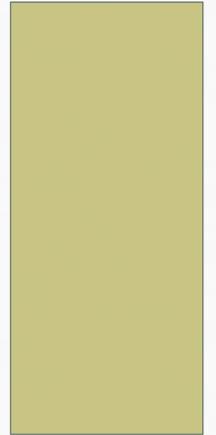


MALE SEXUAL TRAUMA

WHAT YOU KNOW, DON'T KNOW, AND WISH YOU
KNEW



OVERVIEW

- Prevalence of male sexual trauma
- Myths and facts
- Stages of reaction to trauma
- Impediments to reporting
- Barriers to seeking treatment
- Implication for treatment
- Discussion/questions

DEFINITIONS

Male sexual abuse

- Any non-consensual and or/domination which threatens the physical and/or psychological well being of a boy or male adolescent
- Acts involve a misuse of power and may involve physical force

Male sexual assault

- Any non-consensual and or/domination which threatens the physical and/or psychological well being of a man
- Acts involve a misuse of power and may involve physical force

DEFINITIONS

Sexual abuse

- Can occur in one's family of origin, in trust relationships with older youth or adults, in institutional settings, in peer groups and social clubs, and in dating relationships

Sexual assault

- Can occur in intimate relationships, dating situations, institutions, hate-crime situations, and among strangers

DEFINITIONS

Sexual abuse

- Includes unwanted touching, sexual exposure, pornography, sexual harassment, incest, child prostitution, sexual assault and rape

Sexual assault

- Includes sexual touching, oral and anal rape

WHO ARE THE VICTIMS?

- 3% of boys grades 5-8 and 5% of boys in grades 9-12 said they had been sexually abused
- About 3% of American men or 1 in 33 have experienced an attempted or completed rape
- 2.78 million US men have been victims of sexual assault
 - National Institute of Justice & Centers for Disease Control & Prevention. *Prevalence, Incidence and Consequences of Violence Against Women Survey, 1998.*

PREVALENCE

- Male-on-male rape estimated at 5-10% of all sexual assaults per year in Western countries (Scarce)
- Penile rape is more prevalent in females than males who suffer more digital or object penetration (McLean I, Balding V & White C. Forensic medical aspects of male-on-male rape and sexual assault in Greater Manchester. *Med Sci Law* 2004; **44**: 165-169)
- More male victims assaulted by multiple (2 or more) assailants than females, suggesting 'gang rape' (Kaufman et al. and McLean et al.)

MIC HUNTER

*Honor Betrayed:
Sexual Abuse in
America's Military*

- "Sexual assault isn't about sex, it's about violence."

POWER AND CONTROL

- Interpersonal power and oppression
- Perpetrators assert their power over and control victims
- Violence against women kept women in fear thus maintaining male domination leading to the minimization or denial of men's reality of sexual victimization
- Weapons or excessive violence may be slightly more likely with male victims

WHO ARE THE PERPETRATORS?

Sexual abuse

- Can include parents, siblings, extended family members, family friends, dates, intimate partners, acquaintances, peers, and strangers

Sexual assault

- Can include intimate partners, dates, friends, relatives, clients of sex trade workers, co-workers, acquaintances, and strangers

PUZZLE OF SEXUAL ABUSE

- Abuser must be motivated
- Overcome internal inhibitions
- Overcome external barriers
- Overcome victim resistance

CHARACTERISTICS OBSERVED IN MALE SURVIVORS

- Denial of vulnerability
- Confusion regarding sexual orientation
- Confusion of emotional needs with sex
- Gender shame
- Multiple compulsive behaviors
- Physical and emotional symptoms
- Pattern of victimizing self or others
- Boundary transparency
- Chaotic relationships
- Poorly defined sense of self

MYTHS OF MALE SEXUAL TRAUMA

- Women are incapable of being perpetrators
- "I let it happen."
- Most sexual abuse of boys is perpetrated by homosexual males and this is "gay sex"
- Boys abused by males are or will become homosexual
- If a boy experiences sexual arousal or orgasm from abuse, it means he was a willing participant or enjoyed it
- Boys are less traumatized by abuse experiences than girls
- "Vampire syndrome"

MYTHS

- Men are invulnerable to sexual victimization
- Men cannot be victims – “he’s a guy and he could have stopped it if he really wanted to.”
- Boy considered to be fortunate to have been initiated into heterosexual activity by female perpetrator
- *The stronger an individual believes in myths or stereotypes of male rape, the more they will attribute blame to a male victim while simultaneously reducing the blame attributed to the rapist* (Sleath E & Bull R. Male rape victim and perpetrator blaming. *J Interpers Violence* 2010; **25**: 969-988.)

10 FACTS ABOUT SEXUAL ABUSE OF BOYS AND ITS AFTERMATH

REPRODUCED WITH PERMISSION FROM MALESURVIVOR.ORG

- 1. Up to 1 out of 6 men report having had unwanted direct sexual contact with an older person by the age of 16. Non-direct contact/sexual behavior – 1 in 4 men report boyhood sexual victimization. (1,2)
- 2. On average, boys first experience sexual abuse at age 10. The age range at which boys are first abused, however, is from infancy to late adolescence. (1,2)
 1. Lisak, D., Hooper, J., Song, P (1996). Factors in the cycle of violence: Gender rigidity and emotional constriction. *Journal of Traumatic Stress*, 9:721-743
 2. Finkelhor, D., Hotaling, G., Lewis IA, Smith, C. (1990). Sexual abuse in a national survey of adult men and women: Prevalence, characteristics, and risk factors. *Child Abuse and Neglect*, 19:557-68

10 FACTS ABOUT SEXUAL ABUSE OF BOYS AND ITS AFTERMATH

- 3. Boys at greatest risk for sexual abuse are those living with neither or only 1 parent; or whose parents are separated, divorced, and/or re-married; those whose parents abuse alcohol or are involved in criminal behavior; or those whose parents are disabled. (3)
 - 3. Holmes, W., Slap, G. (1998). Sexual abuse of boys: Definition, prevalence, correlates, sequelae, and management. *Journal of the American medical Association*, 280:1855-1862.

10 FACTS ABOUT SEXUAL ABUSE OF BOYS AND ITS AFTERMATH

- 4. Boys are most commonly abused by males (50-75%). Abuse by females is more covert and may be considered “sexual initiation” although he may deny the abuse, he may suffer significant trauma from the experience. (1)
- 5. A smaller proportion of sexually abused boys than sexually abused girls report sexual abuse to authorities. (3)

10 FACTS ABOUT SEXUAL ABUSE OF BOYS AND ITS AFTERMATH

- 6. Common symptoms for sexually abused men include guilt, anxiety, depression, interpersonal isolation, shame, low self-esteem, self-destructive behavior, PTSD reactions, poor body imagery, sleep disturbance, nightmares, anorexia or bulimia, relational and/or sexual dysfunction, and compulsive behaviors like alcoholism, drug addiction, gambling, overeating, overspending, and sexual obsession or compulsion. (3,4)
 - 4. Gartner, RB (1999). *Betrayed as Boys: Psychodynamic Treatment of Sexually Abuse Men*. New York: Guilford Press.

10 FACTS ABOUT SEXUAL ABUSE OF BOYS AND ITS AFTERMATH

- 7. The vast majority (over 80%) of sexually abused boys never become adult perpetrators, while a majority of perpetrators (up to 80%) were themselves abused. (1)
- 8. There is no compelling evidence that sexual abuse fundamentally changes a boy's sexual orientation, but it *may* lead to confusion about sexual identity and is likely to affect how he relates in intimate situations. (3,4)

10 FACTS ABOUT SEXUAL ABUSE OF BOYS AND ITS AFTERMATH

- 9. Boys often feel physical sexual arousal during abuse even if they are repulsed by what is happening. (4)
- 10. Perpetrators tend to be males who consider themselves heterosexual (5, 6) and are most likely to be known but unrelated to the victims (3)
 - 5. Groth, AN, Oliveri, F (1989). Understanding sexual abuse behavior and differentiating among sexual abusers. In S. Sgroi (Ed.), *Vulnerable Population*, (Vol. 2, pp. 309-327). Lexington, MA: Lexington Books.
 - 6. Jenny C. Roesler TA, Poyer KL (1994). Are children at risk for sexual abuse by homosexuals? *Pediatrics*; 94:41-4.

STAGES OF REACTION TO TRAUMA

INITIAL REACTION AND REORGANIZATION STAGES

INITIAL REACTION STAGE

- Physical aspects
- “How could this happen to me?”
- Fear – “will he/she/they find me again?”
- Rumination, vulnerability
- Guilt
- Humiliation
- Retribution
- Misdirected anger towards all homosexuals believing that assailant(s) were homosexual

REORGANIZATION STAGE

- 4 months – 1 year following abuse
- Anxiety of being attacked by “someone”
- Searching for signs of danger – hypervigilance
- May be forced to interact with perpetrator or return to site of assault
- Sense of loss

BREAKING THE CYCLE OF SELF-DEFEATING BEHAVIOURS

BY KEN SINGER, LCSW

- 1. Build up phase – unpleasant feelings are triggered by old negative tapes or messages
- 2. Withdrawal phase – feel victimized by others
- 3. Pre-(behavior) phase– attempt to overcome the negative thoughts and feelings using compensatory behaviors
- 4. Post-(behavior) phase – experience remorse, guilt or shame; make promises to avoid behaviors in the future

STEPS TO HEALTHY BEHAVIORS

- Recognize trigger thoughts and feelings
- Avoid “victim stance”
- Use positive behaviors which empower rather than disempower
- No “correct” interventions – use only those that reduce negative feelings and thoughts
- Reproduced with permission from MaleSurvivor: National Organization Against Male Sexual Victimization (www.malesurvivor.org)

NEIL IRVIN

Executive Director of
Men Can Stop Rape

- “The violence is ignored and your sexual orientation and gender are confronted.”

HOMOSEXUAL MALE SURVIVORS

- Crime is “punishment” for their sexual orientation
- May worry that the assault affected their sexual orientation
- Fear they were targeted b/c they are gay -> withdrawal from community
- May develop self-loathing related to sexual orientation
- Blame themselves b/c they “let it happen”
- Impact gay men’s ability to feel comfortable with themselves, their bodies, their sexual relationships

HOMOSEXUAL MALE SURVIVORS

- If sexual trauma is a gay man's framework for what it is to be gay, then gay may be viewed as shameful, dirty, to be hidden – a dreadful secret
- Being gay is shameful, bad, dirty – I'm damaged goods
- Can feel that their sexuality is as shameful as their trauma was
- (Male-to-Male child Sexual Abuse in the Context of Homophobia by Kali Munro, M.Ed.; www.KaliMunro.com)

HETEROSEXUAL MALE SURVIVORS

- May experience fear that the assault will make them gay
- May believe that male rape is homosexual sex
 - Am I gay?
 - What messages did I send out?
- May feel that they are “less than a man”
- Inconsistent with male identity

MEN RECEIVE IMPLICIT AND EXPLICIT MESSAGES

- that "A Good Man" :
 - Is physically strong
 - Is brave, courageous
 - Is heterosexual
 - Is NOT feminine
 - Is unemotional
 - Is in control
 - Actively suppresses
 - Pain
 - Fear
 - Vulnerability
 - Weakness

But if you are a
man,

AND

you are sexually
assaulted then...

YOUR ASK YOURSELF AM I A REAL MAN?



MALE ATTRIBUTIONS OF SELF-BLAME

- People search for meaning after an event – why do you think you were assaulted?
 - I gave off some gay signal
 - I was too effeminate
 - I was too trusting/eager to make friends
 - I was being punished

RELATIONSHIPS/INTIMACY

- Disrupted by the assault
- Disrupted by others' reactions to the assault – lack of belief/support
- Disrupted by survivor's reaction to or coping with the assault
- Anger leading to outward and inward focused hostility
- Avoidance of emotions or emotional situations stemming from overwhelming feelings that come with surviving a sexual assault

SEXUAL TRAUMA + MASCULINITY = HUGE CONFLICT

- Sexual trauma evokes everything that masculinity rejects
- Fear
- Shame
- Vulnerability
- Helplessness
- Submission
- Intense emotions

POST TRAUMATIC STRESS DISORDER

- A. Exposure to actual or threatened death, serious injury, or sexual violence by directly experiencing or learning that the event occurred, or experiencing repeated or extreme exposure to aversive details of the traumatic event(s)
- B. One or more of the following **intrusion** symptoms:
 - 1. recurrent, involuntary, and intrusive distressing memories
 - 2. recurrent distressing dreams related to traumatic event
 - 3. Dissociative reactions (flashbacks) – content related to traumatic event
 - 4. intense or prolonged psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event
 - 5. marked physiological reactions to internal or external cues that symbolize or resemble an aspect of the traumatic event

PTSD

- C. Persistent **avoidance** of stimuli associated with the traumatic events(s), beginning after the traumatic events(s) occurred, as evidenced by one or both of the following:
 - 1. avoidance or efforts to avoid distressing memories, thoughts, or feelings about or closely associated with the traumatic event(s)
 - 2. avoidance of or efforts to avoid external reminders that arouse distressing memories, thoughts, or feelings about or closely associated with the traumatic events

PTSD

- D. **Negative alterations in cognitions and mood** associated with traumatic events
 - 1. inability to remember an important aspect of trauma
 - 2. persistent and exaggerated negative beliefs of expectations about oneself, others, or the world
 - 3. persistent, distorted cognitions about the cause or consequences of the traumatic event that lead the individual to blame self or others
 - 4. persistent negative emotional state
 - 5. Markedly diminished interest or participation in significant activities.
 - 6. feelings of detachment or estrangement from others
 - 7. persistent inability to experience positive emotions

PTSD

- E. Marked alterations in **arousal and reactivity** associated with traumatic event, beginning or worsening after the event occurred, as evidenced by two or more of the following:
 - 1. irritable behavior and angry outbursts (with little or no provocation) typically expressed as verbal or physical aggression toward people or objects
 - 2. reckless or self-destructive behaviors
 - 3. hypervigilance
 - 4. exaggerated startle response
 - 5. problems with concentration
 - 6. sleep disturbance

PTSD

- F. Duration is more than 1 month
- G. Disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning
- H. Disturbance is not attributable to the physiological effects of a substance or another medical condition

PTSD

- With dissociative symptoms
 - Depersonalization – feeling as though one were in a dream
 - Derealization – unreality of surroundings
- With delayed expression – if the full diagnostic criteria are not met until at least 6 months after the event (although the onset and expression of some symptoms may be immediate).

OBSTACLES TO REPORTING & SEEKING HELP

- Men expected to defend their own boundaries
- Told that “You must have provoked it.”
- No conventional methods for reporting
- Fear of further victimization
- Retribution
- Prosecution – re-traumatized by Criminal Justice System

OBSTACLES TO REPORTING & SEEKING HELP

- Not believed
- Shame
- Victims are lying and responsible for what happened
- Fear of being labeled a homosexual
- It wasn't really rape – it was consensual – NOT an assault

OBSTACLES TO REPORTING & SEEKING HELP

- Men have no expectation of sexual trauma
- More stigmatizing for men
- Difficulty figuring out how it fits into sense of self as a man – experience outside male gender role
- Disclosure perceived as risky
 - “you didn’t fight them off?”
- Limited awareness
 - Social stigma for male sexual trauma vs other PTSD inducing events
- Misrecognition of fear as anger

OBSTACLES TO REPORTING & SEEKING HELP

- Layers of personal shame and official denial
- Increased sense of helplessness, powerlessness, and at risk for additional victimization
- Seen as weak and unmanly to
 - Be victimized
 - To need help
 - To seek help
 - To talk about victimization
 - To share vulnerable feelings

SOCIALIZATION MESSAGES

- Larger society's response to male victimization is significantly different than when the victim is female
- Cultural norms of masculinity vs female norms of femininity
- Gender is influenced by social learning
- Gender socialization impacts our efforts to respond to sexual abuse of males

SOCIALIZATION MESSAGES

- Males are aggressive by birth
- Males are strong/tough in the face of adversity
- Males who express feelings openly are weak, unstable, and unreliable
- Males are logical, decisive, and action oriented; feelings are disruptive, tangential, and will make a person less productive=less successful
- Feelings are never clear; decisions are based on black and white data; social order would collapse if based on feelings; somebody has to keep thinking clearly

SOCIALIZATION MESSAGES

- Feelings imply conflict (difficulty distinguishing specific emotional energies -> conflict)
- Dealing with feelings is a luxury; men must be productive and don't have time to engage in a luxury such as expressing feelings
- Males lack the genetic predisposition to deal with feelings as effectively as females; women are able to take care of men around feelings (Socialization and Its Impact on male Survivors of Sexual Abuse by Jim Struve, LCSW; Male Survivor: National Organization Against male Sexual Victimization)
 - www.malesurvivor.org

CODES OF MALE BEHAVIOR

- Emotional invulnerability and interpersonal independence
- Being in control of oneself and one's surroundings
- "acting like a man" = limit awareness of emotions, stifle feelings, deny awareness of vulnerability
- Embrace a rugged heterosexual code = limits emotional intimacy and sexual expression with other males and perpetuates homophobia
- If you defy the code, then you are perceived as "non-male" = gay

CODES OF MALE BEHAVIOR

- Dominance over women
- “masculine ideal” cannot tolerate any recognition of victimization except for non-males i.e., females and males who breach the code

SOCIAL CONSTRUCTION OF MASCULINITY

- “ideal” is based upon race, culture, sexual identify of dominant culture
- Males aspire to this standard despite it being essentially unachievable (The Paradoxical Elephant: A theoretical framework for male-centred approached to sexual trauma by Rick Goodwin, MSW, RSW; The Men’s Project, 2004)

CLINICAL IMPLICATIONS

FOR TREATING MALE SURVIVORS OF SEXUAL TRAUMA

TARGETS FOR TREATMENT

- Men are socialized to always be in control – If not, then
 - “I did something wrong”
 - “I should have done something differently”
 - Event interpreted as “behavioral” or “characterological” failing
 - Self-blame and “shoulds” imply
 - Disapproval, judgment, morality, need for punishment or consequence, including poor social skills and isolation, especially from other men

TARGETS FOR TREATMENT

- Men are socialized to avoid or minimize expression of emotions
- High co-morbidity of Substance Use Disorders
 - PTSD symptoms may go undetected; Blunts expression of emotion
 - Convenient way to avoid emotional expression
 - Most maladaptive coping methods are less effective over time
 - Facilitates aggression, re-enactment, and re-victimization
 - The solution becomes the problem that may be seen as the “identified problem”

TARGETS FOR TREATMENT

- Men are socialized to use anger and aggression
- Expression of anger vs other emotions
 - “hard core” vs “being soft”
- Reinforces gender rigidity

- Therapy with male survivors of sexual trauma to include focus on
 - Traditional gender socialization

TREATMENT INTERVENTIONS

- Address immediate health and safety concerns
- Conduct a thorough assessment containing a detailed trauma history
- Normalize post-trauma reactions
- Provide education about trauma
- Provide validation
- Support adaptive coping strategies
- Help develop new healthy coping skills to break the cycle of self-defeating behaviors

IMPACT OF TRAUMA

- Men report more psychological and physical problems than women (Elliot, Mok, Brier, 2004)
- Major depressive disorder
- Increased substance abuse
- Self-blame
 - Believing they were not 'strong enough' to fight off perpetrator
 - Confused about becoming physically aroused

PSYCHOLOGICAL EFFECTS

- Sense of self and concept of “reality” are disrupted
- Profound anxiety, depression, fearfulness
- Development of phobias related to assault setting
- Fear of worst happening and sense of foreshortened future
- Withdrawal from interpersonal contact -> isolation
- Stress-induced reactions
- Social reactions to sexual assaults can be more isolating

COMMON REACTIONS TO TRAUMA

A National Center for
PTSD Fact Sheet

Edna Foa, Elizabeth
Hembree, David Riggs,
Sheila Rauch, and Martin
Franklin

Center for the Treatment
and Study of Anxiety
Dept. of Psychiatry, U of P

- Fear and anxiety
- Re-experiencing the trauma
- Increased arousal
- Avoidance
- Anger and irritability
- Guilt and shame
- Grief and depression
- Self-image and view of the world
- Sexual relationships
- Use of alcohol or other substances

TREATMENT

- Initial individual therapy followed by group experience to decrease isolation
- Themes for treatment:
 - Different forms of abuse
 - Effects of the abuse and coping strategies
 - The larger context
 - Permission to feel
 - Permission to have needs
 - Sexuality

STRESS INOCULATION TRAINING

- Behavioral tx to address fear and anxiety
- 3 Phases
 - 1. Education
 - Fear develops as a learned response
 - Which cues trigger fear
 - Learn progressive muscle relaxation
 - 2. Skill building
 - Learn to control fear reactions using PMR, diaphragmatic breathing, thought stopping, mental rehearsal, guided self-talk, and role play
 - Exercises reduce physiological sensations and fearful thoughts

SIT

- 3. Application
 - Apply skills
 - Control self criticism
 - Manage avoidance behavior
 - Rewards for progress

SIT is 10-14 sessions

Effective in reducing fear, intrusion, avoidance

Effective in reducing PTSD symptoms

PROLONGED EXPOSURE

DEVELOPED BY EDNA FOA

- Flooding – exposure therapy
- Individuals repeatedly confront fearful images and memories of traumatic event so fear and anxiety decrease (habituation) (Falsetti, 1997; Foa and Rothbaum, 1998)
- in session use of imaginal exposure
- Recorded imaginal exposure to be listened to outside of session
- Development of in vivo hierarchy
- In vivo exposure

PE

- 8-12 90 minute sessions
- Effective for rape victims with PTSD
- Superior to no treatment, traditional counseling, and SIT in reducing PTSD symptoms
- PE is an effective treatment of depression, anxiety, and adjustment

COGNITIVE PROCESSING THERAPY

DEVELOPED BY KATE CHARD, CANDICE MONSON, AND PATRICIA RESICK

- 12 sessions
- Multicomponent tx based on information-processing model
- Combines exposure therapy and cognitive restructuring
- Process emotions and confront “stuck points”
- Written impact statement – safety, trust, power/control, esteem, and intimacy
- Written trauma narrative

CPT

- Challenges maladaptive irrational beliefs about the trauma
- Learn to accommodate the belief and maintain a balanced and realistic world view
- Provided as individual or group treatment
- Trauma not processed in group

MULTIPLE CHANNEL EXPOSURE THERAPY

- Adapted from CPT, SIT, and Mastery of Your Anxiety and Panic (Barlow & Craske, 1988)
- Treats PTSD and panic attacks
- Individuals who experience panic attacks initially may not tolerate exposure therapy
- MCET focuses on panic symptom reduction before trauma work begins

MCET

- Clients receive education and are taught exercises to reduce panic and to counteract negative and distorted thinking
- Bring about panic attack via structured exposure exercises
- Learn that fearful situations are not harmful or dangerous – only your interpretations are
- Following panic reduction, begin CPT
- 12 weeks in individual or group format

SCHEMA THEORY

DEVELOPED BY DR. JEFFERY YOUNG

- Schemas are defined as: "broad, pervasive themes regarding oneself and one's relationship with others, developed during childhood and elaborated throughout one's lifetime, and dysfunctional to a significant degree."
- Schema therapy integrates elements of cognitive therapy, behavior therapy, object relations, and gestalt therapy into one unified, systematic approach to treatment

SCHEMA THEORY

- The main goals of Schema Therapy are: to help patients strengthen their Healthy Adult mode; weaken their Maladaptive Coping Modes so that they can get back in touch with their core needs and feelings; to heal their early maladaptive schemas; to break schema-driven life patterns; and eventually to get their core emotional needs met in everyday life.
- The four main concepts in the Schema Therapy model are: Early Maladaptive Schemas, Core Emotional Needs, Schema Mode, and Maladaptive Coping Styles

CASE STUDY

- Diamanduros T, Cosentino C, Tysinger P. Dawn and Jeffery (2012). Theoretical perspectives of male sexual abuse: conceptualization of a case study. *Journal of Child Sexual Abuse*, **21**: 131-154.

WEBSITES

- RAINN.org (rape, abuse, & incest national network)
- www.malesurvivor.org
- Sandf.org (Survivors & friends)
- Themensproject.ca/ (the men's project)
- www.malesurvivor.org

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