Sexually Victimized Boys

Sexual abuse of boys has been overlooked or minimized. Very little is written that specifically addresses the effects of sexual abuse on male children. Boy victims have not been readily identified and even when identified, parents have not often sought treatment for their male children. Thus, there is little to guide the clinician in the assessment and treatment of this population.

Incidence

It is difficult to compare incidence studies, as researchers have no common definition of either childhood or sexual abuse. Random population samples are the exception. Two prevalence studies in Ohio appear to be the only exceptions. The most recent method of study appears to be questionable adults about their sexual experiences as a child. One of the earlier studies, a survey of New England college students, found a rate of 8.7 percent reporting sexual activity with a partner five or more years older. If under 15, or 10 or more years older if 15 or 16. The rate of sexual abuse for boys under 13 was 4.1 percent (Feinleib, 1979).

A University of Washington study (Fiecht, Scott and Wagner, 1981) surveyed college students. Out of a sample of 410 males, 4.8 percent said that they had non-consensual physical sexual contacts with an adult. Readers should note that this study excludes adolescents both as offenders and victims, thus excluding a sizeable portion of sexual offenses. Other surveys of college students (Bagley, Linn, Robertson and Sorrenti, 1984; Cassidy, Kilpatrick and Schmidt, 1985; both cited in Salter, 1988) showed rates of five percent and 11 percent respectively.

Studies using college populations have a disadvantage in underrepresenting the lower socioeconomic levels. Feinleib (found in his 1979 study that lower-income females were 80 percent more likely to experience both extramural and intramural child sexual abuse than were middle-income females. Thus, it is possible that studies utilizing college populations underestimate the incidence rate due to socioeconomic sample bias (Salter, 1988).

Several other studies use community samples. Finkelhor (1964), in a 1961 survey of Boston fathers, found nine percent reported sexual abuse as a child (1.2 percent prior to age 5). A 1975 random survey of Texas residents with valid driver's licenses (Karcher & McShane, 1984) found three percent of 451 males reporting sexual abuse. And Bagley (1984, as cited in Salter, 1988) in a Canadian national random survey with a sample of 1002 found nine percent reported sexual abuse prior to age 18 and six percent reported sexual abuse prior to age 16.

In a study of all prior studies, Finkelhor (1984) concluded that the "true prevalence figure" for sexual abuse experiences of boys under 13 might be between 2.5 and 5 percent. Including these three to 4.5 raise the estimate to between 2.5 and 5.7 percent. How does the incidence of sexual abuse of boys compare to that for girls? Finkelhor (1964) in his review of incidence studies concludes that two to three girls are victimized for every boy. His review of research showed rates ranging from 2:1 to almost 10:1.

For example, a retrospective review of 145 sexual abuse cases seen at Children's Hospital of Buffalo in 1975 to 1978 showed that 11 percent of the victims were male (Glenz and Cameo, 1980). A similar review of 1,748 sexual abuse victims examined at Children's Hospital and Health Center from 1979 to 1984 showed that 9 percent were boys (Spencer and D'Alessio, 1985). These two studies are typical of others performed at major medical centers showing males to be between .1 and 16.4 percent of identified child sexual abuse victims (Blanton, 1981; DeFrancis, 1986; Dynneson, Jaffe and Ten Snel, 1975; Pierce and Pierce, 1985; Resch, 1987).

Clinicians interviewed by VCPN, however, disagreed. "I think the ratio is 50-50."
Stage II: Knowing Your Monster

In this stage, boys work on recognizing feelings. They help determine what the high-risk situations are for them to act out sexually and label which behavioral and environmental contingencies make them act out. Group members identify the "red flags" that let the monster out and learn to pay attention to what kind of messages they give themselves.

During this stage, the therapists perform an assessment on the boy and his family. Some assessment also occurs prior to allowing a child to enter the group, including at times, psychological testing such as the Roberts Apperception Test. However, the use of formal testing is limited. Strengths and weaknesses of the child and family are identified mainly through interviews.

Stage III: Planning for Battle

In this stage, the group identifies strategies for battling the monster. The focus is on problem-solving and cognitive skills for impulse control. The boys learn new ways to deal with anger and guilt. Behavioral options, such as socially appropriate ways to get attention or direct sexual feelings, are taught in a step-by-step fashion.

This stage makes use of games. A favorite is the Pet Monster Puzzles. Each group member has a monster puzzle. In order to take a piece of the puzzle, a boy must describe a high-risk behavior (for example, acting-out) and give one way to control himself. The game is over when a player captures all the puzzle pieces and thus, has his monster "under control." Monster puppets are used for play-acting and a magic wand is available for cases where more power is needed.

More conventional techniques, such as relaxation, are taught to the group. Assertion skills are covered. The group learns control methods, such as thought-stopping. The main idea is to combine skills in a way that the boys develop an internalized locus of control.

Stage IV: Rallying Our Forces

In this stage, the therapists help the boys generalize new skills. The behaviors are implemented at home and school. Parents are actively engaged in this process by monitoring homework assignments. The goal is to create a "safe fortress" with one or both parents so that the boys can go to a parent when they feel at risk of sexually acting out.

Stage V: Conquering the Monster

In this stage, the goal is to have the boy internalize the locus of control. Mastery of the skills has occurred, and the stress is on practice as much as situations as possible. The boys try the skills over and over to determine what works and what does not. They learn to adapt to change; for instance, to go to an alternate person for help if the parents are unavailable.

Relapse prevention is also a focus. The boys identify problems that could possibly cause them to act out sexually again. The therapists work hard to lower the guilt for the sexual behaviors so that, should a relapse occur, it will not overwhelm the child. The boys are taught to stop blaming others and themselves and concentrate upon solving the problem.

Stage VI: Becoming a Knight

When a boy is ready to terminate, he has achieved his quest for knightshead and has conquered the "monster." All the wonderful adventures of being a knight are bestowed upon him. There is a ceremony (a ritual) for termination. The boy receives a cape and a scroll. He is presented as a knight to the parents (in a meeting at the same time as the children’s group).

As a knight, the boy is given the responsibility to recognize monster warning signs. He is expected to know that the monster may return, and that the knight may need help to continue to control the monster. Snacks are incorporated into every group. For the knight’s ceremony, the snack is cupped shaped as monsters. The boys eat them, and symbolically cause the monster to disappear.

Ballester and Pierre describe their program with undisguised enthusiasm. It is clear that they believe in their work and that the boys become invested in the process. Ballester and Pierre are hoping to accumulate their practical techniques into a package that can guide other therapists. They plan a journal submission on their methods in the near future. For more information, contact: Sandra Ballester, Psy.D., Children’s Institute International, 711 South New Hampshire, Los Angeles, CA 90005, (213) 835-5100; Ext. 86, or Frederique Pierre, Ph.D., 1427 Johnson Street #7, Sherman Oaks, CA 91423, (818) 990-3773.

Sandra Ballester and Frederique Pierre

Ballester, Sandra, Psy.D., coordinates the Child Abuse Treatment Support Program (CATS) of Children’s Institute International. The CATS program serves approximately 100 clients and presently offers 13 child sexual abuse therapy groups. Ballester and her colleague, Frederique Pierre, a licensed clinical social worker, have developed a therapy metaphor for use with young, abusive reactive boys ages 10 to 15.

Pierre and Ballester teamed to offer therapy to abusive reactive boys. These children, who are sexual abuse victims, are also perpetrators of sexual abuse with siblings or playmates. The idea of using monsters to help the boys engage in therapy evolved gradually. "These kids are not in therapy on a voluntary basis," noted Ballester. "They are here because others don’t like their behavior. We started in our first group to accumulate activities that might engage the boys in treatment."

When Pierre and Ballester associated the sexual acting out with "monster" behavior and found the boys latched onto the idea of an externalized, visual representation. The "monster" was something outside themselves that could be controlled and conquered. Pierre and Ballester began to purchase every monster game, book, and activity they encountered.

"The monster idea allowed us to develop a common theme," Pierre explained. Ballester. "It was something that tied the activities together and set the stage for treatment to begin and end. Relating the skills to the monster metaphor helped the boys learn skills faster and remember them clearly."

Pierre adds, "The boys came to expect some of the same things each week. For example, we found a wonderful pop-up book on monsters and we read it every time, then discuss how to control the monsters. When new members come, the older ones can teach the new members the concepts."

Ballester described the six stages that provide the framework for the group:

Stage I: Building A Strong Fortress

In this stage, the therapists try to provide a stable, safe environment and promote group cohesion. The group meets in a safe place from which to deal with "all the monsters out there." The boys get formal orientation and are introduced to the token system. Each member receives a plastic cup with his name on it. Boys are rewarded for many behaviors during the groups, including participation and adherence to rules. Each reinforcement is the choice of a small ornament or animal. When the child collects 15 of these, he can exchange the 15 monster tokens for a prize such as a new wheels car.
social workers with the Sexual Abuse Treatment Unit at the Los Angeles County Department of Social Services have noted physical aggression and self-destructive behavior in sexual abusers. Paulinger and Durawell were among those who noted that children's grief and impatience of trust resulted when boys were victimized by their mothers. "When the mother is in the perpetrator," stated Durawell, "the victim's ability to trust is destroyed."

Assessment

What to Assess

Given the high incidence of physical trauma in sexually abused boys, it is important that boys suspected of being abused have a medical evaluation. This evaluation should be a detailed one, including examination of the area and rectum as well as testing for AIDS and venereal diseases. The physician should record all bruises, lacerations and tears. If the boy is physically normal, the physician can reassure him about his physical condition (DeJong, 1985; Spencer & Dunklee, 1986).

Most therapists advise doing an assessment of the family. Carolyn Cunningham, Ph.D., director of the Violence Prevention Program at Glendale Family Services in California, mentions some important factors.

"You need a great deal of information about the victim's history. Look for intergenerational patterns of abuse. Motivation for treatment is very important. Children are refractory to their circumstances. What is the family's willingness to cooperate?"

The crucial steps of the evaluation process, however, is the trauma assessment of the child. Several models have been developed containing different steps, protocols, or trauma assessment.

Ann Burgess (Burgess, Groth, Holmstrom & Sgro, 1983) has proposed an information processing trauma model, with four major phases. Phase I is the Pre-Trauma, and encompasses the time period prior to the boy's sexual abuse. The therapist needs to understand the child's functioning and development prior to the abuse. Important factors include the child's personality development, the structure of the child's family, sociocultural factors, and history of prior cumulative events.

Phase II is Trauma Recapitulation. Here the clinician needs to learn about all activities related to the abuse and exploitation of the boy. Key factors of offender behavior include how the offender gained access to the boy, how the offender controlled the child, the range of sexual activities, whether the child showed resistance, or sexual activity or explained others, and the strategies used to maintain secrecy and control.

Offender behavior is responded to by the coping and defensive responses of the child. The therapist must determine what trauma learning (sensory, perceptual or cognitive) is associated with the event. Trauma learning is the basis for self-defeating patterns. Trauma replay, similar to a "flashback," where the child re-experiences the abuse, can occur. As the abuse continues, it is "encapsulated" and disposed to avoid detection. The therapist needs to assess the degree of encapsulation and the frequency of trauma replay.

Phase 3 is Disclosure. Disclosure is upsetting to the boy as it requires the breakdown of defensive structures in order to retrieve information. The therapist needs to assess the degree of stress caused by disclosure and subsequent interactions with family, agencies and the community.

Phase 4 is Post-Trauma Outcome. A boy can choose one of six responses: integrated trauma, avoidant, avoidant/denigrating, aggressive or delinquent. An integrated child is able to talk about the events, shows minimal distress, has control of aggressive and sexual thoughts, believes the offender is in the wrong and responsible for the abuse, views criminal prosecution positively, makes adjustments with family, friends and peers, and is future-oriented. The avoidant pattern involves guilt and self-blame. Victims show unstable family relationships and poor socialization, often preferring younger playmates. They may continue sexually explicit behaviors, drop out of activities and be withdrawn. The avoidant/denigrating pattern involves guilt and self-blame. Victims show unstable family relationships and poor socialization, often preferring younger playmates. They may continue sexually explicit behaviors, drop out of activities and be withdrawn. The avoidant/denigrating pattern involves guilt and self-blame. Victims show unstable family relationships and poor socialization, often preferring younger playmates. They may continue sexually explicit behaviors, drop out of activities and be withdrawn.

Trauma sexualization is a process in which a child's sexuality is shaped in a dysfunctional and developmentally inappropriate way. If the offender rewards the child for sexual behavior (by attention or affection or material things), the child learns to use sex as a way of manipulating others to satisfy basic needs. If parts of the child are feminized and given feminized importance, the child learns misconceptions about sexual behavior. Reprimanding memories are associated with sexual activity, then later arousal can activate the unpleasant memories.

Clinicians can evaluate the child's behavior to determine the degree of traumatic sexualization. Common manifestations are sexualizations and preoccupations, aggressive sexual behavior, phobic reactions or avoidance of intimacy, proneness to sexual activity, confusion about sexual identity, and difficulty in separating affection and sex.

Bereavement refers to the discovery that someone who was supposed to care for the child has sexually abused him. Not only has the offender betrayed him, but there may be other adults who failed to protect the child who were part of the betrayal. Those who disbelieve, blame or ostracize the boy can be part of the betrayal. The psychological impact on the victim is often depression.
The Male Victim Program at Family Service of Greater St. Paul is only two years old. However, reacting new programs to meet community needs is practically a tradition, for the center is the oldest social service agency in the state of Minnesota. Family Service of Greater St. Paul opened nearly a century ago and provides the state’s Department of Social Services. The center is a private, non-profit corporation and receives funds from community sources such as United Way.

A branch office, East Communities Family Service, began a program in 1981 for sexually acting out adolescents. PHASE Program (now Healthy Adolescent Sexual Expression) is now a nationally known program. About five years ago, PHASE also developed a gender-specific program to treat adolescent female offenders.

Two years ago, the program for male victims was started. The program has received a consistently good response. Currently, it is serving about 14 adolescents who are divided into two groups, one for 15 to 18 year olds and one for those who are 11 to 14.

Paul Gerber, M.A., a therapist with the program, describes his work at a conference last year in Hilton Head, South Carolina. Gerber is a retired social worker for the Minnesota Crime Bureau. He specialized in sex crimes against children during the last 10 years of his career prior to entering the mental health field. Thus, he has studied sexual behavior from two perspectives. He has also practiced in both residential and outpatient settings.

Gerber feels that knowledge about offenders is essential to the assessment and treatment of victims. “If you want to learn about victims,” asserts Gerber, “talk to the offenders.” Victims often cope by repression and dissociation or they may minimize the offense. Also, one victim’s experience may be different than other victims who have been abused by the same perpetrator. Gerber cautions that offenders also minimize, rationalize and deny, thus use of multiple interviews and/or polygraph polygraph pneumograph is crucial.

Contact with a male victim begins with an intake and assessment process that is quite extensive. Prior to the initial appointment, the family is seen and has received an extensive family history questionnaire. The initial intake lasts three to four hours and requires at least two therapists, but sometimes as many as four. The entire family is seen when available.

The interview begins with the entire family together. Therapists assess family interaction and climate. The attitudes toward sexuality are explored, with particular attention on signs of denial or minimization of the abuse.

After the conjoint interview, the victim is interviewed and assessed separately. Parents are interviewed and assessed together. Each individual is promised privacy and confidentiality of his or her information. The victim is asked to complete a sexual attitude questionnaire and sentence completion test as part of a more standard test battery. A lengthy interview protocol on family history is used. This program also occasionally employs a partner testing as part of the assessment process.

If a child is chemically dependent or abuses alcohol or drugs, this problem is treated first. There is an expectation in the Male Victims Program that youth will be abstinent during the treatment process. Those with significant conduct problems are referred elsewhere. Some boys are badly damaged and/or very sociopathic. These children and adolescents are referred to residential programs.

Youth who identify themselves as gay are integrated into the groups and allowed to “come out” when they feel safe. There is also a task force in Minnesota for gay and lesbian youth that can provide further assistance. For example, some youth self-identified as gay have benefited from referral to a gay and lesbian youth group which can help normalize feelings of being different and provide more normative dating opportunities.

For those accepted into the program, treatment begins with the child involved in both individual and family therapy. As soon as possible, the child will join a victims group, led by two male therapists. A male and female team is available for times when the group dynamic can benefit from the modeling of both sexes. A clinical team is utilized for most treatment planning.

Treatmen goals center on five main issues:

1) Resolving the experience of the abuse.

The victim will have an opportunity to talk about what happened.

2) Developing empowering strategies.

The male victim will learn strategies for feeling strong and powerful without being inappropriate.

3) Expressing feelings appropriately.

Feelings about the abuse will be discussed and clarified.

4) Moving beyond the victimization experience, which is accomplished through integrating information and skills concerning sexuality, relationships and self-awareness.

5) Exploring sexual identity issues in order to clarify the confusion and anxiety that generally occurs in male victims.

During the sessions, therapists accomplish "a tremendous amount of education," including the use of videos and films. "Initially, we do a lot of normalizing of deviant fantasy to melt shame," explains

Paul Gerber

is administered to both the victim and the parents or parent substitute.

A highly "pro-active" approach is taken with the male victims whenever clinically appropriate. Gerber explains his approach, "We have found that boys respect a pro-active approach. We don't want to give a message that we are uncomfortable about hearing whatever happened. We need to know the whole and breadth of the sexual experience, including what was arousing."

Formal testing is also utilized, although there is not a standardized battery. If the boy is over 15, he generally takes an MMPI (Minnesota Multiphasic Personality Inventory), a self-report measure of personality development. If depression is suspected, a Beck Depression Inventory is given. If the boy has behavioral problems and/or acting out with delinquent behavior, a semi-structured Inventory

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Residential placement or foster care can be considered for cases where the child's safety is in question. This option is also available for those victims whose current foster family provides a very supportive atmosphere. A case where the victim needs substance abuse treatment is one example. Frowning cautions that clinician should inquire about substance abuse even with young children. "Even at nine or ten you need to worry about drugs and alcohol." The clinician may have introduced the boy to substances, then the vicincent seek them out in order to numb feelings. Ask the parents to be aware of the possibility, to check their liquor supply for example, especially if they are noticing mood swings in the child." If the child is offending against other children in the family, placement is also an option. However, few placements are available that limit the child's access to other children. "Kids repeat offenses in foster care or residential treatment," notes Conningham. "If a child has a history of sexual acting out, he should be the only child in the foster home." Children who are less seriously traumatized share common characteristics. Jan Hinkin, a therapist in private practice in Minneapolis, described those with minimal damage. "All were abused with the understanding that they were victims and that the symptoms were supportive. These children reported the sexual contact quality, and received a positive response to disclosure. This makes it difficult for a child to separate the sexual abuse from normal sexual development."
exposure. Without a working alliance with the therapist, parents are likely to deny their own fears and withdraw their son from treatment.

Parent support groups can be very helpful in decreasing isolation and "normalizing" the victimization. Some clinicians (Porter, 1986) suggest support groups just for fathers, as fathers often confuse somewhat different than those of their wives.

Treatment Tasks

The first task of treatment is to ensure safety for the child victim. It is important to consider that some children are victimized by multiple abusers or become involved with additional abuse. If the boy has abused other children, measures need to be taken to ensure that he is not dangerous to other children.

It is important that the therapist convey the message that he or she has the capacity to deal with the abuse. Mayman notes, "You have to be able to hear it. Be aware of your own countertransference issues. With boys there can be a very strong reaction."

The boy must be encouraged to talk candidly about what occurred. Clinicians agree that this is the most difficult task.

Frowning suggests that one misapplying a boy's denial is the propensity to become an abuser himself. "You think you have a victim, but sometimes they are recreationally abusing other children. They feel so guilty about their own sexual aggression behavior that they cannot tell you about their victimization they experienced."

While noting the importance of talking, most clinicians stress allowing the boy to control the timing and pace of revelation. Porter (1986) noted that the boy must be "empowered to protect himself from intrusion and be prepared to handle the emotions that go with a discussion of what happened to him. . . . Any attempts to force the youth to talk are destructive, particularly ineffective as they represent the very worst elements of the situation" (pp. 48-49). Others agree. Mayman comments, "It's very important not to push, but to provide a safe pace for disclosure." Gerber, on the other hand, takes a proactive stance. "Avoiding the sexual abuse makes it shameful," he states. Gerber advocates asking very explicit questions about sexual activity in order to get a more complete version of the activity.

Even though questions against forced disclosure, the therapist must provide structure that allows sexual discussion to occur, as most boys will not volunteer details. By speaking frankly and systematically, a therapist can demystify sexual conversation, model ways to talk about sex and communicate willingness to hear.

Other rejections include the use of anatomical dolls, drawings and writing a journal. Concerns from an organizational and conversational process, talking about the abuse a little at a time. For those who have dissociated from or repressed the events, Frowning uses hypnosis to help boys recover memories. "You need to wait with hypnosis until they are ready," explains Frowning. "or the procedure will not satisfy much. A boy is ready to use hypnosis when he has accepted that the incidents have happened and when the symptoms are worse than the impact of remembering." Still, resistance is needed. Frowning tells of a boy who deny being a victim for 15 months even though everyone in the child's family was openly supportive about disclosing the abuse. Mayman adds, "It takes months for these boys to trust and feel safe." Once the boy is able to divulge the details, the next task is getting in touch with feelings. Porter maintains that boys are not so much uncomfortable with feelings as simply ignorant of them. Lacking tools to recognize and express the pain, the boy becomes at high risk for acting out the abuse.

The most usual feelings are anger, guilt and fear. The male victim is most likely to be aware of the anger. Gerber comments, "Boys don't need so much to be angry. They know how to do this and have culture to express what they need to cry." Failing agrees, "Boys are in touch with anger and often can express it. Sometimes the expression is animal torture or physical abuse of others. Then re-directing the anger is necessary." Porter notes that powerlessness lies behind the anger. Anger can mask the "soft" emotions of sadness, betrayal, grief and loneliness. The therapist must assist the boy in expressing rage without aggression. Role play, the use of symbolic objects on which to focus the anger (such as photographs, drawings, punching bags, etc.), or confrontation of the perpetrator are possible outlets.

Guilt can involve feeling responsible for the sexual abuse or for the negative impact of disclosure on the perpetrator. If the boy was aroused or experienced orgasm, he may feel money or pressure from the perpetrator, if he indulged in substance abuse, looked at pornography or solicited other children for the abuse, then the boy is likely to feel intense guilt. Guilt is also a way of denying vulnerability, since responsibility implies control. If the boy has acted sexually towards other children, guilt is more intense as the anger felt towards the abuser is also turned inward. Frowning notes, "Boys are more likely to be abused by pedophiles. Some react to get the victim drunk, show pornographic and do anything to actively engange the child in the worst of it. In actuality the boy is in a normal situation in terms of tenses of guilt.

Porter cautions that disinempowerment can occur if victims are told they are not of power, for their own behavior. While responsibility for the medication is the offender's, the victim can be held responsible for his own actions, correcting his own behavior and making amends if he has also hurt himself.

A common fear is the issue of homosexuality. Failing notes, "The issue of sexual identity is hard to handle. The kids won't talk about it, so you have to introduce it. It's a real dilemma. Some boys who are sexually abused will later identify themselves as homosexual." Thus, the therapist must reassure the boy that masturbation does not cause homosexuality but at the same time the therapist must give the client permission to choose his sexual orientation.

Tackling the issue of homosexuality often means education about sexuality — both normal and derian. Many victims lack knowledge about sexual development and functioning. Victims also need to learn what is known about people who molest children.

Sex education remains a controversial subject with the general population. Thus, the form and content of sex education must be developed in concert with the boy and his parents.

Porter (1986) outlines an agenda for teaching healthy sexuality. His goals include instilling a concern and respect for the rights of others. The healthy person shows sufficient self-love to allow enjoyment of sexual pleasure without guilt or negative emotions. His third goal is understanding sexual physiology and the range of sexual behaviors. Many mills practical items. "Ahaletable boys need to learn how to handle their normal sexual feelings. They are often dealing with feeling or thinking about dating and becoming sexually active.

Routinely identifying feelings can take a long time. One useful tool is a simple list of feeling words which can be thrust into the boy's hands as he esteems inevitable, "I don't know." The boy can then pick the pace that come closest to what he is feeling (Porter, 1986).

The therapist should not neglect the positive feeling of caring between victim and offender. Valuation of his need for affection and intimacy can be offered, along with distinguishing affection from sex. Interac-

Ment with the therapist can be crucial in this process.

Merely identifying feelings is not sufficient. Having labeled and explored feelings, they must be connected, along with any behavioral problems, to the abusive events.
"Before Brotherstorm began," explained Jim Hepburn, program coordinator, "boys who were sexually abused were typically seen by rape crisis centers. This only heightened their sense that this was a 'woman's problem.' The reaction was 'get me out of here quickly.' Now we have Brotherstorm, and it is a focus just for males."

Brotherstorm began with joint goals of providing both therapy and community education for male victims under 18. In the first year of operation, 1986-87, approximately 25 children and adolescents were served. The following year, the program had 50 referrals. This past year, 63 were helped.

Brotherstorm is a comprehensive program and offers services not only to the victimized children, but also to non-victimized siblings, and to parents or guardians. In fact, it is required that family members be involved, as they are seen as the principle change agents.

Child victims under 12 receive play therapy. Most therapists providing play therapy subscribe to a psychoanalytic orientation, although a variety of other therapeutic approaches may be used for family, group or individual work with older clients. Typically, the first two to five sessions are spent in assessment. These sessions, while unstructured, are more directive than the later stages of therapy.

Therapists are free to choose their own assessment techniques. Hepburn relies heavily on the use of drawings. "I talk with the child about his drawings," he explains, "I watch how the client approaches the task and see what interpretation he is able to do on his own. The drawings are useful to introduce themes. For example, one young fellow drew himself almost emasculated. It was easy to begin talking about helplessness when discussing his drawing."

Brotherstorm also uses drawings to form a common language with the child. "Drawings can help to identify the child's names for body parts," he says, "and they also give clues as to how the child has experienced the events and the feelings connected to the actions."

The total family assessment helps the clinician develop therapy goals. Hepburn stresses, "I think it is important to establish a framework from the beginning and identify the family's concerns." These may center on overt sexual acting out and physical aggression. The program allows each therapist to develop his/her own structure for the family assessment and subsequent intervention.

Most boys see in play therapy for 12 to 18 months. "The process of therapy is to provide a play space," Hepburn declares. "This process can take three to six months. In my opinion there comes a point where the child is very aggressive towards the therapist and the therapist, in turn, becomes aggressive towards the child. Then one comes to the time when the child, now secure, feels safe to regress and uses the therapist to manage his emotions. He then works through issues symbolically."

Direct discussion about the abusive incidents usually occurs during the initial assessment phase. "If it is symbolic of abuse, then we deal with it," states Hepburn. "However, there may be months when the issue does not come up and other issues such as abandonment are more important."

Hepburn rarely introduces a focus on the sexual abuse. "I have found if I am too blunt, the child becomes afraid and closes down."

Direct work between the child and the perpetrator is also rare. "Confrontation between a child and the perpetrator most often occurs with older children. The group is useful for this. A group may invite a perpetrator to talk with them. This is often an intense and angry session."

Older victims may be seen in individual therapy and/or in group therapy depending on the needs of each client. With a larger population of clients, the program recently has split into two groups. There is a new ongoing group for boys ages 15 to 18 and a 'Little Brother' group for boys ages 12 to 14. Groups are open-ended and attendance can vary a great deal. With the average young man remaining in group treatment for over a year.

"Groups are processes-oriented, but incorporate occasional educational material (such as a film or video) and occasional fun activities such as a field trip to an amusement park. One unique feature is camping retreats, held twice a year at a camp owned by Family Resources. "The group is strengthened in the camping setting," notes Hepburn. "Here the groups can mingle and both the girls' groups and the boys' groups are included. Over the space of a weekend, everyone gets close and we learn to know the kids better."

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- Virginia Department of Social Services
- Bureau of Child Welfare Services

The rest of the family is not neglected. Siblings are seen individually, as needed. The program requires parents to be involved in a group. There are separate groups for offenders and non-offending parents. "Our message is that sexual abuse is not simply the child's problem. Rather, it is a problem that affects the entire family," emphasizes Hepburn. "Otherwise, the parent will bring the child and remain in denial."

The second component of the Brotherstorm program has been community awareness and education. Programs are available to community groups and are aimed at increasing the public's sensitivity to the specific needs of male victims of sexual, physical and emotional abuse. The program has expanded in the last year from sexual abuse to include problems of physical and emotional abuse of male children and teens. Training for mental health professionals is also available from Family Resources.

The Brotherstorm Program is part of Family Resources, a non-profit organization formed in 1984 by the merge of the Child Abuse Prevention Center and the Fresh Air Camp Association. Family Resources sponsors other programs, including Parents Anonymous, Parents United, groups for adult survivors of sexual and physical abuse, a therapeutic day care center for abused children, a mentoring class (a 15-week parent training for abusive parents), a family camp program and a fresh air summer camp for disadvantaged youth. More information about Brotherstorm and other Family Resources programs is available from Jim Hepburn, Program Coordinator Brotherstorm Family Resources 429 Forbes Avenue, Suite 412 Pittsburgh, PA 15219 412-562-9460.
This step is seen as crucial in avoiding the cycle of abuse and avoiding the compulsive selfdestructive behaviors and selfhate common in victims of abuse. Having listed the symptoms to the sexual abuse, the next task is to help the boy see that the selfprotective defenses are no longer needed. Negative behaviors are tackled and altered. Confidence and self-esteem improve so the boy is empowered through mastery of his behavior.

The therapy often involves changes in relationships. The boy learns how to establish proper boundaries. Truants in others is reduced. Isolation has been lessened. The offender has been removed, either in person or symbolically. If the offender is still in contact with the boy, there is some control or place to assure the boy's continued safety.

The boy has also received prevention training to assist him in avoiding further abuse.

Reconstructing the Group

A group for group therapy is offered by Porter (1966). He feels that there are three stages in the group: creating a sense of cohesion, working through issues and termination.

During the first stage of the group, the task is to create norms of behavior that allow for safety and respect, plus a clear contract for working on the issues. Porter describes this as an active creation which starts the empowerment process. Therapists work to ensure that the group members feel protected and connected.

Therapists are also active in this first stage, encouraging interaction via "getting to know you" exercises such as having inquirers meet new members and have each introduce himself. The group is also addressed, as specified in the contract agreed to by each boy prior to entering the group.

During the fourth session, each member discusses his molestation. It is rare for a group member to be unprepared by others at this point. A "Tell My Story Chart" assists the boy in this task. Fears are actively labeled and discussed.

One way of facilitating bonding and of conquering reticence, particularly during the initiation stage, is to go on outings. The group plan and executes the outings.

Stage two involves working through the issues of power, sexual identity, intimacy and guilt. Termination varies according to each individual. It is seen as a stepping point that is not necessarily permanent, allowing for the resumption of treatment if needed.

Termination

When clinicians were asked how to determine when to end therapy, the response was universal: "When the boy can comfortably talk about the abuse and is symptom-free." Others mentioned the need for the child to have developed positive relationships and to be able to identify their sources. Finally, mentioned the need for the parents to have worked through issues, gained understanding of their own, and learned how to support their progress.

Abuse-Reactive Children

Several clinicians stress the importance of the victim-offender cycle of behavior. Porter commented, "In my surgical work, I didn't recognize how many victims have acted out sexually with younger children." This is confirmed in clinic reports that patients have been molested, rather than molester. Mayman believes the victim who becomes a perpetrator is trying to renew the experience nonverbally. When the boy's anxiety level rises due to fear of attack, humiliation or abandonment, he emerges his helplessness by hurting another. By being the aggressor, the boy replaces the anxiety with feelings of power and achieves tension release. Cunningham notes that failure to massage the trauma will create a continual need to re-create and re-enact it throughout adult life.

Clinicians note that sexual acting out by victimized boys may be minimized or ignored by parents and professionals alike. Feller explains, "Sexual acting out often gets defined as 'play.' Then it gradually changes from hyperactive behavior to more aggressive sexual behavior. It is a very gratifying activity for the child and once the behavior becomes repetitive and compulsive it is very difficult to stop." Fosson adds, "Parents want to think the sexual behavior is normal, but curiosity, while the sexual activity is generally not like the exploitation that nonvictim children do."

Assessment of sexualized acting out is not easy. Requests by parents and others are very helpful. Culhane also suggests exploring the boy victim's fantasy of "getting back" at the offender. If the boy demonstrates a lot of rage and sexualized aggression, I worry," Culhane asks boys about their "get back" fantasy, and if they have ever acted on it. She asks what they think would happen in real life if they did the fantasy behavior. Attracting realistic consequences to aggression can prevent the boy from acting out and rationally sexual aggression, a pattern which has been observed among juvenile sex offenders. Cunningham suggests examining other related behavioral problems as well, especially fire setting and cruelty to animals, which can be warning signals that a child is at risk for becoming a perpetrator. With younger children, Fosson observes, they will identify with victim when appropriate feelings.

Environmental intervention can be important, especially in the early stages of therapy. Fosson states, "If an older child is showing sign of being out of control, parents must do a lot to supervise their contact." Parents who are not capable or motivated, protection within the home may not be possible. Culhane reports that many of the families she assessed were multiprocess and unmotivated for treatment. "Our population was low income, and often one or more family members were substance abusers. When the environment includes adults who are engaged in 'truck' dealing and prostitution, removal of the child is considered to be the only option." Cunningham directs a program for abusive-reactive boys, and has co-authored a treatment goals for the abusive-reactive child (see review, this issue of "Steps to Health: Touching""). Cunningham explains the program philosophy: "My sense about these boys is that they either have been molested or they have seen a lot of sexual activity in their families. Sex becomes an addictive cycle for them, often times by adolescence."

Noting the young age of many of her clients, Cunningham stresses that treatment must be non-threatening. "The boys do not want to talk about the sexual activity. It's too scary for them. The therapist has to improve the topic."

Cunningham's program teaches children to understand their impulses. She makes liberal use of rewards, praise and stickers to encourage the boys to participate. "We are always looking for ways to adapt materials and keep the sessions interesting," states Cunningham.

Clinicians agree that behavioral control is a key to successful resolution of the therapy. Culhane explains, "Acting-out behaviors like the child from setting, so he never connects with the issues. When the child stops acting out, then feelings emerge and become accessible."

A parent group meets concurrently with the children's group. Feller agrees that parental involvement is important. "I work..."
"It Happens to Boys Too" by Lorraine Stafford, Robert Russell, and Pat A. Bradley, 1987, p. 38. $5.75 plus $1.50 postage. Available from the National Child Abuse Center, 10 Charles Street, Rochester, NY 14603. (413) 444-9708

This book is an ideal resource for young male victims aged 8 to 11, and their families. It covers kinds of touches, defines sexual abuse and presents the "mirrors" and the "telling" of the sexual abuse of boys. The book discusses why children who abuse is not what the child feels, even if the truth left goes left, the child's idea to the activity, or if the child allowed the perpetrator. The book explains how children who act out sexual activity and points out what children can do (like what they can do but might wish they could do) if approached. The book talks about why adults are sexually with children. Especially valuable are several personal accounts from child victims. A section for parents covers the range of potential reactions, ways to help children, and ways to help a son who has been victimized and how to help them.

Every clinician who deals with sexually abused children should have a copy of this excellent resource book.

"Be Safe... Be Aware" by Kevin McGovern, $3.50 plus $3.50 handling cost. Available from Alternatives to Sexual Abuse, P.O. Box 25357, Portland, OR 97229. (503) 444-6500.

Children love to play this game! It is colorful, interesting to learn about and interesting to play. They can draw pictures of how they feel and discuss unrelated touching. They can see questions when they land on questions spaces or "show me" spaces and can earn tokens by answering correctly. Children also receive tokens if they land on a "test" space. The board is well worth because they can land in the test and not be able to get back out. "Be Safe... Be Aware" works well for Ages 5 through 10, though older ages may enjoy it. The game builds confidence and in several areas of use in clinical practice, has been proven to be non-threatening.


This book was written for the parents and families of molested children. It is an example of what a friend, a member of the board, who was molested by his mother, writes about his experience. The book relates the victims' reactions and feelings from the moment they suspect a problem to the point at which the family is aware and what recovery. The book deals with many important topics. It covers warning signs of recovery. The authors discuss how to react and what to say to a child and at 10 years old sexual abuse. The book shows what happens after sexual abuse is reported and explains the legal process. A chapter deals with choosing a therapist and the implications of therapy. The book deals with guilt and the communicating the processes topic are topics from research. All are written to be well-grounded reading, and to help women to be well-grounded in their understanding of the implications of their child.

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"Spider-Man and Power Pack" is available from the Prevention of Child Abuse, P.O. Box 9335, Springfield, VA 22153 (703) 402-4001.


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"Steps to Healthy Touching" by Kee MacFarlane, M.S.W., and Carolyn Cunningham, Ph.D., 1988, 157 pages, $19.95 (bulk orders less). Available from: Kids Rights, 3700 Progress Boulevard P.O. Box 851 Mount Dora, FL 32757 (305) 423-7129

"Steps to Healthy Touching" is a hands-on treatment workbook for children ages 5 to 12 who have problems with sexually inappropriate behaviors toward others. It is modeled after the 12-Step Alcoholics Anonymous and modified to accommodate the young child's developmental levels. The workbook is planned to be a 12-week program but may be used over a longer time period.

The book covers many important issues. These include assisting the problem, identifying helpful sources, learning to ask for help, how to stop blaming others, understanding the victim's hurt, finding other ways to show feelings, accepting things that one can't change, recognizing sexual dangers, making restitution and helping others with similar problems. The format is one of active exercises and homework assignments, designed for a young child, and completion allows the child to advance toward a "touchdown" on a "football field.

Some treatment issues are not covered by the workbook. These include problems of sexual confusion and identity, the child's own sexual victimization, anger management and education about sexuality.

For children who are reasonably viable and who have the patience to draw, write or complete workbook exercises, this workbook is ideal. Many of the activities can be adapted for children with low verbal abilities or impaired concentration. For example, children can act out exercises rather than write them down. The therapist can record answers for those who don't have the patience to write. The exercises make good reference guides to help a child act out exercises. Also, the workbook seems to be adaptable either for group therapy or for individual work.

"I Told My Secret: A Book for Kids Who Were Abused" by Elizabeth Gill, 1986, 16 pp. Available from: Launch Press P.O. Box 349 Walnut Creek, CA 94598 (415) 943-7622

Written in plain language, this book appears appropriate for kindergarten and early elementary children. It tells of what gets abused, who abuses and why abuse happens. How to tell and who to tell are discussed. Typical questions such as "Why me?" and "Does everyone know?" are answered. Even though the book defines abuse as physical, emotional, sexual or neglect, it seems to be targeted for sexually abused children.


This book makes a significant contribution in an area where literature is sparse. The author specializes in treatment of males who are victims or offenders and draws on his clinical experience. Research findings are not neglected; however, the introduction by Fay Homey Knoop covers risk factors, incidence and effects of sexual assault, discussing the need for early intervention. The rest of the book examines the therapeutic process, including individual, group and family therapy approaches. Specific techniques are described. The book is supplemented by several appendices, including a sexual history questionnaire.

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Abuse of Boys

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with the family to get a risk-free environment, she states. "The family is crucial in helping the child keep a lid on his impulses."

Cunningham's program also focuses on the child's own victimization. "The therapy goes back and forth. We work on the victimization, then on the swing-out, and so on." Rather notes that the child who can discuss his own victimization can get in touch with the pain, and can then empathize with potential victims. It can even help to bring the child's victim in to confront him.

Balloun's and Peters offers a similar therapy program, described in this issue (See "Sneakout: Monster Therapy"). Reception is always a concern. All clinicians stressed the importance of helping the young and parents identify high-risk situations and warning signs. Cunningham stressed having the children return for check-ups. "I see this behavior as similar to a drug addiction cycle. It is likely to recur and needs monitoring."

Virginia's Picture

Four clinicians in Virginia were interviewed about their treatment experience with male victims. They varied in their focus on sexual abuse from 100 percent of their work to 50 percent. All replied that, of the sexually abused children seen in their practice, approximately 15 percent were male.

Three of the four clinicians perform a similar assessment. Some, such as Jackie Stopp, therapist with Richmond's Child and Family Unit, use the trauma assessment to structure the therapy. Group therapy is the treatment of choice, but none of those interviewed were aware of group treatment for boy victims in their area. The clinicians interviewed prefer a lengthy treatment of a year or more. Isaac Van Peters, a private practitioner from Roanoke, stressed that there is no termination of cases. Boys are encouraged to return as needed. VCOR would like to hear from programs in Virginia specific to male victims. Social service departments contacted by VCOR are making individual referrals to mental health practitioners for individual and/or family therapy.

System Response

Currently, helping systems have failed many, if not most, male victims of sexual abuse. At the most basic level, that of protection, the system responds much differently to boys than to girls. For example, one study found that only four percent of boy victims, compared to 50 percent of girl victims, were removed from the perpetrating as a precaution against further abuse (Pierce & Peters, 1985). Services for boys differ from those offered to girls as well. Courts rarely order treatment for boys. Studies show that few boys receive a medical evaluation. Psychological treatment is sought frequently for victimized boys. When boys receive treatment, they are seen for shorter time periods than females. For example, in Pierce and Peters' survey (1985), the majority of treated boys were seen for less than four months.

Prevention

Prevention of sexual abuse of boys may be a more complex task than preventing sexual abuse of girls. Society needs to recognize males as victims and educate the general public and children about the possibility that "it can happen to boys, too." The concept that "a boy may never be a victim" needs to be corrected. Boys must be rewarded for disclosure, and professionals need to learn about the unique aspect of working with abused males. Adult males who have been victims as children and who speak out and are visible might be valuable role models for younger boys.

Prevention efforts must extend to boys. There is an acute need for prevention materials that are written for boys. Prevention materials for teenage boys are tenuously lacking.

All children, boys and girls, deserve nurturing and protection. All children, boys and girls, deserve the opportunity to grow free of victimization.

References Available Upon Request