ResearchGate

See discussions, stats, and author profiles for this publication at: https://www.researchgate.net/publication/223991352

Deep and almost unbearable suffering: Consequences of childhood sexual abuse for men's health and well-being

Article *in* Scandinavian Journal of Caring Sciences · December 2012

DOI: 10.1111/j.1471-6712.2012.00981.x · Source: PubMed

CITATIONS
14

READS
182

3 authors:

Sigrun Sigurdardottir
University of Akureyri
10 PUBLICATIONS 64 CITATIONS

SEE PROFILE

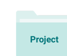
Sigridur Halldorsdottir
University of Akureyri
67 PUBLICATIONS 1,172 CITATIONS

SEE PROFILE

Sóley S. Bender
University of Iceland
24 PUBLICATIONS 204 CITATIONS

SEE PROFILE

Some of the authors of this publication are also working on these related projects:


Midwifery View project

Sálræn áföll og ofbeldi. Vinna í lokaverkefni. View project

All content following this page was uploaded by Sigrun Sigurdardottir on 14 February 2018.

The user has requested enhancement of the downloaded file.

Scandinavian Journal of Caring Sciences
EMPIRICAL STUDIES
doi: 10.1111/j.1471-6712.2012.00981.x

Deep and almost unbearable suffering: consequences of childhood sexual abuse for men's health and well-being

Sigrun Sigurdardottir M.Sc. (PhD Student)[1], **Sigridur Halldorsdottir** PhD (Professor and Director of Graduate Studies)[2] and **Sóley S. Bender** PhD (Professor and Director of Research and Development regarding Sexual and Reproductive Health)[3]

[1]Public Health Sciences, School of Health Sciences, University of Iceland, [2]School of Health Sciences, University of Akureyri, Akureyri and [3]Faculty of Nursing, University of Iceland, Reykjavik, Iceland

Scand J Caring Sci; 2012

Deep and almost unbearable suffering: consequences of childhood sexual abuse for men's health and well-being

Previous studies indicate that childhood sexual abuse can have extensive and serious consequences. The aim of this research was to do a qualitative study of the consequences of childhood sexual abuse for Icelandic men's health and well-being. Phenomenology was the methodological approach of the study. Totally 14 interviews were conducted, two per individual, and analysed based on the Vancouver School of Phenomenology. The main results of the study showed that the men describe *deep and almost unbearable suffering*, affecting their entire life, of which there is no alleviation in sight. The men have lived in repressed silence most of their lives and have come close to taking their own lives. What stopped them from committing suicide was revealing to others what happened to them which set them free in a way. The men experienced fear- or rage-based shock at the time of the trauma and most of them endured the attack by dissociation, disconnecting psyche and body and have difficulties reconnecting. They had extremely difficult childhoods, living with indisposition, bullying, learning difficulties and behavioural problems. Some have, from a young age, numbed themselves with alcohol and elicit drugs. They have suffered psychologically and physically and have had relational and sexual intimacy problems. The consequences of the abuse surfaced either immediately after the shock or many years later and developed into complex post-traumatic stress disorder. Because of perceived societal prejudice, it was hard for the men to seek help. This shows the great need for professionals to be alert to the possible consequences of childhood sexual abuse in their practice to reverse the damaging consequences on their health and well-being. We conclude that living in repressed silence after a trauma, like childhood sexual abuse, can be dangerous for the health, well-being and indeed the very life of the survivor.

Keywords: sexual abuse, men's health, child abuse, suffering, lived experience, mental health.

Submitted 29 September 2011; Accepted 10 February 2012

Introduction

Child sexual abuse (CSA) is a major public health problem (1). Men who have a history of childhood sexual abuse are ten times more likely than men without that history to be diagnosed with mental disorders, and post-traumatic stress disorder (PTSD), (2) and they are at more risk of sexually transmitted diseases and AIDS (3). They have described profound depression (4). Depression is one of the most common sicknesses among victims of sexual abuse, and CSA is considered the single most common cause of severe depression (5–7). PTSD and attention deficit hyperactivity disorder (ADHD) are the two most common diagnoses of children who have suffered CSA (8, 9). The highest risk of PTSD is because of sexual abuse, especially when it is experienced in childhood (10–12). PTSD can set in as a result of repeated psychological shock without any crisis counselling, when there is no admission of the event or events, or nobody who seems to listen and the individual feels repressed (11).

Health problems that have emerged after abuse are digestive tract maladies, respiratory conditions, sexually transmitted diseases, infertility (13), widespread and prolonged aches in women (14), and incontinence among boys (15), neurosis, sleep disorders, tremors, numbness and shock (16, 17). Prolonged fatigue, asthma, heart and circulatory disease, and diabetes are also among the

Correspondence to:
Sigrun Sigurdardottir, Public Health Sciences, School of Health Sciences, University of Iceland, Brekatun 11, Akureyri 600, Iceland.
E-mail: sigrunsiggaboga@simnet.is

© 2012 The Authors

reported health problems of women (18). Psychological problems that have been diagnosed after CSA are depression, anxiety, phobia, low self-worth, shame, guilt and self-destructive behaviour (13) as well as drug and alcohol abuse among women (19). In a study by Lisak (20), men with a history of CSA felt anger, betrayal, fear, helplessness, a desire to escape, isolation, loss, negativity about themselves and others, self-blame, guilt, shame and humiliation. Other symptoms reported from that study are doubts about masculinity, confused sexual orientation, sexual dysfunction and loss of contact with childhood peers. Identical results come from a study on adult male survivors of CSA in which men were found to be more prone to extroverted behaviour, anger, aggression, antisocial behaviour, and behavioural disorders, and suffering from emotional problems and low self-worth (21).

Of the 224 men who visited the genito-urinary unit in London, 12% of the patients over the age of 18 admitted to CSA, and of those, 18% revealed sexual abuse occurring after the age of 16. Those who endured CSA were more likely to report sexual abuse in adulthood, have genito-urinary problems, and none of them had reported the abuse to the police (22).

People who are sexually victimized as children start to have sex very young, change partners often and tend not to use protection against sexually transmitted diseases, and they generally have difficulty with sexual intimacy (23, 24). Men in this group are more likely to take on too much responsibility in relationships and they have trouble being faithful to their wives (4). Moreover, a relationship between sexual abuse, sexual dysfunction and domestic problems has been discovered (6), and survivors more frequently marry alcoholics and are more likely to go through marital problems than people who were not abused as children (25). Living with the traumatic experience of CSA has been shown to have serious consequences. From a sample of 2108 teenagers in 93 schools in Sweden and 475 teens who had quit school, it was found that 33.3% of boys who had been sexually abused as children attempted suicide and exhibited self-destructive behaviour as opposed to 5.1% of the boys who had not been abused (26). A study in the United States of the long-term consequences of sexual abuse in childhood among 9367 women and 7970 men in which 25% of women and 16% of men had been sexually molested during childhood found that suicide attempts were twice as common among men compared to women who had suffered sexual abuse in childhood (25).

In summary, too little attention has been paid to men's experience of CSA. Even though some studies have been conducted, more knowledge is needed regarding men's personal experience of CSA, and no study was found involving Icelandic men. The aim of the present research was, therefore, to study the consequences of CSA for Icelandic men's health and well-being. The research question was, therefore, *How do Icelandic men experience CSA and what are the consequences for their health and well-being?*

Research methods

The Vancouver School of phenomenology (27) was chosen as the methodological approach to answer the research question. The Vancouver School is an interpretation of phenomenological philosophy, and it is being used as a research method for the human sciences with its unique blend of phenomenology, hermeneutics and constructivism. As applies to most studies based on phenomenological traditions, this study is based on the philosophy of holism and existential psychology, as well as on the premise or theory that reality is individually constructed as a result of lived experience (28). The number of participants within the Vancouver School is typically 5–15 and the number of dialogues or interviews at least 10.

Recruitment of participants

The selection criteria of participants included men who had been sexually abused as children; who had been receiving some post-traumatic treatment; and had good support at the time of the interviews. We advertised for participants at various education and counselling centres for survivors of sexual abuse and violence such as at Stigamot (http://www.stigamot.is) in Reykjavik (the capital), Solstafir Vestfjarda (http://www.solstafir.is) in West-Iceland, Aflid Akureyri (http://www.aflidak.is) in North-Iceland, Blatt afram (http://www.blattafram.is) which is the leading grass root child sexual abuse prevention organization in Iceland and SASA (http://www.sasa.is), sexual abuse survivors anonymous. Those working in these centres were the first contacts with the men. The first participant came from Aflid, the second came from Solstafir, and one man saw an interview with the first author in the local newspaper and volunteered to participate. Finally, four men came from SASA.

Description of participants

Seven Icelandic men who suffered sexual abuse as children participated in the study. The men were in the age range of 30–55 at the time of the interviews. The abuse began for most of the men around 4–5 years of age, as far as they can remember, for some earlier and for others later. They all endured repeated sexual abuse, and some were victimized by more than one assailant. All of them have sought professional help, some starting in childhood or adolescence, others only during adulthood. Variation exists in how well the men remember the events of the sexual abuse. Some have carried the memory all the time while others blocked it completely for some time. All are noncustodial fathers, except for one.

© 2012 The Authors

Table 1 The 12 basic steps of the research process of the Vancouver School and how they were followed in the present study

Steps in the research process	*What was done in the present study*
Step 1. Selecting dialogue partners (*the sample*)	Seven Icelandic men were selected through purposive sampling
Step 2. Silence (*before entering a dialogue*).	Preconceived ideas were deliberately put aside
Step 3. Participating in a dialogue (*data collection*)	Two interviews with each participant, total of 14 interviews. The first author conducted all the interviews
Step 4. Sharpened awareness of words (*data analysis*)	Concurrent data collection and data analysis
Step 5. Beginning consideration of essences (*coding*)	Trying repeatedly to answer the question: What is the essence of what this participant is saying?
Step 6. Constructing the essential structure of the phenomenon from each case (*construction*)	The main factors in each participant's story is highlighted and the most important factors are constructed into an analytic framework
Step 7. Verifying each case construction with the relevant participant (*verification*)	This was done with all the participants
Step 8. Constructing the essential structure of the phenomenon from all the cases (*final construction*)	First two authors participated in this final data analysis process and made sure the model and framework constructed were based on the actual data
Step 9. Comparing the essential structure of the phenomenon with the data (*meta-synthesis of all the different case constructions*)	To ensure this all the transcripts were read over again
Step 10. Identifying the overriding theme which describes the phenomenon (*construction of the main theme*)	*Deep and Almost Unbearable Suffering: Consequences of Childhood Sexual Abuse for Men's Health and Well-being*
Step 11. Verifying the essential structure with some research participants (*verification*)	The results and the conclusions were presented to and verified by all the participants
Step 12. Writing up the findings (*multivoiced reconstruction*)	The participants are quoted directly to increase the trustworthiness of the findings and conclusions

(Modified from 26 p. 57).

Data collection and analysis

Each participant was interviewed twice, in all 14 interviews. The interviews were conducted in a location chosen by each participant. The first author conducted all the interviews. The main interview question was: Can you tell me about your personal experience of childhood sexual abuse and how it has affected your health and well-being? Questions were then asked based on how the interview evolved. Data collection was continued until the first two researchers were in agreement that data saturation had been achieved. The research process in the Vancouver School involves twelve main steps, and in Table 1, these steps are delineated and how they were followed in the present study.

In all of the twelve steps, researchers go through seven cognitive processes: to be still, to reflect, to identify, to choose, to interpret, to construct and to validate (see Fig. 1).

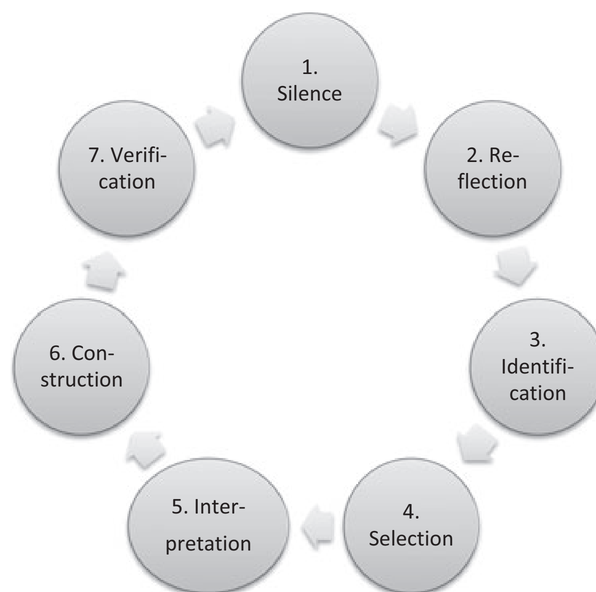


Figure 1 The process of doing phenomenology in the Vancouver School [Modified figure from 26 p. 56. Used with permission]. This cycle is repeated in every of the 12 steps of the Vancouver School.

Validity and reliability

The research process of the Vancouver School has some inbuilt strategies designed to increase validity and reliability, particularly 'member checking' in steps 7 and 11 (see Table 1). The 'researcher triangulation' in this study proved fruitful, especially in steps 10, and 12, where the expertise of three professionals was combined. Triangulation is one of the strategies designed to increase validity and reliability in qualitative research (27). 'Peer debriefings' and 'thick

© 2012 The Authors

description' were also used as strategies to increase validity. Because of the effects of constructivism within the Vancouver School, 'reflexivity' is given. The findings are a construction of the researchers, built on the data. A 'reflective diary' was used at all stages of the research process as required in the Vancouver School.

Ethics

Ethical permission was obtained from the National Bioethics Committee (VSNb2009100019/03.7), and the study was reported to the Data Protection Authority (S4791/2010). All the men received a detailed introduction of the study for informed consent. A long period of time was set between first and second interviews, 1–4 months, so that participants had an opportunity to reflect on the experience of the former interview and to refuse further participation if they wanted to do so. None of the participants opted to quit. Methods of identity protection were, among others: only the first author knew the identities of participants; tape recordings were deleted as soon as interviews had been transcribed; pseudonyms were used; and all information that could identify individuals was removed from the transcripts.

Results

The results of the study reveal *deep and almost unbearable suffering* of which there is no alleviation in sight. The men have lived in repressed silence and along with the feelings of worthlessness have come close to taking their own lives. What stopped them from committing suicide was revealing to others what happened to them and then holding onto life. The consequences of the abuse surfaced either immediately after the shock or many years later and developed into complex PTSD. Table 2 provides an overview of the answer to the research question 'How Icelandic men experience CSA and what are the consequences for their health and well-being?' that includes how the men experienced the trauma; their sufferings as children; the adult psychological health consequences; relational and sexual health consequences; negative consequences for the relationships with their children; and the consequences on their adult physical and social health. Throughout these different areas and life-stages, the men experienced deep and almost unbearable suffering.

Experiencing the trauma

In experiencing the trauma, the men experienced deep suffering characterized by intense fear, emotional disconnection, self-blame, guilt and shame. However, this deep suffering was unacknowledged by others and they lived in repressed silence, which became the tragic story of their lives.

They experienced *intense fear* when the violation occurred as well as the feeling of having *frozen (stupor)*. Finn explains: 'I think the fear was so great that I remember being in the bed…but then nothing else; just like a blackout.'

Table 2 Overview of the consequences of childhood sexual abuse for the health and well-being of Icelandic men: *Deep and Almost Unbearable Suffering*

Experiencing the trauma	*Childhood sufferings*	*Adult psychological sufferings*	*Relational and sexual sufferings*	*Negative consequences for the relationships with their children*	*Adult physical and social sufferings*
Intense fear	Broken self-image	Feelings of rejection Escape and isolation	Unable to be themselves and to trust a partner	Their children make life worth living	Digestive tract maladies
Stupor (freezing)	Indisposition	Fractured self-image low self-esteem	Carrying a heavy secret within a relationship	Symptoms of postpartum depression	Various chronic diseases
Dissociation/emotional disconnection/ detachment	Being teased and bullied	Depression	Relational and sexual intimacy problems	Problems caused by emotional disconnection	Physical relief by disclosure
Self-blame	Learning disabilities	Anxiety and indisposition	Unable to be emotionally intimate	Over-protecting the children	Absenteeism
Guilt	Bad behavior and criminal offences	Suicidal thoughts and attempts	Troubled relationships	Not trusting anyone with the children	Being at risk of losing a job
Shame	Hyperactivity and risk behavior	Emotional numbness	Surfacing of repressed memories during sex	Difficulties in touching	Problems with money
Forced into repressed silence	Desiring numbness Alcohol and drug abuse	Anger and rage	Feeling dirty and awful	Prejudice against them regarding children	Workaholism

© 2012 The Authors

All the participants used *dissociation* and *emotional disconnection* as a way of coping with the terrible trauma. They describe how they endured the shock by leaving their body and how they *detached* themselves from their body and their emotions, detached themselves from the events as Edward said:

> I remember when I stepped out of the car how everything was different. This was not the same world and then I think I detached myself somewhat from my emotions …so I had distanced myself from myself…but it was wonderful to stop hurting.

Finn also recounted: 'I remember the action of getting into bed and I remember myself on the other end of the room watching this and I was like a cameraman, seeing the whole thing from above.

Participants have wrestled with feelings of *self-blame* and *guilt*. They felt that they did something wrong and say that the perpetrators behaved in such a way as to project the blame on to them. Bill reminisces:

> And how he played me, bad conscience and guilt, I didn't want anything to do with this …It's not long since I realized that this was not my fault, I was naturally just a child.

Much secrecy and humiliation accompanied the abuse, and the participants speak about the *shame* that followed the abuse, especially considering that such things are not supposed to happen to boys.

None of the men dared to tell anyone about the abuse, and they all lived in *repressed silence* until adulthood. They were threatened and/or given money, alcohol and gifts. They had nobody to talk to about what happened because they were convinced that nobody would believe them. Gilbert explains:

> He held me in some kind of mental prison until I was 17 years old, or even longer, says that I may never tell anyone of this: 'and who would believe a bratty kid with a bad reputation instead of a respected man like me, an adult man, and I will tell your mother and father about the money' and, I mean, a child believes this.

Childhood sufferings

The men's experienced sufferings during childhood were characterized by broken self-image, indisposition, bullying, learning disabilities, misdemeanour crimes, hyperactivity and risk behaviour. They began drinking in their teen years in which they found desired escape and numbness.

Childhood, which was extremely difficult for all of the participants, was characterized by a severely *broken self-image*, *indisposition* and *bullying*. Anders already had digestive problems before the age of five and until his teen years, and he had faecal incontinence until the age of ten. He reminisces:

> Once, I stood on top of a hill and all the kids in the neighbourhood and school were pointing and laughing at me. That's what I remember. They were saying, 'Did you shit yourself? Has your mommy changed your diaper?' I was 10 years old …and they all knew.

All the participants had *learning disabilities*, such as dyslexia, symptoms of attention deficit disorder, hyperactivity disorder and other behavioural problems, as Bill comments: 'I just stopped functioning in school... I was illiterate and came out of school practically without learning a single thing. I couldn't write a sentence, was practically illiterate at about 20 when I went to therapy.'

The men committed various *misdemeanour crimes* such as breaking and entering, vandalism, theft, and driving without a licence. They lived whimsically, doing things that they knew they were not supposed to do, and they say that all these petty crimes were outcry for help. The participants speak of *hyperactivity* and *risk behaviour*; and feel lucky to have survived. They began drinking in their teen years and discovered that a certain degree of desired *escape* and *numbness* could be achieved with overuse of alcohol.

Adult psychological sufferings

Adult psychological sufferings were characterized by strong feelings of rejection, depression, anxiety and indisposition, suicidal thoughts, emotional numbness, anger and 'volcanic' rage.

The participants have all battled with strong *feelings of rejection* which have had a strong effect on their entire life. They were rejected by their peers when they were bullied. Some of them were rejected by their family after they disclosed what had happened to them. They have experienced hurtful rejection from lovers in the form of infidelity and violence, and they have rejected themselves and felt rejected by society. This has resulted in feelings of wanting to *escape* and *isolate* themselves which have increased over the recent years. They find it difficult to be among others and let nobody get too close. The participants' *self-image is fractured,* as Daniel describes: 'I never saw myself as handsome or ugly, I was just nothing'.

All the men describe suffering *depression*. They also describe *anxiety* and *indisposition* in their lives. Some did not seek help until they reached rock bottom. The participants have all been possessed by some kind of self-destructive impulse, self-damaging behaviour or *suicidal thoughts,* and they are amazed that they have survived these impulses. They have spent a lot of time organizing or planning suicide and have come close to committing the act, as Gilbert says:

> I often thought about killing myself. I have often pointed the shotgun at my head and I have had the shotgun 10 cm from his [the abuser's] head while he slept. I had constant suicidal thoughts once, but I

© 2012 The Authors

> lacked the courage to pull the trigger, more than once and more than twice when I aimed at my head.

They have all searched for *emotional numbness* and have used alcohol and/or illicit drugs to numb themselves. The men say that their characteristics and behaviour are similar to those of addicts; if they are not doing their 'inner work' they are off the wagon and in regards to food, sleep, exercise, work and other things, they do not know their limits.

The participants all report being *angry* for a certain amount of time. They have even felt such uncontrollable *rage* that they thought it must be insanity, another personality or that they must have blacked out as during a fit of rage. They have not harmed anyone but have attacked people who have bullied them and have not understood where the strength for such outbursts came from, as Hank describes:

> I was extremely angry for many years.. the anger was strong and these two feelings were strongest: nothing or rage. I just wanted to kill someone.

They liken the explosion of their anger to a volcanic eruption. Bill was abused by his older brother for many years and says that he lost control of himself when he was 12–13 years old and attacked his brother, throwing the older boy across the room, and does not understand how that was possible.

Relational and sexual health sufferings

All the men felt unable to be themselves and to trust a partner. They felt they always had to carry a heavy secret and they felt dirty and awful. They have all had a variety of relational and sexual intimacy problems that have resulted in troubled relationships. The repressed memories have had a powerful effect on the men's sexuality and have sometimes surfaced while they are with their spouse. These relational and sexual health consequences have caused deep sufferings for the men.

The men all felt *unable to be themselves and to trust a partner* because someone close to them betrayed them in childhood. Bill says: 'For instance, when we went deeper into the relationship I froze; I couldn't do it, couldn't trust'.

The men feel they have always had to *carry a heavy secret* because they could not disclose the abuse and felt that they were hiding something from their spouse. This put them under great pressure: 'I always felt very bad about this, not being able to reveal what happened… I felt I was lying to her and hiding something and that is not conducive to a relationship'.

The men have all had a variety of *relational* and *sexual intimacy problems*. They have been in failed relationships, and all, except one, are divorced from previous spouses and/or the parents of their children. They have entered serious relationships completely devoid of emotional connection, *unable to be emotionally intimate*, as Anders describes:

> I just hopped into a relationship with a woman without discussion and then it would end in chaos. I just didn't function in relationships. I was distant, did not participate in life, lost and I am still searching for myself. I liked leaving, often tired of trying to connect with someone deeply. I was just not competent at being in such emotional closeness.

They have neither self-reliance nor self-assurance which has led them to seek out similar people which have resulted in *troubled relationships*. Edward did not feel comfortable unless he had control, needed to dominate and could not enjoy it if the woman wanted to be close to him or be the instigator of sex:

> As soon as they wanted to control I was instantly insecure and then came the fear, what does she want? What does she intend to do? If she had prepared something I just froze, I just got scared. I didn't understand any of it. Later, I realized that it all centred on sex and she had prepared and that was like my brother; he prepared everything. That was me connecting to my pain.

The *repressed memories* have had a powerful effect on the men's sexuality and have sometimes *surfaced* while they are with their spouse. Daniel recounts:

> Sometimes I have flashbacks, and then I have memories that come forward. It happens sometimes when I'm with my wife and something similar happens. Usually, I try to block it out and think about something else. Sometimes I have to just stop and be left alone, and she just understands that.

The abuse also distorted their sexuality in that they had experienced *feelings of being dirty* and *awful*.

Negative consequences for the relationships with their children

Most of the men feel that their children make their lives worth living and yet they all experienced symptoms similar to postpartum depression when they were born and have for the most part felt emotionally disconnected from their children. Some have tended to be overprotective fathers and most have had difficulty touching their children. The men who have revealed their own abuse faced a great deal of prejudice towards them creating immense suffering.

Most of the men feel that *their children make their lives worth living*. However, all the men describe their feelings after the births of their children as being similar to *postpartum depression*. They all felt a great sense of responsibility when they fathered their first child. They, however, felt *emotionally disconnected*, as described by Finn who was 18 when he had his first child:

> I was not competent to be in a relationship or to raise a child or anything, these feelings were always missing. The first child had a powerful effect but there was never happiness, just trouble, I never enjoyed life. I lacked emotions, was emotionally disconnected.

© 2012 The Authors
Scandinavian Journal of Caring Sciences © 2012 Nordic College of Caring Science

Some have shown a tendency to be *overprotective fathers* without really understanding why because some of them did not remember the abuse at that time. They also recount not trusting anyone for their children as Hank reminisces:

> I went into each and every social event with the kids and I was in the planning committee of everything. I just trusted no one.

They have sometimes had *difficulty touching* their children, for example, changing diapers. Bill reflects: 'I was incredibly shy about how one was allowed to touch the child and such and I experienced it all as complicated.'

The men face a great deal of *prejudice* against them and especially in connection with children. When Finn revealed that he had been sexually abused as a child, he was restricted from coming near his siblings' children. The men say that one of the main reasons male victims of sexual abuse do not reveal the violation is that people have, in general, come to the conclusion that victims of abuse become abusers, because everyone who is caught abusing others say that they have suffered this as well and people reverse this logic.

Adult physical and social sufferings

The men's physical sufferings include various health problems, chronic diseases, and social sufferings that include absenteeism and difficulties keeping a job along with financial troubles. Others speak of being workaholics and using work as an escape, often jeopardizing their relationships with other people.

The participants have suffered various health problems, some all their lives starting in childhood. One such was Bill who had *digestive tract maladies* from the age of five:

> I had stomach illness, stomach cramps and colon cramps until my teens, I was incontinent until I was ten, 24 years of my life have been spent in chronic diseases. As I understand it, these sicknesses are connected to the psyche as much as they are to the body.

The participants also talk about *various chronic diseases* such as asthma, allergies, chronic infections, epilepsy, diabetes, aches and muscle cramps. Daniel states:

> I have chronic muscle cramps in my shoulders and neck, I've had this problem since I was 12–13 years old and it's very often that I get headaches from the cramping, one thing leads to another.

Edward had suffered from epilepsy from the age of 12. He had grand mal seizures and often found himself in an ambulance after such seizures. He checked himself into an alcohol rehabilitation centre where he revealed that he had been abused as a child and three months later the seizures stopped.

Their illnesses, listlessness or restlessness had social consequences because being ill means there is a greater risk of *losing a job* and consequently being in financial trouble.

Daniel has been absent from work because of sickness and has twice lost his job because of *absenteeism*:

> I have a bad back, but I called in more than is normal. I often went to the doctor because of the back pain, got pain killers and swallowed them also just to push down the psychological pain, kill these emotions.

Anders says that he does not manage *money* well to this day and blames that on the abuse because he was paid after each sexual attack. He always got a lot of money but had no respect for it. Others speak of being *workaholics* who use work as an escape, finding peace and even physical release, and this has often jeopardized their relationships with other people.

Discussion

The main results of the study revealed that childhood sexual abuse had extremely serious and prolonged consequences for the men's health and well-being, mentally, emotionally, sexually, physically and socially. The suffering of the men is still profound and almost unbearable, and through most of their lives, they have lived with the feelings of worthlessness in repressed silence and have come close to taking their own lives. The participants projected their emotions outward; they were hyperactive, showed antisocial behaviour and disrespected laws similar to the results of the study by Lisak (20). What stopped them from committing suicide was revealing to others what happened to them. They were at rock bottom when they stood on the precipice and told someone of their experiences and held onto life.

Sentenced to silence

Not one of the men revealed the abuse before they had reached adulthood, even though they had sought some kind of professional help. They did not say anything until they hit rock bottom and faced the choice of revealing what had happened or taking their own life. Social prejudice kept them silenced because of the myth that men who have endured sexual abuse during childhood will then abuse children when they grow up. That is the dominant reason they give for their silence and the last thing they want is to bear such a label. Furthermore, it is generally not accepted in society that boys or men are raped. The unwillingness of men in the current study to report the sexual abuse is consistent with the findings of Holmes and Slap (3) where only 10–33% of male victims reported the abuse. This indicates that the prevalence of sexual abuse of boys is probably seriously underestimated. Furthermore, men are less likely than women to seek the help of psychologists, psychiatrists and other specialists. Men have a tendency not to report sexual abuse and deny that it has an effect on their lives. Their silence results in them not seeking health services and they are not considered victims

© 2012 The Authors
Scandinavian Journal of Caring Sciences © 2012 Nordic College of Caring Science

(29). Research results indicate that talking to someone or writing about their traumatic experiences can have strong positive effects on their health: it can decrease stress, and it strengthens the immune system as well as being important in the processing and healing after a shock (30, 31).

Feelings of worthlessness

During their youth, the men felt terrible; they had a fractured self-image and exhibited self-destructive behaviour. The men had all harboured suicidal thoughts, some from childhood, and in a few cases had gone as far as planning or even attempting suicide but did not execute their plans. These results are consistent with previous studies (8, 32–36) which have indicated that children with similar experiences have suicidal thoughts, exhibit self-destructive behaviour, attempt suicide, are miserable and depressed, and have low self-confidence.

Difficulty reconnecting

All the men describe how they disassociated from their bodies and separated themselves from their emotions and have difficulty reconnecting to themselves and connecting to other people, for example, women and their children. They talk about a profound sense of self-blame, shame and guilt they felt because this is not supposed to happen to boys; they should be able to defend themselves. They had not told anyone about their experiences for years because of the fear of not being believed and because of the self-blame over having 'allowed' it to happen. These results are identical to the findings of those of Feiring et al. (32) who reported that CSA has negative effects on the child's personality in the form of self-blame and disgrace, as well as causing the child to feel unappreciated by his peers and unable to make close personal connections.

Consequences of the deep suffering

The participants all agree that damage has occurred and their lives have been characterized by suffering. Most of the men have not found constructive ways of dealing with the deep suffering. It had resulted in great anger that has been bottled up inside. The participants have a tendency to vent their anger in various ways and show signs of behavioural disorders, especially attention deficit and hyperactivity disorder, and have often broken laws and gotten into trouble with the police. These results are similar to those of Holmes and Slap (3). People who suffered sexual abuse in childhood have also been reported to have personality disorder and social phobias (37–39). The men have a broken sense of sexual self and have problems with relational and sexual intimacy. They have been affected at some point by memories about the sexual abuse they suffered which sometimes has disturbed them during the sexual act. They have all had relational challenges. They have had difficulties connecting with their children; describe symptoms of postpartum depression; and emotional numbness. These are similar results to other studies (40, 41).

A life of prolonged stress

It is clear that all the participants have lived in severe stress which according to Kemeny and Gruenewald (42) may strongly suppress the immune system. Prolonged stress increases the probability of various sicknesses, and it is well-known that depression, from which all participants have suffered, has complex negative effects on the immune system (43). Research results in psychoneuroimmunology show that every human being is a single whole. The mind, the nervous system and the immune system are all closely connected and communicate constantly. There is no real separation between the mind and the body because of the highly evolved communication network between the brain and nervous system, endocrine glands, and the immune system (44). Negative emotions, like those reported by all participants, are a danger to the health of the individual and increase the likelihood of disease (45). Physical symptoms named by the participants can also be connected to the defensive mechanism of freezing, according to Levine and Frederick (46) and Rothschild (47).

Misdiagnosis?

The 2007 prevalence of ADHD drug use among the total Nordic population is 2.76 per 1000 habitants, varying from 1.23 in Finland to 12.46 in Iceland. Prevalence among boys (age 7–15) is fourfold the prevalence among girls (48). As there is a high degree of symptom overlap and co-morbidity between ADHD and SAC (sexually abused children), differential diagnosis can be confusing (8). Misdiagnosis can have serious consequences for sexually abused children. Therefore, routine inquiry about traumatic experiences in children presenting with ADHD symptoms has been suggested to improve differential diagnosis (10). The present authors suggest this should be carefully considered for Icelandic boys.

Study limitations

It is not the intention of the authors to generalize these results to include all men who have suffered CSA, but rather to increase awareness and understanding of the perceived consequences for the health and well-being of these Icelandic men.

Implications

The study provides qualitative findings from an understudied population with major health implications. It is still

rather unusual to elucidate men's experiences of sexual abuse in research and it seems to be a certain taboo about this area in health care. We hope this study will help in decreasing this taboo. Professionals need to be aware that boys and men with certain health problems could be suffering the consequences of CSA and thus have a history of extreme psychological trauma that may never have been treated. It is important for caregivers to know the consequences of childhood sexual abuse in adults. The study findings are valuable to clinical practice. An interdisciplinary community based programme needs to be developed for men who are survivors of childhood sexual abuse. We have already designed such a programme for females who have suffered the consequences of CSA. We will describe that programme and the positive outcome, as measured by the different health professionals, in another paper.

Conclusions

This study adds critical dimensions to the state of knowledge in this important research area by highlighting the danger of repressed silence among men. The findings of this study indicate that childhood sexual abuse can have extremely widespread and severe long-term psychological, sexual, relational, physical and social health consequences. All the participants have survived great suffering which is still profound. We conclude that living in repressed silence after a trauma like childhood sexual abuse can be dangerous for the health, well-being and indeed the very life of the survivor.

References

1 Molnar BE, Buka SL, Kessler RC. Child sexual abuse and subsequent psychopathology: results from the national comorbitity survey. *Am J Public Health*, 2001; 91: 753–60.
2 O'Leary PJ. Men who were sexually abused in childhood: coping strategies and comparisons in psychological function. *Child Abuse Negl* 2009; 33: 471–9.
3 Holmes WC, Slap GB. Sexual abuse of boys: definition, prevalence, correlates, sequelae and management. *J Amer Med Assoc* 1998; 280: 1855–62.
4 Whiffen VE, Thompson JM, Aube JA. Mediator of the link between childhood sexual abuse and adult depressive symptoms. *J Interpers Violence* 2000; 15: 342–51.
5 Anderson KP, LaPorte DJ, Brandt H, Crawford S. Sexual abuse and bulimia: response to inpatient treatment and preliminary outcome. *J Psychiat Res* 1997; 31: 621–33.
6 Cheasty M, Clare AW, Collins C. Relation between sexual abuse in childhood and adult depression: case control study. *Brit Med J* 1998; 316: 198–201.
7 Levitan RD, Parikh SV, Lesage AD, Hegadoren KM, Adams M, Kennedy SH, Goering PN. Major depression in individuals with a history of childhood physical or sexual abuse: relationship to neurovegetative features, mania and gender. *Am J Psychiat* 1998; 155: 1746–52.
8 Norris FH, Murphy AD, Baker CK, Perilla JL, Rodriguez FG, Rodriguez JJG. Epidemiology and trauma and post-traumatic stress disorder in Mexico. *J Abnorm Psychol* 2003; 112: 646–56.
9 Weinstein D, Staffelbach D, Biaggio M. Attention-deficit hyperactivity disorder and posttraumatic stress disorder: differential diagnosis in childhood sexual abuse. *Clin Psychol Rev* 2000; 20: 359–78.
10 Fagan N, Freme K. Confronting posttraumatic stress disorder. *Nurse* 2004; 34: 52–64.
11 Hetzel MD, McCanne TR. The role of peritraumatic dissociation, child physical abuse and child sexual abuse in the development of posttraumatic stress disorder and adult victimization. *Child Abuse Negl* 2005; 29: 915–30.
12 Heather Y, Jennifer S, Brian I, Kim R. Sexually abused children five years after presentation: a case–control study. *Pediatrics* 1997; 100: 600–8.
13 WHO. World report on violence and health 2002. Retrieved from: http://www.who.int/violence_injury_prevention/violence/world_report/en/full_en.pdf
14 Walsh CA, Jamieson E, MacMillan H, Boyle M. Child abuse and chronic pain in a community survey of women. *J Interpers Violence* 2007; 22: 1536–54.
15 Morrow J, Yeager CA, Lewis DO. Encopresis and sexual abuse in a sample of boys in residential treatment. *Child Abuse Negl* 1997; 21: 11–18.
16 Otis JD, Keane TM, Kerns RD. An examination of the relationship between chronic pain and post-traumatic stress-disorder. *J Rehabil Res Dev* 2003; 40: 397–406.
17 Woods SJ, Wineman NM. Trauma, posttraumatic stress disorder symptom clusters and physical health symptoms in post-abused women. *Arch Psychiat Nurs* 2004; 18: 26–34.
18 Romans S, Belaise C, Martin J, Morris E, Raffi A. Childhood abuse and later medical disorders in women: an epidemiological study. *Psychother Psychosom* 2002; 71: 141–9.
19 Ullman SE, Starzynski LL, Long SM, Mason GE, Long LM. Exploring the relationships of women's sexual assault disclosure, social reactions, and problem drinking. *J Interpers Violence* 2008; 23: 1235–57.
20 Lisak D. The psychological impact of sexual abuse: content analysis of interviews with male survivors. *J Trauma Stress* 1994; 7: 525–48.
21 Dhaliwal GK, Gauzas L, Antonowicz DH, Ross RR. Adult male survivors of childhood sexual abuse: prevalence, sexual abuse characteristics and long-term effects. *Clin Psychol Rev* 1996; 16: 619–39.
22 Coxell AW, King MB, Mezey GC, Kell P. Sexual molestation of men: interviews with 224 men attending a genitourinary medicine service. *Int J STD AIDS* 2000; 11: 574–8.
23 Steel JL, Herlitz CA. The association between childhood and adolescent sexual abuse and proxies for sexual risk behavior: a random sample of the general population of Sweden. *Child Abuse Negl* 2005; 29: 1141–53.
24 Fleming J, Mullen PE, Sibthorpe B, Bammer G. The long-term impact of childhood sexual abuse in Australian

© 2012 The Authors

women. *Child Abuse Negl* 1999; 23: 145–59.

25 Dube SR, Anda RF, Whitfield CL, Brow DW, Felitti VJ, Dong M, Giles WH. Long-term consequences of childhood sexual abuse by gender of victim. *Am J Prev Med* 2005; 28: 430–8.

26 Edgardh K, Ormstad K. Prevalance and characteristics of sexual abuse in a national sample of Swedish seventeen-year-old boys and girls. *Acta Paediatr* 2000; 88: 310–9.

27 Halldorsdottir S. The Vancouver School of doing Phenomenology. In *Qualitative Research Methods in the Service of Health* (Fridlund B, Hildingh C, eds.), 2000, Studentlitteratur, Lund, 47–78.

28 Spiegelberg H. *The Phenomenological Movement: A Historical Introduction by Herbert Spiegelberg*, 3rd enlarged edn. 1984/1965, Maritinus Nijhoff, The Hague.

29 Holmes G, Offen L, Waller G. See no evil, hear no evil, speak no evil: why relatively few males who have been sexually abused receive help for abuse-related issues in adulthood. *Clin Psychol Rev* 1997; 17: 69–88.

30 Chaudoir SR, Fisher JD. The disclosure process model: understanding disclosure decision making and postdisclosure outcomes among people living with a concealable stigmatized identity. *Psychol Bull* 2010; 136: 236–56.

31 Pennebaker J, Kiecolt-Glaser JK, Glaser R. Disclosure of traumas and immune function: health implication for psycotherapy. *J Consult Clin Psych* 1988; 56: 239–45.

32 Feiring C, Rosenthal S, Taska L. Stigmatization and the development of friendship and romantic relationship in adolescent victims of sexual abuse. *Child Maltreatment* 2000; 5: 311–22.

33 Ystgaard M, Hestetun I, Loeb M, Mehlum L. Is there a specific relationship between childhood sexual and physical abuse and repeated suicidal behavior? *Child Abuse Negl* 2004; 28: 863–75.

34 Martin G, Bergen HA, Richardson AS, Roeger L, Allison S. Sexual abuse and suicidality: gender differences in a large community sample of adolescents. *Child Abuse Negl* 2004; 28: 491–503.

35 Gutierrez PM, Thakker RR, Kuczen C. Exploration of the relationship between physical and/or sexual abuse, attitudes about life and death, and suicidal ideation in young women. *Death Stud* 2000; 24: 675–88.

36 Santa Mina EE, Gallop RM. Childhood sexual and physical abuse and adult self-harm and suicidal behaviour: a literature review. *Can J Psychiat* 1998; 43: 793–800.

37 Chen J, Michael P, Dunne BA, Ping H. Child sexual abuse in Henan province, China: association with sadness, suicidality and risk behaviors among adolescent girls. *J Adolescent Health* 2006; 35: 544–9.

38 Golier JA, Yehuda R, Bierer LM, Mitropoulou V. The relationship of borderline personality disorder to posttraumatic stress disorder and traumatic events. *Am J Psychiat* 2003; 160: 2018–24.

39 Colman AR, Widom CS. Childhood abuse and neglect and adult intimate relationships: a prospective study. *Child Abuse Negl* 2004; 28: 1133–51.

40 Kia-Keating M, Sorsoli L, Grossman FK. Relational challenges and recovery processes in male survivors of childhood sexual abuse. *J Interpers Violence* 2010; 25: 666–83.

41 Horwitz AV, Widom CS, McLaughlin J, White HR. The impact of childhood abuse and neglect on adult mental health: a prospective study. *J Health Soc Behav* 2001; 4: 184–201.

42 Kemeny ME, Gruenewald TL. Psychoneuroimmunology update. *Semin Gastroint Dis* 1999; 10: 20–29.

43 Brosschot JF, Godaert GL, Benschop RJ, Olff M, Ballieux RE, Heijnen CJ. Experimental stress and immunological reactivity: a closer look at perceived uncontrollability. *Psychosom Med* 1998; 60: 359–61.

44 Brower V. Mind-body research moves towards the mainstream. *Eur Mol Biol Organ Rep* 2006; 7: 358–61.

45 Kiecolt-Glaser JK, McGuire L, Robles TF, Glaser R. Emotions, morbidity and mortality: new perspectives from psychoneuroimmunology. *Annu Rev of Psychol* 2002; 53: 83–107.

46 Levine PA, Frederick A. *Waking the Tiger, Healing Trauma*. 1997, North Atlantic Books, Berkeley, CA.

47 Rothschild B. *The Body Remembers*. 2000, W. W. Norton, New York.

48 Zoëga H, Furu K, Halldórsson M, Thomsen PH, Sourander A, Martikainen JE. Use of ADHD drugs in the Nordic countries: a population-based study. *Acta Psychiatr Scand* 2011; 123: 360–7.

© 2012 The Authors
Scandinavian Journal of Caring Sciences © 2012 Nordic College of Caring Science

View publication stats