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SEE NO EVIL, HEAR NO EVIL, SPEAK NO EVIL: WHY DO RELATIVELY FEW MALE VICTIMS OF CHILDHOOD SEXUAL ABUSE RECEIVE HELP FOR ABUSE-RELATED ISSUES IN ADULTHOOD?

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ABSTRACT. *This literature review explores the reasons why comparatively few adult males with a history of childhood sexual abuse are seen by professionals for help with difficulties relating to that abuse. Two potential explanations are discounted as myths—that relatively few males are sexually abused, and that abuse has little effect on males. However, it is suggested that society (including professionals and the victims themselves) has given credence to these myths. Male victims are relatively unlikely to disclose their experience of childhood abuse, and (as a coping strategy) they deny the impact of sexual abuse on their lives. Professionals fail to hypothesise that their male clients may have been abused, and do not create the conditions that would enable males to talk about the abuse. Blumer's (1971) model of the social construction of problems is applied to account for these beliefs and behaviours on the part of victims and clinicians. It is argued that*

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the childhood sexual abuse of males has not yet acquired legitimacy as a problem recognised by society, thus lagging behind the abuse of females. In short, the 'evil' of childhood sexual abuse in the male population is not being seen or heard by clinicians, and is not being recognised or talked about by victims. Clinical implications are considered. © *1997 Elsevier Science Ltd*

ALTHOUGH THE LITERATURE on female victims of childhood sexual abuse has been described as in its infancy, the parallel body of literature on male victims is better conceptualised as at an 'embryonic' stage (Urquiza & Capra, 1990). Apart from a few isolated papers, it is only in the last decade that books and papers on male victims have been published. One of the main themes of this literature is that male victims of childhood sexual abuse are not coming to the attention of professionals during adulthood, and that therefore they are not getting an appropriate service. This review examines reasons for these omissions, including critical analysis of the arguments that few males are sexually abused in childhood and that sexual abuse does not tend to lead to psychopathology in adult males. We go on to consider whether people in western society, including clinicians and the male victims themselves, do not readily conceptualise males as potential victims of childhood sexual abuse.

It is important to note that the central theme of this paper is the experience of adult men who have been sexually abused in childhood. As will become clear, the literature to date on male victims has focused principally on this aspect of the problem. Even when the titles of articles and papers mention boys, it is generally the case that the data are largely self-report by adult males of their childhood experiences (e.g., Finkelhor, 1984; Watkins & Bentovim, 1992). It seems that it is only as the topic of the long-term consequences of childhood abuse gains a firm footing that there is a development of a comprehensive literature on the more immediate effects of such trauma in childhood (or, indeed, of traumatic experiences in adulthood). The same phenomenon can be seen in the early years of the literature on sexually abused women, where an understanding of the immediate impact of sexual abuse upon girls was informed by the preliminary literature on the long-term consequences among adult women.

THE EXTENT OF THE PROBLEM

The first point that needs consideration is the discrepancy between prevalence rates of childhood sexual abuse identified among men in the general population and among men in the clinical population. In order to determine the extent of this discrepancy, it is necessary to determine whether males who have had an abusive sexual experience in childhood are proportionally unlikely to be identified as such during therapy. However, that proportion can only be understood relative to the likelihood that women will discuss an experience of childhood sexual abuse during therapy.

The majority of large-scale prevalence studies have focused on women's experiences of childhood abuse (e.g., Mullen, Martin, Anderson, Romans, & Herbison, 1996). However, a number of major national surveys have described population prevalence rates of childhood sexual abuse for both males and females. For example, Baker and Duncan (1985) found rates of 8% for male compared to 12% for female victims in Britain. Finkelhor, Hotaling, Lewis, and Smith (1990) cited rates of 16% for males and 27% for females in the USA. Finally, in Canada, Badgley et al. (1984) concluded that 13% of males and 34% of females reported sexual abuse. In other words, national surveys show that approximately 30% of all childhood sex abuse victims are male,

while the remainder are female. Studies that emanate from narrower geographical areas yield similar results (see Peters, Wyatt, & Finkelhor, 1986, pp. 20–21). These findings support Watkins and Bentovim's (1992) conclusion—'males are rarely abused' is one of the major myths about victims of childhood sexual abuse.

The prevalence figures yielded by these studies are influenced by a range of methodological factors (e.g., Briere, 1992; Kuyken, 1995). For example, no single definition has been consistently employed across studies, and changing the definition of sexual abuse has been shown to substantially influence the prevalence rate (Fromuth & Burkhart, 1987). The method of data collection (e.g., telephone survey, postal survey, face-to-face interviews) will also affect the readiness of a person to disclose whether they have been abused (Urquiza & Keating, 1990). Sampling is an important consideration, since different samples will yield different rates of abuse. Despite the complexity introduced by such factors, it is difficult to maintain the argument that childhood sexual abuse is an uncommon experience for males. The highest estimates of prevalence suggest a problem of epidemic proportions (Watkins & Bentovim, 1992).

These results from the general population demonstrate that women are twice as likely as men to have a history of childhood sexual abuse. If all else were equal, one could conclude that this pattern of prevalence rates should be reflected among those who come to professional attention. Since overall prevalence of psychiatric morbidity is relatively similar across males and females in the community (Meltzer, Gill, Petticrew, & Hinds, 1995), it appears that one should expect males to represent approximately 30% of the clinical population who report an abusive history in childhood. However, Mendel's review (1995, pp. 48–51) concludes that the majority of studies of adult males in clinical groups report a prevalence rate substantially below that level. For example, between 1979 and 1984, only 9% of referrals to a hospital-based team for evaluation of possible sexual abuse were boys (Spencer & Dunklee, 1986).

Clearly, childhood sexual abuse is not reported proportionally as often among adult males as among females who have taken part in such clinical research. However, the imbalance may be even greater among the broader clinical population. It should be remembered that the studies cited above are generally derived from research where the participants are asked directly about a history of abuse. It is recognised that making such a direct enquiry yields much higher rates of disclosure than simply waiting for the client to raise the issue (e.g., Briere & Zaidi, 1989). Over recent years, many clinicians and researchers have stressed the need for routine enquiry about childhood abuse among female adult clients (e.g., Jacobson & Richardson, 1987; Rosenfeld, 1979), and it is likely that this suggestion has entered the 'culture' of clinical expectations more in work with females than with males. This point is addressed in more detail later in this review (see 'Do clinicians fail to suspect or enquire about histories of sexual abuse in adult male clients?'). Therefore, it is probable that our identification rate for male cases will be even poorer in general clinical practice, where there is less expectation that sexual abuse is a potential factor in the formulation of the case.

To summarise, there is evidence to support Watkins and Bentovim's (1992) conclusion that the rates of childhood sexual abuse in the total population are higher for females than for males, but not as high as the differences in female to male ratios in the adult clinical population would suggest. These discrepancies can be seen as evidence that a history of childhood sexual abuse in adult males is both under-reported and under-identified.

WHY DO PROFESSIONALS IDENTIFY RELATIVELY FEW MEN WITH HISTORIES OF CHILDHOOD SEXUAL ABUSE

From the literature outlined above, it can be seen that there is a marked discrepancy between the ratios of men and women reporting childhood sexual abuse in clinical samples, despite the relative similarity between prevalence rates of male and female cases of such experiences in community samples. There are four distinct hypotheses that might be advanced to explain this pattern. First, such abuse may have a lesser impact on males, thus leading to a much lower referral rate for psychological disturbance in adult life. Second, men with a childhood history of sexual abuse may develop characteristics that lead them to be seen by services other than the helping professions (e.g., the criminal justice system). Third, it may be the case that men tend not to disclose their experiences of childhood sexual abuse. Finally, it is possible that clinicians do not suspect or enquire about histories of sexual abuse in adult male clients. Each of these hypotheses will be considered below.

Does childhood sexual abuse have little effect on men?

The majority of studies of the effects of childhood sexual abuse have focused on its impact upon females. However, theoretical analyses have concluded that the critical factors in the development of social and psychological dysfunction are not directly gender-linked, but that they are much more dependent upon developmental and environmental factors (e.g., Cole & Putnam, 1992). For example, Spaccarelli's (1994) transactional model cites gender as simply one of a number of moderators in the relationship between the stress of being abused and the cognitive and behavioural responses to that stressor. Support resources, developmental level, age and personality are equally likely to be important moderators. These conceptualisations suggest that one is likely to find relatively similar patterns of long-term symptomological response to childhood abuse among adult male and female victims, since gender is only one of a number of moderators that will influence the generalizability of the links. Where there are differences in psychopathology, there is no clear conceptual reason to expect male victims to have levels of symptomatology that are greater or lower than those of female victims. In this review, we will consider the evidence that child sexual abuse has a long-term impact on men, both in clinical and non-clinical samples.

Clinical groups. A number of studies compare men who do and do not report childhood sexual abuse. They indicate a wide-ranging impact on males, both in the short- and the long-term. Reviews of the literature suggest that this impact is not confined to a minority of the victims (e.g., Neilsen, 1983). In a study of 124 adult males sexually abused as children, Mendel (1995) found that all 124 perceived their abuse as severely damaging to most aspects of their lives. Short-term effects on males have been shown to include: anxiety and fear reactions (Conte & Schuerman, 1987; Sebold, 1987); self-worth problems (Rogers & Terry, 1984; Sebold, 1987); shame (Sebold, 1987; Vander Mey, 1988); suicidality and depression (Rogers & Terry, 1984; Spencer & Dunklee, 1986); anger and aggression (Rogers & Terry, 1984; Sebold, 1987); and homophobic reactions and confusion over sexual identity (Sebold, 1987). These difficulties are also common long-term effects, extending into adulthood (Hunter, 1990; Johanek, 1988; Lew, 1990; Mendel, 1995; Olson, 1990; Watkins & Bentovim, 1992). However, there are a number of further long-term consequences, including: drug and alcohol problems (Bruckner & Johnson, 1987; Dimock, 1988; Olson, 1990; Schulte, Dinwiddie, Pribor & Yutzy, 1995); sexual difficulties, including compulsive

sexual behaviour, sexual dissatisfaction and sexual dysfunction (Dimock, 1988; Fromuth & Burkhart, 1989; Hunter, 1990; Johnson & Shrier, 1987); relationship problems (Dimock, 1988; Lew, 1990; Olson, 1990); dissociation (Briere, Evans, Runtz & Wall, 1988; Mendel, 1995; Steele & Colraine, 1990; Urquiza & Capra, 1990); 'hypermasculine' behavior (Johanek, 1988); criminal behavior (Olson, 1990); and shame and gender shame (Mendel, 1995).

Although the studies cited above are relatively consistent in showing short- and long-term psychological effects of childhood sexual abuse in males, it is important to consider the methodological and sampling issues that limit the generalizability of some of the conclusions. For example, most of the studies do not include female victims or make no direct comparison between males and females (e.g., Dimock, 1988; Fromuth & Burkhart, 1989; Johnson & Shrier, 1987; Olson, 1990; Spencer & Dunklee, 1984), some are based on relatively small samples (e.g., Johnson & Shrier, 1987; Rogers & Terry, 1984; Schulte et al., 1995), and others involve unstandardised measures (e.g., Dimock, 1988) or simple clinical impressions (e.g., Johanek, 1988). There is also little agreement about what psychological consequences should be measured. Some papers are based on psychiatric diagnosis, while others assess psychological functions or behavioural indices. Given these methodological and sampling issues, it is important to place particular emphasis on studies that have overcome these methodological issues (e.g., Mendel, 1995).

There are relatively few studies that have directly compared the impact of childhood sexual abuse upon males and females in adulthood. Those studies that do exist tend to support the proposal that the outcome is similar. In one such study, Roesler and McKenzie (1994) examined the nature and extent of psychological disturbance in adult males and females who had been victims of childhood sexual abuse. They demonstrated that the level of psychopathology was broadly similar across the genders, and that where there was a reliable difference (in the field of sexual dysfunction) it was the males who were less healthy. In another study, Briere, Evans, Runtz, and Wall (1988) studied adult males and females presenting to a crisis counselling service. They found that both males and females who had been abused in childhood reported higher rates of dissociation, anxiety, depression and sleep disturbance than non-abused controls. However, there were no differences between male and female victims.

The findings of these well-controlled and methodologically sound comparison studies clearly support the conclusions that had been reached by the other studies outlined above. Although it is often difficult to make direct comparisons, the profile and levels of psychopathology in adulthood are relatively similar across the genders (Cahill, Llewelyn, & Pearson, 1991; Dimock, 1988; Finkelhor, 1990). Where there is a difference, it tends to be in the subsequent sexual functioning of the male and female victims (e.g., Dimock, 1988; Roesler & McKenzie, 1994). However, such qualitative differences do not allow one to conclude that either gender has a worse outcome per se.

To summarise, there is a growing body of evidence from studies of clinical groups to refute the argument that adult males are not adversely affected by childhood experiences of sexual abuse. There is a need for more research that directly compares clinical populations of abused and non- abused males and females. Such research should consider the importance of controlling for other mediating variables, such as age and family dynamics.

Non-clinical groups. Studies of non-clinical groups (e.g., students) have also suggested that childhood sexual abuse is a risk factor for psychological disturbance in adult males. That disturbance is relatively general, covering many aspects of psychopathology. For example, Collings (1995) has demonstrated that non-clinical men (a sample of South African students) had significantly greater levels of psychopathology on all scales of the Brief Symptom Index if they had been victims of contact childhood sexual abuse. A number of other authors have reached similar conclusions (e.g., Brown, 1990). However, the methodological difficulties in making comparisons across studies makes it difficult to use such data to determine whether males and females are differently affected by childhood sexual abuse. There are relatively few community studies that directly compare the psychological impact of childhood sexual abuse on men and women. However, where the two genders are compared directly, females with such a history of abuse have a different pattern of psychopathology than males. For example, Stein, Golding, Siegel, Burnam and Sorenson (1988) demonstrated that males and females had similar additional lifetime risks of developing a psychiatric disorder if they had a history of childhood sexual abuse, but males were more likely to develop a substance use disorder, whereas women were more likely to develop a depressive or phobic disorder. The abused women's tendency to develop more affective problems than abused men was confirmed in their greater level of a wide range of psychological symptoms (e.g., guilt, anxiety, insomnia).

It can be concluded that non-clinical men and women who report a history of childhood sexual abuse each show a pattern of broad-based psychological disturbance, with relatively high levels of affective symptoms. Where there is a gender difference, it seems to be in the nature of the symptoms that develop. Male victims are more likely to develop problems in substance and alcohol use, while females have greater levels of anxiety and depression. This disparity (which cannot be taken to suggest a poorer outcome for either gender) maps onto the pattern of general population differences in the distribution of psychological and psychiatric disorders among adults (Meltzer et al., 1995).

Are Men who have been Childhood Victims Seen by Services Other than the 'Helping Professions'?

It has been suggested that male victims of childhood sexual abuse are more likely than females to develop externalised, aggressive characteristics in adulthood (Kaufman, 1984). Therefore, men would be more likely to show rage, attempt to reassert their masculinity, and become perpetrators of sexual abuse, all of which would predispose them to come into contact with the criminal justice system rather than psychiatric/psychological care. The criminal justice system is unlikely to enquire whether a person has been a victim as well as a perpetrator of violence. In support of this argument, there is research evidence to indicate high rates of histories of childhood sexual abuse in adult male prisoners (Petrovich & Templer, 1984; Condy, Templer, Brown & Veaco, 1987). It appears that there is a "filtration effect,"in which many cases may manifest in ways that lead them to be dealt with outside of traditional psychological and psychiatric services. However, this is unlikely to be the whole story. It has already been shown that male victims of childhood sexual abuse have generally similar levels of psychological disturbance to female victims. The relatively low level of offending behavior in any population (relative to the extent of psychological disturbance) means that this filtration effect cannot completely account for the poor identification of victims of childhood sexual abuse among male clinical cases. Therefore, the filtration

hypothesis may be necessary to explain part of the discrepancy, but it cannot be seen as a sufficient explanation.

Do Adult Males Tend Not to Disclose Their Experiences of Childhood Sexual Abuse?

A number of studies have concluded that male victims of childhood sexual abuse do not readily disclose the fact that they have been abused (e.g., Boyd & Beail, 1994; Dimock, 1988; Finkelhor, 1984; Johanek, 1988; Lew, 1990; Nasjleti, 1980; Struve, 1990). Some evidence comes from a series of patient studies. While some of these studies involve comparatively small numbers of patients or do not report the number of participants (e.g., Nasjelti, 1980), others involve more adequate samples. For example, Dimock (1988) conducted a relatively small-scale study, which showed that only one of a sample of 25 men who had been abused disclosed the experience at the time it was occurring. The larger-scale surveys of non-clinical men tend to support these clinical impressions. For example, in a student sample in South Africa, Collings (1995) found that none of the 82 men who had been abused in childhood had reported the experience to the police or had previously sought counselling for abuse-related issues.

Obviously, the key studies are those which examine whether males are less likely than females to disclose their experience of childhood abuse. There is a moderate level of discrepancy among non-clinical groups. Finkelhor (1984) found that only 25% of male students who had been sexually abused in childhood had told anyone about their abuse, compared to 33% of abused female students. In a national survey, Finkelhor, Hotaling, Lewis and Smith (1990) found that 43% of men and 41% of women had told at least one person within a year of the childhood sexual abuse occurring. However, only 14% of men (compared to 24% of women) said that they went on to tell someone later, and 42% of men (compared to 33% of women) said that they had never told anyone. This discrepancy is even greater among clinical groups. In a direct comparison of male and female victims, Roesler and McKenzie (1994) found that disclosure during childhood was the only sexual abuse variable that differentiated the genders. 61% of adult women had told someone as a child, compared to 31% of men.

Many reasons for non-disclosure (e.g., the long-term effects of having been engaged in the perpetrator's secrecy strategies) are common to both male and female victims of childhood sexual abuse. It is also possible that men are less likely to seek help from their family doctor when they have a psychological problem that arises from childhood sexual abuse, although there are few data that might test such a hypothesis. Researchers have emphasised the following three key areas as offering potential explanations for non-disclosure in the male population. It will be noted that none of the three is unique to male victims in psychological or practical terms. However, there are reasons to see male and female socialization as potentially leading to qualitatively different conclusions (and courses of action).

Men do not define their childhood experiences as abusive, and do not think that their abuse experiences have had a negative impact. Before one can suggest that males have a bias towards defining their experiences as non-abusive, it is important to bear in mind that such self-definitions could be accurate, and that boys might be sexually abused in less severe ways than girls. Therefore, it is necessary to consider whether the sexual

experiences of boys are qualitatively similar to those of girls or whether they are objectively different. There is a body of research that makes direct comparisons of the nature of the experiences of males and females. These studies suggest differences on some indices of severity, but not on others. For example, Pierce and Pierce (1985) found that boys are more likely than girls to experience repeated penetrative acts, oral intercourse and masturbation, but less likely to experience fondling and abuse involving their natural fathers. Faller's (1989) data also indicate that boys are more likely to experience repeated extrafamilial abuse. Baker and Duncan (1985) suggested that boys in Britain have their first experience at a later mean age than girls. However, this age difference is not reliable, probably due to sampling methods (Faller, 1989). Some authors (e.g., Finkelhor, 1984; Pierce & Pierce, 1985) found directly contradictory evidence (boys abused at a younger age than girls) in US samples, and others (e.g., Finkelhor et al., 1990; Roesler & McKenzie, 1994) have found no age differences. To summarise, there are some differences and some similarities between the abusive experiences of male and female children. However, it is not possible to characterise one gender as having an overall profile of more severe abuse, since the direction of severity is a product of the characteristic investigated. For example, boys suffer more frequent, penetrative acts, while girls are more often abused by relatives.

Having established that boys' experiences of abuse cannot be classified generally as less severe than those of girls, it is now necessary to determine whether males have a tendency to describe those experiences as non-abusive. For a boy, a sexual experience with an adult may be culturally defined (by society, his friends, and by the boy himself) as an early introduction to sexual prowess and 'manhood' (Bolton, Morris, & MacEachron, 1989). Male sexual socialisation tends to encourage males to define sexual experiences as desirable provided there is no homosexual involvement (Fromuth & Burkhart, 1987). In keeping with this proposition, Condy, Templer, Brown, and Veaco (1987) found that male victims of sexual abuse by females did not report the experience as traumatic unless coercion was involved.

Early sexual experiences with older boys are sometimes defined as "experimentation." Boyd and Beail (1994) described British cases where abusive experiences in childhood were labelled in ways that made them seem less important. In one such instance, they outlined the case of a man with a 39-year history of severe psychological problems, which dated back to his being repeatedly anally raped and orally penetrated by older boys. He described these incidents to his therapist as "horseplay." In another case, a 22-year-old man (admitted to hospital following a suicide attempt) later admitted in therapy to being "bummed" (anal intercourse) by an older boy when he was 10. The victim labelled this as "mucking about."

The fact that males can have a clear physiological reaction during their abuse (i.e., an erection and possible ejaculation) may also lead some males to rationalise their abuse as something that they desired or invited (Watkins & Bentovim, 1992). Unlike in females, male arousal is markedly visible and this can enhance what Gerber (1990) has called the "myth of complicity." Coupled with this feeling of having been a willing participant may be the fact that boys may have been successfully "groomed" by the abuser—the sexual contact may be preceded by (and coupled with) affectionate real or substitute parenting, attention, and rewards. Males with these experiences may find it hard to acknowledge the abusive nature of the relationship (Watkins & Bentovim, 1992).

The findings from a large-scale survey (conducted in the UK) are important here, as they support the observations from clinical practice that have been reported above. Baker and Duncan (1985) found that men reported being significantly less damaged than women by their experience of childhood sexual abuse. Only 4% of men (com-

pared to 15% of women) felt it had caused permanent damage, while 57% (compared to 34% of women) stated that it had had no effect. Thus, there is evidence to suggest that some males do not define their experiences as abusive or harmful. Such people are not likely to identify themselves as wanting help for abuse-related issues, although that may be the type of help that some of them need.

It cannot be concluded that this self-description as either "damaged" or "not affected" is necessarily valid. Finkelhor (1984) concluded that sexually abused boys rate their experiences as less abusive than a comparable group of girls, even though the long-term effects on boys' self-esteem appears to be as high as (if not higher than) the impact upon girls. Evans (1990) has suggested that when there is no evidence of physical damage, males may be less likely to see their abuse as traumatic and less likely to seek help, but may be more likely to develop psychological problems. In a large-scale study undertaken by Mendel (1995), men were asked about their sexual activity during childhood, and were then asked whether they considered it abusive or not. Sexual activity with parents (of either sex) was associated with negative outcomes, regardless of whether or not it was considered abusive. Similarly, in a study of male college students who had been sexually abused in childhood, Fromuth and Burkhart (1989) found significant negative consequences associated with childhood sexual experiences with older women, despite the fact that these experiences tended not to be considered abusive. This is a particularly significant finding, given that many studies suggest that over 40% of all male victims have had an experience involving a female perpetrator (e.g., Fromuth & Burkhart, 1987, 1989; Johnson & Shrier, 1987; Olson, 1990).

To summarise, there is considerable evidence that some males suffer adverse long-term effects of childhood sexual abuse. However, it is also evident that men often do not disclose the abuse to professionals because they fail to define the experience as abusive or to regard it as significant.

The consequences of disclosure are perceived as worse than the consequences of non-disclosure. Over recent years, professionals have come to see disclosure of childhood sexual abuse as a positive, empowering experience for the client. However, the client has reasons for being reluctant to disclose (particularly fear of disbelief or adverse reactions), and may see the prospect of disclosure as negative and disempowering. Increased societal awareness of childhood sexual abuse among females may have gone some way towards making women less reluctant to disclose than men. In the past decade, there has been a more general public acceptance that a large number of girls are abused, but there has been far less public awareness of boys having had the same experiences. This process of social construction (e.g., Blumer, 1971) of childhood sexual abuse is discussed in more detail below. The greater awareness and acceptance of girls as victims of childhood sexual abuse may make it easier for women to disclose with appropriate support. Males may not have learned that their childhood experiences are far from unique, and hence will have no reason to expect either acceptance or support. Thus, their fears of the consequences of disclosure might be expected to be greater than those of their female peers.

In addition to these processes of social construction, the pattern of masculine socialisation might be expected to contribute to men's reluctance to disclose childhood sexual abuse. Society casts the normal male as sexually active, rather than sexually passive (Finkelhor, 1979). He is knowledgable, potent, and a successful seducer (Bolton, Morris, & MacEachron, 1989). From early childhood, boys learn that masculinity means not depending on anyone, not being weak or passive, and not being a loser in a confrontation (Nasjleti, 1980). Boys are socialised to be dominant

and in control. These factors are not easily reconciled with the experience of being abused, defining oneself as a victim, and disclosing abuse.

There is evidence that these processes of social construction and masculine socialisation have an impact on men's willingness to disclose childhood sexual abuse. In a study by Dimock (1988), fear of the consequences of disclosure were instrumental in preventing all but one of a sample of 25 men from telling anyone about the abuse at the time it was occurring. Males cite threats from the abuser and fears of reprisal as common reasons for not disclosing (Dimock, 1988; Nasjleti, 1980; Sebold, 1987). Even when the threat is no longer apparent (e.g., when the boy is grown up and no longer in contact with the abuser), the psychological residue of the threat may still provide an effective barrier to disclosure.

There are also issues of shame, stigma and self-blame (McMullen, 1990). There may be shame regarding the inability to prevent what happened. One victim said "Deep down if I were a real man I should have been able to stop the abuse" (Dimock, 1988, p. 209). In other words, "real men" do not get abused. Shame was cited by the majority of adolescent boys in Nasjleti's (1980) study as a reason for non-disclosure. There is shame and guilt over allowing the assault, coupled with guilt about being unable to cope afterwards (Evans, 1990). The masculine ethos of self-reliance, of it being "unmanly" to seek help, also means that males may be less inclined to seek treatment (Struve, 1990). The "ideal man" is silent, strong and in charge of his emotions; such men do not go into therapy to talk about being abused (Mills, 1993). The abuse experience thus undermines many men's concepts of their masculinity. To talk about it would involve further threats to their male self-concept.

Surveys and patient series studies have shown that boys who have been sexually abused by men have fears about other people thinking that they are homosexual, and about becoming homosexual (Dimock, 1988; Finkelhor, 1984; Nasjleti, 1980). Homosexual activity is considered by most Western heterosexual males as abhorrent and shameful (Nasjleti, 1980). Reporting that you have been abused by a man may be seen as tantamount to an admission that you are gay. As well as having to contend with the incest taboo, a sexually abused male has to cope with the homosexuality taboo and with the feeling that his masculinity itself has been undermined by the abuse. Fearing damage to their reputation with peers, many males choose not to disclose (Sebold, 1987).

Many of these issues are brought to life by the comments of Leo, a 19-year-old rape survivor, cited in Evans (1990):

> If I had my way I wouldn't have told anybody. When you ask me "Hey did I tell some friend of mine or somebody in my family?" you oughta imagine what's gonna happen if I go sit down with them and say, "Your Leo is still your Leo but his ass belongs to the man who scared him into taking down his pants." You ask some stupid questions for a man. You're lucky I talk to you because nobody else is gonna ever hear this boy's story. (Evans, 1990, p. 198)

These fear, masculinity and shame dynamics are likely to be at their strongest during adolescence. There is evidence to suggest a drop in referrals for male victims of this age group (Watkins & Bentovim, 1992).

In addition, male victims of childhood sexual abuse frequently describe fears about becoming, or being seen as, potential abusers (Mendel, 1995; Nasjleti, 1980). Bruck-

ner and Johnson (1987) describe this as the male survivor's Sword of Damocles. In reviews of the literature, Watkins and Bentovim (1992) and Mendel (1995) both concluded that the risks of cyclical victimization may have been overstated. The fact that some studies have shown high rates of histories of childhood sexual abuse amongst perpetrators of sexual abuse (from 32% (Groth, 1979) to 90% [Carlson, cited in Kasl, 1990)] is not the same as saying that similar proportions of abused men will go on to abuse others. In a rigorous study of cyclical victimization, Kaufman and Zigler (1987) concluded that approximately 70% of families in which parents suffered some form of abuse do not "transmit" the abuse to their children. In another well-conducted study, Briggs and Hawkins (1996) demonstrated that childhood sexual abuse per se does not influence men's subsequent offending behavior, although there may be some impact if the abuse was seen as a normal part of childhood, if more perpetrators were involved, or if the victim enjoyed some part of the experience. Clinicians are more likely to have access to and understand such statistics compared to the victims themselves. It appears that one of the few messages that has got across to male victims of childhood sexual abuse is the inaccurate one that they are highly likely to re-enact their abuse. Such men are unlikely to disclose their abuse to professionals, especially if they are adult males with children of their own.

To summarise, there is an intense cocktail of pressures on males to use the defences of denial and dissociation regarding their childhood abuse. In extreme forms, these pressures will lead to repression and inacessibility of memories. Even when those memories are available, there may be extreme reluctance among abused males to seek help or to disclose their experiences to other people, including professionals. Whereas disclosure may be gaining acceptance as an empowering experience for female victims of sexual abuse, it still seems to be feared and experienced as disempowering for males. Aspects of disclosure and therapy (e.g., acceptance of the abusive aspects of the experience, seeking help, talking about what happened and the associated feelings) all clash with the male self-concept of physical and emotional invulnerability. Males find themselves enclosed in a tightly pulled knot: "If I was abused, then I am not a man; if I am a man, then I was not abused" (Mendel, 1995, p. 206). The unravelling of the knot necessitates skilled and informed action on behalf of others to facilitate disclosure and start the recovery process.

There is a paucity of services for adult male victims of childhood sexual abuse. Sexually abused males frequently suffer the damaging and isolating effects of believing that they are the only one to have ever been abused (Evans, 1990; Hunter, 1990). Organisations such as Rape Crisis either don't provide a service for men, or are perceived as not doing so (Evans, 1990). The lack of known resources means that men are not able to access help easily. They tend to have inadequate personal support networks within which to disclose and talk about their experiences (Evans, 1990), and when they look around for outside support they find nothing (Singer, 1989). The availability of services for female victims has helped to reduce the stigma of being abused in the female population and has assisted women to come forward and access help. This has not been the case in the male population (Mendel, 1995).

The establishment of services has centred on the proposition that females are victims and males are perpetrators. It might be worth considering whether the development of services for treating female perpetrators lags behind the development of services provided for male abusers (where the lag is measured temporally, as well as in terms of the proportional allocation of resources). Such a disparity in service

provision would be consistent with the hypothesised process of social construction of childhood sexual abuse (see "Conclusions").

Do Clinicians Fail to Suspect or Enquire About Histories of Sexual Abuse in Adult Male Clients?

There are several interrelated processes involved in this question. First, are clinicians less likely to hypothesise that childhood abuse has occurred in adult males than in females? Second, are clinicians less likely to enquire about childhood abuse if the client is a male? Third, if the client does disclose, does the clinician believe him? Finally, assuming that the client has disclosed and been believed, does the clinician respond appropriately? These questions will be addressed in turn.

Clinicians' hypothesising about childhood abuse. It has been suggested that clinicians are more reluctant to suspect childhood sexual abuse in male clients than in females (Finkelhor, 1984). This reluctance reflects cultural norms. Society tends to perceive males as perpetrators of sexual violence and females as victims. Many books refer throughout to perpetrators as "he" and victims as "she" (Bolton, Morris, & MacEachron, 1989). Although it is true that the majority of perpetrators are male and the majority of victims are female, the emphasis on this imbalance may preclude some clinicians from bearing in mind that the opposite can be true (and does occur).

In terms of adult services, our clinical impression is that outside agencies (such as family doctors) increasingly refer to childhood sexual abuse when making referrals of female patients, but this potential aetiological factor is rarely mentioned in referrals of men. Johanek (1988) suggests that such a failure of early identification may be because male victims of childhood sexual abuse are highly likely to come with a disguised presentation, such as anxiety, suicidality, hostility, rage or hypermasculine behaviour (e.g., aggression). It is not clear how well adult male and female victims can be differentiated by such presenting symptoms. However, some of the indicators of sexual abuse considered above (see "Does childhood sexual abuse have little effect on men?") may be particularly gender-congruent with normal male behavior (e.g., anger), and thus may be overlooked in men (Bolton et al., 1989). Therefore, there is a greater onus on the clinician to be alert to the possibility of a history of childhood sexual abuse in a male client.

Unfortunately, there is clear evidence that clinicians are not alert to that possibility, and are less likely to suspect sexual abuse in male clients. Ramsey-Klawsnik (1990) conducted an archival study of referrals to a child protection service between 1984 and 1989. She found that referrals based solely on the presence of psychosocial indicators of sexual abuse were four times more likely to be made for girls than boys, indicating that when professionals see a child in distress they are more likely to consider the possibility of sexual abuse when that child is female. Boys have been shown to be referred to such services predominantly when their sisters have been found to be abused, rather than as the index case (Finkelhor, 1984; Pierce & Pierce, 1985).

In a study that we conducted on clinical psychologists in Britain (Holmes & Offen, 1996), clinicians were presented with vignettes describing case material. The case material included phenomena that have been associated with a history of sexual abuse in male and female victims (e.g., dissociative symptoms, phobic reactions, anger). Half of the clinicians were told that the client was female, while the other half were told that the client was male. They were then asked to hypothesise about the possible

aetiological factors that they would want to consider in this case. Significantly more clinicians hypothesised a possible history of sexual abuse where the client was female, even though the presenting features were identical.

These findings confirm that professionals are particularly unlikely to hypothesise about a history of childhood sexual abuse if the client is an adult man. More research is needed in this area, to verify whether clinicians' perceptions of their male clients are skewed away from the possibility of thinking that childhood sexual abuse may be an important antecedent to the presenting problems.

Clinicians' enquiries about childhood abuse. Whether or not they hypothesise that males might have been sexually abused, it is clear that few clinicians inquire about a possible history of sexual abuse in their male clients. In a study of men attending a British psychiatric clinic, Mills (1993) found that the majority had not been previously asked about sexual abuse. Dimock (1988) found that 19 men in a sample of 25 had received previous counselling or treatment for psychological problems, and yet had still not disclosed that they had been abused. As well as not hypothesising that their adult client may have been sexually abused, some professionals may be reluctant to enquire about it when it is appropriate to do so, as they perceive themselves as having a lack of knowledge or training about male victims (Hunter & Gerber, 1990,).

In addition, clinicians' models of female sexual abuse are predominantly based around victimization in the family, and may not be applicable to some male victims. For example, recent years have seen an increase in our understanding that many children are abused by professionals working in institutional settings (e.g., Faller, 1989; Kelley, Brant, & Waterman, 1993). There are two reasons why clinicians are less likely to enquire about such a history of abuse. First, there may be a reluctance to contemplate the possibility that other clinicians would be involved in perpetrating sexual abuse, despite the evidence of recent years (e.g., Garrett, 1994; Garrett & Davis, 1994). Second, by definition, such children will be considered as having had extrafamilial experiences. Because many definitions and discussions of childhood sexual abuse have centred on incest, clinicians and researchers have not always treated such individuals as being at risk (Finkelhor, 1984). Since extrafamilial experiences are proportionally more common in boys than in girls (e.g., Faller, 1989; Pierce & Pierce, 1985), it can be hypothesised that boys are at particular risk of abuse in such settings. Thus, a failure by clinicians to enquire will have a disproportionate effect on the number of identified cases of adult male victims of childhood sexual abuse.

Clinicians' belief in male clients' disclosures of childhood sexual abuse. High rates of disbelief have been cited in professionals' reactions to female victims (Frenken & Van Stolk, 1990). No systematic study has been undertaken with mental health clinicians into whether male victims are believed less frequently than female victims. However, it is clear that the nature of the reported abuse contributes to the process whereby clinicians accept that an adult male client has a history of childhood sexual abuse. The perpetrator's identity seems to be particularly important.

Abuse by females has traditionally been considered extremely rare, and only perpetrated by women who are under duress or psychotic (Lawson, 1993). Recent studies, however, have shown the proportion of boys abused by women to be surprisingly high, often over 40% of all male victims (Fromuth & Burkhart, 1987, 1989; Johnson & Shrier, 1987; Olson, 1990). Mendel (1995) speculated that this increase in identified prevalence during the 1980s and 1990s is largely a result of the greater acceptance of women as potential perpetrators and boys as potential victims, leading to the use of

more appropriate questions and methodologies. Underpinning this whole topic is the issue of whether or not male clients make such disclosures. It should be remembered that there is evidence to suggest that it may be only in long-term therapy that adult males will trust their therapist sufficiently to reveal abuse perpetrated by a female (Lawson, 1993).

The process of disbelief is well illustrated by a patient series study by Krug (1989). In a sample of eight males who alleged abuse by their mothers, Krug initially disbelieved the claims as fantasies rather than real memories, before discovering evidence that confirmed the abuse. He found no evidence to suggest that the mothers in that sample were psychotic. In a review of the literature, Lawson (1993) found that mother-son sexual abuse tends not to be reported to the authorities, but when it is reported it is largely ignored or not included in statistics. Although there may be a particular "blind spot" regarding the recognition of possible female-male abuse, there is also anecdotal evidence that males' claims to have been abused by other males are frequently disbelieved (Langsley, Schwartz, & Fairbairn, 1968; Nasjleti, 1980).

Clinicians' responses to disclosure of childhood sexual abuse. Finally, as well as the dangers of disbelieving and discounting claims of being abused, one should consider the clinician's response when a male client discloses a history of childhood sexual abuse. It has been suggested that some clinicians may believe that males are not damaged by that experience. There may be complicity between clinician and client that the abuse was experimentation, or an early entry into manhood (Bolton et al., 1989). Clinicians may too readily accept a male client's denial of his experience as abusive, or denial that it relates to the presenting psychological problems.

There is research evidence to suggest that some clinicians believe childhood sexual abuse is a less damaging experience for males than it is to females. In a study of British nurses, health visitors and medical students, Eisenberg, Owens, and Dewey (1987) found that a substantial minority of clinicians (33%) felt that females would be more affected by sexual abuse than males. Father-daughter incest was ranked as more serious than father-son incest, and mother-daughter incest was ranked as more serious than mother-son incest. In a study of court cases, Pierce and Pierce (1985) found that boy victims were provided with significantly less counselling than girls, even though perpetrators of sexual abuse on males were significantly more likely to be imprisoned. Finally, in a study using vignettes, Broussard and Wagner (1988) found that attribution of responsibility for the abuse was not significantly different for male compared to female victims. However, they did find significant interactions with the gender of the judges (who were students): male judges attributed more blame to male victims and less blame to their abusers. In addition, when a male victim's response was manipulated to appear encouraging of the abuse, perpetrators were seen as less responsible than when the victim's response was resisting or passive. In contrast, this manipulation had no effect where the victim was female. A similar study conducted on clinicians would be valuable as a test of the hypothesis that male clinicians are more likely to collude with male victims in order to deny the impact and abusive nature of the victim's experiences.

CONCLUSIONS

This review has considered the literature on adult males who have been victims of childhood sexual abuse, in order to explain why the number of male clients who report such experiences is low (relative to both the number of males who have been

abused and the identification rate in females). Four possible explanations were considered.

First, it was shown that childhood sexual abuse has a similar psychological impact upon male and female adults, indicating that one cannot conclude that men are referred less often for psychological help because the experience has only a minor impact on them. Therefore, the severity of impact cannot account for the imbalance in identified cases. Second, boys who are sexually abused may go on to develop characteristics that lead them to be seen in adulthood by services other than the helping professions (e.g., the criminal justice system). However, the influence of this factor is not sufficient to explain the imbalance in identified cases in clinical practice. Third, it has been shown that males disclose their experiences of childhood sexual abuse less often than females, a factor that will certainly have some influence upon the relatively low number of males who are identified. Finally, it has been demonstrated that clinicians are less likely to suspect or enquire about histories of childhood sexual abuse in adult male clients. Even where such cases are identified, clinicians are less likely to believe in the disclosure or to treat it as an issue for therapy. The remainder of this review will consider the social processes that might account for these conclusions, and will address their clinical implications.

The Social Construction of the "Problem" of Male Victims of Childhood Sexual Abuse

The social constructionist approach maintains that reality is not self-evident, stable, and waiting to be discovered, but is constructed. Reality is a product of human cognition, and is defined by the ways that people talk about the world (i.e., by discourses) (Von Glaserfeld, 1984). These ideas are not new. In the early 18th century, the Italian philosopher Giambattista Vico made the statement *verum ipsum factum*—"truth is the same as the made" (Von Glaserfeld, 1984). However, it is only in the last 25 years that sociology and (belatedly) psychology have started to apply these ideas to social, personal and interpersonal problems. Blumer (1971) argued that it is an error to locate social problems in objective conditions, saying that:

> Social problems have their being in a process of collective definition. This process determines whether social problems will arise, whether they become legitimated, how they are shaped in discussion, how they come to be addressed in official policy, and how they are reconstituted in putting planned action into effect. (Blumer, 1971, p. 298)

He concluded that social problems go through a developmental process, starting with emergence (or recognition) and ending with the implementation of policy decisions aimed at bringing about their alleviation. Of particular relevance to the themes discussed in this paper are his comments on emergence:

> A social problem does not exist for a society unless it is recognized by that society to exist. In not being aware of a social problem, a society does not perceive it, address it, discuss it, or do anything about it. The problem is just not there . . .. The pages of history are replete with instances of dire social conditions unnoticed and unattended in the societies in which they occurred. (Blumer, 1971, pp. 301–302)

The problem of child sexual abuse undoubtedly has a history dating back centuries, but it did not become noticed and emerge in the field of psychiatry until the late 19th century (van der Kolk & Van der Hart, 1989). Even then, its emergence did not lead to its legitimisation as a problem worthy of the attention of psychiatry, psychology or society in general. Freud's rejection of the seduction theory in favour of theories based on fantasy and the Oedipus complex has been cited as instrumental in this process (Finkelhor, 1984; Masson, 1984).

Spector and Kitsuse (1987) emphasise the role of claims-makers in the identification and social construction of problems. Without the activities of the feminist movement as the claims-makers of the issue of child sexual abuse, it would not have been identified and legitimised as a social problem in the 1970s. Blumer (1971) argued that social legitimacy is acquired when a problem gains recognition through being part of public discussion in arenas such as the press and other media, health and social services, and assembly places of officialdom. The feminist movement enabled this discussion, and in turn permitted policy decisions to be made to address the problem of childhood sexual abuse. However, social constructionism also emphasises the need to study the values of the claims-makers, and the relationship between the claims-makers and the claims made.

It is clear that male victims of childhood sexual abuse have benefitted from society's greater awareness of the general problem of sexual abuse. However, it is also clear that the social construction of the problem of sexual abuse of males has lagged behind the process for female victims. The feminist sponsorship of the movement to increase awareness of sexual violence and abuse focused attention on male perpetrators and female victims. Male victims have not had a lobby group to assist them specifically, or indeed a developed ideology from which to make their claims or from which others might make claims on their behalf. The social construction of males (as people who are competent, dominant, able to protect themselves, invulnerable, and not needing help) does not match the experience of the sexually abused male, and does not lead easily to claims for help. Males have not readily been perceived as victims: their role in the ideology of sexual abuse has been that of victimizers. The dominant ideologies have also precluded contemplation of women as abusers, and of males as suffering adverse effects following sexual activity with older and more powerful females.

Social constructionist models predict that there will be an escalation in the number of identified cases as professionals and members of society increasingly become aware of the existence of a problem. This is what has happened regarding female victims of child sexual abuse. In the US, there has been an increase from 6,000 cases of sexual abuse referred to child protection services in 1976 (3% of all maltreatment cases) to almost 500,000 (17%) in 1992 (Mendel, 1995). Although the identification of male victims is lagging behind, there is also evidence of an increase in reported cases in the male population. Spencer and Dunklee (1986) have noted a year by year increase in the proportion of males evaluated for sexual abuse at a children's hospital, from less than 1% of all referrals in 1979 to 14% in 1984. The ratio of male to female child sexual abuse appears to be decreasingly divergent as new studies are published each year (Mendel, 1995; Watkins & Bentovim, 1992). Improved awareness among health professionals, social services, and society in general regarding male victims of childhood sexual abuse may be the dominant factor in explaining these changes. In order to enable more males to access help, professionals, victims and society in general need to open their eyes, uncover their ears, and speak of the "evil" of male sexual abuse.

Clinical Implications

Of course, recognition of the problem is only the first step. Next, one must consider what action needs to be taken. First, there has been a need to overcome a succession of myths about female victims of childhood sexual abuse in the last century. These have included: girls are not abused; girls' claims of abuse are fantasies rather than realities; girls are only abused by strangers, not by family members; only a very small minority of girls are abused; abuse has no (or only a minor) damaging effect on girls; and abused girls are "no angels." These same myths have been applied to male victims, but have not been challenged so vociferously or successfully. It is incumbent on all of us to challenge our own assumptions, and the assumptions of others, about male victims of sexual abuse. We need models that address the vulnerability and lack of power of all children, not just girls.

Second, the social constructionist approach helps us to recognise that what we observe is influenced by what we think: we see what we expect to see, or are open to seeing. As clinicians, we need to believe in, think about, and feel the horror of sexual abuse and its consequences in boys (Boyd & Beail, 1994). Only then will we be in a position to be of help to the abused boys and men who present to our services. As researchers, we need to be prepared to ask questions of males that have so far been confined to females. Only then will we obtain a fuller picture of the extent and effects of sexual abuse on males.

Third, we need to be aware of the indicators of possible sexual abuse in adult male clients, particularly as many cases involve a disguised presentation and the men do not readily disclose their abuse. In conjunction with this awareness, we need to think about how to facilitate disclosure of childhood sexual abuse in male clients. Addressing issues of masculinity appears to be of key importance to this process. We need to ensure that we have the skills and confidence to enable issues of masculinity to be a focus for therapy, both as a prelude and conjoint to discussion about the abuse. A lack of enquiry about early sexual experiences risks reinforcement of the victim's denial and shame. Therapists should model a willingness to listen to and talk about early abusive sexual experiences (Hunter & Gerber, 1990; Johanek, 1988). A negative response to disclosure, such as disbelief and minimalisation, has been associated with increased disturbance in female victims (Browne & Finkelhor, 1986; Waller & Ruddock, 1993). It is likely to be similarly damaging for male victims. Overall, we need to utilise our knowledge and expertise with female victims in our efforts to help male victims, but we also need to be aware of gender differences and to adapt our techniques as appropriate.

Finally, whereas the issue of female child sexual abuse has gone through the various stages of becoming a collectively defined social problem, the issue of male victims is still at the stage of acquiring social legitimacy. Clinicians can assist this process through incorporating the issue of male victims into academic and public debate (through the publication and dissemination of research findings, through lobbying, and through access to the media and other means of mass communication). The claims-makers for male victims of sexual abuse are unlikely to be the victims themselves, due to the multi-faceted aspects of the stigma associated with being a male victim. If we are unwilling to take this role, the problem may not acquire social legitimacy or attract the funding and services needed to address it. In addition, the stigma, taboo and feeling of being "the only one" will continue, and will prevent males from coming forward to

access help. Myths such as "males are not abused" or "males are not affected by their abuse experiences" can only flourish in such an environment.

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