

Professional responses to male survivors of childhood sexual abuse: A literature review on current research and professional practice.

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ABSTRACT

Professional approaches to working with male survivors of sexual abuse have been questioned by some social agencies advocating for and supporting male survivors of sexual abuse [MSSA] as well as MSSA themselves. This literature review set out to consider the evidence for and against addressing male childhood sexual abuse [MCSA] inside the mental health system. After considering the research of four databases debate of this issue was not found. Instead researchers seemed to agree that childhood sexual abuse [CSA] has both long and short term effects for both male and female survivors which should be considered by professionals both inside the mental health system, and in community settings. The research suggests however that there is a continuing discrepancy between theory and practice. According to the literature health professionals (psychologists, psychiatrists and nurses) and social work professionals follow common discourses about stereotypes without considering the research evidence that suggests screening and consideration of CSA are critical in assessment and treatment of mental health and social problems of clients. Consideration of the code's of ethics for psychologists, psychiatrists, nurses and social workers lead to the conclusion that these professions have a responsibility to screen and address MCSA, educate themselves, promote and conduct research on MCSA, as well as bring the issue to the attention of society at large.

INTRODUCTION

An enquiry into Male childhood sexual abuse [MCSA] will lead to the realisation that [CSA] of men is common (eg. Dhaliwal, Gauzas, Antonowicz, & Ross, 1996, p. 619; Dube, Anda, Whitfield, Brown, Felitti, Dong, & Giles, 2005, p. 434 & 436). Statistical data shows that between one in four and one in three victims of childhood sexual abuse are males. Fieldman and Crespi (2002, p. 145) suggest that one in four girls and one in ten boys fall victim of sexual abuse. Dube, et al. (2005, p. 430 & 434) state that sixteen per cent of males and twenty-five per cent of females are victims of sexual abuse.

In more targeted "at risk groups" statistical evidence suggests that the ratio between males and females who experienced CSA is even closer. Molnar, Shade, Kral, Booth, and Watters (1998, p. 213) found that among street youth seventy per cent of females and thirty-five per cent of males reported CSA. Targeted research into homeless men found that 55.6 per cent were victims of CSA with most experiencing re-victimisation in the form of adult sexual abuse (Kim, Ford, Howard, & Bradford, 2010, p. 43). Johnson, et al, (2006, p. 75) discovered that fifty-nine per cent of male prison inmates disclosed being childhood survivors of CSA. In New South Wales prisons sixty-five per cent of male and female inmates are victims of CSA (Community Affairs Reverences Committee, 2004, p.168).

Some researchers now believe that statistics indicate half of childhood victims are male due to underreporting of the crime by male survivors (Crome, 2006, p. 2; Holmes, & Offen, 1996, p. 497; Hopper, cited in Ouellette, 2009, p. 70-71; Knoppas as cited in Feiring, Taska, & Lewis, 1996, p. 775; Maikovich-Fonga, & Jaffee, 2010, p. 435; O'Leary, & Gould, 2009, p. 952-953). One common explanation for underreporting of MCSA is cultural stereotypes related to masculinity and in particular the sex role socialisation of males (eg. Crome, 2006, p. 5; Mendel; Paine and Hansen, as cited in O'Leary, & Gould, 2009, p. 952). Another theory is that MSSA are not believed by professionals when they disclose (Rubin & Thelen, as cited in O'Leary, & Gould, 2009, p. 952).

SHORT AND LONG TERM EFFECTS OF CSA AND A COMPARISON OF GENDER

Despite the high statistics of MCSA, research in the area of MCSA has recently been described as a new discovery (O'Leary, & Gould, 2009, 953). Since female childhood sexual abuse [FCSA] has received more research attention, an enquiry on relevant professional responses of MCSA demands identifying gender differences of different affects and treatment options. There is however not only a lack of male specific research but also a lack of gender comparative research (Dube, et al. 2005, p. 430). This results in ambiguity and inconsistency regarding the long term effects on MSSA, as well as relative uncertainty about

the appropriate treatment options (Dhaliwal, Gauzas, Antonowicz, & Ross, 1996, p. 636-637).

In a representative gender study Silverman, Reinherz, and Giaconia, (1996, p. 709) found that eighty per cent of CSA's fit the diagnostic criteria of at least one psychiatric disorder. This is supported by Maniglio (2009, p. 647), Warne and McAndrew, (2005, p. 679) who also describe CSA as a risk factor for medical, psychological, behavioural, and sexual disorders for both sexes. Chen et al., (2010, p. 625) suggest that the psychological consequences of CSA can be lifelong in both sexes. Wilson's enquiry led her to conclude that the evidence for various psychological problems among CSA survivors is robust (2010, p. 57).

CSA has been identified as contributing to the development of various mental illnesses and disorders (Collins, 1995, p. 4-5; Maikovich-Fonga, Jaffee, 2010, p. 435; Maniglio, 2009, p. 647; Roberts, O'Connor, Dunn, & Golding, 2004, p.525). Psychological disorders associated with CSA include post-traumatic stress disorders [PTSD]: (Chen, et al., 2010, p. 620-621; Endrass & Rossegger, n.d., S57-03; Silverman, Reinherz, & Giaconia, 1996, p. 709), borderline personality disorders [BPD]: (Endrass & Rossegger, n.d., S57-03; Widom, Czaja, & Paris, 2009, p. 433), anxiety disorders (Chen, et al., 2010, p. 620-621), depression (Chen, et al., 2010, p. 620-621; Silverman, Reinherz, & Giaconia, 1996, p. 709; Wilson, 2010, p. 56), eating disorders (Chen, et al., 2010, p. 620-621; Wilson, 2010, p. 56), sleep disorders (Chen, et al., 2010, p. 620-621), and obesity (Wilson, 2010, p. 56).

The shame resulting from CSA can limit a survivors' social adjustment (Feiring, Taska, & Lewis, 1996, p. 767). These social adjustment difficulties associated with CSA include: marrying an alcoholic (Dube, et al., 2005, p. 434), family and relationship problems linked to a CSA history, (Dube, et al.,2005, p. 434). Related to the social issues is addiction and illicit drug use of survivors (Dube, et al., 2005, p. 434) (Endrass & Rossegger, n.d., S57-03; Wilson, 2010, p. 56); alcohol problems, (Dube, et al., 2005, p. 434; Endrass & Rossegger, n.d., S57-03), gambling (Endrass & Rossegger, n.d., S57-03), sexual risk taking (Endrass & Rossegger, n.d., S57-03; Paula, Cataniaa, Pollacka, & Stallb 2001, p. 557; Smith, & Ford, 2010, p. 87; Welles, Baker, Miner, Brennan, Jacoby, Rosser, 2009, p. 1079) and suicide attempts (Chen, et al., 2010, p. 620-621; Dent-Brown, 1993, p. 329; Dube, et al., 2005, p. 434; Silverman, Reinherz, & Giaconia, 1996, p. 709). O'Leary, and Gould (2009, p. 950) argue that sexually abused men are ten times more likely to attempt suicide than the control group in their research. In addition to these issues Gill and Tutty (1997, p. 31) found that male survivors frequently struggle with their gender and social sex role identity; this issue will be discussed further later.

Recent research suggests that the long term effects of CSA are similar for men and women (eg. Banyard et al. cited in Dube, et al. 2005, p. 435; Chen, et al., 2010, p. 620-621; Dube, et al. 2005, p. 435; Endrass & Rossegger, n.d., S57-03; Maikovich-Fonga, Jaffee, 2010, p. 429; O'Leary, & Gould, 2009, p. 951-952). Maikovich-Fonga and Jaffee's research led them to argue that while gender differences between the context of abuse itself were likely,

the effects in relation to trauma symptoms of the CSA's do not differ between genders (2010, p. 429). Maikovich-Fonga and Jaffee accept the possibility that specific psychopathology symptoms may vary (as their research was too broad to consider specific psychopathology symptoms) but argue against gender differences on a universal level (p. 435). Crome similarly concludes that in relation to different treatment approaches there is room for debate but states that the practical approach to treatment and the principles of treatment are similar for both genders (2006, p. 5-6). Crome further suggests that decisions of practice approaches should be client led (Crome, 2006, p. 5-6).

Some researchers point to different coping strategies of genders (eg. Chandy, Blum, & Resnick cited in Dube, et al., 2005, 435; Feiring, Taska, & Lewis, 1996, p. 776; Rew et al. cited in Dhaliwal, Gauzas, Antonowicz, & Ross, 1996, p. 627.); These authors argue that MSSA use external coping strategies such as aggressive, antisocial behaviours listed above, while female survivors of sexual abuse [FSSA] use internalised coping strategies such as emotional and expressive techniques.

However, this research has its critics. Dube, et al. (2005, p. 435) Dhaliwal, Gauzas, Antonowicz, and Ross (1996, p. 628) point to research enquires into the social and psychological effects of CSA and conclude that both external and internal coping mechanisms are evident in both male and female survivors. Dhaliwal, et al. accept that the difference between coping strategies may exist but proposes that female survivors of sexual abuse may have had more support from professional services that helped them develop more effective coping strategies (1996, p. 627).

One gender difference that seems to gain support from various researchers is that some MSSA's that experienced abuse during adolescence rate this experience more positively than females (Dhaliwal, et al., 1996, p. 627). Maikovich-Fonga and Jaffee, (2010 p. 435) point to Moore and Rosenthal and Durham who suggest that this is due to biological changes that increase their sexual drive at this age. However, these feelings of pleasure have been shown to have negative consequences as they create shame and contribute to the confusion of a male survivors experience and their sex role identity (Durham as cited in Maikovich-Fonga, & Jaffee, 2010 p. 435). Dhaliwal et al. also accept that some survivors rate their abuse as a positive experience but show that these men still experience the negative long term consequences associated with CSA that the non-victims in their control group did not experience (1996, p. 627-628).

PROFESSIONAL RESPONSES OF MEDICAL AND SOCIAL WORK PROFESSIONALS

In light of the current research a professional response should display awareness of the frequency of MSA. Recent statistical data from researchers such as Dhaliwal, et al. (1996,

p. 619), Dube, et al. (2005, p. 434 & 436) and Fieldman and Crespi (2002, p. 145) shows that the male to female ratio is between one in six and one in four, with the possibility of one in two due to under reporting of MCSA. In addition research does seem to indicate that while coping mechanisms may be different between male and female survivors, the effects of CSA on men and women are largely similar and there is no evidence suggesting that this should be reflected in their treatment. Furthermore professionals of all disciplines should be aware of the cultural stereotypes that affect male survivors and the general public, preventing MSSA's from disclosing their abuse (eg. Dhaliwal et al., 1996, p. 627; Fergus, & Keel, 2005, p. 3; Lab, et al. 2000, p. 400; Ouellette, 2009, p. 69). A logical response for all professionals would be to incorporate a standard enquiry about a history of CSA into needs assessments.

While debate regarding the effectiveness of different therapeutic responses exists and a gendered understanding of CSA is still limited (Fergus, & Keel, 2005, p. 3), researchers agree that professional intervention is an effective and important asset in the recovery of survivors of sexual abuse (Tingus, Heger, Foy, Leskin, 1996, p. 63; Warne, & McAndrew, 2005, p. 681). It has however been suggested that many survivors of sexual abuse and particularly males fail to receive treatment (Tingus, Heger, Foy, & Leskin, 1996, p. 36).

Holmes and Offen (1996, p. 439) questioned whether the hypothesis of clinical psychiatrists would differ between genders. These researchers found that after considering case summaries in which the gender of the patient had been changed, a significant majority of clinicians hypothesised CSA in females as contributing factor (p.493). With twenty-one of thirty-two females being hypothesised as being CSA survivors this was seen as the main hypothesis identified. In comparison only nine of twenty-nine males were given the same prognosis (p.497). Psychosis, schizophrenia, marital or family problems and strain in the relationship with parents were the main issues hypothesised for men (p.497). Holmes and Offen concluded that clinicians were reluctant to hypothesise a history of MCSA (1996, p.493).

The realisation that therapists were twice as likely to identify CSA in females than they were in males led Holmes and Offen (1996, p.497) to conclude that clinicians might have a weakness in relation to MSSA. The authors suggested that one consequence of this failure on behalf of therapists could be that the therapeutic environment this creates will prevent MSSA from disclosing their experience, as well as predetermine failure on behalf of professionals to address the needs of MSSA (Holmes, & Offen, 1996, p. 498).

Holmes and Offen (1996) suggested that the reluctance of male victims to discuss and accept their abuse which had previously been identified in different research (cited in Holmes and Offen, p. 498) is likely to be linked to the gap between therapist and patient. The researchers go on to point out that their research indicates that clinicians are apprehensive to discuss MSSA. Holmes and Offen predict that this apprehension will increase the already existing divide between therapist and MSSA during the course of therapy (p. 498). Their research prompted Holmes and Offen (1996, p. 499) to question

whether the professional response to MSSA is partly to blame for the underreporting and lack of effective treatment of MSSA. Holmes and Offen assessed that professionals display a lack of awareness regarding the issues faced by MSSA and conclude that this unawareness acts as a disincentive for male survivors of CSA to reveal their history of CSA and seek professional treatment for the consequences of CSA (p. 953).

In 2000 Lab, Feigenbaum, and De Silva, (2000, p. 391) commenced a follow up study to test the results of Holmes and Offen's research. Nurses, psychologists, and psychiatrists completed a ten question questionnaire related to MSSA (p. 391). This enquiry revealed that male patients were either never or infrequently assessed for a history of CSA (p. 391, p. 399). The professionals that did enquire about CSA were evaluated as doing so ineffectively and immethodically (p. 391). As a result of their research Lal et al. attributed part of the reason why care of MSSA is inadequate and undetected by professionals to the fact that professionals fail to question CSA histories of men (p. 399).

Lab et al. (2000) further determined that while professionals are aware that CSA exists, they fail to realise the need to enquire when assessing patients (p. 400-401). Professionals in Lab et al.'s research communicated that they did not find it important to ask males about a history of CSA. Some reasons to qualify these decisions included that CSA is not necessary for certain diagnosis, and that the belief that men have more important issues that require attention was also expressed (p. 400). This led Lab et al. to conclude that society's frequent ignorance regarding the phenomenon of MCSA is reflected by professionals and their responses to MSSA (p. 400-401). This evaluation is further reflected by Fergus and Keel (2005, p. 3) who also explain that social myths associated with CSA frequently influence professional responses.

On a positive note Lab et al. (2000, p. 401) discovered that most nurses and psychologists did take action or make referrals if CSA was discovered in male clients. Over half of clinicians conveyed that they were willing to address the issue of MCSA if they felt competent to do so (p. 401). But two thirds of professionals saw themselves ill-equipped due to lack of training (p. 401). While this suggests that some professionals are aware of MCSA and are willing to address this issue if they received the necessary training, Lab et al. also discovered that one quarter of psychiatrists communicated that not acting on the discovery of CSA in male patients is an approach they implemented (p. 402).

Lab et al. (2000, p. 404) summarised their research by pointing to their discovery that mental health professionals frequently fail to enquire about MCSA. Any methods of enquiry that are utilised are unmethodical and unsuccessful. Furthermore Lab et al. suggest that the lack of specialised training results either in inaction or practice approaches with potentially negative consequences for patients. In relation to these findings Crome (2006, p. 5) draws attention to the fact that there are limited services for MSSA.

Moreover Warne, and McAndrew,'s (2005, p. 681) literature review also reinforces the conclusions reached by Holmes, Offen, Lab and colleagues as well as Crome. Warne, and McAndrew observed that despite the fact that a high percentage of mental health patients have a history of CSA, only a minority receive treatment (p. 681). These authors argue that this represents a discrepancy between theory and practice within the mental health profession (Warne, & McAndrew, p. 681).

It is important to recognise that these findings are not only applicable to the mental health professions. Crome (2006, p.2) discovered that different professions utilised by MSSA failed to record CSA and that these records were frequently unavailable. O'Leary and Gould, (2009, p. 953) describe social work responses to MCSA that are frequently uneducated and apathetic (p. 953). Spencer and Tan (cited by O'Leary and Gould, p. 953) found that social work students were more likely to attribute blame to MSSA than they were to FSSA. The research of Spencer and Tan's tested student's assessments of hypothetical cases where only the survivor's gender was altered. O'Leary and Gould, also refer to the research of Holmes and Offen, pointing out parallels between the results of enquiry into the mental health professions and attitudes held within the social work profession (O'Leary & Gould, 2009, p. 953).

Hetherington and Beardsall (1998, p. 1265) conducted research that investigated if social workers and the police took allegations of CSA by females as seriously as allegations of male perpetration of CSA. These authors found that CSA offending by females is frequently not taken as seriously as male perpetration of sexual abuse (p. 1265). This raises questions in relation to the issue discussed above which showed that some male survivors of CSA experience a sense of pleasure particularly when the perpetrator is a female. Hetherington and Beardsall's findings not only dispose the failure of social work professionals to recognise detrimental effects of female perpetration of CSA, but they also highlight the likelihood of social workers and the police to underestimate the effects of female perpetration of CSA against boys, who then struggle with the mixed emotions related to female perpetration explained by Dhaliwal, et al. (1996, p. 627).

In her research Denov (2003, p. 47) discusses the importance of the professional response upon disclosure of CSA; her research revealed the impact of positive and negative professional responses on the wellbeing of CSA. Denov's research shows that recognition and confirmation of the CSA experiences significantly affect the wellbeing of survivors (p. 47). According to Denov the failure to acknowledge a survivor's experience of CSA results in re-victimisation while recognition of CSA had a therapeutic effect in which negative effects of CSA were limited (p. 47).

The qualitative research conducted by Denov (2003), revealed that MSSA frequently experience negative experiences when CSA is discussed with professionals. She quotes four of seven male survivors of CSA who have experienced negative responses by professionals when they sought professional help after being victims of female CSA (p. 56-57).The

negative responses of MCSA survivors discussed by Denov included developing distrust towards professionals, feeling betrayed by professionals, as well as anger towards professionals (p. 56). These responses had the effect of leaving survivors confused and questioning if their personal experience of CSA and the associated resentment is justified (p. 56).

Wood, Orsak, Murphy, and Cross (1996) conducted research at a multidisciplinary assessment centre. These researchers investigated whether there is a pattern that impacted professional acceptance of child abuse claims (p. 81). This research involved observing interviews between professionals and children identified as having a high risk sex abuse history. Wood et al. identified that the child's gender is one significant aspect that swayed assessments. CSA disclosure of girls was more likely to be believed than that of boys (p. 87). This pattern was observed even though the disclosures of boys were as detailed as those of girls (p. 89).

In conclusion of this section there are reoccurring themes observed by different researchers that deserve attention. Firstly MCSA remains an underestimated occurrence among professionals. Secondly there is an apparent reluctance to screen for CSA in male clients. Thirdly failure to address the effects of MCSA seems apparent, commonly identified reasons for this are a lack of training and disbelief that the CSA does affect males as severely as it does males. These themes represent a disparity between the researched evidence that is available so far and the practice approaches that are applied by professionals of different fields.

CULTURAL GENDER DISCOURSES AND THE EFFECTS OF MASCULINE STEREOTYPES ON MSSA

Ouellette (2009, p. 69) considered the phenomenon of MSSA and suggests some answers which are summarised discussed below. Ouellette suggests that the phenomenon of male abuse is incompatible with current dominant discourses associated with masculinity (p. 69). Lew states that this discourse has "no room for a man as victim" (Lew cited in Ouellette, 2009, p. 69). Ouellette believes that this stereotype is so ingrained in our culture that it not only affects society at large but also professionals and even MSSA themselves.

Lab, et al.'s suggestion is that professionals fail to acknowledge the phenomenon of MCSA just like the wider society (2000, p. 400). The potential that cultural stereotypes affect service delivery is also expressed by Fergus, and Keel, (2005, p. 3) who see therapeutic responses to MSSA as not having been evaluated sufficiently. One specific gender stereotype that is of particular relevance to professionals working with MSSA is the view commonly held which sees males as seeking and appreciating early sexual experiences (Dhaliwal et al., 1996, p. 627). While research does indicate an appreciation by some MSSA

when compared with FSSA the research also shows that the negative effects of CSA still remain (p. 627-628). Treatment is therefore still important.

The findings of other researchers such as Back and Lips, (1998, p.1247), Crome, (2006, p. 5) Gill, and Tutty, (1997, p. 31) also support the theory that gender stereotypes affect MSSA themselves. Crome's research revealed that men are frequently hesitant to search for help because of their sex-role socialisation (2006, p. 5). This explanation is also suggested by Lab et al (2000, p. 400) who point to societies acceptance that males pursue sex while disbelieving that women can be perpetrators of sexual abuse. This is in concurrence with gender stereotypes identified by Hetherton (1999, p. 161) that prohibit women to be seen as perpetrators of sexual abuse despite evidence by researchers such as Denov (2003, p. 47) that highlight sexual abuse by mothers. These issues contribute to the effect of underreporting identified by Crome (2006, p. 5).

According to Ouellette change therefore requires a radical shift in thinking (p. 69). Doctor Fred Matthews of Toronto Youth Services accepts that professionals fail to acknowledge males as victims because they are generally seen as perpetrators of sexual abuse (Matthews quoted by Ouellette, p. 71). A colleague of Matthews stated that the dominant discourses criticising female victims of rape that were expressed twenty years ago are comparable to those of male sexual abuse today (Ouellette, p. 71).

An example of the strength of cultural stereotypes is Graham-Kevan's observation that in the United States male victimisation by women was an unexpected consequence of mandatory arrest policies (2007, p.3). On a positive note there has been an increase of scholarly interest in men's issues in the United States since this observation.

THE NEED FOR SCREENING

The first reoccurring message that is repeatedly reiterated by researchers is the need to screen and treat all survivors of CSA (eg. Bebbington, Cooper, Minot, Brugha, Jenkins, Meltzer, & Dennis, 2009, p. 1135; Dent-Brown, 1993, p. 329; Dube, et al., 2005, p. 434; Lab, Feigenbaum, & De Silva, 2000, p. 399; & O'Leary, & Gould, 2009, p, 950; Smith, & Ford, 2010, p. 87). Chen et al (2010, p. 627) claim that only five per cent of sexual abuse victims disclose their experiences with physicians, the authors attribute this low statistic to the failure of professionals to enquire about CSA. Dent-Brown, (1993, p. 329) addresses frequent concerns of professionals that oppose enquiry into a history of CSA in initial assessments by suggesting that many survivors have waited their whole life for someone to ask that question.

Lab, et al. (2000, p. 399) emphasise the professionals aim to gain an understanding of their clients difficulties as this is seen as necessary to provide the best psychological care. Such an enquiry is seen by Lab et al. as incomplete if a history of CSA not considered.

Bebbington et al. (2009, p. 1135) and Dube et al. (2009, p. 1135) further emphasise the need for focused treatment of CSA for both genders and therefore call for routine screening.

THE NEED FOR TRAINING

The second message commonly articulated by researchers is that of a need for training. In their research Holmes and Offen identified that psychiatrists were more confident to hypothesise CSA in females than in males (1996, p. 497). Holmes and Offen pointed out research in which the lack of training regarding CSA had previously been identified (Attias & Goodwin, Frenken & Van Stolk, as cited in Holmes, & Offen, 1996, p. 498) and promote further training focused on MSSA in particular (p. 497). Holmes and Offen insist that professionals need to be aware of the possibility of CSA of male clients and the frequent reluctance of male clients to disclose their CSA.

Furthermore, awareness of commonalities between male and female CSA's is seen as essential for effective work with MSSA (Holmes & Offen, 1996, p. 499). Holmes and Offen suggest that these issues require professionals to be prepared to modify their assessment and therapy if they ought to be effective in working with MSSA (p. 499). The authors explain that as soon as FCSA became recognised by professionals the number of identified cases rose dramatically (p. 499) Holmes and Offen further found that the history of sexual abuse was identified as the central issue that needed to be addressed with female patients in therapy (p.493). These facts led Holmes and Offen to the conclusion that professionals need to change their attitude towards MSSA.

Lab et al. (2000) came to similar conclusions that Holmes and colleagues reached. The research of Lab et al. revealed that one third of mental health staff did not have training in the area of CSA and consequently feel ill-equipped to enquire about MSSA (p. 391). Lab et al. further expressed concerns about professionals that are untrained in the area of MCSA addressing this need as this is seen to potentially magnify these problems (p. 404). Consequently Lab et al join those researchers that emphasise the need for training in the area of MCSA.

After Richey-Suttles, and Remer, (1997, p. 56) tested psychologists' attitudes toward MSSA they came to the conclusion that professionals attitudes towards men impacted the blame attributed to MSSA. Psychologists that held to traditional male stereotypes were likely to attribute the blame for CSA to survivors (p. 56). Professionals with more experience in the area of MSSA on the other hand were seen as acknowledging MSSA as victims, validating that the event which took place was abuse (p. 57). These findings led Richey-Suttles, and Remer to motivate professionals that have not received training to pursue this (p. 57).

These limitations are also evident in the social work profession (O'Leary, & Gould, 2009, p. 952-953). Limited knowledge and indifference are identified as two critical shortfalls of the profession that needs to be addressed in order to provide a professional service (O'Leary, & Gould, 2009, p. 953).

THE NEED FOR RESEARCH & SCHOLARLY NEGLECT

Finally researchers point to the need for further research into the area of MCSA. There is a broad acknowledgement of scholarly neglect and an appreciation that to date most CSA research is focused on women and therefore knowledge about MCSA is limited (Crome, 2006, p.1, Feiring, Taska, & Lewis, M, 1996 p. 775; Freeman & Morris, 2001, p. 159; Graham-Kevan, 2007, p.3). MSSA on the other hand is seen as a new discovery that has only recently received some attention (Dhaliwal et al, 1996, p. 619). Dhaliwal et al. go as far as to state that: "there is a complete absence of male-specific empirical treatment studies" (p. 636). These authors therefore emphasise the need for further and larger studies to add rigour to the research that does exist (p. 636-637).

In relation to practice approaches a lack of research is also seen as adding to uncertainty (Feiring, Taska, & Lewis, M, 1996 p. 767). Researchers acknowledge that many questions regarding effective treatment options still remain. Therefore Dube et al. and Feiring et al. call for research specifically focused on the treatment of MSSA (Dube et al., 2005, p. 435; Feiring et al, 1996, p. 636-637).

Linked to questions of treatment are those about risk taking (Smith, & Ford, 2010, p. 87), coping mechanisms (Feiring, Taska, & Lewis, M, 1996 p. 767) and consequences of CSA on MSSA (Chen et al., 2010, p. 627). These are also identified as needing further attention. Hetherington (1999, 170-171) also sees future enquiries into professional responses in relation to CSA as necessary due to revelations of her research.

ETHICAL RESPONSIBILITIES OF PROFESSIONALS ACCOUNTABLE TO THE ANZASW, THE NZPS, NZMA AND THE NZNA

Lab et al.'s (2000, p. 399) argument that comprehension of a client's situation is a fundamental requirement of assisting mental health clients is reflected in both the code of ethics for the New Zealand medical profession (New Zealand Medical Association [NZMA], 2008, p.6), as well as the code of ethics for psychologists working in Aotearoa/New Zealand (Code of Ethics Review Group [COERG], 2002, p. 9). This statement can further be extended

to other professions. Social workers (Aotearoa New Zealand Association of Social Workers [ANZASW], 2008, S. 2.2) and nurses (New Zealand Nurses Association, [NZNA], 2010, p. 17) both emphasise the importance of understanding a client's circumstances and history associated with problems as an essential requirement in order to facilitate any recovery. Therefore all professions accountable to the NZMA, COERG, ANZASW or the NZNA codes of ethics should seriously consider the need for screening and treatment expressed by researchers in this literature review (eg. Bebbington, Cooper, Minot, Brugha, Jenkins, Meltzer, & Dennis, 2009, p. 1135; Dent-Brown, 1993, p. 329; Dube, et al., 2005, p. 434; Lab, Feigenbaum, & De Silva, 2000, p. 399; & O'Leary, & Gould, 2009, p. 950; Smith, & Ford, 2010, p. 87).

Furthermore these codes of ethics emphasise that individual professionals have a responsibility to continued professional development (ANZASW, 2008, S. 7.2 & 7.3; COERG, 2002, p. 10; NZMA, 2008, p.5; NZNA, 2010, p. 19). It is therefore the ethical responsibility of individuals to seek training opportunities in the area of MCSA, as various researchers have identified a lack of professional competency in this area (Holmes, & Offen, 1996, p. 498; Lab et al. 2000, p. 391; Richey-Suttles & Remer, 1997, p. 57; O'Leary, & Gould, 2009, p. 953).

In order to adequately fulfil these expectations a continued commitment to research into the MCSA is essential and also reflected in codes of ethics (ANZASW, 2008, S. 7.2; COERG, 2002, p. 10; NZMA, 2008, p.10; NZNA, 2010, p. 23). As scholarly neglect in the area of MSSA has been identified by a number of different researchers (eg: Crome, 2006, p.1, Feiring, Taska, & Lewis, M, 1996 p. 775; Graham-Kevan, 2007, p.3), it is an ethical responsibility of professionals and professional bodies to pay increased attention to MSSA in research.

Finally the codes of ethics express a responsibility of professional bodies and their members to advocate for clients/patients and to educate society at large about the issues of concern (ANZASW, 2008, S. 2.2; COERG, 2002, p. 15; NZMA, 2008, p. 9; NZNA, 2010, p. 24-25). Therefore confrontation of dominant discourses without evidence that have been identified by researchers (eg.Crome, 2006, p. 5; Dhaliwal et al, 1996, p. 627; Fergus, & Keel, 2005, p. 3; Gill & Tutty, 1997, p. 31; Lab, et al., 2000, p. 400; Ouellette, 2009, p. 69) are a further ethical responsibility according to these codes.

LIMITATIONS

The initial aim of this paper that set out to compare arguments for and against addressing MCSA in a mental health setting was not possible as such male specific research was not found for either case. This prompted focus of this review to be on research that considered gender comparisons and looked at the professional responses to MSSA. The reviewed research demonstrates that current practitioners fail to engage in debates of how to treat MSSA. Consequently the initial question of how a professional response to MSSA should look still requires

clarity. At this point the research does not allow conclusions that treatment of MSSA should differ than that of FSSA.

Time constraints and limitations of MCSA and mental health knowledge were further issues that potentially limited the depth of this literature review. Future reviews would benefit from a multidisciplinary team with experience in CSA.

Accessibility allowed only four databases to be searched and some research articles that could have been useful could only be accessed partly. These research articles were excluded as a partial perspective could have potentially generated a misrepresentation of this research.

Finally the amount of gender specific research available was very limited which made it difficult to read broadly and establish a variety of different viewpoints. The scarceness of research also prevented a comparison of international findings with local, New Zealand research.

CONCLUSION

The present literature review identified a discrepancy between theory and professional responses to MSSA. While research suggests that CSA affects males and females similarly the responses of professionals to MCSA victims suggests otherwise. Several researchers identified a lack of professional enquiry and treatment, as well as limited training and research in the area of MSA. As a result of this a case has been made that it is the ethical responsibility of social workers and mental health professionals to confront these issues.

REFERENCES:

- Aotearoa New Zealand Association of Social Workers (2008). *Code of ethics* (2nd ed.). Christchurch, New Zealand: ANZASW National Office.
- Back, S., & Lips, H. M. (1998). Child sexual abuse: victim age, victim gender, and observer gender as factors contributing to attributions of responsibility. *Child Abuse & Neglect*, 22(12), 1239–1252. doi:10.1016/S0145-2134(98)00098-2
- Bebbington, P. E., Cooper, C., Minot, S., Brugha, T. S. Jenkins, R. Meltzer, H., & Dennis, M. (2009). Suicide Attempts, Gender, and Sexual Abuse: Data From the 2000 British Psychiatric Morbidity Survey. *American Journal of Psychiatry*, 166, 1135-1140. doi: 10.1176/appi.ajp.2009.09030310
- Chen, L. P., Murad, M. H., Paras, M. L., Colbenson, K. M., Sattler, A. L., Goranson, E. N., Elamin, M. B., Seime R. J., Shinozaki G., Prokop, L. J., & Zirakzadeh, A. (2010). Sexual abuse and lifetime diagnosis of psychiatric disorders: systematic review and meta-analysis. *Mayo Clinic Proceedings*, 85(7) 618-629. doi: 10.4065/mcp.2009.0583
- Code of Ethics Review Group. (2002). *Code of Ethics for Psychologists Working in Aotearoa/New Zealand*. N.p.: Author
- Collings, S. J. (1995). The long-term effects of contact and noncontact forms of child sexual abuse in a sample of university men. *Child Abuse & Neglect*, 19 (1), 1-6. doi:10.1016/0145-2134(94)00098-F
- Crome, S. (2006). Male survivors of sexual assault and rape. *The Australian Centre for the Study of Sexual Assault*, 2. Retrieved from Australian Institute of Family Studies website: http://www.aifs.gov.au/acssa/pubs/wrap/acssa_wrap2.pdf
- Denov, M. S. (2003). To a safer place? Victims of sexual abuse by females and their disclosures to professionals. *Child Abuse & Neglect* 27(1), 47–61. doi:10.1016/S0145-2134(02)00509-4
- Dent-Brown, K. (1993). Child sexual abuse: Problems for adult survivors. *Journal of Mental Health*, 2(4), p. 329. Retrieved from CINAHL with Full Text database.
- Dhaliwal, G. K., Gauzas, L., Antonowicz, D. H., & Ross, R. R. (1996). Adult male survivors of childhood sexual abuse: prevalence, sexual abuse characteristics, and long-term effects. *Clinical Psychology Review*, 16(7), 619-639. doi:10.1016/S0272-7358(96)00018-9
- Dube, S. R., Anda, R. F., Whitfield, C. L., Brown, D. W., Felitti, V. J., Dong, M., & Giles, W. H. (2005). Long-term consequences of childhood sexual abuse by gender of victim. *American Journal of Preventative Medicine*, 28(5) 430-439. doi:10.1016/j.amepre.2005.01.015
- Endrass, J., Rossegger, A. (n.d.). Mental disorders in victims of sexual violence. *Psychiatric/Psychological Service of Criminal Justice System, Zurich, Switzerland*. doi:10.1016/S0924-9338(09)70515-2

- Feiring, C., Taska, L., & Lewis, M. (1996). A process model for understanding adaptation to sexual abuse: the role of shame in defining stigmatization. *Child Abuse & Neglect*, 20(8), 767-782. doi:10.1016/0145-2134(96)00064-6
- Feiring, C., Taska, L., & Lewis, M. (1999). Age and gender differences in children's and adolescents' adaptation to sexual abuse. *Child Abuse & Neglect*, 23(2), 115-128. doi:10.1016/S0145-2134(98)00116-1
- Fergus, L., & Keel, M. (2005). *Adult victim/survivors of childhood sexual assault*. The Australian Centre for the Study of Sexual Assault, 2, 1-6. Retrieved from Australian Institute of Family Studies website:
http://www.aifs.gov.au/acssa/pubs/wrap/acssa_wrap1.pdf
- Fieldman, J. P., Crespi, T. D. (2002). Child sexual abuse: Offenders, disclosure, and school-based initiatives. *Adolescence*, 37, 145-160. From ProQuest Nursing & Allied Health Source.
- Freeman, K. A., & Morris, T. L. (2001). A review of conceptual models explaining the effects of child sexual abuse. *Aggression and Violent Behavior*, 6(4), 357-373. doi: 10.1016/S1359-1789(99)00008-7
- Gill, M., & Tutty, L. M. (1997). Sexual identity issues for male survivors of childhood sexual abuse: A qualitative study. *Journal of Child Sexual Abuse*, 6(3), 31-47. doi: 10.1300/J070v06n03_03
- Graham-Kevan, N. (2007). The re-emergence of male victims. *International Journal of Men's Health*, 6(1), 3-6. doi: 10.3149/jmh.0601.3
- Hetherington, J. & Beardsall, L. (1998). Decisions and attitudes concerning child sexual abuse: does the gender of the perpetrator make a difference to child protection professionals? *Child Abuse & Neglect*, 22(12), 1265-1283. doi:10.1016/S0145-2134(98)00101-X
- Hetherington, J. (1999). The idealization of women: its role in the minimization of child sexual abuse by females. *Child Abuse & Neglect*, 23(2), 161-174. doi:10.1016/S0145-2134(98)00119-7
- Holmes, G., & Offen, L. (1996). Clinicians' hypotheses regarding clients' problems: are they less likely to hypothesize sexual abuse in male compared to female clients? *Child Abuse & Neglect*, 20(6), 493-501. doi:10.1016/0145-2134(96)00031-2
- Johnson, R. J., Ross, M. W., Taylor, W. C., Williams, M. L., Carvajal, R. I., & Peters, R. J. (2006). Prevalence of childhood sexual abuse among incarcerated males in county jail. *Child Abuse & Neglect* 30, 75-86. doi:10.1016/j.chiabu.2005.08.013
- Keel, M. (2005). *Adult victim/survivors of childhood sexual assault*. The Australian Centre for the Study of Sexual Assault, 2, 1-6. Retrieved from Australian Institute of Family Studies
- Kim, M. M., Ford, J. D., Howard, D. L., & Bradford, D. W. (2010). Assessing trauma, substance abuse, and mental health in a sample of homeless men. *Health & Social Work*, 35(1), 39-48. From ProQuest Nursing & Allied Health Source.

- Lab, D. D., Feigenbaum, J. D. & De Silva, P. (2000). Mental health professionals' attitudes and practices towards male childhood sexual abuse. *Child Abuse & Neglect*, 24(3), 391–409. doi:10.1016/S0145-2134(99)00152-0
- Maikovich-Fonga, A. K., Jaffee, S. R. (2010). Sex differences in childhood sexual abuse characteristics and victims' emotional and behavioural problems: Findings from a national sample of youth. *Child Abuse & Neglect* 34(6), 429–437. doi:10.1016/j.chiabu.2009.10.006
- Maniglio, R. (2009). The impact of child sexual abuse on health: A systematic review of reviews. *Clinical Psychology Review* 29, 647–657. doi:10.1016/j.cpr.2009.08.003
- Molnar, B. E., Shade, S. B., Kral, A. H., Booth R. E., & Watters, J. K. (1998). Suicidal behaviour and sexual/physical abuse among street youth. *Child Abuse & Neglect*, 22(3), 213-222. doi:10.1016/S0145-2134(97)00137-3
- New Zealand Medical Association (2008). *Code of Ethics for the New Zealand medical profession*. N.p.: Author.
- New Zealand Nurses Association. (2010). *Code of ethics: Towards improving health outcomes in New Zealand*. Wellington, New Zealand: Author.
- O'Leary, P., & Gould, N. (2009). Men who were sexually abused in childhood and subsequent suicidal ideation: Community comparison, explanations and practice implications *British Journal of Social Work*, 39, 950–968. doi:10.1093/bjsw/bcn130
- Ouellette, M. (2009). "Some things are better left unsaid": Discourses of the sexual abuse of boys. *Jeunesse: Young People, Texts, Cultures*, 1(1), 67-93. From Academic Onefile Database.
- Paula, J. P., Cataniaa, J., Pollacka, L., & Stallb R. (2001). Understanding childhood sexual abuse as a predictor of sexual risk-taking among men who have sex with men: The urban men's health study. *Child Abuse & Neglect* 25, 557–584. doi:10.1016/S0145-2134(01)00226-5
- Richey-Suttles, S., & Remer, R. (1997). Psychologists' attitudes toward adult male survivors of sexual abuse. *Journal of Child Sexual Abuse*, 6(2), 43-61. doi: 10.1300/J070v06n02_03
- Roberts, R., O'Connor, T., Dunn, J., & Golding, J. (2004). The effects of child sexual abuse in later family life; mental health, parenting and adjustment of offspring. *Child Abuse & Neglect* 28, 525–545. doi:10.1016/j.chiabu.2003.07.006
- Silverman, A. B., Reinherz, H. Z., & Giaconia, R. M. (1996). The long-term sequelae of child and adolescent abuse: a longitudinal community study. *Child Abuse & Neglect*, 20(8), 709-723. doi:10.1016/0145-2134(96)00059-2
- Smith, L. H., & Ford, J. (2010). History of forced sex and recent sexual risk indicators among young adult males. *Perspectives on Sexual and Reproductive Health*, 42(2), 87-92. doi: 10.1363/4208710
- Tingus, K. D., Heger, A. H., Foy, D. W., Leskin, G. A. (1996). Factors associated with entry into therapy in children evaluated for sexual abuse. *Child Abuse & Neglect*, 20(1), 63-68. doi:10.1016/0145-2134(95)00116-6

- Warne, T., & McAndrew, S. (2005). The shackles of abuse: Unprepared to work at the edges of reason. *Journal of Psychiatric & Mental Health Nursing*, 22(6), 679-686. doi: IO.IIIII/j.13652850.2005.00893.x
- Welles, S. L., Baker, A. C., Miner, M. H., Brennan, D. J., Jacoby, S., Rosser, B. R. (2009). History of childhood sexual abuse and unsafe anal intercourse in a 6-city study of HIV-positive men who have sex with men. *American Journal of Public Health*, 99(6), 1079-1086. doi: 10.2105/AJPH.2007.133280
- Widom, C. S., Czaja, S. J, Paris J. (2009). A prospective investigation of borderline personality disorder in abused and neglected children followed up into adulthood. *Journal of Personality Disorders*, 23(5), 433-446. doi: 10.1521/pedi.2009.23.5.433.
- Wilson, D. R. (2010). Health consequences of childhood sexual abuse. *Perspectives in Psychiatric Care*, 46(1), 56–64. doi: 10.1111/j.1744-6163.2009.00238.x
- Wood, B., Orsak, C., Murphy, M., & Cross, H. J. (1996). Semistructured child sexual abuse interviews: interview and child characteristics related to credibility of disclosure. *Child Abuse & Neglect*, 20(1) 81-92. doi:10.1016/0145-2134(95)00118-2