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## Experienced clinician's understanding and approach to treatment with male survivors of child sexual abuse

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EXPERIENCED CLINICIAN'S UNDERSTANDING AND APPROACH  
TO TREATMENT WITH MALE SURVIVORS  
OF CHILD SEXUAL ABUSE

by

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Bachelors of Arts  
University of Hawaii, Manoa  
2004

A thesis submitted in partial fulfillment  
of the requirements for the

**Master of Science Degree in Marriage and Family Therapy  
Department of Marriage and Family Therapy  
Greenspun College of Urban Affairs**

**Graduate College  
University of Nevada, Las Vegas  
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**THE GRADUATE COLLEGE**

We recommend the thesis prepared under our supervision by

**Blendine Perreire Hawkins**

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**May 2010**

ABSTRACT

**Experienced Clinician's Understanding and Approach  
To Treatment with Male Survivors  
Of Child Sexual Abuse**

by

Blendine Perreire Hawkins

Dr. Gerald Weeks, Thesis Committee Chair  
Professor & Department Head  
University of Nevada, Las Vegas

The number of males abused sexually as children are significant and while the awareness of the needs of this population has increased, the process in treatment has not been sufficiently examined. The purpose of this study was to explore experienced clinicians' approach and understanding within treatment with adult male survivors of child sexual abuse. A qualitative research design was utilized, using purposeful expert sampling procedures. In this study, data was collected from phone interviews with five participants who were identified as highly experienced clinicians in the area of male survivors of child sexual abuse treatment. Using qualitative methods within phenomenological inquiry, several themes emerged as clinical considerations and implications within the assessment, treatment and termination phases of therapy with male survivors of child sexual abuse; respect for client's direction and pace, multi-focus in treatment, somatic interventions, safety to address feelings of shame and inadequacy, and insight used to understand latent effects of the abuse.

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I am immensely appreciative of my five participants who were willing to share with me their joy, challenges, experiences and commitment to the disempowered. Within your words I found hidden jewels of knowledge that only self-reflective and vigilant individuals can offer. The wonderful experts that added depth and breadth to the picture of a clinician's experience -Mikele Rauch, Stephen Braveman, Mic Hunter, Bill Burmester and Ken Singer- I am so grateful for your insight and willingness to share them.

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## CHAPTER 1

### INTRODUCTION

Child sexual abuse (CSA) has been a rising concern for the past few decades with speculations of incidence rates of up to one in eight children being victimized. The rates of CSA in clinical populations are as high as 20-60%, some reporting up to 42% of male adolescents in a treatment setting (Carlin & Ward, 1992; Harrison, Hoffman & Edmall, 1989; Rohsenow, Corbett, & Devine, 1988). Statistics from the National Child Abuse and Neglect Data System (NCANDS), showed upwards of 80,000 reports of CSA cases in 2006 (US Department of Health and human services Administration for children and families, 2009). Retrospective studies have shown that a significant number of children who are abused are males and in general boys were less likely to disclose their experience (Finkelhor, Hotaling, Lewis, & Smith, 1990). It is estimated that currently there are 60 million CSA survivors in the US alone (Pandora's box, 2006). These numbers indicate that a large proportion of clients who present for treatment may have been sexually victimized as children and some may have yet to disclose their traumatic experience.

#### Definition of Male Sexual Abuse

CSA has no universal definition, yet many consider variables such as age difference, the nature of the activity, whether violence or physical

aggression is used, etc. Furthermore, most legal sectors specify that an act of coercion or force when used on a minor to fulfill an adult's sexual desires is deemed sexual abuse. CSA "may include fondling a child's genitals, masturbation, oral-genital contact, digital penetration, and vaginal and anal intercourse" (APA Public Affairs, 2001). The other form of sexual abuse, identified by Gartner, (1999) as non-contact sexual abuse, is commonly viewed as less severe as physical contact. These include such behaviors as exposing genitals to a child, engaging in sexual talk with a child, showing a child pornography and using sexual punishment.

### Significance of the Study

To effectively treat a CSA survivor and his/her family, a therapist must have a knowledge base of the many effects of CSA, the gender response difference, the ongoing impact upon the system, the interpersonal and relational issues common in this population and also the frequent dangers and risks involved in treating CSA survivors. Kessler, Nelson, Jurich, and White (2004) identified the high occurrence of clients who choose to disclose their experience of being abused as children only when they are adults and to a therapist or counselor thus highlighting the usefulness of understanding how a therapist may help this underserved population. While there appears to be a profusion of resources for women survivors of CSA, male survivors are often

disregarded in the literature. My study aims to gain an in-depth awareness and clinical understanding of how clinicians from different fields approach, conceptualize and treat adult male survivors of child sexual abuse.

Because there appear to be key gender differences in the experience of male CSA survivors and the clinicians who treat them, it is crucial to procure an in-depth understanding of the core facets that need to be addressed within the therapy room and effective interventions specific to this population. Adult CSA survivors have reported having difficulties in confiding to their partner, having more frequent arguments, and generally displaying less satisfaction in their intimate relationship (Hunter, 1991; Plant, Miller, & Plant 2007). Consequently the impact of CSA breaches interpersonal relationships (Nelson & Wampler, 2000).

Partners and family members are impacted by personal and individual difficulties, and their response can be helpful or discouraging. The area of attachment and mutual support have been briefly discussed in the research and asserts that interpersonal relationships can act as potential mediators between CSA and its long term effects, even depression (Runtz & Schallow, 1997; Whiffen, Judd, & Aube, 1999). Although some research has begun to explore how the treatment of male and female survivors of CSA may be different in its direction, focus and approaches, this much needed information has yet to be tackled within a systemic context.

## Research Questions

Most authors studying the effects of CSA on males conclude that at this time investigators are only beginning to speculate and postulate the possibility that “adverse effects of CSA are different for men and women” which allows for my research efforts to be apt and elaborative especially when focused on the experience of expert clinicians in treating his population (Alaggia & Millington, 2008, p. 266).

Clinicians who treat adult MCSA survivors contend with issues of emotional intensity related to traumatic experiences, transference and countertransference, sexual issues and many other loaded areas within treatment. Furthermore, it appears that sensitivity and awareness may be especially crucial when working with this population. The approach to treatment and how theories play out is also important in shaping a clinician's expectations and direction.

This study aims to answer the question: How do experienced therapists understand and treat male CSA survivors?

## CHAPTER 2

### REVIEW OF THE RESEARCH

In this section, I will briefly review the findings and themes present in various research publications and books pertinent to the treatment of CSA, and highlight some areas that have been overlooked within the research.

#### Effects of Child Sexual Abuse

Much research has been conducted exploring the many effects of CSA and the findings have shown that the negative impact is both persistent and increasingly reinforcing. Individuals who have been sexually abused reported higher levels of general psychological distress and higher rates of both major psychological disorders such as PTSD, depression or antisocial behavior and personality disorders like Borderline personality symptoms and also higher levels of substance dependence than nonabused subjects (Beitchman, Zucker, Hood, DaCosta, Akman, & Cassavia, 1992; Horwitz, Widom, McLaughlin, & White, 2001; Hyman, Gold, & Cott, 2003; Putnam, 2003; Ray, 2001; Ullman & Filipas, 2005). In addition, CSA survivors reported higher rates of substance abuse, binge eating, somatization, spiritual distress and suicidal ruminations than nonabused participants (Fater & Mullaney, 2000; Krug, 1989; Ratican, 1992; Young, Harford, Kinder, & Savell, 2007). Adult survivors of CSA display poorer social and interpersonal relationship functioning,

poorer coping skills, greater sexual dissatisfaction, dysfunction and maladjustment including high-risk sexual behavior, and show a greater tendency toward revictimization through adult sexual assault and physical partner violence (Allen, Huntoon, Fultz, Stein, Fonagy, & Evans, 2001; Chauncey, 1994; Dhaliwal, Gauzas, Antonowicz, & Ross, 1996; Dolezal & Carballo-Diequez, 2002). While the focus of many studies has been on the individual psychopathology of CSA survivors, some have noted that long-term relationship issues persist within this group. Allen Huntoon, Fultz, Stein, Fonagy, & Evans, (2001) revealed that in a sample of women in an inpatient treatment institution for trauma related psychiatric disorders, the desire for attachment was present despite the findings that patients with trauma-related disorders have fewer secure attachments and more insecure attachments than persons without such disturbance. While this study looked at a group of individuals who were both engaged in a romantic relationship and those who were single, the findings have implications for interpersonal issues that CSA survivors face.

#### Male vs. Female Experience of CSA

The focus of many gender and CSA studies have been the nature and characteristics of abuse on both genders, (Gold, Elhai, Luckenko, Swingle, & Hughes, 1998; Kendall-Tackett, & Simon, 1992) and some detail the effects of CSA (Ketring & Feinhauer, 1999; Young, Harford,

Kinder, & Savell, 2007; Young, Bergandi, & Titus, 1994). Researchers have only recently begun to explore the gender difference in effects, response and treatment of sexual abuse and a few studies have uncovered the effects of sexual abuse that are particular to male survivors. White (1988) hypothesized that men and women respond differently to sexual abuse by showing different patterns of symptomology. In Horwitz, Widom, McLaughlin, and White's (2001) study, results indicate that men who were abused and neglected as children have more dysthymia and antisocial personality disorders.

Fater and Mullaney (2000) conducted a thorough phenomenological study with males who had been abused by members of the Catholic clergy and discovered unique themes of the impact of sexual abuse. Participants reported recalling the trauma with a sense of pervasive powerlessness, being tormented by fear, guilt, shame and loss of spirituality, feeling overwhelmed with depression and thoughts of suicide, and having the abuse invade all areas of their life resulting in "self-sabotage, negative self-perceptions, altered relationships, and estrangement from support systems" (Fater & Mullaney, 2000, p. 289). While the results from this study may not be generalized to homogenous population of MCSA survivors, themes within these findings appear to corroborate other research regarding trauma symptoms.

Some studies did not find a difference in the symptomatology between both sexes, reporting that all survivors of CSA had "significantly higher

levels of global mental health problems, hostility, paranoid ideation and psychoticism" (Young, Harford, Kinder, & Savell, 2007, p. 1315). These researchers, however, also suggests that these mental health problems while found in both sexes can manifest differently in men than they do in women; internalizing symptoms in women and externalizing behavior in men.

A few researchers have found variances in the symptomology between male and female survivors. Hunter (1991, p. 215) reported that there were many similarities between both sexes; however, males evidenced increased signs of "heightened levels of anxiety, worry and rumination, particularly related to identity issues". Lev-Wiesel's (2000, p. 2), study discovered that male survivors "judged their quality of life as less satisfactorily" than did female survivors. The sexual abuse experience, along with coping, disclosure and the reaction of others can be very different for a male survivor (Ullman & Filipas, 2005). While women may seek emotional support and receive it more readily helping them cope with the hurt, the culture that we live in has somewhat proscribed vulnerable emotional expression from men. Consequently, the coping skills, the act of disclosing a sexual abuse, and the response that a MCSA survivor experiences can vary drastically from what a woman experiences. Alaggia and Millington (2008) succeeded in uncovering the core aspects of child abuse as it pertains to males; its prevalence and incidence, the growing research, discrepancies in reports of male child



sexual abuse (MCSA) and possible reasons for these limitations. Such symptomology as anxiety, suicidality, substance abuse and externalized aggressive characteristics were noted as more prevalent in MCSA survivors. Male participants in their study identified distinct themes in their childhood age and as adults. These themes were such as denial, early sexualization, confusion around their role and responsibility in the abuse, specialness, and later as adults the themes of anger and rage, sexual disturbance and ambivalence, and loss and hope. Dimock (1988) found that his sample of male survivors displayed three common characteristics; sexual compulsiveness, masculine identity confusion, and relationship dysfunction.

A segment of researchers speculate that when differences arise they have a social basis related to gender roles and rules (Banyard, Williams, & Siegel, 2004; White, 1988). Friedrich (1995, p. 8-13) identifies 9 aspects that distinguish the experience of male survivors to female survivors; physical abuse history differences, externalizing vs. internalizing, maternal support differences, language as a moderator, socialization for group work, feelings identification, conversation as posturing vs. listening, differences in severity of abuse and gender differences in sexuality. Some, however, postulate that both genders are equal in their response because despite social power, resources and the feminist perspective, sexual abuse strips all its victims of power and makes them helpless and vulnerable (Finkelhor & Browne, 1985; Hare-

Mustin & Maracek, 1990). Furthermore, these researchers note that this learned helplessness can overwhelm a person, whether they are male or female.

The response to CSA may be similar in male and female survivors - despite a segment of studies challenging it- however the trauma may be different based on physiology and demographics. Some articles displayed the possibility that sexual abuse when perpetrated against males appeared to have significantly greater use of threats and force. Not only do these effects and symptom manifestation appear to be dissimilar between sexes, the actual types of experience may generally differ in these two populations (Kendall-Tacket & Simon, 1992). Early researchers contending with this unexplored area of MCSA uncovered that males abused were more likely to live with their mothers and have no father in the home, and once identified as victims, received less treatment than did females (Sheldon & Sheldon, 1989). The literature has consistently shown that 80% of male sexual abuse victims' perpetrators are male, a slightly higher percentage of males are molested more than once as compared to females who are molested, and the mean age of males who are molested is eight years old (Hunter, 1991). Another study discovered that male survivors were more likely than female survivors to have had oral sex performed on them by the perpetrator (Gold, Elhai, Luckenko, Swingle, & Hughes, 1998). These basic demographic differences highlight

the important variance between the genders and furthermore the need for a unique approach and conceptualization of MCSA.

Despite the debate of whether sexual abuse greatly affects male survivors and the few studies detailing no difference in impact between genders, a few variables prevent accurate data. While researchers have worked hard to construct superior methodology and data collection methods, the paucity of male samples and the disinclination to disclose abuse continues to obstruct a systematic and comprehensive representation of the many aspects of MCSA. While there is more to explore on the gender differences in CSA experiences, this study hopes to present this distinction by focusing primarily on the treatment of male survivors. Some unique features within treatment will be highlighted, yet it is beyond the scope of this paper to extensively compare the treatment of male and female survivors of CSA.

### CSA Effects on Relationships

The effects of sexual abuse are prevailing, both in a victim's personal and social life. Young, Bergandi & Titus (1994, p. 302) studied school aged children who had been sexually abused and found that they were "more aggressive, socially withdrawn, overly sensitive to others' opinion, lacking in appropriate social skills, and exhibiting inappropriate sexual behavior". Sexual abuse is traumatic and those who endure it are made to feel helpless, confused and vulnerable. These characteristics can

become an enduring filter for how a survivor responds and interacts with others thus influencing every relationship. One study has documented the relationship difficulties present in couples where the female partner is a CSA survivor. Chauncey (1994) found that there were several areas of concern in male partners of CSA survivors; conflicting needs, difficulty with closeness, difficulties with spontaneity and unpredictability, anger, guilt and shame, sexual relationships, survivor's improvement and relatives. These self-reported issues identified by partners of CSA survivors evidences a reciprocal affect within a relationship where one partner has been sexually traumatized.

Intimate relationship difficulties have been observed in MCSA survivors (Dhaliwal, Gauzas, Antonowicz, & Ross, 1996; Krug, 1989). Nelson and Wampler (2000, p. 171) also found that "couples in which one or both partners reported childhood abuse, reported significantly lower marital satisfaction, higher individual stress symptoms, and lower family cohesion than couples with no abuse history". Moreover they discovered that unabused partners of abuse survivors also showed higher symptomology, compared to couples where neither were abuse survivors, indicating a secondary trauma effect. While few researches have studied the continuing social and interactional effects of sexual abuse in adults, fewer still have examined the couple relationship where the CSA survivor is the man.

## Attachment and Support

The mediational model has been useful in conceptualizing and treating CSA from a systemic framework. This model advocates the intervening effects of a social support system in cases of abuse and derives from the attachment theory. When an abused individual is able to disclose of his/her experience, depend on strong social or familial support and is not mistrusted, disregarded or concealed, he/she has a higher chance of recovering (Liem & Boudewyn, 1999; Tremblay, Hébert, & Piché, 1999). One does not have to subscribe to Bowlby's theory of attachment to understand that the impact of being deeply betrayed by those who you expect to be able to trust and depend on, can shift your world view and mar later relationships, reinforcing or healing hurt and anguish. CSA occurs in a relationship context thus can cause a disruption in the normal development of forming attachments with others. The long-term correlates of CSA are conceptualized within the systemic theoretical framework based on a theory of emotional avoidance (Polusny & Follette, 1998). A deep distrust of others coupled with a profound desire to engage in intimate relationships can develop into a conflictual pattern of relationship problems. With the postulation that a strong support system can mediate the effects of CSA in childhood, researchers began to explore whether a strong support system in adult survivors can help the healing process. Findings have shown that adult attachment styles -often within a marriage- mediates the relationship

between CSA and psychological adjustment (Godbout, Sabourin, & Lussier, 2008; Roche, Runtz, & Hunter, 1999).

One study showed that both male and female CSA survivors have “more difficulty in confiding in a partner and (have) more frequent arguments with a partner” (Plant, Miller, & Plant, 2007, p. 49). There is also some evidence of male survivors having difficulty maintaining intimate relationships and being faithful to their partners (Dimock, 1988; Mendel, 1995). It appears that aspects of the relationship with the sexual aggressor remains and is displaced in later intimate relationships. Dorais (2002, p. 110) postulates that the “aggressor’s imposition of his own rules and desires blocks a young man’s development of a sense of autonomy, including that needed to free himself from the control imposed upon him by the observer”. Because relationships consists of two individuals who have their own set of values and expectations, the lack of autonomy and a coherence of self appears to be counterproductive to a successful relationship.

#### Gender in Relationships

Male CSA survivors are different from their female counterpart not just in the area of biology and physiology but the culturally informed gender roles that they learn and by which they live. There are traits often associated with the traditional male role; Corey and Corey (2010) identify emotional unavailability, independence, power and aggressiveness, denial of fears, protection of inner self, invulnerability, lack of bodily self-

awareness, remoteness with other men, denial of feminine qualities, avoidance of physical contact, and rigid perceptions. Larson, Newell, Holman, and Feinauer (2007, p. 175) suggest that because MCSA survivors often internalize problems such as depression, anxiety and avoidance, they may be unable to engage in secure relationships and “seriously hamper (their) successful completion of age-appropriate developmental tasks”. Lamb and Edgar-Smith (1994) found that male survivors disclosed less often than females and that not being blamed was perceived as the most supportive response received from others. Some may go as far as to postulate that the higher occurrence of victim to perpetrator roles among males evidence the sex difference in experience and response of sexual abuse (Dorais, 2002). Most studies of CSA impact have not explored the interactional aspects and difficulties between a couple where the male is a sexual abuse survivor, instead research has focused on abuse characteristics, coping and attributes.

Sorsoly, Kia-Keatng, and Grossman’s writings paralleled previous articles in their assertion that the topic of MCSA is a less studied occurrence despite estimates of upwards of 16% of men reporting some form of sexual abuse and the possibility of underreported or limited disclosure (2008). These authors who describe themselves as “constructivist-interpretivist clinically oriented, feminist researchers” focus on the complicated phenomenon of disclosure and its rates, patterns and unique themes as it pertains to men (Sorsoly, Kia-Keatng,

& Grossman, 2008, p. 335). Their results uncovered barriers to disclosure deriving from personal, relational and socio-cultural contexts which can continue to stigmatize and cause severe inner conflict in male survivors. This factor appears to be a prevalent feature of MCSA and ultimately an important aspect for clinicians to be sensitive.

Due to the inchoate findings which show symptoms of vicarious traumatization, patterns of marital discord and low relationship satisfaction in couples where one is a CSA survivor, it would appear useful to conceptualize symptomology, diagnosis and treatment within a relational framework.



## CHAPTER 3

### TREATMENT OF CSA

CSA treatment approaches vary according to the focus, direction and aim of treatment. Curtois (1988) identified that early therapist utilized treatment conceptualization deriving from psychoanalytic traditions, feminist theory, traumatic stress or victimization theory, self developmental theory and loss theory. Family therapists by virtue of holding to systemic philosophy, can be effective as helping professionals to this client segment due to the relational dimension of betrayal which exists in CSA. While the mental health field continues to expand and evolve, there is still a dearth of information and knowledge pertaining to the treatment of MCSA.

#### Treatment Modality

Within treatment, male survivors may choose to present for treatment individually or join a group specialized to treat CSA. Much like a survivor's experience within individual psychotherapy may vary from one therapist to another, groups can be vastly different depending on their focus, leadership and setting.

#### Individual Modality

CSA has traditionally been treated individually, owing to the idea that survivors should be allowed the privacy to express their anger and hurt without possible feelings of shame in the presence of others. Margolin

writes that individual therapy can initially “benefit most victims of trauma by allowing the development of a safe and trusting relationship in which to disclose the trauma, express, explore, and validate emotions and experiences, and teach affect regulation (1999).

Many CSA survivors may present for treatment initially with mood and anxiety disorders, substance use, eating disorders and other conditions which could be fairly individual in their focus. These symptoms can be connected to a history of sexual abuse and clients often disclose this in the course of treatment. Within individual therapy, the approach can be tailored to the pace and specific needs of the client unlike treatment that involves other individuals. Romano and De Luca found that this treatment modality showed possible effectiveness in reducing feelings of self-blame, anger and anxiety (2006). Often the trauma resulting from sexual abuse results in posttraumatic stress disorder (PTSD) and within individual therapy, a clinician can help the client explore and resolve the current effects of this victimization. Additionally, many consider trauma as an experience which impacts an individual’s identity and sense of self. Individual therapy is suitable in addressing these deep psychological issues.

#### Group Format

Early treatment models considered for males appeared to extract aspects of female survivor groups and treatment. One resource for treating sexually abused boys found in the literature, utilized a feminist

perspective by using the phenomenon of empowerment as the foundation of treatment (Camino, 2000). Dimock (1988) suggested the use of a male therapist and male support groups with key areas of focus such as assessing compulsive behavior, sexual abuse, psychopathology and abuser potential, and validation, an encouragement of expression, learning to separate the past from the future and confronting the abuser. Bolton, Morris, and MacEachron (1989) were also proponents of using group treatment with a final focus on confronting the abuser and mapped out a list of multi-remedial techniques targeting interpersonal dysfunctions, sexual dysfunction and deviant sexual responses, within a group modality of treatment.

There are different types of male survivor groups, namely ones which are psychoeducational, support groups and groups which are purely psychotherapeutic. The goals, direction and interactions within groups differ depending on its structure. Within psychoeducational groups, the facilitator focuses on knowledge and guidance, while intrapersonal exploration may not be the main aim. Psychotherapeutic groups which are often conducted by clinicians and are closed groups, endeavors to remediate in-depth psychological problems. At times groups such as support groups are led by non-professional facilitators and these groups resemble those in the 12-step tradition.

Goals within survivor groups include such as “decreasing feelings of isolation, stigma and shame, challenging survivors’ perceptions of

themselves as different, increasing feelings of self-esteem, instilling hope for recovery, developing trust in others and developing a social support network” (Draucker, 2000, p. 115). Yalom, in speaking about the notion of universalism found within the bounds of group therapy states that it is particularly useful to be validated and accepted by others for individuals for whom “secrecy has been an especially important and isolating factor” (1995, p. 7).

### Theoretical Approaches and Models

The other crucial element of treatment with adult male survivors of CSA is a clinician’s theoretical and philosophical view. Margolin proposes that treatment with survivors should be “guided by certain philosophical values”, among which are empowerment, recovery within relationships, collaboration, education, integration, accountability and pacing (1999, p. 15). The theory, led by underlying philosophical assumptions, is the lens by which a clinician uses to understand the presenting problem, to choose areas to focus on in assessing and treating the client, and can shape the roles and expectations within the therapy room. Among the theories used in the treatment of CSA, the literature explores Psychodynamic, Experiential and Cognitive-Behavioral therapy. Within those three factions, many models and techniques have developed to address treatment with survivors.

### Psychoanalytic Approach

A clinician subscribing to psychodynamic philosophy may hold the belief that many unresolved and unconscious issues within the psyche have to be uncovered for a survivor to resolve his trauma experience. Often this approach is both “nonintrusive and nondirective, with little explicit attempt to shape or guide the therapy experience, although such passivity may mold in its own ways” (Gonsiorek, Bera, & LeTourneau, 1994, p. 27).

Gartner, in his book, describes such areas as encoding of sexual abuse as sexual initiation, struggles about masculinity, the effect of chronic boundary violations and intimate relatedness, which are useful to address (1999). While these issues may be present within any treatment approach, the manner in which a clinician intervenes is unique depending on his theoretical orientation.

### Experiential Approach

Another approach which can be connected to psychodynamic techniques is the experiential approach which developed out of existential and humanistic philosophy. The basic commitment is towards individual awareness and self-actualization. A therapist utilizing this theory aims to help the client expand their emotional experience within the immediate here and now. A common theory within the Experiential approach, Gestalt therapy was established by Fritz Perls and holds that

the basic philosophy is “that of nature- differentiation and integration” (Stevens, 1975).

Techniques that may be employed within the experiential approach are externalizing feelings, the empty chair, role playing and using art, dance or drama to facilitate expression and re-experiencing the body. Velsor and Cox (2001) demonstrated the effectiveness of using anger expression as a mediating force to recovery in treatment with female CSA.

Spiegel, recognizing the need for treatment specific to male survivors, put forward the Sexual Abuse of Males (SAM) model which has been used for both individual and group treatment modalities (2003). The essence of SAM is to help a male survivor “explore, identify, and express the dynamics and effects of his experience of CSA and to bring back to its original and authentic state the meaning emanating from the abuse” using experiential techniques (p. 365). SAM treatment outcome studies have evidenced clinically significant improvements in the areas of mood, trauma symptomology, distorted thinking, and feelings of blame, guilt and shame.

### Cognitive-Behavioral Approach

Within the cognitive-behavioral theory, focus is often placed on identifying and analyzing distorted thoughts, and aiming to replace them with accurate ones. This thought restructuring is achieved through

examining and monitoring automatic cognitions and reactions for distortions and adopting accurate alternatives.

Cognitive behavioral techniques for use with survivors of sexual abuse are reframing, decatastrophising, self-talk, and desensitization (Sanderson, 1990). Owens, Pike, and Chard (2001) postulated a connection between cognitive distortions and the severity of PTSD in their clinical study using cognitive processing therapy. Significant improvements were noted in participants, however they were all female.

#### Other Models

Other models commonly used in treatment with survivors of trauma that are worth noting are Eye Movement Desensitization Reprogramming (EMDR) and 12-step for survivors of sexual abuse.

EMDR is an information processing therapy past experiences that have set the groundwork for pathology, the current situations that trigger dysfunctional emotions, beliefs and sensations, and the positive experience needed to enhance future adaptive behaviors and mental health (EMDR Institute Inc., 2004). In treatment a client engages in dual stimulation using bilateral eye movement, tones or taps which works to encourage insight and new associations. This approach has been recommended as effective treatment for trauma (American Psychiatric Association, 2004).

Another model that has reached wide acclaim is the 12 step program for survivors. These groups grew out of the spiritually-based, peer-

support traditions of Alcoholics Anonymous (AA) groups started in the early 1950's. Generally, the survivor groups are facilitated by peers and those who have had a history of sexual trauma or incest. The 12 step program can be useful due to its flexibility and accessibility in that there are multiple groups available and most are free. Survivors may proceed through the 12 steps at his own pace with a mentor. Sanders wrote a functional book for male survivors to use in their 12-step recovery process which outlines activities, journal exercises, and lists of affirmations. Within this program, individuals have 12 steps that help in recovery adapted for survivors; "acknowledgment, belief, awareness, self-examination, admission, healing, forgiveness, specifying amends, making amends, daily growth, seeking serenity, courage and wisdom, and new life" (Sanders, 1991, p. 7-8).

#### Systemic Treatment with MCSA Survivors

Few resources conceptualize the treatment of male CSA within a systemic frame although it can impact the spouse and children of the survivor. Teram Stalker, Hovey, Schachter, and Lasiuk (2006) offer an innovative lens termed 'malecentric communication' which can assist in overcoming the barriers to the acknowledgement of MCSA by both survivors and those who help them. Any perceived skepticism or disbelief from a health care professional, the common attitude of a lack of concern regarding the sexual abuse of a boy by a woman, feeling of homophobia, and the stigma of the male survivor becoming a potential perpetrator



among other things can deter a survivor from disclosing their abuse experience to their partner or even seeking treatment.

Within a marriage and family where the male spouse has been sexually abused as a child, very specific issues and problems can arise. It appears that it would aid treatment if a therapist can address systemic and reciprocal effects of trauma on the romantic or parent-child relationship. Familial and marital partner support can be a mediator for effective treatment and recovery. Johnson and Williams-Keeler notes that spousal relationships which are more secure can help the survivor process their traumatic experience and “re-establish a sense of safe connection with others” (1998, p. 37).

Reid, Wampler, and Taylor (1996) highlight the need to include partners in the therapeutic process for the treatment of CSA survivors, calling these partners secondary victims of the abuse. Because the primary focus of treatment has been to understand the abuse experience from the perspective of the survivor, "ignoring current relationship issues when treating childhood sexual abuse ignores how the abuse issues are played out in the relationship" (Reid, Wampler, & Taylor, 1996, p. 444).

With the increased understanding of attachment and how it is affected by relational traumatic experiences such as CSA, the mediational model is often used in case conceptualization. A few studies have continued to show evidence for the utilization of this model in treatment, however many were conducted with only female participants.

Roche, Runtz and Hunter (1999, p. 20) hypothesize that exposing a survivor in therapy to new interpersonal experiences may “help modify the implicit expectations of self, others, and relationships, thereby altering the attachment style and ultimately improving psychological adjustment”. This is most ideally achieved with the inclusion in treatment of a survivor’s immediate support system.

In MacIntosh and Johnson’s (2008) study of CSA survivors and their partners with Emotion-Focused Therapy (EFT), "half reported clinically significant increases in mean relationship satisfaction" and half reported "clinically significant decreases in trauma symptoms" (p. 309). While this study evidenced the usefulness of treating couples when one partner is a survivor of CSA -therefore necessary to refer to, especially with the use of a systemic theory-, all the survivors in their study were also female making the results less generalizable to the male population. When the effects of abuse are associated with the systemic functioning of a dyad or family system, it is necessary to refer to the professionals who approach treatment in this manner. Nelson and Wampler (2000) note that the systems-theory concept of mutual influence has been used to describe the impact of individual symptoms on another giving further support to the phenomenon of secondary trauma within relationships. Hunter (1991) reported that the areas of dysfunction in adult CSA survivors were "self-esteem, dyadic relationship functioning, sexual adjustment and general emotional adjustment" even displaying less satisfaction in their

intimate relationship. When a partner's experience negatively impacts him/her in a manner which pervades all his/her interactions which in turn is reciprocated or responded to in a repeated fashion, it is logical to use a systemic frame of conceptualization.

Furthermore these studies confirm that there is a need to include partners in the treatment of CSA "for initial discussions of the likely time-frame for the survivor's therapy, a description of likely behavioral and emotional changes that will be seen at home, information on available resources, and possibly a discussion of possible goals for conjoint therapy, including sex therapy" (Wilson & James, 1992, p. 450).

Narrative treatment approaches have been proposed for use with CSA with the aim of moving clients towards a sufficient distance to construct their story and gaining power in their voice. While the process of this treatment approach has been discussed the effectiveness has yet to be confirmed (Etherington, 2000). An article by Sheldon and Sheldon (1989) gave a description of a case study using a treatment model known as neurolinguistic programming (NLP) deriving from the models developed by Virginia Satir, Fritz Perls and Milton Erickson. While the strategy appeared to be successful for an adult MCSA survivor, further studies are needed to establish this approach as a treatment of choice. Dolan proposed a solution focused approach with a component of Erisksonian hypnosis to therapy with survivors of CSA (1991). Within this treatment,

supportive family members are invited to sessions and to assist survivors in healing ways.

It appears that a relational focus can be a useful approach to treatment considering the interpersonal effects of betrayal and trauma. Additionally, social and familial support, during and after the sexual abuse experience is a resiliency factor in the recovery process.

### Lack of Research and Treatment Guides

Despite its prevalence rates among male and female children, the focus of studies in sexual abuse has been on female survivors or on both sexes as a homogenous group. Some researchers have suggested that female survivors of CSA have greater and more traumatic affects from their experience than males do (Horwitz, Widom, McLaughlin, & White, 2001; Fiering, Taska, & Lewis, 2002). Gonsiorek, Bera, and LeTourneau (1994, p. 49) go as far as to label this position as the myth of gender stereotyping and note that this can “often encourage repression and denial” in male survivors. Ullman and Filipas (2005, p. 768) speculated that the "bias of males underreporting CSA and its consequences" may increase the appearance of greater effects in women survivors.

As noted previously research has mainly focused on the affects of CSA, demographics and narrow aspects of treatment such as the ‘disclosure’. Initially many overlooked male victims and when researchers began exploring this population, male children and adolescents were the

focus. A number of studies pursue the victim-abuser or victim-victimizer focus when studying the male survivor population (Burton, 2003). Social learning theory lends to the rationale of how the experience of sexual abuse may predispose one to offend in the same manner. Deriving from this idea is the support for preventive measures in the way of treatment, however, there exists a dearth of effectiveness and efficacy research (Bagley & King, 1994; Biere & Runtz, 1989; Itzin, 2001). A number of books have been written on the experience of MCSA, assessment and treatment planning, and conceptual models for use with male children and adolescents (Bolton, Morris, & McEachron, 1989; Camino, 2000; Dorais, 2002; Friedrich, 1995; Gonsiorek, Walter, & LeTourneau, 1994). Far less resources exists for adult male CSA survivors.

Adult survivors of CSA seek treatment for a variety of reasons related to the long term effects of their traumatic experiences. While there are many resources for recovery for women CSA survivors and treatment guide books for clinicians treating female CSA survivors, male-focused sexual abuse has been scarce, limited in their scope and lacking within the field of Marriage and Family Therapy. The fields of Psychology and Marriage and Family Therapy offers useful ways in which the treatment of CSA can be conceptualized, yet these frameworks have no empirical support for use with male survivors. Research considerations for treating CSA are both varied and limited to a female sample with the risk of not being able to be inclusive or effective with a male population.

Few treatment interventions for MCSA have been discussed in the literature and fewer still have been empirically tested for efficacy. Many resources provide therapeutic guides for use with male children and adolescents who have been sexually abused with a beneficial focus on the family system as a source of support within treatment. Friedrich (1995) put forward a model in treating adolescents using attachment, disregulation and self theory, combining the different strengths of treatment modalities to form a comprehensive approach to MCSA for adolescents.

Young, Bergandi and Titus (1994) noted two very valid reasons why the research and treatment of MCSA had far lagged behind female sexual abuse. They highlighted the evolution of treatment models for sexual abuse which originated from the rape model; the model conceptualizing abuse as primarily that of a female victim and a male perpetrator. This is why many early studies overlooked males as victims. Another reason derives from the common social mores of gender roles. It is socially compatible to envision women as vulnerable yet particularly difficult to comprehend males as subjects to victimization. Additionally, Young, Bergandi, and Titus (1994) hypothesize that there is a strong cultural bias that maintains that males cannot be victimized and that the victimization does not have psychological effects on males. This may be an added perspective on why there is male's hesitance to report or disclose sexual abuse which possibly causes inaccurate rates of MCSA.

A limited number of descriptive and experimental studies documenting clinicians experience treating adult male survivors exist presently. A computer search for "adult male" and "sexual abuse" and "treatment/therapy" including current Psychinfo, ERIC and Medline databases yielded a small amount of studies focusing on male survivors, of which a limited number explored treatment issues and none delved into the clinician's experience in treating MCSA. A search through the library holdings produced eight books addressing treatment of male CSA, and did more to examine the experiences of clinicians.

### Self of the Therapist

The therapist's experience treating survivors of CSA can be a challenging one. Due to the lack of resources and treatment models available for working with male survivors, clinicians may feel ill-equipped to handle the tumultuous therapy process that is often involved with issues of trauma. Some research have identified that for those clinicians who primarily treat sexual abuse survivors, self-esteem and self-care can be negatively impacted (Way, Van Deusen, & Cottrell, 2007). A treatment plan informed by clinical research, experience and an expanding knowledge base can help a clinician conceptualize and guide treatment effectively. Without an awareness of smaller goals within treatment, safety plans, options for interventions and markers of recovery, a therapist can feel overwhelmed with the weighty content in sessions.

Comorbidity or co-occurring diagnoses is another area which clinicians may encounter often in treating MCSA survivors. Anxiety, suicidality, substance abuse, and depression have been observed to have high incidence rates in this population (Alaggia & Millington, 2008; Horwitz, Widom, McLaughlin, & White, 2001; Lev-Wiesel, 2000). Clients may present with lower coping skills, externalized aggressive characteristics, relationship dysfunction, sexual compulsiveness and masculine identity confusion. These symptomology can obscure immediate and ultimate goals which may discourage clinicians and cause them to lose focus and direction in treatment.

Additionally, there can be a degree of emotional intensity involved within the therapeutic process of treatment with an adult male survivor. As referred to earlier, secondary trauma or vicarious trauma is a phenomenon that can occur for those who connect closely with a CSA survivor. Much like the emotional reactivity and reciprocity which fuels patterns of interactions, the effects of trauma can be communicated and responded to in maladaptive ways. Curtois noted that the therapist reactions to such emotional encounters with a client's sexual trauma may be of fear, horror, denial, grief, guilt, pity, a sense of voyeurism and possible sexualization of the therapeutic relationship (1988).

For a clinician, transference and countertransference within treatment is an area of concern. Clients may be sensitive to the gender, appearance, tone of voice or other characteristics of a person which may



inadvertently create a roadblock within sessions. With survivors, these feelings which may come in the form of a flashback or memory may be particularly arousing, intense and severe. There is a great need to address or manage transference issues in treatment.

Another consideration important for clinicians concerns the treatment modality and theoretical approach. Depending upon the clinician's specialty and training, an individual or group modality may be employed. Psychologists may focus on intrapsychic aspects of trauma and recovery or the distorted cognitions arising from the trauma, while Marriage and Family Therapists or clinicians that possess a systemic view may conceptualize the client's family of origin and current relationships as disadvantageous or mediating factors in his recovery. These decisions clinicians make rests on their assumptions about treatment, human problems and strengths, and ultimately the process of change.

The questions arise: How do clinicians manage these relevant concerns and what informs treatment?

### Study Rationale

There is a significant amount of literature documenting the negative long-term effects of CSA (Allen, Huntoon, Fultz, Stein, Fonagy, & Evans, 2001; Beitchman, Zucker, Hood, DaCosta, Akman, & Cassavia, 1992; Chauncey, 1994; Dolezal & Carballo-Dieiguez, 2002; Fater & Mullaney, 2000; Horwitz, Widom, McLaughlin & White, 2001; Hyman, Gold & Cott,

2003; Krug, 1989; Putnam, 2003; Ray, 2001; Ullman & Filipas, 2005; Ratican, 1992; Young, Harford, Kinder & Savell, 2007). The experience of CSA can be different for males and females, be it from a gender role perspective or the details and response to the trauma (Horwitz, Widom, McLaughlin & White, 2001; Hunter, 1991; Lev-Wiesel, 2000; Banyard, Williams & Siegel, 2004; White, 1988). Male CSA survivors face intimate and familial relationship difficulties (Dhaliwal, Gauzas, Antonowicz & Ross, 1996; Krug, 1989; Nelson & Wampler, 2000; Plant, Miller & Plant, 2007). While there are useful resources and treatment guides for use with adult male CSA survivors (Crowder, 1995; Etherington, 2000; Gartner, 1999; Gonsiorek, Bera & LeTourneau, 1994; Hunter, 1995; Mendel, 1995) no research study has explored the in-depth process of treatment of clinicians who have had extensive experience treating adult male survivors of CSA.

The present study aims to explore the experiences of expert clinicians in their conceptualization and decision-making when treating adult male CSA survivors using a qualitative method of inquiry. My explorative study aims to garner a holistic view of the process of treatment in areas such as the assessment procedure, interventions utilized in real world settings and their rationale, common challenges and risks faced, implications from the client's spousal relationships, and other important topics that should be addressed from the experience of expert clinicians. The goal is to analyze and combine the understandings and perspectives

of experts to gain a comprehensive understanding of how to approach treatment with male survivors of sexual abuse. I would like to answer the questions: How do experienced therapist understand and treat male CSA survivors, and what can we gain from such in-depth discourses?

## CHAPTER 4

### METHODOLOGY

The purpose of this study is to examine the experiences of expert clinicians in the treatment of adult male CSA survivors. Prior research has focused on specific topics within male CSA such as gender and sex issues, and risk of later perpetration while using mainly quantitative methods. The very nature of sexual abuse in adult male populations make it historically difficult to study due to under-reporting and variable focus in treatment. While there are guides and resources for therapy with this population, the expert or experienced clinician's understanding and decision-making within the process of treatment with male survivors has largely not been explored. For these reasons, a qualitative approach was chosen to obtain the essence of the phenomena of treatment with adult male survivors.

Qualitative methods are often used to explore in-depth processes that have yet to be extensively examined. This study utilized qualitative descriptive inquiry to investigate the clinician's perspectives of treatment with male CSA survivors. Creswell (2007) noted that the primary enterprise of phenomenological study is to describe "the meaning for several individuals of their lived experiences of a concept or a phenomenon" (p. 57). Additionally this method is "used to obtain intricate details about phenomena such as feelings, thought processes, and emotions that are difficult to extract or learn about through more

conventional research methods” (Strauss & Corbin, 1998, p. 11).

Because, the area of treatment with male survivors of child sexual abuse had not been studied extensively, using a phenomenological approach was optimal to conduct an in-depth study of treatment, such as the decision making process, components within treatment, and the therapeutic relationship. This methodology generates experiential data which can contribute to credible theories and is an effective means for exploring the practice of clinicians treating adult MCSA. While the data was approached using phenomenological philosophy, a purely descriptive qualitative method was utilized to present the results and findings in this paper.

The clinicians were chosen due to their expertise with this population to ensure that a collection of actual treatment options was acquired from those who have both knowledge and experience on treatment with adult male survivors. The experts were screened for their systemic considerations -whether they take into account a client’s relationship with partners and family- in making treatment decisions, when they were contacted by phone and email. A 60 minute phone interview was scheduled where the clinicians were asked a set of questions on their conceptualization of treatment with this population. The interviews were digitally recorded and then transcribed. The transcribed data was analyzed and coded for themes and shared perspectives using procedures explained further in the data analyses section.

## Participants

Certain criteria were used in selecting panelists in this study to ensure that the sample represented individuals who are experienced in the area of CSA treatment. Panelists were required to meet at least two of the following criteria:

1. have at least five years of clinical experience as a licensed clinician
2. have had at least 2 cases involving the treatment of adult male survivors of child sexual abuse
3. have presented at one or more state or national conferences on the subject of child sexual abuse
4. has published one or more journal articles or a book or given a professional presentation on the topic of trauma and child sexual abuse

Several recruitment methods were used to select a group of expert panelists. I identified prospective panelists by using an academic search of authors who have written journal articles, books and other publications on the area of CSA. In addition to this avenue, I also generated a list of therapists provided by the Male Survivor website, a site dedicated to the helping and support of this population. The authors and clinicians were contacted via e-mail and telephone. Initially, I attempted to recruit only participants who were licensed in the field of Marriage and Family Therapy however this proved challenging. Thus the participant pool was widened to include clinicians who employed a

systemic viewpoint in the treatment of male adult survivors. A screening for the clinician's systemic considerations -whether they take into account a client's relationship with partners and family- in making treatment decisions, was necessary. This was measured for by scoring 'moderately' or higher on a scale answering all of the following questions aimed at assessing whether clinicians conceptualized the treatment of male survivors systemically and to screen if they were appropriate to be included in the participant pool:

1. How important are the relationships male survivors have, in their recovery?  
*Not At All – Slightly – Moderately – Considerably – Extremely*
2. Does therapy involve a focus on survivor's familial and romantic relationships?  
*Not At All – Slightly – Moderately – Considerably – Extremely*
3. How much do you consider the effects of the survivor's relationships and interactions with others on his recovery process?  
*Not At All – Slightly – Moderately – Considerably – Extremely*
4. How much do you consider the effects of the survivor's recovery process on his relationships and interactions with others?  
*Not At All – Slightly – Moderately – Considerably – Extremely*

#### Data Collection Procedure

The data collection aimed to acquire the perspectives and viewpoints of clinicians who had extensive experience with male survivors of child sexual abuse.

When it was ascertained that the clinicians contacted met the criterion described above and were eligible to be expert panelists for this study, a phone interview session lasting 60 minutes was scheduled at a convenient time. In the interview, the panelists were asked to answer biographical questions asking about their age, gender, ethnicity and profession and questions about their level of experience when treating adult CSA survivors. For the participant who was not a Marriage and Family Therapist the additional screening questions were asked concerning systemic treatment and he answered 'considerably' or higher for all four questions making him an appropriate candidate for the participant pool.

The resulting responses gathered from the expert panelists was transcribed and analyzed for similar or corroborative experiences and clinical emerging themes in a process described in the next section.

### Data Analysis

Moustakas expounds that the main principles of qualitative research, among others, are obtaining Epoche, reduction, imaginative variation, and creating a synthesis of collected meanings (1994). To obtain Epoche, a researcher has to embark on "a process of setting aside predilections, prejudices, predisposition, and allowing things, events, and people to enter anew into consciousness, and to look and see them again, as if for the first time (Moustakas, 1994, p. 85). Reduction is achieved through



the process of continual reflection and where the experiences are condensed while still reflecting the essence of the phenomenon. Within this paper this is illustrated by the grouping of concepts -which are themes which emerged according to shared properties- under a category. Imaginative variance refers to seeking “possible meanings through the utilization of imagination, varying the frames of reference, employing polarities and reversals, and approaching the phenomenon from divergent perspectives, different positions, roles, or functions” (Moustakas, 1994, p. 98). The principle of imaginative variance with the aim of expanding the depiction of treatment provided by the experts, was incorporated into the analysis of the data, by utilizing the extant literature to augment the understanding of the phenomenon, and with the added dimensions and perspectives of a second coder. Through the review of literature on male sexual abuse, I discerned specific concepts that were frequently cited as features present in the treatment of this population, such as sexual issues and mental health problems. These concepts were coded throughout the transcribed data with the use of symbols and colors to add substantiation to the presented treatment approach. A second coder conducted a reading of the transcribed data and compiled a list of emergent themes as well. These 2 lists were compared for common items and coded once again throughout the transcribed data. Please refer to table 2 in the findings section for an overview of this analysis.

In the attempt to create a synthesis of collected meanings, this paper will present a description of the most highly rated treatment options for adult MCSA survivors through the experiences of the clinicians.

The data analysis involved reading, discarding, categorizing and coding multiple times to arrive at a descriptive approach to treatment. In Corbin and Strauss's chapter on analyzing data for concepts, they described categories as concepts under which analysts group corresponding concepts according to shared properties and can be referred to as themes (2008). These categories or themes represent the relevant phenomena under study and allow for reduction to ultimately create a synthesis of meanings.

I began by transcribing the phone interviews. I then inserted the transcribed data into a table with five columns of experts' responses and a sixth column to the far left with the questions asked. Later the questions asked were grouped into major headings for the presentation of the findings in this paper. The data was initially read indiscriminately from start to finish. I took special care to monitor my own biases and ideas about the treatment of male CSA which I had garnered from the literature and my own clinical experience. My aim was to obtain Epoche in having a renewed ability to grasp this phenomenon through the expert's experiences. In the second reading I began picking out words or terms which were a) distinctive and b) common in that more than one expert mentioned or spoke about it. This process was also undertaken by

a second coder -an academician and clinician- who read the data and listed themes which emerged in her reading.

When these themes were extracted, the transcribed interviews were read once again to allow for them to be grouped together into categories. After “scrutini(zing) the data in an attempt to understand the essence of what was being expressed in the raw data”, I delineated conceptual names for these categories, at times researcher denoted and other times in-vivo from the participant’s words (Corbin & Strauss, 2008, p. 160).

For example, when reading the transcribed data, multiple therapist explained that they often asked the client to explain how he saw himself and what he was presenting for. The themes that emerged from this was having the client set the tone of treatment, allowing the client to direct the pace and -in the words of the clinicians interviewed- having the client feel control over the course of therapy. Thus the unifying category from these themes is ‘client-centered’ or collaborative. Using this analysis progression, a description of the findings are presented in this paper.

The use of this qualitative method is appropriate and advantageous when the research question centers on processes, treatment and the tailored use of theoretical conceptualization.

### Researcher’s Reflections

I was drawn to this topic because I have always wanted to give voice to populations that have been marginalized and underserved. Not too

much is written about this population and even less about treatment with them and I felt the need to add to this limited body of research.

With male survivors, I discovered through my own clinical experience, there was less of an identification as victims and intense emotions that often were quelled. I understand that while this may have been the impetus for my interest in this population, it was also my bias about male survivors; that they had difficulty with emotional language and struggled with the idea of being domitable.

Initially, I found that there was some difficulty in researching the topic of male CSA which led me to question its rate of occurrence in presenting within the therapy room. The literature was limited and eventually I saw that both the knowledge and resources were localized to specific organizations, authors and clinicians. Anecdotally, I knew that my colleagues, supervisors and other clinicians had encountered work with male survivors, and conservative numbers reported upwards of one in seven men have been sexually abused, thus there was great clinical significance to this research.

Using a resource for male survivors, I sought out marriage and family therapists who were self-identified as adept with this population. This proved to be challenging and consequently the snowballing method of recruitment was also utilized. This moved me to ponder why it was a difficult process and why many were less inclined to respond. Was the time and energy required for the interview too much? Maybe the sensitive

nature of the discussion deterred clinicians from wanting to participate. Among my experiences with clinicians who declined the invitation, I perceived a reluctance to provide a scheduled time. The clinicians who were willing to be interviewed appeared passionate about disseminating information about effective treatment with male survivors. Their commitment to the distribution of expertise was evidenced by their multiple publications and initiatives, and -within the interviews- their eagerness to talk at length, elaborate and provide further resources and ideas beyond the questions asked.

Following each interview, I considered my experience in discourse with the clinician, and each time I felt privileged to gain practical and reflective responses about the treatment process. While every expert had different perspectives and was very knowledgeable, I appreciated their willingness to speak honestly about their experience and understand the value of sharing their knowledge.

In my follow-up questions and in analyzing the data I began to be aware of my personal biases. While treatment with every client is tailored to meet their unique needs, I wanted to see a practical consensus of opinions when it came to the action phase of treatment. I was invested in the idea that in most cases the exploration that came with the telling or the narrative of trauma would be necessary to move towards uncovering the underlying causes for present difficulties. The majority of experts held this position as well yet expressed a divergent view from my own.

They noted that often the somatic re-experiencing or body work -despite level of cognitive awareness and insight of the trauma- could be more operational than revisiting the CSA with the use of language.

Throughout the analyzing of the data and with help from an accomplished researcher who was on my committee, I began to understand the paradigm shift that one had to experience to conduct a qualitative and phenomenological study. Putting aside notions of calculable information and investments in specific outcomes, I had to avail myself to the data unencumbered. Being open to flexible and abstract ideas within practical discourse was rewarding both as a researcher and clinician and provided a coherent description of the phenomena.

## CHAPTER 5

### FINDINGS OF THE STUDY

The first section of the findings is dedicated to describing the experts that were interviewed. The following sections are organized to correspond with the main topics within the interview questions. The topics are assessment, treatment plans, challenges in treatment, treatment termination, unique features and key elements, common mistakes and partner issues in male CSA treatment. Beneath these headings the themes which emerged and common aspects discussed by the experts from the interview data will be delineated.

#### The Experts

A total of 25 clinicians from various professional backgrounds who were identified as highly experienced in the treatment of male CSA survivors were contacted. Five experts agreed to be interviewed; four men and one woman. The participants had an average age of 57, ranging from 52 to 61 years and were of Caucasian ethnicity.

The academic background and training of the experts varied however all held a masters level degree or higher. Four out of five of the experts were licensed in the field of marriage and family therapy.

The experts all had extensive experience working with adult male sexual abuse survivors and were licensed for 15 years and over. The participants reported having treated hundreds or thousands of male

survivors and were providing treatment currently to this population. The experts indicated that an average of 38% of their caseload, ranging from 25% to 50%, was composed of male survivors.

All of the experts were actively involved in reaching the public and offering information about male CSA -it's incidence and treatment- through online publications, written books, book chapters and journal articles, magazine interviews given, presentations at professional conferences, documentaries and movies, and providing continuing education and supervision to students and clinicians alike.

The allotted interview time was 60 minutes and three out of the five experts used the entire 60 minutes, the other two for 45 and 50 minutes.

### Assessment

All clinicians perform some type of assessment within and throughout treatment. Assessments serve two primary functions which are “as a guidance for what the clients need and how best to intervene, and later, in evaluating clinical progress and therapeutic outcome” (Goldenberg & Goldenberg, 2008, p. 409). One of the primary areas explored in the interview was the initial assessments clinicians conducted when treating adult male survivors. Themes that emerged from the discussion with the experts in this initial phase of treatment were keeping a slow pace, maintaining a present focus, assessment of sexual issues, and insight.



The assessment procedure can appear both unique and similar for those whose clients present for treatment expecting to address and focus on their experience with CSA. Often the areas that are assessed for includes the client's history, how CSA continues to affect the client, possible mental health problems, and the client's experience with CSA if he is ready or willing to talk about it. The experts stated that this process was undertaken slowly. One expert noted that his clients were active participants, and treatment was not "something being done to them". A major theme in their responses concerned allowing the client to work at their own pace around issues of disclosure and how much in detail they felt able to share initially with the clinician. One expert shared that at times, the sexual abuse is not the primary topic in this initial stage:

"But as they tell me about it (CSA), I'm aware that...the first story they tell me is not the whole story. In the meantime, we're doing work around many other aspects of their lives, not just the sexual abuse. We may be dealing with their sexual addictions and their relationships, their fear, their body image, their shame...the other aspects of growing up, or of their present life that seem like they have nothing to do with sexual abuse."

Another expert appeared to share the same view and expressed having flexibility with clients to work with the direction the client takes such as focusing on the present difficulties, revisiting the trauma or both concurrently. This expert went on to explain that clients have expressed confusion when encountering clinicians who seemed obsessed with their past and -when discussing a case- stated that "some of the therapists

were sure that the more he talked about his abuse, the better he would feel but it seemed like he was just pulling the scab off and it was never healing, whereas other therapists stated ‘that’s not at all important and we’re just going to focus on the present’ so he thought that I had a balance”. This expert delineated the importance of not being overly invested in one area of focus but allowing the client to direct.

The experts maintained a present focus in this assessment phase, asking questions such as ‘how the client describes/sees himself’ while not glossing over the history or abuse experience as the impetus for treatment. This was evident in how their responses reflected numerous statements about the client’s current level of functioning and less statements concerning the historical traumatic events. However the story of their abuse and their family history was still important throughout treatment. An expert stated that an important step in assessment was to “explain to the patient what we’re going to do during the time, that we’re going to ask them a bunch of questions having to do with why they are coming to see us...and then an overview assessment” to engender the feeling of comfort and ease in this initial stage.

Four of the five experts discussed assessing for sexual issues within treatment such as sexual addictions, sexual compulsions, and possible sexual perpetrations. Considering that this was the first question about treatment posed to the experts, the need to address sexual concerns appears to be a relevant treatment consideration with this population.

When discussing why these areas were important to assess for, the experts expressed that clients may begin to conceptualize the correlations or connections between their past experience with CSA and their current difficulties. Insight, emerged as a theme even in the assessment phase of treatment. As one expert so articulately stated:

“Because unless somebody can talk about and hear themselves, almost hear their own narrative, talk about the rest of their life, it doesn’t make any sense in terms of the context of what happened to them.”

The clients responded to this assessment positively. One expert explained that hope is engendered when a client perceives treatment to be collaborative. There appeared to be a strong component of respect for the client and a genuine desire to consider the client’s pace and direction within treatment.

When analyzing the transcribed interviews, it was apparent that in a practical sense, the assessment protocol was different depending on the method of referral and the modality of the treatment offered by the experts. When a client has been referred by the legal system or another professional for the specific treatment of CSA, assessment may be slightly more direct. The assessment procedure may be increasingly structured if the client presents for group treatment as the clinician is concerned with the client’s suitability for group process. Hence, such areas as suicidality, homicidal or harmful tendencies, substance use,

and psychopathology can engender distinct complications within a group setting.

### Comfort & Safety

Within the assessment phase, it is crucial that clinicians attend to the client's feelings of comfort or safety. There is a distinction between feeling comfortable and feeling safe as one expert noted. While feelings of comfort may be present, one may not be safe and within treatment clinicians understand that safety is necessary for healing even when the client may not feel comfortable. This is illustrated most poignantly in the survivor's life where he may have in the past felt comfortable spending time with a dangerous person and not been safe, psychologically or physically. It is then important to facilitate safety within the therapeutic relationship and explain that there may be discomfort in the vulnerability and exposure which comes from deep emotional recovery. While safety is a construct earned with time and testing, facilitating client comfort can be a useful aim in the initial phase of treatment.

Almost all of the experts -when discussing strategies to increase comfort- talked about the shame and inadequacy that male CSA survivors come into treatment with. One expert explained that focusing on a client's strengths are important to helping them feel safe. This expert explains:

“The most crucial piece in doing therapy is dealing with the inherent shame that ... because they've been subject to humiliation and power violation, so I think that one of the subtle things that I pay particular

attention to is how pathologized the patient feels because they come in already feeling marginalized or less than and certainly have enormous issues around self-esteem, I'm usually very respectful, I look for a person's strengths and capacities. When they come in to therapy, often people assume all they're going to be dealing with is their problems and their debilities. I make a point that there is equal room for their successes."

Feelings of shame and inadequacy appeared to limit comfort and safety in a client's life. One expert noted that when meeting with a clinician, it may be the first time that a client has disclosed his history of CSA and providing a 'safe container' by discussing confidentiality and by setting up the room to help the client feel like he has a method of physical escape, can be helpful in facilitating greater comfort and paving the way for a client to feel safe.

A common theme that the experts noted in this initial stage of treatment is explicitly acknowledging how difficult it is for a client to talk about their experience. While different strategies were utilized, the aim that was mutual among the experts was to facilitate feelings of control for the client. By establishing a contract of being safe together, discussing clients rights and confidentiality, looking for strengths and capacities within the client and simply asking the client "how would you be most comfortable doing this today?" the client may begin to feel increasingly empowered, and validated, thus facilitating safety within the therapy room.

## Treatment Plan

Treatment planning is an essential skill required of any clinician when providing treatment. While its presentation may be either formal or informal, flexible or structured, and general or specific, a treatment plan is a way to articulate “how the therapist intends to address the concerns a client brings to therapy” (Gehart & Tuttle, 2003, p. 2). It can delineate how a clinician will intervene to elicit change as it relates to the presenting issues thus allowing for a treatment direction.

To gain an in-depth understanding of how expert clinicians conceptualize treatment with male survivors, areas explored within their treatment plan were their theoretical approach, and strategies and interventions used. Themes that emerged from the answers given by the experts were tailored-treatment approaches, establishing a foundation of trust, and also addiction and compulsions as it plays a role in the direction of treatment.

While the experts reported different components within their treatment plan, the collective theme, was a tailored treatment direction for the client. The experts appeared very conscientious and in tune to the client’s unique presenting problems and allowed that to guide their treatment plan. When co-occurring disorders were present, they were attended to by either providing treatment which addressed both presenting issues concurrently, referring the client to a 12 step program or providing both individual and group therapy.

The experts spoke of building a foundation before addressing deeper issues. One expert stated that “the real depth of treatment wasn’t going to take place until we had established a relationship”. The foundation can resemble various forms depending on the clinician’s theoretical affiliation which will be discussed in the next section. Examples of efforts to build a therapeutic base included such things as constructing a contract -abstaining from use when presenting for sessions-, allowing the client to “run the show” as one expert explained until it was clear that the client was ready for the next step, having a structure for clients to address their feelings about the abuse that is organized through the use of a letter, and helping the client stabilize and decrease compulsions before exploring the deeper issues causing these behaviors.

The overwhelming consensus among all the experts in treating adult male survivors was how addictions and compulsions influenced the treatment plan and direction. Consistent with the literature, these experts, through their experience, have a weighty understanding of the possible substance abuse and sexual obsessions with their male survivor clients and make provisions for such. One expert stated plainly that many male survivors turned to drugs or alcohol to numb the pain. Another expert stated that through the use of the question “How it (CSA) has affected my life” clients may come to their own cognizance of the possibility that substance abuse or compulsive use of pornography is connected to their trauma. One expert explained that:

“...the first thing was to assess sexual behavior and then to decide if it was compulsive...what was appropriate...and then look at what’s the fuel that’s driving these compulsions in the first place”.

‘Over-training syndrome’ -seeming similar to other compulsions- was identified by one of the experts as a common feature of male CSA that is witnessed. Over-training is where one exercises so intensely as a means to “take back control over the body that was stolen by the sexual abuse” and is usually unconscious.

### Theoretical Orientation

Almost all of a clinician’s decision-making in treatment –from the areas assessed, techniques used, conceptualization of change, and markers of improvement- depends upon the theoretical approach and philosophy he or she subscribes to. Treatment theories may also inform how a clinician views their role within the therapy room, be it as teacher, confidant, guide, etc. Sometimes, the demarcation between theories, models or approaches can be inconsistent. For example, some may make distinctions between the term Existential and Rogerian, while others may consider both connected and label themselves an ‘Existential’ therapist. Additionally, some clinicians may subscribe to simply one theoretical approach, however many clinicians embrace different components of a few theories in either an eclectic or integrative manner. All theories contain philosophical underpinnings which have real treatment implications. It is beyond the scope of this paper to explore this in-depth,



for more on the hidden assumption within theories, please refer to Slife and Williams (1995).

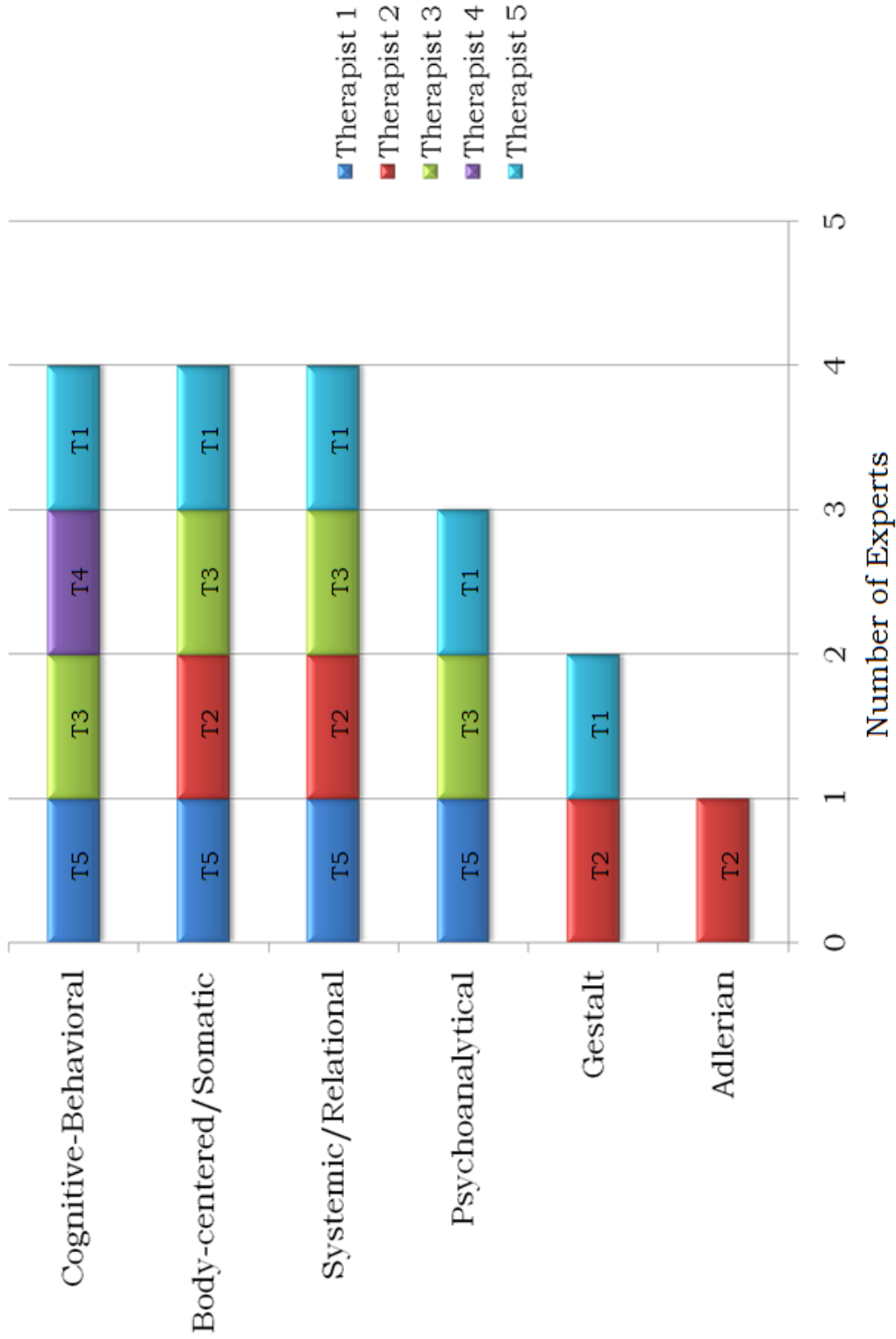
The theoretical approaches to treatment with male CSA survivors reported by the experts are presented below in Figure 1. Within Figure 1, the horizontal axis refers to the number of clinicians who had stated their theoretical approach corresponding to the theories listed on the vertical axis. Within the bars, the different shades indicate the 5 experts, listed as Therapist 1, 2, 3, 4 and 5.

The theories identified by the experts were Analytic/Psychoanalysis, Cognitive-Behavioral Therapy (CBT), Family systems/Relational, Body-centered/ Somatic, Gestalt, and Adlerian. Within these, the experts identified models, components and interventions, such as 'Trauma-focused Cognitive Behavioral Therapy' within CBT, the component of psychoeducation consistent with Adlerian therapy, and sensory-motor psychotherapy which is considered a Somatic psychology approach. Other models discussed that are not reflected in the figure were EMDR and techniques within the 12-step programs.

As evidenced from the figure, the majority of clinicians subscribed to more than 3 theoretical approaches. CBT, somatic work , and relational interventions were mentioned more frequently than any other theories while psychoanalytic approaches were noted second in frequency. One expert explained:

“...it’s flexible, it changed to meet the needs, but that does not mean that it is willy-nilly, it has to be grounded, it has to come from something. It’s sort of like being a jazz musician, instead of a classical musician, it doesn’t mean it’s just chaotic notes. There’s a real music line.”

Figure 1 is meant to delineate the affiliations of the experts, however should not give an oversimplified viewpoint of the data.



**Figure 1. Theoretical Orientation of Experts Interviewed**

*Figure 1.* Frequency of theoretical approaches identified by the therapists interviewed.

## Techniques & Interventions

In the expert's discussion of their decision making within the therapy room, three categories emerged: 1) the targets, which were the effects of the CSA, 2) the specific techniques that addressed these targets, and 3) the rationale or aim of these interventions. The main theme that arose for the target of intervention was the experience of the trauma, be it emotional, somatic, cognitive or preverbal, and the effects in the present. Somatic interventions were most commonly cited as useful techniques and the reason experts utilized these interventions was because the body retains the memory and experience of the CSA.

One expert noted that clients may be provided or prompted with a directory of common symptoms of male CSA, which as he later expounded were such as sexual issues, addictions, mental health problems, somatic complaints, and relationship difficulties among others. This indicated his experience with survivors who may have difficulty recognizing or conceptualizing the effects of their abuse. Other experts corroborated this position when noting that dissociation is common and at times the abuse may have happened at such a young age that the client does not have the words to express them. Other effects of abuse that is targeted through the interventions, with expert consensus, were the negative messages received, the shame felt, and what the survivor tells himself about his experience. A couple of the experts expressed active intervention with the immediate experience of the

trauma and targeted such areas as the “way the client responded to the memory/feeling” and tracked the “defensive and self-protective movements which were blocked in the abuse”.

In analyzing the techniques described by the experts, the common consensus was somatic interventions. Experts utilized body scanning, authentic movement, relaxation techniques and other physical expression such as movement using music, or sounding out vocally. Other interventions noted were methods of expression to specific individuals through letter writing and Gestalt’s two chairs technique. With these methods of expression, one expert commented that empowerment was the primary aim where the client gained more knowledge and was better able to do away with the “fear and the mystery of the abuse, the secrecy, that keeps them in the dark”. EMDR was another method utilized by three of the experts.

When asked about the rationale behind the interventions used, it was a common perspective that at times the abuse experience was preverbal and the body contained these memories that may not be accessible through words thus somatic techniques helped “provide a whole other level of therapeutic work which has nothing to do with words” explained one expert. Another goal expressed by one expert included changing the belief system through challenging distortions, increasing knowledge, and working to explore the ‘needs’ that drive behavior. The faulty belief

system included taking on the responsibility for the abuse. Another expert stated that treatment with male survivors is:

“...basically working with grief, putting a different ending on the story because what the person has is a negative message, the moral of the story is ‘I’m bad, I’m unlovable’ or something like that...and then forgiveness of self and others...shame-reduction because that’s what I think drives the self-destructive behavior”.

Another expert weighed in on self-destructive behavior and “relationship blocks”, noting that tracking defensive and self-protective movement can be a vehicle to hinder repetition-compulsions. Using this body awareness method called sensorimotor psychotherapy aimed at ceasing dissociation, the client begins to become conscious of the signals his body gives him, and the world around him by slowing down and examining his level of arousal. Increased awareness was an area discussed by another expert who stated that some deliberate work and desensitization is used to help the client “heal through the triggers”. One expert stated poignantly that “trauma is that the person’s relationship with themselves and the rest of the universe has been damaged”. A focus on relationships and bonding were observed in the discourse with most of the experts and will be delved into more extensively within the spousal relationships of male survivors section.

### Challenges in Treatment

When discussing challenges in treatment, the expert’s responses were varied with little consensus, because they were considering specific cases

when discussing this aspect of treatment. Their responses included different dimensions throughout the course of therapy that acted as a barrier to treatment, such as aspects of the client's life and the client's belief system, characteristics of the therapeutic relationship, and the treatment process itself.

One expert explained that often client's present for treatment in the midst of a crisis and when the crisis is resolved they choose to terminate without exploring the possibility of healing in other aspects. This expert continued to explain that often with male survivors especially, healing is not complete until there is sexual healing as well. To address this tendency to curtail treatment, the expert utilizes education, highlighting their progress, and the use of strategic interventions to get them to "buy into the full healing".

Having a client excessively involved in his compulsions or addictions can be an obstacle in treatment. An expert described approaching a client with a circumstance: "You know, some people can't stay sober until they deal with this (the abuse and its effects), and some people can't deal with this until they stay sober". The expert explained that from all the clients treated, none have been unable to state their position.

Another aspect that was identified by one of the experts, was the challenge of staying invested when early in treatment there were limited avenues of exploring feelings and deeper issues with the client. This expert explained:



“Possibly the most challenging was to stay engaged emotionally when I felt, early in the treatment, when I felt there was no way getting through and there was a lot of talk but not a lot of feelings and I knew I had to move slowly and respectfully.”

The expert noted that discussions can be fairly verbal, intellectual and event-based with little talk of feelings. It was important for this expert to meet the client where they were, thus the expert moved slowly while discerning when the client was ready to be challenged. Additionally, EMDR was used to help the client speak more directly and assertively.

Two experts talked about different dimensions of the client’s romantic relationships; one where a client’s spouse was less accommodating to the treatment process and another client whose lack of relationships afforded him a sense of inferiority. For the former client, the expert worked with the client to establish boundaries. The second client had a sense of resignation and the expert challenged his assumptions about himself and used confidence boosting statements to help the client look at the “reality of their situation”.

One expert affirmed that a way to not burn out in treatment is when a clinician does not have to feel like the ultimate authority and power in a client’s life. The expert explained that when a client does not have any spirituality or spiritual resources, -making the distinction between religiosity and spirituality- treatment can be challenging.

Another challenge expressed by an expert was a possible feature within the therapeutic relationship which was transference and counter-

transference. This expert stated that this was handled through vigilance, self-awareness, and having someone else monitor the treatment provided. The expert averred that while it feels like every other kind of work (referring to providing therapy to various populations and for diverse presenting problems), it is different and the use of supervision is important as “you need to make sure you’re not just working in a vacuum”. A real concern in male CSA treatment is to avoid creating a place where there would ever be an experience of reenactment for the client.

#### Termination of Treatment

Terminating treatment is an important part of therapy and when not executed well is “comparable to learning how to drive but never learning how to properly park the car and turn off the engine” (Patterson, Williams, Grauf-Grounds, & Chamow, 1998, p. 216). Patterson and colleagues go on to state that termination serves to bring closure to the therapist-client relationship and can be effective in consolidating and reinforcing the therapeutic learnings for the client.

When discussing treatment termination, the experts described having the client ‘signal’ the end of therapy. There were the use of markers and specific goals in the shape of working through symptoms, predicting and preventing triggers, an improvement in relationships with outside support systems, and an increase in awareness of emotional experience

and the ability to communicate them effectively. The majority of the experts specifically noted that the enhancement of a client's relationship with his partner or family was a major indicator for the termination of treatment. The experts spoke of the client being able to evaluate themselves and their progress, and most of the experts relayed that the client would say that they were ready to terminate. An expert explained that the client "has reached a point where they feel like either they have successfully worked through all or most of the symptoms, the ones they are willing to or wanting to work through and they usually say they're done". One expert who provided male survivor group treatment as well as individual therapy noted that a graduation ceremony was conducted for clients who were terminating group treatment. Another expert stated that there were "titrated sessions" where they would meet every other week and have a couple follow-up sessions before ending treatment. The expert explained this was:

"So there wasn't an abrupt break in his work and he got to test out what it was like going forward with his life without me in it. That whole process allowed the client to internalize what they've gotten from the relationship, without abruptly losing it."

Finally, a couple of experts noted that at times client's would continue attending a peer support group or 12-step program after ending treatment.

Another expert explained the difference between counseling and therapy was that the former worked with your conscious mind where

else, therapy was delves into the subconscious or unconscious and aiming to “change the way you look at the world”. Ultimately in thinking about treatment termination, one expert explained poignantly that “we can only go as fast as the slowest part of our client”. A summary of the findings were condensed into a table which outlines the treatment options for the three stages in therapy; Assessment, Treatment and Termination. Please refer to Table 1 for this summary.

Table 1. Summary of findings for the three stages of treatment

Treatment Stage	The Findings
Assessment	<ul style="list-style-type: none"> <li>- Engage in assessment with sensitivity and discernment</li> <li>- Actively slow down the process to allow the clients to move at their own pace</li> <li>- Fairly present focused such as how the abuse continues to affect them</li> <li>- Screen for areas such as sexual compulsions and substance addictions</li> <li>- Keen awareness to the feelings of shame and inadequacy that the male survivors often present with and actively work at validating and increasing the client's sense of empowerment</li> <li>- Have a sense of clients level of insight in making the connection between their CSA history and their present level of functioning</li> </ul>
Treatment	<ul style="list-style-type: none"> <li>- Features that guide treatment planning process are co-occurring disorders such as substance and sexual compulsions (refer clients to adjunct treatment programs or address these issues simultaneously within treatment)</li> <li>- Building a foundation in the initial stage in treatment is important and help the client stabilize in terms of intense symptoms</li> <li>- May not use just one theoretical approach to treatment with male survivors (common approaches utilized were Cognitive-Behavioral, Body-Centered/Somatic, and Systemic/Relational)</li> <li>- Somatic dimension impacted by the abuse, the feelings of shame and defensiveness, and the effects on a survivor's relationships were important to address within treatment</li> <li>- Challenges in treating male survivors were such as boundaries, transference and countertransference, and specific client features such as having emotional blocks or presenting for treatment in a crisis state, or continuing to utilize addictions to numb the pain</li> <li>- Externalizing behaviors such as violence, sexual compulsions, substance addictions, and possible perpetration towards others Those who have been abused by clergy -a dimension of religious exploitation and the questioning of spirituality</li> <li>- Masculinity and gender roles are possibly the most unique and crucial aspect of treatment with male survivors</li> <li>- Due to the boundary violation, trust and emotional difficulties that male survivors may face, relationship issues are common in treatment</li> <li>- Boundaries within the treatment relationship should be continually monitored with male survivors and physical touch is always discouraged</li> <li>- Do not take too much control within the treatment process and direction, and treating client's with respect and dignity</li> <li>- Do not pathologize or marginalize these clients by taking on a fascination with the client's historical account of the abuse or projecting severe psychological symptoms or disorders on the client</li> </ul>
Termination	<ul style="list-style-type: none"> <li>- Terminating treatment is largely left up to the client's evaluation of his progress</li> <li>- The lessening of triggers, the ability to feel and express emotions, and the improvement of family and romantic relationships as markers that treatment is successful</li> </ul>

## Unique Features and Key Elements in Male Survivor Treatment

The aim of asking the experts about the unique features and key elements of treatment was to combine a list of aspects encountered within therapy with the male survivor population by a group of clinicians who have had extensive experience with hundreds of male CSA survivors. This section will focus on areas that areas of treatment with males that may be different from treatment with female survivors of CSA. Specific themes emerged which were common in that more than one expert mentioned or spoke about it. I took special care to monitor and reflect on my own opinions of what makes male survivor treatment different from other treatment when reading the transcribed responses to these questions. To augment these findings, I matched my themes with the second-coder's themes and the literature findings to reach a consensus. I then coded these themes throughout the transcribed data with the use of symbols and colors. Please refer to table 2 in the findings section for an overview of this list which will present the themes and the frequency in which the themes were mentioned throughout the transcribed data.

Violence and physical aggression were reported by the experts as features that would modify the treatment direction. The approach to treatment can be additionally complicated when the survivor is in a current relationship that is volatile. One expert recalled a male survivor who had a wife who was beating and bruising him. Another expert remembered a client whose two marriages ended because of domestic

abuse. Aggression and violence could be a feature of retaliation from touch, as one expert noted; clients may not be able to handle any intimacy, touch or closeness and it would trigger a defensive response that could manifest in violent behavior.

Another unique feature of male CSA is the prevalence of clients who have been abused by a member of the clergy. Religion and spirituality then becomes an area that begs to be addressed in treatment as one expert fluently put it, the task would be “healing the wound of religion” and often, an expert explained that it would be recommended that ways were found to connect with a higher power. Most of the experts uncovered this kind of sexual abuse and one expert observed how it was important to take note of the parallels between the power differential within the therapist-client relationship and the often mentoring nature of the client and his former perpetrator. Eventually, it would be ideal for the client to make a change in the vulnerability that allowed for him to be exploited, by increasing empowerment according to one expert’s experience.

All of the experts talked about the possible sexual issues of the male CSA clients that often manifest in sexual compulsions -such as excessive use of pornography, having affairs, the use of prostitutes, and sexual fixations- or sexual aversions, where a man retreats from having any sexual interactions with others. One expert explained that male survivors may be trying to “control being in a hyperactive body state by being the

ones who do it to themselves”. Another expert affirmed that sexual issues have to be addressed in order for healing to be complete.

Literature has documented that being a male victim of CSA is a risk factor of becoming a perpetrator later in life for a minority of male survivors (Glasser, Kolvin, Campbell, Glasser, Leitch, & Farrelly, 2001). This area was discussed by the majority of the experts as a consideration that many clients are involved with the legal system. While some clients have criminal records arising from substance use or violence, a percentage of clients may have sexual offender charges. At times this becomes a complication -clinically, ethically and legally- when treatment is court mandated and a probation officer is to receive updates from the clinician. At times clients who are sexual offenders are not accepted into treatment especially when it is group treatment that is provided to ensure that the group is safe, as one expert explains.

As noted by all the experts interviewed and explored in the previous section, substance use or addictions are a very possible and common feature of treatment with adult male CSA survivors.

The experts also spoke about gender roles as an important aspect that should be addressed in treatment with male survivors. One expert explained that the socialization of gender roles is a culture and thus there are multiple ‘masculinities’. Often female CSA survivors do not grow up to question their femininity while many male survivors grow up to question their masculinity. This expert goes on to caution that just



like culture, if this world view is not explored, much damage can be done and some make this mistake because they treat male survivors as they would female survivors. Another expert explains:

“...the more subtle things in terms of sexual identity, sexual arousal, sexual fixations, the perception of oneself as a man, just a whole lot of stuff that these guys labor under and because most therapist don't ask the questions, they never get answered”.

Last but not least, the experts explored the relationship difficulties that are common within treatment with male survivors. One expert stated that trust and the experience of emotional overwhelm can obstruct relationships that male survivors have. Many other factors such as shame -which was mentioned by most of the experts-, self-esteem, defensiveness, and the need for self protection can manifest negatively in the relationships that male survivors have.

### Common Mistakes in Male Survivor Treatment

In discussing mistakes that clinicians make in the treatment of male survivors, all the experts talked about boundaries- physically, professionally and clinically. They noted that any clinician-initiated touch was never recommended especially as one expert stated with a population who have been sexually abused by people in authority. Professional boundaries which include physical touch, also pertains to a proscription of interactions beyond the scope of the therapist-client relationship. This can arise as an ethical dilemma when a client invites

the clinician for a social function and one expert identified this as a big issue and emphasized that therapist should remember their role.

Another expert explained that working within the sexual abuse field, one has to be particularly cognizant of any kind of behaviors that might be construed as intrusive. This expert also explains the importance of being sensitive to the language used so as to not incur more feelings of unfounded responsibility for their CSA. The example given was instead of asking the question “Why didn’t you tell?” and therapist should instead ask “What kept you from telling?”.

Another area commonly identified by the experts was how male survivor clients were misunderstood within treatment. One expert when asked about mistakes that clinicians make stated that:

“They project, they pathologize. Even when there is pathology, they pathologize, and create more shame. Sometimes they enable the client. Sometimes they get enthralled with the material, especially if the client is a male, and there is a fascination with the material, which can then cloud their judgment, and their work. I think that sometimes therapists project too much, interpret too quickly, or interpret at all.”

A useful tool to prevent marginalizing clients is for clinicians to attend to their own process, this expert noted. Another expert expounds that the biggest mistake is “to treat a survivor as somebody with an illness rather than somebody who is struggling with the natural consequence of trauma”. This expert goes on to explain that what can block the success of therapy is a basic level of respect which can “come up subtly, with the

enormous amount of shame that the male survivor can carry, that just shuts them up completely and often they won't disclose".

In connection with this risk, the majority of experts stated that assuming too much control within treatment with male survivors can be another liability. One expert talked about clients who have told him of experiences with other therapists that they had where the directions and goals of treatment were mapped out for them by the therapist. This expert noted how these therapists can "have goals for the client rather than figuring out what are the client's goals" and cautions against this "cookie-cutter mentality" where clinicians have a set view of the treatment process with male survivors and don't take into account that these clients have been victimized and are already accustomed to people doing things to them. Another expert supported this respective and collaborative stance and explained that the client's intuition is viewed as an important guide in treatment, and by communicating to clients that "internally you have the best sense of what you need", trust in engendered which is a crucial factor for those who have lost trust in their own instincts and self-direction. One expert states that he'll say "Well, this is just my job, it's your life we're talking about, and I'm not going to work harder than you are".

Often the outcome of treatment when mistakes such as violating boundaries, marginalizing clients through pathologizing or treating their

experience with fascination, and assuming too much control, can be disastrous in that clients drop out of treatment, explained the experts.

Table 2. Themes found in the transcribed interviews

	T1	T2	T3	T4	T5
Sexual issues					
Compulsions (pornography, prostitutes, anonymous sex)	X	X	X	X	X
Aversion (shut down)	X	X	X	X	X
Substance issues					
Chemical addictions (alcoholism, substance abuse)	X	X		X	X
Mental Health issues					
Anxiety				X	X
Depression				X	X
Self esteem			X	X	X
PTSD		X	X		
Dissociation & Numbing		X	X		X
Violence & Aggression	X	X	X		
Gender					
Roles and masculinities	X			X	X
Relationship					
Romantic and familial relationship difficulties	X	X	X	X	X
Safety in the therapeutic relationship)	X	X	X	X	X
Religion and spirituality					
Clergy abuse	X	X			X

Note. X=Clinician identified these themes in treatment; T1=Therapist 1; T2=Therapist 2; T3=Therapist 3; T4=Therapist 4; T5=Therapist 5

## Spouses/Partners of Male Survivors in Treatment

The experts were asked about their decision-making as it applied to their experience with treatment where a male partner disclosed a history of CSA. The questions following this pertained to what effects the experts perceived that the male survivor's CSA had on his female spouse and how this was addressed in treatment. The following sections will present the findings of what the experts said in these two areas of male survivor relationships within treatment.

### Decision-making Following Disclosure of male CSA

When asked how the clinician will respond when a male partner discloses CSA, the experts unanimously stated that the male survivor needed to receive individual treatment. While one expert stated that they would refer the client to couple's therapy, two other experts explained that they would invite the female partner into treatment for a few sessions to explore reactions to the CSA, communication and the partner as a part of the male survivor's support team. Another expert stated that:

“So we try to start off more with the individual and group therapy, um and we'll definitely do some couples therapy, but sometimes we just set the couples therapy aside, and say look, this is what we're going to have to do. We'll bring you back in, in a year or two, or something like that. But other couples... you know the decision on which way to go with that really lies with the assessment of the couple and what they want.

The experts stated that there were complications in treating a couple where the male disclosed CSA. One expert had a policy of not working

simultaneously with an individual and couple, especially with issues of abuse where boundaries are important. Another expert echoed this position and explained that the work is complicated and “confusing in terms of boundaries and loyalty” and when the spouse is invited to treatment the “focus is on communication strategies and instead of being in the role of psychotherapist I am more in the role of coach”.

Other issues that were discussed by the experts were of readiness to work on couple issues, stating that sometimes some healing will have to take place before the relationship can be truly mended. Another practice, noted by one of the experts, was providing a mix of individual sessions to both partners, interspersed with joint sessions and ending with a few months of couple therapy.

Two experts affirmed the usefulness of couple retreats and workshops where male survivors and their partners are allowed to feel less isolated in their problems and be able to leave their daily worries behind and focus on their relationship in an extended length of time. One expert described its helpfulness because the couple “is really a couple, because they are away from their kids, and email and everything and that they get to be with other couples so they don’t get to think of themselves as total freaks and that they don’t have to put themselves back together and go to work in an hour”.

## Effects of Male CSA on Female Partner

Common themes which emerged when discussing how the female partner is effected by the male survivor with the experts were, sexual issues and the meaning the abuse carried for the female partner.

The main area that was considered by the experts to be a common effect of male CSA on their female partner was sexual issues. The experts described sexual behaviors that were either excessive or restrictive. Among the sexual dysfunctions uncovered were engaging in anonymous sex with men or women, seeking prostitutes, having affairs, using pornography, sexual offending or being sexually avoidant where a survivor experienced a diminished or no sex drive. Crossing the marriage boundary was common. One expert stated that:

“The effects are quite varied and tends to go in extremes around issues of sexuality, either the husband acts out in respect to the boundaries of the marriage and either has affairs or something else in the way that they had their boundaries violated sexually as kids. Or they’re anorexic sexually.”

Much of the complications noted by two of the experts were in the way in which female partners responded to the CSA experience of the male. An expert spoke of encountering many female partners of male survivors who diminished the impact of the abuse by “not taking it seriously and maintain(ing) the focus on the current symptoms”. This expert also stated that the couple relationship may disintegrate. Another expert observed that there was a possibility that the female partner would assume a co-dependency or caretaker role. This expert went on to relate



of an experience with a male survivor client where the wife was invested in confronting the perpetrator and husband's family.

Because the experts were asked about how the effects of male CSA was addressed in treatment their responses referred to how they treated the individual with regards to relationship issues. One expert did state that the he "did not normally focus on sexual relationships in couple therapy when working with a survivor... work with them individually for that" but when the expert did focus on the sexual aspect of treatment, "body-awareness and respecting one's sense of boundaries and being able to say no" were things worked on. Once again retreats were recommended and other couple treatment as an adjunct to individual male CSA therapy.

### Chapter Summary and Synthesis

After completing the extensive review of the descriptions provided by the experts, qualitative inquiry requires the researcher to further reduce and synthesize the experiences of the experts which maintaining the 'essence' of the explored phenomenon- the treatment of adult male survivors. In this section the synthesis of the expert's experience is presented.

The experts interviewed appeared somewhat similar from their ethnicity and their level of education, and in their length of clinical practice, their passion for giving the underserved population of male

survivors' added exposure. While the majority of them were licensed in the field of marriage and family therapy not all received their degrees in this profession yet pursued continuing education in this field. The experts were chosen due to identifying themselves as clinicians who were knowledgeable in the treatment of male survivors via the internet and through various publications.

Within the initial phase of treatment the experts expressed a willingness to engage in the assessment with sensitivity, discernment and actively slowed down the process to allow the clients to move at their own pace. The information sought by the experts were fairly present focused such as how the abuse continued to affect them. A concept of importance which was discussed by the experts was the clients level of insight in making the connection between their CSA history and their present level of functioning. Sexual issues and other compulsions was another area that the experts were screening for.

The distinction between feeling comfortable and feeling safe within the therapy room was made. There was a keen awareness to the feelings of shame and inadequacy that the male survivors often present with and the experts actively worked at validating increasing the client's sense of empowerment within treatment.

Features that guide the treatment planning process were co-occurring disorders such as substance and sexual compulsions where the experts may refer clients to adjunct treatment programs or address these issues

simultaneously within treatment. Building a foundation in the initial stage in treatment is important and helping the client stabilize in terms of intense symptoms and using such aids as 'safety contracts' were methods that could help this process.

Most clinicians do not use just one theoretical approach to treatment with male survivors. The common approaches utilized were Cognitive-Behavioral, Body-Centered/Somatic, and Systemic/Relational. The Psychoanalytical, Gestalt and Adlerian theories were also cited as approaches utilized with this population. The experts explained that the somatic dimension impacted by the abuse, the feelings of shame and defensiveness, and the effects on a survivor's relationships were important to address within treatment.

Challenges in treating male survivors were such as boundaries, transference and countertransference, and specific client features such as having emotional blocks or presenting for treatment in a crisis state, or continuing to utilize addictions to numb the pain.

Terminating treatment was largely left up to the client's evaluation of his progress. The experts discussed the lessening of triggers, the ability to feel and express emotions, and the improvement of family and romantic relationships as markers that treatment was successful.

Specific issues arise from treatment with adult male survivors. Externalizing behaviors such as violence, sexual compulsions, substance addictions, and possible perpetration towards others -which occurs in a

minority of male survivors- are real concerns in treating this population. Male CSA survivors may also have been abused by clergy which adds a dimension of religious exploitation and the questioning of spirituality that may have to be addressed in treatment. Masculinity and gender roles are possibly the most unique and crucial aspect of treatment with male survivors. Finally due to the boundary violation, trust and emotional difficulties that male survivors may face, relationship issues are common in treatment.

Boundaries within the treatment relationship should be continually monitored with male survivors and physical touch is always discouraged. The experts caution against taking too much control within the treatment process and direction, and treating client's with respect and dignity. A common mistake made by clinicians in treatment with male survivors is to pathologize or marginalize these clients. By taking on a fascination with the client's historical account of the abuse or projecting severe psychological symptoms or disorders on the client, treatment is disastrous and clients often drop out.

In addressing spousal relationships in the treatment of male CSA survivors, the experts pay heed to the boundary and loyalty complications and often refrain from providing both individual and couple therapy simultaneously. A major area identified by the experts as being a standard relationship consequence of male CSA is in the area of the violation of sexual boundaries in the marriage or dyad.

## CHAPTER 6

### DISCUSSIONS

The goal of this study was to capture the essence of the experiences and knowledge of experts who have had extensive practical knowledge and definite passion for providing treatment to adult male CSA survivors. The experts were willing to share complicated treatment situations and the emotional issues within their decisions. Much of their focus in discussion advocated for a holistic treatment for these client, making distinct effort to uncover the common and realistic problem areas that arise in treatment. Their discourse evidenced immense respect and appreciation for the client, often emphasizing the need to avoid pathologizing the client. This chapter will expound on some implications for treatment derived from the interviews, limitations of the study and considerations for future research. My own reflections on my experience conducting the study will also be presented at the end of the chapter.

#### Implications for Treatment

It appears that treatment with male survivors of child sexual abuse is different from other types of treatment in that a converging of complicated factors make it important for a therapist to be informed and have important clinical skills to treat this population effectively. The literature and the experts identify externalizing behaviors in male survivors such as aggression, substance abuse, and sexual issues. These

behaviors, while serving the function of maladaptive expression perpetuated by dissociation, are indicative of a drive to violate boundaries. Additionally, betrayal, distrust and defensiveness reinforce the crossing of boundaries. While it is important to explore the reasons beneath such problematic issues, the therapist must also help the client stabilize or feel safe within the therapeutic relationship.

Consequently, a major skill that clinicians need to have when providing therapy to adult male survivors is the ability to simultaneously treat co-occurring problems. Quite often the pressing concern can involve compulsive or addictive behavior. These self-destructive behaviors can be symptoms of deeper issues such as shame, guilt and feelings of inadequacy yet quite often the family and partner of the male survivor are more focused on these symptoms. When therapists choose to invite partners of the survivor into treatment, the roles have to adjust to ensure that boundaries and loyalties are not breached. The role of the therapist then becomes one of guide and instructor; helping the partner gain perspective, aiding the couple in communicating effectively, and ultimately ensuring a strong support system for the survivor.

A therapist needs to have a secure sense of personal power due to the often turbulent treatment process when treating this population. Part of having personal power is also being able to self-monitor their own process, boundaries and implicit messages within therapy. A therapist

will need to explore a way of communicating with the survivor which will not cause him to feel judged or blamed.

Within adult male survivor treatment, a therapist must be keenly aware of gender -sometimes coupled with power- issues and should not refrain from discussing this within treatment. If a male survivor's perpetrator was a female and the therapist is also a female, transference and countertransference is expected. Masculinity is a culture and this culture can communicate messages that men cannot be weak nor victimized. This can prevent disclosure but also progress in treatment when the client is overwhelmed by the dissonance experienced from having intense feelings of vulnerability and the enculturated role of invincible warrior. A therapist overlooking this issue or addressing it without discernment can cause a survivor to feel disempowered.

What arose from the multiple readings and analysis of the interviews with the experts was a synthesis of collected meaning to guide an approach to treatment with adult male survivors of CSA. These are:

- assess and address externalizing behaviors in initial and later stages of treatment
- have personal power to ensure the ability to create stability within treatment
- acquire skills to simultaneously treat mental disorders and chemical/process addictions

- have foundational and definite understanding of roles and boundaries when including partners of male CSA survivors OR treating couple where male partner is a CSA survivor
- continually self-monitor for transference or countertransference issues
- examine and transform language and actions to prevent any blame or marginalization of client
- avoid hasty diagnosis and pathologizing
- consider the dimension of gender and social cultures in the understanding of the client's experience

### Limitations and Future Research

While this study provided a rich and textural account of expert clinicians treating male survivors, there are several limitations. The sample was small and while the results reflected established approaches to treatment by experienced individuals, it may not be indicative of the larger population of therapist treating this clientele. Many declined among the clinicians invited to participate and this may have in itself created a homogenous subgroup of experts who do not represent the majority of experienced clinicians treating male survivors.

Creswell noted that subjectivity was a feature of qualitative study and this study is no different (2007). While great efforts were made to



increase the triangulation of emergent themes, at every point of data analysis, the researcher's experience and perceptions played a role.

In the efforts to gain a complete picture of treatment with male survivors of CSA, the collection of questions was not extensive in looking at the different aspects within therapy. The questions, if aimed at just one aspect of the phenomenon studied could have resulted in an exhaustive review. Opportunities to obtain deeper clarification and wider perspectives were missed due to time constraints. In the future to further augment these pilot findings, quantitative methods of inquiry can be used to verify the considerations for treatment found, in larger populations.

While this study explored relational aspects of male CSA such as the effects on a partner, a more in-depth study is required to understand how to intervene within the couple relationship. Because the experts were known for their skills in treating the male survivor, there was less of a focus on the couple patterns, interactions and treatment. Interviews with therapists treating specifically couples where the male partner has been sexually abused as a child may engender a better view of the dimensions within couple or marriage therapy.

This study did not aim to compare the treatment between male and female CSA survivors but to explore treatment with male survivors of CSA with experienced clinicians. To further corroborate the differences in approaching treatment with a male survivor as compared to a female

survivor, a study should be conducted where experts with extensive experience treating males are matched up to those who treat female survivors.

## CHAPTER 7

### CONCLUSION

This study aimed to procure a picture of the phenomenon of treatment with adult male CSA survivors through the understanding and approach of expert clinicians, to inform therapy. There were unique contributions of treatment considerations to the extant literature offered by this study.

Five experts who specialize in treatment with this population and who additionally initiate the movement for increased effectiveness in treating adult male sexual abuse survivors through their published works, and training, offered their perspectives on approach and treatment with their clients. These perspectives were dissected, categorized and merged to present a congruous view of clinical implications.

The findings indicated several treatment considerations: having awareness for the self of the therapist and both interpersonal and intrapersonal issues, assessing and addressing the areas of gender as a culture, and possible externalizing behaviors that harm clients, creating a container of safety within the therapy room, working with the somatic dimension of trauma, and being perceptive to boundaries with treating the couple. Clinicians who treat adult male survivors of CSA can benefit from increased understanding of these various elements.

## APPENDIX I

### RECRUITMENT SCRIPT

Dear Marriage and Family Therapist,

My name is Blendine Hawkins and I am a Masters graduate student in the Marriage and Family Therapy program at the University of Nevada, Las Vegas. I am conducting a research study and I am contacting you because you have been identified as an expert in the clinical area of male survivors of child sexual abuse.

It will be a privilege and honor to include you as one of the experts in consultation on the experiences of clinicians treating adult male child sexual abuse (CSA) survivors. The purpose of this study is to gain a comprehensive understanding of the choices experienced clinicians make concerning the treatment direction, case conceptualization and therapeutic interventions when treating this population. If you choose to participate, we will schedule a day and time for a phone interview. The interview will be conducted by me, Blendine Hawkins, over the phone, at a time of your convenience and will take no more than 60 minutes. This phone interview will be digitally recorded and transcribed. The transcribed data will be kept confidential. We can also send you a copy of the informed consent through mail or email.

In the interview you will be debriefed on the full informed consent and will be given the opportunity to consent. You will then be asked basic demographical questions about your experience in this field and then about your approach to treatment; including your theoretical affiliation, interventions used, markers of improvement and termination of treatment with male survivors. Your shared knowledge and expertise will be invaluable to this study and our field.

Please indicate if you would be willing to participate in this study as an experienced clinician. [If yes, continue to scheduling phone interview]

## APPENDIX II

### PHONE INTERVIEW SCRIPT

Dear Licensed Clinician,

Thank you for allowing us to interview you. Before we proceed, can you confirm that you have fulfilled two of the following: (1) have at least five years of post-licensure clinical experience; (2) have had at least 5 cases involving the treatment of male adult survivors of child sexual abuse; (3) have presented at one or more state or national conferences on the subject of child sexual abuse or has published one or more journal articles or a book on the topic of trauma and child sexual abuse. I am about to turn on the digital recording device. Please do not give me your name or identifying information during the interview to maintain anonymity. If you do identify yourself by mistake, we will make sure that it will be erased from our data.

Do you have any questions before we proceed? [If no, start recording]

Thank you so much for your participation in our study on clinician's experience treating male survivors. The phone interview will last for 45 to 60 minutes and will be digitally recorded and transcribed. In this interview you will be asked basic demographical questions about your experience in this field and then about your approach to treatment, theoretical affiliation, interventions used, markers of improvement and termination of treatment with male survivors.

There may be direct benefits to you as a participant in this study. You may directly benefit from this study with increased insight and greater perception to make effective treatment choices. You will also be helping the field progress with a deeper understanding of the treatment of male survivors.

There are risks involved in all research studies. This study may include only minimal risks. There is a risk of emotional discomfort when

discussing a sensitive topic. If at any time you become distressed or overwhelmed, you can withdraw from the study.

Your participation in this study is voluntary. You may refuse to participate in this study or in any part of this study. You may withdraw at any time without prejudice to your relations with the university. You are encouraged to ask questions about this study at the beginning or any time during the research study.

All information gathered in this study will be kept confidential. No reference will be made in written or oral materials that could link you to this study. The electronic data (transcription of phone interview) will be stored on the researcher's computer which is password protected in a document that will be password protected as well. All hard copies of the data will be stored in a locked facility at UNLV for 3 years after the completion of the study. After the storage time the information gathered will be destroyed.

If you have any questions or concerns about the study, you may contact the Principle Investigator, Dr. Gerald Weeks at 702-895-1392. For questions regarding the rights of research subjects, any complaints or comments regarding the manner in which the study is being conducted you may contact the UNLV Office for the Protection of Research Subjects at 702-895-2794. I can repeat this information at the end of the interview if you would like me to.

Will you give your consent to participate in this interview? [If yes, continue]

I will now ask you a few questions about yourself.

5. What is your current age?
6. What is your ethnicity?
7. How many years have you been seeing clients as a Licensed Marriage and Family Therapist?
8. How many male CSA survivors have you treated?

9. Approximately what percentage of your caseload is composed of male CSA cases?
10. How important are the relationships male survivors have, in their recovery?  
(On a scale of)  
*Not At All – Slightly – Moderately – Considerably – Extremely*
11. Does therapy involve a focus on survivor's familial and romantic relationships?  
(On a scale of)  
*Not At All – Slightly – Moderately – Considerably – Extremely*
12. How much do you consider the effects of the survivor's relationships and interactions with others on his recovery process?  
(On a scale of)  
*Not At All – Slightly – Moderately – Considerably – Extremely*
13. How much do you consider the effects of the survivor's recovery process on his relationships and interactions with others?  
(On a scale of)  
*Not At All – Slightly – Moderately – Considerably – Extremely*
14. Have you seen and treated couples where a male client disclosed a history of CSA?
  - And how did you proceed with treatment after this disclosure?

I will now be asking you to answer questions relating to treatment.

Please recall a recent case that you had treated involving a male CSA survivor, thinking of this case:

1. Briefly describe your assessment procedures in this case.
  - a. Why did you feel that these areas were important to assess for?
  - b. How did the client respond to your assessment?
  - c. What strategies would you say are important in helping the client feel more comfortable during this assessment phase?
2. What was your treatment plan for this case?
  - a. What was your theoretical approach in this treatment plan?

- b. Is this theoretical approach one that you commonly use with cases such as this one?
3. What techniques/interventions did you employ with this case?
  - a. What areas of focus were you addressing with these techniques/interventions?
  - b. What is your rationale for using these interventions?
4. In thinking about this case, what was one of the most challenging aspects?
  - a. How do you overcome these challenging aspects?
5. Did you use individual, split or couple sessions for this case? How many and for how long? Explain your rationale for this.
6. What effect do you think the MCSA would have on the female partner?
  - a. If you do, how do you address this in treatment?
7. Are there unique features in this case that would change your treatment?
  - a. Apart from the unique feature(s) you mentioned, what other client aspects may affect treatment?
  - b. How do these aspects change the treatment direction and process? (Slow down treatment, require a change of focus, ethical deliberations, etc.)
8. How did treatment end?
  - a. How were the goals achieved or not achieved?
9. What are the key elements clinicians need to be attending to for these cases?
  - a. How should clinicians address these areas?
  - b. Why do you feel that clinicians may overlook such key elements?
10. What is the most common mistake clinicians make in treating this group?



- a. What do you feel the outcome of therapy is when clinicians make mistake 'A', 'B', etc.?

Our interview is now over. Thank you so much for your time and consideration. Your thoughtful responses were invaluable. Will you give consent to be recognized in the published work by mentioning your name with a statement of thanks in the acknowledgement section? [After response, recording device is turned off]

Do you have any questions at this time? [If no, conversation is ended]

APPENDIX III



**Social/Behavioral IRB – Expedited Review  
Approval Notice**

**NOTICE TO ALL RESEARCHERS:**

*Please be aware that a protocol violation (e.g., failure to submit a modification for any change) of an IRB approved protocol may result in mandatory remedial education, additional audits, re-consenting subjects, researcher probation suspension of any research protocol at issue, suspension of additional existing research protocols, invalidation of all research conducted under the research protocol at issue, and further appropriate consequences as determined by the IRB and the Institutional Officer.*

**DATE:** August 28, 2009  
**TO:** Dr. Katherine Hertlein, Counseling  
**FROM:** Office for the Protection of Research Subjects  
**RE:** Notification of IRB Action by Dr. Paul Jones, Chair *PJW*  
Protocol Title: **Clinician's Experience Treating Adult Male Child Sexual Abuse Survivors**  
Protocol #: 0905-3105

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This memorandum is notification that the project referenced above has been reviewed by the UNLV Social/Behavioral Institutional Review Board (IRB) as indicated in Federal regulatory statutes 45 CFR 46. The protocol has been reviewed and approved.

The protocol is approved for a period of one year from the date of IRB approval. The expiration date of this protocol is July 29, 2010. Work on the project may begin as soon as you receive written notification from the Office for the Protection of Research Subjects (OPRS).

**PLEASE NOTE:**

Attached to this approval notice is the **official Informed Consent/Assent (IC/IA) Form** for this study. The IC/IA contains an official approval stamp. Only copies of this official IC/IA form may be used when obtaining consent. Please keep the original for your records.

Should there be *any* change to the protocol, it will be necessary to submit a **Modification Form** through OPRS. No changes may be made to the existing protocol until modifications have been approved by the IRB.

Should the use of human subjects described in this protocol continue beyond July 29, 2010, it would be necessary to submit a **Continuing Review Request Form** *60 days* before the expiration date.

If you have questions or require any assistance, please contact the Office for the Protection of Research Subjects at [OPRSHumanSubjects@unlv.edu](mailto:OPRSHumanSubjects@unlv.edu) or call 895-2794.

Office for the Protection of Research Subjects  
4505 Maryland Parkway • Box 451047 • Las Vegas, Nevada 89154-1047

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