SEXUAL VICTIMIZATION OF BOYS: AN ONGOING STUDY OF AN ADOLESCENT MEDICINE CLINIC POPULATION

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An ongoing clinical research project on sexual victimization of boys was begun in 1982. The study population is boys aged 12 to 21 years attending an adolescent medicine clinic for reasons other than having been sexually abused. More recently, comparison populations have been obtained from a sexual abuse clinic, from an adolescent medicine clinic for girls, and from a group of adolescent sexual offenders.

The authors first became interested in young male sex victims because of the sparsity of information available in the literature on this population.[1] Most studies did not distinguish child victims by sex, and also frequently focused on skewed populations such as those drawn from psychiatric clinics, from the justice system, or from those presenting with complaints of having been sexually abused. Further, a number of prevalent misconceptions about young male victims appeared to exist that did not fit with the experiences in the adolescent medicine clinic—among them, that young male victims are uncommon, that the traumatic psychological impact of male sexual molestation is not particularly severe, and that female molesters of boys are rare. The most recent and comprehensive review of the theoretical and clinical literature on child sexual abuse in particular and the male adolescent victim and the female molester in specific was published by Finkelhor in 1984.[1]

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METHODS

Study Population

The Division of Adolescent Medicine of the New Jersey Medical School's Department of Pediatrics has provided outpatient services for adolescents since 1976. There are separate clinics for male and female patients, and about 500 male patients are seen each year. The patients visit the clinic for a variety of physical and psychosocial complaints and for post-hospitalization care. Most of the adolescents are seen at each visit by the same male health care provider, who is also the director of the Division.

During the first or second clinic visit, each patient has a complete physical examination preceded by an interview conducted by the examining physician. A complete medical and psychosocial history is obtained, including the following questions:

1. Are you sexually active?
2. If you are active, are you sexually active with individuals of the same sex, the opposite sex, or both sexes?
3. Have you ever been raped, sexually abused, or forced to engage in a sexual act?
4. Are you satisfied with your current sexual status?

In the event a youngster reports a history of sexual victimization, details of the experience are obtained about the molester, the actual experience(s), and the self-perceived acute and long-term impact. Counseling is provided as indicated.

Based on initial findings, in the second phase of the study a 31-question semistructured interview was developed to provide additional information, both demographic and about the molestation and its impact.

In the first phase of the study a retrospective chart survey was done on all adolescent male patients attending the clinic between 1976 and 1982. Forty adolescents reported having been sexually assaulted by a man prior to puberty and were compared with a number of variables with an age-matched control group of 40 male adolescents who denied molestation experiences.[2] In the next phase of data collection, from 1982 to 1984, the study population was broadened to include male adolescents molested by young women and male adolescents molested after puberty in addition to those molested by men prior to puberty. The original study population was thus increased by adding 11 male adolescents molested by women and 14 male adolescents molested by men and the newly developed semistructured interview also was implemented.[3]

In the last two years, while continuing to add to the sample of male victims molested by women and those molested by men, the study project has expanded to include three additional groups. These are boys who have been seen in a sexual abuse clinic—the Children of Rape Trauma Syndrome (CORTS) clinic—where they were referred because of a presenting complaint of sexual abuse; adolescent girls seen in the adolescent medicine clinic who report having been sexually abused; and adolescent sex offenders referred for evaluation and/or counseling related to their alleged sexual offenses. Some of these adolescent sex offenders also reported having been sexually molested.

A chi-square contingency table was used to test the statistical significance of the results.

RESULTS

In phase one of the study the 40 male adolescents molested by men during prepuberty were compared with a control group (Table 1).[2]

Despite the fact that the age range of boys seen in the clinic was 12 to 21 years, no adolescent under 15 years of age reported having been sexually assaulted, and only six of the 40 were under the age of 17, so it was primarily the late adolescent who was willing to admit to having been sexually molested. The mean age at the time of the sexual assault was 7.6 years, with a range of 5 to 12 years. Thirty of the 40 boys reported that their molestation had occurred in early latency (age 6 to 8 years).

TABLE 1. STUDY AND CONTROL GROUP CHARACTERISTICS

Characteristics	Study Group (n = 40) No. (%)	Control Group (n = 40) No. (%)
Age range (years)	15 to 21	15 to 21
Mean age (years)	17.7	17.7
Racial/ethnic group		
Black	32 (80)	31 (77.5)
Hispanic	4 (10)	4 (10)
White	4 (10)	5 (12.5)

None of the 40 patients presented with chief complaints relating to sexual victimization (Table 2). Nearly 70 percent presented for general medical care and normative adolescent psychosocial problems. However, nearly one quarter of the study group, compared with only 7.5 percent of the control group, presented with sexually related psychosocial problems. These included confusion about sexual orientation, problems with interpersonal relationships, and problems with sexual performance. The difference approached but did not reach statistical significance.

The assailant was most frequently someone known to the patient. Nine of the assaults were by a total stranger, six by a casual acquaintance, and the remainder (25) were by a well-known and trusted adult. Six of the latter were relatives, including three older cousins, two fathers, and an uncle.

Only three of the 40 subjects reported having been molested on more than one occasion. Two experienced molestation twice, and one was repeatedly molested over a six-year period by a single assailant.

Only six of the 40 patients reported having told anyone about the molestation prior to the clinic interviewer. The 34 patients who had not previously revealed the assault gave the following reasons: they had wanted to forget about the incident; they had wanted to protect the assailant; or they were afraid of the reactions of their peers and family.

Most striking was the finding that members of the study group identified themselves as currently ho-

TABLE 2. REASON FOR CLINIC VISIT

	Study Group (n = 40) No. (%)	Control Group (n = 40) No. (%)
General medical care	15 (37.5)	23 (57.5)
Normative adolescent psychosocial problems	12 (30)	13 (32.5)
Sexually related psychosocial problems	9 (22.5)	3 (7.5)
Other	4 (10)	1 (2.5)

TABLE 3. STATED SEXUAL ORIENTATION OF THE STUDY AND CONTROL GROUPS

Sexual Orientation	Study Group (n = 40) No. (%)	Control Group (n = 40) No. (%)
Heterosexual	17 (42.5)	36 (90)
Homosexual	19 (47.5)	3 (7.5)
Bisexual	4 (10)	1 (2.5)

TABLE 4. AGE AND RACE OF BOYS MOLESTED BY WOMEN AND BY MEN

	Boys Molested by Women (n = 11) No. (%)	Boys Molested by Men (n = 14) No. (%)
Age at time of reporting (years)		
Mean	18.2	18.2
Range	14–24	15–24
Age at time of molestation		
Mean	11.9	10.0
Range	5–17	4–16
Race		
Black	6 (55)	11 (79)
Hispanic	2 (18)	1 (7)
White	3 (27)	2 (14)

mosexual nearly seven times as often and bisexual nearly six times as often as the control group (Table 3). This difference was highly significant at the .0001 level. In addition, nonorganic sexual dysfunction was identified as a problem in 25 percent of the study group compared with only 5 percent of the control group, significant at the .05 level (Table 4). Nonorganic sexual dysfunction included inhibition of libido, premature ejaculation, erectile dysfunction, and failure to ejaculate.

Twenty-four out of 40 (60 percent) of the study group reported that the molestation had had a significant impact on their lives. This subgroup included all of those who complained of sexual dysfunction and all four bisexual patients.

In the second phase of the study in which an additional 25 molestation victims were identified—11 cases of boys molested by young women and 14 cases of boys molested by men—more detailed information was obtained, particularly about the nature of the molestation experiences and its impact on the victim. The focus was primarily on comparing the female- and male-molested groups and in determining whether the results of the initial study could be confirmed and expanded.[3]

The female-molested group and the two male-molested groups were all of comparable age at the time of the initial visit to the adolescent medicine clinic (Table 4). The only notable difference between the female- and male-molested boys was that twice as many of the female-molested boys were Hispanic or white, a finding for which there is no known explanation.

The mean age for the molesters, both male and female, was 26 years, with an age range of 16 to 36 years for female molesters, and 15 to 45 years for male molesters. The female molester was far less likely to be a relative or a stranger and far more likely to be an acquaintance (8 out of 11 cases). Most often she was a neighbor, a babysitter, or other trusted older adolescent or young adult. The 14 male molesters were nearly equally divided among relatives, acquaintances, and strangers.

The molestation experience with both male and female molesters involved a variety of sexual acts including fondling, mutual masturbation, and oral, anal, and genital activities. Most commonly, multiple types of acts were performed. In 10 out of the 11 female molestations, the molester persuaded the victim to comply rather than using physical force or threats. In contrast, one half of the male molesters used physical force or threats. More than one half of the female molestations occurred more than once, compared with only one third of the male molestations. Three quarters of the female molesters attempted to get their victim to ejaculate, and nearly one half succeeded in doing so. In contrast, only one third of the male molesters attempted to produce ejaculation in their victim, and they succeeded with

only 20 percent of the boys. Some of this difference may be accounted for by the slightly older age of the female-molested victims, with more of the boys having reached puberty. Five out of the 14 male-molested victims told someone about the experience, compared with only two out of the 11 female-molested victims.

In terms of current sexual dysfunction (Table 5), approximately one quarter of the victims, whether male- or female-molested, in contrast to only 5 percent of the control sample, reported nonorganically based dysfunction as previously defined. Slightly fewer of the female-molested victims (21 percent) and slightly more of the male-molested victims (25 percent of the original 40 boys and 28 percent of the more recent sample) had such complaints, but the numbers studied are small and the difference not significant.

In terms of current sexual identify (Table 6), findings with the 14 male-molested boys confirmed the earlier findings with the 40 boys that approximately one half of the victims currently identified themselves as homosexual and often linked their homosexuality to their sexual victimization experience(s). The female-molested group, in contrast, seemed no more likely to identify themselves as homosexual than the control group of nonmolested adolescents, though there was some increase in bisexuality in both male- and female-molested boys.

In regard to the effect of the sexual molestation, both in recollecting the immediate effect and in reporting the current self-perceived impact on the victim's life, no significant differences were noted between the male-molested and female-molested boys. The majority of both groups experienced the molestation as having had an intense traumatic impact on their lives, both at the time of the experience and at the time of reporting several years later. A four-point scale was used, ranging from "devastating" to "strong" to "some effect" to "not much effect." Seventy-three percent of the female-molested boys (8 out of 11) and 64 percent of the male-molested boys (9 out of 14) recalled the immediate impact as strong or devastating. At the time of reporting, sometimes more than ten years later, 54 percent (6 out of 11) of the female-molested boys and 50 percent (7 out of 14) of the male-molested boys found the experience continued to have a strong or devastating effect on their lives.

TABLE 5. SEXUAL DYSFUNCTION IN BOYS MOLESTED BY WOMEN OR MEN COMPARED WITH UNMOLESTED CONTROLS

	Boys Molested by Woman (n = 11) No. (%)	Boys Molested by Men (n = 14) No. (%)	Controls (n = 25) No. (%)
Sexual dysfunction			
Yes	3 (21)	4 (28)	1 (4)
No	8 (79)	10 (72)	24 (96)

TABLE 6. SEXUAL IDENTITY OF BOYS MOLESTED BY WOMEN OR MEN COMPARED WITH UNMOLESTED CONTROLS

	Boys Molested by Women (n = 11) No. (%)	Boys Molested by Men (n = 14) No. (%)	Controls (n = 25) No. (%)
Sexual identity			
Heterosexual	8 (72)	6 (43)	23 (92)
Homosexual/ bisexual	3 (28)	8 (57)	2 (8)

DISCUSSION

The identification of 11 male adolescents who reported having been molested by women during the same two-year period in which 14 male-molested adolescents were identified suggests that female molestation of boys is not an uncommon experience. Though the study sample is small, the findings are similar to those of Fritz, Stoller and Wagner,[4] who found that of the 4.8 percent of undergraduate psychology male students who reported childhood sexual victimization, 60 percent were by women. These percentages of female molestation of boys are significantly higher than those found in other retrospective surveys, which range from 14 to 27 percent.

Nevertheless, it is highly questionable to try to estimate the incidence and prevalence rates of sexual molestation, by either sex, in an adolescent medicine clinic population of approximately 500 patients per year. Almost certainly, those adolescents who admit to having been sexually molested represent only a portion of the true numbers, if for no other reason than that no boy under the age of 14 years and few under the age of 17 years admitted to having been molested, although most of the molestations occurred during the early school-age years.

The findings of the high rate of homosexuality in the study population are a confirmation of Finkelhor's

1979 college student survey,[1] in which nearly half of the men who reported "a childhood sexual experience with an older man were currently involved in homosexual activity." It was Finkelhor's impression that the boy who has been molested by a man may label the experience as homosexual and misperceive himself as homosexual based on his having been found sexually attractive by an older man. Once self-labeled as homosexual, the boy may later place himself in situations that leave him open to homosexual activity. It should be emphasized that the vast majority of homosexuals do not report childhood sexual experiences and also that the vast majority of male pedophiles do not regard themselves as homosexual.

The finding that the majority of the male- and female-molested boys in the study experienced the molestation as strongly or devastatingly traumatic, even years after the experience, is noteworthy. The group studied represents a community-based population not drawn from mental health, social service, or criminal justice sources. The traumatic impact of their experiences cannot be attributed to the interventions of any protective, health, or mental health agencies. It appears—and this has been found in studies of adult female rape victims—that the impairments suffered by the victims are primarily in the areas of sexual identity, sexual functioning, self-esteem, and interpersonal relationships.

In the third phase of the study, while the sample of male- and female-molested boys was continuingly expanding, three other populations were considered as well for purposes of comparison. The first undertaking of this phase has been a retrospective chart survey on young male victims who were referred to a sexual abuse clinic between 1983 and 1985. The sexual molestation experience for those boys was reported close to the time the abuse occurred, and the referral was made specifically because of the molestation, in contrast to the adolescent medicine clinic population, where the abuse was picked up in routine history-taking that had occurred, in most cases, many years previously. Thirty-seven boys were identified who had been referred to the CORTS clinic, a program based in a tertiary care pediatric hospital in Newark, NJ. The intention is to compare this group with the 25 boys (14 male-molested, 11 female-molested) identified in the adolescent medicine clinic around the same period. Unfortunately, the data from the CORTS clinic cases are less complete than that obtained with the adolescent medicine clinic study population, and another sample of boys referred specifically for sexual abuse was being sought for comparison with the study population. The data obtained are still in process of being analyzed, but it appears that the CORTS clinic group consists of very different subsamples of sexually abused boys with more signs of physical trauma and more chaotic family backgrounds.

Second, a population of girls from the adolescent medicine clinic is being collected, using similar collection procedures, to see how they differ from the boys. The data are only in a very preliminary phase of collection, but one striking difference is that most of the girls previously reported their molestations to a sexual abuse clinic in contrast to none of the boys. Differences between the boy and girl victims—in terms of the nature of the abuse, of the molester, and of the short-term and long-term impact—will be examined.

Finally, data are being gathered on a third population that may ultimately become a major focus of this multi-phase study. These are male adolescent sex offenders, some of whom were also sexual molestation victims. These offenders appear to fall along a spectrum ranging from single episodes more in the nature of experimentation by a generally well-functioning young adolescent to repetitive incidents by a more psychologically impaired youngster. From a review of the literature, it is clear that the adolescent sex offender population needs to be much more thoroughly studied from many perspectives. Also, male adolescents who were molested but who did not go on to molest others may be studied in comparison with those who did become sex offenders to see if differences along a variety of variables can be delineated.

In considering the initial study population, it would also be desirable to learn more about those boys who were highly traumatized by their experience and those who were not particularly affected, and the factors that made for the difference.

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