SARAH NELSON | HEALTH IN MIND

understanding me

Working with Male Survivors of Childhood Sexual Abuse Who Self-Harm and Consider Suicide

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To a Man

Does a man who shows his feelings
Make him any less a man?
Some people seem to think that this is weak
But I think there is strength inside of
Any man who can
Express his mind and teach his heart to speak.

The stigma that we live with is that
- Men are made of steel
And women are more delicate and break;
Unwritten rules are stereotyped
And branded with a seal
To break that mould would be a grave mistake.

I'd only be half a man
If half of me felt dead
Displaying my aggressive, macho role
A lack of sensitivity is
Butter without bread
Together and as one - they make me whole.

So if you're one who thinks of me
As less than any man
For expressing what I feel - then think again!!
The 'dead-inside' can't change their world
The 'living, feeling' can;
For passions are the inner strengths of men.

Andy McGuinness
From Fragments: *A Book of Poetry* (2001),
Salty Press, Angus, Scotland.
With thanks to the author.

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Foreword

Health in Mind has been at the forefront of providing support and counselling to survivors of childhood sexual abuse (CSA) since 1985. We have undertaken a number of research projects which inform our work with survivors including:

- The needs of female survivors of abuse: Beyond Trauma: Mental Health Care Needs of Women Who Survived Childhood Sexual Abuse, June 2001;
- Male survivor needs: Care and Support Needs of Men who Survived Childhood Sexual Abuse, 2009;
- Scoping of psychotherapy and counselling services for male survivors across Scotland; Counselling and Psychotherapy Service Provision for Male Survivors of Childhood Sexual Abuse, 2011.

These research projects have helped inform practitioners in the field and over the years there has been a growing understanding and acknowledgement of the impact of CSA) particularly on girls and women. What has been more difficult to recognise and acknowledge is the impact of abuse on boys and men.

Men may be less willing to talk about their abuse, due to perceived male stereotypes that they may feel they have to conform to – a stereotype that says men talk less and are 'doer's', rather than being in touch with their feelings. Risky behaviour amongst men, such as driving at high speed, going on 'benders', or picking fights they cannot win, is often not recognised as a possible form of self-harm. Our research found that joining the armed forces, for example, can be a way for men to escape an abusive environment. However, they may then find themselves in situations where their lives might

continue to be at risk. All of this can be perceived as ‘normal’, as ‘what young men do’ and are sometimes even expected to do, to be seen as ‘a man’.

Our research also showed a high incidence of self-harm and suicide amongst survivors of CSA. Awareness of this can create heightened concern and anxiety amongst staff supporting men who present with these issues and they may worry that their own skills and knowledge are insufficient. However, research tells us that survivors welcome staff being open to them talking about childhood abuse. They find staff who show personal warmth and empathy to be the most supportive. They also valued staff who are informed about abuse issues, rather than necessarily possessing a special qualification in sexual abuse work.

In working with male survivors of abuse, staff can forget that each man is a unique individual, who has skills and potential, as well as a history of serious harm. We hope that this booklet will help staff and volunteers to feel more at ease discussing abuse issues with men and will help men to find different ways of relating to their histories, rather than choosing self-harm and considering suicide as a way to ease the pain.

Gwenn McCreath
Chief Executive, Health in Mind

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Introduction: why this booklet?

Childhood sexual abuse (CSA) can be one of the most difficult topics to confront – whatever our profession and whether or not we are survivors of abuse.

Thus, many people in youth work and caring professions find it daunting to work with the effects of sexual abuse trauma, respond to disclosures, or ask if abuse might be in someone's history. They fear that their skills or training will be insufficient, they don't know how the person they are working with will react - they may have their own personal issues, or may worry that they might somehow 'make things worse'. This can be especially true for people working with men. Historically, there has been little information and knowledge about male sexual abuse and its effects, one of the reasons being that men usually find it even harder than women to talk about this past experience in their lives. Other reasons include the notion that men should 'be strong' and not 'be victims'.

When the difficult issue of sexual abuse is combined with the equally difficult issues of suicide and self-harm, it can often feel even more daunting for staff and volunteers to broach these topics with men they are working with. Yet it's very important that people working with men of all ages, feel more confident, informed and able to understand.

Through the work of Choose Life, we have all been made aware of how high the rates of completed suicide are for men in Scotland. In Edinburgh alone in 2010, seventy four people were estimated to have committed suicide. On average two people take their own lives in Scotland every day: three out of four suicides are by males. It is the leading cause of death among under-thirty fives, and young men are a particularly at-risk group. A history of sexual abuse is a major risk factor for suicidal feelings and self-harm.

Health in Mind hope this booklet will give you the confidence to recognise and respond to men of all ages who have been sexually abused, who may be at risk of suicide or self-harm and to work positively with them. We believe this will also increase your confidence and effectiveness. This booklet will provide information about CSA based on both research and practice and its links with suicide and self-harming behaviours. It will illustrate and explain some of the feelings that CSA survivors have when they self-harm or attempt suicide, through personal quotes from male survivors drawn from the research report *Care & Support Needs of Men who Survived Childhood Sexual Abuse* by Sarah Nelson. This was a collaborative study between Health in Mind and CRFR, the University of Edinburgh (2009). Several survivors were also directly involved in preparing this publication.

Fears and assumptions that staff and service users often have about broaching the issues will be considered and how far they are justified in reality. The booklet will offer a range of practical suggestions about working more openly, supportively and confidently with male survivors, again using quotes from survivors themselves about what they have found helpful or unhelpful. It will also consider the needs of staff and volunteers for support and supervision and the responsibilities of managers to offer a supportive working environment. The booklet by Sarah Nelson and Sue Hampson, *Yes You Can! Working with Survivors of Childhood Sexual Abuse* (2008) has also been drawn on for these chapters.

Chapter 1

Information about childhood sexual abuse

What is childhood sexual abuse (CSA)?

Scottish child protection procedures say:

> *CSA Involves forcing or enticing a child or young person to take part in sexual activities, including prostitution, whether or not the child is aware of what is happening. The activities may involve physical contact, including penetrative or non-penetrative acts. They may include non-contact activities, such as involving children in looking at, or in the production of sexual online images, watching sexual activities, or encouraging children to behave in sexually inappropriate ways* (Edinburgh & Lothians Inter-Agency Child Protection Procedures, 2007).

Childhood sexual abuse is committed for the sexual gratification of others. It is a criminal offence and always wrong: the child is never at fault.

Who commits CSA?

Perpetrators come from all backgrounds and walks of life, all ethnic and religious groups. Therefore, in your work you should not assume CSA is unlikely to happen in certain types of family or community. For instance it is not confined just to working class families. In recent years, the high numbers of people from 'professional classes', with no criminal record, who have been convicted of child pornography offences illustrates this point. Whilst most offenders are men, about 10% are estimated to be women; at least 25% of CSA is committed by young people under eighteen. Although a large majority of those working with young people do so with integrity, abusers will often seek work for its opportunities to assault children.

Most children are abused not by strangers, but by people they know. Although only wider population studies would confirm this, work with male and female survivors suggests it is slightly more

common for females to be abused within the immediate family, and for males by people outside it, for example youth leaders or family friends.

Who experiences CSA?

Victims come from all backgrounds and occupations, all genders, and all ethnic and religious groups. *Anyone* can be sexually abused. However, some young people are at higher risk, such as young people with disabilities; those facing stigma, ill treatment or neglect; or sometimes those whose above-average sporting or other talents involve them in private coaching or in adult working environments (eg the entertainment industry). Children are more vulnerable to sexual abuse if they depend heavily on others for basic care, if they cannot communicate well or have poor access to outside help (for instance in some institutions and boarding schools), or if sincere carers believe ‘people like them’ won’t get abused. Those are some reasons why young people with disabilities can be at higher risk of abuse of all kinds.

Prevalence of sexual abuse among boys

Most studies of CSA indicate that girls experience sexual abuse more frequently than boys, but that male CSA is still a common and serious problem. Prevalence rates vary widely, depending on the definitions of CSA used (e.g. whether you include non-contact abuse, such as being made to view pornography), the types of questions asked and the methods used to gather data.

Studies once suggested only 1–3% of males were sexually abused. More accurate / sensitive modern studies have usually found that between 11–17% of males in the general population will experience some incident(s) of sexual abuse before age sixteen. But some

groups of men have much higher prevalence rates. These include young men in care; homeless men; men with HIV; non-sexual and sexual offenders and users of psychiatric services. This should be considered if you work in such settings. The higher rates relate to their vulnerability to abuse, or their behaviour following abuse, which places them in at-risk groups, as outlined below.

There is no Scottish-specific prevalence data on CSA. However, research into more than 14,000 calls made to ChildLine Scotland between 2003 and 2004 about sexual health issues found that sexual abuse was the second most common concern (after ‘facts of life’), with 39% of male callers to Childline reporting sexual abuse.

How do research and practice define self-harm?

Self-harm or deliberate self-harm (DSH) is defined as the intentional, direct injuring of body tissue without suicidal intent. The best known and possibly most common form of self-harm is skin-cutting, but self-harm also covers a wide range of behaviours including, but not limited to, scratching, banging or hitting body parts, interfering with wound healing, hair pulling and eating of substances or objects. Although it is not the intention of self-harm, the relationship between self-harm and suicide is complex, as self-harming behaviour may be potentially life-threatening.

Self-harm is most common in adolescence and young adulthood. However, self-harm can occur at any age, including in the elderly population. A broader definition of self-harm might also include those who inflict harm on their bodies by means of disordered eating. Self-harm often becomes a response to profound and overwhelming emotional pain that cannot be resolved in a more functional way.

Effects and high-risk groups you may work with

There is no single ‘sexual abuse syndrome’. People are affected by this trauma in different ways and to different extents. It is very important to state that many survivors lead successful and rewarding lives, but there are often long-term effects which can manifest themselves at different times in a survivor’s life. Many of these are common to both male and female survivors, as outlined below.

- **Suicide attempts and suicidal feelings, self-injury and other forms of selfharm:** self-blame, depression, a sense of hopelessness, and serious loss of self esteem.
- **Sexual identity issues:** boys and men may often struggle with issues about sexual identity, sexual orientation and masculinity; there may be confusion about whether they are straight or gay and high-risk sexual behaviours through loss of self-worth can be common. These issues can be especially hard for them to discuss with their peers, with partners or with professional staff. If they have been abused by men this can lead to homophobic feelings.
- **A wide range of mental and physical ill health** can result from such traumatic experiences. Many male survivors have received psychiatric diagnoses, including personality disorder, major depression or psychosis before anyone has asked them whether they have a history of abuse, which could result in post-traumatic effects.
- **Heavy alcohol and drug use** can be an effort to dull or blot out the effects of trauma. It can also reflect early dependence, because abusers often ply young people with substances to make them compliant. Whilst it not uncommon for youth cultures in our society to misuse drink and drugs, very early or intractable substance misuse should sound a warning that it may be self-medication relating to trauma.

- **Aggression, anger and sometimes offending**, especially in boys and younger men. Pathways into offending can include substance misuse, being drawn into crime by abusers, misdirected rage, mental health effects on behaviour, school exclusions, involvement in the sex industry, or street homelessness. It needs to be said that most male survivors do not offend. Indeed, retreating into oneself is another common response.
- **Difficulties with trust and relationships** because that trust has been so betrayed. Sometimes male survivors will avoid intimate relationships altogether or have a whole series of very superficial relationships, which avoid the intimidating need to engage emotionally.
- **A major loss of self respect and self-worth**, through being treated as an object for the pleasure and gratification of other people.
- **Some vulnerable teenagers may become involved in prostitution**; reasons can include being deliberately groomed or forced into prostitution; the feeling they are only good to be used for sex, and a belief that they will now at least have some control; for financial survival after running away.
- **Vulnerability to homelessness** - survivors may have run from abusive carers and ended on the streets, often to be re-victimised. Substance misuse may bring ejection from hostels or flats and lead people back to the streets - a ‘revolving door’ syndrome.
- **At risk of being looked-after in residential or secure care**. This may happen either because the abuse was already known and recorded, or because reactions to CSA often seen in young people – such as school exclusions after difficult or distressing behaviour – draw the authorities’ attention to them. The survivors are then seen as being a risk to themselves or others.

Sexual abuse survivors will exist in any group of men you are working with, but especially in groups who are vulnerable or at-risk. People may disclose to you, because they trust and value your support. Many people may need help to address their underlying issues, not just the symptoms, before they can change their behaviour.

Therefore, it is important to feel confident and supported in your own efforts to assist survivors, or – where appropriate – to refer them for specialised help.

Chapter 2

Suicide and self-harm

What does research and experience with survivors of CSA tell us?

Both research and the practice experience of working with survivors of CSA suggest strong links between CSA, self-harm and suicidal thoughts and behaviour. This doesn't mean that everyone who tries to kill or harm themselves has been sexually abused. There are many other reasons. But it does mean that the effects of CSA trauma should be considered as one possibility, especially if behaviours are repeated.

Most research studies cover both men and women. But given the higher national suicide rates for males – and because they are less likely to confide in anyone – we can assume completed and attempted suicides may be even more prevalent among sexually abused boys and men, than among sexually abused girls and women.

What has research revealed about sexual abuse, suicide and self-harm?

- The great majority of research studies have found that sexual abuse is significantly correlated with a higher likelihood of recent or past suicide attempts than in non-abused people. This is true of studies with people in the community and people in clinical settings. Some research has found the risks are doubled or even trebled for sexual abuse survivors. Like physical abuse, it is what is known as an independent risk factor- it remains, whatever other influences are taken into consideration.
- The more frequent, severe and intrusive the CSA and the longer it goes on, the more depression and self destructiveness – including acts of self harm, suicidal thoughts and attempts – are reported in adulthood.
- The majority of self-harm incidents are not disclosed, and only a small percentage are seen by physicians.

- Self-harm is a risk factor for suffering further abusive relationships as an adult. Childhood trauma contributes to people starting self-destructive behaviours and a lack of secure attachments helps to maintain it.
- Survivors of CSA or other severe childhood traumas, who repetitively attempt suicide or chronically self-cut, are often reacting to present-day stresses by returning to their childhood trauma, neglect or abandonment. Current experiences that threaten a survivor's safety or emotional needs, or cause anger, can trigger dissociation and self-destructive behaviour, especially if they re-experience intrusive images of their trauma (such as flashbacks) and their own body's reactions to these.

Alternatively, they may re-experience the numbing sensations and 'dead emotion' they once used to dissociate themselves from pain. At such times, self-harm may spring from a desperate wish to 'feel something' again. This reflects the well-known finding that self-harm does not usually imply the wish to kill oneself, but the wish to find relief from unbearable feelings – temporary 'though the relief may be.

What does practice experience with CSA survivors tell us?

- That a majority of survivors, both male and female, have repetitively self-harmed at stages in their lives, especially as young people. With males this can include not only the more familiar self-cutting but behaviours that can appear to others as extremely reckless – such as long alcohol 'benders', fights they cannot win, reckless driving or other dangerous risk-taking.
- That nearly all survivors, both male and female, have seriously contemplated suicide; and that a high percentage have attempted it – often several times – as children, teenagers or adults, and that they often remain troubled by suicidal feelings.

- That despite the force of their messages, very often the underlying trauma has not been identified by others. Nor has help been available to address the effects of their trauma and protect them from further abuse.
- That it is not uncommon for victims of CSA to complete suicide. This is well known by their survivor friends, by CSA support groups and staff working with the topic. Statistics are very hard to gather because many people do not give reasons for taking their lives, especially if they are ashamed of the abuse. Others are often unaware of their abuse history. Thus assumptions are readily made that it may relate to issues such as school bullying, bereavement or relationship breakdown.
- It is therefore all the more important for us to do all we can to support survivors to overcome their trauma and rediscover hope in their lives. These facts are not intended to be demoralising, but to help show that it is genuinely possible to support survivors to see the possibility of *different* choices in their lives.

What does research recommend?

- If adults are suicidal they should be routinely assessed for sexual and physical abuse.
- In adolescents with emotional and clinical problems, routine history should include questions about suicidal behaviour and sexual abuse.
- Early, supportive intervention with sexually abused children can reduce later suicidal behaviour and adults also need more support services to address their trauma.
- High rates of re-victimisation as adults suggest that it is very important for professionals to promote self esteem and self-protective skills among CSA survivors.

What does research and experience with survivors suggest?

- That they want suicide attempts to be taken seriously, not ignored, left unnoticed, belittled as attention-seeking, or blamed solely on other issues, such as school bullies.
- That they welcome sensitive opportunities to talk about the root causes of their feelings which often lead to suicidal thoughts or self-harm.
- That reducing sexual abuse and sexual assault, in both childhood and adulthood, is likely to reduce the incidence of suicide and suicidal ideation in our society.

In the next chapter, male survivors of CSA talk about the feelings and motivations behind their suicidal thoughts or self-harm, and how they expressed them.

Chapter 3

Explaining the pain

Indirect Murder

When all is said and done,
As if it ever could be,
The issue of suicide is not one
That rates much sympathy.

Murder, for some reason, is more
Written about and understood.
To the box office, glorified gore
Is artistically valued and good.

Murders and murdered are news. Fame
Or even notoriety is their lot.
Suicide is looked upon with shame
As something it's better we all forgot.

Yet suicide is murder in disguise,
Caused by some unremembered crime,
Not understood by our present eyes,
For it has its roots in an earlier time.

Because we don't know the beginning
Of such long-term murder, we see
Suicides as people who are sinning
And reject them accordingly.

Those untouched by such murder, in resentment
Or fear, not knowing enough about
It, come up with some facile comment
Such as 'suicide is the coward's way out'.

Like primitive man, who saw
No relation between sex and birth,
And later man, whose immature and raw
Greed fatally threatens the earth,

We seem totally unable to relate
Effect to a cause that isn't obvious to see
Or to realise that a suicide's state
Is murder rooted in personal history.

Not by something as obvious as a knife
Or a gun, but by acts that the perpetrator
Cannot recognise as threatening to life
Because the dying happens years later.

Brenda Nicklinson

From Malone C., Farthing L., Marce L. (eds),
The Memory Bird, Temple University Press 1997.

With thanks to the author.

Why do many male survivors harm themselves or attempt suicide?

It can be very difficult to understand the feelings that CSA invokes. To help staff and volunteers, male survivors interviewed for the research report *Care & Support Needs of Men who Survived Childhood Sexual Abuse (*Nelson 2009*)* suggested some reasons and give personal quotes.

Reasons for self-harm in relation to CSA can be:

- To express anger, distress or sadness
- To distract from the emotional pain of abuse and soothe unbearably strong emotions
- In contrast, to try and counter a sense of numbness and deadness in a desperate attempt to feel something
- To cleanse oneself by ‘letting the dirt out’
- To punish oneself due to feeling guilt, shame, self-blame for the abuse, self-disgust or self-hatred
- To re-enact an abusive act on oneself over and over again, without being able to resolve it
- To feel some sense of control over their own bodies when they previously had none
- As a reaction to bullying in settings like schools or the armed forces. The effects of CSA can make survivors particular targets for bullies.

Suicide attempts or suicidal thoughts in relation to CSA can result from:

- Feeling unable to face the daily pain of flashbacks, depression, self-blame, physical pain or other effects any longer – a belief that at least the 'pounding of the waves of past harm' will all stop
- Breakup of an important personal relationship, especially if due to their own reactions to abuse (e.g. mental illness, alcohol addiction or anger)
- Self-blame, guilt, the sense of being a bad person who doesn't deserve to live
- A sense of and sometimes a declaration of hopelessness
- Triggers to sudden intense painful memories or flashbacks. A range of triggers can include major family events, death of the abuser, or hearing of their abuser again, for instance through media reports of an arrest
- Fears that they themselves might abuse a child
- Reaction during recovery. Recovery is a positive experience, but feeling safe at last can also allow painful issues to emerge which are initially hard to confront. That's not a reason to avoid the journey, but extra support may be needed at times
- As a reaction to bullying in settings like schools or the armed forces. The effects of CSA can make survivors particular targets for bullies.

Self-harming or suicidal?

Most self-harm doesn't have suicidal intent. On the contrary, it is very often used, and felt, as a survival mechanism. But some self-damaging behaviours are hard to pigeonhole as *either* 'self-harming'

or suicidal, because the underlying feelings cover both categories. In particular, some apparently reckless behaviours, which are extreme forms of distraction, escape or avoidance, reflect that people have come not to value their lives and no longer care if they live or die.

Both self-harming and suicidal acts also have a sense of isolation and alone-ness, of being unable to tell, or of no-one listening to the truth: these are very common experiences in sexually abused people.

'Swallowing the pain': dealing with trauma alone

> *For many of these young men, they've experienced trauma with domestic violence. And because of it they felt so isolated. 'Who can I tell?' They've felt there was no one. So what do you do with that pain? You swallow that pain.*
>
> *Ilene Easton, Scottish prisons counsellor*

In the report on the *Care & Support Needs of Men who survived Childhood Sexual Abuse(2009)*, three - quarters of the male survivors felt unable to tell anyone in childhood and most of the rest faced disbelief, or a reaction that the abuse was not important. Those who could not tell gave numerous different reasons including fear, shame and loyalty to their family. For instance, men in the *Chosen* documentary about abuse in boarding schools (*see Appendix 1*) told how they felt they had to protect their parents, who had thought they were sending them to a trustworthy institution. Young Scottish women in another study also gave numerous reasons for not telling as children (Nelson 2008: *see Appendix 1*). Both women and men tried to send many indirect messages that something was very wrong, which were not picked up. It is important that we become

confident to hear what we are being told indirectly and not look for people to make the first move, whilst still allowing them some control.

This means that the **majority** of CSA survivors deal with trauma alone for much of their lives and have often had bad experiences of trying to tell. So they have to deal alone with much hidden emotional pain. Disbelief can powerfully impact on how they value their own lives, or see that anyone is likely to help them. This helps us understand why some men take drastic and unsafe steps to drown their pain and why some do not care whether they survive or not.

Survivors talk about despair

Dean and Adam went through phases of feeling hopeless, with a total disbelief that people cared, because no-one had helped them nor really listened. Young offender Dean's cumulative experiences of being repeatedly disbelieved through a series of assaults in his childhood and teens (including a traumatic gang rape) illustrate this. First punished at seven after reporting an assault in care, he was asked*:*

Q: Do you remember how you felt then when people didn't believe you?

A: *I felt nobody wanted me, I was lonely and my mum and my family didn't want me.*

Eventually the disbelief stopped him bothering to tell anyone:

I just blocked it out with doing drugs.

He kept running from care even though it was dangerous on the streets:

> *When I ran away I didn't care what happened to me. Because I had nothing to look forward to and I had nothing in my life, just bad memories so I didn't really care, I just took drugs and drink.*

He then became involved in major car crime and mentally survived each day 'blotting out' his past by taking huge amounts of substances:

> *Every day of my life….I was taking drugs… drinking every day from when I woke up in the morning…I was taking cocaine to work, I was taking Valium to bring myself back down on the level, and I was drinking. Cocaine makes you more capable, mellow, want to do things.*

Dean didn't care at all whether he lived or died. As a teenager he would drive cars crazily and at great speed.

> *Aye, I nearly killed myself a couple of times….I didn't care. I took too many chances.*

By his mid teens, Adam had concluded bitterly:

> *Nobody at that point will be listening, so what's the bloody point of talking? It's not (even) nobody helped me - it's nobody wants to help me. Nobody's really interested you see, this is allowed. This behaviour is wrong, but it's allowed.*

Survivors talk about harming themselves

Self-harming is often assumed to be more of a female response to the traumas involved in abuse (and it can initially be more difficult to detect male forms of wider self-harm, such as extreme risk-taking), but in the study it was common for male survivors to hurt themselves, both as children and adults. Here are some of the reasons they described.

Feeling dead inside, wanting to feel something

Mike described doing ‘crazy, stupid things’ to try and hurt himself:

> *Like hitting my head off walls and stuff. And deliberately getting myself battered… (but) It wasn’t sore. I didn’t feel it. I wanted to feel something.*

Reaction to bullying

Boys who have experienced abuse cope in a variety of ways. Some become aggressive whilst others become loners, isolated, ashamed and depressed. This often makes them easy targets for bullies. Stuart expressed the burden of *a dreadful thing to be carrying about with you, and there is an amount of shame attached to it*. Jeff’s image was powerful:

> *I was bullied a lot at school. There was a group of us which…the odds, and people who just hung out together… we were called the dustbin boys because we hung out next to the dustbins, I mean it was like a f***ing derogatory name…*

Alec was isolated from other boys by a brutal teacher:

> *The way he ridiculed me and ostracised me I was an outcast already. It (abuse) is not something you could talk about to the other boys, because the way to inhibit me would be embarrass me and humiliate me in public.*

Self-punishment

Liam recalled:

> *Been there, done that, got the t-shirt, got the scars to prove it. And it's – there's a pay off for about five seconds. For me it was about punishment, it was another way of punishing myself; whereas for some people, it's just a release.*

Sign of extreme distress

When Preston was extremely distressed by his abuse, his visible signs of this were interpreted by the school as a general anxiety:

> *I would go to school, ask to be excused and sit in the cloakroom because I had a headache…I would pull my eyelashes and eyebrows out. I feel angry now that none of these things were noticed…hair - pulling is something I do to this day.*

Re-enacting an abusive relationship

Two gay survivors, Roy and Padraig, described sexual behaviour as young adults which was almost a compulsive re-enactment of their own assault, and only made them feel demeaned. The relief they gained was momentary:

Roy: I began having sex in toilets. If I was rejected, I would feel shit. So to make myself feel better I would overeat… then because I felt fat and ugly and horrible because I was putting on weight, I would think, right, I'll go out and try and test anybody to see if they'll have sex with me or not. And if they do…I can't be that bad. In a way, it was also a re-enactment of being abused. It was self-sabotage.

Padraig: I've done some terrible things, some dangerous things to myself. My friend F who I could speak to, I told her, and I was saying to her that I felt that I couldn't stop it (sex in toilets). And she framed it in such a way that…she thought it was self-harm, you know, it was another way to explore the pain.

Fears of becoming an abuser

Male survivors appear much more likely than abused women to be told by professionals or public that they would be likely become abusers and sexual predators themselves. They were more prone to believe this and more likely to be silenced and anxious through direct prejudice. Also, their experiences left them uncertain about what were 'normal' sexual behaviour and feelings and what were not.

An extreme example was of Pete, once jailed for theft, who banged his head repeatedly against his prison cell walls, thinking abused men must become abusers and trying to smash any such thoughts out of himself. He was terrified that he might perpetuate a 'cycle of abuse' against children. Staff thought his behaviour was due to mental illness. He pictured himself assaulting a young child:

I didn't I'd never do that and never would… What triggered it off was, there's a saying, 'a victim of a victim'. I've seen

that in prison... And I thought: have I to do that (assault a baby)? Am I expected to do that, because it happened to me? Then I started smashing my head against all them walls…trying to get it out of my head.

Survivors talk about suicide

Everyone in the study had thought seriously about committing suicide, and more than two-thirds admitted to having attempted it: several more than once, usually starting in childhood. Alec confessed that for much of his life he felt he would be 'better off the planet' while Innes felt like 'giving up'. Roy was deeply suicidal for many years. Kit tried to kill himself in boarding school then later with a shotgun, while Jay admitted that even now, his son is the only thing that really keeps him going. Aged twelve, Phil swallowed tablets and made several further attempts as an adult, one of them publicly observed. Yet suicide attempts rarely seemed to prompt from services an exploration of why this was happening. That itself exacerbated the feelings.

Not fitting a mental illness model

Roy's experience with hospital psychiatrists who didn't consider trauma as a possible cause, saw him being told by one psychiatrist, at a brief consultation:

Despite this terrible feeling that I had, this portent of doom that hung over me like a cloud all the time, she said, 'There's nothing wrong with you, on you go. Cheerio. You're fine.'

One night, Adam 'freaked out' and swallowed all his tablets 'to try and get some rest'. In psychiatric hospital, the attitude he discovered was reflected in the words of the Senior House Officer, who wrote that Adam had 'self-harmed to manipulate the system'.

Breakup of a relationship

Preston failed to secure contact with his child of his first unhappy marriage, which greatly distressed him. His happy second marriage broke up, to his devastation, through his own behaviour, after he suffered panic attacks and depression and drank heavily as a result of the abuse. He then tried to take another overdose.

Resolving issues brings temporary distress

Pete eventually managed to report his abuser. Although he was delighted when the man was jailed, finding his self-confidence and a sense of closure, the experience of preparing for the court case exacerbated his mental health symptoms at the time, including anxiety and aggression. However he had excellent professionals supporting him through it.

> *When the case was coming up to court, I was at death's door, I tried to commit suicide – in a terrible state, I heard a humming bird inside my head. I starved myself…*

Other triggers set back progress

Sudden flashbacks (like Andy's, in his poem below) can trigger a temporary, yet sometimes overwhelming, sense of distress. Stuart overcame many obstacles to achieve a university degree in his 40's but a 'trigger' meant he almost fell at the last hurdle:

> *By the time I got to my 4th year, when I was doing my dissertation I was looking at the rise in demand for abuse survivors and it was the most difficult exercise I undertook…I began to reflect on my own abuse, and I was just in an awful state – from feeling kind of suicidal to being*

angry, violent, drinking heavily - struggling through my fourth year, and going down the tubes quickly.

Learning more about abuse (as Stuart did) and trying to understand their feelings as children can have positive effects in the longer term, as it did with him. However, in the short term it can increase stress and doubt.

The words of the survivors in this chapter have emphasised how important it is to always consider the possibility of a history of CSA in someone who tries to take their own life, or who repeatedly self-harms over periods of time.

It is important to give someone the respect and the space to talk about it, if they want to. All these strong feelings and doubts can be reassured and reduced, with the right support.

Flashback

I was back there,
Just for a second or two.
In the time that it takes
For someone to sneeze.
Not that long.

The length of a good cough.
It was the shampoo.
Something in the scent
Reminding me about the colours
That filed along that bath.

Miniature, glass bottles.
Bubble-baths that wore small, gold ties.
For those seconds, I was there.
Those colours, sharpened in my mind
Brought back to life in the scent of my shampoo.

For a moment, I was warm.
Then I remembered the rest of it.

Andy McGuinness
From *Fragments: A Book of Poetry (2001)*,
Salty Press, Angus, Scotland.

With thanks to the author.

Chapter 4

Overcoming barriers

Previous chapters have outlined why it can be very important to help male survivors address issues arising from their CSA trauma. The first stage of working with survivors is usually about receiving and responding to disclosures, or asking about a possible abuse history.

What are some of the anxieties of staff and volunteers, especially with male survivors?

- Fears of opening a 'can of worms' for the survivor, especially if they already behave in unstable or self-harming ways
- A sense of inadequacy and lack of training, particularly around male survivors
- Having to break confidentiality, perhaps resulting in a distressing legal case, if a young person or adult at risk of harm reveals CSA
- Worry that the survivor might be offended or that males in particular might be aggressive
- Inadequate support at team or management level, or the sense that managers do not 'buy into' this work as part of your remit
- Anxiety that there will not be continued support for the service user.

Survivors themselves are often fearful of volunteering a sexual abuse history, without being prompted in a supportive way. What are some of the common anxieties, especially for males?

- Shame, humiliation, self-blame and guilt, especially among young men;

- Having been disbelieved before – especially if labelled a disruptive teenager, offender or substance misuser
- Strong male fears about their sexuality or masculinity, which they think that others will doubt
- Fears about the consequences of legal action being taken
- A perception that the worker is uncomfortable with the subject
- Fears that they will be assumed sex abusers themselves and unsafe around their own or others' children. This silences many males from telling, yet it is not common for survivors to become sexual abusers
- Perceived pressure from society to conform to a male stereotype.

In his excellent resource on working with sexually assaulted young men, the Australian writer and practitioner Dr Noel Haarburger (formerly Noel MacDonald) illustrates and reflects sensitively on several of the points above. He describes how many boys do everything they can to live up to the boys' code of heterosexual masculinity and to avoid 'losing face' in front of their peers. The cost of this is that many young men feel ashamed to acknowledge any experience that violates this code:

> *In disclosing to another friend or worker, young male survivors must often risk being disbelieved, shamed, overwhelmed by feelings, judged, misunderstood, and having many of their worst fears confirmed e.g. 'I must be gay because my body enjoyed it', 'It was my fault' or 'I will become an abuser'. They must also choose to begin the often painful and uncertain journey of acknowledging to themselves and another person the impact of what happened …this task is coupled with the fears of disclosure and its impact on their sense of self, family, reputation and relationships.*

(From www.livingwell.org.au/workersresources)

…But don't assume that they do not want to be asked

Remember that survivors are already suffering the effects of their abuse, often in very damaging and distressing ways – for them 'the can of worms' is already open. Also, research and practice with survivors themselves finds they are often far more frustrated at professionals *failing* to recognise or ask about problems relating to sexual violence. Men who give their views throughout this booklet described many instances when as children, young people or adults they tried desperately to give out hints about their abuse, without being able to say it directly. They can find considerable relief at being believed, and acknowledged.

MY VOICE

I want my own voice.
I want to reclaim my inner land.
It is not enough to be the shell
In which the child can hide.
We need to stand and speak as one.

When I first told the secret
I was disbelieved.
An oedipal myth
The counsellor said.

Needing reassurance
I told everyone.
Inappropriate disclosure
The group leader said.

At last I found a therapist
Who believed what I said.
He is helping my voice
To find the strength
To speak out.

Ron Wiener

With grateful thanks to the author.

HOW CAN WE HELP?

You can help the men you work with to overcome their fears by being sensitive to their signs and signals; by increasing your own confidence and understanding; by introducing the topic tactfully and by having posters, leaflets and contact lists around which 'give permission' to talk about CSA. Here are some simple principles which survivors, especially males, usually appreciate:

- **Listen respectfully, stay calm**: If someone discloses sexual violence to you, don't brush it aside as if it's unimportant and best forgotten. They have been unsuccessfully trying to forget. Nor should you insist details of the assault are given to you. Respect their desire for privacy on this. Listen; stay calm and supportive and tell them you appreciate them telling you. Use, without feeling panicked, the same listening skills and empathy you would use in other human situations. Sometimes, an adult who discloses may become temporarily childlike in language. It's helpful to be aware of this and to work with it calmly.
- **Do not express disbelief or distrust**: don't say you think it's unlikely to have happened to them. CSA can happen to *any* kind of person.
- Adam: *When you tell people you were abused the first thing is 'are you an abuser?' And the next thing is disbelief, because when they get a guy at my size they don't put me down as a child, they put me as an adult, and say 'how does a guy your size get abused?' I was a child; I wasn't an adult.*
- **Without prejudice**: Do not assume that an abused male is likely to abuse. The great majority do not. People should be assessed individually, not pre-judged. If you need to assess a person (e.g. for job recruitment, or in a family context) for anything relating to the safety of children or adults at risk of harm, use the same

standards for screening risk as your agency would use for every individual.

- **Consult before assuming**: Give survivors control over what they need. Do not assume they are irreparably damaged! They trusted you to disclose to: don't refer them on too hastily. Ask if they would like longer-term help from a support agency. For some, telling and being acknowledged will be sufficient. Ask what problems, if any, THEY would welcome help with, because needs vary. Survivors have knowledge and experience: consult them respectfully.
- **Have information available**: Although you should not assume that all CSA survivors want to be 'referred on', make sure your agency does have access to a list of current survivor support agencies and websites, ones which work with men as well as women, or men alone. Ask if the survivor would like a copy of this.
- **Some people need specialist help**: Some CSA survivors will undoubtedly need help from more specialised services. Take expert advice rather than trying to address problems yourself if, for instance, someone has severe mental health problems, if they seem completely 'stuck' (perhaps repeating their abuse history over and over), or if they are a victim of sadistic multiple abuse with bizarre symptoms.

Other survivors, who are otherwise coping well with most areas of their lives, sometimes benefit from being referred for specialist help for a single frustrating problem. Examples might be persistent intrusive thoughts, a troublesome phobia, or repetitive flashbacks. Flashbacks, involuntary recurrent memories, happen when someone has a sudden powerful re-experiencing of a past experience or parts of this. The term is used particularly when the memory is so intense that the person 'relives' the experience, unable to fully recognize it as memory and not something that is happening in 'real time'.

Flashbacks for people suffering post-traumatic stress can be so disruptive as to seriously affect daily living.

- **Using self-help groups**: Survivor self-help and support groups can also be valuable, making contact with other survivors with similar experiences. They can remove feelings of isolation suffered over years and be a ‘safe place’ to discuss the range of emotions and reactions they feel. However, groups don’t suit everyone. Some survivors find it easier to work one-to-one on issues arising from their abuse, before feeling able to join a group setting.
- **Leaving the door open**: If a man has not disclosed CSA, but you have reason to suspect they may have suffered childhood sexual assault which has affected their wellbeing, trust or behaviour, then asking sensitively is quite OK. You might suspect this, for instance, if he has had longstanding mental health problems, an intractable drink or drug problem, is long-term homeless or has serious problems with his anger and relationships. You might ask directly or say, for example, ‘A lot of people with this problem had a bad/difficult childhood, I wonder if that happened to you?’. Enabling CSA to be named can bring great relief to people, who find it extremely hard to introduce by themselves. In doing so, you are also conveying that CSA issues are taken seriously by you and your team.

Some young people who have been abused may sharply deny it, because they are too ashamed or too fearful of the consequences. Do not ‘interrogate’ them, nor insist that they must have been abused. Leave things open in a supportive atmosphere, where CSA is visibly an ‘OK subject’, not a shameful secret, to discuss with your or other staff if they wish. Having posters and leaflets naming CSA in your workplace helps convey this message to service users.

Planning for temporarily increased distress

Although most survivors feel relieved to be able to talk, some experience short-term worsening of distress. Sometimes with males this can include aggression, 'though more likely against themselves than others. Temporary worsening of symptoms is natural and a feature of work with other kinds of trauma too. That isn't a reason to shy away from asking the question or responding to disclosures. But it does mean you need to plan, with the survivor, some extra support and self-help resources, to help deal with issues like panic attacks or dissociation. Planning is also valuable for sudden crises or temporary setbacks, because progress in recovery from CSA trauma is rarely linear and straightforward.

Child and adult protection issues: dilemmas about asking and hearing

Staff working with young people and with adults at risk of harm will have clear statutory responsibilities and practice guidelines about reporting sexual abuse and/or if a named perpetrator still has contact with children. These regulations will be followed in your own work setting and you will have received training in what you are expected to do.

However, staff and managers cannot protect people, change damaging behaviour, nor promote recovery from the effects of trauma if they avoid asking just *because* they may need to report the answer. They may fear that reporting will distress the client further, unleashing an unknown set of events. Consider it honestly together if this is a risk in your own workplace. Discuss how you might supportively help each other to overcome such fears. It may help to remember that:

- Many fears can be reduced through thoughtful, sensitive practice. For instance, telling people abruptly and fearfully that

you must report and break their confidentiality can silence them straight away! It is possible instead, to explain gently why you can't keep particular secrets. But you should also be able to assure survivors that they will be kept informed at each stage and will be able to talk through their fears and doubts about reporting. For instance, a survivor may worry greatly that a loved parent will be distraught on suddenly hearing about the abuse. He might be reassured by working out together how that parent could be informed sensitively and by whom. Fears that an abuser may immediately retaliate can also be talked through, in order to arrange greater safety. There are many examples of thoughtful practice to address fears. Not all of the potential repercussions of reporting can be made less difficult, but some *can*.

- Don't assume that if a young person or adult at risk manages to reveal abuse from years ago, gaining relief, support and therapeutic help, that an investigation will always be necessary (or damaging). If any details do still need to be reported and investigated, these can be dealt with as they arise.
- If discussion of sexual abuse is taboo or shrouded in secrecy in settings like young people's residential care, there is a greater risk that abuse could be committed by some young people on others and silenced again.
- Young men and adult men, who may still be facing assault by perpetrators, need staff to have courage on their behalf.

Working with young men: further advice

If you or your organisation are working with male survivors on a longer term basis, rather than simply responding to disclosures, or if you want to feel more confident about 'asking the question', you will want to improve and increase your skills, your training and reading.

Dr Noel Haarburger (formerly Dr Noel MacDonald) has made useful and sensitive suggestions for staff working with teenage boys and young men. These give examples of the kinds of deeper issues staff or volunteers need to think about. For instance, he shares some points he has found valuable in engaging with young male victims of abuse, as follows:

- Most feel safer when asked if they want to talk about *effects* of sexual abuse, rather than about the abuse itself.
- Openly acknowledge a young man's strength in taking a stand, against the pressure to 'tough it out' on his own.
- Accept that the young men you work with often have many complex and contradictory feelings towards the abuser, including love.
- Honour the underlying need for their current survival strategies (such as drug abuse, aggression, avoidance or self-harm). You are then in a better position gently to challenge their strategies and support them in developing new skills to manage the trauma, especially if they disown responsibility for hurting others or themselves. Haarburger says we cannot expect survivors to change the ways that have worked for them in desperate conditions, unless we help them to develop new resources and support.

Acknowledging Powerlessness

Haarburger also describes how many young men feel ashamed and guilty at not being able to stop the abuse and protect themselves. They may think they had the power to stop it. Gently challenge their beliefs that they were responsible. For example – as a small child, in what ways did they actually have the power? Because young men are expected to be strong and invulnerable, they often do not

consider the unequal power dynamics between themselves and the abuser. It can also be useful to discuss the many tactics and tricks that perpetrators use to make the victim feel responsible (www.livingwell.org.au/workersresources).

Chapter 5

Help and support: whom did survivors value?

Listen

When you listen you affirm me,
but your listening must be real:
sensitive and serious,
not looking busily around, not with a worried or
distracted frown,
not preparing what you will say next,
but giving me your full attention.
You are telling me that I am a person of value,
important and worth listening to,
one with whom you will share yourself

I have ideas to share,
feelings, which too often I keep to myself;
deep questions which struggle inside me for answers.
I have hopes only tentatively acknowledged
which are not easy to share,
and pain and guilt and fear I try to stifle.
These are sensitive areas and a real part of me,
but it takes courage to confide in another.

I need to listen too if we are to come close.
How can I tell you I understand?

I can show interest with my eyes or an occasional word,
attuned to pick up not only the spoken words,
but also the glimmer of a smile,
a look of pain, the hesitation, the struggle
which may suggest something as yet too deep for words.

So let us take time together,
respecting the other's freedom,
encouraging without hurrying,
understanding that some things may never be brought to light,
but others may emerge if given time.
Each through this listening, enriches the other
With the priceless gift of intimacy.

Keith Pearson,
Melbourne, Australia.

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This booklet has described how staff very often fear that they are not sufficiently trained or qualified to respond to even a disclosure of CSA, let alone to talk through a situation, or suggest helpful follow-on services. What survivors recall about the most helpful people they met shows once again that such fears are usually unjustified.

It is striking that when they describe people who gave them strength or support, or where there was impetus to seek help later, these were people with skills and basic human qualities of empathy, honesty and perception. They believed and respected the survivor. It was also these qualities in counsellors or therapists, rather than any particular therapeutic approach or qualification, which enabled them to engage, and to begin improving their lives.

The 'ordinary', although unfortunately uncommon, elements of the positive support given to survivors, outlined below, illustrate that whatever work you do, responding with humanity enables survivors to seek further support.

The survivors recalled:
Supportive, respectful, perceptive friends or partners, teachers or youth leaders

Here are some examples:

Jeff felt suicidal at school after being repeatedly abused by trusted adults he confided in. But one teacher memorably told him:

> *He just said, you know, it was a real shame if I did kill myself … because I was such a very great person, and if I felt like that again I needed to go and see him, so that's why I felt special that … someone was actually noticing me, and someone was actually there for me.*

He also found a courageous friend of his own age, whom one perpetrator rightly saw as a threat:

> *When I was seventeen, I spoke to a friend of mine called S; he was the same age as me; but he was supportive and saying that I shouldn't be friends with these (abusers). The guy who wrote me all the letters, he told me that I shouldn't listen to S…he was very scared of S.*

Adam always remembered a schoolteacher who believed in him and was not afraid to speak her mind openly:

> *What Mrs R did for me, she said I was a good person. The last thing she did, she gave me a book… (and said) 'you are a good boy, you're going to be a great man, but you have a really bad father.'*

Adam became intensely homophobic after his childhood experiences, until he met kind and perceptive gay friends who guessed his history:

> *I got a lot of gay friends I didn't know were gay…they said, 'did you know we were gay? We live together, we have sex together and we love one another'. (I said) 'No you're not – cos you're nice people!' And one of them who was very intelligent said, 'if you were abused, your abuser wasn't gay, he was just cruel…homosexuality and abuse have nothing in common.'*

Liam's behaviour unit at school changed his angry hostility to adults and enabled him to learn, because:

> *Instead of talking to you as an authority figure, they come down to your level and spoke to you… one of them did ask me what was wrong. And then after that I ended up in care*

because he listened and he actually believed me…it was more along the lines of, 'We're here, you know we're here. You can come to us whenever you want and we'll not betray you. '(This was) completely different to the way everybody else used to treat me. That I was actually worth something.

Survivors also valued staff who weren't specialists in anything related to abuse, but they noticed, helping them to find support

For instance, an Air Force Sergeant, who happened to be involved in child protection liaison work, told Innes about two local sexual abuse support projects and explained them knowledgeably to him. No-one else in the Forces had done this – nor, it appeared, had they bothered to find out.

An alert and sympathetic Job Centre staff member enabled Jo to find support when his depression and drinking spiralled out of control:

I had a couple of days off and I was supposed to go back to work, but….you don't contact anybody, just shut yourself away, and …I just got a few bottles of Buckfast and sat in the house drinking…people tapped my door and all this kind of thing.

Then I was at Asda and I bumped into this woman that worked in this Job Centre and she said, 'are you okay?' And I was crying and that and that's when she started getting the help; she says, 'go to your GP, get a sick letter into your work.'

Many of the male survivors also valued staff and volunteers who helped them with basic life skills, like tidying the house, eating regularly and budgeting. These supportive people did not think such

help was *all* the men needed, but they understood that a sense of chaos and depression, often with heavy drinking and self-neglect, frequently followed abuse trauma. This was especially the case for young men.

Survivors valued GPs and other health professionals who noticed, took time, took them seriously and referred them to helpful services.

Adam: *Dr G sat with me and said 'Adam, I'm sorry these things have happened to you, but the difficult thing is that you now need to deal with the consequences of it.' And that really gave me the first step to healing … I'd be on my own personal journey…it was the first step for the NHS that I had any real support.*

> *I found out later that she automatically made double appointments, even if I went in for a cold, and she would ask me every time 'How are you doing? How do you feel about your issues? What is happening?' And we would talk. And we went through the whole thing, and she supported me right through my healing process. She cared that I should have a good life - not merely an existence.*

When Padraig fell very ill at twelve and his history of abuse emerged, he recalls no psychological help or counselling, nor action about his predatory abuser.

> *What I did get, I got one nurse…who was incredibly patient with me and incredibly supportive and was not negative about anything… I said that I was frightened of being gay and that I didn't want to be gay and stuff like that and she was just sensitive, you know and just told me it was OK to be myself.*

Pete recalled of his psychiatric hospital:

> *In there you don't develop relationships, just conversations. But there was this nurse S, and he knew the court case was coming up… I was carrying on and being hyper…but he really got through to me. He was standing there with his arms… up and down … 'Pete you've got to listen! We have got to get you in the best possible state for you to go through with this court case!' I says 'S…not only do you just care, but you passionately care.'*

Qualities of therapeutic work

If you do therapeutic work, or refer survivors to therapy, these are characteristics the survivors valued in counselling, therapy and support agencies. Basic respect and empathy was vital. So was being knowledgeable and understanding about CSA and its effects, especially on males, and being able to adapt approaches to the survivor's needs.

Gordon appreciated this voluntary sector support agency for what he had failed to find previously:

> *The fact that they've kept in touch, always kept in touch, there's no continuous break sort of thing – it's genuine support, caring – even if you phoned up out of the blue, there's always a warm, sincere, empathic person on the end of the phone. I am restarting counselling again as well.*

For Scott too the simple appearances of services gave an atmosphere of respect and warmth, such as couches, thoughtful furnishings and décor – as he recalled about his voluntary sector support agency:

Positive, comfortable, friendly – and even the initial interview, understanding, professional, very calm. The calming aspect is a huge thing…because you are so uptight. And because these people have the experience and know what they're doing.

Jeff had previously been told by one psychiatrist after another that they couldn't help him with his abuse trauma:

The psychologist sat down with me for the first time and said 'I'm quite ashamed by the way my colleagues have treated you; you shouldn't be seeing lots of different people… and I'm here to help you.' And I remember starting to cry, that he was the first person in my life that I'd been looking for – someone to give me help and he was there to help me.

Roy could relate to his counsellor because:

She seemed knowledgeable about people's sexuality, about the difference between men and women. She knew things about society, how we portray sex…and it absolutely made me feel that she would know the subtle stuff that goes on, and the subtle sort of pain that you actually put yourself through.

Stuart's psychiatrist:

Fed back to me how much sense I was making, I thought I was making no sense at all: she listened and explained (that) some of the feelings I was having, were normal and natural… there were hundreds and hundreds of men – I was amazed because I thought I was a unique case…. it was the first time I'd managed to find anybody that could actually listen to me without criticising.

Liam recalled telling his prison counsellor that previous drugs programmes didn't try to work out why you were taking drugs:

> *It was just a case of, 'don't take drugs'. But she doesn't try and tell me what should and shouldn't happen. She gets to the root and we dissect it from the root, instead of what's happening on the outside.*

The counsellor managed very successfully to enable young male offenders to engage with counselling, because:

> *She never, ever pushed and pushed and pushed. If I brought something up that I was finding really difficult, she'd leave it and come back to it. But she would ask me when I said it, what I was finding hard about it.*
>
> *You can go at your own pace… because she made me feel so at ease….that for once it wasn't actually my fault. If I talked about It, then I could sort through it and deal with it myself.*

Finally here are some thought-provoking but positive points to bear in mind, drawing on the words of Amsosa, a leading UK male survivor support group. They have urged staff and volunteers to:

'Remember that we did nothing wrong as survivors - something wrong was DONE to us.'

- We didn't ask to be sexually abused, and don't deserve to live with these feelings any more. They belong to our abuser(s).
- CSA survivors need to be able to express the hopelessness they may be feeling, which has previously been expressed through self-harm or suicide attempts.
- It can be encouraging to say:

The child who was abused survived this, by whatever means it took, and you made it this far, and so can you, as the adult, even if feeling those painful memories again. Your feelings of despair are due to the abuse you suffered. The painful emotions and low self-esteem can be overcome. They will come and go but also pass – you CAN keep overcoming them.

You've lived this long with the painful memories and grief, perhaps hiding it as best you could, but by speaking out now you have started to recover, and overcome all this.'

We are grateful to Amsosa (formerly Survivors Swindon) at www.amsosa.com *for parts of the above text.*

My Journey

My first few experiences – introduced 'Secrecy',
Growing and developing as I hid away.
I felt – I wasn't allowed to express myself,
Yet it's enriched me to talk and feel.

My next few experiences – introduced 'Stress',
Growing and developing in an arguing world.
I felt – I had to stop it all,
Yet it's gifted me to work with others.

My next few experiences – introduced 'Complications',
Growing and developing with difficult problems.
I felt – there was something wrong with me,
Yet it's strengthened me to like myself.

My next few experiences – introduced ‘Intimacy’,
Growing and developing with little trust.
I felt – I would never receive any love,
Yet it’s taught me the importance of touch.

My next few experiences – introduced ‘Education’
Growing and developing in a private school.
I felt – life was all about being alone,
Yet it’s taught me to like my own company.

My next few experiences – introduced ‘Addictions’,
Growing and developing with little enjoyment.
I felt – I would never have any control,
Yet it’s taught me to the path of meditation.

My next few experiences – introduced ‘Exams’,
Growing and developing in a failing world.
I felt – I had to be a success,
Yet it’s given me the lesson to persist.

My next few experiences – introduced ‘Bullying’,
Growing and developing in a harsh place.
I felt – I had to just keep on coping,
Yet it’s strengthened me when life is tough.

My next few experiences – introduced ‘Worth’,
Growing and developing in a challenging world.
I felt – I was not really enough,
Yet it’s enriched me to accept myself.

My next few experiences – introduced ‘Madness’,
Growing and developing in an insane world.
I felt – I was never going to be normal.
Yet it’s taught me to be myself.

My future experiences – I hope will bring ‘Awareness’,
As I journey and adventure in this world of life.
I hope to love – enrich – and be whole.
And continue to learn about life.

Jim Campbell

With thanks to the author.

Chapter 6

Support and supervision

We have emphasised throughout that asking tactfully about any history of CSA, or responding constructively to initial disclosures, does not have to be frightening. Many survivors will feel great relief and may not wish to go further than having their history acknowledged, explaining what needs they would like to follow up, or discussing with you which other agencies could offer support and advice.

You may, however, be someone who works regularly and in depth with survivors on abuse issues, someone involved in counselling or longer term one-to-one-support, or someone whose job could involve hearing, at any time, painful and difficult revelations. If so, and whether you are on the frontline or a manager, it is essential that you have regular supervision; either within your organisation, or from an external supervisor.

Also, many people working in the caring professions can themselves be survivors of childhood sexual abuse. While this experience can often help them to assist and understand others, it can also trigger difficult feelings and memories which they may need to talk through in a supportive environment – without feeling they are in any way stigmatised at work for being a survivor.

Working with trauma, suicide and self-harm can be rewarding and many staff felt that it added to their own sense of growth and satisfaction. However it is recognised that this work can also have negative effects, which have variously been described as secondary trauma, burnout or vicarious trauma. There are some risk and protective factors that either increase or decrease the risk of this secondary or vicarious trauma.

Risk factors include:

Carrying a high case load of clients with a history of trauma, self harm or suicide; having limited access to supervision; not having a supportive work environment; having a personal history of trauma without having worked through the issues it has left; having little experience of working with survivors; having worked with survivors for a long time without proper breaks or professional support.

Protective factors include:

Having access to continuous professional development (CPD); having a balanced case load of clients; having the opportunity for peer consultation and support; taking regular time out from work through leave entitlement; being offered quality supervision; and having consistent self-care, through maintaining balance between work and private life and through regular exercise and sleep.

Training and Continuous Professional Development (CPD)

Staff working regularly with trauma, suicide and self harm require adequate and ongoing training. This should include training on appropriate interventions as well as how to identify experiencing secondary or vicarious trauma. This should include recognising signs and symptoms, as well as preventative techniques. It is also important to keep up to date with the latest training and research developments relating to this field.

Support and supervision

All staff working regularly with trauma, self harm and suicide should be offered regular support and supervision. This includes both

frontline staff and their line managers. Support and supervision can include peer support, consultation with other colleagues and experts, as well as reflective supervision.

At minimum line managers will need to offer regular supervision sessions, the frequency and duration of which will be determined by the hours worked, case load carried and complexity of the cases. This supervision should provide an opportunity to reflect on the impact the work has on the supervisee, how they can be supported with this and what they might need to be able to continue with this work.

Support and supervision are also of course an opportunity to identify further training and development needs for staff – as well as ensuring that staff work within supportive policies and procedures.

Senior managers' key role

This support and supervision highlights the importance of managers at every level feeling comfortable and confident themselves with issues of sexual abuse and having their own support network. Senior managers and commissioners need to be encouraged to allow all staff, including themselves and middle managers, to take time for related confidence-building training. Of course, it is difficult in this economic climate, but can directly benefit their employees' work. Ultimately it is also likely to save resources and time, enhancing the recovery and wellbeing of service users who may be making heavy demands on services.

Appendix 1: References

The survivors' quotes are drawn from:

Nelson S. (2009). *Care and Support Needs of Men who Survived Childhood Sexual Abuse. Report of a qualitative research project.* CRFR, University of Edinburgh/Health in Mind. (Available from Health in Mind, 40 Shandwick Place Edinburgh. Tel 0131 225 8508).

Chapters 4 and 6 draw upon:

Nelson S. and Hampson S. (2008). *Yes You Can! Working with Survivors of Childhood Sexual Abuse* (2nd Edition). The Scottish Government.

Chapter 1:

Recent authoritative evidence supporting a 1 in 6 prevalence estimate for male contact abuse:

Dube S., Anda R., Whitfield C., Brown D., Felitti V., Dong M. and Giles, W. (2005). Long-term consequences of childhood sexual abuse by gender of victim. *American Journal of Preventative Medicine*, 28(5).

Research on college students by Lisak *et al.* gave prevalence rates of approx. 17% for CSA of males involving physical contact:

Lisak D., Hopper J. and Song P. (1996). Factors in the cycle of violence: Gender rigidity and emotional constriction, *Journal of Traumatic Stress,* 9(4), 721–743.

See also:

Backett-Milburn K., Ogilvie-Whyte S., Newall E., Popham F., Houston A. and Wales, A. (2006). *Children and young people's concerns about their sexual health and well-being.* Edinburgh: Scottish Executive.

For thoughtful discussion of difficulties in assessing prevalence, see:

Sexual abuse of males: prevalence, possible lasting effects, and resources at www.jimhoopper.com

For higher prevalence of CSA in male populations such as homeless, imprisoned, HIV positive, intravenous drug-users, psychiatric inpatients and sexual offenders see:

Holmes W. and Slap G. (1998). Sexual Abuse of Boys: Definition, Prevalence, Correlates, Sequelae, and Management. *Journal of the American Medical*

Association, 280, 1855–1862.
Johnson R., Ross M., Taylor W., Williams M., Carvajal R. and Peters R. (2006). Prevalence of childhood sexual abuse among incarcerated males in county jail. *Child Abuse & Neglect,* 30, 75–86.
Lab D. and Moore E. (2005). Prevalence and denial of sexual abuse in a male psychiatric inpatient population. *Journal of Traumatic Stress,* 18, 323–330.

Chapter 2:

For links between CSA, suicide and self-harm, see:

Dube, S., Anda R. F., Felitti V. J., Chapman D. P., Williamson D. F. and Giles W. H. (2001). 'Childhood abuse, household dysfunction and the risk of attempted suicide throughout the life span' *Journal of the American Medical Association*, 286:24.

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Joiner T. E. Jr., Sachs-Ericsson N. J., Wingate L. R., Brown J. S, Anestis M. D. and Selby E. A. (2007). Child physical and sexual abuse and lifetime number of suicide attempts. *Behaviour Research & Therapy,* 45 (3), 539–547.

Oates R. K. (2004). Sexual abuse and suicidal behaviour', *Child Abuse & Neglect,* 28, 5.

Romans S., Martin J. and Mullen P. (1995). Sexual abuse in childhood and deliberate selfharm. *Psychiatry,* 152, 1336–1342.

Van der Kolk, B., Perry J. L. and Herman J. L. (1991) Childhood origins of selfdestructive behaviour. *American Journal of Psychiatry,* 148, 1665–1671.

Weierich M. and Nock M. (2008). Posttraumatic Stress Symptoms Mediate the Relation Between Childhood Sexual Abuse and Non-suicidal Self-Injury. *Journal of Consulting and Clinical Psychology,* 39–44.

Whitlock J., Eckenrode J. and Silverman D. (2006). Self-injurious Behaviors in a College Population. *Pediatrics*, 117, 1939–1948.

Chapter 3:

Nelson S. (ed). (2008). *See Us-Hear Us! Schools working with sexually abused young people-the voices of young survivors.* VIP Publication, 18 and Under, Dundee.

Also True Vision Films (2008). *Chosen: Selected, Groomed, Abused.* Dir. Brian Woods.
www.chosen.org.uk

Appendix 2: Health in Mind and Choose Life

Health in Mind

Trauma Counselling Line Scotland

Run by Health in Mind, this is a national telephone counselling service for adult survivors of childhood abuse including sexual abuse. 08088 020 406
www.health-in-mind.org.uk/tcls

Men's SHARE Project

Men's SHARE (Suicide Harm Awareness Recovery Empathy) Project works with males across Midlothian, providing early prevention, intervention and support to reduce the risks that may lead to suicidal behaviour and deliberate self harm. The service provides a range of individual and group supports, information and activities.
www.health-in-mind.org.uk/services/orchard-centre-services

Pathway (Men)

Pathway (Men) offers support to men (aged 16 and over) from Edinburgh and the Lothians who have experience of childhood sexual abuse, rape, or domestic abuse. Emotional and practical support is provided weekly or fortnightly, with the person meeting a member of staff either in our offices or out and about. Emotional support can give people an opportunity to talk about the abuse that they have experienced, and how it is impacting them now. Practical support could include making changes to their life, such as taking up a new activity, or finding ways to meet new people.
www.health-in-mind.org.uk/services/traumaservices

CLEAR: Substance Misuse and Mental Health Project

Community Lived Experience for Alcohol and Drugs Recovery. A peer support programme, based in Midlothian, whereby a volunteer who has experienced drug/alcohol misuse but is now recovering provides support to another who is at the start of their journey. The Monday drop-in provides an opportunity to socialise with others experiencing similar challenges.
www.health-in-mind.org.uk/services/orchard-centre-services

Choose Life

Choose Life (www.chooselife.net) is NHS Scotland's suicide prevention programme. Their strategy and action plan was

launched by the Scottish Government in 2002. The City of Edinburgh Council also has its own Action Plan, which is available by contacting John Armstrong at john.armstrong@edinburgh.gov.uk.

Choose Life sets out a framework to ensure that action is taken nationally and locally to build skills, develop training, encourage people to seek help early, improve knowledge and awareness of 'what works' to prevent suicide, and to encourage partnership working and better co ordination among services.

Local Choose Life Plans focus attention on:

- Preventing suicide within communities
- Improving the capacity of local communities to raise awareness of suicide
- Delivering prevention and intervention activities
- Involving a range of partners in preventing suicide.
- Providing practical support to those affected by suicide

The Edinburgh Choose Life Action plan has a particular focus and challenge to identify and close the gap between those who are excluded from the benefits of prosperity or the many opportunities on offer and the rest of the community. These include particular groups such as people from minority ethnic communities, people from the lesbian, gay, bisexual or transsexual communities and people with mental health problems. It estimates that around 28% of people who have completed suicide having been in contact with mental health services in the last year. Choose Life in Edinburgh is taken forward by a multi agency approach with a Co-ordinator and a Steering Group, which includes service users and carers as well as a range of agencies.

Examples of work promoted by the Edinburgh Choose Life Action Plan:

Early Prevention and Intervention: for instance the work of the Self Harm Project which addresses the issues surrounding self harm as this is identified within research to reduce suicidal behaviours at a later time.

Responding to Immediate Crisis: such as continuing to support the work of the Edinburgh Crisis Centre.

Longer-Term Work to Provide Hope and Support Recovery: Such as working with partners like SeeMe and the Scottish Recovery Network as well as agencies who support service users and carers.

Educating and raising public awareness of suicide prevention: such as Working with other institutions including the financial sector including the Ministry of Defence and the Prison Service.

Appendix 3: Other Useful Information and Training

These resources are principally for informing inform staff and volunteer. For survivors themselves, SurvivorScotland, has a large listing of organisations. These sources are examples that may prove helpful, rather than being a comprehensive listing.

Websites

www.survivorscotland.org.uk
The National Strategy for Survivors of Childhood Abuse, developed by the Scottish Government. It aims to raise awareness, improve services, and enhance survivors' wellbeing. It funds a number of support organisations and projects, a national training programme, and initiatives with in-care survivors. The website includes a large national and local help & support section for survivors.

www.jimhopper.com/male-ab/
is regularly updated: with male prevalence statistics, effects, useful book lists and articles, and many other topics.

www.handsonscotland.co.uk/topics/self_harm/general.html
Gives wide range of information about self harm in young people.

www.selfinjurysupport.org.uk/resources
Lists Scottish organisations supporting young people and adults who self harm; explains the issue; give training resources.

www.nshn.co.uk
National Self Harm Network

www.chooselife.net
Choose Life is NHS Scotland's suicide prevention programme. Includes national programme objectives, suicide statistics, training, national campaigns and research.

www.wellscotland.info/guidance/tamfs/reducing/index.aspx
Gives info on reducing suicide, self harm and common mental health problems.

Additional Resources

Edinburgh Crisis Centre, A free and confidential service for short-term support, with capacity for overnight stays up to a maximum of seven days.
Freephone: 0808 801 0414, Textphone: 0808 801 0415, Text: 07974 429075.
Email: crisis@edinburghcrisiscentre.org.uk

Breathing Space is a free and confidential phone line service for any individual, who is experiencing low mood or depression, or who is unusually worried and in need of someone to talk to.
www.breathingspacescotland.co.uk
Tel: 0800 83 85 87

Samaritans provide confidential non-judgemental support, 24 hours a day for people experiencing feelings of distress or despair.
www.samaritans.org.uk
Tel: 08457 90 90 90. Edinburgh and Lothians number: 0131 221 9999.
Address: 25 Torphichen Street, Edinburgh. Email: jo@samaritans.org**.**

PAPYRUS is a voluntary UK organisation committed to the prevention of suicide amongst young people and the promotion of mental health and emotional wellbeing.
www.papyrus-uk.org
Tel: 01282 432 555

Survivors of Bereavement by Suicide (SOBS) attempts to meet the needs and break the isolation of those bereaved by suicide. They have a National helpline which is open from 9am to 9pm daily.
www.sobs.admin.care4free.net
Tel: 0870 241 3337

Examples of Sexual Abuse Training

Scottish Association for Mental Health, Safe to Say, its national training programme, **www.samh.org.uk/samh-training/courses**
These courses are experiential, helping workers feel more confident, competent and aware working with adults of both genders who disclose sexual abuse, with a particular focus on male survivors. There is now a national network of Safe to Say Trainers throughout Scotland, including the Scottish Prison Service. There are courses for frontline staff, supervision courses, and training for trainers. Consultancy work and commissioned training for organisations are also available.
Further information: maureensafetosay@samh.org.uk**.**

Barnardos Scotland: Skylight Project run a number of training courses for professional staff, including social workers and residential staff, working with young people who have been sexually abused. They also consider requests for tailored training. **www.barnardos.org.uk/skylight**
18 and Under, Dundee: Violence is Preventable (VIP) projects
These violence prevention and personal safety projects cover a wide range of ages,

but for instance the Teen VIP programme, which includes DVDs and workbooks, has age-appropriate coverage of sexual exploitation and abuse, domestic abuse and positive relationships which challenge the roots of violence. Includes resources for LGBT and minority ethnic work. **www.violenceispreventable.org.uk**

Training: Suicide Issues

SuicideTALK is an exploration of suicide awareness**; safeTALK** is a course of suicide alertness aimed at everyone; **ASIST** is a course of applied suicide intervention skills training. **STORM** helps frontline workers inhealth, social work and criminal justice services develop the skills needed to assess and manage a person at risk of suicide. For further information on all these courses, please see **www.chooselife.net/Training/index.aspx**

Useful DVDs

Lifting The Lid: Men Who Survive Sexual Abuse As Children (2009). Dir. Sitar Rose: Pilton Video.

This film focuses on men who have survived sexual abuse as children. Three male survivors talk candidly about their experiences. This film aims to reduce the self-stigma associated with this abuse, and encourage men who feel vulnerable to come forward, and to inform staff and volunteers about male abuse. Also available from SAMH: contact maureensafetosay@samh.org.uk.

CHOSEN: Selected, Groomed, Abused (2008). Dir. Brian Woods: True Vision Productions.

Three men describe their abuse at a private boarding school and suggest lessons for the future. 2-Disc educational edition includes an educational licence to screen and additional footage from the original interviews, as a resource for professionals, teachers and parents. Contact:True Vision Productions, 49a Oxford Road South,London W4 3DD. www.chosen.org.uk. This video can also be viewed on-line for a small donation.

JAKE'S JUSTICE (2007): Ryde: Practitioner Alliance Against Abuse of Vulnerable Adults. Produced by Sunny Arts, Lewes, Sussex.

About the sexual abuse of a man with learning disabilities in a care home, and his reactions. The events portrayed highlight the importance of responding quickly and appropriately to signs and signals around adult abuse. The film and accompanying resource book are aimed to be a learning and awareness-raising tool for anyone who may come into contact with people with learning disabilities. It also sets an agenda for agencies to review their arrangements for safeguarding vulnerable people. info@sunnyarts.co.uk

Helpful Resources

Acts of Recovery: Moving on from childhood sexual abuse.

This is an aid for people who have experienced childhood sexual abuse: **www.scottishrecovery.net/images/stories/downloads/acts_of_recovery.pdf**

Reclaiming Our Lives: Workbook for males who have experienced sexual abuse

Drawing on the direct experiences of the two authors' (Jim Campbell and Ron Coleman) personal recovery journeys from sexual abuse – Reclaiming Our Lives *guides the reader through the recovery process. We seek to break the silence, and assist male survivors of all ages to reclaim and recover from their lives in a positive and practical way.* Available at **www.workingtorecovery.co.uk**

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Who Are These Men?

Who are these men who would do you harm?
Not the mad-eyed who grumble at pavements
Banged up in a cell with childhood ghosts.

Who shout suddenly and frighten you. Not they.
The men who would do you harm have gentle voices
Have practised their smiles in front of mirrors.

Disturbed as children, they are disturbed by them.
Obsessed. They wear kindness like a carapace
Day-dreaming up ways of cajoling you into the car.

Unattended, they are devices impatient
To explode. Ignore the helping hand
It will clench. Beware the lap, it is a trapdoor.

They are the spies in our midst. In the park,
Outside the playground, they watch and wait.
Given half the chance, love, they would take you.

Undo you. Break you into a million pieces.
Perhaps in time, I would learn forgiveness.
Perhaps, in time, I would kill one.

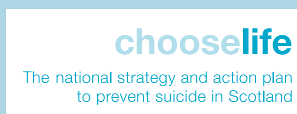
Roger McGough
From *Defying Gravity* (1993), London, Penguin.
With grateful thanks to the author.

understanding me

A history of sexual abuse is common among people who self-harm or feel suicidal. Yet survivors are often ashamed to reveal it, while staff and volunteers are scared to ask – especially if their client group is male.

If your organisation works with men, this booklet may be helpful. It explains some potential effects of sexual abuse and its links with self-harm and suicide. Male survivors themselves describe feelings that can lead to selfharm, and the support they find most helpful.

This booklet suggests how staff and volunteers can overcome barriers to addressing trauma in men they work with. The support and supervision they need is also outlined and useful contacts for those who work with survivors are listed.



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