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Screening and Stigma: Lack of Male Representation in Childhood Sexual Abuse Research and  
Literature

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Submitted in Partial Completion of the  
Requirements for Departmental Honors in Social Work

Bridgewater State University

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### **Abstract**

The purpose of this study is to explore available screening tools for assessing male childhood sexual abuse. This form of abuse is a problem that is often underreported. Males disclose less often than females because of the stigma associated with being a sexual abuse victim and questioning their own sexual orientation. Nine different screening instruments from child welfare, medical, and clinical settings were analyzed and prevention efforts within public schools are also discussed. There is a lack of literature specific to male sexual abuse victims, and what is available is severely outdated. This study is a thorough literature review of screening tools for male sexual abuse victims. The findings of this assessment show that there are zero screening tools that have been developed specifically to screen males for sexual abuse. Suggestions for improving existing tools to screen for sexual abuse in males are identified and discussed as needed. Prevention efforts within school settings are stressed, as this is where children spend most of their time and are most likely to disclose.

*Keywords:* Childhood sexual abuse, male victims, boys, screening, stigma

### **Introduction**

Sexual abuse can happen to anyone of any age, race, gender, or religion. There are various ways that someone could experience sexual abuse, such as, but not limited to, pornography, touching, or penetration (Cermak & Molidor, 1996; Finkelhor, 2009; Valente, 2005). Generally speaking, society believes girls are victims of sexual abuse more frequently than boys; this has to do with boys underreporting abuse. Data shows an inconsistency regarding how frequently male sexual abuse occurs. The data ranges anywhere from 3-31% of males reporting sexual abuse in their childhood (Finkelhor, 2009; Cermak & Molidor, 1996, Valente,

2005). It is unlikely that the general population is screened for childhood sexual abuse. Perpetrators of male victims are usually close family friends (60%) and not family members (Finkelhor, 2009). The people who have abused these children earn their trust and end up controlling them in a sexual manner that they were not able to consent to (Valente, 2005).

If untreated, childhood sexual abuse can leave a lasting impression on the victim. Hendricks-Matthews (1992) and Bennet, Bernstein, Thombs, Walker, & Ziegelstein (2007) list depression, anxiety, post traumatic stress disorder, learning disabilities, and physical pain as just some of the many long-term effects. By investigating screening tools that identify childhood sexual abuse in males, disclosures could be made and victims could receive the help and support they so desperately need. Primary care doctors have the ability to identify these disorders in their patients; however, they are not always linked to sexual abuse, especially if a disclosure has not been made. Disclosures are not usually made by victims for a number of reasons such as guilt, shame, or embarrassment (Hendricks-Matthews, 1992). Males disclose less often than females due to a fear of being called a homosexual (when the abuser is male), and are self-conscious after such a traumatizing event (Valente, 2005). Asking adults and/or children if they have been sexually abused can be a difficult and fragile conversation.

Some victims disclose what had happened to them years after the abuse. Victimized men have said that their primary care doctor and nurse did not do anything in an effort to help them as the abuse was going on (Valente, 2005). Children often wish that adults just knew, or could sense that they are being abused without actually having to say it. Sometimes children disclose indirectly and think their parents will help them, but the parent misses the disclosure (Lovett, 2004; Palmer, Brown, Rae-Grant, & Loughlin, 1999; Sgroi, 1982). Doctors could be provided with more education on identifying and assisting children who have been or are currently being

sexually abused (Valente, 2005). It would be beneficial for doctors and nurses to have the knowledge of sexual abuse so that when they are assessing patients, they can screen them for this type of violence. It is vital to identify screening tools within the medical setting.

It can be difficult for an untrained professional to know what to do when someone discloses sexual abuse. It is a taboo subject; however, research suggests (Finkelhor, 2009) educators, administrators and people within school systems receive training on what to do in the event that someone discloses. Although the school setting may not be best for screening children for sexual abuse, providing students with education on the topic would be beneficial. Educators would be valuable resources to have when implementing prevention strategies for childhood sexual abuse. Children spend most of their time within a school and would be more likely to tell school staff if faculty members bring awareness and education to the students, which in turn could promote disclosures.

Social workers and caseworkers performing intakes for mental health or substance abuse assistance could also screen their clients for sexual abuse. This adult population may have a history of sexual abuse in childhood, adolescence, or adulthood that has yet to be disclosed. Upwards of 70 percent of childhood sexual abuse victims report an addiction to substances (Center for Substance Abuse Treatment, 2000). If these workers had knowledge of screening and what services to offer once a disclosure has been made, then effective treatment could be provided. Sexual abuse among males is a problem that is underreported and needs to be identified and treated. The goal of this study is to examine and identify possible screening tools for sexual abuse among males.

### **Definitions**

The definitions below were adapted from peer-reviewed articles about childhood sexual abuse. Definitions of these terms can vary; therefore the following are the working definitions for this paper:

- Sexual abuse- any sexual act (removal of clothing, pornography, touching, fondling, rubbing, oral/anal penetration or contact) performed on someone who does not consent (Cermak & Molidor, 1996; Finkelhor, 2009; Valente, 2005).
- Childhood sexual abuse- the sexual act performed on a child under the age of seventeen who is unable to consent (Cermak & Molidor, 1996; Finkelhor, 2009; Valente, 2005).
- Grooming- when an adult earns a child's trust, and then betrays him or her by subjecting the child to abuse (McAlinden, 2006).

### **Risks and Grooming**

Factors that put children at risk include living with a single parent or divorced parents, being a victim of physical violence, and living with a disability. Some research suggests that boys are most at risk of sexual abuse around puberty (Finkelhor, 2009). However, other studies have shown that family members tend to abuse boys before the age of 6, and as early as 6 months old (Valente, 2005). When a child has been groomed, the adult abuses the trust they have earned by manipulating the child through violence or coercion to perform or be the recipient of a sexual act. Living with a single parent is a risk factor because offenders are skilled at making the parent feel comfortable with the offender. In some instances, offenders will begin a relationship with a parent as a way of obtaining access to a child. This is especially true for male offenders and

single mothers. Divorced families are also at risk because offenders seek out families where only one parent is present at a time (Elliot, 1995; McAlinden, 2006).

### **Signs and Effects of Sexual Abuse**

Boys have reported that the abuse first started as wrestling, tickling, and fooling around playfully, and then escalated to a sexual level. When the abuse intensifies it leaves the child feeling trapped, which makes it difficult to leave or disclose (Valente, 2005). Summit (1983) discusses child sexual abuse accommodation syndrome (CSAAS) and how this “syndrome” helps to describe characteristic responses of being a victim of abuse. This syndrome contains five categories: secrecy, helplessness, entrapment and accommodation, delayed unconvincing disclosure, and retraction. These are the general responses over time for a victim of sexual abuse.

Anxiety and losing trust in adults are effects of being a victim of childhood sexual abuse (Finkelhor, 2009). Other effects of childhood sexual abuse are depression, panic attacks, anger, withdrawal, dissociation, insomnia, post traumatic stress disorder, aggression, poor self-esteem, suicide attempts, school truancy, stomach pain, eating disorders, mental health disorders, substance use, paranoia, fear, headaches, reduced quality of life, phobias, change in hygiene, and problems with sexuality/sexually inappropriate behavior (Bennet *et al.*, 2007; Center for Substance Abuse Treatment, 2000; Cermak & Molidor, 1996; Finkelhor, 1990; Hendricks-Matthews, 1992; Valente, 2005.).

Finkelhor (1990) reports that boys are more likely to act aggressively (externally), whereas girls act sad and depressed (internally) as a result of childhood sexual abuse (Cermak & Molidor, 1996). There can be physical effects as well such as contracting a sexually transmitted disease, urinary tract infections, or cut/swollen genitals (Valente, 2005). Some children may also fear being bathed or having their diaper changed because this may be the setting where they were

abused. Excessive masturbation is another common sign of abuse. Enuresis (uncontrollable urination), encopresis (uncontrollable defecation), and fire setting are less common indicators, but more so in male compared to female victims (Cermak & Molidor, 1996).

### **Prevalence**

There is no clear percentage as to how often male sexual abuse occurs. The data is inconsistent because of varying methodologies. Research has been conducted on samples of victims of varying ages, including college populations, and in clinical settings such as mental health and substance abuse clinics. It has been proposed that the frequency of sexual abuse has been on the decline, but this has yet to be confirmed due to the lack of reporting associated with the male gender (Finkelhor, 2009).

It is clear that girls comprise the majority of reported sexual abuse victims. Male victims do not disclose as often as females, which is why the numbers tend to look so much lower for males (Gries, Goh, & Cavanaugh, 1996). When this situation is underreported, we do not know how often the abuse truly happens, and because of the low numbers, it does not get as much recognition and attention because no one knows that it is a problem (Cermak & Molidor, 1996). The research to date is inconclusive as to the prevalence of male sexual abuse, and that is evident by inconsistent data.

Finkelhor (1990) reports that 3-4.8% of males had sexual contact before puberty with an adult male who was an acquaintance. In a later study, Finkelhor (2009) cites surveys of US adults where one study presented 13% of men reported a history of sexual abuse, while another indicated 8%. Other rates show 4-16% as the frequency of abuse to boys (Valente, 2005). Abuse of male children has also been reported to be between 3-31% (Cermak & Molidor, 1996).

In 2015, National Children's Alliance (NCA) released their statistical report for how many children were served by a Child Advocacy Center (CAC). CACs were developed in the mid 1980's to investigate child abuse and create a therapeutic environment for child victims and their families after disclosure. CACs and partnering organizations work together and share information to provide support and minimize risk of further trauma for the victim or family (Elmqvist *et al.*, 2015). CAC staff consists of approximately four professionals who would be in contact with the child and family. A forensic interviewer questions the child about a suspected event of abuse. A family advocate educates and refers the family to services. A SANE nurse (sexual assault nurse examiner) performs the medical exam on a child. A therapist treats a client and helps them cope with their presenting problem (National Children's Advocacy Center, 2016).

On a national level, 305,985 children were served by CACs. Of that group, 203,091 were served because of sexual abuse; that is four times the amount of children served for physical abuse, the second leading form of abuse. Of the total number of children served, about 112,765 were male, about one-third of the total victims (National Children's Alliance, 2016).

In the northeast region of the country, 44,097 children were served by CACs. Of those, 32,162 were sexual abuse victims: four times more children than those who were victims of physical abuse. Of the total number of children in the northeast who were served, about 15,340 were male (National Children's Alliance, 2016).

On a state level, in Massachusetts 5,858 children were served by CACs. Four thousand three hundred and eighty one of those were sexual abuse victims, still four times more than physical abuse victims. Of the almost 6,000 children served, 1,983 were male (National Children's Alliance, 2016).

This data is vital information when discussing sexual abuse. Consistently, about one-third of all victims were male, and approximately three-quarters of all victims referred to the CACs were sexual abuse victims. Many children are referred to CACs for sexual abuse because these cases are more likely to go to court. Children are referred to CACs to evaluate prosecution and work with the District Attorney's (DA) office. The DA will review any evidence and may file criminal charges against the abuser (Lacey, 2015). The report from National Children's Alliance (2016) does not state how many boys were victims of sexual abuse; it only states how many boys were identified as victims of abuse in general.

Children's Cove is the Cape and Islands Child Advocacy Center. From January 1, 2011 to December 21, 2015 they interviewed and provided services for 86 victims of abuse. Of those 86 victims, 19 were male victims of childhood sexual abuse. The ages of the victims range from 2 to 16 years old (Children's Cove, 2016).

### **Underreporting and Culture**

Children who have been exposed to sexual abuse may feel like it is their responsibility, and have a sense of guilt. Other reasons why boys may not disclose are fear of retaliation and homosexuality, not feeling masculine, and loss of self-worth (Center for Substance Abuse Treatment, 2000; Finkelhor, 2009; Holmes & Offen, 1996; Valente, 2005).

Studies suggest (Alyan & Haboush, 2013; Casanova, Lowe, Pavkov, Wechler, 2005; Correa & Nuñez, 2010) it is important to consider the importance of culture in a sexual abuse case, especially if the period between abuse and disclosure took a significant amount of time. Fontes & Plummer (2010) discuss how childhood sexual abuse is prevalent in most cultures and is considered a taboo subject in all of them. Many children do not disclose the trauma they suffered as children until they are adults. Children also struggle with whom, when, and where to

tell because they do not want to ruin their family. There have been studies that suggest some races are more likely to disclose than others, but that has yet to be confirmed (Fontes & Plummer, 2010).

Research demonstrates that shame is negatively correlated with disclosing. (Cermak & Molidor, 1996, Correa & Nuñez, 2010, Fontes & Plummer, 2010) Shame is involved in all areas around sexual abuse for victims including religion, viewing it as a prohibited topic, and homosexuality. Puerto Rican, Arabic, and Hispanic families tend to look at the topic of sex as a taboo subject. Many of these cultures tell their children that by thinking or talking about sex they will upset God and not go to Heaven. A value in Hispanic culture is elder respect; as a result, if the abuser is an older male, the child may not disclose. Boys have a difficult time confessing their abuse because the abuser is usually male, which affects their view of masculinity. In many cultures, parents and family members are shamed if they are viewed as homosexual, which might happen if they say another male abused them. If victims do not feel like they can blame their abuser, then they end up blaming themselves and keep the abuse a secret (Fontes & Plummer, 2010).

Since we do not know how often boys are sexually abused, it is hard to prepare people to identify and treat victims. Clinicians and other staff may not be asking the right questions at the right time which could be yet another reason why males are underreporting (Cermak & Molidor, 1996). Children have told social workers that if they had to do it again they would not disclose. Other reasons that make it difficult for children once they disclose are separation from their family if a caretaker is the abuser, the long legal process, and tactless responses (Fontes & Plummer, 2010). The disclosure process must be easy and comfortable for victims; it is necessary

that anyone in contact with children allow this to be possible. Self-blame is reduced and mental health is increased when survivors of sexual abuse make a disclosure (Finkelhor, 2009).

### **Institutions**

#### **Church**

Sexual abuse within the Catholic Church has gained more attention in recent years. Podles (2008) wrote a book on this topic; he describes the vulnerability of children and the power that priests and other religious members hold. Men are typically in power within the church and may use that power and trust that families have to satisfy their desires. Many men who abuse children identify as heterosexual but target pre-pubescent boys because they are not fully developed which these men find attractive. These priests found victims in a number of ways; one way was to use the confessional as a way of targeting boys struggling with masturbation and sexual thoughts. A second way was targeting boys without a father, and then the priest attempted to be that father figure for them. By 2005, there were 4,977 priests who had been accused of child sexual abuse: about 3-6% of priests. However, Podles (2008) reports that 5,000-10,000 priests is a more accurate number. Number of individual victims per priest ranged from 2-250, with 8 being the average. Most child victims came from poor to middle class families who were in need of attention.

These pious victims' families often idolized their priest and urged their child to spend more time with the priest. Parents did not want to hear anything bad about the idolized priest, so the boys would not disclose. Priests have been known to say things such as, "if you love God, you will do this" and in an effort not to disappoint God, their family, or their priest, they follow through with the action. Even though in Church, priests would stress how masturbation, homosexual acts, and premarital sex were wrong, they convinced their victims that it was

acceptable as long as it was with a priest. Boys often think they are homosexual once they have had these interactions with an older male, such as a priest. It is natural for boys to feel pleasure from sexual stimulus regardless of who is performing the sexual act (Podles, 2008).

### **Boy Scouts of America**

The Boy Scouts Association (BSA) has been a trusted and useful organization since 1910. Scout leaders- always male- serve as positive role models for their troops. The goal of this group is to teach boys how to be men, and to follow in the footsteps of their influential leader. Boy Scouts is attractive to young boys because of its military-like qualities; the uniform, the oath, and the badges all add to the appeal. However, where young boys are recruited, pedophiles are attracted as well. Boy Scouts are told to be obedient and to follow the orders and directions of their scout leader. Most reported sexual abuse would happen at campouts, which many boys looked forward to, as it was a special event without many, if any, chaperones. Some scout leaders would use badges as a way to silence their victims. The founder of Boy Scouts had good intentions when he said he wanted scout leaders to assist with sex education. The Boy Scout handbook encouraged boys to talk to their father or scout leader when it came to sexual urges. Most Boy Scouts did not have a dependable father figure in their life, which left only the scout leader as a male confidant (Boyle, 1994).

For about 80 years, the BSA did not screen volunteers or check their confidential files to see if a scout leader was a child molester. When reports of sexual abuse came in, the BSA tried to cover it up and downplay it; they would work harder to protect the offender rather than past, current, and future victims. There have been cases where a banned leader would leave the troop in which he had been accused, move to a different state, and volunteer as a troop leader again with a made up name. No identifying documentation was ever necessary for the job. Boyle

(1994) asserts that the reason more than half of all scout leaders were banned from the organization since 1971 was because of sexual abuse.

### **Screening Settings**

Sexual abuse needs to be identified through screening since most victims do not disclose this information on their own. Primary care physicians and caseworkers would benefit from training on how to screen males and females of all ages for sexual abuse. As difficult as this subject matter may be, if these workers are comfortable with sexual abuse they can better serve the population they work with (Hendricks-Matthews, 1992). Cermak & Molidor (1996) stress how important it is for clinicians, social workers, parents, friends, and other helping professionals to be aware of the warning signs of sexual abuse, especially those who work with children and adolescents.

Clinicians, doctors, case managers, and other professionals require training to ask these questions. This is a necessary step so that these professionals are comfortable with the content, asking the right questions, and providing resources once a disclosure has been made. If someone does not have training on how to do this, then a qualified person would administer the screening. Training should include effects of childhood trauma on adults and childhood trauma in general (Center for Substance Abuse Treatment, 2000).

Hendricks-Matthews (1992) and Stevens (2007) consider whether or not to screen all people, or just those who show signs of sexual abuse. It was discussed how if someone does not show a symptom at a specific time, it does not mean they have never suffered sexual abuse. Therefore, everyone could be screened in some way, especially at a doctor's office where 83.2% of adults and 92.4% of children attend at least once per year (Centers for Disease Control and Prevention, 2016).

The way the questions are worded is extremely important so that the patient does not feel like any abuse was their fault. Patients may not disclose the first time that they are asked, so staying persistent and asking every year is very critical (Hendricks-Matthews, 1992). If a doctor asks about sexual abuse and the patient answers “no” despite having been abused, it produces a false negative; this is why it is necessary to continue asking the patient.

When interviewing children it may be worthwhile to separate the parent from the child in case of parent-child abuse. Using appropriate language, not pushing too far, stopping if the child asks to, reminding child that they have asked these questions to other children before, and thanking the child for talking to them are important aspects to remember. If a disclosure has been made, appropriate actions need to be taken in order to provide support to the survivor. Referrals should be made so counseling and healing can begin. It is critical for the child to understand that the provider knows of other children who have been through this process, and that any information the child offers can help other kids in the future (Hendricks-Matthews, 1992).

### **Child Welfare**

Child welfare agencies provide services to individuals and families to guarantee the safety of children. The goal of child welfare workers and agencies is to ensure that children are not experiencing abuse or neglect and to find permanency with a family. If a child is found to be in need of services, an agency will investigate and coordinate services (Child Welfare Information Gateway, 2012). Examples of public and private child welfare agencies are the Department of Children and Families (DCF), foster homes, adoption agencies, residential settings, and domestic violence services (Child Welfare Information Gateway, 2013).

Although not a screening tool, a 51A (Massachusetts General Law, Chapter 119, Section 51A) is a form to report child abuse or neglect. This reporting tool is necessary because physical

and sexual abuse can coincide with one another. If a child were only reported for physical abuse, it would be wise for a child welfare worker to screen a child for sexual abuse as well.

Once a 51A has been filed and received by DCF it is either “screened in” or “screened out.” If the report is screened in it is because there is enough information for an investigator to look further into the suspected abuse or neglect. Once screened in, a caseworker would visit the family, conduct interviews, and decide the level of risk associated with the abuse. In high-risk cases, the child would be removed from the home and placed with kin (family) or in a foster home. Services and legal proceedings would then be put in place. From October 1, 2014 to December 31, 2014, Massachusetts reported that 23,521 reports were filed. Of those, 51% were screened in for investigation (Massachusetts Department of Children and Families, 2015).

### **Medical Setting**

Males rarely report being victims of sexual abuse unless they trust the person to whom they are about to disclose. A therapeutic environment helps promote disclosures because children feel more comfortable in these settings. Screening tools that are used in medical settings generally revolve around physical abuse, but sexual abuse needs to be added because of how many people are affected by it. Sexual abuse is harder to talk about, but screening children for sexual and physical abuse is essential. Some experts say that it is a nurse’s duty to detect sexual abuse and to refer the patient out to receive treatment and to be protected (Valente, 2005).

Britton (1998) reviewed the impact that a medical exam would have on a child once they have been sexually abused. A medical exam entails the examination of a child’s body and genitals by a medical professional. The reason for doing this exam is to see how the body has reacted to the trauma, and to reassure the child that their body is normal and that it will be okay. Some people have argued that the medical exam is further emotional traumatization; however,

professionals have worked hard in reducing those negative outcomes. Gender and friendliness of the examiner may affect the outcome of the exam, but there is not enough research to support a definitive conclusion. Britton refers to the fear children have about their body as “damaged goods syndrome,” and how this exam can help reassure children that their body is okay (Britton, 1998).

### **Mental Health and Substance Abuse Setting**

Many survivors of sexual abuse turn to substances to help them cope with their experiences. Individuals who use substances report higher rates of sexual abuse compared to individuals who do not use substances. Drugs and alcohol are examples of substances that sexual abuse survivors use to cope (Center for Substance Abuse Treatment, 2000; Valente, 2005; Little, Simpson, Trujillo, Westerberg, 1994). In substance abuse treatment programs, males who have reported sexual abuse are about the same percentage as those in the general public. This could also be due to underreporting (Little *et al.*, 1994).

In many substance abuse treatment programs, counselors and intake workers either choose not to or are not required to ask about a history of abuse. However, in cases where intake workers or counselors have asked their clients, disclosure rates have risen. It would be beneficial for counselors and intake workers to continue asking and take ongoing assessments of their clients because it may take a while for someone to disclose. Once a disclosure has been made, a record should be established so they are not continually asked the same questions (Center for Substance Abuse Treatment, 2000).

Many studies have supported the hypothesis that therapists do not suspect sexual abuse in boys as often as they do in girls. In a study conducted by Holmes & Offen (1996), research discovered that clinical psychologists were twice as likely to suspect sexual abuse in female

versus male clients when given identical case studies where only the gender was manipulated. This could be the reason why many males do not receive as much treatment for a sexual abuse related issue. The report continues to say that many clinicians want to have more training on this issue, but that receiving information on male victims is vital.

### **Methodology**

This report is an attempt to analyze the screening tools available to identify childhood sexual abuse in males. This study strives to answer the questions, what tools exist to screen males for childhood sexual abuse? In order for social workers, health care practitioners, case managers, and teachers to screen or prevent childhood sexual abuse, they must have a tool or strategy to do so. A valuable resource for discovering these tools was the Internet. There are many databases, government websites, and organizations that publish their findings online. Using tools that others have already developed and tested helps increase consistency of findings when implemented in one's own setting. A database and Internet examination was conducted to determine what tools were available to screen and prevent childhood sexual abuse.

A thorough literature review was conducted on this topic. Peer-reviewed articles were found using multiple databases from the Bridgewater State University library. The databases included Academic Search Premier, PsychInfo, Psychology Collection, and Psychology and Behavioral Sciences Collection. Government websites were utilized to find statistics to use as data. Academic Search Premier was the first database used because it is an interdisciplinary database. The peer-reviewed option was always used if available. The first 50 results were the only ones reviewed due to relevance. Even before reaching 50 results, there were articles written on other topics not relevant to this research.

The goal of this research was to discover what screening tools exist for various professionals who have contact with children and adults. When a screening tool was found, it was reviewed to see if the researchers had administered it to any males. The tool was also reviewed to see if the questions were relevant to male sexual abuse. Table 5 shows that there were zero screening tools administered to males concerning sexual abuse only.

Table 1 depicts how many peer-reviewed articles were discovered for the search terms “male childhood sexual abuse.” The findings from these articles were discussed in the literature review. A total of 48 articles contained information on male childhood sexual abuse. Many more articles appeared in the results list, but were not relevant to male childhood sexual abuse and contained information such as female victims of sexual abuse and prison rape. In an effort to expand the information further, another set of search terms was used “boys childhood sexual abuse” which can be seen in table 2. Fewer results emerged from the second set of search terms. Many articles were repeated from the initial search, which further shows the lack of research and information available on this topic. Table 2 indicates that information is limited on boys and childhood sexual abuse. The bulk of research has been conducted on male childhood sexual abuse survivors, especially in adulthood. The term “childhood” was retained in each search to eliminate any articles written about sexual abuse in adulthood. This research was not intended on identifying screening tools for adult rape.

Table 3 identifies six databases that were searched for peer-reviewed articles to identify child sexual abuse screening tools. Each database yielded few results, if any. A regular Internet search had to be conducted to complete the research. More results were found this way; however, government and reputable agency websites and articles were favored over possible non-trustworthy websites. The research was focused on three settings: child welfare, medical,

and mental health/substance use. Table 4 shows the date ranges of articles used for this study. Only 25 of the 44 references were published in the last 10 years, most of which came from government agencies. Eleven of the 43 articles were published in the 1990's when childhood sexual abuse was a popular topic. However, the amount of research decreased in the next few years. It is important to understand the dates of when articles are published to see the trends of popularity pertaining to a particular topic.

**Table 1: Literature Review Search Terms**

<b>Search terms: "Male childhood sexual abuse"</b>			
<b>Databases</b>	<b>Total number of results discovered</b>	<b>Number of repeated relevant results (of the first 50)</b>	<b>Number of new relevant results (of the first 50)</b>
Academic Search Premier	58	0	28
PsychInfo	111	22	13
Psychology Collection	54	13	7
Psychology and Behavioral Sciences Collection	17	11	0
<b>Total</b>	<b>240</b>	<b>46</b>	<b>48</b>

**Table 2: Literature Review Search Terms II**

<b>Search Terms: “Boys childhood sexual abuse”</b>			
<b>Databases</b>	<b>Total number of results discovered</b>	<b>Number of repeated relevant results (of the first 50)</b>	<b>Number of new relevant results (of the first 50)</b>
Academic Search Premier	2	0	0
PsychInfo	4	2	2
Psychology Collection	4	0	0
Psychology and Behavioral Sciences Collection	0	0	0
<b>Total</b>	<b>10</b>	<b>2</b>	<b>2</b>

**Table 3: Screening Tools Search Results**

<b>Search Terms: “ Screening tools sexual abuse”</b>				
Databases	Total number of results discovered	Total number of relevant results	Number of repeated results	Number of new relevant results
Academic Search Premier	2	0	0	0
Criminal Justice Collection	1	1	0	1
Eric Ebsco (Education)	0	0	0	0
Health Source: Nursing/Academic Edition	0	0	0	0
Psychology & Behavioral Science Collection	0	0	0	0
Social Work Abstracts	0	0	0	0
<b>Total</b>	<b>3</b>	<b>1</b>	<b>0</b>	<b>1</b>

**Table 4: Dates of Articles Used in this Paper**

10 Year Range of when article was published	1980's	1990's	2000-2005	2006 to present
Number of articles used	3	11	7	25

**Existing Screening Tools**

**Table 5: Screening Tools**

<b>Table 5: Screening Tools</b>			
Screening tools administered to males only (Emotional, physical, and sexual abuse)	Screening tools for sexual abuse only	Screening tools for male sexual abuse only	Total screening tools examined
1 -RADAR for men	2 -Screening tool for Pediatric Sexual Assault to Reduce Emergency-Department Visits -SAVE: A Tool for Screening for Sexual Assault	0	9

## **Child Welfare Setting**

### **Questions Every Judge and Lawyer Should Ask About Infants and Toddlers In The Child Welfare System**

Dicker, Grace, Lederman, Maze, & Osofsky, (2002) compiled a checklist of services that child advocates, lawyers, and judges should reference when placing children in foster care. There are four areas examined: physical health, developmental health, mental health, and educational/childcare setting. What is problematic here is that there is nothing concerning sexual abuse. If a child has been sexually abused, there should be careful consideration when it comes to placing the child in a foster home. One of the questions they do recommend asking is: “Has the child received a comprehensive health assessment since entering foster care?” It is important that these children receive a physical exam to identify any health problems. They do not discuss the possibility of sexual abuse and why it would be important to screen a child for that. The child should receive a thorough physical exam, and the parents or current caregivers should be asked about possible symptoms of abuse depending on the child’s age, such as physical complaints or sexualized behavior (Dicker *et al.*, 2002).

## **Medical Setting**

### **A Brief Two-Item Screener for Physical or Sexual Abuse**

A two-question screening tool was developed by Bennet *et al.* (2007) to quickly and accurately identify physical or sexual abuse in patients within a medical setting. This screener was adapted from the CTQ-SF (Childhood Trauma Questionnaire- Short Form), which contains 28 questions. Only two questions were used for this particular screener because it would be easy to implement and add to a yearly medical exam by a doctor. The sexual abuse question is:

“When I was growing up, someone tried to touch me in a sexual way or tried to make me touch them.” (Bennet *et al.* 2007).

The answers range from 1 (I was never) to 5 (I was very often). If the response is anything other than a 1, then it is identified as a positive screen. This screener has only been tested on a random sample of females (2,225) between the ages of 18-65 and was proven to be accurate, however the accuracy is unknown when used by males. A primary care physician or any other form of a medical clinic could administer this short questionnaire with ease (Bennet *et al.* 2007).

### **RADAR for Men: A Domestic Violence Intervention**

This tool, developed by the Institute for Safe Families, is primarily for victims of domestic violence who are male (Centers for Disease Control and Prevention, 2007). Domestic violence is a topic that has also been seen as a primarily female issue. The RADAR acronym is used as a guide for health care professionals to use on their patients. Each letter signifies a step-by-step approach as follows:

- “R-Routine inquiry of all patients 14 years or older: Health care providers should ask their patients every year about abuse, because most patients do not offer that information without being asked.
- A- Always ask: It is important to ask questions about all types of abuse.
- D- Document findings: Document anything that is said, denials or admissions.
- A-Assess for safety and lethality: Identify if they are safe at home, or if other people are safe at home.
- R- Respond: Comfort the patient if they have made a disclosure, and let them know that they will receive help” (Centers for Disease Control and Prevention, 2007).

There is a list of suggested questions, but this guide stresses how everyone has their own style. The questions can be changed and asked in any way the professional sees fit. Before or after the patient discloses that they have been a victim, the doctor is encouraged to say that women are not the only victims of domestic violence, ask them if they need help, and refer them to therapists (Centers for Disease Control and Prevention, 2007).

One problem with this tool is that the questions are framed solely for sexual abuse between spouses, but this tool could be manipulated to ask about recent and childhood sexual history (Centers for Disease Control and Prevention, 2007).

### **SAVE: A Tool for Screening for Sexual Assault**

Lynne Stevens developed this screening tool in 2003 (Centers for Disease Control and Prevention, 2007); it does not list specific questions to ask, but acts as more of a guideline and gives suggestions when it comes to screening patients.

“S-Screen all your patients for sexual assault”

Anyone can be a victim, males and females. Everyone should be screened, and doctors are usually trusted, so they are a great resource for disclosure.

“A-Ask direct questions in a non-judgmental way”

Use simple language that anyone and everyone of all ages can understand.

“V-Validate the patient’s response”

If they disclose, offer support and properly document the disclosure. If there is no disclosure but there is still suspicion, they should document it in the patients chart and make a note to possibly ask again in the future.

“E-Evaluate, educate, refer”

If they disclose, the health care provider should ask if there is anything they can do to help. They should also make referrals, and thank them for being honest (Center for Disease Control and Prevention, 2007).

This screening tool has been used on men and women (Center for Disease Control and Prevention, 2007).

### **Screening Tool for Pediatric Sexual Assault to Reduce Emergency-Department Visits**

This tool was developed by Floyed, Greenbaum, Hirsh, & Simon (2011) and uses the following four questions to determine whether the child should go to the Emergency Room or if other evaluations would suffice, such as a Child Advocacy Center, a regular doctors visit, or beginning therapy. This screening tool was initially used on 163 children, where 90 of them met positive criteria for entering an emergency department; this tool was discovered to have 100% success rate.

- “1. Did the incident occur in the last 72 hours and was there oral contact or genital-to-genital or genital-to-anal contact
2. Did the patient have genital or rectal pain, bleeding or discharge, or known genital injury?
3. Was there an immediate concern for the child’s safety?
4. Was there an unrelated emergency medical condition present?” Floyed, Greenbaum, Hirsh, & Simon (2011).

If any of these 4 questions are answered with “yes” then it warrants an Emergency Department visit and is considered a positive screen. If the incident occurred more than 72 hours before, the need for an examination may be unnecessary since forensic evidence might be gone, especially if the child has bathed. The child’s genital area could have already healed. The first 24

hours after sexual abuse are the most crucial hours for a child to be examined, but up to 72 hours will also suffice. This screening tool is useful so that children who do not require immediate medical attention can get the assistance they need without having to visit the emergency department (Floyed *et al.*, 2011). However, a medical exam performed days after abuse may still be beneficial, even if it is not performed in the emergency department. Even if the exam is not for forensic reasons, it may still be valuable so children know that their bodies are okay (Britton, 1998).

### **Suggested Screening Questions- The Family Violence Prevention Fund**

The Family Violence Prevention Fund developed these screening questions in 2002 (Center for Disease Control and Prevention, 2007). This screener has been used on male and female patients. It suggests health care practitioners to frame the topic by asking about violence. A framing statement could be “Because violence is so common in many people’s lives. I have begun to ask all my patients about it.” This is another tool that screens for multiple forms of abuse such as physical, emotional, and sexual abuse. There is only one particular question about sexual abuse and it deals with intimate partner violence. The suggested question is, “Has your partner ever forced you to have sex when you did not want to? Has your partner ever refused to practice safe sex?” (Center for Disease Control and Prevention, 2007). This question could be modified to fit childhood sexual abuse; a possible question could be: “Has anyone ever forced you to have sex when you did not want to?” However, when asking this question to children the practitioner may want to substitute the word “sex” for something different. As used in the definitions, words such as “touched” “took photos” “made me touch them,” etc. may be more suitable for children (Center for Disease Control and Prevention, 2007).

## **Mental Health and Substance Abuse Setting**

### **Addiction Severity Index (ASI)**

This is a 161-question clinical interview developed by the National Institute on Drug Abuse. It is used to collect information on substance abuse and all other forms of abuse (emotional, physical, and sexual). This screening tool is better for screening for PTSD as opposed to childhood trauma, but does contain questions in terms of childhood sexual abuse within the family. There is a version for females, which asks additional sexual abuse questions. It is worth mentioning that due to how long this interview is, it would be difficult to administer in a timely manner (Center for Substance Abuse Treatment, 2000).

### **Brief Childhood Abuse Screening Questionnaire for Substance Users**

This is a brief 5-question self-report questionnaire; the questions were adapted from Dembo, Shaefer, and Finkelhor (Little *et al.*, 1994). The answers to the questions are reported as either “yes” or “no.” The first two questions deal with physical abuse, and the last three are for sexual abuse. This instrument was used on adults and asked questions about experiences prior to them being 16 years old. If they selected “yes,” the perpetrator had to be at least 5 years older than them.

This instrument contains the following questions:

1-2. Physical abuse questions

“3. When you were 16 years old or younger did someone at least 5 years older than you touch or grab you, kiss you, or rub against you, either with your clothes on or off in such a way that felt uncomfortable or frightening?”

4. When you were 16 years old or younger did someone at least 5 years older than you take nude photographs of you, or show you their sex parts, or perform a sex act in front of you?”

5. When you were 16 years old or younger did someone at least 5 years older than you make you perform a sex act on them (for example: intercourse, anal sex, oral sex, putting their fingers inside you, masturbation)?" (Little *et al.*, 1994).

Of the 147 males who completed this assessment, the self-referred clients reported higher levels of abuse than those who were court mandated to attend the treatment center. They also received more alcohol related treatment. The men who reported sexual abuse also reported more mental health issues once in treatment. Far fewer men disclosed sexual abuse compared to physical abuse; this underreporting could have to do with the stigma associated with sexual abuse. Many people agree that it is necessary for mental health and substance abuse treatment centers to screen their patients for a history of abuse. This questionnaire has proven to be effective in detecting abuse; it was initially used on male and female clients (Little *et al.*, 1994).

### **Childhood Trauma Questionnaire (CTQ)**

This questionnaire consists of 70 questions where the client self-reports any maltreatment experiences prior to the age of 18 (Ahluvalia, Bernstein, Handelsman, & Pogge, 1997). This questionnaire relies on the person taking it to disclose any reports of abuse. It is not exclusively a sexual abuse questionnaire, but also asks about physical abuse and neglect. Some sexual abuse questions are: "When I was growing up, someone tried to touch me in a sexual way or tried to make me touch them" (Center for Substance Abuse Treatment, 2000) and "When I was growing up I believe I was sexually abused." (Center for Substance Abuse Treatment, 2000). The questions are objective (fact-based, measurable) and subjective (opinion) in nature, and definitions of sexual abuse are provided. This screening tool would be best used in a clinical setting such as, but not limited to, residential care or non-profit organizations. This questionnaire is also fairly lengthy to administer. Males and females (398) were administered this test initially;

they were between the ages of 12-17, and this test proved to be valid (Ahluvalia *et al.*, 1997).

It is worth mentioning that the cost of administering these assessments can cause a financial burden in these settings. Training staff members and buying the rights to the tests can be expensive, but clients can benefit if everyone is trained. Exploring whether any mental health professionals would volunteer their services to screen would also be a good option (Center for Substance Abuse Treatment, 2000).

### **Prevention**

Finkelhor (2009) stated how important it is to notify the community of registered sex offenders, limit where they can live, and conduct background checks of new employees, especially when working with children. These are effective preventative measures, but only if someone has already been convicted of sexual abuse. There is also limited information regarding how effective these measures are in preventing further sexual abuse. He also discusses how schools are the primary setting for educating children about sexual abuse.

Schools educate students efficiently and effectively when it comes to academics. Schools that have implemented sexual abuse prevention educate their students on knowing what a dangerous situation is, what forms of touching are unwanted, how to refuse an abuser, and how to get help. Porter & Sloan (1984) and Hilarski, Wodarski, & Feit (2008) describe how necessary it is for all schools to implement a prevention effort. School nurses, police officers, and social workers may be willing to present this preventative information to children if properly trained on the topic.

Screening options may not be the most feasible route for identifying sexually abused children within the school setting. Implementing prevention efforts into all schools would be the most effective way to bring this information to children, and to also encourage disclosures.

Finkelhor (2009) said that bringing prevention efforts to schools increases disclosures because children feel as though there is a trusted person they can tell, since they are already talking about it within that setting. All schools could encourage this type of curriculum to be brought to them through either a health class or a school-wide information session.

It is necessary that parents, friends, and siblings have knowledge of sexual abuse because the child is not responsible for protecting themselves in these dangerous situations. Some parents have been hesitant for their children to learn about childhood sexual abuse because they fear their children developing anxiety around the subject, but Finkelhor (2009) says that the opposite has been discovered. Parent-child communication even improves through these prevention efforts. These prevention efforts can reduce stigma associated with sexual abuse and promote disclosures (Finkelhor, 2009).

Savell, Kinder, & Young (2006) researched the effects of administering a sexually explicit questionnaire to a group of abused and non-abused females, with ages ranging from 18-25 and an average age of 19.73 years old. Of the 207 females who were administered the questionnaire, none were found to have heightened feelings of anger, anxiety or depression. The feelings were measured before and after the sexually explicit questionnaire was administered.

Rojas & Kinder (2007) replicated the above study with males (125) and females (125) between the ages of 18 and 36 with an average age of 25.57 years old. The study showed the same outcome as before; there was no significant difference between pre and post-test measures of anxiety, depression, and anger. There were also no differences in results between males and females. Findings of this study are consistent with other research stating that about one-third of participants were victims of childhood sexual abuse.

These studies further show how necessary it is to screen for childhood sexual abuse. They also prove how there is minimal risk associated with administering sexually explicit questionnaires. Researchers, physicians, and social workers do not want to cause further emotional damage to someone who has experienced sexual abuse. However, if sexual abuse can be detected from these questionnaires, and the participant can receive the help they deserve without being further traumatized, then there is no reason not to administer the questionnaire. Whether given verbally or documented by the participant, questionnaires are valuable screening tools to identify childhood sexual abuse in people of all ages. A precondition to administering any type of childhood sexual abuse questionnaire is to have resources on where to find help- such as local crisis centers and referrals to therapists- in order to alleviate any possible stress that may occur.

### **Implications**

Research surrounding male childhood sexual abuse has been lacking. Social workers will benefit from this research by understanding how important it is to screen children and adults for childhood sexual abuse. Social workers are advocates for their clients and people lacking privilege and power. Many people view the topic of sex as taboo and avoid it all together, when in reality it needs to be talked about. Sex is a human instinct and must be discussed with children so they understand the importance of staying safe but also disclosing if they are abused.

The effects of childhood sexual abuse can be immediate or delayed. They can be short or long term, related in part to disclosure and the aftermath, including support and treatment. It is imperative that social workers working with all populations recognize how traumatizing this experience is. However, this work may also be traumatizing to the workers themselves. It would be helpful for organizations to provide support for staff when working in

this area. Effective coping strategies are essential for workers dealing with clients suffering from trauma (Gil & Weinberg, 2015). Some effective coping strategies include talking to coworkers or supervisors, physical activity, or relaxation and meditation. If more screening tools were created and used, then more disclosures would happen, which could lead males to receive the assistance and healing that they need.

Social workers are not the only discipline that will benefit from this research. Teachers, administrators, doctors, and nurses will see the importance of this research, as some of their students and patients are survivors of sexual abuse. Implementing screening tools and prevention efforts for children and adults on childhood sexual abuse will create a therapeutic environment that will promote disclosures. Then, patients and students will be able to receive the direct care and support that they need.

Suggestions for further research would place emphasis on the involvement of childhood sexual abuse survivors. The survivors are the experts on what could make the disclosing process more therapeutic. By asking male survivors what questions are the best questions to ask, professionals would better be able to identify victims. It would also be useful for professionals from child welfare, medical, and mental health/substance use settings to collect data when implementing screening tools. This data could help to suggest improvements, and allow us to better understand any obstacles. Further research could also be done on the prevalence of male childhood sexual abuse to see if the numbers we found through statistics (about 33%) are accurate. There is limited research available on sexual abuse and young boys; any improvements to that topic would be greatly appreciated by working professionals in any discipline.

### **Conclusion**

This research is the first of its kind. No other published paper attempts to investigate the screening tools available for use on male victims of childhood sexual abuse. There is an obvious need to screen males for childhood sexual abuse because their disclosures are so much lower compared to that of females. No tools are specifically available for male victims of childhood sexual abuse.

The strengths of this study are that it shows the need for an important issue, it brings attention to an issue where the research appears to be stagnant, and the data was collected from multidisciplinary databases. Another strength of this study was the use of up to date statistics from government agencies. Although research is lacking, relevant information was identified from the Centers for Disease Control and Prevention, National Children's Alliance, and Children's Cove. Along with that, childhood sexual abuse was investigated on a national, regional, state, and county level based on those statistics. From these statistics, a pattern emerged where about one-third of reported victims were male; this information gives researchers a number to begin with when exploring this topic further.

The weaknesses of this study are the use of some outdated references due to the lack of published research on this topic. Administering screening tools can be costly and time consuming to the agency that decides to screen its clients. It could also be costly or time consuming for organizations to provide support resources for staff since they will be exposed to traumatic stories. The Bridgewater State University online library was the only library used for research, and only one database from each discipline was explored.

Despite the limitations of this study, the evidence found through journals, government websites, and books depict how important it is to screen children for sexual abuse. Females are

overrepresented in the category of sexual abuse, and more attention must be paid to male victims. Better screening tools could lead to improved services for sexually abused males. Social workers are the advocates for this victimized group.

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