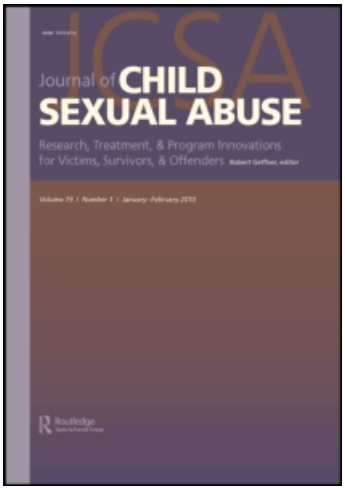

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Practical Ways Psychotherapy Can Support Physical Healthcare Experiences for Male Survivors of Childhood Sexual Abuse

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THE IMPACT OF CHILD SEXUAL ABUSE ON VICTIMS/SURVIVORS

Practical Ways Psychotherapy Can Support Physical Healthcare Experiences for Male Survivors of Childhood Sexual Abuse

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Many survivors of child sexual abuse who engage in psychotherapy also experience physical health problems. This article summarizes the findings of a multiphased qualitative study about survivors' experiences in healthcare settings. The study informed the development of the Handbook on Sensitive Practice for Health Care Practitioners: Lessons from Adult Survivors of Childhood Sexual Abuse *(Schachter, Stalker, Teram, Lasiuk, & Danilkewich, 2009), which is intended to help healthcare providers from all disciplines understand the effect of child sexual abuse on some survivors' abilities to access and benefit from health care. This paper discusses what psychotherapists can learn from the healthcare experiences of the male survivors who participated in this project. It also offers practical suggestions for supporting male clients who experience difficulty seeking treatment for physical health concerns.*

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Psychotherapists have an important role in supporting clients' efforts to achieve and maintain their overall health and well-being. This may be particularly true for clients with histories of difficult or chaotic childhoods, given the clear association between childhood adversity (e.g., sexual, physical, and emotional abuse, parental discord and/or loss, family violence, substance abuse, and mental illness) and adult health problems. Publications from the ongoing Adverse Childhood Experiences (ACE) Study (e.g., Anda, n.d.; Felitti, 2003; Felitti et al., 1998) report a direct and graded relationship between the number of adverse childhood experiences and adult health risk behaviors (e.g., smoking, alcohol abuse, obesity, physical inactivity, illicit drug use, promiscuity, and suicide attempts) and disease (e.g., ischemic heart disease, cancer, chronic lung disease, skeletal fractures, and liver disease). Similarly, other research reveals that a history of physical and sexual abuse is associated with multiple health problems, poor to fair self-rated health, pain that interferes with activities, disability, and frequent visits to emergency rooms and healthcare professionals (Chartier, Walker, & Naimark, 2007).

Even when other types of adversity are controlled for, childhood sexual abuse (CSA) remains a powerful predictor of health problems in adulthood (Briere & Elliott, 2003). Studies that compare adults with histories of CSA to those without report that survivors of CSA more frequently seek health services, have greater functional disability, more physical health symptoms, poorer perceptions of their overall health, and are more likely to engage in risk behaviors (Burgess, Watkinson, Elliott, MacDermott, & Epstein, 2003; Hulme, 2000; Newman et al., 2000; Sickel, Noll, Moore, Putnam, & Trickett, 2002; Walker et al., 1999; Walker, Newman, & Koss, 2004). That being said, it is important to note that children who have been sexually abused are at increased risk for other forms of child abuse and/or victimization (Finkelhor, Ormond, & Turner, 2007), which means that these adult health problems may stem from a range of adverse experiences, not solely CSA. To date, the association between childhood adversity and poorer adult health has been primarily studied in women, but the few studies of men report similar findings (Banyard, 2009).

The increased risk of CSA survivors for a wide range of physical, psychological, and interpersonal problems means that those who seek psychotherapy may concurrently be under the care of other healthcare practitioners. It is important, therefore, that psychotherapists understand how CSA can affect an individual's physical health and survivors' ability to seek and benefit from healthcare services.

This article draws on the findings of a multisite, multiphased qualitative study. Although the aim of the study was to bring CSA survivors and health practitioners together to develop practice knowledge to improve the healthcare experience of survivors, the findings reiterate and extend what is known about the benefits of patient centered care for all patients (Stewart et al., 2000). While the current study included both male and female survivors in different phases, this report focuses on what psychotherapists can learn from experiences of the male participants. It discusses practical ways that psychotherapists can support their male clients who experience difficulty in their encounters with healthcare providers.

THE STUDY

The study reported here is the second phase of a multidisciplinary, multisite study that employed grounded theory and action research methods to explore the healthcare experiences of CSA survivors. The overall aim of the study was to facilitate a collaborative process through which CSA survivors and healthcare practitioners developed practice knowledge to improve the healthcare experiences of adult CSA survivors. Both phases are reported elsewhere (e.g., Schachter, Stalker, & Teram, 1999; Teram, Schachter, Stalker, Hovey, & Lasiuk, 2006). Briefly, the first phase explored women survivors' experiences of physical therapy and culminated in a draft of a handbook on sensitive practice (for a comprehensive account of the methodology, see Teram, Schachter, & Stalker, 2005). The draft handbook was reviewed for clinical relevance by survivors, physical therapists, and physical therapy students across Canada and published by Health Canada as the *Handbook on Sensitive Practice for Health Professionals: Lessons from Women Survivors of Childhood Sexual Abuse* (Schachter, Stalker, & Teram, 2001).

From this project we concluded that the primary goal of sensitive practice is to foster a sense of safety for patients and clients. The following eight subthemes were identified by participants as being key to helping them feel safe during healthcare encounters: respect, rapport, sharing information, sharing control, respecting boundaries, mutual learning, nonlinear healing, and demonstrating understanding of CSA.

The second phase extended the findings by including men and a wide range of healthcare practitioners (e.g., physicians, nurses, nurse practitioners, dentists, dental hygienists, massage therapists, complementary therapy practitioners, and other healthcare practitioners who had no training in mental health/psychiatry or psychotherapy). After receiving approval from the Research Ethics Review Boards at Wilfrid Laurier University and the University of Saskatchewan, male CSA survivors were recruited through letters and posters sent to agencies and individuals providing counseling and support services in five Canadian provinces (British Columbia, Alberta,

Saskatchewan, Ontario, and Nova Scotia). Advertising materials invited male survivors to volunteer for an interview or participate in a focus group.

The men self-identified as CSA survivors and we made no attempt to verify their survivor status. Consistent with the traditions of qualitative inquiry, we were not concerned with the number or representativeness of participants but rather with their ability to reflect on and share specific details about their experience. Although this does not allow generalization of the findings to all men with histories of CSA, it does offer valuable insights into their experiences.

Forty-nine men[1] participated in face-to-face interviews with one of the authors (CLS, CAS, and ET); we also talked with 9 men in a group setting. One man participated in both an interview and a group discussion. The mean age of the men was 41 years (range 24–61 years). Twenty-five men were single, 26 were married or living with partners, 6 were separated or divorced, and 1 did not specify his relationship status. Three men had attended or completed primary school, 20 had attended or completed secondary school, and 35 men attended or completed postsecondary college or university education earning college diplomas or undergraduate or graduate degrees. Seven men identified themselves as Aboriginal, and 51 men self-identified as Caucasian. Forty of the men were employed full- or part-time, 1 man was a student, 3 were retired, 4 reported being unemployed, 6 were on disability pensions. Demographic data were unavailable for 4 men.

The open-ended interviews began with an invitation for participants to talk about their experiences, both positive and negative, with healthcare providers from all disciplines. The interviewers also asked about practices that participants thought would improve male survivors' healthcare experiences. As in the first phase, the interviews were audiotaped, transcribed and analyzed for themes. Themes from the interviews, along with the principles of sensitive practice, served as the starting point for phase two of the study, in which researchers brought survivors and healthcare practitioners together in a series of working groups. The groups' task was to integrate new information and refine the principles. Two working groups, one comprised of survivors and nurses and the other of survivors and physicians were conducted in Saskatoon, Saskatchewan. At the same time, another group of survivors and nurse practitioners met in Winnipeg, Manitoba. Information from both studies was incorporated into a draft of a second handbook for healthcare practitioners. Successive drafts of the handbook were reviewed by approximately 200 survivors and healthcare practitioners from across Canada. In early 2009, the *Handbook on Sensitive Practice for Health Care Practitioners: Lessons from Adult Survivors of Childhood Sexual Abuse* (Schachter, Stalker, Teram, Lasiuk, & Danilkewich, 2009) was published by the Public Health Agency of Canada's Clearing House on Family Violence.

WHAT MALE SURVIVORS OF CSA MAY BRING TO HEALTHCARE ENCOUNTERS

It is very important for psychotherapists who work with male CSA survivors to understand what these men may bring to healthcare interactions and to appreciate the risks they take by avoiding needed health care. Although much of the emphasis in psychotherapy focuses on the survivor's psychological recovery or healing (see Crowder, 1995; Herman, 1997; Lew, 2004; O'Leary, 2001), supporting his ability to care for his physical health is clearly related to this process.

Issues that affect healthcare interactions identified by survivor participants (see Schachter et al., 2009, for detailed results of the full study) include distrust of authority figures, anxiety about being abused by the healthcare practitioner, discomfort with practitioners who are the same gender as the person who abused them, experiencing of triggers and dissociation during healthcare procedures, ambivalence about their bodies, feeling unworthy of care, and the experience of physical pain. The male survivor participants identified additional issues related to being a male victim. They worried about being perceived as a "weak victim" rather than a "manly man" if they disclosed their CSA to a healthcare practitioner. As one man said, "Men are tough. Men are macho. Men don't need [help]. All we have to do is to 'get over it! Get over it—be a man!' You know, men don't cry" (Teram et al., 2006, p. 509).

Many of the men also expressed fear that if they revealed their secret, health practitioners would assume that they were perpetrators of CSA because of society's misinformed belief that all abused boys inevitably grow up to be men who sexually abuse children. Research has revealed that while some child victims of CSA later sexually abuse children, the vast majority do not (Salter et al., 2003).

For some men, the gender of the healthcare practitioner was not an issue; however, others spoke about their difficulties with healthcare practitioners who were the same gender as their abuser(s). One man stated "I can tell you that I don't like men touching me. Particularly when I'm half naked. So I always look for a female physiotherapist." For some, the discomfort with seeing a male practitioner is associated with homophobia. That is, several participants who were abused by a male feared that they would be presumed to be homosexual. A few of the men talked about their own negative reactions to male practitioners whom they judged to be gay, as illustrated by these words:

> I had to go into the hospital where I had a problem with some medication I had [taken] and there was a male nurse there and he was obviously very effeminate, and he had to give me an IV. I refused him because I didn't want him touching me. (Teram et al., 2006, p. 506)

Participants who had been abused by women often expressed extreme discomfort with being cared for by a female practitioner. One man said, "My abuser was my mother. I don't like to be touched by women, especially strange women." Some were reluctant to disclose that they had been abused by a female because they feared it might make them seem weak or vulnerable. In such cases, the authors suggest the therapist should explore the client's preference for a male or female health practitioner and discuss the options available to him. In some cases, the client may require support to negotiate a referral to another healthcare practitioner.

An important beginning step for psychotherapists is to ask about the survivor's awareness of the possible links between CSA and physical health problems and to assess for difficulty with certain healthcare procedures or avoidance of health care completely. The importance of exploring this awareness with men, in particular, is articulated by this participant:

> I think men rather than women are less apt to admit to themselves the effect that their abuse has had and so even if they can acknowledge it intellectually, they have a hard time seeing their own difficulties with it, I mean they may be having responses and reactions that are troubling but they are not connecting them. (Teram et al., 2006, p. 510)

Clearly, psychotherapists who are themselves aware of the association between CSA and health problems in adulthood will be motivated and prepared to explore issues around self-care. For example, does the client have regular physical checkups? Do they practice safe sex? Have they been checked for sexually transmitted disease if such is indicated? Do they seek regular dental care?

Psychotherapists may want to suggest to male survivor clients that they read Schachter et al. (2009) and related literature to increase their knowledge about the associations between child abuse, difficulties interacting with healthcare practitioners, and to learn about the experiences of other survivors.

WAYS TO SUPPORT MALE SURVIVORS: ENACTING THE PRINCIPLES OF SENSITIVE PRACTICE

As noted earlier, facilitating a sense of safety for survivors must be the overarching consideration in all healthcare encounters. The authors use the metaphor of an umbrella to conceptualize safety, with the principles of sensitive practice being the spokes that hold the umbrella open. When the umbrella is open, individuals feel safe and are more able to remain present and to participate in the experience.

Just as feeling safe is essential to developing the therapeutic relationship in order to engage in effective psychotherapy (Herman, 1997), male survivor participants in the current study spoke about the critical importance of "safety" when seeing healthcare practitioners. Some described the need to feel safe as "feeling comfortable" with the healthcare practitioner. They stressed that the practitioner needed to be someone in whom they could develop sufficient trust in order to candidly discuss their physical healthcare issues. Here is how one survivor described what he needed from healthcare practitioners to feel a sense of safety:

> I think that [the] approach, with anybody, whether a physiotherapist or chiropractor or doctor, before whatever it is they are doing starts, they should . . . [ask], "How can I make you more comfortable here? . . . If there's something I'm doing, the way I'm touching you or the way I'm handling you makes you feel uncomfortable, let me know." . . . That would be great. For myself, that would really open the door for me to say, "Hey, maybe this is a safe place."

A psychotherapist can encourage the male survivor to think about what he needs to feel safe when seeing healthcare practitioners. It is expected that the needs most male survivor clients identify will correspond to the principles of sensitive practice derived from the research. These are: respect, taking time, rapport, sharing information, sharing control, respecting boundaries, fostering mutual learning, understanding nonlinear healing, and demonstrating awareness and knowledge of interpersonal violence. Although the purpose for their development was to provide guidance for healthcare practitioners working with survivors of CSA, these same principles can be used as a framework to think about how a psychotherapist can help survivors conceptualize their needs and develop practical strategies for healthcare interactions.

Respect

One participant described respect as "the difference between treating someone as a person and treating someone as a number, or a case." To invite the survivor to consider the principle of respect as an important aspect that contributes to feeling safe, the psychotherapist could ask the following questions: How might a health practitioner demonstrate their respect for you? How do you react when you feel disrespected by a healthcare practitioner? Although the survivor cannot control how the healthcare practitioner behaves, he can develop an awareness of the specific elements of the relationship (e.g., behaviors, attitudes, words, phrases, etc.) that convey respect and support a positive working relationship with the healthcare practitioner.

From there, he can consider what he might say or do to increase the likelihood that the healthcare practitioner will respond in a way that is helpful to him.

Taking Time

Survivors said time was important in two major ways: establishing a connection and the pacing of the healthcare encounter. Study participants made it very clear that they appreciated when practitioners took even a small amount of time to acknowledge them as unique individuals. One man said, "It's the ones that . . . stop and give you a moment, and that's one of the biggest healing things right there, that moment" (Stalker, Schachter, Teram, & Lasiuk, 2009, p.173).

The pace of an appointment was also an issue for most participants. When they felt rushed during an appointment, survivors said that they felt like objects or numbers and that this, in turn, triggered negative memories or feelings related to past abuse. In addition, when they felt rushed, they were less likely to ask questions or raise issues relevant to their health.

Conversely, the men also spoke about the incalculably positive impact of healthcare practitioners who take enough time to help them feel comfortable and safe. One man said:

> Particularly when it comes to the genital area, it's really a safety thing, right? And you know, being touched by so many people that you don't really know very well can be scary, and if you don't get enough interaction or, you know, they don't take the time to make you feel comfortable.

Again, psychotherapy can explore the experience of time with the male survivor and encourage him to consider how to address this issue in light of his unique needs. Some questions that a psychotherapist might ask a male survivor:

- Is being rushed a trigger for you?
- How might you (or do you) react when an appointment is rushed?
- What would you like healthcare practitioners to know about taking time with you during appointments?
- Are there one or two questions that you consider most important that you can be prepared to ask in the event that the healthcare practitioner does not have time to respond to all of your questions?
- How might you let the healthcare practitioner know that you need more time?

Rapport

Just as therapeutic rapport is foundational for psychotherapy, rapport with a healthcare practitioner was identified as extremely important for most survivors. Trust, as an element of rapport, was a major issue for most participants. One man said, "Just because they're health professionals doesn't mean that we trust [them]." Another survivor described an experience that was contrary to what he needed:

> Well I guess the biggest thing that stuck out was . . . it just felt like the guy just didn't even care. He just didn't care about me at all as a person . . . didn't see me as a person. . . . So when it came to my treatment as a . . . person, it didn't really matter. I felt really abused, really used and abused. . . . It was terrible, and I ended up walking away.

By discussing the therapeutic rapport needed in psychotherapy, the psychotherapist can help the male survivor generalize the principles of rapport to other relationships and other contexts. Questions the psychotherapist might ask the client include:

- What can you do to cope with the situation when a healthcare practitioner seems cold and uncaring?
- How can you begin to develop trust with healthcare practitioners? What qualities will you pay attention to when seeking to develop a level of trust?
- What was helpful to you in developing a trusting therapeutic relationship in our therapy? How could this information be helpful to you in your relationship with other healthcare practitioners?

Sharing Information: A Two-Way Exchange

Communication between the survivor and the healthcare practitioner is primary to their relationship and to the survivor's understanding of his healthcare needs. Participants stressed their need for information about the examination and treatment from the healthcare practitioner and their need to be invited to provide feedback to the clinician on an ongoing basis. The healthcare practitioner should inform the survivor beforehand about the rationale for procedures, what to expect during a procedure, why certain information is needed, and communicate information in a way the survivor can remember it and understand it. The men spoke about their tremendous anxiety over the unknown and unexpected. They felt that being prepared for what was to come helped them to avoid "surprises" and the intense negative responses they evoke. Some survivors, like the following, indicated a need to be informed about every aspect of an examination/treatment,

> [He] always [gave me] a reason why he was doing something, which was great . . . it wasn't just doing things and then leaving you in the dark. Or if he was asking questions, you don't have to second guess—"Why did he ask that question?"

Psychotherapists might ask the male survivor the following questions:

- What could you say if a healthcare practitioner is going to begin an examination or procedure without explaining what he or she is going to do?
- What specific questions might you ask to better understand an examination or procedure?
- What would help you to provide information to the healthcare practitioner about your body and your response to the treatment/examination etc. even when he or she does not ask?
- Are there self-statements you can rehearse that would make it easier?

Receiving information in terms that they understand also helps the survivor remember the information after the appointment is over. Strategies to help the survivor remember information provided by the healthcare practitioner enable the survivor to discuss his understanding with the psychotherapist at a later time, allowing for support in processing its meaning. Some of these include (a) asking the healthcare practitioner to provide the information in written form, (b) bringing someone to the appointment to provide support and to help remember what happened and (c) informing the healthcare practitioner that information may need to be repeated more than once and during more than one appointment.

Sharing Control

Encounters with healthcare practitioners can replicate the abuse dynamic for some survivors, particularly if the survivor experiences himself as powerless and the healthcare practitioner as having complete control of what happens during the appointment. Participants discussed their need to feel that they have some sense of control to ensure their comfort when seeing a healthcare practitioner: "It makes me feel safer and more comfortable that, that, you know, I'm in control." The sharing of control may take many forms, such as the healthcare practitioner asking for consent before (and during) an exam or treatment and checking in with the survivor by asking if he is okay, comfortable, able to continue, etc. While participants uniformly stated that they want healthcare practitioners to invite them to speak up when they feel uncomfortable, many survivors do not feel sufficiently empowered to do this and want healthcare practitioners to check back with them frequently.

It was evident from the interviews that consent is an important issue and that a healthcare provider's failure to obtain consent triggered memories of past abuse. Again, psychotherapy can provide a safe place for survivors to discuss their perceived lack of control. This man suggested a strategy that would be helpful to him during appointments: "Give me a panic button [a signal] and show me how to use it. Let me use it and stop when I do; it is not negotiable." The following questions can be used to begin a discussion about the survivor's needs:

- What helps you feel that you have some control during your healthcare appointments?
- What are your needs regarding consent during an examination or treatment? Do you require the healthcare practitioner to ask for your consent before each step of an exam, or only at the beginning of an exam?
- How will you let the healthcare practitioner know that you are not comfortable and need to stop the procedure?

Respecting Boundaries

Psychotherapy with CSA survivors often focuses on establishing and maintaining healthy boundaries, which is essential for most survivors to feel safe with healthcare practitioners. As noted earlier, an important way that practitioners can demonstrate respect for the survivor's boundaries is by asking for consent before any examination or treatment and waiting until they are given consent[2] before they proceed. Psychotherapists can support the survivor's need and right to require consent in a manner that makes him most comfortable. Touch without consent was clearly identified as a boundary violation for many survivors as illustrated by this man's words:

> [Male physical therapists] have automatically assumed that it's okay for them to go, "Okay, well we're going to work . . . on these muscles [as they touch me] because we need to strengthen this because this does this and..." . . . It's not meant [to be sexual touching] . . . Once I've gone home and calmed down, [and I] thought that they did [not do] anything inappropriately sexual. But at the time, when you first get triggered, it's an extremely difficult situation to deal with. It triggers a lot of memories . . . and then you completely lose whatever you are there for.

Many CSA survivors feel revictimized during their interactions with healthcare practitioners. Some felt physically violated by the practitioner's physical proximity during eye exams, oral health treatments, and spinal adjustments, etc., particularly when they were unprepared for such physical closeness.

To begin an exploration of a survivor's need for clear boundaries when seeing healthcare practitioners, psychotherapists might ask:

- What feels like a boundary violation when you are with a healthcare practitioner?
- What can you do to maintain boundaries between you and a healthcare practitioner?
- What can you do if you feel that your boundaries are being crossed by a healthcare practitioner?

Fostering a Mutual Learning Process

Providing effective health care to anyone, particularly CSA survivors, requires a healthcare practitioner to be attentive and to remain open to learning how to work together most effectively. The healthcare practitioner learns from the survivor by listening to him. Becoming an active partner in their own health care can be important to survivors' healing because past abuse often leaves them feeling that they are damaged and unworthy of care. One man stated:

> But I do think maybe one of the reasons why for a long time I didn't go [for healthcare] . . . regularly until sort of forced by not feeling well or something coming up. Quite frankly, I just didn't feel worthy . . . worthy of the care, the attention. I mean doctors are busy.

For many survivors, challenging their beliefs about being undeserving is a central part of the psychotherapy. Therapists frequently encourage clients to examine their thoughts, feelings, and/or behaviors and to question whether they are so "bad" that they must continue to punish themselves. If a client is depriving himself of health care, the psychotherapist can point this out and encourage his client to explore the issue of who is responsible for CSA. As male survivors revise erroneous beliefs about being unworthy, they may be more able to communicate their needs to their healthcare practitioners and to work with their psychotherapist on what they will say to the practitioner.

Along with supporting the survivor to believe in his right to good health care, the psychotherapist can encourage him to become more active in caring for his own body. This can be part of general efforts to increase self-esteem and to support the recognition that the survivor is the expert about his own needs. Men in the study spoke about their journeys of recovery and about applying some of the knowledge they were gaining from psychotherapy to caring for their physical health.

> I've been doing, for the last three years, a lot of work on myself, both mentally and physically trying to take care of my body and trying to take care of my stress, working on [the aftermath of] my abuse . . . But this is

> also the first time in my life for the last three years that I've really given a damn about my physical well-being. I never gave a damn before.

Questions that a psychotherapist might use to facilitate this discussion include:

- How do you stop yourself from making or attending appointments with healthcare practitioners?
- What experiences, thoughts or feelings stop you from taking more responsibility for your own health care?
- What might you do to ensure that you express your preferences and needs clearly?

Understanding the Nonlinear Healing Process

Participants stressed that healthcare practitioners should be attuned to the nonlinear nature of the healing process in order to respond flexibly to survivors. The notion of a nonlinear healing process refers to the fact that a survivor may be unable to tolerate or participate in examinations or treatment at various times, depending on what is occurring for him in his recovery. As one man said, "Even though you have a good rapport with the professional . . . the professional should always check because something might have changed. "

Psychotherapy can provide an arena for empowering male survivors to assess the willingness and ability of the healthcare practitioner to adjust his or her approach based on clients' feedback. It can also be the place to examine whether he feels safe enough to work with a particular practitioner. The psychotherapist can help the survivor learn how to work optimally with a particular healthcare practitioner. Also, with the survivor's permission, the psychotherapist may communicate with the healthcare practitioner to develop alternative approaches to engaging with the survivor on difficult days. A discussion of how to manage the nonlinear nature of healing may be broached with the following questions:

- What might you do if you cannot tolerate a certain treatment or exam on a specific day?
- How can others support you when this occurs?
- What might you say to the healthcare practitioner if you are feeling this way?

Additional suggestions for asking the healthcare practitioner to modify the way in which they proceed can be found in the following section on task-specific disclosure.

Demonstrated Awareness about CSA

Many men in the study said that when the healthcare practitioner had a good working knowledge about the effects of CSA, it improved the care they received: "If they were aware of it [abuse issues] and then made the client aware . . . that they're aware of it, it would make it a lot smoother, make it a little bit easier." The men stated that they are always looking for signs that a healthcare practitioner "has a clue" about the potential long-term health consequences of abuse and trauma. Posters or pamphlets in waiting and examination rooms allow patients to know that the practitioner has knowledge of these issues. Survivors emphasized that the signs need to clearly acknowledge that both girls and *boys* are victims of CSA. As one survivor suggested, the healthcare practitioner should have a "poster in all the examining rooms . . . [stating] 'Boys and girls who have been victimized as children are welcome."'. . . [and] have the picture [include both]—a boy and girl" (Teram et al., 2006, p. 512). Some men said that having information about the effects of sexual abuse in a waiting room can provide patients with both useful information and a signal that the healthcare practitioner understands this as an important issue.

The psychotherapist can help survivor clients develop questions to determine a healthcare practitioner's awareness of the prevalence and effects of CSA. He or she can also remind clients to look for overt cues that the practitioner is knowledgeable about the effects of abuse and violence on health. Male survivors who are successful in finding healthcare practitioners who are empathic and understand the dynamics of abuse are likely to have much better experiences.

Psychotherapists can also remind male survivor clients that the word "trauma" is usually interpreted by most healthcare practitioners to mean physical trauma. When survivors and psychotherapists speak to these practitioners about trauma, it is important to make it clear that they are referring to psychological trauma associated with experiences that have overwhelmed the individual's capacity to cope.

In addition to the nine principles of sensitive practice described in this section, two other issues relevant to psychotherapists were discussed by the participants; one is related to disclosure of the abuse history and the other to intense emotional and physical reactions to being touched.

DISCLOSURE OF PAST ABUSE AND TASK-SPECIFIC DISCLOSURE

The participants in the research described a range of experiences and attitudes about disclosing their abuse history to healthcare providers. It is clear that disclosure of past abuse to a healthcare practitioner is a multifaceted decision (Sorsoli, Kia-Keating, & Grossman, 2008). Each survivor must make

this decision for himself; however, therapists can point out that disclosure exists on a continuum and can vary in terms of detail, such as disclosing about past abuse experiences or using task-specific disclosure. See Schachter et al. (2009) and Teram, Schachter, and Stalker (1999) for a more detailed discussion of the distinction between these two types of disclosure.

Some survivor participants were definite in their opinion that healthcare practitioners should routinely ask about a history of abuse or interpersonal violence. Others talked about the risk that a survivor takes when he discloses, and many talked about the variables that affect a decision to share this sensitive information including fears of not being believed, of being blamed for the abuse, concerns about confidentiality, and that the disclosure might lead to an assumption that the man is a perpetrator of CSA. Schachter et al. (2009) provides information about the debate regarding routine inquiry about past and current interpersonal violence. The research on which this article is based supports the argument that routinely inquiring about past abuse is not harmful and, if done sensitively and in an informed manner, is likely to lead to improved health for all patients. Later in this section, strategies that psychotherapists might consider when working with a male survivor who does not feel ready to disclose his history to a healthcare provider are identified.

If a survivor does choose to disclose that he was sexually abused as a child, the psychotherapist can help him recognize that this decision doesn't mean he must give the healthcare practitioner details of the abuse. Rather, the survivor can be guided to speak about aspects of the exam/procedure that are extremely difficult and about ways that the practitioner can assist him during an appointment. When the survivor decides that he wants to reveal that he is a survivor of abuse, the psychotherapist can facilitate a plan for disclosing by exploring the following questions with the survivor:

- What terms would you be most comfortable using to disclose your history of abuse?
- If you do decide to reveal that you have a history of abuse, how can you tell your healthcare practitioner that you are not ready to offer more details?

This man shared his strategies:

> If I don't let the doctor know what's going on, it's not going to work. You somehow have to communicate that part of it, that abuse to them. I mean it's easy—you just say, "Off the record, Doc, I have this problem." You don't have to admit details. You don't have to say the type of abuse, you can just say, "I had abuses. I've triggers" and stuff like that. "I get upset if you try to touch without asking or telling me" and stuff like this.

Another man provided the following rationale for disclosing at a first meeting with his physician:

> I made sure that [the new family doctor] did know that I was potentially a survivor of childhood sexual abuse. That was sort of out on the table and if I had weird reactions to things, coming in with weird presentations, that he could at least know either to ask me about it or perhaps to speak to my therapist.

This quotation points to the importance of the psychotherapist working closely with the client's healthcare practitioners to support optimal healthcare interventions.

Task-specific disclosure is a concept that can be very useful for the survivor who chooses not to reveal the history of abuse but needs to communicate difficulties with the healthcare encounter. This form of disclosure involves telling the practitioner that the client finds certain experiences (e.g., body positions or types of touch) very difficult to tolerate. In essence, task-specific disclosure informs the practitioner of potential problems without revealing that the client has been abused. For example, a man might ask the practitioner not to approach him from behind because it makes him very uncomfortable, or he might ask if an examination can be done while he is sitting up rather than lying down. Task-specific inquiry provides a means of asking the practitioner to problem solve with the survivor to address particular sensitivities and is not an "announcement" that the man was abused as a boy. Using task-specific disclosure can support the goal of increasing the survivor's comfort with the examination. The psychotherapist can explore with the client the parts of an exam or treatment that he finds difficult by asking the following:

- What aspects of a healthcare examination/treatment do you find difficult?
- Which aspect is the most difficult to tolerate?
- Which aspect is the least difficult to tolerate?
- Is there any part of the examination about which you could tell the healthcare practitioner that it makes you very uncomfortable?

After generating a list of all the difficult aspects, the client could be asked to rate each on a scale of 1–10 according to his ability to tolerate each aspect. The psychotherapist may then work with the survivor to find ways to communicate this to the healthcare practitioner. The less difficult items can be addressed with regard to things he could do or steps he could take to make them more tolerable.

TRIGGERS, TOUCH, AND OTHER REACTIONS

Psychotherapy commonly addresses the survivor's response to experiences that remind him of his abuse and evoke involuntary and usually intense reactions, termed "triggers." The study participants described a range of responses to triggers they encounter during healthcare encounters, including flashbacks, dissociative reactions, and strong emotions such as anger and fear. Touch (particularly, but not limited to genitals, rectum, and mouth) was considered a very strong trigger for many participants. One man said, "Touch . . . can bring you right back to . . . that time of feeling very vulnerable and abused." The psychotherapist can help the survivor develop a preemptive plan to deal with these situations, such as, "Before you start, I need to tell you that having people touch my [body part] is really challenging for me to tolerate."

Men who participated in the study pointed out that triggers could be manifested both during and after seeing a healthcare practitioner. "When I got braces on [my teeth, as an adult], for three nights in a row, I just had horrible nightmares." Although individuals respond differently to triggers, anger was a very common response to triggers identified by the male participants. "Anger shows up often when you are triggered—like [when] somebody touches you in the wrong place. You are frightened and everybody is frightened of you." The participants indicated that an anger response was not always the result of a "trigger" per se but may be their way of coping with anxiety, lack of trust, or feelings of powerlessness in the healthcare encounter.

Psychotherapy sessions can help the male survivor develop strategies for coping with triggers, anger reactions, and appointments that are difficult for any reason. Questions might be organized to reflect the temporal sequence of an appointment in order to identify difficulties:

- Have you ever cancelled or simply not attended a healthcare appointment because you felt too anxious or fearful?
- What feelings do you experience when you are at home, getting ready to go to a healthcare appointment?
- What are you aware of or thinking about when you are in the waiting room before your appointment or in an examination room waiting to see the healthcare practitioner?
- What difficulties do you think you may experience during the actual visit with a healthcare practitioner?

The psychotherapist can then work with the survivor to develop a plan to get through appointments. For example, some participants indicated that they felt safer when another person was present during the interaction with the

healthcare practitioner. "I can remember feeling awkward having another man touch me. But my wife was there right beside me too, she was in the room any way and it was easier. . . . I felt safer" (Stalker et al., 2009, p. 190). In contrast, another man saw definite drawbacks to having someone else in the room when he saw a healthcare practitioner: "I've never done it [had someone else present during a healthcare visit] though I've thought—I've been offered for someone to come with me, but then I'm up against two people." The common strategy of teaching and encouraging survivors to practice grounding techniques can certainly be useful in dealing with potential triggers and helping the survivor to avoid cancelling appointments as a means of coping. Again, in this context, task-specific disclosure can promote understanding for the healthcare practitioner and maintain the privacy of the male survivor while proactively addressing the triggers and reactions to the healthcare interventions.

WORKING WITHIN THE REALITIES OF THE HEALTHCARE SYSTEM

The principles of sensitive practice can help psychotherapists work with male CSA survivors to get the most meaningful and sensitive care during healthcare appointments. The authors recognize that all patients are affected by the pressures of an overloaded healthcare system; however, survivors may be less able to tolerate being rushed or disrespected than nonsurvivors. In particular, time pressures certainly work against the survivor's wish to ask all the questions he has or to negotiate ways to help him tolerate healthcare procedures. If a practitioner is pressed for time, the psychotherapist should work with the survivor to identify his *most pressing* issues and to strategize with him about ways to "make it through" the healthcare encounter with the most positive outcome.

CONCLUSION

Psychotherapy can make an important contribution to the physical, mental, and emotional health of male survivors of CSA. Knowledgeable psychotherapists can educate and support their male survivor clients to address the issues that interfere with their ability to access or follow through with needed health care. Ideally, the psychotherapist will work as a member of a team of professionals that communicates directly with one another to enhance the health care provided to the survivor. As this man said,

> I've been doing, for the last three years, a lot of work on myself, both mentally and physically trying to take care of my body and trying to take care of my stress, working on [the aftermath of] my abuse. And I sort of

look at it like a team who are all helping me get better, be better or feel better. . . . I really do believe that it's a holistic thing.

The *Handbook on Sensitive Practice for Health Care Practitioners: Lessons from Adult Survivors of Childhood Sexual Abuse* (Schachter et al., 2009) is an excellent resource for both psychotherapists and survivors and provides a useful framework for thinking about how psychotherapy can support survivors to achieve a better quality of life. The hope is that, in time, all healthcare practitioners will integrate the principles of sensitive practice into their interactions with all of their patients because these principles are universally applicable. Until that time, psychotherapists can be critical in helping male survivors make the link between the difficulties they experience when receiving health care and their history of CSA. They can also support survivors as they make the effort to cooperate with healthcare practitioners and learn how to value and care for their physical well-being.

NOTES

1. The authors also interviewed 27 women sexually abused as children for the previous phase, focusing primarily on experiences with physical therapists and 19 women sexually abused as children focusing on experiences with all healthcare providers (Schachter, Stalker, & Teram, 2001).

2. We have discussed the issue of consent, but we wish to point out that the failure to seek consent can also be experienced as a failure to respect boundaries. Because the violation of boundaries is such a significant dynamic in CSA and because participants emphasized the importance of healthcare practitioners demonstrating their respect for client boundaries, we chose to make it a separate principle of sensitive practice.

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