Childhood Sexual Abuse:
Consequences and Holistic Intervention

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Thesis for the degree of Philosophiae Doctor

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Afleiðingar og heildræn meðferðarúrræði

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This thesis is dedicated to my loving father Sigurður Finnbogason. He passed away only 52 years old when I was pregnant with my first child.

This untimely loss has affected me and my whole life and has taught me so much about trauma and the consequences of trauma, through generations.

He taught me honesty, respect and never to discriminate people, it is very important when working with people suffering from violence.

He inspired me with his spirit on this journey and I often felt his presence through the hardest time of this work.

„I miss you every day Dad

You are the wind beneath my wings

Thank you“

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Ágrip

Bakgrunnur: Kynferðislegt ofbeldi í bernsku (e. Childhood Sexual Abuse, CSA) getur haft alvarlegar og víðtækar afleiðingar fyrir heilsufar og líðan karla og kvenna. Mikilvægt er að byggja á dýpri þekkingu á reynslu þolenda á Íslandi af þessum víðtæku afleiðingum við þróun heildræns meðferðarúrræðis fyrir þolendur CSA innan heilbrigðiskerfisins.

Markmið: Að auka þekkingu og dýpka skilning á afleiðingum CSA hjá þolendum af báðum kynjum í því skyni að auka hæfni hjúkrunarfræðinga og annarra heilbrigðisstétta í að veita viðeigandi umönnun. Að þróa og skoða reynslu íslenskra kvenna af heildrænu meðferðarúrræði og reynslu af heilbrigðiskerfinu.

Aðferð: Notuð var fyrirbærafræðileg rannsóknaraðferð til að auka þekkingu og dýpka skilning á afleiðingum CSA. Í *rannsókn I* voru þátttakendur sjö íslenskir karlar með sögu um CSA. Tekin voru tvö viðtöl við hvern þeirra, samtals 14 viðtöl. Í *rannsókn II* var borin saman reynsla þessara sjö karla og sjö íslenskra kvenna (frá annarri rannsókn höfundar). Fjöldi viðtala sem notuð voru í greiningunni var samtals 28. Í *rannsókn III* voru tekin sjö viðtöl við eina íslenska konu með langa áfallasögu af reynslu hennar af líkamlegum afleiðingum CSA og reynslu hennar af heilbrigðisþjónustunni. Í *rannsókn IV* voru tekin viðtöl við 10 íslenskar konur sem tóku þátt í Gæfusporunum, heildrænum meðferðarúrræðum. Tekin voru þrjú viðtöl við hverja konu, samtals 30 viðtöl. Samtals voru því 65 einstaklingsviðtöl lögð til grundvallar í greiningarvinnunni í doktorsverkefninu.

Niðurstöður: Helstu niðurstöður rannsóknanna voru að afleiðingar CSA, bæði fyrir íslenska karla og konur, voru alvarlegar fyrir heilsufar og líðan. Þátttakendur töldu að þeir hefðu ekki fengið nægjanlegan stuðning eða skilning frá heilbrigðisstarfsfólki, en þátttaka í Gæfusporunum virtist bæta heilsu og líðan þeirra sem tóku þátt í þeim.

Í *rannsókn I* upplifðu karlarnir sjálfsmynd sína brotna. Í æsku áttu þeir við námsörðugleika að stríða og urðu fyrir einelti. Þeir voru ofvirkir og leiddust út í afbrot, áfengis- og fíkniefnaneyslu, auk þess að vera með ýmis flókin heilsufarsleg vandamál. Upplifun karlanna einkenndist af reiði, hræðslu og líkamlegri og sálrænni aftengingu. Þeir áttu erfitt með að tengjast mökum og börnum, höfðu gengið í gegnum hjónaskilnaði og voru allir forsjárlausir feður.

Þeir lifðu í þögulli og kvalafullri þjáningu vegna eigin fordóma og samfélagsins og leituðu því ekki hjálpar eða sögðu frá fyrr en á fullorðinsárum.

Í *rannsókn II*, samanburðarrannsókninni, mátti greina mun á milli karla og kvenna. Konurnar höfðu meiri tilhneigingu til að beina tilfinningalegum sársauka sínum inn á við, sem kom síðar fram í flóknum andlegum og líkamlegum heilsufarsvandamálum. Karlarnir höfðu hins vegar meiri tilhneigingu til að beina tilfinningalegum sársauka sínum út á við, sem kom einkum fram í hegðunarvandamálum og andfélagslegri hegðun.

Í *rannsókn III* sýndu niðurstöður að CSA og löng áfallasaga getur haft alvarleg og niðurbrjótandi áhrif á heilsufar. Þátttakandinn hafði haft mörg líkamleg vandamál eins og langvinna verki, vefjagigt, síendurtekin móðurlífsvandamál og krabbamein. Hún hafði einkenni áfallastreituröskunar og hafði ekki mætt nægilegum skilningi og stuðningi í heilbrigðiskerfinu.

Í *rannsókn IV* kom fram að konurnar sem tóku þátt í Gæfusporunum voru í upphafi meðferðarinnar félagslega einangraðar og áttu við mjög flókin heilsufarsleg vandamál að stríða. Þær upplifðu sig með brotna sjálfsmynd, treystu sér ekki í vinnu eða nám og töldu það hafa haft veruleg áhrif á fjölskyldur þeirra og lífsgæði. Jákvæðan árangur mátti sjá varðandi alla þessa þætti hjá konunum 12-15 mánuðum eftir að meðferðinni lauk. Starfsgeta þeirra allra hafði aukist eftir Gæfusporin, þær voru komnar í launaða vinnu, nám eða áframhaldandi starfsendurhæfingu.

Ályktanir: Kynferðislegt ofbeldi í bernsku getur haft alvarlegar og víðtækar langtímaafleiðingar fyrir heilsufar og líðan, bæði íslenskra karla og kvenna, og þjáning beggja kynja getur verið djúp. Mikilvægt er fyrir heilbrigðisstarfsfólk að þekkja einkenni og afleiðingar CSA til að vera betur í stakk búið að veita stuðning og viðeigandi meðferð sem tekur mið af einstaklingnum og kyni hans. Mikilvægt er að halda áfram að þróa heildræn meðferðarúrræði fyrir konur á Íslandi og þróa slík meðferðarúrræði fyrir karla sem hafa orðið fyrir CSA. Með því að byggja einstakling markvisst upp eftir áföll vegna CSA getur margt áunnist fyrir hann, fjölskyldu hans og samfélagið í heild.

Lykilorð: Kynferðislegt ofbeldi í æsku, afleiðingar kynferðislegs ofbeldis í æsku, karlar, konur, heildræn meðferðarúrræði, fyrirbærafræði.

Abstract

Background: Childhood Sexual Abuse (CSA) can have serious and far-reaching consequences for the health and well-being of both men and women. In order to develop a holistic program for Icelandic survivors of CSA it is important to base such a program on in-depth knowledge and understanding of these consequences for CSA survivors in Iceland within the healthcare system.

Aim: To increase the knowledge and deepen the understanding of the consequences of CSA, for both Icelandic men and women, in order to increase nurses' and other healthcare professionals´ competence in giving gender appropriate care to CSA survivors. To develop and explore a holistic therapy for female CSA survivors, from the women´s own perspective and look into the experience of the healthcare system.

Methods: A phenomenological research approach was used, to increase the knowledge and deepen the understanding of the above phenomena. In *Study I*, participants were seven Icelandic men with a history of CSA. Two interviews were conducted with each of them, a total of 14 interviews. In *Study II* the experience of these seven men and seven Icelandic women (from another study of the author) were compared, 28 interviews in total. In *Study III* seven interviews were conducted with one Icelandic woman with a long trauma history after CSA. In *Study IV* 10 Icelandic women who participated in the *Wellness-Program*, a holistic program for female CSA survivors that was developed by the author, were interviewed thrice, a total of 30 interviews. Thus, in all, 65 interviews were used as the basis for this thesis.

Results: The main results of the studies were that the consequences of CSA, for both men and women, were serious for their health and well-being. They felt they had not received adequate support and understanding from healthcare professionals, but participation in the Wellness-Program seemed to improve the health and well-being of those attending.

In *study I* the men's experience of CSA was characterized by broken self-identity and self-image, anger and fear. They were bullied, had learning difficulties and had been hyperactive, displayed criminal behaviour, misused alcohol and drugs. They had numerous complex health problems and physical and psychological disconnection. They had difficulty relating to their spouses and children, had gone through divorce and were all divorced non-custodial fathers. They lived in silent and painful suffering because of their

own prejudice and from the society and did not seek help or talk about the CSA until they were adults.

In *Study II*, gender differences were found in the consequences of CSA. Women had a greater tendency to *internalize* their emotional suffering, which was later observed in complex health problems. The men, however, had a greater tendency to *externalize* their emotional suffering, observed in various problems and antisocial behaviour.

Study III showed that CSA and a long trauma history can have serious and destructive effects on health. The participant had severe physical problems such as chronic pain, fibromyalgia, recurring problems in the pelvic area as well as cancer. She had symptoms of PTSD (posttraumatic stress disorder) and felt she had not met adequate understanding and support in the healthcare system.

In *Study IV* the women who participated in the Wellness-Program were in the beginning of the program socially isolated and had complicated health problems. Their self-esteem was low, they could not work or study and their lack of wellbeing significantly impacted their families and their own quality of life. Positive results were found regarding all these aspects in the participating women 12 to 15 months after the program. All were active in work, study or in further rehabilitation.

Conclusions: CSA can have serious and far-reaching consequences for the health and well-being of both Icelandic men and women and their suffering can be deep. It is important for healthcare professionals to know and recognize the symptoms regarding the consequences of CSA to be better able to provide support and gender-specific care. It is important to continue to develop a holistic program for female CSA survivors in Iceland as well as to develop such program for men survivors of CSA. Through an organized program much can be gained for the individual, his family and society as a whole.

Keywords: Child Sexual Abuse (CSA), Consequences of CSA, Men, Women, Holistic intervention, Phenomenology.

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First and foremost, I would like to thank all the men and women who participated in my studies and shared their deep experience of CSA and recovery. They trusted me for some of their most painful, difficult and hidden experiences in their life, I respect that and I am grateful.

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This has been a long journey and has often been overwhelming when working on the most difficult studies. I gave my heart to it, especially the Wellness-Program and often I cried at my pillow because of the suffering of the survivors and knowing of people´s cruelty.

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On this PhD journey I have learned the meaning of life and to prioritize my life, that is the lesson I learned.

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List of abbreviations

ACE:	Adverse Childhood Experiences
ADHD:	Attention Deficit Hyperactivity Disorder
BBAT:	Basic Body Awareness Therapy
CAM:	Complementary and Alternative Medicine
CSA:	Childhood Sexual Abuse
CST:	Cranio Sacral Therapy
DESNOS:	Disorder of Extreme Stress Not Otherwise Specified
GAS:	General Adaption Syndrome
MBSR:	Mindfulness Based Stress Reduction
PA:	Physical Activity
PE:	Physical Exercise
PTSD:	Post-Traumatic Stress Disorder
TF-CBT:	Trauma Focused – Cognitive Behavioural Therapy
WHO:	World Health Organization

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List of original papers

This thesis is based on the following original publications, which are referred to in the text by their Roman numerals (I–IV):

I. Sigurdardottir, S., Halldorsdottir, S., & Bender, S. S. (2012). Deep and almost unbearable suffering: Consequences of childhood sexual abuse for men's health and well-being. *Scandinavian Journal of Caring Sciences, 26*(4), 688-697. *

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III. Sigurdardottir, S., & Halldorsdottir, S. The burden of childhood sexual abuse (CSA) on the body and the silencing effects of the healthcare system: A phenomenological case study with a female CSA survivor. Manuscript to be submitted.

IV. Sigurdardottir, S., Halldorsdottir, S., Bender S. S., & Agnarsdottir, G. (2016). Personal resurrection: Female childhood sexual abuse survivors' experience of the Wellness-Program. *Scandinavian Journal of Caring Sciences, 30,* 175–186. *

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Additional publication related to the doctoral thesis:

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Declaration of contribution

Study I

Sigurdardottir and Halldorsdottir designed the study and Halldorsdottir was responsible for obtaining approval. Sigurdardottir was responsible for collecting and analysing the data and she wrote the first draft of the paper, with supervision from Halldorsdottir. Halldorsdottir and Bender critically revised the manuscript, edited it and gave approval of the final version of the manuscript to be published.

Study II

Sigurdardottir and Halldorsdottir designed the study and Halldorsdottir was responsible for obtaining approval. Sigurdardottir was responsible for collecting and analysing the data and she wrote the first draft of the paper, with supervision from Halldorsdottir. Halldorsdottir and Bender critically revised the manuscript, edited it and gave approval of the final version of the manuscript to be published.

Study III

Sigurdardottir and Halldorsdottir designed the study and Halldorsdottir was responsible for obtaining approval. Sigurdardottir was responsible for collecting and analysing the data with supervision from Halldorsdottir. Sigurdardottir wrote the first draft of the paper. Halldorsdottir critically revised the manuscript, edited it and gave approval of the final version of the manuscript.

Study IV

Sigurdardottir designed and developed the Wellness-Program in co-operation with the Rehabilitation Centre in Akureyri (Starfsendurhæfing Norðurlands). Geirlaug B. Bjornsdottir and Halldorsdottir were advisors. Halldorsdottir was responsible for obtaining approval. Sigurdardottir collected the data and analysed the data, wrote the first draft of the paper with supervision from Halldorsdottir. Halldorsdottir, Bender and Agnarsdottir critically revised the manuscript, edited it and gave approval of the final version of the manuscript to be published.

1 Introduction

It has been well documented that CSA can cause serious and widespread health problems for survivors and survivors often suffer deeply from the consequences. However, our knowledge is often limited to the consequences for women and girls and much less is known about the suffering of boys and men who have been sexually abused. We also need to know if there is a difference in the experience of CSA consequences for men and women. Furthermore, much is known about effective psychological treatment after CSA, but this knowledge is often limited to single problems and less is known about the effect of holistic treatment and treatment offered that addresses the various symptoms holistically after CSA.

According to a report from the World Health Organization (WHO, 2002) Child Sexual Abuse (CSA) is a worldwide health problem. Many leading causes of death such as heart disease, stroke, cancer and HIV/AIDS can be the result of being a victim of violence. It is in connection to risk behaviour such as smoking, alcohol and drug abuse and unsafe sex to cope with the psychological impact of violence. Therefore, it has become increasingly common to view violence from a public health perspective. Violence also places a heavy strain on the healthcare systems, social and welfare services (WHO, 2014). The dynamics of CSA differ from those of adult sexual abuse. Children rarely disclose CSA immediately after the event; disclosure tends to be a process rather than a single episode and is often a physical complaint or a change in behaviour. Definitive signs of genital trauma are seldom seen in CSA cases and physical force is rarely involved (WHO, 2003).

Through the years different definitions of CSA have been presented and that can cause the difference in frequency of CSA observed, since people answer questions about CSA based on the definition applied in each study. The World Health Organization (WHO) defines CSA as:

> The involvement of a child in sexual activity that he or she does not fully comprehend, is unable to give informed consent to, or for which the child is not developmentally prepared and cannot give consent, or that violates the laws or social taboos of society. Child sexual abuse is evidenced by this activity between a child and an adult or another child who by age or development is in a relationship of responsibility, trust or power, the activity being intended to gratify or satisfy the needs of the

> other person. This may include but is not limited to: the inducement or coercion of a child to engage in any unlawful sexual activity; the exploitative use of a child in prostitution or other unlawful sexual practices; the exploitative use of children in a pornographic performance and materials" (WHO, 2003, p. 75).

Another definition connected to CSA, is grooming, defined in the following way: In which an adult or older adolescent uses a child for sexual stimulation, includes asking or pressuring a child to engage in sexual activities, indecent exposure with the intent to gratify their own sexual desires and by doing so is intimidating or grooming the child. *Grooming* is befriending a child, and sometimes the family, to lower the child's inhibitions for CSA. It is the process by which an offender draws a victim into a sexual relationship and maintains that relationship in secrecy (Craven et al., 2006).

One of the pioneers in the field of CSA was Finkelhor et al. (1990) and they defined CSA a behaviour violating the human rights of the child under eighteen. It includes sexual intercourse or an attempt to have intercourse through mouth, anus or vagina, or to touch, fondle, kiss, or take sexually suggestive pictures. It can also include touching a naked child, or showing genitals to a child or letting a child touch one's genitals or letting a child watch some type of sexual behaviour.

The consequences of psychological trauma after CSA can be widespread and serious for health and well-being (Kirkengen, 2010; Sigurdardottir & Halldorsdottir, 2013). People suffering because of CSA are often dealing with complex mental, physical and social problems in adulthood which affects their well-being and quality of life (Fergusson et al., 2013; Singh et al., 2014). In the research projects by Kristinsdóttir (2014) which are based on qualitative methodology a great view of how children and women experienced domestic violence is provided. However, more qualitative research is needed, to get a better and deeper understanding of how CSA affects people´s lives, from their point of view.

Since people suffering CSA are not only dealing with psychological problems, as researchers found out in the earlier studies of CSA, it is important to focus also on the consequences with a holistic view. Through the years survivors of CSA often sought help from psychologists and psychiatrists within traditional therapy, acknowledged within the healthcare system. However, there are limitations of traditional therapy, people´s needs are not being met, people don´t disclose their experience of CSA or they drop out of the therapy. Since more is known about the multifaceted

consequences of CSA it may be important to offer other therapies, such as complementary and alternative medicine (CAM), which may be more gentle to accept after CSA experience. That is now used in the integrative mental health nursing where there is whole-person, relationship-based care with use of the best range of therapies to support health and healing (Kaas et al., 2014). There seems to be a growing interest and support for using alternatives along with psychotherapy and medicine, with body, mind and spirit approach (Su & Li, 2011). Although the methods have offered several solutions to CSA survivors there is a need for a holistic therapy where different methods are integrated.

In this thesis CSA is discussed from a nursing and healthcare professional perspective. The history, development and epidemiology of CSA are presented in order to get a better view of the problem. The widespread consequences of CSA for health and well-being of males and females will be explained. The focus has been more on women suffering CSA and the consequences for their health and well-being and there is limited knowledge about men suffering CSA. There has also been a more quantitative focus in the field of CSA researches and, therefore, there is a need for a deeper understanding with qualitative studies, to get better understanding of the nature of the suffering of CSA survivors.

CSA as a psychological trauma will be described as well as how it can lead to a complex Post Traumatic Stress Disorder (PTSD). Moreover, to get a deeper understanding of the serious consequences of CSA for health and well-being, the connection between mind and body, shown by research within Psychoneuroimmunology (PNI), will be explained, and how CSA and psychological trauma can break down body and mind. The connection between CSA and health problems, the healthcare system and the various costs involved will also be described. The basic principles of therapy with a person-centred and holistic approach, with traditional and complementary and alternative therapy (CAM), are presented.

In order to increase nurses and other healthcare professionals competence in giving gender appropriate care to CSA survivors such in-depth knowledge and understanding is needed. Nurses and other healthcare professionals need more knowledge and deeper understanding about Icelandic men and women, regarding the consequences of CSA as well as the gender similarities and differences related to these consequences. The phenomenological approach has been developed to provide such in-depth knowledge and understanding. Particularly, there is a need for more in-depth

qualitative studies on men´s experience of CSA and how it affects their health and well-being and the consequences of a long lasting trauma history of CSA survivors.

1.1 Historical and theoretical background of CSA

Sigmund Freud, an Austrian neurologist and father of psychoanalysis, was the first scientist to develop a theory of CSA at the beginning of the 20th century. He claimed that his female patients with a history of CSA had “hysteria” symptoms (Freud, 1954, cited in Williams, 1994). Later, he changed his theory and said that women with an apparent history of CSA had not necessarily been sexually abused as children but rather had sexual desires/dreams about their fathers (Freud, 1966, cited in Williams, 1994). These theories were dominant until 1980 when family-system theories were postulated and pointed at the guilt of the mothers when discussing fathers’ incest with their daughters. The Women’s Movement also postulated its own theories. At that time CSA was often defined as a father’s sexual intercourse with his daughter. From 1980 on, the discussion has also been about CSA outside the family and acknowledged that CSA could be more than just sexual intercourse (Bolen, 2000).

According to a report from the World Health Organization (WHO, 2002) research around 1975, mental health professionals and child protective services became increasingly aware of CSA cases (Finkelhor, 1987). At the same time the concept of PTSD was coined (Burgess & Holmstrom, 1974). Actually, it had been well recognized in World War I as shell shock and in the mid-1970s became known a “Post-Vietnam Syndrome”. The condition was added to the DSM-III (*Diagnostic and Statistical Manual of Mental Disorders*) as PTSD early in 1978. It was used for soldiers after the Vietnam War who had suffered trauma from the war. Later PTSD was also connected to the consequences of CSA. The consequences of CSA can be signs and symptoms of PTSD and in severe cases can be diagnosed as complex PTSD, with myriads of psychological and physical symptoms, and complex PTSD is especially common after CSA (van der Kolk et al., 2007).

Solmon & Moos (1964) introduced the term Psychoneuroimmunology (PNI) in 1964 and were the first to connect emotions, immunity and disease (Kiecolt-Glaser & Glaser, 1988). PNI studies have explained some of the mechanisms defining how psychological trauma such as CSA affects health. These studies provide the basis of the understanding of how health problems and illnesses may be caused by severe or overwhelming stress and resultant

PTSD (Kendall-Tackett, 2009). At first the consequences of CSA were mainly connected to mental health problems, such as depression, anxiety and phobia, and were connected to symptoms of PTSD. Then, Felitti et al., (1998) found out that people experiencing four or more incidents of adverse childhood events, such as CSA, were for example at increased risk of heart disease, cancer, stroke, bronchitis, emphysema and diabetes.

Finkelhor & Brown (1985) developed a hypothesis about the consequences of experiencing CSA. Children experience psychological trauma when they experience inappropriate sexual behaviour and their own idea about themselves gets very confused. Children can experience betrayal that can lead to depression, hostility and isolation and weakness that can lead to anxiety. They can also experience decreased personal strength and can be at increased risk of re-victimization later in life. They can experience humiliation or disgrace that can affect their self-image and can lead to self-blame and self-accusation. These factors can explain why there is increased risk of low self-esteem of children after experiencing CSA that can increase depression, anxiety, unhappiness and the danger of eating disorders, self-mutilating behaviour and suicidal thoughts and attempts.

According to Scaer (2001) people can experience psychological trauma when experiencing circumstances where they are in danger or witness a fearful incident, where death or near death occurs, serious injury or a threat to their own health or others. Psychological trauma is often about loss of connection; to ourselves, our bodies, our families and the world around us. It often does not happen all at once, which is why it is often hard to recognize the hidden effects of trauma. Researches have shown that in all kinds of violence the most serious consequences that have been documented occur when the person is close to the victim, a close friend or a relative (Levine, 2008). Trauma can affect the person so strongly that they cannot get away from the painful emotions. The consequences of the trauma can be so tremendous that the person’s reactions are characterized by fear, helplessness and terror, with strange thoughts and feelings (Rothschild, 2010).

In nursing, the concept of stress and stress response has varied throughout the centuries since Florence Nightingale wrote about it. Nightingale believed that all patients were experiencing some stress in connection with illness. She asserted that if people would pay more attention to sickness where no reason seemed to be found, they could often find the cause of distress according to that sickness, which is a challenge for nursing.

Since then theories have been developed about the biological response of the body to stress to explain the connection of neuro-biophysics, hormones and behavioural incidents. Seyle, a pioneer in stress theories, developed the theory of General Adaption Syndrome (GAS) as a response to chronic stress, characterized by three steps: sudden fear, resistance and exhaustion. He described the fight/flight response and the influence it has on the body when life threatening stress becomes chronic. It can be the reason for most illnesses, such as infections, cancer, and heart disease (Rice, 2012).

Kendall-Tackett (2009) points out that the human body has interdependent mechanisms to preserve life in the face of danger. When threatened, such as in any form of violence, the body tries to respond with a fight or flight reaction. The sympathetic nervous system (SNS) responds by releasing the catecholamine norepinephrine, epinephrine or dopamine. Then the hypothalamic–pituitary–adrenal axis (HPA axis) responds to the hypothalamus to release corticotropin-releasing hormone (CRH), which causes the pituitary to release adrenocorticotropic hormone (ACTH). This causes the adrenal cortex to release cortisol, a glucocorticoid that is released in response to stress and low blood-glucose concentration. The immune system responds to threat, such as violence, by releasing pro-inflammatory cytokines which increase inflammation to help the body heal wounds and fight infection. That is why people with trauma experience are in greater risk of serious illness, such as cancer (Kendall-Tackett 2009). The knowledge from the literature mentioned above, indicates that CSA can have serious and multifaceted consequences for health and well-being. Therefore it should not be surprising that it affects the body, mind and spirit so seriously, even though it still often not seems to be known within the healthcare system.

1.2 Epidemiology of Child Sexual Abuse

According to WHO (2002) it is hard to determine how common CSA truly is because it is largely a hidden problem, kept secret by those who are ashamed or do not want to be found or named, and is therefore very difficult to investigate. The WHO report on violence shows that sexual abuse is a widespread problem. About 57,000 children died worldwide because of CSA in 2000. Meta-analysis of the prevalence of CSA around the world confirms that CSA is a global health problem, affecting the lives of millions of children (WHO, 2014).

In *Table 1* the prevalence of CSA in several countries is reported. A meta-analysis of CSA in community and student samples in 22 countries showed that 7.9% of men and 19.7% of women had suffered some form of CSA before the age of 18. Africa had the highest prevalence rate of CSA 34.4% and Europe had the lowest 9,2%. America and Asia had a prevalence of 10,1% and 23,9% respectively (Pereda et al., 2009). The prevalence of CSA worldwide is estimated 18% for girls and 7.6% for boys (Stoltenborgh et al., 2011). In the ACE study (Adverse Childhood Experiences) among 19,337 participants in USA, 17.8% met the criteria for CSA (Edwards et al., 2012).

A cross-sectional study was done with 3641 women attending five departments of gynaecology in Denmark, Finland, Iceland, Norway, and Sweden, 1999-2001 In that study 33% of the Icelandic women had suffered sexual abuse during their life, of those 10,4% suffered CSA, before age of 18 (Wijma et al., 2003). A report based on interviews with 42.000 women, aged 18-74, across the 28 member States of the European Union (EU) shows that just over one in 10 women (12 %) has experienced some form of sexual abuse or incident by an adult before the age of 15. This corresponds to about 21 million women in the EU (Violence against women: An EU-wide survey Results at a glance, n.d.).

Table 1. The prevalance of CSA in some countries

Countries	Men	Women	Authors	CSA age before	Research design	Sample
Worldwide 22 countries	7,9%	19,7%	Pereda et al., 2009	18 years	Meta-analysis	Community and student samples
Iceland		10,4%	Wijma et al., 2003.	18 years	Cross-sectional study	3641 women at gynaecology
Iceland	6,3%	17,6%	Gault-Sherman et al., 2009	17 years	Cross-sectional national survey	8618 Icelandic youth
Iceland	17,8%	35.7 %	Asgeirsdottir, 2011	18 years	Cross-sectional survey	9085 Icelandic College students
Norway	3,5%	10,2%	Thoresen et al., 2015.	18 years	Cross-sectional survey	2435 women 2092 men aged 18-75
Nordic Countries	3-23%	11-36%	Kloppen et al., 2016.	18 years	Literature review	
Swiss	17.2%	40.2%	Mohler-Kuo et al., 2014.	16 years	Cross-sectional study	6787 ninth grade adolescents
USA	16%	27%	Finkelhor et al., 1990.	18 years	National survey	Adults
USA	14,2%	32,3%	Briere & Elliott, 2003.	18 years	Random sample	1442 adults
USA	5,1%	26.6%	Finkelhor et al., 2014	17 years	National telephone surveys	Adults

According to these studies CSA seems to be at least two times more likely to happen to girls than boys. It is also interesting that there seem to be differences between countries and continents. However, all comparison must take into account that there may be differences regarding such parameters as the definition of CSA and age limits.

1.3 Consequences of CSA for health and well-being

People suffering because of CSA are often dealing with complex mental, physical and social problems in adulthood which affects their well-being and quality of life (Fergusson et al., 2013; Singh et al., 2014). Women suffering both physical and sexual abuse before the age of 18 have poorer health status such as depression and physical symptoms compared to women without a history of such abuse (Bonomi et al., 2008). Sudbrack et al. (2015) found that people with trauma history have a higher frequency of anger, anxiety and depression. People with more childhood adversity and who experience severe early life stressors have poorer cellular immune function and are at greater risk of immune system dysregulation which can lead to greater stress sensitivity (Fagundes et al., 2013).

Research results indicate that children who have experienced physical abuse have a smaller brain volume compared to children that have not experienced physical abuse (Hanson et al., 2010). It has been suggested that serious psychological trauma in childhood can affect the size and structure of the brain and the functioning which controls, for example, depression, alcohol abuse, physical symptoms and mental illness (Vythilingam et al., 2002). Under normal physiological conditions, a balanced release of stress mediators can mediate adaptation to the stressor and the response is terminated in good time (Peters et al., 2012).

The physical, psychological and social symptoms, some survivors of CSA are often suffering from, are listed in *table 2.* In the table there are some examples of studies. In accordance with the widespread and complex consequences of CSA observed, it appears to be important to offer holistic and person-centred therapy with a focus on mind, body and soul. Because of the multifaceted consequences it is also important for health professionals to work together in offering a holistic intervention to be able to meet the different needs of each person, with multiple health problems, physical problems like musculoskeletal, circulatory, digestive, respiratory, reproductive and neurological problems. Also psychological problems such as depression, anxiety, personal disorder, PTSD, self-destructive behaviour and suicide as

well as social problems, such as behavioural problems, difficulty regarding sex life, relationship, parenting and re-victimization.

Table 2. Known consequences for health and well-being that some people are suffering from after CSA.

Physical consequences	Studies
Widespread and chronic pain	Chartier et al., 2007; Leserman & Drossman, 2007; Levine, 2010; Nelson et al., 2012; Paras et al., 2009; Seith & Talbot et al., 2009; Teichman, 2008; Wegman & Stetler, 2009.
Sleeping problems	Chapman et al., 2011; Sigurdardottir & Halldorsdottir 2013; Wegman & Stetler, 2009.
Adult onset arthritis	Sigurdardottir & Halldorsdottir, 2013; Von Korff et al., 2009.
Fibromyalgia	Dube et al., 2009; Sigurdardottir & Halldorsdottir, 2013; Wilson, 2010.
Long-term fatigue, diabetes	Romans et al., 2002; Sigurdardottir & Halldorsdottir 2013.
Circulatory problems	Kendall-Tackett, 2009; Romans et al., 2002; Sigurdardottir & Halldorsdottir, 2013; Wegman and Stetler, 2009.
Digestive problems	Dube et al., 2009; Kendall-Tackett, 2009; Kuhlman et al., 2012; Leserman & Drosman, 2007; Levine, 2010; Nelson et al., 2012; Paras et al., 2009; Wegman & Stetler, 2009; Wilson, 2010.
Respiratory problems	Anda et al., 2008; Dube et al., 2009; Talbot et al, 2009; Wegman & Stetler, 2009; Wilson, 2010.
Musculoskeletal problems	Sigurdardottir & Halldorsdottir, 2013; Talbot et al., 2009; Wegman & Stetler, 2009.
Reproductive problems	Beck et al., 2009; Paras et al., 2009; Seith & Teichman, 2008; Sigurdardottir & Halldorsdottir, 2013.
Neurological problems	Beck et al., 2009; Kendall-Tackett, 2009; Paras et al., 2009; Seth & Teichman, 2008; Wegman & Stetler, 2009.

Table 2. Continued

Psychological consequences	Studies
Depression	Asgeirsdottir et al., 2011; Chen et al., 2006; Dube et al., 2005; Fergusson et al., 2013; Monteiro et al., 2015; Morais et al., 2016; Nehls & Sallman, 2005; Ramirez & Milan, 2016; Thoresen et al., 2015; Wilson & Scarpa, 2015.
Anxiety	Fergusson et al., 2013; Nehls & Sallman, 2005; Ramirez & Milan, 2016; Thoresen et al., 2015.
Phobia	Cantón-Cortés & Cantón, 2010; Chen et al., 2006; Fergusson et al., 2013; Hetzel & McCanne, 2005; Nehls & Sallman, 2005; Spitzer et al., 2009.
Self-destructive behaviour	Asgerisdottir et al., 2011; Chartier et al., 2009; Dube et al., 2005; Ferguson et al., 2013; Nehls & Sallman, 2005.
Addiction	Anda et al., 2006; Chartier et al., 2009; Dube et al., 2005; Ford et al., 2011; Fergusson et al., 2013; Heim & Binder, 2012; Ullman & Sigurvinsdottir, 2015; Zhu et al., 2015; Wilson, 2010
Post-Traumatic Stress Disorder (PTSD)	Brown et al., 2015; Cantón-Cortés & Cantón, 2010; Fagan & Freme, 2004; Hetzel & McCanne, 2005; Morais et al., 2016; Ramirez & Milan, 2016; Spitzer et al., 2009.
Suicidal thoughts and attempts	Chartier et al., 2009; Dube et al., 2005; Edgardh & Ormstadt, 2000; Martin et al., 2004.
Personal disorders	Cantón-Cortés & Cantón, 2010; Chen et al., 2006; Heim & Binder, 2012; Hetzel & McCanne, 2005; Spitzer et al., 2009; Wilson, 2010.
Eating disorders, obesity	Anda et al., 2006; Chartier et al., 2007; Chartier et al., 2009; Duncan et al., 2015; Jia et al., 2006; Power & Pinto Pereira, 2015; Ramirez et al., 2016; Wilson, 2010.

Table 2. Continued

Psychological consequences	**Studies**
Re-victimization	Barnes et al., 2009; Brenner & Ben-Amitay, 2015; D'Abreu & Krahé, 2016; Dube et al., 2005; Elwood et al., 2011; Erdmans & Black, 2008; Hetzel & McCanne, 2005; Wegman & Stetler, 2009.
Antisocial and criminal behaviour	Krug et al., 2002¸Levenson & Socia, 2016.
Difficulties in sex life and in connection with spouse	Colman & Widom, 2004; Lemieux & Byers, 2008; Sobański, et al. 2014.
Difficulty trusting mates	Colman & Widom, 2004.
Marriage problems	Colman & Widom, 2004; Erdmans & Black, 2008; Lemieux & Byers, 2008.
Anxiety and stress as parents	Erdmans & Black, 2008; Freysteinsdottir, 2005.
Sexual risk behaviour	Messman-Moore & Brown, 2004; Senn et al., 2007.
Having many sexual partners	Chartier et al., 2009.
Sexual problems and aggression	Anda et al., 2006; Vaillancourt-Morel et al., 2016.
More likely to marry an alcoholic	Lemieux & Byers, 2008.
Increased problems during pregnancy, risk of difficulties during the postpartum period	Kendall-Tackett et al., 2013; Kendall-Tackett, 2007.

1.3.1 Post-Traumatic Stress Disorder (PTSD)

Post-Traumatic Stress Disorder (PTSD) is one of the common consequences after CSA (Boney-McCoy & Finkelhor, 1996; Hooper & Warwick, 2006). PTSD is a severe anxiety disorder that can develop in some people after exposure to extremely traumatic events, such as combat, crime, an accident, a natural disaster and sexual violence (American Psychiatric Association, 2000).

PTSD is a disorder that is included in Trauma- and Stress- Related Disorder in which exposure to a traumatic or stressful event has been experienced. The diagnostic criteria for PTSD according to the Diagnostic and Statistical Manual for Mental Disorders DSM-5, require people to have had a specific number of symptoms in each criterion in order to be diagnosed (American Psychiatric Association, 2013). The first DSM criterion states that the person was exposed to: death, threatened death, actual or threatened serious injury, or actual or threatened sexual violence, in the following way(s): direct exposure, witnessing the trauma, learning that a relative or close friend was exposed to a trauma. Diagnostic criteria for PTSD include four symptoms clusters. The first symptoms cluster consists of the persistent re-experiencing of the event in several ways, such as images, dreams, illusions or hallucinations and dissociative flashback episodes. The second cluster involves avoidance of thoughts, feelings, people, places, conversations or activities that may trigger recollections. The third is symptoms of negative alterations in cognitions and mood associated with the traumatic event, for example inability to recall important memories, overly negative thoughts and assumptions about oneself, exaggerated blame of self or others for causing the trauma. Finally the fourth cluster is marked alterations in arousal and reactivity, for example irritable behaviour and angry outbursts, reckless or self-destructive behaviour, concentration problems and sleep disturbance.

A large group of people experience some symptoms of PTSD after psychological trauma, most of them recover normally during the first weeks and months after the trauma, but others are dealing with symptoms for many years. Even though most of people, in general, experience some kind of trauma in their lives, only 9-14% develop symptoms of PTSD (Kessler et al., 1995). The highest risk of PTSD has been shown to be because of sexual abuse, especially when it is experienced in childhood (Hetzel & McCanne, 2005; Brown et al., 2015). Babies and toddlers can have PTSD, the minimum age for diagnosis is one-year-old (American Psychiatric Association, 2013). Rape victims of serious sexual abuse are at increased risk of PTSD and at

higher risk for other trauma (Resnick et al., 1993). Sexual abuse is the cause of almost half of the PTSD cases in women (Kessler et al., 1995). Highest rates of PTSD are found among survivors of rape and there may be a delay of months or years before criteria for PTSD are met. PTSD is more prevalent among females than males and females in general experience PTSD for a longer duration than males. In older people the disorder is often associated with negative health perception, primary care utilization and suicidal ideation. CSA increases a person´s suicide risk and PTSD is associated with that (APA, 2013).

More severe and longer lasting PTSD is normally caused by trauma that people are responsible for, such as violence (Resnick et al., 1993). Complex PTSD or Disorders of Extreme Stress Not Otherwise Specified (DESNOS), is caused by repeated traumatic events. There is a significant relationship between C-PTSD symptoms and a history of sexual abuse (Zlotnick et al., 1996). Adults, suffering severe childhood trauma, who have somatic symptoms are at greater risk of developing C-PTSD (Spitzer et al., 2009).

Complex PTSD, when symptoms after trauma are more complicated than PTSD can cover, is divided into six main groups and then divided into subgroups in the following way (Herman, 1992): a. Alteration in regulation of affect and impulses (affect regulation, modulation of anger, self-destructive, suicidal preoccupation, difficulty modulating sexual involvement, and excessive risk-taking). b. Alterations in attention or consciousness (amnesia, transient dissociative episodes and depersonalization). c. Alterations in self-perception (ineffectiveness, permanent damage, guilt and responsibility, shame, nobody can understand, minimizing). d. Alterations in relations with others (inability to trust, re-victimization, victimizing others). e. Somatization (digestive system, chronic pain, cardiopulmonary symptoms, conversion symptoms, sexual symptoms). f. Alterations in systems of meaning (despair and hopelessness, loss of previously sustaining beliefs).

Complex PTSD is considered to be especially likely to occur following exposure to repeated, prolonged, interpersonal trauma exposure (Perkonigg et al., 2015). Adult who are CSA survivors may be at increased risk of Complex PTSD since PTSD is not extensive enough when people have chronic problems after CSA.

1.4 Male survivors of CSA

The studies examine gender differences indicate that more women than men are victims of CSA (Table 1). The prevalence of men suffering CSA is probably higher since male survivors often delay disclosure of CSA for years or even decades. There are many factors which can contribute to the seriousness of CSA among men like physical force, penetration and physical injury. This is positively related to increased problems in adulthood (Easton, 2012). Factors related to mental distress of male CSA survivors include the number of other childhood traumas, years until disclosure, conformity to masculine norms and overall response to disclosure (Easton, 2014).

Even though awareness is increasing regarding the disclosure about CSA by boys, there are still only a few studies available. Men in general do not seem to seek help and access resources for healing (O'Leary & Barber, 2008; Easton, 2014). Men suffering CSA have been believed to represent a highly stigmatized and marginalized population (O'Leary & Barber, 2008). O'Leary & Barber found that boys were less likely than girls to disclose CSA at the time it happened and it took the men a longer time to reveal and discuss their CSA. Disclosure is very important for well-being and recovery, suffering inside can break down people´s self-image and affect their health. The men with experiences of disclosure found they received both positive and negative responses and they rarely identified themselves as victims. In a study by Sorsoli et al. (2008) the men described the following relational and socio-cultural reasons for their struggles with disclosure which had to do with distinct personal reasons, including lack of cognitive awareness, intentional avoidance, emotional readiness and shame. The main relational reasons were fears about negative repercussions and isolation. Socio-cultural reasons had to do with lack of acceptance for men to experience or acknowledge victimization. Disclosure is a complex process for victims of CSA and masculine norms and stereotypes have contributed to an environment that often neutralizes the experiences of men suffering CSA (Gagnier & Collin-Vézina, 2016).

Lisak (1994) indicated that men with a history of CSA felt anger, betrayal, fear, isolation, loss, helplessness, self-blame, guilt, shame and humiliation. CSA can have a profound effect on the long-term mental health of boys and men. Men suffering CSA are ten times more likely than men without CSA history to be diagnosed with mental disorders and PTSD (O′Leary, 2009) and they are at risk for long-term mental health problems, including suicidality (Easton et al., 2013). 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 suffering CSA exhibited self-destructive behaviour and attempted suicide as opposed to 5.1% of the boys without CSA history (Edgard & Ormstad, 2000).

Studies among men have been more focused on mental than physical problems. There is, therefore, a need for more studies on physical symptoms of men suffering CSA. Examples of such physical symptoms include incontinence (Morrow et al., 1997) as well as risk of sexually transmitted diseases and AIDS (Holmes & Slap, 1998). In a study conducted by Coxell et al. (2000) at a sex and urology unit in London, 224 men, older than 18 years were asked about CSA, 12% had suffered CSA before the age of 16 and 18% in their adult years. Those who suffered CSA were more likely to report sexual abuse in adulthood and have genital-urinary problems.

CSA affects males sometimes in ways that are gender-specific. They may show signs of broken male identity and confusion regarding sexuality (Lisak, 1994; Dhaliwal et al., 1996; Kia-Keating et al., 2005; O'Leary et al., 2015). Men suffering CSA are more likely to shoulder too much responsibility in relationships and they have trouble being faithful to their wives (Whiffen et al., 2000). Male survivors of CSA often report disturbing memories of CSA during intercourse (Andersen, 2008) and report unwanted sexual compulsions or engage in offending sexual behaviour (Schraufnagel et al., 2010). Also, they often experience sexual dysfunction (Dhaliwal et al., 1996; Andersen, 2008).

When trying to avoid thoughts and feelings regarding memories of the CSA, men often use escape behaviours such as workaholism, alcoholism and overeating (Alaggia & Millington, 2008). They are also often dealing with aggression and antisocial behaviour (Dhaliwal et al., 1996). Not all men suffering CSA are dealing with complex consequences. Despite an increased risk of long-term mental health problems, many survivors of CSA experience positive changes, appreciation of life, personal strength and good interpersonal relationships. Men that had a better understanding of the CSA described less traditional masculine norms and experienced a turning point. A turning point has been defined as when something happened in their life that changed their view of the experience, as key motivators of positive change, the men start to recover and managed to develop new hope and purpose, the courage to live and to love (Easton et al., 2013)

Recovery for male CSA survivors involves their need to understand the meaning and impact of CSA on their lives (Easton et al., 2013). Part of the healing process is becoming vulnerable and accepting painful feelings. They need to reconnect with others and gradually develop resilience. It is important

to raise awareness about masculinity myths in clinical interventions (Kia-Keating et al., 2005). To improve mental health services for men with histories of CSA, health practitioners should incorporate information on CSA severity, current mental health and adherence to masculine norms into assessment and treatment planning (Easton et al., 2013). Since there is increased risk of suicidal attempts in adulthood after CSA, a systematic assessment of psychiatric disorders and suicide risk in CSA survivors is recommended (Pérez-Fuentes et al., 2013).

There are not many qualitative studies focusing on men suffering CSA or treatment for men suffering CSA. These qualitative studies mostly focus on psychological and social consequences. There is a need for more qualitative studies on men suffering CSA especially to explore men´s physical health and well-being in more detail than has been done in previous studies. No Icelandic study on men suffering CSA was found in the Icelandic literature.

1.5 Gender similarities and differences

Studies indicate that both males and females experience CSA but females are at greater risk of CSA (Finkelhor & Baron, 1986; Martin et al., 2004; Ullman & Filipas, 2005) as shown in table 1. According to the literature, studies regarding women suffering CSA are more common than studies regarding men (Banyard et al., 2004) as well as studies regarding long-term consequences of CSA among adults (Dube et al., 2005).

Researchers do not agree on which consequences of CSA are the same and which are different for men and women. Some argue that CSA has a greater negative effect on females than males (Ullman & Filipas, 2005), but others argue that the consequences of CSA are the same for men and women (Finkelhor, 1984). Long-term impact of CSA on health and social problems was similar for both men and women (Dube et al., 2005). Also, in a study by Hussey and co-workers (2006) no gender differences were reported between men and women in regard to health consequences for adolescents. Gender similarities and differences regarding adult CSA survivors seem to be understudied (O'Leary & Barber, 2008) and gender comparison can, therefore, have many limitations. A comparison of the long-term effects of CSA by gender also needs further exploration and studies on psychological trauma indicate that women are more likely than men to meet criteria for PTSD (Olff et al., 2007; Tolin & Foa, 2006).

One of the possible reasons for women's higher PTSD risk is because of gender-specific psychobiological reactions to trauma, but there is a need for further studies of gender differences in regard to PTSD (Olff et al., 2007). Untreated PTSD can affect development of substance abuse and dependence and PTSD more often affects alcohol dependence in women than men (Zlotnick et al., 1996). Men with PTSD reported earlier onset of alcohol dependence and greater intensity of alcohol use. This was to some degree supported by the survey by Asgeirsdottir et al. (2011), where males recounted substance abuse more frequently than females (23,5%; 17%) and also by Chandy et al. (1996) who found that adolescent males were at higher risk of more extreme use of alcohol and marijuana but adolescent girls showed higher risk of frequent use of alcohol. In some other studies adolescent girls showed higher risk of frequent use of alcohol and men were more likely than women to become substance abusers (Hooper & Warwick, 2006; Martin et al., 2004).

Results of some studies have shown that CSA has a greater negative psychological effect on females than males such as in an Icelandic study of 8618 youths aged 16-20, the females suffering CSA were more likely to experience depression and general anxiety symptoms (Gault-Sherman et al., 2009). According to Ullman & Filipas (2005) female students suffering CSA reported more distress and self-blame than male students. Women suffering violence had significantly more shame and guilt than men, which was partially explained by violence exposure and more types of violence that were reported (Aakvaag et al., 2016). However, less is known about gender differences of shame and guilt in relation to trauma and CSA (Tolin & Foa, 2006). The association between CSA and depression was similar for men and women (Garnefski & Arends, 1998; Ullman & Filipas, 2005) and no gender difference was found in the relationship between CSA and trauma-related symptoms, such as psychological distress after trauma (Boney-McCoy & Finkelhor, 1996). Furthermore, the genders did not differ in their relationship between CSA and youth emotional problems (Maikovich-Fong & Jaffeeb, 2010).

Self-harm and suicidal thoughts are one of the serious consequences after CSA. In a national survey by Asgeirsdottir et al., (2011) among 9085 Icelandic high-school students, 16-19 years old, 45,7% females and 31,8% males suffering after CSA reported self-injurious behaviour. According to Chandy et al. (1996) adolescent girls showed higher risk of suicidal ideation and behaviour than boys. Looking at long-term consequences of CSA it is indicated that suicide attempts were twice as common among men compared

to women who suffered CSA (Dube et al., 2005). Gender similarities were, however, found in the study by Edgardh & Ormstad (2000) where suicidal attempts or other self-harm behaviour were reported by 33.3% of the male students who had experienced CSA and by 30.4% of female students. In a study by Wan et al. (2016) CSA was significantly associated with suicidal ideation and suicidal planning among boys and girls and there was no gender difference. However, studies do not agree on the frequency of consequences such as suicidal attempts by men and women suffering CSA.

In some studies adolescent males suffering CSA have demonstrated poor school performance (Hooper & Warwick, 2006: Martin et al., 2004) but Boden et al., (2007) and Fergusson et al., (2008) did not find significant gender differences after CSA in regard to educational achievement. Men have also been reported to have more aggressive behaviour than women (Hooper & Warwick, 2006; Martin et al., 2004) and boys suffering CSA reported more conventional crimes (Pereda et al., 2016). However, in an Icelandic study by Gault-Sherman et al., (2009) there were no gender differences regarding theft and violent behaviour. Sexual risk behaviour has also been reported as possible consequence of CSA and adolescent males have been found to be more prone to risk-taking sexual behaviour (Chandy et al., 1996; Hooper & Warwick, 2006; Martin et al., 2004).

In the literature much more focus has been on women´s physical health than among men´s and there is, therefore, a need for more studies on physical consequences among men after CSA. Studies on gender similarities and differences focus mainly on prevalence and types of violence and psychological and social consequences, but not on physical consequences after CSA. However, data from the 2012 Canadian Community Mental Health Survey among 23,395 people, 18 years or older, showed that gender was a significant moderator between child abuse and back problems, chronic bronchitis/emphysema/COPD, cancer and chronic fatigue syndrome, with slightly stronger effects for women than men (Afifi et al., 2016).

Disclosure of CSA is important for a healthy recovery. Males have been found to be less likely than females to disclose CSA. For men, disclosure was difficult at the time the trauma happened, and it took them longer to discuss their CSA experiences later in life (O´Leary & Barber, 2008; Ullman et al, 2005). In a study by Ullman & Filipas (2005) women were more likely to receive positive reactions to their disclosure compared to men. Disclosing CSA is a complex process, much is hidden, especially from professionals. In a study by Edgardh & Ormstad (2000) no abused boys and few abused girls

did disclose their CSA experience or sought help from health professionals, despite having severe symptoms and distress. Gender differences in disclosure indicate that a gender perspective is an important focus in guidelines for professionals (Priebe & Svedin, 2008).

It is not clear if one sex is more vulnerable to negative consequences of CSA than the other or affects girls and boys differently. However, there are some indicators, that women are more vulnerable regarding psychological, emotional and physical health problems but men regarding aggression and behavioural problems. Both genders are vulnerable regarding self-harm behaviour and men seem to be more vulnerable regarding suicide and different addiction, but women regarding eating disorder, use of alcohol and suicidal thoughts. The processes which make some CSA survivors more exposed to more and complex impairments than others are complicated. In the literature, quantitative studies on men and women are most frequently conducted and no qualitative study was found, focusing on gender similarities and differences. With a qualitative approach it is possible to look more closely into the lived individual experiences of the consequences of CSA and to explore the possible gender similarities and differences.

1.6 The Healthcare System

There is an association between adverse childhood experiences, poor adult health and high healthcare utilization (Chartier et al., 2007; 2010). Strong and consistent relationship has been found between histories of sexual abuse and of physical abuse in childhood and people with such a history have a worse health-related quality of life and more healthcare utilization (Leserman & Drossman, 2007).

People with a history of physical and sexual abuse in childhood have frequent emergency room and health professional visits, and this is more common in women than men. Women with such history have significantly higher annual healthcare use and costs, 36% higher than for women without a history of abuse, and they have higher annual mental health, emergency department, hospital outpatient, pharmacy, primary care and specialty care use (Bonomi et al., 2008). Even if female CSA survivors frequently seek help in the healthcare system because of complex and widespread health problems they do not mention the abuse (Wijma et al., 2003; Sigurdardottir & Halldorsdottir, 2013).

Finally, people suffering from childhood traumatic stress are at increased risk of hospitalization with a diagnosed autoimmune disease, decades into adulthood (Dube et al., 2009). They are also at higher risk of medically unexplained symptoms (Nelson et al., 2012) and at greater risk of having somatic symptoms (Anda et al., 2006; Nelson et al., 2012). People with an adverse childhood experience are more often hospitalized and use more frequently prescription medications for treatment (Anda et al., 2008).

Many survivors of sexual abuse are dealing with serious consequences, but despite that, it seems that few of them seek help (Nesvold et al., 2008). For that reason worldwide emergency services have been developed (Nesvold et al., 2005). San Diego County Sexual Assault Response Team (SART) model was developed in 1990 and is aimed at survivors of sexual abuse. The service is based on a model which emphasizes easy access for everyone, provision of comprehensive service where evidence is gathered accurately and systematically (San Diego County Sexual Assault Response Team, 2001). It is located in hospitals or other health services and the service is provided by multidisciplinary teams, with nurses, doctors, social workers and psychologists (Nesvold, et al., 2005). The aim of the SART model is to ensure that victims of sexual violence think it is the right choice to seek help in the wake of the crisis (Campbell & Ahrens, 1998).

1.6.1 Treatment for CSA survivors

Despite the fact that psychological trauma in childhood, because of CSA, can have widespread and serious consequences for health and well-being, treatment options for CSA survivors seem scarce (Kirkengen, 2010; Sigurdardottir & Halldorsdottir, 2013).

Broader theoretical and practical knowledge related to the different consequences of violence in childhood is needed in healthcare to facilitate more accurate identification. There is also a need for specialized training for nurses and other health care professionals to increase their competence at work (Pabiś et al., 2011). Svavarsdottir & Orlygsdottir (2009) found it important to offer women, suffering from violence, immediate intervention as needed and to ensure future provision of appropriate healthcare services. Based on their results they recommended screening for abuse of women at emergency and high risk clinics. Nurses are in a special situation when working with people in relation to CSA, since they follow people from their birth until their death in variety of settings. They work with pregnant women, they see the children in their first years and they work in the school system where they continue seeing the children. They also work in the public health

service, where people come in, as the first stop into the health care system.

Kalmakis & Chandler (2014) recommend promoting a model of primary care that pays attention to the social and familial influences on the health of individuals worldwide. CSA survivors must be assessed by healthcare professionals with a holistic perspective, since the mind, body and soul is connected and can influence each other (Wilson, 2010). Each health problem needs to be addressed in treatment; treating one problem and not another can be insufficient in meeting CSA survivors' needs (Sachs-Ericsson et al., 2009). People suffering CSA seek help within traditional therapy and complementary and alternative medicine (CAM).

1.6.1.1 Traditional Therapy

The public health service is one part of the traditional therapy. It is often the first stop for people searching for help or support because of some health problems. It is also often the first stop for people suffering after CSA, when they come in with all kinds of health problems as possible consequences of CSA. People suffering CSA often do not know about the possibility of the consequences of CSA and the connection between mind, body and soul, and sometimes neither do the healthcare professionals. That can be one of the reasons some people do not feel that they get support and understanding in the traditional health service.

Traditional therapy is the acknowledged therapy used in the healthcare system, such as psychological therapy, nursing care, medical diagnosis and interventions and physical therapy. Within the traditional therapy, the guidelines are mostly made for symptoms of physical or psychological problems, but not from the person´s life experience, such as trauma and CSA. That can be another reason why people suffering CSA do not feel they meet support and understanding, the guidelines are not trauma-focused, rather disorder driven.

Evidence-based and international guidelines from the National Child Traumatic Stress Network (NCTSN) and the National Centre for PTSD and the guidelines of the National Institute for Health and Clinical Excellence (NICE) are used in psychological services for PTSD. According to the instructions of the NCTSN it is important to provide counselling within a few days or weeks after the trauma event (NCTSN and National Centre for PTSD, 2006). Guidelines of NICE are made especially for the treatment of PTSD. They stress the importance of finding out about the consequences of violence as well as the interests and needs of the PTSD victim for therapy

and trauma counselling (National Institute for Health and Clinical Excellence, 2005). Also, there are guidelines in the Nordic countries like in Norway where there is a Centre of violence and traumatic stress studies (Nasjonalt kunnskapssenter om vold og traumatisk stress, NKTVS) which provides such guidelines (https://www.nkvts).

Psychological therapy includes Cognitive behavioural therapy (CBT) that has been the most common therapy through the years (Resick et al., 2002) and Trauma-focused CBT (Webb et al., 2014). Mindfulness approach is also used in the healthcare system, mostly by psychologists and nurses (Kammer et al., 2010) as well as Mindfulness-based stress reduction (MBSR) (Grossman et al., 2004).

Through the years psychological therapy has been the most common therapy for people suffering from mental health problems following CSA. The literature suggests that cognitive behavioural therapy (CBT) is an effective treatment for PTSD, one of the consequences of CSA (Resick et al., 2002). Trauma-focused cognitive behavioural therapy (TF-CBT) is mostly used by psychologists. Using TF-CBT in treating child traumatic stress showed that symptoms of PTSD, as well as internalizing and externalizing problems, decreased significantly during the six months therapy and these gains were maintained over the next six months. This suggests that TF-CBT can be implemented effectively in combating PTSD symptoms, and internalization and externalization of problems were maintained up to one year after treatment began, although the changes in externalizing symptoms were the least stable (Webb et al., 2014). Exposure Therapy (EX) is often categorized as CBT and is successful for avoidance, anxiety and PTSD symptoms (Shapiro, 2010). Research also shows that group psychotherapy may be useful for people with symptoms of dissociation and low self-esteem, as consequences of psychological trauma (Karatzias et al., 2016).

Mindfulness approach to stress management encourages awareness in the present moment and has been useful for people suffering CSA. It is used in the healthcare system mostly by psychologists and nurses. The practice enables people to be self-aware and self-regulated about physical and emotional responses and has been successfully used in treating patients with chronic pain. It can decrease pain and pain-related drug utilization and increase activity levels and feelings of self-esteem (Kabat-Zinn et al., 1985). It is a powerful way to help women after trauma. Women speak to each other about their experience and put more distance between themselves and their pain and they feel less victimized. It is the actual comprehending of the other

that heals; an intense and emotional bonding develops between people who are going through a similar experience (Kammer et al., 2010). Mindfulness-based stress reduction (MBSR) is a structured group program that employs mindfulness meditation and it is suggested that it may help a broad range of individuals to cope with their physical, psychosomatic and psychiatric disorders, both clinical and nonclinical problems (Grossman et al., 2004).

People suffering CSA are often dealing with dissociation and their feeling of connection to their body can be limited. In recovery after CSA it is important to build up the connection again and one helpful therapy is Basic Body Awareness Therapy (BBAT). It is mostly used and researched in mental health but also in physiotherapy and has positive outcomes for depression, anxiety, sleep difficulties, self-confidence and chronic pain and builds up a positive attitude towards body movement. The therapy is psychosomatic, working both for body and mind through movement/exercise and for self-assessment, where psychological, medical and pedagogical frameworks can be interwoven (Mattsson et al., 1998).

Basic Body Awareness Therapy (BBAT) is one of the traditional therapies used mostly by physiotherapists in the healthcare system (Mattsson et al., 1998) as well as Physical exercise (PE) (Eyre & Bernhard, 2012) and Physical activity (PA) (Eyre et al., 2013). Physical exercise (PE) is being used more now and is important to reduce stress and since stress is one of the consequences of CSA it is important to practice PE in treatment after CSA. Research indicates that PE may reduce inflammation and oxidation stress via a multitude of cellular and humoral neuro-immune changes (Eyre & Bernhard, 2012). Physical activity (PA) is increasingly investigated as a preventative, early intervention, and treatment option in depression. The investigation of the neuro-immune effects of PA on depression and depression-like behaviour is a rapidly developing and important field. PA affects the neuro-immune system and reduces the detrimental effects of that system (Eyre et al., 2013).

Traditional therapy is often mostly to cure symptoms, disorder driven but not trauma informed service. It is not often provided with a holistic approach, with connection of mind, body and soul. People with widespread and complex health problems as possible consequences of CSA often do not feel they meet support and understanding within traditional therapy, they often try Complementary and Alternative Medicine (CAM). However, CAM is also found in some traditional therapy today, as in mental and oncology nursing and is increasing. Integrative mental health nursing applies principles of the

whole person, relationship-based care, using the best range of therapies to support the person´s health and healing (Kaas et al., 2014).

1.6.1.2 Complementary and Alternative Medicine (CAM)

The purpose of healthcare professionals using CAM is not to cure symptoms but rather to help people to feel better, to give people support to enable them to acquire energy or power to get through difficult experiences. It is also important to build up strong relationships between healthcare professionals and patients by giving them enough time (Mackereth & Stringer, 2005).

Research on CAM, also called body-mind therapy, is increasing as a result of a rising demand in many countries (Bishop et al., 2007). CAM practices are often grouped into broad categories, such as natural products, mind and body medicine and manipulative and body-based practices. Although these categories are not formally defined, they are useful for explaining CAM practices. Some CAM practices may fit into more than one category (The National Centre for Complementary and Alternative Medicine, USA, n.d.). Not many studies were found on CAM, especially for people suffering CSA, more on symptoms and consequences known after CSA. It is important to increase research into that field since it is stated in Icelandic healthcare laws that patients should have access to the best care available at all times, including integrative therapies, but it is unclear how organizations should enforce the laws (Kristofersson & Gunnarsdottir, 2014).

There are some research findings indicating the effectiveness of some body-mind therapies when dealing with some of the problems CSA survivors are experiencing, such as PTSD (Kim et al., 2013). People with PTSD are using CAM, such as mind-body practices, with stretching movements and postures combined with deep breathing, such as yoga, Tai-chi, qi-gong and meditation (Libby et al., 2012). A variety of integrative mind-body interventions have recently emerged that are increasingly used in the treatment of PTSD and research has shown that mind-body interventions have a positive impact on quality of life, stress reduction and improvement of health outcomes among individuals with PTSD (Descilo, et al., 2010; Kimbrough et al., 2010).

In 2010, 39% of people with PTSD reported using complementary and alternative medicine (CAM) interventions, such as mind-body practices with various types of stretching movements and postures combined with deep breathing, such as yoga, tai-chi, qi-gong and meditation (Libby et al., 2012). There is evidence that multiple components of mind-body practices show

therapeutic effects to decrease symptoms of PTSD (Staples et al., 2011;Telles et al., 2010). Body-oriented therapy, with massage, body awareness exercises and inner body focusing processes to aid recovery from CSA, indicate significant improvement on all outcomes for psychological well-being, physical well-being and body connection (Price, 2007).

Massage therapy has been widely used for fibromyalgia patients and CSA survivors and been found to be beneficial (Kalichman, 2010). Reflexology can also be helpful to decrease fibromyalgia symptoms; it can affect the symptoms of pain such as in the head, neck and arms (Gunnarsdottir & Peden-McAlpine, 2010). Research results on reflexology indicate positive effects of reflexology in the treatment of pain as well as a significant decrease in fatigue, depression, disability and quality of life for people suffering from Multiple Sclerosis (Hughes et al., 2009). Reflexology can also reduce the biological symptoms of the body in stress and can help the body to relax (Poole et al., 2007).

Not many studies are found on Cranio-sacral therapy (CST) but the therapy is known to decrease somatic complaints such as pain which is a common consequence of CSA. Research results indicate that CST can alleviate migraine symptoms (Arnadottir & Sigurdardottir, 2011). CST was also found to be an effective means for treating lower urinary tract symptoms and improving quality of life in MS patients (Raviv et al., 2009). CST therapy can improve the quality of life of patients with fibromyalgia, reducing their perception of pain and fatigue and improving their night rest and mood, with an increase in physical function. It can also reduce anxiety levels, partially improving the depressive state and must be considered as a complementary therapy within a multidisciplinary approach to patients that also includes pharmaceutical, physiotherapeutic, psychological and social treatment (Matarán-Peñarrocha et al., 2011).

Depression and anxiety are known consequences of CSA and there is growing evidence for using relaxation techniques for their treatment (Jorm et al., 2008). Studies have found yoga-based intervention effective in treating depression (Pilkington et al., 2005). Controlled studies demonstrated that yoga can decrease symptoms of PTSD and anxiety disorder (Descilo et al., 2010). Practicing yoga can also reduce stress and anxiety in people without a psychiatric diagnosis (Granath et al., 2006). Back pain and depression have both been successfully treated with yoga-based interventions in randomized controlled studies by Sherman et al. (2005). Integrative and therapeutic Yoga practice was used for young people recovering from the trauma of sexual

abuse. The program made most of the people feel more energetic, happier, more focused and less nervous and tense (Lilly & Hedlund, 2010). Streeter et al. (2012) proposed that mind-body interventions such as yoga may be associated with reduction of PTSD symptoms.

Writing about a painful experience can result in significant improvement in physical and mental health (Pennebaker, 1997). Writing serves the function of organizing complex emotional experiences and research indicates positive results when people write about their traumatic experience compared to people who write about a non-traumatic experience (Francis & Pennebaker, 1992). People, with a mood disorder participating in expressive writing and positive writing show significant improvements over time in mental health and some physical health outcomes (Baikie et al., 2012). It is suggested that expressive writing can be used as a therapeutic tool for survivors of trauma and in psychiatric settings (Baikie & Wilhelm, 2005). Expressive writing is mentioned as a way of coping with the trauma experience (Morrow et al., 2012).

In regard to CSA cases early symptom recognition and appropriate interventions are important factors in successfully treating or even preventing the development of mental disorders (Lesmana et al., 2015). It is evident that CAM therapies are a rising field of research. However, more research is needed to further understand how they can benefit CSA survivors.

1.6.1.3 The treatment for CSA survivors in Iceland

In the last 20-30 years progress has been made in Iceland regarding increased knowledge and increased availability of services for people who have experienced CSA. However, the services being offered are experienced as limited by Icelandic female CSA survivors (Sigurdardottir & Halldorsdottir, 2013).

The Rape Trauma Service at The University Hospital of Iceland in Reykjavík was opened in 1993 where people suffering sexual violence can seek help from a multiprofessional team (Nesvold et al., 2005). In 1998 the Children's House (Barnahus) was established in Iceland where help and appropriate support is offered to children suffering CSA. It is a child-friendly inter-professional centre, investigating CSA victims in line with the Children Advocacy Centre. The activities are based on a partnership between the State Police, the State Prosecution, the University Hospital and the local Child Protection Services as well as the Government Agency for Child Protection which is responsible for its operation. It was established after

similar houses had been established in the USA (The Children's House in Iceland - Barnahus).

In most countries, there are community-based counselling programs offering support such as Stigamot in Reykjavik (http://www.stigamot.is/), Solstafir in Isafjordur (http://solstafir.is/), Aflid in Akureyri (http://aflidak.is/) and Blatt Afram, which is also a prevention program (http://www.blattafram.is). The Women's Shelter in Reykjavik offers a help to battered women, children and offers support and counselling for victims of rape (http://www.kvennaathvarf.is). Bjarkarhlid in Reykjavik is a Centre for victims of violence and was opened in February 2017. The goal is to provide support and counselling as well as education and discussion of the nature and consequences of violence (http://reykjavik.is/bjarkarhlid).

Survivors of CSA have numerous healthcare needs and therapies should therefore be developed within the healthcare system taking these multiple needs into consideration. Moreover, CSA survivors have often suffered for a long time and the abuse has already negatively affected their lives and health (Sigurdardottir & Halldorsdottir, 2013). Even though conventional pharmacologic and psychotherapeutic interventions have shown efficacy in the treatment of PTSD, residual symptoms and therapeutic efficacy can be a problem (Cukor et al., 2009).

Even though The Rape Trauma Service at The University Hospital of Iceland has been here since 1993, not all rape victims come forward to seek help. According to Darnell et al., (2015) it seems that most victims are not obtaining treatment for their condition, even though acute medical care is well positioned in most countries. There seems to be the same problem within the mental health service, where relatively few rape victims, who need treatment, receive it in the following months after the rape. That is a serious problem since sexual assault increases the risk for psychopathology (Price et al., 2014). The hindrances for CSA survivors to seek help might be within the healthcare system but also in the society. Not all health professionals ask about CSA or psychological trauma and if CSA survivors disclose CSA, the professionals are not always ready to show support or they do not always know where to find appropriate help. Because of the silence surrounding CSA in the society, people are not always ready to disclose and often are faced with prejudice and shame. There is a need for increased knowledge about CSA within the healthcare system and in the society.

1.7 Holistic and person-centred approach to CSA

There are many indications that treatment options for people with a history of CSA need to change and become more holistic. Each health problem needs to be addressed in treatment, and addressing one problem and not another can be insufficient to meet people's needs (Sachs-Ericsson et al., 2009).

There are important interactions between body and mind. As Rothchild (2000) points out, when people experience serious psychological trauma, such as CSA, the limbic system senses whether it is better to fight or flee. If there is not enough time or space, the body senses that death may be imminent, escape is impossible or the traumatic threat is prolonged, the limbic system can simultaneously activate the peripheral nervous system causing a state of freezing or tonic immobility. The freezing responses can also increase the chances of survival. Some people feel a great deal of guilt or shame for freezing or "going dead" and not doing anything to protect themselves or others around them.

Since CSA survivors have complex physical and mental health problems it is important to look at each person with a holistic view and not to concentrate on physical symptoms alone (Kirkengen & Jörgensen, 1993). Holistic approach means treating the whole person by taking into account mind, body and soul, because what breaks down the soul, also breaks down the body, and there is no real distinction between mind and body (Brower, 2006). It is, therefore, necessary to look into complex breakdowns as the consequence of CSA, such as dissociation, broken boundaries, a freezing response, shame and guilt and consequences such as broken trust, being unable to connect, addictions, a broken self-image, self-destructive behaviour, somatic symptoms, emotional problems, mental health problems and complex PTSD (Sigurdardottir & Halldorsdottir, 2013; Levine, 2009).

There are many programs in the Nordic countries for children who are suffering after violence providing psychological, social and health related help. However, no published study was found reporting a team-based program for adults CSA survivors with mixed traditional and complementary and alternative therapy. One unpublished study was found, a final essay in psychology, reporting results from a program for adults CSA survivors in Norway (Betania Malvik, n.d.). Six women participated and all of them experienced increased physical and mental well-being after 10 weeks (Haugen, 2007). Since the health problems being experienced by survivors of CSA are diverse, it is necessary that health care professionals from several disciplines work together as a team to improve the health of these individuals.

1.8 Nurses responsibility regarding CSA

The International Council of Nurses (ICN) has taken a stance that nurses should unite against violence in all the many different forms, but studies indicate that nursing education has not followed the lead (Agrawal & Banerjee, 2010; Bradbury-Jones & Broadhurst, 2015). Centrally issued guidelines are needed on how nurses and other health professionals can identify children who have been sexually abused, since nurses are ideally placed to identify the warning signs and indicators of CSA (Gadda & Taylor, 2015). Nurses need broader theoretical and practical knowledge related to CSA (Pabiś et al., 2011) in order to be more competent in doing the screening and provide care for adult CSA survivors.

Nurses are ideally placed to identify the warning signs and indicators of CSA and it is imperative that they are supported in being better able to identify the early signs of abuse. Nurses characteristically gather the clients' nursing health history and analyse the health history of the individuals they care for (Gadda & Taylor, 2015). Finally, nurses have a huge responsibility in inter-professional collaboration and they also need specialized training to increase their competence at work (Pabiś et al., 2011).

1.9 Summary and rationale

Florence Nightingale believed that people experiencing illness had been negatively affected by the environment and the challenge for nursing was to treat the patient holistically. In many ways she was ahead of her time in her thinking. There are many indications that treatment options for people with a history of CSA need to change and become more holistic in the spirit of Florence Nightingale. People suffering CSA seek help within traditional therapy and complementary and alternative medicine (CAM). CAM, also called integrative mind-body intervention, is not systematically used in the healthcare system. However, it is important to deal with both physical and psychological consequences experienced by the CSA survivors and treat them holistically. A holistic program within the healthcare system needs to be developed since holistic therapies seem to be beneficial for CSA survivors. However, such a program needs to be built on an in-depth knowledge and understanding of CSA consequences from the perspective of CSA survivors.

Research on the lived experience of Icelandic CSA survivors and the consequences for their health and well-being have been largely missing in the literature. Internationally, much is known about the many consequences of CSA for survivors´ health and well-being. However, much more is known

about the consequences for female CSA survivors. Men suffering CSA are often dealing with long-term physical, psychological and social health problems. More knowledge and understanding is needed regarding the consequences of CSA for Icelandic men's health and well-being. More specifically, more qualitative research is needed to get a better understanding of how these consequences really affect the CSA survivors.

When looking at genders, females are more likely to experience CSA than men, and are more likely to experience depressed mood and general anxiety. Men are at higher risk of poor school performance, sexual risk behavior, more extreme use of alcohol and marijuana. Women show higher risk of suicidal ideation and behavior, eating disorder and frequent use of alcohol. However, the gender similarities and differences in the effects of CSA on survivors' health and well-being, needs to be analysed in more depth in order to increase nurses' competence in giving gender appropriate care to CSA survivors. More specifically, qualitative research is needed where men´s and women´s experience of CSA is compared.

Nurses should be able to identify children who have been sexually abused since they are ideally placed to identify the warning signs and indicators of CSA. Nurses, however, need broader theoretical and practical knowledge related to CSA, e.g. regarding genders differences in order to improve their over-all competence regarding caring for adult CSA survivors in their practice

2 Aims

The general aim of this thesis is to increase the knowledge and deepen the understanding of the consequences of CSA, among men, but also regarding gender similarities and differences, in order to contribute to competence of healthcare professionals in providing gender appropriate care to CSA survivors. Also to develop and study the experience of a holistic wellness-program for female CSA survivors and to explore how the healthcare system responded to the needs of a CSA survivor.

The specific aims include:

Study I: To study the consequences of CSA for Icelandic men's health and well-being.

Study II: To analyse gender similarities and differences in the consequences of CSA survivors' health and well-being by comparison of the author's own datasets with Icelandic men and women.

Study III: To study the physical consequences of CSA for an Icelandic woman who has a long trauma history caused by multiple CSA experiences and to explore her experience of the healthcare system.

Study IV: To study the experience of women participating in the Wellness-Program, a person-centred and holistic program for Icelandic female CSA survivors.

3 Materials and methods

This thesis is based on four independent studies. *Study I* was a phenomenological study on Icelandic men's experience of CSA and the consequences for their health and well-being. *Study II* was a comparison of Icelandic men's and women's experiences of CSA and the consequences for their health and well-being. *Study III* was a phenomenological case study of an Icelandic female CSA survivor with a long story of trauma, caused by multiple CSA experiences, and the consequences for her physical health and well-being, as well as her encounters with health professionals. *Study IV* was a phenomenological study on Icelandic women's experience of the Wellness-Program, a ten weeks holistic intervention for female CSA survivors. An overview of the studies is listed in *Table 3.*

Table 3. Overview of the methods used in each study

Study	N	Age	Interviews	Methodology
Study I	Seven Icelandic male CSA survivors	30-45	14 (two with each participant)	Phenomenology
Study II	Seven Icelandic female and seven male CSA survivors	30-65	28 (two with each participant) datasets from study I and another study of the author	Comparison of two phenomenological studies
Study III	One Icelandic female CSA survivor	40	Seven interviews in two years	Phenomenological Case study
Study IV	Ten Icelandic female CSA survivors	22-53	30 (three with each participant); one week before the Wellness-Program and one week and 15 months after the program.	Phenomenology

3.1 Phenomenology

Phenomenology was chosen as the methodological approach in the studies because phenomenology provides the in-depth knowledge and understanding portrayed in the aims. Phenomenology is associated especially with the foundational writings of Edmund Husserl and Martin Heidegger. However, in Spiegelberg´s (1984) analysis of the history of phenomenology Paul Ricoeur (1990) is also to be considered one of the foundational writers on phenomenology.

The phenomenological method is an influential and complex philosophical tradition (Van Manen, 2007). According to Creswell et al. (2007), phenomenology studies human experience to discover underlying aspects of this experience. The aim is not to find cause and effect, but to understand how things are experienced, lived, interpreted, and what people see as significant. Phenomenology focuses on life situations and sees meaning in routine human behaviour. Phenomenology collects experiences from participants and describes what participants have in common as they describe a phenomenon. The emphasis is on people's subjective experiences and interpretations, the ‘lived experience’ of the phenomenon.

By using phenomenology, the researchers do not believe that their data will be contaminated or biased by full participation (Claspell, 1984). Participants are instead invited to become co-researchers (Freire, 1970). That kind of research takes place among persons on equal levels without divisiveness of social or professional stratification (Colaizzi, 1978). According to Anderson (1991) the purpose of phenomenology is to describe the lived experience of people and the documentation of their experience should be done in such a way that it is true to the lives of people´s description. The inquiry aims are oriented to the production of reconstructed understandings from the point of view of the interacting individual. Spiegelberg (1984) has asserted that the common concern of phenomenology is that of giving the phenomena a fuller and fairer hearing than traditional empiricism has accorded them. The researcher must make sense of the data in a meaningful way, along with the research participants. As applies to most studies based on the phenomenological tradition, the studies in this thesis are built 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 (Spiegelberg, 1984).

3.1.1 The Vancouver School of doing phenomenology

Different versions of phenomenology have been developed over time, but they all centre on investigating the essence of human experience (Denscombe, 2010). The version of phenomenology chosen for the studies was the Vancouver School of doing phenomenology (in short The Vancouver School), because it is a very user and student friendly school of doing phenomenology. It is presented in 12 clear steps as well as a cycle of seven abstract thought processes that are repeated in each of the 12 steps of the Vancouver School. Within the Vancouver School, emphasis is placed upon seeing all individuals in their own context, as well as the understanding that each person perceives the world in a unique way and that their perception is moulded by former experience and their own interpretation of that experience. The method is thus person-centred (Halldorsdottir, 2000).

According to Halldorsdottir (2000) the Vancouver School is an interpretation of phenomenological philosophy and is a unique blend of phenomenology (Spiegelberg, 1984), hermeneutics (Ricoeur, 1990) and constructivism (Schwandt, 1994). The Vancouver School involves following belief system of the constructivist and the interpretivist that in order to understand the world of meaning one must interpret it (Schwandt, 1994). According to Mertens (2005) constructivism is about assuming that reality as we know it is socially constructed through the meanings and understandings developed socially and experientially. It assumes that we cannot separate ourselves from what we know (subjectivist). Constructivists generate or inductively develop a theory or pattern of meanings throughout the research process (Creswell, 2007).

Hermeneutics, however, is the theory and methodology of text interpretation. It emerged as a theory of human understanding in the late eighteenth and early nineteenth centuries (Reese, 1980). Modern hermeneutics includes both verbal and nonverbal communication. It sometimes refers to the theories of Paul Ricoeur who advocated interpretive phenomenology (Grondin, 1994). Ricoeur asserts that phenomenology should seek to go beyond a static description of experience towards interpretation. He, thereby, claims that phenomenology and hermeneutics need each other (Ricoeur, 1990).

In the Vancouver School each interview is transcribed. The findings from each interview are constructed into an analytic framework. Then main themes and subthemes are identified. During the data collection and data analysis the data are constantly critically evaluated. The researcher, who collected all

the data in studies I-IV, repeated this procedure for each participant until a holistic understanding of all the participants' experience was constructed. Each of the analytical frameworks and the essential structure of the data analysis are verified with the relevant participant to ensure that the researcher had understood the participant's words correctly. The research process in the Vancouver School involves twelve main steps, and in *Table 4* these steps are delineated as well as how they were followed. The table is based on Halldorsdottir (2000) and used with permission. In *Figure 1* the process of doing phenomenology in the Vancouver School is portrayed. Firstly there is silence, followed by reflection, then there is identification, followed by selection, interpretation, construction and verification.

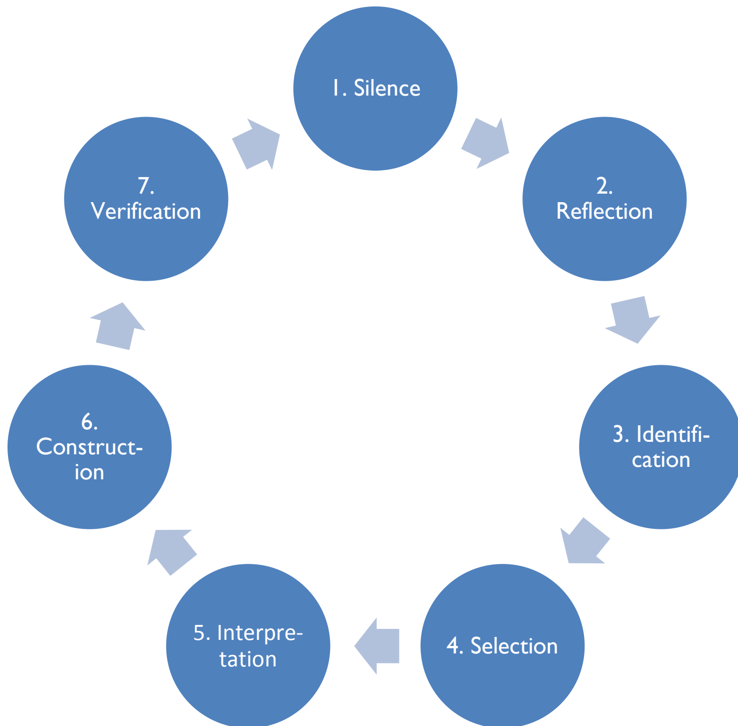

Figure 1. The process of doing phenomenology in the Vancouver School

Modified figure from Halldorsdottir, S. (2000) p. 56, used with permission. This cycle is repeated in each of the 12 steps of the Vancouver School.

Table 4. The 12 basic steps of the research process of the Vancouver School and how they were followed

Steps	Steps in the research process	What was done in the studies
1.	Selecting dialogue partners (*the sample*)	Seven men in study I, seven men and seven women in study II (from datasets), 10 women in study III and one woman in study IV were selected through purposive sampling
2.	Silence (*before entering a dialogue*)	Preconceived ideas were analysed deliberately and put aside as much as possible
3.	Participating in a dialogue (*data collection*)	Two interviews with each participant in study I and II, three interviews with each participant in study III and seven interviews with the woman in study IV. The doctoral candidate conducted all the interviews
4.	Sharpened awareness of words (*data analysis*)	Concurrent data collection and data analysis
5.	Beginning consideration of essences (*coding*)	Trying repeatedly to answer the question: What is the essence of the meaning of what this participant is saying?
6.	Constructing the essential structure of the phenomenon from each case (*construction*)	The main factors in each participant's story are highlighted and the most important factors are constructed into an analytic framework
7.	Verifying each case construction with the relevant participant (*verification*)	All the participants verified their analytical framework
8.	Constructing the essential structure of the phenomenon from all the cases (*final construction*)	To combine all the interviews for each study
9.	Comparing the essential structure of the phenomenon with the data (*meta-synthesis of all the different case constructions*)	All the transcripts were read over again to make sure the important meaning conveyed were included
10.	Identifying the overriding theme which describes the phenomenon (*construction of the main theme*)	Done for each study
11.	Verifying the essential structure with some research participants (*verification*)	The essential structure were presented to and verified by some of the participants in each of the different studies
12.	Writing up the findings (*multi-voiced reconstruction*)	The participants are quoted directly to increase the trustworthiness of the findings and conclusions

3.1.2 Phenomenological case study

The benefits of qualitative case study methodology arising from its emphasis on the uniqueness of each case and the subjective experience of that case (Stake, 1995). A case study allows the examination of complex cases to deepen our understanding of unique phenomena and is a research method involving an up-close, in-depth and detailed examination of a subject of study (Yin 2014). A particular case is examined to provide insight into a certain phenomenon of interest. The case plays a supportive role in facilitating understanding, a case of lived experience (Stake, 1994). Phenomenological approaches are good at surfacing deep issues and making voices heard. The Vancouver school of doing phenomenology is constructed as case study (steps 1-7) which can be called within case analysis, followed by cross-case analysis (steps 8-12) (Halldorsdottir, 2000).

3.2 Participants

In all qualitative studies sample selection has a profound effect on the ultimate quality of the individual study (Kitson et al., 1982). In the present studies the participants were chosen through purposeful sampling. According to Patton (1990) the power of purposeful sampling lies in selecting information-rich cases for study in depth, from which one can learn a great deal about issues and the main purpose of the research in question. The sample is always intentionally selected according to the needs of the study (Glaser, 1992).

In qualitative research the design needs to remain sufficiently open and flexible to permit exploration of whatever the phenomenon under study offers for inquiry (Lincoln & Guba, 1985). In the studies the researcher initially chose to interview those who had experienced CSA, as the studies progressed, the description and interpretation were expanded with more specific information. An informant for Study IV with an atypical experience was sought so that the entire range of experiences and the breadth of CSA might be understood. As a whole, the samples were directed by a desire to include a range of variations of the phenomenon in the study as recommended by Morse (1991).

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

Seven Icelandic men, CSA survivors, aged 30-45, participated in study I. Two interviews were conducted with each participant. The selection criteria of participants included Icelandic men who had been sexually abused as

children; who had received some post-traumatic treatment as adults; and who had good support at the time of the interviews. We advertised for participants at various educational and counselling centres for survivors of sexual abuse and violence such as Stigamot (http://www.stigamot.is) in Reykjavik, Solstafir Vestfjarda (http://www.solstafir.is) in North-West Iceland; Aflid Akureyri (http://www.aflidak.is) in North Iceland; Blatt afram (http://www.blattafram.is), which is the leading grass roots 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 doctoral candidate in the local newspaper and volunteered to participate. Finally, four men came from SASA. They had all endured repeated sexual abuse as children, and some had been victimized by more than one assailant. Variation existed in how well the men remembered the events of the sexual abuse. Some have carried the memory with them all the time while others blocked it completely for some time. All are noncustodial fathers.

Study II: *Consequences of childhood sexual abuse for health and well-being: Gender similarities and differences*

The participants were seven Icelandic female CSA survivors aged 30-65 from datasets of the study of Sigurdardottir and Halldorsdottir (2013) and seven Icelandic male CSA survivors aged 30-45 years old from datasets from study I (paper I). The selection criteria for participants included men and women who had been sexually abused as children. All the research participants had professional support at the time of the interviews.

Study III: *The burden of childhood sexual abuse (CSA) on the body and the silencing effects of the healthcare system: A phenomenological case study with a female CSA survivor*

One woman, aged 40, who had a traumatic history about being sexually abused in childhood, participated in the study. She was chosen through a purposeful sample from a group of 12 women who participated in the Wellness Program. The participant had a history of severe and prolonged abuse from more than one close relative and she felt she did not get adequate support and understanding from the healthcare system and the social system.

Study IV: *Personal resurrection: Female childhood sexual abuse survivors' experience of the Wellness-Program, a holistic intervention*

Twelve Icelandic women participated in the Wellness-Program in the beginning. Two women were unable to finish the program because of mental health problems so they did not participate in the study after the program. Study III is, therefore, based on interviews with 10 women. The women came into the program through the healthcare system, a family unit service and a counselling centre for survivors of sexual abuse and violence. Requirements for participation in the program were to be over 20 years of age and to be a female Icelandic speaking CSA survivor. The women in the program were between 22 and 53 years of age.

3.3 Data collection and analysis

Study I

The research question was: How do Icelandic men experience CSA and what are the consequences for their health and well-being? Questions were then asked, based on how the interview evolved. Each participant was interviewed twice, in all 14 interviews. The interviews were conducted at a location chosen by each participant. The doctoral candidate conducted all the interviews. Data collection was continued until 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 4* these steps are delineated as well as how they were followed.

Study II

The research question was: What are the gender similarities and differences for health and well-being in regard to the consequences of childhood sexual abuse? The datasets involved the study of seven female CSA survivors' experience (Sigurdardottir & Halldorsdottir, 2013) and seven male CSA survivors' experience (Paper I) of the consequences of CSA for their health and well-being. The doctoral candidate conducted all the interviews. Comparative analysis was conducted of 28 in-depth interviews with 14 purposefully chosen participants. Two datasets were used, of two phenomenological studies. The research process in the Vancouver School involves twelve main steps, and in *Table 4* these steps are delineated as well as how they were followed.

Study III

The research questions were: What is the experience of a female CSA survivor of the physical consequences of CSA and what is her experience of the reactions of the healthcare system? This phenomenological study was based on seven interviews over two years with one Icelandic female CSA survivor. Each interview was conducted at a location chosen by the participant. The doctoral candidate conducted all the interviews. The research process in the Vancouver School involves twelve main steps, and in *Table 4* these steps are delineated as well as how they were followed.

Study IV

The research question was: What is the participating women's evaluation of the different therapies in the Wellness-Program and what is their experience of the program's effects on their life, health and well-being? Three phenomenological interviews were conducted with each participant, one week before the Wellness-Program started, one week after the program ended and also 15 months after the program ended. The research participants chose where the interviews were conducted and had professional support at the time of the interviews. The doctoral candidate conducted all the interviews. The research process in the Vancouver School involves twelve main steps, and in *Table 4* these steps are delineated as well as how they were followed.

3.4 Development of the Wellness-Program

The ideas of some kind of a holistic, person-centred program for female CSA survivors came up when the author completed her Master´s thesis, a study on long-term consequences of CSA for female survivors (Sigurdardottir and Halldorsdottir, 2013). The idea was further developed when the doctoral candidate visited a therapy program for CSA survivors at Betania Malvik in Norway (Betania Malvik, n.d.). In Betania Malvik there was a 10-week program for CSA survivors. The professionals working there were psychologists, nurses, physiotherapists, physicians and occupational therapists (Betania Malvik, n.d.). Based on the experience provided by women in our previous study, it was apparently important for them to use Complementary and Alternative Medicine (CAM) along with traditional therapy.

Based on a holistic perspective and because of multifaceted health problems after CSA, healthcare professionals from different professions were recruited. They were nurses, physiotherapists, an occupational therapist, a

psychologist, a social worker, a health consultation therapist and an educational and vocational guide. A psychiatrist and physicians were available for the women if they needed. In the beginning we defined the scope of the service and we used the experience from own research on long-term consequences of CSA for female survivors, where we listened to and observed what worked for them when dealing with the consequences of CSA (Sigurdardottir and Halldorsdottir, 2013). At that time there was no such program in Iceland.

The Wellness-Program lasted ten weeks, five days a week from 10:00 to 14:00. Group therapies were offered all days before lunch for one and a half to two hours a day, as well as Basic Body Awareness once a week, Yoga once a week, psychological group therapy once a week, creation and communication therapy once a week (a kind of Art therapy), and education about the known consequences of CSA for health and well-being once a week, as well as time to talk and be together. Private therapy was offered after lunch where each woman could choose a therapy such as deep relaxation/hypnosis one hour a week, mindfulness-based psychological therapy one hour a week, cranio-sacral therapy one hour a week, reflexology and massage one hour a week. After lunch there was also physical exercise; walking, fibromyalgia exercises and/or exercises in water one hour twice a week. All the women were offered personalized consultation regarding diet and nutrition once a week. They were all encouraged to write a diary every day about their feelings and experiences. After the program the women were offered two weeks of follow-up, where they could come together every day with one professional if they felt they needed it. They could also enter work-training for at least six months and they are being supervised for two years after the program’s completion by the doctoral candidate, with meetings once each month and online when needed.

3.5 Validity and reliability

It is difficult and complex to assess the validity of qualitative research. Some say that validity is primarily a quantitative concept, and therefore not relevant in qualitative research (Altheide & Johnson, 1998; Leininger, 1994), and as such there is no reason to consider the concept or how it relates to qualitative research. Others propose new definitions of validity (Lincoln & Guba, 1985; Rubin & Rubin, 1995; Stenbacka, 2001). However, many, particularly in Europe, have continued to use traditional quantitative terms (e.g. Kvale, 1989, 1996; Morse et al., 2002).

The research process of the Vancouver School has some in-built strategies designed to increase validity and reliability, particularly ‘member checking’ in steps 7 and 11 (see *Table 4*). The ‘researcher triangulation’, where two or more researchers work together, in the studies proved fruitful, especially in steps 10, and 12, where the expertise of two or more professionals was combined. Triangulation is one of the strategies designed to increase validity and reliability in qualitative research. ‘Peer debriefings’, i.e. introducing the studies to colleagues at colloquiums and conferences, and ‘thick description’ were also used as strategies to increase validity. The findings are a construction of the researchers, built on the data. A ‘reflective diary’ was used at all stages of the research process in all the studies, as required in the Vancouver School (Halldorsdottir, 2000).

Each interview in the studies was analysed thoroughly, with emphasis on critical assessment of the quality of the data collection, data analysis and presentation of findings, to enhance the validity of each of the studies. The doctoral candidate, who conducted all the interviews, is experienced in working with CSA survivors and decided to have ample time between interviews so that participants could reflect on the interviews and withdraw from each study if they so wished. None opted to do that.

3.6 Ethics

Since all the studies involved vulnerable individuals, we made every effort to protect them ethically. The four basic principles of biomedical ethics – respect for autonomy, non-maleficence, beneficence and justice –were the ethical ideals followed in all the studies. The studies were explained to the participants in all the different studies to ensure that their rights were safeguarded, for example, confidentiality, and the right to waive (Beauchamp & Childress, 2008).

The studies were introduced to all the participants through an introductory letter and were also explained to them and they all gave their informed consent. Before the first interview commenced, the participants were given an introductory letter in which all the main ethical aspects were addressed. The doctoral candidate also gave an oral presentation of the study before the interview started and the participants signed an informed consent. The letter of introduction and the oral presentation included names of experts who had signed consent to be available for the participants if difficult emotions emerged during the interviews. The doctoral candidate chose a ‘research name’ (pseudonym) for each participant to be used only in that particular

study. Methods of identity protection were stringently followed, among others: only the doctoral candidate knew the identity of the participant; tape recordings were deleted as soon as interviews had been transcribed; pseudonyms were used; and all information that could identify the individuals was removed from the transcripts.

Study I

Ethical permission was obtained from the National Bioethics Committee (VSNb2009100019/03.7), and the study was reported to the Data Protection Authority (S4791/2010).

Study II

Ethical permission was obtained from the National Bioethics Committee (VSNb2009100019/03.7) and (VSNb2005030020/03.7) and the study was reported to the Data Protection Authority (S4791/2010) and (S2478/2005).

Study III

In study III ethical permission was obtained from the National Bioethics Committee (VSNb2011080004/03.7) and the study was reported to the Data Protection Authority (S7663/2016).

Study IV

In study IV ethical clearance was obtained from the National Bioethics Committee (VSNb2012060008/03.07) and the study was reported to the Data Protection Authority (S5826/2012).

4 Results

The main results of the studies based on the thematic analysis were that the consequences of CSA for both men and women were serious for their health and well-being. The Wellness-Program seemed to improve the health and well-being of those attending.

The men experienced the trauma in such a way that they lived in repressed silence which affected them psychologically and physically. They could not talk about their suffering and they thought about taking their own lives; in fact, some of them tried to commit suicide. When comparing men and women the themes showed that both men and women experienced deep and almost unbearable suffering with great psychosocial and physical effects on their lives as children and adults. The consequences were in many ways similar but in other ways different between men and women. The women tended to direct their feelings more inward, they had more physical symptoms and were more likely to seek help from the healthcare system. The men tended to be outward, acting out their feelings through hyperactivity, criminal behaviour, and addiction and they did not seek help. In the case study the woman experienced deep suffering all her life and felt she did not get support or understanding from the healthcare or the social system. Healthcare professionals did not ask her about violence and were not ready to listen, even though she tried to point out the connection between the CSA and her suffering of mind and body.

The Wellness-Program seemed to meet the needs of women suffering from CSA. The women experienced improvement regarding their physical health, mental well-being, personal lives and relation to partners, family and friends improved. They felt empowered, more in control of their lives and developed increased trust towards others and all except one were back to work, school or in further rehabilitation. Before the program they were unable to work or attend school; were on disability allowance; socially isolated and had complex health problems. Earlier they had sought professional help within the healthcare system without getting adequate help.

4.1 The consequences of CSA for men

The men in *study I* experienced deep suffering, almost unbearable. The main themes in the results of the study were; experiencing the trauma, childhood sufferings, adult psychological sufferings, relational and sexual suffering, negative consequences for the relationships with their children and adult

physical and social sufferings.

After the trauma they were suffering with intense fear, emotional disconnection, self-blame, guilt, and shame, as well as feelings of freezing and blackout. They reported coping with their experience by using dissociation and emotional disconnection. They detached themselves from their body, their emotions, the events and themselves to survive. They lived in secrecy, humiliation and shame since such things were not supposed to happen to boys. They could not report it because they were threatened or received payment and they were convinced that nobody would believe them. It was like a “mental prison”.

Their childhood was extremely difficult; they suffered a broken self-image, experienced bullying, had learning disabilities, conducted misdemeanour crimes, were hyperactive and demonstrated risk behaviour, teenage drinking and experienced numbness. Some of them also had physical symptoms, e.g. one had serious digestive problems and faecal incontinence that led to being bullied. They had learning disabilities, such as dyslexia, symptoms of ADHD and other behavioural problems. They committed various crimes such as breaking the law, theft, and driving without a licence and lived by doing things that they knew they were not supposed to do.

The men had strong feelings of rejection, depression, anxiety and suicidal thoughts, emotional numbness, anger and rage when they were growing up. At some time they felt even uncontrollable rage, and felt insane or like another personality. They had feelings of wanting to escape and isolate themselves. They did not seek help until they reached rock bottom. They all had some kind of self-destructive impulse, self-damaging behaviour or suicidal thoughts. Some of them used alcohol and/or illicit drugs to numb themselves and therefore struggled with addiction.

The men have experienced relational and sexual intimacy problems which has caused them deep suffering. They had a heavy secret to hide with a powerful effect on their sexuality. They felt dirty, awful and were unable to trust. They have entered serious relationships unable to be emotionally intimate. When they had their children they experienced symptoms similar to postpartum depression and felt emotionally disconnected from their children. Some of them have been overprotective fathers and some had difficulty touching their children. They faced a great deal of prejudice, e.g. that victims of CSA become abusers, which was one of the main reasons why the men did not want to reveal the violation. They said that their children were one of the main reasons they did not take their own life.

Some of the men suffered various health problems, such as digestive tract maladies, stomach illness, stomach cramps and colon cramps. Other illnesses they suffered include asthma, allergies, chronic infections, epilepsy, diabetes, aches and muscle cramps, back pain and headaches. The health problems create a greater risk of losing a job and consequently being in financial trouble, they numbed themselves with medicine and drugs to find peace.

4.2 The consequences of CSA: Gender similarities and differences

In study II both the men and the women went through deep suffering in all areas of life; they experienced deep emotional pain and emotional dissociation. The main themes of the results were; poor childhood health and lack of well-being, poor adult health and lack of well-being and difficulties in relationships with mates and in relating to their children. All the participants felt shame, guilt and self-accusation and felt they were themselves responsible for the crime of CSA. The men felt also that CSA was not supposed to happen to boys. Of the fourteen participants, none, except one woman, told about the abuse when they were young. The main gender difference was that women described how they tended to direct their feelings inwards, became suppressed, had somatic symptoms and depression, while the men described how they tended to express their feelings outwards, with rage, aggression and anger, breaking the law, and other behavioural problems. The women, to a greater extent, turned to the healthcare system to get help, while the men were more in contact with the legal system and treatment for addiction.

Childhood for both men and women was characterized by harassment and distress; they were bullied and isolated, dealt with learning disabilities and dyslexia. The men described being hyperactive and had difficulty concentrating and sitting still and both genders used self-harming behaviour, were suicidal and tried to take their own lives. All the men and two of the women started using alcohol during adolescence to escape or numb their feelings and the women were more prone to eating disorders than were the men. The men spoke of having been prone to risk taking and experienced physical problems such as myalgia, gastric problems and migraine headaches.

All the women and four of the men had been dealing with complex health problems and had sleeping difficulties. Both men and women used self-destructive behaviour such as alcohol and drug abuse, sexual risk behaviour and considered taking their own lives. The men especially used alcohol and drugs to numb their emotional pain. Both men and women dealt with feelings of rejection, by themselves and others, and the families of some of the men have rejected them after they disclosed the CSA. The men experienced emotional numbness or hypersensitivity and found it difficult to be among people and the women let no-one close to themselves. They had been dealing with anxiety, depression and deep emotional problems at some point in their lives, but some also spoke of having been very active, even hyperactive. The men talked more about overwhelming rage than did the women.

Both men and women have had difficulties relating to and in trusting their mates/partners, children and other people. The men have felt emotionally disconnected after the CSA and they could not talk about it. The women found it hard to be touched and to enjoy sexual intimacy, which had a deep impact on their sexual health and sexual pleasure. Both genders spoke of flashbacks during their sexual life or as a distortion of reality. Men described symptoms similar to postpartum depression and could not trust anyone with their children. They have not been able to set their own boundaries, to be able to defend themselves, and the men sensed great prejudice.

4.3 The consequences of CSA and experience of the healthcare system

The woman in *study III* has been suffering from psychological and physical symptoms all her life. The main themes identified were; the burden of CSA on Anne's body and her experience of the silencing effects of the healthcare system. She has been suffering from anxiety, depression and social anxiety since childhood and heavy postpartum depression after the birth of her children. She used dissociation after the CSA, got flashbacks, nightmares and sleeping problems. She was not connected to herself or her environment, tried to be invisible and to disappear. She felt that CSA at such a young age from such a close relative (father) had harmful consequences for her boundaries, she could not define herself as separate from others and it made her vulnerable to re-victimization.

She had physical symptoms from her teenage years, often became very ill, she felt that her body made clear how she suffered inside, she lost nearly all her sight and hearing for a while, as if she did not want to see or hear. She was a regular patient in hospital because of pain, muscle aches and uterine problems. She often experienced stomach aches, appendicitis, and gastritis and suffered from colon spasms. She had back problems, severe myositis (muscle pain) in all her muscles and has not been able to work since her early thirties. She was diagnosed with fibromyalgia and she also had symptoms of arrhythmia, and a growth on her parathyroid gland; she was diagnosed with parathyroid adenoma and has been overweight since her teens.

She has had chlamydia many times and repeated abdominal infections, also in her ovaries, fallopian tubes and kidneys; she felt that her whole system had broken down. She had repeated urinary tract infections after sex and inflamed fallopian tubes. After the birth of her second child she had repeated urinary tract infections and chronic ovarian cyst infection since she first became sexually active. She was diagnosed with cervical dysplasia and had a cervical conisation. She had two ectopic pregnancies and became very depressed after the second one. She got a horrendous bladder infection with heavy menstrual bleeding and pain. She had a hysterectomy because of fibroids, heavy bleeding (menorrhagia), pain and endometrial hyperplasia. She consulted a cardiologist, had a Holter monitor of her heart. Many examinations were done. She was sent to an endocrinologist who diagnosed her with abnormal growth of the parathyroid gland and she had an operation.

The participant felt that she was exhausted because of repeated visits to doctors and felt she did not get the support and understanding she needed. The healthcare system's solution for her problems has mostly been medication and surgical operations. She experienced rejection and silence from the professionals. She was convinced that the CSA committed by her father at such a young age has had the terrible effects which she has to deal with today. She told her gynaecologist that she was always in such pain because of her womb, especially after sex, and it was because she was damaged in the pelvic area, when she was so small and sensitive but she never got any response. There was only silence. As time goes by she has learned not to leave the body as she used to, to dissociate. She felt the healthcare system had no solution for her except medications and surgical operations. She has been regularly to hospital because of the pain without any explanation. She went to see many specialists, among them urologists, and was constantly getting antibiotics and was on a great deal of medication

for insomnia, pain and inflammation, “eating codeine like candy” Doctors were always willing to write a prescription and she has a lot of prescriptions that she never collected from the pharmacy. She also got antidepressants, pain medicines, Lobac and Diazepam, but it was difficult to get referral to a physiotherapist. She had numerous operations, such as on her ovaries, hysterectomy, parathyroidectomy and appendectomy.

She looked for various ways to deal with her afflictions, by writing, singing, painting, praying, self-help meetings and various religious congregations. She went to rehabilitation programs, including programs for obesity and pain, and tried all kinds of non-traditional therapies.

4.4 The experience of the Wellness-Program

In *study IV* through the Wellness-Program the women’s physical health, mental well-being, personal life and relation to partners, family and friends improved. The main themes of the study were; feeling totally lost, releasing experiences, developing trusting relationships, gaining control, physical and mental health and feeling empowered. They described how they felt totally lost before the program and how the experience of the program was releasing. They also explained how they learned to develop trusting relationships and to gain control and, finally, how their physical and mental health improved and they felt empowered.

When they came into the program they had feelings of being alone, experiencing lack of boundaries, were exhausted, about to give up, having tried everything, feeling lost and socially isolated, without a job and not studying. They were very unhappy and their whole life was negatively affected. They felt it a challenge and stressful to participate in the program and it was important for them to be seen holistically, with body, mind and soul. They learned to work with their personal space, boundaries, go through flashbacks, to get rid of self-accusations, self-blame and guilt. The most rewarding experience, they felt, was the feeling of not being alone in the world.

They felt they gained more self-confidence, serenity, trust in others, positive changes in their relationships with children and mates/partners and slowly learned to enjoy sex life. They felt less fearful, realized their own limits, and it was very important for them to get to know other women in similar situations and to be able to confide in them and trust them. They had to face and deal with co-dependence, food addiction, prescribed medicine addiction, alcoholism and obesity, since they used food, alcohol and drugs to numb

their hurt feelings. Two women had experienced stomach bypass surgery before the program because of obesity and one was previously into alcohol rehabilitation, but she did not quit drinking until she learned to deal with the memories of the violence. They have all been given a great deal of medications through the years; most often it was the only solution offered within the healthcare system. They have been dealing with widespread and complex health-related problems, such as lack of sleep, digestive and uterine problems as well as fibromyalgia. In the program they learned to live with it and experienced positive changes. They felt their mental health improved following the program and their use of medication decreased.

The women experienced great understanding and support from the group of fellow CSA survivors and the therapists. Some lost weight; some went back to work after many years of unemployment. They felt more at peace in their hearts and souls than ever before and the program was like a "physical, psychological and spiritual resurrection". They became revitalized.

4.5 Overall results

The consequences of CSA for both men and women were serious for their health and affected their whole life and well-being. Their suffering was deep and almost unbearable and some felt they had not received adequate support and understanding from healthcare professionals.

The men's experience of the consequences of CSA was characterized by anger, fear and physical and psychological disconnection. They were bullied, had learning difficulties, were hyperactive, turned to crime, alcohol and drug use and have had numerous complex medical problems. Their self-identity and self-image was broken and some had used sex to prove their masculinity. They had difficulty relating to their spouses and children, had gone through divorce and were all non-custodial fathers. They said nothing about the abuse at the time because of fear and their own and perceived societal prejudice. Gender differences were found in the consequences of CSA in that women had a greater tendency to internalize their emotional suffering, which was later observed in complex health problems. The men, however, had a greater tendency to externalize their emotional suffering, observed in various problems and antisocial behaviour. Gender similarities were also found. The phenomenological case study showed that CSA and a long trauma history can have serious and destructive effects on health. The participant in question had severe physical problems such as chronic pain, fibromyalgia, recurring problems in the pelvic area as well as cancer. She

had symptoms of PTSD and felt she had not met adequate understanding and support in the healthcare system and asserted that health professionals need to ask about trauma history and be willing to discuss it.

The women who participated in the Wellness-Program were, in the beginning of the program, socially isolated and had complicated health problems. Their self-esteem was low, they could not work or study and their lack of well-being significantly impacted their families and their own quality of life. Positive results could be seen in all these aspects in the participating women 12 to 15 months after the program. They, all but one, were active in work, study or in further rehabilitation.

5 Discussion

This thesis focuses on phenomenological analysis of CSA and its consequences, as well as the experience of a holistic intervention for CSA survivors. The participants in our studies had all gone through a long period of suffering. The results of these studies show how these CSA survivors have been psychologically and physically broken down. All the participants described how they have been permanently damaged; how their lives have been a continuous struggle; and how their suffering is still deep and in fact almost unbearable. All the participants in our studies had some type of health problems but the healthcare system rarely responded to their needs for support and understanding.

The results of our studies are consistent with other studies which show that CSA can have serious consequences throughout life. Our participants described their suffering from CSA, they had complex psychological, physical and social problem identical to other studies (Chartier et al., 2010; Kirkengen, 2010; Van der Kolk et al., 2007; WHO, 2002). They were dealing with self-accusations, shame, felt they were not recognized by friends, had difficulty with close relationships with friends and family. During times of desperation they had suicidal thoughts and plans about suicide, similar to Easton et al. (2013), Martin et al. (2004) and Ystgaard et al. (2004).

In adulthood participants in our study felt emotional stress, suffering and inner pain, symptoms of depression, anxiety and emotional disconnection which is consistent with studies by Dube et al. (2005). Dube et al. (2005) also found that people suffering after CSA were dealing with shame and self-blame, as the results from our studies. In our studies the participants lived in enormous and chronic stress after the CSA that could have contributed to suppressive effects of the immune system and increased the risk of different diseases. Such experience and the negative emotions after CSA can be a serious threat to health and well-being according to Kiecolt-Glaser et al. (2002).

Even though many different therapies are available for people suffering CSA, especially psychological therapies, they have been limited to addressing only a part of the CSA survivor´s needs. There is growing awareness of the need for holistic therapy, focusing especially on CSA as the main reason for seeking help, but not only the consequences, physical and psychological symptoms. No published study was found with the same focus as the Wellness-Program. Although it is inspired by Betania Malvik, the

Wellness-Program has some unique characteristics, such as the use of Complementary and Alternative therapy. According to WHO, CSA is a widespread and serious global problem, but it is still a hidden problem. People suffering CSA often keep it silent and do not disclose their experience (WHO, 2014).

5.1 The consequences of CSA for male survivors

The men in our study were all victims of repeated CSA from an early age and some of them from more than one offender and they did not disclose the CSA until they were adults. According to Easton (2014) the number of childhood traumas and years until disclosure is a risk factor for serious consequences. Regarding our participants, the symptoms came either immediately after CSA or many years later and developed into complex health problems, such as symptoms of PTSD. This is similar to findings in the study by O'Leary (2009). Our results indicate that CSA can have serious and chronic physical, psychological and social consequences for men´s health and well-being. Their suffering cuts deep, affecting their whole life and the lives of their loved ones. The men in our study experienced psychological trauma after the CSA, they felt enormous fear, went through freeze response and felt separation of body and soul, emotional disconnection, self-blame, shame and guilt and were suffering in silence like in a psychological prison which is similar to the results of Lisak (1994).

In childhood the men went through great pain, had low self-esteem, were bullied, had problems with learning and difficulty at school, as in a study by Lisak (1994). They also had behaviour problems that made them vulnerable towards other kinds of violation and crimes. According to Dhaliwal et al. (1996) men suffering CSA are often dealing with aggression and antisocial behaviour. During adolescence our participants' emotional pain increased, they had self-destructive behaviour with more suicidal thoughts and plans which is in accordance with Edgard & Ormstad (2000). They found that 33.3% of boys suffering CSA exhibited self-destructive behaviour and attempted suicide but only 5.1% of the boys without a history of CSA. They knew some boys that had taken their own lives after such experience when no help was in sight which is in accordance with Easton et al. (2013) and Dube et al. (2005).

The men felt great mental distress in their adulthood, emotional numbness or hypervigilance. They had low self-esteem and low confidence. They experienced rage at some point and even enormous rage which has been

found to be connected to factors related to mental distress after CSA (Easton, 2014). In a study by O′Leary (2009) men suffering CSA were ten times more likely than men without CSA history to be diagnosed with mental disorders and to avoid thoughts and feelings. Our participants were suffering from anxiety and depression. Their thoughts of suicide increased in their adulthood which is consistent with a study by Easton et al. (2013). They started to use alcohol, drugs and even strong prescribed painkillers to numb themselves emotionally. Some of our participants increased the use of alcohol, drugs and prescribed medicine to numb their feelings and they felt that the anxiety and depression increased as in a study by Lisak (1994) and Alaggia & Millington (2008). Because of CSA men often use work and alcohol in order to escape (Alaggia & Millington, 2008).

After the CSA, the men used dissociation to cope and they have been having trouble reconnecting again and connecting to others which is similar to findings in other studies (Manzano-Mojica et al., 2012; Nijenhuis & van der Hart, 2013). All of the men in our study had difficulty connecting to their partners and children. They had difficulty trusting their mates and had sexual problems, experienced rejection and isolation. According to Whiffen et al. (2000), male CSA survivors are more likely to take on much responsibility in relationships and have trouble being faithful. The men in our study often had flashbacks in their love life, which affected their relationship with their partners. This is similar to the findings of other studies (Andersen, 2008, Dhaliwal et al., 1996, O'Leary et al., 2015; Schraufnagel et al., 2010). The men in our study experienced great responsibility towards their children and the relationship was like their lifeline. The positive emotions to their children were important for them but they also were dealing with difficulties touching them. Although no studies were found specially addressing this, these are well known PTDS symptoms when the individual is re-experiencing the event when something reminds him of it (APA, 2013). More focus has been on women and the importance of connection between mothers and their children.

The men were dealing with multiple and complex health problems in their adulthood but studies among men have been more focused on psychological problems than physical health problems. It is therefore difficult to know if their physical health problems are similar or different to other studies. However, physical symptoms reported after all kinds of violence have been digestive diseases, respiratory diseases, genital diseases and infertility, widespread and chronic pain, tremors and numbness (WHO, 2002). This is similar to what men in our study described. One man talked about incontinence, such

as in a study by Morrow et al. (1997). Other symptoms men are dealing with after CSA are sexually transmitted diseases, AIDS (Holmes & Slap, 1998) and genital-urinary problems (Coxell et al., 2000). These problems were not reported by our participants.

No man in our study talked about the CSA with anyone when they were young. It was not until they reached adulthood that they were able to talk about it, at that time they were forced to talk because they reached the bottom in their life. They did not tell because they experienced great prejudice and ignorance from others and in society in general, such as it was not possible to rape men and that women were never the perpetrators (O'Leary & Barber, 2008). They also sensed that men suffering CSA would become perpetrators. Prejudice from others felt almost unbearable to them. According to Kia-Keating et al. (2005) and O'Leary et al. (2015) the prejudice might also be because CSA can sometimes affect their male gender identity and create confusion regarding their sexuality.

The men in our study also saw it as a weakness to talk about the CSA experience, because they were men and men are not supposed to cry. They talked about having to prove themselves as men all the time, to hide the suffering and be strong. That was their way to hide their suffering and shame, to put on a mask. This is consistent with studies from O'Leary & Barber (2008) and Gagnier & Collin-Vezina (2016), that male image can prevent men from seeking help when something is wrong. Meanwhile they try to escape their pain and memories with all kinds of addiction, such as drug, alcohol and work. This is also consistent with a study by Alaggia & Millington (2008). This is why it is important to raise awareness about myths about masculinity for men suffering CSA in society as mentioned by KiaKeating et al. (2005) and Easton et al. (2013).

Even though the men in our study did not talk about the CSA until they reached the bottom, they said that the best thing they could do was to talk about the experience of CSA. It was a great relief, to lose the "mask" and find freedom. The study by Galdas et al. (2005) also revealed that men wait to seek help until they reach the bottom. To reach the bottom might be like some kind of a turning point according to Easton et al. (2013) when they get a better understanding of the CSA and their view of the experience changes. The CSA experience was so serious that they were close to taking their own lives, until they could speak out. O'Leary & Barber (2008) found that boys were less likely than girls to disclose CSA at the time it happened and it also took the men longer to discuss their CSA. This silence can have a negative

impact on health and well-being and it can really affect their life since talking to someone or writing about traumatic experiences can have strong positive effects, decrease stress, strengthen the immune system and contribute to healing after a trauma according to Chaudoir & Fisher (2010) and Pennebaker et al. (1998). Disclosure is therefore very important for well-being and recovery. It is, however, a complex process for male victims of CSA to disclose their experience which can be because of masculine norms and stereotypes in the society (Gagnier & Collin-Vézina, 2016). Even though awareness is increasing regarding boy´s disclosure about CSA there still are few studies available.

In adulthood the men tried to get professional help but did not receive adequate treatment. It is known that men are less likely than women to seek help because of CSA. Men in general do not seem to seek help and access resources for healing (Easton et al., 2014; O'Leary & Barber, 2008).The men's silence results in them not seeking help within the healthcare system and it seems that they experienced that they were sometimes not considered victims.

5.2 The consequences of CSA, gender similarities and differences

The results of our study regarding gender similarities and differences indicate that women seem to direct their feelings more inwards, were more introvert. Their emotional pain was characterized by more feelings of despair. The men seem to direct their feelings more outwards, were dealing with behavioural problems, addiction, drug abuse and criminal behaviour and said it was a call for help, since they could not talk about their experience. The men in our study displayed behavioural problems after CSA such as criminal behaviour. There were, for example, no gender differences regarding theft and violent behaviour in a study by Gault-Sherman et al. (2009).

No qualitative study on gender similarities and differences was found in the literature. It is complicated to compare men and women since there has been more focus on women than men suffering CSA (Dube et al., 2005). In the literature there has also been more focus on physical health of women than men and some studies indicate that CSA has more serious consequences for women than men (Ullman & Filipas, 2005) while others show no difference (Finkelhor, 1984).

In our comparative study both men and women described negative emotions right after the CSA experience such as from psychological trauma. According to Fagundes et al. (2013) and Kiecolt-Glaser et al. (2002) such trauma can be dangerous for health and can increase the likelihood of developing a disease because of immune dysregulation right after such trauma or later in life. Known consequences after psychological trauma such as CSA is PTSD (Boney-McCoy & Finkelhor,1996; Brown et al. 2015; Cantón-Cortés & Cantón, 2010; Hooper & Warwick, 2006; Spitzer et al., 2009) and the men and women in our studies described symptoms of PTSD even though they had not received the diagnosis. The participants in our study also experienced dissociative symptoms, such as leaving their own body which is one of the diagnostic criteria for PTSD (van der Hart et al., 2008). Since our participants had not gone through a formal diagnosis of PTSD it is not possible to say if men or women were at higher risk, but according to Olff et al. (2007) and Tolin & Foa (2006) women are more likely than men to meet diagnostic criteria for PTSD and one of the possible reasons for that is based on gender-specific factors (Olff et al., 2007).

Both genders talked about psychological problems after CSA ever since childhood which is similar to other studies (Garnefski & Arends, 1998; Hussey et al., 2006; Dube et al., 2005; Ullman & Filipas, 2005). Symptoms of depression and anxiety were described in our study by both genders which is consistent with other studies (Godbout et al., 2006; WHO, 2002). Other studies indicate that there may be specific gender differences such as in the study by Gault-Sherman et al. (2009) among Icelandic students, females suffering CSA were more likely to experience depression and anxiety symptoms. Also according to Ullman & Filipas (2005) female students had more distress and self-blame than male students. According to Aakvaaga et al. (2016) women were dealing with more shame and guilt after CSA than men. In our study gender differences regarding these specific factors were not identified. Both genders in our study exhibited self-destructive and self-harming behaviour and that is comparable to results found in other studies (Edgardh & Ormstad, 2000; Martin et al., 2004). In a study by Edgardh & Ormstad (2000) suicide attempts or other self-harm behaviour was similar for male and female students after CSA. According to several studies self-injurious and suicidal behaviour was more common among girls than boys (Asgeirsdottir et al., 2011; Chandy et al., 1996; Wan et al., 2016).

In our study men had different ways than women to numb their emotional pain. The women used food to a greater extent and were dealing with eating disorder and obestiy, similar to other findings (Chartier et al., 2009; Duncan

et al., 2015; Jia et al., 2006; Power & Pinto Pereira, 2015; Wilson 2009). They also used more prescribed medicine to numb themselves. Even though men did that also, they seemed to use more alcohol, drugs, work and showed more criminal behaviour. That is consistent with the findings of Asgeirsdottir et al. (2011) where men reported earlier onset of alcohol dependence and more legal problems after CSA and Chandy et al. (1996) where men had more substance abuse as well as higher risk of more extreme use of alcohol and marijuana.

Physical symptoms were more commonly described among the women than the men in our study. All the women had different complex physical symptoms since childhood and four of the men. These findings agree with another study that showed that early life stressors have lasting immunological consequences which can lead to physical problems (Fagundes et al., 2013). According to Afifi et al. (2016) there were significant gender differences regarding back problems, COPD (Chronic Obstructive Pulmonary Disorder), cancer and chronic fatigue syndrome, where it was slightly more common in women, similar to the results of our studies. Studies on physical symptoms after CSA have been lacking especially regarding men.

None of our participants got help or support because of the CSA when they were young. One woman tried to talk about her experience but nobody listened, so she kept quiet. During their adolescence there was difference between the men and women regarding disclosure. All the women looked for help because of their health problems and talked about the CSA but the men did not disclose their experience until they were forced to when they reached the bottom. Disclosure of CSA is important for recovery in order to prevent further health problems and men are less likely to disclose CSA than females. It seems to be more difficult for men to talk about the experience (O´Leary & Barber, 2008; Ullman & Filipas, 2005). Gender differences in regard to disclosure are therefore an important focus for healthcare professionals (Priebe & Svedin, 2008).

5.3 Mind, body, soul and the healthcare system

All participants in our studies had experienced repeated trauma in relation to CSA. It seems that they experienced some kind of a breakdown of the mind, body and soul in their experiences of repeated trauma without any trauma assistance or counselling. They did not tell their stories when it happened in their childhood, except for one woman that tried to talk about it but no one paid attention to that. They started to talk about the CSA in their adulthood

but no one seemed to listen to them and they were suffering in silence. Studies on emotion and disclosure indicate that expression of emotions and feelings has positive effects on the immune system (Pennebaker et al., 2001). The results in our studies indicate some similarities with studies in the field of psychoneuroimmunology showing that every human being is a total whole, body and soul (Fagundes et al. 2012). There is no real distinction between soul and body because the brain, the nervous-, endocrine-, and immune systems are constantly communicating (Brower 2006). That explains why individuals suffering from trauma after CSA are at greater risk of serious illnesses, both physical and psychosocial (Kendall-Tackett, 2009).

The participant in the phenomenological case study repressed her memories from the abuse, felt frozen and numb and she began having flashbacks and nightmares, similar to the results of the studies by Hermann (1992) and Levine (2010). When she became sexually active she disconnected herself from her body and her feelings because of the pain inside. As other studies show, dissociation is a factor that people use when experiencing trauma and it is a defence mechanism that protects people from suffering (Nijenhuis & van der Hart, 2013; Rothschild, 2000). Dissociation during traumatic experience has been connected to a long-term coping strategy (Manzano-Mojica et al. 2012) and it can increase the risk of developing PTSD (van der Hart et al. 2008). As described above she had several symptoms of PTSD, but was not diagnosed with the disorder until in her thirties which is common after CSA (Brown et al. 2015; Cantón-Cortés & Cantón 2010; Spitzer et al. 2009).

In her childhood she began to have feelings or symptoms of anxiety, phobia and depression without knowing what was wrong with her, since she could not talk about her feelings or her experience. In her teenage years the symptoms increased, still at that time she did not connect her problems to her CSA experience. She also had sleep disturbance, in childhood she slept too much and fell asleep everywhere, but later she had difficulty sleeping. All these symptoms are common among CSA survivors (Monteiro et al., 2015; Sudbrack et al., 2015; Thoresen et al., 2015; Wilson & Scarpa, 2015). In adulthood she suffered from heavy postpartum depression after the birth of her children. It was not until she had her first child that she realized that her emotional problems since childhood could be because of her CSA.

She suffered from multiple physical health problems. She was dealing with all kinds of problems in her pelvic area, which is similar to other studies (Beck et al. 2009) and she suffered from interstitial cystitis/painful bladder

syndrome like in the study by Seith & Teichman (2008). She had widespread pain since her childhood like other studies have demonstrated (Nelson et al., 2012). She was diagnosed with fibromyalgia, and has not been able to work since her early thirties because of related symptoms. She had symptoms of arrhythmia and was diagnosed with parathyroid adenoma. These findings support the findings of other studies (Dube et al., 2009; Talbot et al., 2009; Wegman & Stetler, 2009; Wilson 2009).

As the above description of our case shows she has been dealing with both psychological and physical problems. She felt that the consequences of the psychological trauma after CSA, started with psychological breakdown, breakdown of the soul and mind; broken self-image, anxiety and depression. She felt that the breakdown of her soul and mind affected her physical health, with breakdown of her body, with all kinds of physical symptoms. Mind, body and soul are connected and can affect each other. She connected her physical problems to her inner fear that she could not talk about. What makes the soul weak also makes the body weak as pointed out by Kirkengen & Jörgensen (1993), Rotchild (2000) and Levine (2010).

Moreover, CSA survivors often develop medically unexplained symptoms (Nelson et al, 2012) which goes hand in hand with significantly higher healthcare use such as greater number of visits to emergency department, hospital outpatient, pharmacy, primary care and specialized care (Bonomi et al. 2008; Chartier et al. 2007; Leserman & Drossman 2007). She has been a regular patient in hospital, comparable to other studies (Montgomery et al., 2015; Yampolsky et al., 2010). Our participant went regularly to see doctors and had all kinds of tests, operations, and medical treatments, but there was seemingly no medical explanation for all her symptoms as Nelson et al. (2012) have also found. Her experience is similar to findings in other studies where people are at greater risk of somatic symptoms (Anda et al., 2006; Nelson et al., 2012) have worse health-related quality of life and more healthcare utilization (Leserman & Drossman, 2007). She felt she did not get the support or understanding she needed within the healthcare system and felt disappointed.

Despite the fact that studies have identified CSA victims as a particularly vulnerable group only few attempts have been made to study their lived experience of the health consequences of CSA. No phenomenological case study was found where the life course of a CSA survivor was examined. It can deepen the knowledge and understanding how the body reacts to CSA and breaks it down, as well as the soul and spirit. It can also increase the

knowledge how suffering it can be for a person when the healthcare system is silent.

5.4 The Wellness-Program – A holistic intervention

The most common therapy for people suffering CSA is psychological therapy and has been from the beginning of the definition and discussion about consequences of CSA. Recently, more focus has been on the need of treating the physical symptoms along with the psychological symptoms in a more holistic way (van der Kolk, 2014). People suffering CSA have also been seeking help in CAM therapy since the traditional therapy does not seem to meet all their needs (Sigurdardottir & Halldorsdottir, 2009).

The women who participated in the Wellness-Program had all previously sought professional help within the healthcare system without getting adequate help. Their lives, before the program, were characterized by feeling totally lost. The main results of the Wellness-Program indicate that all the participating women experienced increased physical, mental and social well-being, even to the extent of resulting in a "personal resurrection". The therapy focused on them individually and offered multiple ways to deal with symptoms, which is consistent with a previous finding from Finestone et al. (2000). They learned to live with the pain; experienced positive changes regarding sleep and rest; learned to live with fibromyalgia; dealt with mental health problems; and dealt with anxiety and social phobia. Furthermore, their personal life and relationships to family and friends improved. The women emphasized how they experienced the different therapies working well together; for them the holistic nature of the Wellness-Program was the most important factor. The women shared how important it was for them that both physical and psychological factors were dealt with in the program, similar to the findings in a Norwegian study (Haugen, 2007). An earlier study showed that it is important to focus not only on treating symptoms, such as depression, but also the prior experience of CSA (Strine et al., 2012).

All the women shared the power of being understood by the group and the therapists and "not being alone" in their world of suffering. The importance of belonging to a group of women with a similar experience was clear in the study. It created a sense of belonging, a sense of trust and a sense of solidarity. It helped them to learn to speak to each other about their experience, learn to support and heal each other by developing a sense of positive camaraderie, as found in another study (Kammer et al., 2010). The women felt they gained self-confidence, serenity and trust in others. They felt

greatly supported.

5.5 Violence prevention

People with a history of child abuse and other traumatic experiences are at great risk of health related physical and psychological symptoms, which can be a great public health problem (Clark et al., 2009). Because of the serious consequences it is very important to prevent CSA. Preventing all forms of violence is a public health priority (Krug et al., 2002). All nations in the world have been encouraged by WHO (2002) to strengthen and increase prevention of violence and to include it into their educational, social and law systems as well as their healthcare systems. It is important to start prevention early and try in all possible ways to decrease neglect and violence against children (Stoltenborgh et al., 2011).

It has been emphasized to increase education and training of pregnant mothers and of parents after birth, also to create educational and training programmes for parents in their upbringing role (WHO, 2002) and to provide this training for them. Mendelson et al. (2015) proposed that CSA prevention efforts should target parents of young children. The results of research by Godbout et al. (2014) indicate that, compared to other groups, CSA survivors with supportive parents report less anxious attachment, psychological symptoms, and dyadic maladjustment; perceived parental support thus serves as a protective factor among those exposed to CSA.

Nurses have a great responsibility for protecting children, even nurses who do not work directly with children (Taylor & Bradbury-Jones, 2015). It is also important that school nurses are aware of the significance of the problem of child maltreatment and the effects it can have on children as they mature into early adulthood (Beard, 2014). A study by Rossiter et al. (2015) demonstrated high rates of childhood trauma amongst adults attending a general adult mental health service and they recommend the use of a standardized questionnaire for the assessment of childhood trauma when taking a comprehensive mental health history. Because of the serious consequences of CSA it is very important to use all measures to prevent it. Not only the individual, but the family and society as a whole, is left shouldering the results of the negative consequences of CSA.

Nurses are in a great position to work towards CSA prevention and there should be more focus on that in nursing education programs. School nurses are encouraged to teach school-based childhood sexual abuse prevention programs. Nurses in the healthcare system can use similar programs to work

in the field of prevention, such as with pregnant mothers and their husbands where prevention strategy for CSA involves educational programs delivered to children in the school environment (Fryda & Hulme, 2015).

5.6 Strengths and limitations

The major strength of this thesis is the number of interviews which the data analysis is based on, altogether 65 interviews, which increases the trustworthiness of the findings and deepens the understanding of the phenomena being studied. Moreover, the qualitative approach deepened the understanding of the serious and widespread consequences of CSA. It has also contributed more knowledge of the serious consequences for men's health and well-being and the similarities and differences between Icelandic men and women. The studies also add important knowledge about the physical symptoms suffered as a result of CSA. Furthermore, they provide information about the healthcare system and health professionals who did not seem to listen. Within the healthcare system it might not be enough to have a holistic therapy, it might also be important to have holistic approach in diagnosing people when they seek help in the beginning. It is important to integrate the whole healthcare system holistically to be able to meet each person with enough care and to ask about the experience of violence.

The thesis also provides additional knowledge about what kind of support is needed for people suffering CSA. Furthermore, very few qualitative studies have focused on the consequences of CSA for health and well-being and very few doctoral theses in nursing have focused on this important subject. The uniqueness of the Wellness-Program is that women suffering CSA came to the program primarily because of their CSA experience, not because they had physical or psychological symptoms. Also, the program has a holistic approach with traditional therapy and CAM used together.

This thesis adds valuable knowledge and understanding about the holistic and person-centred intervention provided in the Wellness-Program and the importance of looking holistically at each person´s, physical and psychosocial needs. Since many CSA survivors do not meet support within the healthcare system it is important to integrate such a program into the healthcare system, where their holistic needs are met with support and understanding. The doctoral candidate had daily encounters with female CSA survivors for ten weeks in the Wellness-Program which greatly increased her depth of knowledge and understanding of the experience of the women.

The studies have several limitations. It is not the aim of the present studies to generalize the findings to all Icelandic men and women who have suffered CSA, but to deepen the understanding of the consequences of CSA for the health and well-being of each CSA survivor. In the Wellness-Program none of the women's family members joined the program or participated in the research project. It would probably add to the strengths of the program if a family therapist involved the family in future development of the program. Also, the findings of the Wellness-Program do not provide information about the effectiveness of different treatments and the differences between individual and group therapies. The evidence of the program's effects cannot be proved using this kind of study design alone.

In the Vancouver-school of phenomenology people are chosen from the purpose of the study. There might be people with an experience of CSA with different problems mentioned here, for example people in jail or in a drug addiction therapy. They might have different experiences and that is why the purpose is not to generalize the results to all people suffering CSA and because of small sample size.

5.7 Implications

It seems that qualitative studies focusing on men's experiences of CSA are uncommon. In Iceland this was the first qualitative study conducted. The findings show that the participants seem to face prejudices in the healthcare system and in society. A holistic and person-centred program for men suffering CSA is needed since they seem to delay disclosure of the trauma and they are a silent suffering group without much help. Delayed disclosure of trauma caused by CSA makes the consequences continue to worsen or cause deeper suffering, reduces quality of life and has a snowball effect on many aspects of the victims´ health into adulthood, e.g. impaired mental health (Bicanic et al., 2015). Since all the men in our study were dealing with suicidal thoughts and attempts and according to other studies there is increased risk of suicide attempts in adulthood after CSA, there is a need for healthcare professionals to have a systematic assessment of possible consequences and suicidal risk factors of CSA survivors (Easton et al., 2013; Pérez-Fuentes et al., 2013).

The Wellness-Program has only been developed for female CSA survivors and it is important to develop a special program for men, since in many ways there are different consequences of CSA for men and women even if some consequences are the same. Men seem to be more external in

behaviour, so it is important to focus on this aspect and masculine norms when developing a program for them. To improve mental health services for men with histories of CSA, mental health practitioners should incorporate sexual abuse and adherence to masculine norms into assessment and treatment planning similar to what Easton et al. (2013) proposed.

Healthcare professionals need broader theoretical and practical knowledge related to violence similar to what Wilson (2010) has already pointed out. It is important that they have the necessary knowledge about the serious consequences of CSA and the possible gender differences. They need to recognize that the origin of the problem of CSA lies with the perpetrators and not the children who become the victims. Healthcare professionals need to be aware that boys and men with certain health problems could also be suffering the consequences of CSA, just as women, and thus have a history of severe psychological trauma that may never have been treated. The findings of this thesis indicate that healthcare professionals should ask clients about CSA even if it is not the presenting problem. This has also been pointed out by Alaggia and Millington (2008) and Kia-Keating et al. (2010).

Our participants had never been asked by healthcare professionals about abuse or violence. Many of them pointed out that the first step is to ask, or being able to just put an x somewhere to say that you have suffered violence. Even though people may not check it at first or even the second time, there should at least be the possibility of indicating what had happened. Therefore, it is important to screen for abuse of women and men within healthcare and offer CSA survivors the immediate support that they might need similar to what Svavarsdottir and Orlygsdottir (2008) and Kalmakis and Chandler (2014) have suggested. Rossiter et al. (2015) claimed that there is a need for the use of a standardized questionnaire for the assessment of CSA and that it should be considered when performing a comprehensive mental health history. This idea is supported by the present thesis.

The findings of the present thesis indicate that individuals who have suffered CSA are vulnerable and need to be met with far more understanding of their problems and that they are in need for a supportive attitude. Each person who is a recipient of healthcare should be seen as a whole person, with body, mind and soul, and should be respected for what he or she stands for. It is important that people with such serious health problems are assessed by nurses and other healthcare professionals with a holistic perspective.

It has been pointed out that there is a need for evidence based guidelines on how nurses and other healthcare professionals can identify children who have been sexually abused (Gadda & Taylor, 2015). Also, healthcare professionals need better knowledge, theoretical and practical, related to CSA (Pabiś et al. 2011) in order to be able to carry out this assessment. Furthermore, there are indications that their over-all competence regarding caring for adult CSA survivors in their practice needs to be increased. Hopefully, what this thesis will bring forth is that nurses become more aware of the need for prevention early in life but are also aware of the consequences of CSA and will actively listen and be better able to recognize and detect CSA survivors' need for appropriate care.

5.8 Future studies

There are few qualitative studies which have focused on men or treatment for men suffering CSA. Earlier studies, primarily quantitative, focus mainly on psychological and social consequences. There is a need for more qualitative studies on men suffering CSA, especially to explore men´s physical health and well-being in more detail than has been done in previous studies. There is also a need for further studies regarding their connections and relationship to their children, since that seems to be a preventive factor in their life. There is also a need for studies on holistic therapy for men, similar to the Wellness program. No Icelandic study on men suffering CSA was found in the literature.

It is not known for certain if one gender is more vulnerable to CSA than another or how CSA affects girls and boys differently. There are primarily quantitative studies on gender similarities and difference regarding CSA in the literature and no qualitative study was found regarding that issue. A qualitative approach to study gender differences is likely to provide more in-depth information about this issue.

It is important to continue developing holistic programs for CSA survivors such as the Wellness-Program and to study the short-term as well as the long-term effects of such an intervention. Helping women and men rehabilitate after trauma like CSA and increase their well-being can make a difference for CSA survivors, their families and the communities in which they live. The program has contributed considerably by generally improving the well-being of the women who have attended. However, further development and assessment of the program is recommended before making it available within the healthcare system. This can be done, for example, by using a

randomized controlled trial where program participants are compared to a comparable group. The benefits of better understanding and having more detailed knowledge of the experience of CSA survivors can contribute to development of adequate training for healthcare practitioners as well as contributing to improved treatment which can reduce the burden of the CSA survivors as well as the healthcare system.

The need for further studies includes, but is not limited to the following studies:

- To study disclosure of males suffering CSA.
- To study the relationship between men suffering CSA and their children.
- To study physical problems after CSA, especially in male survivors.
- To continue studies on gender similarities and diffrences, especially with a qualitative focus.
- Continue to develop holistic interventions, such as the Wellness-Program for women.
- To develop a holistic intervention especially for male CSA survivors and to study long-term effects of such a program - for example, five and ten years later.
- To study the effectiveness of the Wellness-programs by using a randomized control trial where program participants are compared with a comparable group.
- To study how the healthcare system provides care for CSA survivors in Iceland.
- To study what is taught about CSA survivors and their healthcare needs in the education and training programs of healthcare professionals.

6 Conclusions

This thesis presents an increased understanding of the serious, multifaceted and complex consequences of CSA for health and well-being, especially regarding men and by comparing gender similarities and differences. This knowledge is valuable for nurses and other healthcare professionals so that they are better able to meet the needs of CSA survivors in a gender appropriate way. Also to encourage people to get help as soon as possible and to encourage people to disclose as soon as they can. It also provides a better understanding of the importance of holistic and person-centred therapy for women suffering CSA, as offered in the Wellness-Program. One importance of this thesis is highlighting the danger of silence among men. They experienced great suffering in part by living in repressed silence which was demonstrated though behavioral problems and life threatening behavior.

The women in our studies have suffered more from physical problems such as chronic pain, fibromyalgia, uterus problems, obesity and cancer while the men suffered more from psychological, behavioural, antisocial and problems with alcohol and illicit drugs. There is a need for increased education within the healthcare system and in society about these consequences since people are often not connecting, they don´t seem to know about the possible consequences after CSA. It is important to keep in mind that it is difficult to compare men and women since studies on women suffering CSA are more common than among men and few are of a qualitative nature.

Neither the men nor the women survivors studied had been able to find adequate help within the healthcare system and that is why nurses and other healthcare professionals need to be aware of the fact that CSA survivors may have unexplained health problems. Based on the experience, especially from our phenomenological case study and those who participated in the Wellness-Program, the women were in great need for more support from the system.

The Wellness-Program considerably improved health and well-being of the women attending it. However, it is recommended to assess the program before it will be available in the healthcare system. There is also a need for such a program for men, since it seems that men have different needs regarding recovery than women. If people are not getting adequate support within the healthcare system after CSA it is very important to make changes.

CSA can have serious, widespread and long-term consequences. There seems to be a lack of knowledge in how to support CSA survivors. It is therefore important to ask CSA survivors about violence, listen with attention, provide information about possible consequences and show understanding and support.

7 References

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Original publications

Paper I

Paper II

Paper III

Paper IV

Appendix A: