Men Sexually Abused in Childhood

Sequelae and Implications for the Family Physician

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Although the majority of childhood sexual abuse victims are women, male children are also at risk for sexual assault and consequent long-term effects including major psychiatric disorders, substance abuse, sexual dysfunction, and somatization syndromes. Male patients sexually abused in childhood or adolescence may present to the primary-care physician with specific interpersonal or developmental crises or with persistent depression, anxiety, or somatic complaints. The physician can serve a therapeutic role by validating the patient's experience and can provide the patient with information on the prevalence and consequences of male sexual abuse. Assessment of the impact of sexual abuse will rely on the sensitive and systematic evaluation of critical variables related to the abuse. More severely traumatized patients will require assessment for suicide potential and referral for mental health services. *(Arch Fam Med. 1993;2:29-33)*

The sexual abuse of children is prevalent in our society. Many individuals sexually abused as children experience psychological and emotional consequences that endure into adulthood.[1-5] Historically, women have been assumed to be the primary victims of sexual abuse, and little attention has been devoted to the nature, prevalence, or long-term consequences of the sexual abuse of men. As a result, the dynamics and effects of male sexual abuse are likely to be inadequately understood by physicians, and victims may be subjected to misinformation and myths that interfere with intervention.

Current research indicates that 2% to 10% of men are sexually abused during childhood or adolescence, and many experience significant and lasting effects.[2,6-8] These consequences may be equal to or greater than those experienced by female victims for comparable degrees of abuse.[8-10] In addition, the dynamics associated with the sexual abuse of men have unique aspects differentiating them from women.[6] Consequently, recommendations for intervention with female victims may not be relevant for male victims.

The adult male patient who was sexually abused as a child presents to the primary-care physician with complicated psychological issues. Spontaneous disclosure of a history of abuse is unlikely although the presentation of relationship difficulties, psychiatric symptoms, and somatic concerns is common and may serve as a clue to the physician. Disclosure may often occur during crisis, thus intensifying the clinician's need for sensitivity and effective action. It is essential that the family physician recognize that male sexual abuse has serious long-term clinical, social, and legal implications.[11]

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PATIENT REPORTS

Patient 1

A 47-year-old school administrator had been married for over 25 years, and was a patient at the clinic for the past 8 years. Well liked and respected in the community, he was very active in his church and honored for his teaching and leadership skills. He presented at the clinic with general health concerns that included somatic and psychological symptoms consistent with moderate depression. He indicated that he was experiencing marital difficulties, and had been considering divorce.

In the years that the family physician had taken care of the couple, there had been no evidence of marital problems; however, the patient indicated that the relationship with his wife had been distant for many years. The current problem was precipitated by the wife's insistence that the couple assume caretaker responsibilities for his recently disabled father. The patient refused to consider this possibility and would become enraged when his wife brought it up.

After seeking reassurances of confidentiality, the patient told his family physician that he had been repeatedly fondled and, on occasion, sodomized by his minister father. He had never shared this information with anyone, including his siblings and wife. The abuse occurred for approximately 5 years when he was between 7 and 12 years old, after the death of his mother. He was ashamed about what had happened and expressed hatred for his father.

In addition, the patient was concerned because he had begun "cruising gay bars" and worried that he might molest male students at his school. He denied being sexually active with any men or children but feared contact was inevitable. After a prolonged discussion with the physician, he hesitantly agreed to see a therapist.

Patient 2

A male patient in his mid-20s was seen by his family physician for complaints of depression attributed to family conflict. The patient had recently married an older woman with two teenaged children. The patient acknowledged current alcohol abuse and previous cocaine use. He had recently initiated contact with a psychiatrist.

After a number of office visits, he revealed to the family physician that he had been sexually assaulted on repeated occasions between ages 8 and 13 years by a group of four adolescent and adult men. He began having flashbacks and nightmares of the sexual abuse, became hypervigilant and agitated and, at other times, withdrawn and uncommunicative for hours.

His symptoms intensified as he recalled and disclosed details of the sexual abuse. He began to exhibit self-injurious behavior that included banging his head against walls and cutting his arms with sharp objects. His wife brought him to the clinic during one of these episodes, when he threatened to cut himself because it would "put the pain from my heart on another part of my body." He was admitted to a psychiatric unit for a month but shortly after discharge, he took an overdose of his antidepressant medication. He was admitted to the intensive care unit and, when medically stable, was readmitted to the psychiatric unit.

Following hospitalization, the patient continued to have difficulties with alcohol abuse and violent behavior. His wife moved out of their apartment and he became involved in sexual relationships with male and female partners. He also began to express homicidal intent toward the individuals who sexually abused him.

PREVALENCE OF MALE SEXUAL ABUSE

Most prevalence studies of childhood sexual abuse exclude male victims, include only small numbers of male victims, or fail to differentiate abuse rates by gender.[9] Prevalence studies specifically examining male victimization indicate rates that range from 2% to 30% of all boys younger than 16 years, but the majority of studies suggest a rate between 2% and 10%.[12,13] International studies report similar prevalence rates.[14,15] The wide variance in prevalence rates is believed to be due to differences in the definition of abuse, methodological difficulties, and diverse samples.[9] The reporting rate for male sexual abuse is believed to be lower than that for women but the number of male children who are victims of sexual abuse has increased.[12,16] The incidence of sexual abuse in the developmental history of male psychiatric patients is noted to be significantly higher than among nonclinical samples,[14,17] and rates among the incarcerated and sexual offenders are similarly high.[8,11,18]

Case reports of the sexual abuse of male children document that such abuse can occur in infancy and throughout childhood and adolescence. However, the typical male victim of sexual abuse is between 8 and 13 years old,[9,19] and the perpetrator is most frequently a trusted male authority figure. Female perpetrators have been implicated in a small percentage of cases.[8,20] In contrast to female victims, male victims tend to be subjected to more physical abuse and threats; are more likely to be abused by non–family members; are at increased risk for anal penetration; and are less likely than girls to report the assault.[8,9,16,19] When sexual abuse of a male child occurs within a family, its consequences are believed to be more serious due to the violation of social taboos and issues of trust.[19]

FACTORS THAT INHIBIT DISCLOSURE

Disclosure of a history of sexual abuse can be inhibited by psychological, social, and cultural factors and by individual belief systems. Repression is

the psychological defense mechanism most commonly associated with a failure to disclose a history of emotional trauma. Through repression, the memory of the incident(s) is blocked from recall, and may not reemerge without a specific precipitant; yet the event continues to drive emotions and behavior throughout the victim's life.[21] Some victims may fail to recognize an association between psychological symptoms and past sexual abuse, which may constitute another form of repression.[14]

Disclosure is also inhibited by cultural stereotypes and social stigma. These include beliefs that men are not victims and are nonemotional individuals in control of their thoughts, actions, and behavior. Characteristics of male socialization such as values of self-reliance and reluctance to seek help also make disclosure less likely. Sexual abuse of boys by male perpetrators also carries an implied relationship to homosexuality and shame about an inability by victims to defend or protect themselves.

Male victims often report that they develop a pattern of nondisclosure that starts with their fear of retaliation, rejection, and/or disbelief.[19,21,22] In one study only 25% indicated ever having told anyone at the time of the incident,[19] and Russell[13] suggests that fewer than 6% of child molestation cases are ever reported to official agencies. Sexual victimization is associated with issues of power and domination, which serve to reinforce the child's fear of further victimization. This apprehension continues into adolescence when many victims report that they would prefer to forget the abuse even happened[15,22] and that they believe no one can understand what the experience was like.[19] Rates of disclosure have been found to decrease with age.[23]

Other victims have pleasurable memories of the attention they received, or recall having been sexually aroused.[21] They experience guilt, shame, or confusion about these feelings. Some continue to associate the events with the cognitive stages of childhood, which reinforce self-directed judgments of having been bad or being punished. As a result, they may not consider the perpetrator to have been abusive.[9]

It is critical to understand that disclosure is an ongoing process,[15] with the tendency of male victims to omit details.[16,23] Victims make delayed, conflicting, and unconvincing disclosures in an unconscious attempt to defend their self-esteem. Disclosure is a frightening process that compromises the individual's coping mechanisms and can lead to emotional and psychological decompensation.

There is a tendency to associate disclosure or "breaking the silence" with acceptance and resolution of the sexual trauma.[8] While some patients may be able to move on with their lives after disclosing the events of past abuse, most sexually abused men must confront difficult memories and confusing feelings as they struggle through stages of healing. The following tabulation lists the factors that are useful in assessing the impact of sexual abuse in male patients.

Assessment

- Type and frequency of sexual contact
- Age of patient at time of abuse
- Relationship to perpetrator
- Concurrent physical abuse or coercion
- Previous disclosure: when? to whom?
- Patient's sense of guilt or shame
- Relationship of abuse to current functioning

THE LONG-TERM CONSEQUENCES

The consequences of sexual abuse of male children range from no apparent effect to subtle interference with optimal functioning to devastating psychiatric and social dysfunction.[8-10,14,16,19] Among the variables believed to have a significant impact are the age of the child, the type of act involved, the identity of the perpetrator, the duration and frequency of the abuse, and the degree of physical threat or violence involved. In situations in which the sexual abuse does not appear to result in permanent trauma, it remains an unpleasant and negative event.

Although most authors conclude that sexual victimization of boys in childhood will bring about changes in the child's life, there are few studies that have attempted to determine the percentage of victims who experience significant effects as adults. In one study of sexually abused adolescent boys, over 60% reported the abuse as having a significant negative effect on their current functioning.[22] It is generally believed that the morbidity from sexual abuse of children is high, and that it is common for symptoms to develop and redevelop months and years after molestation.[11] Thus, the effects of sexual abuse should be viewed as ongoing and interactive, and not as a singular event.[24] Sexual abuse is unlikely to occur exclusive of other family or social problems, and the effect of the abuse is likely to be intensified by other psychological, developmental, and situational difficulties.

The long-term consequences of male sexual abuse can be viewed as a chronic form of posttraumatic stress disorder because common symptoms include reexperiencing the traumatic event through flashbacks and nightmares, emotional numbing, hypervigilance, anxiety, sleep disturbance, and impulsive behavior.[8] However, this constellation of symptoms is not always present for all victims. In fact, despite the wide range of disabling symptoms reported, many do not meet the clinical criteria for formal psychiatric diagnosis.[23]

Other authors have provided a psychodynamic perspective that attempts to account for the wide and often discrepant symptoms manifested by adult survivors of sexual abuse. Among the common elements of these descriptions are traumatic sexualization, confused sexual identity, fear of intimacy, and feelings of betrayal, powerlessness, anger, and rage.[8,9,15,21,25]

Issues of betrayal are often manifested through disrupted interpersonal relationships in which victims find it difficult to develop intimacy. Victims frequently report an internalized perception of distance in relationships and, in more extreme cases, develop a mistrust of others to avoid further vulnerability. For many male victims, their experience is often reported to result in a loss of identity with their gender, ranging from a a sense of being "different" to gender shame.[15]

Stigmatization and powerlessness are the result of the experience of abuse, and are manifested as low self-esteem, symptoms of depression, anxiety, and self-doubt. In the extreme, the manifestation of these dynamics can be seen in the self-directed rage that leads to suicidal behavior, self-injurious acts, or substance abuse. A number of authors believe that male victims are more likely than female victims to externalize their anger through impulsive and violent behavior.[4,15] A significant treatment issue for male victims confronting their history of abuse are the homicidal feelings that emerge toward the perpetrator.

Childhood sexual abuse of males has been found to correlate with later sexual identity and behavior.[19,22,26] Victims can experience significant confusion about their sexual identity, low sexual self-esteem, and/or sexual dysfunction.[15,20,23] In a report by Woods and Dean,[27] over one third of victims reported a negative effect on their sexuality, including sexual dysfunction, dissatisfaction with sexual performance, infidelity, and preoccupation with sexual fantasies. Other victims report confusion about homosexual ideation, homophobic reactions, or sexual fantasies about children.

Finkelhor[19] reported that by adulthood, men who have been victims are four times more likely than those who have not to be homosexual; homosexual orientation was increased if the abuse had occurred before age 13 years. In another report, male victims identified themselves as homosexual nearly seven times as often and as bisexual nearly six times as often as controls.[22] In a study of a nonclinical sample, 12% of male victims of sexual abuse had a homosexual experience during the past year.[27] The link between the experience of sexual abuse and a homosexual orientation as an adult is not clearly understood, but it cannot automatically be assumed that the abuse is the only reason for the individual's homosexual identity. It should also be noted that the vast majority of individuals who identify themselves as homosexual are not victims of sexual abuse.

One of the more disturbing areas of concern is the pattern of cyclical revictimization. Investigations with incarcerated sex offenders have revealed a high frequency of sexual abuse in the offender's background.[18] Although the vast majority of men who were abused as children do not go on to molest children, for a small percentage of men there is a relationship between having been a victim and future perpetration. It has been suggested that for these individuals, their pedophilic behavior may be an effort to master the trauma of childhood abuse, and represents an attempt to overcome the feelings of powerlessness that they experienced while being victimized.

A common misconception is that the majority of pedophiles are homosexual men.[19] According to Bolton et al,[8(p61)] "In reality, most molesters of boys indicate that they do not have adult homosexual preferences." There is, in fact, no profile of the typical offender.[11]

INTERVENTION BY THE FAMILY PHYSICIAN

The family physician can encourage disclosure by routinely using screening questions in the review of systems and sexual history. This can be facilitated by asking: "Have you ever experienced traumatic events in your past?" or "Have you ever had any upsetting sexual experiences?"[11,28,29] It is recommended that physicians start asking such questions of adolescents.[22] The physician must also objectively and nonjudgmentally pursue questions about sexual orientation as a routine part of history-taking. The manner in which such questions are asked is more important than the exact wording.

If the patient reveals a history of sexual abuse, more detailed questions should be asked. Specific information should be sought about the nature of the sexual contact; age of the patient when the abuse occurred; the age and relationship of the perpetrator; the duration and frequency of incidents, and if coercion was used; the patient's sense of blame; and if or to whom disclosure was made.[29] It is important to proceed at a pace acceptable to the patient and to assess the patient's awareness of the relationship between current functioning and the past sexual abuse.[22]

disclosure is an ongoing process

At the time of disclosure the physician should provide unconditional support and serve an educational function. Victims can benefit from learning that an unexpectedly high percentage of the male population has been sexually abused. In addition, the family physician will be able to anticipate some of the beliefs held by the victim. For example, patients may experience relief to learn that a history of sexual abuse does not necessarily lead to homosexual or pedophilic behavior even though the individual may have experienced, and be distressed by, such ideation. A particularly valuable intervention is to emphasize that the individual is a "survivor" more than a victim. This approach allows for the recognition of a personal role in coping, as opposed to a passive, victimized identity.[8,15]

Because a history of sexual abuse is unlikely to have been disclosed by male victims, the physician needs to consider two additional concerns. First, because sexual abuse of males is associated with physical abuse and with penetration or manipulation of the genitals, a thorough examination is indicated to determine any long-term physical effects such as neurologic sequelae, unusual scarring, or anal laxity.[16] Second, the experience of sexual abuse may make many victims avoid the topic of sexuality. Consequently victims are reported to have inadequate or inaccurate sexual information, which can be corrected through discussion or patient education materials.[15]

Because disclosure can compromise the psychological defenses of victims, the potential for suicide should be assessed.[3,23] The availability of qualified mental health providers should be noted and referral expedited. Particular attention should be given to patient concerns about confidentiality, gender of the therapist, and individual or group treatment modalities. It is vital that the patient should not sense abandonment by the family physician at the time of referral. A follow-up visit should be scheduled shortly after the disclosure and referral.

Unfortunately there are few support groups or therapists who specialize in treating male victims of sexual abuse.[15,21] There are also few studies of the efficacy of specific psychotherapeutic approaches with this population. Because male victims present a multidimensional clinical challenge, it is unlikely that any single or short-term approach will succeed in overcoming the multiple residual problems.[8,21]

Finally, physicians and other health care professionals must remain aware of mandatory child abuse reporting laws. Disclosure by a child or adolescent requires reporting to the local child abuse registry.[9,11] The tabulation below lists the interventions that physicians can use.

Interventions

- Provide unconditional support
- Reframe "victim" to "survivor"
- Educate about prevalence and consequences
- Anticipate incomplete disclosure
- Evaluate suicide potential
- Referral for psychotherapy (if indicated)
- Schedule follow up at brief interval

COMMENT

The sexual abuse of male and female children remains a serious problem in our society, and the family physician is likely to treat adult male patients who were sexually abused in childhood. Many of these patients will present with indirect complaints and others will display significant decompensation as they attempt to cope with the trauma of abuse. The family physician has the opportunity to identify victims, encourage disclosure, and promote resolution of the patient's trauma through education, office counseling, or referral. As we expand our understanding of the long-term effects of sexual abuse of males, guidelines for intervention will continue to emerge.

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