kritisk etnografi – Swedish Journal of Anthropology
VOL. 3, NO. 2
URN:NBN:SE:UU:DIVA-432445

Developing Gender and Culture Sensitive Conversations with Sexually Abused Men by Blending Ethnography and Psychotherapy

Charlotte C. Petersson | Senior Lecturer in Social Work, Malmö University

ABSTRACT Child sexual abuse can have long-term impact on the survivors' emotional, physical, and psychological wellbeing. Male survivors of sexual abuse are less likely to disclose and report their experience compared to females because of aspects related to male gender socialisation. Feelings of shame, guilt or confusion about sexual or masculine identity silence sexually abused men. They report difficulties in both seeking and receiving formal support services tailored to their specific needs. This article presents collaborative work performed by an anthropologist and a psychotherapist during therapy of adult men with a history of sexual abuse. By using certain tools of ethnography in narrative therapy, we developed culture- and gender-sensitive conversations with sexually abused male clients from diverse backgrounds. A case study is provided to demonstrate how we worked with the various stages and practices of ethnography and narrative therapy, focusing on how sexually abused men were invited to unpack the discourses of masculinity that influenced their ways of understanding themselves and their traumatic past. The article offers an example of how anthropological knowledge and methods can be applied in contexts of clinical social work and demonstrates the way that postmodernist and constructive therapies combined with the tools of ethnography can generate constructive conversations about gender for sexually abused men.

Key words: child sexual abuse, masculinities, psychotherapy, narrative therapy, ethnography, applied anthropology

Introduction

Anthropology and psychotherapy have a long historical and, sometimes, controversial relationship. Readers may be familiar with Malinowski's (1927) examination of the psychoanalytical model based on data from the Trobriand Islands, which caused him to argue that the Oedipal complex was not universal. The critical stance of anthropology is still challenging to the field of psychotherapy, which adheres to medical science. Anthropologists have critiqued psychotherapy's exclusive focus on the inner world of bounded individuals because it excludes social and cultural aspects of illness (Kleinman 1988; Martin 2019).

When reviewing the clinical and research literature on the psychological consequences of sexual assault, we can see how the body is depicted as a biological fact, reacting to a certain stimulus in the environment. In general, therapy with individuals who have experienced physical or sexual violence focuses on identifying and treating the effects of such experiences rather than addressing how individuals respond to violence (Wade 1997). Cultural constructions of gender affect the way men understand, process, articulate and

Contact: Charlotte Petersson ✉ charlotte.c.petersson@mau.se

respond to experience of sexual abuse (Kia-Keating et al. 2005). Studies within the field of psychotherapy have identified a need to adopt a gender and culture sensitive approach in practice. Understanding how boys and men from diverse backgrounds experience masculinity and supporting them in reflecting on the multiple and shifting masculine norms that shape and constrain them have been addressed as particularly important in order to engage men in psychological treatment more effectively (Pederson and Vogel 2007). Cultural competency has become a popular term within psychotherapy but deconstructing concepts like gender and culture in the therapeutic encounter is still uncommon (Davies 2019).

Anthropologists have stressed the importance of crossing disciplinary boundaries in order to carry out applied anthropology and expand the field and its knowledge base (Hastrup 2017; Podjed et al. 2016). As an anthropologist, I have spent the last 15 years of my professional life working with sexual health and violence by combining the fields of medical anthropology and social work. I have moved between conducting anthropological research within academia and realising social work in the community by supporting abused women, children and men in shelters and consulting rooms. However, it was not until 2019 that my knowledge and skills as an anthropologist were purposefully applied in a clinical setting when I had the opportunity to conduct collaborative work with a group of psychotherapists. I first met the psychotherapists at a conference where I presented the findings of my research concerning sexual violence against males (Petersson and Plantin 2019). My presentation outlined how notions of masculinity may facilitate or impede the process of recovery for male survivors of sexual abuse and invited psychotherapists to discuss the ways in which they can address masculinity as part of their services to help boys and men recognise that such ideas can interface with their experience of sexual abuse. Narrative therapy (White and Epston 1990), which critically examines wider social discourses and encourages clients to reauthor their life stories, was mentioned at the conference as an alternative therapeutic approach for male survivors of sexual abuse (O'Leary 1998). The psychotherapists contacted me a few months after the conference and asked if I could provide them with consultative support in their process of developing gender and culture sensitive practices in their work with sexually abused boys and men from diverse backgrounds.

This article draws on my experience as an anthropologist and the collaborative work I performed with a psychotherapist during therapy of adult men with a history of sexual abuse in childhood or adolescence. The purpose of our collaboration was to cultivate practices that support sexually abused men in reframing their life stories by embracing and reinforcing the use of certain aspects of ethnography within narrative therapy. The article provides a window on the process by which the two disciplines join, blending the methodological tools of ethnography and psychotherapy in order to develop a more culture- and gender-sensitive therapeutic approach to sexually abused males. It offers an example of how anthropological knowledge, perspectives and methods can be applied in contexts of clinical social work.

Male Child Sexual Abuse and Masculinity

Research on child sexual abuse (CSA) has grown significantly during the last decades, including in particular the victimisation of females. Male CSA has received less attention and is less common, but awareness is growing. CSA is known to have adverse, long-lasting health outcomes for both genders (Cutajar et al. 2010; Easton et al. 2011). Research that

studies the long-term impact of CSA on males shows increased risk for adverse mental health outcomes, including anxiety, depression, post-traumatic stress disorder (PTSD), hostility, loneliness, isolation, and alcohol and substance abuse (Alaggia and Millington 2008; Boroughs et al. 2015; Easton and Kong 2017). Sexually abused males also report struggling with sexual dysfunction, sexual risk behaviours (Mattera et al. 2018) and troubled thoughts about fatherhood (Price-Robertson 2012). In Sweden, studies seeking to establish prevalence rates and health outcomes show that male CSA is widespread and significantly affects the men's wellbeing (NCK 2014; Swahnberg et al. 2012).

Much research on male CSA has emphasised the impact of dominant masculine constructions (e.g., Alaggia and Millington 2008; Easton and Kong 2017; O'Leary 1998). Male sexual abuse stands in contrast to conventional masculine attributes such as being dominant, physically strong, able to defend oneself, emotionally in control, sexually assertive and heterosexual. Such norms can make sexually abused boys/men feel that they did something to trigger the assault or did not do enough to ward it off. They often report confusion regarding their sexual identity and worry about being labelled as homosexual (if the perpetrator was a man) or weak (if the perpetrator was a woman) (Corbett 2016). In some cases, the experience of CSA undermines the men's own sense of power and control, which may result in accentuated masculine attributions, including the display of aggression, violence, hyperactivity, hypersexuality and overcontrolling behaviour (Lisak 1994). Strong feelings of shame and self-blame hinder men from disclosing their history of CSA. Males are much less likely to report their experience of sexual abuse and seek psychotherapeutic help than female victims (O'Leary and Barber 2008.). Those men who turn to professional support services face a number of obstacles. Many rape crisis centres refuse services to sexually abused men and some offer counselling that is insensitive to the assaulted men's specific needs (Corbett 2016).

Masculinities are not fixed but involve practices that can be remade (Connell 1995). In Sweden, a context that has been strongly anchored in unique gender equality policies aimed at producing equal conditions for men and women both at work and in family life, men relate to transforming masculinities (Plantin 2015). The term "emergent masculinities" has been applied within the field of medical anthropology to capture new forms of embodied masculinities that emerge in relation to processes of social change (Inhorn and Wentzell 2011: 802). Men act out masculinities differently and respond differently to major events in their personal lives, including bodily changes such as aging, illness, traumatic experiences and medical treatment. Research shows how men with experience of CSA can move away from an identity formed by the trauma (Andersen 2008; O'Leary 1998). To understand, accept and recover from the abuse, men may renegotiate their masculine identity by adopting multiple and alternative forms of masculinities (Kia-Keating et al. 2005; Petersson and Plantin 2019). Research suggests that this group of men can be supported by therapy that helps them to deconstruct the gender system that affects their ways of understanding sexual abuse. In fact, research on the overrepresentation of male survivors of CSA in mental health populations found that those men who were able to reinterpret and reframe their experience of abuse were also associated with more positive health outcomes (O'Leary and Gould 2010).

Integrating Gender and Culture in Psychotherapy

As noted in the introduction, anthropologists have a long interest in the intersection of culture and psychology. Well-known anthropological literature draws on a combination of ethnography and psychotherapy (Crapanzano 1980) and psychoanalytical perspectives have been applied to analyse ethnographic data (Schwartz et al. 1992). Psychotherapists have in general been more reserved when it comes to adopting anthropological knowledge. Notions of power, gender and cultural difference did not enter psychotherapy until the end of the 1980s. At that time, anthropologists like Kleinman (1988: 131) argued that a therapeutic explanatory system must provide a "symbolic bridge" between people's experiences and the socio-cultural context. Since then, mental distress has gradually been associated with gender and cultural expectations, including the social position and power of the individual. Feminist therapy has critiqued stereotypical gender ideas and sexist assumptions within traditional forms of therapy and demonstrated how gender biases are reproduced in therapeutic relationships (Seem and Clark 2006). To engage men more effectively in psychological treatment, addressing their experiences of masculinity and how this may be related to their presented problems has become increasingly important within psychotherapy (Addis and Mahalik 2003; Berger et al. 2013). Nowadays, cultural competency, which includes masculinity, is an important skill in psychotherapy and clinical competencies have been developed for psychotherapists working with men (Liu 2005). The American Psychological Association (APA) established practice guidelines to enhance gender- and culture-sensitive psychological practice with boys and men from diverse backgrounds (APA 2018). According to the guidelines, these practices are applicable to any psychotherapeutic approach across various professions, such as nursing, social work, counselling, school counselling and psychiatry.

Within medical anthropology, the cultural competency model has been questioned because it assumes that culture resides inside of practitioners and clients (Kleinman and Benson 2006). Culture, in the mind of psychotherapists, refers to the identity of individuals or to a certain ethnicity (Martin 2019). Thus, culture and gender may easily be represented in stereotypic terms and clients are assumed to have culturally-rooted responses and reactions that may clash with those of others. Often psychotherapy frames cultural competency as the counsellors' capacity to negotiate the cultural differences that exist between counsellor and client (Martin 2019). Models that place emphasis on concepts such as "structural vulnerability" (Quesada et al. 2011) and "structural competency" (Hansen et al. 2018) have been employed in clinical settings to overcome problems of the cultural approach, reduce inequalities and enhance health outcomes. Kleinman and Benson (2006), however, suggest that clinicians should be trained in ethnography rather than cultural competency. Ethnography is useful for investigating the relationship between individuals and sociocultural contexts because it places emphasis on what people do, their engagement with others and their lived experience of illness. From an ethnographic perspective, culture is a process that cannot be separated from political, economic, religious, psychological and physiological circumstances. Cultural processes may differ not only between members of different social groups but also between individuals within the same social group. Variables such as age, gender, class, ethnicity, religion, disability and sexuality affect experience. Ethnographic techniques can help psychotherapists to understand illness and distress the way that their clients understand, feel and respond to it (Kleinman and Benson 2006).

Ethnography and Narrative Therapy

While the work of an ethnographer and a psychotherapist are different in many aspects, certain similarities exist. Anthropology and psychotherapy (in particular psychoanalysis) are both involved in studying lives over time while trying to remain as close as possible to people's experiences. By relying on participant observation, listening and interpretation, both try to understand the significance of meaning. The similarities between ethnography and psychotherapy open opportunities for anthropologists and psychotherapists to learn from each other. In the collaborative work upon which this article is based, I supported the psychotherapists in adopting certain ethnographic techniques that narrative therapy draws upon. Before identifying these techniques, a brief summary of narrative therapy is needed.

Narrative therapy, with its origin in family therapy, was developed by social workers Michael White and David Epston (White and Epston 1990). This approach is influenced by anthropologists like Bateson (1972), Geertz (1973), Turner (1969), Bruner (1986) and Myerhoff (1986). Rooted in postmodern philosophy and social constructionism, narrative therapy takes specifically into account Foucault's (1973) ideas concerning discourse and power and is based on the idea that dominant discourses in a given context shape individual constructions of identity and truth claims. Traditional therapies, situated within positivism or liberal humanism, depict problems such as depression, anxiety or abuse, as individual pathologies associated with specific biological or characterological circumstances. In contrast, White and Epson (1990) argue that people live storied lives and that stories constitute us. The counsellor should therefore pay attention to the stories that people create to make sense of their world (White 2007). Narratives both describe and shape people's lives and reflect the meanings that they make of their lived experience. The way that clients tell their narratives is connected to their identity. Narrative therapists are particularly interested in the way that discourses surrounding gender, culture, ethnicity, class and sexuality shape and influence people's understanding of themselves and their lives. When a dominant narrative does not sufficiently represent lived experience, the individual may suffer from problematic behaviour or distress (Brown and Augusta-Scott 2007; White 2007). Narrative therapists consider problems as separate from the individual, and the role of the therapist is to assess the problem rather than the person's biology or disorder – a process that is called externalisation. The therapist must distinguish between the effects of what the clients find to be problematic and their preferred ways of being and acting in their world (White and Epston 1990).

To develop gender- and culture-sensitive conversations with sexually abused men in our collaboration, we focused on three aspects of ethnography. The first concerns ethnographic enquiry. The way that narrative therapists ask questions of their clients is similar to ethnography. White and Epston (1990) were influenced by Geertz, who emphasised the importance of approaching culture from the native's point of view. Like ethnographers, narrative therapists take the stance of a curious interviewer. We adopted person-centered interviews, which combine both informant and respondent techniques of interviewing (Levy and Hollan 2000). By moving back and forth between questions that focus on the client's understanding of the external context, and questions that require intimate and personal responses, the interactions, conflicts, coherence and transformations between the private and the sociocultural context can be unpacked. In narrative therapy, a sexually abused male client may present internalised descriptions of himself as personal problems, but in therapeutic conversations these personal problems can be related to dominant constructions

of masculinity (O'Leary 1998). Meanings that are made of male sexual abuse are influenced by cultural understandings of gender and power. By externalising hegemonic discourses on masculinity and discussing the way they may shape, influence, constrain and disempower men's lives, the client reaches an understanding of how these discourses work and becomes able to question them.

The job of a narrative therapist is to help the client reach new and more useful understandings of his place in social contexts and relationships. This leads us to the second area of emphasis that our collaborative work developed upon, namely the role of collectives for social change or change in relationships. According to narrative therapy, identities are formed in relationships with others. Such relationship thinking is well established in anthropology and Bateson's work on cybernetics is developed from this tradition. During narrative therapy, the client is invited to reflect on or step into alternative ways of thinking or being and develop preferred stories of the self (White 2007). An outsider witness may be invited to the therapy sessions, whose participation, feedback and personal responses to the conversations in the therapy room will expand and enrich the client's story by giving it multiple meanings (White 2007). This outsider witness can be another therapist or professional, people with inside knowledge, family members or friends of the client. This technique is inspired by the work of Myerhoff (1986), who saw similar ceremonies arranged in an isolated Jewish community in Venice, California, in order to deal with experiences of invisibility and marginality. In narrative therapy, this technique helps clients to present themselves in preferred ways and to regain strength, agency, power and voice.

The third aspect of ethnography in our collaborative work concerned positionality in the therapeutic alliance. In traditional models of psychotherapy, such as psychoanalysis, the therapist tends to take the role of an expert. Psychoanalytical tools involve close observation of the relationship that develops between the psychoanalyst and the client, resulting in a power imbalance between them. In classical ethnography, little attention was paid to the researcher's position vis-à-vis the people s/he studied, but in the 1990s the field of autoethnography began to develop (Reed-Danahay 1997; Tedlock 1991). Autoethnography problematises ethnographic knowledge by discussing dichotomies such as insider/outsider, familiar/unfamiliar and objective observer/subjective participant; it represents a reflexive and collaborative approach in which both ethnographer and interlocutor are seen as embodied subjects whose relationship needs to be explored.

Our collaborative work was informed by these insights. Whereas some therapists have tried to resolve issues of power imbalance by adopting a neutral and not-knowing position and letting the client be the expert in the therapeutic encounter (see Brown and Augusta-Scott 2007), adopting a neutral stance with clients who are dealing with experiences of sexual abuse may have serious consequences. We chose instead to acknowledge and be clear about our position and work from the premise that therapist and client are both embodied subjects with knowledge, agency, and power (ibid.). The clients were aware of the expertise of both the therapist and the anthropologist regarding sexual abuse. As professionals, we were going to help clients to deconstruct and re-author oppressive stories, including the relations of power that constitute them (White and Epston 1990).

In Sweden, the adoption of narrative therapy in practice is limited and mainly situated with family therapy. Yet extensive research supports the use of narrative therapy, which has been employed with good results on clients who suffer from depression (Vromans

and Schweitzer 2011), eating disorders (Weber et al. 2006), schizophrenia (White 1987) and who have experienced physical or sexual violence (Brown and Augusta-Scott 2007; Lee 2017; O'Leary 1998). A growing interest in narrative therapy is found among psychotherapists who work in marginalised and indigenous communities where people have been traumatised by war, genocide and violence (e.g., Denborough et al. 2008; Kangaslampi et al. 2015; Mitchell 2006). However, using the narrative approach in acute situations and when the client's safety is threatened has been questioned. According to Miller (2012), the narrative approach to therapy should be introduced first when the immediate crisis has passed. White and Epston (1990) argue that experiences such as violence and abuse should never be externalised in narrative therapy. It is the attitudes and beliefs that underpin the violence that should be externalised, including the strategies that maintain the abuse, such as the secrecy and isolation.

The Anthropological Assignment and Clinical Setting

The collaborative work presented here occurred during four months of clinical participation in 2019. The professionals at the clinic were all female psychologists or social workers with additional training in cognitive, psychodynamic and family therapies. The clinic, which is a small private psychotherapy practice, specialises in treating emotional and psychological trauma, including experiences of violence and sexual assault. It provides individual, couples and group therapy and arranges self-help recovery groups. The clients are of different ages and have various social and cultural backgrounds. Sexually abused male clients typically arrive for treatment of difficulties such as anxiety, hyperactivity, hypersexuality, hostility, identity crisis, sexual dysfunctions, PTSD and self-harming behaviour. The male clients' first visit to the clinic generally takes place several years after the sexual abuse was experienced. The majority of male clients are of Swedish origin, but clients with culturally diverse backgrounds have increased slightly over the years, which was one reason why the clinicians sought an anthropologist to support them.

By cultivating narrative practices and placing emphasis on ethnography, the psychotherapists at the clinic wanted to develop a gender- and culture-sensitive approach to counselling. Inspired by family therapy training techniques, which include working in a team that observes the therapy sessions by being present in the therapy room or via a telephone or video link, my role was to assist, observe and supervise the psychotherapist during our work. By discussing with me each counselling session after it had finished, the psychotherapist would receive methodological support and feedback. Because of the traumatic and sensitive character of the clients' experiences, we decided that I should be present in the therapy room rather than via a screen. The psychotherapist had the main responsibility for the conversations held during therapy. I was expected to assist the therapist in ethnographic enquiry, clients' engagement with others, and shared reflections on positionality. In fact, developing self-awareness of the knowledge, biases, norms and values that we would bring with us into the therapy room as two female middle-aged professionals started before the therapy sessions. We shared the stance that adverse mental health outcomes of sexually abused men may be linked to specific masculine perceptions and attitudes. Further, we did not prescribe a specific male role for the clients to adopt. Men "do gender" by combining various forms of masculinity, both conventional norms and new cultural influences that, for example, place emphasis on emotional expressiveness, caring, love, reciprocity and gender equality.

The psychotherapist identified clients for whom the adoption of a narrative approach would be suitable. The clients were informed about the purpose of our collaborative work and then asked if they wanted to participate. Client anonymity and confidentiality were promised. The clients who approved were asked how they felt about sharing their sensitive and painful experiences with two female professionals. All stated that they preferred working with female therapists as they felt more comfortable in talking about issues of sexual abuse with women.

In the following pages, I present a case study to demonstrate how we worked with the various stages and practices of narrative therapy and ethnography, focusing on how the psychotherapist and I invited sexually abused men to unpack the discourses of masculinity that influenced their ways of understanding themselves and their traumatic past. The case illustrates our work with a specific client, who is called Omed here. Omed is an 18-year-old man from Afghanistan, who migrated to Sweden in 2014 as an undocumented and unaccompanied minor. As an orphan, Omed had spent many years of his childhood at a military base in Afghanistan where he had been exposed to significant forms of trauma, including both physical and sexual violence. Omed had attended therapy previously at other clinics. Language barriers made therapy difficult initially but Omed's wellbeing had improved during his first years in Sweden. When Omed started high school, he began to experience increasing difficulties with social anxiety, isolation and substance abuse. At the time of the narrative therapy, Omed, fluent in Swedish, explained that he was looking for an alternative therapeutic approach. He attended seven narrative therapy sessions, which varied in length between 60-75 minutes.

The following description highlights some of the events of Omed's life while others have been removed or changed to preserve his anonymity. As a result, some material is lost. Details about Omed's experience of sexual violence have been excluded as the publication of intimate and sensitive information may have consequences that are difficult to foresee. Omed read the case illustration before publication to ensure that he could not be identified and gave permission to publish the case study.

Case Study

During the first session, the therapist and I encouraged Omed to tell us about his cultural background and life circumstances. Omed disclosed that he had been kidnapped as a young boy and was raped and sold to a warlord. For several years he had to dress up in women's clothing and dance in front of groups of men who abused him sexually afterwards, a phenomenon that is called *bacha bazi* in Afghanistan. After being hospitalised for severe physical injuries, he managed to flee from Afghanistan in 2013. Together with a few other boys, he made his way to Sweden by selling sex. In Sweden, he suffered from PTSD, insomnia, anxiety and had difficulties with establishing bonds of trust and close attachments. Despite this, he was doing well in school and had made new friends, mainly other Afghan boys. Omed revealed that he had not disclosed his experience of CSA to any of his friends because of feelings of shame. He told us that he was extremely worried that his close friends or people at school would find out about his history of CSA and prostitution, and label him as gay. Omed explained that it was important for him to have Afghan friends in Sweden, mentioning aspects such as language, food, traditions and a sense of belonging to a community. Despite this, Omed recounted that he could not be himself among his Afghan

friends in a cultural sense. He described that he found most of them to be tough, insensitive, sexist and shallow – attributes that he felt that he had to adopt in order to gain respect. By contrast, Omed described himself as a highly sensitive and emotional person.

The psychotherapist started Omed's second session by asking him what he regarded to be the core of his problem today and how he would define or label that problem. Omed said that "weakness" was his problem. He explained that if he could be tougher and not so emotional and sensitive, he would have less problems. Using an externalising conversation, the therapist asked Omed how this notion of being weak was influencing his everyday life. Omed disclosed that he was always feeling weak, anxious, fearful and unmanly. Omed was concerned that perhaps the experience of CSA had made him gay because he had continued having sex with men even after he had managed to flee from the military base. I asked Omed about how notions of being weak affected his relationship with family and friends in Sweden. Omed revealed that he had tried to be tougher, extroverted and more powerful and charismatic, like his friends, but this felt wrong. While being tough and strong made him behave in a socially approved manner, he found it difficult to identify with such attributes. Instead, his problems with anxiety increased and he began to avoid social interaction. This deprived him of interpersonal attachments and disconnected him from his cultural background. Even if he had many friends, he explained that he felt lonely, isolated and unwell.

During the following therapy session, we started to link Omed's ideas of being weak to past contexts. I asked curious and person-centred questions, such as how it could be that Omed viewed himself as weak and from where he thought that such notions came. Omed disclosed how he, in the absence of women in Afghan war camps, had been forced to do female duties, both domestic chores and sexual activities. Our curious questions made it easy for him to explain gender roles in Afghanistan from his point of view. He said that being a young boy meant that gender roles, sometimes and by certain men, could be stretched. As a child without the protection of parents or other relatives, he was transformed into a woman. Omed said he lived in constant fear in Afghanistan. Like other boys in the same situation, he used drugs to cope with the abuse and the fear. Omed told us that his feelings of being weak had actually increased in Sweden. He explained that while male aggression and violence were normalised in Afghanistan, professionals at the migration agency, health units and social services in Sweden were shocked by his life story and tended to pity him. Professionals treated him like a damaged and fragile person. Omed said, "It makes me feel small, like a child, as if I never grew up". Omed told us that he would like to be a father someday and have a family of his own. At the same time, he worried about being too weak and sensitive. Perhaps he would not be able to protect and support his children in a good way.

I asked Omed if he could think of any situation where he had not felt weak in Sweden. Omed mentioned his recent work as an intern at a school. With pride, he explained how he had prevented fights from breaking out when groups of boys had ended up in disputes with one another. The children respected him for his calm and diplomatic skills. Perhaps he would be a good teacher someday. As Omed continued telling us narratives about situations where he did not feel weak, hidden accounts of courage and resistance came to surface. He realised that his feelings of weakness were not a consequence of deficiency within himself. He began to separate himself from what he found to be problematic. This allowed him to take a position against the effects of CSA.

During our fourth and fifth sessions, the conversations thickened, and we began to unmask the many expectations that men are up against in various contexts. Omed revealed that he, in Sweden, often felt pressured to have updated knowledge about technology, cars, sex and sports, which were topics that he did not have any real interests in. In fact, Omed felt sickened by what he described as an exaggerated interest in sex among his friends. He said that such conversations made him feel disconnected from what he believes in and finds important, such as respect, security, interdependence and empathy. The psychotherapist and I introduced discussions on different forms of manhood and the idea that masculinities are socially and historically constructed. I gave several examples of this, including how notions of fatherhood have changed in Sweden over time. Omed could easily relate to the cultural differences of fatherhood in Sweden and Afghanistan and told us his perspectives on differences and similarities. He could reflect that he had certain ideas of gender based on experience from past contexts and that he had encountered a different gender order and gender practices in Sweden. Omed gradually realised that he had practiced certain forms of masculinity and that these norms and practices were incongruent with his lived experience of sexual abuse. Male sexual abuse contradicts many of the expectations about men's ways of being and acting. Victimisation resulted in feelings such as shame, self-blame, powerlessness and weakness. Omed understood that he had experienced extremely insecure conditions during his childhood in Afghanistan with serious threats and challenges to his life. His lived experience made him develop a certain sensitivity and empathy.

In light of these new realisations, Omed began to reinterpret the idea of himself as a weak person. He understood that he could take up other practices than those of his friends and still be a man. During our last two sessions, he started to redefine his notion of being weak as a strength. Our discussions made him realise that there were other ways of living life, and that male gender could include new cultural influences that, for example, placed emphasis on emotional expressiveness, caring, love and reciprocity. In this way, Omed was able to start reauthoring the dominant story of weakness. Together we identified individuals who supported his preferred ways of being, and social situations where he did not feel that he had to pretend to be someone else. Outsider witnesses enabled Omed to receive social recognition, which made him gain confidence and agency. He could renegotiate his masculine identity.

The Contribution of Ethnography

The experience of CSA leaves survivors forever changed, and the journey from such trauma to rebuilding one's life is complex. The case study shows how Omed's internalised and problematic stories were deconstructed and reconstructed in the process of narrative therapy. I now scrutinise more closely the role that ethnography played in this process, and reflect on how ethnography can contribute to the development of a therapeutic approach that is sensitive to gender and culture in conversations with sexually abused males.

Initially, the collaborative work was challenged by the medical gaze (Foucault 1973) of the psychotherapist, who was focused on providing the clients with a diagnosis and the correct treatment. When people's identities are labelled by diagnoses or when they are described as victims associated with certain attributes such as being weak, powerless, helpless and vulnerable, they may experience marginalisation. Omed's previous encounters with professionals in Sweden had resulted in increased feelings of being weak and damaged. More generally, I noticed that the clients told the therapist a few fairly "thin" or undetailed stories

about their life experiences. The meanings that people create from such thin narratives are often incomplete and do not include reflections on how they would like to live their life (Combs and Freedman 2012). The contribution of ethnography in the narrative therapy process was, then, to elicit thick descriptions (Geertz 1973) from the clients, i.e., detailed, rich and meaningful life stories. We invited Omed to tell us narratives that were not only a part of his problematic story line but included other life events as well and their significance. These thicker life stories offered different meanings and possibilities than the story of being weak and abused. Omed told us about situations where he did not feel weak and revealed stories of courage and resistance. Simply engaging clients in rich storytelling does not solve what they find to be problematic, but encouraging the development of alternative stories may help clients find other perspectives and ways of responding to what they find problematic (Combs and Freedman 2012). During our conversations with Omed, he embraced life stories that were of importance to him and that could not be associated with what he found to be the problem. He told us about his work with children at the school where he was a trainee, resulting in reflections about perhaps becoming a teacher someday. Inspired by the work of Bateson (1979), White (2007) argued that the meaning we attach to an experience is often made with reference to other experiences. It is in the light of contrasting experiences that meaning is created. Thus, a story about a problem is often told in contrast to something that is preferred or desired, like Omed's ambivalent feelings about fatherhood.

The psychotherapist found it difficult to contextualise the problems that the clients expressed and include the social, cultural and political aspects of illness. She admitted that the cultural competency model made her think that clients with a certain ethnic background need to be approached and treated accordingly. By using an ethnographic approach and considering culture from the client's point of view, Omed became the one who told us about how he experienced gender, culture and ethnicity in various settings. We used curious and person-centred interview questions that focused on a combination of the client's understanding of the external context and his own experiences or responses (Levy and Hollan 2000). By this, we were able to expose various gender discourses and power differentials that supported the problem addressed by Omed. The process of externalising problems, such as anger, hopelessness or weakness, separated the person from the problem. Helping clients to locate such problems in discourses reduces their self-blaming attitudes and makes it easier for them to make changes in their lives. It is easier for clients to respond to a problem that is located outside of him/herself rather than changing their biology/disorder and/or adjusting to a life with mental health difficulties. During our conversations in the therapy room, Omed was able to locate the responsibility for the abuse, including the consequences or effects he was suffering from, with the abusers in Afghanistan. Omed understood that CSA does not happen because the child is weak. It is a crime committed by adults whose actions take place within a context of children's powerlessness and vulnerability. Omed realised that his understanding of CSA and his ways of responding to those experiences could be located in contexts of shifting masculine constructions.

The ethnographic shift in the therapy room generated the development of local, personal and contextualised knowledge. We worked from the stance that all the members of the therapeutic encounter were embodied and positioned subjects who actively engaged in deconstructing and co-authoring the clients' stories and identities. As two female professionals who supported sexually abused male clients to deconstruct and re-author oppressive stories, we could not adopt a neutral or passive stance. Inspired by the autoethnographic approach,

we used personal reflections as a strategy to understand and analyse our positionality in the therapy room. By focusing on the clients' engagement with others, including the processes and patterns that constitute social contexts, we could, as embodied subjects, help the clients to see that their stories contained both knowledge and power. The stories were both socially constraining and involved social agency (Brown and Agusta-Scott 2007). As outsider witnesses who listened, retold and acknowledged the preferred stories and identities of the clients, we helped to give the stories multiple meanings and new perspectives. The psychotherapist and I noted a significant shift in the power dynamics that took place both in and outside of the therapy room, as a result of which our clients gradually improved their position during therapy. They were able to make choices in their life to overcome feelings of marginalisation and isolation. In this sense, narrative therapy fosters agency and makes it possible for the clients to oppose patterns of marginality and injustice (Combs and Freedman 2012). In a conversation with Omed more than six months after the narrative therapy had finished, he told me that our curious questions and our openness and interest in his past experiences made him look at himself and his life in a different light. He felt that he was not approached as a patient with severe mental health issues. He said that he felt that he could express himself freely without experiencing discrimination or shame, which basically had been the core of his problems.

Conclusion

Research has shown that men who have experienced CSA are less likely to be well-served in therapeutic and clinical encounters. Yet professional responses can be of crucial importance for those who need to renegotiate and reformulate their identities, including male sufferers from CSA. The focus of this article has been to reflect on how ethnography can facilitate to the adoption and practice of narrative therapy. My intention is not to suggest that narrative therapy is the only suitable and effective therapeutic approach for sexually abused males. Men with a history of CSA have unique needs. Clinical practitioners must take into account the limitations of this approach, including its shortcomings as a treatment for acute and complex symptoms and PTSD.

By describing how aspects of ethnography contributed to a specific therapeutic collaboration, I hope to generate insights that others might find useful for further elaboration. Recognising gender and culture as central principles in organising individuals' social lives, and situating individual experience of illness and distress in the larger socio-political-cultural context in which it takes place, was an approach that psychotherapists, their clients, and I found productive. Postmodernist and constructive therapies combined with the tools of ethnography can generate good conversations about gender for men who have experienced isolation and marginalisation and want to overcome feelings such as shame, guilt and self-hate.

References

Addis, M. and J. Mahalik. 2003. Men, Masculinity, and the Contexts of Help Seeking. *American Psychologist* 58(1): 5–14.

Alaggia, R. and G. Millington. 2008. Male Childhood Sexual Abuse: A phenomenology of Betrayal. *Clinical Social Work Journal* 36: 265-275.

Andersen, T. H. 2008. Men Dealing with Memories of Childhood Sexual Abuse: Conditions and Possibilities of 'Positive Deviance'. *Journal of Social Work Practice* 22(1): 51–65.

APA. 2018. *APA Guidelines for Psychological Practice with Boys and Men*. Washington: American Psychological Association.

Bateson, G. 1972. *Steps to an Ecology*. New York: Ballantine Books.

Bateson, G. 1979. *Mind and Nature: A Necessary Unity*. New York: Dutton.

Berger, J. L., M. E. Addis, J. D. Green, C. Mackowiak and V. Goldberg. 2013. Men's Reactions to Mental Health Labels, Forms of Help-seeking, and Sources of Help-seeking Advice. *Psychology of Men & Masculinity* 14: 433–443.

Boroughs, M. S., S. E. Valentine, G. H. Ironson, J. C. Shipherd, S. A. Safren, S. W. Taylor and C. O'Cleirigh. 2015. Complexity of Childhood Sexual Abuse: Predictors of Current Posttraumatic Stress Disorder, Mood Disorders, Substance Use, and Sexual Risk Behaviour among Adult Men Who Have Sex with Men. *Archives of Sexual Behavior* 44(7): 1891–1902.

Brown, C. and T. Augusta-Scott. 2007. *Narrative Therapy: Making Meaning, Making Lives*. Thousand Oaks, Calif: SAGE Publications.

Bruner, E. 1986. Ethnography as Narrative. In *The Anthropology of Experience* (eds) V. Turner and E. Brunder. Chicago: University of Illinois Press.

Combs, G. and J. Freedman. 2012. Narrative, Poststructuralism, and Social Justice: Current Practices in Narrative Therapy. *The Counseling Psychologist* 40(7): 1033-1060.

Connell, R. W. 1995. *Masculinities*. Cambridge: Polity Press.

Corbett, A. 2016. *Psychotherapy with Male Survivors of Sexual Abuse: The Invisible Men*. London: Routledge.

Crapanzano, V. 1980. *Tuhami: Portrait of a Moroccan Tile Maker*. Chicago, IL: The University of Chicago Press.

Cutajar, M. C., P. E. Mullen, J.R.P. Ogloff, S. D. Thomas, D. L. Wells and J. Spataro. 2010. Psychopathology in a Large Cohort of Sexually Abused Children Followed up to 43 Years. *Child Abuse & Neglect* 34: 813–822.

Davies, J. 2019. Lessons from the Anthropological Field: Reflecting on Where Culture and Psychotherapy Meet. In *Psychotherapy, Anthropology and the Work of Culture* (ed.) K. Martin. Oxon: Routledge.

Denborough, D., J. Freedman and C. White. 2008. Strengthening Resistance: *The Use of Narrative Practices in Working with Genocide Survivors*. Adelaide: Australia: Dulwich Centre.

Easton, S. D., C. Coohey and P. O'Leary. 2011. The Effect of Childhood Sexual Abuse on Psychosexual Functioning During Adulthood. *Journal of Family Violence* 26: 41-50.

Easton, S. D. and J. Kong. 2017. Mental Health Indicators Fifty Years Later: A population-Based Study of Men with Histories of Child Sexual Abuse. *Child abuse & Neglect* 63: 273-283.

Foucault, M. 1973. *The Birth of the Clinic: An Archeology of Medical Perception*. London: Tavistock.

Geertz, C. 1973. *Thick Description: Toward an Interpretative Theory of Culture*. New York: Basic Books.

Hansen, H., J. Braslow and R. M. Rohrbaugh. 2018. From Cultural to Structural Competency-Training Psychiatry Residents to Act on Social Determinants of Health and Institutional Racism. *JAMA Psychiatry* 75(2): 117-118.

Hastrup, K. 2017. Collaborative Moments. Expanding the Anthropological Field through Cross-Disciplinary Practice. *Ethnos* 83(2): 316-334.

Inhorn, M. C. and E. A. Wentzell. 2011. Embodying Emergent Masculinities: Men Engaging with Reproductive and Sexual Health Technologies in the Middle East and Mexico. *Journal of American Ethnologist* 38(4): 801-815.

Kangaslampi, S., F. Garoff and K. Peltonen. 2015. Narrative Exposure Therapy for Immigrant Children Traumatized by War: Study Protocol for a Randomized Controlled Trial of Effectiveness and Mechanisms of Change. *BMC Psychiatry* 15: 1–14.

Kia-Keating, M., F. K. Grossman, L. Sorsoli and M. Epstein. 2005. Containing and Resisting Masculinity: Narratives of Renegotiation Among Resilient Male Survivors of Childhood Sexual Abuse. *Psychology of Men and Masculinity* 6: 169-185.

Kleinman, A. 1988. *Rethinking Psychiatry: From Cultural Category to Personal Experience*. New York: Free Press.

Kleinman, A. and P. Benson. 2006. Anthropology in the Clinic: The Problem of Cultural Competency and How to Fix it. *PLoS Medicine* 3(10): 1673-1676.

Lee, J. 2017. Responding to Children in Situations of Family Violence: Narrative Therapy Group Work with Children. *International Journal of Narrative Therapy & Community Work* 1: 57-69.

Levy, R. and D. Hollan 2000. Person-centred Interviewing and Observation. In *Handbook of Methods in Cultural Anthropology* (ed.) R Bernard. Walnut Creek: AltaMira Press.

Lisak, D. 1994. The Psychological Impact of Sexual Abuse: Content Analysis of Interviews with Male Survivors. *Journal of Traumatic Stress* 7(4): 525-548.

Liu, W. M. 2005. The Study of Men and Masculinity as an Important Multicultural Competency Consideration. *Journal of Clinical Psychology* 61: 685–697.

Malinowski, B. 1927. *Sex and Repression in Savage Society*. London: Kegan Paul/Trench, Trubner and Co. Ltd.

Martin, K. 2019. Therapy and the Rise of the Multicultural. In K. Martin (ed.), *Psychotherapy, Anthropology and the Work of Culture*. Oxon: Routledge.

Mattera, B. E. C. Levine, O. Martinez, M. Muñoz-Laboy, C. Hausmann-Stabile, J. Bauermeister, M. I. Fernandez D. Operario and C. Rodriguez-Diaz. 2018. Long-term Health Outcomes of Childhood Sexual Abuse and Peer Sexual Contact Among an Urban Sample of Behaviourally Bisexual Latino Men. *Culture Health & Sexuality* 20(6): 607-624.

Miller, L. 2012. *Counselling Skills for Social Work*. London: Sage Publications Ltd.

Mitchell, S. 2006. Debriefing after Traumatic Situations—Using Narrative Ideas in the Gaza Strip. In *Trauma: Narrative Responses to Traumatic Experience* (ed.) D. Denborough. Adelaide, Australia: Dulwich Centre.

Myerhoff, B. 1986. "Life not death in Venice": Its second life. In *The Anthropology of Experience* (eds.) V. W. Turner and E. M. Bruner. Chicago: University of Illinois Press.

NCK. 2014. *Våld och hälsa: En befolkningsundersökning om kvinnors och mäns våldsutsatthet samt kopplingen till hälsa*. Uppsala: NCK-rapport. Uppsala University.

O'Leary, P. J. 1998. Liberation from Self-blame: Working With Men Who Have Experienced Childhood Sexual Abuse. *Dulwich Centre Journal* 4: 24-40.

O'Leary, P. J. and J. Barber. 2008. Gender Differences in Silencing Following Childhood Sexual Abuse. *Journal of Child Sexual Abuse* 17(2): 133-143.

O'Leary, P. J. and N. Gould. 2010. Exploring Coping Factors Amongst Men Who Were Sexually Abused in Childhood. *British Journal of Social Work* 40: 2669–2686.

Pederson, E.L. and Vogel, D.L. 2007. Male Gender Role Conflict and Willingness to Seek Counseling: Testing a Mediation Model on College-Aged Men. *Journal of Counseling Psychology* 54(4): 373–384.

Petersson, C. C. and L. Plantin. 2019. Breaking with Norms of Masculinity: Men Making Sense of their Experience of Sexual Assault. *Clinical Social Work Journal* 47: 372–38.

Plantin, L. 2015. Fathering Across Work and Family Life. On Contemporary fatherhood in Sweden. In *Fathering Across Culture: The Importance, Roles, and Diverse Practices of Dads* (ed) J. Roopnarine. Santa Barbara: Praeger Press.

Podjed, D., M. Meta Gorup and A. B. Mlakar. 2016. Applied Anthropology in Europe. *Anthropology in Action* 23(2): 53-63.

Price-Robertson, R. 2012. Child Sexual Abuse, Masculinity and Fatherhood. *Journal of Family Studies* 18: 130–142.

Quesada, J., L. K. Hart and P. Bourgois. 2011. Structural Vulnerability and Health: Latino Migrant Laborers in the United States. *Medical Anthropology* 30(4): 339-362.

Reed-Danahay, D. (ed.). 1997. *Auto/ethnography: Rewriting the Self and the Social*. Oxford and New York: Berg.

Schwartz, T., G. M. White and C. A. Lutz (eds).1992. *New Directions in Psychological Anthropology.* Cambridge: Cambridge University Press.

Seem, S and M. Clark. 2006. Healthy Women, Healthy Men, and Healthy Adults: An Evaluation of Gender Role Stereotypes in the Twenty-first Century. *Sex Roles* 55: 247–258.

Swahnberg, K., J. Davidsson-Simmons, J. Hearn and B. Wijma. 2012. Men's Experiences of Emotional, Physical, and Sexual Abuse and Abuse in Health Care: A Cross-sectional Study of a Swedish Random Male Population Sample. *Scandinavian Journal of Public Health* 40: 191–202.

Tedlock, B. 1991. From Participant Observation to the Observation of Participation: The Emergence of Narrative Ethnography. *Journal of Anthropological Research* 47: 69–94.
Turner, V. 1969. *The Ritual Process*. Chicago: Aldine.
Vromans, L and R. Schweitzer. 2011. Narrative Therapy for Adults with a Major Depressive Disorder: Improved Symptoms and Interpersonal Outcomes. *Psychotherapy Research* 21: 4-15.
Wade, A. 1997. Small Acts of Living: Everyday Resistance to Violence and Other Form of Oppression. *Journal of Contemporary Family Therapy* 19: 23-40.
Weber, M., K. Davis and L. McPhie. 2006. Narrative Therapy, Eating Disorders and Groups: Enhancing Outcomes in Rural NSW. *Australian Social Work* 59(4): 391-405.
White, M. 1987. Family Therapy and Schizophrenia: Addressing the "In-the-Corner" Lifestyle. *Dulwich Centre Newsletter* 14-21.
White, M. 2007. *Maps of Narrative Practice*. New York: Norton.
White, M. and D. Epston. 1990. *Narrative Means to Therapeutic Ends*. New York: Norton.