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Childhood Sexual Abuse in Boys Under the Age of 18: Nonverbal Disclosure Patterns Through Behavior

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Childhood Sexual Abuse, Adverse Childhood Events, and Trauma

Adverse childhood events (ACE), such as childhood sexual abuse (CSA), result in maladaptive function in cognitive, behavioral, social functioning, and other life domains; if left untreated, sexual trauma continues into adulthood and may result in re-perpetration by an individual who experienced sexual abuse (Jardin, 2017; Wang et al., 2021). Perpetrators of sexual abuse, identified as peers or adults, are those who force the unwilling victim into developmentally inappropriate sexual acts. Yoon et al. (2018) define categories of ACE, such as physical and emotional abuse and neglect; various forms of ACE often concur concurrently with sexual abuse. In cases of abuse and neglect, the abuser, often a parent, guardian, or trusted adult, fails to provide access to necessities for healthy child development, including food, shelter, healthcare, attentiveness, and age-appropriate affection toward the child. Developmental concerns, as a result of sexual abuse present in daily activities, which emphasize why sexual abuse remains a pertinent issue in society.

Brassard et al. (1987a) and Shevlin et al. (2018) define sexual abuse as a prolonged, continuous, and sustained exposure to sexual content or stimulation. Sexual abuse, according to Shevlin et al. (2018), consists of noncontact, nonpenetration, and penetration. Noncontact sexual abuse, also called indirect sexual abuse, includes having explicit sexual encounters described by an adult, teasing the victim about their sexual development, and exposure to pornography; using sexual language incongruent with the child's state of development is also identified as a form of noncontact sexual abuse. Direct sexual contact, nonpenetration, and penetration are where sexual abuse exposes the victim to direct contact or inappropriate touch with an identified abuser. Patterns observed in children with a history of noncontact sexual abuse include sexually explicit content used in dialogue. Topics shared with others indicative of noncontact sexual abuse include fondling, acts depicted in pornography, and sexual behaviors the child witnessed.

Nonpenetrative contact is where the child is forced or coerced into making skin-to-skin contact with the abuser; often, nonpenetrative contact includes fondling genitalia or breasts, one-party masturbation,

or mutual masturbation, and being told to touch their own genitals or the genitals of the perpetrator. Other forms of nonpenetrative sexual abuse include inappropriate kissing and being told to simulate physical acts displayed in pornography. Whereas nonpenetrative abuse involves forced sexual contact, penetrative includes oral, vaginal, or anal intercourse. Sustained behavioral patterns in sexual abuse perpetrators include grooming, friendship forming, or making themselves a boyfriend or girlfriend to the child (Finkelhor, 1979). In order to initiate the pattern of abuse toward the child, the abuser initiates each of these processes to make the victim accessible and to develop a safe, secure relationship with adults identified as important to the child.

Perpetrators and Victims of Sexual Abuse

Grooming is the process by which the abuser will purchase material objects and provide special treatment for the child. Friendship forming is the way in which the abuser will attempt to form a mutual friendship, which allows the abuser to form a more intimate relationship to the child; mutual friendship often manifests into the introduction of romance into the friendship. In order to progress toward full involvement in the child's life, the abuser will use these advances to initiate acts of sexual abuse, since a trusting relationship between the abuser and the victim has been established. Once the cycle of abuse begins, the abuser will use tactics to ensure the victim will remain obedient to the abuser; such tactics include manipulation and blackmailing (The National Child Traumatic Stress Network, 2009; Townsend & Rheingold, 2013; YWCA, 2017).

The use of threatening speech patterns to force another into engaging in sexual contact is common in sexual abuse by either a peer or an adult. Ways in which sexual abuse may escalate are moving through noncontact, nonpenetrative sexual abuse, then progressing into forced penetrative sexual abuse; as with the trust-building stages between the abuser and the child, the degree of sexual abuse may become more intrusive as well. The abuser will often use a lexicon that reinforces the power dynamic between the child and the abuser; the child is told that they would not be believed, others would consider them to be a liar, or that the abuser will disclose information the victim would not want others to know. The abuser may fear legal ramifications, thereby maintaining control over their victim to ensure their safety (The Children's Assessment Center, 2021). The potential consequences of the victim's learned helplessness may lead to disruptions in several life domains including family, school, and community settings.

Children with a sexual abuse history display many concerning behaviors that may alert members in the community to potential sexual assault against that child. Initiated and continued by the abuser, the abuser maintains the state of control exerted over the child, thereby leaving the child fearful and powerless. Since victims often experience heightened states of vulnerability, the child may perform nonverbal behaviors that include the assertion of power through sexual aggression over other objects, including another person, animal, or toy. When trauma reactive behaviors (TRB) occur, the abused child often returns to a more child-like state, often to the developmental age, where the sexual abuse most significantly impacted them. Often times, the intention is to exert control over another in-

dividual, forcing another to submit to them as the child did at the hands of their abuser. Children who experience nonpenetrative and penetrative abuse are at a loss of control; using a nonconsenting object may help the child regain a sense of control. Since unwanted sexual contact diminishes perceptions of autonomy, the child may demonstrate these behaviors as means of subduing a victim to help regain self-control.

A common misconception about sexual abuse is that the abuser is outside of the child's social circle; these individuals are identified as immediate and extended relatives, individuals working in schools, members of church or clergy, and youth-oriented community-based programs (YMCA, Boy Scouts of America, etc.). Ninety-one percent of sexually abused children are victimized most commonly by their primary caregivers, stepparents, siblings, aunts, uncles, and cousins; male family members account for a significant finding (Hébert et al., 2021; The National Child Traumatic Stress Network, 2009; Townsend & Rheingold, 2013). The Centers for Disease Control and Prevention (2019) reported similar findings, concluding that 93% of CSA survivors were abused by an immediate family member. In addition to CSA within the household, other ACE concur, including exposure to domestic violence, substance abuse, parental divorce, inconsistency in caregivers, frequent moving, and uncensored sexualized language or behavior normalized during the child's preadolescent years (Wang et al., 2021; Yoon et al., 2018).

Children under the age of 12 account for 26% of CSA victims, whereas 8% of children are age 13 through age 17 (Centers for Disease Control and Prevention, 2019; Finkelhor, 1994; YWCA, 2017). Children who are susceptible to combinations of ACE, including CSA, are from different ethnic backgrounds, maintain lower socioeconomic status, have a parent incarcerated, or live without either biological parent involved in their care. Children within this category have heightened vulnerability and the potential to be sexually abused (The Children's Assessment Center, 2021; YWCA, 2017).

Among CSA rates in racial and ethnic minority children, Black and Hispanic children are found to be most likely to experience CSA in their childhood (The Children's Assessment Center, 2021; Trinidad, 2021; Wang et al., 2021). The prevalence of CSA in Hispanic children is reported to be slightly higher than Caucasian children, although African American children experience CSA at some stage of childhood development at double the rate of Caucasian children (YWCA, 2017). Children with disabilities, children with unemployed parents, and children who live in rural areas report higher rates of sexual abuse because the perpetrator, 93% of times, is reported to be the parent or primary caretaker and has immediate access to their victim. (Centers for Disease Control and Prevention, 2019; The Children's Assessment Center, 2021). The child's exposure to interfamily violence may manifest into maladaptive attachment styles, when immediate family members are responsible for exposing the child to ACE (Jardin et al., 2017; Mishra et al., 2020; Schakel, 1987). Exposure to ACE in households predisposes the child to an array of complex physical and mental health issues that carry into adolescence and young adulthood, if untreated (Mishra et al., 2020; Wang et al., 2021).

Shevlin et al. (2018) recruited 454 adolescents admitted to inpatient hospitals who were asked to iden-

tify who perpetrated CSA against them. Children who participated in this study were under the age of 18, with their identified perpetrator being an adult over the age of 18. Children reported most of their abusers were immediate caregivers, defined as parents, stepparents, aunts, and uncles; a significant finding showed that smaller populations identified being sexually abused by a stranger. Although the identification of perpetrators helps to unveil that the majority of CSA cases occur within the victim's family dynamic, there are no demographics identified to capture cultural differences in CSA cases.

Reports on the prevalence of sexual abuse in African American children double the rates at which Caucasian children are sexually abused; Hispanic children experience sexual abuse slightly higher than Caucasian children as well (YWCA, 2017).

Children who are most susceptible to sexual violence are particularly trusting of adults and lack secure family structure, such as single-parent households, or where a stepparent is involved. Children under the age of 12 are the most susceptible age category of victims of CSA; 8% of male CSA cases are within the 13 to 17 age range compared to 26% of victims who are under the age of 12 (Centers for Disease Control and Prevention, 2019; Finkelhor, 1994). Since perpetrators of sexual assault against a child are often identified as individuals the child knows, disclosure may present even more of a challenge; often, children do not disclose because of the fear of not being believed, breaking the secrecy established throughout the grooming process. (The National Child Traumatic Stress Network, 2009; Townsend & Rheingold, 2013).

Perpetrators of CSA use techniques called grooming, which entails giving the child special attention, isolating the child from others, fulfilling the child's unmet needs, treating the child as if they are more mature than they are, developing inappropriate and intrusive boundaries with peers, and imposing secrecy of the abuse by using techniques to lead children into sexual contact. (The National Child Traumatic Stress Network, 2009; Townsend & Rheingold, 2013; YWCA, 2017). What establishes even more difficulty is the forcible involvement in the child's immediate family to gain more immediate access to the child. Often, this leads to inappropriate touch and externalizing the abuse on the child to maintain control, compliance, and obedience from the child (The Children's Assessment Center, 2021). Even in cases where a perpetrator does not forcibly involve themselves in the immediate family system, the child is obliged by the perpetrator to secrecy about the abuse to protect the perpetrator in order to maintain control of the child and to avoid the legal ramifications of a report of CSA.

Diagnostic and Clinical Implications

Children whose CSA backgrounds show lack of progress in their physical and psychological growth with developmental milestones such as walking, talking, and toilet training not met or having regressed to an earlier developmental stage. Diagnostic categories for children with a CSA history include mood; anxiety; personality; and disruptive, impulse-control, and conduct disorders. Diagnoses include major depressive disorder, disruptive mood dysregulation disorder, generalized anxiety, specific phobia, acute stress disorder, and posttraumatic stress disorder (Brassard & McNeill, 1987a; Conway et al., 2013; Hébert et al.,

2021; Jardin et al., 2017; Mishra et al., 2020; Schakel, 1987; Trinidad, 2021; Wang et al., 2021). Although personality diagnoses cannot be made until the age of 18, behavioral patterns may predispose the child to a diagnosis when eligible (American Psychiatric Association, 2013). Children with a CSA history often meet criteria for borderline personality disorder; a primary concern is the frequency of suicidal statements made, which is characteristic for individuals living with bi-polar disorder (BPD).

Suicidal thoughts and behaviors among adolescents who were the target or witnessed ACE, such as physical, emotional, and sexual abuse as well as neglect, were measured by Yoon et al. (2018) in a study that evaluated the severity of outcomes resulting from ACE. In their sample of 307 adolescents, 5% disclosed physical abuse, 43.4% disclosed emotional abuse, 44.0% disclosed neglect, 15.8% reported sexual abuse, and 18% reported suicidal ideation. The study concluded that most participants who disclosed suicidal ideation were those who disclosed sexual abuse, whereas there was no significant correlation between the other categories (Yoon et al., 2018). Suicidality, including suicidal thoughts and attempts, put sexually abused children at a significant risk. Additionally, children may develop cognitive distortions, mood disturbances, posttraumatic stress, interpersonal problems, isolation, fear of intimacy, revictimization, self-injurious behavior, substance abuse, somatization, and somatoform disorders, eating disorders, mild to chronic psychosis, and dissociative personality disorder (Conway et al., 2013; Hébert et al., 2021; Mishra et al., 2020). Diagnoses in children with a history of CSA often meet criteria for several of these diagnoses, especially with depression, disruptive mood dysregulation disorder, posttraumatic stress disorder, and borderline personality disorder.

The long-term effects of ACEs predispose the child to risk-taking behaviors inappropriate for their developmental age; unhealthy sexual behaviors include engaging in unprotected sex and non-consensual sex. Risky behaviors associated with maladaptive coping strategies include excessive consumption of alcohol, use of illicit substances, and internalized or externalized adaptation profiles. Internalized behavioral patterns in response to sexual trauma include repression and denial, where externalized behavioral patterns refer to sexual acting out and using manipulation tactics to force others into compliance (Hébert et al., 2021). In addition to risk-taking behaviors and adaptation styles, there may also be a fear around attaching to adults or peers, unstable relationships with peers, and projecting trauma-related stressors (Brassard & McNeill, 1987b; Hébert et al., 2021; Mishra et al., 2020; Trinidad, 2021; Wang et al., 2021;). Critical long-term effects that warrant attention in ACE research are youth suicide rates. Deaths by fatal suicide attempts account for 13% of premature deaths in adolescents; this percentage may be heightened in child victims of CSA (Yoon et al., 2018).

Historically, data collected through various agencies show that child suicide rates occur more frequently in girls than in boys. For one male child who attempts suicide, three female children attempt suicide (Centers for Disease Control and Prevention, 2019). Although girls report suicide attempts more frequently, the methods in which they may attempt are less likely to result in death than in boys. Boys, in contrast, do not report suicide attempts as often as females, but the

means used result in fatalities more often than in girls. The concern remains that there is a significant underreporting for boys who experienced ACE; possible explanations include fragile masculinity, denial of the impacts of the trauma, or thoughts that they would bring shame on their family and loved ones. Since boys are often sexually abused by older men, a potential barrier to self-disclosing may be related to others interpreting the result of the abuse as homosexuality.

Underreported Sexual Abuse in Boys

Male children often do not disclose sexual abuse for fear of retaliation, unveiling the secrecy of the abuser-child relationship, demasculinizing the child, and dismissing the abuse as not having a part of their lives (Brassard, 1987a; Schakel, 1987). The statistic around male CSA appears significantly lower than females on paper; however, this may also be inaccurate because the likelihood of a female disclosing sexual abuse is significantly more likely than a male. Male children also hold the preconceived notion that because they are a boy, no one will believe them. Additional factors that may inhibit boys from disclosing CSA are that boys feel less comfortable sharing deviant sexual behaviors with others, and the taboo around homosexuality, if the victim-to-perpetrator relationship is between two males. Sexual abuse between boys and another man may reinforce the secrecy (Brassard & McNeill, 1987a; Finkelhor, 1979; Groth, 1979).

Reported data on the frequency of ACE in boys misguides the scientific community about its prevalence (Hébert et al., 2021; Jardin et al., 2017; Shevlin et al., 2018). Another factor is the inaccuracy of capturing the prevalence of CSA in boys, as the research suggests that boys do not disclose sexual abuse nearly as often as physical abuse (Hébert et al., 2021; Jardin et al., 2017; Shevlin et al., 2018). One out of three boys who report CSA relive their trauma (Trinidad, 2021). Since the topic of CSA in boys is considered taboo in Western culture, children often do not disclose, since they shame themselves, question their sexuality following an assault, and believe in the expectation that boys are supposed to be strong (Brassard & McNeill, 1987a).

Explanations as to why males are less likely to report CSA in childhood may be contingent on the fact that they fear damaging the relationship to a manipulative perpetrator, the stigma surrounding sexual abuse in males, not being believed by others, beginning to question their sexuality, feeling less masculine, and being perceived as weak by others (Leeb et al., 2011; Schakel, 1987). Research indicates that one in three men who experiences ACE, more specifically CSA, will re-enact and offend a minor (Shevlin et al., 2018). Since there is an abundance of male perpetrators reported in multiple studies, it is important to recognize and identify the warning signs and implications of children with a suspected or confirmed history of CSA to prevent the continuation of the cycle of abuse.

Behavioral Presentation of Nonverbal Sexual Behavior

Sexualized behaviors characteristic of children with either a confirmed history of sexual abuse is trauma reenactment on an adult, peer, or animal; excessive masturbation; exposure of genitalia to others; boundary violations; the convincing of peers to engage in "games" involving sexual behavior; the use of sex-

ualized language and behaviors inappropriate for the child's level of development; and the use of similar manipulation tactics perpetrators would use on their victims to engage in sexual acts with peers of their age (Barnett et al., 2017; National Center on the Sexual Behavior of Youth, 2017; The Children's Assessment Center, 2021; Yoon et al., 2018; YWCA, 2017). Children often cannot process the abuse they survived, which manifests into nonverbal behaviors normalized to the child, but inappropriate to others. If left untreated or not provided trauma-informed interventions, these behaviors can create disruptions to interpersonal relationships and other important areas of life such as pursuing a career, forming romantic relationships, and developing friendships with others their age, just to name a few (Barnett et al., 2017).

Unresolved symptoms of confirmed or suspected CSA can create pathological issues with development, including repeating similar behaviors to what the child witnessed or survived, domestic abuse relationships, and symptoms associated with personality disorders. Long-lasting effects of CSA can develop into antisocial personality disorder, borderline disorder, or schizoid personality disorder (Conway et al., 2013). Trauma reenactment on another object involves acting out the assault a perpetrator performed against the child. Reenacting trauma can take the form of taking the person or object and demonstrating behaviors identified in Shevlin et al. (2018), which are kissing, fondling, performing oral sex, and penetrating the object. These behaviors may reveal a history of sexual trauma, since these behaviors may not suit the child's level of development. Excessive masturbation is another form of excessive sexual behavior, where the child becomes obsessed with their genitalia, often a symptom of inappropriate sexual stimulation (Kellogg, 2010).

Another sign and symptom of inappropriate sexual stimulation incongruent with a child's developmental age is self-exposure to adults and other children (Kellogg, 2010; The Children's Assessment Center, 2021). Since children are particularly vulnerable to either being exposed to their perpetrator or being forced to be exposed, this is another nonverbal form of trauma-reactive behavior. Convincing peers to play "games" that involve inappropriate sexual context also entails the child trying to convey their experiences with inappropriate sexual contact and boundary violations, especially in a dysregulated household, where sexual abuse has become normative (Barnett et al., 2017; National Center on the Sexual Behavior of Youth, 2017). Manipulation tactics may also be reenacted on other children due to the normativity of sexual behavior exclusive to sexual abuse cases.

Kellogg (2010) defines characteristics of sexual behavior as coercive and poses emotional or physical pain to others if left untreated. How this differs from sexualized behaviors compared to children without suspected or confirmed sexual abuse history is that these behaviors are rather frequent and developmentally inappropriate for their age. Exposure to sexual experiences and instances of suspected or confirmed abuse increase the likelihood that a child will exhibit externalized sexual behaviors. Children who are sexually abused demonstrate different forms of sexualized behaviors, which include externalized behaviors and internalized behaviors. Sexualized behaviors may pose debilitating harm to other children who witness or are perpetrated by their peers; who have a suspected or

confirmed case of CSA; and who are at-risk for developmentally inappropriate sexual behaviors, language, and content (Kellogg, 2010).

The Children's Assessment Center (2021) and Townsend & Rheingold (2013) indicate that childhood abuse, specifically sexual abuse, is difficult for adults to talk about, since it may be uncomfortable to discuss matters that involve harm to a child. Since children are shown to fear consequences associated with self-disclosing sexual abuse due to fear of questioning their sexuality and blaming themselves for the abuse, it is important adults intervene in a way that affirms the abuse the child experienced. Listening, believing, and remaining calm are interventions that are effective to help children feel supported by adults (YWCA, 2017). Referrals to social services agencies and law enforcement help to remove the child from an abusive household (Child Welfare Information Gateway , 2021; Font et al., 2018). This may contribute to the steady decline of reported CSA cases; however, unreported cases remain a contemporary issue in society (Finkelhor & Jones, 2012).

Conclusions and Recommendations

Boys exhibiting nonverbal sexualized behaviors may suggest having experienced sexual abuse; overt sexual behaviors serve as both trauma-reactive and trauma-reenactment. Understanding how trauma-reactive and trauma-reenactment behaviors present may help to identify suspected patterns of sexual abuse; information gathered may help to justify whether or not a child is a victim of CSA. Although CSA is a societal concern for children of all genders, attending to cases of boys is vital to help identify behaviors characteristic of a child who may not be ready, does not feel able to, or remains fearful to disclose sexual abuse history, especially if the abuser is male or an individual within the child's immediate social circle. Identifying the signs and symptoms that may support a suspected case of CSA may help to advocate for a child in need, or who is fearful to share their trauma.

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