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The Arts in Psychotherapy 31 (2004) 19–28

THE ARTS IN PSYCHOTHERAPY

Recreating masculinity: drama therapy with male survivors of sexual assault☆

Marty Mulkey, M.A.

California Institute of Integral Studies, 1453 Mission Street, San Francisco, CA 94103 USA

The topic of adult male rape has only recently begun to receive attention by researchers and clinicians. Most of the scant research that has been done since the topic was first tentatively broached in the late 1970s (Scarce, 1997, p. 12) has focused on the demographic characteristics of victims and perpetrators (Groth & Burgess, 1980; King & Woollett, 1997; Lipscomb, Muram, Speck, & Mercer, 1992), the presenting symptomology of survivors (Goyer & Eddleman, 1984; Rogers, 1997), the attitudes and attributions of blame by friends and professionals (Mitchell, Hirschman, & Hall, 1999; Washington, 1999), and attempts to understand both the prevalence of the crime and the causes for underreporting (Pino, 1999). There have been a few activists and cultural researchers who have endeavored to make the stories of male rape survivors known on a sociological level (McMullens, 1990; Scarce, 1997). While all of this research represents a much needed effort by a few pioneers to understand the nature and effects of this brutal crime, there has not been much offered, to date, in terms of descriptions of treatment progressions for survivors. In this paper, I will offer a review of some of the literature that has emerged about male rape and narrate a first-hand account of a drama therapy group treatment of three male veterans who were sexually assaulted while in the military. This admittedly small group may not represent the treatment needs of a majority of male survivors of sexual assault. I offer the work of this small group as an initiation of discourse towards the creation of a model of clinical work with survivors of male rape.

Uncovering male rape

When I was asked, during my first drama therapy internship at the Concord Vet Center, to lead a group of men who had been sexually assaulted in the military, necessity became the mother of curiosity. With so little clinical research to guide me, I approached the creation of the group with many questions. How should I begin to predict which of the techniques and approaches to drama therapy should inform my work? What are the symptoms and issues I could expect to find among the men in my group? And what techniques of drama therapy best create the safety and containment necessary to approach the traumatic memory and address its enduring impact?

Male rape: research versus assumptions

Discussions of male rape have, historically, been clouded by misapprehensions about the nature of this crime, which are reflected in the language used to describe it in legal documents. As recently as 1995, the rape and sexual assault laws of 13 US states defined rape as something that happens to a woman by a male perpetrator—often only when there is vaginal penetration (Scarce, 1997, p. 199). According to these laws men cannot be raped. This legal prejudice seems to mirror a cultural blindness to the reality of this crime.

McMullen (1990), in his seminal book *Male Rape: Breaking the Silence on the Last Taboo*, points out that this blindness may be related to societal homophobia. Until recently, the crime was often referred to as *homosexual rape*: "The sexual content in male rape misleads the uninformed observer into thinking ... of the offense as being primarily sexually, and thus

☆ The work in this article was carried out at: Concord Vet Center, 1899 Clayton Road, Suite 140, Concord, CA 94520, USA.

E-mail address: mmulkey@aol.com (M. Mulkey).

0197-4556/$ – see front matter
doi:10.1016/j.aip.2003.11.003

homosexually, motivated . . . this is, however, *not the case*" (p. 24).

Scarce (1997) expands on this in *Male on Male Rape: The Hidden Toll of Stigma and Shame* when he explains that "the sexual orientation of men who rape other men tends to be heterosexual . . . virtually every study indicates that men rape other men out of anger or an attempt to overpower, humiliate, and degrade their victims rather than out of lust, passion, or sexual desire" (p. 17).

However, research has also shown that observers are more likely to attribute responsibility and even pleasure to male victims of sexual assault than female victims (Mitchell et al., 1999). Researchers speculate that this confusion of male rape with homosexual pleasure is a major contributor to the underreporting of this crime (Pino, 1999).

Despite underreporting, up to 10% of victims who do report to rape treatment centers in the United States are men (Kaufman, DiVasto, Jackson, Voorhees, & Christy, 1980). In his review of clinical research on victim symptomology, Paul Rogers shows that men who are sexually assaulted often present for treatment with symptoms matching the American Psychiatric Association (*Diagnostic and Statistical Manual of Mental Disorders: Fourth Edition*, 1994, p. 424) criteria for post-traumatic stress disorder (PTSD) including: re-experiencing the trauma, avoidance of trauma related stimuli, and symptoms of increased arousal:

> Furthermore, male rape survivors appear to develop a loss of masculinity, with confusion about sexual orientation (Myers, 1989). Some men believe that the assault occurred because they were not 'man enough' to avoid or escape the situation. They may keep reviewing the incident for years, trying to think of what they should have done to prevent it (Groth & Burgess, 1980). (Rogers, 1997, p. 5)

The misapprehensions described above often cause family members and caregivers to respond negatively to male rape victims. The very people that the victim turns to for help may deny that the rape occurred at all or call into question the victim's masculinity and/or sexual orientation implying that the victim desired the assault. These reactions can create further trauma and contribute to the survivor's sense of shame and self-blame (Washington, 1999). This re-traumatization has been referred to as a "second assault" (Williams & Holmes, 1981).

Approaches to treatment

> The core experiences of psychological trauma are disempowerment and disconnection from others. Recovery, therefore, is based upon the empowerment of the survivor and the creation of new connections . . . . (Herman, 1997, p. 133)

> Recovery unfolds in three stages. The central task of the first stage is the establishment of safety. The central task of the second stage is remembrance and mourning. The central task of the third stage is reconnection with ordinary life. Like any abstract concept, these stages of recovery are a convenient fiction, not to be taken too literally. (p. 155)

Drawing from her own pioneering clinical experience with psychological trauma, Judith Herman has proposed the above Stages of Recovery as guidelines for clinicians working with trauma. She stresses that clients will not necessarily follow in a straightforward, linear manner through these stages, but that the therapist should be able to perceive some progression from "unpredictable danger to reliable safety, from dissociated trauma to acknowledged memory, and from stigmatized isolation to restored social connection" (Herman, 1997, p. 155). The specific techniques used to facilitate the client's progress from one stage to another, however, will vary according to the client's needs and the therapist's training.

Drama therapist, David Read Johnson has done extensive work with combat veterans. He has found that creative arts therapies are able to facilitate creative, symbolic access to the (often dissociated) traumatic memories. He suggests that the arts media itself can provide distance from the distressing affect giving the client greater control over the emerging process. Johnson asserts that while art therapy is especially effective during the process of accessing the memory, drama therapy—with its emphasis on interaction and direct communication—is particularly suited to the later stages of trauma treatment (Johnson, 1987, p. 12).

The men in my group had already accessed the traumatic memory and had been working through the trauma in individual therapy. As I began to prepare a group treatment that would emphasize the sharing of traumatic memories while encouraging connection around a commonality of experience, I relied upon my training in Renée Emunah's Integrative Five-Phase Model of Drama Therapy (Emunah, 1994, 1996, 2000). Rather than a pre-imposed structure, the Five-Phase Model is a description of the developmental stages that a drama therapy group progresses through as the sessions spiral towards increasingly deeper levels of understanding and integration (Emunah, 1996, p. 29). The first phase, Dramatic Play, nurtures group cohesion and trust while the second phase, scene-work, utilizes the distance of dramatic enactments that are not overtly biographical to enhance the group's capacity for dramatic expression. These phases lay the groundwork for the third phase, Role Play, in which the client's current life situations or issues become the material for dramatic work. The present-day enactments tend