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Male childhood sexual abuse : do not overlook it

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Abstract

Male childhood sexual abuse (CSA) is often unrecognized and under-reported; therefore, its symptoms are often left untreated. The research reveals it is more prevalent than previously thought and is accompanied by a variety of maladaptive symptoms. Clinicians' awareness of these findings, along with self-awareness of their own beliefs about male CSA, is likely to lead to identification of its presence and the opportunity to choose appropriate interventions.

MALE CHILDHOOD SEXUAL ABUSE: DO NOT OVERLOOK IT

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Abstract

Male childhood sexual abuse (CSA) is often unrecognized and underreported; therefore, its symptoms are often left untreated. The research reveals it is more prevalent than previously thought and is accompanied by a variety of maladaptive symptoms. Clinicians' awareness of these findings along with self-awareness of their own beliefs about male CSA is likely to lead to identification of its presence and the opportunity to choose appropriate interventions.

Male Childhood Sexual Abuse: Do Not Overlook It

Child sexual abuse (CSA) is a complex social problem. Its traumatizing effects are far-reaching and negatively impact the survivor's mental health, emotional health, familial and personal relationships, and compound social problems (Avery, Massat, & Lundy, 2000; Swenson & Hanson, 1998). The sexually abused child's life often becomes a continual struggle to survive the fear, emptiness and memories resulting from the abuse (Osmond, Durham, Leggett, & Keating, 1998). This makes it necessary to recognize and address symptoms as soon as possible.

Awareness of sexual violation of young children has expanded in recent years. Whereas much of the research has examined variables related to female victims, more research is currently being done on males (Cermak & Molidor, 1996). Traditionally there has been under-reporting of male sexual abuse. This creates a problem in the collection of data on males. Without an accurate portrayal of the prevalence of male sexual abuse, there is less focus on the role it may play in the pathology of male clients and therapists are then less likely to recognize and treat it.

The purpose of this paper is to explain why many sexually abused male clients may not be receiving the help they need in the therapeutic relationship. A comprehensive definition of what constitutes child abuse will be described as well

as the prevalence rates for males and reasons why male abuse is underreported. A comprehensive list of possible symptoms that are often associated with male childhood sexual abuse will be constructed. This will allow counselors to be alert to the many signs of possible abuse in order to further investigate for disclosure and proper interventions suggested by a review of treatment literature. Finally, recommendations for both recognizing and treating male sexual abuse victims will be offered.

Definition of Child Sexual Abuse

Sexual abuse has been described as sexual exploitation that is physical contact between a child and another person (Cohen & Mannarino, 1993). The word exploitation denotes the inequality of power in the interaction. A more thorough definition of CSA is "...any inappropriate sexual contact between a child and a person or persons who have power or control over the child; this person(s) may or may not have used force" (Osmond et al., 1998, p. 8). Therapist and author, Hunter (1990), treated many clients devastated by what some would not view as abuse, including the victims themselves. His definition of child sexual abuse is any touch or behavior between a child and an adult that must be kept secret. Hunter's list of the many types of abuse he has dealt with follows; however, the reader must remember there are always new ways adults invent to abuse children that may not be listed.

The adult sexually touching the child, having the child touch the adult sexually, photographing the child for sexual purposes, sexualized talk, showing the child pornographic materials or making them available to the child, making fun of or ridiculing the child's sexual development, preferences, or organs, the adult exposing his or her genitals to the child for sexual gratification, masturbating or otherwise being sexual in front of the child, voyeurism, forcing overly rigid rules on dress or overly revealing dress, stripping to hit or spank or getting sexual excitement out of hitting, verbal and emotional abuse of a sexual nature, having the child be sexual with animals, engaging the child in prostitution, witnessing others being sexually abused. (pp. 8-9)

Prevalence

Prevalence rates vary from study to study. There are many factors that seem to contribute to this. Holmes and Slap (1998) reviewed 166 studies done from 1985 to 1997 which showed that prevalence ranged from 4% to 76%. Overall, sexual abuse of boys was found to be common, underreported, underrecognized, and undertreated. Generally, females are victimized more often than males; however, males are more reluctant to disclose the information (Osmond et al., 1998).

Prevalence of CSA, as ascertained by interviews and questionnaires to adults about their childhood, range from 12 to 38% for women and 8 to 30% for men (McGlinchey, Keenan, & Dillenburger, 2000); however this is thought to be underreported and therefore a conservative estimate of abuse. One in four to six boys are sexually assaulted at least once before age 18 (Kentucky Child Assault Prevention Project and National Committee to Prevent Child Abuse, as cited in Wolman & Kindler, 1997).

Identification

Medical evidence is rare, as many forms of CSA do not cause injury (Adams, 2001; Homeyer & Landreth, 1998; Lahoti, McClain, Ginardet, McNeese, & Cheung, 2001). The majority of sexually abused children do not have severe injuries of the genitalia and anus. Witnesses are even more rare (Adams, 2001).

There is no identified sexual abuse syndrome; therefore, identifying victims of child sexual abuse is not easy (McClellan, Adams, Douglas, McCurry, & Storck, 1995). Symptoms vary in degree and type such that no single symptom characterizes the majority of sexually abused children (Swenson & Hanson, 1998). Many of the symptoms can be indicative of other problems. In youth, for instance, the typical mixture of emotional and behavioral problems are related to most mental illness in this age group (McClellan et al., 1995). Family and environmental factors associated with sexual abuse such as physical abuse, family

discord, marital separation or divorce, out-of-home placements, parental psychopathology, and parental substance abuse are by themselves risk factors for child psychopathology further confounding the identification of child sexual abuse.

Disclosure

Another big hurdle in identifying children who have been sexually abused is the fact that they rarely disclose purposefully (Wurtele, 1998). The abuse is surrounded by secrecy. A direct question from a counselor may not be truthfully answered by a child who has been told to keep it a secret. An 11% disclosure rate following a sexual abuse educational program was considered a large success for the program while other programs have had 0% disclosure rates following the presentation of information.

Although most children rarely tell about their abuse, boys have been found to disclose even less than girls (Cermak & Molidor, 1996; DeVoe & Faller, 1999; Holmes & Slap, 1998; Wurtele, 1998). A group of sexually abused boys (Maddocks, Griffiths, & Antao, 1999), had symptoms that were not much different than nonsexually abused boys except in terms of persistence. Their symptoms had persisted more than a year yet none disclosed their abuse to general practitioners when visiting with health complaints. There are many factors that play a role in this reluctance to disclose.

Culture

American culture fails to acknowledge extent and magnitude of male sexual abuse, thus, the victims themselves have a more difficult time recognizing their own victimization. Ten men, sexually abused as children, participated in a study by Gill and Tutty (1999) and agreed that society does not accept sexual abuse of males. All reported their participation was fueled in a large part by hopes that society would accept that sexual abuse happens to males. Nine of the ten did not tell for fear of disbelief or blame. The remaining subject who told was exposed to a lack of support from his family.

Societal expectations about male sexuality also prevent recognition of abuse by the victim. Males are socialized to hide physical and emotional vulnerability (Cermak & Molidor, 1996). They may perceive themselves as emotionally and physically weak for allowing it to happen. If the perpetrator is male, the male victim's masculinity is at risk of being distorted (Gartner, 1997; Zamanian & Adams, 1997).

Males may not view the actions as abusive. Pleasure and arousal during abuse may increase self-blame and therefore fend blame away from the perpetrator. A study by Briggs and Hawkins (1996) (as cited in Hall, Mathews, & Pearce, 1998) found that victims who experienced pleasure during the abuse did

not tend to see the experience as abusive. For males, an erect penis or ejaculation is often viewed as evidence that they were willing participants in their own abuse (Zamanian & Adams, 1997). If the abuser was the same gender as the man's eventual sexual partner choice, he again may not view the experience as abusive (Gartner, 1997).

Stigma

Other possible reasons for not reporting are fear of retribution, social stigma against homosexual behavior, need to take care of self, and worry about loss of independence after disclosure. Boys often report they just want to forget it, protect the perpetrator, or fear reactions of others. Abuse by women may be more difficult for men to report as they are socialized that this is not abuse (Cermak & Molidor, 1996). Abuse by mothers is especially difficult for society and professionals to accept.

Mental Health Professionals' Biases

Many mental health professionals were not regularly asking male patients about histories of sexual abuse (Holmes, Offen, & Waller 1997; Lab, Feigenbaum, & De Silva, 2000). Lab et al (2000) found the majority of their respondents rarely inquired about sexual abuse in male patients, the methods used were often ineffective and were irregular, knowledge of prevalence was notably variable, and many did not have specific training in assessment or treatment of sexual abuse.

Attitudes towards male childhood sexual abuse also plays a role in underreporting. One study about professionals' beliefs about the prevalence revealed significant gender differences (Gore-Felton, Arnow, Koopman, Thoresen, & Spiegel, 1999). It found that women are more likely to believe that child sexual abuse is common as compared to males and therefore are more likely to look for signs of its having taken place. Clinicians were also found to be greatly affected by their own characteristics including history of child sexual abuse, gender, and theoretical orientation. If questions about abuse are not asked of the identified patient in the family, then they may not ever be asked of the siblings either, neglecting to identify other potential victims.

Symptoms

While trust and boundary violations have definitely been compromised for all victims of sexual abuse (Gartner, 1997), actual sexual abuse histories often vary greatly between individuals. They differ in terms of duration, severity, age of onset, relationship to offender, and type of abuse. This may, in part, explain the varying degrees and types of symptoms.

Children may exhibit any or all of the following symptoms: anxiety, fear, post-traumatic stress, guilt, shame, self-blame, depression, conduct problems, sexualized inappropriate behaviors, suicidal behaviors, somatization problems, avoidance and isolation, eating disorders, dissociative symptoms, and low self-

esteem (Avery et al., 2000; Feiring, Taska, & Lewis, 1999; Grotzky, Camerer, & Damiano, 2000; Lanktree & Briere, 1995; McClellan et al., 1995; Swenson & Hanson, 1998). More symptoms include anger, aggressive behavior, poor school performance, runaways, and legal troubles (Holmes & Slap, 1998). Sexual dysfunction and substance abuse are often seen in older children and adults. Some survivors display symptoms of borderline personality disorder such as mood lability and self-injurious behavior (SIB) (McClellan et al.). Gill and Tutty's (1999) subjects all reported difficulties in both emotional and sexual relationships as adults.

Abused males were often found to be more disturbed than abused females (Dykman et al., 1997) and were hospitalized for psychiatric treatment at higher rates than either females or nonsexually abused males. They displayed more of both emotional and behavioral problems, including suicidality than the females (Garnefski & Diekstra, 1997).

Morrow, Yeager, and Lewis (1996) studied boys in a residential treatment center. Their study suggested that encopresis may often be a sign of sexual abuse, past or current while Maddocks, Griffiths, & Antao (1999) found both encopresis and enuresis related to child sexual abuse. Children displaying this behavior often have the belief that the wet and stink will keep them safe from further abuse (Homeyer & Landreth, 1998).

A play therapy study (Homeyer & Landreth, 1998) resulted in identifiable, highly interrelated behaviors in sexually abused boys. Boys from three to six years played out sexual intercourse positions, drew pictures of large open mouths, showed dissociative behavior while playing with water and sand or while reenacting abuse, and exhibited various regressive or nurturing behaviors. Boys from seven to ten years expressed nurturing behaviors, more sexualized behaviors, and more cleaning and washing behaviors.

It is important to note when boys demonstrate any sudden emotional and behavioral changes and to inquire as to the cause. This, along with long duration of symptoms, is a common thread throughout the many possible symptoms of CSA (Wells, McCann, Adams, Voris, & Dahl, 1997).

Post Traumatic Stress Disorder

Posttraumatic Stress Disorder (PTSD), a psychological disorder including a cluster of symptoms such as nightmares and phobias, and often observed in victims of traumatic events, such as natural disasters and wars has often been found in CSA victims (Avery et al., 2000; Kendall-Tackett, Williams, & Finkelhor, 1993; Mc Leer et al. 1998). One study by Avery et al. (2000) found that nearly all the children in the study were experiencing a clinical level of posttraumatic stress and were diagnosed with PTSD.

Treatment Procedures

Treatment can simply be defined as helping the child find a better way to survive. It is not thought of as a cure, because a sexually abused child is not sick (Osmond et al., 1998). It is a process by which children are helped to learn to choose healthy versus destructive coping skills. This is done by maximizing strengths and changing faulty patterns of behavior and thinking.

Coping methods developed by children to deal with the aftereffects of sexual abuse can be both positive and negative. The strengths, such as self-sufficiency and high achievement can be built upon while the negative, self-defeating behaviors, such as stealing and belligerence, need to be replaced with more positive survival skills.

Goals

Since there is no specific spectrum of symptomatology for childhood sexual abuse, treatments often need to be tailored for each individual, yet there are general goals of treatment of CSA. These include alleviating the aftereffects of CSA by lessening negative symptoms, processing the abuse, regaining safety and trust through education, and protection from further abuse (Grotzky et al., 2000; Horowitz, Putnam, Noll, & Trickett, 1997). One specific goal that must be included in any chosen treatment is for the survivor to understand and internalize that the abuse is never the child's fault (Osmond et al., 1998).

Factors Affecting Outcome

Many factors greatly influence outcome. These include duration, use of force or threat of force, penetration, and abuse by father or stepfather (McClellan et al., 1995). Greater trauma was determined by the severity of the abuse, was affected by whether or not the abuse included penetration, and by the relationship of the perpetrator to the victim (Horowitz et al., 1997). The effect of age at the time the abuse occurred was found to be inconclusive in the McClellan et al. (1995) study, but in a study by Feiring et al. (1999), both age at the time of abuse and gender of victim were related to greater psychological distress. Greater amounts of trauma were found to be associated with older age of child when abused, longer duration, more aggression, greater threat of harm, closer relationship with the abuser, frequency of abuse, and disbelief by adults in the victim's life (Veltkamp & Miller, 1994; Horowitz et al. 1997). Swenson and Hanson (1998) also reported similar findings about greater mental health problems with the presence of threats, use of force, weapons or penetration, intrafamilial, more frequency, longer duration, lack of maternal support at disclosure, and victims' outlook and coping style.

Shapiro and Levendosky (1999) found that attachment style and coping strategies influenced the psychological and interpersonal functioning. A healthier

attachment style and coping strategies were found to mediate the negative effects of the sexual abuse.

The sooner the survivor was treated, the easier it was to lessen the symptoms and effects (Grotzky et al. 2000). This would suggest the importance of earlier identification and intervention.

Length of Time in Therapy

The amount of therapy needed varies from child to child but a general guideline is that both earlier onset and more negative symptoms will predict more sessions (Horowitz et al., 1997), averaging from 9 to 25. Other studies found that about 50% of survivors had shown measurable improvement by eight sessions. Lanktree and Briere (1995) reported that the number of months spent in treatment was more predictive of positive changes than amount of time from the end of the abuse to beginning of treatment or end of treatment.

Specific Treatment Modalities

There is little consensus for which treatment is most effective. This may be due to the lack of research in the area of child sexual abuse. There are no published results of randomized controlled trials of sexual abuse treatment in children.(Horowitz et al., 1997). The lack of research is due, in large part, to ethical problems faced when doing scientific research; therefore, much of the information available is from practitioners' own experience with what has

worked. The small amount of actual research available is outcome research. It is generally not focused on a theoretical orientation, but rather group versus individual or short-term versus long-term.

The problems encountered conducting research with child sexual abuse are obvious. It would be unethical not to treat children who are known to be victims of sexual abuse. To counteract this, some studies have compared treated children to a group of children whose parents refused treatment for their children or to a group of children on a waiting list for treatment (Lanktree & Briere, 1995). Other common problems in research include inconsistent use of definitions, sampling bias, retrospective designs, and a lack of standardized measures. The following gives an overview of some of the most often used methods in treating sexual abuse.

Cognitive Behavioral Treatment

Cognitive behavioral treatment (CBT) is often used in treatment of child sexual abuse. The primary focus in CBT is to change thinking and doing which will in turn, change the maladaptive feelings. Two studies (Cohen & Mannarino, 1998; King et al., 2000) suggested use of CBT strategies as treatment of choice when working with sexually abused children.

A survey of child psychiatrists and nonphysician therapists in the treatment of PTSD suffered as a result of childhood sexual abuse also found support for

CBT (Cohen, Mannarino, & Roga, 2001). It was the most often used treatment by the nonphysician group and third behind pharmacotherapy and psychodynamic therapy in the psychiatrist group.

Deblinger, Steer, and Lippmann (1999) sought to determine whether 12-session pre-to posttest therapeutic gains using CBT with sexual abuse victims had been sustained after two years. Externalizing behavior problems, depression, and PTSD symptoms had been significantly reduced in the original 1996 study. The findings in this follow-up study suggest the pre- to post treatment improvements held across the 2-year period. This is significant given the chronic and recurrent nature of PTSD symptoms.

Cognitive behavioral treatment has also been shown to be successful in several studies involving preschool children who have been sexually abused (Cohen & Mannarino, 1996) and for treating school-aged children when the nonoffending parent is included in the treatment as well (Deblinger, Lippmann, & Steer, 1996). CBT has also shown to be effective in treatment for other trauma-related emotional symptoms such as fear, anxiety, and depression. (Swenson & Hanson, 1998)

Art Therapy

Artwork is found to be an effective mode for safely releasing feelings in sexually abused children (Koplewicz & Goodman, 1998). Both artwork and

writing are avenues in which children can find solutions to distorted thinking and problems. They can also be used as a means to communicate. Many children have been told not to tell anyone. They are frequently threatened not to break this demand. By drawing or writing the information, versus verbalizing it, they have not violated the agreement.

Groupwork

Group is a medium that can deal with the range of cognitive, affective, and behavioral symptoms resulting from CSA (Grotzky et al., 2000; Kruczek & Vitanza, 1999) and is often the preferred treatment for child sexual abuse (Beautler & Clarkin, 1990, as cited in Lomonaco, Scheidlinger, & Aronson, 2000; Osmond et al. 1998). It is the most efficient intervention modality as it is both effective and economical in enlisting a therapist and peers to facilitate change.

Although groupwork is not a particular theoretical orientation, the group process itself is conducive to helping children with issues. Children are natural for groups. Their world is full of groups, from play groups, to clubs and athletic teams. There are unique opportunities offered by the group medium such as universality, peer support, interpersonal feedback, reduced isolation, and enhanced self-esteem (Lomonaco et al., 2000). The group is a safe place to confront and work on shared experiences. Even conflict in a group is used as an opportunity to turn feelings and thoughts into words (Zamanian & Adams, 1997). Members are

not alone in the journey. Reactions and feelings are felt to be more normal when shared with how others feel. Grotsky et al. (2000) felt children did better in a group because of less isolation and children used the group to learn the abuse was not their fault. They soon learned that other children still liked them even when they knew about the abuse. While family support is important, peer support is equally important in the area of belonging and feeling less isolated.

Lomonaco et al.(2000) cautioned that groupwork would not be recommended for certain children. Extremely fragile and fearful, extremely impulsive, paranoid, or masochistic children are generally poor candidates for groups.

Family Treatment

The impact of child sexual abuse is a family problem, not just a child problem. Siblings may require treatment as indirect victims (Swenson & Hanson, 1998). They may have observed the abuse, have questions about what has and is happening, and may also suffer from PTSD symptoms. Parental support increases treatment success (Cohen & Mannarino, 1998; Grotsky et al., 2000; Jones, 1995; Osmond et al., 2000; Swenson & Hanson, 1998) and accelerates their children's recovery (Grotsky, et al., 2000). Children with more parental support were more likely to lessen their self-blame about the experience, a crucial step in healing. The nonoffending parent may have symptoms that also need treatment. Grosz,

Kempe, and Kelly's (2000) study found a family approach with services for parents in addition to intervention for the child was a key component in facilitating recovery. Common symptoms in parents are guilt, anxiety, and anger (Swenson & Hanson, 1998).

A study by Lanktree and Briere (1995) implemented family and group sessions. Some parents also received individual, conjoint, and group treatment. Their follow-up assessments on the Trauma Symptom Checklist for Children and the Children's Depression Inventory showed continuous lowered scores at three month, six month, nine month and one year intervals. It is impossible to measure the effects of the amount of time on the positive results; however, the authors hypothesized the change was mostly due to treatment.

Lesser Known Treatments

Eye movement desensitization and reprocessing (EMDR) is gaining more acceptance in the therapeutic field for sexual abuse. A study by Edmond, Rubin, and Wambach (1999) used a randomized experimental evaluation that found strong support for EMDR in reducing trauma symptoms in adult survivors of CSA.

Residential therapeutic milieus are good for those children needing routine and safety (Osmond et al., 1998). They include behavior management techniques that are fair, consistent, and planned. Generally, children who are acting out in

more violent ways and need more structure around-the-clock are recommended for this treatment.

Another therapeutic method is a treatment foster care home. This is a family setting where the parents are specially trained in the behaviors, feelings, and thoughts related to CSA (Osmond, et. al, 1998). They are trained in child development, counseling skills, and the needs of abused and traumatized children. Some positives to this type of treatment include a family setting, the caregiver to client ratio is low, there are no sharing of negative attitudes and bad behaviors like in a group setting, and it is community based. The foster parents are also linked to the community supports such as church, neighborhood, and extended family.

Implications for Mental Health Professionals

Knowledge of the varied symptoms and how they may be closely related to other common yet less harmful experiences, such as divorce or typical teenage rebellion can arm professionals with more information to make a correct diagnosis. Clearly, there are many factors surrounding the assessment of male childhood sexual abuse. It would seem that all professionals would benefit from assuming that CSA is a possibility and must always be ruled out. They can do this by having a better understanding of what actually constitutes abuse and therefore play a role in a client's pathology. This is essential in order to educate the reluctant or unsuspecting client.

The awareness of the difficulty in disclosure will enable the mental health professional to have a systematic plan that is sensitive to the client's needs, yet informative to the client about the importance of sharing this information.

Finally, treatment options vary greatly. Each mental health professional may then choose an option that most closely fits his or her theoretical orientation and own comfort zone. It can also be matched to the client's personality and ways of relating to the world through feeling, thought and behavior.

Conclusion

Identifying children who have been sexually abused is difficult. Clearly the first thing needed is a universal definition for what constitutes abuse. Aside from a clear definition, identification is further compounded by several things including varying symptoms, symptoms that mimic other psychopathology, and the lack of disclosure related to fear and shame. A better method of assessment and more research would allow for earlier interventions and give better insight into the best therapeutic choice for children who have been sexually abused.

Therapists need to become aware of any and all possible symptoms, especially chronic symptoms, those lasting more than a year, and any that suddenly appear. Therapists also need to be aware that sexual abuse work is a challenging task. They need awareness of their own perceptions and of the factors that influence their beliefs. These greatly impact their clinical judgment in both

assessment and in treatment choices. Males need to be questioned about their sexual abuse history and there is a need for more training for professionals about male sexual abuse.

Scientific research for CSA is difficult to achieve because of the many ethical dilemmas involved. Much of the information available is from clinicians' own experience with what works for them. Groupwork seems to be a popular method of treatment, often using CBT along with other creative theoretical interventions such as artwork and writing. Inclusion of family members in treatment has been shown to be successful as well.

Given that PTSD is commonly diagnosed in sexually abused children, it would seem any treatment modality should include a component to specifically address this disorder and its symptoms. From the research and experience of clinicians two other main areas of focus stand out. One is that the child needs to know and believe that the abuse was not his fault and second, parental support in both believing the child and encouraging the child is helpful in the recovery process.

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