



MEN SUBJECTED TO SEXUAL ABUSE

Experiences from psychoterapeutic work

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Special thanks to the patients we have had the privilege to follow.

Creating the conditions for changing and improving people's lives has been the driving force of RFSU since the very start in 1933. RFSU is a politically and religiously independent non-profit organisation with the aim of spreading a knowledge-based and open view of sex and relationship issues. Through information, education and political advocacy, RFSU strives to overcome prejudices, bridge the knowledge gap and improve sexual health, both in Sweden and internationally. RFSU has a liberal and rights perspective on sexuality, founded on the freedom of all to be, to live and to enjoy as one wishes. When you purchase a product, become a member or partner, or support the work of RFSU, you are contributing to continued changes in people's lives.

Foreword

In this report we describe our experiences of six years of psychotherapeutic work with men subjected to sexual abuse. The report focuses on the inner experiences of the men. Based on a psychological perspective we have wanted to create a deeper understanding of the inner world and the subjective perceptions. We also highlight the interplay between the inner perception and society's values when it comes to abused men, because society's norms and values concerning masculinity and sexuality affect both victim and therapist. The report is mainly aimed at therapists who might meet men subjected to sexual abuse in social services, healthcare, youth services and victim support, etc. Since we start from our experiences from psychotherapeutic work acute care is not described here to any great extent. Publications that take up emergency care following abuse are discussed by others NCK (2008:1), RFSU (Göthberg & Hedlund, 2005) and Rädde Barnen [Save the Children] (www.raddabarnen.se).

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Introduction

The RFSU Clinic has been commissioned to seek to make visible groups of patients who for various reasons have difficulty in having their needs satisfied within the context of public health care. Over the years the clinic has therefore focused on various areas in which we have conducted method development, treatment and advocacy with the aim of contributing to better care for the different groups.

The RFSU Clinic has extensive experience of treating people subjected to sexual abuse. In 1977 RFSU started the country's first rape clinic for women. Over the years society's care of raped women has developed, and knowledge of these women's needs has deepened. However, male victims of sexual abuse are still an invisible group. Within health care there is a lack of routines for care. The pervading silence around the fact that men can also be subjected to sexual abuse contributes to those in need not seeking help. In recent years RFSU has therefore had a particular focus on working with men subjected to sexual abuse, and in psychotherapeutic contacts we have so far treated 42 men with such experiences. In addition

to offering support and treatment to the men who approached us, the aim has been to try to understand more about the consequences of the trauma and contribute to increased knowledge about the fact that men can also be subjected to sexual abuse.

An aspiration has been to put our psychotherapeutic work into a context. As early as in the autumn of 2009, we made contact with counsellors at the emergency departments of large hospitals in Stockholm County to examine the existence of experience in meeting men subjected to sexual abuse at an acute stage. All services stated that there was very limited experience of this. In order to obtain and disseminate knowledge we have in the subsequent years, in parallel with our clinical work, had talks and meetings with several professionals active in the Stockholm area who work with men subjected to sexual abuse. In the spring of 2014, we also made phone calls to all counties in Sweden regarding their readiness to help abused men. The results of this survey are reported under the heading *Meetings with health care*.

The Men Who Approached Us

The men who approached us to seek help represent a heterogeneous group, aged 18-65, with different backgrounds and different sexual orientations. The men had found us online, were referred to us by various healthcare units or came via internal referrals from the RFSU Clinic's section for sexual medicine. In order to provide a description of the group we have met, we anonymously compiled background data. Of the 42 men we have worked with, 24 were subjected to abuse in childhood, 10 were abused as teenagers and 8 as adults. Of the 10 abused as teenagers, 7 were abused by a casual partner, for some it was their first sexual experience. Several were involved in abuse on repeated occasions, in different periods of their lives and by different perpetrators. A wide variety of abuse was experienced. For some it had been going on for several years, while others had been abused on a single occasion. The abuse involved rape, bodily violations or being forced to perform sexual acts. The perpetrators have been both men and women. When abuse occurred during childhood the perpetrator was the father, mother, male cousin, sister, brother, or another important person in the child's vicinity. As for those who were

abused as teenagers or adults, the perpetrator was in all cases a man or woman who the victim knew or was familiar with. Of the 42 men we have worked with, 12 were abused by female perpetrators, 5 of these 12 were also abused by males on another or the same occasion.

Common to all of the men who approached the RFSU Clinic is that the abuse had serious consequences for the men's physical, mental and sexual well-being. The reason for seeking help was formulated in various ways. Most approached the clinic wondering whether the difficulties they experienced were caused by the abuse they were subjected to. They have expressed a wish to be close to someone at the same time as feeling a lack of ability to establish intimate relations with another person. Others have described some form of sexual dysfunction or recurring and intrusive thoughts, fantasies or nightmares with sexual content. Only a few men have previously talked about what they were subjected to. Almost no one had previously sought any professional help for what they had been through. For many, a long period of time had elapsed between when the abuse had occurred and when the man was able to talk about it.

Reasons for seeking help at the RFSU Clinic have concerned different aspects of sexuality and have been associated with themes related to attachment and relationships. Treatment has been psychodynamic and has consisted of counselling, crisis intervention, and psychotherapy of shorter or longer duration. We have started from the individuals' wish to begin to approach their difficulties and the desire to achieve some kind of change. If anyone had a particular preference for a male or female psychotherapist, we have been able to provide for this. None of the men we have met, however, has expressed such a need. We have not treated people with serious psychiatric disturbance or serious drug abuse that we assessed were unamenable to outpatient care. Psychotherapeutic contracts have taken a variety of forms. These have been designed individually, sometimes as six-month contracts extended in steps, and sometimes as psychotherapy without time limits. Sometimes we have offered consultations for couples when the need has arisen, or offered a single contact for one partner.

The Report's Contents

Our experience of working with abused women led us to wonder whether there may be different consequences for men and women subjected to sexual abuse. If so, what are the differences? How is the abuse described and how can we understand it? There are both similarities and differences between men and women in terms of the consequences of sexual trauma, but it is of greater importance to remember that individual differences regardless of gender are paramount in the treatment of trauma. Our intention has been to investigate the specifics of men's experiences in order to learn more about issues that are important in the treatment of men who have been abused.

We start with the focus on *Societal Aspects* and link aspects of sex and gender to issues of sexuality, in order to describe some of the myths and conceptions that affect the view of men as victims of sexual abuse. Men's vulnerability, and any differences between men and women, needs to be understood from an overall societal perspective since structural issues and norms also affect the individual experience. From a more clinical perspective, under the heading *Meeting Men Subjected to Sexual Abuse*, we later describe our experiences of

working with the men we met in longer and shorter treatment contacts. Systematically reviewing notes and reflections from all treatment contacts, we have found, for example, that some areas were given more focus, compared to our experiences of working with women subjected to sexual abuse. In the report we have chosen to highlight and emphasise what has been particularly characteristic of our psychotherapeutic work with men, and in our *Conclusion* we return to these themes in a brief, concluding summary of our results.

In order to help the clinical material come alive we have made use of brief case descriptions and vignettes. All case descriptions and vignettes are, however, fictitious. No vignette describes a single person; instead it is a mixture of different people's stories. We have often been struck by how the descriptions of experiences and feelings recurred for many of the men, and we believe this probably makes it easy as an abused man to identify with the content of the vignettes.

Societal Aspects

Sexual abuse – a brief historical perspective

Views of sexuality shift in different times and societies. Changes in the law have great importance for norms and attitudes generally, but changes in attitudes concerning sexuality occur slowly. Over the years, great changes in legislation have taken place in Sweden in the area of sexuality. Homosexuality was first decriminalised in 1944, but was considered a disorder until 1979. Sweden was the first country in the world that legislated on gender affirming treatments in 1972. It became possible for transgender persons to change legal gender, when fulfilling the legislative requirements. In 2013 the requirement for sterilisation of transsexuals who undergo sex confirmatory treatment was abolished.

Laws on sexual offences have been amended several times since the 70s. Over the years, various government inquiries have investigated questions about gender roles, power and equality. A shift has taken place towards protecting sexual integrity.

Until 1984, sex crimes were classified as public order crimes, i.e. crimes of a moral nature. In con-

junction with the 1984 amendment the provision on rape has also been made gender-neutral. Previous legislation stipulated that only women could be raped by men. The legislation was based on a heterosexual view of rape. Although the current law still bears traces of the norm, it is no longer explicit in the legal text. Later, the legislation has gradually changed the practise of using the technical action as a reference for defining the offence. Better legal protection for children has also been established. In 2016, a review of sexual offences legislation was presented, focusing on voluntary consent.

Political advocacy has been instrumental in driving the process of change in the area of sexuality. In Sweden in the 1970s, the issue of rape was primarily driven by the women's movement; the victim became the focus and had a clear voice. This meant that the issue was politicised and the relationship between men and women was described in terms of the perspective of power and conflict. Rape of women was thus defined as a societal problem and the care of raped women became organised (Lindberg, 2015). With rape described as a societal problem, women could begin to see their abuse in a broader context and identify reasons

beyond the individual. This made it possible to break the silence and talk about sexual vulnerability. When an abuse no longer is regarded simply as an individual problem a large part of the shame and guilt is also removed from the victim. Today, the situation of abused men is in some respects comparable to the situation of raped women about 40 years ago.

Sexual Trauma – Incidence and Consequences

A study from The National Centre for Knowledge on Men's Violence Against Women (NCK, 2014) shows that 20 per cent of Swedish women and 5 per cent of Swedish men have at some time during their lives been subjected to sexual trauma which involved violence or the threat of violence, being forced to have sexual intercourse, attempted sexual intercourse or the like. This means that out of the whole of Sweden's population aged between 18 and 74, approx. 670,000 women and approx. 170,000 men have had such experiences. It is only in recent years that men subjected to sexual trauma have been surveyed. The numbers grow when men and their experiences are included. This clearly shows that sexual trauma is not just a women's issue and that the real number probably is

very substantial when it comes to men's subjection to sexual trauma (BRÅ, 2008).

The NCK study indicates that there are extensive consequences for physical and mental health as a result of sexual trauma. Psychosomatic symptoms are **twice** as common among women and **three** times more common among men with experiences of serious sexual violence in childhood or adult age, in comparison with women and men in general. Among adults who have been subjected to serious sexual trauma as children symptoms of post-traumatic stress disorder (PTSD) are around three times more common than for those who have not been subjected to such trauma. In the case of subjection to serious sexual violence as an adult there is an even stronger connection with the symptoms of PTSD and is particularly pronounced for men, where PTSD is five times more common than for other men. Self-harm related to serious sexual violence in adults is three times more common among women and five times more common among men compared to the general population (NCK, 2014). Several studies focusing on men's experiences of sexual trauma suggest significantly increased risk of somatisation, depression and PTSD (McLean, 2013; Masho & Alvanzo, 2010; Rentoul & Appleboom, 1997).

Beliefs, Myths and Attitudes

There are many beliefs and myths about male and female sexuality that also permeate our way of thinking about victims and perpetrators of sexual violence. A myth says something important and provides us with an image of our reality. Myths have many different purposes, but what is common is that they are not a direct reflection of reality. As for the myths and beliefs about femininity, masculinity and sexuality, they mask reality and can confirm prejudices, reinforcing stereotypical gender role beliefs that are difficult to combat. When it comes to men, masculinity, and subjection to sexual abuse, there are a number of myths that consolidate and reinforce prevailing norms of masculinity. The image of the male victim of sexual abuse is more mythologized than that of the female victim, which over the years has come to comprise greater complexity. Marginalisation and making sexual abuse of men invisible perpetuate not only myths about masculinity but also about femininity and sexuality generally. The belief that men cannot be raped is a common and widespread myth. Although the image of masculinity and male sexuality has become increasingly multidimensional in recent years, there is still

the conception of the man as strong and energetic, and someone who is always willing to have sex. This makes it more difficult to imagine that a man can be sexually abused. Another prevalent myth is that it is only men who are perpetrators. We have difficulty in imagining that a woman could be a perpetrator of sexual violence. Female perpetrators challenges the myth about “the sacred” mother. There are many portrayals of women, both in books and films that depict older women’s sexual relationship to pubescent boys. We often do not see this relationship as abusive, but perhaps as a boy being introduced to sexuality. We find it easier to define an older man’s sexual relationship to a young girl as abusive.

In line with conceptions about masculinity, both boys and men who have been subjected to abuse have often denied that the abuse had any significance, and healthcare professionals tend not to ask them about the consequences (Tidefors, 2010). Even adult men who had been exposed to sexual trauma earlier in life tend to deny its impact on their lives and health (Masho & Alvanzo, 2010). Denying that boys and men are vulnerable to abuse and ignoring its serious consequences also exist on a societal level. When the fa-

mous Swedish athlete, Patrik Sjöberg, publically talked about being subjected to sexual abuse as a young boy, it was difficult to keep the focus on the boy. Instead the focus was on the perpetrators, the sports movement, not on those who had been abused - the victims. With regard to girls, the scenario has been the opposite. The whole focus has been on the victim, making it more difficult to talk about the perpetrators.

Experience of shame can be an obstacle to talking about being abused. Among men, societal myths surrounding masculinity contribute further to reinforcing the feelings of shame following sexual abuse. Men who have been subjected to sexual abuse may feel that it undermines the very essence of what it means to be a man. It contributes to many men avoiding seeking help and talking about their experiences if there is no need for emergency medical care. Often there may be a concern of not being met with understanding and respect (Ellis, 2002). Men’s subjection to sexual abuse is usually associated with the assumption of homosexuality. As if the abuse in itself says something about the victim’s sexual identity. At times, those who have been affected are also subject to homophobic perceptions, and this may be

one of the reasons that they are reluctant to report the incident or seek help. A long time may often pass before men seek counselling after being sexually abused; 10, 20 and 30 years may elapse before it is possible (McLean, 2013). Several studies show that under-reporting of sexual abuse is even more pronounced in the case of men compared to women (BRÅ 2008; McLean, 2013; Rentoul & Appleboom, 1997).

There are also various preconceptions of the sexual orientation of the perpetrator. It is often assumed that men who subject other men to sexual violence are homosexual. Studies focusing on the issue of the perpetrator's sexual orientation report different findings depending on the study context and the questions asked. Abdullah Khan (2008) notes that the only conclusion one can safely draw is that men who abuse other men differ in terms of sexual orientation, and the myth that men who abuse other men always identify themselves as homosexual is not confirmed.

Attitudinal studies show that victims are judged on the basis of their sexual orientation and are blamed for their actions in the abusive situation based on heteronormative perceptions. A hetero-

sexual man, for example, suffers more guilt for having been passive during the abuse itself, while a homosexual man on the contrary may be regarded as more guilty if he fought against the abuse and tried to defend himself but failed (Davies et al., 2008). Men abused by a female perpetrator tend to be even more burdened by guilt in line with gender stereotypes. People who were abused as children tend to become burdened by guilt in the same way when they as adults describe the abuse. This is particularly true if the victim is a man and the perpetrator was a woman (Davies & Rogers, 2006).

The burden of guilt does not only come from outside. The abused person is affected by the same social values and attitudes. Their own accusations may often be the ones that are the most difficult to relinquish. To accuse oneself is common in both men and women who have been abused. Internalised guilt leads to shame and self-contempt. Guilt can also be reinforced by thoughts of being in environments that could be perceived as risky or that they had made contacts with people who later became the perpetrator.

Homosexual and transgender people are more ex-

posed to sexual violence than heterosexual people. A large meta-study from the US shows that homosexual and bisexual women and men report many times higher instances of sexual violence than the general population. Homosexual and bisexual women reported maximum vulnerability for childhood sexual abuse and abuse in close relationships, while homosexual and bisexual men reported higher figures in terms of the experience of sexually-related hate crimes (Rothman et al., 2011). In one Swedish study (Folkhälsomyndigheten, 2015), 30 per cent of transgender participants reported that they at some point had been forced to have sex against their will.

Knowledge is an important tool to combat myths and beliefs that may get in the way of understanding another person's perception and experience. Studies of sexual abuse of men have increased but are still very limited compared with studies and research on women who are subjected to sexual abuse.

Meetings with Health Care Services

As mentioned previously, the RFSU Clinic conducted a study in 2014 that focused on the care and treatment of men who have been sexually

abused (Fagerström, 2014). The study was based on interviews with the heads of emergency departments, primary care and mental health services. The aim was to get a picture of how well these services function based on about 100 telephone interviews in all counties and regions of Sweden. Questions were asked about routines in the case of rape and the extent to which psychological treatment could be offered in an emergency, but also what was offered at a later stage after the trauma. Another question was whether men were treated differently from women. Managers of the emergency departments who were contacted in each county stated that they had routines and were well prepared to help raped women. However, for raped men there were documented procedures in less than half of the surveyed departments. Several departments had only recently introduced clinical routines after facing cases of men falling victim to sexual abuse, having realised that they lacked knowledge of the problems and action plans.

Compared to women, there was generally greater uncertainty about where abused men should be referred in order to obtain emergency help. In some cases, a phone call from a man subjected to sexual trauma had been transferred to several people

or departments and institutions before he came to the right one. With regard to psychological care, the reply was that support should be offered to both women and men "as required". However, the interviews showed that it was highly doubtful whether men would be offered this on a routine basis at an acute stage, largely because there was a lack of clarity about which department was responsible for such work.

For a person who at a later stage sought counselling regarding the consequences of sexual trauma there was a lack of clarity about whether counselling should be offered by primary care or mental health services. This uncertainty was true for both men and women. In the survey it emerged that female patients in primary care and mental health services were generally asked about experiences of various kinds of trauma to a significantly greater extent than men. Regarding long-term measures, such as psychological crisis treatment for abused men and women, there were major shortcomings in terms of both health care resources and expertise.

In his thesis *Orsak: våldtäkt – om våldtagna män I medicinsk praktik*, Lindberg (2015) describes how

health care services are organised and categorised on the basis of gender, sexuality and body parts. The dominating biological approach in medicine makes it natural to think differently about women and men. A likely consequence of this is that the gender of the abused person determines how care is organised, rather than the type of rape that the person has suffered. When it comes to female rape victims, the gynaecological department is an obvious care unit. There is no equivalent department for men. There are very few andrology clinics in Sweden. The men who seek emergency services because of sexual trauma are usually channelled to surgical clinics since these traditionally receive crime victims. However, in most cases knowledge about the victims sexual crime is missing here. The risk is that the focus is put on physical injuries, while other consequences of the trauma are overlooked. The increased emphasis on diagnostics and formalisation that takes place in health care today tends to oversimplify complex situations. Medical interventions are focused on the cost of care in an attempt to adapt to the market and streamline costs (ibid.). This has implications for cases of sexual trauma since the provision of emergency somatic care is given priority. Yet the trauma includes both psyche and

soma. In many cases no physical harm is evident following rape, while the experience has definite psychological consequences. Since the autumn of 2015, Stockholm has a clinic for the victims of rape, regardless of gender and gender identity, which offers both somatic and psychological care. The clinic is an example of how health care can be better organised and less fragmented. By providing a more holistic approach to care it becomes possible to counterbalance a fragmented system of care that categorises individuals on the basis of gender and body parts.

Conceptions about sexuality have considerable impact on how people think about male rape victims. Assumptions about homosexuality and sexual practices often shape the care and treatment of raped men, and can make it difficult to draw the line between homosexual acts and homosexual identification. This may mean that men risk being faced with a stigmatising identity. Differences between groups of rape victims in care are fostered by focusing on gender and sexuality, despite the fact that there are many similarities between the abuse of men and women. Like men, many women are also subjected to oral and anal rapes (ibid.).

The thoughts and fantasies that a victim has about how their story will be received by others, is crucial to whether they will attempt to talk about what has happened. Talking about sexual abuse is often difficult. If there is fear of being faced with trivialisation, denial, or guilt there is a risk that victims will remain silent and keep their experiences within them.

The National Board of Health and Welfare (2014) showed in a survey that staff within health care do not always ask questions about violence in close relationships, despite there being good reasons for doing so. Most sexual trauma is committed by someone known to the victim. It is difficult to speak about physical violence. It is even more difficult to speak about sexual violence. But perhaps the most difficult thing to speak about is sexual violence against men. We therefore need to constantly challenge the assumptions and values that are embedded in our culture and that we ourselves reinforce, often without reflection. Conceptions about sexual trauma in relation to gender and sexual identity among healthcare staff, psychotherapists and representatives of the legal system are of great importance. Routines concerning the treatment of sexual trauma are important and provi-

de security for both staff and patients, but these routines need to be constantly reviewed in order to provide good care.

Meeting Men Subjected to Sexual Abuse

As mentioned previously, studies show that men who have experienced sexual trauma during childhood or later in life report substantially more physical and psychological symptoms than other men (NCK, 2014; McLean, 2013; Masho & Alvanzo, 2010). In the mental health field there is considerable over-representation of people who have been subjected to abuse early in life. Seeking help in the form of counselling or psychotherapy opens up the possibility of getting in touch with different aspects of oneself, which is important for psychological well-being. Being able to talk about one's experiences within a professional setting strongly reduces symptoms, no matter how much time has passed since the abuse (O' Leary, 2009).

For most men who have approached us the sexual abuse took place a few or many years before. Many of the men have been through things earlier in life that affected their trust in others. For some,

the abuse has linked to experiences of other traumatic events. These previous events have meant greater vulnerability, and thus the sexual violations have had additional consequences. During treatment we have started from the men's own stories and the suffering they described. Focus has not only been on the sexual trauma, but also other difficult life experiences that were awakened.

Meeting Men Subjected to Sexual Abuse in Psychotherapy

The capacity to endure various events, losses and challenges in life is affected by experiences of security and care in previous relationships. It is in relationships with significant others that shortcomings in our inner structures can arise, but it is also through relational experiences that these shortcomings can be bridged and new experiences created (Wennerberg, 2010). A psychotherapeutic relationship can involve a change at several levels. Because many men have borne their experiences in silence, the experiences have acquired wordless expressions, especially in various forms of somatic or psychosomatic symptoms. Going from somatisation through emotions to expressing feelings in words is often a long road. For a psychotherapist, it is an aspiration, together with the patient,

to create an intermediate area where people can begin to transform the concrete into a more symbolic form. The psychotherapist's task is to try to awake curiosity and the desire to explore the context of a fragmented inner world by capturing threads of thought, associations, and daydreams in order to help the patient begin to form a story. Earlier experiences and patterns will be reflected in the psychotherapeutic process. The experience of closeness and distance, confirmation and rejection will shape and affect the relationship between patient and psychotherapist. The psychotherapeutic work starts when the patient begins to identify himself with the therapeutic process in a joint investigation. Then there is hope for the possibility of a trusting relationship.

Sexual Abuse Disturbs Identity

Our sexuality forms early in life, where it shapes and develops in an interface between psyche and soma. Sexual violation involves penetration of both the psychological and physical, and is thus an attack on the whole individual, especially if the abuse occurs early during the formation of one's identity. The Ego first takes form as a body-Ego, which forms the foundation of our identity. Bodily experiences at the beginning of our life form the

basis of our mental life. Based on early experiences, we create an inner world of infantile wishes, desires, fantasies and conceptions that influence, shape and lay the foundation of Ego development and sexuality, an inner world that is deeply rooted in physicality. We grow up in the hands of others. Anzieu (2000) has coined the term skin ego as a symbolic description of the interface between the psyche/soma. The skin, our largest sensory organ, is the first contact surface with the world and lays the foundation for our thinking. It is with the skin we will distinguish the outer from the inner. Anzieu describes the early relationships between mother and infant in terms of a common skin that also functions as a protective membrane. He is of the opinion that it is by separating from the mother that the child can develop its symbolic function, when a space between their bodies arises. The development of the symbolic function is to bring together our inner and our outer and our early experiences with what we later experience in order to thereby create meaning and context. During early development the child tends to perceive inner reality as a concrete reflection of the outer. It feels like it's real (Segal, 1957). The beginning of mental development is a state of being one and the same with the caregiver. This early

dependency is founded on **non-separation** where differentiation of a distinct Ego takes place gradually. With time the other emerges as a separate individual with characteristics and its own inner life (Quinodoz, 1996). The separation and formation of one's own identity creates a basis for being able to get closer to other people in intimate and authentic relationships and the development of one's own identity occurs through contact with the significant others. The fragile building of identity continues throughout life. It is through our emotional expression being reflected in the reactions of our surroundings that we learn to understand ourselves and trust our feelings. Without this form of confirming response it becomes difficult to understand ourselves and our inner world. In the absence of sufficiently confirmatory responses or when a caregiver places their own needs before the child's, the child may suppress their own feelings in order to maintain the relationship (Wernerberg, 2013).

Most abuse is committed by family members and therefore, for the victim, important people. Dealing with a combination of affection and aggression is contradictory and confusing. The longing and desire for closeness as well as security is viola-

ted by betrayal when boundaries are violated. Igra (1998) describes how sexual abuse of a child not only affects the child's body, but also demolishes the child's early symbolic structures. It is not possible to integrate sexual acts initiated by an adult and directed towards the child into the child's symbolic world. Something from outside is forced into the child. Fantasies and emerging symbolisation are destroyed by concrete sexual acts that the child is not able to contain. This may have major consequences for the child's later body experience, identity and sexuality. If the abuse takes place during adolescence it can mean confusion at a time of searching for identity. But even when abuse takes place in adulthood the abuse can threaten the structure of the self. Sexual abuse involves a serious violation of body boundaries. This gives rise to different issues and conflicts relating to boundaries. Confusion may arise about the boundary between outer and inner, or whose body is whose, or confusion about pleasure and displeasure.

Trauma

The word trauma means injury or wound. An experience-based description of trauma was made by Pöstényi (1996). He argues that trauma is a sub-

jective story where the definition of traumatic is everything that traumatises. The trauma becomes an experience that creates a black hole in the fabric of meaning in our memory. The trauma is unimaginable, something completely foreign, and which in that sense is not perceivable. The trauma becomes too much for the psyche to take care of and goes beyond our experiential capacity and emotional readiness. This means that no structure and meaning can be created to integrate and deal with the incomprehensible. The first trace of a trauma is the traumatic anxiety that becomes a sign of survival in chaos, and therefore also can provide an opportunity for recovery.

Working With Sexual Trauma

Facing psychological trauma involves meeting people's vulnerability. In the case of natural disasters it is easy to feel for the victims. When a person is behind the traumatic event we tend to end up in a difficult conflict between victim and perpetrator (Herman, 2007). *Has it really happened? Is it true? Can it be possible?* These questions are examples of unconscious attempts to escape knowledge of human cruelty. Regardless of whether we are victims, perpetrators, witnesses or anyone else who comes in contact with such terrible things,

our natural impulse can be to consign them to the realm of the forgotten. This type of defence takes place at the individual level, but is also a social phenomenon that is expressed in collective need to deny evil.

To listen to a story of sexual abuse may give a feeling of being abused yourself. As a therapist, it can then be easy to feel sceptical about the story and distance oneself from the patient. It can lead to the therapist having to contend with an inner condemnation of the patient's behaviour in the situation. A clear tendency can be to defend oneself if the victim does not live up to the image of the ideal victim as based on our norms and conceptions (Christie, 1986). The reaction of the therapist can also be the opposite. If the abused person has experienced considerable helplessness this can arouse strong impulses for the therapist to need to be the one who rescues the patient. A difficulty may arise involving balancing the desire to take care of the patient without reinforcing the adoption of the position of a victim.

Creating a trustful relationship can take a long time for people who have been subjected to traumatic events. By sharing feelings related to the abuse it is possible to bear the pain without be-

ing overwhelmed. One does not need to always go through the trauma completely and in detail. Sometimes it may be about having the feeling of being able to share and to put something into words together with the psychotherapist. An important tool for the possibility of working through trauma is to associate and dream and thus create a space where symbolisation can begin to take shape. Putting experiences into words makes it possible to understand and explain the link between the outer and inner, between self and other, thus enabling the creation of a web of meaning, a context and comprehension of what has happened. Symbolisation has a significant impact on our ability to process difficult events that we are faced with. Context and meaning can be created through symbolic expressions, and these may become a path to increased understanding and sympathy for oneself and others. The basis for the processing of trauma is through the ability to form internal mental representations and finding a voice for the silent story. Herman (2007) describes how psychotherapeutic work makes it possible to conquer the ability for trust, independence, competence, identity and intimacy. By recapturing the right of self-determination and freeing oneself from the traumatic feeling of powerlessness, it

becomes possible for the abused person to regain control of life.

Despite the fact that sexual abuse involves both an internal and an external attack, it does not always need to be a traumatic event or give rise to a crisis reaction. How one is affected by various events depends on what one has been subjected to, when in life it happened, and what preparedness there is for dealing with the event on the part of one's inner self and one's surroundings.

Protection, Resistance and Defence

To talk about a painful experience that one has hidden in oneself means facing the pain anew. What one has not been able to approach can be so difficult that the only way to handle the pain is to try to escape or deny it. The central conflict in the trauma is the contradictory desire to deny the painful and the simultaneous desire to tell. Two powerful forces, one wanting to move forward towards development and the other resisting. It is this ambivalence that forms the core of the mental dialectic of trauma (Herman, 2007).

Ambivalence

A characteristic of our psychotherapeutic work has been a remarkably strong ambivalence among everyone we met, especially during the initial stages. It has appeared over time, in different phases and during individual sessions. It is as if a part of one's self strives to reach out and approach unknown parts of the self, while another force strives to do the opposite, to escape and deny. The patient's only way of trying to regulate the balance between closeness and distance may become too late or fail to arrive at all. To try to navigate this balance, we have offered different kinds of contacts, ranging from meeting twice a week to sessions with longer time spans. The aim has been to establish a safe form of contact that is not felt to be invading or distancing.

It is so difficult to come here. It is so strange, because when I'm here it feels good. And then I don't want to leave. But then I don't remember any of the conversation, I forget everything we talked about.

Is it possible to tell? Is it a story that can be taken in? If one feels listened to, it becomes a good experience that forms the basis of further therapeutic work. The story can serve as a trial balloon. The feeling of having exposed oneself can be strong and difficult to deal with. Since there is no trust at the beginning of treatment, both therapist and patient must be prepared for the therapeutic relationship to undergo tests, frictions and reconstruction (Herman, 2007). This becomes especially evident for those who have been traumatised early in life. A longing for being accepted and confirmed is pitted against the fear of being drawn into a relationship that could lead to dependency on the therapist. The dilemma is that the experience of being separated and alone is as difficult as the fear of being together in a close relationship.

Shame can lead a man to feeling forced to tell his story in order to get out of the shameful situation as quickly as possible. Several times in new contacts we have slowed down intense stories of abuse that have not previously been mentioned. We have felt the risk was too great that the man would not be able to return next time and face the shame he revealed.

Ugh, I remember how hard I thought it was in the beginning when I came here. I was so ashamed I could hardly bear it. I really just wanted to disappear. I was so full of what you would think of me that I almost didn't want to come back.

Sometimes it has not been possible to stop a detailed story. The pressure to tell and the emotional build up before the session has been too great. In such cases we can only hope that our approach and focus on reducing shame and guilt in the situation can create opportunities for him to return, and lead to the experience of having been listened to. To begin approaching what one has tried to hold at arms length involves a restructuring at several levels. As a psychotherapist, one needs to accept ambivalence and help to verbalise areas where conflicting desires appear. There may be reasons for not approaching the painful inner spaces.

Threads of my story disturb the image of the man I am today. As I approach it, it feels like all of my foundations are shaky, I'm anxious to face everything I have carried within myself.

Thoughts of suicide or fear of an internal collapse are sometimes expressed. It is easy to under-

stand this as a driving force for choosing to terminate a therapeutic contact. It is not an end in itself to talk about what is difficult, uncover defences and bring experiences of abuse to the surface. Psychological defences are there for good reason and need to be respected. But sometimes defence strategies create difficulties that hinder positive development. In psychotherapy one may need to move back and forth, toward or away from difficult topics in a constant pendulum-like movement. It is important not to challenge the patient more than what he can cope with. The man must set his own boundaries about what he wants to approach, based on how he assesses his own suffering. Therefore a brief therapeutic contact need not be seen as a failure.

Defence

We all use various defences and defence mechanisms to protect ourselves against difficulties or psychological stress. To split the Ego into one part that is aware of what has happened and one part that denies what has taken place is an effective way of keeping painful memories in check. Defending against pain is a way to surviving. Denial or avoidance can be used to protect oneself. Initially in psychotherapy this has become clear in many different ways.

Silence can serve as a hiding place for unpleasant experiences. This can act to preserve the trauma and restrict life. To start relinquishing one's defences can feel very threatening. Many of those we have met have a pronounced lack of trust, especially men who were subjected to abuse early in life and who have never told anyone about it. For example, we have repeatedly been made aware of the time needed to get through the layers of defences that protect against, for example, shame.

Defence Strategies – Some Definitions

Defence and defence mechanisms are something that we all use to cope with conflicts and difficulties. Cullberg (1998) describes defence mechanisms as functions of the Ego that are equally important for mental survival as the body's immune system is for physical survival. When it comes to traumatic experiences defences tend to create rigid systems that risk being cemented. These defences then become an obstacle to development and growth rather than a protection. The younger we are, the less sophisticated are our defence mechanisms. In psychotherapy with the abused men many different defence systems can be discerned. Here we have chosen to focus and highlight defences like **splitting** and **denial**, **trivialisation** and

isolation, as well as **doublethink** and **dissociation**, all of which are examples of an internal division of the psyche that holds things apart. **Projection**, **projective identification** and **acting out** are other strategies where the psyche tries to get rid of unbearable experiences and thereby places internal difficulties in the external world. These concepts are defence mechanisms that try to explain the various strategies of the Ego for protecting itself against chaotic and overwhelming emotional experiences. The terms are a way of trying to capture the different complex psychological stages in distinct linguistic expressions in order to describe conditions that are not so easy to describe. We have chosen to pay attention to these defence mechanisms because they helped us to understand some of the complex expressions that appear in psychotherapy. In the section *Resistance and Defences in Psychotherapy* we provide some concrete examples of how this process has appeared in the contact with the men.

Splitting and Denial

Splitting is an active defence that can be described as a way of escaping inner conflicts by keeping bad and good experiences apart. The term is also used to describe a division within a person of bad and

good sides. Originally it was Freud (1997) who coined the term splitting when he was referring to a division of the self. In "Mourning and Melancholia" (Freud, 2003), he expanded the concept by adding an aspect of a denial of reality. He maintained that for one and the same person there may be a denial of reality by part of the Ego and at the same time another part of the Ego that can accept it. The perpetrator is often a close and important person who represents something good while committing bad acts. One way of dealing with this in the inner world is to split off the bad parts, deny reality and in this way maintain the abuser as good. Today the concept of denial is used in a similar way and can be described as an avoidance of experiencing and recognising threatening aspects of internal or external reality.

Trivialisation and Isolation

Trivialisation is a milder form of denial of what has been experienced, a denial of the **seriousness** of what has happened. This means that one is aware of what happened but the impact of the event is diminished. Isolation can be described as a way of repressing the **emotional** content of what is experienced even though the event is conscious (Cullberg, 1998).

Doublethink

Herman (2007) refers to George Orwell who in the book *1984* describes doublethink. Orwell describes the ability to simultaneously think of two contradictory beliefs and accept both of them. Orwell's idea is that there is an awareness that reality is distorted. Thanks to doublethink, however, it is possible to maintain the illusion that reality has not been distorted. Orwell describes this process as both conscious and unconscious. Conscious because it is carried out with precision, and unconscious because it would otherwise involve a sense of falseness. It is a description of two different but concurrent parallel worlds where one is partially denied. In for example work with grief in children, this is a known phenomenon: when one part of the child's Ego knows that the parent is dead, while another part of the Ego carries on as if the parent were still alive.

Dissociation

The term dissociation originally comes from Janet (Herman 2007). He was referring to the condition when people due to disruptive life experiences have lost their ability to hold together the Ego. Janet described an abnormal condition that

served as a psychological protection in dangerous situations when the memory or the existence of malevolence is separated from ordinary consciousness. The traumatic experiences that cannot be integrated are split into different dissociated systems, disengaged from each other (Wennerberg, 2010). Dissociation is today a recognised term in traumatology. It is a complex concept that is difficult to find a uniform description of. Dissociative syndrome is a diagnostic term within psychiatry that designates a spectrum of different conditions. Dissociation is described as disturbances in the integration of consciousness, memory, identity and perception in various degrees (ibid.). Traumatized people can sometimes develop dissociative symptoms as a way of managing unbearable events by mentally distancing themselves from the situation. This can often mean that one has difficulty being in contact with one's own body, as if the body was not a part of oneself. It can also lead to having difficulty in being in contact with others. In psychotherapy, it may appear as a lack of contact with the psychotherapist when the defences are activated by the charged theme. In psychiatry, traumatized people with dissociative syndrome can risk being misdiagnosed and therefore incorrectly treated because of the many

different complex reactions and symptoms exhibited by the patient.

Projection and Projective Identification

The concept of projection is used in psychology and psychoanalysis to describe unconscious feelings and desires that the Ego does not want to acknowledge and that are instead transferred somewhere else. One ascribes to others the characteristics that one does not want to recognise in oneself and in this way avoid being in contact with frightening feelings from one's own inner world. Projective identification is a concept that was introduced by Klein (1988) to describe how the infant splits the inner world and places the "bad"/aggressive parts of him/herself into the mother. From the child's point of view it is the mother who becomes the "bad", because the child has freed him/herself from these feelings. This also means that the boundaries between self and other become unclear. Bion (2001) developed these thoughts and describes projective identification as an unconscious communication, a natural part of the early interplay between child and mother. As such it can be seen as a language beyond words, where the mother's intuitive ability becomes a host by receiving, digesting and giving back the

child's anxiety in a more processed form. Bion ascribed projective identification a further meaning. He maintained that the concept aids development and described it as an interplay embodied in all human relationships, especially in the psychotherapeutic relationship.

Acting Out

Overwhelming experiences that have not been integrated into the psychic experience and that are not possible to put into words or think about, can instead be expressed through acting out. To act out instead of thinking and feeling is a way of doing away with painful feelings. The action may be a means of reshaping powerlessness into an experience of control. By acting out one can keep away something that would otherwise be felt. In this way acting out becomes an unconscious way of communicating.

All of these concepts, and the theories surrounding them, have with time been developed in different ways in psychology, psychoanalysis and traumatology. These are theories and concepts that have been formulated on the basis of different experiences and clinical realities, in meetings with patients who have all been subjected to traumatic

events that have impacted on their inner world. What is important is that the concepts have been formulated to aid in understanding the complex and inventive systems a person may adopt to shield themselves and try to escape the memory of unbearable experiences.

Resistance and Defence in Psychotherapy

Different forms of resistance and defence have characterised all of our psychotherapeutic contacts. The concept of splitting has helped us to understand and accommodate the conflicting forces of the trauma's dialectic, when we tried to orient ourselves in the contradictory parallel worlds that are often articulated in psychotherapy.

Splitting, Denial, Isolation and Trivialisation

In most men we have encountered a **denial** of the abuse experiences, and thus a **splitting** of the inner world.

I don't think it's that bad really, what I was subjected to. I wasn't so young either, should have been able to defend myself in some way. Talking about what happened with the rest of the family

has felt completely out of the question. It's a terribly serious matter to accuse someone of!

Denial is a powerful force that allows a life where memories of abuse can be warded off by completely or partially being **isolated** and cut off from other parts of the Ego. It can lead to a kind of emotional blunting, which permeates the person and makes it difficult to form close relationships. Some of the men have described an inner lifelessness, a sense that they live life in a kind of stupor, cut off from their feelings. This involves screening off emotions such as terror, anger, fear, and shame, which in turn engenders a sense of alienation.

Sometimes it feels like I've been living in a shadow world. Almost like a life of apathy. When I read my perpetrator's obituary it was as if I woke up and could suddenly begin to cry. I've been a servant my whole life, always done everything for others but forgot about myself.

Very few of the men we met have previously talked to anyone about what they were subjected to. Guilt and shame about being someone who has been abused have been strong obstacles. The men have also said that they sensed **denial** from tho-

se around them when they attempted to communicate their experiences. Concern about what the story would cause has been a reason not to tell. They have not wanted to be the one who contributes to the family or relatives splitting up or an important person being identified as the perpetrator, with all that would entail. All the men we have met have had clear memories of all or part of the abuse they were subjected to. The abuse has been kept in a wordless state in their inner world, usually in the form of intrusive images, as a whole or in the form of picture fragments. One man expressed it like this:

I know exactly what happened, it's in my head. I have very clear images but, if I talk, it becomes real. Then it's really scary. I somehow don't want to get it out of me. Perhaps it wasn't so bad anyway.

Expressing what happened has been associated with fear and deep anxiety. Denial has functioned as a kind of storage space, a separate part of the mind, until the story of the abuse could be gathered together, communicated, listened to and integrated. One man could talk about the abuse he suffered for the first time after being sick-listed

when he got in touch with someone at the health centre he could trust. He had borne his well-encapsulated secret for many years. The meeting proved to be a good experience and he could seek further professional help. The consequences of the abuse overshadowed and limited his life and he wanted, as he expressed it, to become more “whole”.

Denial may be present for decades before cracks arise. One man was overwhelmed by memories of abuse when his son was the same age as he was when the abuse took place. Over twenty years had elapsed. The denial shattered when he suddenly saw his son as a mirror of himself. In others memories of abuse erupted in dreams and fantasies, or were brought to life by other traumatic experiences. Most men we met have found it difficult to define the abuse as an abuse and **trivialized** the incident.

Perhaps it wasn't so serious. I went there again and again. He offered beer, we masturbated together, and it felt OK. But when it came to penetration I really didn't want to. It hurt and it was terrible.

We have sometimes understood the **trivialisation**

of the abuse as a way of explaining and understanding one's own sexual arousal, as well as the guilt and the shame of it. Self-imposed guilt about their own participation can be understood not only as a way of **denying** the abuse, but also as a way of keeping powerlessness at bay, thereby maintaining a sense of control.

I was of course curious about sex. I preferably wanted to meet a partner. It was my first date and I myself had taken the initiative. It was my own fault. I had almost rigged the situation, because I had somewhere hoped we would sleep together. But not in this way.

Several of the men have initially found it difficult to look at themselves with understanding and get beyond feelings of contempt, shame and guilt. The road to empathising with oneself has sometimes gone via others. By **projecting** their own feelings and placing them in someone else, a gradual identification with their own vulnerability is enabled.

To **deny** what has happened, the abuse, and in that sense distort reality, involves killing part of the Ego, because the emotions associated with the

experience are **isolated**. This dead, lifeless area becomes a cavity in the inner world while other parts of the Ego are capable of creativity and vibrancy. Many of the men we have worked with have described artistic endeavours where stories with links to the experienced trauma have taken shape. Through music, writing, painting, photography or other pursuits they have formulated a beginning to a story that has been difficult to approach. Dreams and daydreams have also sometimes been a path to understanding and processing. In psychotherapy this becomes a way of beginning to approach and understand the alien and denied aspects of the Ego.

Working With Resistance and Defence

Keeping aspects of one's experiences from consciousness awareness for any longer period of time requires strong effort. A consequence of this is that it becomes difficult to be in touch with oneself, and thereby also be in touch with others emotionally. Psychotherapy can then pose a considerable challenge. To repeatedly return to the psychotherapeutic space involves acknowledging what has happened and its consequences. The psychotherapist can symbolise both security and threat in the role of someone who acknowledges and confirms

abuse. The therapist may feel as if she/he is forcing the patient to relive the pain of the trauma. This may mean that there is a risk that the therapist becomes reluctant to explore the trauma, even if the patient is prepared to do it. That which is terrifying is paradoxically also the path to liberation and, hopefully, to a more functional way of dealing with the trauma. Strong resistance may be invoked to avoid bringing together **split off** parts of reality, which provided protection against the pain. In psychotherapy, this may manifest itself in shorter or longer periods of impasse, muteness or lack of contact. It can lead to a feeling of impotence and powerlessness for the therapist. To rid oneself of the feeling the impetus to act can become strong. There is a risk of forming an alliance with the patient's defences by **acting out** and thinking in terms of terminating treatment rather than using cautious curiosity to investigate the causes of the silence.

The trauma's dialectic entails rapid shifts between different moods. It may feel confusing to the psychotherapist to deal with these changes. Working with people who have been subjected to abuse, especially cases where the incident has been kept away for a long time, cannot be forced. To

prevent defences from fracturing and the experiences from become overwhelming and chaotic, time is needed to approach and return to what has been difficult. Losing their shells, their protective walls, means becoming defenceless and, in the worst case, the boundary between the external and internal ruptures.

It feels like I'm standing on a mountain edge and the ground just slips away beneath my feet. I'm so afraid of completely losing my footing.

A joint investigation, focusing on everyday functions, can become a protective structure in the chaos. This may involve paying attention to and talking about basic functions such as resting, sleeping and eating. How are you finding it to relax? What social support is available in your environment? How does everyday life function in terms of work, school or other activities? Protecting and supporting Ego functions is an important task. As therapists we need to be aware of the patient's **dissociative** reactions and mental presence in the room. We may need to move away from a focus on feelings and experiences, and instead focus on the here and now and what is happening between the patient and the therapist. Was con-

tact lost because something became too difficult? The patient's ability to **dissociate**, and thus set limits for himself, can be confirmed and strengthened by the therapist showing that they have seen and understood that a boundary has been crossed. It is the task of the therapist to normalise and explain the **dissociative** defence structures.

I often get this sense of unreality. When you're told that others have also described what they endured as well as yourself in terrible situations, it didn't feel quite as daunting. I realised that maybe I won't go crazy. It was very liberating.

Sometimes it is important to clarify common reactions to traumatic events to make physical and mental experiences understandable. In all psychotherapy, but especially in trauma treatment, imparting knowledge needs to be a regular feature.

Different Forms of Acting Out

For some of those we met the **acting out** we have encountered has not been so easy to identify, as it has manifested itself in socially accepted forms that also had some positive aspects. This has involved working very intensely; performing at all

levels, both in working life and in social life, or taking great responsibility for the well-being of others.

I always felt stressed about keeping up with everything at work, and always had to hurry home. My boyfriend became so irritated if I was late. He always wanted us to do things together. But it was difficult, because the job also demanded a lot from me. I really tried to make it so that everyone around me was happy - even though I myself felt almost ready to faint from stress. In the end it could no longer go on. I had to go on the sick-list.

During our work it has become clear how intense needs to perform serve as a wall against coming into contact with troublesome emotions and thoughts. In some of the men the **acting out** is articulated in sexualisation. It may be expressed as a strong preoccupation with sexual thoughts and fantasies that are not possible to control. By placing oneself in a constant state of arousal one can alienate oneself from emotions like sadness, grief, abandonment and aggressiveness. Sometimes the sexualisation has existed as a strong force for many years and served as an escape route from emotions, worry and anxiety.

This arousal. I've always been looking for it really. It has continued to persist. I've not thought of it before as something that has fulfilled some function. More like that I've been overly sexual in some way.

Preoccupation with sexual thoughts can make one feel abnormal. It can give rise to feelings of shame and guilt, which in itself can be a barrier to seeking help. Some of the men have described behaviour that has periodically been aggressively charged and alternately aimed at one's own body and at others.

I can see that sex is a kind of self-punishment. But there's an excitement in it too in a way. Although I hurt myself it feels good at the time. It was as if I just had to do it, don't really know why.

When the aggressiveness is sexually charged it can be destructive, sadistic and/or masochistic. This has been articulated, e.g. by consuming porn and masturbation in a way that is experienced as compulsive rather than pleasurable. To self-destructively expose oneself to dangerous sexual situations or to initiate sexual contacts where boundaries are broken risks new abuse. The behaviour can some-

times take the form of a recurring staging of the abusive situation in the form of a repetitive compulsion, a non-verbal communication and an unconscious attempt to free oneself from difficult emotions. By moving the inner to the outer world, it is possible to be the director of one's own drama. In this way, powerlessness is turned into an experience of power.

For most of the men who sought treatment at the RFSU Clinic aggressiveness has been less dominant. Aggressiveness often forms a barrier against thinking and reflection, where psychotherapy is not seen as an opportunity to change a difficult situation. Among the men we encountered, we have instead often seen a lack of aggressiveness in its constructive form, that is, as energy, setting boundaries and self-assertion. The aggressiveness may instead have been directed inwards towards one's own self and become expressed in the form of guilt and feelings of shame.

Working With Acting Out

In all work with acting out it is basically about finding ways of approaching the emotions that have been evacuated, and instead expressing them in a more constructive way. Psychotherapeutic treat-

ment aims of getting access to one's repertoire of emotions. Aggressiveness is an important force. Rage about what has occurred is often not even accessible at a conscious level. Lack of outward aggression is also part of **denial**. Nothing is felt, nothing that has happened has been serious, and therefore nothing that can cause an upset. Strong defences have also been a strategy for psychological survival. Approaching one's genuine feelings often arouses anxiety. It can be arduous and horrifying to approach an inner rage. Concerns about transforming murderous fantasies into real events, and the fear of being unable to control feelings can be great.

I had decided to confront him with what he had done. I was in a trance when I set off to his apartment. I don't know what I would have done if he had opened the door. Luckily he wasn't at home!

The initial contact with their aggressiveness needs to be balanced through a slow approach, where the feeling can be identified and verbalised in order to gradually be integrated into a manageable form. Regardless of the emotion that is isolated by acting out, the collaborative psychotherapeutic work involves transforming the unbearable that is

located in the outer world into bearable feelings in the inner world. It is a process that requires time. If they have kept secrets for a long time in one's inner world a backlash can involve telling one everything. It may then be difficult to know where to draw the line in relation to others. After time in psychotherapy, some men start to express strong condemnation of those who commit abuse. When the paralysing sense of guilt and shame begins to subside, aggressiveness becomes more accessible. Some of the men have then expressed a strong desire to talk about the abuse they have been subjected to more publicly. This can be understood as a way of laying the blame where it belongs, on the perpetrator. This has raised our concern that the men will be exposed again in the media, in the workplace, in front of those they know and do not know. In such cases we have then jointly reflected with the men on their inner driving forces and ideas of what may underlie such openness, as well as what the consequences might be for them.

As a therapist, it may entail a serious challenge to listen to descriptions of a particular behaviour. It can lead to feelings of powerlessness and desperation in relation to the situation that the patient returns to again and again. It may also arouse the

impulse of wanting to intervene and save the patient from his own **actions**. If the therapist endures and succeeds in containing his or her concerns, the desire to care can become an important inroad for working with the patient in exploring and trying to assess whether there is a need for concrete protection or other interventions.

Sometimes the patient's story is formulated in a sexualising and intrusive manner. For the therapist becoming embroiled in sexualisation often involves a difficult balancing act. Sexualisation of the patient's story can be understood as a way of protecting himself from emotions that awaken discomfort or fear. At the same time sexualisation of the relationship between therapist and patient needs to be talked about, so that the non-verbal communication and distancing become clear. Sometimes we may need to ask whether telling the story itself may involve sexual arousal. By discussing the question of sexualisation in a careful inquisitive manner a loaded atmosphere in the room can often be diffused. In this way we can also prevent the patient suffering from guilt and shame afterwards, which hinders continued contact.

Counter transference reactions can help us to understand more about what happens in the work with the patient. By listening to and becoming aware of what is awakened within oneself as a therapist it is possible to take a step towards a better understanding of what is taking place in the patient's inner world. Access to supervision is a very important tool. We need a space for reflection and sharing of what happens in the treatment room in order to capture and put into words both conscious and unconscious processes.

The Body That Speaks

When we cannot deal with psychological pain through symbolisation the result may be physical expressions of the psychological pain or psychosomatic symptoms. If we cannot put our needs, emotions and feelings into words, then the body has to speak for us. When it comes to sexual abuse bodily symptoms most often come after a period of denial (Herman, 2007). By splitting off the emotions that the abuse gave rise to the body becomes a mouthpiece. We have seen that the body has significance as its own defence system, or as a way to conveying experiences that could not be otherwise communicated. We have encountered bodies that have talked and bodies that have thought. Several

men have also sought help in somatic care, but no one has asked about the origin of the bad.

In school they thought I found it hard to hear, so I had to go for several examinations. But there was nothing wrong with my hearing. I think now that my head was so full that it couldn't find space for any more. I just couldn't take it in.

In our work with men we have encountered different kinds of bodily expressions and symptoms, both initially and continuously throughout treatment. They have told of a paralysing sense of having ice in their arms, burning balls in the stomach, pains in their back, stomach, heart, penis or anus, all of which could not be explained medically. Other men have described sudden and acute ill-health.

Something very strange happened last week. I went past the house, you know, there, where it happened. Suddenly I had an enormous pain in my heart; I almost fell to the ground. There were people on the street who called an ambulance. But at the hospital they said there was nothing wrong with my heart.

We have seen many examples of these types of severe bodily sensations that are experienced as confusing, frightening and unexplainable. In therapy several men have suddenly barely been able to hold back the need to vomit. Others have suffered from an "unexplained" fatigue or have fallen asleep when emotionally charged areas were touched upon. Concrete bodily reactions and expressions discharge the strong feelings that are not accommodated in the inner world.

Several patients have described a strong feeling that the room where psychotherapy was conducted served as a common protective cover around what was talked about. The therapy room could be described as a symbolic form of a common skin, a sort of sanctuary where the inner world can be uncovered and shared, a space where it has been possible to dump or spew out various reactions, feelings and thoughts. To then differentiate and separate, has sometimes been perceived as a breach of the common skin. The desire for a respite, a space for recovery in order to prepare oneself for the encounter with reality is something that many men expressed.

Inner images of the body

Sexual abuse has sometimes given rise to fantasies and ideas about the physical body that mirror the inner body. This can be expressed in feelings of being soiled, consumed, dirty and disgusting. It has also been described as an experience of something incorporated into one's own body, as if it were contaminated. Different ways of getting rid of these feelings may involve periods of intensively washing oneself or using enemas, both as a concrete and symbolic cleansing process. Through bodily expressions powerlessness and fear can be spoken of symbolically. Examples of this can be seen in exercising to build up their body to escape feelings of inadequacy. Many men have spoken about starving themselves to maintain the feeling of still possessing a boy's body. The symbolic significance of the boy's body may be that it functions as protection against identification with the adult male who in turn symbolises the perpetrator. Others have talked about comfort eating, which in turn led to troublesome overweight. One's own body binds not only the anxiety but also becomes a shelter for it. The body becomes a concrete protection and at the same time a painful reminder of powerlessness, since the overweight is perceived as painful.

It is as if something is gnawing inside me. It feels like a cavity. It just eats away. I eat and eat, shovelling in food. I'm insatiable but don't feel hunger. I neither sense smell or taste. Isn't that strange?

The emptiness of being beyond their bodily and sensory needs is something that several have described. An inner conception that several of the men shared is the idea that they themselves could be perceived as perpetrators.

It feels as if something has been implanted in me, something alien, nasty, disgusting and frightening, as if something has taken hold of my inner world. It almost feels like I've been poisoned. I have a fantasy, or a fear, that really does not want to leave me. What if I just might suddenly be transformed, from one day to another, and be like the man who abused me. I've heard that he was also abused as a child.

The terrifying feeling of being merged with the perpetrator is something that many men and women subjected to sexual abuse contend with, as if the "bad" has been transferred and introjected in a concrete and deterministic manner. This is a kind of fantasy that recurred in several of the men,

and which we have come to refer to as a "vampire theme". For men, a further dimension is added that is interrelated with societal conceptions of abused men. The dread of what others will think is not only an expression of a **projection** but also a serious concern about the stereotypical and erroneous conceptions that exist that men who are abused are potential perpetrators. An important feature of treatment is to talk about norms, attitudes and conceptions, which may be found in both the inner and outer worlds.

I have found it hard to approach other people. I have fantasies that they know what I've been through. Then perhaps they think that I could be a perpetrator, too, although I have never been tempted by or felt any attraction to children. I have not even told my girlfriend what I've been through, because if she knew perhaps she would think that I would do something to her children and not allow me to meet them.

Identification with the perpetrator is a common experience among those who have been subjected to sexual abuse as children or teenagers. Several of those we have worked with have in silence, and for a long time, within themselves dealt with unspea-

kable fantasies. It is a task of the therapist to dare to approach and understand the content of these thoughts through collaborative investigation. It may be a frightening fantasy, a more compulsory fantasy, or it is about the membrane between fantasy and reality bursting. No matter what lies behind it, there is often a great relief when it becomes possible to think and talk about fantasies about identification with the perpetrator, which have often created anxiety and shame.

Knowledge Intermediaries

Knowledge about the body and its workings is often poor. Therefore, information about how the body functions, is an important element in dispelling the confusion following sexual abuse. Violations of integrity and bodily violations can awaken conflicting emotions. A common misconception regarding sexual abuse is that if the victim reacts sexually, such as an erection and ejaculation, then it is not abuse. As if the body's reaction is proof of the existence of reciprocity. Nothing could be more wrong. There are two different sexual trigger patterns. One goes via the hypothalamus and pleasure centre in the brain, the other works with mechanical stimulation. Both erection and ejaculation can be triggered by anxiety,

dread, fear, anal penetration or persistent touch. This means that the man's ability to get an erection or ejaculate lies entirely outside his control. Sexual abuse can also lead to confusion about experiences of desire, discomfort and disgust. It is not uncommon during an abuse to experience a form of arousal.

Although it was so terrible and uncomfortable I still had an erection. It was like an excitement in my body, although I didn't want it. It felt sick in a way. These images of her sometimes come up when I have sex with my girlfriend. I can't control it. I am very ashamed about it. It is as if it comes between us, and I don't want to talk to her about it in case it perhaps gets even worse.

This describes of the double and contradictory nature of the body's betrayal since the arousal conflicts with the patient's own will, resulting in confusion and shame.

The amalgam of disgust and arousal that this entails can be difficult to manage and can long afterwards create confusion about one's own sexuality. It can also lead to feelings of shame and guilt, which is why the men have thoughts about not

reacting as they should have done. As a therapist, it is therefore important to normalise the various types of sensations, bodily and psychological experiences, linked to the abuse. To help the patient talk about his experiences, the therapist can describe how both discomfort and arousal can coexist and how the body can react beyond voluntary control in an abusive situation.

In abusive situations the most common reaction is to “freeze” and feel paralysed, which is a reaction that can be particularly difficult for men to understand and accept. As with many female victims, men who feel that they failed to offer resistance to the abuse can come to believe that they provided consent (Monk-Turner & Light, 2010). In the inner world they have experienced their inability to defend themselves as demolishing their perception of being a man. This applies no matter whether the perpetrator was a man or a woman.

I have been training in various martial arts since I was a kid, karate, aikido, jujitsu. I know how to defend myself, but it was as if I was completely paralysed, could hardly move. How will I be able to tell someone what happened to me, what will they think?

Details of the abuse may be omitted in the story depending on how much shame they experienced. In the case of sexual abuse that included penetration, the body’s boundaries become violated in a brutal manner with strong physical and psychological impact. Many of the men we met have experienced penetration as the worst part of the abuse. There are also studies that point out that just the experience of having been penetrated in sexual abuse entails a significantly lower likelihood of seeking help (ibid.). When the man seeks help it can be difficult for him to say that he was penetrated anally or orally. One man told how for several days he visited a number of health centres and provided urine samples, for the checking of sexually transmitted infections, before he could in the end speak about being subjected to oral abuse and get help taking the tests needed.

Consequences For Sexuality

More than half of the men we met have expressed that they are troubled by sexual symptoms. They have described erection problems of different kinds, such as not being able to get an erection or getting an erection and losing it. Other difficulties involve rapid ejaculation or non at all. A few of the men have experienced some body parts be-

coming completely unusable such as for example the mouth or penis. A lack of sexual desire can also be experienced as a consequence of the abuse.

Sex in a relationship is purely painful. For me it's only performance. This is particularly the case when I have a more solid relationship. I feel no pleasure, I don't want to touch my own genitals and I can't ejaculate.

Several have talked about a sense of losing touch with their own sexuality and describe it as if their own bodies have become just a tool for the other. As a therapist, it can be important to talk about how what they have been through can affect sexual experiences in the present, and that the abuse has consequences for sexual practice. Sexuality and intimacy are not separate fields within the individual but are closely interwoven with identity, self-image, psychological, and physical health.

Male and Sexual Identities

Questions about male identity and sexual identity have been a theme that has often been a focus in treatment contacts with the men. Our experiences here are consistent with studies showing that, for men who later in life seek help for abuse they have

been subjected to as a child or youth, the most important theme is to clarify male identity (Rentoul & Appleboom, 1997).

In our society we tend to view masculinity from a dualistic perspective, where it is defined in terms of what is not feminine. Masculinity is a complex and elusive concept that can comprise different meanings depending on who defines it. A more open approach is to think in terms of masculinities. Masculinities are shaped by a complex interplay of biological, psychological and socio-cultural factors and are interpreted in various ways in different times, societies and traditions of thought. Irrespective of the different interpretations of the concept, it is the subjective definition and perception of masculinity that is, from a treatment perspective, the starting point.

Body and gender are central in our psychosexual development. Early in life the child discovers and learns to relate to gender differences. Both conscious and unconscious conceptions about sex and gender are communicated to the child long before they are aware of their gender identity. Identity slowly begins to be built through identification with the first significant other and the incorpora-

tion of both "masculine" and "feminine" aspects into the child's inner world. We believe this is not linked to gender per se but to the male and female functions that we all have access to regardless of biological gender. Among several of the men we worked with there were many whose identification with "the father function" deteriorated for various reasons. This may have been to do with a parent who was emotionally absent despite their physical presence, or who was too intrusive or authoritarian in a frightening way. For some, it has been difficult to internalise the nurturing "mother function" because of deficiencies in terms of protection or boundaries. Many have had experiences of earlier trauma and separations. When the new trauma evokes experiences that are interwoven with previous traumatic events major challenges are involved in creating a stable Ego. If one is abused early in life the basis for the already fragile development of identity becomes complicated, and makes more difficult the formation of a stable identity of which the experience of male identity is a part.

Moving from childhood to adulthood is a long and complex process. It means separating, becoming autonomous, and claiming one's own

body and sexuality in order to shape one's identity. With the help of desire, fantasy and conceptions we create our inner world of sex, gender and sexuality. The fantasies become a bridge for developing male sexual identity. Through identification with others it is possible to discover, explore and strengthen one's self. Trying out different roles in fantasy or play is an important means of creating one's identity. We make use of all the different phases of becoming an adult, when we come to terms with idealised internal parental figures and replace them with other adults, idols and friends. Homoerotic fantasies also have an obvious and natural place here. Experiences of sexual abuse can, however, restrict and inhibit fantasising because of what the concrete action means. Images of abuse can destroy by penetrating into fantasies and sexual situations.

Every time I make out and am about to approach a girl the memory turns up of what I've been through. I become almost completely paralysed. She then thought of course that I'm not interested! What if I can never be with someone! What should I do?

Many men have expressed that they would have been a completely different person if the abuse had not occurred. They believe they would be more genuine, being able to stand up for and assert themselves in relation to others. No matter whether they were abused as a child, teenager or adult the men we have worked with have in different ways wrestled with their perception of male identity. One man expressed it like this:

I feel myself to be less of a man than most men. I'm not comfortable in my own body. Sometimes I look at pictures of other men and then I look at myself in the mirror and try to understand how others see me. Sometimes I think that perhaps they see a little boy.

The inability to live up to one's own ideal image awakens feelings of worthlessness. For some this has been experienced since early in life. The longing for confirmation may therefore have been very strong. The perpetrator may have been an important person who for a time fulfilled the need of being recognised or being a person one could look up to and identify with. As a psychotherapist it can be important to confirm the part of the patient who felt this longing, in order to help the patient to understand him-

self better and deal with the ambivalent feelings they may have had for their perpetrator.

Some have felt "feminised" by the abuse, which can lead to confusion or questions about gender identity or puzzlement about sexuality. Where the perpetrator has been a man the abuse may emerge in nightmares or fantasies in a terrifying way. This has caused several of the men we encountered to ponder on the question of whether these horrifying scenes had to do with the trauma or were about themselves or their sexual identity.

Why did he choose me? Was it something to do with me that made him approach me? Did I look in some special way? I can't get the thought out of my head, it buzzes around so much that I nearly think that I'm going crazy. I wonder all of the time whether I'm really homosexual, although I know I'm not.

For men who define themselves as homosexual the abuse can reawaken previous conflicts about masculinity and male identity, which they thought had been resolved earlier in the development of their identity.

In my teenage years I'd never have been able to say that I was attracted to guys. My Dad would have been mad. He hated gays. That made it even more difficult to say that I'd been abused. I found this man on the internet, and I didn't know he would force himself on me in this way.

The abuse may have additional dimensions, where it becomes an attack on both male identity and a central aspect of the individual, especially if the abuse involves a hate crime, and is thereby directed against identity itself. If you become a victim of a hate crime, the fear can lead to changing one's behaviour and limiting the space for living life, which in turn can affect one's perception of identity. The instinctive feeling may be to flee from awareness of the abuse as quickly as possible. But pausing for a time in a kind of acceptance of one's identity as a victim may be important since it confirms that an unjust abusive act occurred and that it is the perpetrator who is to blame. When having acknowledged oneself as a victim one needs to go on and reclaim male identity (Dunn, 2012). The man's inner beliefs about himself as a man and a homosexual may after a hate crime need to be explored and talked about in psychotherapy. Internalised negative attitudes about one's own identity

have been linked to increased psychological symptoms following a homophobic hate crime and prevent the man from reclaiming his male identity (Gold et al., 2007).

The identity can also be experienced as being so attacked by the abuse that changes are made in sexual practice in order to avoid coming into contact with feelings of rejection and betrayal. One man described how after having been subjected to serious abuse in a relationship with a male partner he was no longer able to have sexual relations with men. There was a strong longing for a deeper intimate contact, but he refrained from devoting himself to a man and instead established sexual relations with women. For him this form of splitting was a way of protecting himself from the double betrayal of what abuse of a trusting relationship means. At the same time he was able to describe how the perception of his own identity became limited as a consequence of the splitting.

Shame

In addition to the physical and psychological consequences, the person who is subjected to sexual abuse often struggles with feelings of shame.

Shame is a painful feeling, and we can make great efforts to avoid coming into contact with shame, both our own and others'. Shame arises in situations where we, for different reasons, have failed to meet the expectations of our surroundings. At an inner level shame may also be about not living up to one's own ideal of who we should be. The judicial authority in our inner world can sometimes evolve into something severe and ruthless. Shame is thereby expressed within the individual, or perhaps more accurately between two different aspects of the individual, one judgemental and another suffering from self-contempt.

Shame and Self-contempt

The concern about being condemned by others is something most of the men talk about. One's own self-contempt is projected into the eyes of the other.

Sometimes it becomes so unbearable to just walk down the street. It's not possible to face the glances of others; I really just want to disappear. I feel it as if they could see straight into me, and then they just see what I've been through.

There is often a perception that the people around would re-evaluate the person if the abuse became known, an inner belief of being regarded as of less value or defective.

I explained the abuse to my partner for the first time ever when the relationship was in total crisis and nothing could really get any worse. That was how I felt it. I had kept quiet about it for so many years and didn't tell anyone. But in the last days before we broke up with each other I told him about it. I would lose him now anyway.

Often the shame has affected the perception of one's own self for a very long time. The consequences of shame will then permeate one's whole person. One aspect of shame is the desire to hide, where there is a temptation to give up on oneself, not to protect one's own boundaries, to please others and have a hard time saying no. Another way is to evade and avoid getting close in order not to risk being seen as one is, which would mean being revealed in all one's shamefulness.

It was like I locked all the pain inside, deep inside of me. But in the end I had to try and unlock it, because it became so difficult to be together with others. I was completely closed off. In the end it was a big burden to live a life without emotions.

Shame, unlike guilt, is not something you can make amends for and put things right. Guilt is connected to something we have done while shame says something about who we are. Shame is thus more related to the experience of fundamental aspects of who we are rather than what we do.

Shame, Self-contempt, Depression

Shame can be devastating and impede growth and development. We need the acknowledgement of others in order to learn, step by step, that we are good enough. When these conditions are lacking, due to for example being used for another's needs, a deep sense of shame arises, a feeling of not being worthy of being loved and respected. The shame of not being acknowledged for who one is can also awaken feelings of hatred and anger. The aggressiveness will then often be directed inwards towards the Ego, which through a lack of confirmation is perceived as inadequate. In this way, the aggressiveness and the underlying shame can be

an important driving force in the development of depression (Beck-Friis, 2005).

She'd have thought that I was disgusting if I told her what happened. Everyone would have looked down on me and condemned me. So I thought, anyway. I've always wished that I could just run away. Not that I thought I'd take my life. But just to be away.

Shame following sexual abuse has strong links to the body and thereby the capacity for intimacy and sexual relations. It is therefore essential in the treatment of those subjected to sexual abuse to help them approach shame. In a treatment setting, shame can often be expressed through silence, and feeling devoid of thoughts and feelings (Hauge, 2012). It can be difficult to work with the shame. Working with it requires a trusting relationship with the therapist. Because the patient wishes to hide their shame, the therapist's presence in their inner world becomes a threatening judgemental eye, someone who can despise and condemn. For many patients, it can be difficult to maintain eye contact when telling their story (Myers, 1989). Since deep shame leads to withdrawal from relationships and the repression of genuine feelings, a

long time may be needed for healing. Shame arises when there is a threat of losing one's own sense of worth in relationships. Overcoming shame therefore needs to focus on relationships, trust and emotions. Creating opportunities for the healing of shame involves establishing a relationship with the therapist that engenders courage and the ability to expose the inner self to another person and to be accepted (Petterson, 2013).

Conclusion

Our initial questions concerned whether there are differences in the effects of sexual abuse on men and women and how such effects can be understood. Most of the effects of abuse on men that we have described can also be applied to work with abused women. Nevertheless, in our psychotherapeutic work we have seen that there are some differences that we have chosen to emphasise. These primarily concern questions linked to male and sexual identity but also shame. Shame is something that the majority who were subjected to sexual abuse have had to contend with. Our experience is that the shame for the men we met touched on a number of dimensions of identity and therefore had a deeper impact on self-image. We have understood this among other things as a consequence of the prevailing masculine norms. Generally, many of the differences that became visible between men and women who have been subjected to sexual abuse are shaped or reinforced by the myths, norms and values that surround and affect us.

The experience of being defiled and contaminated through abuse - what we came to call “the

vampire theme” - is something that both men and women often describe as an uncomfortable inner belief following sexual abuse. The erroneous conception that all men who are abused are potential perpetrators means that men may have to contend with both their own fantasies and the fantasies of those around them. The inner image of masculinity is not only related to social conceptions but is also created by earlier experiences of important relationships. The incorporation of one’s own “mother and father functions” for protection and self-assertion may as we mentioned earlier have been inadequate. Most of the men we met had previous experiences of trauma or other difficulties that were connected to the experience of abuse. Whether the abuse occurred at a young age or as an adult it has in different ways shaken the foundation of their inner perception of male identity. When men subject men to sexual abuse there is often an assumption about homosexuality, as regards both victim and perpetrator. For the victim the abuse often arouses concerns about one’s sexual identity, regardless of sexual orientation. What we consistently found was that identity, both male and sexual, was an area that is espe-

cially important when working with male victims of sexual abuse. It is important during sessions to provide an opportunity to explore the subjective meaning of the abuse for the person. Questions about both male and sexual identity are important because these aspects of identity form the basis for the ability to be close to another person. By putting experiences into words it becomes possible for the men to see themselves in a context in which they can gain a new understanding of their own behaviour and their own reactions. Being able to face their own vulnerability becomes a basis for achieving a form of masculinity that accommodates both “male” and “female” aspects.

I don't think about the abuse any more. Previously it plagued me every day. Now I can say no, which I found hard to do so before. I can also have male managers. I'm no longer afraid of them. My perception now is that I'm just as capable as man.

Statements like this describe the relief men can express when guilt and shame have subsided and they have more access to their own energy and ability. During long-term psychotherapeutic work we have had the privilege of following the reclamation of essential aspects of the self. By being

able to share experiences and create a narrative of their experiences, self-image has changed. Above all, it is in cases of long-term psychotherapy that we witnessed the most positive effects and the greatest changes. Many men expressed how the feeling of being swallowed up in every relationship has been replaced by an increased ability to set boundaries for relationships that lack mutual respect. Others have described how loneliness and isolation have given way to a feeling of being in contact with both themselves and others.

It felt like I've been completely barricaded in my inner solitude. Something has happened! Now I can express both the longing for and need for closeness. I have dared to venture into a new relationship. I think it could be something. It feels as if it's more alive and mutual.

We have been able to follow how a controlled discourse during therapy has eventually given way to open and unprejudiced reflection. An increased ability to identify and express their own feelings and thoughts has led to greater freedom in relation to others.

It's much easier for me to talk about what I feel, I'm not as afraid. I can affirm my own desire and can initiate sex without feeling weird. I have access to my own sexuality.

Among the men who showed destructive behaviour, many have gained a greater understanding of themselves. Shame has decreased since they have been able to see how it played a role in dealing with what is not possible to think about and put into words. Many of the men we have met have encapsulated the abuse in silence and solitude. Denial on the part of society that men can be victims of sexual abuse has contributed to the difficulty in opening up and seeking help. The long-term silent storage of traumatic experiences can have severe consequences for the internal world and self-image. Over time, psychological defences become increasingly more rigid, which impedes development. Destructive acting out can evolve to keep anxiety at bay. In Swedish health care today there is a great shortage of care for sexually abused people. When someone is subjected to sexual abuse it is important to have emergency care, both medically and psychologically, but particular care needs can vary. Brief counselling can be a way of daring to approach what has happened in

order to make it possible to return to later. Health care services need to be able to offer crisis therapy at an acute stage and long-term psychotherapy later in life if it then becomes more possible to approach the abuse. In order for care needs to be uncovered health professionals must dare to ask questions about experiences of abuse.

If silence has been enduring and shame great, it will be difficult for victims to approach what they have been through. The ambivalence that characterises all psychotherapy places great demands on the therapist's ability to handle both closeness and distance. Sexual abuse can raise many difficult feelings for the therapist. It is therefore important to have access to supervision.

The supervisor's role as a "third eye" makes it possible to create a space where the therapist can sort, reflect and understand all the unprocessed emotions that may be awakened.

This report is a summary of experiences of psychotherapeutic work with victims of sexual trauma. By focusing on males, we have sought to break the silence that still surrounds men who have been traumatised sexually. The important

work that has been done in Sweden with focus on female victims of sexual trauma has in many ways paved the way for acknowledging men as victims. Much knowledge and experience of work with women who have been victims of sexual abuse are applicable to work with men. Here we have highlighted important issues that stand out, issues that we consider important to reflect on when working with men who have experienced sexual trauma.

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