provided a framework for participants' experiences and insights to be explored in great detail, and each subject's account was considered in its larger context as well as within the individual's narrative.

Clinical and Theoretical Relevance

The value of this research is in discovering how mental health clinicians experience their work with male survivors, finding commonalities in strategies that are being used and insights gained, as well as areas of disagreement or that lack clarity. The findings of this study may be used to inform (or chronicle) best clinical practices with adult male incest survivors, as well as detect areas where future research is needed; findings may also promote much-needed awareness and future collaborative dialogue among health professionals about this subject. Throughout this research process, a primary goal has been to facilitate space for mental health providers who are doing this work to share thoughts, ideas and insights, and to reciprocally support one another in their professional endeavors. Accessing and analyzing the knowledge and understanding of these therapists may create a foundation for awareness about the

prevalence of CSA and adult survivors in therapy to be expanded, and through which survivors, their loved ones, and treatment providers might find a sense of community or belonging.

Author Note Regarding Language and Terminology

For purposes of conciseness and clarity, the author uses certain labels or identifiers that are deemed appropriate, but may not accurately represent the experience of individuals being referred to. For example, the term survivor is used throughout to describe a person with a history of childhood sexual abuse or victimization; however, there are times when the term victim provides more descriptive or linguistic accuracy. While the most thorough label might be to each time refer to “A male-identifying person who experienced childhood sexual abuse by a family member or caregiver”, this is shortened throughout to more efficient and easily recognizable denominators.

The following is a review of the literature on CSA, including incest and male survivors of sexual abuse, as well as prevalence and reporting of child sexual abuse in general, and among males and incest survivors. It will also cover psychological impacts of child sexual abuse, gender stereotypes impacting male survivors, clinical considerations with this population, as well as clinicians’ experiences working with male survivors, specific treatment approaches in use, and existing psychometric tools related to incest and child sexual abuse.

CHAPTER II

Review of the Literature

Definition(s) of Child Sexual Abuse

In their manuscript on child sexual abuse (CSA), Murray, Nguyen and Cohen (2014) cite multiple definitions of the term and explain that CSA encompasses numerous types of sexually abusive acts toward children, such as rape, sexual assault, incest and commercial sexual exploitation. There are a variety of definitions of CSA in use, with each containing subtle distinctions in terminology or coverage that impact surveillance and reporting efforts, which may in turn lead to altered service, policy or legal implications.

In a set of recommendations that were "designed to promote consistent terminology and data collection related to child maltreatment", the United States Centers for Disease Control and Prevention (CDC) identifies child sexual abuse as "any completed or attempted (non-completed) *sexual act*, *sexual contact* with, or exploitation (ie, *noncontact* sexual interaction) of a child by a caregiver" (Leeb, et al., 2008). The CDC elaborates on the above terms:

- *Sexual acts* include contact involving penetration, however slight, between the mouth, penis, vulva, or anus of the child and another individual; or penetration, however slight, of the anal or genital opening by a hand, finger, or other object. Sexual acts can be performed by the caregiver on the child or by the child on the caregiver; a caregiver can also force or coerce a child to commit a sexual act on another individual (child or adult).
- *Abusive sexual contact* includes intentional touching, either directly or through the clothing, of the following: Genitalia; anus; groin; breast; inner thigh; or buttocks. Abusive sexual contact *does not involve penetration* of any of the above. Can be performed by the caregiver on the child or by the child on the caregiver; or between the child and another individual (adult or child) through force or coercion by a caregiver. Abusive sexual contact does not include touching required for the normal care or attention to the child's daily needs.

- *Noncontact sexual abuse* does not include physical contact of a sexual nature between the caregiver and the child. Noncontact sexual abuse can include the following: 1) Acts which expose a child to sexual activity (e.g., pornography; voyeurism of the child be an adult; intentional exposure of a child to exhibitionism); 2) Filming or recording a child in a sexual manner (e.g., depiction, either photographic or cinematic, of a child in a sexual act); 3) Sexual harassment of a child (e.g., *quid pro quo*; creating a hostile environment because of comments or attention of a sexual nature by a caregiver to a child); 4) Prostitution of a child (e.g., employing, using, persuading, inducing, enticing, encouraging, allowing, or permitting a child to engage in or assist any other person to engage in, prostitution or sexual trafficking.

Leeb, et al. preface these guidelines by reminding readers, “Recognize that the parent and child behaviors and child outcomes which can be markers for child maltreatment are diverse and can result from other stressors or trauma.” Researching and attempting to identify and understand child maltreatment within discrete categories presents abundant challenges (as does any systemic approach that aims to measure, or quantify an element of human experience).

In a book titled *Abused Boys: The Neglected Victims of Sexual Abuse*, Hunter (1990) describes child sexual abuse as any of the following behaviors: An adult sexually touching a child; having a child touch an adult sexually; photographing a child for sexual purposes; sexualized talk; showing pornographic materials or making them available to a child; making fun of or ridiculing a child’s sexual development, preferences, or organs; an adult exposing his or her genitals to a child for sexual gratification; masturbating or otherwise being sexual in front of a child; voyeurism; forcing overly rigid rules on dress or overly revealing dress; stripping to hit or spank, or getting sexual excitement out of hitting; verbal and emotional abuse of a sexual nature; having a child be sexual with animals; engaging a child in prostitution; or witnessing others being sexually abused. Hunter, a licensed psychologist with extensive experience treating male survivors of CSA, notes that for children who are sexually abused, it is rarely just

one type of abuse, and reflects that the above list of types of sexual abuse is by no means a complete one.

In 2016, the Terminology and Semantics Interagency Working Group on Sexual Exploitation of Children – comprised of representatives from organizations including the International Centre for Missing and Exploited Children, INTERPOL and United Nations Children's Fund, among others – published Terminology Guidelines for the Protection of Children from Sexual Exploitation and Sexual Abuse. These guidelines specify that the sexual abuse of children "requires no element of exchange, and can occur for the mere purpose of the sexual gratification of the person committing the act" and that it can be committed without explicit force, given other elements at play such as power, authority, and/or manipulation. According to these internationally accepted definitions, CSA serves as an appropriate umbrella term for many other more specific forms of child exploitation and abuse; the guidelines state that child sexual abuse "defines the harm caused to children by forcing or coercing them to engage in sexual activity, whether they are aware of what is happening or not" (p. 20).

Definition of incest as a specific form of CSA. Lew (2004) argues that, "Incest appears to cut across all racial, religious, ethnic, age, class, geographical, and rural/urban/suburban lines" (p. 15). The same author refers to incest as "a violation of a position of trust, power, and protection," and points out that it differs from other forms of sexual abuse in that the perpetrator is assumed to stand in a protective or parental role to the victim.

According to terminology guidelines published by the Interagency Working Group (2016), incest refers to the sexual activity between two individuals who are closely related in a family, and incest involving a child constitutes sexual abuse. While certain legal systems require blood ties for a sexual activity to be considered incest, others have expanded the notion to include family members who are not blood-related but who are still thought to be too close to engage in sexual activities (i.e., step-parents). Major dictionaries consider incest to be "sexual

relations between people classed as being too closely related to marry each other" or "the crime of having sexual intercourse with a parents, child, sibling, or grandchild" (p. 20).

For the purpose of an exploratory study on male survivors' perspectives of incest and sexual abuse, Ray (2001) defines incest as sexual activities such as intercourse, exposure, fondling of breasts and genitals, oral-genital contact, and penetration of any kind with blood/nonblood family members and/or with quasi-family members. "Quasi-family" member refers to those substituting in family, caretaker or authority roles from whom the child should not expect sexual advances, such as family friends or a parent's sexual partner (Benward, & Densen-Gerber, 1975).

Male survivors of incest. The majority of treatment studies do not distinguish between individuals abused within the family or by someone outside the family, despite research suggesting certain disparities between these two groups, such as increased guilt and/or reluctance to disclose abuse among those abused by a relative, as well as decreased improvement following therapy (Murray, et al., 2014; DiPietro, et al., 1997; Hetzel-Riggin, Brausch, & Montgomery, 2007). The lack of specificity within most of the relevant research creates challenges in teasing out the differences between the impacts of CSA within or outside of a family. In a 1975 study investigating incest as a potential cause of antisocial behavior, Benward and Densen-Gerber point to a clear need to identify causes of incest and to develop the tools for detection, prevention, and treatment. In their conclusion, the authors call for future research to help "move beyond the taboo toward prevention of this age-old trauma" (p. 340). Over 40 years later, research on this topic remains limited and the largely hidden population of male incest survivors continues to be under-represented in the clinical literature.

Ford, et al. (1999) explain that, "Children who are incestuously abused suffer the dynamics of traumatic sexualization *and* betrayal within a relationship that is defined as nurturant. … The consequences of this betrayal can be severe" (p. 140). Furthermore, according to Huss, et al. (2012), "A specific characteristic of incest is the secrecy that is

intensified through the need of both sides of the incest to deny the social and psychological reality of the sexual contact" (p. 402). Hetzel-Riggin, et al. (2007) conducted a meta-analytic study examining treatment outcomes for survivors of CSA, and found that a higher percentage of intrafamilial abuse was associated with lower effect sizes. The authors concluded that if the perpetrator of sexual abuse is a family member, the child may realize that someone they trusted (and may even be dependent on) has treated them with disregard to their wellbeing and safety, which can lead to more secondary problems.

In the book *Men Surviving Incest*, Thomas (1989) addresses some of the potential physical consequences of incest, such as broken bones, sexually transmitted diseases (including AIDS), and physical damage from anal, genital or oral abuse. Thomas adds that while other types of damage may not be as easily linked to CSA, "We are physiological, psychological, spiritual entities, and the traumatic stress of abuse when held inside for years wears on our bodies as well as our spirits" (p. 13).

Ray (1997) conducted an in-depth exploratory study (n=25) to examine the severity of the immediate, long-term, and overall effects of child incest. The study was designed to identify whether there was an existing relationship between the severity of the long-term effects, the overall effect, and various demographic variables. Results confirmed previous findings that male survivors suffer from a negative self-concept as a result of sexual abuse, and all of the subjects reported marked to severe negative effects in the immediate psychological/emotional sphere. Ray points out in conclusion that having a more accurate understanding of the severity of the aftereffects of incest and their correlation with demographic variables may aid therapists in detecting and assisting male survivors in resolving a past incest experience.

In another article published several years later, Ray (2001) again emphasizes that further qualitative research was necessary to better understand male survivors' experiences of incest. The secrecy and stigma surrounding most sexual abuse is exacerbated in situations where incest has occurred, and even further exaggerated when the victim is a male.

Prevalence and Reporting of CSA

The World Health Organization (WHO) published a World Report on Violence and Health that likened the magnitude of CSA to an iceberg floating in water, in that a minute portion is reported to authorities, a slightly larger but still only partial portion reported on surveys, and an entirely unknown amount goes unreported due to fear, shame and other factors (Krug, et al., 2002). Evidence indicates that experiences of childhood sexual abuse often go undisclosed and unrecognized. Furthermore, of the survivors who told someone in childhood, many were neither supported nor protected, and a negative response to the disclosure was found to be correlated with increased current mental distress (Easton, 2013).

Numerous studies have attempted to determine factors influencing disclosure. Dipietro, Runyan, and Fredrickson (1997) conducted a retrospective record review at a hospital referral clinic (*n*=179, with an average participant age of 7.5 years) which confirmed previous research indicating that disclosure was related to older age. The authors propose that this is due to the fact that communication is clearly facilitated by developmental maturation, and an older child, adolescent or adult is likely to be more cognizant of social norms and less prone to being influenced by the perpetrator's request for silence. Stoltenborgh, van Ijzendoorn, Euser and Bakermans-Kranenburg (2011) conducted a comprehensive meta-analysis combining prevalence figures of childhood sexual abuse reported in 217 publications published between 1980 and 2008, with a total of nearly 10,000,000 individual participants. Their analysis suggests that the combined global prevalence of CSA is approximately 11.8% or 118 per 1000 children (7.6% of males and 18% of females). The study also confirmed a substantial disparity between the combined prevalence from self-report and informant studies; self-report studies yielded a combined rate that was 30 times higher than the rate of informant studies (127 per 1000 children versus 4 per 1000 children).

This indicates that methodological issues drastically influence the self-reported prevalence of child sexual abuse, and points to a lack of clarity or consistency in data gathering

when it comes to this subject. Murray, et al. (2014) attribute the difficulty of accurately measuring the prevalence of CSA to multiple methodological issues; definitions of CSA vary across studies (i.e., age used to define childhood, if peer abuse is included, types of acts considered sexual abuse), and prevalence estimates are also influenced by decisions of sample selection, survey methods and screening questions utilized. Ultimately, the knowledge base around prevalence of CSA – including any specifics as narrowed by gender of the victim or abuser or the victim's relationship with the abuser – is vastly limited and cannot be quantified accurately given the complex challenges to gathering accurate data.

Prevalence and reporting of CSA among males. There has been a significant gap in the literature in the understanding of incest and other forms of sexual abuse from the perspectives of male survivors (Ray, 2001). Easton (2013) refers to men who were sexually abused during childhood as "a stigmatized, under-studied, and marginalized population that is at risk for long-term mental health problems" (p. 344). Easton conducted a cross-sectional survey using purposive sampling (*n*=487) exploring disclosure patterns for male survivors of CSA and their relationship to current mental health, and found that, on average, participants waited more than two decades to first tell someone about the CSA, and three decades to have an in-depth discussion of the CSA. Furthermore, only 26% of participants told someone during their childhood and 15% reported the CSA to authorities; these results are consistent with other studies on disclosure rates and self-silencing within this population. O'Leary and Barber (2008) designed a survey (*n*=296) to test the hypotheses that males are less likely than females to disclose CSA at the time it occurs and take longer than females to discuss their experiences, and their research supported the assertion that males are more likely to feel silenced following childhood sexual abuse than are females, and that they tend to take significantly longer to discuss their experiences of the abuse.

Prevalence and reporting of CSA among incest survivors. Ray (2001) found that 60% of male survivors in therapy sought treatment for suicidal ideation and depression, while

52% had addictions to drugs and alcohol. Interestingly – and tellingly of the group's invisibility – only 4% of the participants in that study initially sought therapy for sexual abuse. This finding supports past studies that found male survivors tend to present to therapy with a variety of other issues and may disclose about the abuse once in treatment.

According to a study on disclosure of child sexual abuse among adult male survivors that was published in the *Clinical Social Work Journal*, delays in disclosure are extremely detrimental; the research indicated a positive correlation between the length of time before first telling someone about the CSA and mental distress including symptoms of anxiety, depression, somatization, and suicidality (Easton, 2013). This research also determined – similarly to prior findings in other studies (i.e., Smith, Letourneau, Saunders, et al., 2000; Spataro, Moss, & Wells, 2001) – that being abused by a family member can even further inhibit disclosure for male survivors, such as decreased rates of reporting to authorities, telling someone in childhood, and discussing with a partner or spouse in adulthood.

Psychological Impact of CSA

Research indicates undeniable negative effects of CSA on children's psychological well-being and their development into adulthood (Stoltenborgh, et al., 2011). Studies have confirmed immediate and long-term effects of CSA on males including (but not limited to) depression, anxiety, shame and stigma, substance abuse and other self-destructive behaviors (Ray, 1997). The comprehensive literature review on child sexual abuse by Murray and colleagues (2015) cite numerous studies demonstrating the varied mental health effects of CSA and advises that survivors of child sexual abuse are at increased risk for posttraumatic stress disorder (PTSD), depression, anxiety, anger, guilt, shame, inappropriate sexual behavior, and other behavioral and emotional issues throughout their lifespan. Their report also shows that CSA survivors are more likely to experience psychosocial and health problems in adulthood including problematic substance use, suicide attempts, and family or relational problems.

Attachment theorists and practitioners of contemporary psychoanalysis have delved into the complex and deeply ingrained nature of early attachment relationships and their profound effects on subsequent psychosocial and cognitive development. Fonagy and Allison (2014) explain that while a secure attachment history – where the child felt recognized and thereby gained confidence in their own experience, belief and judgment – increases the likelihood of trust in a credible communication source, a disorganized attachment history may generate epistemic hypervigilance, defined by the authors as the mistrust of both the attachment figure and strangers as a source of information. Their research showed that a history of disorganized attachment leaves children with the unresolvable question of who they can trust, often mistrusting attachment figures, strangers, and even their own experience. The child, in other words, “Seeks others to confirm or deny his/her own understanding, which he/she has little faith in, but, being unable to trust information received from others, remains in a state of uncertainty and epistemic vigilance” (p. 9). The attachment trauma from being sexually abused by a family member or caregiver is a type of developmental adversity particularly likely to trigger destruction of trust, which in adulthood may present as inability to internalize or communicate emotions, and being generally experienced as difficult to connect with or interpersonally inaccessible.

Psychological impact of CSA on males. In examining male survivors’ perspectives on their experiences of childhood sexual abuse, Ray (2001) found common themes such as anger, isolation, depression and suicidality, addictions, low self-esteem and interpersonal difficulties. Dorahy and Clearwater (2012) conducted a study with the hope of better understanding the experience of shame and guilt in men with a history of childhood sexual abuse, and were able to identify four major themes that characterized the experiences of these males, including a pervasive sense of unconditional shame, denial and doubt from others which heightened the sense of shame, dissociation, and a sense of uncontrollability with regard to their own anger and their experience of emotional pain and “haunting intrusive symptoms” (p. 173). Another study examined the long-term impact of childhood sexual abuse on men in eight life areas,

citing major and pervasive disturbances in each category: Social, psychological, physical, sexual, familial, sense of self, relation to men, and relation to women (Ray). Vulnerability to borderline personality structure is also recognized as a developmental consequence of incestuous child abuse, as related to the impact of the abuse on the victim's capacity for self-regulation.

Lew (2004) reported that men who participated in a weekend recovery workshop for survivors compiled a list containing responses to the question, "In what ways does childhood sexual abuse continue to affect your adult life?" (p. 6). Common responses included the following: Intense and violent nightmares; fear that everyone is a potential attacker; shame; anger; guilt; fear of intimacy; difficulties in communicating; self-abuse; suicidality; isolation; and countless other ongoing impacts. Ray (2001) echoes these statements, asserting that empirical studies have identified a number of long-term negative effects of CSA on males, such as "Fear, anger, depression, self-destructive behavior, anxiety, feelings of isolation, shame and stigma, poor self-esteem, [and] substance abuse" (p. 50).

Gender Stereotypes Impacting Male Survivors

Teram and colleagues (2006) wrote an article based on an ongoing multidisciplinary, multi-site study exploring ways that health professionals can best address the health care needs of adult survivors of CSA. Many of the survivors interviewed in the study reported feeling like being male added an additional series of barriers to addressing issues associated with their abuse as children. The authors argue that while the sexual abuse of girls has been institutionalized as a social problem (as evidenced by the establishment of programs to support female survivors), such resources are not as readily available to male survivors.

Similarly, Richey-Suttles and Remer (1997) assert that current societal attitudes discourage male victims of sexual abuse from sharing their experiences, which is why this topic has not been adequately addressed in the literature. These sociocultural norms and expectations about gender can be deeply damaging. Lew (2004) identifies a "particular focus of

the problem faced only by men," which arises from "our culture providing no room for a man as victim. … A 'real man' is expected to be able to protect himself from any situation" (p. 40). Cochran (2006) writes that, "The maxim 'big boys don't cry' is potentially one of the most emotionally damaging of [the negative, restrictive admonitions that mirror the culture's prevailing attitudes about masculinity]" (p. 91). When these attitudes are internalized by boys and men, this proscription against sadness and crying "deprives them of the full depth of the universal human experience of loss," causing them to repress and deny feelings associated with such traumas. Ray (2001) also picks up on the sociological factors contributing to this gender-based distinction, writing that, "Society in general does not recognize the victimization of males" (p. 50). This sense of social unacceptability can create an element of emasculation that both reinforces and complicates the shame already felt by male survivors of CSA.

Clinical Implications and Treatment Considerations with Survivors of CSA

Hunter (1990), whose clinical expertise is working with adult male CSA survivors, explains why many victims of CSA remain unidentified, writing that the clinicians they meet with do not give them permission to talk about sexual issues, either by never bringing it up and thereby implying that the topic is taboo, or by glossing over certain experiences because what was done to a certain client does not fit with the professional's definition of abuse. Teram, et al. (2006) write that, "While acknowledging and disclosing past CSA is the responsibility of individual survivors, it is the collective responsibility of all health professionals to educate themselves about working effectively with male and female survivors of CSA" (p. 515).

Hunter (1990) also notes that some mental health professionals report that they avoid bringing up the subject of incest, "because they don't want to insult the client by implying that he might have come from 'that kind of family,' or because it might encourage the client to make up false incest experiences" (p. 29). The author describes observing counselors during the assessment portion of a training he gave and noticing that many clinicians used open-ended questions throughout the interviews until they reached the topic of sexual abuse, at which point

one of the counselors asked his client, “You weren’t sexually abused, were you?” (p. 29). While that is just one example, this type of framing or covert discouragement of disclosure is unfortunately common, and does not allow space for clients to speak freely or comfortably about past abuse.

A study by Simpson and Fothergill (2004) explored clinicians’ views on appropriate therapeutic pairings when it comes to working with adult survivors of CSA, and noted that many people, perhaps incorrectly, assume that survivors would prefer to work with a therapist of their same gender. In fact, one participant in their study disagreed emphatically with that notion, arguing that the primary objective of survivor counseling is to develop appropriate trust with both sexes. After conducting a systematic review of the perspectives of adult survivors of CSA on psychotherapy and counseling services, Chouliara (2012) reported that survivors have identified awareness and specialist knowledge about CSA and complex trauma as core requirements for a positive and constructive therapy experience.

In a study on the needs of adult survivors of CSA when it comes to community mental health, Harper, et al. (2008) found that therapists were seen as most helpful when they were able to instruct survivors about using effective strategies for managing intense emotions, and help them maintain a positive self-image in spite of their presenting issues. For adult survivors of CSA, learning to self-regulate their emotional and affective experience may be a key component of successful psychotherapy; this is consistent with the attachment-based literature on mentalization and reflective functioning in relation to self-regulation and the disruption sexual abuse by primary caretakers has on this personality domain. The study’s participants agreed that it was most beneficial when their therapists encouraged them to come to their own solutions in their own time (vs. imposing a preexisting clinical structure or prescriptive timeline that could detract from their sense of self-efficacy and determination). Participants also emphasized the importance of clinicians trying to understand the intense fear and shame associated with the expression of their feelings around these issues.

Clinical considerations with male survivors of CSA. Teram, et al. (2006) conducted a study exploring the experiences of male survivors of childhood sexual abuse in interacting with health care professionals and found that, “Much work is required before men’s experience of victimhood is acknowledged by society in general and by health professionals in particular” (p. 508). The same authors cite one participant as suggesting that clinicians have more sensitivity towards female than male survivors because they do not recognize the high prevalence of male CSA victims, and stating, “To be fair, men don’t disclose as frequently or as easily as women do … so therefore [health professionals] aren’t going to ask the question. … But I think they need to be better aware of some of the signs, especially in men, and to, if necessary, ask the questions” (p. 511).

Adams and Betz (1993) point out that research indicates the existence of negative attitudes toward clients who have been the victims of childhood sexual abuse – victims have been accused of lying, fantasizing, seducing the adult, and partially contributing to the incestuous act. They also identify a gap in the research, pointing out that, “Conspicuously lacking in this literature is cognizance of the fact that the victims of incest can be male and the perpetrators female” (p. 210). These authors found that male counselors endorsed narrower definitions of incest and were more likely to believe that incest claims are not necessarily true, while female counselors were more optimistic that the survivor could overcome the problem. Additionally, their research suggests that therapists will encounter, and need to contradict, “considerable self-blaming in incest survivors” (p. 215).

Easton (2013) suggests that using a lifespan perspective is important for both gathering information during a clinical assessment, and potentially for treatment of male survivors of CSA. Although maintaining secrecy about the sexual abuse may at times function as a protective mechanism, decades of holding the truth alone may increase feelings of isolation and stigma for survivors. In this circumstance, a clinician can help the client learn that disclosing about the abuse will not necessarily mean being ostracized or judged, that he is not alone, and that talking

in depth about his experience of CSA might be useful in better understanding himself in relation to current mental health or psychosocial issues.

Easton (2013) points out that rarely have studies involved experts in the field who work with members of this population [adult male CSA survivors] in clinical practice on a daily basis, suggesting that, “Studies that incorporate the valuable experiences and clinical wisdom of practitioners who specialize in treating male survivors would be useful for general practitioners who also may treat men who have histories of CSA” (p. 352). Exploring clinicians’ perspectives on their therapeutic work with adult male incest survivors may benefit not only male survivors and their treating therapists, but also a wide range of other health providers that inevitably interact with this population, perhaps unknowingly.

Clinicians’ Experiences Working with Male Survivors

Training deficits in treating survivors of CSA. Brown, et al. (2011) explain that despite the fact that survivors of childhood sexual abuse represent a disproportionate percentage of individuals who are clients of mental health services, very few mental health professionals receive formal training in either the assessment or treatment of sexual abuse, incest or trauma. Easton (2013) argues that clinical graduate programs “should be infused with information on male survivors of CSA and continuing education workshops should offer opportunities for licensed clinicians to improve their treatment skills with this population” (p. 352). While research highlights the critical role of mental health professionals in the recovery of male survivors from CSA, other studies have indicated that clinicians may hold biases that in fact obstruct the identification, assessment and treatment of male survivors (Spataro, Moss, & Wells, 2001). Numerous studies indicate that cultural norms discourage clinicians from inquiring about sexual abuse in male clients, which contributes to failed identification and missed opportunities for important clinical work.

McElroy and McElroy (1991) suggest that not only do therapists lack specific training to deal with issues around sexual abuse, but they are actually “covertly trained to avoid such

issues" (p. 48). They assert that, "Therapists who have not worked through their own countertransference issues regarding incest are at risk to cause more harm than good," and in light of this, clinicians working with incest survivors must overcome these obstacles by becoming more aware of their own attitudes, beliefs and values. It is especially important that feelings of anger or blame are thoroughly explored; the countertransference experienced by psychotherapists working with incest survivors has the potential to reinforce the individual's sense of neglect and exploitation, which is why clinicians doing this work should be receiving adequate training and supervision. The authors recommend that in order to minimize countertransference difficulties, in addition to specialized training and supervision, therapists working with incest survivors may want to seek personal therapy or psychoanalysis, as well as participate in group case discussions and outside consultations.

Treatment Approaches

Hetzel-Riggin, et al. (2007) conducted a meta-analysis investigating the independent effects of various treatment elements on different secondary problems related to childhood and adolescent sexual abuse, in addition to moderators of treatment effectiveness. This study reviewed 28 studies that provided treatment outcome results for youth who had been sexually abused, and the authors concluded that the choice of therapy modality should correlate with the individual's most distressing secondary problem. Behavioral outcomes improved in response to abuse-specific, supportive and group therapy, whereas psychological distress levels were most responsive to cognitive-behavioral and other individual psychotherapy modalities. It is important to note that the presence of intrafamilial abuse did act as a significant moderator of the effectiveness of treatment, as did ethnicity of the sample and length of therapy; however, age, gender and therapist training were not significant moderators of the effectiveness of treatment. This reaffirms the need for additional research on treatment outcomes that is specific to survivors of incest, male survivors, and that factors in additional individual differences.

Cochran (2006) describes the therapy relationship as “a vessel for reclaiming, holding, and learning to contain the lost sadness and grief that a man has carried throughout his life” (p. 92), pointing to the importance of a therapeutic foundation of trust and safety. Ford, et al. (1999) advocates for a dialectical framework when working with adult survivors, explaining that the dialectical approach “acknowledges the tensions and respects the decisions made by survivors in their efforts to make sense of their lives … and underscores the many intra- and interpersonal issues faced by adult survivors and their spiraling, rather than linear, progression” (p. 155). Freedman and Enright (1996) conducted a study to examine forgiveness as a therapeutic goal for incest survivors, and found that forgiveness can be psychologically beneficial for incest survivors, a group of individuals who have experienced “one of the deepest hurts possible” (p. 989).

Male survivors expressed that the social aftereffects of CSA were perhaps the most encompassing, which is why Ray (2001) recommends group therapy and suggests that “The curative factor of universality in group therapy could provide the needed identification with other male survivors to reduce or eliminate the sense of isolation/aloneness” (p. 57). Voigt and Weininger (1992) explain that very few empirical investigations have been conducted to support the efficacy of group treatment models with incest survivors, although one study found that short-term group therapeutic treatment resulted in reduction of overall psychological distress and depression for these individuals.

In support of this idea, Huss, et al. (2012) posits, “An incest survivors group enables the survivors to create a group narrative that validates the subjective and silenced experience within a social context that places blame on society rather than on the individual” (p. 402). Huss and colleagues suggest that individual insight-based interventions may be less effective for incest survivors in confronting defenses than therapy within a group of fellow sufferers, suggesting art therapy interventions within a group treatment context to enable survivors to address the trauma in a way that is indirect enough to be tolerable. Lew (2004) also recommends participation in

group therapy for male incest survivors, pointing out that group participation is an important means of exploring one's identity within a safe context. He writes that, "Once the pain is felt in a non-abusive atmosphere, it can be examined, understood, put into perspective, and diminished" (p. 234).

With regards to approaching group treatment for survivors of CSA, Lew (2004) emphasizes the distinction between "comfort" and "safety" in a group therapy setting, explaining that, "Group participation will always be important, but rarely comfortable. … The safety of the group—*genuine, uncomfortable safety*—provides what [clients] need to do the work of recovery" (p. 235). This suggests that group members can offer acceptance and support of one another simply by being themselves and exploring their own internal experiences; this peer-to-peer connection, and the sense of normalization or identification that accompanies it, will be critical in moving individuals toward their treatment goals.

Lew (2004) also addresses the question of group composition, citing that he has "found no clinical justification for ranking the severity of different types of sexual child abuse," since the similarities of the effects and feelings are much more important than the specifics of the abuse. Lew continues to explain that, "I stress this point because I have found that survivors are able to latch on to any excuse for feeling that they don't belong in the group" (p. 233). This is an important insight for clinicians doing this work so that they can be conscientious about creating a safe space where individuals can feel connected and supported without exposing too much of themselves. Follette, et al. (1991) attempted to identify individual factors that predict response to treatment in a group therapy setting, and results of their study suggest that clinical benefits of group therapy can be maximized with the addition of individual therapy, and couples therapy if applicable, either before or concurrent with group.

Voigt and Weininger (1992) investigated specific therapeutic interventions and direct client responses to those interventions, and discovered that stabilizing interventions (those directed towards group members feeling understood, acknowledged, and reinforced) provided

most effective in generating deeper levels of client experiencing in the initial phases of the group therapy. In this study, three varieties of therapist responses were designated as stabilizing: *information-giving* (where the therapist supplies factual information), *minimal encouragement* (where the therapist states simple agreement, acknowledgement, or understanding), and *approval*-reassurance (where the therapist provides emotional support, approval or reinforcement). The authors found that at the onset of therapy, group members were less responsive to activating interventions, but by the fourth session were better able to receive and respond to these interventions.

Activating interventions in the aforementioned study by Voigt and Weininger (1992) included *confrontation* (where the therapist points out discrepancies between stated words/behaviors and actual words/behaviors), *interpretation* (where the therapist comments on defenses, feelings, resistances or patterns not yet recognized by the client), and *non-verbal referent* (where the therapist mentions some affective gesture manifested by the client). In the final phase of the treatment, members displayed productive responses to interpretive and confronting interventions, which is consistent with Yalom's (1985) premise that groups need to develop cohesion before members can engage effectively in challenging therapeutic interventions.

Survivors of incest and other forms of CSA may experience existential, identity-based, or spiritual consequences of the abuse. Beveridge and Cheung (2004) note that female incest survivors often struggle with ambivalent and hostile feelings toward God, religion and spirituality, and as a result of this, "Survivors may find a focus on spirituality as a way to replace what was stolen from their past in childhood" (p. 111). These authors identify self-integration as a goal, defining this as a complex process in which the survivor "identifies and disputes her irrational beliefs, retrieves her lost self, and gains control of her environment," and suggest that, "Successful treatment incorporates learning about connections with not only the physical and emotional self, but also an appreciation of the self in relation to spiritual beliefs" (p. 116).

Psychometric Tools Related to CSA and Incest

In terms of current screening and assessment tools that specifically relate to incest, the Substance Abuse and Incest Survey—Revised (see Appendix C) consists of 28 perception items that are answered using a Likert scale where small values indicate greater agreement (1 = Strongly Agree, 2 = Agree, 3 = Disagree, and 4 = Strongly Disagree) (Janikowski, et al., 1997). This assessment tool looks at five relevant factors: Stigma and resistance to counseling, substance abuse and incest, ambivalence, fear and anticipation, and receptivity to counseling, including prompts such as, “I do not talk about incest with my counselor because I feel that it is my fault,” “If I were to get counseling for incest, I would like to have group counseling with others who have had incest contacts,” and “I do not talk about incest with my counselor because I think my counselor can’t deal with it”. This tool could open up a number of important conversations between a clinician and client, as well as provide useful clinical information about the client’s self-regard and fears about counseling.

The Responses to Childhood Incest Questionnaire (see Appendix D) consists of 52 items that are divided into 11 subscales that fit within the diagnostic criteria for PTSD and hypothesized stress response themes (Donaldson, & Gardner, 1985). Stress response factors include: Vulnerability and isolation (6 items), fear and anxiety (6 items), guilt and shame (5 items), anger and betrayal (5 items), reaction to the perpetrator (4 items), sadness and loss (4 items), and powerlessness (3 items). PTSD factors are: Intrusive thoughts (5 items), intrusive behaviors and emotions (5 items), detachment (3 items), and emotional control and numbness (4 items). Clients are asked to read each item and indicate on a 6-point scale (where 0 = never, 5 = always) how frequently they experience each symptom. Sample items include statements like, “I feel guilty that I didn’t do something to stop the incest,” and “I feel detached and estranged from others”. This questionnaire is specifically targeted to individuals with traumatic incest experiences in their history and, as such, may be more likely to capture relevant diagnostic parallels to PTSD.

CHAPTER III

Methods

The aim of this research was to explore and qualitatively analyze the experiences and perceptions of mental health professionals who have had substantial clinical experience in providing psychotherapeutic treatment to adult male incest survivors. This study used an interpretative phenomenological analysis (IPA) approach to data collection and analysis, which focuses on how people make sense of a phenomenon, in this case the experience of clinicians working with men who are survivors of incest. Participants each completed a semi-structured interview that lasted between 90-120 minutes and was conducted either through Skype, Zoom, or in person. The Institutional Review Board (IRB) at the University of San Francisco approved the recruitment of participants for this study.

Research Question(s)

This study is aimed at understanding the primary research question: *How do clinicians experience working with (i.e., providing psychotherapeutic treatment to) adult male incest survivors?* An interview guide – or an interview schedule as it is referred to in IPA – was created to facilitate consistency between interviews and direct the flow of questions and subtopics being explored (see Appendix B). Before beginning exploration of the primary research question, participants were asked to identify their professional qualifications and summarize their clinical experience with adult male incest survivors, to describe in what setting they have worked with these clients, and approximately how many clients they have had from this group.

The following prompts were also included regarding specific areas of interest:

- What, if any, common themes or presenting issues have they noticed in their clinical work with these individuals?
- Can they identify specific therapeutic obstacles or treatment barriers for this population? What about strengths, supportive factors, and/or general clinical considerations?

- Did they notice any particular challenges in working with these men?
- Can they identify particularly rewarding aspects of working with these individuals?
- Did they notice ways in which these men were similar to one another vs. the remainder of their caseload? What about ways in which the aforementioned clients were similar to the rest of their caseload?
- What is/was their relationship like with these clients?
    - Did they notice countertransference? How did they feel about these men?
    - Did they pick up on any transference? If so, what did they attribute this to?
    - How do they think their own intersecting identities impacted the relationship?
- How would they describe their treatment approach with adult male incest survivors? What do they think worked well? What hasn't worked?
- How did they experience clients' disclosure of the abuse?
    - When/how did it come up?
    - How were the clients making meaning of these experiences?
- What is their understanding of the availability of relevant resources or specific guidelines of care for this population?
    - What information or resources do they think would be useful in working with adult male incest survivors?
    - How accessible do they think these resources felt to their clients, if they knew about them?
- What role do they think stigma plays for these men? What about cultural assumptions or expectations around masculinity?
- What in their clinical training prepared them for this work? What was missing from their training that might have better prepared them for this work?

Procedures

Sampling. This research methodology uses smaller sample sizes due to the detailed case-by-case analysis of individual transcripts that is required. Smith and Osborn (2003) identify the aims of an IPA study as saying something in detail about the perceptions and experiences of a particular group, as opposed to making more general claims prematurely. Relying on purposive sampling, this qualitative methodology demands a more narrowly defined participant group for whom the research questions are particularly significant; the participant pool should consist of individuals who have been identified as the "expert group" and for whom the research question will be meaningful (Oxley, 2016). Each subject that was selected provided the researcher with their professional degree, license type and license number.

Selection criteria. Eligibility for this particular study required participants to identify as licensed mental health professionals who have substantial clinical experience working with male survivors of incest. Eligible participants had to demonstrate English language proficiency, since qualitative research relies heavily on language and important material could get lost in translation. Subjects could be located in the San Francisco Bay Area, in which case they were interviewed in-person, or anywhere they felt was private and comfortable, as long as they had access to a phone or internet-based video conferencing service through which the one-time, approximately two-hour interview could be conducted. Expanding the geographic constraints was particularly beneficial due to the relative scarcity of this clinical specialization. By allowing connection with clinicians who practice elsewhere in addition to local providers, the researcher was able to obtain the desired number of participants with extensive related expertise – individually and collectively.

Recruitment. Participants were recruited via purposive, snowball sampling. In order to cast a wider net in searching for participants who fit the requirements, a flyer about the study was distributed by the researcher to individuals, agencies, professional organizations and networks across the country related to or affiliated with the provision of clinical mental health

services, especially programs and clinicians that identify as treating survivors of trauma, sexual abuse and assault. The flyer was also sent out through numerous list-serves and passed along by contacts to referrals along with other related resources and suggestions of additional providers to whom the researcher should reach out.

Informed consent. Subjects who were interested in this study were provided with a written description of the research project, including its aims, benefits and risks before scheduling an interview (see Appendix A). The researcher explained the nature of the study, interview process, associated risks, and measures taken to protect confidentiality. Each participant provided written consent that they understood the research procedure and goals, and they were all informed that extracts from their interview may appear verbatim in this report. Each subject was offered a copy of the signed consent.

Protection of confidential materials. Interviews were recorded and stored in a password-protected electronic file. Confidentiality of subjects' personal material was rigorously maintained. With the exception of aforementioned consent forms, all identifying information was omitted from records and stored securely in a password-protected electronic file.

Data collection and interview procedure. For this study, a total of six participants were interviewed, all licensed mental health professionals who identified as having substantial clinical experience working with adult male incest survivors. However, only five participants' accounts were included in the analytical process, as one subject's relevant clinical experience was rather limited compared to the other accounts and thus did not provide the same level of meaningful content on the topic.

A semi-structured interview with each participant was conducted, which offered some organization and guidance for the researcher while also allowing for flexibility to adapt the interview to each participant as the interview proceeds; therefore, discussion was expanded around whatever issues presented as most salient for the specific interviewee. Each interview lasted between 90 minutes and 120 minutes. Four interviews were conducted over Zoom or

Skype, and two took place in person. All interviews were audio recorded, transcribed in verbatim and coded by the primary researcher in accordance with methodological standards of interpretative phenomenological analysis.

The Researcher

The interviews and subsequent analysis were conducted by Kathryn Rosenberg, who was a 28-year-old White American woman completing a doctoral clinical psychology degree (PsyD) at the University of San Francisco. Throughout the study design, interview and analysis process, Richard Ferm, PhD, a psychologist experienced in attachment and mentalization-based therapy, and Brac Selph, PsyD, a psychologist and qualitative researcher well-versed in interpretative phenomenological analysis, were both consulted.

Qualitative Analysis

The perspective taken by researchers using IPA involves focusing on how people make sense of a phenomenon, in this case the experience of clinicians working with men who are survivors of incest. Dorahy and Clearwater (2012) explain that, “Analysis in IPA involves a ‘double hermeneutic’ in which a meaningful narrative is co-constructed between the participant’s phenomenological account and the researcher’s interpretations of that account” (p. 160). A fundamental assumption in this methodology is that a participant’s account during the interview is their attempt to make sense of their personal experience and the world; another is that the interviewee’s account is inevitably filtered through the individual lens of the researcher. Thus, constant monitoring of the researcher’s conceptions, attitudes and beliefs is imperative in the analysis process; self-awareness on the researcher’s part is a necessary condition for a thorough, comprehensive analysis of the data.

Data analysis in IPA is a lengthy iterative process that unfolds through repeated immersion in the transcripts to confirm that the emergent themes and interpretations are supported by the text; it is not a discrete stage of the research so much as continuous process with intermittent write-up phases (Dorahy, & Clearwater, 2012). The first stage of analysis

involves careful reading and re-reading of the interview transcripts, which have been done verbatim. Unlike thematic analysis, IPA starts with exploratory coding, examining the language and semantics used by the participant prior to identifying themes. There are three levels to exploratory coding in this process. The first level is simply descriptive and aims to describe the content of the participant's account, the second level delves deeper and explores the language that was used, and the third is conceptual and requires engaging with the data on a more interpretative level and searching for meaning behind the data (Oxley, 2016). Larkin and Thompson (2011) suggest that eventually the researcher will want to be able to draw the themes together to form some kind of a structure or framework in which to present readers with an overview of the analysis, and should develop a narrative with detailed commentary on the data and collection process. These authors recommend an initial "free coding" period where the researcher tries to get any and all initial ideas or reactions to the content down on paper in order to facilitate a more systematic focus in the next phase of analysis.

The next step is referred to phenomenological coding – a line-by-line annotation of the transcripts with the goal of identifying *objects of concern* (events, relationships, or values that matter to the participants) and *experiential claims* (narrative and linguistic hints as to the meaning of those objects). These detailed interpretive notes are done first for each transcript individually, clustered into potential themes along with passages that seemed somehow significant, compared back with the transcript – a process through which new themes can emerge – and then considered in relation to results from the other interviews. This integration across subjects' accounts continues the iterative process, with the goal of identifying organizing principles to facilitate concise and meaningful communication of how these therapists experienced their clinical work with men who were incestuously sexually abused as children. Themes identified throughout this process were then clustered into broader overarching domains, re-checked against the transcripts for validity, and then presented in narrative form in the following chapter.

CHAPTER IV

Results

Participants

A total of six subjects were interviewed for this study, five of whose accounts were ultimately included for analysis. The additional interview was excluded from the study's results because that participant's relevant clinical experience and knowledge was significantly less than the others. Of the remaining subjects, all were between 46 and 70 years of age, and identified themselves as White men. Each participant reported having a significant background in providing psychotherapy to men who experienced childhood sexual abuse (CSA), including incest. All participants were licensed mental health professionals at the time of the interview, at either a masters or doctoral level, practicing (either currently or in recent history) within the United States. Among the subjects interviewed, most if not all have contributed to the body of published literature on the topic of clinical work with male survivors of sexual abuse, been involved in the development or practice of various advocacy and consultation work about this topic (i.e., providing professional trainings, including to governmental agencies and military personnel; serving as expert witness in criminal prosecution of individuals who have a documented history of CSA).

The five participants are described below, listed in the order in which they were interviewed. Participants' names have been changed to preserve anonymity.

Matt. Matt had worked as a therapist for 35 years and self-identified as a trauma survivor. He estimated that 50% of his clientele has always been around the issue of sexual abuse, and described working with "hundreds" of male clients who were sexually abused by family members.

Chris. Chris explained that he started a private practice in 2013 after training and practicing in dual diagnosis agency settings with adolescents and young adults, where he estimated that 40% of his male clients had sexual abuse histories. He stated that the ratio has

remained similar with his private practice clients in terms of how many have incest or sexual abuse histories.

Ben. Ben had worked as a therapist for over 25 years and described his orientation as mindful, body-centered and relational psychotherapy for trauma, although he was originally trained in psychodynamic and family systems therapies. During his interview, he referred numerous times to Weekend of Recovery (WOR) retreats (See Appendix E) as a resource that has been indispensable in learning to provide effective mental health treatment to male survivors of sexual abuse.

Hal. Hal was a self-identified survivor of sexual abuse who had been working as a psychologist for over 35 years. He described his clinical specialty as providing psychotherapeutic treatment to male survivors of sexual trauma, and added that his background is in recreation therapy which he incorporates elements of into his psychotherapy practice.

Greg. Greg stated that in his career he had provided therapy to over 100 men who have been sexually abused by family members, and worked for the past 30+ years at a practice specializing in treating sexually abused children and families. He also described having done significant clinical work with male sex offenders, including facilitating group therapy.

Domains and Themes

While individual accounts of their experiences were of course varied in tone, individual context and specific content, a consistent pattern of themes emerged across participants. The analysis found 14 salient themes, which are listed in Table 1 on the following page along with the number of participants who endorsed each theme. Via review and further analysis, these themes were grouped into three broad domains. The overarching domains that encapsulate the list of identified themes include: Therapist's experience of self, therapist's experience of other (clients), and their experience of the therapeutic relationship. Rather than representing completely discrete, independent entities, the domains are heuristic organizing categories which are intended to help frame and understand the salient themes (as suggested by Macran, Stiles

and Smith (1999) regarding adherent implementation of interpretative phenomenological analysis). Each theme is considered within these three domains, using verbatim excerpts to illustrate each theme. Below is Table 1, followed by a more detailed description and exploration of these themes, with specific quotations from participants to support effective representation of their experiences and opinions.

Table 1: Constituent Themes Grouped into Domains

Domain and theme	No. of participants with theme
Experience of self: therapist as provider, guide, interpreter	
1. Understanding incest (significance of caregiver role)	5
2. Needing personal agency to learn (lack of training)	5
3. Contextualizing clients' disclosure of CSA history	5
4. Formulating treatment approaches	5
5. Clinical consultation as therapist self-care	5
Experience of other (clients): parallel process of survival, isolation, fear	
6. Presenting psychosocial and behavioral patterns (learned coping/stress response)	5
7. Reactions to maternal covert incest	3
8. Living with pervasive shame, self-blame	5
9. Internalizing stigma (toxic masculinity)	5
10. Barriers and risks to disclosing abuse	5
11. Supportive and resilience factors	4
12. Conceptualizing healing; new narrative and relationship to self	5
Experience of the relationship: therapist as change agent, expert, role model	
13. Personal identification with/connection to client experience	4
14. Intersecting identities (therapist's gender) and countertransference	4

Domain 1: Experience of Self: Therapist as Provider, Guide, Interpreter

This domain concerned participants' perceptions of themselves in the context of providing mental health treatment to men who experienced intrafamilial CSA. The group of themes within this domain are focused on participants' descriptions of how they understand their role as therapist - what they brought to the therapy based on their unique knowledge or context, what was salient for them about providing therapy to these individuals, and how they understood the issues at hand. Overarching themes reflect ideas of self as provider, self as guide (emotional, relational, spiritual), and self as the interpreter for men who have been previously silenced. This domain includes themes related to participants' experiences of engaging in psychotherapy with male incest survivors, their sense of lacking adequate clinical training or education through academic or professional institutions, their attributions about clients' disclosure of abuse in therapy, how this work has informed their therapeutic model, stance or approach, and the importance of seeking clinical consultation as a form of self-care for the therapist.

Theme 1: Understanding incest (significance of caregiver role). Participants described how they viewed the particular subsection of CSA victims who were sexually abused by someone within the family or a caregiver, and what was unique about intrafamilial abuse.

> Incest is interesting because the relationships are way more complex than you would think of as a third party... If it's the bad guy down the street that nobody had any emotional investment in, it's pretty easy to just be mad at him and want to just see bad things happen to him and never think twice about how they do or what's going on, but when the person who causes the harm is maybe the very person that raised them and did a lot of fun and interesting things and met a lot of their social and emotional needs and that kind of thing, then it's way more complex than that. (Greg)

Greg and Hal both emphasized the salience in experiencing the betrayal of trust by a caregiver or family member and its uniquely devastating consequences.

> Well, the betrayal of trust is huge. That's the biggest difference. If someone is abused by someone they don't know, there's not as much of that feeling of betrayal of trust. Then oftentimes it's much more, they internalize it much more as this is my fault, I did something wrong. Not that that's not true with incest. But the added part of incest is that betrayal of this primary relationship that somebody is supposed to be trusted and is supposed to be watching over your safety, who they betray you, is what's so devastating. (Hal)

Similarly, Ben described the salience of betrayal by a caregiver and how deeply impactful this can be on a child experiencing abuse and their ongoing ability to form an individual identity as they move forward.

> I think the primary experience, and this is not exclusive to incest, but it does make a difference is betrayal. Not to mention impact on the family system and that core security that gets, sometimes men are abused sometimes pretty severely outside the family, even by a trusted family member. But this family is so cohesive, and responsive and supportive that the impact and the results are radically different. Trauma is not just the bad thing that happens. It's whether you have some place to take it. When you don't have someplace to take it, that's when the PTSD is likely to be the worst. (Ben)

Like the other subjects, Chris addressed the complex nature of coping with breaches of trust or security when sexual abuse has happened within a family, and explained the problematic learning process that can be internalized by children who experience incest.

> When our caregiver is our perpetrator, it really affects that in a deep and harmful way. One of the primary reasons for that is when we're children we do two things. We generalize things and we internalize them. It's a survival mechanism. If I go and burn my hand on a stove, I now know stoves burn so I don't go around keep putting my hand on stoves trying to figure out if they all burn; I generalize that. Oh, now I know stoves burn.

> Then as a kid, because I'm egocentric, I internalize that and I go, 'Oh-oh, I'm bad for touching the stove.'
>
> When our caregivers are the perpetrator we can't view them as bad because it threatens our survival. We need them to survive and so we generalize now people will hurt me because our parents are the mold for the world and then we internalize my parent can't be bad because I could die if that's the case so I must be bad. (Chris)

Matt described a similar take on the distinctions of intrafamilial sexual abuse, but expanded on the true powerlessness of a child being sexually abused within their family system.

> The family member is so much more complicated than a non-family member. These guys are in this impossible situation that if they really try to heal themselves they might lose their families. And that's an unconscionable position to put a child or adult into. Incest victims are the ultimate victims as far as I'm concerned because you have no power. You're powerless in the situation. If you had power in the situation, that's a different kind of healing.
>
> How many layers of healing there are to do depends if it was a single incident or a lifetime of abuse. What you're really doing is constructing a self because they were never really able to form a self. If it was just one incident, that's tragic and awful and should never happen, but it's a lot different. Characterological disorders and pathology happen mostly in the family; those are the people who are supposed to love us. (Matt)

Theme 2: Personal agency needed to learn (lack of training). Participants described feeling unprepared for the overwhelming amount of sexual trauma they immediately began to encounter as they started their clinical careers, and eventually recognizing if they wanted to feel better equipped to navigate this realm of trauma work, they would need to seek out (and pay for) additional education or training on their own. Chris, Matt and Hal talked about the pressure to use evidence-based practices, particularly cognitive behavioral therapy (CBT), which they all felt was inadequate to address the complex needs of CSA survivors in therapy.

> There wasn't much in my training, honestly. Systems theory was helpful just to understand big picture sort of things. I went to a program that was largely behavioral, and certainly CBT has its place in work with survivors. Those were helpful skills, but I think trauma-informed therapy should be taught in every program. And programs need to clearly identify how working with men and working with women is different. It's not the same. Similar, but it's not the same.
>
> I used hypnosis in my work, and I learned that after graduate school not during graduate school. Ideally, in terms of graduate school, I'd want people to have a very firm understanding of addiction treatment from a trauma-informed perspective. These are things which typical graduate programs I don't think really cover. I went through five days of training when I was first hired as a drug and alcohol counselor. That was my training. Thankfully, I did much more and learned a lot more. Because those are the outcomes of trauma, it's really important that people understand what those outcomes are and how to work with them, and how to do it from a trauma-informed perspective. (Hal)

Participants were specific and consistent in their assertions that there are a number of existing clinical models and tools that they have found to be useful in their work, but accessing these resources required their individual initiative and often, the ability to pay for any extra trainings out of pocket.

> The education is out there. Everything I've learned around trauma was not in my coursework. I had to go read books, specialized trainings and workshops. Now I do think trauma is a specialty just as addiction is a specialty and so not everybody is fit to do trauma therapy. I think people need to be educated on what is trauma and then how it affects people and then what are the modalities that people in the field are using.
>
> I think one thing that gets in the way is this huge draw for evidence-based treatment which has heavily been focused the last 30 years on CBT. That's what people

are being taught is CBT. I use CBT. I incorporate it but it's superficial when it comes to trauma. (Chris)

Matt and Ben were explicit about their beliefs about the impossibility of anyone becoming an effective psychotherapist without having had their own individual therapy.

There wasn't any training on sexual abuse in my program – people don't want to talk about the really icky stuff, they want to talk about depression and anxiety and they want to use CBT to put a band-aid on it and send them back into the war. They don't want to deal with the messy stuff because that gets complicated... There's got to be a significant percentage of most people's practices where this comes up and they don't have the basic skills to deal with this. And what the fuck are they doing?

That's a problem in our field – we're letting in people who have not done their own psychotherapy. You can't do psychotherapy if you haven't been in psychotherapy; if you haven't been that vulnerable you can't expect your clients to be that vulnerable. And I don't think you have to be a sexual abuse survivor to work with sexual abuse survivors, any more than you have to be an alcoholic to work with alcoholics, but it does require some real training and more than just ten minutes of an overview. (Matt)

Matt's emphatic reaction was to what he seemed to identify as a double standard reinforcing an us versus them mentality between therapist and client; Ben had a similar one.

I was appalled when I found out that there were graduate programs where people could become licensed psychologists without ever having been in individual therapy and all the hair went up on my body and I thought, 'Oh my God.' It's like malpractice. You've got to have the experience to know how to facilitate it. (Ben)

Interestingly, Chris explained that while his graduate program did allow students to count personal therapy toward their hours for licensure, that step in itself did not seem to be enough.

Self-awareness is so crucial to being able to attune to someone and attune to yourself and be aware of what issues are coming up. I practice mindfulness every day and I do

> yoga, different things that help me have that self-awareness. That was not taught to me in my master's program. Absolutely not. I mean, I got triple hours for going to my own therapy but they didn't really teach self-awareness, and humility, and refer out and things like that. (Chris)

Participants' experiences of not feeling prepared, informed about, or aware of enough relevant information or resources have been echoed by clients as well, as Greg explained.

> I've had people say, 'Are there groups for men of incest abuse?' I'm like, 'I wish I knew where to send you, but I really don't know of those.' So, I don't think there are adequate resources, and I think that just adds to male victims feeling like there's something so wrong with them or whatever that there's not even specialization in it. (Greg)

Theme 3: Contextualizing clients' disclosure of CSA history. Therapists explained how they experienced clients' disclosure of sexual victimization, and how they made sense of clients' decisions or to make themselves vulnerable to the participant in that way at that particular time. Individual and personal factors were considered as well as specific clinical practices, and most participants addressed the significance of having a reputation in their communities for treating men who are sexual abuse survivors. Greg and Chris identified an important factor in clients' comfort disclosing about an abuse history as their practices of normalizing the difficulty of talking about traumatic experiences.

> A lot of times [at my practice], we'll talk to kids and adults about all of the reasons the kids don't tell, because that way they are less likely to feel like they failed by not telling somebody. (Greg)

Preempting the need for clients to volunteer their status as an incest survivor decreases the chances of missing key information (such as a client's history of CSA) that should inform diagnostic considerations and treatment decisions, while increasing opportunities for clients to be asked specifically about what they might not otherwise offer or bring up.

> Even under the assumption that I'm a trauma therapist and by the time people get referred to me I pretty much know why they're coming to me, they're still really scared to talk about it. It goes back to that to talk about it is to experience it, to live it again.
>
> Usually I just assume everyone has trauma, because in a way we all do. We all have imperfect parents. We all have experiences in life that affect us. I've come up with my own model of how I explain trauma, which is using Maslow's hierarchy of needs, and I explain that in order to self-actualize we need all these needs met and that when our safety is disrupted, that is a shock trauma. When our love and belonging need is disrupted, that is a relational trauma, and that these traumas leave belief systems imprinted on us and with those belief systems our nervous system stays in a state of vigilance. (Chris)

Ben and Matt alluded to their specific reputation for treating survivors of sexual abuse as being integral in encouraging clients to be forthcoming about experiences of CSA and incest.

> I think I'm an anomaly because I'm known for the work. People contact me with the intent. They'll advertise. It's always interesting the subtleties when people will say some version of it on the telephone. Well, I have a certain history that I think you'll be able to help me with. I've never pushed that because they have their own privacy for that, but usually they'll say something about sexual abuse. I'll say, 'Yeah. I've done a lot of that kind of work. I'll be happy to meet with you.' (Ben)

Matt's description of his experience and his attribution of clients' empowerment to disclose to him was quite similar to Ben's perspective as he described it.

> Because I was known for working with sexual abuse, it was often the first thing that came up. About 50% of the time they came in specifically because they knew I worked with this. I have some incredibly horrible stories. Sometimes it just came out. When people start to trust you they just start telling you about these bad things that happened

> in their childhood and they may not even understand what it means or how much it impacted who they are now. (Matt)

Matt touched on a question with multilayered implications, which Hal described in even greater specificity – how can someone process or heal from abuse or trauma that they have not recognized as such?

Dissociative symptoms are common for male victims and can complicate both real-time and retrospective attempts of survivors to make sense of the traumatic experiences. This can present a challenge for the therapist; clients whose most relevant memories or salient details from the past exist at a subconscious (or perhaps for some unconscious) level may require any number of external factors to align which are out of the therapist's control before they can access these subconscious trauma memories and bring them into consciousness.

> If you ask the right questions you find this information out. Unfortunately, many people don't. They just don’t explore it, and men don't talk about this unless you ask them. People don't generally come to therapy for that reason, even if it's in their consciousness. And for many men, it's not in their consciousness, or they've repressed it, or they haven't framed it as sexual trauma. (Hal)

Theme 4: Formulating treatment approaches. Each participant had developed their own strategies for treating male survivors, either through trial and error or by integrating various elements of other therapeutic models. While some mentioned personal qualities or characteristics, others alluded to specific modalities or interventions they have found useful.

> I think that having the ability to be, if you will, warm and engaging, all these qualities that are good for therapists, that we also need to be able to be really quite clear about boundaries and know how to do that. I don't just mean the obvious disclosure statement that says, ‘No sex with clients,’ kind of thing but more subtle things, like when I deal with male therapists, as a supervisor I'll often say, ‘You've got to think about things like how you go through a doorway. While you might have been taught you open the door and

stand back and let somebody go through, then if somebody's been a sex abuse victim, then having you behind them may not be something that is comfortable for them. (Greg)

In addition to generally trauma-informed therapeutic interventions, participants also identified the startling and significant progress that can be achieved for clients who experienced CSA through different forms of somatic healing.

People can't heal on an emotional level if their body is still shut down so I use a lot of somatic interventions. So even doing simple things like just teaching people how to breathe is a somatic intervention. Helping people just being very aware of their posture. I'd be very aware if somebody was crunched down like this. And I might ask them, 'Could you just open your arms and experience that?'

What it did was that it helped them get in touch with the pain of that, that they were just, at first they would just say the words and it didn't have any impact because they weren't feeling it. Once they could embody it, the feeling came out and they got in touch with the pain of it. Then we could move from there to them saying, 'I'm lovable and worthwhile,' and pushing me across the room. Then they'd feel that sense of the power that they didn't feel before. Therapy is that balancing act of helping them know that this is their life, and they're in charge. Giving them enough support so that they have the courage and the willingness and the ability to reach out for that support, and the belief that they're worthy of it. (Hal)

Ben described group therapy as his clinical bread and butter, citing numerous benefits of a group, peer-oriented therapeutic setting for male clients who are CSA survivors.

Group has always been an important part of my work. I think there's a crucial place for individual therapy because of the safety and the experience and the grounding and telling your story as a survivor. The real work and healing happens, much of it in group.

I've been at 28 of these Weekends of Recovery [WOR; see Appendix E]. They include large group processes, safety building to begin with. Then there are small groups

within the weekend, so there were four meetings of the small groups. Most of the men say that's the most significant part of the weekend because they really create intense, strong connections with one another. They know they've got four sessions to do it in, so things happen quickly. But from a developmental point of view, from a group life cycle, they go through the group life cycle very rapidly. There's a joining phase and then there's a challenging phase and there's another.

The most profound healing happens when that repetition gets handled differently in a way that feels it is therapeutic. That doesn't repeat the elements of the abuser, abused or victim perpetrator even though you've got to start there. Otherwise the pattern isn't present to be changed.

It's what Freud called the repetition compulsion, which I think is an unfinished piece of an emotionally charged, traumatic unfinished piece of history that acts as a template. There's been a violation and it keeps getting restaged in a person's life in order to work out differently. I mean, this is the nature of most trauma therapy. Somebody comes in, they bring their trauma. The challenge of it is you've got to get close enough to the actual trauma for the pattern to change. It tends to get played out or inactive, but many survivors are just too terrified of doing that work one on one. (Ben)

Theme 5: Clinical consultation as therapist self-care. Participants talked about seeking clinical consultation while practicing the type of work they do, and noted the value of consulting with peers as a way to maintain a balanced perspective.

I've had really brilliant consultation. My belief is that I needed to pay for the best therapy and consultation I could get if I was going to be a really great psychotherapist, so I got training galore. And it takes a long time to get really good at therapy because it’s an art and not a science. (Matt)

Hal and Ben both echoed Matt's statements and expanded on what they felt they got from continuing to engage in clinical consultation.

> I used a lot of consultation with colleagues who did a lot of work in this area. Without them, I could never have done this work. Most of the time, it really wasn't an issue of having another strategy. Sometimes it was really helpful just to have permission, be affirmed for the struggles I was having. Once that was normalized, then I could get out of my way. But if I'm feeling ashamed or whatever I'm experiencing, then obviously that's not going to be helpful for anybody, me or the client. So it's trying to work through that, and having people remind me of my strengths. And at times, going, 'You're really off the mark here. What you're doing isn't right.' And sometimes I needed to hear that. Then I could work to understand, how did I get there? (Hal)

Ben explained that he currently participates in three consultation groups that meet bi-weekly and praised the groups' members for influencing his personal and professional growth.

> The level of discourse and when you're lucky - and I went looking for this, it's still rare. You've got to make it happen. You incorporate the triggering that happens in the consultation room. You're talking about your own version of what's getting triggered as you were talking about the trauma process. That's the height of consultation.
>
> You do parallel process focus. There is a level of it, which is like good group work where you're getting that from your peers. There's just something unique about that. That's why it's so important for survivors to get that connection from peers because they always say, and probably rightly so, 'Well, of course you're going to be empathic and nice to me. I pay you for it.' I have individual clients who say that to me quite directly. I said, 'Yeah.' It's hurtful, but you don't make that the issue. You work with it. (Ben)

Chris alluded to an alternative possibility when consulting about a case - when therapists are not trained or proficient in providing trauma-informed treatment and as a result cannot offer a useful perspective in consultation.

> I like doing consultation with other therapists that are trained in what I'm trained in. I have a hard time … If someone is doing consultation with me on a trauma client and

> they're not trained in any trauma modalities, I'll usually just tell them they need to refer out because I don't think they're equipped. (Chris)

Domain 2: Experience of Other (Clients): Parallel Process of Survival, Isolation, Fear

The second domain concerned participants' perceptions of their clients (as related to practicing psychotherapy with male CSA survivors) and responds to broader questions about the experiences of adult men who as children were sexually victimized by a caregiver or relative. This domain contains themes that reflect the double hermeneutic that is conceptually inherent to this study's aim - gaining a broader understanding about the experiences of one group of people through the lens of another (all of which, of course, is then filtered through the lens of the researcher through the interpretative analytical process). Overarching emotional notes throughout this domain related to participants' countertransference or parallel experience of their clients' keenly developed (and highly disorganized) survival instincts - the hypervigilance, isolation, and constant fear that drove their existence by allowing them to survive. Themes within this group explore therapists' impressions of their male survivor clients through various identifiers, ranging from observable psychiatric symptomatology and problematic behavioral patterns to internal struggles and self-concept. This domain also includes participants' thoughts about the role of dominant cultural narratives that typify gender and define masculinity in their clients' experiences, and offer interpretations and insights about how the development of these issues was related to - and inextricably intertwined with - clients' experiences of abuse, as well as how they view clients' resilience and what healing might mean or look like for these men.

Theme 6: Presenting psychosocial and behavioral patterns (learned coping/stress response). Participants shared their clinical estimations of how men with a history of CSA tended to experience psychological, sexual, behavioral and relational consequences of the trauma, and how that manifested within their therapy. Dissociation was a frequent topic that arose in this theme.

Dissociation is very common. I think it just depends upon the circumstances. And some people dissociate a little, some people dissociate a lot. It just depends on the situation and how old you are and how wired you are. I think the younger you are, the more likely you're going to dissociate because your brain isn't capable of processing this. (Matt)

Chris and Ben explain Matt's assertions from a different angle, citing the learned behaviors of sexually victimized children which could have been adaptive when they were developed but are no longer serving them.

> If we first learned to deal with stress by going to our caregiver and our caregiver nurtured us and then talked us through it, that must have been scary, Billy pushed you on the playground. I bet you're really sad and hurt. I'm sorry and held them and let the kid process and then move on and say, ‘I love you. You're good.’ Then we fall back on that default way of dealing with stress.
>
> If our caregiver was dismissive, wasn't supportive or even worst, was harmful to us we don't have the ability to fight or flee as kids because we need them to survive. Really, our only option to survive is to dissociate physically, emotionally, structurally. For those early child abuse survivors later in life if they haven't resolved that trauma when they get activated in any kind of stress they fall back on that dissociation. (Chris)

Ben and Greg both expanded on men's socially conditioned tendency to revert to sexualized behaviors in reaction to feeling vulnerable.

> I think often what happens, and this is also a much broader picture, that when the going gets really tough for us as men emotionally we go sexual, and it's an escape hatch. It's a way of getting out of something that feels too overwhelming because we're programmed to be assertive sexually. I don't know how much that affects the abuse, but I think it affected pretty deeply. I think men go sexual when something else is going wrong that is not manageable. It's an escape hatch and clearly in the abuse scenario, the roles are so

> polarized in terms of who's powerful and who has none that you step into the one with all the power and so you're no longer going to be assaulted by the vulnerability.
>
> It actually it's a defense. It's a protective strategy, and a defense move that ends up putting the victim into the position of the holder of the perpetrators own pain and forcing them to live it out. People survive sexual assaults, men and women. It's the other level, what it does to relationships and trust that's the more profoundly damaging. (Ben)

Greg explained that in his experience, one example of how aftereffects of CSA can manifest for men is by using sexuality as a way of proving something, and overcompensating with sexualized behaviors and avoidance of emotional intimacy.

> There are certainly male victims that just avoid intimacy a lot because it's kind of the opposite coping attempt, just because again, it's hard to talk about. That brings up anxiety or it brings up shame or it brings up trauma responses. It's very common for males to talk about there are certain behaviors with a partner than they can't do because it's like what happened during their abuse, oral sex or things like that, that they might avoid just because again, there's too many triggers to their original abusive experience.
>
> Again, this extreme machoism kind of thing. I don't want unduly label people in broad categories, but sometimes it's things like people who go to the gym five times a week and they're all about how strong they can be and that kind of thing. (Greg)

Theme 7: Reactions to maternal covert incest. This theme was referenced by three participants which made it significant enough to include despite not being unanimously described. Matt expressed a strong perspective about covertly sexualized mother-son dynamics, and described his sense of the seriousness and pervasiveness of this issue.

> I think the single most untreated, most common issue out there, is emotionally incested children by one or both parents. The classic case is that mom grows up with the absentee father, and she goes out there and finds this lovely man, but the more intimate

> it gets, the more he checks out. And then she has a beautiful baby boy who's going to love her completely now, and she can give all of her love to, and guess what happens?
>
> And then he gets intruded upon by mom, and he finds that to be loved, he has to give himself up to be loved by her. And then he goes off, and so anybody that comes toward him just to devouring him, and so he can handle the connection when it's sexual, but when it's not sexual, he runs away because it gets overwhelming, and consuming. And you have the cycle just repeat itself over and over and over again. (Matt)

Greg described how he has noticed the same phenomenon, and acknowledges the exquisite nuance in how psychosexual development is impacted by their close relationships.

> Sometimes some of the most damaged male victims of sexual abuse have been cases where their relationship with their mother was highly sexualized but maybe to the best of their knowledge wasn't ever actual abuse, but it was just highly sexualized. So they may not have ever acted on it but in terms of development of male sexuality, just lack of clear boundaries and that blurring of what's sexual and what isn't and that kind of thing has often been a very psychologically damaging sort of thing for male victims. (Greg)

Ben also explained his perception of this dynamic, how it can manifest and what makes it so confusing for the child.

> Then there's the whole oedipal dynamics of the kids taking the place of the spouse, becoming the favorite kid. This happens a lot with girls we think, but it also happens with boys. The boy becomes the favorite child especially if there is abuse between mother and son. That happens more often than one would assume. I've had numerous clients with mother-son incest. Sometimes it doesn't have to be literal and completely overt. It could be devastating. (Ben)

Theme 8: Living with pervasive shame, self-blame. Participants described the overwhelming nature and intensity of shame and the internalized sense of responsibility and

self-blame that plagues survivors of incest. Hal shared his observations about clients battling shame in the context of their therapeutic healing.

> To me, the healing is mostly about shame, healing the shame and developing trust again, developing the ability to have confidence and to redefine what masculinity is. To heal spiritually, and that doesn't necessarily mean going to a church or synagogue. I mean that ability to offer yourself compassion and forgiveness is a significant piece of the healing.
>
> Most male survivors blame themselves. Most male survivors think, it's a failure on my part. So the primary part of forgiveness is not about forgiving the other person. It has to start with forgiving yourself. Once you've done that, then I think it's possible to forgive other people. But it has to start with forgiving yourself (Hal)

Ben spoke about his understanding of the prevalence, depth and intensity of shame and self-blame experienced by CSA survivors.

> There's all the issues of shame and disclosure and all the assumptions of what it will mean if I tell anybody this. I am continually taken by surprise by men who were clearly victims, and used, who have internalized the blame and the fault. Even though they 'know better' so called, they can think it through, that's not what happens at the level of feeling memory. I think that also has a great deal to do with the dynamics of sexual abuse – there's an emotional exchange. At some level the child intuitively knows that their role is to carry the badness because this guy was doing this stuff but not stopping because it's bad, is not going to be available to hold his own badness. (Ben)

Greg also talked about his experiences processing these core identity issues with clients in therapy.

> Probably the biggest issue is the self-blame part about feeling that they're somehow responsible. As human beings, I think we do that to begin with. If bad things happen in our life, like there's a car wreck or somebody dies, it's pretty common to go back through

> and go, ‘If I'd only done this. If I had talked to him a little longer, maybe they wouldn't have been there when that happened.’ If you run into somebody at an intersection, you always go, ‘If I'd done this' or 'If I wouldn't have been going so fast.’ There's that reprocessing of things, trying to make sense of it. Victims very often conclude that it's in fact partly their fault - that they should've done something differently or they should've told sooner or they should've said no. (Greg)

Theme 9: Internalizing stigma (toxic masculinity). Participants emphasized the unique challenges for male survivors based on cultural assumptions and expectations about masculinity. We are inundated through media and predominant narratives with problematic and damaging stereotypes, and these ideals are internalized by young people, shaping their development to align with socially constructed notions about gender roles. Hal's take provided a bigger picture view, framing the idea that gender is binary as a destructive paradigm.

> It’s a variety of things, but primarily it's socialization - how men learned about sex and about masculinity. We're supposed to be in control. We're supposed to always know what we're doing. We're supposed to be in charge. So if you're in one of those situations where you're not in control, you somehow had to figure out a way to make it like it wasn't a failure on your part. So you just call it something different. You're like, 'That's how I learned about sex.'
>
> It’s partly just basic understanding of masculinity and femininity, and having the opportunity to really tease that out on a course. It's changing every day, every week, every year exactly what we mean by those terms and the whole continuum. But I think it's really important for us to understand what the messages are that men learn and that women learn about how to survive in this world. All of those messages are the very messages which will impact upon somebody if they experience a trauma. (Hal)

As Hal mentioned, that which is seen as feminine is traditionally viewed as the opposite of, or counterpart to what is masculine.

> When a woman comes in, you immediately talk about her as being a survivor of sexual abuse. When a man comes in, you first have to get them to understand that they were a victim. You can't go straight to survivor because a man is not allowed to be a victim, and owning that he's a victim is the first step to healing. It's a real primary foundational difference between men and women – as long as women hold the victim identity, men cannot heal. (Matt)

Ben's emotional reaction was evident as he described the interrelatedness between survivors' internalized stigma around masculinity, and common lasting emotional and relational consequences of CSA for men.

> We think one of the worst issues for male survivors is isolation and of course it's a male issue period, but it really gets exacerbated because of the shame and the violation of traditional male standards of what it means to be male and it's all grounded in low self-worth. There's an unconscious assumption if you're abused as a boy, you no longer get to be male because males don't let that happen. Which is bullshit.
>
> I don't know quite what it is, but it's …. Yeah, I do know what it is. It's that visceral prohibition against emotional vulnerability, physical and emotional vulnerability, because that's immediately identified as female. The whole gender equation breaks down. You don't get to be a male if you have any of those feelings. (Ben)

Paradigmatic perceptions about what is acceptable expression of gender identity dictate what is allowed to be classified as male in the public eye. For Greg, like the other participants, it was clear that gender socialization played a huge part in male survivors' experiences of the abuse and how they made sense of what happened to them.

> The part that's different about males is that in our society, males tend to be raised in a way that you feel like you're not supposed to be vulnerable or you're not supposed to lose control. They're not necessarily good things, but nonetheless are part of our socialization as males. Oftentimes, there's a different sort of layer of issues around

> disclosure for males because they feel like somehow it makes them weak or it makes them feel - if they're uncomfortable with sexuality stuff, and if they were abused by a male, then they're homosexual and that's not really their orientation and maybe there's fears that they'll be believed to be that or whatever kind of thing. (Greg)

What the therapists depicted is a dangerous fallacy embraced and asserted by popular social norms and narratives that, when it is inevitably internalized by boys and young men as they develop a sense of self - teaches them that being male and being sexually victimized are mutually exclusive.

Theme 10: Barriers and risks to disclosing abuse. Therapists identified numerous obstacles preventing or interfering with male survivors' ability, safety, desire, or incentive to disclose that they were sexually abused. Ben talked about some of the reasons people continue to struggle with whether to disclose about the abuse to other members of their family, citing the fact that many parents were not aware of the abuse when it was happening and expanding on larger implications of that lack of awareness.

> It's a big struggle to disclose. It's typical that the parents didn't notice in the first place. They're already not oriented to picking up or be available to the disclosures even much later. Added to that is the obvious factor of guilt. I'm a bad parent that I didn't notice this, so it didn't happen, or it can't have been that bad. There's a lot of minimization. When the abuse is in the family, everybody is suffering. (Ben)

Hal and Greg both described the specific risks and potential consequences of disclosing abuse when the abuser is a family member.

> Many survivors don't tell anybody in their family about they don't want to damage the relationship with whoever that person is. Then there's the issue of the people in the family who knew, or could have known, or may have known, and did nothing, so the non-protectors. That makes it just as difficult, because if they didn't do anything to help you, what makes a survivor think they're going to about helpful now if they disclose? Because

> they didn't help when it was going on, so why would they help now? Wouldn't they be just as threatened and loyal to the perpetrator? (Hal)

Not only does experiencing intrafamilial abuse create an immensely complicated scenario for a child, who must choose between protecting or maintaining their family system – which they likely rely on for survival – but it also centers the child in isolation and confusion over who in their family they can trust and how to navigate these relationships safely.

> I think there are tons of reasons why kids, or people who become adults who were abused as kids, don't tell, some of which are the very things that offenders do to prevent them from telling. A common one of those is that offenders involve kids in a way that makes them feel partly responsible, everything from comments like, 'We shouldn't be doing this,' or, 'Nobody's going to believe you if you try to tell anybody.' We've had cases where people say, 'Your mom will lose the house and you guys will be out on the street if I go to jail,' or, 'I'll kill myself if you tell anybody,' those kinds of things. (Greg)

Being responsible for the incarceration or endangerment of parents or family members, or in any way putting other loved ones at risk inevitably compounds a survivor's struggle to determine a path forward.

Theme 11: Supportive and resilience factors. Participants expanded on their understanding of what contributes to the development of individual resiliency, and what supportive factors can bolster someone's inherent capacity for resilience.

> I think a big factor is how much clarity there is about who's the victim and who's the offender ... Another way to say that is the more clarity there is about where the responsibility for it lies, the less traumatized people tend to be. The more confusion there is about that, the more traumatized they tend to be. (Greg)

While Greg's response focused on survivors' retrospective understanding of the abuse and how that informed its meaning to them, Hal described his experience of what seems to

impact clients' outcomes in therapy as a more comprehensive picture of their lives and access to support and resources.

> Factors include the amount of support they have, which is really important as well. That makes a huge difference. The kind of resources they have, financial resources, emotional resources, spiritual resources. All those things made a difference.
>
> But having somebody who can walk with you, who can witness with you is critical to that aspect of shame that I keep talking about. Just knowing you're not alone, and knowing if you're falling apart you can call somebody and say, 'Hey, I'm falling apart.' And they can say, 'Okay, talk to me. I'm here. I'm not going to abandon you. I'm not going to reject you. I really care, and I want to know what's happening with you.' (Hal)

Ben addressed a more historical element of relevant psychosocial development and explained that for a variety of reasons, children react very differently to sexual abuse.

> It really has a ton to do with either the inherent or acquired resourcefulness and resilience. If there's somebody else in the family who is safe and trustworthy, sometimes it's a grandmother. Got a couple of guys in my groups now who I have grandmothers or a grandfather and it helped them survive, psychically survive the incest, but it doesn't take much.
>
> Resilience typically has its roots in the one maybe unique or only relationship that was profoundly healthy and close. Maybe there's a strain of it in a family system, or maybe it's a teacher. For some people it's a teacher who totally believed in them, listened, cared, but had enough distance as somebody outside of the system to feel genuinely trustworthy. It's rare, but it happens. Then I just think that people are constitutionally and temperamentally different. (Ben)

Chris echoed the assertions of Hal and Ben about the instrumental role that one trusted person can have on a child's ability to develop resilience and build trusting relationships.

> A lot of the research around resilience finds that if we have one person in our life that sees us, understands us, sees our strength and our qualities, loves us, then that can set the foundation for a healthy attachment style, which builds our resilience to navigate situations. (Chris)

This theme reflected undisputed and enthusiastic endorsement of the idea that a single trusting, close relationship in which a child feels accepted and loved within appropriate boundaries, can plant a seed for that child to learn to trust themselves and others later in life.

Theme 12: Conceptualizing healing; new narrative and relationship to self. Participants shared how they understand or envision the healing process for their clients within a therapeutic and humanistic framework. Throughout the interviews, participants mentioned having a clinical sense of their male survivor clients as being constantly in a state of internal conflict struggling to grant themselves permission to feel or to trust their emotional experiences.

> It's one reason why 9/11 didn't have as many occurrences of PTSD as they expected, because it was a nationwide trauma that we were all able to talk about and experience and share. But for people who have an individualized trauma that feel like they're alone and nobody will understand or get them, we're left to our devices to deal with it. (Chris)

Chris highlighted an interesting alternative perspective in referencing the psychological impact of 9/11 in the United States as an example of how collective trauma can foster community within the shared experience of grief and mourning; even the concept of collective trauma seemed in striking contrast to this study's focus on a type of trauma that is individual, often secret, and extremely isolating.

> I think the true healing marker in therapy is that the therapist has to fall in love with the client, in very much the same way a parent falls in love with a child. Even if the child does stupid things, the therapist still loves them. I say that unconditional love taken in in the right way can save a person's life, and ultimately that is what psychotherapy is about - the heart opening of the therapist and the client finding a way to take that in, that allows

them to heal and become whole. For a therapist to really dig into why are you so angry, what's the fuel that keeps this fire going – there's real power in going after that, because once you get through the anger and get to the hurt underneath it, then you can start healing. (Matt)

Ben talked about healing from sexual abuse in the context of revisiting and being able to process or engage in stages of development that were missed as a result of CSA.

You can't be both victim and male at the same time. That's the heart of the socialization, and it's such a brittle position. It's such a weak position. That needs to be articulated and theorized because that's how it gets deconstructed. You show them what it looked like was a strength is actually completely based and grounded in a state of unacknowledged weakness. Men know that because they know that we're in capable emotionally. They aren't given the permission. They aren't given the training. They aren't given to be expressive or exploratory or cry.

I think in reality a lot of male survivors skip the victim stage, and they certainly want to for all the reasons we just discussed, but actually part of the healing, and the treatment is to be able to go back and acknowledged the victimization, and also contacted the aggressive feelings that get unleashed as well as the collapsed and hurt and diminished feelings. A lot of these men are terrified that if they make contact with their anger and rage, they'll destroy everything. You'd never guess it from meeting them and working with them, but it's an internal terror that the force of it will be so great that everything, the world would be destroyed. (Ben)

Chris described his experience of witnessing clients' healing and their personal transformations firsthand, and the reciprocal power of this healing.

It's beautiful to see these people who think they're broken and damaged and defective to come up with their own new truth that I am not the one. If I ever have to help someone they might just say ... I'll go, 'What's your new truth?' and then I say four or five

> sentences. I might just have to coach them like, ‘How do you simplify that to a belief about yourself?’ I might have to help coach them with that, but it's their belief. It did not come from me. (Chris)

Domain 3: Experience of the Relationship: Therapist as Change Agent, Expert, Role Model

The first and second domains explored participants' experiences of themselves in therapy with male incest survivors and their experiences of these clients, respectively. The third and final domain encapsulates a smaller but still significant group of themes that fell into an area of overlap between the first two domains involving how participants experienced the therapeutic relationship between themselves and these clients. This included themes related to the intersection between their personal selves and the men to whom they provided psychotherapy, hoping to contribute to their healing by way of building connection and some level of mutual understanding. Within this domain, superordinate tones reflected therapist in the role of catalyst or change agent, as relative "expert" within the duo, and as role model.

Theme 13: Personal identification with/connection to client experience. Of the five participants, four shared about having significant personal experiences that contributed to their insight and understanding of male clients who report having been sexually victimized.

> I have my own personal history that is, I would say mild by comparison, but the dynamics are there enough that I was drawn into the work unconsciously. But once I was there I thought, and I actually didn't realize the personal connection until after my work at that treatment center. The perpetrator was an older female cousin... I didn't have any clue until she brought it up decades later.
>
> When I realized that, when that interaction happened, I thought, ‘Oh my God, there's the connection.’ Annoyed me ever since that I don't remember a thing about it. In the field I do the work. I know the work backwards and forwards, but I don't have the

personal memory. I don't doubt her. She had a lot to get off her chest and she did it in a way that reenacted the dynamics. That reinforced for me that it was real.

So the personal piece... I think that's inevitably got to be there to do this work. Hopefully because those are the street creds, the experience credentials, and besides it's very difficult for a survivor to trust somebody who doesn't feel like they know what it's like. I've sensed it. I think it's a good qualification. It's related to abuse because kids have to develop a hyper-acute sense of where the people in charge and the people with power are emotionally. It's part of the survival strategy. You've got to know. Often survivors developed this incredible, almost intuitive sense of emotional perception. (Ben)

Like Ben, Matt talked about his own memories of victimization resurfacing once he was a practicing therapist, and about his assumption that clients are able to intuitively perceive his ability to empathize. He explained that as a child he was sexually abused by his father.

I had been in practice for some time before those memories came to the surface. In retrospect it was so painfully obvious; I don't know why my therapists didn't pick up on it – some of them maybe tried. When I would talk to my clients about their sexual abuse, they would look at me and say, 'You really understand.' And I would say, yes I do. And I would not disclose that I had been sexually abused but they could tell in the room that I got it, and there's an authenticity in that that can be communicated without words – that they would understand that I understand. And that's so healing for them. (Matt)

Chris suggested that many clinicians are drawn to the mental health field because of unresolved issues that they never end up working on and which are ultimately likely to negatively impact clients.

The therapeutic relationship is the foundation to trust and safety. Now, sometimes there's a natural fit. I have clients that, we just click. It's just like, 'Oh yeah, this is easy and effortless.' That is just a good fit, but what I hear a lot is 'you are safe.' You feel safe, you're authentic, you're genuine and I can incorporate self-disclosure without it being

about me. My motive for disclosing is therapeutic, not to make the session about me. When people experience that, it makes them feel safe. Now, I have lots of clients go, 'Yeah, my last therapist, it's just all about their issues.' That's not good.

That safety and trust is crucial. These people are detecting minor facial expressions, tone of voice, body language because they're scanning at a deeper level than we are and they're not even conscious of it. I really try to make my self-disclosure be brief as well. I might mention, 'I got into this because my sister was molested, I was her secret keeper and my family didn't talk about things and that made me fascinated about trauma, or 'I got into addiction because I'm a recovering addict myself.' I try to make it just a brief connection where people would go, 'Oh, Chris didn't just read about this stuff in a book. I think he knows what he's talking about.' (Chris)

Hal described his identity as a survivor and how that impacted his ability to meet his clients' needs, and similarly to Matt and Ben he reported that his memories of abuse were not conscious when he was starting his career.

I'm a survivor myself. But I don't know how much aware of that I was at the time that I started. Pretty much even from early internship, I think I started having clients who had survivor issues. My own experience certainly made me much more compassionate earlier in my career... I have suffered with all the same symptoms that survivors suffer with, learning how to set appropriate boundaries, how to start sessions and end them on time, how to not be a caretaker, all the things that survivors struggle with I've struggled with. It makes me much more able to see the struggles and what's going on.

It's also empowered me to be able to challenge them when I see them going down a road that's really self-destructive or self-defeating, because I've walked down that road. I know what feels like. I had to go into my own therapy to really work on my own healing. Early in my career, I felt like I was this far ahead of some of my clients. That was really uncomfortable to feel like, I don't know what I'm doing here. Thankfully,

more and more support and education became available to me so that I could learn techniques to help me, and them, through those difficult situations.

I think knowing that I'm a survivor helped them to feel less ashamed, to know that they weren't alone. That's one of the biggest feelings that survivors have is this feeling that nobody understands me, nobody's like I am, nobody's experienced the same things I have. So knowing that I had been through a similar experience helped them, even without talking about what I experienced. As I was terminating with my clients, I talked to them about how I had come to really understand that psychotherapy is a spiritual process. And that I felt deeply honored and trusted that they were willing to share the depth of feeling that they did with me, and it changed me forever. I couldn't possibly be the same person to have had the opportunity and the privilege and the honor to have them trust me enough to share at the depth that they were sharing. I would like to think that I'm a much deeper more healed man because of all of that experience.

The other part we talk about is post-traumatic growth, which is the other thing that happens in the relationship is that they get to see me thriving. They got to see that it's possible to survive and thrive. So that's the other side of that. It's not all about how I understand all your pain. It's also about really embodying the possibility that there's hope for them, real hope. (Hal)

Theme 14: Intersecting identities (therapist's gender) and countertransference. Participants spoke about their perceptions of what role their own gender played in their experience of therapy with male survivors, as well as their perceptions of how these clients felt about having a male therapist.

I think that my being a male therapist, whether it be for females or males, can be especially challenging unfortunately because too many people have had bad experiences with males. So initially, it can be extra challenging to gain some trust and connection, but the other way I look at it is once we get past that, then I think it's

particularly helpful for them to have had good safe relationship with a male. I'm sort of joking when I tell people sometimes that unfortunately as a male therapist, all I have to do is show up and not be mean and I'm therapeutic.

For male victims, on one hand, they're abused by males and there's the issue of trust and safety that they have to get past and that kind of thing. If they were abused by a female, then there's the issue of that macho thing of having to admit to another male that they were sexually abused by somebody that was an important female in their life.

I don't know. I mean, it's sort of like I can identify with some of the struggles that males have around the way we're raised in society and the difficulty talking about emotion or the lack of good training that we have around intimacy and affection versus sexuality and that kind of thing. (Greg)

Hal, like Greg, discussed the dyadic possibilities for clients' transference depending on the gender of their abuser, as well as the value of - once the client is ready - integrating a provider who can challenge the client's previous negative assumptions about individuals who hold a certain gender identity.

There were definitely male survivors who would never talk to a man. They would be so afraid that they would be judged and thought negatively of because they're not man enough that they couldn't face the possibility, the shame that would come from disclosing that. On the other hand, there are people who would never tell a female because it would just be too embarrassing and too shameful to have to admit to a woman that I wasn't a man and I wasn't powerful. It really matters a lot about who the perpetrator was and who the protector or non-protector was. Because a lot of times, if the person has basically male perpetrators, it's maybe much more difficult for that male survivor to be able to trust a male therapist because of the fear of, I'm just going to get abused again.

> It may be that their mom or some other female was the only safe person, and so that's the gender, the therapist that they feel safe with. As I was terminating with clients trying to figure out who the next best person was, there were guys who it seemed clear, well they had issues with their moms either because they were abusive or because they didn't protect them. We had done a lot of good work together, and I was like, 'You know, I really think that this female therapist will be really good for you as a next step to complement what we've already done.'
>
> There were men who said, 'Okay, I get it. You have women here. But I don't have anything to do with them.' Those very same men wound up having these profound, moving, healing experiences with the women because the women did understand, and they did get it. And they weren't shaming, and they weren't blaming, and they weren't minimizing. So it was immensely powerful to have females on the Weekend [see Appendix E] so that they could have a different kind of experience. I would never say only men can work with survivors. I think that's just patently wrong. (Hal)

Matt had a different perspective, suggesting that as a gay man many male survivors find him a uniquely safe person to open up to about issues around their sexuality.

> I think a lot of men really need to see another male to have their experience validated. As a gay man, the straight men in particular put me in this other category - I was never closeted, I didn't have a gay flag in my office but many of them knew I was gay, and I think some sought me out for this reason because they didn't feel comfortable talking to a woman or straight man.
>
> I think a female therapist can offer the same type of validation as a male therapist if they're willing to. My caveat there is that a lot of women have never worked through their stuff around men. So they can't see men as victims, and it pushes their own buttons because only women can be victims. I mean, the whole society says men are perpetrators and women are victims. But I see examples of women victimizing men all

> the time, or men getting victimized by other men and that makes them not a man anymore. And so consequently if a woman hasn't worked through her own stuff around men she's going to dump that on male clients. (Matt)

CHAPTER V

Summary, Limitations, Discussion, and Implications

Review of Purpose and Clinical Implications

This clinical dissertation aimed to gain a broad understanding of the experience of psychotherapists who work with adult men who experienced childhood sexual abuse (CSA) by a family member or caregiver. A qualitative methodological framework was employed to allowed the researcher to conduct an in-depth comparative analysis of expert opinions and perspectives from a narrow subspecialty within the mental health profession that is desperately under-resourced, underrecognized and highly stigmatized. A primary goal of this study was to establish context through which to further understand: 1) Who is providing psychotherapy to male survivors of sexual abuse/incest? 2) How do they experience therapy with these clients? and 3) What can we learn from these therapists' experiences about how to better meet the needs of this client population, as well as the mental health providers who want to support and treat them?

The study's results confirm a drastic need for increased awareness and relevant support for boys and men who have been sexually victimized, and indicate parallel needs for the therapists who work with these clients and inevitably experience vicarious traumatization and some level of the internalized shame and stigma that can be paralyzing for male survivors of CSA. Engaging in the difficult, complex and in many ways pioneering work of providing trauma-focused psychotherapy can be especially isolating for clinicians when there is a deficit in relevant training (clinical and academic) and in intra- or interdisciplinary discourse about the issues they treat and the unique suffering they bear witness to. The sexual abuse and exploitation of children - regardless of gender - is a multilayered, rampant issue which percolates through institutionalized healthcare, legal, social, generational, familial and cultural systems at shocking and disproportionate rates. It is clear that organizational change is needed at every level to even begin to understand or address the psychological needs of individuals

who have experienced sexual trauma. However, the shift toward a new paradigm in which labels or assumptions are not assigned to people based on their gender takes place in the minutiae of day to day human interactions. Everyone has a role in shaping others' experiences, and themes that emerged throughout this study confirmed how incredibly important one person's kindness and acceptance can be for someone who is struggling.

Limitations

The sample of participants was small (*n* = 5) and not necessarily representative of therapists generally, as it was a self-selected group of therapists who were (as indicated by their willingness to participate in the study) interested in reflecting on their clinical work and engaging critically with this specific content. While the generalizability of this study's findings is unknown, the striking commonality of themes within the group suggests that many of these themes would likely appear in a wider sample.

Research shows that no accurate data exists to represent the true scope of the problem of CSA. As addressed in detail throughout the current study's literature review and results, there are innumerable barriers for sexual abuse survivors when it comes to disclosing their experiences of abuse, which are further complicated when the abuser is a family member or caregiver, and even further for survivors who identify as male. There are many adult survivors of CSA who have never told anyone about the abuse, or perhaps even acknowledged it as abuse to themselves; therefore, the male survivors who made up participants' clientele may not be representative of the male survivor population as a whole, as they were self-selected by virtue of their participation in psychotherapy and disclosure of their abuse, which may indicate that they are further along in their processing of the traumatic experiences.

Recommendations for Future Research

Possible future work could expand on the current study's findings by doing more interviews with a larger number of therapists and additional qualitative analysts, using an interview guide that's been updated based on the scaffolding of what has already been learned.

Further qualitative studies could involve interviewing other types of clinical providers (besides psychotherapists) whose professional roles entail significant exposure to/interaction with the male survivor population (i.e., healthcare professionals, pastoral counselors, legal support, forensic or correctional staff).

Greater clinical insight could, of course, be gained by directly interviewing male survivors about their experiences of psychotherapy; however, as described above there are significant barriers to conducting this research in large scale (including confidentiality concerns regarding recruitment of subjects, stigma, and other preexisting obstacles for male survivors to coming forward about experiences of child sexual abuse). While the last decade has witnessed undeniable progress in public recognition of women's experiences of sexual harassment, abuse and assault - brought to the forefront of public conversation through the rise of the MeToo movement - there is much more advocacy work that must be done so that men who experienced incest and CSA can share in the privilege of their victimization being acknowledged and their pain being validated. It is imperative that mental health providers learn to create space for men's stories of sexual abuse – and of healing from abuse – to exist, to be heard and recognized as important, and for their resilience to be honored alongside female counterparts.

Summary of Discussion

This study's findings align with and expand on thematic components from previous research related to psychotherapeutic work with survivors of CSA, as well as clinical or psychosocial distinctions or implications based on the survivor's gender. The themes and broader domains that emerged through phenomenological coding provide novel and meaningful information about how clinicians understand and experience their psychotherapy with male survivors of incest, and may be useful in informing the development of collaborative practice guidelines, or resources for providers who find themselves at a loss for how to effectively provide mental health treatment to male survivors. The prevalence and pervasiveness of gender-based stereotypes is by no means new information, examining the experiences of

therapists who treat male sexual abuse survivors has depicted the devastating process male survivors must go through to reconcile dominant social narratives and cultural ideals around masculinity, with their experiences of sexual victimization.

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Appendix A

Participant Informed Consent

CONSENT TO PARTICIPATE

You have been asked to participate in a research study conducted by Kathryn Rosenberg, MS, a doctoral student in the Clinical Psychology (PsyD) program in the School of Nursing and Health Professions at the University of San Francisco. This faculty supervisor for this study is Dr. Brent Richard Ferm, a professor in the PsyD program, and this study has been approved by the Institutional Review Board at the University of San Francisco.

Please read the following description of the procedures for participating in this study. An explanation of your rights as a participant is also discussed. Read this information carefully and ask me if you have any questions regarding the study or what is being asked of you. By signing this form, you are indicating that you understand the information on this form and agree to participate.

WHAT THE STUDY IS ABOUT:
The purpose of this research study is to explore and qualitatively analyze the experiences and perceptions of mental health professionals who have had substantial clinical experience in providing psychotherapeutic treatment to adult male survivors of incest.

WHAT WE WILL ASK YOU TO DO:
During this study, you will be asked to participate in a series of semi-structured interviews, either in person or over Zoom/Skype.

DURATION AND LOCATION OF THE STUDY:
Your participation in this study will involve one interview that will last approximately two hours, conducted either via a virtual meeting platform or in a location that is professional and private. The interview will be audio recorded for the purpose of data transcription and analysis; recordings are necessary for this research as they will provide detailed information pertaining to the nature and purpose of the study.

POTENTIAL RISKS AND DISCOMFORTS:
We do not anticipate any risks or discomforts to you from participating in this research, although there is a potential risk for minimal psychological discomfort or distress due to the nature of the topic. If you wish, you may choose to withdraw your consent and discontinue your participation at any time during the study without penalty.

BENEFITS:
You will receive no direct benefit from your participation in this study; however, information from this study may benefit other people, including male survivors of incest, as well as individuals who conduct clinical work with this population.

PRIVACY/CONFIDENTIALITY:
Any data you provide in this study will be kept confidential unless disclosure is required by law. We will not publicly share information that will make it possible to identify you or any individual

participant. We will take precautions to de-identify any personal information. Only the Principal Investigator and Supervisor will have access to personally identifying information. Any electronic data collected (including interview recordings) will be stored in a password-protected database, and other data will be stored in a locked file cabinet that can only be accessed by the researchers. Data that is collected from this study will be kept for a maximum of three years and will be destroyed at the end of that time.

COMPENSATION/PAYMENT FOR PARTICIPATION:
You will not receive any financial compensation for your participation in this study.

VOLUNTARY NATURE OF THE STUDY:
Your participation is voluntary and you may refuse to participate without penalty. Furthermore, you may skip any questions that make you uncomfortable and may discontinue your participation at any time without penalty. In rare instances, the researcher may exercise the right to withdraw you from participation in the study.

OFFER TO ANSWER QUESTIONS:
Please contact me, the Principal Investigator, at any point if you have questions about the study: Kathryn Rosenberg, MS at kbrosenberg@usfca.edu. If you have questions or concerns about your rights as a participant in this study, you may contact the University of San Francisco Institutional Review Board at IRBPHS@usfca.edu.

I HAVE READ THE ABOVE INFORMATION. ANY QUESTIONS I HAVE ASKED HAVE BEEN ANSWERED. I AGREE TO PARTICIPATE IN THIS RESEARCH PROJECT AND I WILL RECEIVE A COPY OF THIS CONSENT FORM.

PARTICIPANT'S SIGNATURE *DATE*

Appendix B

Interview Schedule (Research Questions)

Main research question:

- **How do clinicians experience working with (i.e., providing psychotherapeutic treatment to) adult male survivors of incest?**

Specific areas of interest to be explored:

- Please summarize your clinical experience with adult male incest survivors.
    - In what setting have you worked with these clients?
    - Approximately how many clients have you had from this group?
- What, if any, common themes or presenting issues have you noticed with these individuals?
- Can you identify specific therapeutic obstacles or treatment barriers for this population? What about strengths or supportive factors? General clinical considerations?
- Did you notice any particular challenges in working with these men?
- Can you identify particularly rewarding aspects of working with these individuals?
- Did you notice ways in which these men were similar to one another vs. the remainder of your caseload? What about ways in which they were similar to the rest of your caseload?
- What is/was your relationship like with these clients?
    - Did you notice countertransference? How did you feel about these men?
    - Did you pick up on any transference? If so, what did you attribute this to?
    - How do you think your own intersecting identities impacted the relationship?
- How would you describe your treatment approach with adult male incest survivors? What do you think worked well? What hasn't worked?
- How did you experience these clients' disclosure of the abuse?
    - When/how did it come up?

    - How were they making meaning of their experiences?
- What is your understanding of the availability of relevant resources or specific guidelines of care for this population?
    - What information or resources do you think would be useful in working with adult male incest survivors?
    - How accessible do you think these resources felt to your clients, if they knew about them?
- What role do you think stigma plays for these men? What about cultural assumptions or expectations around masculinity?
- What in your clinical training prepared you for this work? What was missing from your clinical training that might have better prepared you for the challenges of this work?

Appendix C

Substance Abuse and Incest Survey – Revised (SAIS-R)

PsycTESTS®

doi: 10.1037/t18595-000

Substance Abuse and Incest Survey—Revised
SAIS–R

Items

Factor 1 : Stigma and Resistance to Counseling

Item No.	Item Content
32.	I do not talk about incest with my counselor because I don't trust him/her enough.
33.	I do not talk about incest with my counselor because I am afraid others will find out.
34.	I do not talk about incest with my counselor because I feel ashamed about it.
35.	I do not talk about incest with my counselor because he/she will think I am a homosexual.
36.	I do not talk about incest with my counselor because he/she will think I am weak.
38.	I do not talk about incest with my counselor because I feel that it was my fault.
40.	I do not talk about incest with my counselor because it is too painful to talk about.
43.	I do not talk about incest with my counselor because I don't want to think about it.
44.	I do not talk about incest with my counselor because it is too private.
47.	I do not talk about incest with my counselor because I have also been a victim of other sexual abuse that was not incest.

Note. 1 = *Strongly Agree;* 2 = *Agree;* 3 = *Disagree;* 4 = *Strongly Disagree.*

Factor 2 : Substance Abuse and Incest

Item No.	Item Content
26.	Incest has caused me problems with drinking.
27.	Incest has caused me problems with taking drugs.
28.	I have used alcohol to help me forget about incest contacts.
29.	I have used drugs to help me forget about incest contacts.
31.	Counseling for incest should be made a part of my substance abuse treatment.
50.	If I talked to my counselor about incest I think it would help me with my substance abuse problem.
51.	If I were to get counseling for incest, I would like to have group counseling with others who have had incest contacts.

Note. 1 = *Strongly Agree;* 2 = *Agree;* 3 = *Disagree;* 4 = *Strongly Disagree.*

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Substance Abuse and Incest Survey—Revised
SAIS–R

Items

Factor 3 : Ambivalence

Item No.	Item Content
39.	I do not talk about incest with my counselor because I don't think that it will help me.
41.	I do not talk about incest with my counselor because it is not a problem for me.
45.	I do not talk about incest with my counselor because I have only vague feelings of having had a contact.
46.	I do not talk about incest with my counselor because I'm not sure if I have had an incest contact or not.
52.	If I were to get counseling for incest, I would like to meet alone with a counselor.

Note. 1 = *Strongly Agree;* 2 = *Agree;* 3 = *Disagree;* 4 = *Strongly Disagree.*

Factor 4 : Fear and Anticipation

Item No.	Item Content
30.	I am afraid that I'll have incest contacts in the future.
37.	I do not talk about incest with my counselor because I am afraid legal problems will result.
42.	I do not talk about incest with my counselor because I think my counselor can't deal with it.

Note. 1 = *Strongly Agree;* 2 = *Agree;* 3 = *Disagree;* 4 = *Strongly Disagree.*

Factor 5 : Receptivity to Counseling

Item No.	Item Content
48.	If I were to talk about incest with a counselor, I would want a counselor of the same sex.
49.	I would talk about incest with my counselor if he/she asked me about it.

Note. 1 = *Strongly Agree;* 2 = *Agree;* 3 = *Disagree;* 4 = *Strongly Disagree.*

Appendix D

Responses to Childhood Incest Questionnaire (RCIQ)

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Responses to Childhood Incest Questionnaire
RCIQ

Items

The RCIQ is a 52-item scale, divided into 11 subscales within the two sections of hypothesized stress response themes and the diagnostic criteria for PTSD. Seven factors correspond to hypothesized stress response themes and four factors correspond to the diagnostic criteria for PTSD. Hypothesized stress response themes include,

•*Vulnerability and Isolation* (6 items): This pertains to having difficulty trusting men or women, feeling vulnerability in relationships with women and men, feeling emptiness, and feeling that one could not trust oneself.

•*Fear and Anxiety* (6 items): This pertains to feeling frightened that one is "going crazy," feeling frightened and anxious when alone, and thinking about the incest and feeling frightened that one will be hurt sexually by someone again.

•*Guilt and Shame* (5 items): This pertains to feeling guilty that one had not stopped the incest, not liking oneself as a woman, feeling guilty that one had not told someone sooner, and blaming oneself for the incest.

•*Anger and Betrayal* (5 items): This pertains to feeling anger and blame toward one's mother, feeling angry that someone did not help sooner, and feeling like one could explode with anger.

•*Reaction to the Perpetrator* (4 items): This pertains to feeling so much anger and blame toward the perpetrator that one would like to hurt the abuser.

•*Sadness and Loss* (4 items): This pertains to feeling sad at the thought of the incest and about the fact that one's family life was not what one wanted it to be, difficulty trusting men, and a fear of losing one's identity if one got close in a relationship.

•*Powerless* (3 items): This pertains to feeling little control and much vulnerability with respect to work or school, with men, and a lack of confidence in oneself.

Sample items include,
•"I feel angry toward men."
•"I feel guilty that I didn't do something to stop the incest."

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Responses to Childhood Incest Questionnaire
RCIQ

Items

Diagnostic criteria for PTSD include,

•*Intrusive Thoughts* (5 items): All pertain to the experience of intrusive thoughts about the incest in numerous situations (e.g., at work, with men, in sexual situations).

•*Intrusive Behaviors and Emotions* (5 items): This pertains to experiencing strong emotional reactions to people or places that remind one of the incest and active avoidance of such situations.

•*Detachment* (3 items): This pertains to experiencing difficulty in expressing emotions and being unable to experience any feeling about the incest because these feelings are buried.

•*Emotional Control and Numbness* (4 items): This pertains to feeling numb inside, having others tell one they are "in control," and feeling detached from others.

Sample items include,
•"I have intrusive thoughts about the incest when I am alone."
•"I feel detached and estranged from others."

Note. Research participants are asked to read each item and to indicate on a 6-point scale how frequently they experience that symptom. The scale choices range from 0 = "never" to 5 = "always."

Appendix E

Weekends of Recovery (WOR) Handout

WHAT ARE WEEKENDS OF RECOVERY?

A Weekend of Recovery (WOR) retreat provides a three-day healing experience that is complimentary to other mental health healing services. Any male sexual trauma survivor – 18 years or older – who has experienced sexual abuse, assault, or exploitation as a child and/or as an adult may apply to participate in a WOR. By engaging participants in creating an environment that supports safety needs for male survivors, our program format seeks to acknowledge and honor the authentic diversities of attendees at each WOR (racial, ethnic, class, spirituality, sexuality, gender, etc.). We welcome heterosexual and cisgender males; gay, bi, queer and nonconforming males; and our trans brothers living and identifying as male.

The program moved from MaleSurvivor in 2017 and incorporated independently as MenHealing, a 501(c)3 non-profit, tax-exempt organization dedicated to expanding healing resources for male survivors of sexual violence and maintain long-term sustainability for the WOR program.

GOALS OF LEVEL 1 WEEKEND OF RECOVERY

1. To provide an opportunity to experience a safe environment in which participants can discover they are no longer alone in their recovery;
2. To provide an opportunity to co-create and experience safety with other survivors as they explore further aspects of their healing journey;
3. To provide an opportunity where survivors can share their inner pain, strength and hope with others who have been sexually assaulted;
4. To provide an opportunity for survivors to give a voice to their experiences as a survivor;
5. To provide a safe way for participants to share the story of their sexual trauma with others who will understand and offer support;
6. To provide a safe place for participants to experiment with letting go, opening up and being vulnerable, and practice asking for the support they need;

7. To provide an opportunity for participants to explore safe ways of expanding their comfort zones, to find ways to deal with obstacles that prevent them from moving beyond their trauma, and to experience a greater sense of freedom in their minds, bodies, and spirits; and
8. To provide a safe place where participants can experience a sense of community, brotherhood, and joy.

ADVANCED WEEKEND OF RECOVERY OVERVIEW

Survivors are resilient and have developed the ability to feel better and experience safety, self-worth, intimacy, and freedom. Difficult emotions, such as shame, guilt, depression, anxiety, anger and many others, may feel like inner perpetrators for many survivors by shutting them down and trapping them in unhealthy patterns.

This Advanced Weekend of Recovery is designed to help participants develop a conscious and healing relationship with these difficult emotions – a relationship characterized by exquisite self-compassion, self-respect, and self-direction. Similar to Level I, we will utilize mindfulness skills, body awareness and empowerment, experiential activities, music, art, outdoor exploration, movement, play, and small-group processing to reach these goals.

General goals for an Advanced Weekend of Recovery – to help you leave the weekend with:

1. Increased awareness and understanding of the impact of abuse on building and enhancing intimacy
2. Enhanced ability to connect with other male survivors and their partners, with an intimate partner, with the significant people in your life, and with your own inner experience
3. Practical skills for ensuring safety
4. Building and enhancing the intimacy in your life and working together with a partner to further your healing
5. The power to identify and remove psychological, emotional and spiritual blocks to your healing process
6. If you are a partner of a male survivor, to gain additional support and skills to enhance your own self-care and deepen intimacy in relationships.

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