BOY VICTIMS OF SEXUAL ABUSE

TREATMENT OF BOY VICTIMS OF SEXUAL ABUSE

—by Kathleen Coulborn-Faller

At least 20% of the identified victims of sexual abuse are male (American Association for Protecting Children, 1989). But attention to their treatment needs has lagged behind attention to the needs of females. Although in many respects boys suffer the same trauma from sexual abuse as girls, there are ways in which the impact of sexual abuse is different for boys, either in degree or in absolute terms. This brief article presents an explanation for gender-specific effects of sexual abuse, boy victim treatment issues, and treatment techniques. Unfortunately, space does not permit consideration of the full spectrum of boy victim treatment issues or indepth discussion of the appropriate treatment modalities, which include individual, family, and group therapy.

To a considerable extent the sequelae of sexual abuse differ for males and females because of gender differences in socialization. Traditional expectations for males in our society include the following tenets, which mediate the effects of sexual abuse on boys:

1. A "real man" doesn't cry, and by extension doesn't talk about and display emotion about his problems;
2. A "real man" can protect and defend himself;
3. A "real man" likes sex and looks for opportunities to have sex.

Societal homophobia also mediates the effect of sexual abuse upon boys (Bolton, Morris, and MacEachron, 1989).

Treatment issues for boy victims

Four issues will be described: difficulty with disclosure, emotional reactions to victimization, hypersexual behavior, and sexual identity issues.

Difficulty with disclosure. Societal prohibitions against men talking about their problems can make it more difficult for boys to disclose sexual abuse than girls. Even when there are other victim witnesses, an offender confession, or medical evidence of abuse, boys may still deny having been abused. If boys deny in the face of other evidence, they probably deny even more frequently when no corroboration exists. Societal homophobia may also contribute to boys' difficulty with disclosure. Because boys are abused by males about 67% of the time (Faller, 1989), abused boys must overcome two taboos: that against sex between adults and children, and that against same-gender sexual encounters. Shame over their inability to protect themselves may inhibit boys' willingness to disclose as well. In addition, like girls, boy victims may dissociate and not be able to disclose abuse because it is not among their conscious memories (Hunter, 1990).

Emotional reactions to being sexually victimized. When boys do describe their victimization, they may do so with almost no affect. This may reflect male socialization not to display feelings, and may be accompanied by overt denial of traumatic impact of the abuse. Alternatively, male victims may not evidence distress because they did not perceive the encounter as abusive, but rather as an opportunity to gain sexual experience. This is a consequence of male socialization about sexuality and is particularly likely to be the attribution if the offender was a female (Hunter, 1990).

When boys do demonstrate affect, it is likely to be anger and aggression (Rogers and Terry, 1984), again a consequence of gender socialization. Anger may be expressed directly toward the offender. It is also frequently focused on the therapist, sometimes verbally and sometimes physically. Moreover, boy victims seem more likely than girls to be belligerent with adults, to hurt or bully more vulnerable children, and to harm or mutilate animals. Other antisocial behavior, for example fire-setting and vandalism, may be expressions of anger as well.

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Sexualized behavior. Sexually abused boys appear to be more likely than girls to engage in hypersexual behavior (Faller, 1989; Rogers and Terry, 1984). There are two common dynamics for this behavior. Boys may gain a sense of control and mastery by sexually overpowering others, dealing with their sense of shame and feelings of vulnerability by identifying with the aggressor and sexually victimizing others, usually younger, smaller, and/or more naive children. The aggression involved in this activity is a manifestation of the boy's repressed anger toward his abuser(s). The other response is seen in children who experience the abuse as ego-syntonic and, as discussed above, view it as an opportunity rather than as abuse. Having experienced the pleasure of sexual activity, the child wishes to repeat it. Often this involves initiating peers and sometimes younger or older children into sexual activity. In many cases, there may be nothing inherently exploitive in this type of hypersexual behavior, because it usually involves children sexually pleasuring one another. Nevertheless, it is likely to have negative consequences for both the initiator and the initiate, because children engaging in sexual activity are stigmatized in most social contexts.

Sexual identity issues. Boy victims are likely to experience confusion about their sexual identity as a consequence of their victimization. This is in part because most boy victims are sexually abused by males. The child and adults in his life may equate a same-gender adult-child sexual encounter with a homosexual encounter. The boy victim commonly wonders why he was targeted, and concludes that something about him attracts males, hence he must be gay. Or he may believe that the sexual experience has made him gay. Because of societal homophobia, caretakers may be even more concerned about this issue than the child.

Even if the offender is a female, however, the boy may question his sexual identity. Because gender role socialization dictates that males should enjoy sex, a sexual encounter with a female which is frightening, overwhelming, or aversive may cause a boy to question his sexuality. The fact that he did not enjoy the abuse may lead him to conclude that he is not a "real man"; therefore he must be gay.

Treatment techniques

Boys' difficulty with disclosure. The author and other clinicians believe (e.g., Friedrich, 1990; Porter, 1986) that full disclosure of sexual abuse is fundamental to successful therapy. Without it, the therapist does not know what should be treated. Moreover, disclosure usually elicits the substance of therapy: the child's perceptions, feelings, and behaviors caused by the abuse.

There are no easy solutions to the problems boys have with disclosure. With some boys, the first six months of treatment is devoted to discovering the extent of abuse. Having the child demonstrate what happened with anatomically explicit dolls, draw a picture, or write what happened may facilitate disclosure. Sometimes drawing a picture of the offender or the self and then talking about the people is easier than actually drawing the abuse. Even more removed and therefore less threatening is drawing a man or a boy and talking about them. In addition, talking to the child about some of the reasons he might be having difficulty discussing his abuse and, if any of these are acknowledged by the boy, discussing them, may assist disclosure. Finally, discussing the benefits of telling may be useful.

Group treatment can be quite helpful, since there are almost always some boys in group who have talked about their abuse. These boys can help both by becoming models and by urging others to disclose. Sometimes group norms that require each boy to describe his victimization work. It may be efficacious to allow reluctant boys to "pass" during the first treatment sessions, as long as it is clear that they will eventually describe their abuse. Porter (1986) suggests that around the fourth group session is an appropriate time for disclosure to occur. Porter

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helps boys organize their disclosure by providing a "Tell My Story Chart" which specifies the topics disclosure is expected to cover (e.g., identity of the molester, type of abuse, frequency).

Aggression. Anger at the offender is a very appropriate response, and its expression is often a goal of therapy. Anger becomes problematic, however, when it leads to assaultive behavior towards others or animals and when it results in antisocial behavior.

With many victims, the mere act of talking about the person with whom they are angry (the offender) and their reason for being angry (the abuse) will diminish problematic behavior. It can be useful as well to develop avenues for expression of anger toward the offender. With young boys, this may involve acting out feelings using anatomically explicit dolls or a punching bag. The author has a make-believe jail, in which children may lock up the offender. An effective strategy is to have the family obtain a doll that represents the offender; the therapist instructs the victim and family that when he feels angry, he should take out the anger on the offender doll, not on his little sister or the kitten. Being able to express anger toward a doll that cannot manipulate or overpower him may help the victim gain a sense of mastery over the abuse. However, boys should be admonished that in a real-life encounter with the offender, they will not prevail. With older children, keeping a diary, writing a letter to the offender, making a tape for the offender, or directly confronting the perpetrator in treatment may be appropriate ways to express anger. Role play can also be used to facilitate appropriate expression of anger. Competitive sports or karate may provide an acceptable outlet for aggression. These activities have the additional advantages of providing victims a sense of mastery and an opportunity to feel good about their bodies, as opposed to feeling ashamed or uncomfortable.

Re-enacting the boy's aggression toward other children or animals, with either the boy or the therapist playing the victim, can help the child appreciate the effects of his harmful behavior. Writing about his aggressive behavior from the viewpoint of his victim may also help the boy understand the pain he causes. The therapist can also counsel the boy regarding the negative impact on himself of aggression and anti-social behavior. For example, the clinician points out that the boy, rather than the offender, is in trouble because of the boy's aggression.

Hypersexual behavior. Stopping hypersexual behavior is perhaps the most difficult treatment task. Once sexual acts become known, eliminating them from the child's repertoire is very difficult. Yet stopping sexual behavior is crucial to recovery. Every time the boy engages in sexual acts he increases the likelihood of subsequent incidents and, especially if he is caught and chastised, increases the boy's stigmatization in the eyes of others and his own image of himself as a stigmatized sexual being.

Sexual aggression and teaching sexual acts to other children, the hypersexual behaviors most characteristic of boy victims, should be handled differently from masturbation. If the caretakers can tolerate it, private masturbation should be allowed. However, as Ryan (1990) points out, even though masturbation does not hurt others, it may occasion negative feelings for the boy because it reminds him of his abuse. Thus, it may be important to control opportunities to masturbate.

Therapists should be careful not to treat abuse reactive boys like perpetrators. Hypersexual behavior *could be* the precursor to adolescent sexual offending if not treated, but the boy already has the burden of his own victimization to deal with. Under the circumstances, a heavy-handed approach to his hypersexual behavior may be overwhelming. Nevertheless, for the protection of other children as well as for themselves, abuse reactive boys should have their interaction with other children supervised, and they should not be placed in situations in which being sexual is easy. Therefore, they should not babysit. They should bathe and go to the toilet alone. They should not sleep in bed with another child. If they sleep in the same room with another child, that child should be told of the boy's problem and be instructed to "Say no, yell, and tell," should the boy attempt to be sexual.

Caretakers should involve victims in activities that are incompatible with and can compete with sexual behavior, such as sports, hobbies, and group activities. Every hour of satisfying, age-appropriate, non-sexual enterprises is an hour in which the hypersexual child is countering his stigmatized self-concept.

Talking to the boy about the dynamics of his behavior and reminding him of how he felt when he was victimized may terminate the behavior. One six-year-old boy explained, "I was child-abused. They weren't. I want them to know what it feels like," referring to children in his class, who shunned him after he grabbed their genitals. Helping him recall his state of mind when he was being abused ended his sexual acting out. As with aggressive behavior, a re-enactment with dolls in which the boy plays his victim can have considerable impact. An apology to his victim(s) may be in order as well.

Behavioral interventions can be quite successful in stopping hypersexual behavior. Operant techniques work well with young children. With children as young as four, a monitoring system in which they receive a star or sticker for each day in which they do no "bad touching" and then an additional reward, such as a toy, a meal at McDonald's, or a trip to the zoo at the end of a perfect week, can be very effective.

Children who are a little older can understand the chain of events leading to their sexualized behavior and interrupt it by thought-stopping or covert sensitization. An example of the former is an eight-year-old who engaged in episodic sexual acting out after being sexually abused in daycare at age three. He described "getting that feeling" (an urge to molest another child) and decided to hit himself in the forehead with an open hand to interrupt the thought. He successfully used this technique four times in the first week after he devised it. Thereafter, he reported a decrease in "that feeling," and only had to use the technique twice more during the next six months.

Sexual identity issues. Boy victims and their families need education regarding worries about homosexuality. If the offender was male, they can be told that the choice of victim is related to the offender's attraction to children, not to the victim's sexual orientation. Some offenders describe singling out needy, deprived, compliant children—characteristics which have nothing to do with the child's sexual orientation. In some cases sharing this information may be helpful. It may also be useful to explain that sexual attraction to children is different from homosexuality, a point that may be supported by the perpetrator's adult heterosexual relationships. As well, the child and family should be told that being victimized will not make the boy gay.

If the offender is female and the boy questions his sexuality because he found the experience negative, it is important to explain to him that pleasurable sex is usually mutually decided upon between equals.

Conclusion

This discussion of treatment issues and techniques is based upon clinical experience alone. To date, there have been no systematic evaluations of sexual abuse treatment for boys.

References

American Association for Protecting Children (1989). *Highlights of official child neglect and abuse reporting, 1986.* Denver: American Humane Association.

Bolton, F., Morris, L., and MacEachron, A. (1989). *Males at risk.* Newbury Park, CA: Sage.

Faller, K.C. (1989). Characteristics of boy and girl victims of sexual abuse: How they differ. *Child Abuse and Neglect, 13* (2), 281-291.

Friedrich, W. (1990). *Psychotherapy of sexually abused children and their families.* NY: W.W. Norton & Co.

Hunter, M. (1990). *Abused boys.* Lexington, MA: Lexington Books.

Porter, E. (1986). *Treating the young male victim of sexual assault: Issues and intervention strategies.* Syracuse, NY: Safer Society Press.

Rogers, C., and Terry, T. (1984). Clinical intervention with boy victims of sexual abuse. In I. Stuart and J. Greer (Eds.), *Victims of sexual aggression.* NY: Van Nostrand Reinhold.

Ryan, G. (1990). Sexual behavior in childhood. In M. McNamara and B. McNamara (Eds.), *Adoption and the sexually abused child.* Portland, ME: University of Southern Maine.

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