Male Survivors of Childhood Sexual Abuse

Out of the most recent developments in the field of childhood sexual victimization is the identification of males who have been sexually victimized. Adult males, in particular, have been silent about childhood sexual abuse. Now, some are speaking out. The reader should keep in mind that there is little published information and current ideas are based on small samples. As more knowledge is gained, the ideas presented in this article may be shown to be inaccurate.

Incidence

In a review of all prior studies, Finkelhor (1984) places the incidence of sexual abuse for males under 13 between 2.5 and 5 percent. Including those aged 13 to 18 extends his estimate to between 2.5 and 9 percent. VCPN, volume 29, offers a complete review of incidence data for males.

Long Term Effects/ Presenting Problems

There are few studies of males which empirically confirm a relationship between sexual experience in childhood and long-term effects (Brown & Finkelhor, 1986). However, marital and growing clinical literature is beginning to document the common difficulties for male survivors. "Survivor" is a term that refers to any adult who was sexually victimized as a child. A great number of problems have been documented. Simply listing them is overwhelming. An effort is made here to group difficulties. Space necessitates that we take a simplistic overview. Readers are referred to Brower (1989), Lew (1990) and Hunter (1990) for discussions that offer more depth.

Male survivors experience many of the same problems as females (see discussion about female survivors, this issue). The following discussion will focus on differences that have been noted in the response of males and females and will address some of the responsiveness as it pertains prevalent for males.

Briefly, responses are divided into multiple categories. Psychological: Bereavement, guilt, identity; confusion and relationship dysfunction.

Multiple Compulsive Behaviors: Sex, food, chemicals and work are examples of common compulsive behaviors used to satisfy an internal drive to continuity past oneself. Less common distractions are overeating or religious or "collecting." The compulsive activity serves to distract the person from pain and anxiety. The self-indulgence allows the individual to gradually dependency needs are ultimately unfulfilling because the activity is not self-sustaining.

T. Thomas, in his personal account, "Surviving Incest," relates, "Dead drunk. Ma overate. I did both. If only I gained weight and wasn't so scrappy maybe my parents would love me... At home food was a gift of affection that was perverted... By the time I was 28 I wasn't even working anymore. I was around food, drunk more and more, worked constantly and kept my mind occupied by memorizing all kinds of professional sports statistics as an amnestic activity."

Clinicians report relatively high levels of compulsive behaviors in their clients. For example, Dimock (1988) found 44 percent of 25 survivors in his practice were sexually compulsive and 60 percent were substance abusers.

Masculine Identity Confusion: Difficulties in this area can be multiple. One common problem is confusion about male roles. The survivor generally has had few positive role models. Some are extremely uncomfortable around other men and isolate themselves from male friendships. Many question their masculinity, thinking a "real man" should have been able to stop the ghost.

Two researchers (Finkelhor, 1984, Johnson & Sher, 1985) have documented a statistically strong relationship between child sexual abuse and adult homosexual activity. Johnson and Sher compared 40 adolescent males reporting sexual victimization to an age-matched sample of 40 adolescents seen for other complaints. The victimized males identified themselves as currently homosexually oriented nearly seven times as often and sexual six times as often at the control group. Using a sample of over 200 college males, Mclatchie and Birk (1979), men boys vacillating between older men were more than four times more likely to be currently engaged in homosexual activity than were controls. Close to half of those victimized by older males were currently involved in homosexual activity.

The relationship between childhood sexual victimization and adult sexual orientation is not necessarily causal, and clinicians note that males sexually abused in childhood account for a majority of the total adult homosexual population. However, Mclatchie (author of Victims No Longer) questions the reliability of research showing a relationship between...

The Courage to Heal Workbook was written to accompany the acclaimed book, The Courage to Heal. (The Courage to Heal was the most frequently cited resource in four surveys of Virginia therapists.) The workbook offers information, exercises, checklists, activities and approaches for survivors to tackle the many aspects of the healing process.

Survival skills are undertaken first. This section lays the groundwork for establishing safety, building a support system, finding a counselor, dealing with crisis, and nurturing oneself. Part two, "Taking Stock," is a self-assessment. Analysis of childhood upbringing is related to current self-esteem, relationships, sexuality and parenting. The negative effects of abuse are balanced by an assessment of strengths. Coping mechanisms are examined in detail, with an emphasis on developing positive coping skills.

The third section is titled "Aspects of Healing." Starting with the decision to help, the person develops a "warrior spirit," hope, and courage to persevere. Then the workbook tackles memory, believing the abuse occurred, breaking the silence, telling (or not telling), learning self-trust, and grief and mourning for lost childhood. Anger is assessed and dealt with. The sticky issues of continuation and dealing now with family are worked through. Finally, the text summarizes with the "Resolution and Moving On" section. An appendix offers guidelines for healing sexually.

The Courage to Heal Workbook is a wonderful guide for groups and individual survivors. Some survivors may find the workbook taken as a whole overwhelming. Thus therapists may wish to introduce the exercises and material piece-meal, rather than introducing the book as a unit.

Also available:

-- Audio cassette: The Courage to Heal by Ellen Bass and Laura Davis. 2 cassettes, $15.95.

Available Soon

The Assessment and Treatment of the Sexually Abused, by author Mic Hunter. Available from: Lexington Books

D. C. Heath and Company

125 Spring Street

Lexington, MA 02173

Treating the Adult Male Sexual Abuse Survivor, 11 papers, available only as a set, $6.95. Available from: Peter Dimock, A.C.S.W., 4914 Science Avenue, Minneapolis, MN 55403.

Guidelines for Interviewing the Male Sexual Abuse Victim

This two-page guide outlines behaviors that may indicate a past history of sexual abuse, questions and approaches that can elicit disclosure, and methods for gaining information after disclosure.

Taking a Sexual Abuse History & Sexual Abuse Assessment Inventory

This four-page document offers a model for taking a sexual-abuse history. Six categories are offered, with examples of key behaviors in each: sexual offenses, exposure to repressive sexualization, sexual boundary intrusiveness, abuse of sexuality, sexualized adult-child relationships, and ritualized or satanic sexual abuse. A two-page assessment inventory can be completed by the client or used as an interview tool.

Male Sexual Abuse Survivor Issues

This four-page handout lists 13 topics related to sexual abuse. Each topic includes a brief description with questions to assist the survivor in exploring how this relates to his own recovery. These guides are well-written, concise, and can be used as teaching aids for presentations or as therapy tools. Other papers included are Male Sexual Abuse Bibliography (three pages); Critical Issues in Achieving Survivors' Trust (four pages); Victim-Offender Differential Treatment Characteristics (four pages); Characteristics Observed in Male Sexual Abuse Victims (two pages); Masculinity and Male Sexual Abuse Victims Socialization Gone Awry (one page); Myths of Male Sexual Abuse (two pages); Differences Between Adult Male & Female Victims of Childhood Sexual Abuse (one page).


Briere's book is a major new development in the field of sexual abuse. Written for the therapist, Briere's work is sophisticated and innovative, and it will likely have an appreciable impact on clinical practice and research. Readers should be prepared to reconsolidate and grow through reading the work: Briere's effect on my own practice of clinical psychology has been immediate and extremely beneficial.

The first chapter summarizes the effects of post-sexual abuse trauma, grouping them into post-traumatic, stress, cognitive effects, emotional effects and interpersonal effects. Chapter two discusses identity and body image, noting the relationship of these disorders to effects of sexual and continuous sexual trauma. The rest of the book deals with treatment.

The treatment chapters are covered in depth. Specific therapy principles and techniques are discussed. One very helpful chapter deals with client dissociation during treatment. Seven common forms of dissociation are discussed, including detachment, possession amnesia and total repression. The tension between the dissociative processes and the therapy goal of integration is examined and intervention techniques are suggested.

Another very helpful chapter examines the process of "degeneration" and the increase in self-destructive behaviors that can accompany the therapeutic process. How to handle the intensified symptoms in a productive fashion (as opposed to therapist panic at the "acting out") is discussed. Awareness of ways to structure the client and keep him safe might prevent some instances of hospitalization, increased medication, or violation of confidentiality in an effort to protect the client.

The use of group and family therapy is covered more briefly. A thoughts-provoking chapter on gender issues and gender effects on therapy raises more questions than it answers. The impact on the therapist of dealing with sexual assault is detailed, with an emphasis on how the therapist can remain psychologically healthy.

Appendices review data on psychological testing of survivors and contain a new chapter, The Trauma Symptom Checklist (TSC-30). (See separate review under assessment instruments.) Therapists who are weary of simplistic answers to complex questions will welcome this book. Although not a final answer, it is a new conceptual beginning that leaves room for expansion and elaboration. This work may improve your capacity to help others.

Outgrowing the Pain: A Book for and About Adults Abused as Children by Elaine GA. PhD, 1983, 88 pages, $5.95. Available from: Lunch Press, 7445 E. Elephant Road, Walnut Creek, CA 94598 (415) 932-4023

Written for both men and women, this book is for any adult who was abused as a child or who witnesses abuse in his/her family. Abuse is defined, and the child's reactions to abuse and the common defenses used by children are explained. Emotions and behavioral after-effects, such as difficulties in trust, low self-esteem and issues about self-protection, are explored. Patterns for example "I'm Tough" or "I'm Weak" or "I'm Unloved" or "I'm Last" are described. The final chapter talks about how to "take hold of your past" and "say goodbye to the parents you never had." Brief sections are included for the non-abused sibling and parents of adults abused as children.

This book is excellent for those with limited reading skills. The language is simple and cartoon-like illustrations are frequent. For survivors who find "in-depth" reading painful, this book can include many important ideas in a non-threatening fashion. However, those grappling with the complexities of recovery for those seeking deeper information, this book has limited usefulness.

Outgrowing the Pain is now available in Spanish.
Male Survivors
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Hunter discounts victims from searching for external evidence. The perpetrator is unlikely to admit the abuse. Family members will also deny it. Hunter observes, "A suspect who refuses to take any action to stop the sexual abuse of her boy is likely to refuse to take any action to assist him in his adulthood recovery, such as coming to therapy sessions or providing information about his childhood."

While belief in the victim’s memories and emotion is the most important step, sometimes the use of pictures to assist in remembering or visiting the site of the abuse can be useful. Occasionally medical records may exist. Hunter relates that one man recalled himself with bleeding from an inserted rectum, and remembered going to the hospital while holding himself up off the seat because sitting was the painful. Hospital records revealed he had been admitted and treated for anal wounds. As a result the case might involve a case of sexual abuse and neared sexual assault. There is no striking similarity about the cases. In neither incident did the discuss the child what had happened to him.

Therapy Tools to Assist Survivors

Journal keeping
Letter writing
Cognitive therapy to correct distortions
General therapy or psychodrama to uncover feelings and work with dreams
Hypnosis
Guided imagery
Art
Viewing old photos of self when a child
Self-help groups
 Assertion training
Self-defense training
Writing therapy — a three day Outward Bound program (Agran & Lovig, 1989)

Part of acknowledging the victimization is recognizing how the abuse has continued to affect his life. Dimock suggests one method to assist this process is to identify any problems as possible that could be associated with the abuse. While victimization is not the cause of all of a person’s problems, it is nevertheless important to explore the common difficulties experienced by adult survivors to determine to what extent these may relate to the abuse. Bruce also stresses this point as key to successful treatment. As opposed to other approaches, survivor-oriented therapy focuses on the original abuse, relating the early experiences to later and current problems, experiences, and psychologic functioning.

Another helpful technique is obtaining a three-dimensional sexual history (see assessment section). Have the client write his history and read the material in group or individual sessions. Begin to make connections between the past events and present reactions. Encourage him to warn on the information he provides. The person has achieved acknowledgment when he can recall the abuse sufficiently to establish the degree of trauma, recognize that the older person was responsible for the abuse, and understand what factors in his history made him vulnerable at the time of victimization.

Reconstructing the Impact Men put a great deal of energy into being invulnerable. They are expected to control feelings, limit disclosure of feelings, and take care of themselves. Thus, dealing with vulnerability and the affects of victimization is an especially difficult task for men.

The impact is generally enormous. "Childhood sexual abuse is more than a sexual act," asserts Hunter. "It affects all aspects of the victim’s life." Hunter divides the 10 areas affected by the abuse into five large categories: physical, mental, emotional, behavioral, and spiritual. He states, "A man’s entire spiritual aspect makes his formulation unique. He explains, ‘I believe that sexual abuse is also a spiritual abuse. In my work with abused persons I have found that unless the spiritual aspect is addressed, healing is incomplete.’"

Hunter speaks of victims who ‘shun religion because God has not protected them from the abuse. Others are terrified of God and basically reject him as a way to be safe. Others thought the abuse was God’s punishment for their sins.

Part of reconstructing the impact is the expression of feelings. Work is groups facilitates emotional exposure, as the group members can provide both support and modeling for each other. Dimock suggests encouraging group vulnerability through various themes such as group art, sexuality discussion, guided fantasy with relaxation, or role-playing a vulnerable situation with the help of group members.

Hunter stresses that the therapist must be comfortable with the patient’s expressed emotion of intense emotion. He says, "Therapists who have little experience with sexual abuse survivors sometimes think, when their client is getting in touch with powerful emotions, that something is going wrong in the therapeutic process or that the client is uncompromising (getting worse)."

Briere agrees, saying, "... the release of emotions is not necessarily a necessary condition of full recovery" (p. 65). Further, Briere emphasizes the need for therapists to handle the emotional wrecks of patients without therapists co-panic. The process of "getting worse before getting better" is seen as a natural one that should not be overanalyzed or pathologized.

Reconstruction allows the ability to recognize the impact of the abuse on the child within. He speaks of using photos of the child when he was a child to facilitate the process. "A second technique is having the client write a letter to the man who abused him as a child, telling the child about his good qualities, assuring the child that he will survive, and that the child will end. Lew also advises one client to find new ways to play, as it is "never too late to have a happy childhood."

"Recovery is about freedom — freedom to make choices... that aren’t determined by the abuse."

— Mike Lee

Hunter employs the use of 10 animals to help the client connect with the wounded child within. "As long as you hate, ignore, deny or fear that vulnerable childlike part of you recovery will only be superficial," states Hunter. He asks his clients to spend considerable time finding just the right toy stuffed animal animal to animal. In most cases Hunter relates several examples of how relating to the stuffed animal allowed them to increase their understanding and learn to be gentle with themselves.

The two discussions ‘brain technique’ get back beyond logic to ‘deeper realms to the heart itself’. Creative imagery and expression can revitalize the process of channeling energy into coming up and protecting. Imagery includes many words and thought pictures. He suggests repeating calming affirmations such as "I am a lovable child" many times each day. If your feet are stuck to a maddaluddle, visualize it. Use meditation to quiet mind and spirit. Art, music, poetry and dance can empower survivors and self-exploration.

Dimock suggests journaling as a way to recognize feelings and allow their expression. Writing must be combined with sharing into be effective. Lew understands the need for冷冷 isolation and sharing with others. "The witch to recovery begins with putting an end to your isolation," he states. A group can become an adult support system, a substitute family, a safe place to start. Of all the feelings to sort out — anger, shame, guilt, rage, grief, sadness — perhaps
New Directions for Men was started by four therapists in 1980. The therapists had been associated with Lamere, an organization founded in the mid-70s to address the problem of male battering. Emerging began to receive calls from men who were not batteries, but who, wanted referral for therapy for other problems. New Directions for Men was established to meet this need.

New Directions for Men offers a wide-range of services including marital counseling and group and individual therapy for problems ranging from anxiety to sexual dysfunction. The organization also treats men who are sexual offenders.

The demand for help for adult male victims of child sexual abuse is more recent. Presently, many survivors of childhood sexual abuse are offered individual therapy. New Directions is in the process of organizing a treatment group.

Joe Doherty, Ed.D., explains the approach, saying, "There is no formal training of clients, but I assess the impact of the abuse. I look at development, degree of depression, the use of alcohol and drugs, and the person's work history." Doherty adds that those with substance abuse problems are referred for concurrent treatment.

Doherty tries to help clients articulate the impact of the abuse. "I encourage the individual to get in touch with resources, read books, and break the isolation that frequently is part of survivors' doubts." On one occasion involving isolation is to attend a monthly drop-in group for male survivors. Doherty helped organize the group that started in September 1987. Six members attended the first meeting. Now a core group of eight men attended regularly with plans meetings occurring as many as 14.

The group is organized around themes. Each month features a different topic, for example, dependence, intimacy, substance abuse or sexuality. Doherty gives a short description of the topic, followed by open discussion.

Guidelines for the group are very simple. When someone new comes to his first meeting, he gives a written copy of the guidelines. The group is open to any non-offending male survivor of childhood sexual abuse. Those who attend the group are asked to maintain confidentiality and to disclose information outside the group. There is no touching without permission. Those attending are asked to arrive on time, refresh from advice-giving, and avoid monopolizing the group. The guidelines ask that those attending refrain from racism, sexism, and homophobia remarks. Anyone has permission to leave the group at any time for any reason.

The drop-in group is not a treatment group. There is no formal follow-up of those who attend. However, Doherty notes that the vast majority who attend are also in individual or group treatment. The group is often recommended by the therapists, but some members learn of the group through a listing in the local newspaper's calendar of events.

"There is a great deal of shame and embarrassment when dealing with the abuse," says Doherty. "Sometimes the events seem too painful to seek it. People want to be healed. It's hard to accept that someone else has done destructive to one's life. It's easier to deny the impact." Most clients remain in individual treatment less than a year. Doherty typically does not involve family members in treatment. Part of the reason is that, to date, no married men have presented themselves for treatment.

New Directions for Men plans to start a treatment group for male survivors in the spring of 1980. Doherty plans to carry a wider range of trauma disorders. He is a consultant to a Roman Catholic organization with patients in Winooski. None of whom have experienced post-traumatic stress problems. Doherty serves as a trainer for legal personnel and police and has also been an expert witness in a variety of court cases concerning sexual abuse.

More information is available from:
New Directions for Men, Inc.
P.O. Box 510
Boca Raton
Boston, MA 02117
017-498-9081
Incest Survivors Anonymous “I.S.A.”

This international organization/world service office/telephone machine was founded in July 1980, by an incest survivor. The emphasis is on a self-help peer program, open to men, women and teens. The program is based on the 12 steps and 12 traditions of Alcoholics Anonymous, adapted to incest. The group is happy to help new meetings start. Speakers are also available, as are three packets of information. The group is not open to survivors who have become perpetrators.

For further information, contact: Incest Survivors Anonymous (I.S.A.), P.O. Box 563, Long Beach, CA 90805-0613, (213) 428-5599.

Incest Survivors Resource Network International (ISRNI)

ISRNI was founded and is operated by incest survivors from a variety of professions. Quaker affiliated, ISRNI was instigated as a peace movement because it saw unresolved traumatic stress as the genesis of much strife in the world. It evolved into an international educational resource devoted to primary prevention and functions mainly by participation in committees and conferences of international and state national organizations.

ISRNI facilitated the first mixed gender incest-survivor-only peer group for five years and until early 1980 operated the ISRNI helpline. This was the first help-line answered only by incest survivors that responded to calls from all over the U.S. and Canada. ISRNI was a pioneer in the promotion of awareness of female offenders/males victims and the concept of emotional incest. ISRNI continues to encourage communities to develop Parent United chapters.

For further information, contact: Incest Survivors Resource Network International, P.O. Box 911, Hicksville, NY 11802, (516) 935-3031.

P.L.E.A., Prevention + Leadership + Education + Assistance

Prevention — Leadership — Education — Assistance (P.L.E.A.) is a non-profit organization with the purpose of combating physical, sexual, and emotional abuse of males. P.L.E.A. helps exclusively non-abusing or non-offending adult male survivors of childhood abuse connect with resources. Services include a nationwide referral service to professionals experienced in helping male survivors, the quarterly newsletter “The Survivor” and a bibliography available for a $5 donation.

For further information, contact: P.L.E.A., 356 West Zia Road, Santa Fe, NM 87505-5723, (505) 982-9184.
The Safer Society Program

The Safer Society Program is a non-profit nationwide project of the New York State Council of Churches. It is a national research, advocacy and referral center for the prevention of sexual abuse. It serves as an informal clearinghouse, a public service. The program operates Safer Society Press which publishes research, studies and books. Write for a list of publications. The program also maintains the only annotated nationwide directory of agencies, institutions and individuals providing specialized assessment and treatment services for juvenile and adult sex offenders. Referential for survivors and offenders are provided by phone at no cost.

Two national networks are maintained, one for professionals creating female sexual abusers and the other for professionals training intellectually disabled sexual offenders.

Survivors of Incest Anonymous, Inc.

The self-help group of men and women, 18 years or older, is based on the 12 step Alcoholics Anonymous model. The organization has international groups, 40 pieces of literature (including two pamphlets for males), bimonthly bulletins, pen pals, and a hotline. For a starter packet, a $5 donation is requested. If a survivor cannot afford the $5, the packet will be sent free of charge.

For further information, contact: Survivors of Incest Anonymous, Inc., World Service Office, P.O. Box 2187, Baltimore, MD 21223-8817, (301) 283-3400.
Male Survivors

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Confrontation will not make the effects of the abuse disappear. Sometimes the family relationships will worsen. Often the survivor experiences another grief response. The confrontation may be met with denial or lack of concern.

Both Hunter and Lew recommend considerate practice prior to the actual confrontation. There are also alternatives to face-to-face confrontation. Symbolic confrontation can occur through letter writing, guided fantasy or role play. Another option is making a tape. Legal action is possible. If the perpetrator is dead, the survivor can visit the cemetery and talk to him/her at the grave. Non-offenders who failed to support the victim can also be confronted.

Separating the Past from the Present: It is often difficult for the survivor to separate his reactions to present experiences from feelings related to the past victimisation. Separating the past from the present is a gradual learning process, according to Dimock.

First comes the ability to recognize that a present experience might be connected to the abuse. Gradually, the survivor begins to identify situations in which he has responded and is responding with feelings connected to the victimisation. As the survivor begins to realize that he has choices, he can look back and attempt to clear the confusion. Finally, the survivor is able to anticipate and make arrangements prior to allowing contamination from the past.

Part of this process can be "reclaiming" one’s body. Those who were sexually abused as a major survival technique need to reconnect, feel safe and secure in their bodies, and honor their physical being with love and care.

Bodywork and non-traditional healing can play a role. Physical exercise is readily available and offers the advantage of no physical contact for the survivor/recipient. Other body techniques such as massage, Therapeutic Touch, Reiki Healing or Rolfering require trusting another person with one’s body. While not every technique is suitable for all, a program of bodywork can assist in learning to experience touch as loving and healing.

Consolidating the Learning: The test of a recovery process is the survivor’s ability to sustain change in daily living and to continue to make adaptations on his own. The survivor eventually outgrows the need for a therapist. He is able to give that he has support. The abuse begins to recede into the background and more current events become important.

Hunter feels that acceptance and forgiveness are a crucial part of this process. He explains, “Forgiveness does not mean that you condone the abuser’s actions. Forgiveness allows the hurt to be in the past and not to contaminate the future. The emotional energy that was used to maintain resentment is available to be used in other, respectful relationships.”

The survivor needs to forgive, according to Hunter, so he is not bonded to the abuser by hatred. “You forgive others because it helps you, not because it helps them,” he says.

Hunter emphasizes that acceptance and forgiveness will produce a sense of serenity. Unlike the “pseudo-forgiveness” prominent in the bargaining stage, true forgiveness does not require great effort to maintain. The feeling is deep and broad. Given the likelihood of premature forgiveness, others such as Briere and Lew caution against therapist encouragement of forgiveness. Forgiveness can be a form of denial and a defense against truly feeling continuing anguish and rage. Lew notes, “Forgiveness is not mandatory. It may or may not make sense. The only person it is important to forgive is oneself.”

Likewise, reconciliation with the offender is often impossible. Briere suggests that offenders forfeit the possibility of reconciliation due to their actions. He states, “The vast majority of victims do better, and are safer, when their therapy and their futures do not include their abusers.”

The controversy over forgiveness and reconciliation might be side-stepped by concentrating on a summary statement offered by Lew: “Forgiveness is about freedom — freedom to make choices that are right for the individual and that aren’t determined by the abuse.”


Courtoe’s work is very comprehensive. She considers not only the typical father/daughter dyad, but also discusses father/son incest, sibling incest, sibling incest and incest in the extended family. A section of the book is devoted to after-effects, presenting problems, and diagnosis. An appendix contains a 12-page incest history questionnaire.

The remainder of the book is devoted to the process of therapy. It is packed with information. Special sections are devoted to group treatment, special populations (ethnic, gay, male survivors, physically impaired, incest pregnancy, military families, and others) and to special treatment issues. The latter includes dealing with dissociation, self-abusive or suicidal behavior, additions and compulsions, coping with medical treatment, eating disorders, and sexual difficulties. Issues such as legal remedies for the survivor, confronting the perpetrator and dealing with family reaction are covered.

Healing the Incest Wound offers much to practitioners. It reviews current knowledge, describes treatment strategies, and discusses the exceptions and empirical issues that the work of helping survivors is complex.
Women Survivors have been studied longer than male survivors. There is a
considerable quantity of literature about female adult survivors; however, much of
the literature is repetitive. Clinicians and survivors have detailed the long-term impact
of childhood sexual abuse on women and the treatment issues. Much remains to be
learned about the process of recovery and how to best facilitate it.

Incidence
Several studies have sought to estimate the
number of adult women who were molested
as children. Frankboh (1979), surveying
college females, found a rate of 14 percent.
Russell, in a carefully selected cross-section
sample of 250 women found 16 percent had
been molested prior to age 18 by a family
member and 31 percent had been molested by
non-family members for a combined total of
38 percent.

Impact
The long-term effects of childhood sexual
abuse on females have been extensively
documented. Early writings, such as Corbin
(1979), stressed that the impact of incest
was highly subjective and not predictable.
More recent studies, however, are docu-
menting significant group differences
between sexually victimized and non-
victimized populations.

The symptoms that have been docu-
ment ed for women appear to be valid for
male survivors as well. Thus, the following
discussion of impact applies to both male
and female survivors.

There is no commonly accepted grouping
for symptoms as problems. This article will
divide these into four groups: self-destructive
behaviors, emotional reactions, relationship
problems and physical disorders.

Self-destructive behaviors include sub-
stance abuse, indiscriminate sexual activity,
prostitution, eating disorders and suicidal
behavior. Survivors are at increased risk
for rape or other victimization.

Emotional responses include depression,
anger, guilt and shame. Many survivors
experience repeated nightmares and exagger-
ated fear responses. Some have large memory
gaps. Dissociative experiences are common
with a more severe reaction being multiple
personality. Serious personality disturbance,
often diagnosed as borderline personality,
avoidant personality or schizoid personality,
is possible.

One study (Ellenon, 1986) found that all
of the 60 survivors interviewed experienced
"astonishingly similar" hallucinations.
These included shadowy figures, moving
objects "seem out of the corner of the eye"
and occasionally more elaborate visions.
Auditory hallucinations included footsteps,
breathing, doors opening or closing, bumps,
windows being slammed with, children
calling for mom, and voices threatening,
condemning or directing the survivor to
violent acts. Tactile hallucinations of being
touched were also noted. Most women do
not report these experiences to anyone, for
fear of being labeled "crazy." The fear is
well founded, as those who described the
hallucinations had been diagnosed schizophre-
nic, schizoaffective, or schizotypal per-
sonality. In contrast, Ellenon sees this
symptom as a predictable reaction to
catastrophic stress.

Relationship problems are characterized
by interactions that are conflictful, empty,
sterile or sexualized. Survivors typically
are described as unable to engage in self-
expressive, schizophonic, or affectful
behavior.

Identification of these problems as typical
correlations for sexual abuse survivors is
beginning to appear. Wheeler & Watson
(1977) documented the Meehan Clinical
Multiassen Inventories to 28 insecure and 12 non-
insecure subjects. They found 9 of the 20 scales
showed significant group differences. Those
with histories of sexual abuse were higher in
depression, anxiety, alcohol abuse, somatoform
disorders, psychotic thinking, borderline
personality, passive-aggressive behavior,
vigilant personality and schizoid personality
(social distancing).

Gold (1986), examining 103 victims and
88 controls on a variety of surveys and
psychological tests, also found a considerable
number of significant differences similar to
those found by Wheeler and Watson. Briere
and Runco (1988) found sexual abuse
survivors were more likely than controls to
be taking psychoactive medications, have a
history of substance abuse, be re-victimized
sexually as an adult, have at least one suicide
attempt, give evidence of dissociative
experiences, exhibit sexual problems, and
show self-destructive behaviors.

Even frommolt (1986), using a sample of 383
college students in which 60 per cent had
only one abusive experience (for example,
exhibitionism by a stranger) found signifi-
cant differences between groups. Those
with a history of sexual abuse were more likely
to be victims of coercive sex acts as adults, were
more sexually active, and showed a wider
distance of sexual activity (intracourse, homo-
sexual activity, masturbation).

Thus, while more study is needed, there
is support for the idea that childhood sexual
abuse produces predictable effects in
adulthood. Most clinicians are labeling the
symptoms post-traumatic stress disorder.
This disorder requires that the individual
have a history of trauma and be re-
experiencing the trauma either through
dreams, flashbacks or distressing recollec-
tions. The individual also experiences numbing and persistent arousal.

"The effects of abuse are equally profound whether the victim is male or female, they are also generally similar."

Mike Lew

Assessment
Assessment of female survivors is
easier by several tools. Courrion (1988)
offers an 11-page index history questionnaire
in her book, Healing the Inner Wound (see
review). Donaldson (1983) has published
Responses to Childhood Incest: A Tool for Self-Assessment (see review). Davis' The Courage to Heal (1990) contains a scale for
"assessing the damage" and chapters on
identifying coping behaviors. As noted
earlier, a variety of studies using traditional
psychological tests are showing systematic
differences between adult survivors and non-
victimized populations.

Recovery is an ongoing process. All
the information cannot be gained in a few
contacts. For the survivor to express the
depth of her pain requires trust in the
therapist and a wait on the recovery process.
Women Survivors

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Disguised Presentations

Some women seek treatment because of sexual abuse and self-identity as childhood victims. Some survivors seek treatment due to problems that they do not associate with sexual abuse. While they recall the abuse, they don’t disclose it initially. Other survivors have repressed the abuse and can’t recall it. Since not all sexual abuse victims will self-identify, it is important to carefully inquire if indicators of sexual abuse are present.

Carcin clinical populations are especially likely to be sexual abuse survivors. A high percentage of women substance abusers have childhood histories of sexual abuse (Farkas & Boelhavský, 1984), as do prostitutes. As many as 66 percent of those with eating disorders may be survivors (Oppenheimer et al., 1985). Those with sexual problems may be survivors, especially if they have difficulty separating sex from affection, have dreams of a sexual nature, or are unable to remember past sexual experiences.

Galinas (1983) notes that the usual disguised presentation is characterized by depression with complications and with avoidant, impulsive, and dissipative elements. A high percentage of borderline personalities also have histories of childhood molestation. Galinas has developed these clinical findings into an "incitement recognition profile."

Therapists are encouraged to ask clients if they notice incest indicators. As least one study (Josephson & Page, 1984) has found that disclosure is directly related to therapist inquiry.

One caution for therapists is to avoid the automatic assumption that the sexual abuse has ended the client’s past. For some, sexual abuse is ongoing and the client is too embarrassed and traumatized to admit to the continuing, normalization. Even if the sexual contact has ceased, the survivor may still be emasculatory or financially dependent upon the abuser. Disclosure of ongoing abuse is easier if the client knows that the therapist is aware of this possibility and is prepared to be understanding and supportive in these cases.

Treatment

Male and female survivors appear more alike in response to sexual victimization than they are different. Experts agree that the trauma impacts equally on males and females (Briere, 1989; Lew, 1990; Roth, 1987), hence, severity of symptoms are similar.

Despite the commonalities, males and females are different in some respects. Males in their response to sexual victimization. The sexes are socialized differently with regard to sexuality and aggression and in how to express emotional pain.

Socialization may explain why females who are sexually abused are prone to victimization, whereas male survivors show a higher risk for becoming perpetrators (Briere, 1989). Socialization may also account for why women seem more willing to communicate their feelings about the victimization and seek help.

Treatment approaches appropriate for one sex are generally applicable to the other. Indeed, the resource reviewers contain a number of books and workbooks meant to be used by both sexes. Gender differences appear to relate more to the process of treatment than to what sexual techniques are utilized. Differences in emotional expression, freedom to be vulnerable and responses to emotional data determine, to some extent, how the issues are worked through (Briere, 1989).

"I know that recovery is possible. It isn’t quick and it isn’t easy, but it is real."

—Mike Lew

While males easily convert pain to anger, many women have difficulty expressing anger at all. Women are more likely to use sadness or fear to hide anger. Thus, while therapists working with males need to focus on recognition of the vulnerability, hurt and sadness, female survivors need to recognize and express the anger.

One issue that may be important is to consider is matching the sex of the therapist and clients. Most experts suggest that a same-sex therapist is the most advantageous match. However, the issue is a complex one, with any program having complicated interaction possibilities. For a discussion of these, the reader is referred to Briere (1989; see book review).

In any event, the therapist must establish and maintain appropriate boundaries. Involvement will be a constant issue, since the survivor learns in a child that at least some adults are untrustworthy.

Group and individual treatment both should be considered. Each modality addresses different issues and generally both are needed. Group support helps the survivor to break the isolation, acknowledges the abuse and see the symptoms as expected consequences of the trauma. Individual treatment allows intense focus on the survivor without interruption.

Stages

There is no universally accepted process of recovery for female survivors. Thus, the "stages" presented here are a simplification of steps and will not necessarily occur in order or be relevant for every survivor. For a more complete discussion, readers are referred to Cournoy, 1988; Davis, 1990; Gill, 1987; and Swenson and Mavis, 1986.

After disclosure and assessment, considerable time may be spent simply building a therapeutic alliance. The counselor must be forming or strengthening relationships with others (such as other survivors in a support group). This process involves learning to use others for support (without depleting these resources), gaining control of presenting problems (such as the current crisis that brought her to therapy), effects of depression, managing stress of job and home, learning about family interactions and the dynamics of sexual abuse, and acknowledging the "child within."

The child within is the focus of the next stage of recovery. The abused child is brought forth and the survivor reconnects with the feelings and experiences of childhood (Cournoy, 1988). In particular, the survivor must come to terms with guilt and responsibility, learning to view the child as helpless and percievez the child with compassion instead of judging. Regressions, including a return of intrusive symptoms and body sensations often accompany this stage, as the survivor experiences the pain of the trauma. Many survivors get worse before getting better and desolate or depersonalize. Since the work of the stage is intense, counselors who assist must closely monitor the survivor. The counselor must react to the reactions and validate the experience.

An important aspect is grieving for the loss of childhood. The survivor has been cheated and has missed many vital growth experiences. The survivor not only mourns for the competent, caring parents that should have been available, but she also must reprimand the hope that her parents will somehow change.

The next phase involves integrating the various aspects of the trauma experience and redefining one’s self. Maleadaptive patterns are replaced with patterns that are healthy. A positive self-concept replaces the old self-image. A radical redefinition of the self can result (Cournoy, 1988).

Survivors who have used dissociation cater to the repression of all or part of their personality, present the greatest challenge during this phase of recovery. Anxillation and integration of all parts of the person requires anamnesis of some aspects of personality, a frightening step.
Whether symbolically within the support group or therapy room or directly, disclose and confront others allow further integration of the trauma experience. By breaking the silence, the survivor claims her selfhood, her experience and her voice.

Part of confrontation is protecting others from abuse. Indeed, some cases reveal the therapy only when their own children support the abuser. The abused may still be involved in the survivor's life and may still be a threat to children, including the survivor's own children. Providing protection for one's children or grandchildren can be a vital aspect of recovery.

Therapy for childhood sexual victimization, like other forms of therapy, can vary greatly in length, focus and intensity. Short-term crisis intervention may offer restitution, support, and a focused approach to a particular situation. Some survivors may tolerate only limited intervention before being able to embark on more intensive and long-term work. Long-term intervention is the choice for others. Survivors have many differing needs and there is room for many different approaches to recovery.

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Virginia's Picture

To order to learn about services in Virginia for adult survivors, VCNPN surveyed Virginia's 21 sexual assault centers. Out of 19, 19 agencies responded. Of these, two had no services for adult survivors. The remaining 17 centers offered programs for women (12), individual counseling or support (4), referral to a community survivor's group (6), and referral to a community agency or private therapist (14). Services for men were sparse. Only a few centers had referrals to private therapists that specialized in treating male survivors. The two centers that could estimate, most said males were "a very low number" (8 centers) or less than one-tenth of a percent (5 centers) or none (2 centers). One center reported that 12 of the 40 calls from survivors last year were males. Most centers (16 of 19) are training volunteers and staff about male response to sexual assault. However, very little emphasis is placed on males. Training about responding to male callers is less than 5 percent of the training time for all but two centers. The two centers with more emphasis on males still spend less than 10 percent of training time on males. VCNPN also asked the sexual assault centers about calls concerning children. Many centers did not keep this data. Of the 11 that did report, five said less than 15 percent of calls were about children. 3 centers reported 20-25 percent of their calls were about children, and 3 centers said 35-40 percent of the calls they handled were child sexual abuse. Of the calls concerning children, 26 percent (6) said less than one percent were male child victims, three centers placed the male victims at 5-10 percent and one center estimated that 20 percent of the child calls. A number of centers commented that calls involving male children were so rare that they did not keep track of how many calls were received. One center noting that child calls had nearly doubled in the last year. Even with such a high incidence of calls concerning children, only 12 of the 19 centers contacted adult male staff about child sexual assault. Of the 12 offering such training, one center spends half the training time on child sexual abuse, and three centers spend one-fourth of the time on children. The non-designate 5 percent of their training to child sexual abuse. Most centers do not target any training towards male child victims.

It is apparent that rape crisis center are handling many calls from adult survivors and from child victims. Those working with child victims and adult survivors need to network with rape crisis services to improve the response to all sexual assault victims.

VCNPN also interviewed mental health practitioners in Virginia to learn more about services in our state. We asked each rape crisis center for names of therapists who were expert in the treatment of adult survivors. Fourteen of the referrals agreed to be listed.

The 14 therapists were from ten different areas. Both rural and urban areas were represented. Most of the therapists were 25-39 years old, and nine were female. Six of the therapists had been working with adult survivors for more than ten years, four had five to nine years experience, and four had two to four years experience.

While nine of the therapists had some experience with adult male primary focus was on female survivor. Five therapists (36 percent) had never worked with any male survivors.

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Asessment Tools

The Trauma Symptom Checklist (TSC-33) developed by J. Briere and M. Runtz, 1989,

This instrument is still in the design stages. It is being used in clinical research as a module of traumatic impact (primary but not exclusively) in the area of long-term sexual abuse effects. The instrument contains 33 items each of which is rated on a four-point scale. An additional seven "experimental" items are included.

These items are currently being researched to see if they will increase the reliability of the scale and add an assessment of abuse-related sexual difficulties. If these items prove valuable, they will be integrated into a new "TSC-40" scale.

Initial research shows that this brief instrument is relatively reliable and demonstrates reasonable predictive validity of long-term sexual abuse effects. Norms are not yet available and it is suggested that the use of this scale be continued with care.

A description of the scale and the research data can be found in John Briere's book Trauma for Adults, Mental Health American University Press, 1992.
Third, a great variety of therapeutic approaches are being offered to survivors, suggesting that therapy for survivors varies greatly from one practitioner to another.

It is apparent that services for adult males who were sexually victimized as children lag far behind the available services for female survivors. Since there are many similarities between male and female survivors, males can benefit from the expertise and knowledge that clinicians have gained from years of helping women. If males begin to ask for services, it is likely that skilled clinicians will respond.

Summary

Many questions remain. The role of key variables of the abuse remains unclear. We are not certain about the effects of variations such as type of abuse, duration, frequency, use of force, age of onset and family dynamics. The lack of research for further study of sexual abuse victims who entered adulthood with few or no apparent problems. More information is needed about matching clients to various therapeutic strategies.

Meanwhile, survivors male and female are finding the courage to focus us on the issues while they learn to heal. The process is summarized by Lev, “I know that recovery is possible; . . . . It isn’t quick and it isn’t easy, but it’s real.”

References available upon request.