

MASCULINITIES AND MALE TRAUMA

MAKING THE CONNECTIONS

Masculinities and Male Trauma: MAKING THE CONNECTIONS

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About Promundo:

Founded in Brazil in 1997, Promundo works to promote gender equality and create a world free from violence by engaging men and boys in partnership with women, girls, and individuals of all gender identities. Promundo-US partners in more than 40 countries to achieve this mission by conducting cutting-edge research that builds the knowledge base on masculinities and gender equality; developing, evaluating, and scaling up high-impact interventions and programs; and carrying out national and international campaigns and advocacy initiatives to prevent violence and promote gender equality. For more information, see: www.promundoglobal.org

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EXECUTIVE SUMMARY

What are the links between salient masculine norms and the experience of trauma and adversity among boys and men?

What implications do these links have for individual, interpersonal, and community coping mechanisms surrounding trauma and adversity? And how else do they impact the formal and informal support systems for mental health and well-being among boys and men?

This report aims to outline the specific gendered aspects of male trauma and adversity, including the collective vulnerability of boys and men to such experiences and their ability to cope with trauma healthily and sufficiently. As demonstrated throughout this report, boys and men can experience adversity and trauma at every stage of their lives – from childhood to adolescence to adulthood and old age. Depending on the context, these experiences can take a wide range of forms, including in terms of severity, proximity to the individual, frequency, and other variables. And depending on the individual, these experiences can result in a wide array of responses and outcomes. Deploying lenses of intersectionality – such as race or ethnicity, sexual orientation and gender identity, geography, age, and socioeconomic status – allows for a more nuanced picture and highlights disparities of traumatic adverse exposure among subgroups of boys and men.

This document is targeted toward parents, teachers, clinical practitioners, researchers, humanitarian actors, and policymakers who have an interest in improving the global response to issues of mental health and well-being among boys and men.

Throughout the report, the authors emphasize the need for mental health and psychosocial support (MHPSS) services to integrate masculinity-informed approaches and improve access for men and boys, alongside women, girls, and individuals of all gender identities. The authors find it useful to center the conversation on changemakers in our MHPSS services and in the informal social support systems that could influence

and improve MHPSS services for boys and men who have experienced trauma. We must build on existing frameworks that offer widely accessible services informed by a gendered, masculinities-informed understanding of trauma, including efforts to change norms and encourage men’s help- and health-seeking.

In the full report, the authors detail three common types of adversities that can cause the trauma experienced by boys and men: (1) assault and abuse; (2) war and violence; and (3) racism, ethnic discrimination, and oppression. Although not an exhaustive list, these poignant examples highlight the ubiquity of trauma in the lives of boys and men across the life course. In addition to specific traumatic events over a man’s lifetime, research has shown that boys’ early child development and the socialization of boyhood can contribute to normative male trauma and maladaptive coping responses. For each type of adversity, some key facts about the topic are outlined, including prevalence around the world, common impacts on boys and men’s health and well-being, and the connections between masculine norms and adequately coping.

The authors fully recognize that women and girls face tremendous trauma for similar reasons and motives. In calling attention to men and boys’ specific gendered realities and reactions to trauma, we should never pose this analysis as oppositional or as an issue of competing needs. In fact, the work ahead of us does not need an “either-or” approach between or among genders. In many ways, the

trauma of different genders is entangled and can be assessed and addressed simultaneously – each with an appropriate gendered lens. The authors seek to provide an additive voice in this discussion, never pitting the needs of women against those of men but rather affirming that a full gender lens on trauma requires also understanding masculine norms and masculinities.

Connections to masculine norms at a glance

This report fits within Promundo’s “Making the Connections” series, which collectively illustrates the intersections between salient masculine norms and different aspects of men and boys’ lives. Consistent with the other reports, the take-home message remains clear – masculine norms and the way boys and men are socialized deeply impact their behavior and subsequent outcomes. In past reports, authors have illustrated the various ties that societal expectations of manhood and masculinity have with men’s increased likelihood of violence perpetration, unhealthy lifestyle behaviors and illness, and participation in extremist groups.

Similarly, the evidence included in this report supports that at the individual and societal levels, gender norms around masculinity and manhood inhibit boys and men’s ability to properly cope with trauma. Through this report, the authors examine how internalizing and manifesting a subset of masculine norms simultaneously reduces men and boys’ ability to effectively cope with trauma, and equally important, defines how support services are offered (if any are offered) to men and boys who have experienced trauma. Most of these barriers are rooted in the masculine social construct that men are simply not vulnerable to trauma and in men not being seen as “victims” – by themselves or the people around them. Even when male trauma is recognized, the help provided often falls short of meeting his needs. Systemic gender biases toward men within psychotherapy and other fields have led to stigma around men’s help-seeking behaviors, further exacerbating the severity of the unresolved trauma (American Psychological Association, Boys and Men Guidelines Group, 2018).

Male trauma is not a recent phenomenon, nor are the notions of masculinity that normalize male trauma.

From ancient allegories to current pop culture, one consistent theme in male heroism is that of sacrifice and resilience in the face of adversity. Across history, geographies, and cultures, pervasive narratives idealize men who experience traumatic events and can endure hardship, suffering, and physical and/or psychological violence. Historically, the male body and mind have often been considered expendable, and men have been expected to be strong, tough, and defenders of honor. As such, male violence and subsequent trauma have always been, and continue to be, woven into the fabric of masculinity and humanity.

In today’s societies, salient masculine norms related to enduring trauma include bravery, honor, sacrifice, and physical and emotional strength. The connection between heroism and masculinity encourages men and boys to either cope with their vulnerabilities and traumas as trophies of manhood or act as though they did not happen. Social expectations of manhood to be strong, in control, and stoic define the responses of boys and men experiencing trauma. Loss of power and control and feelings of vulnerability and weakness may injure the perception of male identity and generate feelings of humiliation and shame, among other responses. Men and boys who subscribe to these masculine norms may find it difficult to process emotions and vulnerability. Acting out, avoidance, or denying unwanted feelings and thoughts in response to traumatic experiences may serve to maintain the self-image of “being a strong man.”

The inability to practice healthy coping mechanisms in the face of adversity has crippling impacts on boys and men, their families and friends, and the societies in which they live. Research has shown that males’ perpetration of violence and aggression, including men’s violence against women, is strongly associated with their own experience of trauma – especially that of childhood trauma (Reavis et al., 2013). Additionally, there is an increased likelihood of harmful behaviors such as drug and alcohol misuse, depression, and suicidal ideation linked to unresolved male trauma. As discussed at length throughout this report, trauma responses among men and boys are strongly linked to destructive health, social, and economic implications that not only affect the individual but also deeply impact interpersonal and community relationships.

Common experiences of male trauma

Assault and abuse

Although there are many subcategories and common instances of assault and abuse that result in single-incident and/or complex trauma among men and boys, this report focuses specifically on three: childhood physical abuse, bullying, and sexual violence. The magnitude of assault and abuse is enormous, resulting in various impacts on psychological, social, and physical health and well-being:

- Nearly three in four – or 300 million – children aged 2 to 4 endure regular physical punishment and/or psychological violence at the hands of parents and caregivers (World Health Organization [WHO], 2020).
- The global prevalence of bullying is hard to quantify, but synthesized survey data reveal approximately one in three boys were bullied in the 30 days leading up to the survey (Biswas et al., 2020).
- Global estimates indicate 3 to 17 percent of boys experience sexual violence before age 18 in middle- and high-income countries, compared to 8 to 31 percent of girls (WHO, 2020).

A number of psychological and behavioral problems across the life course have been associated with physical, emotional, and sexual assault and abuse. They include poorer academic and intellectual outcomes, posttraumatic stress disorder (PTSD), depression, substance abuse, personality disorders, suicidal behavior, aggression, and criminality (Barth et al., 2013; Hughes et al., 2017; Kalmakis & Chandler, 2015).

Experiencing assault and abuse – be it physical, psychological, and/or sexual – and “admitting victimhood” are antithetical to the socialized conventions of manhood: invulnerable, impenetrable, and emotionally controlled (Connell, 1995; Petersson & Plantin, 2019). Widely held myths that boys and men cannot be victims of assault or abuse, especially of a sexual nature, impede their agency to seek help under the assumption that they will not be

believed. The stigma around reporting such incidents is predicated on the notion that men should be tough enough to overcome the temporary pain, shame, or embarrassment, as well as that help-seeking in the form of legal or psychological assistance would be considered weak and cowardly.

War and violence

For centuries, boys and men have been targeted for war recruitment, socialized to fight, and encouraged to remain resilient in the face of violence and adversity. Due to their proximity to violence and active participation in armed groups and combat, they are more often traumatized by war and conflict-related violence.

- The phenomenon of children associated with armed forces and armed groups (CAAFAGs) is quite common globally. In 2020, the United Nations verified over 25,000 grave violations against children in 19 conflicts around the world. However, given the secretive and hidden nature of these populations, the real prevalence of children engaged in armed groups is estimated to be much higher – around 300,000 children in 50 conflicts (United Nations Children’s Fund [UNICEF], 2015). In one United Nations brief, 92 percent of the CAAFAGs identified were boys (United Nations Security Council [UNSC], 2013).
- Around the world, men and boys have always been more heavily involved in combat and war-related violence. Although women have become increasingly involved in Western militaries, the percentage of enlisted women still dwarfs that of men. Additionally, only a few dozen countries allow women to hold combat roles, meaning that in over 100 countries, only men are on the front lines of war (Fisher, 2019).
- Of the 464,000 deaths by homicide in 2017, just over 377,000 (81 percent) were male. Data suggest that adolescent boys and young men are increasingly becoming victims of homicide, and their likelihood of being killed increases with each birthday starting at 10 years old in the Americas and 18 years old in Europe (United Nations Office on Drugs and Crime [UNODC], 2019).

On the battleground, traumatic events such as witnessing, causing, or experiencing death or injury; physically destroying communities; and experiencing significant loss of comrades are commonplace. In addition to observing PTSD, studies have found an increased risk of depression, chronic pain, anxiety, and other behavioral disorders, often leading to substance abuse and suicidal ideation.

Consistent with notions of hegemonic masculinity, honor, aggression, and heroism are central to many interpretations of manhood globally. For many, the role of protector and defender – whether it be for a family, ethnic group, country, or ideology – is the epitome of masculinity. Within militaries and armed groups, these masculine norms are omnipresent and exaggerated in all aspects of service. Perceived weakness by peers and superiors plays a role in a male service member’s unwillingness to seek care and treatment. Mental fragility and vulnerability squarely contradict the “warrior hero” trope that many military members aspire to emulate.

Racism, ethnic discrimination, and oppression

Around the globe, groups experience exclusion and discrimination based on racial or ethnic identity. Racial trauma, or race-based stress, refers to the “reactions to events of danger related to real or perceived experience of racial discrimination” – from receiving different treatment based on race or ethnicity to experiencing more violent forms of oppression, like genocide (Comas-Díaz et al., 2019).

- According to research published by the European Union Agency for Fundamental Rights (2018), 42 percent and 47 percent of male immigrants or male descendants of immigrants from sub-Saharan Africa and North Africa, respectively, living in Europe reported being racially discriminated against in the past five years. In the United States, non-White people who identify as Black, Latinx, Asian, or of Middle Eastern descent regularly experience high rates of racism.
- According to Genocide Watch (n.d.), there are currently 18 reports of conflict that exhibit the early signs of, are in the beginning stages of, or are established and declared genocide campaigns.

Although genocide and systemic oppression affect all genders, research has shown how racialized and ethnicized violence targets men and boys to emasculate, degrade, and weaken them physically and psychologically (Bradford Di Caro, 2019; Ferrales et al., 2016).

Racism and ethnic discrimination are social determinants of health that have dangerous and lasting effects on the well-being of boys and men.

Most commonly, this includes mental health and psychosocial well-being (e.g., depression, anxiety, psychological distress, and PTSD), physical health (e.g., heart disease, obesity, high blood pressure, and diabetes), behavioral health (e.g., smoking, gambling, alcohol consumption, and violence), and social health (e.g., low control over life, confusion or erasure of cultural identity, and social isolation) (Kirkinis et al., 2021; Paradies et al., 2015; Polanco-Roman et al., 2016).

Pride and superiority are notable pillars of hegemonic masculinity around the world. Boys and men are socialized to be protectors and defenders and are expected to be in power. However, this is antithetical to the foundational principles underpinning racial and ethnic discrimination, oppression, and persecution. Structural and personal experiences of racism and of racial and ethnically based trauma continuously prevent boys and men from attaining a socially desired status of manhood.

What needs to be done

Harsh codes of masculinity and manhood, among other reasons, are producing boys and young men who are unprotected, who suffer physical abuse, and who become engaged in war and conflict at an early age. These scripts create vulnerabilities to adversity and trauma and often lead to poor resilience in dealing with negative emotions and challenges. However, we must continue to challenge antiquated models of hegemonic masculinity, liberating boys and men to live safe, protected, and prosperous lives. Ultimately, recognizing expressions of traumatic experiences by men and boys – alongside people of other gender identities – is crucial for health, peace, and equality for all.

In Section 4 of the report, the authors expound on five key insights related to addressing the individual and societal inadequacies in responding to male trauma. We must:

1. Better protect boys and men
2. Make male trauma more visible
3. Create gendered response models to trauma that fit the needs of boys and men
4. Amplify positive male examples and continue to break the gender binary
5. Acknowledge that helping men to develop post-traumatic resilience requires restorative work

In line with these next steps, the authors include a full list of recommendations for all stakeholders in the full report. Efforts by policymakers, healthcare professionals, educators, the nongovernmental organization (NGO) community, and communities at large must adequately place a masculinities lens on their response to male trauma:

- *Researchers and academics* should increase applied research efforts to develop specialized, evidence-based, gendered interventions to deepen the prevention of and response to the trauma of boys and men.

- *The healthcare community* should design and implement specialized training for mental health workers on recognizing and addressing the impact of adverse events on gendered needs, including psychological needs and the vulnerabilities of boys and men.
- *Policymakers* should develop or strengthen institutional and national frameworks surrounding men's health and mental health, ensuring they emphasize community-based public health approaches to improve men and boys' access to MHPSS services.
- *Public health organizations and campaigns* must engage communities to unpack and change the narratives about the relationship between trauma and masculinity/manhood, as some campaigns in the United Kingdom, Australia, and elsewhere have sought to do in recent years, namely reducing the stigma for men to seek help.
- And lastly, *communities at large* should raise boys intentionally, considering their emotional vulnerability and the detrimental impact of harmful masculine norms.



SECTION 1. INTRODUCTION

What are the links between salient masculine norms and the experience of trauma and adversity among boys and men?

What implications do these links have for individual, interpersonal, and community coping mechanisms surrounding trauma and adversity? And how else do they impact the formal and informal support systems for mental health and well-being among boys and men?

The main goals of this report are to highlight the specific gendered aspects of male trauma and to inform parents, teachers, clinical practitioners, researchers, humanitarian actors, and policymakers about common traumatic experiences and coping responses by men and boys, as well as the connections to salient masculine norms. Throughout the report, the authors aim to not only explore the connections between masculine norms and men's individual ability to cope with trauma appropriately and sufficiently. The authors also explore the societal biases and inadequacies of responses to male trauma as they relate to masculine norms. The authors stress the necessity of MHPSS services to integrate masculinity-informed approaches and to improve access for men and boys, alongside women, girls, and individuals of all gender identities. To this end, this report provides recommendations that promote gender equality by addressing male trauma and men's mental health and psychosocial needs.

Over the past decade, the fields of psychology and trauma-informed care have generally acknowledged the importance of gender and culture for experiences of and responses to trauma. Well-intentioned and

much needed, most of this research has explored these connections in the context of women and girls, including how their sex, gender identity, and cultures impact their experiences (Brown, 2004). The mainstream literature largely falls short in terms of acknowledging the vulnerabilities of boys and men and in terms of unpacking the ways in which notions of masculinity intersect with how boys and men experience and respond to trauma. This report builds on existing psychosocial research on experiencing traumatic events and the subsequent trauma response, particularly highlighting the intersections of gender and sex. The authors believe applying a masculinities lens to men and boys' trauma will lead to better responses, with benefits to women and girls, men and boys, and individuals of all gender identities. In bringing this lens, the authors also are conscious of the many ways that mental services fall short in supporting women, girls, and gender non-binary individuals. The authors seek to provide an additive voice in this discussion, never pitting the needs of women against those of men but rather affirming that a full gender lens on trauma requires also understanding masculine norms and masculinities.

What does “trauma” mean in the context of this report?

The word trauma originates from the Greek word for “injuries” or “wounds,” including the psychological injuries that follow an event. The term is colloquially used to refer to either a *traumatic event*, including the individual’s experience during the exposure to the stressful event, or to the *individual’s response* to a *traumatic event*, whether immediately after or over an extended period.

How we’re using trauma-related terms

The mental health and psychosocial well-being of men and boys are not defined by the mere absence of adversities and trauma responses. Rather, they are built on a wide range of psychological needs that should be met in appropriate, meaningful ways throughout someone’s lifetime. Psychological needs that are ignored, denied, or neglected may generate mental health problems, including psychotrauma and stress-related disorders. Likewise, direct or indirect exposure to life-threatening situations, violence, sexual abuse, or a wide range of other adverse events may generate responses of stress, trauma, and serious psychological suffering and mental illness. In this report on male trauma, the authors are focusing on men and boys’ responses in coping with psychological stressors, adversity, and trauma. The authors acknowledge that trauma and PTSD are contested concepts, and therefore, we clarify our use of terms throughout the report:

- **Trauma:** A psychological state developed when the experience of threat overwhelms an individual’s coping resources. Trauma can be one-off, acute experiences or chronic experiences based on how the event is perceived, how often it occurred or occurs, and its meaning to the individual.
- **Male trauma:** A broad range of responses and reactions by men and boys coping with traumatic events and adversity, with special consideration of the intersectional and gendered context within which they are situated. Many of the common ways men and boys respond to trauma are similar to the ways women and girls respond; however, others are different because of salient ways boys and men are socialized to respond to life stresses.
- **Traumatic events:** Adverse experiences that impact mental, psychological, and emotional health and well-being, which include violence (including sexual violence) and all forms of abuse, discrimination, and exclusion.
- **Posttraumatic stress disorder (PTSD):** Diagnosis of a mental health condition caused by terrifying experience(s) that trigger trauma responses. Throughout this report, we caution readers not to compare PTSD prevalence data, as the data may be based on different versions of the diagnostic tools at the time of the primary research’s publication. In the vast majority of cases, we have included PTSD data and the term PTSD as it was written by the author(s) of the primary research. Readers should also interpret these PTSD indicators through cultural lenses, historical contexts, and other factors (as discussed in this section).

A short history of the concepts of trauma and PTSD, and their limitations

The concepts of trauma and PTSD have been contested since their conceptual origins. There are two schools that consider trauma to be a medical problem that can be diagnosed through symptoms: the American Psychiatric Association and the World Health Organization (WHO). The main distinction is geographical – the American Psychiatric Association model is used in US and Anglo cultures, while the WHO model is broader and applicable to a more global audience. However, a

third school is challenging the medicalization of individuals' responses to adversity and trauma and is highlighting the role of political, economic, and sociocultural factors in how people are affected and respond. According to this school, PTSD, stress, and trauma are socially constructed concepts and illnesses; cultural variations in symptoms and contextual factors should not be ignored.

The American Psychiatric Association first produced the *Diagnostic and Statistical Manual of Mental Disorders (DSM)* in 1952, and the manual has an Anglo perspective on defining mental health problems that primarily focuses on psychiatrists and psychologists. In 2013, the fifth and most recent edition of the DSM defined a traumatic event as "actual or threatened death, serious injury or sexual violence" (American Psychiatric Association, 2013). This definition excludes events that may involve psychosocial stressors but not an immediate threat of death or physical injury, such as divorce, job loss, or exposure to violence through media (Pai et al., 2017).

The WHO's International Classification of Diseases (ICD), first adopted by the International Statistical Institute in 1893 and later published by the WHO in the 1940s, takes a public health perspective, with diagnostic guidelines to guide health professionals in diagnosing symptoms of mental health problems, including PTSD. The ICD distinguished two main types of trauma, among others: **single incident trauma**, which is characterized by an unexpected single event, and **complex trauma**, a pattern of traumatic events that are chronic or repetitive in nature. Complex trauma is more frequent but less recognized, as it often includes a cumulation of seemingly isolated experiences (Cloitre, 2020).

The diagnosis of PTSD was first described in the third edition of the DSM in 1980 and was largely based on the symptoms of American male veterans of the Vietnam War. Subsequent research, insights, and eventually criticism revealed the limitations of the PTSD diagnosis, as people are exposed to – and respond differently to – a wide range of adversities. People from different cultures, age groups, and sexual and gender identities (among other factors) experience different forms of adversity and show different reactions to trauma. Additionally, discussions, research, and debates on trauma and PTSD largely focused on clinical use in the Global North and specifically the United States. Researchers and practitioners working in humanitarian settings highlighted the shortcomings of this PTSD concept for groups collectively traumatized by war, terror, and/or natural disasters. The medicalized, individualized, and apolitical concepts of PTSD were developed in and by Western, majority White, privileged researchers based on Western knowledge – and these concepts became the basis of psychiatry and psychology for people who do not share the same experiences and cultural norms (Bracken & Petty, 1998).

At the turn of the 20th century, a growing number of studies in humanitarian crisis areas revealed trauma's impact at the individual, family, community, and societal levels (de Jong, 2004; Kienzler, 2008), and the focus moved away from identifying mental health symptoms and toward reinforcing positive coping strategies at the individual, family, and community levels. Personal narratives of suffering that acknowledged cultural, gender, and age-related explanations helped mental health service providers to understand the needs of individuals and groups. Correspondingly, the United Nations Inter-Agency Standing Committee (2007) developed guidelines for MHPSS in emergency areas that promote a holistic approach to addressing the effects of conflict and crisis on mental health and psychosocial well-being, with a focus on strengthening people's coping responses in dealing with stressors.

Today, PTSD diagnostic criteria are included in both the ICD-11 and the DSM-5. The ICD-11 concentrates on three broad categories of symptoms to diagnose PTSD: re-experiencing the traumatic event(s) in the present, accompanied by emotions of fear or horror; avoidance of traumatic reminders; and a sense of current threat that manifests as excessive hypervigilance or an enhanced startle reaction (Hyland et al., 2016). The DSM-5's diagnostic criteria include, in part, directly experiencing a traumatic event; traumatic exposure from directly or indirectly witnessing the event; learning of a traumatic event occurring to a loved one (e.g., their experiencing rape, violence, or some other form of trauma); or repeated confrontation with aversive details of such events (e.g., emergency responders) (Substance Abuse and Mental Health Services Administration, 2014; Roehr, 2013).

What we know about the intersections of gender and trauma

The field of gender-specific trauma research is nascent. In fact, it is only since 2016 that authors in the *European Journal of Psychotraumatology* have been asked to segregate research data on trauma by sex (Olf, 2016). Two years later, the American Psychological Association's Boys and Men Guidelines Group (2018) released foundational clinical guidelines to better attend to boys and men's needs and reduce barriers to care and treatment. Given the discrepancies in definitions, criteria, and reactions, there are various challenges related to the intersection of mental health diagnoses and gender.

Epidemiological studies in multiple country settings reveal trauma- and stress-related disorders are more prevalent in women and girls than in men and boys, across both children and adults (Gradus, 2017). This disparity in rates can be partially explained by gender-related concepts, such as gender roles and sexuality – including psychosexual development in early childhood – as well as the sensitivity and accuracy of current diagnostic tools (Christiansen & Elklit, 2012; Martin et al., 2013; Olf et al., 2007; Tolin & Foa, 2006). Other studies indicate that men generally show different symptoms of depression and other mental health disorders compared to women (Carragher et al., 2016; Olf et al., 2007; Valdez & Lilly, 2014). Furthermore, common reactions to adverse events tend to differ between men and women, whereby men tend to cope more often using social withdrawal, anger, irritability, intimate partner violence, and increased engagement in risk-taking behaviors (Martin et al., 2013; Taft et al., 2011). Differences are ascribed to women's higher exposure to severe traumatic experiences, such as sexual abuse, and to gender-specific expectations surrounding men's and women's normative coping responses, such as the notion that men should be stoic.

Given the differences in diagnostic criteria, international reviews face limitations in generalizability. However, these trends should not be ignored, but rather interrogated. Critical reflections about these findings highlight key questions:

- Are men indeed less exposed to traumatic experiences?
- Are they less affected by adversities?
- Are they coping differently?
- Are their coping responses to trauma and psychological problems less recognized because they do not fit in the narrow criteria definitions?

Effects and impacts of trauma

A variety of factors influence someone's trauma response – including prior exposure to or familiarity with trauma. Some responses are physical, whereas others are psychological. A portion of people are aware of their trauma responses, while others unconsciously experience them, and reactions could be visible or invisible to onlookers. Perceptions of gender identity are innately interwoven with stories of adversity and inform subsequent responses. Primarily, these perceptions are based on how people see themselves within power structures (e.g., related to racial/ethnic hierarchies and sexual identity), societal and cultural expectations for their gender, and gendered perceptions of psychosocial well-being, illness, and disease. Thus, adversities and responses are gendered, subjective, and hard to capture in standardized categories of symptoms. Many MHPSS service professionals rely on individualized narratives and accounts to reveal the impact of suffering and pain.

Over a half-century of research has shown the experiences and consequences of traumatic events can leave traces on our mind, emotions, and body (American Psychological Association, Boys and Men Guidelines Group, 2018; Levine, 2010; van der Kolk, 2014). The impacts of traumatic events are subjective and variable: Some people may perceive an event as traumatizing, while others do not; some individuals do not develop symptoms afterward, while others do (Benjet et al., 2016; McLaughlin et al., 2017). Immediate reactions could include shock, withdrawal, and freezing, but they could also include uncontrollable rage and anguish, insomnia, flashbacks and re-experiencing the trauma, and emotional numbing and

dissociation. Longer-term effects include diminished capacity to form relationships, paranoid alterations of the personality, a cynical worldview, an easy trigger to rage and violence, generalized anxiety, depression, and emotional dysregulation. Boys and men often exhibit maladaptive coping behavior to trauma that poses dangerous outcomes for them and those around them. Manifold health-inhibiting behaviors are more common among boys and men experiencing adversities, including poor diet, low physical activity, substance use, risky behaviors, and avoidance of help-seeking behavior.

Besides maladaptive forms of coping through harmful negative behavior, trauma can also catalyze growth and resilience. People apply constructive coping responses due to interactions with positive social networks in their family and community, including access to spiritual and moral resources for support. Thus, not all men and boys show negative behavior, and not all trauma responses are expressions of individual pathology. As stated earlier, trauma is a social matter that interacts with family, community, and society at large. Local cultural and social expectations of boys and men define the space within which they navigate and strongly influence the ways in which they cope with trauma.

Trauma can be transmitted over generations – labeled “transgenerational trauma.” Physical and psychological responses to traumatic experiences explain a wide range of the conscious, as well as the unconscious and unexplained, symptoms related to trauma (Porges, 2009). It is the manifestations of responses that explain how experiences can be transmitted unconsciously or consciously from one generation to another through many subtle forms of psychic projection or behavior. For example, parents may transmit their pain and suffering to their children because of the adversity or trauma they have experienced. This could result in feeling unable to love, feel affection for, or meet the basic needs of their children. Another pertinent example is the intergenerational cycle of violence, whereby parents or elders may be driven by personal traumatic memories and repeat violence inflicted against them on their own children. Additionally, violent tendencies or maladaptive coping mechanisms can be adopted by younger generations and integrated into their own behavior.

Insights from the field: Transgenerational trauma

These “Insights From the Field” boxes are personal anecdotes from two of the authors of this report: Henny Slegel is a therapist and medical anthropologist located in the Democratic Republic of the Congo, and Warren Spielberg is a psychologist and associate teaching professor at the New School in New York City. They have both worked in a variety of settings of high adversity, and these boxes narrate experiences from their practice in responding to male trauma.

Spielberg: I once worked with a boy aged 10 in New York City. At school he was shy and withdrawn and was often bullied by his peers. At home, he spent a lot of his time with his grandfather, who was a harsh and non-communicative man who had been a marine during the US war in Korea. The grandfather often spoke with pride of his role in the war, but never discussed the horrors with which he continues to be haunted. One day, my patient had been taunted at school and lost control. He took a broom stick and chased a boy repeatedly yelling “I will kill you.” The next day he was suspended. But I wondered, how did his grandfather’s trauma get into him?

Traumatic historical narratives and storytelling can also impact the way children are raised and treated, and many of these experiences are embalmed in bodies as sites of inchoate fears and angers. Traumatic experiences are integrated into large-group identities that are based on belonging to a people, nationality, religious group, or ethnic group that shares similar traumatic suffering in the present or past. Identification with the collective suffering or triumph of ancestors is represented in “chosen traumas” and “chosen glories” and is transmitted over generations (Volkan, 1998). Ethnic and religious wars, as well as other conflicts, have continued to be fueled across generations – usually under the banner of their ancestors’ or relatives’ struggle. Examples include violent responses to colonial powers, ethnic conflicts in Africa, and Middle Eastern wars and conflicts. Movements, revolutions, and resistance against racism and discrimination within abusive and violent systems illustrate positive responses of large-group identities affected by trauma.

Around the world, boys and men are vulnerable to adversity that can cause psychological trauma.

Deploying lenses of intersectionality – such as race or ethnicity, sexual orientation and gender identity, geography, age, and socioeconomic status – allows for a more nuanced picture and highlights disparities of traumatic adverse exposure among subgroups of boys and men. Although they generally hold unequal power and exercise disproportionate privilege relative to people of other gender identities, men also experience higher rates of some kinds of mental and physical health issues globally and of other public health concerns, like violence, substance abuse, incarceration, and academic failure (American Psychological Association, Boys and Men Guidelines Group, 2018; Ragonese et al., 2018). This paradox of power and privilege positions boys and men to experience high levels of adversity that could result in undiagnosed or unaddressed psychological trauma throughout their lifetime.

Throughout the report, the authors highlight three common types of adversities that can cause trauma experienced by boys and men: (1) assault and abuse; (2) war and violence; and (3) racism, ethnic discrimination, and oppression. Although not an exhaustive list, these poignant examples highlight the ubiquity of trauma in the lives of boys and men across the life course. Each subsection in the report has a similar structure that outlines the prevalence of the topic, common impacts on the health and well-being of

boys and men, and the connections between masculine norms and adequately coping. Again, the authors emphasize that women, girls, and gender non-binary people face tremendous trauma for similar reasons and motives; in calling attention to men and boys' specific gendered realities and reactions to trauma, we should never pose this analysis as oppositional or as an issue of competing needs.

In addition to specific traumatic events over a man's lifetime, boys' early childhood development and the socialization of boyhood can contribute to normative male trauma. As detailed in the following box, researchers have explored the gender role paradigm and its relation to trauma strain, particularly in boyhood and adolescence. Early in life, boys begin to receive messages aligned with traditional masculine norms like restrictive emotionality and toughness (Levant & Rankin, 2014). These teachings can inhibit their ability to foster proper coping strategies for responding to traumatic events or adversity. (Parallel, of course, to this analysis of normative male trauma, there is a vast and important body of research on the specific ways that girls' gender socialization is traumatic and repressive, in addition to a growing body of research on how gender norms are doubly repressive for LGBTQIA* individuals. In particular, Carol Gilligan's *In a Different Voice* was key in calling gendered attention to girls' socialization, which in turn contributed to the study of boys' gendered socialization.)

What the fields of psychology, developmental psychology, and psychotherapy say about trauma and masculinity

As stated earlier, little knowledge is available on specific male responses and symptoms to adversity and trauma. However, there is some evidence that boys and men are less resilient in coping with traumatic experiences (Beckwith & Murphey, 2016). Boys' early development and attachment styles can foster poor resilience and a variety of poor coping abilities, ultimately making these boys more vulnerable when confronted with traumatic experiences (Beckwith & Murphy, 2016; Diamond, 2015; Katherine Weinberg et al., 2006; Möller-Leimkühler, 2003; Pasco Fearon & Belsky, 2011). Research has begun to show that boys who experience unsafe attachment in childhood tend to show more externalizing behavior, such as substance abuse and aggressive and violent behavior (Amin et al., 2018; Fearon et al., 2010; Groh et al., 2012).

To fully understand the current discourse around trauma and masculinity, it is important to acknowledge the foundational research and theory in this space. In the 1970s, US feminist psychoanalytic psychotherapist Nancy Chodorow examined the gender role differences in early childhood development. Chodorow (1978) argued that girls and women are better in caretaking roles because as babies, girls enjoy a longer loving, caretaking relationship with their mothers. By contrast, in the symbiotic relationship with his mother, a boy's first separation is driven by his growing awareness of physical differences between his body and hers. Going from being fully dependent on his mother, a boy may have to differentiate from her when still very young, generating feelings of fear and abandonment. The common absence of caretaking fathers intensifies his longing for intimacy and support and reinforces his feeling of standing alone (Lundberg, 2017; Golding & Fitzgerald, 2016). However, this does not mean that boys are more traumatized *per se*, but rather that boys and men may be challenged during their lives to find adequate strategies for coping with stress and adversity.

Boys' gender socialization also encourages independence. Messages and interactions with caretakers often reinforce the importance of independence and being strong: "Big boys don't cry." "He can do it alone." Independence has turned into a valued "male" characteristic. Vulnerability, loneliness, and fear are overwritten with proudness and independence in early stages of a boy's life (Chodorow, 1978). However, this process is culturally specific, as childrearing practices and parenting styles are strongly influenced and shaped by cultural and contextual factors (Heine, 2011). Generally, in the Global North, boys are expected to give up their strong bonds to their mothers in a process that many times happens too early in life – often by the age of 3 or 4 – by which parents begin trying to toughen up boys by depriving them emotionally. In this process, they usually physically and emotionally resign from maternal relationships, as well as are forced to abandon their inner emotional life and various coping strategies necessary to deal with the irregularity of life (Pollack, 1998). Boyhood initiation rituals all over the world include customs and practices that aim to prepare boys for manhood, starting with separation from the mother through a transitional phase in which he learns through endurance and bravery to become responsible and independent as markers of adult manhood (Whiting et al., 1958). This early childhood separation from the mother aligns with globally held notions of manhood that expect men to be independent and unemotional. As stated earlier, this may provide a partial explanation as to why some men and boys find it difficult to reach out for help or make social connections when feeling vulnerable or affected by trauma.

Boys, by virtue of their age and emotional maturity, are rarely able to recognize their own trauma. However, the same is seemingly true for adult men. The aim of many masculine scripts has been to quell biological and somatic experience to make men immune to, and unable to recognize, their own emotional and physical reactions to experiencing overwhelming events. This has had the effect of prolonging their grief and trauma, as they fail to develop healthy coping strategies. Research shows this inability to process trauma is rooted in boys' socialization at a young age, whereby their emotional resilience is undermined by constant messages of independence and strength. Interesting research by Tronick and others points to an uncomfortable fact: Boys are more reactive to

emotional ruptures, transitions, and separations than girls are. They are harder to soothe and require more emotional support in early childhood than girls do. As a result, boys – and later, men – have greater difficulty controlling their negative emotions and developing meaningful relationships (Tronick, 2007; Tronick & Reck, 2009; Way, 2019). These findings present us with an ironic dilemma: Boys appear to need more early caretaking and psychosocial support to self-regulate and function emotionally; however, instead, people give them less support because as boys they are expected to be stoic, strong, and silent in the face of adversity.

Boys' early emotional deprivation and their difficulties in emotional regulation, if combined with various forms of exposure to trauma, can result in a wide range of behavior, with implications for their ability to learn, socialize, and deal with the challenges of living. When feelings of insecurity, emotional hurt, or injury persist, some may portray severe psychological responses of shame, anger, humiliation, and betrayal. This can easily evolve into extreme, violent responses directed at others or at themselves, such as suicidal ideation and high-risk behavior. They can become abusive and retaliatory when their defense mechanisms are challenged, often leading to bullying, community violence, and domestic violence against women and children. Their difficulties with impulse control, when coupled with early deprivations and/or abuse, may lead to their inability to focus in school, substance misuse, uncontrolled aggression, and other unhealthy behaviors (Pasco Fearon & Belsky, 2011; Shulman et al., 2015; Tronick & Reck, 2009). Furthermore, boys and young men are more vulnerable to recruitment in armed and/or extremist groups or gangs, as such groups often leverage boys' frustration with not being able to attain the desired "manhood" status of having income and defending their family and country. Lastly, this could have future implications for their emotional intelligence and ability to effectively express themselves. To this end, researchers in Mexico studied the emotional vocabulary of urban unemployed men and began to unpack their relationship with both positive and negative emotions in their daily life (Ramírez Rodríguez, 2019). He emphasizes the centrality of men and boy's emotional vocabulary in their lives and underscores its importance for fostering healthy social relationships.

Thus, men and boys affected by traumatic experiences may feel extremely vulnerable, as male socialization has not taught them to deal with such emotions. The overwhelming emotions – often hidden and unknown – may evolve into explosive, uncontrollable responses. However, it is important to note that gender socialization has many variations around the world, and boys and men may perform multiple forms of masculinities. The cultural context and social expectations are crucial in providing space for those variations in masculinities, including intersections of sexual orientation and gender expression. On the other hand, being a "nontraditional" man in a hegemonically masculine context could increase vulnerability to adversity and trauma.

Responses to trauma are situational and contextual, whereby the frequency and intensity of adversity occur to varying degrees and reactions are based on a variety of intersectional determinants (including religion, sexual orientation, geography, age, race and ethnicity, gender, family structure, and culture). Boys and men, and those who seek to support them, need to label and interpret these adverse experiences through both individualized and collective lenses to recognize their traumatic nature and to then apply these boys' and men's intersectional

identities to the situation. All these factors, and more, play a key role in either increasing or decreasing a man or boy's vulnerability to experiencing traumatic events and adversity. Like other public health challenges, racial, age, socioeconomic, and other disparities exist among men and boys in terms of the degree of adversity they are exposed to and the availability and accessibility of informal and formal support services. Therefore, any efforts to address male trauma should not only be masculinity-informed but also intersectional in approach.

Promundo's "Making the Connections" series: What do we already know?

Promundo has published four other reports in the "Making the Connections" series, which have illustrated the intersections between salient masculine norms and different aspects of men and boys' lives. The take-home message has been clear: Masculine norms and the way boys and men are socialized deeply impact their behavior and subsequent outcomes.

Reports in the Making the Connections series:

[Masculine Norms and Violence: Making the Connections](#)

[Masculine Norms and Men's Health: Making the Connections](#)

[Masculinities and Preventing Violent Extremism: Making the Connections](#)

[Masculinities and COVID-19: Making the Connections](#)

These reports have been grounded in the conceptual framework of masculinities, which refers to the plural, dynamic ways that boys and men identify and express themselves based on the social script of what it means to be a man. Around the world and within communities, there are variations in masculine social norms, attitudes, and behaviors. However, many researchers (including from Promundo) have distilled a particular subset of masculine norms that are salient in most instances. These hegemonic norms emphasize an expression of masculinity that reinforces men's dominance, power, and privilege over women, as well as over other men.

Through this series and other publications, Promundo has consistently demonstrated how these norms manifest as behavior and outcomes that are harmful not only to boys and men but also to women, girls, and individuals of other gender identities.

At the individual and societal levels, gender norms around masculinity and manhood inhibit men and boys' ability to properly cope with trauma. Widely held notions of manhood and masculinity are built on assumptions that men are more emotionally controlled and resilient in the face of adversity. These socially constructed gender norms, including around honor and physical and emotional strength, tend to glorify the ability to appear unaffected by traumatic events (as well as glorify the traumatic event itself) and discourage the individual practice of evidence-based coping strategies. Furthermore, these gendered notions are perpetuated by the larger society that controls access to, availability of, and acceptability of MHPSS services, such as psychologists and counselors, emergency response personnel, and policymakers. Over the past decade, there has been a growing recognition of the psychological suffering of men, including male trauma; however, the literature detailing these occurrences is

often anecdotal or cautioned as being small in scale, and it often comes from a handful of Global North settings or in some of the most adverse, conflict-affected areas in the world.

The societal and personal inadequacy to properly deal with male trauma has grave impacts on everyone. Research has shown that males' perpetration of violence and aggression, including men's violence against women, is strongly associated with their own experience of trauma – especially childhood trauma (Reavis et al., 2013). As with other forms of violence, being a victim of violence as a boy is linked to a significantly higher likelihood of sexual violence perpetration as adult men (Heilman et al., 2014). Additionally, a lack of support services in the face of childhood sexual violence is associated with the future use of violence (Heilman & Barker, 2018). As discussed at length throughout this report, trauma responses

among men and boys are strongly linked to destructive health and social behaviors that not only impact the individual but also deeply affect interpersonal and community relationships. Although this report does not explicitly focus on the trauma inflicted on women and girls by men and boys, it is necessary to acknowledge the magnitude of harm from men and boys' perpetration of violence and other harmful behaviors linked to their own trauma.

As the authors have repeatedly emphasized, addressing trauma among boys and men does not mean paying less attention to other genders.


The work ahead of us does not need an "either-or" approach between or among genders. In many ways, the trauma of different genders is entangled and can be assessed and addressed simultaneously – each with an appropriate gendered lens. There is a great need to extend beyond the binary gender paradigm and include properly tailored services and attention for individuals of all gender identities, including non-binary, transgender, and cisgender people. While all psychosocial efforts should be coordinated and complement one another, they should be wholly centered around the individual's lived experiences and realities.

To adequately mitigate the impact of unresolved adversity and trauma, we must acknowledge and remove individual, interpersonal, and societal barriers to healthy coping mechanisms in response to trauma. Most of these barriers are rooted in the masculine social construct that men are simply not vulnerable to trauma and in men not being seen as victims – by themselves or the people around them. Even when male trauma is recognized, the help provided often falls short of meeting men's needs. Systemic gender biases toward men within psychotherapy and other fields have led to a stigma against help-seeking behaviors among men, further exacerbating the severity of the unresolved trauma

(American Psychological Association, Boys and Men Guidelines Group, 2018). This is rooted in the fact that the localized notion of trauma is equally socially and culturally constructed, as are the localized norms around gender – and both paradigms interact and influence each other positively or negatively. Dangerous socialized norms have become embedded in the informal and formal services and support systems that glorify male trauma, whereby the most traumatized man is considered the strongest and most manly. Recognizing expressions of traumatic experiences by men and boys – alongside people of other gender identities – is crucial for health, peace, and equality for all.

The efforts of policymakers, healthcare professionals, educators, and the NGO community must adequately place a masculinities lens on their response to male trauma.

Academics and researchers should increase applied research efforts to develop specialized, evidence-based, gendered interventions to deepen the prevention of and response to the trauma of boys and men. Specialized training for mental health workers on recognizing and addressing male trauma should be compulsory in healthcare professionals' training. At the national and institutional levels, policymakers should develop and strengthen men's health and mental health frameworks to emphasize that mental health interventions are necessary to a community health approach. Public health campaigns must engage communities to unpack and change the narratives about the relationship between trauma and masculinity/manhood, as some campaigns in the United Kingdom, Australia, and elsewhere have sought to do in recent years, namely reducing the stigma for men to seek help. Lastly, communities should raise boys intentionally, considering their emotional vulnerability and the detrimental impact of harmful masculine norms. A full set of recommendations can be found at the end of the report.



SECTION 2. CONCEPTUAL FRAMEWORK

This report explores the various connections between salient masculine norms and trauma. Using the three common types of trauma outlined in the report, the authors argue that understanding how normative masculine behavior and attitudes are embedded in all aspects of male trauma – from the likelihood of experiencing a traumatic event in the first place to the individual’s response to adversity to global systemic inadequacies – are key to properly address male trauma. Additionally, research has shown a strong connection between masculine norms and the perpetration of traumatic events, particularly violence (Heilman & Barker, 2018).

In this report, the authors examine how internalizing and manifesting a subset of masculine norms simultaneously reduces men and boys’ ability to effectively cope with trauma, and equally important, defines how support services are offered (if any are offered) to men and boys who have experienced trauma.

In other reports in the “Making the Connections” series, authors have discussed how social norms impact individuals and the collective male population. Looking at topics such as perpetrating violence and extremism and engaging in health risk behaviors, we know that norms around what it means to be a man influence individual behaviors; this has consequences for men themselves and for those around them (Promundo Global, n.d.b). Through its work on men’s health, Promundo has explored the internalized norms at play, such as on toughness and emotional control, that keep men from seeking mental health services. These “Making the Connections” publications build on

Promundo’s strong foundational research on masculine norms, including the Man Box study and the results from various iterations of the International Men and Gender Equality Survey (IMAGES) that have been conducted around the world (Heilman et al., 2017; Promundo Global, n.d.a). In this report, the authors continue to highlight these norms as they relate to the individual, but we also approach the framework using a systems lens. The authors further our explanation of how structures influence and perpetuate these beliefs, and therefore, further deter or restrict men from accessing necessary services to cope with their trauma.

It is imperative to center the conversation on changemakers in our MHPSS services, as well as on informal social support systems that could influence and improve MHPSS services for boys and men who have experienced trauma. We must put the onus on psychologists, social workers, relevant policymakers, and others to create and offer widely accessible services using a gendered, masculinities-informed understanding of trauma, including efforts to change norms and encourage men’s help- and health-seeking. The social norms discussion tends to overemphasize individual agency in widespread behavior change. At the same time, balance is needed – solutions that do not adequately recognize and appreciate individual agency run the risk of homogenizing and stereotyping men and boys. Though necessary to the equation, focusing only on the individual is insufficient to create lasting, systemic solutions. As the authors discuss in this report, even when an individual man breaks away from normative behavior and acknowledges his trauma, the gendered and culturally specific MHPSS services that he yearns for are often nonexistent.

Section 2.1.

General connections to masculine norms

Salient masculine norms related to enduring trauma include bravery, honor, sacrifice, and physical and emotional strength. The connection between heroism and masculinity encourages men and boys to either cope with their vulnerabilities and traumas as “trophy of manhood” or act as though these vulnerabilities do not exist and traumas did not happen. Social expectations

of manhood as strong, in control, and stoic define the responses of boys and men experiencing trauma.

Loss of power and control – along with feelings of vulnerability and weakness – may injure the perception of male identity and generate feelings of humiliation and shame, among other responses. Men and boys who subscribe to these masculine norms may find it difficult to process emotions and vulnerability. Acting out, avoidance, or denying unwanted feelings and thoughts in response to traumatic experiences may serve to maintain the self-image of being a strong man.

Insights from the field: Male victimization

Spielberg: I treated a US firefighter after the terror attacks on the World Trade Center on September 11, 2001. He had narrowly survived the collapse of the buildings. He had jumped into an underground garage that saved his life. However, he was required to go back to work immediately. When I met him at the firehouse to which I was stationed, he had not slept in days. He was actively hallucinating, and he was torn by feelings of guilt and shame. I asked him, “Do you think you have been affected by trauma?” And he remarked, “What is that?” His family had the same response. His captain wondered if he was faking it all. They all ignored his symptoms and his agony.

Slegh: In 2018, I conducted interviews with Syrian adolescent boys in a refugee settlement in Lebanon, among boys who had been exposed to high levels of violence and also encouraged to use violence. These interviews revealed how traumatic experiences in boys are not recognized and addressed. Instead, boys and men process trauma by coping strategies that are shaped by internalized gender norms on masculinities. One boy (12 years old) explained:

“I saw bombings, killing, burning of our properties and we had to leave all behind in Syria. In the evenings, it is boys sitting with men, discussing politics and problems that are happening in our village in Syria. Listening to all bad things happening in my country makes me angry and frustrated, wanting to take revenge on those who destroyed our homes. Sometimes I fight with other boys, sometimes I withdraw and isolate myself and cry alone where nobody can see me. I lost my childhood while I am still a child, but I should be strong now and defend my country. Syrian boys cannot cry” (Slegh, 2018).

The examples of the US firefighter and the Syrian boy in a refugee settlement illustrate how trauma-related emotions of helplessness, fear, and vulnerability are converted into symptoms such as hallucination, dissociation, fantasizing about revenge, and fighting with other boys. Men and boys are socialized not to see or acknowledge their victimization; instead, they accept abuse, neglect, and trauma as normative to help them “become men.” This lack of consciousness extends past boys and men to parents, teachers, and humanitarian workers, who also miss signs of trauma in boys and men.

At a societal level, aspects of stereotypical masculine norms – including toughness and denying vulnerability or trauma – have precluded the idea that men can be victims of trauma or that they can suffer and develop mental disturbances around trauma. However, there is a growing awareness that boys and men can experience trauma and that their gender socialization embeds its effects in a longer-term way. Critiques of hegemonic masculinity as ideological – that is, as not an essential property of men but rather social constructions of how we make and raise boys – have begun to expand our perspectives. A new consciousness

is allowing the world to see men as vulnerable to trauma, abuse, and neglect and not as biologically programmed for stoicism and the many forms of harm that follow. Fortunately, the changing cultural climate about men and masculinity, driven in large part by feminist activism and research, has created a new openness to studying and understanding male trauma with a gendered lens. Although many gaps in our understanding have been filled over the past decade, however, an intentional, coordinated effort to translate this learning into action remains unseen.

As boys and men typically have few or no words for their pain and trauma, these are often hidden by feelings of

frustration, anger, and depression and are expressed through various forms of self-harm, including suicide. Boys and men also engage in risky behaviors such as reckless driving, fighting, substance abuse, and other addictive behaviors that deaden their feelings of vulnerability, psychological injuries, and fears. The responses of therapists, parents, and humanitarian programs often focus on violent and problematic behavior or social skills, while failing to address the psychological and trauma-related roots of the behavior. In working with boys and men, it is extremely important that we try to see beneath their behavior and empathize with their pain and confusion.

In focus: A historical perspective on pervasive narratives

Male trauma is not a recent phenomenon. Nor are the masculine norms that understate male trauma. As we discuss the present vulnerabilities of male trauma, we must also look back in history to understand the full picture. Our historical stories shape our collective consciousness and narrate our current interpretations of violent and traumatizing events. Just as trauma is carried over from one generation to another, so are our ideas and practices of masculinity. The two are linked, and history is made up of both chosen traumas and chosen glories. Those experiences and memories engraved in our identities become part of us, our families, our ethnic groups, and our gender identities (Volkan, 1997).

From ancient allegories of Odysseus and Greek and Roman warriors to religious leaders such as Jesus, Buddha, and Muhammad to more recent figures like Mahatma Gandhi and Nelson Mandela, one consistent theme in stories of male heroism is sacrifice and resilience in the face of adversity. Across history, geographies, and cultures, pervasive narratives idealize men who experience traumatic events and can endure hardship, suffering, and physical and/or psychological violence. The male body and mind are often considered expendable, and men are expected to be strong, tough, and defenders of honor.

In modern history, glorified imagery of war has epitomized strength and honor. The phenomenon of “shell shock” (a term coined in 1917) illustrates the disconnect between trauma-informed care and masculine norms among soldiers. At the height of World War I, thousands of soldiers suffered from a mental condition characterized by vivid flashbacks, an inability to sleep or eat, and other psychological symptoms. This was later found to be connected to the intensity of combat but was long believed to be – or diminished as – an emotional and physical weakness of *some men* (Jones, 2012). In fact, many soldiers were charged with desertion, cowardice, or insubordination, and upon returning home, were ostracized and admitted into psychiatric asylums. This is a clear example of how hegemonic masculinities work to subordinate and silence male expressions of vulnerability, pain, and trauma – which continues to this day in militaries, police forces, workplaces, schools, and communities.

The glorification of heroic militarization, among other forms of male sacrifice in defending honor and pride, often leaves out the cost of suffering and death in the “glories of war.” This omission perpetuates the normalization of male trauma as a price for participating in patriarchy and privilege. Male violence and subsequent trauma have historically been woven into the fabric of masculinity and humanity. Breaking the cycle means acknowledging the full, vulnerable humanity of men and boys, alongside women, girls, and gender nonbinary individuals.

COMMON EXPERIENCES OF MALE TRAUMA

3.



SECTION 3.1.

TRAUMA RELATED TO ASSAULT AND ABUSE

This broad category of trauma includes physical, psychological, and/or sexual assault or abuse inflicted on men across their lifetime. Although there are many subcategories and common instances of assault and abuse that result in single-incident and/or complex trauma among men and boys, this report focuses on three: childhood physical abuse, bullying, and sexual violence. A multi-country study revealed that interpersonal violence is the most predictive factor for being exposed to subsequent traumatic events. In other words, men (and women) experiencing interpersonal violence are most at risk of facing other traumatic events, and thus, developing related symptoms and/or PTSD (Benjet et al., 2016).

Section 3.1.1.

Breaking down assault and abuse

Childhood physical abuse

Child abuse “includes all types of physical and/or emotional ill-treatment, sexual abuse, neglect, negligence and commercial or other exploitation, which results in actual or potential harm to the child’s health, survival, development, or dignity in the context of a relationship of responsibility, trust, or power” (WHO, 2020). The public health significance of physical abuse in childhood is clear from its high incidence and prevalence rates worldwide, as presented by WHO (2020):

- Globally, half of all children aged 2 to 17 have experienced physical, sexual, or emotional violence or neglect in the past year.
- Nearly three in four – or 300 million – children aged 2 to 4 suffer regular physical punishment and/or psychological violence at the hands of parents or caregivers.

- One in 13 men report having been sexually abused as a child aged 0 to 17.
- The global homicide rate for boys aged 0 to 17 is 2.4 per 100,000 population, over twice the rate among girls (1.1 per 100,000). Further disparities exist within the male population, highlighting intersectional vulnerabilities (e.g., race, geography, and age).

Since the early days of corporal punishment-related research, many studies have shown that boys experience significantly more corporal punishment than girls (Mahoney et al., 2000; Turner & Finkelhor, 1996). For example, a large-scale study of families in Hong Kong found significantly more boys than girls aged 5 to 12 had endured corporal punishment (Tang, 2006). In a nationally representative study in the United States, researchers found that boys had a statistically significant increased likelihood of experiencing seven of 12 violent acts inflicted by a parent, stepparent, or guardian during their childhood (Thompson et al., 2004). Overall, 54 percent of male respondents in the study had experienced some form of physical violence as a child, compared to 40 percent of female respondents.

This difference between sons and daughters is most prominent in the context of milder forms of violence (e.g., corporal punishment) during middle childhood (Bardi & Borgognini-Tarli, 2001; Straus & Stewart, 1999). Often, boys are physically punished for minor infractions and/or for infractions against traditional masculinity, such as crying or whining (Lynn, 1959; Sorbring et al., 2003). Many boys are pushed into premature fighting and bullying by older siblings or by fathers who taunt their boys into rough horseplay

but then punish them for aggression. This pattern may vary among cultures, ethnic groups, and social contexts (Lysenko et al., 2013), and the incongruence of relevant findings may be partially explained by differences among research populations and samples in terms of age, culture, ethnicity, and social context.

Bullying and emotional abuse

Bullying during adolescence and young adulthood is common around the world and can take different forms – mainly physical, emotional, or cyberbullying. The global prevalence of bullying is hard to quantify, but synthesized survey data from Biswas et al. (2020) reveal approximately one in three boys had been bullied in the 30 days leading up to the survey. Prevalence data show bullying of adolescent boys aged 12 to 17 to be most endemic in Africa and the eastern Mediterranean, at over 40 percent of boys surveyed; it is least prevalent in Europe, at 8 percent (Biswas et al., 2020). The majority of bullying occurs in school or recreational settings, such as athletic teams.

Researchers have found that bullying victimization generally carries across multiple years of adolescence and creates chronic challenges for youth. For example, one study found that two-thirds of students bullied one year reported continued victimization the next year (Bond et al., 2001). The intensity of bullying varies by case, but generally, it is not a brief or infrequent occurrence. In one study, 57 percent of respondents reported being emotionally or verbally bullied at least every week; 30 percent reported physical bullying (Rosen & Nofziger, 2019).

Trends show boys are more likely to be the victims of physical bullying, including hitting, kicking, and choking. Additionally, indirect and psychological bullying does occur often and is more likely to go unnoticed by adults. This can include name-calling, starting rumors, and making discriminatory jokes. Surveys have shown an increased likelihood of bullying victimhood for boys who do not conform to stereotypical tropes of manhood – including their gender expression or sexual orientation (Kosciw et al., 2012).

Sexual violence against boys and men

Sexual violence can be part of child maltreatment, youth violence, intimate partner violence, or institutional and societal violence. Boys and young men are sexually abused in an array of settings: familial, educational, juvenile justice, religious, and military. There are many forms of sexual violence, which include rape, unwanted touching and harassment, covert sexual abuse by a parent, forced witnessing, forced sexual relations with others, and pornography.

The prevalence of sexual violence among boys and men has long been overlooked and is certainly underreported. The mask of masculinity creates barriers to disclosure and explains the serious underreporting of male sexual victimization. Moreover, methodological differences in study design and definitions of sexual violence, among other factors, make it difficult to estimate prevalence worldwide. According to the WHO (2020), 3 to 17 percent of boys experienced sexual violence before age 18 in middle- and high-income countries, compared to 8 to 31 percent of girls; in low-income countries, this range was 3 to 21 percent of boys, compared to 4 to 35 percent of girls. In the United States, one in four men will experience unwanted sexual events over his lifetime (National Sexual Violence Resource Center, n.d.; Cook & Ellis, 2020). A study across 10 European countries found the overall prevalence of forced nonconsensual sexual contact was 16 percent among men and boys above age 14, with national prevalence varying from 6 percent to almost 42 percent (Krahé et al., 2015). In the same study, researchers revealed higher rates for “at least one act of sexual aggression perpetration” among male respondents than female respondents in all surveyed countries, ranging between 5.5 to 48.7 percent among male, compared to 2.6 to 14.8 percent of females (Krahé et al., 2015). Another study found 19 percent of Dutch men have experienced a broad range of unwanted sexual behavior, such as touching in a sexual way (Rutgers, 2018). Research in Australia found that 4.5 percent of men have experienced some form of sexual assault over their lifetime, and a study in South Africa found that 10 percent of men reported a history of some form of sexual assault perpetrated by another man (Dunkle et al., 2013; International Society for Traumatic Stress Studies, Sexual Violence Briefing Paper Work Group, 2018).

Disparities in prevalence are often tied to demographic or individual characteristics or to boys' and men's institutional ties. Around the world, high rates of men's sexual violence perpetration against boys and other men are better known in the context of institutions such as churches, boarding schools, the military or armed groups, and prisons (Dressing et al., 2017; Elder et al., 2017; Hoyt et al., 2011; Wolff & Shi, 2009). Although the magnitude remains largely unknown, male military sexual trauma is common across the world's military institutions and often occurs when unequal power dynamics are at play within a culture of control and obedience (Elder et al., 2017). Similarly, in prisons, staff-perpetrated sexual assault against male inmates is reported to be higher than inmate-perpetrated sexual assault: In a sample of 12 US male prisons, 10 percent of male inmates surveyed had reported sexual victimization in the past six months (Wolff et al., 2009).

Additionally, gay, bisexual, and transgender men experience elevated rates of sexual assault and abuse (Rothman et al., 2011). In one US study examining college students, sexual minority men were more than nine times as likely to report having been sexually assaulted as heterosexual men (Beaulieu et al., 2017). In the Netherlands, 15 percent of gay men

reported they had experienced sexual violence at least once (Rutgers, 2018). In Norwegian and Dutch studies, 40 percent and 35 percent of transgender men, respectively, reported at least one type of sexual violence (Cense et al., 2017; Rutgers, 2018). In-depth interviews with gay young Brazilian men revealed traumatic sexual experiences in a variety of settings and a lack of support due in part to systemic homophobia (Ferrari et al., 2021).

Less is known about the perpetrators of sexual violence against boys and men. Researchers in one US study found that 77 percent of boys aged 10 to 17 endured unwanted sexual experiences perpetrated by other juveniles; the sex of the perpetrator was evenly split between girls (45 percent) and other boys (55 percent) (Gewirtz-Meydan & Finkelhor, 2020). The sex of and relationship to the perpetrator depends heavily on the context of the sexual violence. Power inequality plays a crucial role in cases of sexual violence and abuse against boys and men. Motivations for using sexual violence are complex and not well understood, and they may vary between sexual lust and the will to destroy, harm, or humiliate others (Baaz & Stern, 2013; Beck et al., 2013; McCarthy & McCarthy, 1989; Sarrel & Masters, 1982; Staub, 2003; Wilson, 2018).

In focus: Sexual violence against boys and men in emergency settings

Boys and men in emergency settings around the world are extremely vulnerable to sexual violence. Reports from 25 armed conflicts in the past decade demonstrate increased accounts of sexual violence against males, with some identifying it as “regular and unexceptional, pervasive, and widespread” (Chynoweth et al., 2017; Piccard, 2011). These acts usually include forcing a man or boy to take part in – often humiliating – sexual acts or inflicting pain and/or damage to the genitals to prevent future reproduction or sexual satisfaction (Sexual Violence Research Initiative, 2016).

Recent accounts have captured evidence of widespread sexual violence in various current emergency situations and the ways in which men and boys have begun to cope with this trauma. In-depth research efforts among Rohingya and Syrian men and boys clearly illustrate the magnitude of these acts, and the lack of support and services for survivors (Women’s Refugee Commission [WRC], 2018; Chynoweth, 2017). Although the issue remains largely unaddressed by the international community, survivors have taken the initiative to respond to the issue and raise awareness, including a refugee group in Uganda that has started community-led healing efforts to compensate for the lack of formal support services for boys and men who have suffered sexual violence (Edström & Dolan, 2019). Despite varying accounts of magnitude and severity, global evidence suggests that this human rights issue prevails in many contexts around the world.

As in other settings, sexual violence against men and boys in emergency setting impacts survivors, their families, and their communities across multiple dimensions. Physical impairments can include pain and scarring of the genitals, rectal fissures and abscesses, urinary and bowel incontinence, sexually transmitted infections, and sexual dysfunction and infertility (WRC, 2018). Psychological consequences include anxiety and depression, self-harm, suicidal ideation, sleep disorders, anger and aggression, PTSD, and compulsive sexual behavior. The social impact on survivors and their families can include shame, ostracization, and threats of violence (WRC, 2018; Sexual Violence Research Initiative, 2016).

In emergency settings, common misconceptions around male vulnerability also influence the incidence of sexual violence among men and boys and prove detrimental to the humanitarian response. Men and boys are often considered to be less vulnerable than their female counterparts. However, this does not eliminate their vulnerability, and subsets of men and boys have increased vulnerability to sexual violence, particularly older adolescents and young men, unaccompanied boys, men and boys in detention or being trafficked for labor, children associated with armed forces and armed groups (CAAFAGs), and LGBTI individuals (Kiss et al., 2020). For example, African migrants traveling to Europe are overwhelmingly boys and men (UNICEF, 2017). These journeys are often filled with situations presenting an increased risk of sexual violence, including border crossings, hunger, and unemployment.

Section 3.1.2.

Consequences of assault and abuse

Psychological and behavioral problems that have been associated with physical, emotional, and sexual assault and abuse across the life course include poorer academic and intellectual outcomes, PTSD, depression, substance abuse, personality disorders, suicidal behavior, aggression, and criminality (Barth et al., 2013; Hughes et al., 2017; Kalmakis & Chandler, 2015). A wide range of physical health problems has been associated with physical abuse, including damage to the nervous, endocrine, circulatory, musculoskeletal, reproductive, respiratory, and immune systems (Hughes et al., 2017; van der Kolk, 2014).

Over the past two decades, researchers, practitioners, and policymakers have expanded on Felitti et al.'s (1998) original Adverse Childhood Experiences (ACEs) research (Kalmakis & Chandler, 2015; Hughes et al., 2017). Five of the 10 adverse experiences measured in the survey relate to physical, emotional, and sexual abuse and neglect. In a systematic review and meta-analysis, Hughes et al. (2017) found individuals with four or more ACEs were up to six times as likely to experience all health outcomes – including physical inactivity, being overweight or obese, diabetes, respiratory disease, cancer, heart disease, and mental ill-health. Another systematic review and meta-analysis across North America and Europe affirmed significant adverse physical, mental, and behavioral health impacts among individuals exposed to two or more ACEs; researchers were able to attribute 31 percent of illicit drug use in Europe and 41 percent in North America to the existence of adverse childhood events (Bellis et al., 2019). Staggering correlations between ACEs and mental health outcomes, including anxiety and depression, highlight the short- and long-term effects of childhood trauma on men and boys.

Researchers have also established strong correlations between experiencing ACEs and perpetrating violence or aggressive behavior (Duke et al., 2010; Reavis et al., 2013). In a study comparing a group of male offenders

(which included nonsexual child abusers, domestic violence offenders, sexual offenders, and stalkers) to a normative sample, Reavis et al. (2013) found that members of the group of offenders were four times as likely to have experienced four or more ACEs in their lifetimes. Although many studies have highlighted the long-lasting effects of ACEs, others have concentrated on the more immediate effects of teen aggression. In a study with middle and high schoolers, researchers found a dose-response increased likelihood of perpetrating violence or aggression for each adverse event experienced, ranging from 35 percent to 144 percent (Duke et al., 2010). ACEs have also been shown to have negative effects on future education, employment, and economic prospects as an adult in the United Kingdom (Hardcastle et al., 2018). The body of research demonstrates a clear link between the existence of ACEs and myriad negative consequences later in life.

The experience of physical punishment can be traumatizing. Boys may log experiences of fear and pain in their bodies and begin to shut down their normal exuberance. Others may become aggressive in turn, adopting methods of bullying and intimidation toward others and internalizing violence as a legitimate way of performing manhood to gain a safe place in the world. Physical punishment also may affect their worldview and interpersonal perspectives, wherein violence is considered necessary to survive in a hostile world or wherein overwhelming fear of the violent world affects their mental health and psychological well-being. According to Levant's (2010) research in the United States, traditional masculine socialization through punishment estranges and isolates many boys from their genuine inner lives and vital connections to others. These dynamics may increase their hostile narcissism, and it heightens their risk of engaging in acts of violence or other serious mental health problems, including isolation, obsessive behaviors, and substance abuse, among others. As a result, they may become even more alienated from their wishes, longings, and vulnerabilities – intensifying their feelings of anger.

Insights from the field: Physical abuse

Spielberg: George*, a brilliant and high-achieving 16-year-old boy, appears in my office for our fourth session. He begins every session trying to argue and fight with me. He challenges the efficacy of my work, makes provocative racial and ethnic comments (he knows of my work as an advocate for boys of color in schools), and becomes belligerent when I try to assess with him the reasons he is in treatment (fighting and bullying at school and at home). As we go further, his vulnerabilities, emotional emptiness, and related history of physical abuse become more apparent. At the end of the session, he stands up menacingly to try to leave before the session ends. I remark to him, "I am not sure whether you want a hug or want a fight." Pausing for a second, he remarks, "I'm not sure either." However, his reflections last only seconds. He gives me the middle finger on the way out.

This example illustrates the impact of physical abuse on boys' ability to embrace social connection and intimacy due to deeply rooted feelings of insecurity and mistrust. Longing for safe physical contact may be shielded by anger and rejection.

**George is a pseudonym to protect his true identity.*

Relatedly, bullying during male adolescence has grave short- and long-term consequences on developmental and emotional growth. Feeling unsafe at school leads to a general disinterest and inability to concentrate in school, which often results in poorer educational outcomes and progress (Rosen & Nofziger, 2019). Socially, bullying can be detrimental to the natural development of friendships and other social support systems during adolescence, further isolating and stigmatizing victims. Additionally, emotional callousness, low self-esteem, and mental health outcomes such as depression and anxiety are common among people who are bullied (Sourander et al., 2007). These can lead to suicidal ideation, violent or criminal behavior, and other unhealthy coping mechanisms (Rosen & Nofziger, 2019).

The repercussions of sexual abuse or assault are enormous. The common responses to sexual violence among men and boys are consistent with other genders: self-isolation, lack of trust, denial, embarrassment, guilt, PTSD, and other cognitive-

related disorders (Association of Alberta Sexual Assault Services [AASAS], n.d.; Washington Coalition of Sexual Assault Programs, n.d.). Researchers have found that sexual abuse often leads to intense states of destructive behaviors, including drug and alcohol addiction, suicide and self-harm, and violence among men (Tewksbury, 2007). Beyond the physical effects of sexual assault, including rectal or penile injury, the emotional and psychological toll is severe. Most male survivors recoil from social relationships and have an increased likelihood of experiencing depression, anxiety, and other psychological disturbances after an incident. Alternatively, some men may react with more hostility and aggression or attempt to overcompensate in sexually suggestive ways (AASAS, n.d.; Tewksbury, 2007). After an incident of sexual assault or abuse, men commonly experience sexual dysfunction and/or question their sexuality, especially if they experienced any form of sexual arousal during the assault; this can have lasting psychological consequences related to their identity and sense of masculinity (Tewksbury, 2007).

Insights from the field: Sexual abuse

The following accounts of sexual abuse are compiled from both authors Sleggh and Spielberg from their clinical experiences.

Case example, United States

Joseph* was a 16-year-old young man whose parents divorced when he was an infant. He was raised by his biological mother. John grew up sleeping in the same bed as his mother until he was 10. The only exception to this was when his mother brought home her lovers. At that time, John was often forced to watch their sexual activity by some of her boyfriends. At the time of our meeting, John was extremely traumatized by these events. He was highly anxious and dissociated from his feelings. His victimization had also led to repeated episodes of sexual exploitation in the community. Unfortunately for him, no one had believed his reports or had explored his sexual mistreatment. As he aged, he began to engage in unsafe sex and was sexually promiscuous. At school and at home, he would become violent and out of control with the slightest stress. In general, he was unable to pursue educational and/or vocational goals.

Case example, Democratic Republic of the Congo

A father brought his 9-year-old son to see a psychologist because his son had been raped by a group of uniformed (military) men a few weeks before. The father had immediately reported the case to officials in the village. Unfortunately, as word spread, the family experienced severe retaliation from one of the rapist's family and was eventually forced to flee from the village. Since they had arrived in Goma, the boy's friendly and nonviolent demeanor had changed to be very problematic. He did not play football (soccer) anymore, he did not want to wear trousers, and he walked in a strange way (his inner thighs so closed that his skin was red and irritated). He was fighting with his brothers and sisters and beating other boys with a stick when they were bullying him. His defensive body posture (pelvis turned forward, pushing his inner thighs to each other) and defensive attitude served to hide his overwhelming fear and anger related to the trauma.

Case example, the Netherlands

A 31-year-old man came to see a psychologist because his girlfriend had decided to end the relationship. He felt depressed and somber. He described himself as being "detached from myself" and he was worried about his body that felt "numb and deaf." One day, he disclosed that he started to have sex with men in dark rooms (in the gay scene in Amsterdam). He was not enjoying the sex, which he described as "very rough and almost aggressive," but he felt it as an almost compulsive way of stress relief. The aggression and sexual arousal were waking up his body. While in therapy, he explored the aggression he felt and realized how his anger was directed at a priest of the Catholic church in his hometown. The priest had sexually abused him when he was between 10 and 12 years old. Serving as an altar boy, he felt affection for the priest and was very confused about the sexual acts. He had never spoken to anyone about his experiences. After the priest had moved to another city, the abuse stopped, and the man said that he had "forgotten" what had happened. The anger toward the abusive priest had been frozen in his body and blocked his feelings of intimacy in (sexual) relations. Unsafe and rough sex with other men unlocked those memories of abuse, and in therapy, he was able to process his anger in a healthy way and reconnect with his body, with his emotions, and with others.

**Joseph is a pseudonym to protect his identity.*

Section 3.1.3.

Connections to masculine norms

Individual barriers to coping with assault and abuse

Across all genders, coping with various forms of assault and abuse is psychologically and socially challenging. However, given what we know about the gendered societal expectations placed on men and boys, these internalized notions of masculinity complicate the coping process. Men and boys who adhere to traditional masculine norms (e.g., strength, aggression, and toughness) often struggle to recognize themselves as victims or survivors of assault or abuse. Throughout foundational literature about hegemonic masculinities, violence and power are central themes – a means of domination and achieving status as an “alpha male.” Experiencing violence – be it physical, psychological, and/or sexual – and admitting victimhood are, therefore, antithetical to the socialized conventions of manhood: invulnerable, impenetrable, and emotionally controlled (Connell, 1995; Petersson & Plantin, 2019).

The stigma of reporting such incidents is predicated on the notion that men should be tough enough to overcome the temporary pain, shame, or embarrassment, as well as on the notion that seeking help in the form of legal or psychological assistance would be considered weak and cowardly. The underreported nature of male survivorship of physical and/or sexual assault or abuse further perpetuates the myth that men cannot be victims and encourages men to feel as though they must be the only ones experiencing such incidents (Hlavka, 2017). In a review of help-seeking among male victims of domestic violence and abuse, Huntley et al. (2019) found several key themes: a fear of disclosure, a challenge to masculinity, a commitment to the relationship, and an invisibility (or perception of invisibility) of services. These findings expose a deep hesitation to disclose due to internalized shame or emasculation.

A wealth of research has been conducted on the connections between the act of bullying and masculine norms, but less has been written on the gendered aspects of coping related to bullying victimization (Heilman & Barker, 2018). In a general sense, barriers to coping are consistent with those for other forms of assault and abuse. Given that many instances of bullying are because an adolescent boy does not conform to hegemonic expectations of masculinity (particularly homophobic bullying), their reactions are generally overcompensating to

appear (hyper-)masculine. These coping strategies include becoming a bully themselves or harnessing frustration and aggression in other ways. Physical dominance, social status, and heteronormativity, usually expressed through hypersexuality, are all key aspects of hegemonic masculinity and responses to homophobic bullying.

Sexual abuse of boys has more insidious long-term effects on male identity that challenge healthy coping strategies. O’Leary et al. (2017) and others have found a pronounced sense of trauma among male survivors of childhood sexual violence due to social norms of manhood. Boys develop personality scripts infused with a sense of victimhood that is incompatible with dominant notions of masculinity. Sexual coercion and abuse undermine feelings of male legitimacy, sexuality, and agency. According to hegemonic masculine norms, men should always want to have sex and seek out opportunities for sexual activity. Furthermore, men are expected to be able to defend themselves against aggressors, especially women. As such, male survivors of sexual assault or abuse internalize notions of femininity as helpless, powerless, and damaged (Kwon et al., 2007; Petersson & Plantin, 2019). Questions and insecurities related to sexual orientation could further complicate a man or boy’s ability to properly cope with sexual assault.

Societal and structural barriers to responding to assault and abuse

In many cases, society’s collective response to male survivors of assault and abuse is inadequate, which further deters timely and proper coping strategies. As previously discussed, there is often a fear of humiliation, retribution, or shame in disclosing or reporting an incident to friends, family members, or medical or psychiatric professionals (Tewksbury, 2007). Widely held myths that boys and men cannot be victims of assault or abuse, especially of a sexual nature, impede their agency in seeking help under the assumption that they will not be believed. With these compounding factors, it is unsurprising that men usually disclose sexual abuse in childhood an average of 22 years after the assault – nearly twice as long as women survivors (O’Leary & Barber, 2008; O’Leary & Gould, 2009). Books, articles, pamphlets, online content, and direct service program outreach initiatives rarely include stories or resources that reflect their lived experiences as male survivors, further discouraging them from seeking help (Michigan Resource Center on Domestic and Sexual Violence, n.d.).

Although most research on male survivors' help-seeking is small in scale, the anecdotal findings reveal a consistent message: Even when boys and men overcome their personal reservations about seeking help, they often are not believed or adequately supported. In most cases, this includes service workers' attitudes and perceptions and also services' availability and perceived usefulness. These societal limitations, compounded by the individual barriers to coping with assault or abuse, leave many men unsupported in their victimhood.

In many cases, there is a severe lack of services tailored to male survivors of assault and abuse (Burrowes & Horvath, 2013; Foster et al., 2012; Lowe & Balfour, 2015). Most male survivors are, therefore, forced to engage with the existing systems and structures that were built for women and girls. Given the frequency of male patients relative to female ones, healthcare and social support personnel are not accustomed to dealing with men. In interviews with researchers, men have characterized professionals as "a wall of silence" and "a lack of sensitivity and compassion" (Hogan, 2016). One study asked 75 male survivors of intimate partner violence to rate the helpfulness of various support outlets, finding that police, courts, medical institutions (e.g., hospitals), and shelters were not considered helpful. Informal support systems like friends, family, and the internet generally scored higher and were preferred by respondents, highlighting the need for a trusting relationship to ease the burden of disclosing. In an interview, one respondent commented, "Nobody believes men. Police and courts believe the women and always side with them"; another said, "Police were, in fact, actively anti-helpful" (Tsui, 2014). Shelters were consistently ranked the least helpful service, highlighting the persistent discrimination against male survivors within the US shelter network. This is a shared reality in many parts of the world; for example, in 2018, there were more than 3,600 beds in shelters for women compared to only 20 earmarked solely for men in England, with none for men in London (BBC, 2018).

Attitudes and perceptions of formal support personnel (e.g., police, counselors, and medical personnel) are also critical for adequately responding to male assault and abuse trauma. Through interviews with British police officers, one qualitative study found common themes of doubt that men can be raped and pervasive messages that "real men" should be able to defend themselves, especially from women (Javaid, 2017). In highly patriarchal contexts, these sentiments could be more strongly held.

These attitudes manifest themselves in a variety of ways – whether by assuming the man is the perpetrator rather than the survivor or inquiring in a derogatory or blaming manner. In one interview, a male survivor of domestic abuse said, "The professional [from social services] always treated me as if I was an offender" (Machado et al., 2016). Tied to this societal disbelief, there is usually great fear of men losing custody of their children because of the gendered biases of family courts (Huntley et al., 2019).

Lastly, policies and laws often dictate the acceptability of and assistance provided to male survivors of assault and abuse. Language of inclusion matters. Although definitions of assault and abuse at an international level intentionally include "persons" or "people," the three most cited international documents regarding violence – the Convention on the Elimination of All Forms of Discrimination Against Women, the United Nations Declaration on the Elimination of Violence Against Women, and Sustainable Development Goal 5 – often fail to explicitly or implicitly include male survivors in their titles or content. In the United States, most national protections for survivors of assault and abuse are found in the Violence Against Women Act. Although this law has been recently broadened to protect people of all sexes and genders, the title can be misleading. Globally, many countries' specific laws or policies do not include men in their definitions of sexual violence survivors, or they use gendered pronouns to refer to victims (she/her) and perpetrators (he/him) of assault or abuse.

At the national level, Onyango and Hampanda (2011) note that various anti-gay laws around the world strongly discourage reporting by men who experience sexual assault or abuse from other men. In the approximately 70 countries where homosexual behavior can lead to legal penalties, there can be grave repercussions for reporting such incidents, including life in prison in Uganda.

The lack of legal protections and political will around male survivors of abuse and assault discourages societal acknowledgment of the problem's severity and magnitude, which further influences funding allocation and attention. These legal frameworks are compounded by the apathetic or negative attitudes of service providers and a scarcity of available and helpful services, which ultimately result in help-seeking behavior being highly discouraged among male survivors.



SECTION 3.2. TRAUMA RELATED TO WAR AND VIOLENCE

For all of human history, boys and men have been disproportionately exposed to war and conflict-related violence. In some cases, this is because of their sex as males (think of physical strength or non-childbearing). In many other cases, though, it is because of the attributes ascribed to their gender as men (think of aggression, stoicism, or being powerful). For centuries, boys and men have been targeted for recruitment, socialized to fight, and encouraged to remain resilient in the face of violence and adversity.

Due to their proximity to violence and active participation in armed groups and combat, men and boys are more often traumatized by war and conflict-related violence. Furthermore, the traumatization of men and boys pushes many to take revenge and engage in more violence. Several factors contribute to elevated risks for boys and men to experience traumatization from war-related violence because of their gender.

Section 3.2.1. Breaking down war and violence

Early recruitment into armed forces and armed groups

The phenomenon of children associated with armed forces and armed groups (CAAFAGs) is quite common around the world. In 2020, the United Nations verified over 25,000 grave violations against children in 19 conflicts around the world – mainly in the Middle East and Africa, with smaller numbers in South America and Asia. Most of these violations were committed by non-state actors, and another third by government or international forces. In 2019 alone, 7,747 newly recruited children aged 6 to 18 joined armed groups (UNSC, 2020). Given the secretive and hidden nature of these populations, the real prevalence of children engaged in

armed groups is estimated to be much higher – around 300,000 children in 50 conflicts (UNICEF, 2015).

Although the 2020 United Nations report did not specify the sex of the children, other evidence suggests most soldiers are boys. According to a study on recruitment patterns of children in eastern Democratic Republic of the Congo from 2012 to 2013, most documented children were aged 15 to 17, while one-third were under 15 and 17 children were under 10. Among the 997 children, 92 percent were boys (UNSC, 2013). Tasks and roles given to children differ by conflict, but common roles include porters, cooks, spies, sex slaves, guards, human shields, minesweepers, and combatants (Betancourt et al., 2013; UNSC, 2013). In most situations, children are regularly engaged in village raids and mass atrocities. In a study in Uganda and the Democratic Republic of the Congo, researchers found that 92 percent of the surveyed former child soldiers had witnessed a shooting, 54 percent had committed murder, and 27 percent had been forced to participate in nonconsensual sexual activities (Bayer et al., 2007). In any setting, CAAFAGs experience and witness repeated physical, psychological, and sexual violence and suffer from subsequent complex trauma.

Recruitment of young and adolescent boys mainly takes place in schools and recreational spaces. Their motivations for joining vary and could include being promised an important position in the army or in the new government after victory. Other motivations are far more personal, like seeking revenge for the loss of family members in conflict or seeking the protection of an armed group after losing their entire family (United Nations Organization Stabilization Mission in the Democratic Republic of the Congo, 2013; Sleggh et al., 2014b). In most cases

of recruitment, boys are forced by peers, community members, and families to defend their ethnic group or family against threats. Other push factors for boys to voluntarily join extremist or anti-government groups are experiences of injustice and violence committed by police, military, and other authorities, as seen in studies in Mali and Cameroon (de Bruijn, 2018; Slegel et al., 2018). Frustrated and angered by the injustice, the boys' fear and trauma are often converted into violence to meet masculine norms of defending the honor of family and ethnicity. Violent extremist groups and movements target youth for their rebellious energy and frustration and offer them a sense of belonging, identity, and hope for a better life, as opposed to marginalization and exclusion.

Adult male participation in war

According to the Armed Conflict Location & Event Data Project (n.d.), nearly 100,000 violent and armed events occurred globally in 2020, resulting in 121,075 casualties. These events could include violence against civilians, battles, explosions or remote violence, or riots and protests.

War and conflict have been omnipresent across history. Around the world, men and boys have always been more heavily involved in combat and war-related violence. Although women's involvement has increased in Western militaries, the percentage of enlisted women still dwarfs that of men. Additionally, only a few dozen countries allow women to hold combat roles – meaning that in over 100 countries, only men are on the front lines of war (Fisher, 2019). Depending on the region of the world, male involvement in conflict takes on different characteristics and consequences, but boys and men generally bear the burden of death and trauma associated with war violence.

Beyond loss and injury on the battlefield, wartime captivity is a common tactic in many conflicts around the world. Although the duration and severity of maltreatment can differ, prisoners of war experience high levels of physical, mental, and sexual assault and torture, isolation, lack of medical care, and malnutrition or starvation (Stein et al., 2017; Ursano & Benedek, 2003).

Non-conflict homicides

Aggregated United Nations data from 1990 to 2017 show that crime has caused more deaths than war and terrorism combined (UNODC, 2019). In 2017 alone, there were 464,000 deaths by homicide globally, compared to 87,000 in armed conflict and 26,000 due to terrorism. Worldwide, data consistently show males and adolescent boys account for a greater proportion of homicide victims. Of the 464,000 deaths by homicide in 2017, just over 377,000 (81 percent) were male. It is important to note that 90 percent of all homicides are committed by males, which furthers the narrative of men being perpetrators and not victims. Data suggest that adolescent boys and young men are increasingly becoming victims of homicide – and their likelihood of being killed increases with each birthday starting at 10 years old in the Americas and 18 years old in Europe (UNODC, 2019). Around the world, young men aged 15 to 29 are more likely to be homicide victims than the rest of the male population – who collectively are already up to almost 10 times more likely than women to die from homicide (Decker & Pyrooz, 2010). Data from Promundo's IMAGES Brazil study highlight the ubiquity of exposure to violence in Rio de Janeiro – with 85 percent of men having been exposed to any form of urban violence in their life (Taylor et al., 2016).

Various situations can result in homicide or other violence, including interpersonal disputes, organized crime or gangs, and mass shootings. In many parts of the world, organized crime and gang violence far exceeds normal rates of homicide and violence. Gang membership or affiliation – which mostly involves young men – is highly correlated with victimization and perpetration of violence (Decker & Pyrooz, 2010). For example, a common initiation rite for joining an El Salvadorean gang is to kill someone, preferably a member of the LGBT community (Arevalo, 2017).

Section 3.2.2. Consequences of war and violence

The holistic toll of war and violence is immeasurable and carries an incredible physical, social, and psychological burden for individuals and communities and an incredible economic burden for nation-states. Foundational to the concept of PTSD, participation in war and violence deeply traumatizes both the victims

and the perpetrators. Across historical narratives dating back to the Battle of Marathon in 490 BCE, trauma and war have always been intertwined. Men in armed groups or formal military institutions suffer an acute amount of trauma on and off the battlefield (Beneda, 2017; Tanielian & Jaycox, 2008).

On the battlefield, traumatic events are commonplace and can include witnessing, causing, or experiencing death or injury; physically destroying communities; and experiencing significant loss of comrades. Although an unspoken reality for generations, psychological disorders as a product of war historically were not well understood and took on a variety of identities, including "shell shock," "battle fatigue," and "post-Vietnam syndrome" (Reisman, 2016). It wasn't until the 1980s that medical professionals more closely examined these common symptoms and formally diagnosed PTSD. Studies have estimated 20 to 30 percent of US veterans exhibit symptoms consistent with PTSD (Norris & Slone, 2013; Reisman, 2016; United States Department of Veterans Affairs, 2015). Given the protective factors within Western militaries, this prevalence is estimated to be higher in other regions of the world. In addition to observing PTSD, studies have found an increased risk of depression, chronic pain, anxiety, and other behavioral disorders, often leading to substance abuse and suicidal ideation. The Costs of War Project recently reported that 30,177 post-September 11 US service members have died by suicide, compared to 7,075 by combat, in the past two decades – meaning a four times greater chance of dying by suicide than in combat (Suitt, 2021). The mental injuries of war are often coupled with the physical injuries and disabilities that veterans are forced to simultaneously cope with. Additionally, veterans experience an elevated rate of chronic homelessness, joblessness, and family instability upon returning from war. In the United States, veterans account for one in four homeless persons – making them twice as likely to experience homelessness than the average population (American Public Health Association [APHA], 2014).

The acute trauma related to war captivity and being a prisoner of war has extensive consequences – including elevated rates of PTSD, depression, loneliness, and suicidal ideation and completion – even compared to non-captive combat veterans (Avidor et al., 2021; Nice et al., 1996; Stein et al., 2017). Additionally, prisoners

of war usually experience severe uncared-for physical injuries and malnutrition because of their torture and abuse. This can cause short- and long-term health consequences, including "gastrointestinal disorders (predominantly peptic ulcer disease and gastritis), musculoskeletal disorders, and cognitive disorders—including head injury, stroke, and dementia" (Ursano & Benedek, 2003). Socially, studies have found a decreased likelihood of employment and marriage and an increased likelihood of divorce among prisoners of war (Jukić et al., 2019).

Other theories have taken a more institutionalized approach to trauma in the context of armed groups and militaries (Beneda, 2017). Before stepping foot on the battlefield, military members undergo a significant amount of trauma during indoctrination and training processes. The collective identity of the military institution or group quickly overtakes individual decision-making agency, morality, and in essence, one's self-identity. After disarmament, they experience a great sense of anxiety and confusion as to who they are besides being a soldier. Research from the Democratic Republic of the Congo found male ex-combatants who reintegrated into their communities without weapons or their uniform experienced a severe psychological impact in terms of their perceptions of power and security, which resulted in feelings of fear and anxiety (Elbert et al., 2013). Researchers highlight that continuing to rely on the same survival mechanisms used in conflict – such as fight or flight – is inadequate for effectively coping after war (Slegh et al., 2014b). Additionally, Beneda (2017) explores "moral injuries" in the context of military institutions and authorities of power. Many times, in war, there is a disconnect between the moral judgment of the soldier and the institutional decision. The process of reconciling these differences can be traumatic and debilitating for soldiers who have behaved in ways they would not have otherwise if not for the mask of authority.

Children involved in armed groups and conflict experience a heightened complex traumatic response – physically, socially, and psychologically – due to their ongoing development. (Betancourt et al., 2013). Qualitative studies have found common effects for CAAFAGs include violent outbursts and behavioral challenges, addiction to drugs and alcohol, and psychological challenges consistent with PTSD

(Johannessen & Holgersen, 2014). In studies examining trauma among CAAFAGs, researchers have found elevated rates of moderate to severe PTSD symptoms compared to normative samples of children who were victims of the conflict (Kizilhan & Noll-Hussong, 2018; Klasen et al., 2010; Kohrt et al., 2008; Nasiroğlu & Çeri, 2016; Omona & Matheson, 1998; Thabet & Vostanis, 2000). In Uganda, Rwanda, Sudan, and Iraq, studies found PTSD symptoms in 30 to 67 percent of the surveyed child soldier population (Derluyn et al., 2004; Kizilhan & Noll-Hussong, 2018; Omona & Matheson, 1998; Schaal & Elbert, 2006). These symptoms included psychosomatic conditions, sleep disturbances, low self-esteem, and depression.

Issues of reintegration also remain a challenge for most CAAFAGs, as stigma exists in their home communities – which furthers their isolation and, at times, fosters extremist ideologies (Johannessen & Holgersen, 2014). Other challenges faced by CAAFAGs upon returning to their communities are the loss of education, employment, or ability to otherwise financially contribute to the family; this can prolong their trauma across their life course (Betancourt et al., 2013). As detailed for the general male population in Section 3.1, CAAFAGs who witness or experience sexual assault or abuse generally greatly suffer psychologically from that trauma and do so solitarily.

Men and boys who are not directly involved in armed groups can also experience substantial trauma from war and conflict. Specifically in highly patriarchal contexts – in which men are considered the protector, procreator, and defender of family and country – targeting wives and children can be a strategy to destroy the lives of all and hurt masculine honor. Although particularly prevalent in war and conflict settings, these experiences of men are also applicable to rape that occurs outside of a conflict setting. Studies among husbands of women in the Democratic Republic of the Congo that were raped or had a child after rape reveal severe traumatization of men (Liebling et al., 2012). In some cultures, a man is supposed to reject his wife after she is raped, and failing to do so will result in stigma or ostracization from his family or community. A study in the Democratic Republic of the Congo showed that even though most men in the focus group admitted that the wife cannot be blamed for the rape, some saw no solution other than rejecting her to save his

social position (Liebling et al., 2012). The accounts of husbands whose wives were raped reveal high levels of traumatic stress for men. Men and women in qualitative research say that most men react with intense anger and violence when they hear that their wives were raped. Some men in this focus group disclosed feelings of depression, intense anger, headaches, lack of appetite, and suicidal ideation.

Homicide-associated trauma closely mirrors the psychological impact of assault and abuse in the above Section 3.1. Data from Promundo’s Brazil IMAGES study show a variety of social and relational impacts of high rates of urban violence, including public and private violence perpetration, other risky behaviors, and fear and mistrust of police (Taylor et al., 2016). Depending on the context, men who are involved in gangs may experience a set of traumatic responses consistent with men involved in war-like violence. In studies with actively and formerly involved gang members, researchers found an increased likelihood of an antisocial personality disorder. One study in the United Kingdom found that gang members were 56 times as likely as men without histories of violence and 5.5 times as likely as men with histories of violence to have antisocial personality disorder (Coid et al., 2013). Other studies found increased rates of oppositional defiant disorder, depression and anxiety, substance use disorder, and suicidality (Henry, 2019). In fact, the UK researchers found gang members were 12 times as likely as men without histories of violence and 2.9 times as likely as men with histories of violence to have attempted suicide (Coid et al., 2013). Unlike most soldiers, gang members also have an increased likelihood of being imprisoned, which exposes them to additional trauma.

Section 3.2.3. Connections to masculine norms

Individual barriers to coping with war and violence

Consistent with notions of hegemonic masculinity, honor, aggression, and heroism are central to many interpretations of manhood around the globe. For many, the role of protector and defender – whether it be for a family, ethnic group, country, or ideology – is the epitome of masculinity. Within militaries and armed groups, these masculine norms are omnipresent and exaggerated in all aspects of service.

When entrenched in a hegemonically masculine military culture, coupled with distractions of war, a soldier's mind seldom has the time or encouragement to reflect on and unpack traumatic experiences as they happen. Therefore, most situations result in complex traumatic episodes whereby a soldier becomes overwhelmed by the trauma and suppresses it further. An individual's ability to appropriately cope or undergo evidence-based PTSD treatments is predicated on their ability to recognize and acknowledge symptoms as signs of illness. This is the first step toward an intrinsic motivation and willingness to disclose and process trauma. These processes can elicit emotions of fear, shame, and guilt, which often challenge norms of hegemonic masculinity (Neilson et al., 2020).

Recent research suggests that strict adherence to hegemonic masculine norms is associated with more severe cases of PTSD among veterans (Neilson et al., 2020). In their systematic review of masculinity-related barriers to seeking post-war treatment, Neilson et al. (2020) identified several main themes, among others: stoicism and emotional control, status, trauma as weakness, and hypermasculinity via aggression and sexuality. In general, men who ascribe to hegemonic masculine norms are less likely to seek and engage with mental health treatment. Stoicism and emotional control play a pivotal role in a man's unwillingness to express emotions that could be construed as feminine or weak. Among male US veterans, one study found that a commonly cited barrier was pride in self-reliance and the assertion that a "real man" could adequately deal with trauma alone (Sharp et al., 2015). Additionally, perceived weakness by peers and superiors can play a role in a male soldier's unwillingness to seek care and treatment. Mental fragility and vulnerability squarely contradict the "warrior hero" trope that many soldiers aspire to emulate.

Elements of hegemonic masculinity (e.g., courage, self-sacrifice, and endurance) are rooted in power and aggression, and they usually manifest in acts of interpersonal violence. Normalization of violence is a poor, yet common, coping strategy to address trauma. In some situations, violence and aggression can even elicit sexual arousal or feelings of fascination. Appetitive aggression is a phenomenon whereby an individual develops a pleasurable perception of violence (Elbert et al., 2017). Research among ex-combatants in the Democratic Republic of the Congo found high levels of appetitive aggression – 44 percent of respondents said they feel satisfaction when harming others, 35 percent have an urge to fight, and 40 percent find it difficult to resist being aggressive (Elbert et al., 2013). The presence of appetitive aggression, which is deeply connected to gendered norms of masculinity, significantly inhibits the ability to acknowledge and cope with trauma related to violence.

Consistent with notions of honor and pride, there is also a strong connection between masculine norms and the existence of and inability to cope with "survivor's guilt," a term used to describe the shame of returning from or surviving battle when fellow soldiers did not (Linehan, 2019). Some soldiers struggle to reckon with feelings of failure, self-hatred, and guilt for how they executed their stereotypical masculine duties to protect and defend their fellow soldiers or communities. Survivor's guilt extends past war to other emergency response situations. In fact, this was a crucial theme that emerged in the treatment of firefighters after the September 11 terror attacks on the World Trade Center (Spielberg, 2005).

In focus: Sexual violence as a weapon of war

As noted throughout Section 3.2, sexual violence is often used as a weapon of war to destroy, demoralize, and dehumanize boys and men. This has major complications for their masculine identity and ability to properly cope. In patriarchal cultures, boys and men who are raped often feel emasculated and ashamed that they could not protect themselves. Moreover, in a context with strong stigma around homosexuality, male victims of rape may be accused of being “contaminated with homosexuality” and become rejected or ostracized by their family and partner.

Sexual violence against women and girls also directly and indirectly affects men. It also partly explains why the rape of women is indeed effective as a strategy of war: It humiliates men. Men who are forced to rape or watch the rape of relatives often suffer extreme guilt and shame, as illustrated in the experience of a man in Luvungi, Democratic Republic of the Congo:

“I saw how my daughter was raped. I wished they had killed me. What kind of man am I not able to protect my family? I am not able to revenge those men, I have not the courage and physical strength anymore. My life is destroyed; I lost my sexual life and I have no will to live anymore” (Slegh et al., 2014a).

Guilt and shame among men who have been forced to rape or whose female family members have been raped is strongly associated with social stigma rooted in hegemonic masculinity. Men explained how they lost courage and pride in being men after they were forced to watch when armed men raped a woman or girl. It made them feel “less of a man.” Rape of the wife is considered to be a man’s failure to protect his wife and family. It is felt as an attack on, and humiliation of, his male identity.

Loss of power and control can be felt as a humiliation of his male identity, his social image, and his right to exist. In coping with loss, he may search for ways to regain his manhood and social position. Interpersonal violence, substance abuse, suicidal ideation, and rejecting his wife are common maladaptive ways to cope with trauma and loss in this situation.

Societal and structural barriers to responding to war- and violence-related trauma

Much of the international attention surrounding war and violence concentrates on civilians – mainly women and children. However, this narrative leaves out oft-untold stories of trauma and loss from combatants, who are often male, and others intimately involved in the conflict. To assist in veterans’ coping process, some countries have made financial and social investments. In many Western contexts, MHPSS services are available for veterans through specific veteran-focused government projects, such as the US Department of Veterans Affairs, or through a specialty branch within a national health program, like the UK National Health Service. In other contexts, the lack of research and

information suggests a general absence of formal support services for veterans in many countries around the world.

Military subcultures, steeped in hegemonic masculine tropes, impede men’s help-seeking behavior. During each stage of their service, from recruitment to training to combat, men are conditioned and socialized to be hypermasculine and exude toughness, stoicism, and pride – all of which create future barriers to help-seeking (Juanito Laver, 2013; Reit, 2017). In many cases, supervisors and institutions incentivize this through preferred tasks, moving up the ranks, and better treatment. For active-duty military members, this environment is clearly not conducive to help-seeking behavior. Furthermore,

these subcultures and norms do not disappear when a military member returns home – and many times are exacerbated by realizations of trauma.

Although there is a growing recognition that veteran and reintegration mental health support is necessary, active-duty MHPSS services remain even more scarce. In many patriarchal cultures, men are regarded as resilient, self-sufficient, and not in need of mental health services, as those denote weakness and shame. However, even where formal support exists, there are a multitude of barriers to access. Estimates show a low uptake of mental health services among veterans, even for those who theoretically have access. In the United Kingdom, only around 50 percent of veterans seek mental health services; this drops to 13 to 44 percent among US service members (Blais & Renshaw, 2013; Mellotte et al., 2017). The disinterest or apprehension in seeking MHPSS services are rooted in both social and logistical barriers to care.

Coupled with the self-stigma connected to the masculine norms we have described, there is a pervasive element of public stigma – whether perceived or actual – that deters help-seeking behavior. Researchers found that military commanders negatively viewed service personnel who accessed mental health services compared to their peers (Porter & Johnson, 1994). This is a particularly pertinent barrier to active-duty personnel who are still within the power structure and cultural indoctrination of the military. Studies have found common social structural barriers to include statements like “would be seen as weak,” “my unit leadership would treat me differently,” and “members of my team would have less confidence in me” (Gorman et al., 2011; Hoge et al., 2004; Warner et al., 2008). Similar to Section 3.1 on assault and abuse, studies have found a general fear among military members that they will not be believed or that their symptoms will be minimized. In one UK study, a participant remarked, “It worried me that everybody would think that I was bluffing it, even though I wasn’t, so I just carried on and on.” (Mellotte et al., 2017).

Direct barriers to seeking mental health services include a variety of factors depending on location. For most, the availability of formal services in any form is limited to nonexistent. Even when general

mental health services are offered, researchers have found military members to be unsatisfied with medical personnel’s knowledge of or intimate experience with the military – rendering these soldiers unable to connect and trust in the process (Mellotte et al., 2017). Although informal support systems help fill the support gap, they suffer the same limitations. Most friends and families of active duty military personnel and veterans cannot relate to or intimately understand the trauma. Reintegration into communities can be met with animosity or stigma, which discourages soldiers from confiding in others about their mental health challenges.

Other commonly cited barriers to care are long waiting lists, a shortage of staff, and limited accessibility of appropriate services near them (APHA, 2014; Hester, 2017; Mellotte et al., 2017; National Academies of Sciences, Engineering, and Medicine, 2018). The US Department of Veterans Affairs has additional systemic complexities that create barriers to care for returned military personnel: To be eligible to access services and receive benefits, a veteran a) must have either an honorable or general discharge; and b) “must have served at least 24 continuous months, or the full period for which they were called to active duty” (APHA, 2014). From there, veterans are placed in priority categories, whereby different service eligibility, availability, and out-of-pocket costs could be prohibitive to seeking care (APHA, 2014). These structures exclude many men and others who are suffering from trauma and need access to MHPSS services.

Despite its flaws, a formal military does usually provide some structure for mental health services. For gang members, members of informal armed groups, and other perpetrators of violence who experience trauma, there are even more barriers to care and treatment. The lack of social safety nets set up to deal with mental health challenges places these men at a severe disadvantage and a higher level of stigma surrounding care. In many cases, the criminal justice systems and prisons used to rehabilitate criminals do not provide mental health services, and often create environments where traumatic events and toxic cultures continue to be a part of daily life.

In focus: The power of media in violence, masculinity, and mental health

Popular depictions of war and violence may also act as a barrier to proper coping among boys and men. The glorification of heroism and resilience is rather consistent across all forms of media. These depictions often omit narratives about mental health and trauma, or they actively ridicule help-seeking behavior. Whether it be television shows that glorify gangs (like *The Wire*), movies that romanticize organized crime (like *The Godfather*), or blockbuster war hits (like *Saving Private Ryan*) that capture pride and strength on the battlefield, media plays a pivotal role in the societal narrative of violence and masculinity.


These masculine messages of strength, aggression, and emotional control are not only found in adult films and media. They are also instilled at a young age. The Geena Davis Institute on Gender in Media, Promundo, and the Kering Foundation (2020) examined messages about masculinity in TV shows popular among boys aged 7 to 13, drawing from a data set of 3,056 characters from 447 episodes. Two of the main findings demonstrate the detrimental implications of gendered norms and normative acceptability of male behavior as they pertain to violence and help-seeking behavior.

- *The most prominent stereotype about masculinity depicted in children's television is of boys and men as aggressors:* In boys' favorite TV shows, male characters committed 62.5 percent of violent acts against another person, compared to 37.5 percent of acts perpetrated by female characters. This portrayal of aggression is particularly true for male characters of color, who were less likely to express an emotion other than anger to other male characters (7.0 percent compared to 14.5 percent of White characters), revealing the perpetuation of a harmful racial stereotype.
- *Overall, male characters are shown as less likely to express emotions in healthy ways than female characters are, keeping even positive emotions to themselves:* Male characters were less likely than female characters to express empathy (22.5 percent compared to 30.6 percent) and even happiness (68.3 percent compared to 75.2 percent). When it comes to romantic relationships, men of color were less likely to be shown communicating with an intimate partner.

Media can also be used by men involved in war and violence to display, influence, or instill a culture of hypermasculinity. Gangs have increasingly used social media to publicly prove their dominance over rival gangs. The use of social media platforms has been found to externally validate gang members, who have larger audiences and an ability to document and broadcast incidents (Irwin-Rogers et al., 2018). Through an in-depth analysis, Reit (2017) found a strong presence of masculine language and virtue signaling on various US military websites and promotional videos and materials. Across a multitude of media platforms targeting different audiences, the connections between violence and masculinity are ubiquitous.

In addition to boys and young men constantly absorbing hegemonically masculine messaging from media platforms, cyberbullying and digital violence are an increasingly serious problem with vast mental health implications. Violence and bullying via social media and private messaging increase vulnerability to high levels of self-harm behavior, including suicide (John et al., 2018). The intersections of gender and cyberbullying victimization and perpetration are complex, but threads of relevant norms around gender expression and masculinity exist around the globe (Navarro, 2016).

Another study, by the Geena Davis Institute on Gender in Media, Oak Foundation, and Promundo (2021), looking at masculinities on the online gaming platform Twitch affirms how prevalent male-on-male and male-on-female lethal violence is in the online worlds that young (and adult) men around the world inhabit.



SECTION 3.3. TRAUMA RELATED TO RACISM, ETHNIC DISCRIMINATION, AND OPPRESSION

Around the globe, groups experience exclusion and discrimination based on racial or ethnic identity. Racial trauma, or race-based stress, refers to “the reactions to events of danger related to real or perceived experience of racial discrimination, including threats of harm and injury, humiliating or shaming events, and witnessing harm of others who share that identity” (Carter, 2007; Comas-Díaz et al., 2019). The scope of this trauma spans from the long-lasting effects of colonialism to the persistent threat of hate crimes and violence because of someone’s race or ethnicity. Due to its chronic and sometimes hidden nature, this exposure can result in complex trauma that accumulates over countless adverse experiences. It is generally difficult to distinguish symptoms that are directly related to racialized rejection, as many people may perceive responses of racism and exclusion as “normal” facts in a world they are forced to cope with.

Racialization and ethnicization are defined the social process of “attributing racial [or ethnic] meaning to people’s identity and, in particular, as they relate to social structures and institutional systems, such as housing, employment, and education” (University of Winnipeg, n.d.). This process is foundational for the preservation and institutionalization of race and ethnicity as social constructs, and it enables the process of creating hierarchies that present opportunities for discrimination, oppression, and exploitation based on these identities. These social forces squarely interact with gendered aspects of the same systems

– further putting boys and men who belong to racial and ethnic minority groups at an increased risk of adversity and trauma.

Explicitly intersectional explorations of masculinity, manhood, and racialization/ethnicization are limited, especially outside of the United States and some European, Caribbean, and Latin American contexts. Recently, health researchers in the United States have used the theory of syndemics, defined as two or more epidemics interacting synergistically, to explore the disproportionate mortality of COVID-19 among US Black men. They unpack the multifaceted risk levels caused by the intersectionality of structural racism, masculinity, and illness comorbidity (Griffith et al., 2021). Additionally, research has been conducted in the United States, Canada, and Germany on the gendered racialization of Muslim men in the context of post-September 11 surveillance and the recent migrant and refugee influxes (Selod, 2019; Yurdakul & Korteweg, 2021). However, the body of existing research does not sufficiently explore the global intersectionality between racialized/ethnicized masculinities and mental health challenges, especially male trauma.

This section attempts to shed light on the unique challenges of racial and ethnic minority boys and men around the world, as pertains to their frequency of adverse exposure and to their ability to adequately cope.

In focus: Discrimination and racism against Indigenous peoples

Indigenous peoples have historically suffered greatly from individual and systemic discrimination – including in the United States, Canada, throughout Central and South America, Asia, and Oceania. Today, over 370 million Indigenous people inhabit 70 countries around the world. They often face mass persecution, forced displacement from ancestral lands, underrepresentation in government, and a lack of social and infrastructure resources (Office of the United Nations High Commissioner for Human Rights, n.d.).

Unfortunately, limited research exists on the specific gendered aspects of Indigenous male vulnerability to trauma or adversity. It is also very difficult to generalize findings, as Indigenous communities around the world are not monolithic. Some researchers have explored the gendered aspects of mental health more broadly in Indigenous communities. For example, Vinyeta et al. (2016) detail the complex intersections of mental health resiliency and vulnerability, climate change, and masculinity among Indigenous communities in the United States. Their findings suggest the changing climate has exacerbated existing health disparities – including mental health disorders – among men within these communities. In terms of discrimination and oppression, Vinyeta et al. (2016) cite earlier research that found, particularly with Indigenous men, “the stress, loss, and cultural changes associated with colonization, combined with the introduction of alcohol, have led to unusually high rates of substance abuse, suicide, and violence within Indigenous communities.” In many parts of the world, colonization has a particular impact on boys and men and on their socially subscribed role in communities as providers and defenders. For instance, the origin of street gangs in Kinshasa, Democratic Republic of the Congo, known as “Bills and Yankees,” emerged in the 1950s as young men’s protest against the domination of Belgian colonialists. These gangs, now known as “Kulanas,” are performing their hegemonic and militarized masculinities by using violence and robbery to protest poverty and inequality (Gondola, 2016).

More broadly, research demonstrates that Indigenous peoples experience a high level of acute interpersonal forms of discrimination. In the United States, studies have found 49 to 98 percent of Native Americans surveyed report experiencing racism from time or time or regularly (Jones & Galliher, 2015; Lee et al., 2019). Men in Aboriginal communities in Australia experience similarly high rates of regular racism—44 percent reporting low-intensity daily racism and 12 percent reporting moderate to high levels (Thurber et al., 2021). Common occurrences include receiving worse customer service, feeling less respected by others, being met with perceptions of fear or criminality (e.g., followed around stores, watched at work or school, and police encounters), and enduring physical or verbal assault or abuse (Thurber et al., 2021).

In some cases, the most detrimental manifestations of racism against Indigenous people are generations of systemic racism in land or social policies and laws. Researchers have documented New Zealand’s Māori Indigenous population’s experiences of differential treatment across most facets of life – from academic success to medical services to conviction and sentencing rates within the criminal justice system (Houkamau et al., 2017). The impact of structural racism against Canada’s First Nations Indigenous people is evident in high rates of poverty and incarceration and in disproportionately low access to clean water, quality education, and adequate healthcare (Loppie et al., 2014). The historical nature of this discrimination results in a collective social trauma that can be passed from generation to generation and inscribed into the Indigenous identity.

Section 3.3.1.

Breaking down racism, ethnic discrimination, and oppression

Racism and ethnic discrimination

In most societies around the world, there is a racial or ethnic majority and one or more minority subpopulations. To create social hierarchies within society, the majority population usually marginalizes the other population(s) and sets structures to assert and maintain dominance (de Leeuw et al., 2011). Racism and other forms of discrimination are most common at the interpersonal and systemic levels of the socioecological framework and take many forms – including acts of violence, subtle microaggressions, implicit biases, or living within systems of oppression that negatively impact them based on their identity.

According to research published by the European Union Agency for Fundamental Rights (2018), 42 percent and 47 percent of male immigrants or male descendants of immigrants from sub-Saharan Africa and North Africa, respectively, living in Europe reported being racially discriminated against in the past five years. In the United States, people who identify as Black, Hispanic, or Asian regularly experience high rates of racism. According to one recent study, 67.5 percent of the Black Americans surveyed, 45 percent of Hispanic Americans, and 56.6 percent of Asian Americans have experienced racism from time to time or regularly (Lee et al., 2019). Although those data are not disaggregated by sex, studies have commonly found an increased rate of perceived racial discrimination among Black men compared to Black women (Assari et al., 2017; Ezzedine & Poyrazli, 2020).

Even in more monoethnic countries like Russia, researchers have found instances of racism against ethnic minorities, including a widespread preferred ethnic hierarchy for hiring practices among Russian employers. Additionally, they have found that minority men experience greater levels of ethnic and racial discrimination in Russia than their female counterparts do (Bessudnov & Shcherbak, 2020). In Ethiopia, men belonging to the Manjo ethnic group face regular discrimination and ethnic aggression by other groups due to their “culture, religion, lifestyle and socially acceptable norms” (Dengechi et al., 2018). In Brazil, 25.4 percent of Black Brazilian adolescents recall

experiencing a racist event, compared to 8.5 percent of non-Black respondents (Santana et al., 2007). In South Africa, racialized experiences of discrimination and adversity, especially during the Apartheid era, disproportionately burdened Black men and forged toxic masculine norms that have since manifested into violence and inequality (Epstein, 1998; Williams et al., 2008). Interpersonal racial discrimination can be perpetrated by random individuals, community members, authorities, service providers, and others.

Systemic or structural racism, or “a system in which public policies, institutional practices, cultural representations, and other norms work in various, often reinforcing ways to perpetuate racial group inequity,” is often seen as less dramatic or detrimental than violent, overt racism but creates lasting inequalities within a society (The Aspen Institute, n.d.). Racial and ethnic minorities in Europe reported heightened levels of discrimination in all aspects of their lives – including police profiling, labor market participation, and access to adequate housing (European Union Agency for Fundamental Rights, 2018). In the United States, structures of oppression based on race and ethnicity are embedded in all facets of policies, laws, and society: immigration policy, criminal justice and policing, employment, education, healthcare, welfare, and more (Tourse et al., 2018). Although it is important to acknowledge that women are deeply adversely affected by these structures, the gendered realities of discrimination also have profound effects on men and boys’ mental well-being.

Black boys and men in the United States and other Western countries epitomize racialized fear, which presents a heightened risk for violence and discrimination by authorities. In the United States and in other parts of the world, the intersection of masculinity and Blackness presents a special space of danger for Black boys and young Black men. This danger is evident in the negativity and fear-mongering common in the media, and it has real-life consequences in their unequal treatment with policing and the criminal justice system. Boys of color are routinely seen as six to eight years older than their actual age. After Tamir Rice, a 12-year-old boy, was mistakenly shot by a White police officer, for example, another officer arriving at the scene noted “Black male down, age 20” (Vaughans & Spielberg, 2014). This racial profiling and perceived

criminality have grave consequences, especially for Black men and boys. The NAACP (2021) reports that Black people in the United States are five times as likely to be stopped by police without cause as White people are – and Black men are twice as likely as Black women to be stopped. Researchers have employed a public health approach to explore the intersections of race and gender as it applies to police behaviors that lead to “justified killings” and other forms of state-sanctioned police brutality of Black men and boys in the United States (Gilbert & Ray, 2016). This racialized and gendered bias results in Black men being 2.5 times as likely as White men to be killed by police in the United States (Edwards et al., 2019).

Criminal conviction rates and sentencing in the United States also demonstrates extreme bias within the justice system. Black men are incarcerated more than five times the rate of White men, resulting in one of every three Black males being sentenced to prison over his lifetime (NAACP, 2021; Spielberg & Vaughans, 2016). Additionally, in the United States, Black male offenders receive an average 19 percent longer sentences than similarly situated White male offenders (United States Sentencing Commission, 2017). Structural racism is omnipresent in education as well – resulting in 24 percent of US Black students being suspended from school at least once, compared to 8 percent of White students (Zill & Wilcox, 2019).

Although less researched through a gendered lens, structural racism and oppression exist in many contexts around the world. Discrimination or inequalities based on tribe or ethnicity are common throughout sub-Saharan Africa, most of which are a legacy of colonialism. Colonial occupation by European powers in most of the world brought physical, psychological, and social violence and trauma to millions of non-White communities, most of which are still suffering from the legacies of inequality (Lloyd, 2011). These narratives are also pervasive in Brazil, where Black and other ethnic minorities are vastly underrepresented in higher education due to anti-Black structural barriers (Daniel, 2020). Often, racial and ethnic minorities are at higher risk of experiencing poverty. One illustrative example is the Roma ethnic group across Europe, 80 percent of whom lived below their country’s at-risk-of-poverty

threshold, according to a 2018 survey (European Union Agency for Fundamental Rights, 2018).

Racism, ethnic oppression, and genocide

Although oppression and genocide fit under the umbrella of racial and ethnic discrimination, these most egregious and severe forms deserve their own subsection to fully highlight the negative psychological, social, and physical trauma they can cause. As of this writing, Genocide Watch (n.d.) reports 18 conflicts that exhibit the early signs of, beginning stages of, or established and declared genocide campaigns: in Iraq (2), China, Azerbaijan, Syria, South Sudan, Ethiopia, India (2), Turkey/Syria/Iraq, Yemen, Myanmar (2), Burundi, Nigeria, Central African Republic, Somalia, and Sudan. The common historical examples of Nazi Germany and Rwanda serve as reminders of the immense devastation and human toll that follow such an event. However, it is important to note that these atrocities continue to happen around the world.

Common tactics during genocide include mass starvation, mass forcible displacement, bombardment of service centers like hospitals and schools, rape and torture of civilians, and obstruction of humanitarian aid (United States Holocaust Memorial Museum, n.d.). Although genocide and systemic oppression affect all genders, research has shown how racialized and ethnicized violence targets men and boys to emasculate, degrade, and weaken them physically and psychologically (Bradford Di Caro, 2019; Ferrales et al., 2016). These occurrences are seen across all regions of the world. Since 2017, the Rohingya ethnic minority in Myanmar has been attacked and forced to flee to neighboring Bangladesh; over 880,000 people had been displaced and required shelter, food, security, healthcare, and more as of mid-2021 (UNICEF, n.d.). For decades in Darfur, Sudan, militias have been bombing and destroying villages; raping, torturing, and murdering hundreds of thousands of people; and displacing more than 2 million people from their homes (World without genocide, n.d.). These campaigns aim to permanently exterminate groups of people based on race, ethnicity, or religion, which is unfathomably traumatizing.

In other situations, genocidal or ethnic cleansing campaigns are subtler and do not involve mass violence to communities in the form of destruction. Rather, state or non-state actors employ strategies to eliminate certain beliefs or identities of minority groups – as currently exemplified with the Uyghurs in China and also historically with residential schools for the First Nations Indigenous population in Canada and with internment camps for people of Japanese descent during World War II in the United States (Human Rights Watch, 2021; Cecco, 2021; Nagata et al., 2019; Su, 2011). Although intersections with gender are largely missing from the research on these topics, it is evident that boys and men have experienced a wide range of adverse events, including forced labor, sexual assault and abuse, and more. Beyond these campaigns’ immeasurable trauma to populations, governments or institutions hiding these operations, gaslighting, or manipulating the narrative are added elements of experienced trauma.

Section 3.3.2.

Consequences of racism, ethnic discrimination, and oppression

Racism and ethnic discrimination are social determinants of health that have dangerous and lasting effects on the well-being of boys and men (Harrell et al., 2011; Paradies et al., 2015; Williams et al., 2003). Population-specific studies have found consistent negative well-being outcomes associated with race- and ethnicity-related trauma. Most commonly, this includes mental health and psychosocial well-being (e.g., depression, anxiety, psychological distress, and PTSD), physical health (e.g., heart disease, obesity, high blood pressure, and diabetes), behavioral health (e.g., smoking, gambling, alcohol consumption, and violence), and social health (e.g., low control over life, confusion or erasure of

cultural identity, and social isolation) (Kirkinis et al., 2021; Paradies et al., 2015; Polanco-Roman et al., 2016). It is important to note that one outcome rarely presents itself independently; in many cases, comorbidities and multimorbidity exacerbate health outcomes for individuals who experience racism or ethnic discrimination.

Mental health and psychological well-being

Globally, men and boys who experience racial and ethnic discrimination experience adverse mental health outcomes. Common among these are lower self-esteem, psychological stress, anxiety, lower life satisfaction, PTSD, suicidal ideation, and paranoia (Paradies et al., 2015). These outcomes are almost universal across racial and ethnic minority population-specific research. There is no definitive correlation between gender differences and racial and ethnic discrimination, as this relationship is highly dependent on the nature of the trauma; however, some studies have found gendered associations for racial discrimination to be predictive of poor mental health outcomes for males and not females, particularly within Arab American and Black American groups (Assari et al., 2017; Assari et al., 2015; Assari & Lankarani, 2017). Among Manjo ethnic minority men in Ethiopia, researchers have found that perceived ethnic discrimination is significantly associated with poor psychological well-being, self-acceptance, purpose of life, and personal growth measures (Dengechi et al., 2020). Additionally, Aboriginal people in Australia who had experienced moderate-high discrimination were three to four times as likely to report low life satisfaction and low happiness compared to those who reported no discrimination, and they were two times as likely to report psychological distress and doctor-diagnosed anxiety and depression (Thurber et al., 2021).

Insight from the field: Racial trauma

Spielberg: A 12-year-old Black boy comes to my office for my therapy. He has recently been suspended from his all-White school. He has been accused of cheating and aggressive behavior. As he enters the room, he refuses to acknowledge or speak with me. He remains silent for months. At first, I believe that he was defiant towards me. However, with time, I realize that he has been traumatized. His feelings are frozen; he is fearful, depressed, and angry. His mother reports that after facing a tribunal of teachers and administrators, he has been unable to sleep well. He has also taken to bullying his younger siblings.

Later, a complaint by his parents instigates an investigation by an outside advocacy group. He is exonerated. But the damage has been done. It will take us months before he trusts his White therapist and even longer before he feels comfortable in his new school. Unfortunately, he has become one more casualty of a biased school system, where Black children and boys are significantly overrepresented in suspensions and expulsions (United States Government Accountability Office, 2018). Not only was he psychologically impacted by the traumatizing attack, but he also faces continual threat to selfhood in an environment that does not fully appreciate his humanity and positive identity.

In cases of genocide or ethnic cleansing, the psychological toll on survivors is far more severe than with other forms of daily interpersonal discrimination based on ethnicity or race. More intense and longer-lasting symptoms of PTSD are common among survivors, including boys and men. For example, in a refugee camp on the Thai-Cambodia border, a study found that symptoms of PTSD and acute depression were common. Flashbacks and reliving horrors were nearly unanimously present in all victims 12 years after suffering genocidal trauma (Meierhenrich, 2007). Researchers in Rwanda affirmed a significant dose-response correlation among children who were exposed to extreme trauma during the genocide. Of a sample who were 3 to 7 years old during the genocide, 44 percent interviewed exhibited strong symptoms of PTSD and other psychological ill-health (Schaal & Elbert, 2006). Similar studies of Bosnian survivors of ethnic cleansing found enduring mental health and psychological scars from repeated trauma (Momartin et al., 2003; Weine et al., 1998).

Boys and men experiencing displacement face significant obstacles that can negatively impact their mental health and well-being. Rooted in feelings of unsettledness and a lack of agency and purpose, boys and men generally are anxious, are frustrated, and have reduced self-esteem. Their trauma from their journey to exile is exacerbated by their current experiences of homelessness, financial instability, and sometimes a loss of family. These stresses

are particularly amplified for unaccompanied boys, who are often newly separated from their social support system (CARE & Promundo, 2017).

Poor psychological health, a common consequence of racial and ethnic discrimination, greatly influences participation in unhealthy behaviors. Manifold health-inhibiting behaviors are more common among boys and men experiencing racialized stress and trauma, including related to diet, physical activity, smoking and substance use, risky behaviors, and help-seeking behavior (American Psychological Association, Working Group on Stress and Health Disparities, 2017; Ehlers & Gizer, 2013; Skewes & Blume, 2019; Thurber et al., 2021).

Illness and disease

A global systematic review of research found common physical health outcomes from experiencing racial and ethnic trauma include high blood pressure and hypertension, heart disease, diabetes, being overweight, and physical disability. Other sources have found a higher likelihood of experiencing various physical health outcomes, including asthma, bodily pain, exhaustion, fever, headache, major paralysis, muscular problems, nausea, and neurological conditions (American Psychological Association, Working Group on Stress and Health Disparities, 2017;

Paradies et al., 2015). The cumulative physical effects of racial and ethnic discrimination are starkly seen in life expectancy data. In the United States specifically, White men on average live 4.9 years longer than Black men (Arias & Xu, 2020). These disparities in physical health have been exacerbated by the COVID-19 pandemic, wherein rates of infection were significantly higher in racial and ethnic minority populations (Griffith et al., 2021). Due to these disparities, life expectancy differences along racial and ethnic lines in the United States widened – between 2018 and 2020, life expectancy fell 3.88 and 3.25 years for Hispanic and Black populations, respectively, compared to only 1.36 years for White (Woolf et al., 2021).

Social belonging

Tied closely to the broader psychological consequences of discrimination based on race and gender, racial or ethnic minority boys and men experience high levels of “othering” and social exclusion, which deeply affects their sense of identity and relationships with other groups. For example, in the United States, Black boys and men experience very high rates of psychological othering, rooted in the societal viewpoint that they are threatening and dangerous (Vaughans & Spielberg, 2014). However, it is important to note that social belonging and support are not particular to racial or ethnic trauma. In fact, they are widely seen by the MHPSS community as a preventative factor related to PTSD and other stress-related problems after a traumatic exposure.

A study in Australia revealed a correlation between experiences of racial and ethnic discrimination and “feeling torn between Aboriginal and Torres Strait Islander and non-Indigenous culture,” indicating

a feeling of disconnect from their culture. A key indicator of cultural health is self-determination and self-control of their lives, which was found to also be negatively impacted by experiences of discrimination (Thurber et al., 2021).

US people of Middle Eastern descent experienced a rise in hate crimes and overt racism after the September 11 terrorist attacks. Awad et al. (2019) offer a conceptual model to explain this collective ethnic trauma and its impact on identity. The authors highlight simultaneous feelings of hypervisibility, characterized by experiences of persistent discrimination, and invisibility as an overlooked minority group that is not generally recognized as such. The intersectionality of religion and ethnicity also plays a large role in the Middle Eastern American identity and can heighten the internalization of discrimination (Awad et al., 2019).

Racial and ethnic persecution and genocide are extreme situations that incite extreme collective trauma. Models of trauma for genocide survivors, or survivors of human rights violations generally, include aspects of social awareness and cohesion. One model highlights the common impacts of such trauma, including negative beliefs about humans, decreased interpersonal trust, expectations of harm and betrayal, and a decreased sense of belonging and collective self-esteem (Nickerson et al., 2014). Interesting research in Rwanda has explored the relationship between traumatic exposure and attitudes toward reconciliation and justice; it found that survivors with increased exposure to traumatic events were less in favor of reconciliation or renewed interdependence with other ethnic groups and less likely to support the national Gacaca community justice system (Pham et al., 2004).

In focus: Black men and boys in the United States

Unaddressed racialized trauma leads to violence within communities. Boys and men of color in the United States are directly and indirectly exposed to community violence at very high rates. Homicides are the leading cause of death for Black American boys and men aged 15 to 39 – accounting for 85 percent of all victims of nonfatal and fatal violent crimes in the United States (Annest, 2013; Graham et al., 2017; Harrell, 2011). Miller and MacIntosh (1999) found that urban Black and Hispanic boys reported high rates of lifetime exposure to community violence. Almost all (96 percent) had witnessed at least one violent event, and three-quarters had witnessed four or more different violent events. Of the sample, 84 percent had heard gunshots, 87 percent had seen an arrest, and 25 percent had seen someone be killed. These numbers represent a cumulative impact on boys and young men that is staggering.

Rampant community violence leads to paranoid substitutes for trust: Aggression replaces nurturance, and forms of negative identity emerge that involve criminality. Social bonding becomes tribal, which allows individuals to defend themselves against loss (Patterson, 2016). Unable to acknowledge the pain and hurt or to find safety in healing relationships, Black men and boys may develop hypervulnerability to trauma characterized by depression, rejection sensitivity, and fear – resulting in a quarter of violence-exposed Black males exhibiting PTSD symptoms (Cassidy & Stevenson, 2005; Thompson, 1996).

In societies that hold exaggerated racialized fear and prejudice, racial and ethnic minority boys often experience early traumatization in school. In school, boys of color are overly disciplined and placed in programs for people with mental health issues without proper evaluation (Gregory et al., 2010; Marchbanks et al., 2018; Shepard, 2021; Skiba et al., 2002). In research with Black boys and their families, researchers have heard stories of boys being rejected by teachers, of being asked to always sit in the back of the class, and of being accused of cheating when they did well (Spielberg, 2014). Their early mistreatment in school and their inability to cope with the negative minds of teachers are factors behind their inordinate rate of school suspension and expulsion.

As detailed earlier in Section 3.3, racial and ethnic minorities around the world face disproportionate amounts of policing and incarceration. These experiences impact their health and well-being. Research in the United States demonstrates that Black boys and men who experience traumatic racial discrimination (e.g., being stopped by the police or suspended in school) develop significant health challenges. Boys and young men who suffer racial trauma are more likely to engage in riskier behaviors as a way of coping with their diminished self-esteem and lack of felt protection. Such behaviors include smoking, substance misuse, and violence (Powell, 2015). The effects of mass incarceration are devastating to the mental health of currently and formerly incarcerated people. A random sample of adult men residing in a single high-security prison was screened for trauma exposure and PTSD symptoms. Trauma was a universal experience among incarcerated men, and rates of current PTSD symptoms and lifetime PTSD were significantly higher (30 to 60 percent) than rates found in the general male population (3 to 6 percent) (Wolff et al., 2014). Moreover, these rates of trauma and PTSD were associated with other psychiatric disorders.

Community racial trauma becomes magnified because of mass incarceration and high rates of surveillance and policing. It becomes a primary source of continued disempowerment, as well as economic deprivation for communities of color. Exposure to the formerly incarcerated is itself vicariously traumatizing and also leads to a pessimistic outlook underpinned by the sense that masculinity itself leads to danger from the authorities. This sense of inner toxicity, compounded with provocations by peers and authorities, becomes a self-fulfilling prophecy as boys and young men are set up for future violence, trauma, and punishment (Vaughans, 2021).

Intergenerational health effects of trauma

As discussed in the introduction, racial and ethnic discrimination over generations can lead to transgenerational trauma for groups, regardless of group members' own individual exposure to traumatic events. Transgenerational trauma has significant negative health effects, consistent with other forms of racial and ethnic trauma. In this regard, Yehuda and her colleagues (2016) have found an association of parental and community trauma with epigenetic changes in offspring. In one qualitative study with Native American individuals, one respondent said:

"There's a hole in your heart that cannot be filled due to losing a loved one, due to something that happened maybe three or four generations ago with our grandparents. We carry that, but we don't know what it is. And if we don't know what it is, and we're not offering things to help our children and our people understand, then how are we going to heal? So, you have intergenerational trauma. You carry that, and it's in our genetics" (Skewes & Blume, 2019).

These sentiments are consistent with many historical wounds of cumulative traumatic events, such as genocide, slavery, and war. For instance, the present-day lived experience of Black men and boys in the United States still carries the historical narratives of traumatizing events like chattel slavery, the Three-Fifths Compromise, and Jim Crow segregation, among others.

Another example of transgenerational trauma is the cognitive and noncognitive effects among fatherless or single-parent children. Being raised by one parent or placed in a temporary or transitory housing situation (e.g., foster care) is more common among racial and ethnic minority children given increased rates of incarceration and violence and decreased life expectancy. In fact, Black children in the United States are six times as likely as White children to have a parent currently or formerly incarcerated. Common consequences provoked by traumatic events like fatherlessness include an increased likelihood of living in poverty, drug and alcohol use, suicidal ideation, and more (Fathers.com, n.d.). The Economic Policy Institute and others have found that children in this category experience poorer educational achievements, including

an increased likelihood of dropping out of school, developing learning disabilities, misbehaving in school, and suffering from "migraines, asthma, high cholesterol, depression, anxiety, PTSD, and homelessness" (Gualtieri et al., 2020; Morsy & Rothstein, 2016).

Section 3.3.3.

Connections to masculine norms

Individual barriers to coping with racism, ethnic discrimination, and oppression

As with the literature on coping with trauma, few researchers have explored the intersections of masculine norms and race. Depending on the type of racial or ethnic trauma experienced, Section 3.1 on assault and abuse and 3.2 on war and violence could be relevant as well. It is important to note that the added factor of race or ethnicity significantly intensifies feelings of "otherness" and social isolation, compounding the connections detailed in these sections.

Elements of restrictive emotionality are commonly cited masculine norms that inhibit racial or ethnic minority men from properly coping with discrimination (Hammond, 2012). Significantly strong associations have been documented between higher levels of restrictive emotionality and increased depressive symptoms among Black men aged 18 to 39 (Powell, 2016). Furthermore, the presence of depressive symptoms and adherence to hegemonic masculine norms have been found to greatly impede a man's willingness and desire to seek help (Powell, 2016).

Research highlights the norms of control and autonomy as factors in a Black male's possible reluctance to engage in help-seeking behavior – specifically attempting to regain a sense of freedom and self-sufficiency amidst threats to his racial identity (Powell, 2016). Consistent with other studies, Powell et al. (2016) found that a diminished sense of personal mastery and of control are critical barriers to help-seeking behavior and are far more common among men who experience racial discrimination regularly. This research found everyday racial discrimination is a significant barrier to help-seeking behavior among men, with a dose-response relationship, specifically when men perceive a presence of threatening events or discrimination related to help-seeking.

The level to which a man or boy embraces his racial or ethnic identity has also been found to play a role in the way he copes with racially related stresses, particularly among adolescents who are transitioning from boyhood to manhood. Thomas et al. (2015) found aggression and poor coping strategies to be particularly common among boys and men in the early stages of identity development, both in terms of their race and gender expression.

Pride and superiority are notable pillars of hegemonic masculinity around the world. Boys and men are socialized to be protectors and defenders and are expected to be in power. However, this is antithetical to the foundational principles underpinning racial and ethnic discrimination, oppression, and persecution. Structural and personal experiences of racism – and of racially and ethnically based trauma – continuously prevents boys and men from attaining the socially desired status of manhood. The socially constructed hierarchy places them in an inferior position, which can elicit feelings of inadequacy and shame. Frustrated and denied their right to freely live, they are forced to be overly resilient in coping with stress, a capability that is beyond many young men. Instead, many boys and young men exposed to racial and ethnic trauma overreact to threat and may engage in risky and omnipotent behavior as they attempt to counteract the vulnerability associated with states of powerlessness and abuse.

Societal and structural barriers to responding to racism, ethnic discrimination, and oppression

As highlighted in Section 3.1 on assault and abuse, structural barriers to high-quality, tailored healthcare exist in many contexts for men, particularly around the perceived acceptability and accessibility of mental health services. These barriers and disparities, most of which are rooted in socialized beliefs of masculinity, are further exaggerated when intersected with race and ethnicity. This section builds on Section 3.1 by highlighting the compounding nature of racial and ethnic biases throughout society.

First, it is important to mention that this is not a new phenomenon. The 1999 and 2001 US surgeon general's reports on mental health highlight the lack of access to mental health services among racial and ethnic

minorities. The reports assert that racial and ethnic minorities not only are less likely to receive the care they need but also receive poor-quality care when they do access services (McGuire & Miranda, 2008; United States Department of Health and Human Services, 1999). Unfortunately, little research has been conducted regarding access to, use of, and satisfaction with mental health services among non-US-based racial and ethnic minorities.

Over the past two decades, research efforts have documented systemic discrimination and racism within the US health system and across other sectors of society (Bailey et al., 2017). Highlighting other consequences of structural racism, commonly cited logistical barriers to accessing mental health services include physical access to services due to location and transport needs, service availability outside of normal working hours, and cost of services vis-à-vis insurance coverage (Snowden, 2003; American Psychological Association, Working Group for Addressing Racial and Ethnic Disparities in Youth Mental Health, 2017). Additionally, attitudes toward and trust of the healthcare system are commonly cited as more negative among racial and ethnic minority populations given negative historical experiences of widespread racism in science and medicine (Perzichilli, 2020).

On a human level, service providers' racialized and ethnicized gender bias toward boys and men – both implicit and explicit – plays a large role in the quality and appropriateness of diagnosis, care, and treatment (American Psychological Association, Working Group for Addressing Racial and Ethnic Disparities in Youth Mental Health, 2017; Whaley, 1998). Widely shared beliefs and attitudes about specific populations can include lack of receptiveness to treatment, hostility, naivety, superstition, or being otherwise challenging or unpromising patients (Snowden, 2003). These perceptions, compounded by widely held beliefs on masculine norms, result in devastatingly low levels of compassionate care for racial and ethnic minority men and boys. Recent research of medical records has revealed: "African American males were disproportionately and incorrectly diagnosed with more severe disorders (e.g., schizophrenia) than White males because of psychiatrists' biased beliefs that African American males were likely to be violent, suspicious, and dangerous" (American Psychological

Association, Working Group for Addressing Racial and Ethnic Disparities in Youth Mental Health, 2017; Gara et al., 2019; Schwartz & Blankenship, 2014). These racialized diagnostic biases resulted in Black men being diagnosed with long-term schizophrenia three to four times more often than White men (Schwartz & Blankenship, 2014).

Commonly, men and boys – particularly those belonging to racial and ethnic minority groups – are not provided the benefit of the doubt in situations of misbehavior or perceived criminality. This is compounded by intersections with race. Notions of racialized and gendered fear of racial or ethnic minority boys and men often exist among the majority population (Day, 2006; Wilson et al., 2017). This fear and perceived threat commonly result in inappropriate responses to problems or situations that are unnecessarily escalated. Research has found pervasive stereotypes of young Black men in the United States (i.e., more physically threatening and less innocent) to strongly influence the behavior of police and the criminal justice system, resulting in more police brutality and killings and in more frequent convictions and longer sentences for young Black men (Wilson et al., 2017). In general, the “services” provided to racial and ethnic minority men and boys are punitive rather than supportive. This is starkly illustrated by differences in

police actions during episodes of mental illness and involuntary civil commitment. Research found that Black men and boys are more likely to be brought into the emergency room by police involuntarily than White men and boys are (Lindsey & Paul, 1989; Rosenfield, 1984). This also partially accounts for the disproportionate rates of corporal punishment, detention, and suspension in schools among racial and ethnic minority boys in the United States.

It is crucial for healthcare providers, social workers, law enforcement officers, and others to recognize racial trauma in racial and ethnic minority men and boys. This can commonly manifest as deviant behavior, vulnerability to abuse and violence, high sensitivity toward rejection and accusation, oversensitive self-awareness, feeling observed and judged, elevated levels of negative experiences, and feeling excluded or criticized. In fact, all racial and ethnic minorities may experience a wide range of responses in terms of their physical appearance being different, some of which may not be medically labeled as “traumatic.” Recognition and acknowledgment of the influence of color on mental health and well-being is important, and furthermore, should aim to positively address the root causes of the racialized response rather than be a disciplinary response to the subsequent behavior.

In focus: A gap in gendered responses in humanitarian situations

Often, and for valid reasons, “gender” or “gender mainstreaming” connotes “women and girls.” Humanitarian and post-conflict emergency responses are no exception. Over the past decade, heightened efforts to integrate gender-sensitive approaches into refugee and other humanitarian responses have resulted in more intentionality tailoring services and support to women and girls experiencing trauma. However, this has unintentionally left men and boys out of the gendered lens. As discussed earlier in this report, racial and ethnic cleansing and genocide result in desperate and vulnerable situations around the world, including for men and boys. In a crisis context, whereby increased levels of sexual abuse, psychological trauma exist, and basic needs are not met, a gendered approach that is inclusive of men and boys is necessary to adequately address high rates of severe and chronic trauma. However, support remains largely nonexistent. The role of male trauma as an important driver in the continuation and revivals of conflict, as well as the psychosocial needs of men and boys, have been neglected in this field. A recent meeting of the International Organization for Migration (2020) stated, “Men and boys have been neglected in the field of humanitarian services as they are considered less vulnerable and face cultural barriers to seeking and receiving mental health services.”

A large-scale analysis of key policy texts and interviews with humanitarian workers revealed three common stereotypes of men in emergency situations: perpetrators of violence and discrimination, powerful gatekeepers and potential allies, and emasculated troublemakers (Olivius, 2016). Furthermore, a report detailing unaccompanied boys’ and men’s experiences found similar narratives describing a lack of male vulnerability and a dangerous gendered stereotype that “men can cope” by themselves (CARE & Promundo, 2017). This is also consistent with an analysis conducted on United Nations Development Programme materials and response to domestic violence during the aftermath of the Kosovo conflict in the late 1990s; findings affirmed that most of the attention, awareness, and action largely ignored male victims of violence, particularly adult men (Piccard, 2011). Through language used for reports or programs – like the “Women’s Safety and Security Initiative” – the absence of male consideration has left many forms of trauma among men and boys unaddressed. In the Syrian refugee context in Jordan, researchers explored perceptions of refugee men and boys and masculinity among humanitarian workers, finding strong evidence that the way these workers viewed refugees as objects of humanitarian care was detrimental to the assistance offered and provided to them (Turner, 2019).

Generally, structural biases allow for humanitarian workers to not recognize or address the vulnerabilities of refugee men and boys (CARE & Promundo, 2017). The system of “status-based categorization” within the current framework generally further isolates males from services, particularly lone men ages 18 or older, as they do not fit within a high-risk category. This de-prioritization of boys and men in emergency response is rooted in donors’ and international organizations’ lack of political will to meaningfully acknowledge that vulnerability exists beyond women and girls (CARE & Promundo, 2017). Chronic inattention to boys and men has resulted in programs, services, and spaces not being sufficiently tailored to meet their needs. At the global level, this common narrative has problematic consequences: Most notably, gendered power relations are obscured, refugee men’s masculinity is pathologized as “primitive,” and attempts to take the needs of men into account often turn into an argument against the empowerment of refugee women (Olivius, 2016).

WAYS FORWARD

4.



SECTION 4.1. KEY TAKEAWAYS AND INSIGHTS

Social exclusion – in forms such as poverty, violence, racism, and sexism – is among the consequences of global power inequality. Trauma responses are not only symptoms of individualized problems but also expressions of protest, inequality, suffering, and pain by people trying to survive in an imperfect and unjust world. Structural changes are fundamental steps toward a safe and equitable world for all people, and recognizing and acknowledging gendered responses to trauma and the psychosocial needs of men and boys is a first step to achieving this change. It is more important than ever to carefully examine men and boys' harmful, often destructive behavior toward themselves and others as a possible sign of suffering, trauma, and/or protest. Men and boys – alongside women, girls, and people of all genders – should be united in building sustainable peace and promoting holistic health and well-being.

We must do a better job of protecting boys and men

Harsh codes of masculinity and manhood, among other reasons, are producing boys and young men who are unprotected, suffer physical abuse, and who become engaged in war and conflict at an early age. These scripts create vulnerabilities to adversity and trauma and often lead to poor resilience in dealing with negative emotions and challenges. These challenges to resiliency and healthy coping responses are rooted in the early childhood development and socialization process, which evolves into diverse masculine identities that are often characterized by maintaining power, being tough, and being in control. As discussed in Section 3.3, we must recognize that racial and ethnic

minority boys and young men experience unremitting discrimination on both the structural and personal levels, which leads to early exposure to violence, social exclusion, and incarceration.

We must continue to challenge antiquated models for raising boys and young men and liberate them to live safe and protected lives. This will require interventions with policymakers, the media, community leaders, and parents with the message that compared to female peers, boys and young men are similarly vulnerable to mistreatment, ruptures in attachment, and neglect. Protecting boys in childhood will go a long way toward helping them become more resilient adults.

As noted throughout this report, the systems and environments within which men and boys live, play, work, and learn need to be conducive and assistive to their individual and collective identity. Discriminatory or oppressive systems and structures are chronically detrimental to the mental health and well-being of billions of men and boys around the world. We must begin to dismantle these systems and move toward a more inclusive and equitable society.

Intersectionality is key to our understanding of, and response to, trauma. Social support and protective structures should consider vulnerabilities that increase the risk of traumatic events, such as having links to specific institutions, being sexual or gender minorities, or belonging to minority races or ethnicities. In humanitarian and conflict settings, we must improve protections for refugee and migrant boys and men, especially unaccompanied boys and young men. Widely held dismissive attitudes toward

male vulnerability discussed in this report should be interrogated and shifted toward a trauma-informed and psychosocially aware approach to supporting and protecting boys and men.

We must make male trauma more visible

Although we hope to protect boys and girls better than we do now, we must acknowledge that adversity and exposure to traumatic events are part of living. Children will continue to experience parental loss, household and community violence, and institutional racism. However, such experiences do not have to turn into complex trauma. It is incumbent on us to provide protection and support to children who have experienced traumatic events. Unfortunately, this is increasingly difficult, as men and boys' trauma exposure to adverse experiences is often hidden and denied. Adults may assume that boys who are aggressive, stoic, or oppositional are simply "acting like boys." We must educate stakeholders (such as parents, policymakers, and schools) to acknowledge the vulnerabilities of boys and men and recognize the signs of and responses to trauma and anguish underneath their dysfunctional behaviors. In this regard, we must further educate the public, particularly gatekeepers like the police and teachers, on the signs of male responses to trauma. These include a wide range of behaviors and signs, such as bullying, alexithymia, emotional numbness, substance abuse, and risk-taking behavior, as well as criminality, abusive and/or inappropriate sexual behavior, and the use of violence. We also must educate all those actors to rethink possible motivations for negative behavior and provide space and time to listen to the narratives behind them.

In this regard, we must acknowledge and recognize men and boys' gender-specific responses to a wide range of traumatic experiences, including adverse childhood experiences. We must strive to counteract the stereotypical denial and neglect of their mental health and psychosocial needs because they are male. Many problems at the individual and collective levels related to violence, insecurity, and conflict are rooted in perceptions and experiences of masculinities. Men and boys are disproportionately involved in war, homicide, gun violence, and terrorism compared to women

and girls. While women and girls are most affected by sexual and gender-based violence in war and in peacetime, boys and men deserve equal attention, care, and treatment at the societal level and at home.

Making the connections between masculinities and trauma starts with recognizing and acknowledging men and boys' traumatic experiences and trauma responses. Problematic, deviant, stereotypical, risk-taking, violent, and dominant behavior may be connected to such experiences. Gender norms on masculinity and femininity are interconnected with the trauma response of men and boys (and of women and girls). Interventions and programs to address male trauma should include social norms change interventions and go beyond psychomedical models of trauma treatment as only an individually diagnosed problem. Feministic psychotherapy movements in the 1980s made an important shift from categorizing women and girls as hysterical, weak, ill-functioning, and needing psychiatric treatment toward women and girls being affected by an environment of violence and abuse. The politicization of women and girls' MHPSS needs was crucial for the women's rights and gender equality movements. A similar shift is needed to not think of men and boys' criminal and violent behavior as being driven by male hormones and men's natural drive to dominate; rather, these should be considered context- and culturally facilitated behaviors that deny and neglect male vulnerabilities and psychological needs.

We must create gendered responses to trauma that fit the needs of boys and men

Successful treatments must consider the gendered needs of boys and men, including their gendered responses to adversity. How do they define and understand their problems in the context of being a boy, man, (or any gender identity)? Men and boys face a wide range of difficulties that cannot be separated from their contextual and cultural expectations of being male. A normal neurological reaction to a threatening event mobilizes our autonomic nervous systems for "fight or flight" to survive. Scholars have found differences in men's and women's psychological responses: Men show more active defensive coping responses and more often engage in violence - "fight"

- while women tend to employ more passive responses - "flight" (Olff et al., 2007). However, these responses cannot be isolated from the sociocultural context and gender socialization.

Models of more effective responses to addressing men and boys' mental health and psychosocial challenges must include individual and/or group and community-based interventions. However, the major challenge is to provide context-specific models for providing psychosocial support and treatment to men and boys that is sustainable and that can be used in both the Global North and South. Trauma treatment models in the Global North include a wide array of specialized psychotherapeutic and psychiatric models that are, in general, gender-blind and not applicable to all cultures and contexts. There is growing awareness and acknowledgment globally of the limitations to the Global North psychological framework in understanding the psychology of cultures and people with other cultural norms and backgrounds. In all cases, we must develop and adopt models that are fully gendered and culturally appropriate.

Clinicians around the world must be better trained to offer mental health services to boys and men. Psychotherapeutic treatment models - regardless of approach - should fully integrate a gender-specific lens that uses a gender-equal perspective. Whether clinicians use cognitive behavioral, psychoanalytic, emotion-focused, trauma-focused, eye movement desensitization and reprocessing (EMDR), or group-dynamic therapy - or another form of treatment - they must strive to approach their work with a gender-specific lens. Psychologists and mental health workers working from Indigenous psychological frameworks using pluralistic therapeutic models should also include the gender-specific lens. Success in working with men and boys depends most on the therapist's attitude and competence to apply the model in a gender-sensitive way; to acknowledge, recognize, and address the psychological needs of men and boys, including male trauma, as rooted in cultural attitudes about masculinity; and to make the connections with masculinities. One of the objectives of any treatment must be to support men and boys in creating more space in their own gender-role perception to deal with the consequences of stress.

We must further strive to create effective models for helping boys and young men cope with collective trauma. Families, communities, and societies traumatized by disaster, war, conflict, genocide, and natural disasters need collective responses and treatment. That is to say, traumatic experiences that are collective need collective responses. Acknowledgment, recognition, and gender-specific responses are crucial to understanding how men and boys, women and girls, and people of all gender identities are coping with the problems they are facing.

We must also develop models for working with perpetrators of violence. Punishing such men without providing psychosocial support - including, if applicable, psychotherapeutic treatments that encourage redemption and reparative justice work - is both cruel and ineffective. Increased attention and interventions are needed for men and boys who are at risk of, or already engaged and involved in, violence. This includes the huge number using violence on behalf of their nation (e.g., peacekeepers, police, and militaries), those serving in the name of their people or groups (e.g., members of rebel, terrorist, or extremist groups), and those engaging in criminal violence.

We must do a better job of amplifying positive male models of identity and continue to break the gender binary

Trauma and masculinity are inexorably tied by virtue of the link between violence and identity. Many boys and men strive to be "heroes" - an identificatory maneuver that can help them transcend many of the traumas they have experienced. Portraying their better selves as "being responsible and wise" provides men and boys with a meaningful, respected role and position.

However, many of their ideas about male heroes and "being responsible and wise" are deviant, in that they promote violence as a solution or justification to psychological suffering.. However, there are other, more powerful and reparative ways to overcome catastrophic loss and abuse. These ways often involve helping others, taking up positive responsibility, and addressing the emotional needs of men and boys in a concerted manner. In

this regard, there are already healthy models of masculinity available in the cultural, spiritual, and religious lives of many communities. Boys and men can look up to these male heroes and respected, responsible men who are constructive and nurturing in their orientation. In every community, there are men who are good fathers and male community leaders who are conducting their lives with dignity and integrity. We must provide men and boys with the freedom to break out of rigid expectations of manhood to experience the full emotional range of humanity and human relations based in connection, reciprocity, and empathy.

We must acknowledge that helping men develop post-traumatic resilience requires restorative work

In our work, we have seen that the way out of trauma requires going into it. That is, overcoming trauma requires that we open ourselves up to the experience of trauma and that we acknowledge the harm we have often caused stemming from our own harmful coping. However, healing does not stop there. There are various figurative examples of this, including the example of the young man who was sexually abused and agrees to call out his abuser in court but also goes on to build an NGO that protects young men from such abuse. And the example of a firefighter who loses his brother on September 11 and turns his trauma and grief into building a foundation to help wounded soldiers.

A Black man from Chicago who suffered race-based abuse and rejection at school and dedicates himself to ending mass incarceration. Another man orphaned young in life doing the work to become a good father, and by doing so, heals himself and others. A former child soldier in the Democratic Republic of the Congo serving as a social worker in schools to prevent boys from being recruited. A traumatized and violent husband whose wife was raped by rebels starting to study psychology to help others. While we often tell the stories of violence and trauma paying forward as more violence and trauma, these stories of resilience and restorative approaches must be the way forward. Cycles of male trauma can be broken.

In this regard, we must build support for understanding and addressing male trauma by engaging and involving men and boys to support others who have faced hardship and/or trauma. Women's empowerment activities have been healing for many women and girls who have been the victims of sexual and gender-based violence, as well as have shown their strength and power to fight as survivors. Similarly, engaging men and boys in supporting gender equality, providing care work, and combating sexual and gender-based violence is helping men and boys to change their harmful actions and attitudes and to initiate constructive, pro-social, caring actions. Ultimately for men and boys, recovery from trauma means building healthy masculinities – healthy humanity – and not merely the absence of harm and trauma.

SECTION 4.2.

RECOMMENDATIONS

FOR ACTION

Researchers and academics

1. Conduct global research on the prevalence and course of male trauma (experiences of adversity and responses), with an intersectional lens to identify subgroups of men who experience disproportionate vulnerabilities; this could include the impact of adverse events on boys and men, how different expressions of masculinities mediate such events, and what the ensuing symptoms or responses are to these events.
2. Increase applied research efforts in non-Western countries and among refugee/migrant populations – led by Global South researchers and others – to develop specialized, evidence-based, gendered psychosocial interventions to deepen the prevention of and response to men and boys’ trauma.¹
3. Increase attention to the psychology of boyhood and male social development and its links to male trauma, including cultural differences in parenting and broader social interactions from infancy through adolescence.
4. Ensure research in humanitarian contexts intentionally includes boys and men and interrogates their vulnerabilities to adverse events to inform a meaningful response by protective and social structures.

5. Research the role of unaddressed, denied, and/or neglected trauma experiences of men and boys, particularly on vulnerabilities to war and conflict in society.

Clinical practitioners, social workers, healthcare professionals, and humanitarian workers

1. Provide specialized training for mental health workers on recognizing and addressing adverse events’ impact on gendered needs, including psychological needs and vulnerabilities of boys and men.
2. Ensure MHPSS focuses on men and boys’ personal narratives in their context (as it should for women and girls); avoid medicalization and individualization of trauma responses to adversity and disempowerment.
3. Build out community-based models to address the gendered nature of trauma and address men and boys’ responses to adversity and exposure to traumatic events; these interventions should be tailored to the specific sub-population of boys and men and be in concert with women and girls, and they require understanding how cases are detected, how the community reacts to mental health problems, and what spiritual and communal practices can be used for healing.

1. An example is Living Peace, which provides psychosocial support and group education to men and their partners in post-conflict settings to address the effects of trauma and develop positive, nonviolent coping strategies: <https://promundoglobal.org/programs/living-peace/>

Governments and public policymakers

1. Educate policymakers and NGO actors on the effects of male trauma and exposure to adverse events; this should involve funding a report to determine how legislation can decrease male trauma in schools, communities, and other institutions.
2. Bolster support to veterans or ex-combatants, emergency response personnel, and boys and men who have experienced the criminal justice system to ensure they are equipped with proper and adequate coping skills.
3. Develop or strengthen institutional and national frameworks around men's health and mental health that emphasize community-based public health approaches to improve men and boys' access to MHPSS services.
4. Take active steps to dismantle structural racism, inequality, and other systems of oppression that increase vulnerabilities to trauma and adversity; particularly, policymakers need to implement interventions that consider race, ethnicity, and gender as social determinants of health (Bailey et al., 2017; Griffith et al., 2011).

Schools, teachers, parents, and communities

1. Integrate gender-transformative approaches related to gender identity, gender roles, and socialization into standard curricula to help boys and young men manage violence, racism, and bullying.
2. Include curricula for both boys and girls that can mitigate the effects of and prevent adversity and trauma, including bullying and violence prevention; these should guide boys and girls to apply emotional regulation strategies that are not limited by gendered expectations.
3. Train teachers in general MHPSS skills and gender-specific needs to handle gender-stereotypical manifestations of adversity and trauma.
4. Encourage parents and community members to address their own trauma and mitigate intergenerational trauma transmission, including with psychosocial education.
5. Raise boys intentionally, considering their emotional vulnerability and the detrimental impact of widespread masculine norms.

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