ADULT MALE SURVIVORS OF CHILDHOOD SEXUAL ABUSE

NEEDS ASSESSMENT: LOTHIAN

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A Report Commissioned by NHS Lothian

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CHAPTER 1
INTRODUCTION AND BACKGROUND

ADULT MALE SURVIVORS OF CHILDHOOD SEXUAL ABUSE NEEDS ASSESSMENT: LOTHIAN

Chapter 1 Introduction and Background

In September 2003, NHS Lothian commissioned *health in mind* to undertake a needs assessment. The **overall aim** was:

"To undertake a quantative and qualitative appraisal of the needs and resources for adult male survivors of sexual abuse across Lothian, to identify gaps in service provision: and to make recommendations."

This report presents the findings of this study.

The **client group** in question comprised adult males over the age of 16, who have experienced sexual abuse in childhood. We have adopted the definition used in the current Edinburgh & Lothians Child Protection Guidelines (2003): *"Any child below the age of consent will be deemed to have been sexually abused when any person, by design or neglect, causes that child to be involved in any activity that might reasonably be expected to lead to the sexual arousal or gratification of that or any other person, including organised networks".**

Key issues: As well as assessing current provision and identifying gaps in services, the researcher was asked to comment, where possible, on issues of access to services; needs that appear particular to males; training requirements; communications between services; and examples of good practice . A short-life Reference Group was set up for the duration of the needs assessment to provide support, guidance and a "sounding board".

Background: Building on earlier work….

In carrying out this needs assessment, we were aware that there was already wide concern about lack of services in the Lothians for male survivors of childhood sexual abuse. Indeed there remains significant concern - especially in Edinburgh City itself and in East Lothian - that so little help has been available for abuse survivors of either sex.

In fact valuable work had begun in Edinburgh between 1998 and 2000 to explore the feasibility of a service for adult male survivors, and to investigate

*Edinburgh and the Lothians Child Protection Committee (2003). *Child Protection Guidelines*, Edinburgh.

funding possibilities. The main impetus came from investigations into historical abuse in residential care homes in Edinburgh. A steering group drawing on social work, health, police and voluntary sector was set up with Alistair Stevenson seconded from field social work to a temporary funded post. The remit was to examine gaps in services, and to make recommendations, especially on the feasibility of establishing a phoneline for male survivors.

Mr Stevenson reported on a significant and considerable service need including advice and counselling. At that time, however, no funding was available to continue the post, nor to progress establishment of a suitable agency to deliver services.

Partnership between NHS Lothian and *health in mind*

A number of developments and policy initiatives at national and local level have contributed to a more promising environment for this needs assessment. NHS Lothian are, with their partners, reviewing their mental health and wellbeing strategy. This occurs at a time of radical legislative change within mental health, and within the context of the National Programme for Mental Health and Wellbeing.* The National Programme highlights social inclusion, and its initiatives include the reduction of suicide and self-harm (Choose Life); action in respect of depression (Doing Well) and tackling stigma and discrimination (See Me).

The NHS Lothian's agenda is not only to focus on the more traditional statutory services and approaches to treatment, but to build the strategy on the principles of social justice and social inclusion; a strategy that means being more aware of the holistic needs of vulnerable groups. These groups may be more vulnerable to mental health problems because of their life circumstances, and can find it difficult to either access or find available the services they need. Both *health in mind's Beyond Trauma* report (2001) ** and the Scottish Executive's *Mind the Gaps* report on co-occurring substance misuse and mental health problems (2004)*** were critical of a tendency for clients to have to "fit" into existing services, rather than services being designed to meet the individual needs of clients.

Beyond Trauma highlighted the lack of services for women who had been sexually abused in childhood. But it also raised the issue of provision for men and recommended that an assessment of male survivors' needs be carried out. NHS Lothian were keen to know what would assist male survivors and what were the gaps in services for this socially excluded group. The recommendations of this report will inform the way they work with partner agencies who work regularly with survivors of sexual abuse. These agencies may also be in the process of redesigning or developing provision which takes cognisance of the views both of clients and of funders.

*National Strategy for Mental Health and Wellbeing: for further information about this major programme, visit the following websites: www.show.scot.nhs.uk; www.mentality.org.uk; www.mentalhealth.org.uk;
**Nelson, Sarah. (2001) *Beyond Trauma: Mental Health Care needs of Women who Survived Childhood Sexual Abuse*. Edinburgh Association for Mental Health, Edinburgh. ***Scottish Advisory Committee on Drug Misuse,(2004) *Mind the Gaps: Meeting the needs of people with co-occurring substance misuse and mental health problems*. Report of the Joint Working Group. Scottish Executive, Edinburgh.

health in mind is an Edinburgh-based voluntary organisation that provides a diverse range of initiatives into the promotion of mental health, and the alleviation of mental health difficulties. Direct services are run alongside the development of alternative and complimentary therapies, training initiatives and action research. Campaigning with, and on behalf of, vulnerable groups is mainly done through practice demonstration and by disseminating lessons learned from practice, training and research.

For *health in mind,* this needs assessment follows directly from its work on the Beyond Trauma report recommendations. Discussions with NHS Lothian highlighted a shared agenda and this project was born out a joint wish to contribute to strategic thinking. *health in mind* was subsequently commissioned to undertake the work and contracted Sarah Nelson, author of the *Beyond Trauma* report, to carry it out.

This needs assessment is one of a series of initiatives by *health in mind* in their work with sexual abuse and mental health issues. A *Beyond Trauma* training officer has been recruited to develop training packages for statutory and voluntary staff across Scotland ; the Information and Training officer will be developing a specialist section on sexual abuse issues for the Information and Resource Centre at *health in mind*; the sexual abuse counselling and housing support services are now operational; development work with women and young people is under way; the development of proposals for further research on male survivors, in collaboration with a university research unit, is currently at an early stage.

Research methods for this needs assessment:

- A <u>questionnaire</u> (copy at Appendix) was sent to a wide range of statutory and voluntary sector organisations in Edinburgh, Midlothian, East Lothian and West Lothian (discussed in chapter 2).

- <u>Follow-up interviews</u> were held with nine statutory and voluntary agencies, to assess further the needs of particular groups of male survivors, and to explore further general issues which particularly affected male survivors. Two small-group interviews and two individual interviews with male survivors also took place. All these interviewees were linked to survivor organisations, which were able to give support should any issue discussed prove distressing. (Interviews with organisations and survivors are discussed in chapter 3.)

- The <u>Reference Group</u> commented on regular progress reports, and gave input into the questionnaire design and recommendations. The <u>recommendations</u> are set out in Chapter 4.

- A seminar (see below) to design an Action Plan around these outline recommendations has been organised and will itself form part of the research project.

The interviews and questionnaire survey were carried out between October 2003 and March 2004.

Taking the proposals forward

The findings of this needs assessment are being presented at a seminar at the John McIntyre Centre, Pollock Halls, Edinburgh on 1st June 2004. All questionnaire respondents have been invited along with key decision makers in health, social work and criminal justice.

The event is intended to be a working seminar that will achieve the following.

- Provide feedback on the findings and recommendations of this report, including the identification of any provision which has still not been located by this needs assessment.
- Produce the outline of a practical Action Plan for implementing improved service provision. This would be further developed with key agencies.
- Establish a network of interested and committed people throughout Lothian who will actively assist in taking forward the proposals.

Finally it is important to stress that this needs assessment cannot be, and is not intended to be, a comprehensive study of male survivor needs and issues, and should not be judged as such. It has been a limited-scale, six-month project. We hope and believe however that it will be seen as a valuable reference document which can lead to implementation of new services, improvement of existing ones, and directions for further research.

Thanks are due to everyone in the needs assessment reference group, which met regularly with Sarah Nelson and depute chief executive Sarah Smith: they were Linda Irvine, Craig Hutchison, Martin Henry, Dick Fitzpatrick, Ian Fuller, Andy McAleevy. Thanks also to Annmarie Mitchell and Julie Dick for their invaluable help with questionnaire analysis and report design.

CHAPTER 2

RESULTS OF QUESTIONNAIRE, EDINBURGH & LOTHIANS

Chapter 2
Results of Questionnaire, Edinburgh & Lothians

Introduction

This chapter summarises the results of the needs assessment questionnaire, which was sent to a wide range of organisations and services in Edinburgh, Midlothian, East Lothian and West Lothian. A copy of the questionnaire can be viewed at the Appendix.

Because less is currently known about male than about female survivors' use of services, we distributed the questionnaire widely. We did not want to limit our assumptions about where male survivors with support needs might be found, and what their presenting problems might be.

We distributed to statutory mental health services including psychological services, multi-professional community mental health teams, primary care liaison teams, specialist psychiatric services and social work teams concerned with mental health and criminal justice. We sent forms to services dealing with issues such as homelessness, counselling, drugs/alcohol misuse, mental health, community health, domestic violence, offending, older men, young people, people with disabilities, young people, lesbian, gay, bisexual and transsexual (LGBT) issues, and people with HIV/AIDS.

The number of questionnaires finally distributed (after a second tranche, due to the level of interest shown) was 105.

In the statistical information which follows, please note: Totals reaching less than 100% exclude N/A or D/K answers, which are only described where relevant; totals reaching more than 100% indicate respondents can select more than one choice; figures rounded to nearest percentage point; anyone wishing more detailed statistical information from the survey, please contact Annmarie Mitchell at health in mind, 0131 225 8508).

1) PERCEIVED URGENCY OF THE ISSUE

There were several pointers to a high degree of interest, concern and commitment in relation to services for male survivors of childhood sexual abuse.

- There was an unusually high return rate for a postal questionnaire of **78%** (82 questionnaires. Another two were returned too late to be processed for this report). The returns reflected the wide range of projects which received the questionnaires, and **46%**, or nearly half of

all replies, came from the statutory sector.

- Comments expressed relief and/or enthusiasm that the needs assessment was being carried out, e.g.:

"Very glad to see this initiative is happening as it is urgently needed"

"Fantastic if there was an Edinburgh based service for male survivors"

"There is no adequate service…current limited services have huge waiting lists"

- **From the entire survey, only three agencies said they thought current service provision for male survivors of sexual abuse was adequate.**

- **Forty six agencies said they were interested in helping to take any proposals forward. This is a considerable commitment on which to build.**

2) HIGH AWARENESS OF MALE SURVIVORS

One striking finding was the high level of awareness among agencies that male survivors were among their service users. These findings were perhaps unexpected, in that male survivors have been thought of as a more "submerged", less identifiable group than abused women. Male survivors themselves have described the reluctance of men to speak to agencies about their problem, and of a widespread failure of services to identify a history of abuse in their service users.

However it seems that whatever difficulties there may be in this area of work, a need to persuade agencies that the problem exists is not one of them.

- When asked, "How often would your service come across male clients whom you know have experienced childhood sexual abuse?"

32% of agencies said regularly; **62% said sometimes.**

- When asked "how often would your service come across male clients whom you think may have experienced childhood sexual abuse"

40% of agencies said regularly; 58% said sometimes.

A number of agencies commented in more detail on issues about their client groups, for example:

An older men's project: *"I believe that the problem is greater than statistics indicate and that many people do not and will not disclose information about their own personal experiences".*

An HIV/Aids support service: *"There is no doubt that men who were sexually abused in childhood are over represented in our client group. Sometimes this is linked to having spent time in public care".*

Written comments sometimes suggested noticeable differences in perceptions between organisations working in the same field in their general awareness of sexual abuse. For instance in comparison to the agency just quoted, another agency working with HIV/Aids wrote that this was not their area of work, and left most of the questionnaire blank.

3) DO YOU ASK ROUTINELY ABOUT A POSSIBLE HISTORY OF ABUSE DURING ASSESSMENT?

- **24% said yes (with some caveats)**

A range of research has suggested two tendencies. Firstly that most survivors of sexual abuse do not mind, or indeed welcome being asked sensitively about a possible abuse history, in order that their needs may be addressed; but secondly that in contrast many staff feel very reluctant or nervous about doing this.* (see Nelson 2001; Goater & Meehan 1998; Reid & Fraser 1998a&b). For this survey, just under a quarter of agencies said they routinely asked about a history of abuse during assessment of their service users. This 24% figure may overestimate the numbers who actually ask the question because some respondents put in caveats such as "only if indicated", "if evidence suggests", "not in those words", or "Ask referrer not client".

It is possible that the survey question was too narrow and specific to capture a range of practice which did explore for an abuse history. Some agencies may have assumed we were asking only about their first meeting with clients. The word "assessment" may also have caused problems, since some agencies and counselling approaches would not agree with using formal assessments or very specific questions. Yet as the "good practice" sections of the ***Beyond Trauma*** report on women survivors showed, staff might still have the perception and sensitivity to identify and offer help quickly to abuse survivors.

Questions about childhood trauma can be put in several ways to service users early on in their contact with a support service or organisation. Perhaps on reflection, a broader survey question, such as "Do you explore for a history of childhood sexual trauma in the early weeks of contact with your service users?" might have drawn a more accurate, useful picture of current practice.

* Goater, G & Meehan, K. "Detection and Awareness of child sexual abuse in adult psychiatry*", Psychiatric Bulletin*, 22.
Read, J. & Fraser, A. (1998a) "*Abuse histories of psychiatric patients: to ask or not to ask"?* Psychiatric Services 49, 355-359
Read, J. & Fraser, A. (1998b) "Staff response to abuse histories of psychiatric inpatients", *Australian and New Zealand Journal of Psychiatry*, 32, 206- 213.

With these reservations we can make a few comments.

a) **There was no obvious pattern in the agencies/services who asked, or did not ask, the question routinely.** Some agencies/services which did not ask were working with client groups (including distressed young people, high risk offenders and those with acute psychiatric problems) who might be considered heavily at risk of a CSA history; and where it might appear important for treatment, planning or protection to know of such a history. Some agencies who did ask the question had client groups who may not have been at such high risk, or for whom it may not have seemed so relevant.

b) **A coherent picture did not always emerge across service types**: for instance some community mental health teams said they did ask routinely, and some said they did not.

4) HIGH RECOGNITION OF SERIOUS DIFFICULTIES

Another notable finding was that nearly all agencies identified a number of significant problems resulting from childhood abuse in their male client group. Seven out of 13 possible problems listed in the questionnaire were ticked by more than 50% of the respondent agencies.

We asked agencies: what, in your service's experience, have been the main problems which sexual abuse causes for male survivors?

Only one respondent out of 82 answered "no particular problems".

- **85% said mental health problems;**
- **80% said low self esteem;**
- **76% said relationship problems;**
- **76% said aggression/anger;**
- **71% said self- harm;**
- **71% said substance misuse;**
- **58% said suicidal feelings.**

Sexual identity problems were named by 49% of respondents and offending by 40%. Other problems identified but mentioned by fewer than 40% were: parenting problems, homeless issues, flashbacks, and voice-hearing.

Respondents were invited to write down any other effects noticed in their client group, which were not on our questionnaire list. Those given were:

- Sexual offending
- Powerlessness
- Lack of trust of people in authority

- Lack of faith in statutory services
- Unrealistic expectations that women partners would " mend" their childhood
- Attachment difficulties
- Sexualised behaviour to women – "this is quite subtly different from the usual sexual behaviour towards women"
- Fire-raising

A number of agencies commented further on problems identified in their client groups.

A social worker: "*Sexual abuse is one area that is a direct cause of mental health problems- in my experience it leads individuals to issues like depression, suicide attempts, self harming behaviour and homelessness…more needs to be done in terms of having support available for service users".*

A community mental health team: *"Clients unfairly labelled with mental health problem, because primary care don't know where else to refer them".*

A criminal justice team working with teenagers and young men**:** *"Of major concern in our work are clients abused by a network of paedophiles and (who) feel powerless because of their own lifestyles/offending/drug misuse etc".*

(This issue was explored with the team, and is discussed in more detail in chapter 3.)

5) WHAT SERVICES WERE CURRENTLY BEING OFFERED TO MALE SURVIVORS IN LOTHIAN?

- **5% said they offered a direct service**
- **73% said they dealt with abuse issues as they arose**
- **70% said they referred client elsewhere for abuse issues**

In a majority of cases, agencies ticked both "deal with as they arise" and "refer client elsewhere". They worked with certain issues if they came up, but they also referred clients on for more specialist help.

Unfortunately those answers are limited in what they can tell us. They do suggest that most statutory and voluntary agencies try to address the issue to some degree, but that they also feel they should be referring on clients with sexual abuse trauma. However, they cannot reveal at what stage most survivors are being referred on, nor the quality and extent of work being done by 73% of agencies. There may be a lot of variation between and even within organisations, depending on staff expertise available at the time.

Information from the "direct service" question proved complex to interpret, and actual questionnaire responses did not give a very accurate picture. Therefore a broader more accurate picture of actual provision is attempted below. The survey question was not clear enough to some respondents, so only services working directly on survivor issues were included in the 5% figure. Again, some survivor services described below did not return their forms, or they were only identified after this questionnaire was distributed. (The form from one statutory agency failed to mention its own service, which was only confirmed after a 'phone check!) The information below thus includes non-questionnaire material.

- **No dedicated service for male survivors only was identified in the Lothians.**
- **Several services were identified in the questionnaire which worked with both adult male and female survivors. These are outlined below, along with specific services identified subsequently. We remain aware that there may still be others not yet identified. There are geographic limits, and strict funding/resource constraints on many of these services, and age criteria for some. Nothing based in East Lothian has yet been identified.**

1) ***health in mind's* Counselling Service** (from April 2004) offers counselling support to men and women who wish to address issues of childhood sexual abuse. This service is based at its Edinburgh offices and is mainly targeted at the Edinburgh population.

2) **Psychotherapy Department Royal Edinburgh Hospital** As part of its individual and group psychotherapy programme, the department runs a small direct individual service for male and female survivors of childhood sexual abuse, as well as two groups. However they currently receive no extra resources for this service in addition to their normal departmental funds, and there is a waiting list of several months. The Department are keen to develop it further, and to be able to respond to the level of need that is referred.

3) **Cambridge Street Day Unit, Edinburgh** as part of their treatment and support service for adults with mental health problems, have developed a nurse-led programme of longer-term therapeutic work with people who experienced complex trauma. Most to date have been women, many of whom have been given the diagnosis of borderline personality disorder. (This service is described in detail in *Beyond Trauma*, pp.98-100)

4) **The sexual abuse team of the Young People's Unit, Royal Edinburgh Hospital** offer a range of therapeutic individual and

groupwork to young people of both sexes under 21 who have experienced sexual abuse. However they noted in the questionnaire: *"Males tend to drop out, and a high proportion do not attend at all".*

5) **Survivors United** is a self- help survivor led support group in Midlothian. It aims to bring survivors aged over 16 together and build a network of support, through one to one work, groupwork and advocacy for both men and women. Some of this work takes place in the Glenesk Centre in Dalkeith.

6) **Barnardos Skylight Project, Edinburgh** offers "non directive therapeutic support which is not time limited" to children and young people who are survivors of childhood sexual abuse. It provides direct intervention and support, and consultancy and training for professionals.

7) **St John's Hospital in Livingston** has developed nurse-led services to address specific issues of sexual abuse trauma, including one-to-one work, and a repeat groupwork programme, currently for women, of modified cognitive behavioural therapy (CBT), called *Beyond Sexual Abuse.* They have seen an increase in referrals for one-to-one work with men.

8) **Midlothian criminal justice team** offers among its services in Midlothian one-to-one counselling for male survivors "if deemed appropriate," but not if the client has been convicted of a sexual offence. "Personal victim work" would be referred elsewhere to avoid confusion.

Assessing total service provision, however, is made more complicated for three reasons.

First of all, general counselling/ therapeutic services in community or in medical settings, plus certain social work services, will routinely be working on sexual abuse trauma issues with some clients.

Secondly some organisations are de facto working heavily with a survivor clientele. To give two examples, the Edinburgh-based self-help group Wounded Wings' remit is more widely to support anyone affected by self harm and self injury (including one-to-one work with men). Again, trauma work at the Rivers Centre, Royal Edinburgh Hospital frequently involves sexual abuse survivors, but it covers wider groups of trauma sufferers.

Thirdly, thoughtful work with male survivors appeared to be taking place in several agencies with other remits, due to high awareness or to the skills of particular staff, or both. This included projects working with offenders, gay men, older men, disabled people, and people in mental distress.

This finding is reflected in the recommendations (chapter 4) which emphasise not just creating additional services across Lothian, but the need to provide supports for working with abuse issues to staff and volunteers in a wide range of organisations. This finding also recalls the *Beyond Trauma* report on women's needs, where many good-practice statutory and voluntary services proved not to be specific sexual abuse services. Rather they were aware of abuse trauma issues, encouraged a safe environment for disclosure, worked consultatively with clients, and were skilled and sensitive.

6) IF YOU REFER CLIENTS ON, WHERE WOULD THAT USUALLY BE?

(Please note respondents could give more than one answer)

The leading choice for questionnaire respondents was **"voluntary sector" (57% of respondents).**

This perhaps points to a problem often voiced by voluntary organisations, especially in relation to sexual abuse and mental health, that they are heavily used for onward referral both by statutory and other voluntary agencies, but are not necessarily funded to take on this role.

This referral choice was followed by **"psychiatric or psychological services" (48%** of respondents) and **"individual counsellor" (38%).** However **18%, or almost one in five of respondents, said there was "nobody suitable to refer them to".(** It may not surprise oversubscribed voluntary organisations that some agencies said they were still referring clients to the voluntary sector - even if they also claimed there was no-one suitable to refer them to!)

Some agencies also made comments in this section, e.g.

"Distinct lack of statutory work"
"Referral to above agencies in absence of particular services"
"Very little provision available in Edinburgh"

7) LARGE MAJORITY THOUGHT CURRENT SERVICES WERE INADEQUATE

Agencies were asked: do you find existing service provision for male survivors adequate?

Only 4% of respondents thought they were adequate; 67% of respondents thought current services inadequate; 27% said they didn't know.

These responses appear unequivocal and provide a strong rationale for improving services in Lothian.

Some respondents added specific comments, for instance:

A senior social worker: *(There is a) "Tendency in social work not to value ongoing counselling and support - makes it difficult to offer a service"*

Alcohol counselling service: *"There is no adequate service. The current limited services have huge waiting lists".*

A mental health charity: *"It's difficult due to timescale to access psychologic services in NHS"*

A voluntary sector counselling service: *"Provision of counselling throughout the city remains inadequate and we strongly support increasing this."*

8) WHAT SHOULD PRIORITIES FOR SERVICES BE?

Respondents were asked: "If you think more services are needed, what should the priorities be?" They were invited to list three priorities. The most popular choices selected were:

- **Individual counselling and support (named by 83% of respondents)**
- **Groupwork and group support (51%);**
- **Resources for referring clients on (50%);**
- **Staff training (40%).**
- **Public awareness and campaigning (40%).**

Some agencies commented more specifically on initiatives that were needed, for instance:

A counselling service: *"Would also wish to contribute to the debate on whether specialist services on CSA improve access"*

A GP practice: *"More public awareness needed….if Scottish Executive is considering a "wife beaters register", what might a "child abusers" equivalent be?"*

A counselling service: *"Less stigma needs to be attached, hence need for public awareness campaigns"*

A support project for teenagers and young people: *"The issue of gender of worker needs to be addressed, so that males have a choice where possible"*

A gay men's project: *"Also essential to provide support to men raped, sexually assaulted and abused as adults".*

Domestic violence project: "*We need a free accessible Edinburgh based service for male survivors of abuse by an agency with a shared understanding of domestic violence. It is important that this is accessible when men are ready to do the work. If they have to wait they often go off the boil"*

A mental health charity: "*We would welcome more training for staff and more resources in the community"*

A community mental health team: *"Whilst as a mental health service we attempt to support survivors, we feel we do not have adequate training or resources"*

It is perhaps surprising that **staff training** did not figure more highly in the "tick-box" responses, given that it usually does in interviews, discussions and seminars with staff on working with sexual abuse, and was prominent in staff interviews in the *Beyond Trauma* report. Because for this question, respondents were invited to choose the three top priorities, it is possible that some may have chosen first what they perceived as direct survivors' needs, rather than service quality needs for training, support and supervision.

9) BEST ACCESS POINTS FOR MALE SURVIVORS?

Respondents were asked where they thought new services would best be accessed. Their three most popular choices, in order, were:

- **Mental health settings,**
- **Independent counsellors,**
- **"Any settings."**

Other choices offered, such as penal establishments, homeless projects or educational and training settings, only attracted occasional support.

However, this was another case where we reconsidered afterwards the value of the question. Agencies answered sincerely, but were in fact being asked to provide their own understanding of survivor preferences. This question would better have been put directly to survivors and their support organisations. The value of responses also depended on how much agencies knew about where male survivors tended to cluster. For instance it emerged through this needs assessment that many existed in offender contexts. Penal establishments might thus prove very promising points of access to support. In contrast, while the "independent counsellors" option might sound promising, men actually use counsellors less often than women and may be less familiar with these settings.

The substantial minority who ticked "any setting" most closely reflected the views of survivor interviewees. **Male survivors (see chapter three) stressed the need to publicise services very widely in ordinary mundane settings where men regularly go - such as public transport, pubs, football grounds, colleges/nightclasses, GP and dental surgeries; even public toilets or bus shelters.** Also, when they talked about the best settings for services, survivors saw location as less crucial than the qualities of services and workers. Thus they stressed the importance of independence, privacy and discretion, integrity, the ability to respond to individual needs, respect for and between sexual abuse survivors. The most urgent need as they saw it was simply for good services to exist. Survivors' views were echoed by questionnaire comments such as these, from a community mental health project and from a mental health unit for people with severe problems:

"Most important thing is that environment has to be right – non-threatening, safe, supportive".

"Any setting for access, but very secure places and people to refer to."

10) SHOULD NEW SERVICES BE STATUTORY OR VOLUNTARY?

- **Joint 71%**
- **Statutory only 5%**
- **Voluntary only 15%**

These responses (and provision of the "joint" tickbox) may have expressed more idealistic hopes than realism! This is because it can be difficult to plan and set up genuinely "joint services" or successful working partnerships between the two sectors. But the responses do suggest that respondents overwhelmingly believed two things. Both sectors must be actively involved in providing these services with neither opting out, and they should work closely together in planning and provision.

For example, in the words of a community health project: *"I feel there is a gap in this service. More commitment is needed from both voluntary and statutory services."*

One psychotherapist working from the statutory sector felt strongly enough to add verbal comments after filling in her questionnaire. She said: *"Other services are valuable but I also feel very much that the statutory services have a responsibility in their own right. They shouldn't be saying, 'someone else can do the work, it's not our job.' It is our job. I want them to take that responsibility on board."*

11) HAVE YOU FOUND ANY SERVICE OR ORGANISATION ESPECIALLY HELPFUL IN WORKING WITH MALE SURVIVORS?

A substantial majority of respondents to our questionnaire could not name any helpful service at all.

The only services which received more than one mention were Psychotherapy Department, Royal Edinburgh Hospital (REH) (4 mentions); Gay Men's Health, Edinburgh (3 mentions); Simpson House, Edinburgh (Church of Scotland); Open Secret (Falkirk); Barnardos Skylight Project (Edinburgh); Young People's Unit, REH (Edinburgh); and Men Against Sexual Abuse (MASA), Glasgow (all 2 mentions).

The extent of this list may initially sound promising in terms of service provision for sexual abuse survivors in Lothian, but several caveats need to be made.

Only five services could be described as providing direct services for survivors of sexual abuse (both male and female) and only MASA is a separate service for men. There are also several geographic, age or other restriction/access problems. MASA is based in Glasgow, while Open Secret is funded to work in the Falkirk and Stirling area. Gay Men's Health is for gay and bisexual men and while willing to give general advice, has often had to direct elsewhere abused heterosexual men. Nor is it a direct service for survivors. Barnardos' Skylight Project and the sexual abuse team at the Young People's Unit are purely for teenagers and young people. Simpson House is a drugs rehabilitation and AIDS counselling service, not a direct service for survivors of sexual abuse.

It should be stressed that the absence of other named statutory or voluntary sector services from the lists above of "helpful agencies" does not imply lack of quality in those services. It may mean agencies are unaware of the services, and what they do.

12) WOULD YOUR AGENCY OR TEAM BE INTERESTED IN HELPING TO TAKE ANY PROPOSALS FURTHER?

A high level of interest was expressed with **56% of agencies saying they would be interested, 27% replying that they did not know, and only 16% replying that they would not be interested.** Even in this last category, several made a point of explaining that this was due to lack of time or resources and not to lack of interest. This appears to be a strong basis on which to devise an Action Plan for Lothian, and to invite participation in carrying it out.

IN CONCLUSION

The main points which emerged from the questionnaire exercise were:

- **There was a high degree of interest and concern about the issue;**
- **Nearly all agencies knew or suspected that male survivors existed "regularly" or "sometimes" in their client groups;**
- **Less than a quarter asked about a history of childhood sexual abuse during assessment;**
- **Nearly all agencies recognised a range of serious life problems resulting from CSA, with mental health problems identified by 85%;**
- **There were no services identified in Lothian specifically for male survivors, but eight services were found which offered support to both men and women who had been sexually abused; five as part of wider services, one for children and young people and two for adults abused in childhood;**
- **More than two thirds thought current services were inadequate;**
- **Respondents identified individual counselling and support as the greatest need;**
- **They overwhelmingly endorsed collaborative service provision between statutory and voluntary sectors ;**
- **There was considerable interest in helping to take further proposals for new service provision;**

CHAPTER THREE

ISSUES FOR PARTICULAR CLIENT GROUPS OF MALE SURVIVORS

Chapter Three
Issues for Particular Client Groups of Male Survivors

In order to help inform the recommendations, this chapter supplements the questionnaire data with further information from interviews. It first considers the needs of particular client groups (of course some male survivors will belong to more than one group). It then summarises some general issues for male survivors.

Nine organisations, including survivor support organisations, gave valuable insights and reflections on their own users' needs. Male survivors also made direct comments which are taken from discussions with two small groups (at M-Line and Open Secret) and two individual male survivors from the Lothians. (it was necessary at times to draw interviews from a wider geographical area in this section, due to the dearth of survivors' organisations in the Lothians).

Some considerations are made below about:

1) **Men with mental health problems**
2) **Gay and Bisexual Men**
3) **Men with Disabilities**
4) **Older Men**
5) **Offenders**
6) **Minority ethnic men**

This is followed by a summary of general issues also derived from interview information.

1) MEN WITH MENTAL HEALTH PROBLEMS

a) **Experience of mental health services:** Survivor interviewees had had largely unsatisfactory experiences of psychiatric and psychological services and even of primary care, often along similar lines to that described by women survivors in the *Beyond Trauma* report. Clearly much larger- scale research would be needed to see if these experiences were replicated, but survivors interviewed all felt that services need to be far more aware of the issues.

For example when R first suffered a nervous breakdown five years ago his GP:

"*Didn't have a clue. I went to my GP because I was going to crack up and blow my top. It was boiling up, the aggression, I was punching walls, I saw fear in my wife's eyes…. None of the (psychiatric) nurses spoke to me about my problems. They were supposed to be assessing me. I started reading*

books myself…to educate myself. I had a couple of psychologists – the first didn't know what to do - gave up on me. I asked for a second opinion and, this psychologist was pretty good… gave me feedback instead of just going "Mmm, yeah!" That's what most of them do …it's really frustrating and useless."

E: "Psychologists going through training only touch on sexual abuse. They need to be educated about what survivors really feel. My situation came out through a court case My mother pushed me to get help. I told her I was OK then I took a nervous breakdown. I went to my GP first, and was referred to a (foreign) psychologist, and she could hardly understand what I was saying, and I couldn't understand her! … it was hopeless."

M: " *It was actually 20 years before I told anyone. The first person I told was the doctor…he didn't really know if there was anything he could do. In (psychiatric) hospital the nurses listened, but didn't really give any advice".*

G: "*They can't deal with the CSA thing in psychiatric wards. They are overwhelmed by what they see and some nurses don't want to listen or think it's outside their expertise. There is a problem in having to be referred to (psychiatric) services, you can't refer yourself…but it can be an advantage when you get it, as it can mean access to other services like pain clinics."*

But there were positive comments about some services. The MOOD agency –

"The psychiatrists at St John's Hospital (Livingston) are very sensitive I find. Abuse issues are normally channelled through psychological services. It's picked up on the wards in the 6 to 8 week assessment or in the ward meeting…I'd say the cases get priority even if the person is still on the ward."

b) **Do men attract more serious diagnoses?** Several organisations, reflecting on how abuse issues may not be picked up by mental health services, commented that male survivors of abuse seem to attract more diagnoses of psychosis – especially of paranoid schizophrenia - than women, perhaps because of exhibiting more extreme behaviour. For instance Kingdom Abuse Survivors Project have a specialist mental health worker, she gave her personal observations: "*There are a lot of guys with diagnoses of bipolar disorder, schizoaffective disorder, paranoid schizophrenia, and a lot who hear voices. Males seem to have more paranoid symptoms than women – the idea that everyone is talking about them or watching them. The manic depression diagnosis is more readily given to males, because one or two episodes of manic behaviour may be picked up, yet these mood swings may in fact be post-traumatic stress disorder."*

c) **"Offloading" to the voluntary sector** Voluntary sector organisations wanted the mental health statutory sector to work in co-operation with them, instead of simply offloading difficult "cases" on to

them. There were several experiences reported of community psychiatric nurses referring men and then simply ending contact with the men, which could be distressing for the survivors particularly where they had built up a long relationship with that CPN.

2) GAY AND BISEXUAL MEN

Gay Men's Health (GMH) made a number of points in relation to the needs of gay and bisexual men. In general they made the point that many services are not geared up to work with lesbian, gay and bisexual people and that there was a need for gay-friendly services.

GMH see a high proportion of gay and bisexual men who have been abused. This includes men abused as children, men abused as children then raped as adults, and men raped as adults.

a) **Need for research into incidence:** GMH are concerned at the findings of national research in 2002 that more than 7% of gay and bisexual men surveyed in Scotland said that they had been forced to have sex over the past year. "*Although there are no comparative statistics, it is relevant to wonder whether gay and bisexual men may be more vulnerable to sexual abuse, as recent research shows a worryingly high level of sexual abuse and assault which we can find no comparison with amongst heterosexual men. We would strongly recommend further research which looked at sexual orientation as a variable in the incidence of sexual assault, rape or sexual abuse amongst men.*"

b) **Problems of groupwork:** Some of the existing organisations offer group-work, which is not always safe for gay and bisexual men. *"Coming out in a group where the sexual orientation and attitudes of other members is unknown, assumed to be, or known to be heterosexual has been identified as a problem for other group-work (specifically drug and alcohol use) and groupwork in prisons. This may be a barrier for some men to accessing services which are male-specific. They have a dilemma that they either do not come out as gay, or they come out and meet prejudice. The particular problem with groupwork will continue unless the facilitator is very aware and careful."*

c) **Attitudes to their sexual orientation:** Like lesbian women, gay and bisexual men abused as children can face the assumption by mental health or other professionals that their sexual orientation is a direct result of the abuse they experienced. They may also worry about this themselves. *"Confusion about sexual orientation can be a result of sexual abuse, but it is important not to pathologise lesbian, gay or bisexual people."*

d) **Vulnerable boys and men:** The experiences of vulnerable people who have been in care requires attention, while rent-boys (whom GMH stressed are not necessarily gay or bisexual) are very vulnerable to sexual abuse. *"Mistrust of the police amongst rent-boys and, to a lesser and decreasing extent amongst the gay "community" may make reporting less likely, leading to very worrying situations, where individuals repeatedly (sometimes quite openly) abuse vulnerable boys. This needs to be challenged.. Lothian and Borders Police have made significant steps to alleviate this problem of reticence to report sexual crime to the police. However we have spoken to men who have not been keen to report harassment or sexual assault, because they have been involved in illegal activity at the time it happened (e.g. cruising", cottaging (having anonymous sexual encounters in public toilets), "rent)"*

3) MEN WITH DISABILITIES

Research already suggests that the risk of sexual abuse for children and adults with physical or learning disabilities is higher than for the population in general. Lothian Centre for Integrated Living (LCIL) reflected on some issues they had come across.

a) **A common background issue in counselling:** Childhood sexual abuse comes up as one of the issues for people with disabilities, though not usually as the presenting problem. " *We see about 20 people a week, and my guess is that at any one time, there are a couple who have come out about it, and possibly more who haven't…in particular, some people with learning disabilities have begun revealing this after we've been working with them. I think the main issue is, when you're dependent on someone to care for you…there is no chance of disclosing, or it's much more difficult."*

b) **Sometimes direct or indirect cause of people's disability:**
As can be seen in the quote below sometimes disability organisations such as LCIL have been struck by the fact that abuse is itself the cause of a person's disability. This is a challenging observation and the possibility may often be missed or ignored. Many survivors of sexual abuse are on disability living allowance (DLA) and the range of reasons for this needs to be sensitively explored.

"People developing physical disabilities after being sexually abused….through destructive behaviour, jumping out of windows, self harming, self destructive behaviour, drink and drugs…suicide attempts - one person I know lost a leg after jumping out of a window. There are quite a few male survivors also who have painful genital or anal injuries, they have been so messed up. And certainly some people with HIV/Aids have this background…generally these people (who have self harmed) are careless with their lives, in the sense that they do not value themselves".

c) **The need for careful checks on carers for adults.** Disabled adults who rely on others for physical care such as dressing and bathing, can be very vulnerable to abusive behaviour.

d) **Disability organisations need skills and awareness within their own agencies:**
"If there was a choice, I think there should be more resources in agencies like this. A specialist agency for sexual abuse is very good, but we need the resources here, to work with it…people come to trust us, and they don't like being referred on all the time".

4) OLDER MEN

Survivor support organisations said they saw a big difference in the generations and that younger men were much more prepared to talk openly about their abuse. In certain children's home cases where men had been approached by police later in life some had been devastated, as they had not even told their families about it, and this increased their need for sensitive counselling and support.

Survivors: G. "*In my generation it wasn't talked about.*" M: "*You think you'd better just get on with it…be a man and all that. The stiff upper lip attitude in the older generation".*

MOOD (Mental Health Options for Older people with Depression), who also work with men at risk of suicide and self harm, are based in West Lothian made some valuable points about the needs of older men. Their service is generic and not specifically aimed at abuse survivors.

a) **Problems of speaking out:** *"The times CSA has come out are in one to one with men. Only a minority have (previously) shared the secret of being abused. They will talk one to one, they will share but it's very difficult to get to that point. There is a feeling of guilt – of 'did I encourage that?' "*

b) **Dementia assumed:** Older people tend to be diagnosed with dementia even when the root problem might be other mental health issues. *"Also, there is a lot of dual diagnosis of dementia and depression …the condition and the forgetfulness makes people more depressed, and they become more isolated, turn in on themselves."*

c) **The burden for former psychiatric hospital patients:** *"For institutionalised older people, who have been in mental hospitals a very long time and become very dependent….another issue is, how much abuse has gone on against them in the hospital?"*

d) **Sensitive publicity material:** *"Naming the issue in written material for older men would have to be done sensitively and discreetly. We*

phrased our general publicity something like 'under stress'- even the word "suicidal" can be a problem – suicidal people don't always want other people to know that they are. Services need to be tailored to small groups based on an interest like an activity which people can focus in on. If you can attract into a common interest, this can be used to discuss more personal problems."

e) **Carers, such as partners or close family members, need support after disclosures of CSA:** *"We also need to work with carers. CSA is definitely an issue for carers, it's difficult for them - when someone does divulge and go into that sort of history you need to be aware – will it affect the relationship?"*

f) **Staff awareness:** Education of staff is very important. *"Generally, it's no good just setting up a day centre and expecting people to come- they say 'I'm no daft, there's nothing wrong with me, or it's full of old people!' People (staff and volunteers) must be sensitive and listen to what older folk are saying, and be able to hear (disturbing) things they wouldn't expect… I find semi retired people in their fifties are often the best sessional workers of all."*

5) OFFENDERS

The issue of male survivors falling foul of the law and ending up in prisons or institutions came up frequently during this needs assessment. Penal settings of all kinds may be important locations for "hidden" survivors, and potentially important places for work with survivors.

a) The consequences of anger, aggression and heavy substance misuse:

Anger was a very common response among male survivors and very often it was taken out on inappropriate people. This could lead to breaking the law, sometimes seriously. Heavy substance misuse could also lead to lawbreaking as well as admission to mental institutions.

R: (survivor) *"I felt I was taking 20 years of aggression out on somebody in the pub! Men can be torn up with anger. If they are forced to suppress it all, they are likely to explode. They could find themselves doing a long sentence maybe for attacking someone …the price of an explosion….You have this aggressive body language, swearing, and the physical pain too, it can make people very angry and frustrated, very uncomfortable. If you are forced to hold in your anger, not allowed to retaliate even as an adult person…and people don't want to know…this is how it can come out"*

E*: "You are having to deal with feelings about the abuser. This anger means, say you even drop a cup or something trivial, you would be swearing and aggressive".*

The Open Secret prisons worker: gave an example of one client: *"He was full of self loathing…he was in for violent behaviour and drugs…. He takes most of his anger out on himself, but all of his offences are to do with anger."*

Social worker: "*Some men cope with flashbacks of abuse by self medicating with alcohol and other substances. Alcohol is known to increase the likelihood and severity of any violence."*

Criminal justice social worker: "*Violence is exacerbated by drugs and alcohol. Persistent young offenders should be being picked up for this….someone should be noticing why this might be happening."*

Heavy substance misuse was not just a response to pain but became a lifestyle. R: *"Taking a lot of hash was making me paranoid. I think I was diagnosed with a schizotypal disorder."* Open Secret and other agencies saw men who had drunk themselves into a coma, or gone on benders for days when they had no idea what they were doing.

b) Loss of credibility as survivors:

The life experiences of male survivors who are offenders may not be taken so seriously, just as women survivors who are psychiatric patients may not be taken seriously. They may also be more vulnerable to claims that they have underhand or financial motives in coming forward about childhood abuse. The causes which led to their offending may be lost. As one experienced male worker expressed it, "*The main problem I have seen is that male survivors' reactions will often lead them into criminal behaviour, and then they're damned, because nothing they say is believed…they're silenced. I think a lot more work has to be done in prisons."*

c) Some domestic violence offenders have hidden abuse issues:

While domestic violence is a widespread social problem in which attitudes to women and children are key factors, histories of physical and sexual abuse in the childhoods of some violent men can also inhibit personal change. The Domestic Violence Probation Project, Edinburgh is aware that staff only see a small minority of violent men but have found that in their particular client group, these histories are common. *"We see men with a lot of behaviour aimed at keeping their feelings down - and trying to be in control of their memories as well as in control of other people. They have so much fear of being abandoned. They also expect their partners to make it better - their partners are supposed to see their aggression as sadness - then they are enraged at being misunderstood. We do quite a lot of work around*

getting the adult part of them to look after themselves, but what we are able to offer is limited."

d) Young offenders abused by organised rings:

One criminal justice (social work) team reported work with a number of 18-25 year olds, most of whom had been in jail and who disclosed, while reflecting on their violent behaviour or drug misuse, that they had earlier been abused by a particular paedophile ring. As workers talked to each other and with staff like homeless workers, they realised other male clients had been abused in the same way. Their problems could range through offending (often violence), self harm, substance misuse, mental health difficulties and HIV status. Many had not used other services, but met the criminal justice team frequently, because they had to attend and because they were able to build up a positive working relationship over time, for instance when on parole or release licence.

These young men had severe problems. They were very angry and very distrustful, through experience of the police and legal system and fearful of the consequences of telling, so justice issues in their lives could not be resolved. Their anger often made them very violent to other people. They had extremely low self esteem and a lot of self blame, especially if they had been inveigled into various illegal activities, so they cared little for themselves or for what happened to them. Often they said that several of their closest peer group had died through overdoses or other desperate behaviour. Sporadic press coverage of allegations brought flashbacks and bad memories. Such men often needed a lot of help in their relationships with women also: "they seem to gravitate to women who are as damaged as they are".

The team felt that much more work was needed to identify and work with such young people when they were in prison. They and their families also needed to feel safer, and to know other people would also come forward, before they could give information about their abusers and see justice done. Services for men needed to be discreet and workers needed to understand that some survivors had done "difficult and scary things" which they might need to talk about. Workers needed to see the person beyond the sometimes outrageous offending behaviour. The social worker advocated the importance of basic social work skills and the value of these skills to clients. (Similar views were put in *Beyond Trauma* by some social workers who worked with female survivors and by female survivors themselves).

"Social work is now about compartmentalised support packages. There is very little space for exploration, for just talking. If you ask social workers what skills they use, very few would say counselling…social workers are people who are notoriously late, always rushing somewhere else to another appointment, they are seen as unreliable.

Working with someone over two years is a tremendous opportunity…we can still use those skills".

e)(i) Sex offenders: reluctance by agencies to confront issues of victimisation

While most male survivors do not become perpetrators, many perpetrators have been sexually abused as children. However, a concern by agencies that this may be used as an excuse by offenders militates against work with such offenders on their own victimisation – even though it may be one important way of increasing empathy with victims.

The Open Secret prisons worker: finds this reconnection work very productive with sex offenders: *"I never met a sex offender who acknowledged his own feelings of being a survivor. Sex offenders could talk to officers about their crime, but not about their victimisation – they're all blocked. They shut off all their childhood pain. One guy I was working with who was able to reconnect with his childhood victimisation was physically sick when he read what he had done…."*

A sex offender programme co-ordinator: sees a clear need for this work which is not yet being met. *"Our programme is based on adult learning, and emotional disturbance is an obstacle to learning. It reduces the possible effectiveness of our programme."*

A criminal justice social worker noted: "*The STOP programme doesn't deal with their own abuse. There is this reluctance to combine victim and offender issues which leads to ignoring the victim part."*

e)(ii) Sex offenders - Need for separate services:

It emerged clearly in discussions with male survivors that non-abusing male survivors have very strong feelings against sex offenders, and would not wish to be alongside them in any project. Several gave examples of young men sent to prison who discovered they were in the same jail as their abuser. Survivor support groups themselves were aware of the ethical difficulties in situations when some survivors might also be offenders:

M Line: "We are aware how many perpetrators get off on our stories. The instinctive feeling is you want to chase them down the road with an axe!

"Sometimes it is difficult where to draw the boundaries – for example one young guy we were working with, who confessed that at age of 16 he had been involved in offending. We went on working with him

but…it is a very difficult one especially if you don't know they are abusers when you start working with them."

Women survivors less often have to confront this problem in settings where they meet, because most were abused by men. It will be important to consider how both non-abusing and abusing male survivors can receive sensitively-organised services in both community and institutional settings. It will be valuable in this context to explore what projects currently exist in the UK which work with abusers on their own victimisation, to see what lessons may be learned from them.

6) MINORITY ETHNIC MEN

Staff from *health in mind's* service, Men in Mind, the service for minority ethnic men with mental health problems, made a number of comments. As a general point they highlighted the dearth of research studies about the effects of childhood sexual abuse on minority ethnic men, which made for a difficult starting-point.

"As a project, we would like as comprehensive a service as possible, but very much in collaboration with organisations, who also work in the area of sexual abuse."

Lack of proactive outreach: *"We have not been aware that other agencies set up to support men who have been sexually abused have proactively tried to engage minority ethnic men , or to present an image and atmosphere which encourages them to look for that support. Also, existing agencies do not tend to pick up on sexual abuse issues nor, indeed, general emotional issues unless presented openly to them."*

Differences among communities: The many differences among minority ethnic communities, including differences in family networks, extended family living situations and attitudes to elders, make it difficult and often patronising to generalise.

"There is also a big issue around whether every culture would define the same experiences as abuse, and about what kinds of shame are more important than others".

Refugee/asylum seeker issues: Sexual forms of political torture, though mainly affecting women and girls, are also known to be used against men in conflicts across a number of countries, and are likely to have affected some refugees and asylum seekers to the UK. Most refugee organisations are based in Glasgow rather than in eastern Scotland. *health in mind* have "*experienced some difficulty so far in liaising with refugee organisations because of our mental health label….perhaps workers are reluctant to identify with us or find it difficult. Yet work with refugees certainly does suggest sexual violence…in*

the images of the Rwandan genocide for instance, it was noticeable how many men were stripped naked….there is a strong element of "secret shame".

Interpreter needs: "*Another issue is that I am not convinced interpreters' training is rigorous enough to deal with mental health issues generally, let alone issues of sexual abuse. (Distressed) people latch on to interpreters as if they are a life raft, but the interpreters are going to disappear afterwards. Interpreters have to be able to deal with difficult issues, and with the fact that someone is offloading."*

GENERAL ISSUES FOR MALE SURVIVORS

A number of general issues for male survivors emerged during these interviews.

1) Recognising sexual violence across the lifespan:

A number of agencies felt it was important for any services for men not to limit their work solely to childhood abuse but to include various forms of sexual violence in both childhood and adulthood. This is especially the case since like women, men victimised in childhood often become targets for further victimisation as adults – more often, it appears, through "stranger rape" than is the case with women, whose main assailants continue to be men whom they know. Gay Men's Health wanted male rape in prisons to be addressed. *"This is such an issue, but generally prison authorities don't want to know. We would be very keen to see counsellors, social workers and others in prisons who are comfortable working with issues of male rape, and to ensure the authorities acknowledge and address this problem."* Experiences of sexual torture among refugees and asylum seekers form another example of a lifespan issue.

2) Worries/uncertainties about sexuality and sexual identity often appear to persist over many years:

The survivor groups stressed how common sexual worries about themselves were for boys abused in childhood. Some had wondered if they were gay and felt very confused. *"You feel very contaminated by the abuse."* Some men also behaved in a more "macho" way to prove themselves.

3) Anger, overt or repressed, which expressed itself in many different ways, was the most commonly discussed issue:

Such behaviour may help to identify previously unidentified male survivors, provided services ask them intelligent questions. While

female survivors with mental health or offending problems may suffer from not being culturally accepted (treated as mad or bad, and as failed mothers) male survivors may not be sufficiently noticed just because they do follow a certain cultural stereotype (many men are violent, drink to excess, and cannot control aggression well).

4) Seriousness of self – harm and the risk of suicide:

Although self harm in terms of practices like cutting has been seen as more typically female than male behaviour, agencies and survivors both pointed to examples of serious self harm among male survivors using a wide range of practices. Often this was not being identified as self harm, let alone as the desperate act of abuse survivors, but as (for instance) more typical reckless risk- taking or drink-fuelled violence.

The Open Secret prisons worker talked of some very serious instances:

"The damage the guys do is extremely severe. One (severely abused as a child) looked as if he had put both his arms in a shredder. There was one who broke both his legs jumping from bars in the gym hall - he said, 'I knew if I hurt myself badly enough, they might take notice'. Some eat glass, full of rage and self blame. In one man's case, no part of his body was unaffected."

The disability worker (above, this chapter) described serious incidents which had led to permanent physical harm. Other workers described violent slashing of arms, cutting, burning, sexual risk taking, and unsafe sexual relationships.

Self-harming behaviour may or may not indicate suicidal intent. But the importance of picking up on suicidal behaviour and including sexual abuse issues in suicide prevention campaigns (such as the major Choose Life initiative) was stressed by a number of agencies and survivors. Most survivors interviewed had made serious attempts at suicide; and some had done so repeatedly yet not been identified, e.g. E: " *I tried to commit suicide - actually I tried at the ages of 6,16 and 17…and this wasn't picked up".*

5) Many different, often "culturally accepted" ways are used to blot out feelings, which may therefore not be picked up by professionals:

Apart from drink and drug misuse for instance, "workaholism" was often mentioned and even compulsive exercising. A survivor noted: *"A guy pumps himself up for distraction, to defend himself and also to feel in control. You have to learn to communicate instead. This is the most important thing but the most difficult."*

6) Male survivors may particularly welcome positive help with parenting issues:

Most male survivors along with the agencies which work closely with them talked of problems with relationships with children, especially relating to fear of harming them, or of getting too close to anyone emotionally. However this went along with a strongly felt wish to relate better to their children. Many male survivors may have taken to heart the commonly- expressed view that they present potential risk to children, even if this is not in fact the case.

7) Many male survivors value well-run groups:

Men consulted who had been involved in groups all questioned the accepted wisdom that men do not take easily to groups and that help should concentrate on one-to- one work. They felt that if a group was thoughtfully organised and run, and based on supportive values, it was very helpful: *"You realise you're not alone and this has happened to other people…and get a lot of support from each other".*

This does not diminish the importance of one- to- one work for men who may find groupwork intimidating or difficult. Organisations also had experience of men who did not wish to enter groupwork and felt it would be intimidating or unsafe. One experienced agency also pointed out that groupwork could raise ethical issues about working with victims who were also perpetrators, and this needs to be addressed when planning services (see 5(e) above)

8) Need for imaginative publicity for male survivor services:

It was felt particularly important (especially by survivors themselves) that very wide access and publicity were crucial where male survivors support services were concerned.

For example men are referred to M line, or refer themselves, through a wide range of routes.
"*We advertise everywhere we can…pubs and that to reach people… leaflets for male survivors should be in doctors' surgeries, clinics, education colleges, pubs, even on buses. A lot of men won't go to counsellors and places like that and wouldn't see the adverts".* M-Line give a lot of talks and video presentations, and have spoken at poetry readings and other public events. At such events, men have sometimes come forward to join the group.

9) A particular need for support to be offered to all men involved in court cases about historic abuse in care homes:

This is especially the case since the men concerned have usually not been in control of the initial contact by law enforcement agencies. Nor

have most been in control of the nature, extent and timing of information which has come out publicly about their abuse.

10) Workers in the caring professions also need support. Some will also be survivors themselves. They may face traumatic situations and may also need to struggle against their own feelings:

It is easy to forget that in the case of support for male and female survivors alike, workers may themselves be survivors of childhood sexual abuse. They themselves need access to support if society wishes them to carry out this work.

One male worker with a counselling organisation, who has worked with a number of male survivors, described a series of disturbing or difficult events he had to confront.

"I was abused by a male teacher. I suppressed a lot of this. Later events in my life connected for me. For example when I went to work on a building site, four workmen stripped me for an "initiation ceremony" and this was terrifying to me, I was screaming. Then in the 1980s (as a psychiatric nurse) I went to a Body Positive conference, and they had leaflets on the chairs, leaflets showing naked men - I came home quite traumatised. I heard things then I had never heard before, and I still feel it was more of a promotion or publicity thing and was not necessary. In my work (and in voluntary church work) I have to deal with people who say they are homosexual, I have to be very aware of my feelings and background because of my abuser…and be careful not to show bias…"

The discussion of special needs and general issues in this chapter will be reflected in the recommendations in Chapter 4.

11) Many organisations face funding problems in meeting needs of male survivors:

Repeated concerns were voiced among voluntary organisations, including significant providers of services to survivors such as Open Secret, about the inadequate funding support they received and within which they had to operate, even though they were potentially saving other sectors considerable costs. (This is one issue which has been taken up by the Scottish Executive's Short Life Working Group on Care Needs of Adult Survivors, this group is due to report in mid-2004). They were particularly concerned that mental health statutory workers tended to refer on clients with more complex needs, yet there was little financial support from health boards or other statutory services in acknowledgment of this.

A number of voluntary sector organisations gave examples of continual short-term funding and time-consuming service and research applications and described in particular how this affected ability to recruit and retain staff and take on more clients. They stated that statutory organisations with whom they liaised did not seem to understand their financial position. For instance small voluntary organisations would be asked to speak about work with survivors but not even offered travel expenses.

These problems were for voluntary sector organisations inextricably linked with the type and extent of service they were able to provide. Their financial position had to change and their funding become more stable, before they could make any significant improvements in their services.

CHAPTER FOUR

RECOMMENDATIONS OF THE REPORT

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Recommendations of the Report

1) DIRECT SERVICES:

a) A dedicated service for survivors of sexual abuse should be established in Edinburgh.

This would principally serve the capital city but with the capacity to take referrals from across Lothian. It could also for example specifically consider developing an outreach service in East Lothian.

A voluntary sector organisation is likely to win more trust from service users, albeit with close collaborative working with the statutory sector. The models used by Open Secret (Falkirk) and KASP (Kirkcaldy) should inform the structure and delivery of this service. It should offer facilities including individual support, groupwork, and telephone support.

Given the dearth of services for sexually abused women in Lothian and especially in Edinburgh, it would not be acceptable or justifiable to propose such a service only for men. If sensitively constructed, such a service can cater for both men and women.

Although this service may take time to fund adequately and to set up, it will be important for a wide range of agencies to have this as a clear goal, for which they can campaign as a priority.

In the planning and design stages there should be close consultation with, among other groups, the female survivor organisation *Sexual Abuse Survivors' Support in Edinburgh,* (SASSIE) which recently received a Scottish Executive grant to develop services; and *health in mind*, in relation to its sexual abuse counselling and support initiatives and resource centre services.

b) Existing, small-scale direct services require further resources, to develop specialist services which have sometimes substantial waiting lists.

One example is the therapeutic work with sexual abuse survivors of both sexes currently being undertaken by the Psychotherapy Department at the Royal Edinburgh Hospital.

2) TRAINING AND SUPERVISION:

All staff working with males who have been sexually abused should have access to skills training and ongoing supervision. This measure is equally required for work with abused women. Measures to encourage this in relation to male survivors will include:

a) Basic training / awareness packages should be developed to give confidence to existing staff, in support organisations and services where survivors congregate, should be seen as a priority, and these packages should include a module on working with male survivors.

health in mind has been awarded Scottish Executive funding to design training packages for both statutory and voluntary sectors across Scotland, and the *Beyond Trauma* training officer has now been appointed.

b) On supervision and support, we can only repeat the recommendation made in *Beyond Trauma* which was published in 2001: "**An advice, support, information, training and consultancy service is needed for staff and volunteers who work with sexual abuse survivors. This should include information and support on all aspects of working with people with complex trauma and self harm".**

Supervision and support for workers is crucial, especially for staff who have developed positive, trusting relationships with clients who may disclose abuse later on in that relationship. The clients may not wish to be referred on to another agency, yet the worker may not feel sufficiently skilled to continue.

c) Good practice training seminars on working with abused men and boys should be designed, to be implemented as soon as this is feasible.

These could draw on the work of individuals and agencies discussed in this needs assessment and from other Scottish and English projects. For instance they might draw on M Line's video and training presentation, criminal justice social workers' work with severely damaged young men, Open Secret's work in prisons, Gay Men's Health's work on sexual assault issues, MOOD's work with older men in West Lothian, Skylight's work with abused young people, Fire in Ice's website work, and so on.

d) A resource pack to help male survivors and those working with them would be a valuable asset and one which might be adopted in other parts of Scotland.

e) **Development of sexual abuse multi-media resources at the resource centre at *health in mind* should specifically include material on working with male survivors.**

3) ACCESS TO COUNSELLING AND SUPPORT FOR RELEVANT ORGANISATIONS

(This equally applies to female survivors).

a) **In addition to training and support opportunities for staff, organisations working in fields such as substance misuse, lesbian, gay, bisexual and trans-gender (LGBT), disability, offending, sex work, mental health and homelessness need more opportunities and funding to access counselling/support hours for clients who disclose sexual abuse.**

There are various models for achieving this, such as a fund available for access with which to pay independent counsellors or outreach services, or to provide additional training for existing counsellors within organisations.

b) **Discussions should take place around ways of supporting statutory sector teams to explore sensitively for an abuse history, and to help clients obtain support for addressing abuse issues should they wish to do so.**

This reflects that fact that the questionnaire suggested that practice in exploring for an abuse history, and working with abuse issues, varied between teams in a number of statutory sector services in social work, health (including primary care) and mental health.

4) A STRONG CASE HAS BEEN SUGGESTED FOR MORE WORK WITH MALE OFFENDERS, INCLUDING IDENTIFICATION OF POSSIBLE ABUSE ISSUES IN RELATION TO VIOLENT AND ANGRY BEHAVIOUR.

a) **More counselling/support posts need to be funded for work with male survivors within penal institutions, and in secure or semi-secure mental health settings**.

This work is required with both non-sexual and sexual offenders. The existing expertise of Open Secret workers and prison staff currently working with them should be consulted in designing these posts.

b) **A specific offender research initiative exploring serious self-harm and suicide among male survivors would be valuable.**

The Choose Life national strategy may provide a good opportunity to support such an initiative.

c) **All criminal justice teams should consider ways of exploring for a sexual abuse history in their client group, and ways of attempting to address the issue in support packages, including greater use of traditional social work skills.**

This reflects the fact that a range of practice within criminal justice social work teams was suggested by this needs assessment.

d) **Further exploration is needed of ways to develop links, which are as sensitive as possible, between criminal justice agencies and young men abused through paedophile rings, so that information can be given in confidence and as safely as possible.**

Such links may also need to be developed with young men in the sex industry.

5) SERVICE PLANNING FOR MINORITY ETHNIC MALE SURVIVORS OF CHILD & ADULT SEXUAL ASSAULT (INCLUDING POLITICAL COERCION).

The possibility should be explored of setting up a small working group in the Lothians bringing together refugee and asylum seeker organisations with Men in Mind and other relevant organisations, to agree the range of priority issues for minority ethnic male survivors.

6) FUNDING ISSUES

When abuse survivors are being regularly referred on to the sector by statutory agencies, voluntary agencies need to be equipped to take on these cases through adequate financial support by health boards, local authorities and where relevant central Government funding.

The Scottish Executive's short-life working group on care of survivors of childhood sexual abuse is due to report in mid- 2004 and is expected to make recommendations on this issue.

7) IN-DEPTH RESEARCH

In-depth research into the care needs of male survivors of sexual abuse needs to be carried out, in order to inform service provision over the longer term, both in Lothian and more widely throughout Scotland.

8) PROGRESS TOWARDS IMPLEMENTATION

a) These recommendations should be discussed by the respective strategic development /joint planning groups in each of the local authority areas of Lothian, and should inform and be reflected in the final recommendations of the Lothian Mental Health and Wellbeing Strategy.

b) An implementation group should be established to work towards specific targets in the action plan drawn up at the seminar (June 1st 2004).

The questionnaire produced a high level of stated commitment from statutory and voluntary sectors. An implementation group needs to include key stakeholders. It would also draw upon members of the current steering group who wished to continue, experienced interested workers identified during this needs assessment; and others who commit to the implementation group at the seminar.

DISSEMINATION

Whilst this needs assessment has concentrated on the position in Lothian, most of the issues are not restricted to that geographical area. Indeed, information used in the report has in part come from survivors from other areas of Scotland because of the dearth of survivor groups in Lothian. We are very pleased that the Scottish Executive is keen to see the wider issues disseminated across the voluntary and statutory sectors in Scotland and steps are in progress for this to be achieved.

APPENDIX
COPY OF QUESTIONNAIRE

NOTE ON AUTHOR

APPENDIX

COPY OF QUESTIONNAIRE:

SERVICES FOR MALE SURVIVORS OF CHILDHOOD SEXUAL ABUSE

health in mind and NHS Lothian are carrying out a needs assessment of services in the Lothians for adult men (over 16) who have experienced sexual abuse in childhood. We would be most grateful if your organisation could fill in this questionnaire and return it to health in mind, in the enclosed SAE or by e mail, where appropriate, by Friday 12th December 03. We would also be grateful if you could ensure that this questionnaire is passed to the most appropriate staff member(s). Many thanks.

1. Name of your Agency

……………………………………………………………………………………………

2. If you are completing the survey on behalf of a team, department of service within this agency. Please name it here

……………………………………………………………………………………………

…………………………………………………………………………………………..

3. Please describe the main service(s) you provide, and your main client group

…………………………………………………………………………………………..

…………………………………………………………………………………………..

Many people do not reveal their abuse history to services. However it would be helpful if you could give an approximate estimate in response to questions a and b:

4. a) How often would your service come across male clients whom you know have experienced childhood sexual abuse?

Regularly ☐ Sometimes ☐

Not to our knowledge ☐ Don't know ☐

b) How often would your service come across male clients whom you think may have experienced childhood sexual abuse?

Regularly ☐ Sometimes ☐

Not to our knowledge ☐ Don't know ☐

c) Would your service routinely ask clients about a possible history of childhood sexual abuse during assessment?

Yes ☐ No ☐

5. What, in your service's experience, have been the main problems which sexual abuse causes for male survivors?

mental health problems	☐	low self-esteem	☐
self harm	☐	flashbacks	☐
voice hearing	☐	suicidal feelings	☐
relationship problems	☐	sexual identity problems	☐
aggression/anger	☐	offending	☐
parenting problems	☐	substance misuse	☐
homeless issues	☐	don't know	☐
no particular problems	☐		

other (please describe ....

6. Does your agency:

Provide a specific service for male survivors ☐

Work with abuse-related issues if they arise ☐

Refer client on to another agency for abuse-related issues ☐

7. If you provide a specific service, could you describe it?

....

....

8. If you refer clients on, where would that usually be?

Voluntary Sector	☐	Churches	☐
Social Work	☐	Individual Counsellor	☐

Psychiatric/psychological services ☐

Nobody suitable to refer them to ☐

Other *(please describe)* ....

9. Do you find existing service provision for male survivors adequate?

Yes ☐ No ☐ Don't Know ☐

10. If you think more services are needed, what should the priorities be? (*please list your three main priorities 1,2,3*)

1. Individual counselling and support ☐
2. Groupwork/group support ☐
3. Anger management work ☐
4. Public awareness and campaigning ☐
5. Resources in your own organisation ☐
6. Resources elsewhere, where you can refer clients ☐
7. Staff training ☐
8. Staff supervision ☐
9. Multi-disciplinary support networks ☐
10. Other (*please describe)* ....

11. a) Which settings do you think would provide the best points of access for male survivors? (*please list your main priorities 1,2,3)*

mental health	☐	Independent counsellors	☐
drug/alcohol projects	☐	Education & training settings	☐
homeless projects	☐	Social Work	☐
Penal establishments	☐	Any setting	☐

Other (*please describe)* ....

b) Do you think services should be mainly:

Statutory sector ☐ Voluntary sector ☐

Joint statutory/voluntary initiatives ☐

12. If there is any service or organisation you have found especially helpful in working with male survivors, please give their name(s):

    ……………………………………………………………………………………………

13. Would your agency/team be interested in helping to take any proposals further?

    Yes ☐ No ☐ Don't Know ☐

14. Feel free to write any other comments for this questionnaire

    …………………………………………………………………………………….

    …………………………………………………………………………………….

    …………………………………………………………………………………….

    …………………………………………………………………………………….

Name ………………………………………………………………………………….

Job Title ………………………………………………………………………………….

Tel. No: …………………………………………………………………………………

e-mail …………………………………………………………………………………….

We may get back in touch with you. If a different person should be contacted for follow-up about this questionnaire, please give contact details:

Name …………………………………………………………………………………

Job Title …………………………………………………………………………………

Tel No……………………………………………………………………………………..

e-mail ……………………………………………………………………………………..

NOTE ON THE AUTHOR

SARAH NELSON, senior research officer at *health in mind*, has specialised in research on childhood sexual abuse since the publication of *Incest: Fact and Myth* (Stramullion 1982/ 1987).

The author of *Beyond Trauma: Mental Health Care Needs of Women who Survived Childhood Sexual Abuse* (EAMH 2001), she has published chapters in; H Westcott & J Jones (eds) *Perspectives on the Memorandum: Policy, Practice and Research in Investigative Interviewing*, Arena 1997; C Itzin (ed) *Home Truths About Sexual Abuse*, Routledge, 2000; P Cox, S Kershaw & J Trotter (eds) *Child Sexual Assault: Feminist Perspectives,* Macmillan 2000. Other publications include “Time to Break Professional Silences”, *Child Abuse Review* 7(3) 1998; “Physical symptoms in sexually abused women: somatisation or undetected injury?” *Child Abuse Review,* 11 (1) 51-64, 2002; Nelson, S and Baldwin, N “Comprehensive Neighbourhood Mapping: Developing a Powerful Tool for Child Protection, *Child Abuse Review,* 11: 1, 214-219, 2002.