Toxic Masculinity, Male Childhood Sexual Trauma, and the Challenges to How Young Men Heal

by

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Submitted in partial fulfilment of the requirements

for the degree of Master of Social Work

at

Dalhousie University

Halifax, Nova Scotia

June, 2020

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DEDICATION

This work is dedicated to male childhood sexual trauma survivors everywhere:

We see you, we hear you, and we stand with you.

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ABSTRACT

This study critically examined impacts of toxic masculine culture on males who experience childhood sexual trauma and explored how myths surrounding dominant masculinity serve to impact healing. Through the perspectives of twelve mental health therapists, this work explored gaps in current research in understanding needs of survivors, and highlighted the importance of engaging with social constructs of masculinity and healing through a gendered lens. Data was analyzed through a narrative inquiry approach, utilizing thematic and discourse analysis.

Findings were consistent with current literature that described strong adherence to traditional masculine norms as having negative impacts on male survivors. Stigma related to homophobia and misogyny within a heteronormative, patriarchal society were problematic and impeded disclosure. Gendered male approaches are arguably non-existent at present in mental health systems in Nova Scotia, yet this study demonstrated how clinical service providers might be poised to intervene in important gender specific ways with young male survivors.

LIST OF ABBREVIATIONS USED

APA	American Psychological Association
LGBTQI2S+	Lesbian, Gay, Bisexual, Transgender, Queer, Intersex, Two Spirited, Plus
PTSD	Post Traumatic Stress Disorder
TF-CBT	Trauma Focussed Cognitive Behaviour Therapy
DSM-V	Diagnostic and Statistical Manual, Fifth Edition
NSHA	Nova Scotia Health Authority
NSCSW	Nova Scotia College of Social Workers
APNS	Association of Psychologist Nova Scotia
BSW	Bachelor of Social Work
MSW	Master of Social Work
DBT	Dialectical behaviour therapy
BPD	Borderline Personality Disorder
ADHD	Attention Deficit Hyperactivity Disorder

ACKNOWLEDGEMENTS

First of all, I want to acknowledge tremendous thanks and extreme gratitude to my thesis committee – Dr. Catrina Brown, Dalhousie University, School of Social Work; Dr. Marion Brown, Dalhousie University, School of Social Work, and Dr. Deborah Norris, Family Studies and Gerontology Department, Mount St Vincent University.

Catrina – I have been in awe of your knowledge, your passion, and your commitment to critical social work practice from the moment I entered your classroom, and it has been my privilege to take this journey with you. As thesis supervisor, I want to thank you for all the support and guidance, and the freedom to allow me to find my own voice. You will always be an important mentor of mine, and you are everything I aspire to be as a social worker, a therapist, a researcher, and a human being.

Marion – Thank you for all your thoughtful and incisive critiques. You pushed me to grow and develop my ideas while still allowing me to forge my own path. Your knowledge and wisdom are at the heart of this work and serve to make it that much better, and for that I am forever indebted.

Dr. Deborah Norris – Thank you for agreeing to be external reader. Your vast knowledge of trauma and its impacts as contributions here are much appreciated.

To Coleen Flynn, MSW RSW, I wish to express thanks and gratitude for your contributions to this study (including serving in an advisory role as supervisor through the IWK and in introducing me to the concept of "moral distress"). Thank you for all your encouragement and guidance, and for keeping me laughing throughout it all – I am proud to be part of "the Cols".

I would like to thank the many inspirational professors I have had throughout my MSW experience at Dalhousie - particularly Senator Wanda Thomas-Bernard, Dr. Cassandra Hanrahan and Dr. Jeff Karabanow - who have helped develop my critical thinking skills and ignite my passion for fighting social injustices through a welcoming learning environment filled with thoughtful, open debate.

I would also like to thank Professor Ginette Abraham and Louise Sabourin of the University of Manitoba for their encouragement in pursuing an MSW and ultimately thesis work.

I wish to thank the family and friends of the Lawrence Hancock Scholarship, the Sonia Weil Bursary, and the Margaret Cragg Award for their tremendous financial support that helped to make this work possible.

I wish to thank all of my MSW classmates – in particular Katrina, Kaitlyn, and Jillian. I am so proud to have taken this MSW journey with you all, and I believe together we *can* and *will* change the world.

Thank you to the twelve amazing clinicians at the heart of this work for being so brave and generous in sharing their stories of experience. I will be a far better social worker and therapist just by virtue of knowing you all.

Thank you to all IWK Managers past and present who have supported me throughout this work, and my coworkers and colleagues, all of whom continue to inspire me every day.

Thank you to my friends for their enthusiastic and unwavering support. I especially want to thank Karen Carey for all the fun, friendship, and laughter over the years, and for encouraging me to follow in her path and return to academia.

Thank you to Barry Nahirnak for his wise counsel and Dr. Kevin Carbyn for his compassionate care.

Thank you to my family for always loving and supporting me, even when you did not always understand my path – although we do not see each other often, you are always in my heart.
To Mom, dad, and Raylene – I miss you every day, and while you are not here to share in this moment, I know that you are somewhere together watching and you are proud.

Thanks to Carol for her kind heart and for accepting me as part of her family, and for raising on her own such a strong, caring, and compassionate son.

Thanks to Edward and Mungo, two of the sweetest ginger cats that ever existed, for all the times they kept me good company while I was researching and writing long into the night.

And finally, to my partner Shawn Miner: Thank you for always picking me up whenever I fall, and for lending me your strength when it seems I had none of my own. This work would not exist without your endless encouragement, enthusiasm, and support, and it is your countless hours of constructive feedback and thoughtful critiques that have served to make this work so much better. You make the world a much better place just by being in it, and I am so lucky to be on this journey through life with you. You show me every day what it means to be a good man, and my love for you truly knows no bounds.

CHAPTER ONE: INTRODUCTION

This study critically examines the impact of toxic masculine culture on young men and boys who experience childhood sexual trauma and explores how myths and assumptions surrounding dominant masculinity in the world today serve to influence, impact, and potentially disrupt healing processes for young male survivors. The study also examines how we might work to reduce the stigma, shame, and silence that surrounds this phenomenon, and seeks to contribute to literature around the experiences of young men and boys and early childhood sexual trauma. The study presents an overview of the experiences of young male survivors understood through the perspectives and personal narratives of mental health clinical therapists, those who counsel and provide therapeutic interventions to this population. Through this work, I critically examine gaps that exist in current research in understanding the unique needs of survivors, explore constructs of masculinity and male identity as it relates to experiences of childhood sexual trauma, and highlight the importance of engaging with these issues through a gendered, male-centric lens.

Chapter one outlines the framework of this study and provides some background to the research topic. Therein, I present a working definition of the term “toxic masculine culture” that places it within the context of male survivors’ experiences with early childhood sexual trauma and abuse. Chapter two explores relevant literature pertaining to hegemonic or dominant masculinity and toxic masculine culture, early childhood sexual trauma, boyhood socialization, and a brief overview of treatment and healing processes. Chapter three contains the methodology section, including a discussion of theoretical foundations, an outline of the recruitment processes, and an overview of ethical considerations. Chapter four presents the narratives of the study participants as mental health therapists engaged with this unique population. Chapter five

discusses the interpretive findings of the research in a results section. Chapter six provides an analysis and critique and considers some future implications for social work practice. Lastly, chapter seven offers an overall summary of the work, closing remarks, and a final conclusion.

This study explores narratives of clinical therapists detailing their work with young male sexual trauma survivors. Their narratives of that work consist of stories within stories, as participants shared their interpretations and meaning making of the narratives of those under their care. The study examines and interprets the effects of toxic masculine culture on young males through their narratives and considers the resulting impact on their healing process. It also explores the complex gendered nature of the treatment work participants provide to survivors. Research questions that guided this study are: How does the experience of childhood sexual trauma impact the lives of young survivors? In what ways does the phenomenon of childhood sexual trauma intersect with the experiences of being socialized as a young male? How do expectations of dominant masculinity – and particularly those of toxic masculine culture – impact or disrupt healing processes of young survivors? What current treatment interventions and strategies are utilized in treating male survivors, and what appears most effective and what might be missing or lacking? How might we reduce the stigma for males associated with being a survivor of childhood sexual abuse and address the dominant discourse related to poor mental health help- seeking behaviours in males?

I chose to use the word *trauma* to describe these early childhood experiences in place of *abuse*. I understand abuse as the violation, disrespect, or harm that befalls or is visited on a person, while I interpret trauma as the physical, emotional and psychological impact of that abuse. Trauma overwhelms a victim, taking away control, severing connection, and disrupting meaning in their lives (Herman, 2015). Not all men and boys who experience childhood sexual

abuse are traumatized, and many go on to live healthy, productive lives without intervention. However, this study focuses on the lives of those who do experience trauma and a loss of control, connection, and meaning in their lives, and the complex interplay between their traumatic sexual experiences and their masculine identity. My hope for this work is to bring attention and shed light on a topic that is poorly understood and not well recognized, to better capture and define some of the more effective ways and means of providing treatment and service, and thereby increase capacity in others working with this unique and underserved population.

Prevalence of Sexual Abuse of Boys

Research shows as many as one in six men are survivors of early childhood sexual trauma histories, yet many clinicians in the field believe that this number is a gross underestimate of those truly affected, noting how many young men and boys struggle to recognize or define the experience itself as abusive, and possess little understanding of the possible impacts or effects of trauma and how they may relate to present day struggles. Men and boys also struggle in disclosing their experiences to others, initiating help-seeking behaviours, and finding appropriate resources (Cohen et al., 2017; Fisher & Goodwin, 2008; Van der Kolk, 2014). Men and women sexually abused during childhood share many commonalities in the psychological and social aftermath they endure following these experiences, and yet for as many similarities that exist there are an equal number of differences. Of particular focus in this study is the unique way for male survivors that victimization intersects with gender socialization and the formation of sexual orientation identity (Gartner, 2017a; Fisher & Goodwin, 2008). As a result of this intersection, men abused in childhood can often face several harmful myths that can serve “to amplify their trauma, limit the services available to them, and block their entry into a healing process” (Fisher

& Goodwin, 2008, p. 2). This study will demonstrate how these myths are often directly related to that crucial period of adolescent discovery and sexual identity formation, and how that confusion, loss and disruption has staggering and long-lasting impacts for many survivors.

Perpetrators of sexual abuse on young males are often adults who have violated positions of power and trust which results in a shattering of the natural trust he possesses in adults and caregivers (Gartner, 2017a). Trauma survivors are potentially left suffering from damaging effects, with little awareness of how impactful and harmful their experiences may have been over the course of their young lives, or how inter-connected trauma may be to any present-day difficulties or challenges (Fisher & Goodwin, 2008; Gartner, 2017a). These unwanted experiences can have severe lifelong impacts on some of survivors and, if left unresolved, can lead to more severe psychological issues like anxiety, depression, and other mood-related disorders, which in turn can promote high risk behaviours involving substance misuse, sexual compulsivity, self-harm, or eating disorders (Fisher & Goodwin, 2008; Gartner, 2017b; Van der Kolk, 2014). Research now shows a clear link between these same resulting high-risk behaviours and long-term physical health consequences like sexually transmitted diseases, cancer, heart disease, and obesity (Cohen et al., 2017; Currie & Spatz-Widom, 2010; Herman, 2015; Van der Kolk, 2014). Furthermore, the impact of delaying recovery can have serious impacts on the struggling survivor's life and a ripple effect on family and community around him, including social dysfunction issues that may lead to failed relationships, intimate partner violence and significant impacts on career or education goals and objectives (Gartner, 2017b; Lisak, 1994, 2017; Van der Kolk, 2014).

In our school and mental health care institutions, these same young men and boys are sometimes wrongfully misdiagnosed with a wide range of mental health disorders, and

subsequently treated with multiple medications and therapies that ultimately prove ineffective because the clinical formulation is unwarranted, the interventions target only a small cluster of symptoms, or most importantly for sexual trauma survivors, the treatments fail to address underlying root cause and effect of early childhood trauma (Cohen et al., 2017; Fisher & Goodwin, 2008; Herman, 2015; Van der Kolk, 2014). As a result, I argue throughout this work that the current services offered through our mental health systems, with their emphasis on brief interventions and short term therapeutic approaches, are often poorly designed and dangerously ill- equipped to address the unique therapeutic needs of trauma survivors.

Hegemonic Masculinity as Traditional Masculinity

Hegemonic masculinity, as described by Raewyn Connell (1995) refers to the socially constructed dominant form of masculinity that is accepted, privileged and exalted over femininity and other forms of marginalized masculinities, including gay, trans, or gender diverse males. It is an idealized form of male behaviour, which privileges the position of some men, a position they are strongly encouraged to aspire to, while it ideologically legitimates the subordination of women and all things considered feminine. Character traits of hegemonic masculinity include physical strength, wealth and power seeking, risk taking, invulnerability, virility, stoic or suppressed emotionality, control and dominance, excessive competitiveness and a rejection of femininity (Connell, 1995; Connell & Messerschmitt, 2005). While portrayed as only one of many different ways men and boys enact masculinity through its social construction, hegemonic masculinity has historically been recognized as the most privileged and sacred among them (Connell, 1995; Connell & Messerschmitt, 2005; Seidler et al., 2017).

It is embodied at the specific intersections of race, class, ableism and sexuality (Collins, 2015), currently defined in Western culture as white, wealthy, able bodied, and heterosexual. Central to hegemonic masculinity is heterosexuality, constructed as a position that is as much 'not gay' as it is 'not female' (Jewkes et al., 2015). These privileged social identities interact and intersect in specific ways that exclude certain groups of men due to their perceived devalued membership, such as those who are racialized, gay, disabled or working class poor.

In January of 2019, the American Psychological Association (APA) released a series of recommendations centred on gendered mental health treatment approaches towards males (APA, 2018). Titled *Guidelines for Psychological Practice with Boys and Men*, these recommendations, reportedly drawn on over forty years of research, described hegemonic masculinity (sometimes referred to in the report as "traditional masculinity") as psychologically harmful when combined with strict and rigid adherence to masculine norms. It also deemed the Western practice of socializing boys to suppress the depth and range of their emotions as causing damage both internally and externally (Pappas, 2019). Traditional masculinity, when combined with extreme adherence to gendered expectations, manifested in harmful and problematic ways for boys and men but also for those closest to them. This strict adherence was harmful and damaging to men in terms of their physical and mental health by often involving excessive substance use, fighting or risk taking, body dysmorphia, and challenges in expressing emotions. It can further present as damaging to others, in terms of violence, transphobia, misogyny, homophobia, xenophobia, racism, and sexual assault or harassment (De Boise, 2019; Pappas, 2019).

Toxic Masculine Culture

The Good Men Project (2020) describes toxic masculinity as a narrow and repressive description of manhood, reducing masculinity to a cultural ideal of manliness, emotions as weakness, and sexual pursuits and forced aggression as measures of success while supposedly "feminine" traits – ranging from emotional vulnerability to simply not being hypersexual – means by which your status as a man might be taken away or negated. Over the past number of years, "toxic masculinity" has become a catchall phrase used to describe male violence and sexism in modern culture. The appeal of the term, which distinguishes "toxic" traits such aggression and self-entitlement from "healthy" ones such as strength and confidence, has grown to the point that the American Psychological Association, while not explicitly labelling it as toxic, warn that extreme forms of certain "traditional" masculine traits are linked to aggression, misogyny, and negative health outcomes (APA, 2009).

Shortly after its release, the APA *Guidelines for Psychological Practice with Boys and Men* was met with considerable controversy and conflict, with some critics describing it as a declaration of war on traditional manhood, while others saw it as helpful in acknowledging and challenging misogynistic behaviour and homophobic behaviour and violence towards women and the Lesbian, Gay, Bisexual, Transgender, Queer, Intersex, Two Spirited, + (LGBTQI2S+) community (De Boise, 2019; Pappas, 2019). The term toxic masculinity itself became highly charged and politicized, and amid heated discourse, popular media has blamed toxic masculinity for rape, mass shootings, gun violence, online trolling, climate change, and the election of Donald Trump (Salter, 2018). Others have argued using a term such as 'toxic masculinity' is problematic in that it releases men of responsibility for troublesome behaviour by positioning

them as victims of a broader vague entity, rather than highlighting their agency in the social construction and reproduction of masculinity (Beasley, 2013; Waling, 2019a).

I believe that the term toxic masculinity is a repressive and restrictive way of defining manhood, and one that essentializes the way masculinity is socially constructed and portrayed in our world today. My intention is to not essentialize masculinity as fixed or problematic, and in fact, I will draw heavily from social constructionism and postmodern theories of discourse on gender with a view of all gender as fluid, socially situated and socially constructed. Within this work, I speak of the male experience with sexual trauma and gender constructs because that is my understanding and my lived experience, and because I believe it is an area of exploration in our culture that has long been ignored or silenced. For an example of this, we need look no further than to the *Nova Scotia Sexual Violence Strategy*, released in 2016 as the first provincial coordinated response to sexual violence, with a focus on improved service delivery and access to supports and resources for sexual violence victims and their families. The strategy noted that youth and children make up 20% of the population of Canada, yet they accounted for 55% of all victims of police reported sexual offences (Nova Scotia Department of Community Services, 2015). It also noted that while women and girls were largely more likely to be impacted, victims of sexual violence also include men, boys, and LGBTQI2S+ persons. While acknowledging there was a need for more focused and increased supports for these populations, those needs and their required supports and resources were not explicitly recognized or addressed.

I recognize within this work that girls and women are statistically much more often impacted by sexual violence as victim and survivor, with research that shows as many as one in three girls will likely experience some form of sexual trauma in their early lifetime (Collin-Vezina et al., 2013; Herman 2015). Furthermore, I believe that it is the work that women have

done to advance the conversation around sexual trauma and its impacts that have allowed space for research on male sexual trauma survivors such as this to exist. So, while I urge for more attention and focus on male experiences of sexual trauma, by no means is that meant to detract from the very significant societal issues we face with violence perpetrated by men and boys towards women and girls. I also recognize that gender expectations can impact everyone, and that women can face impossible standards in regard to dominant or idealized forms of femininity. Boys are not naturally strong and aggressive just as girls are not inherently weak or passive – rather, these are stereotypes related to cultural expectations placed on boys and girls that can lead to a form of behaviour that is toxic. This is not because masculinity itself is innately or inherently bad, but it is because the way boys are socialized in our culture is often harmful and potentially dangerous for everyone. Independence, self-reliance, and stoicism can be admirable traditional male traits, but when a man is unable to ask for help, feels incapable to rely on others, or struggles in the expression of vulnerable emotions of any kind, those traits become increasingly problematic (Augusta-Scott, 2020; Fisher & Goodwin, 2008).

Experiencing trauma in childhood can encourage men to deny their victimization, because to be a victim is to be perceived as vulnerable or weak (Augusta-Scott, 2020; Fisher & Goodwin, 2008). Ironically, by not acknowledging their victimization and seeking to perpetually prove they are not vulnerable and therefore not victims, their trauma remains unresolved and all-consuming of their focus (Augusta-Scott, 2020). Research shows that masculinity, when associated with rigid, restrictive enactment and enforcement of traditional male gender roles, can manifest as toxic both in its associated behaviours and its significant harmful impacts and negative influences on the positive health, recovery and overall well-being of males who are survivors of early childhood sexual trauma (Englar-Carlson, 2014; Fisher & Goodwin, 2008;

Gartner, 2017b; Iwamoto et al., 2018). When describing a toxic male culture, I am not describing masculinity itself as toxic, but the form of gendered behaviour that manifests when expectations of what it means to be masculine fail to match up with reality. A toxic male culture is one that implores young men and boys to grow strong and tough, to hide or suppress many of their outward emotions, to present themselves (often at times rigidly) as strong, independent, assertive, stoic, athletic, sexually potent, successful, and powerful, and to believe that anything less may imply a failure of masculinity (Corbett, 2016; Gartner, 2017a; Kimmel, 2015; Kupers, 2005). While hegemonic masculinity shares many characteristics with what I describe as toxic masculine culture, I maintain that the term "toxic masculine culture" is helpful because it helps to delineate and differentiate between those aspects of hegemonic masculinity that are most harmful or socially destructive, such as misogyny, homophobia, and transphobia, and those that are most honoured or valued, such as courageousness, self-reliance and the desire to provide protection and promote wellbeing in others. Through this work, I will explore this crucial distinction, and deconstruct how strict and rigid adherence to masculine norms can prove especially problematic to young male survivors of sexual trauma in terms of their healing and recovery process.

Narrative Beginnings

As a researcher, I come to this project as a queer cis gendered male, a social work scholar, a youth care worker, a case manager, and a mental health clinician. I have worked with this unique population of male sexual trauma survivors and witnessed first-hand the devastating impact of unresolved and untreated trauma experiences in young men and boys and the far-reaching effects on their lives and those around them. I have been challenged and I have struggled with membership in a health care system whose predominant approach to this

phenomenon either pathologizes or minimizes the very severe and long-lasting implications of trauma. My positionality within this work is grounded by my own experiences of childhood sexual trauma and my interactions as a survivor within systems and agencies that failed to protect me or to provide the even the most basic care and treatment I so desperately sought at a young age. These early experiences with trauma led personally to troubles with anger, challenges with healthy relationships, disruptions at school, and problematic substance use in the past - many of the same issues my work experience in mental health and the research literature explored in this study has shown as commonplace among male childhood sexual trauma survivors.

As a gay male who grew up in a small community that was heteronormative and often largely homophobic, I have faced many challenges within my own understanding, portrayal, and enactment of masculinity. I was raised in a family where my three primary male role models – my father and two older brothers – worked as a firefighter, a naval diver, and a truck driver respectively, and all subscribed to very traditional and stereotypical male gender role patterns. Meanwhile, I was a queer kid who preferred books, art, dance and nature. In struggling to fit in, I identified much more strongly with my sisters and their interest – interests that were deemed too "feminine" for a boy – and therefore rejected many of those traditional masculine norms that were expected. But over time, to avoid ridicule, I had to consciously be aware of things like the way I spoke or carried myself, or the way I dressed. My experiences of gender and how masculinity was performed and enacted was far removed from the traditional normative ideals of my family. I was loved and cared for by my mother and, although at times distant and removed, my father as well, and I shared a close bond with both my sisters. Yet every single day of my childhood was a struggle to belong combined with pressures to conform, and at times my

brothers, in their relentless teasing, were my worst tormentors. Therefore, while I cannot claim to be neutral in exploring the accounts of my participants in their trauma work due to my personal history and narratives, I recognize that all researchers come to their research with prior knowledge, experience and social location that serve to inform and influence their work. Through my experiences, I believe I am uniquely positioned and qualified to explore this research as a survivor of childhood sexual trauma and as someone who has dedicated so much time and effort to helping others who have experienced similar dark journeys and pathways. My work specifically has also afforded me some privilege as an insider, as a mental health colleague to those who share their work narratives and as a fellow survivor to those young boys and men under my care. It is through that privilege that I have learned and grown as person, and how I came to understand the power of the survivor's voice in telling their narrative. For that reason, I choose to illustrate and highlight the voices of my participants and their understanding of the male sexual trauma survivor's voice, and therefore position them as the true experts in this phenomenon and in this research.

Purpose of this Work

The capacities that men and boys have for processing vulnerable emotions can be fostered and cultivated, and with support and guidance can come healing and recovery from trauma. However, the healing work for young male survivors is often explicitly complicated due to the intersection between male boyhood socialization and male sexual victimization (Fisher & Goodwin, 2008; Gartner, 2017b). Within the context of masculine gender socialization, many young men and boys may struggle to perceive themselves as potential victims, which hearkens back to the dominant discourse that a man as victim equates a man who is not strong, powerful, or able to protect himself, and therefore "victimhood" constitutes a potential failure of

masculinity (Corbett, 2016; Gartner, 2000; Kia-Keating et al., 2009; Kimmel, 2012; Kupers, 2005). Under the shadow of abuse, these experiences are very much at odds with one another, setting up powerful and potentially damaging discourses within lives of young male survivors (Fisher et al., 2008; Gartner, 2017a; Lisak, 1994; 2017). Furthermore, as David Lisak (1994) so eloquently tells us, the path to recovery from childhood sexual trauma “winds straight through masculinity's forbidden territory: the conscious experience of those intense, overwhelming emotional states of fear, vulnerability, and helplessness" (p. 262).

As a mental health professional engaged with this distinct population, I will argue that it is crucial to explicitly acknowledge, address, and explore the complex intersection between how young men and boys who experience sexual abuse are at the same time experiencing what it means to be socialized as a man in our world today. Boys and men are often conditioned through socialization to think that the only way to remain safe is to feel angry and avoid any vulnerable emotions (Augusta-Scott et al., 2017). As part of treatment processes, I argue that we must work to actively contend with the intersection between childhood trauma and male socialization through exploration and unpacking and consider resulting impacts on the healing process. Trauma influences masculinity by normalizing avoidance of pain, fear, and sadness, while encouraging only the expression of anger (Augusta-Scott, 2020). Within our mental health systems, the reaction to this expression of anger is often pathologizing in that survivors are either denied entry to service based on what is deemed too hostile a presentation or an unwillingness to engage, or their problems and issues are mislabelled or misdiagnosed based on what is quite possibly a valid and honest response to past unresolved traumatic experiences. These unhelpful responses from professionals, combined with rigid and unrealistic rules and expectations around societal norms of masculinity and systemic barriers that limit pathways to treatment, may serve

to compound experiences of trauma and move young men away from the very capacities they need to heal and overcome the negative impacts of childhood sexual trauma. It is my hope that this work will contribute to the conversation about how we approach problematic notions of masculinity that impact male sexual trauma survivors and offer agency in our work so that they may process emotions and overcome their experiences without shame, humiliation, or defeat.

CHAPTER TWO: LITERATURE REVIEW

This chapter will explore relevant literature pertaining to male early childhood sexual trauma, challenges with disclosure, the psychology of men, hegemonic/dominant masculinity, toxic masculine culture, and a brief overview of current treatment and healing processes. It will also serve to demonstrate the significant gaps in current literature related to experiences of male early childhood sexualized trauma and highlight both the relevance and importance of this research topic and current study.

The Psychology of Men

Interest in the psychology of men grew as a study topic in academia decades ago and saw application in feminist theory around notions of patriarchy and its harmful impacts (Connell, 2005; Fisher et al., 2008; Kimmel, 2015; Levant & Pollack, 1995). It also served to contextualize social determinants of health relative to male experiences and to increase awareness of male antiviolence campaigns (Fisher et al., 2008; Kimmel, 2012; Levant & Pollack, 1995). Fields in academia including sociology, anthropology, literature, and cultural studies also saw a significant increase in scholarly writing that used the feminist critique of traditional gender roles as a starting point for a discourse on masculinity and a cultural analysis of masculine traditions, as well as producing new portrayals of men and boys in literature and popular culture media (Cochran, 2010; Levant & Pollack, 1995).

Masculinity has been described as a “culturally defined phenomenon, contradictory and inconsistent in nature, and individually enacted by men in specific situations that differ and vary across different ethnic groups, family traditions and cultures” (Cochran, 2010, p. 50). Kimmel (2012) says that:

> Manhood is neither static nor timeless; it is historical. Manhood is not the manifestation of an inner essence; it is socially constructed. Manhood does not bubble up to consciousness from our biological makeup; it is created in culture (p.120).

Therefore, masculinity is not a fixed biological state but rather an ever-changing social construct, historically and culturally related. Masculinity refers to the behaviours, relationships, and social roles of men within any given society, and the different ways of being a man. Schrock and Schwalbe (2009) state that studying masculinity involves a marked shift from studying the male sex role and masculinity as a singular trait to examining how men enact diverse masculinities in different contexts. This means understanding men as gendered beings in various contexts – for example, from as individuals, to relationships, to the workplace, and to global politics.

When boys or men violate, deviate from, or fail to meet gender norms of masculinity, they may experience gender role strain (Pleck, 1995). As interpreted by Joseph Pleck (1995), the concept of gender role strain sought to conceptualize the psychological and interpersonal conflicts in both men and women that theoretically stemmed from the application, interaction, and intersection of traditional gender codes (Fisher & Goodwin, 2008; Levant, 2011, Pleck, 1995). Research based on this paradigm focused primarily on examining how gender role conflict potentially impacts men's' psychology, stress, and health outcomes (Cochran 2010; O'Neil, 2013). While acknowledging fundamental differences between genders, gender role strain holds that these concepts of masculinity and femininity were socially constructed from biological, psychological, and social experience and further influenced and dictated by society and culture (Fisher & Goodwin, 2008; Kimmel, 2015; Levant & Richmond, 2007; Pleck, 1995). This view purported that males and females essentially share the same fundamental humanity but that cultures obscure this sameness through an enforcement and policing of gender codes.

The concept of trauma strain has been applied to specific groups of men whose gender role strain may at times be experienced as particularly harsh, rigid, or limiting (Levant, 2011). By virtue of their race, occupation, or sexual orientation, this potentially includes racialized men; gay, bisexual, trans, or gender diverse men; professional athletes; military; veterans; first responders; and survivors of childhood trauma (Levant, 2011; Lisak, 1994; Messner, 2004). Furthermore, it is also widely acknowledged that gay and bisexual men are often traumatized by gender role strain (Levant, 2011; Sanchez et al., 2010), largely due to homophobia and marginalization through being raised in a heterosexist society with dominant expectations around masculinity.

By adopting this framework for the psychology of men, scholars and theorists were able to "break with the then-dominant academic view of masculinity as an inherent, essential, and universal expression of biological maleness" (Levant, 2011, p. 765), something that arguably still remains for many the dominant discourse today. Interest in the psychology of men has also allowed for a critical examination of traditional norms of masculinity, such as an emphasis on aggression, extreme self-reliance, and restrictive emotionality, and to view certain problems that are prevalent among men, such as the devaluing of women or sexual minorities, the detachment from relationships, or the neglect of certain health needs, as both an unfortunate yet predictable potential outcome of male gender socialization processes informed by restrictive traditional masculine ideologies (Levant, 2011). As a result, a deeper understanding of the psychology of men is warranted in our mental health models and among mental health practitioners to help inform more effective treatment processes and outcomes. This understanding may help increase our understanding of why men are disproportionately represented in population groups such as men who use violence against women and children, men who struggle with problematic

substance use, men who are incarcerated, victims of suicide and homicide and the homeless (Gartner, 2017a, 2017b; Levant, 2011). It also helps in the development of a positive new vision of what it means to be a man in the world today, and how that vision contributes to the healthy development of men, women, children, and families (Levant, 2011).

Some gender scholars such as Robinson (2003) and McCarry (2007) argue that focusing on the experiences of women and other subordinated groups is essential in working towards gender equality. Focus on studying men and centering on their experiences therefore leads to a significant risk of drawing attention and resources away from women's' issues, which in turn allows for continued support of male dominance in a patriarchal society (Peretz, 2016). At the same time, feminist scholars and activists are increasingly recognizing the importance of addressing men and understanding their experiences as a means of analyzing gender relations and increasing support for gender equality (Connell, 1995; Gardiner 2000; Kimnel, 2015; Pascoe 2007; White & Peretz 2010).

An overview of the literature clearly demonstrates the vital impact feminist scholars had not only on the study of men but on gendered male approaches to the treatment of men. As Fisher and Goodwin (2008) note, the women's movement introduced the idea of gender analysis in research and theory and gender awareness in therapeutic practice. Masculinity studies owes feminism a tremendous intellectual debt as an example of how to question, challenge, and deconstruct patriarchal power and privilege and unpack and explore gender construction and meaning (Kimmel, 2015; Waling, 2019). Feminist contributions gave momentum to a male-centred approach with an applied gendered perspective to the study of men (Lisak, 1994). Other theorists, however, have criticized masculinities studies' commitment to feminist roots noting how in much of the related literature previous feminist work was disregarded or misrepresented,

particularly in addressing gender inequality and power relations (McCarry 2007, Robinson, 2003). Some, like Robinson (2003), argue that male masculinity theorists draw selectively on feminist theory, engaging only with certain perspectives that appear sympathetic to male issues or problems. Anthony Messner, a self-described pro-feminist masculinity theorist, believes that many prominent texts on masculine studies do not acknowledge feminist theory at all, and the literature that does explore it often appropriates forms of feminism that de-emphasize key issues related to sexual politics between men and women (McMahon, 1993). As Connell (1995) notes in her work, the challenge that presents itself in studying masculinity is the tension in asking men to examine their practices in order to reject those practices, even those they may benefit from, whether individually or collectively.

Overall, the literature demonstrates how gendered perspectives on masculinity have been helpful in particular in understanding men's use of violence by helping to illustrate problematic gender norms, masculine ideals such as emotion restriction and conformity to aggression, and the notion of men's self-perceived failure of living up to masculine expectations. It provides greater insight into the unique ways violence and aggression can intersect with masculine norms, and the potential for impact on physical and mental health. Studying masculinity also allows for further exploration of the work of feminist scholars and activists around the feminization of victimization and the masculinization of oppression. However, critics of men and masculinity studies are concerned about implicit messaging in the literature that disembodies and reifies masculinity (McCarry, 2007, Waling, 2019), which can have a profound effect on how we understand male violence. If we attribute masculinity and the impact of gender norms on certain men as the root of male violence, then there is a risk placing blame on masculinity as some disembodied yet highly influential fixed entity, rather than the behaviour of the men and boys

who perpetrate and perpetuate that violence as part of their culture. Waling (2019) and Beasley (2005) argue that violence against women is often heavily premised on the positioning of women as lesser in society. Therefore, to consider male violence as an effect of toxic masculinity "disembodies men from their actions… [and] denies the long standing history in which women have been consciously been systematically and institutionally marginalized by men" (Waling, 2019, p.370). I argue that this interpretation of the interconnectedness between male violence and toxic masculinity is problematic as it essentializes one dominant form of masculinity with anger as its expression and strips agency from men and boys in both managing and taking responsibility for their aggressive or violent behaviour. The challenge is that these behaviours exhibited by some male survivors are often trauma influenced (Augusta-Scott, 2020) and reinforced by culture's narrow and conformist view of masculinity. Although it serves to advance the conversation around men's use of violence and bring it into the public discourse, the tendency to associate victimization solely with females and perpetration solely with males – and by extension, females as non-perpetrators - is problematic in our understanding of male childhood sexual trauma because it erases the possibility of men and boys as victims, a theme that will be explored further throughout this work.

Social Constructs of Gender

A social constructionist paradigm of gender views masculinity as culturally derivative, contextual, constrained, and often contested within social and interpersonal interactions that are directly related to that individual's experience (Addis & Mahalik, 2003; Cochran, 2010; Jewkes et al, 2015). While gender roles may be reflective of traditional or dominant cultural norms, they are neither considered completely universal nor necessarily entirely healthy (Cochran, 2010), and can serve as explicitly unhealthy in their enactment. Socially constructed men's gender roles can

therefore demonstrate problematic ways individual men enact gender, which may result in barriers to their access to health care and treatment. This may compound problems if physical and mental health interventions are not sought out when necessary or in a timely fashion (Addis & Mahalik, 2003; Cochran, 2010).

However, critiques of gender theory and gender identity models have noted reliance on false, essentializing assumptions that men need to subscribe and conform to a dominant/hegemonic form of masculine behaviour in order to experience successful, healthy development (Kilmartin & Smiler, 2015; O'Neil, 2013). Such approaches to gender theory and identity models have also been criticized for assuming that efforts to follow and adhere to cultural expectations are inherently problematic, because it fails to take into consideration a more positive or desirable outcome or reality, such as traditional male characteristics like strength of character, self-reliance, and a desire to protect other. It also does not acknowledge space for multiple ways to enact masculinity, including those of queer men or those who identify as gender diverse or gender fluid (Kilmartin et al., 2013; Kimmel, 2008; O'Neil, 2013). Kiselica and Englar-Carlson (2010) argue that focus on strict and rigid adherence to male traditional norms and the negative impact of traditional gender roles on men's health is problematic. They suggest a shift in future research on both positive social and adaptive aspects of the psychology of men and boys, such as a willingness to persevere and sacrifice personal needs to provide for others may offer a more complex and nuanced understanding of the construction and performance of masculinity (Addis et al., 2003; Cochran, 2010, Kia-Keating et al., 2009; Kimmel, 2012). At the same time, researchers also make a compelling argument for the need for research to explore the context of the social construction of gender roles, and to consider and investigate more fully those aspects of masculinity that are related to men's violence against women, other men, and

children (Addis et al., 2003; Cochran, 2010, Kia-Keating et al., 2009; Kimmel, 2012; Gartner, 2017a; 2017b).

Where dominant forms of socially constructed masculinity exist, there are also subordinate ones (Connell, 1995; Connell et al., 2005). Dominant/hegemonic masculinity has historically been based on the exclusion of men where not white, privileged, cis-gendered, able-bodied and heterosexual (Liu, 2005). Some forms of masculinity may generally be deemed more highly socially acceptable, such as the privilege Western society gives to white, heterosexual, middle class males, and are associated more closely with authority, social power, and influence within society (Connell & Messerchmidt, 2005). In heteronormative society, LGBTQI2S+ youth who identify or are perceived as feminine are typically subordinated and socially marginalized as they do not fit dominant masculine stereotypes and subsequent expectations because heteronormative assumptions falsely conflate masculinity and sexual identity for men and boys. Therefore, in those instances, the construction, intersection, and renegotiation of masculinities can potentially occur in a highly oppressive and constraining environment of homophobia, transphobia, misogyny and heterosexism (Addis et al., 2003; Kia-Keating et al., 2009; Kimmel, 2012; Gartner, 2017a).

Racialized and ethnically and culturally diverse men and boys are often subject to various forms of prejudice, marginalization and micro aggression and experience conflict between dominant/hegemonic masculinity and their experiences as marginalized (Kiselica et al., 2011; Liu, 2005; Liu & Concepcion, 2010). Men and boys who are racialized, LGBTQI2S+ or lower class, working poor men, among other intersecting identities, can face painful and marginalizing experiences that lead some to conform to dominant masculine ideals rather than face disapproval or adopt behaviours that endorse a form of masculinity that may conflict with their preferred

identity (Kimmel, 2008; Liu & Concepcion, 2010). Marginalizing experience can also lead to these men and boys rejecting their cultural or sexual identity or social class identity as a result. But men and boys can still have agency and in fact often resist and part from traditional norms and create their own communities. Men and boys are diverse in terms of their race, culture, socioeconomic status, abilities, sexual orientation and gender identity, and these identities intersect and interact in unique ways that contribute to their physical, relational, and psychological outcomes in positive and negative ways (Kimmel, 2012; Kiselica et al., 2011).

The sex binary allows for only two rigidly fixed roles or options, either male or female, and yet within modern Western society, we more readily acknowledge today there are many other sex and gender roles available, and that sexual orientation is wholly separate and distinct from sexual gender identity (Kilmartin et al, 2015; Kimmel, 2008). However, dominant discourses maintain there are two distinct sexes (male and female), two gender roles (masculine and female) and three possible sexual orientations (heterosexual, bisexual, and homosexual), when in fact there are multiple ways of constructing and enacting sex, gender roles and sexual orientations. These constructions include, but are not limited to, asexuality, pansexual, transgender males, transgender females, gender fluid, gender queer, gender diverse, non-binary, and intersexed people (Kilmartin et al., 2015, Stainton-Rogers; 2001).

In *Gender Trouble* (1999), Judith Butler examines the division between socially constructed gender and presumed biological sex and describes how that division ultimately fosters the illusion that the subject's gender is grounded in some fixed and binary biological essence. Within Western culture, sex, gender, and sexual orientation are viewed as essential qualities, with biological sex as binary (i.e., male vs. female), essential, and natural, and that it forms the basis for binary gender, the cultural interpretation of sex, and sexual desire. This is the

belief that a baby born with a penis will grow up to identify and act as a man as defined by his specific culture, and, as part of an expected gender role, be sexually attracted to women. Similarly, there is a belief that a baby born with a vagina will grow up to identify and act as a woman and be sexually attracted to men. These configurations of sex, gender, and sexual desire become the only “intelligible” genders – the normative accepted gender identities - in hegemonic patriarchal heterosexual culture.

Butler (1988) argues that gender should not be viewed as biological fact or an internalized state of being, but rather as an enacted performance and an active way of doing and being. Butler (1988) believes that there is a meaningless distinction between sex and gender, noting evidence for the variability in chromosomes, genitalia and hormones that do not always align in the expected binary manner. Drawing on the work of theorist Michel Foucault, in particular his work on the nature of power and subject positions, Butler maintains that sex and gender are discursive products of modern power. Butler (1988, 1999) asks that we rethink our understanding of gender – not through the cultural meanings that are attached to any predetermined sex, but through the process that it is performatively constructed. In that sense, Butler (1999) views gender as neither essential or biologically determined, but rather created through its own enactment or performance. It is important to note that through this argument, Butler is not saying biological processes do not exist or do not affect differences in hormones or anatomy. However, what she does argue is that bodies are material and discursive and the meaning and value attached to bodies are always in the grip of culture. The dominant discursive views of sex and gender are simplistic, limiting, binary and often oppressive.

By redefining gender from a passive and natural ‘state of being,' to an active and performative ‘way of doing,' Butler (1999) transcends the idea that bodies are merely passive

victims to the ways and mean they are influenced and produced. While Butler (1988) acknowledges that gender is always performed within limiting and often policing framework, she describes many possibilities to destabilize, resist and reject this order. For instance, Butler (1988) notes that subversive gender performances, such as cross-dressing, drag, and parody, can be used to undermine the essentialist belief that there is a 'true gender identity', and she furthermore suggests that labels such as 'queen', 'butch', 'dyke' and 'queer' can be discursively reappropriated, which through enactment provide concrete tools for both agency, resistance and subversive action in combating both problematic or restrictive constructs of gender and the policing of gender (Butler, 1988; 1999; Fraser, 1989). In other words, the performance of drag serves to challenge and disrupt by destabilizing gender norms and illustrating the performative nature of gender.

The binary performance of gender is often further reinforced by the reactions to those who fail to adhere to gender norms. Butler (1999) says that those who fail to do their gender right, i.e. do not subscribe to traditional gender norms or somehow violate these norms, are punished. This punishment includes the oppression of women and the stigma towards those who challenge the binary, such as trans people, who in a sense disrupt the link between gender and sex, and lesbian and gay men who disrupt the link between sex and sexuality. These are abject identities, aspects of the individual or subject that are removed or cast aside and labelled "not me". What has been expelled becomes "the Other" and because of its otherness, becomes the object of the subject's repulsion. For Butler (1988; 1999), this process allows the subject to create boundaries for itself between internal and external, or between where their body stops and "the Other" begins. Butler explains that this process is present in homophobia, racism, and sexism, which involves expulsion, exclusion, and repulsion from society when certain identities

come to symbolize the Other. There is clear evidence of this stigma in the form of violence and hatred towards transwomen, particularly transwomen of color, homophobia in the form of assaults on both the rights and the bodies of queer people all over the world, and surgeries performed on intersex babies to achieve accepted or normative sex characteristics.

Butler (1988; 1999) argues that the binary performance of gender serves as tools of patriarchal power structures in society that seek to sustain and reproduce itself – with women serving as a means of reproduction to men as mothers and wives. She calls these power structures prohibitive or proscriptive in that they repress deviations in gender performance, and generative or prescriptive in how they create binary heteronormative gender performance. Butler tells us that if we consider gender identity as some inner truth versus a product of gender performance, we play into the hands of patriarchy and the notion of compulsory heterosexuality and therefore serve to reinforce the gender binary.

Learning Gender

Upon the birth of a child, the first question most commonly asked is whether the child is a boy or a girl? Here, the sex of the child denotes the physical, biological categories of "male" and "female" - a binary of contrasting glands, chromosomes, genitals, hormones, and secondary sexual characteristics. This division between what constitutes male and female, masculine and feminine, "appears fundamental to the operation of most contemporary societies, and so it seems essential that a baby is categorized, assigned to one sex or another, as early as possible" (Paetcher, 2007, p. 5). Gender socialization, therefore, begins from the moment we are born with the presumed ability to look at an infant and assign a sex. From the outset, biological sex then serves to become a central organizing principle around which children learn their gender identity.

Intersexed children – those born with atypical or ambiguous sex organs or markers – disrupt that binary- and the medical profession often pushes a choice on parents to decide which gender, and then proceed with surgeries and medical interventions to bring that infant's gender in line with a chosen sex. Although intersex children may account for 2-4% of the population, intersexuality remains highly stigmatized, with the common discourse of abnormality or unnaturalness surrounding it. However, intersexuality occurs about as often as cystic fibrosis and Down syndrome, two conditions that are more familiar to most of us and certainly cause less shame for parents and family members (Preves, 2003). Intersexuality therefore only becomes abnormal when a society subscribes to only two biological sex genders as normal and natural.

Social theories of gender focus on the impacts of broader social systems on a child's gender development (Fagot et al., 2000) through defining rules and customs about what is and is not appropriate for those boys and girls. Children's gender assignment becomes a powerful social identity that shapes children's lives,, because as soon as a child is identified as a boy or a girl, parents form expectations about the child's interests, skills, and behaviours, and these expectations appear in gendered parenting practices (Martin et al., 2002; Mesman & Groenveld, 2017). During early childhood, girls and boys look to parents and older siblings for guidance, and they provide children with their first lessons about gender in ways that can have profound impact on their gender development. This might include role modelling, gendered division of labour and care in the home, and encouraging gendered activities and interests. When parents consistently buy female stereotyped toys (e.g., dolls, tea sets) for their daughters, and male-stereotyped toys (e.g., trains, dinosaurs) for their sons, they are implicitly linking their children's sex to particular gender roles that are often encouraged as the children play with these toys.

Commercial advertising aimed at children is highly gender stereotyped, as are many children's cartoons (Mesmean & Groenveld, 2017).

The way parents evaluate and provide feedback to children on their behaviour – those that are stereotyped versus those that go against stereotype – is another form of gendered parenting that can have tremendous influence. Research shows that parents are generally less likely to respond negatively to a son's risk taking behaviour, and more likely to notice and reinforce a daughter's positive prosocial behaviour, which can serve to convey and overstate a message that boys are outgoing and adventurous and girls are well behaved and kind (Marks et al., 2009; Mesmean & Groenveld, 2017; Murnen et al., 2015). There are also subtle ways that parents may reinforce gender stereotypes even when they are not overtly encouraging them. This is commonly seen in parents' use of essentialist statements about gender. Examples would be "only girls like dolls" or "only boys like football." In these instances, the parent is expressing what is known as a descriptive stereotype (i.e., describing general patterns or "essences" about each gender) rather than prescriptive stereotype (i.e., stating what should occur).

Gender-typed expectations may relate to personality traits (e.g., "boys are aggressive"), abilities (e.g., "girls are good at schoolwork"), activities (e.g., girls try out for cheerleading), and roles (e.g., "men are scientists and engineers"). As views around gender equality have increased in recent decades, research shows more variation among parents with some holding traditional expectations and some expressing egalitarian expectations for their daughters and sons (Marks et al, 2006; Murnen et al, 2015). Some may also express equal views around certain domains (such as future occupations) but are more traditional about other domains (such as family roles and responsibilities).

Of course, in contemporary Western societies, many women with children work outside of the home. Men's average involvement in childcare and housework has increased, although in most two career two parent households, domestic responsibilities are still predominantly held by women (Marks et al, 2003). Research finds that fathers' active engagement in the family as a co-parent, with equal sharing of roles and responsibilities and modelling of positive relationships between spouses, can have a significant positive influence by demonstrating an adult male in a nurturing, caring role (Buswell et al., 2018). This can be highly influential to male sons, particularly those who identify more with their same sex parent as it can motivate them to start imitating some of those same interests.

Although the literature is limited, research on LGBTQI2S+ families indicate that, when compared to children raised in two-parent heterosexual families, children raised by same-gender parents are less likely to endorse certain gender stereotypes and are therefore more tolerant of children's varied choices of toys or types of play. However, when same-gender parents divided labour with one parent as primary caregiver and the other parent as the primary breadwinner, their children were likely to express stereotyped views similar to children in opposite sex families. Biblarz and Stacey (2010) concluded that single-sex parenting (i.e., single-parent, gay and lesbian parents) employ different socialization practices, they are also models for nontraditional gender roles to their children. Single parents' behaviour indeed is often less traditional, because these parents have to fulfill both roles of economic provider and caretaker. The same is true for gay and lesbian parents, who are more likely to share the roles of caretaker and economic provider (Solomon et al., 2005; Stacey & Biblarz, 2001).

Gender socialization works, according to social learning theory, by rewarding or challenging and punishing children for engaging in sex-typed behaviour that is consistent with

their assigned sex category. A strong example of this is crying - while a little girl may be soothed when she cries, a little boy may be told that boys don't cry. Crying therefore becomes a sex-typed behaviour - mostly acceptable for girls and therefore not a punishable behaviour, but widely not seen as an appropriate behaviour for boys, and so the little boy may be punished, shamed, or corrected for his crying behaviour. Through these kinds of interactions – some subtle and some more explicit - gender socialization occurs. Gendered stereotypes are modelled and communicated through children's dress, their play, and even their household chores from an early age (Kilmartin et al., 2015). In fact, this begins from the moment of birth or even earlier– from the colour of a child's bedroom to the clothes they are presented. Children are provided gender-typed toys such as dolls for girls and trucks for boys, and often receive a more positive response and attention from their parents for choosing those to play with, which in turn can be reinforcing. In contrast, boys are often discouraged from playing with dolls or playing dress-up, while girls are often prevented from engaging in risky sports or activities (Halpern & Perry-Jenkins, 2015; Kilmartin et al., 2015; Stainton Rogers & Stainton Rogers, 2001).

Developmental psychology often views early play and family activity as a rehearsal for later social roles (Kilmartin et al., 2015). As a result, from a very early age, children can demonstrate highly gender stereotypical beliefs that are dominant within their families, their communities, and their culture (Halpern & Perry-Jenkins, 2015). Like their parents and caregivers, young children learn to essentialize gender in ways that make assumptions about what constitutes meaning as male and female based on biological sex (Halpern & Perry-Jenkins, 2015; Kilmartin et al., 2015; Stainton Rogers & Stainton Rogers, 2001). Comparisons of fathers' and mothers' gender typing reveal that fathers, in particular, tend to be more stereotypical in their definition of gender-appropriate activities, especially regarding their sons.

A major criticism of social learning theory is its essentialist application, as it is limiting in the sense of describing behaviour solely in terms of either nature (our genetic makeup) or nurture (our environment) rather than a combination of both (Addis et al., 2010). Studies also show that children do not always model same sex parent behaviour. Children raised in single parent families do not always solely identify with their parent's sex or gender. The influence of children on their environment is not always considered in social learning theory, and they are largely seen as passive recipients, which ignores the active role that they play in their socialization process.

Gender norms are shaped by a broad set of cultural influences and can vary across cultures. In developing countries, many parents have a strong preference for sons based on what they might provide for the family, and as a result, access to resources ranging from health care to education are prioritized to sons over daughters. The United Nations has estimated that female infants and children suffer higher rates of abuse and neglect in countries such as China, India, and Papua New Guinea related directly to the preference for male children. Historically, female infants survived at much lower rates than male infants because parents generally fed the girls less and neglected their basic needs (United Nations, 2000).

In many cultures, the family name can only be carried on by sons because daughters take their husband's name upon marriage. In Hindu religious traditions, rituals surrounding the death of a parent are entrusted solely to sons. While the reasons for this preference for boys vary, they have important impacts on the gender socialization of boys and girls. "Good wife, wise mother" is a Japanese proverb that continues to have strong influence on Japanese culture with its messaging to women that their role is to stay at home and be devoted entirely to the family's needs. These examples, say researchers, lie in stark contrast in the differential treatment of sons

and daughters in Western culture (Bisin & Verdier, 2010; Halpern & Perry-Jenkins, 2015). I would argue, however, on the virtue of being born male, that men have access to many rights, advantages, and freedoms available solely to them. When considering cultural differences, researchers also failed to fully take into account how meaningful traditions or customs might be meaningful to those who enact them, and thereby strip women and men of agency by reducing their actions to the product of their socialization. Also important is the recognition that gender roles are culturally and historically situated, meaning that they cannot be analyzed or interpreted outside of the cultural and historical context of their time.

Nonetheless, there are common ways that parents in these societies may socialize girls and boys differently. Research shows that explicit messages to children (e.g., dolls are for girls) are relatively less common today in most Western societies that value gender equality (Mesman and Groenveld, 2017). There has always been variations in what constitutes family that challenge a Western heteronormative discourse around notions of two parent, opposite sex, male and female led families, and the traditional image of the two-parent heterosexual family with the father serving as the provider and the mother as the homemaker is no longer the accepted norm in many industrialized countries. Instead, many women pursue jobs outside of the home and many men are involved to varying degrees in childcare. In addition, many children are raised by single parents and by lesbian/gay parents. Despite these role changes, studies show that there are relatively few truly equal parenting arrangements in terms of responsibilities in raising children. Also, studies suggest that parents who espouse gender equal attitudes may still act differently with daughters and sons in terms of roles, expectations and freedoms (Gelman et al., 2004).

Gendered lives begin even before we are born because the societies that we enter into have already made decisions about how our sex and gender will be determined. In addition, the

content of the cultures into which we are born will partially dictate exactly what gender lessons we learn. Families surround us with explicit and implicit messages about what it means to be a gendered person. Even those whose biological makeup does not fit within established sex categories are expected to conform to gender expectations. Gender is all around us, and it is therefore not surprising how it quickly becomes internalized by infants and children.

Raising Boys to Men

Because gender is a social category that organizes virtually every segment of society, there are multiple sources of socialization in children's gender development aside from parents and immediate caregivers. Siblings, other family members, peer groups, friends, the media, coaches, group leaders, and teachers all serve to influence gender-related behaviours (Jaffee, et al., 2003; Lippa, 2005; Paetcher, 2007). As children grow into adolescence, the impact of peers and social media become even more profound.

Research shows teachers often respond differently to boys and girls when addressing unwanted or undesirable behaviour, sometimes even when they demonstrate the same behaviour (Jaffee et al., 2003; Lippa, 2005; Paetcher, 2007; Stainton Rogers & Stainton Rogers, 2001). Peer influences become especially important and influential as children grow into adolescence and same-sex segregation can sometimes intensify differences in boys and girls (Lippa, 2005; Paetcher, 2007) reinforced culturally through school and community (Kilmartin, 2015; Lippa, 2005). For example, boys tend to police one another through encouraging masculine behaviour (running, climbing) and ridicule perceived female behaviour (singing, dancing). Sex segregation, which studies show may start as early as the second or third year of life and continue to intensify as children grow older, primarily begin due to family and peer influence, and later reinforced in schools and communities. A hypothesis as to why children themselves choose to engage in sex-

segregated play is that males in general are more aggressive, competitive and group-oriented than females, while girls consider boys more domineering and unresponsive to verbal requests or the possibilities of negotiations (Lippa, 2005; Stainton Rogers & Stainton Rogers, 2001).

Popular culture and mass media continue to be saturated with gender stereotypical behaviours, and children can actively and readily learn expectations about gender from merely observing or being exposed to these influences through film, music, and literature (Jaffee, et al., 2003; Lippa, 2005; Paetcher, 2007). For preschoolers, characters on television or in books exemplify obvious masculine and feminine appearances – a superhero is adventurous and has huge muscles, a princess is beautiful and has long flowing hair. These representations translate to character traits – the superhero is brave and heroic while the princess is fearful and in need of saving. A few years later and these same characters might be interpreted as dominant and aggressive and as submissive and weak, which can be problematic in its messaging. And an important contributing factor to this is that they are often socialized to react and respond to these characterizations and by extension one another in this way.

Research shows that differences in how we raise and socialize young boys and girls contribute to teaching girls about the salience of feelings in early stages of language acquisition, and teaching boys to focus more on the action of doing rather than on the feeling of doing (Jaffee, et al., 2003; Lippa, 2005; Paetcher, 2007; Stainton Rogers & Stainton Rogers, 2001). Collectively, a lack of emphasis on internalized feelings combined with a focus on activities that are outside of the home contribute to definitions of masculinity that serve to emphasize the external, such as material possessions, athletic performance, status and influence over others (Jaffee, et al., 2003; Lippa, 2005; Paetcher, 2007). In contrast, girls are often encouraged, both subtly and explicitly, to internalize their thoughts and feelings and to be more considerate and

demonstrate a heightened awareness of others' perspectives (Jaffee et al., 2003; Lippa, 2005; Paetcher, 2007; Stainton Rogers & Stainton Rogers, 2001).

The literature demonstrates how traditional masculinity ideology influences the socialization of children and the behaviour of adults through social interactions that involves observational learning, punishment and reward (Berger et al., 2005; Levant & Richmond, 2007). The process of toughening boys consists of verbal bullying, calling them sissies and equating their behaviours, responses and actions as something womanly, which in turn serves to separate them from the masculine ideals to which they are expected to aspire (Kimmel, 2012). Words can take on a discursive power and do damage and harm as surely as physical actions (Brown, 2013), cutting a young person's self-esteem, poisoning their self-confidence, and undermining their self-image. This can in turn encourage boys and men to conform to the prevailing male role norms by adopting certain socially sanctioned masculine behaviours and avoiding others, with one very central masculine norm the restriction of emotional expression (Levant, 2011).

However, although a lack of expressive emotion tends to be a defining characteristic of hegemonic masculinity discourse, critics note that throughout the world there is a great deal of cultural variation in the gendered expression of emotion, with some cultures considering women to be the emotional sex, some allowing a wide latitude and range of expressiveness in both sexes, and some expecting both men and women to police, constrain, and regulate their emotions (Kilmartin et al., 2013; Kimmel, 2012). It is crucial to recognize that although cultures influence people and exert normative pressure on people to think, feel and act in specific ways, responses to cultural expectations can vary widely. As a result, even in cultures that expect women to be highly emotional and men less so, there are very expressive men and very inexpressive women.

Gender awareness for many men involves “not only their understanding of the pressures of traditional masculinity but also an appreciation of their advantaged social position" (Kilmartin & Smiler, 2015, p. 19). However, the privilege of masculinity does not fall to all males in equal share or measure, and certainly not to marginalized men who reflect differences in race, culture, class, or sexual orientation. The opportunity to reap the social benefits of being "a real man" is, in fact, available to relatively few. Social constructs of masculinity can exert pressure on all men to experience themselves and the world in specific ways, but these demands intersect and interact in significant ways with the oppression and marginalization of racism, classism, and heterosexism (Kilmartin & Smiler, 2015; Kimmel, 2008). For instance, dominant masculine ideology can serve to impose extreme self-reliance and reflects that quality as some part of an expected order of things. It can also impose assumptions and expectations around power, wealth, and success that for various reasons – ability, opportunity, and ambition - may not be in their grasp (Kia-Keating et al., 2005; Kimmel, 2012).

bell hooks (2005) once said that in order “to indoctrinate boys into the rules of patriarchy, we force them to feel pain and to deny their feelings” (p. 22). Hegemonic masculinity equates stoicism with strength, even when in the face of danger, where it quickly becomes imperative to either dismiss or not acknowledge feelings of fear, uncertainty, or helplessness (Kia-Keating et al, 2005). A consistent argument lacking in much of the literature related to gender socialization of boys and their experiences with trauma is that it is that it ignores or pays little attention to this conceptualization of pain and indoctrination through denial that hooks (2005) so eloquently describes, something that can have profound influence and impacts on male sexual trauma survivors. Therefore, a significant obstacle for male survivors and a likely necessary one to overcome as part of healing includes an ability to set aside this expected stoicism and find ways

and means to reconnect with others, to not depend on self-reliance and instead discover a means of reaching out and asking for help and guidance, and a develop tools and supports so they can acknowledge and accept their feelings of shame, sadness, anger, and vulnerability as they relate to their traumatic histories.

Finding Foucault

Michel Foucault, the French philosopher, has been hugely influential in shaping our understandings of power, turning away from the notion of power belonging to the few, who wield it an instrument of coercion, and toward the idea that power exists everywhere, dispersed and embodied through discourse, knowledge and regimes of truth (Foucault 1991). Foucault (1991) argued that knowledge and power are intimately connected, creating the term "power/knowledge" to signify that one is not separate from the other. Power/knowledge is constituted in society, which is constantly in flux and negotiation, through accepted forms of knowing, understanding, and what is accepted and functions as true.

According to Foucault, each society has its own regime of truth: the types of discourse which it accepts and makes function as true; the mechanisms and instances which enable one to distinguish true and false statements, the means by which each is sanctioned; the techniques and procedures accorded value in the acquisition of truth; and the status of those who are charged with saying what counts as true' (Foucault, 1991). Regimes of truth are the result of discourse that is reinforced, renegotiated, and redefined constantly throughout society, by way of media, educational institutions, healthcare, and justice systems, as well as through our political and economic ideologies. Therefore, there is no absolute truth that can be discovered and accepted, but there does exist a battle about the status of truth and the economic and political role it plays (Foucault, 1991). Foucault (1991) believed that power is not just a negative, coercive or

repressive thing that forces us to do things against our wishes, but that it can also serve as a necessary, productive and positive force in society:

> We must cease once and for all to describe the effects of power in negative terms: it 'excludes', it 'represses', it 'censors', it 'abstracts', it 'masks', it 'conceals'. In fact power produces; it produces reality; it produces domains of objects and rituals of truth. The individual and the knowledge that may be gained of him belong to this production (p.194).

Foucault wrote about issues to do with mental health in several of his works, such as the history of psychiatric practices, psychoanalysis, sexuality, and the formation of identity and subjectivity. His work on the human sciences focused on the rise of professional power throughout the eighteenth and nineteenth centuries, mainly through the development of medical discourse (1990, 1991). Foucault recognized how power is also a major source of social discipline and conformity and pointed to schools, mental hospitals/asylums and prisons in eighteenth century Europe as systems of surveillance and assessment that no longer required force or violence because people had learned to discipline themselves and behave in expected way. Foucault was interested in the mechanisms of prison surveillance, school discipline, population controls, and the promotion of norms about bodily conduct, including sex. He studied psychology, medicine and criminology as bodies of knowledge that define norms of behaviour and deviance.

In critiquing hospitals, asylums, prisons, and schools, sexuality and science, Foucault's underlying themes showed a continuing concern with the relationship between knowledge and power (Bracken et al., 2007). In examining psychiatric discourses, Foucault "'historicizes' the concept of mental illness' by showing how it emerged at a certain historical point within a culture and society, and 'politicizes' that concept by showing how its emergence was

inextricably bound to the political concerns, norms and values of that culture and society" (Roberts, 2005, p. 37).

Foucault's work centered on how some of our most deeply held beliefs and assumptions about ourselves and our societies have been developed over time, and how the human sciences have become a constitutive element in the formation of power-relations in society (Bracken et al., 2007; Randall & Munro, 2010). Through a Foucauldian analysis, psychotherapy may be viewed as a manifestation of one of the most pervasive examples of the power–knowledge relation exists within western societies, that of 'the confession' (Foucault, 1990). Foucault believed that the individual's experience with mental illness is "pathologized through the exercise of the psychiatrist's power to create knowledge about it" (Swerdfager, 2016, p. 291). Thoughts, feelings and behaviours of clients are interpreted based on current psychiatric discourses that categorize specific thoughts, feelings and behaviours as mental illness (Roberts 2005). However, Foucault saw this power as only somewhat localized in the psychiatrist, because he believed it could not be entirely distilled into one body but would flow instead through many points' that make up the psychiatric apparatus of mental health services (Foucault, 1990; Swerdfager, 2016). For Foucault, psychotherapy is not an "emancipatory alternative to psychiatric hospitals and drug treatments. Rather, it incorporates a disciplinary power that is productive but also controlling in its own way" (Bracken et al., 2007, p. 608).

Key to Foucault's approach to power is that it transcends politics and views power as an everyday, socialized and embodied phenomenon. His work has been hugely influential in illustrating how norms can be so embedded they are beyond our perception – causing us to survey and discipline ourselves without any willful coercion or force from others.

Foucault's interest lies in how people are both made into and turn themselves into subjects within our culture (Brown, 2007; Foucault, 1991). Foucault rejects a negative representation of power while suggesting it is the "widely accepted view because it, in fact, masks and hides the complexity and insidiousness of how power operates" (Brown, 2007, p. 17). By criticizing the classical view of power as solely repressive with the focus on the powerful and the powerless, Foucault (1980) viewed power as constitutive or productive while still recognizing its constraining and oppressive traits, (Brown, 2007). However, Foucault believed in possibilities for action and resistance. He was an active social and political commentator concerned with our capacities to recognize and question socialized norms and constraints. To challenge power is not a matter of seeking some 'absolute truth' (which is in any case a socially produced power) but, "of detaching the power of truth from the forms of hegemony, social, economic, and cultural, within which it operates at the present time" (Foucault, 1991, p. 75).

Foucault challenges us to not only reconceptualise our understanding of power but also the role that we, as individuals, might play in those power relations. As Brown (2007) notes, Foucault privileges how power manifests, its techniques and strategies, versus who wields it: "a repressive approach to power is only ever toxic; there is no room for productive power' (p. 15). Foucault (1980) situates the human experience in a particular power-knowledge dynamic that is always in a state of flux, and which in turn defines practices, customs, and discourses through which we become subjects. Foucault (1980) did not believe in a fixed or essential human subjectivity. He argued that "we should be trying to discover how multiple bodies, forces, energies, matters, desires, thoughts, and so on are gradually, progressively, actually and materially constituted as subjects, or as the subject." (Foucault, 1980, p. 28).

Foucault defined technologies of the self as techniques that:

permit individuals to effect by their own means, or with the help of others, a certain number of operations on their own bodies and souls, thoughts, conduct, and way of being, so as to transform themselves in order to attain a certain state of happiness, purity, wisdom, perfection, or immortality" (p. 18).

Defining characteristics such as age, class, sexual orientation, and religion are socially constructed through technologies of self and these constructions converge in a variety of different ways to influence identities. The concept of self is then constructed and deconstructed through changing discursive practices and circumstance, limited by those available to us and by those we choose to occupy or embody.

Foucault describes individuals as vehicles of social power by the way they reify and enact prescriptive and normative practices of self (Brown, 2007). Power becomes insidious because, while individuals might see themselves as enacting their true inherent selves they are enacting or resisting socially constructed discourse of what constitutes the self (Brown & Augusta-Scott, 2007; White & Epston, 1990). Therefore, they often become willing participants in ensuring conformity to normalizing practices of self (Brown, 2007; Foucault, 1991). This is something Foucault (1990) referred as disciplining the docile bodies, the processes and practices through which individuals engage in normalizing, self-monitoring, and disciplinary practices of the self (Foucault, 1980, 1991; Brown & Augusta-Scott, 2007). Foucault (1980) conceptualized the 'normalizing society" by considering how a society composed of individuals becomes trained, modified, and categorized within a system of expected norms (Foucault, 1980; 1991). He then analyzed how these norms and practices reflected and influenced social institutions, which included investigating how discourse and knowledge are produced, reproduced, and then ultimately serve to change our realities (Foucault 1980).

According to Foucault (1980), power is also a major source of social discipline and conformity. Foucault describes a new kind of ‘disciplinary power’ that could be observed in the administrative systems and social services that were created in 18th century Europe, such as prisons, schools and mental hospitals. He noted how their systems of surveillance and assessment did not require force or violence to conform, as people learned to monitor and discipline themselves and behave in expected ways. As Brown (2007) suggests:

> Through a process of subjectification, we turn ourselves into subjects, absorbed by the creation, improvement, management and performance of self. The process turs our gaze inward, as we seek to cultivate and manage ourselves as individuals and renders invisible the social and cultural context in which the subject is made. In anticipating being seen and judged by others, we often shape ourselves accordingly (p. 109).

By making ourselves into subjects we are both constrained by and resistant of power and its effects. The performance of self in culture and society involves agency, self-determination, limitation and social constraint (Brown, 2007).

A Foucauldian analysis of the discourse of masculinity and the notion of technologies to self-illustrate how men might give voice or use silence to turn themselves into subjects. In other words, men may give voice to or embody specific positions and be silent on other subjects, which in turn can contribute to the discursive patterns and applications of power within masculinity. Foucault's (1980) understanding of the process of subjectification as a means of resisting, disrupting, interpreting, and at times transforming dominant discourses of masculinity and what it “means to be a man” may be useful in this study as it puts focus on survivors as active participants in policing their own and others performance of gender.

Brown (2007) notes that by adopting a Foucauldian stance on power, we are able to move beyond the idea that one either possesses or does not possess power, and that this allows us the means to interpret stories as evidence of both social agency and social constraint. "Refusing to conceptualize power and identity as fixed or static produces new possibilities and thus the possibility of new stories" (Brown, 2007, p. 15). These possibilities, along with knowledge of both agency and constraint, become meaningful in our work with trauma survivors by offering that possibility of a new or different narrative and a new or different way of understanding trauma experiences.

Hegemonic/Dominant Masculinity

Our current understanding of hegemonic or dominant masculinity was conceptualized in the mid-1980s through the work of R.W. Connell (1995) as a specific form of masculinity relative to historical and societal settings. Hegemonic/dominant masculinity legitimates men's dominant position in society and therefore legitimizes unequal gender relations between men and women, between masculinity and femininity, and among other types of masculinity, such as those subordinated (LGBTQI2S + persons) and those marginalized (men who are racialized, culturally diverse, or hold lower socio-economic status). Hegemonic masculinity is distinguished from other forms of masculinities, especially subordinated ones, and although not assumed to be normal, it *is* viewed as normative through its enactment, while embodying a current time-honoured and traditional way of being a man, requiring other men to position themselves in relation to it (Connell & Messerschmidt, 2005; Courtenay, 2000). Certain traditional guiding beliefs about hegemonic masculinity include: men and women are inherently different; men are superior to women and superior to men who do not live up to certain prescribed ideals of manhood; activities customarily associated with women are demeaning for men to be engaged

in; men should not express vulnerability or sensitive emotions; the most typical manly emotions are desire and anger; toughness and domination are essential to man's identity; sex is less about pleasure and more about proving manhood and asserting power; and gay or homosexual men are failed men who do not subscribe to masculine norms (Connell, 1995; Fisher & Goodwin, 2008; Kimmel, 2008; Kivel, 2010).

Intersectionality is a term coined by feminist scholar Kimberle Crenshaw (1993) to denote the ways in which race and gender interact and intersect both simultaneously and inseparably, and contribute to marginalization and oppression of racialized women. Intersectionality provides a framework and an analytical lens to examine how each individual experiences social structures differently because of the intersection of identity markers such as gender, race, age, class, and ability and how that contributes to their privilege or their disadvantage. Race, ethnicity, class, sexuality, age, and ability shape the enactment of masculinity, as well as the social contexts in which these performances take place. These inequalities also shape the extent to which men benefit from gender inequality—what Connell (1995) refers to as the "patriarchal dividend" (p. 79). Because individuals share multiple social statuses and claim multiple identities, performances of masculinity are interconnected with performances of race, ethnicity, class, age, and other social identities (Collins 2004; Pascoe 2007). Expectations of masculinity and masculine performance are therefore shaped by the institutional structures and broader social contexts in which they are situated. However, among masculinities lies a hierarchy in which men and masculinity are privileged over women and femininity, but also as a hierarchy within which some men, and some versions of masculinity, are privileged over others (Connell 1995; Connell & Messerschmidt 2005). The more these identifies intersect the more marginalized or oppressed the individual might be – for

example, a poor, black gay male might face overlapping marginalization due to his race and sexual orientation. Race, ethnicity, class, sexuality and other identities therefore shape not only the ways in which men enact masculinity, and the social contexts within which these performances take place, but also the extent to which men are able to benefit from systems of gender inequality.

Masculine scripts refer to internalized gender norms that serve as ideals of acceptable ways for boys and men to think, feel, and behave (Mahalik et al., 2003). Masculine studies scholars such as Richard Gartner, Michael Kimmel and Jackson Katz refer to these scripts often throughout their work. Psychologist Robert Brannon (1976) introduced four phrases to describe masculinity, phrases that encapsulate what is commonly referred to as masculine scripts. Brannon's four phrases included: 1) "No Sissy Stuff!" which translates to never engaging in any activity or behaviour that even remotely suggests femininity. Masculinity, therefore, is the relentless repudiation of the feminine. 2.) "Be a Big Wheel", meaning that masculinity is measured by power, success, wealth, and status. 3. "Be a Sturdy Oak." with masculinity presenting as a calm and reliable demeanor at times of crisis, partly through holding emotions in check. Proving you are a man means either not showing or minimizing your emotions.4. "Give 'em Hell." which calls for an aura of manly daring and aggression, and the willingness to always take risks (Brannon, 1976; Kimmel, 2012).

These rules contained succinct elements of the definition of masculinity upon which men are measured. They are restrictive and repressive, and I do not believe that most men subscribe to these notions. However, a young male impacted by trauma that forces him to question issues around masculine identity and sexual orientation can become entrenched in a belief system that tells him he has failed at masculinity due to his experience of victimization. Failure to embody

these rules, therefore, becomes a source of pain and confusion for many young men and boys, even though their achievement as a whole is unrealistic if not impossible. But masculinity can serve as a relentless test, and first among it – regardless for the most part of race, sexual orientation or class – is the call to *not* be like a woman.

Within any culture, there can exist a hierarchy of masculinities that are compared with a dominant or hegemonic ideal (Connell, 1995). In Western culture, the normative form of hegemonic/dominant masculinity is defined by race (white), sexual orientation (heterosexual), socioeconomic status (middle class) and the possession of certain traits such as assertiveness, dominance, control, physical strength, and emotional restraint (Courtenay, 2000; Kimmel, 2008). Men who subscribe to these standards are often those who have the specific capital or resources necessary to perform hegemonic/dominant masculinity, such as the physical prowess and capabilities to succeed at competitive sports or win physical fights, or economic capital that allows for financial independence and security or access to higher education (Coles, 2007). Kimmel (2008) notes that the definition of hegemonic masculinity is central to:

> a man in power, a man with power, and a man of power. We equate manhood with being successful, capable, reliable, in control. The very definitions of manhood we have developed in our culture maintain the power that some men have over other men and that men have over women (p. 125).

In expanding the definition of hegemonic masculinity to encompass one of *masculinities,* Connell (1995) describes complicit masculinity as men who may benefit from hegemonic masculinity but do not explicitly enact it, while subordinated masculinity describes men – primarily LGBTQI2S+ or gender diverse men - who are oppressed by definitions of hegemonic masculinity. Marginalized masculinity describes men who may potentially possess power in

terms of their gender, but not in terms of their class, race or culture, and are therefore subject to discrimination or marginalization (Connell 1995; Connell & Messerschmidt, 2005; Pascoe, 2007). As noted earlier, Connell and Messerschmidt (2005) emphasize that these configurations of gender are often contextual, and relatively few men are hegemonically masculine, but most men do benefit, to different extents and varying degrees, from this guiding definition of dominant masculinity in society. For example, relative privileges by virtue of being a white, heterosexual male in contemporary society include, among other things, the ability to go out in public without fear of being followed or harassed; the option of seeing people who look and act like them positively portrayed in the media; and the opportunity of having people of the male sex disproportionately represented in government, education, and other institutional settings (Kilmartin & Smiler, 2015, Kimmel, 2015). Men can distance themselves or engage directly with hegemonic masculinities based on their interactional needs, and therefore masculinity does not represent a certain type of man but the way that men position themselves through discursive practices (Messerschmidt, 2019). As a result, masculinity does not mean the same thing to all men, but instead it is varied in how is interpreted, experienced, and lived out (Coles, 2007). Therefore, ways of being masculine are contextual, open to reinterpretation and renegotiation and connected to historical change.

Men who are more marginalized in society due to socio-economic factors, cultural differences, or race are often denied access to the resources and social power needed to enact such standards of hegemonic/dominant masculinity which in turn serve to validate or legitimize their sense of manhood – they are therefore seen as *less than* by those men that are more privileged (Courtenay, 2000). Factors such as class, race, gender, ability, and sexual orientation contribute to marginalization, and viewing male privilege through an intersectional lens (i.e. how

those factors intersect within the context of one's life) helps in our understanding of the complexities of male privilege. Given the dictates of hegemonic/dominant masculinity, physical and verbal dominance and at times violence become more "readily accessible resources for structuring, negotiating, and sustaining masculinities" (Courtenay, 2000, p. 1391). Research shows patterns of more frequent use of overtly coercive behaviour and incidents of intimate partner violence involving verbal and psychological abuse and physical force among poor and working-class men (Schrock & Schwabe, 2009). Other studies illustrate how working-class men engage in "bar culture" by demonstrating their masculinity through heavy drinking, over sexualization of women and aggressive posturing (Eastman, 2017).

While gender socialization is often the central focus in studies of masculinity, it is important to pay close attention and distinguish how cultural expectations intersect with the ways in which society perpetuates masculine norms (Kia-Keating et al., 2005; Kimmel, 2012; Levant, 2011). For instance, many Latino and African American cultures often emphasize the most traditional views of masculinity and maintain rigid standards (Kia- Keating et al., 2005; Levant, 2011), and therefore these already marginalized young men and boys are positioned to face even higher pressures to conform to societal norms. However, while marginalized men of colour might accept that there are culturally dominant masculine ideals, their everyday experiences are not necessarily experienced as feeling subordinate, and rather they might construct and perform their masculinities as dominant in relation to other men's masculinities and challenging to standard norms of hegemonic/dominant masculinity (Coles, 2007). Racialized men might therefore negotiate masculinity by drawing on those aspects of hegemonic masculinity for which they have the capacity to perform or even excel and establish their own standards and meanings of masculinity (Coles, 2007; Griffith, 2018). Despite being located "in a subordinate position in

the field of masculinity, these men's lived experiences of masculinity are not of being marginalized or subordinated, but of being legitimate and dominant" (Coles, 2007, p. 246).

Research has demonstrated the role of masculinity in aggression toward those who do not conform to strict gender narratives, leading to violent and often fatal attacks against transgender and gender diverse people (Gruenwald & Kelly, 2014), something that seems particularly relevant in the recent epidemic of hate crimes against trans women of color in the United States. Traditional masculinity ideology excludes LGBTQI2S+ males because they violate a fundamental criteria for being considered masculine due to their sexual attraction to or engagement with other men (Sanchez et al., 2010). As a result, gay males who value or subscribe to traditional masculine norms "may experience stress, shame, or guilt because being truly 'masculine' is unattainable due to their same-sex romantic attractions" (Sanchez et al., 2010, p. 82). At the same time, other sexual diverse and gender diverse individuals may not correlate traditional masculine norms as an essential component of their male gender identity and view masculinity on a spectrum or continuum without experiencing a need or pressure to conform (Bockting et al., 2009).

The way we construct masculinities is often by default – to be masculine is to be the opposite of feminine - and societal discourse suggests that conversations around gender more appropriately guides the conversation for women and girls but not for men and boys. Some have critiqued discourse around hegemonic masculinity as static and unchanging, questioning how men "conform to an ideal and turn themselves into complicit types without anyone ever managing to exactly embody that ideal" (Wetherell & Edley, 1999, p. 337). Hegemonic/dominant masculinity and its' characteristics are increasingly being viewed from different and varied perspectives. Nevertheless, what we understand as femininity has and

continues to change in the sense that women actively continue to renegotiate, challenge, and redefine it, while masculinity appears to be much more resistant to change (Kilmartin et al., 2015; Kimmel, 2012; Lisak, 1994). This resistance can potentially result in more psychological distress and dysfunction for men and boys and leading to challenges to the way masculinity is constructed, understood, and enacted.

Toxic Masculinity

The term "toxic masculinity" is generally used to describe hegemonic masculinity at its most extreme form. It denotes how some aspects of masculinity such as entitlement, misogyny and homophobia can harm women, children, families, and can impact men's health outcomes (Fisher et al., 2008, Kupers, 2005). Toxic masculinity has been linked to acts of violence in Western cultures such as mass shootings, demonstrations of racial violence and discord, attacks on trans women of color, and campus sexual assault (Haider, 2016; Katz, 2006; Kimmel, 2012; Kupers, 2005). As noted earlier, it is a term that has become highly politicized and polarizing in society and culture, often portrayed and perpetuated in ways that construct masculinity around themes of domination, control, and violence (Katz, 2006; Kimmel, 2012; Kimmel, 2015).

Although growing in popularity over the past few years, the term toxic masculinity was first coined during the short-lived mythopoetic men's movement of the 1980s and 1990s, influenced by the writings of Robert Bly, and motivated in part as a reaction to second-wave feminist thinking. This movement – consisting of male only workshops, wilderness retreats and drumming circles – was designed to rescue masculinity from a society that supposedly feminized boys, supposedly by separating them from their fathers and having them learn what constitutes masculinity from their mothers. Followers reasoned that this denied boys access to rites and rituals to realize and achieve their true inherent masculine identity (Messner, 2004; Salter, 2019).

Ironically, the movement defined what they labelled the feminization of men as toxic masculinity, and blamed society, and by extension women and in particular mothers, for denying men and boys access to their inner selves, which they related to archetypes such as king, warrior, and wild man (Messner, 2004). Their overtly sexist ideology was problematic, particularly in their essentialist ideas of what constituted gender and their lack of analysis of patriarchal institutions and power structures that particularly favoured men.

Through various research studies, interpretations of harmful forms of masculine behaviour, what I describe here as toxic masculine culture, have been closely linked with early alcohol and drug use, delinquency, early sexual intercourse, aggression after drinking, and high risk driving (Edwards et al, 2014; Fisher et al., 2008; Katz, 2006; Kimmel, 2012). Toxic masculinity has also been strongly correlated with personality traits such as high impulsivity and lack of empathy, and with attitudes such as rape myth acceptance, homophobic and transphobic ideas, and misogynistic beliefs (Edwards et al., 2014; Katz, 2006; Kimmel, 2008; Kimmel, 2012). In addition to these noted correlational studies, empirical support for the relationship between toxic masculinity and sexual assault has also been consistently found, with the notion that extreme forms of dominant masculinity "can be thought of as the common thread which binds together the fundamental constructs of coerciveness against women" (Peters et al., 2007, p. 179). Furthermore, certain men who ascribe to this form of masculinity, in an effort to actualize more power, may partake in the use of violence and control to subordinate others, and engage in extreme competition and aggressive athletics and risk-taking behaviours as the true measures of an authentic man (Katz, 2006; Kimmel, 2012; Kivel, 2011).

Today, dominant discourses in contemporary Western societies at times share a similar toxic construct of masculinity, wherein white, middle class heterosexual males specifically might

aspire to reach an unrealistic and at times unhealthy stereotype of manhood, because they believe by virtue of their gender, race, sexual orientation and class they are privileged to do so (Katz, 2006; Kimmel, 2015; Lisak, 2017). The elusiveness of this enactment of manhood means that no man can ever feel totally and permanently confident that he has truly made the masculine grade, and living up to an idealized image of manhood, it seems, becomes almost a virtual impossibility (Kaufman, 2002; Kimmel, 2015). A further rationale behind that 'failed men' assertion is that since masculinity is contingent upon a solely heterosexual orientation, a man is immediately considered substandard should he desire individuals of the same sex (Benke, 1997; Lisak, 1994).

Studies have shown that men who subscribe to these toxic or extreme traditional notions of masculinity are significantly more likely to engage in high-risk behaviour (Courtenay, 2000; Fisher et al., 2008; Katz, 2006; Kimmel, 2012). These studies also find that racialized men of colour are more likely to hold more traditional ideas of masculinity that are reaffirmed by their culture and community (Courtenay, 2000; Fisher et al., 2008; Katz, 2006; Kimmel, 2012). If heterosexual, middle class, white, able bodied men are the signifiers of dominant masculinity, then gay, working class, non-white disabled men fail to measure up or conform. These men may come to struggle and see themselves as powerless due to systemic prejudice and racism in certain contemporary societies, which means they may therefore be more likely to try to assert their manhood through thrill-seeking or risky behaviours (Courtenay 2000). In that sense, such risk-taking behaviours arguably provides a way for marginalized males to prove themselves as men, since they lack other more efficient means and symbols to demonstrate power or authority.

In the United States, men suffer more severe chronic conditions than women, have a life expectancy that is seven years shorter than that of women, and experience higher death rates for all leading causes of death, including suicide, heart disease, cancer and accidental injury

(Courtenay, 2000). Masculinity for some men might mean going to work when sick, refusing to seek medical help for a chronic issue, driving when sleepy or intoxicated, refusing to wear safety equipment, engaging in unsafe sexual behaviour, or ignoring risks to their health associated with tobacco use or an unhealthy diet (Mahalik, Walker, and Levi-Minzi, 2007). Researchers believe that typically when boys are socialized to conform to a rigid adherence to traditional masculine norms, they experience harmful physical and mental health outcomes (Courtenay, 2000; O'Neil, 2008, Pleck, 1995).

Although the majority of young men may and boys may not subscribe to misogynistic, anti-feminine or sexist beliefs, for some sexism may become deeply entrenched in how they understand and construct masculinity ((McDermott & Schwartz, 2013; O'Neil, 2015). From an early age, many young boys are gender policed and may experience negative consequences for violating prescribed masculine gender norms (Reigeluth & Addis, 2016). For example, parents of young children might hold essentialist beliefs that dolls are for girls, or only boys play hockey, and impose their beliefs on the son that loves Barbie and the daughter that wishes to try out for the school hockey team.

Sexual minority, transgender and gender-diverse persons may be seen as transgressing dominant masculinity by not adhering to gender norms. As noted earlier, a great deal of research has detailed the role of masculinity in homophobic and transphobic violence and aggression (both verbal and physical) against those who do not conform to strict gender rules or narratives. On a daily basis, media coverage details horrific violent assaults and often fatal hate crimes against transgender and gender-nonconforming people around the world, with threats and challenges to the perpetrator's masculinity often the root cause (Gruenwald & Kelly, 2014; Kimmel, 2015). 'Toxic masculinity' takes away responsibility of men for their engagements in

violence against LGBTQI2S+ peoples and against women, and instead a vague entity is to blame (i.e., masculinity compels me to act in this way). It renders invisible the acts of misogyny and homophobia/transphobia by men through an ambiguous blaming on the social construct of masculinity (Banet-Weiser and Miltner, 2015; Gruenwald & Kelly, 2014; Waling, 2018). As discussed earlier, in this sense, masculinity becomes positioned as something that is done to men, or something they are victim of, rather than something that men may actively engage, and therefore removes their agency and a sense of responsibility for potentially harmful actions (Waling, 2019).

Another broader challenge with the term toxic masculinity is that it does not consider intersecting identities in men's lives, or consider closely enough the structural issues that shape men and boys. In drawing heavily upon and applying Raewyn Connell's (1995) work on multiple masculinities, Michael Salter (2019) argues that the term toxic masculinity encourages assumptions that the causes for male violence and other social problems are the same everywhere rather than specific to that society and that culture, and that it therefore assumes the solutions are the same as well. Salter believes that in focusing on men as individuals versus culture or broader social structures, those that are most marginalized because they are so impacted by structural inequalities, such as racialized men or men who live in poverty, are targeted as bad men enacting toxic behaviours. Connell (1995) believed that if some men and boys feel inadequate or not masculine enough, then they might act out aggressively or violently as a means of living up to a dominant standard of masculinity. Women and girls hold themselves to similar high standards of femininity, but I argue a key difference is that when some women act out as a means of attaining those standards it can often present as self-harming behaviours such as, for example, restrictive eating or over exercising. However, as Brown (2018) describes, this also serves as a means of

women using their bodies to comply and resist to dominant cultural norms. But for some men, when they are left feeling frustrated, angry, or emasculated, they act out in an external way that causes harm to others.

Although notions of toxic masculinity have been qualitatively theorized extensively in recent times, it is important to note that quantitative studies in this area are scarce and limited. Furthermore, while it is well acknowledged that the development of a masculine identity plays a crucial role in the health and well-being of men and boys, only a few studies have explored that sense of identity as it relates to male survivors of childhood sexual abuse sexual abuse (Easton, 2014; Gartner, 2000; Kia-Keating et al., 2005). What these studies do tell us is that experiences of childhood sexual abuse can and do have significant impact on developing masculine identity and has far reaching impacts well into adulthood for male survivors (Easton, 2014; Kia-Keating et al., 2005; Lisak, 1994). Male survivors can face enormous pressures from parents, peer groups, and their community at large to demonstrate traditional masculine norms while contending with their sexual abuse histories, something directly at odds with basic tenets of dominant masculinity insisting they appear strong and invulnerable (Kia-Keating et al, 2005). Strict adherence to more toxic masculine norms makes it even more challenging for survivors to develop functional and integrated identities (Kia-Keating et al, 2005). As I further discuss the impact of early childhood sexual trauma on the lives of these young men and boys, managing this disconnect between experiences of early childhood sexual abuse and the notion of living up to prescribed cultural standards and norms of masculinity becomes crucial to survivors' healing processes.

Male Childhood Sexual Trauma

Childhood sexual abuse is traumatic and can overwhelm the lives of its victims and result in profound challenges to emotional regulation, physiological arousal, interpersonal relationships, cognition and memory (Herman, 2015; Van der Kolk, 2014). As renowned expert in trauma and abuse Dr. Judith Herman (2015), tells us:

> at the moment of trauma, the victim is rendered helpless by overwhelming force…Traumatic events overwhelm the ordinary systems of care that give people a sense of control, connection, and meaning. . . Traumatic events are extraordinary, not because they occur rarely, but rather because they overwhelm the ordinary human adaptations to life…They confront human beings with the extremities of helplessness and terror, and evoke the responses of catastrophe (p. 34).

Trauma survivors may face triggering events that results in intense emotions without clear memory, or a flashback of memories disconnected from one's emotions. Central to Herman's (2015) work was her assertion that that psychological trauma and outcomes for a survivor were influenced heavily by the society in which it occurred. Herman (2015) argued that by contextualizing the environment and a person's reaction as a normal response to an overwhelming experience or event, it allowed for the shifting of blame away from the survivor, who was previously perceived as weak or defective in their suffering.

Experiences of trauma can result in far-reaching changes in the way meaning is given to life, with those changes mainly centered on the loss of trust and the sense of disconnection from other, and feelings of despair, terror, rage, and hopelessness. After a traumatic experience, "the world is experienced with a different nervous system. The survivor's energy now becomes focused on suppressing inner chaos, at the expense of spontaneous involvement in their lives"

(Van der Kolk, 2014, p. 53). Survivors may find themselves in a constant state of hypervigilance and irritability yet be unable to identify the cause of their arousal state (Herman, 2015). Even when far removed from the traumatic experience, they still sometimes find themselves trying to organize one's life and surroundings as if the trauma is still happening, unchanged and immovable, with each new experience or event somehow tainted or contaminated by the past.

For both males and females, research shows that risk of child sexual abuse may be directly correlated with such factors as divorce and domestic violence within the family, parents or guardians who suffer substance abuse issues, or parents or guardians who have mental health challenges, and as a result are physically or emotionally unavailable or incapacitated in their care-taking roles (Dube et al., 2005). Childhood sexual abuse can also commonly involve the use of force or threats, and there is some correlation between the perpetration of sexual abuse of boys and a statistically significant use of violence as part of that sexual abuse (Dube et al., 2005, Kia-Keating, et al., 2009). Studies of childhood sexual abuse have demonstrated strong relationships to several adverse health, behavioural, and social outcomes among male and female survivors such as severe psychiatric disorders, suicidality, substance abuse, chronic health issues, obesity, and high risk sexualized behaviours (Dube et al, 2005; Fisher & Goodwin, 2008). Impacts of sexual abuse on both genders demonstrate that the most common negative outcomes include emotional and behavioural problems, post-traumatic stress disorder, depression and anxiety, suicidality, substance abuse, poor self-esteem, academic problems, and sexualized/sexual acting out behaviours (Allagia et al., 2008: Kia-Keating et al, 2010: Sorsoli et al, 2008; Van der Kolk, 2014).

The available research literature does suggest that while there are many similarities in the way males and females experience childhood sexual abuse and trauma, there are also some

distinct differences. Some studies using standardized measures, such as the Trauma Symptom Checklist, have shown no significant differences in trauma impacts between men and women who have experienced sexualized trauma in childhood (Allagia et al., 2008; Briere, 1988; Roesler & McKenzie 1994). Other studies concluded that male survivors are less likely than female survivors to experience anxiety, depression and engage in acts of self-harm, while females were more prone to prolonged periods of depressive episodes (Allagia & Millington, 2008, Gartner, 2017a; Kia-Keating et al., 2009). Still other studies found that male sexual abuse survivors are more likely than female survivors to experience suicidality, have more significant substance abuse issues, and show more externalized aggressive characteristics and issues with managing anger and resulting violence (Allagia & Middleton, 2008; Denov 2004). These outcomes are significant to this study, as issues related to challenges with anger, emotional regulation, outbursts of violence, and problematic substance use histories were common in participants' narratives of their therapeutic work with survivors.

While some of these studies noted here have used population-based samples (for e.g., Denov, 2004; Dube et al., 2005), it is important to note that many have been limited by examination of child sexual abuse among very specific clinical samples, such as individuals in substance abuse recovery programs, persons incarcerated or involved in the justice system, and psychiatric in-patients (for example, Allagia, 2004; Sorsoli et al., 2008). A major cross Canada study- *The Canadian Incidence Study of Reported Child Abuse and Neglect 2008* - examined the incidence of reported child maltreatment and the characteristics of the children and families investigated by child welfare by considering almost 16,000 reported allegations over 112 different agencies. Among investigations of childhood sexual abuse, 37% of cases involved boys and adolescent males (Trocme et al, 2003). In the US, a nationwide study that looked at children

in community mental health services, 47.5% of reported childhood sexual abuse cases involved male children (Walrath et al., 2006). These propensity for a high degree of reported sexual trauma in boys and adolescent males among these specific populations is an important distinction to make, as these are incidences of childhood sexual abuse that come to light and are reported, for example, through investigations by child welfare or by youth mandated to mental health or substance use - in other words, they involve an intervention that led to the discovery or disclosure of instances of childhood sexual trauma amongst very specific populations vs. general populations where disclosure is much less common. Reasons for this were not entirely clear from these studies, but I would argue it may be related to factors such as the vulnerability of these youth in relation to the perpetration of sexual trauma, or a heightened awareness among professionals that statistically these boys and adolescent males are more likely to have early childhood sexual trauma histories.

The literature also demonstrated the degree to which young men and boys will not readily disclose experiences of sexual abuse for fear society will neither condone nor even accept it (Fisher & Goodwin, 2008; Lew, 2004; Van der Kolk, 2014). Major studies on the phenomena of early childhood sexual trauma share similar findings, in that the problem is much more common than we assumed, it is vastly under-reported, it is grossly under-recognized, and is often under-treated (Cohen et al., 2017; Denov, 2004; Fisher & Goodwin, 2008; Lisak, 1994; Van der Kolk, 2014). As noted previously, issues that can occur in the aftermath of male childhood sexual abuse include challenges in defining the unwanted experience as sexual abuse or trauma; fear, isolation, and shame; the impact of masculine gender socialization on how the experience is understood; the possibility that abuse by women or even same age same sex peers will be defined

as sexual initiation or exploration; and the impact on sexual and other intimate relationships into emerging adulthood (Fisher & Goodwin, 2008; Gartner, 2000, 2017a).

Sexual abuse perpetrated by a male against another male can bring questions and doubts around one's sexual orientation and sexual identity (Corbett, 2016; Fisher & Goodwin., 2008). Survivors are often left struggling with heightened issues related to homophobia, shame, and stigma (Easton, 2014; Lew, 2004). This is an outcome of being raised and socialized in a heteronormative society that reifies and privileges heterosexuality in its customs, traditions, institutions, and ways of understanding. As such, it illustrates one of the most heightened differences in outcomes for male and female survivors, as abuse by a male perpetrator for many men and boys leads to questioning sexual orientation and sexual identity and challenges in reconciling their membership as masculine within a heteronormative and predominantly homophobic society.

As a means of coping, some male survivors adopt a hyper-masculine persona in which they display exaggerated and toxic masculine attitudes and norms such as violence, aggression, homophobia, and misogyny (Dorais, 2002; Kia-Keating et al., 2005). Hegemonic/dominant masculinity, influenced by a heterosexist society, communicates to young males that, in sexual situations, they can expect to be the one who desires another and to also be the one who typically initiates sex (Corbett, 2016; Kimmel, 2012). Sexual abuse of men and boys subverts dominant expectations of masculinity in such a profound way that it is often experienced as an attack on the male self that is emasculating (Corbett, 2016).

One particularly pervasive myth or untruth that recurs throughout the brief literature available involves the phenomena of sexual abuse of young men and boys by older female perpetrators. If we accept that hegemonic/dominant masculinity and those that subscribe to it

often prides itself on notions of sexual conquest and prowess, then we must acknowledge that young men are sometimes actively encouraged to recognize or accept such experiences as initiation, rites of passage or healthy adolescent exploration, rather than the exploitative abuse of power and control that they are in reality (Denov, 2004; Gartner, 2017b; Lisak, 1994). The fact that this is such a widely accepted myth is dangerous in that it limits the ability of a survivor to speak of his abuse, as to do so would result in ridicule and, in rejecting these sexual advances, call into question their manhood. As constructed within hegemonic/dominant masculinity, male sexual exploits can sometimes appear to young men and boys as something that seems necessary, often aggressively pursued, and an activity they should readily seek to participate in and enjoy (Kimmel, 2008). But when we normalize, trivialize, or sensationalize abuse perpetrated by an older female against a male youth, on both the personal level and the cultural level we overlook the seriousness and the implications of the act itself, both as a transgression of power and a legitimate form of abuse or trauma.

For heterosexual youth, surviving sexual abuse challenges the norms of their perceived masculinities set forth by a heteronormative and patriarchal society. For LGBTQI2S+ youth, it raises concern they were abused because they were perceived as gay after showing some indication or hidden signal to others, or that the abuse experience and the sexual transgression itself somehow contrived to “make them gay” (Cassese, 2000; Corbett, 2016). Male survivors may also feel the need to act out sexually with female partners in an effort to re-establish or reclaim their heterosexual identity. They may also feel hurried into identifying their sexual orientation, and later come to associate their sexual identity and their sexual activity with feelings of betrayal, exploitation and secrecy (Gartner, 2018; Lew, 2004). Within early adolescence in particular, self-concepts of both sexual orientation and gender identity have yet to

fully coalesce, and fears, prejudices, and misinformation regarding identity and orientation can be particularly prominent and therefore especially problematic within developing adolescence (Gartner, 2000). As a result, perhaps one of the greatest crimes of male childhood sexual abuse is how it robs young men of their ability to discover their orientation and sexual interests in developmentally appropriate ways.

As limited as the literature in general is on male childhood sexual trauma experiences, it is even sparser when considering the experiences of LGBTQI2S+ youth. James Cassese's *Gay Men and Childhood Sexual Trauma: Integrating the Shattered Self* (2000) is one of the few works based solely on the experiences of gay and bisexual male survivors, studies and researched primarily by predominantly gay male scholars and therapists. Most of the major gender scholars writing or researching male childhood sexual trauma – Gartner, Lisak, Kimmel, to name a few – are white, cisgender heterosexual men. Their positionality as such arguably brings assumptions to their work that may not fully encapsulate the experience of marginalized masculinities, and in turn views the issue through a privileged heterosexual lens. Missing from their work are more prominent examples, for instance, of a male child who identifies as LGBTQI2S+ prior to the experience of sexual abuse or a racialized child challenged by cultural expectations. From childhood abuse to homophobic jokes that shame and ridicule to hate crimes, certain gay, bisexual and trans men and boys experience dominant culture as traumatic. Experiences of childhood sexual abuse only compound these issues further and exacerbate that trauma; however, it is a phenomenon rarely addressed in current literature.

Herman (2015) describes how traumatic experiences impact not only an understanding of self, but also the systems of attachment and meaning that provide connection and linkage to families and community. Traumatic events can destroy our underlying assumptions around safety

in the world and erode the positive value of self (Herman, 2015). The very act of being sexually traumatized is conceptualized as "contempt for the victim's autonomy and dignity and thus…destroys the belief that one can be oneself in relation to others (Herman, 2015, p. 53). If we accept that a secure connection with caring people is a necessary foundation of healthy personality development, then along with the shattering of this connection through trauma comes doubt, fear, and insecurity. As Herman (2015) tells us, developmental conflicts, which may have been long thought negotiated or resolved, are now often painfully reopened and left uncertain.

Because of the overarching context of hegemonic masculinity and toxic masculine culture, male survivors can struggle with a yearning for connection that conflicts and constricts with an inability to establish closeness to another for a variety of reasons, including fear of some re-occurring abuse, or fears of perpetrating abuse themselves (Kia-Keating et al., 2005; Lew, 2004). It may also seem a requirement of masculine culture that they remain stoic or express little emotion regarding the traumatic experience (Kia-Keating et al., 2005; Lew, 2004). Lisak (1994) describes that "paralleling the damage to the survivor's self is an equally pervasive assault on his connection to others" (p. 545) and notes how the resulting alienation can prevent or prove debilitating to the formation of positive interpersonal relationships. According to Lisak (1994), it is these connections that are needed to mitigate the resultant fundamental mistrust of others, including the expectation that others can and will potentially do us harm. And yet as Herman (2015) tells us, recovery takes place within the context of relationships – connection is recovery, and recovery cannot occur in isolation. Therefore, what becomes key to the treatment of male trauma survivor's experience is the reparation of that sense of connection, and the discovery of safety in trusting relationships that all form parts of his healing process.

Challenges around Disclosure

Several compounding factors impact the identification of childhood sexual abuse victims, from issues such as constructing the experience as abusive to impacts on disclosure rates (Fisher & Goodwin, 2008; Gagnier & Collin-Vezina, 2016; Gartner, 2017a). One significant issue impacting our understanding of the experience of men and boys is the scarce research that is available explicitly detailing the experience of disclosure and help-seeking of young male survivors. Furthermore, the studies that do exist consider experiences of two genders have a disproportionate number of female voices due to challenges with recruitment of males, while other studies have comparatively a small sample of males as participants (Allagia & Millington, 2008). There has also been a tendency to measure only certain types of outcome, such as disclosure that resulted in official accounts being provided to police or child welfare agencies, or the pursuit of criminal charges and prosecution through justice system (Sorsoli et al, 2008). This excludes an act of disclosure that involves conveying or attempting to convey to another person their experiences of trauma without necessarily contacting or involving authorities.

In studies that compared male and female disclosures, findings showed that males struggled with disclosure in similar ways (for e.g., feelings of shame, not wanting to hurt others by disclosing) but in a number of studies there are several distinct factors that stood out as specific barriers to disclosure for male survivors. These factors are what Fisher and Goodwin (2008) call cultural myths that leaves male survivors with profound feelings of isolation and stigmatization. A central myth is the common discourse that boys are rarely victimized. Because of a belief that men and boys cannot be victims, male survivors struggle with feeling vulnerable and weak versus tough and strong, and equate their abusive experience to a *female experience*, something that only happens to girls and women. This serves as a violation or transgression to

their masculine identity (Allagia, 2005; Gagnier & Collin-Vezina, 2016; Kia Keating et al., 2005) influenced by a patriarchal, heteronormative, and misogynistic culture that devalues women and views them as weak and powerless. Boys and men are emasculated by these cultural biases. They also fear being perceived as homosexual or gay, as the result of homophobic and heterosexist biases in culture, and the enormity of pressures in heteronormative society to conform to dominant (i.e. hegemonic and heterosexual) ways of being a man (Allagia, 2005; Gartner 2017b; Lisak, 2017). These same studies demonstrated how female survivors generally felt more conflicted about their responsibility in an abusive experience, and struggled with feelings of shame and blame, while at the same time largely anticipated being blamed or not being believed by those to whom they disclosed their trauma (Allagia, 2005; Gagnier & Collin-Vezina, 2016).

Since experiences of childhood sexual abuse and feelings of hopelessness or terror are seemingly at odds with certain masculine ideals, confiding a history of abuse or the resulting challenges become particularly problematic for some survivors (Kia-Keating et al., 2005; Lew 2004; Lisak, 2017). However, studies show that disclosure is often key to relational development and that the inability to talk about these experiences contributes to disconnections in relationships to families, communities and at times disassociation within themselves (Gartner 2000, Kia-Keating et al., 2005).

In their work with female survivors of sexual assault, McKenzie-Mohr and Lafrance (2011) invoke the term "tightrope talk" to describe survivors' attempts to make meaning of their experiences by negotiating and navigating both agency and blame. McKenzie-Mohr and Lafrance (2011) challenge the oversimplification of binaries such as powerful or powerless, or strong or vulnerable. This is particularly relevant in how mental health clinicians help young

male survivors unpack their stories. Brown (2018) notes that disclosing trauma can be perceived as dangerous by the survivor, as it exposes them to uncomfortable or painful emotions and fears of being blamed or not believed. This danger may, therefore "shape the storytelling, and caution and self-surveillance may render invisible or disqualify aspects of the story (Brown, 2018, p. 46). As Brown (2018) cautions, we should not misinterpret uncertainty in an account as a lack or absence of past traumatic experience.

The powerful messages about what it means to be a man restrict and constrain how men and boys talk about their trauma (Fisher et al., 2008; Gartner, 2017a; 2017b)). When faced with trauma in such forms as childhood sexual abuse, powerfully overt and subliminal messages around masculinity make it difficult for men to acknowledge trauma and seek help, and leave them feeling ashamed to disclose any pain or suffering, or to seek comfort and support (Fisher & Goodwin, 2008; Gartner, 2000; Lisak, 1994). Studies show that men who are better able to locate, recognize and process their emotional experiences within the context of their male identity, including those specific to the trauma experiences themselves, were more likely to be successful in recovery (Kia-Keating et al., 2005; Fisher & Goodwin, 2008; Gartner, 2017b).

Another challenge facing survivors' help-seeking is the lack of a recognizably comfortable or accepting atmosphere within our current mental health settings for the disclosure, and the tendency of mental health professionals to underestimate or dismiss the prevalence of male childhood sexual abuse (Gartner, 2008; Teram et al., 2006). Ironically, it is dominant masculinity's privileged position in our Western culture that "contributes to these impediments, making it difficult for male survivors to acknowledge themselves as victims and furthermore for health professionals to even view them as such" (Teram et al., 2006, p. 513). The myths surrounding male childhood sexual abuse continue to perpetuate in society and serve to

“exacerbate the difficulties men have in disclosing the experience of sexual assault and increase their stigma while hindering the development of appropriate services and empirical research” (Stermac et al., 2004, p. 7). Therefore, addressing these myths directly and working to decrease stigma is key to the male survivor’s recovery process.

Healing Processes

Childhood trauma due to physical abuse, neglect, or sexual abuse is recognized in the research as a severe problem in our society today, and it well documented how traumatic experiences may result in disruption or injury to the developing brain that affect a child's developing functioning and can potentially result in lifelong problems and challenges if left untreated (Ford & Courtois, 2016; Thomason & Marusak, 2017; Van der Kolk, 2014). Treatment modalities used today with young survivors of early childhood sexual trauma include, but are not limited to, trauma-focused cognitive behavioural therapy (TF-CBT), narrative therapy, feminist based approaches, attachment therapy, dialectical behavioural therapy (DBT), acceptance and commitment therapy (ACT), sensorimotor psychotherapy, eye movement desensitization and reprocessing (EMDR), adventure therapy, and mindfulness strategies (Fisher & Goodwin, 2008; Ford & Courtois, 2016; Gartner, 2017b; Herman, 2015; Van der Kolk, 2014). Individual therapy is often observed as the best starting place for men and boys in developing trust and rapport with a clinician (Fisher & Goodwin, 2008; Lew, 2004), but studies show that men and boys also draw strength and healing from therapy delivered outside of traditional office-based settings, such as outdoor nature therapy; self-help books and guided journaling; practiced mindfulness; and, in particular, group therapy processes (Kia-Keating et al., 2005; Fisher & Goodwin, 2008; Gartner, 2017b). Research on group therapy shows that it can serve to reduce isolation throughout the process of healing by demonstrating that people are not alone in having

these experiences, and in providing survivors with a sense of feeling more accepted, validated, visible, and heard (Fisher & Goodwin, 2008; Gartner, 2017b; Lisak, 2017).

For boys and adolescents, employing informal settings outside the office (e.g., playground or recreational areas), involving musical instruments or art activities, using humor and self-disclosure, and providing psychoeducational groups aimed at challenging myths around male sexual trauma may prove more effective than traditional psychotherapy offered in traditional office like settings (Kiselica & Engar-Carlson, 2010; Kiselica et al., 2011). Combining psychological interventions with some form of sporting activities has also been demonstrated to reduce barriers to male-help- seeking, including an impact on what is theorized as a perceived social threat associated with needing help (Kiselica et al., 2011).

Men and boys cope with masculine expectations throughout the therapeutic process, first through deconstruction and subsequent reconstruction of the masculine order, and finally a renegotiation or a new understanding of what it means to be masculine (Fisher & Goodwin, 2008; Gartner, 2017b; Kia-Keating et al., 2005). Ultimately, survivors may seek to develop skills to amend problematic behavioural patterns that may have hindered relationships or impacted their lives in a myriad of different ways (Fisher & Goodwin, 2008; Kia-Keating et al., 2005). Through healing from past violence and abuse, they may also start to seek out, as an alternative, more stable, non-abusive, and supportive relationships with others (Fisher & Goodwin, 2008; Kia-Keating et al., 2005). However, while the ability to connect or reconnect with others is described as a critical component to any healing processes in the literature, the idea of "embracing connection, empathy, and vulnerability continue to be a difficult renegotiation for many survivors in many contexts" (Kia-Keating et al., 2005).

Judith Herman has been described as a pioneering clinician in the field of trauma work

with a tremendous influence on the theoretical understanding of the sequelae of trauma. Although her book *Trauma and Recovery* (2015) was first written and published almost three decades ago, it is still considered one of the most essential theoretical works in the field of trauma (Suleiman, 2008, p. 285). Herman was highly critical of the treatment survivors of child abuse received in mental health systems, and believed in treating symptoms as causes, professionals working in these systems served to perpetuate the culture of blaming the victim, by focusing on the victim's character as the source of the problem. In *Trauma and Recovery,* Herman (2015) proposed the diagnosis of Complex Post Traumatic Stress Disorder (C-PTSD). Herman's definition of C-PTSD differs from the current definition of Post-Traumatic Stress Disorder as it seeks to address the occurrence of multiple, repeated trauma throughout the lifetime as opposed to a single acute traumatic experience (Herman 2015; Van der Kolk, 2014). Although C-PTSD has yet to be recognized as an official diagnosis, it is used extensively as a guideline of practice and treatment in the field of trauma by both therapist and researchers (Van der Kolk, 2014).

Herman (2015) proposes a three-stage model for recovery in the treatment of trauma. According to Herman, these key stages of recovery include establishing safety, reconstructing the trauma story, and restoring the connection between survivors and their community. In stage 1: "safety and stabilization", Herman (2015) notes that establishing safety takes precedence over everything else because, without that secure base, the trauma work cannot begin. In stage 2, "remembrance and mourning", the survivor tells the story of their trauma. As Herman (2015) notes, they tell it "completely, in depth and detail. This work of reconstruction transforms the traumatic memory so that it can be integrated into the survivor's life story" (p. 175). Through the therapeutic relationship, the survivor may be empowered by the clinician in this stage, as "the

choice to confront the horrors of the past rests with the survivor. The therapist plays the role of witness and ally, in whose presence the survivor can speak of the unspeakable" (Herman, 2015, p. 175). Herman (2015) notes that together the patient and therapist must learn to "negotiate a safe passage between the twin dangers of constriction and intrusion" (p. 176). She cautions that "avoiding the traumatic memories leads to stagnation in the recovery process while approaching them too precipitately leads to a fruitless and damaging reliving of the trauma" (Herman, 2015, p. 176). In stage 3: "reconnection," Herman (2015) describes how the survivor has reconciled their traumatic past and is tasked with creating a new future. She notes how the trauma has forever changed relationships, and the survivor must develop new ones. Thoughts, feelings and beliefs once sustaining have now been challenged, and the survivor must look for new ways to reclaim faith (Herman, 2015). As Herman (2015) describes it:

> Traumatic events destroy the sustaining bonds between individual and community. Those who have survived learn that their sense of self, of worth, of humanity, depends upon a feeling of connection to others. The solidarity of a group provides the most reliable protection against terror and despair and the most potent antidote to the traumatic experience. Trauma isolates; the group re-creates a sense of belonging. Trauma shames and stigmatizes; the group bears witness and affirms. Trauma degrades the victim; the group exalts her. Trauma dehumanizes the victim; the group restores her humanity (p. 214).

In *The Body Keeps the Score: Brain, Mind, and Body in the Healing of Trauma,* Bessel Van de Kolk (2014) explores "the extreme disconnection from the body that so many people with histories of trauma and neglect experience" (p. 91). Van der Kolk (2014) draws on three main areas of study as a focus of treatment for trauma survivors that include neuroscience

(function brain processes), developmental psychopathology (the impact of painful traumatic experiences on brain development) and interpersonal neurobiology (a person's behaviour and how that impacts on psychoemotional and neurobiological states of those around them). Through a neurodevelopmental lens, Van der Kolk (2014) describes how parts of the brain that have evolved to monitor for danger remain over activated for trauma survivors, and that the slightest sign of danger, whether real or imagined, can trigger an acute stress response, painful emotions, and overwhelming sensations. Van der Kolk (2014) proposes that these post-traumatic reactions make it difficult for survivors to connect with other people since closeness can sometimes signal a sense of danger, and yet the close contact a survivor may come to dread is often the thing needed most in order to begin healing. While helpful in understanding some of the physiological impacts of trauma, der Kolk's (2014) theories do not fully address impacts of social determinants of health on trauma survivors or, in particular, discursive social forces that can impact how a survivor understands and integrates past trauma into their lives.

It is increasingly recognized that more specific gender-sensitive training is needed for mental health professionals when addressing the unique needs of male survivors (Addis & Mahalik, 2003; Gartner, 2018; Kia-Keating et al., 2005; Mahalik & Burns, 2007; Mahalik et al., 2007). Current treatment practices can pathologize male survivors in terms of their focus on symptomology, particularly within the context of problematic or externalizing presenting behaviour (Gartner, 2000, 2017a; Lew, 2004). This, in turn, can contribute to how survivors often internalize blame and guilt for these traumatic experiences (Lew, 2004).

Studies show that mental health professionals rarely screen their male clients for specific experiences of sexual abuse (Addis & Mahalik, 2003; Gartner, 2017b; Mahalik et al., 2003; Teram et al., 2009), which raises the concern that perhaps one of the reasons why male survivors

have not come to the forefront in our research is that clinicians, physicians, and other mental health professionals are failing to assess appropriately around past experiences of childhood trauma. Clinicians are often less likely to recognize potential symptoms of past trauma in male survivors as internalized (i.e., viewed and formulated as a mood disorder, such as anxiety or depression) and tend to instead focus on externalizing behaviours, such as difficulties with displays of anger, violence, or emotional regulation (Addis & Mahalik, 2003; Kimmel, 2008; Mahalik et al., 2003, 2007; Teram et al., 2009). Many clinicians describe possessing little or inadequate specialized training in regard to working with male survivors of sexual abuse, which may in turn heighten their anxiety and impact their approach to the treatment of male sexual trauma survivors (Teram et al., 2009).

In studies related to sexually abused men's' experiences in psychotherapy, survivors highlighted the need to work slowly, be open to alternative approaches that may lie outside office based norms, and the importance of providing specific psychoeducation at critical points in treatment to assist with development and implementation of healthy emotional skills (Addis & Mahalik, 2003; Fisher & Goodwin, 2008, Gartner, 2000). However, survivors participating in these same studies frequently noted that it is problematic to presume that male clients are emotionally incompetent or unable to manage complex emotional states, and that therapist should not avoid intricate emotional work as part of treatment, but rather be more attuned to helping survivors manage those complicated emotional responses and triggers as they may arise (Fisher & Goodwin, 2008; Gartner, 2000; Mahalik et al., 2007).

To varying degrees, a male survivor is often faced with the challenge of rejecting the traditional standards of masculinity. Lisak (1994) believes that male survivors of childhood sexual abuse must be "given the tools to deconstruct the gender system and their individual

experience of gender socialization in order to fully engage in the process of healing from abuse" (p. 258). While still successfully engaging in traditional expectations of masculinity, survivors must potentially allow themselves to express fear or uncertainty or show vulnerability, all of which are experiences that are often at odds with traditional expressions of manhood. Therefore, a sexual trauma survivor must work to both contain, resist and redefine traditional masculine roles as part of his healing process (Kia-Keating et al., 2009), which ultimately may prove key to a healthy recovery.

Numerous studies have documented that exposure to interpersonal trauma during childhood is related to increased incidence of affect and impulse dysregulation, alterations inattention and consciousness, disturbances of attribution and schema, and interpersonal difficulties. Affect dysregulation may present as lability, flat affect, explosive or sudden anger, or incongruous or inappropriate affect response, while behavioural expressions of affect regulation may include withdrawal, self-harm, heightened aggression, oppositional and defiant behaviour, substance use, or other compulsive behaviour (Cicchetti & Rogosch, 2018; D'Andrea et al.,2012; Pollak et al., 2009). Disturbances of attention and consciousness may manifest as dissociation, which Herman (2015) describes as the numbing of one's self, memory disturbance, inability to concentrate or sustain attention, and poor executive functioning, such as the ability to plan or problem solve (Kaplow et al. 2008).

Children exposed to trauma in early childhood often have distorted attributions about themselves and the world around them that may act to exacerbate feelings of shame and guilt, promote negative or distorted cognitions, and result in a loss of control and poor self-efficacy (Gibb & Abela, 2007; Kim & Cicchetti, 2006; Valentino et al., 2008). Interpersonal difficulties in children following abuse or neglect may include disrupted or poor attachment styles, issues

with trust, diminished social skills, poor perspective taking, an inability to understand social interactions, expectations of harm from others, and poor boundaries (Kim & Cicchetti, 2006; Perlman et al., 2008). Children who are exposed to trauma and abuse are also often at a much higher risk for further victimization through witnessing interpersonal violence in their homes, which has shown increases risks and severity of internalizing, externalizing, relational, and academic problems in later childhood (Finkelhor & Turner, 2016). One of the few major studies that looked at the association between male childhood maltreatment, male childhood sexual abuse and adult mental health outcomes found that men who experienced early childhood sexual trauma with or without other forms of child maltreatment had significantly higher rates of mental health issues, were more likely to be diagnosed with mental health disorders, and were more likely to self-harm and attempt suicide than men who did not experience childhood sexual abuse (Turner et al., 2017).

The scope of this work limits a more comprehensive review of effective treatment modalities and healing processes. However, what is clear from the studies reviewed and from the work of theorists such as Herman and van der Kolk is that following childhood victimization there is a spectrum of specific symptoms commonly experienced by survivors of complex trauma, and these symptoms cannot be accounted for fully by any existing diagnoses or combination of diagnoses, found in the current Diagnostic and Statistical Manual (DSM-V), including Post Traumatic Stress Disorder (PTSD) (D'andrea et al., 2012). A mental health diagnosis can serve the purpose of validating people's experiences, and empower them to seek treatment while recognizing their resiliencies, but it can equally serve to pathologize their experiences, perpetuate stigma related to mental health, and potentially reduce the likelihood of positive treatment outcomes. Sexual trauma survivors are more than their trauma, and more than

their manifestations of pain. By applying interventions that comprehensively address the full range of biopsychosocial issues that men and boys exposed to childhood sexual trauma face while conceptualizing and planning treatment approaches through a gendered lens, I believe we have the potential as a mental health system to dramatically increase the likelihood of positive treatment outcomes and better the lives for male childhood sexual trauma survivors.

Chapter Three: Methodology

This chapter provides a detailed overview of the methodology and research design in the study. It begins with the research question and objectives of the study, and then outlines the research design and methodology that was chosen and utilized. This chapter will also outline the methods used for participant sampling, data collection, and explain the rationale and process related to data analysis. Finally, it also provides an overview of how confidentiality and anonymity was maintained as well as a framework for ethical considerations.

Research Questions and Objectives

This study explored narratives of trauma therapists and their work with young male sexual trauma survivors. It described the experiences of young survivors from the viewpoint of participants as therapists, and interpreted trauma narratives through an understanding of the influence of toxic masculinity culture on young males and the resulting impacts on their healing processes. It also explored the challenges and complexities of the treatment work participants provide to survivors. Research questions that guided this study included: 1) how does the experience of childhood sexual trauma impact the lives of young survivors? 2) In what ways does the phenomenon of childhood sexual trauma intersect with the experiences of being socialized as a young male? 3) How do rigid expectations of dominant masculinity – and particularly those of toxic masculine culture -disrupt healing processes of young survivors? 4) What current treatment interventions and strategies are utilized in treating male survivors, and of those what appears most effective and what is missing or lacking? 5) How might we reduce the stigma for males associated with being a childhood sexual trauma survivor and the stigma related to mental health help seeking in males?

Analysis in this study centered on how society fosters assumptions and myths around meanings of masculinity, which in turn can perpetuate incidents of gendered violence, misogyny, homophobia, and transphobia, all of which serves to hinder the way boys and young men heal from sexual trauma. The study explored how participants, as therapists, approach treatment processes to address the gendered nature of male childhood sexual trauma and how they might challenge rigid and constraining constructs of masculinity that serve to impede healing and recovery. There was a particular focus on the complex relationship between male childhood sexual trauma and homophobia and misogyny, and how these experiences become internalized in some survivors and result in significant challenges with sexual identity and a masculine sense of self (Allagia et al., 2008, Fisher & Goodwin, 2008; Gartner, 2000; Kia-Keating et al., 2005, 2009; Lisak, 2017). This in turn led to deeper exploration of the dangers of injurious speech (Brown, 2007; McKenzie-Mohr & Lafrance, 2011) and the need for counter-stories related to available trauma discourse (Brown, 2007; Brown, 2011). Participants also described struggles with systemic constraints and barriers to treatment inherent in the medical model in which they were situated, and ways in which they worked to resist these constraints.

As previously reported, experience of male childhood sexual trauma is a phenomenon that is under-studied, under researched, and not well understood. My ultimate hope is that this work will add to the literature available on male childhood sexual abuse, and contribute to the conversation about how we might offer agency in our work with young male survivors, so that they may process emotions and story experiences without guilt, shame, humiliation, or defeat.

Theoretical Framework

Participants' narratives of experiences are critically examined through a social constructionist and postmodern lens throughout this study. This work also draws on parts of

feminist and queer theory, in particular their transformative nature, their politicized stance, their interest in knowledge possession, and exploration of gender and sexual identity. Social constructionism seeks to recognize, capture, and honour multiple meanings through consideration of a complexity of views (Berger & Luckmann, 1966; Creswell, 2013). Social constructionism rejects an objectivist viewpoint and purports that there is no objective truth, and believes that knowledge arises from engagement with the world, with knowledge and the knower as interdependent and embedded within history, context, culture, language, experience, and understandings (Berger & Luckmann, 1966; Denzin & Lincoln, 2017). Therefore, what we take as true and objective is the result of discursive social processes that take place within historical and cultural contexts. Understanding experiences and perceptions from a social constructionist perspective offers potentially new ways to consider constructs of masculinity and how they intersect with experiences of sexual trauma outside of currently constructed meanings.

Like social constructionism, postmodernism is interested in challenging what is known and how it becomes known. Postmodernism believes there is no one absolute, universal, or discoverable truth, or one fixed essential self or identity that exists outside human experience (Brown, 2007; Denzin & Lincoln, 2017). Postmodernism calls for a critique of foundational knowledge and privileged discourses, also called grand narratives, and any taken for granted assumptions. The central message of postmodernism is the inherent danger of the *one* story that leaves no room for alternate versions (Payne, 2014). Social constructionism and postmodernism assist in understanding what is constructed, how it is constructed and the very question of what it means to *be* constructed (Payne, 2014). They also offer a framework to deconstruct meaning making of experience, and subsequently consider how that meaning constructs future experiences. Situating men's stories in this study within a social constructionist/postmodern

framework allows for their experiences to be understood within the various contexts that emerge. It also allowed for greater understanding of men's experiences through how they process their experiences, in this case primarily their traumas, and how they consider and construct their identities.

A Turn towards Narrative

As social workers, we are interested in hearing, understanding and working with people's stories, and those experiences told through stories are often very central to our practice. Narrative inquiry, as defined by Clandinin and Connelly (2000), is the study of experience as story rooted in a situational way of knowing. Within that knowing, researchers and participants together can come to understand experience under certain contexts, during certain periods of time, and through interacting with certain others. Narrative inquiry involves a paradigm shift from thinking *about* stories to engaging *with* stories, with stories positioned as a way of both being in and engaging with the world (Bruner, 1991; Clandinin & Connelly, 2000). It promotes a change in power relations, moving away from the pursuit of objective knowledge as a researcher, and towards acknowledging the value of relationship between researcher and participant. Narrative inquirers arguably conduct research that is less generalizable in favour of research that is more specific, with emphasis placed on the use of words and narratives to impart meaning versus numbers and statistics (Pinnegar & Daynes, 2007; Reissman, 2007). Narrative inquiry involves a change from seeking more definitive answers towards valuing subjective and situated knowledges. It rejects one way of knowing and recognizes multiple ways of knowing and understanding human experience (Pinnegar & Daynes, 2007; Riessman, 2007).

As human beings, our lived and told stories become important ways that we fill our world with meaning and engage in relationships with one another to build lives and to build

communities (Clandinin and Rosiek, 2007). My narrative beginnings, as presented in Chapter One, briefly explored my identities within this research as a mental health clinician, as a gay male, and as a survivor of childhood sexual trauma. But a further identity, that of creative writer and storyteller with a great passion and respect for the written word, was what drew me in particular to narrative research and ultimately to narrative inquiry as design and methodology. Story has always served a crucial role in my life, and has provided me a source of knowledge, a means of expression, and at times an escape from difficult realities. Narrative inquiry and its fundamental beliefs in the power of story, story as knowledge, and knowledge as relational provided me with connection and linkage I needed between creative writer and academic writer, and therefore allowed me to position myself as a researcher and creative writer, and as an academic and a storyteller. It is for these specific reasons that I position this study within a narrative inquiry paradigm.

Research Design and Methodology

This qualitative study centered on a narrative inquiry research design and was theoretically drawn from parts of social constructionism, postmodernism, feminist and queer theory. It critically used a discourse analysis to explore themes related to social constructs of masculinities in our world today and how those constructs and the belief systems that surround them might impact male survivors of early childhood sexual trauma. A qualitative research design was chosen as it involves an interpretive approach to the world through studying things in their natural setting while attempting to make sense or interpret phenomena in terms of the meanings that people bring to them (Denzin & Lincoln, 2017). Qualitative research allows for a final research report that includes the voice of participants, the researcher's reflexivity, complex

descriptions and interpretations of the problem, and a contribution to the literature or a call for change (Creswell, 2013; Willig, 2013).

For this research, I have aligned my understanding of narrative inquiry primarily with the writings of Jean Clandinin and Michael Connelly (2004), whose methodology and approach are informed by the work of philosopher John Dewey (2008), and in particular his theory of experience. Dewey (2008) believed in an experiential continuum, where experience takes up something from those experiences that have gone before and modifies in some way the quality of those experiences that occur later. In other words, the way we live, learn, think, and remember is rooted in experience and in how we make sense of experience. All experience is grounded in stories - in how we tell those stories and in how we challenge them. Through conversation, we form and reform our life experiences by creating and recreating meanings and understandings, and therefore constructing and reconstructing our realities and ourselves (Brown & Augusta-Scott, 2007). Narrative inquiry, or "the study of experience as story... is first and foremost a way of thinking about experience" (Clandinin & Connelly, 2004, p. 375). It serves as a "collaboration between researcher and participants, over time, in a place or series of places, and in social interaction with milieus" (Clandinin & Connelly, 2004, p. 20). In a narrative inquiry, the storying of experience becomes both the phenomenon under investigation and the method of research (Pinnegar & Daynes, 2007). As Brown (2007) tells us, experience cannot be treated as absolute truth, conflated as authoritative, self-legitimizing and therefore uncontestable. Stories of experience are "interpretive, political, and contestable. Like all stories, they are multiple, fluid, changing, contradictory, and full of gaps: Like all stories, they are imperfect" (Brown, 2007, p. 192). In this research, I explore with participants their narratives as mental health therapists working with male childhood sexual trauma survivors. Their experiences, and the experiences of

those they care for as stories both lived and told, are the phenomena that I investigate, inquire within, and tell. I chose to follow the Clandinin and Connelly approach to narrative inquiry because it aligns with my own epistemological view of story as experience and experience as relational, with story as a way of being in the world and a way of knowing one's self and of knowing others. Clandinin and Connelly (2004) centred much of their research on teaching and teacher knowledge and worked in exploring and understanding a myriad of experiences in school systems. Their narrative inquiry methodology has also had interesting implications in recent years in nursing research by providing new and rich knowledge and understanding in the patient/doctor relationship (Wang & Geale, 2015). Their approach seemed highly relevant to the study at hand and works influenced by it mirrored what I hoped to accomplish through this study about survivors, treatment approaches, healing processes, and the gendered nature of male childhood sexual trauma.

As a method of narrative analysis, Clandinin and Connelly (2004) describe use of a three-dimensional narrative inquiry space to study experience. Understanding a three-dimensional narrative inquiry space – experience bound by temporality, sociality, and place - and what it means to live and work within that space over the course of a study is something that makes it unique and sets narrative inquiry apart from other forms of qualitative research (Clandinin and Connelly, 2004). Three-dimensional narrative space – temporality, sociality and place -are drawn from a Deweyan perspective that distinguishes experience from what people live through every day versus and an experience which has specific boundaries. An experience is therefore bound by temporality (it has a starting point and has, or will have an end point), sociality (it occurred in relation to one's self or others), and place (it happened somewhere) (Clandinin & Connelly, 2004). As noted earlier, stories of experience and the knowledge that arises from them are

embedded within history, context, and culture (Berger & Luckmann, 1966). Therefore, stories of experience are interpretations of events situated within historical, cultural, and temporal contexts.

Situating and analyzing each story within this three dimensional inquiry space, narrative inquirers are called upon to adopt a multidimensional and interdisciplinary lens; to treat the story or narratives as a whole; to pay attention to form, content and context of narratives; and lastly, to become participants in the understanding and construction of reality (Clandinin & Huber, 2010). Attending to temporality – past, present and future -means thinking about the ways people make links between various experiences, how researchers and research participants write themselves into and out of stories, and how narratives are created. Temporality presented itself as participants reflecting on past experiences with trauma survivors and telling their narratives. It also involved participants reflecting back on earlier times in their career, describing how they came to the work, what theories and principles guide them, and how that might have changed or evolved over time. Within temporality, movement occurs as reflections into the past and future, but also as lateral movements within the present (Clandinin & Connelly, 2004). This continuous nature of experience allows narrative inquirers to look not only to the present of experience, but also to its past by looking *backward* and to its future by thinking *forward* (Clandinin & Connelly, 2004).

The sociality dimension of narrative inquiry – the personal and the social - is based on the idea that people are always in personal and social interaction with both situations and experiences (Clandinin & Connelly, 2004). Personal conditions may include hopes, desires, and beliefs of both participants and researchers, while social conditions might include the environment and people who inform a person's context (Clandinin & Rosiek, 2007). People experience things either alone or with others, but as noted earlier, experience itself is always in

relation to others. Sociality is the looking "inward to thoughts, emotions, and moral responses and outward to events and actions" of the participants and researchers (Clandinin et al., 2018, p. 167). Therefore, attending to relationship within a narrative inquiry means considering how people's interactions with others shape their experiences. Within a narrative inquiry, the relationship between researcher and research participant becomes an especially important context for exploring experience. Clandinin and Connelly (2004) tell us that "inquirers are always in an inquiry relationship with participants' lives. We cannot subtract ourselves from relationship" (p. 480). The third dimension of experience is place (Clandinin & Connelly, 2004).
According to Clandinin and Rosiek (2007), every experience takes place in specific, concrete, physical, and topological boundaries of place although a narrative understanding of place goes beyond the physical or geographical concept of place to a landscape of experience. Thereby, situating a narrative inquirer within the landscape of where experience takes place enables the inquirer to move in four directions (i.e., backward, forward, outward, and inward) from that particular place (Clandinin & Connelly, 2004). Stories lived and told serve as conceptual places where experiences occur, and it is within these conceptual places that we meet and live out the context of our lives (Clandinin, & Connelly, 2004).

Attending to the commonplaces of experience (temporality, sociality, and place) is crucial in order to gain a holistic understanding of experience (Clandinin et al., 2018; Clandinin & Huber, 2010). Experience is "always more than we can know and represent in a single statement, paragraph, or book. Every representation therefore... involves selective emphasis of our experience" (Clandinin & Rosiek, 2007, p. 39). A story might serve as a brief snapshot of an experience, incomplete but framed by temporality, sociality, and place. Narrative inquirers view this incompleteness as a strength rather than as a limitation in narrative inquiry. If a story can

only tell a partial tale of experience, then storytelling becomes an act where situated knowledge and subjective experiences combine to create multifaceted understanding (Connelly & Clandinin, 2004; Pinnegar & Daynes, 2007).

This study also employed a discursive analysis in understanding and interpreting the narratives of participants as therapists working with young male survivors. As discussed in an earlier chapter, a Foucauldian notion of discourse holds that discourse is a socially and culturally constructed representation of reality (Foucault, 1980; 1991). Discourses are interactions expressed in language that enable people in social groups and societies to build up a shared understanding of the meaning of behaviour (Fairclough, 2013; Payne, 2000). Dominant social discourses can shape therapeutic work in terms of influences of both clients' stories of themselves and therapists' interpretations of those stories (Brown & Augusta-Scott, 2007). Taken for granted and dominant accounts of mental health, trauma and violence are often constituted from larger organizing resources that rely upon notions of truth, knowledge, power, gender, experience, the self, and identity (Brown, 2007). Stories and experience then become essentialized, which is problematic in that it does not consider the impact and influence of social and historical forces.

Discourse governs what is possible to talk about and what is not and the taken for granted rules of inclusion and exclusion, and as a result it produces and reproduces both power and knowledge simultaneously (Foucault 1980, 1991). Foucauldian discourse analysis seeks to examine power and knowledge through the meaning-making that has been constructed through discourse. It uncovers how and why some categories of thinking and lines of argument have come to be generally taken as truths while other ways of thinking or being are marginalized. It asks questions such as what is being taken as truth, how that knowledge of truth came to be, and

how meaning is constructed, including what evidence is used and what is left out (Brown & Augusta-Scott, 2007; Foucault 1980, 1991). In considering unhelpful stories and preferred alternatives, such as those that arise from social conversations and culturally available discourses, we need to consider the relationship between knowledge and power. Central to the deconstruction of stories is the notion that through discourse, knowledge and power are joined (Brown, 2007; Foucault, 1991). Using Foucauldian analysis means questioning how power happens and how it operates and functions. It also considers that strategies and techniques that sustain it (Brown, 2007). Through data analysis, I sought answers to questions from the research texts such as: how has this come to be? What is being represented here as a truth or as a norm? What alternative meanings are ignored or left out? What interests are being mobilized or served? What is allowed and what is disallowed? This work will take a Foucauldian discourse analysis approach by seeking to destabilize some of the myths and assumptions around male experiences with early childhood sexual trauma, and uncover the ways in which dominant discourses might exclude, discount, marginalize, underrepresent, or oppress the voices of young male survivors.

In this inquiry, the stories of trauma therapists add a unique perspective to the landscape of therapeutic work with young male survivors of sexual trauma by critically examining myths and assumptions. It also serves to locate socially available discourse for male survivors and considers counter-stories and different narratives in understanding the experiences of childhood sexual trauma for young men and boys.

Participants and Sampling

Ethics approval to begin this study was sought through the IWK/NSHA Ethics Approval Board, and granted in September 2017 for one year, and has since subsequently been renewed in 2018 and again 2019 for the remainder of the project, with a plan completion of Spring/Summer

2020. Recruitment began in early December 2017, in the hopes of recruiting eight to twelve participants who met criteria in having provided treatment to young men and boys impacted by early childhood sexual trauma. Because there is so little research specific to male early childhood sexual trauma experiences, I hoped to recruit at least ten to twelve participants so that I might develop insight from a number of different perspectives. In the end, the participant sample consisted of twelve mental health practitioners who currently or had previously worked in some capacity as a clinician treating male youth under the age of 19. Three other therapists were interested initially in participating but, due to scheduling issues, were unable to commit.

Participants were recruited through purposive and snowball sampling, first from within IWK Mental Health and Addictions and Nova Scotia Health Authority (NSHA) Mental Health and Addictions programs, and later by word of mouth through mental health practitioners working privately in the community. I initially contacted managers of mental health and addictions services through the IWK and Nova Scotia Health Authority via email and provided a brief description of my proposed research. (This recruitment e-mail is included in the appendices section of this study). I received a response from three managers from the IWK and two from NSHA who agreed to distribute my recruitment email through their teams. I also searched through the Nova Scotia College of Social Workers (NSCSW) registry and the Association of Psychologists Nova Scotia (APNS) database and sought out mental health clinicians who worked in the area of male childhood sexual trauma, and contacted approximately ten clinicians to gauge potential interest in participating in the project. During the first few interviews, participants gave suggestions of therapists working in the community for the study who might be interested in the project, so I reached out via e-mail with the recruitment e-mail to those names provided. By late December 2017 I had confirmed and scheduled my first six participants, derived from both the

purposive and snowball sampling described above, and interviews began in mid-January 2018. By early April 2018 I had interviewed six participants with plans to interview six more, but as noted three participants dropped out of the study due to prior work commitments and challenges with scheduling, and so I continued to seek out further participants through word of mouth following interviews until I was able to confirm and schedule a dozen participants in total. Interviews for all twelve participants were completed by early June 2018.

At the time of recruitment, I was serving as a part time social worker/access navigator with IWK Central Referral and a casual youth care worker with Children's Intensive Services, both programs within IWK Mental Health and Addictions Services. I purposefully avoided recruiting in either of those work areas as I did not want potential participants to be current colleagues who might potentially feel pressured or obligated to participate upon receipt of a recruitment email. As there was potential to have some familiarity with other colleagues within the IWK Health Centre or NSHA, I encouraged managers to forward the recruitment email or post a copy of it in their care area and allowed it to serve as an explanation of the study. This email also provided participants the option to connect with either myself or the study supervisor, Dr. Catrina Brown, if interested in obtaining further information. While managers did distribute recruitment emails throughout their teams, I did not seek their direct help in advocating for active recruitment, as I wanted participants to learn about the study from the e-mail or posting and decide of their own volition whether they wanted to participate versus any implication of potential coercion or duress through being directly encouraged by their supervisors to participate.

Information and Consent Process

Participants who expressed interest in being interviewed were then provided a detailed understanding of the purposes of the study, and I sought out written informed consent specific to being interviewed and audiotaped, and noted that this consent will extend to any future publication of the study should that present as a possible outcome. Signed consents were completed at the start of each interview. Participants also had the option, at any point during the process of their involvement in this study, of fielding questions or comments through my supervisor Dr. Catrina Brown rather than myself as principal investigator, and were informed of hat option at the start of recruitment and prior to each interview.

Data Collection

Between late December 2017 and early June 2018, I conducted twelve semi-structured qualitative interviews, using open-ended questions and queries followed by occasional guided prompts. Interviews were recorded on a personal voice recorder device, and electronic files stored on a personal computer used solely for this project, with both computer and files password protected. The interviews lasted anywhere from one hour and fifteen minutes to nearly three hours in length and were rich with robust, detailed stories and perspectives of participants' work with young male survivors. Participants discussed at length the ways they worked to both challenge and mitigate the harmful impacts of dominant constructs of masculinity in their work, how they seek to combat stigma, and how they tailor their approaches to meet the distinct needs of male survivors. Using a narrative inquiry approach allowed for a rich and detailed description of these experiences, and furthermore provided space for an exploration of the meanings that the research participants derived from their experiences, both as practitioners and from within their own lived experiences.

Data Analysis

In this particular study, the stories told are reconstructions of another's experience in terms of the therapist relaying client narratives, and therefore encompass interpretations of stories within stories, all of which impacts on how the stories are told, which stories are told and which are excluded, and how they are both presented and in turn interpreted. They do not represent life as lived but serve as representations of those lives as they were told to the participant as therapist, and later relayed to myself as researcher. According to Bruner (1986), knowledge gained this way serves to bring together layers of understandings about a person, their culture and how they may have created change through their struggles to make sense of the past and create meanings. It is therefore situated, transient, partial and provisional, and is characterized by multiple voices and different perspectives, truths and meanings (Bruner, 1986; Riessman, 2007).

Data analysis in this study was considered through multiple lenses - first through a descriptive analysis and exploration of the detailed narratives of participants experience, then through the use of thematic analysis which served to extend the detailed narratives of experience provided by participants toward understanding and exploring more universal constructs related to trauma experiences and masculine identities and then key texts re-examined through a Foucauldian discourse analysis. Foucauldian discourse analysis allows for a means to consider and think differently about predominant truth claims and challenging taken for granted knowledges. Chase (2005) encourages multiple modes of analysis and suggests that limiting a narrative study to a unilateral mode of inquiry may serve to inhibit the richness of data and preclude more universal theorizing or application.

The process of interpretation or analysis in narrative inquiry involves "many hours (of) reading and re-reading field texts in order to construct a chronicled or summarized account of what is contained within different sets of field texts" (Clandinin & Connelly, 2004). During the initial stages, the interviews were first transcribed verbatim from the audio recorder within 24 to 2 hours of each interview. It was important to complete the transcriptions myself as I believed that would allow me to immerse myself into a participant's narrative and provide me with a richer understanding and deeper insight. I also believed in setting a goal to transcribe as soon as possible following each interview might allow me to better recall the conversations from my memory and capture the intended meanings. However, as Clandinin and Connelly (2004) tell us, meaning in narrative inquiry can often become distorted and cannot ever be fully captured. Following transcription, I studied the raw narratives in their initial rough drafts, and from there I moved toward focusing on and analyzing individual experience. This served as a means to deconstruct the life stories of the participants while attending to the multiplicity of meanings within the interactions between researcher, storyteller (in this case, participants) and listener or audience.

Following transcription, I created a storied draft of each participant's individual narrative (these narratives are described in the following chapter) using a blend of both my voice as narrator and the narrative stories of the participants. From this perspective, I sought to explore and analyze each narrative "temporally, spatially and in terms of the personal and the social" (Clandinin & Connelly, 2004, p. 89) while attempting to understand and retain the participants' intended meanings within the context of their experiences. Clandinin and Connelly (2004) suggest three specific analytical tools – broadening, burrowing, and storying and restorying. Broadening refers to analyzing the transcript interview while reflecting on the literature review

and field notes to better understand participants' values and beliefs within the social, cultural, and historical milieu the research takes place. Burrowing is to focus on specific details of the data, with attention paid to participants' feelings, understandings or dilemmas and impacts of events and happenings. Storying or restorying comes after broadening and burrowing, where the researcher considers ways to rewrite the participants' story to move their experience to the forefront. From there, the narrative interviews were coded by laying each narrative side by side and exploring the data horizontally, looking across narratives to establish "patterns, narrative threads, tensions and themes" and as such, create interim texts of descriptive data (Clandinin & Connelly, 2004, p.132), while also forming a foundation for the next stage of thematic analysis.

Originally, I had planned only to compare and contrast these themes between this stage of analysis and the next and not use the descriptive accounts in the final report (in an earlier and in less cohesive draft I chose not to use them and focused instead on thematic analysis). However, in analyzing and re-analyzing the data, I realized that by not using the texts I was losing important aspects of the participants' rich voice of experience and perspectives. A large part of the insights gained around this phenomenon came from hearing participants own narratives – how they came to this work, what motivated them day to day, how they identified themselves and how their identity was shaped and constructed – and to not include it, in their own words, devalued their contribution to the finished work. The aim of the descriptive analysis was to build brief narratives of the experiences and lives of the trauma therapists and their descriptive retelling of their work with young male trauma survivors, and in so doing, the narratives sought to describe how participants constructed their personal and professional identities as shared in their storied experiences. These narratives are included in Chapter Five: Narrative Accounts.

Following the descriptive analysis, thematic analysis sought to discover and explore common themes. Braun and Clarke (2006) suggest that the analytic process should ideally evolve from description where the data is summarized according to patterns, with focus placed on the significance of the patterns and their broader meanings and implications. Thematic analysis was considered within the framework of narrative analysis by drawing on Braun and Clarke's (2006) techniques. I familiarized myself with the data through transcription and rereading several times and made comments regarding initial possible ideas related to my interpretations of themes. I generated initial codes across transcripts and field texts, looking for interesting data related to research questions and objectives and then connected it back to codes. Codes were collated as I searched for themes, and from there I gathered relevant codes and data under each emerging theme, with ongoing written commentary in journals to help understand content and context. I then reviewed themes for broader themes across the data, and then collapsed and combined themes or considered sub-themes as I defined and named final themes and considered the overall story the analysis told. From there, I considered vivid or compelling examples from across the research texts that would support themes I highlighted and focused upon and inserted those into the final written report. In this way, the thematic content was considered from a postmodern lens in order to "hear the operation of broader social discourses shaping that person's story of their experience" (Clandinin & Rosiek, 2007, p. 55). These findings will be presented in Chapter Six: Interpretive Findings.

A final step to the analysis was to apply a Foucauldian discourse analysis to the narrative accounts and examine elements of power and knowledge through the meaning-making constructed in and as discourse. Analyzing data through this lens uncovers how and why some categories of thinking and lines of argument have come to be generally taken as truths while

other ways of thinking or being are marginalized. In applying discourse analysis to this study, I ask questions of the data, such as what is being taken here as truth or norm, how has it come to be, how is meaning constructed, what evidence is used, and what is left out. This analysis will be discussed as part of Chapter Seven: Discussion and Analysis.

Rationale for Analysis

Thematic analysis allowed me to paraphrase and summarize a large amount of data in relation to the research questions, with a goal of capturing descriptions of participants' thoughts, feelings, behaviours and actions as succinctly and accurately as possible (Braun & Clarke, 2006). Through the process of recoding I was able to observe and uncover broader social discourses that influenced these stories of experience. The descriptive analysis and the use of broadening, burrowing and re-storying allowed entry into the three dimensional narrative space (Clandinin & Connelly, 2004). This allowed me to inhabit participants' stories and understand them contextually in terms of time, space, and in relation to the personal and social. Discourse analysis was always central to this work in considering the relationship between masculinity as a construct and toxic masculine culture as its most extreme form, and the experience of childhood sexual trauma. As an analytic tool, discourse analysis allowed me to examine key discourses through which masculinity, heteronormativity, homophobia, misogyny, and sexual trauma are understood. It also provided a means of understanding the relationship between these discourses by identifying tensions, points of resistance, contradictions, and silences (Willig, 2013). As I considered each of these methods individually, thematic analysis seemed almost too mechanical in its application, and the descriptive analysis, while attractive in its creativity, appeared to lack sufficient scientific rigour on its own. Discourse analysis, while a critical aspect, was highly specific to the meaning, knowledge and beliefs produced through language and social practices.

By combining methods, I gained entryway to these rich and robust stories of experience that in the end allowed for themes to emerge and avenues to explore that might otherwise have gone undiscovered. Ultimately, it also allowed for more universal theorizing and application of a phenomenon – male childhood sexual trauma in relation to the construction of masculinity - that is both poorly understood and sadly under-researched.

This section described the three-part approach to data analysis, including descriptive analysis (narrative accounts), thematic analysis, and discourse analysis. It also provided a justification for using multiple lenses in analyzing the data. This analyses will be incorporated throughout the next three chapters following this section: Chapter Five: Narrative Accounts; Chapter Six: Interpretive Findings; and Chapter Seven: Analysis and Discussion.

Touchstones of Narrative Inquiry as Validity and Rigour

Clandinin (2013) describes a touchstone as a "quality or example that is used to test… excellence or genuineness" (p. 169). There are twelve touchstones that a quality narrative inquiry must meet, and that researchers can use to judge the validity and rigour of the study (Clandinin, 2013). Touchstones of narrative inquiry include: recognizing and fulfilling relational responsibilities; being in the midst; having a commitment to understanding lives in motion; negotiating relationships; narrative beginnings; negotiating entry to the field; moving from field to field texts; moving from field texts to interim and final research texts; attending to temporality, sociality, and place; interacting with relational response communities; explaining justifications (personal, practical, and social); and attending to multiple audiences (Clandinin, 2013, p. 212). According to Clandinin (2013), narrative inquirers must attend to these touchstones if they are to engage in a narrative inquiry that is sound in its ethical and methodological components. In the following section I will address each of the touchstones in

the context of my inquiry and explain the methods of fieldwork that I used while conducting my research.

Recognizing and fulfilling relational responsibilities

Within the researcher/participant relationship it is important for narrative inquirers to negotiate expectations, time constraints, next steps, and outcomes (Clandinin & Rosiek, 2007). By attending to relational responsibilities, we also attend to the emotional needs of participants. In this study, I attended to the emotional needs of my participants by respecting their time constraints, assuring them confidentiality, reviewing mental health supports available to them following our discussions, making myself available for future debrief, and acknowledging and honouring their important contributions to this work.

Being in the Midst

When I began this research, I was living stories of my life as an MSW candidate, a mental health social worker, a trauma advocate, a partner, a friend, and a gay man, among many other things. My participants were also living their stories of being mental health therapists, managers, partners, teachers, parents, sports enthusiasts, writers, painters, and so on. When we met, we were each "in the midst of living and telling, reliving and retelling, the stories of the experiences that make up lives, both individual and social" (Clandinin & Connelly, 2004, p. 20). A researcher begins an inquiry in the midst, progresses in the midst, and concludes it in the same way.

Having a Commitment to Understanding Lives in Motion

Stories are always unfolding and partial and can never tell a complete story of experience. Within a narrative inquiry, Clandinin and Caine (2013) tell us that:

> There is no final telling, no final story, and no one singular story that we can tell. While this is troubling to researchers who rely on the truth or accuracy and verifiability of data, it is opening the possibility of narrative inquirers to continuously inquire into the social fabric of experience and not lose sight that people are always becoming (p. 176).

When we began our research relationship, and when we ended it, the research participants and I were each living complex and busy lives and attending to those complexities and the continuity of fluctuating experience guided this narrative inquiry.

Negotiating Relationships

Narrative understanding of what it means to live alongside each other refers to how we negotiated what our research relationship would look like, beginning with informed consent, to where and when we might conduct the interview, to what was comfortably shared (Connelly & Clandinin, 2000). While some aspects of negotiation were explicit, others emerged organically during our interactions, such as some participants opting to share aspects and insights into their personal lives.

Narrative Beginnings

Narrative beginnings are autobiographical accounts of the "personal, social, and political contexts that have shaped our understandings" (Clandinin, 2013, p. 55). They are reflective and help situate the researcher in relation to the topic, the participants, and the literature, and are revisited throughout the inquiry (Caine et al., 2013). Revisiting narrative beginnings is important, because as a researcher engages in narrative inquiry, perceptions and understandings shift. Clandinin (2013) explained, "Readers often understand an inquiry in more depth when they are able to see the researcher's personal justification in the research texts" (p. 36). By offering some context, narrative beginnings invite the reader to consider from where the inquirer was working

and allows the reader to make judgements about how an inquiry relates to their own understanding of the world. For this inquiry, I asked myself: who am I in this narrative inquiry - Who am I as a man who wants to study experiences with and around male trauma? Who am I as a mental health social worker? Who am I as an academic researcher? Who am I as a male childhood sexual trauma survivor? These questions helped me to write my narrative beginning to this research, which I have shared in Chapter One. It helped me to understand who I am in relation to those participants that I lived alongside and to those fellow survivors for whom I chose to dedicate this thesis work.

Negotiating Entry to the Field

Clandinin and Huber (2010) describe the research field as where research takes place. This may be in reference to a specific three dimensional or geographic space, but it does not have to be. In using a narrative understanding of experience, experiences take place within stories, and thus the field can mean a conceptual place where researcher and participant meet and engage in the narrative inquiry process (Clandinin & Huber, 2010).

Moving from Field to Field Texts

The term "field texts" is used by narrative inquirers to differentiate the various texts and modes of communication that come out of narrative inquiries from the research texts that are meant to be more objective and are called "data" in other methodologies (Caine et al., 2013). As Caine, Estefan, and Clandinin (2013) remind us, "narrative inquirers understand data as field texts that are to be experienced as they are lived and told as narrative compositions. Living is field text" (p. 579). For this narrative inquiry, I recorded the conversations that I had with my research participants on a small audio device, and by using it I hoped to more fully capture the thoughts and words they shared that reflected the nuances of our discussions and conversations.

This also allowed me to rely less on taking actual extensive notes during the interviews, and at times I was able to set notepad and pen aside and listen in more detail, which in turn led to participants seeming more engaged, relaxed and receptive in our conversations and interactions.

Beyond audio recordings, I used the following types of field texts: interview transcriptions, field notes, voice memos, emails, documents, and journal entries. Each of these are described by Clandinin and Connelly (2004) as important for interpreting field experiences. While I initially did not imagine that I would have accumulated such a depth and range of field texts, each became naturally imbedded into the process of my inquiry. For example, some participants provided documentation that explained the goals of their clinical areas, while others shared previous research articles they had written. Others conversed a number of times over e-mail to share further thoughts on our interviews or elaborate on some point or argument they wished to elaborate. I incorporated all these different modes of communication as field texts in an effort to more fully understand the different dimensions of the participants' experiences.

While the transcriptions served as word for word records of the conversations that my research participants and I had, my research journal allowed me to reflect broadly on what I was thinking and feeling during our meetings. The reflections in my research journal helped me to provide much needed context to the transcriptions when I read them later. As I incorporated all the many modes of communication - transcriptions, emails, shared articles, and voice notes -with my research journal reflections, I shifted towards developing interim texts, which ultimately became the final research text that is this thesis work.

Moving from Field Texts to Interim and Final Research Texts

Within a narrative inquiry, interim research texts are narrative accounts of experiences from the field (Connelly & Clandinin, 2004). Field texts detail the experience of living alongside

participants, while interim texts serve as a researcher's attempt to make sense of the field texts as they relate to the larger research puzzle (Connelly & Clandinin, 2004). Interim texts are often shared with participants and are used to further the researcher-participant relational way of knowing. Final research texts may be traditional academic reports such as dissertations, journal articles, and books (Clandinin, 2013), and in my case the final research text will serve as my master's thesis. For this research, I shared written field notes and reflective comments with my participants at the end of our interview, and welcomed their involvement in making sense of what I had written. Sometimes they simply provided a quick approval, and other times this led to re-engaging in deeper conversation following the interview. Participants were provided with contact information and were welcomed to follow up with me at any time should they wish to elaborate on any part of the interview or add further thoughts. It was important to honour the stories that were shared and the important work these therapists provide. Part of how I cared for their stories was by trying to represent them in a way that was genuine, meaningful and respectful.

Attending to Temporality, Sociality, and Place

As discussed earlier, temporality, sociality, and place comprise the three-dimensional narrative inquiry space and must be attended to at every stage within a narrative inquiry (Connelly & Clandinin, 2004). The interviews I had with my participants began with their stories, and looked forwards, backwards, and sideways to their experiences as trauma therapists. In the field, the conversations and interactions that I had with the participants occurred in places, in offices, private homes and coffee shops. I also paid careful attention to how place was attended to in the stories that the participants shared, because where an experience occurred was often important to the telling of a story. Looking backwards on experience was reflective for

participants, and in that process, they storied themselves with insight that comes from living through varied experiences. Storied experiences carried our conversations from thinking backwards, to thinking forwards. For instance, participants reflected on their training in early stages, where perhaps there was less focus on trauma work specifically, and what sort of mentor and teacher they try to be today. Looking forwards allowed participants to speculate on things that might change in our approach to trauma work with young male survivors, and in that contemplation, they carried past and present experience with them as a way of informing their discussion.

Looking sideways is another way of that narrative inquirers attend to experience (Clandinin, 2013). Looking sideways takes the focus off of the obvious and shifts it to something that otherwise might be beyond our attention. Within these interviews, some participants talked about their experiences as parents and partners, and through this sideways looking, I was able to see aspects of their identities as trauma therapists more clearly. For instance, one of the participants described how being the mother of two boys sparked her desire to work with young men and boys, while another described being a parent of teenage girls with a diverse group of friends opened him up to a better understanding of gender fluidity and expression.

Interacting with Relational Response Communities

Relational response communities are people and places where a narrative inquirer can turn to discuss their research and "often consist of people the researcher values and trusts to provide responsive, and responsible, dialogue about his or her unfolding inquiry" (Clandinin, 2013, p. 210). For this research, my response community primarily consisted of my research committee, but also came to informally be comprised of several others. My thesis supervisor Dr. Catrina Brown and thesis committee member Dr. Marion Brown and I met on several occasions

to debrief and discuss processes, theory, methodology, and content and their offered feedback proved invaluable to the final research text. We also regularly corresponded over email as a means of providing updates as work progressed. Their contributions also helped ensure I was navigating my research in a safe and ethical way. My social work candidacy supervisor Coleen Flynn provided lots of opportunity for debrief around processes and offered tremendous emotional support. My partner Shawn was a constant source of strength and encouragement throughout this entire journey, and I owe him a huge debt of gratitude for his unwavering support and thoughtful contributions. I was also fortunate to have a number of peers and friends who had genuine interest in research and provided much needed encouragement along the way. These relational response communities helped me to better understand the importance of relational ways of knowing, and in doing so strengthened my appreciation for narrative inquiry.

Explaining Justifications – Personal, Practical, Social

It is important to offer personal, practical, and social justifications for engaging in narrative inquiry as it fuels both our passion and dedication to the work (Caine et al., 2013). In personally justifying a narrative inquiry, researchers create autobiographical narrative beginnings and include parts of them at the beginning of final research texts (Caine et al., 2013). Practical justifications can emphasize why an inquiry is important and offer a deeper understanding of experience (Caine et al., 2013). Goals of this narrative inquiry were to give voice to the silent phenomenon of male childhood sexual trauma and provide a greater understanding of the lives of trauma therapists and the complex work that they do. Social justifications can be thought of in terms of how an inquiry can impact social policy, how it may contribute to social change, and how an inquiry can contribute to new discipline knowledge (Clandinin & Huber, 2010). It is my hope that sharing stories of trauma therapists and young male survivors can help facilitate new

perspectives, new ways of understanding, and contribute to the literature around the poorly understood phenomena of male childhood sexual trauma.

Attending to Multiple Audiences

Clandinin (2013) tells us that final research texts should be constructed with the intended audience in mind. Because what is shared is ultimately a small part of the research texts, it therefore becomes important that the researcher identify the process through which particular stories were chosen to be highlighted or presented (Clandinin & Huber, 2010). In this study, I attend primarily to the relational experiences of my twelve participants as trauma therapists, and chose to emphasize stories from their individual narratives that I believed helped to explore their identities and experiences, highlighted the phenomenon of male early childhood sexual trauma, and illustrated the unique needs of young male survivors.

Ethical Issues

Ethics approval was received through the IWK/NSHA Research Board in September of 2017, and, as it became necessary due to timelines, ethics approval was renewed in 2018 and again in 2019, until the completion of this study, projected for spring/summer 2020. The difficulties inherent in qualitative research can be alleviated by awareness and use of well-established ethical principles, specifically autonomy, beneficence, and justice. Under autonomy, the researcher is responsible for ensuring that all study participants are well-informed about the purpose of the research they are being asked to participate in as well as their right to withdraw from the study at any time without explanation or reprisal. As part of this study, I provided participants a detailed understanding of the purposes of the study and sought out written informed consent specific to being interviewed and audiotaped and noted that this consent will extend to any future publication of the study should that present as a possible outcome. In

maintaining beneficence, the idea of doing good for others while preventing harm, I ensured participants understood, to the best of my ability, any foreseeable risks to being a part of research as well as any benefits. One foreseeable risk was the emotional nature of some of these discussions, bringing up past difficult or painful thoughts or memories within challenging contexts. In preparation for such issues, I asked about strategies around self-care and maintaining health and well-being, and reflected on those during and at the end of each interview. I made myself available for debriefing immediately following the interview and for the duration of the study if warranted by participants.

Furthermore, in respecting the confidentiality of our subjects, I kept all recorded and written material stored in a locked cabinet in my place of residence. I will destroy all documentation, written and recorded, using IWK/NSHA research protocol standards, after the project is complete and thesis is submitted for final evaluation. I have kept the identities of the participants anonymous throughout our study and use pseudonyms of my choosing in transcribed interviews, research texts, and in the final written report. I demonstrated principles of justice by avoiding any exploitation and abuse of participants, using fair procedures and outcomes in the selection of participants, and noting in the final product their significant contributions to the study. I reminded participants of their right to withdraw from the study at any point in time, and to have any collected data removed up to the point of thesis submission, projected for spring of 2020.

I have used reflexivity throughout the thesis work and separately journaled my thoughts, feelings, and experiences. Reflexivity refers to the researcher's critical self-reflections and impressions of the story, and any personal meaning that it might have for them (Reissman, 2007). Because narrative inquiry is such a reflexive and reflective methodology, as researcher I

spent time self-reflecting before, during and after each participant interview (Clandinin & Connelly, 2004; Clandinin, 2013). Furthermore, I recorded my personal feelings and responses throughout the duration of the study by way of detailed journal entries as a means of documenting my beliefs, values, thoughts and feelings which could influence the interpretations of the field texts. As Riessman (2007) notes, reflexivity through journaling fosters critical self-reflection and awareness of how the research was done and any critical decisions made along the way.

Through reflexivity I have been able to observe, maintain and comment on the impact I have on the research and the impact it has on me as researcher. I have remained vigilant and aware of any unconscious biases, and attempted to employ ethical mindfulness as a means of being "consciously aware of the researchers' values and routinely asking moral questions of ourselves, our practice, and our professional relationships" (Danchev & Ross, 2014, p. 16). Furthermore, I have managed my own self-care and well-being, and have been fortunate to have close support system at hand throughout this process. By following the guidelines set forth through the IWK NSHA Research Board and the Dalhousie University Faculty of Graduate Studies, I believe that the research was conducted safely and ethically.

Conclusion

In this chapter, I have provided a detailed overview of the methodology and research design in this study. I reviewed research questions and objectives, and I described the theoretical framework of social constructionism and postmodernism and the influence of feminist and queer theory on this work. I described the narrative inquiry research design and methodology, and provided rationale for why it was chosen. I discussed the three-part analysis stage, from descriptive, to thematic to discourse. I outlined the methods used for recruitment, participant

sampling, and data collection. I introduced and addressed twelve touchstones by which the validity and rigour of this narrative inquiry can be measured. Finally, it also provides an overview of how confidentiality and anonymity was maintained as well as a framework for ethical considerations which I believe have been maintained throughout this work.

Chapter Four: Narrative Accounts

In Chapter Four, the participants' voices are heard, and stories of their experience and practice with male sexual trauma survivors are presented. While analyzing the research texts, I attended to Clandinin's (2013) belief that in narrative inquiry the participant's voice is the most influential. I engaged in this research by thinking narratively and by attending to Clandinin and Connelly's (2000) commonplaces of three-dimensional narrative inquiry space of temporality, sociality, and place while constructing these research texts, a process that included looking forward and backward with participants, reflecting with them on the social and personal meaning of their experiences in practice, and recognizing the different places and contexts in which their stories are situated. Stories of experience provide insight into the treatment of male sexual trauma survivors and the exploration of discourses in which knowledge that surrounds it occurs. In this study, insight and exploration occurs through the meaning making participants bring to their experiences and of their clients' experiences. It also comes from the combined meaning making that comes from my shared understanding and interpretation of these stories with participants, from the understanding and interpretation as I researcher I make through navigating the final research texts and finally, from the meaning making, understanding, and interpretation that falls to the reader.

The purpose of this chapter is to provide the reader with as much of the rich textual detail and depth of the individual participant's experiences as possible that emerged during the study. Through these texts, I began thinking with their stories and the stories that emerged over the course of each of our conversations, which were co-constructed within the dimensions of temporality, sociality, and space. My hope is this chapter serves to honour the voices of those participants who have chosen to share their experiences in this inquiry and offer an entry point

into the lives of participants as therapists, and a means of exploration to those who read these narratives. I chose to end each narrative with a quote from the participant that was either a significant focus of our conversation or a theme that resonated following the interview. The following stories serve as accounts of working together (Clandinin, 2013) with the participants to understand their individual experiences in the context of their therapeutic practice with male sexual trauma survivors.

Descriptive Overview of Participants

All twelve participants in this study were considered primarily clinical therapists in their individual workplaces. All participants currently either worked directly or indirectly in a clinical and therapeutic role with a wide range of youth and adults, although two participants admittedly had to rely mainly on past or previous experiences with young male survivors to guide their conversations.

Once participants responded to the recruitment e-mail and expressed interest in possibly participating in the project, I arranged for a brief phone chat to introduce myself as a researcher and fellow mental health practitioner interested in the field of trauma work, and from that point scheduled the study interview. This introduction provided a means to position myself as an "insider" with "inside knowledge" to mental health systems, structures, and approaches, which I believed may have helped put participants at ease with the interview process due to our shared understandings of complex mental health systems. Ten of the interviews were conducted at the participants' own office space, all within Halifax Regional Municipality, which I hoped might foster and nurture a comfortable and safe environment for participants to partake in these conversations. This also had the added bonus of allowing me to inhabit the physical space of these therapeutic settings as a client would experience it. Another interview was conducted in a

private space at a local coffee shop in Halifax, and the last at my private work office in Dartmouth, Nova Scotia.

Overall, eight of the participants identified as cis-gender males, and four as cis-gender females. Participants ranged in age from late 20s to early 60s. Ten of the participants were Caucasian or of European descent, one was African Nova Scotian and one was South East Asian. Four of the participants self-identified as members of the LGBTQ+ community. Four of the participants held clinical roles within the IWK Health Centre, three worked within the Nova Scotia Health Authority or NSHA, five were private practice clinicians, and one worked within a community agency. Two of the hospital-based participants had dual roles as managers/team leaders along with their clinical responsibilities, while four did some degree of private practice counselling aside from their hospital-based work. Six of the participants held Master of Social Work Degrees, five held Master of Education in Counselling, one held a Doctorate of Psychiatry and one held a Bachelor Degree in Social Work. The information is displayed on the following page, in Table 1, using pseudonyms to describe participants. Some demographic information, such as specific practice areas, was excluded in order to protect confidentiality.

Participant	Age Range	Sex	Role	Education
Bryce	Mid 30s	M	Clinical Therapist (Private Practice)	Master of Education (Counselling)
Daniel	Late 30s	M	Clinical Manager (Mental Health) & Clinical Therapist (Private Practice)	Master of Social Work
Joanna	Mid 50s	F	Clinical Therapist/Trainer (Private Practice)	Master of Education (Counselling)
Peter	Late 50s	M	Clinical Practice Leader (Mental Health)	Doctor of Psychiatry
Susan	Early 60s	F	Clinical Therapist (Health & Private Practice)	Master of Social Work
Kate	Mid 40s	F	Social Worker/Navigator (Health)	Master of Social Work
Nathan	Early 50s	M	Clinical Therapist (Private Practice)	Master of Education (Counselling)

Gillian	Early 50s	F	Clinical Therapist (Mental Health & Private Practice)	Master of Social Work
Adam	Early 30s	M	Clinical Therapist (Private Practice)	Master of Education (Counselling)
Ben	Late 30s	M	Clinical Therapist	Master of Education (Counselling)
Roger	Late 50s	M	Clinical Therapist	Master of Education (Counselling)
Shane	Mid 30s	M	Community Outreach Worker/Educator	Bachelor of Social Work

Bryce

I met Bryce at his self-described office space/music studio, a high ceilinged room with large sunny windows and an impressively large collection of musical instruments. I wondered if he incorporated music as part of his therapeutic work, and while he said he did not directly, he found for many clients being able to relate to a shared passion for music was often a "way in" – an introduction to therapy that helped put clients at ease, particularly men and boys he noted, and gave them "talking points to sort of ease into a conversation." In describing his career path that

led him to become a therapist today, Bryce described some early struggles in his life that, in the end, set him on a specific course: “Without sounding a bit like a cliché, I was living in a recovery house in Vancouver in my late teens speaking about my experiences, and a counsellor said ‘you should be a therapist someday’”. And so with some support and guidance from that counselor, he followed the advice, and while in the early stages of recovery, he went on to complete a Bachelor Degree in Psychology, then later a Masters in Counselling, and today is working on a Ph.D. in sociology and anthropology.

Bryce is only a few years into his career as a private practitioner, but has already developed a bit of a specialization in what he calls identity and trauma work, primarily with LGBTQI2S+ populations, which developed out of an internship in Toronto. He described his approach to his work as eclectic, drawing on narrative and feminist principles and anti-oppressive practice, and centred on shame and innocence: “for me, it’s about trying to understand the pervasiveness of shame in people's lives and how they've internalized that through their marginalization or their trauma or whatever”.

When working with male trauma survivors, Bryce often starts with some open discussion about dominant cultural norms related to masculinity. He describes these norms as constantly shifting and changing, but ultimately still problematic for many, most notably he believed in restrictive emotional expression. Bryce spoke of male survivors who struggle to process trauma in their therapy sessions in very specific ways:

> They are skilled at talking around it, but never about it. They have all these defense mechanisms: humor and laughing and all these things that kept it [the trauma] and their feelings always at a distance.

Bryce spoke of survivors struggling to come to terms with sexual identity issues and wondering if experiences of sexual abuse have somehow "made them gay". Many survivors also struggled with the belief that sexual violence only happens to women and girls. Therefore, because they "perceive the abuse as outside of the male experience, they are now left outside of it, feeling like maybe they're no longer masculine".

When asked to define masculinity in his own terms, Bryce said his "hopeful answer" was that he believed the concept of masculinity was changing in the Western world, and in particular in what he described as "progressive urban spaces". He saw that evolution in terms of "greater flexibility – flexibility around roles, gender expression, and range of emotional expression." However, Bryce described a very personal way that masculinity plays out in his life. Since moving to Halifax a few years ago, he's described making numerous female friends but struggles in making new male friendships. He believes part of that reason is that one of the ways he would frequently relate to other men – through sharing alcohol – is denied to him now:

> I think – I think somehow it's the difference between 'do you want to go for coffee?' and 'do you want to go for a beer?' That's where masculinity is…I don't know where that is exactly, but this one's masculine and that was not…that's all I know. And it really reveals itself in that moment where – because of my history, and being in recovery – where I just don't have the capacity to ask a dude if he wants to go for a beer. So whatever that reveals about whatever stereotypes roles men are supposed to play - if that's activity and sports and beer and watching and doing things, and not talking about things and feeling things and having meaningful conversations on that level – then that's what masculinity means to me.

Bryce described how often male survivors are marginalized by wider society. When considering societal expectations around masculinity, he drew connections to capitalist society and notions of productivity, and how struggles with traumatic histories might impact:

> If you're a guy on the margins in any way in society, then chances are you're there, in some ways, because you weren't producing in the same way that everyone else seems to be able to do with ease…So when I [as a survivor] end up on the margins, whether from the trauma itself or from my identity or orientation or race or, you know, the struggles ‘]that I have had…when I'm pushed to the margins, I misrecognize that as something fundamental or essential to what I am. All l I know how to do is to describe why I don't contribute to society in the ways that society is demanding of me.

Bryce believes the shame and blame that survivors express is related directly to three areas – worry related to sexual orientation, false beliefs that only women and girls are assaulted, and fear over being perceived as not masculine. Much of his work, as a result, is around unpacking and addressing these "untruths'. Bryce says he likes to spend time exploring the impracticality of self-blame, because he believes the shame and self-blame that male survivors experience contributes to reasons for non-disclosure, but furthermore to the invisibility of the phenomenon, as it "forces people to not talk about it and in that way removes the conversation from public discourse."

Also crucial to trauma work for Bryce is breaking down the stereotypes by exploring masculinity norms and considering how male socialization potentially interferes in the healing process. For some survivors, he says:

> Masculinity itself is therefore part of the marginalization they are experiencing - in the sense of how they are subscribing to these traditional norms. And for those survivors, I

> want to be sure to highlight this as a social problem. 'We're all in it, struggling with these competing messages. It's not just you. You're not alone'.

Peter

Peter and I met at his office in a busy high-rise downtown at the end of an even busier workday. Peter is originally from the UK, and has been a psychiatrist for more than 20 years, and prior to that worked for many years as a family doctor/general practitioner. Peter attributes his overall holistic approach today to those early years practicing medicine. He has always believed strongly in helping his patients build connections, noting that "people get their sense of worth from things that they find rewarding and in- in having some sense of belonging". The challenge, he says, is that people with mental health problems, "by virtue of either anxiety or depression or psychosis often don't easily kind of approach joining in or feel safe".

Trauma survivors he has worked with often suffer from substance abuse issues and have problems with anger and emotional regulation, and help seeking is almost always externally driven: "it's interfering with relationships with family, friends, work colleagues. Life is pretty bad, things are at their lowest, and people are pointing towards…you need to kind of seek some help or else".

Peter believed that men are generally not very well attuned to help seeking, and he says he observed that often during his time as a general practitioner. He says it was relatively rare to see a man enter his office unless it was a matter of some urgency:

> It's women and children and elderly people. That you don't see a man between 20 and – like, maybe 60 years of age unless it's something severe or something significant has happened, like an accident…that to me really speaks to challenges in help seeking for men.

By nature of his role today as a psychiatrist, his patients are often those that are facing significant struggle. He works with a large cross section of people from different walks of life, all presenting with unique and individual needs. He says some are seeking to reflect and process their trauma or their struggles with addictions, while others are less comfortable exploring their past and are seeking more practical skills to use today, or are seeking assistance with medication efficacy. As a result, he says, he is constantly adapting his methods to meet their needs and their unique styles of interacting.

He sees experiences of being sexually abused or sexually traumatized for some young men as “a kind of interruption in their own natural or expected development of their sexual interest – something they have been cheated out of”. Despite working with a fairly significant number of male survivors over his career, Peter has never had a patient disclose being victim to a female perpetrator. In all cases, survivors were abused by other males, and in most, males that were significantly older and often in a position of power or authority or trust.

Peter believed providing psychoeducation around physiological responses helps shift some of the critical self-thinking and helps “normalize in a sense or at least reduce the intensity of feelings around it [the body’s response]”. He described using a combination of cognitive behavioural therapy and acceptance and commitment therapy with a focus on strengths and resiliencies, while still paying attention to the areas that they feel are damaged or uncertain:

> Different people seem to be able to kind of heal differently, or I guess- I guess maybe resiliencies are different. Other people, for a number of factors are often very unforgiving of themselves, and hold on to self-doubt and self-criticism. They have no self-confidence, they are left angry and they feel like they are damaged and nothing will fix them. And all of that – to me, it just serves to undermine people's full on level of participation in life.

Reflecting on how he perceives masculinity in the world today, Peter likened it to his own struggles, starting back in early childhood and raised in what he described as a "judgemental society". He recalled growing up in a strict, authoritarian family with a father who was a police officer who represented, in a way, 'this idealized form of dominant masculinity – strong, powerful, silent." He also went to school in Europe during at a time when sexes were segregated, and it was a generation, he said, where stereotyped roles of masculinity and femininity were expected:

> It's 'what does a man do, what does a woman do?' It's when you are at work… at home… when you're out. It is about - what do you wear? As a man, how do you stand? What do you sound like? And how do you talk? With people, you know what's interesting is that it – that it is all so ingrained.

Intellectually he had always rejected those stereotypes, but at the same time battled with how ingrained these ideas were and how it shaped his own sense of self through the years. He described having two grown children today, and how their experiences in school were light years removed from his in terms of how diversity and cultural differences are more accepted. "Everything is OK, ever shade and color of person, every place on the sexual continuum, any identity, any interest, any preference – to them, none of it is ever a big deal."

Peter said he is always mindful of new and innovative ways to practice therapy. He saw the benefits, for example, in terms of engaging certain men in outdoor therapy techniques and experiential approaches as trauma treatment, but he thought it was most essential when working with men and boys that a focus be placed on talk therapy:

> I really think you do have to learn how to translate experiences into words ultimately, I really do see that as necessary to healing. So I do think that piece is required, even though it doesn't come easily to most men.

Joanna

Joanna works as a clinical therapist and clinical supervisor in a service area that primarily works with men who use violence. Joanna is in her early fifties and became a therapist ten years ago after graduating from Acadia with a Master of Education in counseling degree. We meet an early weekday morning in her office, and spend the first part of the interview talking about her "previous life" as an artist and teacher, and her strong interests in art history and art therapy:

> I discovered early on a lot of research that connects domestic violence and sexual violence to art therapy because those are difficult things to talk about, so drawing about them and creating art was a way to express it- and I just loved the whole notion of that, of beauty and art coming out of it and bridging communication.

She says she brings her passion around art into her work nowadays by always being "flexible and creative and innovative, so that together with the client we can figure out what works and always be open to try new things".

Joanna is a strong advocate for narrative therapy approaches in her work. She said she believes narrative therapy offers an open approach that knows no cultural boundaries: "Narrative allows survivors to understand through their stories that if we can be telling ourselves a different story or seeing things in a different way, then that can really help change people's lives."

She says most men she works with have some form of trauma history, and that the processing of sexual trauma with male survivors often unfolds in a particular way:

> What happens here is they start to put together the idea that they been sexually assaulted and usually even abused before that. That's what tends to make young men vulnerable – so many are in an abusive family situation and they have low self-esteem and are, you know, not connecting with kids at school. And so, they are a little out on the edges and someone picks up on that and takes advantage, and then they are sexually assaulted and all this adds up to having a lot of difficulty in relationships in a variety of ways. And then they either start to make sense of what's happened to them and...stop blaming themselves around what happened or [they are] just being left completely confused by the whole mess.

Common emotions that men will express around the event include guilt, shame, and confusion. She said men will internalize societal messages around stoicism and masculinity and will not speak up about their past trauma and “hide it away inside, but there comes a time when it flashes back before them and they get triggered back to the times they thought they had long buried”. Joanna described adolescence as a confusing time for anyone, and notes how those challenges are compounded that much further by experiences of abuse: “any bodily response leads to a lot of confusion, and they have no one to – we are in a culture where you're not supposed to tell anyone, and so you have to process this all on your own.”

Joanna talked about how expectations around masculinity can intersect with many other aspects of a man’s identity and have a detrimental effect. Although she was clear to state she was not speaking specifically to experiences of sexual trauma, Joanna was able to connect a propensity for violent behaviour to past trauma history:

> Many of the men that I know are able to stand up to some of those things they face, but poverty and disadvantage has left men - it must be difficult for many to think that you are

– for example – if you are this privileged entitled white man and yet you have no job and have no power and, you know, no agency in the world? And it's a precarious position to be in. So perhaps you get the idea that you will be powerful at home and overpower the people there. And so, you know, when you use your anger and rage against not having all the privilege that was supposed to be at your feet…well, you end up pretty pissed off.

Because many clients can struggle in that precarious position, Joanna works to draw connections to masculinity and patriarchal society in exploring some of the harmful messages men contend with in culture related to expectations around privilege, particularly when faced with harsh realities and limited resources.

Joanna says she is always interested in hearing people's stories and looking for hidden strengths or resiliencies:

> I'm always listening carefully for people's skills and knowledge and ways that they've been managing to help develop a bigger story about that. I'm always listening for the effects of assault in their lives so that we can re- author those stories in a way that might be more helpful to them.

Joanna said that for survivors their resiliencies are not always clear from their current perspective, but when they are able to really reflect on what happened and change their perspective from an adult to a vulnerable child at that time, they can see for themselves how skilled and resourceful they may have been:

> people often tell me that there was someone- if not at home, there was someone at school, a sports coach or a teacher or a neighbor or a community person who they respected and looked up to and who saw them as this interesting or good person that, you know, that they aren't able to see. So I work to help them understand how resourceful it was for them

to even have found that person, to attach to that person and to help them see themselves through that person's eyes – 'oh look, it was - they saw in you that, they, you know, reached out to help you or they let you know you were safe. That was a safe place for you to go.' To see themselves through those eyes is incredibly empowering.

Daniel

I met Daniel when he was days away from changing jobs and entering a new role, moving from team lead and clinical social worker in a community mental health clinic to that of manager in another division of mental health and addictions. Daniel identifies as a gay male, one of the few out therapists in his clinical area, and he is married to a fellow mental health therapist. He engages in a lot of advocacy work in the LGBTQI2S+ community, with a particular focus on connecting the queer community to mental health supports, a connection that he sees as significantly lacking. Daniel critiqued how so many of societal systems are highly heteronormative and cis gendered, and therefore not always perceived as welcoming by the queer community. For those reasons, he says it is important to him to ensure that "the community feels welcomed and accepted and are able to recognize aspects of services they are seeking that resonate with them- that they see in themselves -and part of that is working as an out, identifiable queer therapist".

Working primarily in addictions, Daniel sees a strong relationship between harmful substance use and traumatic histories. He is a strong proponent of trauma informed approaches, which to him means "creating safe, open spaces where people felt comfortable in processing and unpacking past traumatic experiences". He believes that as a society we are now having more open dialogue and discussion around trauma and its impacts, and he believes "in general our systems are moving in the right direction towards trauma informed treatment approaches."

Daniel described approaching therapeutic work in addictions as sorting through many different layers of complex problems and issues. While people generally present with some form of harmful substance use problem or gambling addiction, he said as the therapeutic relationship builds, they get to explore "all the things attached to that – the risky behaviours, the aggression, the complicated family or personal relationships" before eventually exploring how that all relates to trauma.

While he believes that many of the clients who come through addictions services have some form of trauma history, he feels most if not all LGBTQI2S+ clients he sees struggle with trauma in one form or another, often due to experiences with marginalization. He notices in particular a disturbing trend in working with trans males who struggle with significant substance misuse that often serves as a coping mechanism due to past trauma. He also believes LGBTQI2S+ men and boys are more vulnerable and susceptible to perpetrators and abuse, and that victimization can affect them in significant ways:

> If we look at trauma as a continuum [from one to ten], and ten as the most severe or most impactful, I would say most of the gay, bi or trans males I've worked with would put themselves in that upper limit, just based on all those things they've been through.

Daniel has worked with youth in other roles, including the Youth Project, a local organization devoted to the needs of LGBTQI2S+ youth, and he works at times with teens in a small private practice he runs. His addictions work has primarily been with those 19 and older, and what is constantly surprising to him is the number of men, ranging from their twenties to their sixties, who disclose childhood sexual trauma for the first time during their addictions counseling. "My hope was that statistic was changing - that people were coming forward earlier - but that doesn't really seem to be the case".

Daniel says that something he feels is very unfortunate yet common with male survivors who concurrently struggle with substance issues is that they often seem very disconnected from their experiences of abuse:

> They disclose this horrific experience and…it [mentioning the trauma history] was kind of just a…it was a passing comment. And what I mean by that is that they have been through so much in their lives, that was just another thing on the list and they weren't emotionally affected. It was down so far that they just glossed it over and it was just a normal part of conversation and I- they just weren't even in tune with this terrible thing that happened.

Daniel says while clients are open to hearing his recommendations, it is important again to always be respectful of their goals:

> It is intertwined - hugely intertwined - it's a hard - it's a hard sell when someone is just trying to keep their shit together. So that's why sometimes it's just a matter of getting the foundation of addictions work down. Maybe learning coping behaviour but then perhaps there's another door [in terms of accessing therapy] at another time that's better for them to take care of the other piece, the trauma work. So, you're always dancing around it, and it's always in the room.

Daniel says that when most men he has worked with initially start to disclose, they have a limited emotional vocabulary to work with, so part of his work is to help expose them to more expressive language and explore more complex emotional states, "because they're happy, they're sad, they're angry – they can only identify these base emotions". While he works with women who struggle with accessing and identifying emotions in similar ways, he sees this much more commonly in men, and therefore the need for more slow and intentional guidance in developing

that vocabulary. He has also observed some unique differences in general between heterosexual and queer clients. He believes that gay male clients are generally “more in tune with their emotions and how they connect to experience, even if they can’t always identify them right away”, and he relates this to their rejection of masculine norms:

> Straight men, by and large, they are still raised in this culture where men don’t cry, men don’t show emotion…gay men tend to access those feelings a bit more easily, but with straight men, I can – I can really see the struggle and the toll that it takes at times.

Susan

Susan was arguably the participant with the most direct experience working with young boys and adolescents’ males who have experienced sexual trauma. She has worked for over thirty years as a trauma therapist and social worker and developed great expertise in working with young males who have experienced physical, sexual, and emotional trauma. We met in a small therapy room at the clinic she works, a room with soft lighting and shelves stuffed with books, puzzles, and toys and games that might appeal to all ages.

Susan said she was initially inspired to work with young men and boys through the experience of being a mother herself to two young sons. Being a mother is one of the greatest joys of her life, and as mother to two boys she says she felt a sense of responsibility to raise them a particular way on their journey to becoming men: “It was important that they learn to be compassionate and in touch with their feelings and willing to express those feelings, and teaching them that it is okay to cry”. And so they were, she said, until one day they started school, and all of that began to change. Her boys were always bright and curious and expressive, but as she watched them interact more and more with their school peers they became more closed off, withdrawn, and at times sullen. This caused her to think more about the gendered

nature of the school environment and the messages that her boys received from the adults that cared for them and the other children that surrounded them about what was appropriate for boys and what was meant for girls: “And so…this experience with my boys…it really afforded me a window into how culture and socialization teaches males to withdraw or get angry, and so watching that - that was simply just fascinating to me.”

Another strong influence was her work in justice and corrections, where she met many men with histories of early childhood trauma, something that was usually unrecognized and as a result more often than not left untreated. The appeal of her current role as a trauma therapist was to work to “interrupt these trajectories and bring healing and recovery to these young men before their life course seemed kind of set’.

Susan described her philosophy and foundational approach as grounded in the work of Carl Rogers, focused on person in environment with the belief that a person can self-actualize to heal and recover and reach their full potential. She believes in a therapeutic relationship between client and therapist that is based on trust, curiosity and compassion, and one that deviates from the therapist as all-knowing to the client as expert in their own lives. She said a good trauma therapist would “focus their energy on what happened to you, and not pathologize you by seeking what is wrong.”

Susan notes few boys and young males make connections between experiences of early abuse and how it may impact their lives at present. She sees the impacts of their current struggles with behaviour and emotional regulation as devastating at times as they often leave survivors “disconnected and isolated away from everyone”. She says because of this, psychoeducation around trauma is so important and an integral early step to treatment as it demonstrates to a

survivor that sexual trauma happens, that it can impact their lives in many ways, that they are not alone in their experience, and that they have the opportunity to heal.

Susan says she is conscious from the start about the environment she works in and how these young men might first perceive the therapeutic setting “because oftentimes two people in a room where confidentiality is maintained doors are closed- that itself can replicate the abuse experience”. One way she alleviates that stress is to offer as much choice as possible to the client. She talked about how even the smallest choice can be empowering to a young survivor, from choosing where to sit to deciding how bright they prefer the lighting in the room. This also helps in terms of building relationships and trust and just helping someone relax into the process.

Susan says she feels it is important to link male survivors with other survivors in terms of having that shared experience and coming through the other side of it. She also sees that help build connections that perhaps are lost, and teaches ways to relate to others. She believes it is very empowering helping survivors to find their voice as the voice is often silenced by stigma and shame. She says that she seeks to:

> identify that it's not about just surviving but really getting to a place in that person's life where…you're thriving, not just surviving…that you feel whole and complete and, you know, while this is always a part of you, it doesn't need to define.

Susan says the most important thing with therapy is to go with the person's pace and to consider whether the trauma was a one-time experience or of a long duration:

> If it was multiple events, then that impacts the healing work. So, some, you know, may come and do a piece of work and go away and they may be fine for a couple of years and then something will bubble up and may need to go back and do a little bit more.

When asked about the future of this work with male survivors, Susan says these are her best hopes for the therapeutic relationship is helping people get in touch with their gifts, their talents, their strengths, and ultimately their ability to heal. She sees this as crucial in combatting stigma and overcoming it:

> It's about always kind of reminding people to be kind and courageous and kind of overcome the stigma. Because the stigma really mimics the abuse, because stigma wants to maintain the secrecy, silence the voice, heighten the fear. [Stigma tells the survivor] 'You can't recover. You can't - all this will be too hard'.

Kate

Kate was born and raised in the United States and completed her social work education there before moving to Canada. She has practiced for more than twenty years and has worked in various roles, including in child protection, as policy advocate and developer, and as a mental health clinician. She says she is passionate about anti-poverty work due to experiences working in child protection services and at an inpatient mental health unit and noticing a strong correlation between poverty and mental health struggles. Kate notes that belonging to a low socio-economic background often leaves one vulnerable to a host of other challenges in terms of their physical and mental health, and by addressing poverty on the macro level some of these issues become "fixable". Kate says she feels a similar way about the trauma work she does today: "it appeals to me for the same reason - if you heal trauma, it improves a whole other host of areas of people's lives- with their mental health and in their social relationships".

Kate says her central role currently is to provide immediate crisis support to families and children during times where a child has experienced physical or sexual assault. The clinic she works in serves as a bit of a nexus point for the various agencies and systems that are involved in

the investigative process following an allegation of abuse, including police, child protection, pediatrics, mental health, and the justice system:

> Before we had a place like this, what they found was that it could be very traumatic for kids and families to go through that investigative process...to go from place to place, person to person, to not know what's happening, feeling afraid to ask questions.

Kate says the families she sees often struggle with so much guilt and shame "it's the worst nightmare. They failed and in terms of their primary job as a parent. That's how they see it - I failed my child". Part of her work is designed to address some of those things parents might struggle with, and involves providing psychoeducation workshops and education related to trauma. She said the inspiration to provide free workshops to families came from families asking the same questions over and over – such as "tell me the signs and symptoms to look for after the trauma". She says that "I think our natural instinct is to be like, here's the name of the therapist, bring them to therapy and it's not really the question that they asked" and so the workshops became an attempt to answer those basic questions.

Kate subscribes to a neurosequential model of trauma and believes that "trauma is a natural side effect of a healthy brain trying to take care of itself". At the same time, she also recognizes the role of social and cultural forces and how they impact on survivors, and how they might contribute to resiliency. She feels that trauma often goes unrecognized and untreated, and sees the medical model, problem-solving approach we often take as problematic:

> Trauma doesn't fall neatly into that category. It's not something wrong that's happening in your brain, it's something right, and so I work to promote the idea that a trauma response is a natural consequence of a healthy brain. It's our body and our brain's way of protecting us from serious harm.

Kate acknowledges that most of her experience treating survivors have been with women in a role as clinical therapist, which has provided her good insight into how gender constructs can impact and impede women's healing. She says she tries to approach working with male trauma survivors with a similar gendered lens:

> My approach to males is to ask the question – do you feel your gender has impact on the way you are experiencing this thing – and to ask in a way that they don't feel like there's judgment…It's an approach as a way to be real about some of the things that people have to deal with in when faced with these traumatic experiences.

Kate believes the vast majority of sexual trauma survivors, both male and female, do not seek help. In her experience as a crisis intervener directly following a traumatic experience, few male victims of sexual assault go on to seek therapeutic interventions. She says they often only seek help if they "absolutely cannot avoid it – like, if it's now an ultimatum to live in one's home, continue to attend school or work, or stay in relationships."

Kate says it is imperative we change the public narrative around childhood sexual trauma. She sees the ways boys are socialized comes with some inherent danger in the sense boys are encouraged or allowed generally to have more independence, which can translate to this notion of never having to rely on anyone else:

> I think that messaging is so - that's dangerous. Because there's an underlying message there, that no matter what, you [as a male] can handle this thing that happened, this terrible thing….that you that you alone need to manage this.

Nathan

I met Nathan late on a Monday evening at his private practice in the downtown core. Mondays are the exception to the rule in Nathan's practice, as it is the only day he offers

traditional office hours. He rents a small room out of a doctor's clinic, but generally he takes advantage of an open lounge area that is available after hours to meet with clients. Initial sessions take place there and center on goal setting, but from that point "how and where we want to work together is up to them". A typical week might involve hiking through Point Pleasant Park, meeting at a diner over bacon and eggs some early morning, or a game of racquetball at a gym. He described a family session he had coming up that Friday at a walking trail off a nearby beach, chosen by the family deliberately "so that we're in a different space and not feeling so literally and figuratively confined."

Nathan started our chat by reflecting on his past as a bit of a self-described adventurer and thrill seeker when he was younger. He left his hometown in Ontario at an early age and lived and worked in various countries all around the world before settling in Nova Scotia. He spent most of his career as a teacher in the public school system before moving to a hospital based mental health care environment, but he soon found the hospital work quite limiting and restricting. During that period, he also returned to school to work towards a Masters of Education in Counselling degree, where an internship in a violence intervention program for men proved quite inspirational. It allowed him to develop what he called a dream project – an outdoor therapy group for men who were mandated into mental health treatment by the justice system. "It gave me a platform to work with these guys who society sometimes had almost written off as unreachable….it was a ways and a means for them to access the treatment they needed". Returning to his old job was difficult, and following the freedom and creativity he experienced in his placement, it proved much too constraining, and eventually he sought a leave of absence for his own mental health and wellbeing:

> There were a number of things that were going on at the hospital that I found very stressful [in terms of expectations and limitations on therapeutic work] and knowing at the same time - this is around the time that my Masters did finish -I really needed to find a way out, because I knew it wasn't the place for me.

Fortunately, he found an "escape" when he was awarded grant funding that enabled him to embark on a two year journey promoting adventure and outdoor therapy at low or no cost, focussed on men and boys who use violence or who have traumatic histories. After great success with this venture, he was able to establish and build a private practice that he now runs full time, with a continuing focus on working with men and boys.

Nathan says he is thankful for his master's program, his internship and his supervisor as they all allowed him to be "a little looser in terms of how I approach this…this framework with my clients and really encouraging this idea of being comfortable, not having a specific label in terms of the way I work". Nathan describes his approach as "part narrative, motivational interviewing, person centered, existential while calling on arts-based, experiential kind of modalities." He critiqued formulaic approaches to therapy because they veered from being client centred: "being formulaic brings along a sense of professional arrogance that [the therapist] automatically know what they [the client] need, and of course that's not the case".

Nathan says he is mindful of not moving too quickly into history taking, because that can be re-traumatizing. He says for that reason he is very intentional about discussing consent and what it means during the therapeutic process. Nathan wants clients to be comfortable sharing what they can and using self-advocacy to slow down or stop when necessary. He said part of his initial work is an assessment piece around how much or how well they might have processed their past trauma:

> Some people, you know, have already come in having worked on stuff and – well, just because I find out that someone has been abused in the past, for example, doesn't mean I need to hone in on that like a cruise missile right? Because they might feel like they're not ready to deal with it or – or they've already dealt with it in some way, shape or form. And that's where the invitation for them to be open and honest with me comes in through in where they're at with that.

Nathan says that if one of the key premises of mental health work is to support a client's sense of self confidence or esteem, then there has to be more openness to allow people the space to be who they are and to enter therapy on their own terms:

> I like that idea is that it's not just about the readiness and in the ability [of the client] to share but the willingness to go there and that we [as therapist] need to be okay with that and whatever they decide, regardless if we think we know what might be best for them. And I think – I think that empowers the individual to possess a greater sense of self efficacy and self-advocacy. Now those are skills I can get behind, and I feel like they almost trump the idea of the stigma card. Stigma is harmful, and the more we as a society talk about things the less stigmatized they become, it's true. So yes, stigma needs to be addressed as a societal construct in the realm of mental well-being, but not at the cost of pushing people past their edges.

Gillian

Gillian described herself as a married mom of two grown children who works to balance her work and home life by challenging herself to take up new hobbies, such as learning to surf for the first time at age fifty. We met on an early Tuesday morning at her office situated in an intensive mental health treatment program for adolescents. A proud graduate of the Maritime

School of Social Work, she has spent most of her career in mental health, starting closer to home in Ottawa where she grew up before making the journey to Nova Scotia. In Ottawa, she began her career at a rape crisis centre, working primarily with women, and learned many therapeutic skills that she carries with her today:

> It was so important in that work to be attuned to not replicating anything that starts to feel overwhelming or overpowering in that therapeutic dynamic. And so I learned from that to constantly do a lot of kind of checking in around – 'Is it okay if we talk about this, you know, can we talk a little further? I need you to correct me if I'm not getting something right.' And then also helping the client see that well for one, it was an issue of power and its sexual expression might have been the weapon but it wasn't- it's different- It was different than sex. It was about power.

Gillian described now working predominantly with adolescents who are struggling with issues related to mood and anxiety, typically teens 13 to 19 years old whose life is "a little more off track than where they would like it to be and figuring out together how things like mood and anxiety might contribute to that." She works from an anti-oppressive, strengths based social justice perspective and uses emotionally focused therapy and dialectical behaviour therapy often in her day to day work.

She said what really guides her work is operating from "a place of success instead of a deficit model or…illness model or disability model...while maintaining an awareness of sometimes where folks are at is through no fault of their own but due to larger societal forces at play." She says it is important to always keep an awareness of the "axis of oppression and where and how they may intersect in someone's life and bring that into some of their understanding of self and what their journey has been".

Gillian said many male adolescent trauma survivors have not sought help previously because adolescents at this age often go hand in hand with avoidance:

> Because it's tough work right and there's not - they are still developing a sense of self and an understanding of who they are. So, most often when I hear about the past work [they might say] 'it was all right but I didn't really get much out of that.' And so the work comes sometimes in slow pieces that I hope layer…layer on, and then start to form a bit more solid piece that someone can sink into. Yeah, so there's lots and lots of ambivalence, and to that I try to give empathy.

Many young males Gillian works have witnessed familial violence and sexual assault within their own homes, which in turn has had a profound impact on them:

> Often the struggle is that where they get stuck is feeling like they somehow weren't good enough to protect someone, or to step in. They weren't strong enough. Or they should have done something at, you know, whatever tender age or so it was…and I do think males experience and carry that differently due to how their socialized than females who have witnessed domestic violence, that might see mom being hurt or hit.

Youth typically spend up to four months in Gillian's program, which really only allows time to develop some skills around distress tolerance so they might manage trauma work in the future:

> mostly foundational stuff to hopefully get someone to a place where they're grounded enough and have enough skills to even look at the implications of what they have been through. And again, reminding them, reminding myself…it's a slow, slow journey."

Gillian believes it is important to address masculinity constructs and stigma related to help seeking directly, and often explores it early on in therapy. She believes stigma that many men and boys struggle with serves to perpetuate the silence that surrounds male sexual trauma:

> I think, just to name it [the stigma around help seeking] and acknowledge it and recognize it and helps break the silence. Helps someone label those mixed messages they receive as men and boys around help seeking and – and just to put it out there and calls that stigma out.

In terms of myths around sexual trauma, the physiological response to sexual trauma as connected with enjoyment is a common one that she feels needs to be debunked for both male and female. She uses an analogy with survivors to how one experiences a burning sensation from touching a hot stove: "if you put your hand on a hot stove…it's going to burn whether you want your hand there or not. So understanding that arousal response…that's a big one that we still need to address."

Gillian says there are many things we could do differently to support all survivors of trauma. She believes it is important to let survivors explore trauma at their own pace and when they feel most comfortable and safe to process their experiences. She says it is important to be flexible in the therapeutic approach and to always recognize when someone is wanting to move forward and respectful if they need to pull back:

> We need to be compassionate, patient, we need to give them time and space. We also need to give people wiggle room so to speak. And once you've said something it doesn't mean it's always in the room and it stands forever. It is always adjustable.

Gillian describes spending a good deal of time focusing on anger as a response to trauma with the youth she works with, because "it is a justifiable and valid response [and] it's also very accepted within the fabric of masculinity". She says the problem with many survivors is that anger can easily overwhelm a survivor and cut them off from an ability to express and

experience a fuller range of emotions, which has significant impact on the survivor and those around him:

> And so it's amputating for them, but it also cuts people in their circle of care that they love and are attached to off from being able to see a fuller sense of a person as well. So, it it's not just damaging -that kind of notion of toxic masculinity isn't just damaging to men. It’s also robbing everyone of a way to be fully expressive.

Ben

I met Ben at his home on an early Saturday morning at his invitation. Ben is a mid-thirties man who shared he was recently out of a long term relationship with a woman and was “now adjusting to a new normal”. He runs a private practice centred around working with mostly men and boys with trauma history that he established following graduating from Acadia with a Master’s of Education in Counselling. Prior to that, he was a high school teacher and guidance counselor for over twelve years. He had reached a point where teaching was not as meaningful as it once was and he felt overwhelmed by “bureaucratic nonsense that came with the job” so he abruptly quit and pursued a Masters of Counseling Degree, so that “I might be in a position to help more people in the ways I wanted to help them”.

Ben said many of his clients struggle with post-traumatic stress disorder (PTSD), borderline personality disorder (BPD), or significant addiction issues. “They often come in with so many unhelpful labels attached, so some of that initial work is just unpacking that and externalizing it and letting it go”. He credits his narrative therapy training in helping clients with meaning making around experience. Ben says that building trust and a sense of safety are his first priorities in the therapeutic relationship, and that starts with listening and enjoying getting to know their stories.

> If you can develop a safe connection and trust – a trusting relationship with your client, they will open up, and if you cannot do that, then it doesn't matter if you throw a thousand different psychological modalities at someone and are trained in all of them - without the connection, they're not going to open up to you, and you're still stuck at square one.

Ben shared that he was a survivor of childhood sexual abuse, and that history was instrumental in him becoming the sort of therapist he is today. As a youth, he faced various struggles, and was labelled wrongly by various professionals as having attention deficit/hyperactivity disorder (ADHD), issues with anxiety, and possible bipolar disorder : "so I was forced to see all these professionals, but no one asked about early trauma stuff…it just never came up in the room."

Ben says it is important to be intuitive and really understand the limitations of your clients who have experienced trauma in terms of processing their experiences:

> Not everyone's going to go at the same pace so knowing when to push down the gas pedal just hard enough and when to ease off and understand, you know, this is where this person's at sometimes and it's nothing that can be rushed. And over time, you can learn when someone's ready to go to the next step, and to challenge them, and other times when to kind of back off - and that's this kind of a big learning curve you go through as a as a therapist.

He says a commonality he sees in the male survivors he works with are relational difficulties, whether that be with romantic partners, family friends, employers or teachers. Attachment and intimacy issues are common: "nobody wants to get hurt again and you're dealing with a lot of triggers and of course if you want to be in an intimate relationship you really need to be vulnerable…and being vulnerable has become scary". He says survivors often do not recognize

their trauma triggers that bring on dysregulated states, so Ben does focused work to help them be more attuned. He promotes this through things like mindfulness, yoga, and physical exercise:

> So, just focusing and taking the time to listen to your body, see where it's at, figure out if really something is a threat or is it imagined – so if my body's still experiencing [a triggering event], how do I proceed with my next move behaviourally based on that? Is there evidence that this is happening again, or is this my body responding to trauma because it's happened in the past? So that's something to be very aware of, and starts with developing that awareness of your mind and your body.

Ben has a strong interest in working with young males and men who experience sex addiction, something he said modern discourses generally are misinformed about or get wrong. He blames that on traditional masculine norms: "with sex addiction…it's an affliction. It can be as harmful as the worst drug addiction. But with young guys in particular, sex with girls is something you pursue, you want, it's constantly something you are supposed to chase".

Ben says that he believes male on male sexual violence is pervasive and yet as a society we do not talk. He feels this is related to living in predominantly a heteronormative society, and while acceptance of LGBTQI2S+ people has grown in recent decades, homophobia is still rampant and more stigmatized when it comes to sexual trauma, "It's another layer for males that makes it harder to disclose".

He says it is still relatively rare that a young client will disclose sexual trauma, and that it is much more common to work with men in their thirties and forties: "this happened to them, you know, at age 10 or 13, but due to the fact that they just didn't trust, that they could not open up about that subject to their parents – that really is quite common". He spends a good deal of time in the beginning of treatment around psycho-education related to sexual trauma in males,

including reviewing the one in six statistic: They often feel alone, and this makes them feel less alone. You can't take for granted what they know or don't know…what's truth and what's a myth". Ben says many of the male clients he has worked with have reached out in some form or another and had a less than empathetic response or the experience minimized or dismissed: "I think that stays with them. If I tell I get slapped in the face. Or I don't know what might happen so I better not open any wounds".

He said in combating stigma we have to be more open and transparent about the trauma that happens to young men, or otherwise survivors will continue to hide their pain and suffer in silence:

> If they felt they could be comfortable enough to reach out and talk to family and friends about it, I think men and boys would be doing it. Why are they not? Because they are still stuck in a place where it's just not safe to talk about that. So really normalizing that, you know, that this happens in our world today and it has now happened to you.

Ben says it is really important for caregivers, parents and teaches to believe survivors when they first disclose, and to support them and not judge them:

> We need to get them resources as soon as possible so that they can let that healing process begin – so they can get back to their lives and kind heal and move past that, as opposed to just learning to deal with it. Otherwise, all sorts of things can happen and combines to affect your life in a very adverse way…it's important to believe them, to support them, not dismiss or downplay, and from there – from there get them to the proper helpful and responsive resources as soon as possible.

Ben says it is important to instill hope for the future in survivors:

> I think with sexual trauma, you don't ever really 'get over it', but you can learn to manage it, and you can understand it, and you can live a very fulfilling life. It's not a life-long sentence. You can heal…you can recover. I'm living proof of that.

Richard

Richard has practiced for over thirty years and describes himself as a clinical social work and a mental health forensic specialist. He has run a highly successful private practice for the past eight years that offers a therapeutic group specifically for men who are victims of sexual assault, the first of its kind in this province, and something which has spun into all different kinds of specialty work related to the lives of men and boys. He has had a long and varied career, and served in many different clinical, front line, managerial and consultative roles. He does a great deal of policy and advocacy work related to the needs of the black community and the LGBTQI2S+ communities, and as a gay black male, Richard is a strong proponent of promoting more culturally sensitive models of treatment and care.

Richard completed most of his studies in New England, and began his career there in child protection before eventually transitioning to working within the prison system, both of which gave him his first exposure to men and boys struggling with significant trauma histories. He says as a result he became a "deep student of trauma there because I found correctional mental health often focuses on the criminogenic issues that these guys had, while doing nothing to address the terrible underlying histories." He centred much of his future research and studies on addressing trauma symptomology among prisoners in protective custody and isolation, and he had success working with men who were "written off as impossible to reach….by virtue of addressing their trauma, not by addressing their criminogenic issues".

Richard says he is a person of faith and that his faith helps guide his work in the sense of what he calls the “interconnectedness of the human family”. He says that is very meaningful to him because “we don't have the luxury of ignoring each other, and so if people are suffering, that's my business. It is all of our business”.

He says what he hopes to achieve is a greater equality in acknowledging and accepting the stories of men and boys and their victimization, and he talks of need for society to arrive at a more unified discourse not bounded by gender, “so that we can see the interconnectedness in all stories of trauma and victimization, and we can promote healing in a way that – that is therefore much less segregated.”

Richard believes there are many similarities, regardless of gender, in working with a sexual trauma survivor, with believing disclosures as the most important part. He says the role of therapist is to:

> lower the bar of skepticism and recognizing the difference between clinical memory and forensic memory – and by that I mean that our interest is not in proving a story beyond a reasonable doubt, but rather in hearing stories, knowing what happened and in what ways it has hurt or affected someone.

Richard states that exploring the concept of confidentiality is a crucial early piece in the therapeutic relationship. He sees some tension with a survivors reporting historical cases of trauma and a duty to report by a therapist allegations of abuse and harm to the Department of Community Services. He believes some therapists currently “get it wrong” in their rush to disclose to authorities:

> I clarify to a client that – well, if you were to tell me a story that currently a child is being abused than, right there, I have a duty to report. But those historical stories of childhood

> abuse that you have suffered, that you've seen other people suffer? As long as those people are no longer children, I'm not required to report, which gives people a lot of confidence in telling historical stories and helps them to guide what they will share with me. I think it is interesting how sometimes we almost coach our clients not to tell us certain stories…because that has such an impact on our clinical relationship. The moment I have to slap my forehead and say, oh, I have to call somebody, then right there your healing work stops.

Richard feels as though some men "literally cannot attach emotion to their abuse. And that's one of the significant consequences of this kind of abuses that it separates one from one's feelings and ones capacity to feel". However, he has also worked with young men who experience high emotions and highly disinhibited, emotionally chaotic states. He said many dismiss the experience, suppress or try to forget it, and struggle through life with some dysfunctional aspect because they've adopted as protection. At times he sees survivors triggered and then suddenly they are:

> flooded with memories of having been abused... So these guys have to kind of come to an awareness that they have been abused and then they have to deal with the chaos, the emotional chaos that that unleashes in their lives and that their brain has been protecting them from for so long.

Richard sees survivors as blaming the abuser, blaming oneself, but something of interest he notes is "a real hesitancy to lay any blame on the caregivers who failed to protect". He says he has seen the most defensive and volatile responses in men he has treated when he asks about the role of their parents. He says he has seen this commonly in families where incest has been tolerated, where parents "discover it has happened, slap the offending child in the head and say 'never do

that' and yet the children go right back to the same sleeping arrangements. Nothing changes". He says this is often an indicator of a much deeper family dysfunction, which "of course needs to be explored and unpacked before… healing can begin".

Richard said in considering the ubiquity of abuse in both young males and females, it is important to remember that: "when something happens to that frequency, it's not healthy or natural, and we have to address sexual abuse as a health issue, rather than a criminal issue." By that, he does not mean sexual abuse should be decriminalized, and that while he sees the criminal justice system as an important intervention in protecting children, "the hard reality is that it does not do much to address the problem of child sexual abuse."

Richard proposes a system of "health surveillance" around sexual health and wellness as part of child wellness programs: "that starting as young children, during routine medical screenings, we are assessed around the state of [that child's] sexual health." He also believed clinicians need to be better prepared and have what he describes as the "internal fortitude" to do the work. He believes this is a huge disservice in our systems today that there are therapists who are not comfortable working with trauma, and so part of not addressing that trauma through therapy is potentially therapists' avoidance of tacking the issue head-on:

> So we need more clinicians who aren't freaked out by this [childhood sexual trauma] and who able to see it for what it is - another mental health dilemma, for both survivors and perpetrators. And - and I think that's part of the mythology, the mythology around this – that essentially the idea that that a sexual assault should primarily be responded to by the criminal justice system and I reject that. And I'm not saying that that doesn't mean that there's there isn't a spot for adjudicating offenders. Absolutely. But I think that that if

we're not doing the healing work, then accessing criminal justice services as our primary approach is a primary approach that is ultimately failing.

Adam

I met Adam at his private practice office in the north end of the city. Adam is in his early thirties and lives with his long term girlfriend. He has a great passion for the outdoors and spends most weekends exploring hiking trails throughout the province. Adam works part time in a private clinic offering general counselling, and two days a week runs a private practice where he focuses primarily on working with men and boys.

Adam initially had plans on becoming a police officer, something he says had dreamed of much of his life. But as he progressed in the program, he started to realize "how dominant approaches to managing crime were not very effective, and that lead to a re-evaluation of my whole career path." He wanted to explore what a rehabilitative or preventative approach might more fully entail, so he took time away from studies to gain some work experience in places like men's shelters and group homes, where he was able to provide support around life skills and offer some informal counselling. That inspired him to consider graduate programs in psychology before finally deciding on the Master of Education in Counseling through Acadia University.

Adam completed a thesis as part of his program that focused on outdoor therapy as a treatment option for men who commit intimate partner violence. Adam's main participant grew up in a rural community, had a significant history of physical abuse at the hands of father, and as an adult became abusive to a series of partners. He had been through many different anger management programs and saw numerous therapists but nothing seemed to connect with him until he became involved in an outdoor therapy program that, as Adam describes, "allowed him

to connect with nature, something he did to feel safe as a boy, and then begin to engage in therapy on a much more authentic level."

An internship at the East Coast Forensic Hospital led to him developing an interest in working with males with significant mental health diagnoses such as schizophrenia and bipolar disorder. Because these men often struggle with aggression in their daily lives, Adam says there were often "written off" as too dangerous. "But once I started to have a conversation with a guy, I very quickly became aware that he didn't want to be doing what he was doing [acting out aggressively] - he just didn't know how *not* to do it".

Adam does not believe there is a "one size fits all approach" to therapy. He says he focuses on social determinants of health, with an understanding that the issue is not located within the individual, and that there are multiple systems – family, community, broader society - that influence someone's thoughts, feelings and actions, and that therapy needs to be responsive to those influences. He works with survivors to "expand their emotional vocabulary" along with their capacity to experience those emotions: "The biggest emotions tend to be anger, rage along with sadness, and feelings of loss, although initially they might not name it as such and usually focus solely on their anger." He has worked with survivors who disclosed at a young age, and often it can seem as though their world falls apart in the aftermath, which they then often internalize as blame and shame around the sexual trauma, and interpret it as the "consequence for doing that *thing* they weren't supposed to do".

Confidentiality is also key to the therapeutic relationship, something he sees as a critical tool for therapist to use "but something that is sometimes forgotten". Confidentially allows the space to have these therapeutic conversations and for some survivors the chance to disclose secrets long kept. Adam says he reiterates confidentiality often throughout the therapeutic

process. Another major piece of the work for Adam centres around consent, especially when exploring past trauma: "It's almost - it's asking a question to ask a question, if you know what I mean…I've got some hints of what happened, and now I am asking permission to ask the question [around sexual trauma]".

Adam feels the stigma is particularly strong around mental health and help seeking:

> There is just that overarching stigma around, you know, not having your shit together or not being able to snap out of it, which is just like such a - it's just such an ignorant position to be in - or ignorant notion to hold - that if you're dealing with depression, you can just snap out of it right? Or if you're dealing with anxiety, you know, if you're dealing with trauma…like 'yeah, but that happened a long time ago, so like, just move on.' Get over - get over it. Like the absolute least helpful words in the English language you could ever say to someone.

He sees young survivors of childhood sexual abuse suffer from unresolved trauma which ultimately results in "a worse off or poorer quality of life". He believes the most devastating impact of childhood trauma for males is the emotional and social disconnection that he often sees experienced:

> Relationships and their ability to be in a relationship, it all suffers…and as social creatures we need - we're humans and we need social connection. Which is another major thing a lot of men are lacking. And I think is - again it goes along with the sort of this masculine script [that] influences our behaviour - our tendency to isolate, and we need - we need social connection to be healthy. That hesitancy to seek help will just fuel that sense of isolation.

Adam talked about young men who struggle with aggression and aggressive acts that in turn can sometimes be traumatizing, and leads to further impacts on them and those closest to them:

> The cycle of violence is real. So many of these guys experienced or witnessed trauma as a kid and they are now acting out as adults – they're harming themselves and their harming others. So without getting help in between it just keeps on happening. And now the kids are experiencing it, and if they don't get help, they might grow up to do the same thing. And while, honestly, I hate - I hate how deterministic that sounds, but it real. The cycle is very real.

Shane

I met Shane over a lunch hour at my office on a busy weekday. Shane is a 34-year-old male employed as a community outreach worker/addictions counselor with NSHA, and holds a Bachelor of Social Work Degree from the University of Manitoba. Shane identifies as queer and is married to a same sex partner who also works in the field of mental health and addictions. Shane's career path is similar to mine in that he worked for many years as a child and youth care worker with vulnerable youth before returning to academic pursuits as a mature student in his BSW studies with plans to eventually pursue an MSW. He has also done significant policy work in the past around child and youth care practice and trauma informed care. In his current job, he works primarily with adults diagnosed with a concurrent disorder, meaning they are presenting with a mental health problem combined with a substance use issue.

Shane was excited to tell me about the recent launch of a "Seeking Safety" group, which is a group therapy offered through NSHA aimed at survivors of physical, emotional, or sexual trauma. He described the group as one centred on developing coping skills while exploring the linkage between substance use and trauma and how previous trauma might impact someone in

present day. This particular group, he says, is unique because it was the first one offered through his program site that was solely focused on men with sexual trauma history, something he had advocated for since starting in his role. While he knew from his work with vulnerable youth that trauma histories in men and boys were fairly common, he was surprised at the sheer number of men who were struggling with sexual trauma history:

> So, I've seen men coming in acting super hyper-masculine and presenting as very agitated or confrontational until the sexual assault dialogue has kind of surfaced within the therapy and then they become a little bit more softened and more authentic. They really have a really hard time articulating around what that means as a male being sexually assaulted either as a child or as an adult. So, it's about exploring this guilt and shame and how that relates to self-compassion and healing and the trauma. So, if we're looking at safety as one of the first stages of trauma, it is about helping them understand what that means to them and how to get that safety

Shane focuses in individual work around dialectical behavioural therapy (DBT), because he likes how it teaches "good coping skills and tools around emotional regulation" but he says a starting place is always exploring with a client what approach might be most relatable to them. He also relies on motivational interviewing as a way to "explore and kind of elicit change talk."

Shane spoke at length about boys and men who use anger and aggression as a means to manage and cope with the stresses that are in their lives that are often related to or a direct result of their significant trauma history. He sees it again as means to protect themselves, to keep them from being vulnerable, but what become problematic is that it served to disconnect them from the resources they need to improve their situations.

He reflected on past work with young men and boys who presented with over sexualized behaviours and says that related discourse in mental health is problematic in that:

> We have this big reaction around preventative stuff. Protecting the other youth or children around them, labelling them as sexually aggressive when really what we need to do is help the child or youth understand what occurred to them, and help them learn new schemas of how to appropriately work with people or even be around people. And as a last step, helping them develop a way – a means where they can articulate what happened to them.

Shane emphasized again how establishing safety was key to starting work with male survivors. After a baseline of safety occurs, Shane focuses on remembering or recalling the traumatic experience, using prolonged exposure to gauge distress tolerance, as it allows a means of managing the discomfort of taking about trauma and not engaging in maladaptive or problematic behaviours as a means to cope.

Shane spends a lot of time with male clients exploring what gender means to them as a means of exploring normative expectations of masculinity. "It's important to explore as well how these two things can exist in the same space - because masculinity and femininity is part of all of us, so recognizing and accepting that femininity is a part of being male." He believes as a culture we need to teach even really young children more explicitly about constructs of gender and help develop a better understanding of gender identity and sexual orientation at an earlier age. "I feel if young people don't have a good understanding of those things, they develop their own understanding and different ways to cope, and sometimes their attachments and their relationships get damaged or disrupted because of that". Shane sees the way young children are socialized in terms of gender roles as still problematic, and has worked with parents to address

some of those tensions in the past. He says he is often concerned when working with aggressive boy that they internalize messages about being “in charge” at home:

> I always cringe when I’m with, say, a mom of a 4 year old who’s acting out significantly and she’ll say ‘well, he’s the little man of the house’, but then we don’t necessarily say to our girls ‘well, you’re the woman in this household’. No, he’s a little boy. He’s just a little boy.

Although he says he generally presents as cis gender male in his outward appearance and dress, Shane more readily identifies as gender fluid, “somewhere on a continuum between masculine and feminine, and I can display myself however I feel in the moment”. He says he notices a conscious shift when around people he has met for the first time or does not know well, as he tends to act more of what he called stereotypically masculine: “how I carry myself, how I walk and how I sound, how I dress – I’m conscious of all that”. He says as a society we continue to “place people’s gender based on their genitalia and not necessarily on how they identify”

Shane believes exploring vulnerability and the way aggression is sometimes used as a means of protection is crucial to how we can help male survivors. He says that many struggle with guilt and shame as it relates to their anger, and that often times it is misplaced:

> I'm recognizing I'm angry right now, but I'm not angry at you, but I am going to display that anger at you because I'm uncomfortable because I'm having these trauma symptoms or triggers or flashback. And then relationships get damaged because I am acting out. And then guilt comes from that and then shame from allowing themselves to feel vulnerable, which can feel like that same vulnerability that led to their assault.

Conclusion

These narrative accounts allowed me as researcher to explore and analyze each narrative "temporally, spatially and in terms of the personal and the social" (Clandinin & Connelly, 2000, pg. 89) while attempting to understand and retain the participants intended meanings within the context of their experiences. The rich, descriptive data also allowed for interpretive themes to emerge which go on to form the basis of Chapter Five. Through including them, I attended to Clandinin's (2013) belief in the participant's voice as most influential in narrative inquiry and my hope is that this serves as a means of honouring those voices included here.

CHAPTER FIVE: INTERPRETIVE FINDINGS

The following chapter includes findings of participants' narratives that were interpreted from the rich textual data provided during the semi structured interviews. Following Braun and Clarke's (2006) analytic process, data was summarized according to patterns which allowed for interpreted themes to emerge, with focus placed on significance of the patterns and themes that emerged and their broader meanings and implications. Braun and Clarke also suggest the use of vivid or compelling examples from participants' narratives that would support themes. The rich, detailed content and resulting themes were considered from a postmodern lens in order to "hear the operation of broader social discourses shaping that person's story of their experience" (Clandinin & Rosiek, 2007, p. 55). Overall there were seven themes that I chose to focus on: *Invisible Victims/Hidden Survivors* (examines the silence that surrounds the phenomenon that renders its victims invisible); *Some Moral Distress* (describes challenges and constraints participants as therapists face within a medical model of care); *Dangerous Disclosures* (details some of the challenges faced by survivors in disclosing their trauma); *Challenging and Renegotiating Masculinity* (considers how participants as therapists work with male survivors to deconstruct and reconstruct different versions of masculinity and address issues in toxic masculine culture); *Misogyny/Fear of the Feminine* (examines how participants challenge dominant discourses around women as weak and narratives of femininity as bad within the context of patriarchal and misogynistic society); *Homophobia: Am I a Fag?* (considers myths that perpetuate homophobia following male on male abuse within the context of heteronormative and homophobic culture); and Re-*Storying Trauma* (details how participants as therapists work with clients to understand resiliencies and vulnerabilities and being the healing work).

Invisible Victims /Hidden Survivors

Cultural myths surrounding the sexual trauma experiences of boys and men pose serious obstacles to understanding the impact on male survivors and serves to derail healing processes. All participants described a sense of profound silence around the phenomena of male childhood sexual abuse within society, which in turn has the effect of hiding or making invisible survivors. Participants believed this occurred in several ways: through a lack of public discourse around the prevalence of male childhood sexual trauma; through a lack of available male centred supports and resources, and through a professional bias in clinicians that fails to recognize the traumatic histories in male clients.

When describing their experiences, participants noted that few young males actually present to their services with sexual abuse histories as a primary presentation and reason for seeking treatment. Yet while participants widely agreed few men and boys enter mental health treatment with childhood sexual abuse as a primary concern, they all spoke of their belief in the ubiquity of male childhood sexual abuse due to their experiences with men who disclose later in life, and often quoted the one in six statistic (Fisher et al, 2007). Daniel noted a significant number of men he works with in addictions services experienced some form of childhood trauma, estimating "at least 75-80% of the men have some physical abuse history, and many of those include sexual trauma history". Susan and Richard described sexual trauma histories among incarcerated men as an even higher statistic, with Richard noting the last prison he worked with in the US "over 80% of men incarcerated had experienced at least one unwanted sexual encounter in childhood". Shane reported that the statistics around males impacted by sexual abuse are similar to those suffering from prostate cancer but noted "the silence that

surrounds that number - I mean, think about it. Only one of those things has fund-raising and an awareness campaign behind it."

Adam believes that male childhood sexual trauma is very prevalent, but something rarely spoken of: “It's a scary thing to think about children being sexually abused. So, I think we prefer *not* to think about it”. Kate and Richard, with their backgrounds first in child welfare services, were adamant that disclosures and investigations of male childhood sexual trauma were higher than what common cultural discourse would suggest, and more specifically, what mental health care services would report.

In her role in helping families navigate complex systems following a child’s traumatic experiences Kate says,

> People don't want to see it until they have no choice…until they are forced to deal with it [the disclosure of sexual trauma]. We need to see it more because people are getting away with it, and that perpetuates the abuse. So, to make ourselves see it, to open ourselves up to these hard things to see, we need as a society to talk about it.

Not recognizing or acknowledging the significant issue of male childhood sexual abuse is problematic in that it serves to minimize the experiences of survivors and therefore divert them from the services they might otherwise need. It makes them invisible to the very mental health care systems that should be readily able to support them. Joanna spoke of the need for mental health professions to bring discourse around male childhood sexual trauma more readily into the public consciousness to raise awareness and reduce stigma. She believed through opening the discourse in society, survivors will be better positioned to access the help they need. By continuing to not recognize the significance of male sexual trauma, we inadvertently silence its hidden survivors.

> It is the silence I think that is difficult -that if men could feel that they would not be judged, if they were to speak about these things openly and readily. And of course, you can do that in counselling, but then there's – the shame about that, there's stigma around that as well [in acknowledging the need and seeking mental health support] you know, so there's a lot of work to be done. A long way to go in recognizing the problem. We are sadly pretty underground so far in this area [of male sexual trauma work].

Peter described the phenomena of male childhood sexual abuse as a "mostly silent area" in trauma work and mental health, and while reflecting on his diverse career in mental health, expressed surprise around the lack of visibility of male trauma work.

> It is definitely not something that surfaces a lot, you know, day to day here in the clinic or - or in the media. There does not seem to be any kind of advocacy rights groups banging the drum. I just know that there really isn't a lot of focus - *no* focus, really.

All participants described themselves as advocates for trauma work and innovative ways to help trauma survivors, but when it came to male childhood sexual trauma that advocacy work comes from a small minority and is conducted, as Joanna noted, almost entirely underground.

All participants were challenged to describe immediately available resources for men and boys who experience sexualized trauma. As clinicians, they claimed they were often highly versed out of necessity in finding available community resources for a wide range of issues impacting their clients, and yet with the phenomenon of male sexual abuse there was no, as Peter described, "obvious fit or ready referral source for male survivors available". Not knowing where to access specific male-centred services in dealing with sexual abuse issues was highly problematic to clients. As Adam described it:

> All of this has much bigger implication on healing processes, because if a survivor does not have an entryway into help seeking or does not feel safe or comfortable when forced to engage, then it comes impossible to do the healing work.

Gillian echoed a very similar sentiment, noting male adolescents who disclose and are open to ongoing therapeutic work have very few options available to them:

> So, once you get to that place of trust willingness, who's there? And it's not like they have their own financial means, especially if they're not - if they haven't disclosed to their family and they're trying to seek services on their own. They can't just go and find a great private therapist who works in trauma. They are left with few to no options.

Participants also noted a professional bias in public health care that reinforces the belief that men and boys cannot or are not sexually abused. Shane described a need to challenge some colleagues and their formulation and approach to treatment with male sexual trauma survivors. He recalled working in an intensive treatment program with a fifteen-year-old male who had been displaying some sexually provocative behaviour towards his male peers. Shane noted this youth had disclosed to his primary therapist his history as a sexual trauma survivor and his experience as a victim of sex trafficking. However, this disclosure was met with a great deal of trepidation and in some cases disbelief by the clinical team:

> This was a group of smart professionals. Caring professionals. And I found myself having to constantly point out the fact that – you know what? Young males can be victimized, they can be trafficked into the sex trade. It happens. And yet it's like – it's almost like they're confused by that notion that young males can be victimized and - and preyed upon. They dismissed his acting out as 'he's confused about his sexuality, he's gay, he's not comfortable with it, so we need to focus on more relationship skills'. Like –

dating skills? For a kid who's been trafficked…can you imagine? So, I think there's a very different focus and…maybe a different empathy for boys when they've had these experiences.

Participants described working with young survivors who had been in therapy in the past and had not disclosed, something they attributed to the multitude of challenges to disclosure that I will discuss in a further section. They also expressed concern over screening processes for experiences of childhood sexual trauma in men and boys, and even more concerning, clinicians' ability and comfort level to identify, explore, and treat the issue. Richard said it is crucial that therapists be prepared to hear these stories and act upon them: "we need clinicians that are competent and comfortable in hearing these difficult stories and can put their biases aside". Richard also believed this had to start before the point of seeking mental health services, with the idea that doctors should be willing and able to screen all men and boys for past history of sexual trauma, and from there have access to resources to refer their patients on for further support.

Along with acknowledging a general lack of expertise, participants were also quick to note there are few if any training opportunities specific to men and boys and sexual trauma available, therefore making it difficult to build a competent practice to address the issue. Participants noted the training and workshops they attended were all specific to female experiences with sexual trauma, and while many of the same principles applied to treatment (such as establishing safety and helping to build tolerance) other aspects, such as challenges to male identity and questions around sexual orientation, were gender specific to the needs of men and boys. Ben stated, "it's not like that [specific work with men and boys] was part of any modules at school". Shane said even when male sexual trauma is addressed in workshops he has

attended on sexual abuse, “the focus is on women and girls…. IF men and boy are mentioned it – it gets tacked on…almost like an afterthought”.

Nathan states that while there is a great deal of research that look at poor help seeking behaviours of men and boys and seeks ways to address that deficit, he believes “for the most part I think the focus of research is all wrong”. He believes it is much more important to focus on the goodness of fit or the general lack of fit between types of therapy offered and how that relates to the way men and boys engage with the world around them:

> Traditional sit, talk based office based time bound, all that kind of stuff. And how men and boys tend to show up – that needs to be the focus. And if we're going to have one iota of a chance, not only to shift the conversation on masculinity, but in giving men and boys an opportunity to voice some of that distress that's going on - sexualized trauma or otherwise - it will happen on the edges of how we offer that therapeutic work, work that is more than just sitting on our asses and talking. So whether that is sitting over coffee, going to a music store going on a walk, walking through a cemetery, going rock climbing…whatever form it takes. Otherwise we'll continue to struggle in the stigma and in the relative voiceless of these men and boys because it's really not about…it’s not about how gender affects men and poor help seeking behaviour. But yet we keep blaming it on gender constructs, when really it is about what the fuck we're doing or what we're not doing to support the boys.

It seems abundantly clear that the silence around the male childhood sexual trauma stifles the conversation and leads to a lack of public discourse. The lack of discourse leads to a lack of disclosure and a lack of knowledge related to supports and resources centred on the needs of men and boys. And then ultimately, the lack of disclosure and lack of supports leads to sexually

traumatized men and boys struggling to heal while silenced and made invisible. Participants unanimously advocated for the need to bring experiences of male survivors out of the shadows and into the light. They challenged the cultural beliefs that men and boys cannot be victims and pushed the need for more public discourse and more focused attention in health care settings. They also described the significant lack of resources and supports available to survivors, and how that not only impacted their ability as an individual clinician to provide effective treatment, but also their faith in the larger systems they work in to address the needs of men and boys with sexual trauma histories, something that will be explored further in the next section.

Some Moral Distress

Participants in this study were open about the impact of perceived barriers and limitations in public mental health system in addressing the needs of male sexual trauma survivors and the moral constraints those systemic issues places upon them as therapist in their therapeutic work. I argue here that this results in experiences of moral distress, which is defined within a health care realm as a helping professional making decisions and judgements about the right course of action to take in any given situation in the best interest of their client, but being unable to carry out that action (McCarthy & Deady, 2008). In other words, the therapist knows what the right thing is to do to help their client, but they are unable to do it for a variety of reasons, or they do what they believe is wrong because they lack other discourses.

Something that came up in all conversations and weighed heavily on participants was the lengthy wait times for service in seeking mental health supports. Participants who worked primarily in adult community mental health (Daniel, Shane, and Peter at present, and Ben and Nathan by history) believed wait times were generally between six months and a year after point of referral to see a therapist for an initial appointment. Wait times for children and adolescents

were generally better, according to Shane and Gillian, with those times anywhere between six weeks and three months for a non-urgent referral. Priority referrals typically were based on risk of harm to self or others or acute psychiatric presentation (e.g., symptoms of psychosis such as hallucinations or paranoia combined with a significant decline in functioning; daily panic attacks; significant compulsions or obsessions). These initial appointments were typically booked within seven days, but the wait time for an ongoing therapist for follow up was also lengthy. Gillian also noted the wait time for a specialized more intensive program like hers was generally at least a year or more. By nature of the program she works with, Kate tended to see boys and young men immediately following a disclosure around trauma, so while an exception in terms of how quickly she provided care and support, she was also limited in her ability to refer people on to other services due to lengthy waits. In her role as a trauma therapist, Susan was constantly triaging children and adolescents referred to her service, so depending on urgency they could be seen quickly, but as a triage system that meant that others that presented less urgent (for example, someone that witnessed a terrible car crash versus someone who suffered a sexual assault) would be pushed down the list to wait further. Either way, this presented to Susan a terrible choice.

Ben was highly critical of the public mental health system in general, and believed the system currently:

> broken and beyond repair in its current state. I mean, the ridiculous wait times, the lack of services available… stories of people where they go down to emergency room when they are dealing with something very acute or long term and can't get support….when you have suicidal thoughts or behaviour and you cannot get a bed, and you just get turned away.

Other participants described similar challenges and stressors within mental health care systems. Peter believed strongly that treatment for trauma always involves a slow and steady approach, designed to build confidence with the process in the survivor, and with time to develop a comfortable rapport with the therapist. He said, however, “with a brief sort of intervention approach, we might fool ourselves into thinking we are doing something when in fact we haven’t done much by virtue of the timeframes allotted for treatment”. He then contrasted that belief with the constraints he saw inherent to the public mental health system:

> It’s kind of pointless just reassuring people or being flippant. And I don't mean flippant as in…well, you know, without ever meaning, it can come across as very shallow if you just adopt certain approaches or make certain assumptions. So, I think you really do need to get to know the person. Which often can take many visits, which is challenging in a system that is not necessarily open to that. We are very action oriented – like, assess, check, treatment plan, check, initiate, check, discharge, check.

Susan, Ben, Nathan, and Bryce expressed similar thoughts on the way mental health systems are structured and how they do not allow for that degree of intense therapy and focus needed for survivors to progress through successful treatment processes. As a result, they believed a hurried approach that often barely touches the surface of the trauma experienced and be in fact traumatic to client in itself.

Bryce critiqued brief focused therapy approaches, and says that most clients he sees reported “traumatizing experiences” with other therapists in public mental health systems where they feel uncomfortable disclosing past history and engaging in treatment:

> Just the fact that my approach is … at the very least, built on validation and is trauma oriented and anti-oppression oriented. I hear a lot about why that approach is so different

than walking into an office and sitting across from a psychiatrist and being diagnosed in twenty minutes. Nobody feels heard in that situation. Nobody feels like…you know, the problem here is 'I still don't feel safe to say these things, and I don't feel safe to say these things precisely because you haven't given me either the time or the space to do so.'

Gillian critiqued current systems and responses that she felt did not provide adequate service to trauma survivors in their healing processes:

> I don't think our system really sets itself up or lends itself to help people get there [recovery from trauma], because that's slow gentle work and we keep trying to piecemeal our response to people in distress instead of recognizing that 'you know what? This is a long slow journey. It's a long slow journey here.

All participants in private practice (Nathan, Adam, Bryce, Ben and Richard) described offering treatment pro bono, at reduced rates or on a sliding scale based on what the individual accessing treatment could pay. But while the intention of offering reduced or no fees is admirable, younger less established clinicians like Adam and Ben are often faced with harsh economic realities of trying to sustain a viable practice and cover rent and administrative costs. Nathan was able to offer no cost services while accessing grant monies in the past, but since starting his private practice "I've tried to offer a sliding scale and lower costs of treatment, but the sad reality is to be self-employed and stay afloat, I'll never be able to offer the free or low cost service I used to".

Kate questioned how often symptoms of sexual trauma were not identified or missed in the histories of young men and boys, and finds it distressing to think of how many agencies and services (school, clubs, organized sports) likely interacted with them and did not identify problematic behaviour as a possible indicator of trauma:

> What's so striking to me is…. well, I see male victims at the time they are victims. There's a lot, right? But you don't see a lot later represented in therapeutic interventions, in other services in mental health. Like, they're here, and I hear their histories, and yet they've never sought help before, but – but it's never been offered. And I think you see a disproportionate representation in criminal justice systems [of males with sexual trauma histories]. And even then, if you asked, they might not disclose. But they're there. So why aren't we more attuned to that?

Gillian admits that in her present work in an intensive treatment unit for adolescents she has worked with few that have gotten to that point of disclosing their past abuse history to her:

> I think my – my much more common experience has been working with kids who were just really kind of behaviourally breaking the rules and non-compliant and you know maybe…you know, finding out years down the road and this piece [around childhood sexual trauma] comes to light. And in those cases, I've been – well, at times I've closed the door and cried, and others I just- I want to bang my head against the wall and say 'damn, what's wrong with me? I missed that. How the hell did I miss that?

Kate, Richard and Joanna all criticized a health care system with research readily available that illustrates the struggles males have with help seeking, and yet with no consistent approach to addressing the issue. As Kate says:

> If we as a collective society know this, if we know this history and we know these struggles with help seeking and we don't react - then it's like we've basically just given up on this entire site segment of population.

Many participants also spoke of unique stressors in their work with male survivors in providing, as Daniel described it, "therapy as a consequence." For most men and boys they have worked

with, engaging in therapy was almost always externally driven, and something survivors are forced to take part in. For Adam in his private practice, this was particularly troubling:

> It's almost always other people either recommending or suggesting or forcing them to go. Especially with the younger guys where it's like, typically a parent you know, or someone at school - someone is saying 'okay you've done this thing and you need to now go for counseling. So, I can often be seen as sort of the *stick,* which is a difficult position to start with, when really [as a therapist] that's not my goal – I don't want therapy to be seen as the punishment.

Gillian also struggled with the idea of these men and boys forced into therapy. She saw help seeking in the adolescent population she serves mostly externally driven, in that other people have pushed them into help seeking:

> It's often a caring well-intentioned family member or teacher - or via justice or police or school suspensions, and often coming out of concern about behaviour, aggression and anger. But the youth are often scared, suffering…. they don't see it that way. And so, it's challenging as a therapist who wants to help- I don't want to be seen as this – as some form of punishment or consequence for them due to their lashing out.

Ben spoke of often seeing young men and boys not ready to commit to therapy but forced into it, usually by a loved one who insists. He said therapy is often presented to his client as "do this or else" and he also struggles with the idea of therapy as consequence:

> It puts us both in an uncomfortable place as therapist and client. I find it's not helpful because generally if you're not willing to go on your own…without that insight or if haven't….well, sadly, if you haven't had enough consequences in your life to get to that breaking point, it generally doesn't last long term for these people. It just becomes about

> readiness, about the readiness to do the work. And it's not fair that – that me or someone else gets to say when that readiness comes.

Echoing what he mentioned earlier regarding a goodness of fit to therapy, Nathan stated he realized over the course of his career as a therapist that it was just as important that the work he did resonate with him as much as it did with the client:

> So as much as it is about the client and what works for them, it also needs to be about us and where we feel most resonant, because if we're not in our most organic states, if we're not doing our most organic work, then we're not being our most organic authentic selves. And if we're not authentic, how do we expect to be a support and help to our clients?

Despite concerns with current service delivery and experiences of what I have labelled "moral distress" in their efforts to provide effective therapeutic work, participants believed that treatment for sexual trauma needs to be a public resource available to everyone and increasing the number of clinicians and developing more specific gendered training related to male sexual trauma would go far in accommodating some of those needs. They were frequently challenged with finding appropriate supports and resources in the community and believed this population of male survivors was under-represented and under served in our systems of care. Finally, they struggled with the idea of therapy as a consequence and the therapist as "the stick" and looked at ways of addressing the challenging introductory client/therapist relationship.

Dangerous Disclosures

Participants talked about challenges centered on acts of disclosure that for many survivors can feel tenuous, uncertain, and dangerous. Some participants, like Joanna, Peter, and Daniel acknowledged having limited experience working with young boys and youth who disclose histories or experiences of sexual abuse and described a more frequent occurrence of

working with men in their twenties, thirties, forties, and even fifties who disclose for the first time. Literature around male sexual trauma (Alaggia, 2005; Allagia, 2010; Gartner, 2000; Lisak, 1999) demonstrate that later in life disclosures were extremely common for male survivors. Although Ben had experience working with both younger and older males who disclose, he more commonly worked with men who had experiences with disclosure as young boys or teens that were met with some level of resistance or disbelief:

> I have worked with men and boys who have reached out at an early age - and I think that those initial negative responses, whether they were patronized, or it was blown off or not taken seriously, whatever - I think that *really* stays with them. They've learned – 'you know what? If I do that and tell I am left deeply ashamed while everyone else is uncomfortable…or no one believes me, or I get my face slapped. So now I'm just going to stay away from that –I'm just not willing to go there.'

Ben spoke of how crucial it was to restory that early experience of opening up and telling their story in his young male clients in a way that illustrated "he was right to disclose…the problem was those he disclosed *to* weren't ready for the telling".

Several participants challenged what they described as the dominant discourse in how society responds to allegation of childhood sexual abuse. Some, like Gillian and Susan, described the experience as the equivalent to a bomb going off in a family's life and then struggling to make sense of the destruction and fallout that follows. Others, like Kate, noted how parents of young children could feel betrayed or judged for not protecting their child, and can internalize anger and upset, which then spills over to the entire family". Kate described parents being overcome with "an immobilizing sense of guilt and shame", something that also contributes to

the silence around it: "It is their absolute worst nightmare. The ultimate betrayal. They failed in terms of their primary job as a parent. That's how they see it - I have now failed my child”.

Richard believed the way society reacts to claims of child abuse is problematic, and can serve to put children at further risk:

> When kids do make disclosures, literally the universe falls on top of them. Think about it. What happens when a kid says, “someone touched me”? The daycare or the school goes wild, and they call Child Welfare. Child Welfare calls the police, and together they investigate to see what happened and who is responsible. And so, the kid’s world completely falls apart – and remember, the kid [from his perspective] is just telling a story. And the next thing they know there are uniformed police officers and child social workers and their parents are crying or angry or distressed and the kid learns – he learns very, very quickly, not to talk about that stuff.

By hitting a "panic button", he argues, we run the risk of silencing children because they may then internalize responsibility for the negative reactions of caregivers and others around him. However, by not responding, there is a risk of creating a discourse that lessens the problem and diminishes the significant and harmful impacts on young survivors.

Bryce believed that “part of how deeply stigmatized male sexual abuse is actually in a weird way contributes to how I [as the male victim] experience the thing itself". He described a commonly held belief that child abusers are punished and possibly murdered in prison by fellow inmates for their crimes. Bryce believes this underscores what is “potentially one of the worst things in society, and therefore that means [as a victim of childhood sexual trauma] I'm experiencing the worst thing there is that could happen. The worst thing ever. And now I cannot say it to anybody, I can’t tell anyone…because it is that bad.”

Several participants critiqued common discourses around mental health and trauma that impact men and boys' disclosures. Shane says the current medical model tends to pathologize men and boys when they are seeking help and support for trauma by nature of the way they present:

> I think when we see men who are seeking help around trauma, one of the ways that they experience their emotions…. their array of emotions is as labeling them as anger or aggression. It comes out that way, and our clients get labeled as hard to work with or difficult or aggressive when really they're trying to manage and cope with the stresses in their lives that result around significant trauma history. So, they get labeled as someone who's -someone who's going to be harmful or even dangerous to work with, which makes it difficult for them to seek help because people aren't willing to work with them.

Other participants described similar sentiments in their work with survivors. Joanna noted how many of the men she sees struggle with emotional dysregulation which makes disclosure that much more challenging and puts focus on their problematic anger or acting out and attention away from the triggering traumatic event(s):

> they struggle to regulate themselves because of it [their past trauma] - they're getting triggered all over the place and don't understand what's happening to them, and that becomes so limiting…so staying in school, holding down a job staying in a relationship, being able to manage the difficulties of parenting, you know, all of those things become hard…just basically getting along in the world is so difficult.

Gillian and Kate described working with young male adolescent survivors that were fearful of disclosing to family because of their potential reactions. Gillian said "these youth are often so vulnerable, and they have no other means of financial support. So, if you are assaulted by

another male live with parents who either do not believe this phenomenon even happens or cannot accept it or have homophobic beliefs or religious beliefs, it silences you…. you simply cannot speak of it".

Kate believed that perpetrators of young males use that fear of disclosing:

> I think that there's a certain amount of- I think our natural tendency [when victimized] is to go to a shame and guilt response, especially if you are a kid, because you don't understand the full context of the situation. If you look at perpetrators, they use that against kids to -they use it in that they – somehow, 'this is your fault' or you know, that they manipulate their victim…that they scare them into silence or into submitting.

Ben acknowledges struggling with disclosing his own sexual trauma history, and noted he was well into his twenties before he first sought out treatment, at that time encouraged by his then-girlfriend. He says his struggles around disclosure were related to feeling unsafe in a closed off environment:

> I grew up playing hockey. I'm still very immersed in the typical Canadian hockey culture which to this day…. you know, the entire sports world…it- it really hasn't moved much in terms of being a safe environment to share - due to the fear of judgment. And I'm not suggesting that there aren't people in these dressing rooms that have not been through it [i.e., experienced sexual trauma], but I can tell you that no one's talking about it. And if I were to speculate it is because they would not feel comfortable about the responses they would get - and those response will be quite negative humiliating and certainly not compassionate or empathetic in any way.

Bryce saw self-blame intertwined with both fear of reprisal of abuse from the perpetrator and fear of disruptions in families as a reason for many to not disclose:

> To say it out loud and threaten the family to say it out loud meant to invite further abuse to say it out loud meant to make your mom feel guilty, whatever, right, you just you just never had any capacity to have this thing exists outside of you in a valid way so it just turns back in and turns back in. I've just learned to be silent. I've learned to be invulnerable in these ways and now I don't ever ask for help or speak up or use my feelings because those are dangerous.

Participants reflected once more on the need for more public narratives around experiences of male childhood sexual abuse and recovery as a means of promoting disclosure. They queried whether having a major public face to the struggle – such as an actor, musician, or an athlete – that might champion the cause would make someone more likely to disclose or seek help through inspiration from that public figure’s story. Regardless, participants believed that more public conversations about the reality of childhood sexual abuse and the ways in which young men and boys may be impacted were crucial to lifting some of the stigma and raising awareness of the issue. At the same time, they recognized that the landscape of disclosure was fraught with dangers and perils in the form of retaliation and rejection which inhibit the survivor from reaching out and contribute to their silent voices. Referencing a theme related to masculine identity that will be discussed in further detail in the following section, Kate summed up the experiences of survivors and their challenges with disclosure in this way:

> There's something about the identity piece that is harder - because if I [as a male survivor] feel like ‘I don't know how to be a man or I am less of a person than I need to be’, then it really does impact every single aspect of your whole life. It's so much harder to seek help. It's so much harder.

Challenging and Renegotiating Masculinity

Participants described an initial stage of therapy in developing specific awareness of masculine norms and the ways in which they play out in an individual survivor's daily life. Understanding how those norms influence men and boys behaviour on an individual and contextual/societal is a crucial starting block for therapeutic interventions with men and boys (Allagia, 2010; Gartner, 2017b; Lisak, 1994). From there, it was often a matter of challenging and unpacking those norms and helping a survivor separate thoughts and ideals that were positive their influence, and those potentially harmful.

Some participants, like Adam and Nathan, said it was important to first help outline what a healthy version of masculinity might look like. And part of that work involved exploring gender constructs and gender expectations for both males and females and how they may present as problematic. As Adam notes:

> …in that sense, I like the idea of masculinities as plural. And so, for me…my starting place is… So, my idea of a healthy masculinity or healthier masculinity is one that allows for I'll say, for starters, the expression the full expression of our range of emotions or human emotions, because we regardless of gender we all have the capacity to experience and express all of the same emotions. What I think gender concepts do in general - like masculinity and femininity - is channel all of those emotions into very specific ones and that's not the healthiest way of being. Not for anyone.

Nathan says he believes it is first helpful to illustrate what masculinity does not have to mean:

> We need to sort of shake the traditional constructs of masculinity around, you know, needing to be adventure seekers and highly sexually exploitive, or doing no wrong and not needing help being self-assured etc. etc. That's the first part…but in doing so, the

invitation then is to explore a whole range of possibilities along the spectrum of masculinity or even the spectrum of - even better said is along the spectrum of masculinity and femininity and I think one thing that this work has taught me is that is to be fluid with my understanding of even what masculinity is and I think the greater the stronger invitation is to a) ask and be curious and b) find ways to be okay with however we're showing up

Accepting the way a client presents in therapy sometimes meant recognizing some of the limitation placed on male survivors who ascribe to traditional masculine norms, especially those related to stoicism and restricted emotions. Joanna described it this way:

> I just see how unhelpful it is in so many ways to -to be told that 'you're supposed to know everything' and 'you're not supposed to ask for help' and 'you're not supposed to have any emotions and…'. No, it's just- just bizarre. What it does is…it just shuts men down. It shuts them down and they live on this very surface level.

Adam says it is broader society where "masculine scripts", what he described as norms of expected masculine behaviour, plays a significant role. He believed that often those impacts were insidious and that men and boys were rarely consciously aware of the impacts: "we're likely for the most part to go on about our daily lives, unaware of the influences that, you know these, really deep rooted beliefs come from and how they're influencing us as men and boys."

Gillian noted similar concerns with male survivors she works with, and sees impacts not only on the survivors, but on those that surround them:

> I think it's just really tragically limiting. In terms of the range and depth of themselves... I'm thinking, particularly around emotional expression and how so much of it gets channeled predominantly down a flow of, you know, anger or and cut off from an ability

> to express you know a fuller range of emotion that includes you know sadness or hurt or joy. And so it's amputating for them, but it also cuts people in their circle of care - that they love and are attached to - off from being able to see a fuller sense of a person as well. So it -it's not just damaging -that kind of notion of masculinity- that toxic way of subscribing to masculinity – it isn't just damaging to men. It's also robbing everyone of a way to be fully expressive.

Peter and Richard, both men and therapists in their late fifties, believed that traditional masculine norms related to power, strength and dominance were still quite pervasive and impacted survivors' ability to seek out and access support. Richard stated that acceptable enactments of masculinity were based on those norms: "the lines are still fairly well drawn. They are well drawn particularly for people of African descent, Hispanic descent…but I think for most men, those boundaries are still quite powerfully and enforced."

Participants saw those messages of what it means to be a man and what the limitations or boundaries might be as influenced by many sources – among those family, friends, school, workplaces, community, social media, and popular culture. Peter sees those influences embedded everywhere in modern society, with expectations to comply with them all around:

> I think about it sometimes -like, what does a man do? What is he supposed to do, as a man? What does a woman do? When you are at work at home… you know, when you're out…what do you wear? How do you stand? How do you talk? And what's interesting is that it is all so ingrained, I think. I mean, I think the culture- the culture around us has a huge influence in how we present ourselves. And I guess most times we don't even realize it.

Daniel says he works initially to understand how survivors define their sense of masculinity identity without first making assumptions. He subscribes to the notion of multiple masculinities, with “people coming from all walks of life, and our constructs are based on where we come from, the families we grew up with, the communities, the media and its messages that surrounds us”. He feels the way masculinity is traditionally played in the media and popular culture is problematic “these whole extremes of masculinity and femininity and we see ourselves in comparison to that. And it’s impossible for anyone...these standards for anyone to meet”.

Although he acknowledges presenting as male in his outward appearance and dress, Shane feels he lies “somewhere on a continuum between masculine and feminine, and I can display myself however I feel in the moment”. He says he notices a conscious shift when he is around people he has met for the first time or does not know well, as he tends to act more stereotypically masculine, and is aware of “how I carry myself, how I walk and how I sound, how I dress. It’s like…sometimes depending on the crowd I’m around, I’ll hear my voice deepen automatically, or I cut loose and hear myself laugh just a bit louder”. He says as a society we continue to “place people’s gender based on their genitalia and not necessarily on how they identify – and that’s a huge problem”.

Participants described trauma survivors sometimes use aggressive or assertive behaviour as a coping mechanism. Ben noted how some survivors might "wield toxic masculinity like a weapon", but how it was important to look at their behaviours in context and consider what might constitute survival skills. Susan echoed similar sentiments:

> It actually makes perfect sense why a person might display toxic masculinity beliefs when they've been sexually assaulted because it's a way to protect themselves from not having the same thing happen. And it serves as a way to almost re-establish my manhood,

> because the messages I've received are that these things – these things don't happen to men. So, I think that normalizing what that actually means about you – that this show of toxic masculinity is really a way to cope and protect yourself, and then being able to say if we're going move forward successfully here, we need to look at new ways to cope.

Participants noted how having a good understanding of societal constructs of masculinity and expectations around dominant masculinity were key to treatment. They viewed a significant part of their role was to help challenge some of the more damaging or harmful standards while working to separate and preserve the positive aspects, and help survivors form a new and healthier understanding of their masculine identity.

Misogyny/Fear of the Feminine

Most participants relayed stories of male survivors receiving messages throughout their lives that sexual assault was something that only happened to women and girls and therefore outside the experience of men and boys. Men could be perpetrators, they might say, but not victims. As Joanna noted, when sexual trauma,

> becomes understood as a woman's issue….it shuts men down and they live on this very surface level, and anything that's remotely to do with women or femininity is just it's a horrible curse – it's every curse word. To have this happen is to have done something feminine.

Ben notes how many survivors in his practice have struggled with their trauma as what they described as "this woman thing that to me", and so his focus is on psychoeducation and reinforcing that it was rather a human experience:

> Whether it's, you know, a man that's been victimized by sexual violence or it's a woman. It shouldn't matter. I think because of some societal norms – that's what holds back a lot

of men from reaching out for support is because this culture that says, ‘you know well that's a woman thing that happened to you’. I mean…what the hell does that even mean? You are now more like a woman? This idea that no man could let that happen to him…it gets in the way of healing. So being mindful of that and certainly realizing that this is someone - it's a human being, who's been victimized, and gender doesn't really matter. But I think for a lot of men, it really *is* harder. It's more difficult for them to disclose and open and so normalizing that experience in - in helping them understand [it could happen to anyone]. Because I find that many clients tend to be dismissive or they minimize or just shut it out….and so, you're helping them understand that this is - these are severe violations that have happened to them as a person – and that doesn’t make you any less of a man for having it happen to you.

Many participants reported having to address issues with misogyny, hatred or mistrust towards women as part of the therapeutic process. Part of that work involved critically exploring the influence of patriarchal society that calls for the positioning and policing of women as inferior or subordinate to men (Manne, 2015). It also means considering how this positioning and policing extends to men and others who exhibit feminine like characteristics that challenge masculine ideals. As Ben, Kate, Shane, Joanna, Susan and others noted, important to the work was addressing that fact that sexual assault was not something that is solely a female experience - it can happen to anyone, regardless of gender, sexual orientation or any other defining characteristic.

Kate and Susan believe how we socialize males towards females and how ideas of gender develop over childhood has a huge impact on how survivors process their experiences. Kate

describes a fear or hatred of anything feminine as central to the problem, something she believes starts when boys are very young:

> If you look at insults - the worst insults you can make relate to like female genitalia. Men learn, starting when they are very little, it's somehow less good to have feminine characteristics and that somehow, it's more feminine to be the victim of violence and sexual violence, that's part of...I mean, it sounds terrible but it's really true, that somehow if you're a victim of a sex crime that - that makes you more female in the perception of it…..and that somehow to be female is somehow not – that it's somehow bad.

Shane states that many male survivors he works with struggle with feeling weak or helpless, and that "by admitting this [trauma happened], they're showing some femininity in some way. And that's problematic…relating femininity to weakness or even vulnerability, but it really is ingrained through how it's understood…through the way we construct it." Susan agrees that experiences of weakness and vulnerability for many survivors go against the male discourse and lends itself to their struggle:

> So, the traditional belief about masculinity, I think, often focuses on dominance, independence, and an orientation to the world that's kind of active, assertive, valuing competitiveness, turning away from intimacy and achieving esteem kind of through force. And I think at the heart of that, you know, the fear is of emotion and if men see or express emotion, then somehow that compares them to females who are believed to be weaker or more dependent.

Bryce describes many survivors he works with equating feelings of weakness as emasculation as they struggled with accepting their past history of trauma:

So, they will…. essentially they will emasculate themselves. 'I should have done more. I should have said something to somebody. I can't believe I'm such a pussy'. I've even heard of stories like 'I was made to feel like a fucking girl'. Like all kinds of ways of … emasculating themselves. Just all kinds of condemnation. Self-condemnation.

Bryce notes that female survivors struggle with similar self-condemnation and questioning things like why they did not fight back more, but for male survivors this is more intricately connected to their male identity and their claim to masculinity.

Kate believes there are cultural expectations and pressures on men not to see themselves as victims, and to admit to being victimized poses a significant threat to one's sense of self and identity.

It does something to the ego and how we identify ourselves. You think of yourself as less of a man, where with women it's a different thing. So, as a woman I might be a victim of a similar thing, but I can see that's not my fault, and that it doesn't necessarily shift my whole view of myself [as a woman or as feminine versus a male's experience].

Joanna reports that most men she works with struggle with cultural expectations around masculine behaviour, and she says for many male survivors of trauma, what that translates into is that:

Literally anything that's remotely to do with women or femininity is just a horrible curse. It [femininity] is literally every curse word. To have this happen is to have done something feminine and so it's, you know, horrible…it's a horrible thing, and so no one wants to get in touch with that. And these male messages in the world -this entitlement and this disrespect for women. I mean, how can you grow up in the world with disrespect for half the population? Like good luck with that!

Managing misogynistic thoughts, beliefs, and attitudes was very common to participants work with male sexual trauma survivors. Participants described how their clients often equated victimhood with femininity and as a result seemed to at times denigrate or demean anything associated with women and girls and tended to internalize anger and frustration towards all things considered feminine. In order to establish their masculinity, men and boys would cast out anything remotely to do with femininity. This finding was interesting because while there is a clear linkage in the literature between misogyny and anti-femininity and men's violence against women, there does not appear to be an established connection between misogyny and anti-femininity and the experience of male sexual trauma, other than the rejection by survivors of emotions related to vulnerability, which is arguably described as a more typical feminine characteristic. This will be unpacked and explored further in the following chapter.

Homophobia: Am I a Fag?

Participants described survivors' struggles to understand why their perpetrator selected them, and how they were often left overwhelmed with feelings of shame, guilt, and self-blame relating to their victimization. Participants all believe this was most shameful and difficult to navigate when the perpetrator was male, and many equated that to a heteronormative culture that continues to perpetuate homophobic beliefs and stereotypes that are harmful to male survivors. Survivors also struggled more intensely if they experienced a bodily response and arousal to the abuse, which they often equated to signifying they either were gay and therefore attracted the perpetrator unwanted attention, or they would now become classified as gay due to the experience. Participants noted there was little pattern to why boys were selected, except that those more marginalized were likely most at risk. Examples of marginalization were given as

young survivors who were isolated from peers, or who grew up in homes with intimate partner violence, or with caregivers struggling with substance abuse or mental health issues.

Survivors who questioned, “what was it about me that made this person select me?” were often left with a silent, inward struggle to understand the experience, which can lead to an undermined sense of self. Peter described working with survivors who struggled where that questioning “has definitely interrupted and interfered with just the kind of stable sense of self, with sometimes a feeling like they are one person to society, and then another person to themselves.”

Homophobia serves as an organizing principle of a cultural definition of manhood, and one that some men struggle to position themselves away from (Kimmel, 2008). Susan says many of the survivors she works with struggle with sexual identity, and she describes “their worry that the experience made them gay or means they are destined to be gay.” She described working in corrections and dealing with homophobia among survivors that impacted their ability to access:

> Many of these men would adamantly refuse to work with male therapists – because it was a male who perpetrated on them - and so they needed the ‘safety or another gender’, but unfortunately sometimes a female therapist just wasn’t an option in those settings.

Kate believes experiences of sexual trauma can leave young men and boys struggling with questions around their sexual orientation and the influence and impact of the sexual act itself:

> Many don’t even realize they were victims. Like it didn't even occur to them, even though it had impacted huge areas of their intimate relationships for years following, even though there was no consent. Because their body right responded in a way they somehow take as their own fault, so therefore they couldn’t be a victim. And if a person isn’t gay or bisexual or anything and it's a male perpetrator, very clearly in their mind

> they know that they didn't consent. But then it's a different kind of thing that they wonder that am I now gay. Does this make me gay? Because of their body's responding in a way that you know that they don't want it to. It's so much more confusion in an already confusing time. Because they can get an erection, they actually they feel like that somehow, they wanted it. So it's almost like it couldn't have happened. It couldn't happen unless you got an erection, so therefore you participated. You are complicit in it.

Richard also sees how male on male abuse sets up some confusion around sexual orientation for many survivors. He says part of the early work in therapy is exploring the concept of "body betrayal", the experience of sexual arousal during the abusive encounter:

> 'I was abused by a man and my body responded positively to that and so I must have liked it'. I think especially when you achieve orgasm while being sexually abused. It creates real problem for men, and something that you often have to work - the fact that your, your body has its own its own neurologically and physiologically way of responding to things that's completely separate from your beliefs and cognitions.

Bryce worries for some that challenging their questioning around sexual orientation leads to further confusion and pain for some survivors, and does not necessarily need to be directly addressed:

> My thoughts are that if trauma has something to do with why somebody ends up preferring men to women, so what? I don't need homosexuality to be a centralized as I was born that born that way because like I think that's something that we think - something that queer communities have had to use to try to secure themselves in some way like "we can't help it." But what if you could? You should be able to… you should be able to choose this too, right? So, if trauma has something to do with why [a survivor]

> ended up feeling safer with men or women or identifying gay or straight, I don't have any problem with that. If that's somewhere in the storyline…I don't think that makes you worse or wrong or bad or anything. There doesn't have to be the right reason to be gay, trans or anything…

On the other hand, Daniel believes that young males who experience sexual trauma in early adolescence and during a time when they are starting to form their sexual identity as particularly harmful and that it needs to be addressed as part of the therapy process:

> I've worked with men who have experienced abuse twenty years before in their early teens, and up until now they've never spoken about it. And they express a lot of sadness and confusion, anger of not being able to make those choices or not coming to that decision in terms of their sexual identity in their mind by themselves because of the confusion added so early in their lives by the abuse. And it leaves them with shame and so many what if questions. So, it wasn't the… process of somebody coming into their own, of identifying how they wanted. And so that's a lot for them to take in, and something that needs to be unpacked and explored.

Richard says that, in general, queer men more often than straight men are more likely to intentionally seek out his group for male survivors:

> It's like they are coming out of the closet as victims of sexual assault, which is like their second or third coming out whereas with straight men – it's a big deal. And I think that a lot of straight men have difficulty with, particularly if they were abused by men, have a hard time squaring that off with their heterosexuality. You know, men will say things like, did he abuse me because he saw something in me? Which is - it's almost a fearfulness of the possibility of queerness within.

Richard says he firmly believes that for heterosexual men, reporting male on male abuse is problematic because “we live in a society where homophobia is still a real thing. And so, to say that this thing happened is not only shameful, but it also has the added dimension of calling into question your sexual orientation”. Susan also echoed this as a complicating factor for many survivors:

> Because then there's the whole issue with sexual identity and how that impacts intimate relationships going forward. And again, creating a safe place to talk about that [experiences of sexual trauma] because that's just not easy for human beings to talk about, period, and let alone, you know, male survivors to be able to kind of talk about that. But I feel what is crucial is to help a survivor not to view every other male person through the lens of the abuse and to really illustrate that there are healthy respecting men that- that can be kind and loving and that men can be with in a relationship.

A heterosexist society is harmful and damaging to male sexual trauma victims of male perpetrators because it stigmatizes what for the survivor is already a shameful act. Fear of a homophobic response makes young male survivors reluctant to disclose, because they are afraid of the resulting stigma and stereotypes. Sexually abused boys often feel deep shame about their abuse but are even more ashamed to disclose due to the insidious effects of a heterosexist and homophobic culture.

Re-Storying Trauma

Meaning making in trauma work requires survivors knowing their larger stories, something that is often challenging, both because their stories are so difficult and because of dissociation and fragmentation among the parts of that hold different aspects of the story (Grossman et al., 2017). Participants felt that a significant part of their work was helping

survivors build a coherent narrative and that a more integrated self was key to the recovery process. They described approaches that I will present under seven distinct subheadings which will help illustrate and explore some of the treatment processes they describe adapting and using with male survivors.

Psychoeducation

Participants talked about the importance of psychoeducation around the prevalence of male early childhood sexual experiences in the early part of treatment and, as Ben described it, the need to "normalize what isn't normal and reassure people they aren't alone in this journey". Gillian stated that "to just sit with them and help them understand, sadly, the harm that we can bring to each other, to know this was an abusive thing that happened to me and it was wrong…there is power in that". Susan saw psychoeducation "as providing a foundation that all of treatment is based upon" and said that:

> to give knowledge and understanding that this is a shared human experience, that others have walked this path and that not only have they survived, but today they are now thriving – that in itself is incredibly uplifting and powerful.

Dealing with Uncertainties

Ben acknowledged a need to correct misbeliefs or untruths around the phenomena of male childhood sexual abuse, particularly in situations where families either did not believe a disclosure or dismissed or minimized the impact of the experience. Through that form of response, a male survivor often questioned the event with their own degree of uncertainty: "if you as a parent are telling me it didn't happen or it's not a big deal, my only choice is to walk away thinking the same".

Kate and Daniel both described working with survivors who did not realize the abusive acts in the accounts they were describing. Kate says “they can recount this terrible story where they have been manipulated, used, threatened, and the story – the story trails off to a question. ‘Was that trauma – was that what I think maybe it was?’”

Richard described uncertainty and denial as playing a significant role in his work with survivors of incest perpetrated by older brothers, and said:

> invariably there will be stories of the abuse having been caught or discovered, where a parent will slap the older child in the head, say ‘don’t do that!’, and still they go right back to sharing a bedroom, the same sleeping arrangements, and the same ongoing cycle of abuse with no one calling it that.

He noted how the incestuous experiences became almost normalized to some survivors, “something that probably happens in lots of families, and so therefore he [the survivor] says ‘maybe then it doesn’t affect me that much’”.

Working through Shame

Julia spoke of how prevalent shame was in a survivors’ beliefs and attributions about himself, and something that had to be tread carefully around. She talked about approaching the work with:

> relentless empathy and validation and curiosity. I think that’s pivotal to kind of...to help someone even be able to come out and begin to peek out under from that veil of shame, to begin to show themselves and to show up in a way that's authentic and true and maybe different.

Shane says the shame around these experiences can be overwhelming, much of which he attributes to heteronormative assumptions in society that make it challenging to process sexual traumatic experiences for men and boys:

> There's so much shame, so much stigma…tied to the sexual abuse, and all the stuff that makes you question around your sexuality, your orientation. 'Did I invite this?' But there are also the other things that are shameful like I mentioned before, like the substance use or the fighting and the constantly trying to prove yourself as – as a man. There's shame that comes with all of that, too.

Susan spoke to the silencing aspects of shame and how it "almost colludes with the abuse", while Bryce approached the issue as "shame is not letting me [the survivor] be vulnerable, and by not being vulnerable, I'm not able to heal".

Attaching New Meaning to the Aftermath

Several participants talked about helping people re-story their lived experience because they were not only dealing with shame and guilt due to the abuse experience itself but sometimes also the aftermath. As Shane described earlier, an important tenet of his work and something he describes as feeling very passionate about is:

> helping people understand the reasons why they – why they…connected with some certain people and not with others, maybe made choices around relationships or substance misuse they weren't proud of…. I feel like it is crucial to redefine some of those things done in the past as was a way and a means to survive, as a means of coping with stuff that was pretty hard to take, and, yeah, that they had to do these things as a means of survival.

Joanna noted how it was important to reconcile the survivor narrative as part of your overall identity, but to always keep in mind:

> there's so much more that goes into what you, as a human being, represent with your many skills and your talents and your wisdoms. If anything, this experience shows that you are strong, and that you can overcome most anything, and that is such an important message to take away from it all.

Susan stated she believed that many people who primarily trauma work do so as a result of their own histories with trauma as a means of contributing and helping others. She believed it was important to work with survivors as they heal "to give back to others, to think of ways they can use their gifts and be the instrument in someone else's healing".

Honouring Survival

Ben described a crucial part of that work involved "empowering that...that ability of being able to survive until now; regardless of how they survived, despite some truly terrible circumstances". Ben labelled this "highlighting hidden resiliencies". Resilience is defined as an engagement in behaviours that helps the individual [the trauma survivor] navigate their way to the resources they need to sustain and flourish (Ungar, 2011). Processes of resilience only occur, however, when the individual's social ecology (i.e., their formal and informal social networks) has the capacity to provide resources in ways that are culturally meaningful (Ungar, 2011). Most participants believed that helping survivors locate these hidden resiliencies was helpful in allowing the survivor to uncover more successful ways of engaging with the world.

Others, however, thought it much more relevant to point to actual capabilities a survivor has in that moment, considering their age, their environment or their circumstance. Richard said

it was “important to put yourself [as a survivor] back in those shoes of that little boy, not the man you are today”. As Joanna described it, that work revolves around helping a survivor:

> realize what a vulnerable little boy he was, because often they put that all that maturity and experience on to that incident but when they sit here, I can remind them over and over: ‘How old were you? Do you know any 8-year-old boys that could…?’ I feel like it’s important to look to change that perspective, to take away the maturity and the experience they infuse in it, and highlight instead the vulnerability

Re-imagining Identity

Gillian spoke of how being a survivor of sexual assault can, for some, become all-consuming to one’s identity. She described working to foster a sense of a more multi-dimensional identity within survivors:

> So, yes, a sexual assault survivor is part of who that person is, but maybe they also do a kick ass job of creating art or maybe they are an incredible baker.... to not see them solely as a survivor, because they really are so much more. Helping them see that, and to re-work or rewrite that story. And yeah, sometimes the survivor piece shows up in the other areas and that is where some work comes in to understand, like ‘oh you know, it was this part that maybe peeked out and popped up there and maybe this was the trigger’. I do a lot of parts work that helps people manage conflicting emotions as well - there could be a part of them that feels something and another part that is pensive or scared, and that is OK. And it gives people wiggle room as well. Once you've said something it doesn't mean it's always in the room and it stands forever. It is always adjustable.

Other participants talked about helping survivors manage conflicting feelings about their histories. Joanna noted that this didn’t always involve their history of abuse but rather:

other stories, like how they are relating now. Often people will tell me things about a time when they lost control and…. hurt or lashed out at their parent or their friend or their partner - something happened, something triggers them back…they're unsafe and they have that trauma response to fight. So, you can ask them, you know, what was going on in that moment? So, we go back and help them realize that what was happening in that moment before they acted or reacted? So that they're just really slowing down what's happening to them, so they can get some understanding of what's going on, how they're getting triggered to past emotions and how they can help ground themselves in a way that assures them that they're safe – and that those around them are safe – right now in this moment.

Richard shared his belief that, through healing, a survivor needs to include their abuse narrative as part of their overall narrative, because "at that point you no longer need to operate from a place of shame". This becomes complicated for survivors because it forces them to evaluate all relationships in their lives, and these relationships may have implications that are shameful or harmful to survivors. If they operate from an assumption they were a dysfunctional person prior to healing work, he says, and now see themselves as a more functional person in the present, they might question whether the relationships they have today are the relationships they need to be healthy and whole. For Richard, it is not only about re-storying the past but also looking to reshape the future:

So, your world actually changes as you heal and you actually have to prepare to live at that next level because there is- well, with growth comes loss…and so, you gain this new level of health and functioning, and you actually have to integrate yourself at this new level. But the thing about growth is that you're going to grow for the rest of your life. So,

> once you've attained some kind of stability at that level, guess what happens? You begin to experience more distress, which is confusing because you're already, in your mind, 'healed enough'. Suddenly, new needs and new opportunities come and then you say, 'Oh, my goodness, I'm seeing things that I've never even seen before.' And now I realize that because of my abuse, I'm not ready for this stuff, so I must go through his healing cycle again for the next level. So, this helps to see that healing from abuse – that it's a cycle, a never-ending cycle, and in that sense, it becomes – it becomes almost a never-ending chance to re-story one's life

Participants all believed that telling and re-storying the trauma narrative were important parts of the healing processes for men and boys. But due to the narrow discourse on experiences of sexual trauma and men and boys, they were often forced to pull together an eclectic mix of approaches to find an effective pathway towards healing work. They all believed it was important to look past the initial presentation of things such as anger issues or substance abuse problems and set aside pathologizing diagnoses and past failed approaches to treatment so that they might look at survivors with a new perspective, and consider how for many their challenging way of being in the world could be a secondary response to some terrible life circumstance they may have tried and failed to successfully overcome.

This chapter explored seven themes interpreted from the rich and detailed data obtained through semi structured interviews with the study's participants. Themes included: Hidden Survivors; Some Moral Distress; Dangerous Disclosures; Challenging and Renegotiating Masculinity; Misogyny/Fear of the Feminine; Homophobia: Am I a Fag? and Re-Storying Trauma*.* These themes will be more fully unpacked and analyzed in relation to current literate around experiences of male sexual trauma in the following chapter.

CHAPTER SIX: ANALYSIS AND DISCUSSION

The following chapter will provide an in-depth analysis of the research findings as well as connect the identified themes back to the current literature. The analysis will help further an understanding of how toxic masculine culture impacts the healing process for male survivors of early sexual trauma. I will begin with a brief overview of how this culture intersects with experiences of male childhood sexual trauma. I will then review current therapeutic practices by participants and provide a critique of the medical model of care. I will then discuss implications of silence around this phenomenon and how it renders survivors invisible and examine some of the myths and assumptions that perpetuate stigma related to male childhood sexual trauma. I will critically examine the impacts of sexualized trauma on male identity and explore ways that survivors might work to re-story these experiences. I will also explore ways we might address and combat perceived stigma within health professions around male childhood sexual abuse. Finally, I will consider some possible male-centred responses and alternatives to traditional office-based talk therapy with male survivors.

Toxic Masculine Culture and Challenges to Healing for Survivors

The findings of this research are consistent with literature that describes strong adherence to traditional masculinity as having negative impacts on the ability of young male sexual trauma survivors to access and receive help (Allagia et al, 2007; Gartner, 2000; Gartner, 2017a; Kimmel, 2008; Sorsoli et al., 2008). Furthermore, stigma related to homophobia and misogyny was demonstrated throughout this study as a problematic to male survivors and a significant impediment to disclosure. This was something that was highlighted by all participants in this study, as they detailed difficult feelings held by male survivor relating to fear, shame, guilt, self-loathing, and a sense of isolation. While the impacts of homophobia on male sexual trauma

survivors within the context of membership in heteronormative culture were well detailed in the literature (Allagia, 2010; Gartner, 2000; Kimmel, 2012), issues relating to male childhood sexual trauma specifically to misogyny or anti-femininity are not clearly described. There does exist a large body of research relating misogyny and male violence against women (Augusta Scott et al, 2007; Katz, 2006; Kimmel, 2012) but no real evidence of male sexual trauma survivors and a propensity for violence or hatred towards women as an impact of their abusive experience. But part of the challenge in drawing conclusions or ruling out connections between misogyny and male childhood sexual abuse is the scarcity of research on male survivors, and more specifically the lack of knowledge around male children and youth and their experiences of disclosure, and if, within that disclosure experience, exists a propensity towards misogynistic thinking and a potential for violence towards women. While the research that is available does suggest boys do adopt some anti-femininity rhetoric or position themselves as masculine away from all things feminine (Allagia et al., 2005; Kia-Keating, 2007, Kimmel, 2012), it would be unreasonable to suggest a certain connection between male sexual trauma experiences and misogynistic violence without focused research in the area. In reality, most male survivors do not engage in violence towards women or in homophobic acts, but they do struggle at times in a heterosexist society that condones both misogyny and homophobia and equates femininity with weakness and submission.

However, in the narratives presented here, participants described survivors who conflated characteristics of strength as aggressive acts, which in turn were problematic and often caused harm to survivors and to those closest to them. We have discussed in earlier chapters how men tend to die earlier, suffer more chronic illnesses and experience undiagnosed and untreated mood disorders. Boys and men are often socialized to keep their emotions in check and present as

strong and silent. Strength can be very positive, and not just physical strength, but strength of character, something that might give voice to calling out injustice and racism and misogyny and homophobia and transphobia in society. But when a man cannot and will not show or express his feelings or emotions, or when he cannot ask for help or seek assistance, he will likely suffer for it. When masculinity impacts men in that way, it is then it becomes toxic.

Participants believed the silence that surrounds the phenomenon of male childhood sexual abuse clearly perpetuates stigma, and the stigma related to mental health issues and help seeking behaviour for men and boys compounds the issue even further and contributes to the hidden victims of childhood sexual trauma. Participants also highlighted some profound effects on masculine identity formation, and how this was highly gendered experience for male survivors, something that is not always apparent in therapeutic approaches with boys and men. This was consistent with literature that called for a review of therapeutic approaches under a more male centered lens that might address issues for men and boys in ways that were more culturally meaningful and responsive, and served to engage them more fully in treatment processes (Allagia, 2005; Fisher & Goodwin, 2008; Gartner, 2000; Kia-Keating et al., 2005; Kimmel, 2012; Lisak,, 2017).

Aside from the few in this study who work in care areas centered mainly around trauma treatment, participants by and large did not have a great deal of experience working with male children and youth at the point of disclosure, as male childhood sexual trauma was rarely a presenting issue in their mental health clinics and settings. Other factors that participants described, consistent with the literature, include a fear of loss of one's masculinity, a fear of being seen as "feminine" or womanly, and a fear of being perceived as homosexual as delaying or preventing disclosure (Alaggia, 2005, Alaggia & Millington, 2018; Sivagurunathan et al,

2019). The literature also references some significant deep-rooted fears of survivors becoming sexual abusers themselves (Allagia, 2005; Gartner, 2000; Gartner, 2017a; Lisak, 1994; Lew, 2005). However, this was not reported or discussed by any participants in our interviews, and when explicitly asked about reports of survivors presenting fears of becoming potential perpetrators on others, participants did not disclose any real experience with this phenomenon. Participants like Joanna, Shane, Richard, and Adam did describe fears reported in some survivors in managing their anger and emotional regulation and the potential in harm to others in relation to that dysregulation. I would surmise, however, that because there is such strong evidence in the literature that fears of perpetration on others is a significant concern for survivors upon disclosure, participants lack of experience with young males at the point of disclosure might have precluded their encounter with this phenomenon. More importantly, however, I would argue that for a survivor to admit fears of one day becoming a perpetrator of sexual trauma is a very dangerous sort of disclosure, one that would likely be met with considerable stigma, rejection, controversy and fear upon discovery. And so rather than risk vulnerability in admitting such a fear, the survivor is silenced by a community that would not welcome such disclosures.

Participants noted a lack of training opportunities and workshops devoted to treating mental health or trauma issues specific to men and boys, something that was also reflected widely in the literature (Alaggia, 2005; Allagia, 2010; Teram et al., 2006; Sivagurunthan et al, 2019). As a result, therapists may feel under trained, have a lack of confidence or feel unsupported in treating male childhood sexual trauma (Gruenfeld, Willis, & Easton, 2017). Again, this was common in reports from participants who critiqued the lack of available training specific to male childhood sexual trauma experiences, or like Shane who criticized how issues specific to men and boys were minimally attached to training around women and girls and sexual

violence as an afterthought. Participants also critiqued the lack of readily available supports and services, which as Adam and Gillian noted, left survivors who were prepared and motivated to access help without an avenue to receive it.

By treating victimhood as outside of cultural norms of masculinity for men and boys, young male survivors are therefore excluded as victims and constrained by social expectations (Hlvaka, 2017). This study supported the notion that rigid adherence to traditional or hegemonic masculinity – or toxic masculinity – can have a negative impact on the help seeking processes for young male survivors. Male sexual trauma survivors are therefore subverted and separated from the resources they need to process and heal from their traumatic experiences.

Break the Silence/Into the Light

Foucault (1991) suggests that it is through discourse that our view of reality is both created and sustained; in other words, language and the ways and means in which we communicate not only reflect our reality, they create it. As Foucault points out, silence is necessary for the construction of language. Because silence forms as absence through exclusion, what Foucault defines as ‘madness’, an opposing discourse based on inclusion and representation can be constructed. However, those things that threaten the dominant disclosure are often excluded, devalued or ignored. In this case, experiences of male childhood sexual trauma that position men and boys as far removed from tenets of hegemonic masculinity and therefore they are dismissed, because their very existence poses a threat to that dominant ideals and normative values of hegemonic masculinity. And yet, the ‘not said’ – those things excluded from dominant discourse – cannot be fully erased or extinguished, and so in their continued existence they also serve to inform what is said. Silence therefore is not necessarily the total absence of voice but rather an inability to be heard, something that can have many causes. As Foucault (1991) tells us,

“there are not one but many silences, and they are an integral part of the strategies that underlie and permeate discourses” (p. 27). Foucault views all discourse as made of up of structures and elements which join together to make a whole. While also an agent of power, silence is one of those discursive elements, and discourse emerges from things said and unsaid, those that are allowed and those that are forbidden. Discourse as a vehicle for power can manifest as the domination of one discourse by another, in an oppositional relationship (Fairclough, 1989) – in this case, that men and boys cannot be victimized – and therefore the , dominated discourse (childhood sexual trauma of men and boys) is silenced, suppressed, and rendered invisible. Discourse around childhood sexual trauma can therefore silence and suppress experiences of men and boys because it goes against dominant discourses that say men cannot be victims and that sexual abuse is something that happens only to women and girls.

In researching and in reviewing the current literature, I found the rampant silences and secrecies that surround the phenomena of male early childhood sexual abuse to be astonishing in its scope and reaches. As a survivor from decades ago, it was disheartening to discover first-hand how little had changed in terms of knowledge related to sexual trauma of males, in the lack of expertise within mental health, and in the available pathways to support and healing over time. Silence around male childhood sexual trauma was central to every conversation I had during this study. Participants noted little capacity to work with male sexual trauma within their own workplaces due to a disparity of skilled knowledge and focused attention, noting, as Peter described, “there currently is no specific centre of expertise or establishment of readily available resources and supports related to male childhood trauma within our systems.”

The few and sparse resources available within Halifax Regional Municipality to help address the needs of sexual assault survivors are designed and intended for women, based on research related to specific needs and approaches with female survivors of sexual trauma. *Breaking the Silence: A Coordinated Response to Sexual Violence in Nova Scotia* (Nova Scotia Government, 2016) was released in 2017 as the first provincial sexual violence strategy, intended as a foundation for coordinating services to help sexual trauma survivors. However, while it does acknowledge that male survivors do exist and that gendered male-centric services would be appropriate in treating their unique needs, it does nothing to define explicitly what those services might be, and does nothing to further address treatment and support for men and boys. As Adam noted when considering available resources for male survivors: "it's not even that men and boys need help navigating the system pathway…it's that there is NO pathway. The pathway simply doesn't exist".

While the literature says that one in six males experience early childhood sexual trauma (Fisher & Goodwin, 2008), it is important again to reiterate about half of the participants in this study described less experience and overall few opportunities to work with boys and young men directly at the point of disclosure. Rather, a more common occurrence was to work with adult men who were externally driven to engage in therapy, sometimes by life events such as the deterioration of an intimate relationship or the threatened loss of employment and livelihood, and from that point hear them disclose early childhood sexual trauma experiences. Haunted perhaps by troubles with addictive tendencies or explosive bouts of anger or tattered relationships, participants report that these survivors found themselves encumbered by pathologizing diagnoses and treatment pathways that did little to address likely the core issue at hand - the aftermath of their early betrayal. At times, successful adult development is difficult for male survivors

because they are hesitant to trust others or express their personal needs and vulnerabilities, which in turn can make them prone to "shutting down", with a desire to isolate themselves in order to feel safe (Lisak, 1994; Kia-Keating et al, 2005). Although acts of isolation and withdrawal could have served as important for protection in childhood and as means of resistance, these behaviours can become highly counterproductive to positive adult development and healthy relational attachments (Kia-Keating et al., 2009; Schuetze & Eiden, 2005).

In her work with female survivors, Brown (2013; 2018; 2020) speaks of the dangers of trauma talk, meaning that patriarchal assumptions and dominant discourses around violence and trauma create problematic stories that are often unhelpful and blaming and in turn work to suppress the voice of survivors. Female survivors try to make sense of their experiences within dominant social narratives promote dominant oppressive discourses, including disbelief and blame. I argue that this explanation has salient meaning within the context of male survivors and their experiences, because much like the women described in these studies (Brown 2013: Brown 2018), men's stories are constrained by the limited discourses available that actually describe or fit the experience of male childhood sexual trauma (McKenzie-Mohr & Lafrance, 2011). Foucault's (1991) notion of technologies of self is useful here in considering male silence as it relates to their experiences of male childhood sexual abuse. As men, we construct our social identity through discourses that include silence. Silence shields portions of life from view, and in turn men can engage in technologies of the self by choosing to reveal different aspects of their identity dependent on their social location, their circumstance and the context of power relations they find themselves within (Sirotich et al., 2012). Silence then becomes best understood in terms of a plurality of silences which are fluid, permeable, changeable, and with boundaries that can be broken (Sirotich et al., 2012). When survivors silence themselves and their experiences in

order to be compatible or congruent with the messages they receive socially, they can become confused and constrained in relation to their masculine identity.

Breaking the silence and changing that discourse therefore involves risk to one's masculine identity. "In the end, silence seems to be a strategy employed to address a yearning for acceptance, or to ensure survival, but its adoption, ironically, often leads to alienation" (Sirotich et al., 2012, p. 59). Part of the work in supporting survivors is to critically examine ways to lift these veils of silence within our system and bring the sequelae of male childhood sexual abuse experiences out into the open and the light in a more mainstream way, perhaps by first acknowledging and recognizing the reality of the phenomenon and its devastating and silencing impacts, and then seeking ways through consultation and working with male sexual trauma survivors to offer and provide appropriate treatment services and resources to aid in healing and recovery.

Stigma in Mental Health Systems

While the long-term sequelae of childhood sexual abuse for men and women have historically been considered similar (Allagia,l 2005; Teram et al., 2009), research has identified some important differences, such as the greater propensity for presenting externalizing, acting out behaviours among boys and for internalizing behaviours among girls (Allagia, 2005; Allagia & Millington, 2018; Teram et al., 2009). Researchers also recognize these differences in what appear as presenting externalizing versus internalizing behaviours are also part of a gender bias in health care, where boys are more likely to be identified as aggressive, hostile, and emotionally dysregulated, and girls are more likely to be perceived as sad, anxious, or depressed. Girls are also challenged and encumbered with the many trappings of a cultural dominant discourse where, and as Marion Brown (2011) tells us:

> girls grow up in a hostile cultural climate that is oppressive to females, sexually charged, and dangerous, circumstances that break them of their pre-teen confidence and splinter their authentic selves into subservient, depressed and alienated versions of the self (p. 111).

Another major difference, and arguably the most impactful with possible consequences on male health, is the incongruence between male role expectation and the experience of victimization, and it is this disconnect that creates barriers to the acknowledgment of sexual abuse by male survivors themselves and by the health care professionals who work with them (Allagia, 2005; Allagia & Millington, 2018; Gartner, 2017a; Lisak, 1994; Teram et al., 2009). Findings of this study also indicated that mental health professionals may use some skepticism and engage in minimizing and take the experience of male survivors less seriously than that of their female counterparts. Participants like Ben, Gillian, Daniel, Richard, and Adam all spoke of disclosures that were dismissed or minimized in a way that caused survivors to retreat from help seeking. Daniel described a disclosure as something that befalls the entire family, and so for a survivor "to name the abuse meant to risk shaming and alienating everyone around him, and so once that happens and you deal with the ripple effect, you learn not to do it again".

While the many barriers to disclosure of sexual trauma in men and boys is described in the literature and voiced by this study's participants, it is important to reiterate that men's social power and their dominant role in patriarchal society likely contributes to the lack of discourse related to male childhood sexual trauma (Allagia 2005; Gartner, 2000; Teram et al., 2009). Ironically, therefore, it is "this privileged position that makes it more difficult for male survivors to acknowledge themselves as victims and for health professionals to view them as such" (Teram et al., 2009, p. 514). While male survivors do not seek out therapeutic support as often as their

female counterparts, the literature suggests that the number of men and boys seeking help is in fact slightly increasing (Allagia, 2005; Fisher & Goodwin, 2008; Gartner, 2000; Teram et al., 2009). These findings from the literature are not consistent with experiences of participants in this study, who saw men and boys vastly underrepresented in sexual trauma help seeking discourse. However, there could be many explanations for this discrepancy in findings. Many of the studies reviewed were conducted in larger metropolitan areas like New York, Los Angeles, Ottawa, Vancouver, and Toronto, so statistically with the sample size under consideration, more instances of male childhood sexual trauma history would likely appear. Furthermore, these same metropolitan areas house centres of excellence that provide male centric treatment options, which may mean they are more likely sought out by professionals and survivors – for example, one of this country's most recognized leading agencies in male centred approaches to working with men with sexual trauma histories, *Men & Healing: Psychotherapy for Men*, is located in the heart of Ottawa.

However, findings of increased demand for access to services could also be an indicator that eventually more and more male childhood sexual trauma survivors will enter our systems of care, and as health care professionals there is both a need and an onus to build more capacity in male centred approaches and to be better prepared to help male survivors manage their unique trauma experiences. But due to the lack of research specific to health professionals' attitudes and practices towards male survivors, it is challenging to determine the extent to which mental health care systems are prepared (or not prepared) to face this demand. One of the few studies suggested that health professionals (including samples of doctors, nurses, social workers, and psychologists) were unlikely to ask male patients about abuse if it was not indicated (Lab et al., 2000), despite evidence pointing to the prevalence of histories of abuse in those with psychotic

disorders (Gartner, 2000; Gartner, 2017a; Lisak, 1994). This arguably indicates that some professionals are not fully aware of the correlations between sexual abuse and mental health and its many impacts. The literature indicates that most professionals have little specific training or experience assessing and treating male sexual abuse survivors (Allagia, 2005; Gartner, 2000. 2017b; Teram et al, 2009), which would also be consistent with the experiences of this study's participants. Furthermore, studies show that mental health professionals do not consistently screen for early childhood sexual trauma with boys and young men, and that there exists a tendency to underestimate the prevalence of male childhood sexual trauma and its long-term effects (Allagia, 2005; Gartner, 2000; Gartner, 2017b; Lisak, 1994).

Moral Distress/Moral Courage

Participants worked in what they themselves described as "pathologizing" and problem based medical models of mental health care, overly focused on assessment, diagnosis, and labelling. Those in community mental health clinics described an almost endless cycle for trauma survivors, regardless of gender, of seemingly inhumane intake processes where they must repeat their traumatic histories over and over. From that point, if allowed entry into service, they were offered a short-term intervention that barely scratches the surface of the challenges they faced before being discharged, then only to start the process over again a short time later with some newly arisen crisis. Participants critiqued current mental health systems for their over reliance on brief intervention therapies, processes that were often, as Bryce noted earlier, traumatizing in terms of their exposure, and problematic approaches that served as what Ben described as "band aid solutions to longer term problems". They described a tension sometimes in working with survivors and treating things like substance abuse issues, as Daniel noted, "as a disease versus a symptom and perhaps a maladaptive way or means of coping" with some larger unresolved

trauma. As Brown and Stewart (2007) note, when treating addictions as a primary disease, the possibility that substance misuse is a secondary response to trauma, depression or anxiety is often totally discounted.

Despite the many challenges' participants faced in reconciling these discourses in mental health work, they described active ways they resisted and advocated for positive change in their work with trauma survivors. Participants presented complex case formulations to team leaders and managers and pushed for longer term sessions and shorter time between visits. They also collaborated through forms of clinical trauma supervision where they present challenging cases and discuss treatment formulation amongst peers and colleagues. Meanwhile, those in private practice, as they described earlier, often offered sessions at reduced rates or on a sliding scale, recognizing how the financial constraints of paying for therapy may place it out of reach for many.

Participants' experiences were consistent in their description of current mental health systems' propensity to conceptualize extreme behaviours and distress as symptoms of mental illnesses, rather than view them as occurring within the context of past or current trauma (Sweeney et al., 2016). As Herman (2015) tells us, most survivors of prolonged, repeated childhood trauma never come to psychiatric attention and those who do recover are often left to do so on their own. Survivors who become patients can present with a bewildering array of symptoms including depression, anxiety, problems with anger, extreme phobias, disordered eating, insomnia, sexual dysfunction, self-harm, suicidality, and substance addiction which at times appears at a higher level of distress than "typical" patients (Briere & Scott, 2015; Herman, 2015). Participants also endorsed what Herman (2015) describes as a "disguised presentation" – symptoms such as difficulty in interpersonal relationships, troubles with sexual intimacy, or

repeated victimization where neither the patient or therapist recognize potential linkages between presenting problems and a history of traumatic experiences. Survivors are therefore “frequently misdiagnosed and mistreated. Because of the number and complexity of their symptoms, their treatment is often fragmented and incomplete” (Herman, 2015, p. 123). This corresponded with findings in this study from participants such as Peter and Gillian, who used words to critique approaches such as “piecemeal”, “hurried”, and “fragmented”.

Participants also acknowledged another persistent theme in the literature in that sexual trauma survivors can accumulate many different psychiatric diagnoses before underlying root causes of complex trauma recognized, identified, and treated (Briere & Scott, 2015; Herman, 2015; Van der Kolk, 2014). Borderline Personality Disorder (BPD) was the one most commonly cited diagnosis by participants, something Herman (2015) says “is frequently used within the mental health professions as little more than a sophisticated insult” (p. 125). BPD is usually characterized as challenges with emotional mood swings, impulsive and self-destructive behaviour, difficult relationships and attachments, fear of abandonment and isolation, self-harm, suspicion or paranoia, and feelings of disassociation. Clinical observations articulated decades ago by Judith Herman and Bessel van der Kolk note that BPD and its identifiable traits are much more representative of the complex sequelae of early childhood interpersonal trauma in which challenges with emotional dysregulation plays such a central role (Ford et al, 2018; Herman, 2015; Van der Kolk, 2014). As Brown (2020) notes, women who receive a borderline diagnosis are seen as “angry, non-compliant, resistant, and attention seeking, experience ongoing suicidality and as such are too often written off as being beyond help” (2020, p. 84). She also notes that little effort is put into understanding why they function this way in the world, and little psychotherapy is ultimately offered. The voices of those diagnosed with “borderline” have not

been heard, and more importantly their relationships have been let down, and most of their interactions with professionals now reinforce their thinking that people cannot be trusted or are incapable of understanding them and will ultimately abandon them (Brown, 2020). Ben says he believes BPD:

> is a highly controversial diagnosis that needs to be retired, because it is stigmatizing and – and I believe serves as code for someone's history with complex trauma. So, if a client walks in with that diagnosis, already I know what to look for in working with them.

Eclectic approaches are not uncommon among social workers (Coady & Lehmann, 2016), and participants in this study described their philosophical approach as eclectic and drawn from various sources. As discussed earlier by participants, a significant part of what restricts and constrains a guiding therapeutic approach for some is the limits and confines of the medical model and its problem/disease centered focus. With the deeply embedded brief solution focused emphasis of current models of care and treatment, the ability to slowly build rapport and unpack the trauma narrative becomes potentially constrained and restricted, which then has harmful implications for the healing process of trauma survivors.

Further critique of current models of care by participants was consistent with literature that centred around the lack of training and guidelines for practice with male survivors, and that available treatment services were designed primarily to meet the unique needs of female survivors (Easton, 2012; Gartner, 2018). Participants also identified a gender bias in trauma work that acted as a barrier at times to identifying, assessing and treating child sexual abuse in male clients (Easton, Saltzman & Willis, 2014). Specifically, therapists and health care professionals did not initially screen for past sexual trauma with male clients, partly due to the gendered nature

of the discourse around early childhood sexual abuse being something that happens mainly to girls (Allagia, 2005; Gartner, 2017a, 2017b).

Masculine Identity and Male Privilege

Patriarchal society demands that men live up to some ideal of traditional masculinity often far removed from their realities, and this divide is particularly true for male survivors of sexual trauma (Kia-Keating et al., 2005; Sorsoli et al., 2017). This dominant discourse around expectations of masculinity and the ways men encounter it in the sociocultural domain may be one of the major differences between male and female survivors in terms of disclosure (Kia-Keating et al., 2005; Sorsoli et al, 2017). For men and boys, sexual trauma experienced against dominant discourses of hegemonic/dominant masculinity are understood by many survivors as weakness and victimization, equate the experience as feminine, and thereby signifying their loss of masculine identity.

There was a gendered difference in this study in how participants approach the work of tackling male gender constructs and helping clients unpack their meaning. Specifically, female participants like Kate, Susan, Gillian, and Joanna were more likely to work with clients to discover and explore incongruities between traditional forms of masculine and their own lived experiences and offer empathy and a great deal of validation for those who had endured or managed a stricter enforcement or enactment of masculine codes. They approached the work with curiosity, and often used terms in our discussions like “tragically limiting” and “an impossible situation to be in” when describing the challenges of surviving sexualized trauma while navigating traditional masculine norms. Most of the female participants described working with clients with a very limited range of emotional expression when detailing their lives – as Joanna described it, “things were very black and white, you could be angry or you could be

happy, and that was it….it was like there was no recognition of the subtleties or of all the greys in between”.

On the other hand, male participants, while recognizing the legitimacy of the discourse around more dominant forms of traditional masculine behaviour, were quick to defend certain constructs of masculinity, and declare what masculinity could be, or perhaps more accurately define what it need *not* be. For the male participants in the study, specifically and carefully unpacking a multitude of masculinity types was deemed a much more helpful starting place in the therapeutic process. Adam and Nathan, for instance, were often much more hesitant to label certain forms of masculine behaviour as “toxic”, but they did acknowledge and recognize the impact stringent adherence to norms might have on clients, including how this rigidity might exclude some from being able to actively seek out and participate in treatment. Instead, they advocated for promoting and unpacking positive aspects of traditional masculinity such as self-reliance, strength of character, with focus on recognizing a sense of vulnerability, and a greater range of emotional expression.

An interesting finding came from three of the participants that identified in their personal lives as members of the LGBTQI2S+ community. Their positioning straddled a border between those described above, by strongly identifying and accepting those limitations around normative expectations of hegemonic masculinities, while also acknowledging the space to resist and renegotiate new forms of masculinity. I would argue that the difference in insight, as opposed specifically to their male heterosexual counterparts in this study, is likely related to challenges gay men face navigating, as part of their membership in a culture of subordinated masculinity within the context of a heteronormative and heterosexist society.

While participants expressed beliefs that while many men might not engage in sexist or

homophobic/transphobic beliefs, the indelible influence of those beliefs on masculinity constructs was undeniable. Male privilege, in the sense of the societal power allotted to most men and boys over women, and the cultural bias towards a heteronormative, cisgender idealized masculine norms stood in stark contrast to the experience of victimization of sexual trauma for male survivors. This was also consistent with research that demonstrates how male privilege is intertwined complexly with the maintenance of strict gender codes of conduct or masculine scripts of behaviour, and how that can then serve to restrict and constrain healthy functioning in men and boys (Allagia, 2005; Dorais, 2002; Gartner, 2017a; Gartner, 2017b). All participants spoke to the problematic tensions that arose from strict adherence to gender norms or masculine scripts which often resulted in men and boys being challenged to express vulnerability and the need for support. All participants used terms like "masculine scripts", "masculine norms", or "the man box" to describe rigid characteristics of masculinity that require stoicism, a denial of pain, and an ability to ask for help, and noted, as Adam and Bryce both stated, they are "so subversive" men and boys do not even recognize their influence or their harm. The findings of this study would therefore underscore the need to help survivors address and, at times, challenge patriarchal sexist and heteronormative beliefs that remain, for many, deeply ingrained in our culture.

Participants described working with survivors who struggled to reassert or re-establish their sense of masculinity in what survivors described as hyper masculine ways, which is consistent with toxic masculine culture under examination in this study. These included observations like engaging in violence or disruptive behaviours, remaining emotionally aloof and detached, and promoting misogynistic and homophobic beliefs. The literature here suggests that young male survivors intuitively recognize some of the societal stigma associated with same-sex

acts, and as a result seek to disassociate themselves from anything that symbolizes femininity or homosexuality because it serves as a threat to the dominant discourse of masculinity (Allagia, 2005; Gartner, 2000; Hlavka, 2017). Some survivors than go on to internalize some of these more hyper-masculine beliefs and act them out, possibly as a means of avoiding further stigma or self- ridicule (McGueffy, 2008). Furthermore, boys that are perceived as gay are stigmatized, while an acceptable masculinity (one that conforms as "masculine enough") can be performed and achieved through homophobic behaviour (Pascoe, 2007).

Much like female survivors, male survivors experience personal and interpersonal factors that impact their ability to disclose and engage in treatment, such as feelings of deep shame or guilt, sharing a sense of blame, or feeling they will not be believed (Allagia, 2005, Kia-Keating et al, 2009). Being labelled a victim for male and female survivors can be understood as shameful and stigmatizing. But what becomes much more damaging to male survivors are those sociocultural factors that dare to wrongly equate victimhood to femininity or impose the question of whether this abusive experience means they can now no longer stake claim to both their masculine and heterosexual identities (Gartner, 2000; Lisak, 1995). Research clearly shows that male survivors struggle with the expectations of traditional hegemonic masculinity, particularly in regard to toughness, stoicism and sexual prowess, and they can also find ways to successfully renegotiate these experiences while keeping their masculine identity intact (Allagia, 2005; Gartner, 2017b).

Victimization disrupts masculine ideologies related to power and control and uncovers unexplored terrain related to victimhood and vulnerability. But the challenge here is that those struggles lie not only within the male survivor but also within the hegemonic and heteronormative culture that responds to his needs. A good deal of research on male rape describes male survivors as routinely judged for having failed in their masculine duty to protect

themselves (Hlvaka, 2017; Stermac et al., 2004). Males are also viewed to generally be less traumatized by rape then female survivors, and their sexual orientation is often called into question (Denov, 2004; Hlvaka, 2017; Sternac et al., 2004). If a female is a perpetrator, claims of rape are often dismissed or minimized due to cultural myths that men are the sexual aggressor and sex is always welcome (Hlvaka, 2017). Male victimhood, therefore, becomes nearly incomprehensible. I argue that part of the key therapeutic work with male trauma survivors involves going beyond unpacking gender constructs and actively challenging these stigmatizing cultural narratives of sexist and heteronormative beliefs that facilitate feelings of guilt and shame that serve to hinder and interrupt help seeking and healing processes.

This study is consistent with research that demonstrates that part of healing for men involves successfully engaging with traditional expectations of masculinity while allowing for the experience of feelings and attributes that oppose certain masculine ideals; therefore, part of the work for survivors is to both contain and resist traditional roles in order to heal (Allagia, 2005). When working with boys and men, mental health professionals should seek to address issues of privilege and power related to misogyny, homophobia and transphobia. Male privilege is often invisible to most men, yet they can become aware of it through a variety of means, such as therapy, mentorship, school-based education, and personal experience (Kilmartin et al., 2013; Kimmel, 2008; O'Neil, 2015). Men who understand their privilege and power may be less apt to rely on power, control, and violence in their relationships (McDermott et al., 2012; Schwartz et al., 2004). Some research shows that men tend to overestimate the degree to which other men hold sexist or homophobic beliefs, and that developing awareness of this discrepancy may reduce that inaccuracy (Kilmartin et al., 2013; Kimmel, 2008). Mental health professionals can also work to help men and boys develop awareness of systems that assume cisgender heteronormative

masculinity expression is the expected norm and identify how they may have potentially been harmed by societal or cultural discrimination or oppression. Finally, I would also argue that it is crucial for mental health professionals explore their own perceptions and biases and to understand that, although not all boys or men hold sexist or homophobic beliefs, these discourses are largely ingrained into our society and experienced each and every day, and as a result are imperative to address.

Challenging Misogyny and Homophobia

Studies on male sexual assault demonstrate how men "confront a set of stigmatizing cultural narratives that contribute to a unique sense of shame. Male sexual victimhood is incomprehensible because it contradicts cultural ideas of what it means to be a man – strong, powerful, self-sufficient and impenetrable" (Hlavka, 2017, p. 483). Heteronormative and toxic masculine discourses equate male sexuality with dominance, aggression and desire, while female sexuality is associated with passivity, vulnerability, and submissiveness (Butler, 2015; Hlakva, 2017). Men and boys are not socialized to see themselves as at risk or as particularly vulnerable to sexual assault (Hlvaka, 2017; Lew, 2000). Myths and assumptions around men's pursuit of sex and the sexual act itself as always being welcome impact a male victim's legitimacy and make the experience altogether invisible (Hlvaka, 2017). These statements are all consistent with findings of this study. Participants spoke of survivors raised in a society where sexual abuse seemed outside of the male experience – it was "just a woman thing that happened". These and other myths continue to permeate society and exacerbate the difficulties that survivors have in disclosing their experiences, which can serve to increase stigma, hinder the development of appropriate services and impact further research on the phenomenon (Stermac et al., 2004).

Anti-femininity, or men's avoidance of all things related to femininity, refers to men's desire to avoid being perceived as feminine by abstaining from any actions, thoughts, and feelings that are commonly associated with femininity (e.g., avoiding the colour pink, equating crying or vulnerability as weakness). Anti-femininity also involves a fear of traditional feminine values and behaviours (e.g., appearing weak or docile), and therefore encourages restricting one's emotions and portraying a façade of toughness (O'Neil, 2013; Zurbriggen, 2010). Internalization of anti-feminine norms and attitudes serves as a necessary component of male socialization in order to achieve perceived masculine dominance in society (Murnen et al., 2015; O'Neil, 2013). As a result, adherence to anti-femininity norms are associated with the devaluation of women because femininity as a whole is seen as inferior and less desirable (Murnen et al., 2002; O'Neil, 2013; Zurbriggen, 2010). There is a significant amount of literature that suggests the internalization of antifemininity has been associated with men's perpetration of sexual violence against women (Lippa, 2008; Thompson & Cracco, 2007; Young et al, 2020).

Philosopher and writer Kate Manne (2015) proposes a definition of the term misogyny that provides a conceptual distinction between what she calls a naive conception and a feminist account of misogyny. The former refers mainly to individual agents – typically, but not necessarily, men – who may feel hatred or hostility towards women generally, "simply because they are women" (Manne, 2015, p.1). A feminist account of misogyny denotes the "system which operates within a patriarchal social order to police and enforce women's subordination, and to uphold men's dominance' (p. 2). Instead of considering the role of the individual, this definition emphasises the role of social structures in the production of misogynistic attitudes that serve a patriarchal ideology. Writer and activist Gillian Serano (2007), in her exploration of the experiences of transwomen, describes misogyny as steeped in assumptions that femaleness and

femininity are both inferior to and exist primarily for the benefit of maleness and masculinity, while also insisting that male and female roles are rigid and fundamentally different, and feminine traits weak and inferior to masculine characteristics.

As discussed earlier, literature that speaks to myths and assumptions on male sexual assault in adult populations' show that male victims are sometimes judged because they are seen as failing in their masculine duty to defend themselves from attack (Hvlaka, 2017; Stermac et al., 2004). Men are therefore seen as culpable, and for this reason their experiences perceived as less traumatizing than female counterparts, and are often assumed to be gay (Hvlaka, 2017; Stermac et al., 2004). These myths contribute to a cultural acceptance of sexual violence and a victim blaming narrative that serves to dismiss male victimization while hiding the very real effects of that victimization, such as shame, stigma, depression, anxiety, substance abuse and suicidal ideation (Dube et al, 2005; Gartner, 2000, 2017a; Hvlaka, 2017; Lisak, 1999).

Myths associated with male childhood sexual abuse, such as survivors are or will become gay, further marginalizes young men who are already struggling to process these experiences (Easton, 2012) and removes them further from capacities to heal. Homophobia – the culturally produced fear of and prejudice against gay people - is a central organizing principle of a cultural definition of manhood (Kimmel, 2015). Homophobia is more than the irrational fear of gay men, and more than the fear that that one might be perceived as gay. "The word 'faggot' has nothing to do with homosexual experience or even with fears of homosexuals. It comes out of the depths of manhood: a label of ultimate contempt for anyone who seems sissy, untough, and uncool" (Leverenz, 1986, p. 455). Homophobia is the fear that others will unmask and emasculate men and reveal that they do not measure up to manhood. Fear leads to shame, because in acknowledging that fear of not measuring up, men find proof of the limits of their masculinity

(Kimmel, 2008). Men can therefore weaponize homophobia, wielding it against any perceived threat of humiliation and the risk of emasculation in the eyes of other men.

Many studies mention the fear of survivors of childhood sexual abuse in their likelihood to engage in and perpetuate a cycle of abuse as being a significant barrier to disclosure. This is despite the fact that only a small minority of male survivors of sexual abuse go on to abuse children themselves (Easton, 2012; Lisak, 1999). This is another issue men and boys often must tackle as opposed to female survivors, making it more challenging for them to come forward and disclose, because societal discourses appear more willing to believe male victims will go on to perpetrate, even though research on perpetration does not see a significant correlation between victim becoming future abuser (Allagia et al., 2005; Fisher & Goodwin, 2008; Gartner, 2000, Lisak, 1994).

Another common myth or assumption cited by participants and discussed extensively in the literature is what Fisher and Goodwin (2008) refer to as the myth of complicity, wherein survivors struggle with deep feelings of shame centred around the physiological response and sexual arousal they may have experienced as part of the abuse. Developing an erection or experiencing ejaculation during a sexually abusive experience serves as one of the most confusing and distressing aspects of sexual abuse for men and boys. Trauma, confusion, and arousal can leave men and boys with feelings of shame and disgust at themselves and their body response. Richard spoke of this as “body betrayal” with the survivors he works with and how he provides psychoeducation around physiological responses. For many, Richard says, “the fear of touch by another man is a real thing, and homophobia is a huge part of that whole dynamic”.

Sexual arousal is a powerful, involuntary physiological sensations, and when experienced can lead men to have questions about sexuality. Nathan and Kate spoke of how they carefully

unpack arousal states survivors might have experienced, and that the visible indication of an erection did not mean they invited or welcomed the abusive experience. Among many gay and bisexual male survivors, however, a common discourse persists that the experience is responsible for influencing or determining their sexual orientation (Allagia et al., 2007; Gartner, 2018; Lisak, 1999). This is described as an area of some controversy in the literature due to the high prevalence of childhood sexual trauma among gay and bisexual men, which would seem to indicate some correlation (Cassese, 2000; Dorais, 2000; Fisher and Goodwin, 2008; Gartner, 2017b). However, Gartner (2018) notes that most sex researchers believe that predominant sexual orientation is established before early to mid-childhood, while most sexual abuse of males occurs more commonly after this period (Fisher & Goodwin, 2008; Gartner, 2000; Lisak, 1994). As some study participants like Shane and Gillian noted, I would argue that gay and bisexual boys, and those questioning their sexual identity, are likely much more vulnerable to being abused by a potential perpetrator as they are already a marginalized and oppressed group. Five of the participants spoke of their belief that many of their LGBTQI2S+ clients had experienced some form of early childhood sexual abuse. Shane and Daniel believed that "almost all have experienced some form of sexual trauma", while Gillian spoke of queer children as "fairly frequently marginalized, often growing up in homophobic environments, and often very vulnerable and susceptible to harm from others". Gillian saw this particularly with young gay males who were "at times exploited by older men, and unaware of the power differential at play". Research shows that sexual predators are more likely able to detect and exploit a sense of vulnerability, while an isolated and distressed sexually questioning youth may welcome some aspects of that attention and interest to overcome their sense of aloneness (Fisher and Goodwin,

2007). However, Richard had strong feelings that the reason LGBTQI2S+ youth were actually overrepresented in the data was because they were much more likely to initiate disclosures:

> I simply believe queer men are more likely to disclose. They are coming out of the closet as a sexual assault survivor, which is like their second or third time coming out – whereas straight men, they have much more of a harder time squaring that off with their heterosexuality.

The literature demonstrates how male victimization can come to equate a loss of a masculine and heteronormative identity for some men and boys (Allagia, 2005; Hvlaka, 2017).

Fisher and Goodwin (2008) tell us that myths and cultural delusions about male sexual victimization are:

> generated in the intersection between the traditional male code and the reality of male sexual victimization. Because the latter is utterly incompatible with the former, the delusions act either to deny or minimize the abuse, or else portray it as a failure of masculinity (p. 56).

Overall, participants believed these myths and assumptions were damaging to healing processes, and psychoeducation to inform and help correct some of these contradictory beliefs was crucial in early phases of treatment. Misogyny and homophobia can serve to silence male survivors. It is a silence centred on a fear of reprisal from other men that allows men to walk past a woman being harassed in the street and not call it out, or to listen to a racist or sexist rant and not challenge it, or ignore a gay bashing joke. These fears serve as the sources of men's silences, and men's silence is what keeps the patriarchal systems running and dominates the cultural definition of manhood.

Re-storying Trauma/Reconstructing Masculinity

A crucial dimension of survivors' recovery "is finding a way to 'make sense' of what happened to them in the past, and to make some kind of meaning of the place the abuse has in their current lives" (Grossman et al., 2006, p. 443). However, despite being understood as a marker of resilience and recovery, understanding ways male survivors make sense of their experience is very limited, as is understanding of how that meaning making relates to recovery and ultimately inform practice and treatment approaches (Grossman et al., 2006).

Overall, very little data exist on how men make meaning of childhood sexual abuse, but the research that does address it suggests that gender socialization strongly influences how males construct meaning from their abuse (Gartner, 1999, 2018; Kia-Keating et al., 2005; Grossman et al., 2006). As research literature and popular media indicate, men in modern culture are often socialized to appear emotionally stoic, invulnerable, and physically forceful and aggressive, while often preoccupied with sex and sexuality (Grossman et al., 2006; Mahalik et al., 2003). Taken together, these pressures make it much harder for them to acknowledge their abuse and victimization, gain support for themselves, be open to supportive therapeutic work, or develop a framework of meaning around their trauma experience (Addis & Mahalik, 2003; Grossman et al, 2006; Lew, 2000). When men and boys attempt to process their trauma, they are walking a fine line between a need as a survivor to be vulnerable and share feelings such as shame, guilt, fear, and anger around the abuse, while at the same time navigating pain or discomfort they might feel through their violation of perceived heteronormative and hegemonic/dominant masculine norms.

Cognitively, generating meaning involves using various frameworks of understanding available to us, whether they be psychological, philosophical, or spiritual, to make sense of our experiences (Grossman et al, 2006). Research has emphasized the importance of trauma

survivors developing a personal account of the trauma narrative, sometimes referred to in the literature as account making or healing stories (Grossman et al 2006; Sorsoli, et al., 2008). Herman (2015) believes the active construction of a truthful narrative is crucial to healing as it helps survivors recall the detailed traumatic memory, process and transform their recollection, and mourn their traumatic losses. Findings in this study also placed an emphasis on processing the trauma narrative for similar reasons and noted the importance of, as Susan describes, "helping children and adolescents distinguish between innocuous stimuli that could trigger a traumatic response versus actual real-life experiences of clear and present danger". Kate, Joanna, and Shane also spoke of doing focused work around identifying triggers that might upset and finding ways to use strategies like mindfulness and journaling to remain present and focused on the here and now. Furthermore, they believed it was crucial to identify unhelpful and inaccurate thoughts or distortions related to the traumatic event that may then benefit from further work in correcting or clarifying later in the therapeutic process.

As Brown and Augusta-Scot (2007) tell us, all stories about social life and subjective experience involve interpretation and are reflective of the social processes of meaning making, which in turn are impacted by cultural and historical influences. For survivors, therapy serves "as a site for the deconstruction of experience and, specifically, the meaning of life experiences" (p. 3). If we do not question or unpack these stories through the therapeutic process, we can inadvertently reproduce unchallenged problematic existing stories and reinforce damaging dominant discourses (Brown, 2007). In working with male survivors of sexual abuse, it is important to note, however, that disclosure and a subsequent narrative for male survivors in particular often comes many years after their initial abuse experiences, and can therefore be challenged by the passing of time and the trouble with memory (Sorsoli et al., 2008). Trauma

experiences disrupt time, as survivors can appear numb, disassociated and removed from their experiences. They can live for long periods in an almost paralyzed memory overwhelmed by their traumatic experience (Herman, 2015; Van der Kolk, 2014). As participants noted in this study, many survivors minimize their experience and, while knowing they were somehow harmed, lack awareness that that the experience was an abusive display of power. I would argue that while female survivors face similar challenges, this is a particularly salient point as many studies show (Allagia, 2013; Kia-Keating, 2013; Kimmel, 2008) the length of time between event and closure is often significant for men and boys, and can further cloud a male survivor's recollection and make the entire process that more complicated and uncertain as a result.

Brown's (2018) work regarding women's narratives of trauma has meaning here as well, as all survivors may try to make sense of their experiences within dominant social narratives available to them, which often provide inadequate or inaccurate accounts of their experiences while reifying oppressive dominant discourses. Much like female survivors, the stories men and boys are often left with are unhelpful and full of self-blame and uncertainty. Stories of experience are a temporal phenomenon: previous experiences shape the present, which in turn shapes and influences the future to come (Clandinin & Connelly, 2004). These stories are also part of the landscape in which one lives and its discursive forces, and therefore not separate from larger social stories that are accepted as truth and remain largely unquestioned (Brown, 2007). The space and time between the actual traumatic event and the act of disclosure is often long and convoluted for male survivors, but as both the research and findings of this study suggest, the process of meaning making and re-storying the trauma narrative remain crucial components in promoting healing, recovery, and future wellness.

Foucault (1991) tells us that discourse "transmits and produces power; it reinforces it, but also undermines and exposes it, renders it fragile, and makes possible to thwarts it" (p. 100). In other words, it establishes power relations and imposes limits within society, with a focus here around normative expectations of dominant masculinity, and men and boys learn to recognize those limits and those power relations, even if they in turn limit or restrict them in different ways. Michael White (1995) reminds us that people are involved in the subjugation of their own lives through processes of power, and by way of narrative approaches, one can resist practices of power, such as internalized problem stories. For male sexual trauma survivors, these problem stories manifest as a perceived failure in masculinity due to dominant discourses which can leave men and boys feeling powerless and without agency. In re-storying trauma and reconstructing their unique version of masculinity as one of many forms, a male survivor can take back agency and move towards a more fulfilling and actualized way of being in the world.

Pathways to Recovery

While men's health problems are generally related to a highly complex interplay between basic physiology, environment, and socio-cultural factors such as race, economic status, and sexual orientation as they relate to power and privilege, the literature highlights patterns in gender health disparity that are connected to heightened risk behaviours for men often first observed during early adolescence (Mahalik et al., 2013). As discussed earlier, male gender role socialization often encourages men to adopt masculine belief systems that can serve to promote high risk behaviours involving substance misuse, violence and aggression, sexual compulsivity, self-harm, or eating disorders (Fisher & Goodwin, 2008; Gartner, 2018; Van der Kolk, 2014). Furthermore, the literature demonstrates a clear link between these same resulting high-risk behaviours and long-term physical health consequences like sexually transmitted diseases,

cancer, heart disease, and obesity (Cohen et al., 2017; Currie & Spatz-Widom, 2010; Herman, 2015; Van der Kolk, 2014).

Other studies also illustrated how men and boy are less willing to consult medical and mental health care providers (Addis & Mahalik, 2003), and are much less likely to proactively utilize preventive health care (Courtenay, 2011). However, the more men perceive that their male friends were seeking help either in the form of talking to someone about a troubling problem or getting an annual physical in the last year, the more likely men report having done the same (Mahalik & Coady, 2007; Mahalik et al., 2007). This is consistent with some of the findings of this study, where participants like Adam spoke of informal yet therapeutic spaces where young men and boys are often more open and comfortable to "share vulnerable thoughts and feelings that then lead to disclosing helpful thoughts and feelings which moved through the group like wildfire".

Participants noted how it as not uncommon for survivors to minimize or understate their challenges and present at times as muted and not overly expressive, or to the other extreme, present themselves through acting out and aggressive behaviours so dysregulated it makes it difficult to determine treatment formulation. When treating problematic acting out behaviour of boys and men, such as hyperactivity, aggression, or issues related to substance abuse, mental health professionals tend to focus on addressing deficits rather than looking at potential strengths (Kiselica et al., 2008). Research also suggests that medication may be relied upon over mental health interventions with boys, particularly in regard to Attention Deficit/Hyperactivity Disorder (ADHD) diagnoses (Kapalka, 2008). These findings in the literature were also supported by participants in this study, who expressed further concern that traumatic responses in young survivors could sometimes be misinterpreted and treated as symptoms of ADHD.

Participants strongly felt that services can and should be more adaptive and integrated to the ways men have been socialized (Englar-Carlson, 2014). Furthermore, they believed that mental health professionals should possess a solid awareness of traditional masculine gender role characteristics that could serve to disguise or inhibit the assessment of underlying mental health issues. For example, participants noted the importance in clinical sessions to probe with questions related to mood and anxiety with boys and men and to ask more extensive or clarifying questions when faced with brief or minimal responses. Mental health professionals need to be aware of the relationship between mental health stigma and traditional masculine ideology which could have certain impacts on how men and boys cope with traditionally stigmatized and gendered mental health issues such as depression or anxiety and how they report it. Participants were quick to note that while many men and boys struggle with mood disorders, a common discourse in their settings is that anxiety and depression are far less common as primary concerns in males, a belief they saw as harmful and in need of correcting

While the literature does support some gender-based adaptations for work with men and boys of diverse backgrounds (Englar-Carlson, 2014; Kiselica et al., 2008; Rabinowitz & Cochran, 2002), except in a few cases, participants were unaware of specific work in this regard in their care areas. The participants did much of what the literature suggests for boys and male adolescents - shorter therapeutic sessions that potentially incorporate some movement breaks; the use of art or musical instruments as components of therapy; and the possibility of moving to more informal settings outside the typical office environment with a focus on natural settings like playgrounds, parks, and hiking trails (Addis et al, 2005; Kiselica & Englar-Carlson, 2008).

Clinical engagement with male survivors begins from the moment of first contact and creating a welcoming process at intake is critical, not only because intake sets the tone of

treatment but also because entry into counselling services can be a particularly charged experience for men and boys abused in childhood due to mental health stigma and challenges in help seeking (Fisher & Goodwin, 2008). This again speaks to the crucial need for mental health professionals to be aware of common discourses and myths and assumptions around male childhood sexual trauma, or otherwise they risk missing out on subtle imitations of past trauma a survivor may have kept long hidden (Fisher & Goodwin, 2008; Gartner, 2000; Lisak, 1994).

When struggling with uncertainty and apprehension around addressing their trauma, and after struggling alone for some time, male survivors can present with a deep sense of hopelessness (Gartner, 2017b). Providing a narrative around recovery to them can help alleviate such fears, such as simply providing psychoeducation in a compassionate way and using statements like "many guys do get better" can alleviate doubts and inspire hope (Gartner, 2017a). The mental health professional's level of comfort with discussing male sexual trauma and recovery is crucial throughout the therapeutic process. As Fisher and Goodwin (2008) note, "having a knowledgeable and trustworthy individual encouraging them to disclose their abuse history represents a significant departure from the isolated way that many of them have previously dealt with their trauma" (p. 177).

The literature describes the benefit from some male survivors to participate in group therapy sessions as a means to counter the negative impacts of male socialization that could potentially impede treatment progress (Fisher & Goodwin, 2008; Gartner, 2000). Some benefits described in the literature include: providing a welcoming, safe space to express anger and pain; countering stereotypes regarding male trauma survivors; allowing for discussion related to a variety of difficult sexual issues and experiences, including potential confusion re orientation; receiving validation from other men and boys in their shared experience; and working together to

redefine definitions of masculinity (Dorais, 2000; Fisher & Goodwin, 2008; Gartner, 2000; Lisak, 1994). This was consistent with findings from this study, but participants encouraged starting much earlier than at a point of intervention regarding sexual trauma, through engaging boys at school and boys and men in extra-curricular group activity settings. They favoured and in some cases worked to create what they described as "small't' therapeutic spaces" in these areas where boys and men could be encouraged to be more open in terms of vulnerability and work on deconstructing any problematic or harmful messages they received or carried related to traditional masculine norms. However, to recognize the relative advantages of group therapy is not to privilege it exclusively over individual therapy (Fisher & Goodwin, 2008) and ultimately what matters most for the survivor is allowing him to discover the best fit.

Four of the participants described aspects of outdoor therapy as an important and at times essential focus to their practice. Outdoor therapies have been shown to provide many positive outcomes in youth dealing with mental health disorders (Ungar et al., 2005). Techniques that are often implemented in order to foster positive change within clients including the use of small groups, natural environment settings, creating positive and supportive atmospheres, employing healthy risk-taking, and offering relational supports (Ungar et al., 2005). The challenging but supportive environment of outdoor group therapy in particular seems to suggest an opportunity for survivors of traumatic experiences to reduce symptoms of trauma and provide opportunities for healing, growth, and the fostering of resilience through their connection with others (Ungar et al., 2005). Providing aspects of outdoor therapy that foster skills connected to strengthening resilience has some potential therefore of providing therapeutic benefit to young men and boys, even those not actively engaged or actively seeking treatment for trauma. A key benefit to any outdoor therapy program is the natural environment and the benefits that are inherent to it.

Therapists might often encourage meaning making by utilizing the outdoors as a metaphor for challenges clients may face in life (Taylor et al., 2010). For example, Nathan described working with a client who compared a wounded animal they came across on a hike to his challenges with his traumatic past, which then served as a "bit of a watershed moment in terms of his understanding what happened wasn't his fault".

Participants noted how traditional methods may at times prove problematic with an emphasis on what the literature describes as feelings, vulnerability and owning up to possible dependency (Gartner, 2018; Rochlen & Rabinowitz, 2014). However, as noted earlier, sometimes therapists can make harmful assumptions that men and boys are unable to express emotions fully which may then serve to preclude them from therapy (Mahalik et al., 2012). Mental health professionals can also misdiagnose boys and men because they do not interpret acting out or externalizing behaviour with depression and anxiety - symptoms that are potentially related to or secondary to past trauma (Addis, 2008; Gartner, 2000; Lisak, 2017) This is further compounded by constraints participants have already described regarding medical models of care which may serve to limit or inhibit a full and complete assessment.

Something that resonated throughout these discussions related to treatment options was the emphasis on choice being offered to male survivors, with a recognition that what worked for one might not work for another, and alternatives were therefore key to a more successful outcome. Participants did not advocate for one treatment modality over another, nor did they debate challenges between office based or outdoor therapy models. What they did emphasize was goodness of fit in terms of treatment options and offering alternatives for male childhood sexual trauma survivors. The creation of open and inclusive therapeutic gender responsive

approaches were considered imperative for all those who continue to suffer or be impacted by early childhood traumatic sexual experience.

Chapter Summary

This chapter provided an in-depth analysis of the research findings and connected identified themes back to current literature relating to masculinity and male childhood sexual trauma. It considered the intersection between toxic masculine culture and experiences of male childhood sexual trauma. It also explored the many implications surrounding the invisibility of male survivors, and examined some of the myths and assumptions that perpetuate stigma related to male childhood sexual trauma, including challenges with homophobia and misogyny. It examined the impacts of sexualized trauma on male identity and explored ways that survivors might work to re-story these experiences. It also considered power and silence and how they related to dominant masculinity and experiences of trauma through a Foucauldian lens. Finally, I considered and critically analyzed some possible male-centred responses and alternatives to traditional office-based talk therapy with male survivors. The following chapter will provide a brief overview of the study including strengths and limitations, implications for social work practice, and an overall conclusion.

CHAPTER SEVEN: CONCLUSION

The purpose of this study was to critically examine the potential impact of "toxic masculine culture" - defined here as a strict and rigid adherence to traditional masculine norms at their most extreme form - on the experiences of young male childhood sexual trauma survivors and their healing processes. The study also examined how we might work to reduce the stigma, shame, and silence that surrounds this phenomenon as a means of offering agency to survivors. It is intended to contribute to public discourse around the experiences of young men and boys and add to the literature around male early childhood sexual trauma. The rationale for the study came from a desire to break the silence that surrounds the phenomena in our current mental health systems and bring attention to a population of young men and boys whose experiences have been under recognized, underreported and understudied. The findings support a more gendered approach to addressing the unique needs of male sexual trauma survivors, something that is defined in the literature as an important part of the healing process for men and boys (Allagia et al, 2007; Gartner, 2018; Fisher & Goodwin, 2008).This focus is arguably almost non-existent at present in our mental health systems in Nova Scotia, yet this study demonstrated how clinical service providers might be poised to intervene in important gender specific ways in the lives of young male survivors.

Chapter One outlined the framework of this study and provided some background to the research topic. It also offered a working definition of the term “toxic masculinity” that places it within the context of male survivors’ experiences with early childhood sexual trauma and abuse. Chapter Two explored relevant literature pertaining to hegemonic or dominant masculinity, “toxic masculinity”, early childhood development, male socialization, the sequelae of male childhood sexual trauma, and a brief overview of treatment and healing processes. Chapter Three

contained the methodology section, which described the qualitative research design, including some discussion of theoretical foundations, an outline of the recruitment process, and an overview of ethical considerations. It centred the study as a narrative inquiry, chosen as a means of understanding knowledge and processing experience (Connelly & Clanindin, 2010) as it honoured the lived experiences of the study's participants and their depictions of work with young male survivors of childhood sexual trauma. The study was also intended as a critical discourse analysis, influenced by the work of Foucault, that examined masculinity constructs and their relationship to experiences of male childhood sexual trauma, and deconstructed some of the thought, speech, and behaviour that contribute to social constructions (Fook, 2002), while it illuminated some of the ways discourse both constitutes and constrains (Healy, 1999). Using a Foucauldian approach allowed for some acknowledgement of what has gone unrecognized, unexpressed, or unspoken when considering discourse related to young male survivors.

Chapter Four presented the participants narratives as they describe their work as trauma therapists. The purpose of this chapter was to provide the reader with as much of the rich textual detail and depth of the individual participant's experiences as possible that emerged during the study. Chapter Five discussed the findings of the research in a results section through seven main themes: *Hidden Survivors* (which examined the silence that surrounds the phenomenon that renders its victims invisible); *Some Moral Distress* (which described challenges and constraints participants as therapists face within a medical model of care); *Dangerous Disclosures* (which detailed some of the challenges faced by survivors in disclosing their trauma); *Challenging and Renegotiating Masculinity* (which considered how participants as therapists work with male survivors to deconstruct and reconstruct different versions of masculinity and address issues in toxic masculine culture); *Misogyny/Fear of the Feminine* (which examined how participants

challenge dominant discourses around women as weak and narratives of femininity as bad within the context of patriarchal and misogynistic society); *Homophobia: Am I a Fag?* (which considered myths that perpetuate homophobia following male on male abuse within the context of heteronormative and homophobic culture); and *Re-Storying Trauma* (which detailed how participants as therapists work with clients to understand resiliencies and vulnerabilities and being the healing work)

Participant stories reflected the challenges young males who have experienced childhood sexual trauma face within the context of male socialization masculinity construction, and how by treating victimhood outside of masculine cultural norms they are both constrained and excluded as victims and survivors (Hvlaka, 2007). Study findings suggested that a more gendered based approach to assessment and treatment for male childhood sexual trauma survivors was warranted, with a significant focus on helping those impacted to challenge some of the more damaging or harmful norms of masculinity while working to separate and preserve the positive aspects of masculine identity. The study also saw a crucial component of therapy was related to meaning making and re-storying as means of processing a trauma narrative for survivors who are struggling to heal so as to not continue to operate from a place of guilt or shame. Participants also acknowledged a general lack of fit between traditional standard therapeutic offerings for some men and boys, and advocated for more creative and open ways to approach interventions other than office based talk therapy, including the endorsement of outdoor therapy techniques, incorporating elements of art or music therapy strategies, or the creation of smaller therapeutic group settings.

Chapter Six provided an in-depth analysis and discussion of the study findings. It related research findings consistent with the literature around how toxic masculine culture, with strict

and rigid adherence to traditional masculine norms, can have a negative impact on healing processes for young male survivors. It critiqued the medical model approach to mental health and current brief interventions as limiting and pathologizing in terms of trauma treatment. It also examined implications of silence around this phenomenon and described how myths and assumptions can contribute to and perpetuate the stigma.

The study explored, within the context of male sexual trauma, homophobia and misogyny as an outcome of heteronormative and patriarchal society that subordinates women and all things considered feminine, and expressed an urgency to address these tensions directly with survivors. Misogynistic and homophobic attitudes served to separate men and boys from healing processes and in challenging their masculine identity, potentially influenced negative interactions and engagement with women and LGBTQI2S+ peoples. It also served to critically examine the impacts of sexualized trauma on male identity and explored ways that survivors might re-story these experiences. It highlighted the importance of re-storying trauma, and the process of finding meaning in the traumatic experience as crucial to therapeutic recovery.

The study also argued that gender bias exists among clinicians when assessing for and treating male trauma survivors, and consider ways to correct the bias and address stigma. Finally, it spoke to themes consistent with the literature regarding the importance of a male centered lens on trauma experience for young men and boys, and more gender responsive alternatives to therapy. Overall, this study demonstrated that childhood sexual trauma has a potentially profound impact on male identity formation, and for young men and boys it becomes a uniquely gendered experience that must be a central focus of our therapeutic processes in order to promote healing.

Strengths and Limitations

Narrative Research as Methodology

The study had a number of strengths and limitations related to the research methodology. A narrative analysis approach was chosen as it allowed for a deeper reflection and understanding of the nature of embedded stories in larger social, cultural, familial, and institutional settings (Clandinin, 2013). The issue of power relations is often a primary concern of narrative research (Clandinin and Connelly, 2000), making the utilization as methodology even more relevant to this thesis topic at hand. By thinking narratively about a phenomenon through research we challenge dominant discourses that view that phenomenon as fixed or unchanging (Clandinin, 2013). As a researcher who serves as both a survivor of childhood sexual trauma and as a mental health clinician with insider with knowledge of mental health systems, it was crucial, as Clandinin (2013) notes, to pay close attention to my positioning within the research, and to understand that as researchers we are all part of the storied landscapes we are studying.

The advantages of this methodology are many in light of understanding and exploring the experience of male childhood sexual abuse under study, particularly through the gathering of thick, rich narratives from service providers that narrative research entails. Narrative research allows researchers to understand experience, and an analysis of people's stories allows for hidden assumptions to come to the surface (Bell, 2002; Clandinin and Connelly, 2002). It also serves to illuminate the temporal aspect of experience, as it recognizes that understanding of people and events can often change over time (Bell, 2002; Connelly & Clandinin). In this case, it served to unpack and better understand the relationship between male childhood sexual trauma and male identity construction and allowed participants to reflect on how their understanding of that relationship changed over the course of their varied careers.

Transferability

A potential disadvantage of narrative research is the challenges in navigating its inherent subjectivity and the privileged voice of the researcher in deciding what stories to highlight and what stories to downplay or omit (Clandinin & Connelly, 2004; Josselson, 2013; Wertz, 2011). Narrative research can be time consuming in terms of the dedicated time in the filed interviewing as well as the amassed amount of rich thick data from interview transcripts and field notes (Clandinin & Connelly, 2004). Indeed, as researcher I transcribed all twelve interviews – which lasted on average two hours each – and compiled these transcripts in addition to field notes recounting all steps of the research process and reflective journals I kept throughout, which amounted to hundreds and hundreds of pages of data. However, I would counter that claim with the plethora of data being, as Josselson (2013) notes, a good problem for a researcher to have in terms of the depth and richness of material available related to the issues under study, and state that the level of reflexivity was necessary in maintaining the integrity of the work. Furthermore, narrative research seems particularly poignant when applied to the experience of early childhood sexual trauma, because, as a methodology, it is defined less by generalities and certainties and more by its imagined alternative possibilities (Clandinin & Connelly, 2004; Wertz, 2011).

Sampling

Purposeful and snowball sampling methods led to the recruitment of participants mostly from the IWK Health Centre or the Nova Scotia Health Authority, and a number of private practice clinicians. Aside from one psychiatrist, participants were divided between social workers and certified counselling therapists. Within their domains, they were representative of some of the specialized clinicians doing trauma work, but other potential participants might have included, among others, psychiatric nurses, occupational therapists, or child and youth care workers. Since

most participants held either a Master of Social Work or Master of Counselling Degree, it is challenging to know whether their views were representative of other trained disciplines in the field. However, of the twelve participants, I was fortunate to have a sample that was relatively diverse across age, gender, race, and sexual orientation.

Participant Interviews

All interviews were semi structured and at times conversational in tone, allowing for rich, thick descriptions of trauma work. In retrospect, I would have liked to have tailored more questions around specific therapeutic approaches and interventions, as when writing the findings I was left with, for instance, some tension around understanding the seeming focus on narrative approaches and how that mapped on to expectations of offering brief solution focused therapy that, as an insider I knew to be time sensitive and limited. A possible interpretation of that tension is that participants were more resistant to systemic constraints by pushing for therapeutic approaches and interventions that were more intensive and time consuming, but this was not fully unpacked and explored in this research.

Implications for Social Work Practice

Social workers pursue social change, particularly on the behalf of vulnerable and oppressed peoples in society. Our work seeks to promote sensitivity and knowledge around oppression, cultural and ethnic diversity, and social justice. Social workers are uniquely positioned to respond to the needs of young male sexual trauma survivors because of our understanding of complex trauma, our insight into intersecting identities, our awareness of the pervasive influence of gender constructs, and our emphasis on strengths-based work and empowerment. Unique to our profession is our ability to take a developmental perspective in understanding the impacts of trauma across the lifespan, and to take into account the intersection

of gender, sexual orientation, culture, race, and family of origin, and the way in which that may shape a trauma survivor's resiliencies and challenges. As a result, I believe more than any other profession, we have the capacity to look at a male survivor's history of trauma through a gendered lens and consider treatment approaches with men and boys as a uniquely gendered experience.

Future Research

The most challenging work I faced over the course of this study was deciding which parts of participant stories to include and which to omit, and when to highlight my voice and that of the voice that of participants. There were various narrative threads that I might have followed but instead chose not to make them a focus. For instance, participants were very interested in engaging in conversations around on issues related to sexual intimacy with adult male survivors, particularly around sexual addiction, sexual exploration, and sexual dysfunction, but due to the focus on adolescent experiences, this was only explored on the surface level. Another interesting narrative was related to experience of trans males- two participants discussed work with trans men who adopted hypermasculine behaviours following transition, and believed they needed to engage in aggressive and sometimes reckless behaviour as a means of staking claim to their masculine identity. Another participant described working with a trans male who had been physically and emotionally abused as a younger child and described their transition as a means of rejecting their feminine identity and adopting one far removed from it. These narratives warrant further research to unpack and explore experiences of sexuality and gender identity.

Other research areas to explore could relate to men and boys' experiences with diagnoses of Borderline Personality Disorder and how described symptomology could mask potential early trauma history. Another point of interest in this study was how participants related misogyny and

feelings of anti-femininity to male sexual trauma survivors, and therefore a deeper exploration of possible correlation between early childhood sexual abuse and perpetration of violence is warranted. I hope to do further research in this area of male childhood sexual trauma, which could include aspects of these issues described. My hope is to work on a major study that will focus on the voices of male survivors as an adjunct to this thesis work.

Conclusion

Throughout the duration of this study, colleagues and friends were often curious and intrigued about my thesis work and its progression until I explained the topic. They were interested in the toxic masculinity part, and curious about the trauma piece, but once I specified my focus was on male childhood sexual abuse, the conversation inevitably took an awkward turn or I would feel a cold, hard wall of resistance. Not only do people struggle with the implications of male childhood sexual abuse as the terrible act itself, but they struggle with the mere mention of it. As Joanna noted in her work, this phenomenon shuts people down at a surface level because they cannot manage the emotional states attached to it.

Fortunately, from their unique perspectives, all twelve of my participants were incredibly insightful, knowledgeable and gracious in sharing their stories and those of their clients. As I noted earlier, I leave this work a better mental health social worker than before thanks to their wisdom, their teachings, and their influence. When I began the research, I had an assumption that I would likely work with eight to twelve women, as women predominantly make up the sample of therapists that was the base of my recruitment. But instead, I started to receive e-mails and calls from men interested in the research topic and hoping for a chance to speak. What was very striking to me, in most cases, were the conversations I had with the male participants. As they shared the pain and the struggles with dominant expectations around masculinity that impacts

their clients, they also shared personal insights of their own challenges and details of their own tragedies. These men spoke of past trauma, of battles with addictions, and the stressors they faced trying to live up sometimes to a hegemonic ideal that was even outside their privileged grasp.

As I reflected on these interviews, I noticed a pattern – each began with some stiff posturing, some awkward small talk, before quickly getting down to business, but then moments after that I could see them each relax and start to unfurl. For some, that allowed me just the slightest peek inside to some of their own fears and vulnerabilities. For others who shared their past triumphs and tragedies more openly, it allowed for a deeply personal look into how they had overcome significant traumatic experiences to now use their gifts and become instruments to help others. By inviting them to have this conversation around toxic masculine culture, it gave them some permission and gave them some space to unpack and explore an issue that, even within this environment of mental health, is a mostly silent discourse.

Originally, I had naively hoped I had hoped to come away with some comprehensive treatment plan for how to work with male survivors – some agreed upon model to follow or sequential steps to take away and "fix" this problem – but I soon discovered that would not happen. However, what I did come away with was hope and determination. Hope came with the creative, passionate, resourceful and meaningful work that is offered by clinicians like these twelve participants, and the way that they challenge and resist systemic barriers in their efforts to provide the best care possible for all trauma survivors. Determination came from recognizing the need, now more than ever, to raise my voice and advocate further for male sexual trauma survivors who continue to be forced into silence. One in six boys are survivors of sexual abuse. These boys often grow up in culture of masculine expectations that can serve to amplify their

trauma and move them away from the capacities they need to heal. This is because those toxic notions of masculinity tell boys to reject those capacities – things like expressing feelings and emotions, accepting help from others, and acknowledging pain and hurt. Masculinity is not innately bad or inherently harmful, but male survivors of sexual trauma suffer in its shadow. I believe we can change that, and it starts with a conversation.

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APPENDIX A – INFORMATION AND CONSENT

Information and Consent Form (Interview)

Study title: Toxic Masculinity, Childhood Sexual Abuse, and the Challenges to How Young Men Heal

Investigators: Colin J. Morrison, MSW Candidate, Principal Investigator
Dr. Catrina Brown, Thesis Supervisor

Introduction and Purpose:

You have been invited to take part in a research study exploring the experiences of mental health practitioners and community advocates who work with young males who identify as early childhood sexual trauma survivors. The study is voluntary, and before you decide whether you wish to be involved, you need to understand the purpose of the study, what risks might be involved, and what benefits may be gained. This information and consent form explains the study.

The purpose of this study is to explore, through the work and experiences of mental health practitioners and community advocates, the influence of "toxic masculinity" in society today on young male socialization and consider how it may serve to impact and disrupt the healing process for young male survivors of early childhood sexual trauma.

You have been considered for this study because you have been identified as having experience providing therapeutic counselling, support, and advocacy in a mental health and addictions or community setting with young males who have been impacted by early childhood sexual trauma.

Please ask the principal investigator (also known as the lead researcher) or thesis supervisor to clarify anything you do not understand or would like further information about. We hope that all your questions are answered to your satisfaction before deciding whether to participate in this research study

If you decide not to take part or if you leave the study early, your professional practice will not be affected.

The researcher hopes to publish the results of this study in an academic journal and to present findings at academic conferences. No identifying material will be available when presenting the research findings. The purpose of presenting the findings of this research study are to contribute new knowledge and support toward the growing body of literature around mental health, addictions and therapeutic practice with young males who experience early childhood sexual trauma.

How will the researchers do the study?

The researcher will seek to recruit 8 to 12 participants to partake in this study.
The method of this qualitative study involves a commitment to attend a 60 to 90-minute interview with the researcher in a setting of the participant's choice. The participant will be asked a series of questions relating to their knowledge and experience with early childhood sexual trauma, role of dominant masculinity in male socialization, and healing practices specific to working with young male's survivors.

The interview will be conducted in an agreed upon location that best serves you, whether that be in your place of work, a public place (library, coffee shop etc.) or on Dalhousie University campus. Interviews will be audio recorded and later transcribed as part of the data collection and research findings.

You may also be asked if you know other practitioners or advocates who could be potential participants in this study. If you agree, you may be asked to pass on a recruitment email. The interviews will be conducted in the Fall of 2017.

Potential Harms and Burdens.

There are no expected harms of the study. It is possible that, given the nature of the research and the discussion centred on early childhood sexual experience, some participants may be triggered in a way that is emotionally or psychologically distressing.

To mitigate any foreseeable risks, the principal investigator will make himself available for debriefing after the interview as well as continued debriefing and discussion post interview as needed. For IWK/NSHA employees, the possibility of accessing EAP services in relation to any distress from the interview may also be referenced or encouraged.

To protect your information and anonymity, the principal investigator will not keep your name or other information that may identify you with the interview transcript, and instead use only pseudonyms. Files that link your name to the pseudonym will be kept in a secure place separate from the interview data. Although no one can absolutely guarantee confidentiality, using a pseudonym makes the chance much smaller that someone will ever be able to link your name and involvement in this study.

What are the potential benefits?

Taking part may be of no help to you personally. It is hoped that what is learned will be of future benefit to others, and that the participants' knowledge, expertise and insight will help contribute to the conversation around the often under studied and under explored phenomena of male early childhood sexual traumatic experiences.

Can I withdraw from the study?

Participants can opt to withdraw from the study any time prior to the submission of the final Master thesis document, which has a projected completion date of April/May 2018. After this date, it will not be possible to remove your data.

If you wish to withdraw your consent please inform the principal investigator at colin.morrison@dal.ca or by telephone at 902.292.3763. If your data has already been collected, you can decide whether you want any or all the information that you have contributed up to that point removed. If you choose to withdraw from this study, your decision will have no effect on your professional practice.

Are there any conflicts of interest?

As the principal investigator, I wish to acknowledge that I have been employed with the IWK Mental Health and Addictions Program for more than 15 years in the role of youth care worker. I have also completed a social work practicum with NSHA Addictions Community Based Services in 2015-2016 and with the IWK Suspected Trauma and Abuse Response Team in 2017. As such, I could potentially have some formal or informal relationship with participants from the IWK or the NSHA as a past or present mental health colleague. In that regard, I will ensure not to use coercion in recruitment, and remind participants of their right to withdraw from the study at any point in time. Potential or interested participants can also have the option of communicating their interest or fielding questions through my supervisor Dr. Catrina Brown if they so choose and will be informed of that option during recruitment.

Costs and reimbursements.

Participants will not be reimbursed for taking part in the study.

Participating in this study may result in added costs to you such as costs for parking and/or transportation to attend the individual interview.

How will my privacy be protected?

Protecting your privacy is an important part of this study. Every effort to protect your privacy will be made. If the results of this study are presented to the public, participants will not be identified in the study.

The principal investigator will keep the information about you confidential, to the extent permitted by applicable laws. Even though the risk of identifying you from the study data is very small, it can never be completely eliminated.

The principal investigator will keep any identifying information about you in a secure and confidential location. All research records and personal information will be stored in locked cabinet in the principal investigator's home office separate from other data. Electronic data will be stored in an encrypted file on a password protected computer used solely for purposes of this research and also locked in principal investigator's home office. All research data will be retained and safely stored for five years and then destroyed as per IWK research ethics policy and IWK Information Technology standards and policy.

Due to the ongoing monitoring of research activities, there is a possibility that the IWK Research Ethics Board may request to view study data or contact participants directly over the course of the study for quality assurance purposes.

Your personal information will not be shared with others without your direct permission.

What if I have study questions, concerns, or problems?

For questions, clarification, or concerns, please contact the principal investigator, Colin J. Morrison, at 902 292 3763 or colin.morrison@dal.ca. You can also contact the thesis supervisor/supervising investigator, Dr. Catrina Brown at catrina.brown@dal.ca, or the IWK supervising investigator, Coleen Flynn, MSW RSW, at coleen.flynn@iwk.nshealth.ca. You may also wish to contact the IWK Research Ethics Office by contacting Bev White, REB Manager, by e-mail at bev.white@iwk.nshealth.ca or by telephone at (902) 470-8520.

You have the right to all information that could help you decide about participating in this study. You also have the right to ask questions about this study and your rights as a research participant, and to have them answered to your satisfaction before you make any decision.

You have the right to ask questions and to receive answers throughout this study.

You have the right to access, review, and request changes to your study data.

You have the right to be informed of the results of this study once the entire study is complete.

The Research Ethics Board (REB) and people working for or with the REB may also contact you personally for quality assurance purposes.

If you have any questions regarding your specific rights to privacy and confidentiality as research participants, you may contact the IWK Research Ethics Office directly by contacting Bev White, REB Manager, by e-mail at bev.white@iwk.nshealth.ca or by telephone at (902) 470-8520.

How will I be informed of study results?

The results of this research should be available May 2018. If you are interested in receiving the summary results, please leave your preferred contact information in the space provided on the bottom of the information and consent signature page.

On the following IWK signature page, you will be asked if you agree (consent) to join this study. If the answer is “yes”, please sign the form in the space provided.

Thank you for your interest in this research study**.**

APPENDIX B – E-MAIL RECRUITMENT (MANAGERS)

Title of Study: Toxic Masculinity, Male Childhood Sexual Trauma, and the Challenges to How Young Men Heal
Principal Investigator: Colin James Morrison, MSW Candidate, Dalhousie University

Dear Manager:

I am connecting with to provide information on a study I am conducting related to childhood traumatic sexual experiences in male youth, and I am hoping you can assist me in recruiting participants from amongst your wider clinical team.

The purpose of this study is to gather information about the current practice of mental health practitioners and community activists who work with young males under the age of 19 who have experienced early childhood sexual trauma. Current literature suggests that the phenomena of male early childhood sexual trauma is under-recognized, the psycho-social impact of male sexual trauma is not well understood, and male specific services are sorely underdeveloped. This study intends to add to the literature and contribute to the conversation around these early traumatic experiences, while considering improved interventions in treatment when working with these vulnerable male youths.

I am seeking input from mental health practitioners and community advocates who have worked directly with males under the age of 19 who have experienced early childhood sexual trauma**.**

I ask that you please open and **forward** the attached recruitment letter entitled E-Mail Recruitment (Mental Health Practitioners/Advocates) throughout your clinical team. The attached letter will provide more detailed information on the study itself and the level of commitment involved.
I wish to acknowledge that, as well as an MSW candidate, I am a youth care worker with IWK Child & Adolescent Mental Health and have been employed in this service for more than 15 years.
If you would like further information to assist you before proceeding, regarding myself as researcher or this study, please contact me directly by e-mail at colin.morrison@dal.ca or by telephone at **902 292 3763,** or contact thesis supervisor Dr. Catrina Brown at catrina.brown@dal.ca
I thank you in advance for help with recruitment in what I hope will be a helpful and informative research study that will help clarify and better our response to early male childhood sexual trauma experiences.

Thank you,
Colin James Morrison, MSW Candidate,
Dalhousie University School of Social Work

APPENDIX C - Email Recruitment (Mental Health Practitioners/Advocates)

Dear Mental Health Practitioner/Advocate:

I am conducting a study that hopes to explore, through experiences and insights of mental health practitioners and community advocates, the influence of "toxic masculinity" in society and a consideration of how it may serve to impact and disrupt the healing process for young male survivors of early childhood sexual trauma.

The purpose of this study is to gather information about the current practice of mental health practitioners and community activists who work with young males under the age of 19 who have experienced early childhood sexual trauma. Current literature suggests that the phenomena of male early childhood sexual trauma is under-recognized, the psycho-social impact of male sexual trauma is not well understood, and male specific services are sorely underdeveloped. This study intends to add to the literature and contribute to the conversation around experiences of young males with early childhood sexual trauma. Through the lens of mental health practitioners and community advocates who navigate therapeutic relationships with those impacted, the study will also focus on the impact of masculinity in its many forms on boyhood socialization and healing processes from trauma.

I am seeking input from mental health practitioners and community advocates who have worked directly with males under the age of 19 who have experienced early childhood sexual trauma**.**

Individuals who volunteer for this study will have the opportunity to participate in a 60-90-minute interview in person in a location of their choosing. During the interview, participants will be asked questions related to their practice and understanding of early childhood sexual trauma and the psycho-social impacts on young male survivors.
This study has been reviewed by the IWK Health Centre Research Ethics Board (REB). There is no reimbursement offered for participation in this study.
If you are interested in participating in this study or would like more information to assist you in making your decision regarding participation, please contact Colin J. Morrison, MSW Candidate, by e-mail at colin.morrison@dal.ca or by telephone at **902 292 3763,** or thesis supervisor Dr. Catrina Brown at catrina.brown@dal.ca If interested, you will then be provided with further detailed information about the study as well as the participant information and consent form. If you know of other individuals who may be interested in participating, please feel free to discuss this project with them and ask them to contact this researcher directly for further information, or feel free to circulate this email to any interested parties.

Thank You

Colin J. Morrison, MSW Candidate
Dalhousie University School of Social Work

APPENDIX D - Information and Consent Signature Page

Project Title: Toxic Masculinity, Male Childhood Sexual Trauma, and the Challenges to How Young Men Heal

Researcher: Colin James Morrison, MSW Candidate, School of Social Work, Dalhousie University

I, ***(please print)*** **______________________**, volunteer to participate in the research project titled *Toxic Masculinity, Male Childhood Sexual Trauma, and the Challenges to How Young Men Heal.* I understand that the project is designed to gather information about the experiences of mental health clinicians and community advocates who work with young males who identify as early childhood sexual trauma survivors

My participation in this project is voluntary. I understand that I will not be paid for my participation. I also understand I may withdraw and discontinue participation at any time without penalty.

Participation involves being interviewed by the lead researcher. The interview will last approximately 60-90 minutes. I agree to the audio recording of the interview and acknowledge the researcher may also take notes during the session.

I understand that the researcher will not identify me by name in any data collected, and that my confidentiality as a participant in this study will be protected.

I agree direct quotations from my interview may be used without any identifying information.

I understand that this research study has been reviewed and approved by the IWK/NSHA Research Ethics Board.

I have read and understand the explanation provided to me. I have had all my questions answered to my satisfaction, and I voluntarily agree to participate in this study.

My signature below indicates my consent to participation:

____________________________	____________________________	__________
Name	**Signature**	**Date**

If you wish to receive a copy of the research summary upon completion, please provide contact information and the preferred manner in which you wish to be notified, such as mailing address or e-mail address, in the space below. If you do not wish to be notified, please leave blank:

APPENDIX E – INTERVIEW GUIDE

1) Can you tell me your approximate age, gender, and place of employment?
2) Can you tell me about your role as a mental health practitioner/mental health advocate?

   (prompts: type of work or advocacy; type of agency your work with)
3) Can you describe specific clinical training that you've had? (prompts: degrees, workshops,

   training sessions)
4) Is there a theoretical approach/philosophy that you subscribe to that guides your work?
5) When working with young males with experiences of early childhood sexual trauma, what was the presenting issue upon referral and what triggered the help seeking? (prompts: behavioural issues? mental health challenges? being "forced" to seek help vs "wanting" to seek help?)
6) Are there specific strategies you employ that are unique to your experiences with young male survivors?

   (prompts: are there ways you approach this work with young males that differ from how you might work with other populations?)
7) Can you describe any challenges and barriers young male survivors face? (prompts: are there issues in the young men's' lives that may impede or impact

   disclosure? In their environment or community? Within larger society?
8) Have these young males usually sought help previously? How do they describe this?
9) Do these young males have a hard time expressing what has happened and what its impact or effect has been on them? Why do you think this might be? (What are some commonly expressed emotions? Examples - anger, shame, fear, disgust?)
10) How do you work to help these young men unpack and understand their experiences?

11) Do these young males understand the experience differently if the perpetrator is male versus female?

12) In your experience, do the young males blame themselves for the abuse?

13) Does the experience of being socialized as "male" impact on how they deal with the sexual abuse, and if so in what ways?

14) How might you personally define cultural expectations around masculinity in our world today? How are they influenced and enacted?

15) How do expectations around dominant masculinity –or "toxic masculinity" in its most extreme form - impact the young males you work with?

16) Are there issues or challenges that present regarding a young male's sexual identity formation/sexual orientation that have been impacted by experiences of early childhood sexual trauma? If so, how do you address it?

17) Are there specific myths around the phenomena of male early childhood sexual abuse that you see perpetuated in society? (e.g. males "cannot" be abused, all sexual contact for males as pleasurable, sexual orientation as a factor/role in "causing the abuse")
Are there particular "truths" you wish were more readily acknowledged?

18) Do you work to promote healing and foster resilience in young males? If so, how do you do this?

19) What is the impact of stigma around early childhood sexual trauma experiences for young males? How do you address the stigma in your practice?

20) Is there anything we may have missed, or you wish to expand?

APPENDIX F – RESEARCH APPRROVAL LETTER (RENEWAL)

5850/5980 University Avenue
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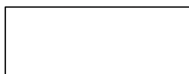
Approval – Annual Renewal
September 1, 2019

Principal Investigator: Colin James Morrison
Title: Toxic Masculinity, Childhood Sexual Trauma, and the Challenges to How Young Men Heal
Project #: 1022764

On behalf of the IWK Research Ethics Board (IWK-REB) I have examined the application for annual renewal. This request for annual renewal was considered at the July 16, 2019 REB meeting. I am pleased to confirm the Board's approval to continue the study.

The IWK-REB approval will expire on September 01, 2020.



Adam Huber
Co-Chair, Research Ethics Board

This statement is in lieu of Health Canada's Research Ethics Board Attestation: *The Research Ethics Board for the IWK Health Centre operates in accordance with:*
- Food and Drug Regulations, Division 5 "Drugs for Clinical Trials involving Human Subjects"
- The Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans - TCPS(2)
- International Conference on Harmonization - Good Clinical Practice Guidelines - ICH-GCP
- FWA #: FWA00005630 / IORG #: IORG0003102 / IRB00003719