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Shame and Guilt in Men Exposed to Childhood Sexual Abuse: A Qualitative Investigation

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This study examined the experiences of shame and guilt in adult males sexually abused as children. Seven participants attending a service for male sexual abuse completed measures of shame, guilt, dissociation, and childhood trauma history and subsequently participated in a focus group. All participants experienced childhood sexual abuse in the "severe" range and showed elevated scores for shame, guilt, and dissociation. Four superordinate themes with associated subordinate themes emerged: (a) self-as-shame (foundations of self-as-shame, fear of exposure, temporary antidote: connection), (b) pervasiveness and power of doubt and denial (from others, from self, consequences of incredulity), (c) uncontrollability (of problems after disclosure, of rage, of intrusions and emotional pain), and (d) dissociation. Results are discussed with reference to the existing literature and the emerging "self-as-shame" construct, which appeared to encapsulate participants' view of themselves.

KEYWORDS shame, male child sexual abuse, qualitative research

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Exposure to childhood sexual abuse (CSA) has a profound effect on the way individuals see themselves and how they relate to others (e.g., Johnson, 2004). Sexual abuse of males has received less attention than sexual abuse of females, yet studies suggest male CSA is far more common than generally perceived (Dhaliwal, Gauzas, Antonowicz, & Ross, 1996; Holmes & Slap, 1998; Hunter, 1990; Lisak, Hopper, & Song, 1996), despite underreporting (Hunter, 1990; Romano & De Luca, 2001). For example, in a representative sample of 935 males between the ages of 19–85, 8.2% reported some form of CSA (Bagley, 1995). Gender socialization may influence the psychological consequences of sexual abuse along with the capacity to disclose the abuse after its occurrence (e.g., Bolton, Morris, & MacEachron, 1989; Spiegel, 2003). For males particularly, disclosure of sexual abuse may heighten fears of being weak or emasculated, being perceived as gay or dependent, and being perceived as the instigator of the abuse (e.g., Dhaliwal et al., 1996; Romano & De Luca, 2001). The "unrealistic internalized ideal of manhood" creates the belief that males are not supposed to be victims (Gartner, 1999, p. 70). One set of feelings often associated with CSA in males and females is shame and guilt (Andrews, 1998; Lisak, 1994; Talbot, Talbot, & Tu, 2004). Socialization processes may exacerbate these self-conscious emotions in men sexually abused in childhood (e.g., feeling they did not live up to their gender role by not doing enough to stop the abuse or protect themselves; Gartner, 1999; Lisak et al., 1996).

Shame is linked to how individuals perceive the self and how they believe others perceive them (Gilbert, 1998; Tangney, Miller, Flicker, & Barlow, 1996). It is associated with internal, stable, and global attributions about causality of negative events as well as a sense of uncontrollability in making things different (Lewis, 1992; Van Vliet, 2009). Lutwak, Panish, and Ferrari (2003) noted, "Shame elicits strong self-deprecating reactions of the entire self, with hostility initially directed towards the self. However, because shame involves a real or imagined rejecting and disproving other, hostility may be redirected towards the rejecting other in retaliation . . . as a 'defensive strategy' or an attempt to turn the tables and to right the self" (p. 910). When shame is evoked and reparative actions to mend the damaged view of self are deemed improbable (De Hooge, Zeelenberg, & Breugelmans, 2010), social functioning is likely to suffer. Interpersonal relationships become eroded or avoided. Chronic shame has a significant impact on the willingness of individuals to connect with others. Shame may inhibit help-seeking for the psychological consequences of sexual abuse. One way of dealing with the intensification of shame feelings is through dissociation (Dorahy, 2010). As Talbot and colleagues (2004) noted, dissociation may be utilized to regulate or even eliminate feelings of shame.

Unlike shame, which is related to appraisals of the entire self, guilt is evoked when individuals believe their actions or behaviors have transgressed a social or moral code or their own beliefs (Lee, Scragg, & Turner,

2001). Guilt activates efforts to repair damage by either reparative action or punishment (Tangney et al., 1996). Thus, the focus of guilt is often on the person who was transgressed or the relationship that was affected. Shame directs attention toward the self rather than the other (Tangney, 1996). Individuals exposed to sexual abuse often develop a belief that they were responsible for the abuse, thereby not only feeling guilt but also accepting blame for what occurred (Lisak, 1994). Self-blame is a complex construct in terms of its connection with emotions, as individuals may blame themselves for the action they took, which is associated with the feeling of guilt. They may, however, attribute the blame to how they are as a person (e.g., weak), and such attributions are more associated with shame.

The primary aim of the current study was to understand further the "lived experience" of male adults who have a CSA history. The central research question addressed the experience of shame and guilt in men with a CSA history. Some previous studies have used qualitative methods to explore male sexual abuse (e.g., Alaggia & Millington, 2008; Spiegel, 2003), but to our knowledge none have used interpretative phenomenological analysis (IPA), which provides an in-depth narrative account of the experience under investigation, nor has IPA been applied to understanding shame and guilt in male CSA.

METHOD

Participants

Participants were seven males attending a support service for men with histories of CSA. Table 1 provides participant pseudonyms, demographic details, and perpetrator relationship. All participants described themselves as New Zealand European, and four were taking psychiatric medication. Three were in current full time employment, and four were unemployed. Two were married, two were single, and three were either separated or divorced. The study was presented by the first author, who was invited to a weekly support group meeting provided by the service. Three individuals attending that meeting declined or were unable to attend the focus group.

Measures

A demographic sheet was designed to obtain basic demographic information about the participants and also included four factual questions about the individual's abuse experience. Questions referred to whether the perpetrator was a family or non-family-member, age abuse started, age of disclosure, and to whom the disclosure was made.

TABLE 1 Pseudonyms, Age, and Abuse Characteristics for Each Participant

Pseudonym	Age (in years)	Age abuse started	Age of disclosure (disclosure source)	Relationship to perpetrator (gender)
Bob	37	12	27 (friend)	Family member (male)
Jack	42	6	20 (family member)	Family member (male/female)
William	49	5	43 (family member)	Family member (male)
Sam	44	8	13 and 40 (doctor and family member)	Family member (male/female)
Zack	64	7	55 (wife)	Nonfamily member (male)
Louis	40	4	23 (counsellor)	Nonfamily member (male)
Chris	45	5	30 (family member)	Family member (male)

The Dissociative Experiences Scale (DES; Carlson & Putnam, 1993) has 28 items tapping both pathological and nonpathological types of dissociation (Waller, Putnam, & Carlson, 1996). Responses are made on an 11-point scale ranging from 0% (*never*) to 100% (*always*). Eight items of the DES (known as the Dissociative Experiences Scale-Taxon; DES-T) index pathological dissociative tendencies (Waller et al., 1996). Total DES score is the mean of the 28 items (DES-T total score is the mean of its 8 items); thus, scores range between 0 and 100. Scores over 30 are generally seen as clinical levels of dissociation. The psychometric properties of the DES have been well supported.

The Personal Feelings Questionnaire-2 (PFQ-2; Harder & Lewis, 1987) is a 22-item scale with 10 questions measuring trait shame and 6 measuring trait guilt. Items are rated on a 5-point scale from 0 (*never experienced the feeling*) to 4 (*experience the feeling almost continuously*). Higher scores signify more shame and guilt. The PFQ-2 has shown good psychometric properties, with the shame and guilt subscales showing a two-week test-retest reliability of .85 and .82, respectively (e.g., Harder & Lewis, 1987).

The State Shame and Guilt Scale (SSGS; Marschall, Sanftner, & Tangney, 1994) is a 15-item measure assessing state shame and guilt—that is, the feeling of shame and guilt that someone is experiencing while completing the measure. Items are responded to on a 5-point Likert-type scale ranging from 1 (*not feeling this way at all*) to 5 (*feeling this way very strongly*). Five items each measure shame, guilt, and pride, with higher scores indicating more experience of that affect. The SSGS has shown good psychometric properties, including Cronbach's alphas for the shame, guilt, and pride subscales of .89, .82, and .87, respectively (Tangney & Dearing, 2002).

The Childhood Trauma Questionnaire (CTQ; Bernstein & Fink, 1998) is a 28-item self-report inventory that screens for histories of child abuse and neglect. Participants respond to items on a scale from "*never true*" to

"*very often true*." The CTQ contains 5 subscales: Childhood Emotional Abuse (e.g., verbal assaults or humiliation), Childhood Physical Abuse (e.g., assaults to the body), Childhood Sexual Abuse (e.g., sexual contact or conduct), Childhood Physical Neglect (e.g., failure to receive basic physical needs, like food), and Childhood Emotional Neglect (e.g., failure to receive basic psychological needs, like love). Severity levels (e.g., moderate, severe) are determined by cutoff scores on each subscale. The CTQ has shown good reliability and validity, with Cronbach's alphas above .7 for all subscales, though the physical neglect subscale has occasionally shown alphas below .7 (Bernstein & Fink, 1998).

Focus Group

Qualitative data were collected via a semistructured focus group interview. A focus group was selected after meetings with the service manager and prospective participants. As potential participants were involved in a weekly support group regarding their sexual abuse history and subsequent experiences, they were in a naturally formed group (Palmer, Larkin, De Visser, & Fadden, 2010), and this format might heighten familiarity and safety even though the topic matter (e.g., shame) is associated with a desire to hide (Tangney et al., 1996). The focus group was held on a different night than support group meetings, lasted 90 minutes, and informed consent was obtained. A provisional interview schedule was used to guide, but not prescribe, the topics covered. The schedule contained a mixture of open questions and closed screening questions with follow-up open probes. Unplanned follow-up questions were also used to allow for the emergence of unanticipated themes. The interview was audio recorded and transcribed verbatim.

Procedure

After volunteering by returning a "permission to contact" slip, participants were contacted by phone and taken through an information sheet outlining the study. Participants were then sent the consent form, the demographic sheet, and the DES, PFQ-2, SSGS, and CTQ. The date, time, and location of the focus group were also sent, and participants were informed they would have another opportunity to ask or clarify any further questions before the focus group started.

The focus group was conducted by the first author; a facilitator from the weekly men's group was present as a support for participants. The focus of the group was on the experience of shame and guilt, and no direct questions were asked about abuse history. Participants were debriefed about their experience at the end and offered individual support if needed. They were also informed that they would be invited to a meeting to

discuss the emerging findings as a way of increasing the rigor of the analysis. The study was approved by the Human Ethics Committee of the University of Canterbury and conducted in accordance with the World Medical Association's Code of Ethics.

IPA Analysis

The complete verbatim transcript was treated as one interview and submitted for analysis. The primary focus was phenomenological descriptions given by individual members. There was awareness of group processes during the focus group and the analysis, but this did not form the central focus of analysis. Data analysis followed the guidelines provided by Smith and Osborn (2003) and included the recommendations, where appropriate, offered by Palmer and colleagues (2010) for focus group analysis. First, the full transcript was reviewed for emergent psychological themes, with particular emphasis on the issues that were of most significance to participants (Larkin, Watts, & Clifton, 2006). These themes were then collated and categorized into groups of connected material under headings representing the superordinate theme of each cluster of initial themes. Each superordinate theme umbrellas a cluster of underpinning themes that make up the subordinate themes. Finally, the superordinate themes and their subordinates were collated and reduced to a final list of themes that represented the key issues to emerge from the interview. In line with Palmer and colleagues' (2010) recommendations with focus group data, awareness was given to individual narratives and how they reflected group perspectives as well as to attempting to ensure that emerging themes reflected both individual and group narratives. Moreover, where appropriate, emphasis was given to the roles and relationships of group members.

The analysis in IPA is an iterative process that involves repeated immersion in the text to confirm that the emergent themes and interpretations are supported by the data (Smith, Jarman, & Osborn, 1999). The process of analysis is not a discrete stage of the research but continues throughout the analysis and write-up phases. It is assumed in IPA that a participant's account during the interview is an attempt to make sense of their personal and social experience and world (Larkin et al., 2006). It is also acknowledged that the participant's account is unavoidably filtered through the researcher's own beliefs, attitudes, and experiences (Smith et al., 1999). Therefore, analysis involves a "double hermeneutic" in which a meaningful narrative is co-constructed between the participant's phenomenological account and the researcher's interpretations of that account. Thus, meaning is made through a dual interpretative process, where "the researcher is trying to make sense of the participants trying to make sense of their world" (Smith & Osborn, 2003, p. 51). Continual monitoring of the researcher's conceptions, views, and attitudes is an integral part of the analysis process. The first author

(MJD) engaged in the analysis and throughout the process reflected on his biases, attitudes, worldviews, and knowledge base that are driven by many factors including him being a male clinical psychologist working with adult survivors of child abuse.

In order to assess the quality of the emerging themes identified, a meeting was convened three months after the focus group with those who participated (one participant was unable to attend). Each emerging superordinate and subordinate theme was outlined and discussed as to whether participants felt it was an accurate representation in terms of internal coherence, credibility, resonance, and significance of the focus group content. An opportunity was also provided to discuss absent themes missed in the initial analysis. Finally, participants were invited to read the final manuscript. Emerging themes were compared to the existing literature in the discussion to provide some professional validation of the findings. In this article, sufficient data in terms of participant information and original transcript material is presented to allow the reader to assess the quality of interpretations against the participants' own accounts.

RESULTS

Descriptive Statistics

Table 2 shows the descriptive statistics for the DES, the PFQ-2, and the SSGS. Of the five participants who completed the CTQ, all reported CSA in the severe range. All reported childhood emotional abuse (low = 1, moderate = 1, severe = 3), emotional neglect (moderate = 2, severe = 3), and physical neglect (low = 2, moderate = 1, severe = 2). Three of the five participants reported child physical abuse (moderate = 1, severe = 2). Mean scores on the surveys showed the sample had high levels of trait and pathological dissociation (e.g., > 30) and elevated scores on guilt and shame. Trait shame and guilt scores were considerably higher than those found in college samples (e.g., $M = 17.42$, $SD = 5.6$; $M = 9.43$, $SD = 3.2$, respectively; Harder, Cutler, & Rockart, 1992, study 2) and mixed psychiatric samples (e.g., $M = 18.66$, $SD = 7.5$; $M = 11.65$, $SD = 6.5$; Averill, Diefenbach, Stanley, Breckenridge, & Lusby, 2002).

TABLE 2 Descriptive Statistics for Quantitative Measures

Questionnaires	*M*	*SD*
DES	58.64	8.88
DES-T	53.00	10.92
PFQ-2: Shame	24.50	6.00
PFQ-2: Guilt	15.50	4.46
SSGS: Shame	17.50	5.68
SSGS: Guilt	14.00	5.33
SSGS: Pride	11.00	2.76

TABLE 3 Emerging Superordinate and Subordinate Themes

1. Self-as-shame
   1.1 Foundations of self-as-shame
   1.2 Fear of exposure
   1.3 Temporary antidote: Connection
2. Pervasiveness and power of doubt and denial
   2.1 From others
   2.2 From self
   2.3 Consequences of incredulity
3. Uncontrollability
   3.1 Of problems after disclosure
   3.2 Of rage
   3.3 Of intrusions and emotional pain
4. Dissociation

Qualitative Analysis

From the analysis of the focus group, four superordinate themes emerged and are outlined in Table 3 with subordinate themes.

Self-as-Shame (SaS)

The first superordinate theme was the perception participants had of themselves as shameful beings. The term "self-as-shame" was adopted because participants described viewing themselves as shameful and perceiving that others' view, or will view, them that way. The term "self" is generally argued to reflect both I (self as subject) and me (self as object; Harter, 1999) and so encompassed the pervasiveness with which participants saw themselves as shame-filled. "Shame" rather than "shamed" was chosen to reflect the noun—shame as a thing the person is rather than the verb (shamed), which would reflect more their actions. One participant, Zack, encapsulated the SaS theme: "To me, guilt is something that you've done that you can correct. Possibly out of character. Shame is actually what you are." Another, Chris, described the sense of permanency of such a view of self: "it's like being put in a box you can't climb out of."

Perceiving the SaS eroded participants' sense of worth. For example, Sam felt "like a sense of failure . . . my self-esteem is shot to shithouse." This shame-related erosion of worth impacted the degree to which participants felt worthy of support from friends and family; as Zack described, "I sometimes feel like I don't deserve it." It also created a feeling of being different from others and thus not belonging (Sam: "So there's that sense of loneliness and not belonging anywhere"). Experiencing the SaS evoked self-doubts about the genuineness of others. Sam stated, "[It's] the constant fear of failure for me. And when I get praised I think, 'Well what's this person after?'" Finally, perceiving the SaS induced a heightened suspicion of happiness, because any feelings of pleasure were quickly overwhelmed by the reinstatement of the SaS: "I think it [shame] takes the edge off enjoying

things . . . you find if you do something reasonably well or something, a little while later, in comes the shame thing and tarnishes it" [Zack].

The SaS superordinate theme was made up of three subordinate themes titled "foundations for SaS," "fear of exposure" and "temporary antidote: Connection."

Foundations of SaS. The perception and experience of the SaS had its origin in both the fact the person was abused and the psychological consequences of that abuse. Zack expressed the feelings he carried as a result of others knowing he was abused: "It was the shame, you know, that others know what had gone on." For William, the shame he felt impeded his ability to disclose the abuse: "This sort of thing didn't happen in my family. But it did, it happened right under their noses . . . I couldn't tell anybody because I wasn't sure what was going to happen to me . . . shame goes all along it." Shame associated with the fact the abuse occurred continued to impact participants' comfort level in discussing their history, and they found it easier to acknowledge the shame associated with the "family secrets" rather than their own history. For Jack, "I'm still a bit uncomfortable with my story. . . . With me it's embarrassment I think. Other people finding out my family business. . . . That's probably my biggest fear." Bob articulated the sense of shame he and others associated with the psychological consequences of their abuse history: "I even find it tough joining a regular club, if they find out that I've had mental illness. It's probably a stigma, a shame issue there with what's happened."

Fear of exposure. A further subordinate theme of SaS was the desire of participants to keep their history of abuse concealed to avoid feeling ashamed. This evoked an intense anxiety when participants were in contact with others and a general desire to avoid other people and their questions. Sam noted, "I found myself lying to people that I run into . . . well not lying but exaggerating facts . . . because I didn't want to delve into my personal life. I'd think 'don't ask me something personal.' I'd just get really anxious about it." For Bob, avoidance of people meant avoidance of seemingly innocuous questions that might touch on his abuse history: "You [see] someone you went to school with and you want to cross the street to avoid them. They might say, 'How are your folks nowadays?' and I'd just say . . . if I was trying to be blunt . . . 'Well my Dad's been through the court system.'"

Fear of exposure and the desire to conceal past abuse appeared to be generated by the unpredictable responses of others to disclosures. Participants expressed a range of fears regarding uncertainty about the way others may respond to disclosures, including whether others would listen or ignore, accept or reject, maintain confidentiality or breach it. Bob described his primary concern being the unpredictability of how others would respond to his psychological difficulties: "[An old school friend] contacted me on Facebook and I didn't contact him back. . . . I just feared that if I told

him I'd experienced mental illness he'd just think I was nuts or something, wouldn't like me, wouldn't accept me." Others, like Jack, feared misperceptions and judgments both before and after disclosure, especially around sexuality: "My biggest fear was being seen as gay . . . that was one of my biggest fears about talking about it."

The terror of disclosure for fear of how others will respond was reflected in the group process during the interview. One person did not speak due to feeling threatened about how another participant would respond. When asked how he was feeling, Louis responded, "I'm terrified; that's all I'll say." Such an experience within the group seemed to mirror fears outside the group when the unpredictability of how others will respond impedes disclosure. Participants typically indicated that if they avoided others they could avoid their history being divulged, which ameliorated concerns about how others would respond. Thus, in order to manage the feared shaming effect others will have, attempts were made to isolate the self from others in order to isolate the "secret." Participants primarily relied on physical isolation from others and creating emotional distance to (a) manage the perception of SaS, (b) reduce feared negative responses from others, and (c) ensure abuse history and mental health difficulties were not disclosed. Isolating oneself from others became a means by which participants' isolated their secret fears and histories and sense of self. This isolation operated on the premise that it is safer to keep true feelings covered up.

Sam articulated his abuse history as the dominant reason for socially and emotionally isolating himself, and his sense of safety, in remaining secluded: "I emotionally isolated myself from about the age of 13. Abuse for me started at home at age 8. . . . I still avoid social groups because I'm shit scared people will find out . . . it's safer to stick to yourself." He went on to describe the degree of his isolation in order to stay safe, and within his narrative was the sense of the emotional cost (e.g., loneliness) of using isolation to manage his feelings of shame about his history: "I've never ever had any true friends . . . I couldn't even allow my wife to enter my world . . . and that's the way it sort of remains today."

Temporary antidote: Connection. While social and emotional isolation provided a means of reducing shame associated with participants' history and experience, it also emerged that connecting with other people could have the ability to reduce shame and provide a sense of belonging. However, a sense of feeling connected with others and the haven from shame that it brought was described as short lived, as the sense of SaS reinstated itself and led to disconnection and painful feelings of being different and unworthy. Sam shared:

> On Christmas day we had a game of volleyball . . . and I actually joined in. . . . But then the game was finished and I felt lonely again . . . I was sitting on my own. I could have joined in, and they kept saying come

> and join in, but I just didn't want to get that close to anybody. . . . Once the fun was gone I was back to the old . . . me.

Bob highlighted the experience of feeling more connected with others who had a similar history of abuse but also feeling uncertain about how and when to discuss this history—again wondering if silence was safer:

> I think that these things happened to us and it would be good if we could talk freely about how shit our childhood was. But there are also concerns, I have concerns about whether [others are] in the right space, or I'm in the right space to talk about that. What the appropriate forum is, it's like everyone's dealing with their own little bit of it but none of that's integrated.

This comment might also reflect a transferential experience of the uncertainty created by having the researcher (a relatively unknown person) in the group and the anxiety about what information was safe to disclose versus what should be compartmentalized (i.e., left unintegrated).

Pervasiveness and Power of Doubt and Denial

The second superordinate theme related to the extent and impact of denial and not being heard by others, along with self-doubts about one's own history that may mirror social disbelief. The experience of disbelief was captured by Sam, who noted, "You speak out loud and nobody seems to listen." Three subordinate themes arose: pervasiveness of doubt and denial in others, pervasiveness of doubt and denial in self, and the consequences (power) of incredulity.

Pervasiveness of doubt and denial in others. Participants described often not being believed by health and mental health professionals and having their disclosure attributed to their psychological difficulties or histrionics. Bob's experience was similar to others: "I told the person at [the mental health service], the social worker . . . about the abuse. . . . And they said 'are you sure that's not just part of your psychosis?'" Sam continued:

> [When abuse started] I became extremely violent and refused to go to school . . . social welfare got involved. I tried to tell them . . . they wouldn't listen . . . my sister actually said to me, "We did actually try to tell them about the sexual abuse, but they wouldn't listen." Effectively just saying I was looking for attention.

Chris poignantly quipped about his experience trying to tell his story during a hospital stay: "When the doors are locked and the needles come

out I'm pretty sure they don't believe you . . . they sweep it under the carpet."

A more subtle form of denial came in attributing other causes for psychological coping strategies, like alcohol abuse. Sam shared, "[Professionals] say . . . alcohol abuse is either learnt behaviour or genetic and I'm saying bullshit . . . I did it because I was in such pain from what happened to me as a child. Oh no no no, it can't be that it has to be one or the other."

Participants also described family members covering up their abuse history, which lessened the likelihood that professionals would investigate further. Again from Sam: "I got my file from the Ministry of Social Development, and it clearly says . . . how my mother would sit there and coach me with what to say, in front of the psychiatrist and the social workers. And yet, they wouldn't believe a thing I had to say."

Pervasiveness of doubt and denial in self. Self-doubts about abuse history emerged as ever present, even when undeniable. Bob stated:

> I've found that very difficult [to fully accept my abuse history]. Did this really happen or didn't it? I get that sort of doubt in my mind, did it happen? Well of course it happened. I don't know why the doubt keeps creeping back when . . . the abuser actually came and told me it happened. And I thought, that's confirmation enough but I still don't completely believe it.

Abuse histories were often experienced as not quite real. Bob described, "It's like surreal, that's the right word, it's like a surreal event," while Sam shared, "It's like a fantasy."

The consequences (power) of incredulity. Subtle and overt disbelief had considerable consequences, which were aptly captured by Bob: "[Having abuse denied] creates shame, because I'm not being believed and this is actually my reality . . . it's a really shattering experience . . . the first person I told didn't believe me. That probably led to me going completely insane."

Uncontrollability

In the third superordinate theme, participants described a sense of uncontrollability for different aspects of their lives, which they viewed as related directly to their abuse histories. Subordinate themes were uncontrollability of (a) problems following disclosure, (b) rage, and (c) intrusions [for past abuse experiences] and emotional pain.

Uncontrollability of problems after disclosure. For William, disclosing his abuse history created unpredictable problems: "When it all comes out it creates a whole lot of other problems that you'd never have thought of ever . . . it's just a whole mine field of stuff that it throws up." Zack described how the effects go on long after disclosure, such that disclosure is a step toward

the end point, not the end point itself: "I didn't disclose or understand it for well over 40 years . . . it opens things up and you do change again. . . . It does affect you in your day-to-day activities . . . we seek help, but it doesn't necessarily mean it all goes away."

Uncontrollability of rage. Intense anger, which could be elicited by triggers ranging from abuse cues to minor frustrations, emerged as uncontrollable and frightening. William shared, "I've gone to the extent of chasing the person who abused me down a road . . . just in a complete out of control rage." Sam continued, "I look at it like spontaneous rage . . . just the slightest little thing would trigger me. I would lash out at whoever . . . it scared the shit out of me." Not only was the spontaneity and uncontrollability of rage frightening to participants, but they also described how it frightened those close to them. Sam stated, "When my wife saw [my spontaneous rage] . . . she really started to panic . . . not that I've ever physically hurt her, but she's seen what I'm capable of."

Uncontrollability of intrusions and emotional pain. Participants' abuse histories were often experienced as uncontrollably intruding on life. According to Zack, "You don't realize that these stupid little things you see or things you hear, just trigger you off and you're back there." For some, including Chris, the pain seemed so uncontrollable that death was perceived as the only antidote: "I don't think anything will cure that [emotional pain] except death itself." For others, physical harm directed at the self became a means of attempting to regulate the otherwise uncontrollable intrusions. Self-harm appeared to both soothe emotional pain and punish the self when shame was evoked. Sam stated, "The way I cope if I feel pain, I'll run a really hot bath and throw myself in it as like a punishment thing . . . I can stand the [physical] pain, the burning of that hot water is nothing to the pain that you go through."

Dissociation

Dissociation and alterations in consciousness were described by most participants as an automated strategy for either regulating emotion or becoming deeply absorbed in internal stimuli, including painful feelings and memories. Bob described attention alterations and absorption in intrusive thoughts: "If I'm in the wrong space, I can sit through a movie and be watching it on the surface but thinking intensely about something negative or horrible." Zack encapsulated the experience of most participants with emotional numbing and severing:

> The emotions when I was young were so overpowering that I've learnt to either dissociate or totally numb out to them. So during counselling, the emotions would really well up inside and then they would be cut off. So it's been very difficult for me to allow myself the emotional range.

This form of affect management was evident during the focus group, as Sam outlined when asked toward the end how he was feeling: "I'm not feeling anything at all, I'm feeling numb. I just sort of drifted away there for awhile . . . I switched off because I was just thinking about those thoughts [from the past], I just drifted away and when I come back that's how I feel, just numb."

DISCUSSION

This study explored the lived experience of adult males with a history of CSA, especially with reference to shame and guilt. Participants had been exposed to sexual abuse by a family member or trusted other (e.g., schoolteacher) and scored in the upper range on measures of dissociation and state and trait shame and guilt. The qualitative analysis revealed four superordinate themes with associated subordinate themes.

The first superordinate theme to emerge from the qualitative analysis was labeled "self-as-shame." This term, rather than "self with shame," seemed to more accurately reflect the narratives of participants as seeing themselves infused with shame rather than simply living with it. It captured the description participants had of feeling that they embodied shame, and this feeling not only pervaded the way they saw themselves but also how they perceived others seeing them. The embodiment of shame was manifest in feeling like a failure, defective, unworthy, value-less, and lacking a sense of esteem and efficacy. In comparison to others, and in the eyes of others, these men reported that shame led to feelings of inferiority and incompetence. These findings are consistent with previous research on CSA in males (Bolton, Morris, & MacEachron, 1989; Lew, 1988; Spiegel, 2003). Lisak (1994) reported that male survivors felt inferior, unacceptable, insignificant, unlovable, and infected with badness. In an account of the motives and behaviors activated by shame, De Hooge and colleagues (2010) suggested that the primary motivation of shame is to repair damage to the positive view of self. When such repair is deemed impossible due to situational or personal factors, avoidance is engaged to protect the self from further damage. Reestablishing a positive self-view seemed remote or even impossible to participants in the current study. Beliefs and feelings centered around personal incompetence that were driven by the perception of SaS were the dominant factors motivating avoidance behaviors to protect the damaged self-image. Such beliefs and feelings rendered impotent any approach behaviors to repair the threatened self.

Shame was experienced as an unconditional feeling that reflected the self and could not be changed. Lewis (1992) argued that shame largely rests on an attributional style that explains experiences like sexual abuse as related to internal (e.g., "I am the cause"), stable (e.g., "I will always be

responsible; that is unchangeable"), and global (e.g., "it was *me* who caused it, not just my behavior") factors (see also Van Vliet, 2009). Feiring, Taska, and Lewis (1996) proposed that sexual abuse, both directly and through other moderating processes like emotional support, impacts attributional style, which then regulates shame-proneness. Shame in turn determines the degree of stigmatization experienced. The SaS concept encapsulates the attributional style (i.e., internal, stable, global), the affective experience (i.e., shame), and the resultant stigmatization (e.g., fear of exposure) described by participants.

Citing several other studies, Romano and De Luca (2001) suggested that guilt and self-blame are nearly universal feelings among sexually abused males. In the current study, guilt as deriving from an action or behavior that could be righted by a reparative gesture or punishment (Tangney et al., 1996) was not exclusively present. Rather, participants saw themselves, not simply their actions, as responsible for their histories. A distinction has long been made between behavioral and characterological self-blame (Janoff-Bulman, 1979), which has been extended to shame associated with behaviors/actions, the body, and the character (Andrews, Qian, & Valentine, 2002). Characterological shame reflects a more global assessment of the self as unworthy and defective and goes beyond shame (and guilt) associated with specific behaviors and appraisals of the body. The SaS construct typifies characterological shame, where the whole self is tainted or tarnished with shame. Thus, the SaS construct seemed to encapsulate guilt (for specific behaviors) and self-blame for what happened and also go beyond them (see also Lisak, 1994). Participants saw themselves as shameful beings, and other constructions, perceptions, and aspects of the self were unrecognized, unacknowledged, or denied (e.g., the self as hardworking, friendly, loving).

The current findings demonstrate the quality of shame in men with a history of CSA. The SaS construction appeared to reside internally, as nearly a solid corporeal structure that the person could see and experience clearly and directly and that was covered by a semitranslucent film that could be seen through by others if they got emotionally or even physically too close. This created the view that if others get too close "they will see me like I see me—even though they may say different" (Zack).

Based on the narratives, the SaS perception had its origins in the abuse itself and the psychological by-products of it, including mental health difficulties. Yet it spawned a set of organized responses that attempted to ensure (a) that the direct emotional and cognitive outcomes of perceiving the SaS were kept at a minimum and (b) others did not see the self in this way. Having a sense of SaS was managed by avoiding others emotionally and physically. This appeared to keep the intensity of the psychological experience associated with the SaS at a more manageable level. The responses of others to disclosures of abuse or mental health difficulties were

unpredictable and may aggravate rather than soothe the SaS. Isolating the self isolated the SaS as well as it origins and outcomes.

In their review of male sexual abuse, Romano and De Luca (2001) outline several gender role socialization factors that impede males disclosing their CSA histories. These include the enculturated belief that it is unmanly to seek help ("male ethic on self-reliance," p. 56), the perception that the abuse occurred because of weakness and vulnerability within themselves (Lisak, 1994), and the belief that disclosure may evoke fears of being perceived as gay, especially when the abuser was a male ("stigma of homosexuality," p. 56; see also Gartner, 1999; Spiegel, 2003). These gender role socialization or abuse myth factors were to a greater or lesser extent threaded throughout the superodinate and subordinate themes. They appeared to be related to fears about how others will respond to participants as males who were sexually abused or to the activation of beliefs about the self (e.g., weak) based on how others may or may not respond. Fears of being perceived as gay or weak were evident and reflected the unpredictability of the actions and assumed views of others (e.g., whether they increase feelings of weakness), perpetuated in part by broader societal abuse myths (Spiegel, 2003). In addition, such concerns related to never truly knowing the internal perceptions of others. Support seeking was eroded by gender role socialization of males being strong, independent, unrequiring of support, and being in control of feelings and not at the mercy of them (Gartner, 1999). Moreover, the trust required to accept that supportive responses were genuine had been eroded by previous betrayals.

Prior responses from professionals, family members, or friends impacted not only trust but fears of not being heard and believed during disclosure. The literature on male CSA is replete with examples of passive and active denial and minimization by health and mental health professionals, which impedes disclosures (Lew, 1988; Romano & De Luca, 2001). Dhaliwal and colleagues (1996) noted that mental health and other professionals are often reluctant to deal with sexually abused males, deny the existence of such abuse, and/or deny or downplay its negative impact. Participants reported painful experiences of active or passive (e.g., "your psychosis talking") denial from professionals following disclosure. Such experiences were described as heightening stigmatization, shame (and the SaS construct), and reducing the likelihood of further disclosures.

Anger outbursts have been reported in males sexually abused as children (e.g., Olsen, 1990), and evident in this study was not only the spontaneity and perceived uncontrollability of rage but also the intense fear it created for participants and those around them. Uncontrollable expressions of rage have the capacity to evoke a shame response in their wake, and participants also described feeling different from others at these times and not understood, which may further maintain the SaS construct.

Often experienced as uncontrollable but arising as far more multifaceted was dissociation and alterations in consciousness. Such experiences are pervasive in the child abuse literature (e.g., Briere & Elliot, 2003). Scores on both overall and pathological dissociation were highly elevated for current participants (i.e., > 30). Of particular interest was participants' descriptions of how emotions would build to a point that dissociation occurred and they would feel either numb (overregulated) or absorbed in frightening past experiences (underregulated). This is akin to the negative (e.g., numbing) and positive (e.g., flashbacks) manifestations of dissociation described in the literature (e.g., Van der Hart, Nijenhuis, & Steele, 2006). In women attending psychiatric care, Talbot and colleagues (2004) found a relationship between shame-proneness and dissociation, which was particularly strong in those reporting CSA. They proposed that dissociation may be a means of reducing shame as the affective experience intensifies.

Taken together, the findings considerably overlap and can be integrated with Spiegel's (2003) Sexual Abuse of Males (SAM) model. This model accounts for "the most frequently observed dynamics and effects associated with the sexual abuse of males" (p. 109). Seven categories that focus on the origin and nature of abuse episodes as well as the psychosocial aftermath and sociocultural context underpin the model. The SaS superordinate theme, along with its subordinate themes of "foundations of SaS" and "fear of exposure" reflect Spiegel's (2003) category of *concealment*. Concealment refers to the "pervasive secrecy" at both a social level and for the victim at a personal level that surrounds sexual abuse generally and in males especially (Spiegel, 2003, p. 167). The superordinate theme of pervasiveness and power of doubt and denial maps onto *invalidation*, in which reality becomes distorted by society/others ("pervasiveness of denial and doubt in others") and the victim ("pervasiveness of denial and doubt in self"). Social (e.g., incredulity) and intrapsychic defenses are called on to create and maintain the invalidation (Spiegel, 2003). As such, the superordinate theme of dissociation can also be integrated into this category.

Implications

The pervasiveness of social and professional denial experienced by participants and the silencing effect of shame suggests health and mental health professionals need to be aware of the existence, dynamics, and effects of male sexual abuse (Spiegel, 2003). The sweeping experience of shame on male survivors' sense of self, along with the avoidance it brings, means that disclosures and exploration are likely to require substantial therapeutic facilitation. Arguably, these results have major implications for therapeutic interventions. Feinauer and Stuart (1996) noted the therapeutic importance of abuse survivors seeing themselves as responsible for their recovery, even if they hold onto some self-blame for the abuse. Getting to the point where

male survivors can see themselves as responsible for and both worthy and capable of bringing about change and progress requires considerable therapeutic endeavor as SaS evokes feelings of ineffectiveness, worthlessness, inadequacy, and powerlessness. In a study of shame-recovering individuals, Van Vliet (2009) found that movement toward a resolution of shame was facilitated by identifying external causes and influences for events, reducing negative social self-judgments, and acknowledging the possibility that change can be achieved. From the current results, therapeutic work on all these attributes requires attention in male survivors of CSA.

Limitations

While qualitative research makes no claim about the generalizability of results and focuses instead on the "lived experience" of participants, the study was limited to a single focus group of seven males. By virtue of the recruiting methods, all men were support-seeking and therefore likely more willing to talk about their experiences of abuse (as well as shame) than non-support-seeking men. Participants also had opportunities since the abuse to reflect on their histories through counseling and/or support group experiences, which may have provided them a greater ability to articulate the impact abuse had on them relative to non-support-seeking peers. The data do provide rich and important information relative to men's experiences of shame, even when they are receiving support. Thus, these findings point to the need to carry out similar research with non-support-seeking men who may have different experiences of shame.

The use of a focus group methodology may have limited the depth to which the construct of shame was fully explored due to the fact that shame often motivates the desire to avoid, withdraw, or hide. Such behaviors were evident in participants' narratives and may have been exacerbated by a group setting (e.g., one participant remained quiet, fearing the reactions of another). However, participants were attending weekly group meetings where their history and experience of living with CSA were discussed, making the group context familiar. Nonetheless, one participant remarked on reading the manuscript before submission that an aspect of shame that he felt was central but did not emerge was shame related to behaviors (see Andrews, 1998). He suggested that "shameful behaviors," which include some reenactment of the abuse (e.g., submission behaviors), maintain and perpetuate the SaS (see Spiegel's, 2003, discussion of "Invalidation'). Such behaviors and their link with the SaS construct require empirical investigation. Finally, further qualitative research should address whether similar themes emerge using an individual interview methodology rather than a focus group. Groups bring with them layers of dynamics (and therefore other levels of investigation) that are less prominent in individual interviews, such as the social discourse of the group, the dominant versus passive voices,

the individual versus group perspective, and potentially heightened social desirability (K. Russo, personal communication, August 12, 2010).

Conclusion

Four superordinate themes characterized the experience of males living with a history of CSA. A pervasive sense of unconditional shame not only originated from the abuse experience but also its psychological aftermath. Denial, incredulity, and doubt from others heightened the sense of shame, with self-doubt, dissociation, and alterations in consciousness evident outcomes and management strategies. The SaS construct may be maintained by the sense of uncontrollability described by participants, especially with reference to the responses of others, their own anger, and their experience of emotional pain and haunting intrusive symptoms. Such uncontrollability fosters a sense that change is beyond the person's ability.

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