

**All Too Often Overlooked:
A Comparative Analysis of Child Protective Service Response to
Male Child Sexual Abuse in Pennsylvania and Georgia**

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Amsterdam, The Netherlands

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A thesis submitted in partial fulfillment of the requirement for the degree of

Masters of Public Health

by

Lorena Gonzalez

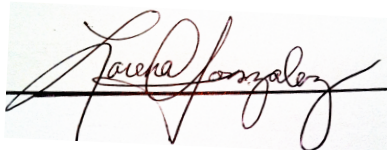
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Declaration:

Where other people's work has been used (either from a printed source, internet or any other source) this has been carefully acknowledged and references in accordance with departmental requirements.

The thesis *All Too Often Overlooked: A comparative Analysis of Child Protective Services Response to Male Child Sexual Abuse in Pennsylvania and Georgia* is my own work.

Signature:

A handwritten signature in cursive script, appearing to read 'Lorena Gonzalez', written over a horizontal line.

51st International Course in Health Development

September 22, 2014 – September 11, 2015

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i. Glossary:

i.i Abbreviations

AACWA	Adoption Assistance and Child Welfare Act
CA	Child Abuse
CAC	Children’s Advocacy Center
CAPTA	Child Abuse Prevention and Treatment Act
CBT	Cognitive Behavioral Therapy
CPS	Child Protective Services
CSA	Child Sexual Abuse
DFCS	Division of Family and Children Services
DHHS	Department of Health and Human Services
DV	Domestic Violence
FI	Forensic Interview
GBV	Gender-Based Violence
IPV	Intimate Partner Violence
MDT	Multidisciplinary Team
NYSPCC	New York Society for the Prevention of Cruelty to Children
PTSD	Post-Traumatic Stress Disorder
SA	Sexual Abuse
SIT	Social Identity Theory
SPCC	Society for the Prevention of Cruelty to Children
SSA	Social Security Act
STI	Sexually Transmitted Infections
SV	Sexual Violence
TF-CBT	Trauma-Focused Cognitive Behavioral Therapy
HIV	Human Immunodeficiency Virus
US	United States
VAWG	Violence Against Women and Girls
WHO	World Health Organization

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ii. Abstract:

US gender-based violence interventions deal mainly with females and fail to address boy victims at highest risk of becoming perpetrators. Therefore, this **study addresses** male child sexual abuse (CSA) impact; US response to male CSA via Child Protective Services (CPS); effective treatments for male CSA; and opportunities within CPS for best responding to male CSA. Based on a literature review and **Tajfel's Social Identity Theory**, this **study indicates**: (1) male CSA victims need to achieve a positive self-esteem and develop a healthy personal and social-identity in order to decrease their risk of becoming perpetrators. (2) CPS collaborates with **Children's Advocacy Centers** (CAC) and uses **Trauma-Focused Cognitive Behavioral Therapy** throughout CSA investigations to help diminish self-blame and -hatred by providing a developmentally compassionate environment that includes parents. However, CPS response is neither described explicitly nor directly targeted toward boys, so it is difficult to conclude how interventions specifically address boys' needs. (3) Ideal treatment for male CSA is geared towards developing solid relationships, a positive sense-of-self and a healthy identity, but further research must be done to identify methods most effective at achieving this, (4) and CPS and CAC's main opportunity to address boy's needs lies within their workforce and treatment methods. In **conclusion**, CPS does not sufficiently acknowledge or meet the needs of sexually abused boys. I **recommend**: the government recognize male victims in their violence against women campaigns; CPS ensures their program meaningfully incorporate male CSA victims; and research continue regarding risk, needs and incidence of male CSA nationally.

Key words: Male Child Sexual Abuse; Tajfel's Social Identity Theory; Child Protective Services; Children's Advocacy Center; Trauma-Focused Cognitive Behavioral Therapy.

Word count: 13,198

Introduction

It is unacceptable that one in three women worldwide experience some form of gender-based violence¹ (GBV), physical or sexual, in their lifetime.¹ Having experienced sexual violence² (SV) and known many female survivors of SV, I have a particular interest in preventing and responding to these atrocities. After spending three and a half years working in Burkina Faso, teaching and promoting gender equality, human rights, and sexual and reproductive health and rights, I have developed a passion for reducing GBV. Upon my return to the United States (US), I worked for a year developing a rape and sexual assault curriculum for high school youth and was disappointed to find that GBV, specifically SV, is as prevalent within the States as it is worldwide. Having once believed I lived in an egalitarian country, I was shocked and motivated by this new reality.

In the US, 20% of women are raped during their lifetime; 44% experience some other form of SV, which can include being forced to penetrate a perpetrator, unwanted kissing, or fondling; 12% are sexually coerced, or pressured into unwanted penetration verbally or emotionally; and 33% experience nonphysical sexual harassment including being flashed, stalked or forced to watch explicit sexual media.² This is a human rights violations and serious public health problem due to its harsh health implications. Women and girls who experience such violence suffer consequences as varied as genital trauma, reproductive tract infections, unwanted pregnancies, sexually transmitted infections (STIs) including HIV, infertility, anxiety, eating disorders, depression, post-traumatic stress disorder, suicide, and even death.³

GBV and SV are a result of many factors at play within different levels of society, which range from individual, interpersonal, community, and structural levels, and each factor can serve as a predictor for revictimization or perpetration of abuse.⁴ Gender-norms are often identified as the root of the problem. In many societies, men are granted use of power, strength, and violence over women as a socially acceptable and even desirable gender trait.⁵ Traditional gender roles and norms that support this hegemonic masculinity influences both men and women to accept SV.⁵⁻⁷ Men's and women's perceptions of gender values affect how they behave in social and interpersonal relationships and how they see and value themselves. Men who grow up in families strongly adhering to patriarchal beliefs and practices are more likely to be violent, sexually coerce, or rape women than men who grow up in families with egalitarian ideals and practices.⁸ While the extent of gender inequality varies from country to country, all societies place a higher value on men than women, and unhealthy cultural norms and power dynamics stem from this hierarchy.⁵ But aside from these norms, other risk factors for perpetrating GBV/SV include: weak legal sanctions against SV, low level of education, childhood exposure to domestic violence, attitudes accepting gender inequality and violence, harmful use of alcohol, abuse or maltreatment during childhood, and antisocial or psychopathy personality disorder.^{6,7,9-11} Most importantly, men who are more "violent and controlling toward women often have notable victimization histories," for they feel incapable of living up to the idea of masculinity society has ascribed for them.^{5,7} The surplus of research around violence, and more specifically gender-based or sexual violence, reveals: 1) the majority of those who perpetrate violence are also victims of violence and 2) gender roles promoted in society around hegemonic masculinity and male identity are the most common contributors of GBV.^{5,13-19} So, it is crucial for society's safety and advancement that we further study this link with a focus on boy victims.

¹ GBV is considered "any harmful act that is perpetrated against a person's will, and that is based on socially ascribed (gender)

² Sexual violence (SV), as defined by the World Health Organization is: "Any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic, or otherwise directed against a person's sexuality using coercion, by any person regardless of their relationship to the victim, in any setting, including but not limited to home and work," which includes rape and child sexual abuse.⁶ Incidents where a person is unable to consent due to age, disability, drugs or alcohol and/or unable to refuse due to cultural norms, power dynamics or threats of physical violence, also fall under the definition of sexual violence.⁷ Sexual violence against women and girls is a form of gender-based violence.⁷

Regardless of the abundance of evidence-based approaches to tackling violence against women and girls³ (VAWG), US policy and public measures do not focus enough on this issue. There is stigma in addressing VAWG, which is exacerbated by injustices and insufficiencies within the US legal and health infrastructures.^{3,20} The US, although committed to the Universal Declaration of Human Rights, has not signed the International Convention on the Elimination of All Forms of Discrimination Against Women. Even though contributing factors often operate at the individual and interpersonal levels, national laws and policies that relate to gender equality could decrease SV.⁸ Secondly, while the US encourages legally reporting sexual abuse (SA) and SV, more than 65% of cases go unreported,^{20,21} and the majority that are, go overlooked or are addressed with flippancy. Only 18% of reported rapes lead to an arrest,²² and many are simply uninvestigated.^{23,24} Furthermore, the majority of US interventions for SV focus on response rather than prevention.^{13,25} This indicates a continued focus on victims and a disregard for perpetrators, which can lead to victim-blaming. The insensitivity toward and stigma around GBV, along with the broken legal infrastructure, contributes to underreporting, insufficient prevention, and inadequate response to GBV and SV in the US.

As a result, I am seeking to understand why the US places so little attention on the role of the perpetrator. The social and legal infrastructures cannot continue to blame victims, but must focus their efforts on preventive measures targeting those most at risk of perpetration from a young age.

“Those who claim to care about victims of child abuse, sexual assault, and domestic violence and who abandon them when they repeat the behavior by acting out against others, fail to make these critical connections. It should not be so difficult to reconcile feelings for victims and feelings for perpetrators in view of what we know about the cycle of violence.”¹⁶

This study will analyze the effects of child sexual abuse (CSA) on boy victims in the US and critically assess the US government’s response to CSA by comparing the Child Protective Service (CPS) programs in two different states, which vary in CSA prevalence, financing, and policy.

³ VAWG is often synonymous with GBV

1 US National and State Overview

1.1 The United States at a Glance

The US is a federal republic consisting of 50 states and a federal district, which grants each state a certain amount of sovereignty by spreading decision-making power between federal and state governments. It is the third largest landmass globally, with a population of 319 million.²⁶ Due to its vast size; geography and climate vary greatly.²⁷ As a result of the country's history racial/ethnic compositions also vary extensively nationwide (Table 1). The population is 51% female and 49% male, with a majority (63%) of people between the ages of 18 and 64.²⁶ The literacy rate is high (99%), considering students stay in school on average 16 years,²⁶ and 86% of those over 24 years old have completed high school or higher.²⁸ Still, 14.5% of people live in poverty,²⁸ and 5.4% of the workforce is unemployed.²⁹ Additionally, 15% of persons under 65 have no health insurance.²⁶

Considering state variation, I focus on Georgia and Pennsylvania for reasons explained under *Methods*.

1.2 Georgia and Pennsylvania Today

Georgia and Pennsylvania are located in the eastern part of the US: Georgia is on the southeast coast, north of Florida and east of Alabama, and Pennsylvania is in the northeast, west of New Jersey and east of Ohio. Georgia has a population of 10 million, accounting for 3% of the US, with a more diverse population than the nation's average. Pennsylvania's population is just over 12 million (4% of the US), with a less diverse population than the national average²⁸ (Table 1).

Georgia has a lower percentage (84%) of high school graduates than the nation, while Pennsylvania has a higher percentage (88%). Furthermore, Georgia's poverty rate is much higher than that of the country (19%), where Pennsylvania's is slightly lower (14%).²⁸ The percentage of those without health insurance under the age of 65 in Georgia is double that of Pennsylvania²⁸ (Table 1).

	US	Georgia	Pennsylvania
Population Estimate (2014)	318,857,056	10,097,343	12,787,209
Persons 18-64 years (2013)	62.6%	63.1%	62.3%
Female Persons (2013)	50.8%	51.1%	51.1%
White alone, not Hispanic or Latino (2013)	62.6%	54.8%	78.4%
Black or African American (2013)	13.2%	31.4%	11.5%
Hispanic or Latino (2013)	17.1%	9.2%	6.3%
Asian (2013)	5.3%	3.7%	3.1%
Other (American Indian, Alaska Native, Native Hawaiian, Pacific Islander) or 2+ Races	1.8%	0.9%	0.7%
High School Graduate or higher, 25+ years (2009-2013)	86%	84.7%	88.7%
Persons in Poverty (2013)	14.5%	19%	13.7%
Persons without Health insurance <65yr (2013)	15.3%	21.2%	11.5%

1.3 Historical Context

History influences a nation's present state, and in Georgia and Pennsylvania, racial distribution,³⁰⁻³² civil rights,³³ gender roles,³⁴⁻³⁶ and social welfare^{37,38} are important historical issues that impact the present.³⁹ To review the historical events influencing these factors, refer to Appendix A.

1.3.1 History of Child Protective Services

US child welfare stems from the New York Society for the Prevention of Cruelty to Children (NYSPCC) formed in 1875. However, child protection existed before this via criminal prosecution for horrendous abuse and a 1642 law that gave judges power to remove children from "improper" households.⁴⁰

By 1922 The NYSPCC inspired the development of 300 other Societies for the Prevention of Cruelty to Children (SPCC) nationally; SPCCs were still non-governmental, however. It was not until 1912 that the Federal Children's Bureau was established, and still, it did not flourish until after the New Deal.^{37,38} Meanwhile, by 1919 most states had juvenile court systems authorizing interventions in cases of physical/sexual abuse and neglect. This court system still plays a major role in child protection today.⁴⁰

In 1935, the Federal Children's Bureau was formalized within the Social Security Act (SSA) and had a mandate "to cooperate with State public-welfare agencies in establishing, extending, and strengthening, especially in predominantly rural areas... 'child welfare services' for the protection and care of homeless, dependent, and neglected children, and children in danger of becoming delinquent".⁴¹ Then, from 1940-1960, pediatricians brought child abuse (CA) to this Federal Bureau's attention, which led to an amendment in the SSA: all states were required to make child welfare available through Child Protective Services (CPS); and the Children's Bureau was called to initiate CA reporting laws.⁴⁰ By 1967, reporting laws were firmly established and most state governments began taking legal responsibility for child protection. In 1974, Congress instated the Child Abuse Prevention and Treatment Act (CAPTA), approving federal funding for strengthening states' response to neglect, physical and sexual abuse;⁴² CAPTA is the foundation of the present-day CPS system.^{40,43}

Nevertheless, the US Child Welfare system has faced many obstacles through its development, which contribute to its current weaknesses. The first major issue is protection and placement of child victims. Children removed from unsafe homes are placed in foster care, which serves to protect them from revictimization but also risks children getting "stuck" or being continuously displaced between homes.⁴⁰ Although the Adoption Assistance and Child Welfare Act (AACWA) mandates that states avoid removing child victims in order to "preserve" families,^{43,44} it prioritizes family preservation over child protection, risking revictimization. To counter the AACWA, the Adoption and Safe Families Act was created to strive for family preservation but prioritize child safety, with the caveat that parents' rights be denied altogether if a child is "subject to aggravated circumstances" like sexual or chronic abuse.^{43,45}

A second major issue concerns less prioritized placement and adoption of abused and neglected Black children before the 1960s. Over time this led to an overrepresentation of Black children in foster care.^{40,46-48} As a result, Congress passed the Multiethnic Placement Act, prohibiting adoption agencies from postponing or refusing adoption based on race. Still, Black children continue to be overrepresented in the child welfare system today.^{47,49}

Third, CPS has always been overburdened with cases. Vincent De Francis noted, "No state and no community has developed a [CPS] program adequate in size to meet the service needs of all report cases of child neglect, abuse and exploitation".⁴⁰

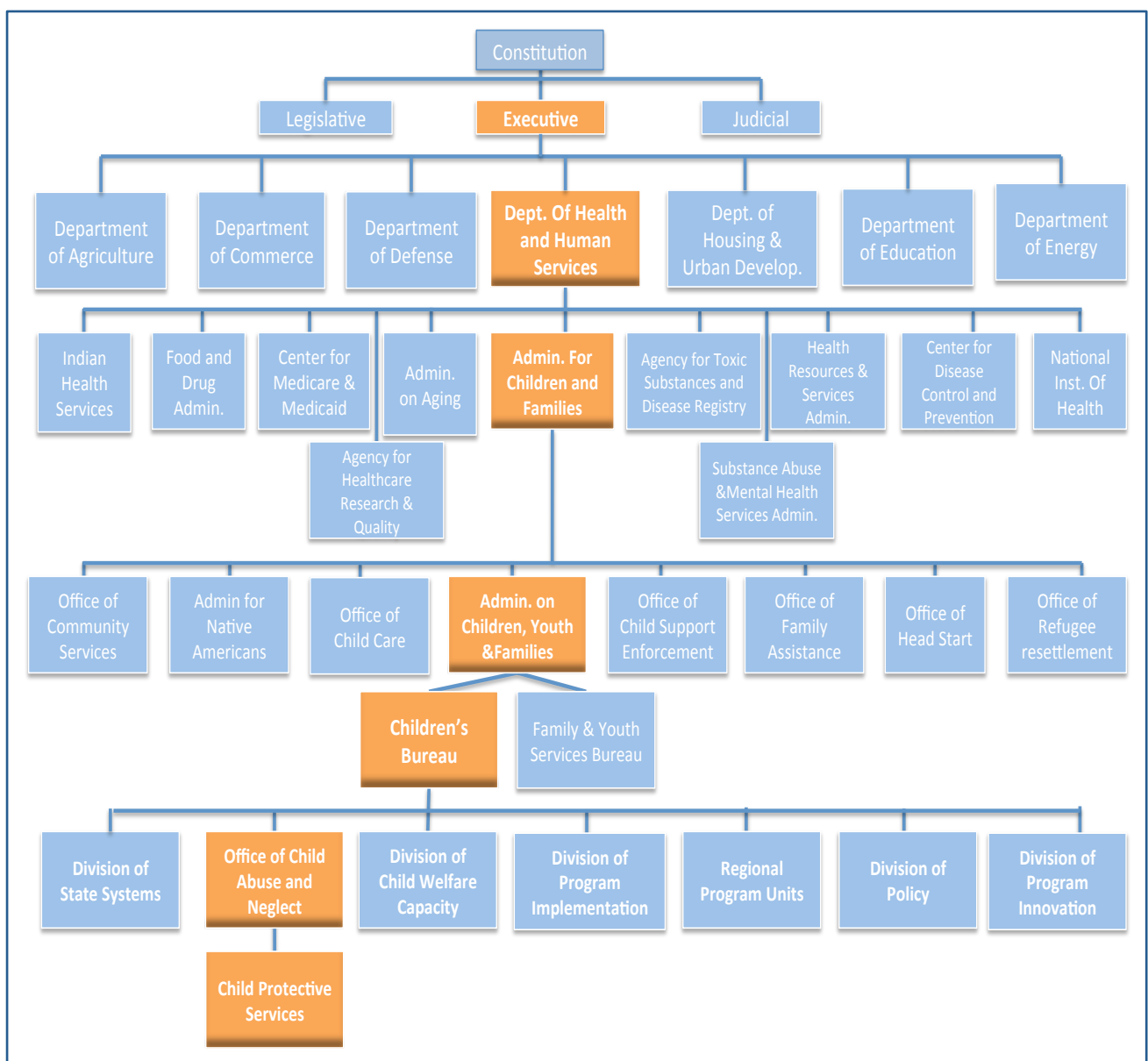
Finally, CPS has confronted issues of proper treatment of CSA victims, including addressing the

stress and anxiety brought about by the investigation process.⁵⁰ In the past, sexually abused children underwent multiple interviews with professionals who knew little about children’s needs and sensitivities. To combat this traumatizing experience, Children’s Advocacy Centers (CAC) were created in 1986, hoping to achieve a smoother, child-focused investigation process.⁵⁰

1.4 United State’s Child Welfare System

Currently, the organization of Child Welfare is divided between federal and state governments, meaning each CPS program varies by state. The Federal Office of Child Abuse and Neglect, a branch of the Children’s Bureau, oversees CPS. The Children’s Bureau is located within the Office of Administration for Children and Families, situated within the larger Department of Health and Human Services (DHHS) and supervised by the Executive Branch.²⁷ (See Figure 1)

Figure 1: US Child Welfare Organizational Chart from US Dept. of Health and Human Services through Child Protective Services²⁶



* Though understanding literature and various sectors of the US government structures, this diagram was created by the author.

2 Problem Analysis

Child sexual abuse (CSA), as defined by CPS is “a type of maltreatment that refers to the involvement of the child in sexual activity to provide sexual gratification or financial benefit to the perpetrator, including contacts for sexual purposes, molestation, statutory rape, prostitution, pornography, exposure, incest, or other sexually exploitative activities”.⁴⁶ CSA and family or domestic violence (DV) witnessed or experienced in early life have been linked with perpetration in adolescence and adulthood.^{2,5,11,16} In the US, up to 15 million children are exposed to DV per year, and over half of DV shelters and transitional housing residents are children.²⁵ One theory suggests adverse childhood experiences like CSA can cause misconstrued ideas about intimate relationships, eventually leading to poor social skills and lack of self-control.⁷ Research shows CA predisposes boys to aggressive, apathetic, impulsive, and violent behavior, sometimes in attempt to reaffirm and prove their masculinity.^{5,51,52} A meta-analysis by Basile and colleagues⁷ found anger and hostile-masculinity strongly correlated to sexual aggression. Some studies reveal 20% of sexually abused boys go on to molest and sexually offend.⁸ However, while a majority of perpetrators have a history of CA, other studies suggest most male victims of SV and child maltreatment do not go on to commit such crimes.^{5,53,54} It should not be assumed that all victims will become perpetrators. Nevertheless, increasing evidence indicates more attention should be focused toward male victims of child maltreatment to break the cycle of violence.^{11,55-58}

There is much debate between the terms *victim* and *survivor* when referring to persons subjected to SV. *Survivor*, although empowering, can downplay the experience. While *victim* can be seen as debilitating, it acknowledges the experience’s severity. Many defer labeling those who experience SV as it can affect one’s identity and journey through rehabilitation. In this paper, I use both terms depending on the context:

*I refer to sexually abused children experiencing negative consequences or undergoing CPS investigation and referrals as *victim*.

* I use *survivor* when referring to sexually abused children who have started or completed treatment or to adults who experienced sexual abuse in childhood.

Men and boys experience more sexual violence than is socially or legally recognized,^{1,9} for it remains a sensitive, overlooked topic.⁶ Additionally, males are much more reluctant to report SV than females.^{8,25,52,59,60} Therefore, statistics are unreliable and unrepresentative of the actual number of male victims. Also, victims concerned with becoming or being labeled as a possible perpetrator do not report.⁵² Bearing this in mind, it is estimated 14% of boys experience CSA globally.⁶ In the US, 2% of men report being victims to rape, while 25% report being subjected to SV other than rape in their lifetime; 11% report unwanted sexual contact and 13%, non-physical

sexual harassment in their lifetime.² The majority of male victims are raped, assaulted or harassed by other men (~79%) and experience victimization in childhood or adolescence.^{2,5,21,25} This is concerning because the interplay of masculinity, fear and humiliation are strongest for adolescent boys.⁵² What’s more, SV against boys has negative health consequences that parallel those of SV against girls. Male victims suffer both short and long-term consequences, which affect them physically, psychologically and socially.⁶ Thus, society urgently needs to formulate an appropriate response targeting these all-too-often overlooked boys.

As CPS is the largest child welfare program in the country, they are legally required to perform initial assessments and investigations of reported CA nationwide. If the reported abuse is founded, CPS aims to provide services to support those children and families in need. The national mission of CPS is to: “assess the safety of children; intervene to protect children from harm; strengthen the ability of families to protect their children; [and] provide either a reunification or an alternative safe family for the child”.⁶¹ Yet, only 1.5-5% of male CSA incidence gets reported to child protection agencies.⁶² Furthermore, just 1% of reported cases

are substantiated every year.⁶² Considering CPS' national stance and status, it is unacceptable so much male CSA be disregarded. By not substantiating or responding to the majority of CSA cases, many boy victims are left overlooked, vulnerable to revictimization, and susceptible to the cycle of violence, gradually increasing their risk of future perpetration.

2.1 Justification

As such, it is crucial that we prevent SV and properly respond to male CSA from a young age.^{21,51,62} Still, most preventive SV interventions fail to address either of the prominent issues that are consistently cited as root causes for GBV: male childhood victimization and hegemonic masculinity. Evidence shows the most effective interventions for reducing SV are: parental support interventions to prevent child-maltreatment; psychological support interventions targeting children/adolescents exposed to violence to reduce future perpetration; community based programs to challenge gender norms and decrease tolerance for intimate partner violence (IPV)/SV; and school-based interventions to improve gender-equitable attitudes and bystander activity.^{5,9,13,21,63} Nonetheless, the two-thirds of US interventions for GBV that are responsive, focus on female victims and neglect young male victims at greatest risk of revictimization and perpetration. The other third of interventions are preventive, but not gender transformative.¹³ More research must be done on the consequences and needs of sexually abused boys, and on the government's current response through CPS, as to identify strengths to scale-up and gaps to address.

"...charged with breaking into the home of a twenty-year-old woman and raping her at gunpoint, ... Antoine had himself been sexually abused at a young age, before he was able to speak. He was abandoned by his mother when he was two-years-old. His body revealed old and new wounds, including signs of anal penetration. He was placed in foster care but did not fare well there. He was sexually abused for months by his foster mother's uncle, who was a frequent presence in the household. Antoine did not tell anyone out of fear that he would be put out of the house. [After] eventually disclos[ing] the abuse to a teacher, [h]e was visibly frightened. His small size and air of vulnerability made him an easy target for frequent sexual assault and humiliation by his peers".¹⁶

2.2 Study Objectives

The overall objective of this study is to explore the consequences for and needs of boys who experience child sexual abuse in the United States, and to critically analyze the government's response to male child sexual abuse through a comparative analysis of Child Protective Services in the states of Pennsylvania and Georgia in order to provide recommendations for strengthening the government child welfare program.

Specific Objectives:

1. To identify the negative effects and needs of boy victims of CSA within the US.
2. To assess the US government's response to male child sexual abuse by comparing the Child Protective Services program in Pennsylvania and Georgia.
3. To identify most effective interventions for responding to male CSA.
4. To find opportunities within the CPS program to respond to male CSA in Pennsylvania and Georgia.
5. To provide policy recommendations for improving CPS for best responding to boy victims of CSA.

2.3 Research Questions

1. **What are the negative consequences of CSA against boys?**
 - a. What are the health implications for boys who experience CSA?
 - b. What are the consequences of CSA on boys' self-esteem?
 - c. How does CSA affect the way boys categorize social groups?
 - d. What are the consequences of CSA on boys' personal and social-identity?
 - e. What are the needs of boys who experience CSA?
2. **What is the US government's current response to male CSA through CPS in Pennsylvania and Georgia?**
 - a. How does CPS work and respond to child abuse in general?
 - b. What are the differences between CPS programs in Pennsylvania and Georgia?
 - c. How do Pennsylvania and Georgia CPS programs respond to male CSA?
 - d. How do Pennsylvania and Georgia CPS programs address issues of identity and self-esteem for victims of CSA?
3. **What are the most effective programs/interventions for responding to male CSA?**
 - a. What types of interventions exist?
 - b. What determines the effectiveness of these programs?
4. **What are the gaps and opportunities within CPS' response to male CSA?**
 - a. How can the US government's response be strengthened?

2.4 Methods

2.4.1 Literature Review

This study is founded on a literature review of published and peer-reviewed articles, grey literature, and US government-produced documents. The literature included is limited to English and predominantly from the US. Sources dating back to 1990 were included in order to broaden search results, considering the topic's sensitivity.^{10,64} Literature dating before this is only referenced if relevant to the framework or welfare laws.

After exploring literature on child maltreatment and GBV perpetrators, but before identifying how to focus my research, I sought help from experts in the US: professionals in the field of social work and child maltreatment; child justice advocates assisting with cases of CA; and experts on gender, psychology and GBV primary prevention. Through their help, I narrowed my focus, refined my objectives, and identified key scholars to explore further.

Next, I searched for literature using: the US DHHS Children's Bureau, the Child Welfare Information Gateway, the US State Child Welfare Policy Database, PubMed (US National Library of Medicine), the Vrije Universiteit Library, Google scholar, Web of Science and Picarta. My study objectives and framework guided my search for and analysis of literature. The following combinations of MeSH terms were used: (See Table 2)

Table 2: MeSH Terms used for Literature Search

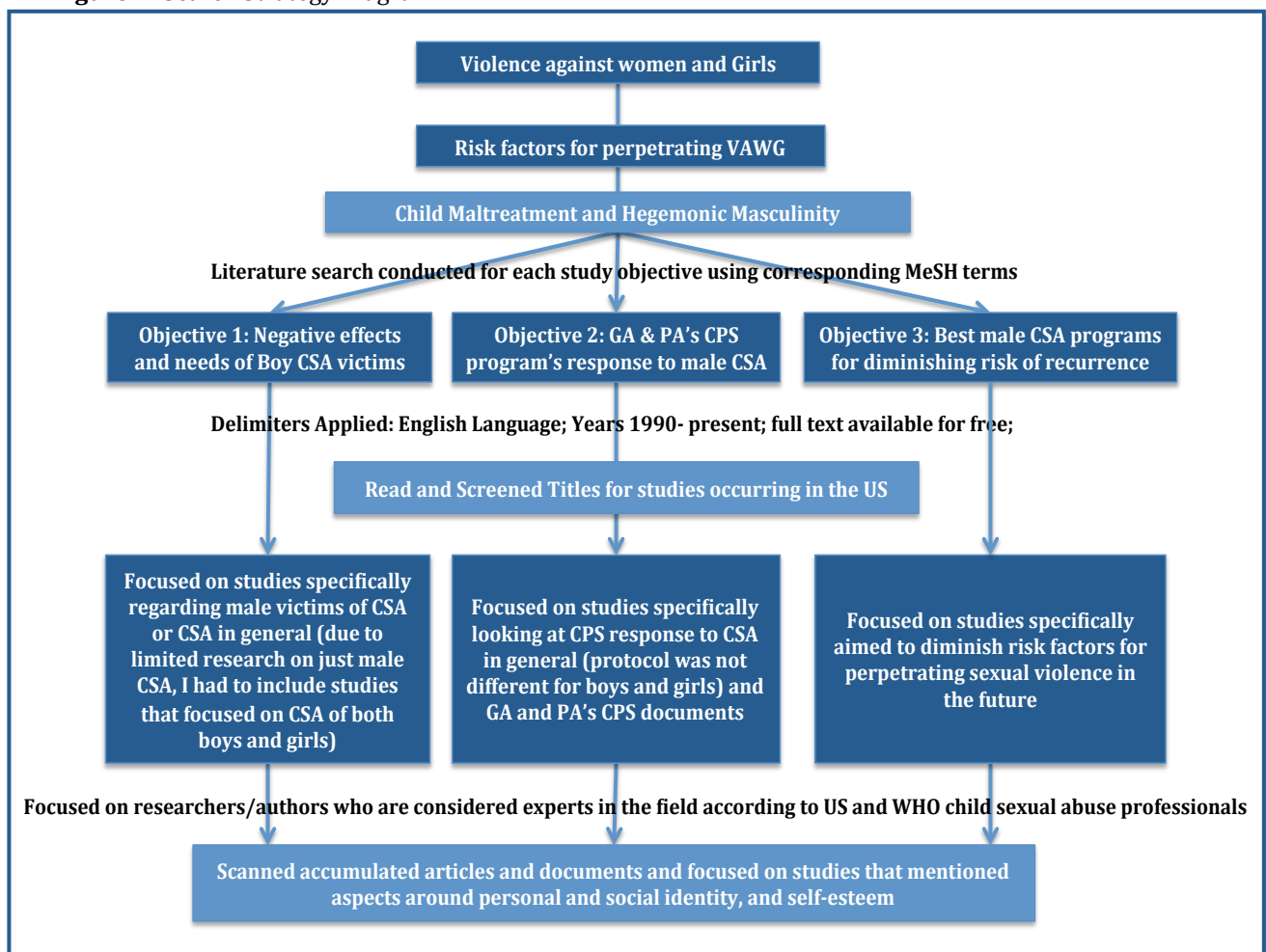
Objective 1	("male child" OR boy) NOT (girl OR female OR woman) AND "(child OR youth) sexual (abuse OR victimization)" AND (US OR USA OR "United States") AND (consequences OR effects OR impact); (male OR boy) AND "child sexual (abuse OR victimization)" AND USA
Objective 2	"child protective services" AND "child welfare" AND (US OR USA OR "United States"); "child protective services" AND (Georgia OR Pennsylvania); "child protective services" AND (Georgia OR Pennsylvania) AND (effectiveness OR success OR impact OR success)
Objective 3	(best OR "most effective" OR successful OR efficient) AND "male child sexual abuse (interventions OR programs OR prevention OR response)"

To narrow my search from VAWG to CPS program response of male CSA in Georgia and Pennsylvania, I used the search strategy from Figure 2. To manage the collection and analysis of

literature, I created a data extraction sheet organized according to my objectives and framework components, and consulted the World Health Organization’s (WHO) Technical Officer for National Child Maltreatment Response Programs.

Analysis of literature was conducted according to my study objectives and framework. Each study regarding the first objective was analyzed for components of self-esteem, social categorization, personal-identity, and social-identity. Studies regarding the second and third objectives were examined for components within CPS that address self-esteem as well as social and personal-identity. Lastly, findings from the analysis used to achieve the first three objectives were applied to attain the fourth objective of identifying opportunities for fulfilling the need for positive self-esteem and belonging under the Social Identity Theory.

Figure 2: Search Strategy Diagram



2.4.2 Why Georgia and Pennsylvania?

Each state CPS programs differs depending on funding, stakeholders and local interests. This research compares Georgia and Pennsylvania, two states with contrasting reported CSA prevalence and funding streams. Additionally, the two states have a similar child population size and sufficiently available information for comparison (Table 3).

Pennsylvania has one of the highest reported levels of CSA prevalence nationwide. To understand the state’s prevalence and CPS response, I believed I would need to understand a state’s response with low CSA prevalence in order to contrast strengths and weaknesses of each program and gain insight to CSA reporting.

Table 3: Pennsylvania and Georgia's CPS Defining Characteristics^{65,66}

Criteria	Georgia	Pennsylvania
Population of Children (0-17years)	2,489,709	2,715,645
CSA State Prevalence (of total reported Child maltreatment)	4.2%	67.6%
Funding (Federal vs. State)	35% State vs. 65% Federal Federal funds: 35% Title IV-E 60% TANF 7% Title IV-B 5% Medicaid	75% State vs. 25% Federal Federal funds: 75% Title IV-E 10% TANF 5% Title IV-B 1% Medicaid
Information Available	Sufficient	Sufficient

Title IV-E: the largest source of federal funding from the SSA dedicated to child welfare; this funding goes to foster care, adoption assistance, guardian assistance and the Chafee Foster Care Independence Program.

TANF: Temporary Assistance for Needy Families is a federal block grant to states for helping: children continue to live with family; children removed from homes; children with financial assistance; and children with non-parent caregivers.

Title IV-B: the second principle sources of federal funds from the SSA dedicated to child welfare; each state determines the eligible populations and certain types of services funded by this money.

Medicaid: federal and state health care program, which insures people below the poverty-line.

I considered comparing Pennsylvania's high CSA prevalence and low federal funding with the low prevalence and higher federal funding levels of Arizona, Nevada, New York, Oklahoma and Georgia.^{65,66} Due to incompatible child population sizes, I ruled out Nevada, New York and Oklahoma.⁶⁷ Then, I eliminated Arizona due to reporting scandals within their CPS program.⁶⁸

2.4.3 Identification of conceptual framework

To guide my study, I use Tajfel's Social Identity Theory (SIT) as a framework. I was introduced to the SIT by my thesis advisor through a South African exploratory study of theoretical frameworks for understanding male interpersonal violence.⁶⁹ Of the multiple theories covered in this study, I considered the Social-Ecological Model (SEM),⁷⁰ Social Identity Theory,⁷¹ Hegemonic Masculinity Theory,⁷² and Social Learning Theory.⁷³

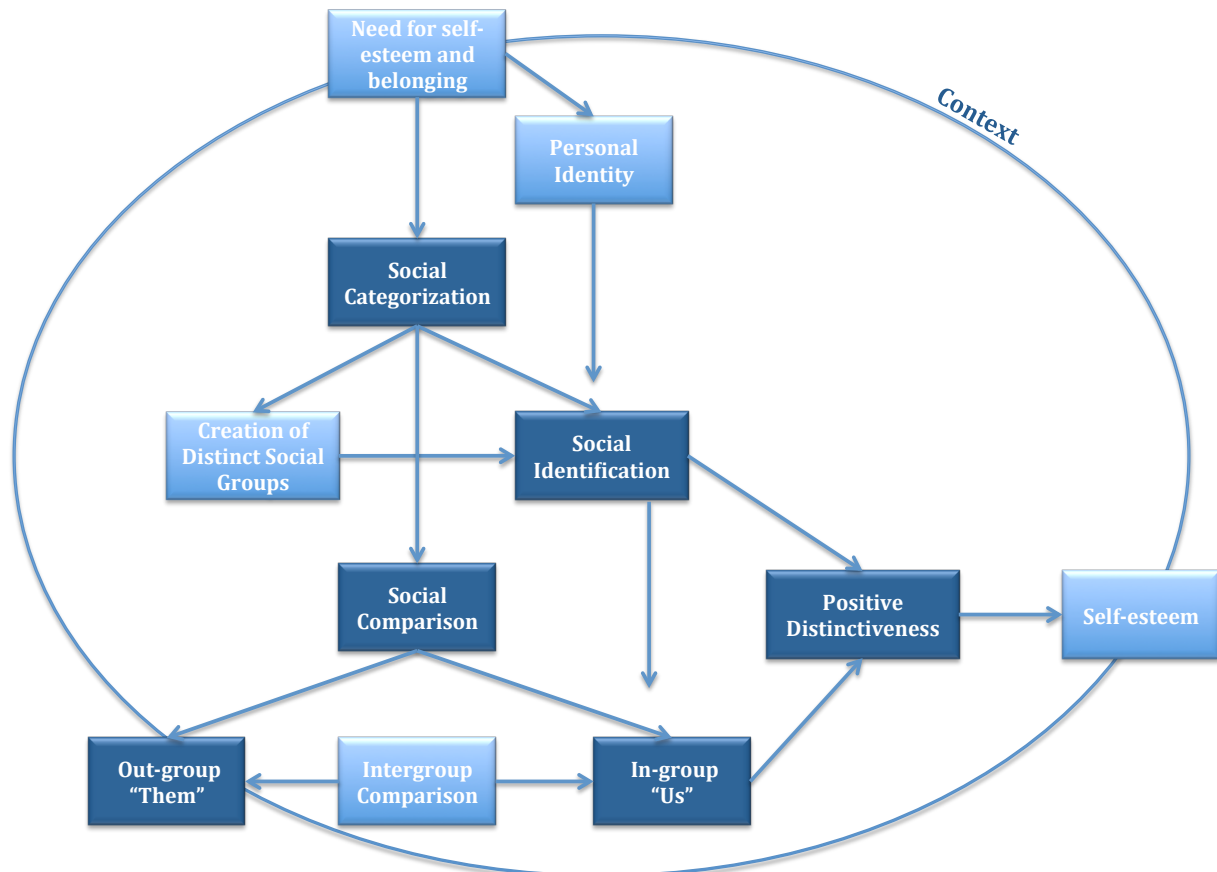
I decided on Tajfel's SIT for multiple reasons. The theory states that an individual's self-conception is based on his/her personal-identification and social or collective-identification, which stems from social categorization.⁷⁴⁻⁷⁶ The SIT is founded on the idea that human identity is defined by the groups a person belongs to and the value that person places on those groups or group members.^{69,71} Individuals associate themselves with social categories, which precede them and exist within an already structured society. These categories are defined relative to contrasting categories (i.e. abused vs. non-abused), whose power, status and esteem depend upon one another. Therefore, within society, individuals gain their personal-identity and sense of self-worth from social categories with which they associate. Every person throughout his/her life then becomes a member of a particular combination of social categories, which contribute to their social-identity and sense-of-self.⁷⁶ See Figure 3.

This theory encompasses the other theories I originally considered.⁷⁴ First, SIT covers all levels within the SEM, for it takes into consideration each person's context: Identity is defined by one's individual make-up and experiences, a person's interpersonal relationships and the value of those

Henri Tajfel, after surviving the Second World War as a Polish Jew, sought to understand genocide, prejudice and discrimination. As a social psychologist, Tajfel conducted studies in attempts to understand social categorization and group favoritism among seemingly unconnected boys. His studies centered on identity, oppression and inequality, which eventually led him to develop the Social Identity Theory. Over time, his findings have influenced our understanding of self-perception and conflict.⁷⁴

relationships within the context of a community, and one's societal structure, which influences the hierarchy and value of a person's social group in comparison to other groups.^{70,76,77} Second, the SIT encompasses Hegemonic Masculinity Theory, as gender is a social construct that defines and dictates the worth of what it is to be a *man* or *woman*, shaping one's identity based on their sex,^{5,6,7,52,77} and as seen in the *Introduction* and *Problem Analysis*, hegemonic masculinity greatly contributes to CSA and SV.⁷² Third, SIT incorporates aspects of Social Learning from the moment one is born through context; one's identity and corresponding behavior are learned and influenced by the environment they are raised in and people/experiences they are exposed to.^{2,5,16,73}

Figure 3: Tajfel's Social Identity Theory



* Though understanding of literature and various diagrams depicting the SIT, this diagram was created by the author.

Following the structure of the SIT, I describe CSA's context in the US first (3.1), and then, in 3.2, I discuss how CSA affects boys/men within all levels of the SIT. Under section 3.3, I cover CPS' response to male CSA and how it addresses self-esteem and identity, and in 3.4, I describe the programs deemed effective for responding to male CSA. Lastly, in 3.5, I identify opportunities within CPS to better address self-esteem and identity based on findings from 3.4.

Each section concludes with a *Discussion* of its corresponding findings.

3 Findings and Discussion

3.1 CSA Context

Following Tajfel’s SIT, this section covers the context of CSA within the US.

3.1.1 Children in the US

In the US, those under the age of 18 are referred to as children, youth or adolescents, depending on their age group. In this study, I use the term child/children to refer to those 0-17 years, unless stated otherwise. Overall, 23% (~74million) of the US population are children, and 19% are 14 years or younger. 51% of children are male and 49% are female.⁷⁸ Race and ethnic composition is differently distributed from the national composition: 52% of children are White, 24% are Hispanic/Latino, 14% Black, 5% Asian, and the rest, other or of mixed race. Additionally, 24% of children live with at least one foreign-born parent, and 64% live with two married parents (Figure 4&5), where at least one parent is employed full-time (73%).⁷⁹

Figure 4: US Living Arrangements of Children, by Race and Hispanic Origin, 2014⁸⁰

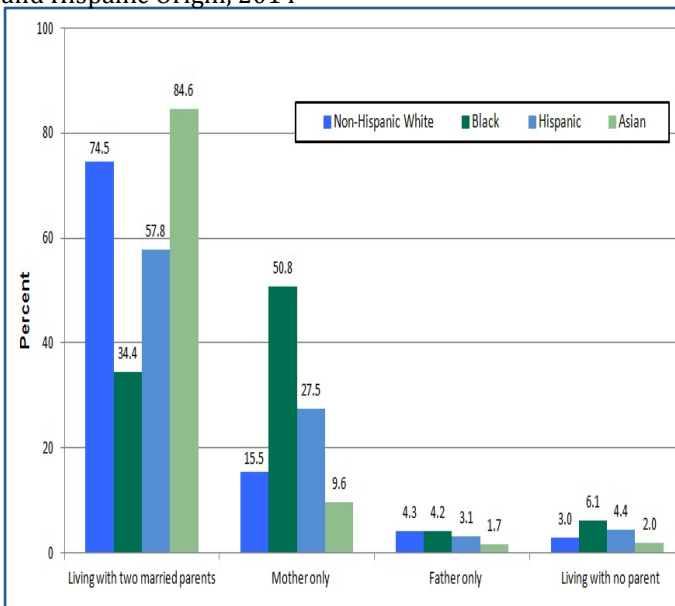


Figure 5: US Percentage of Children Living in Poverty, by Family Structure, Race and Hispanic Origin, 2013⁸⁰

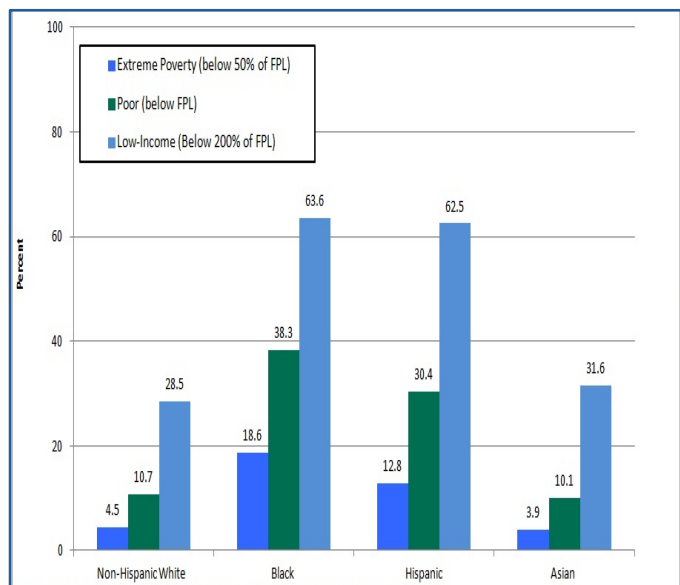
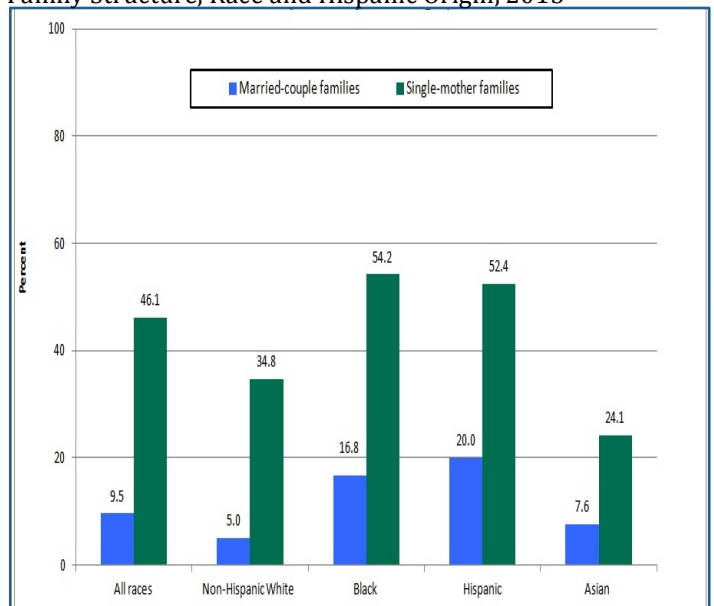


Figure 6: US Percentage of Children who are Poor or Low-Income, by Race and Hispanic Origin, 2013⁸⁰

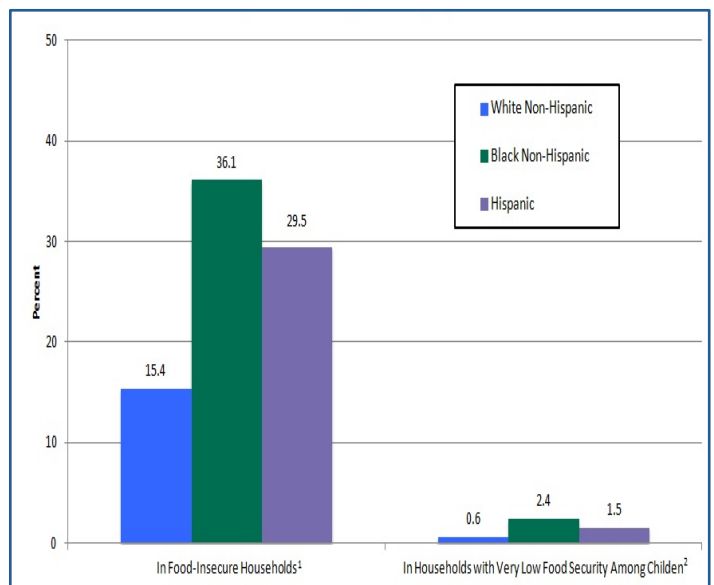


Figure 7: US Percentage of Children (0-17) in Food-Insecure Households, by Race and Hispanic Origin, 2013⁸⁰

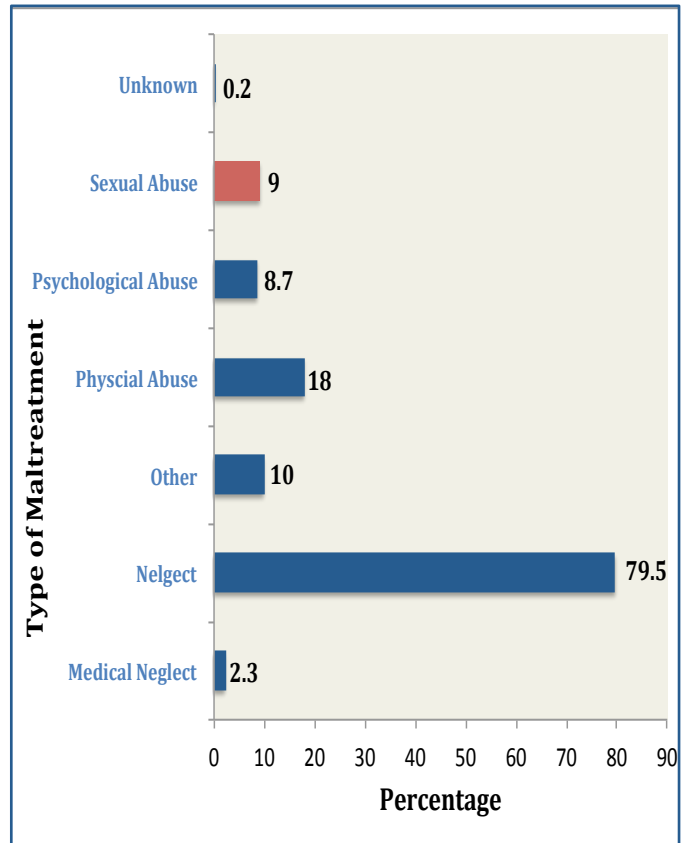
More than one-fifth (22%) of children live in poverty (Figure 5&6) or in “food-insecure”⁴ households (Figure 7).^{79,80} Nevertheless, 91% are covered by health insurance, which helps children confront major health concerns like obesity; limitations resulting from one or more chronic health conditions; severe depression; serious emotional and behavioral difficulties; and child maltreatment.^{46,79,81}

3.1.2 Child Maltreatment

Child maltreatment is a major health concern considering its consequences, and the number of people directly and indirectly affected by it. In 2013, CPS in the US received 3.4 million referrals of child maltreatment, 679,000 of which were substantiated.⁴⁶ These reports included: neglect or deprivation of necessities⁵, physical abuse⁶, sexual abuse (SA), psychological maltreatment⁷, medical neglect⁸, and other. Still, most cases of child maltreatment go unreported; as previously mentioned, only 1.5-5% of child maltreatment gets reported and just 1% of those reports are substantiated.⁶² A national study, unrelated to CPS, indicates 25% of boys and 26% of girls in the US experience child maltreatment in their lifetime, and children aged 14-17 have the highest lifetime rate (41%) of child maltreatment.⁸¹

According to reports collected by CPS in 2013, (Figure 8) child maltreatment comprised the following: 80% neglect, 18% physical abuse, 9% sexual abuse, 9% psychological abuse, 2% medical neglect, and 10% for some other form of abuse such as threats or parental substance abuse.⁴⁶

Figure 8: Maltreatment Types of Victims in US 2013⁴⁶



3.1.3 Child Sexual Abuse

CSA, as defined by state, program and researcher, varies. Commonly used definitions, which differ from CPS’ definition, are: CAPTA’s definition of CSA, “the employment, use, persuasion, inducement, enticement, or coercion of any child to engage in, or assist any other person to engage in, any sexually explicit conduct or simulation of such conduct for the purpose of producing a visual depiction of such conduct, or other form of sexual exploitation of children, or incest with children”;⁸² Finkelhor’s definition, which comprises “sexual activities involving a child and an ‘abusive condition’ such as coercion or a large age gap between the participants, indicating lack of consent”;⁶⁴ and WHO’s definition, as “unwanted and inappropriate sexual solicitation of, or exposure to, a child by an older person; genital touching or fondling; or

⁴ Food Insecurity is “limited or uncertain availability of nutritionally adequate and safe foods or limited or uncertain ability to acquire acceptable foods in socially acceptable ways”.⁸³

⁵ Neglect: A type of maltreatment that refers to the failure by the caregiver to provide needed, age-appropriate care although financially able to do so or offered financial or other means to do so.⁴⁶

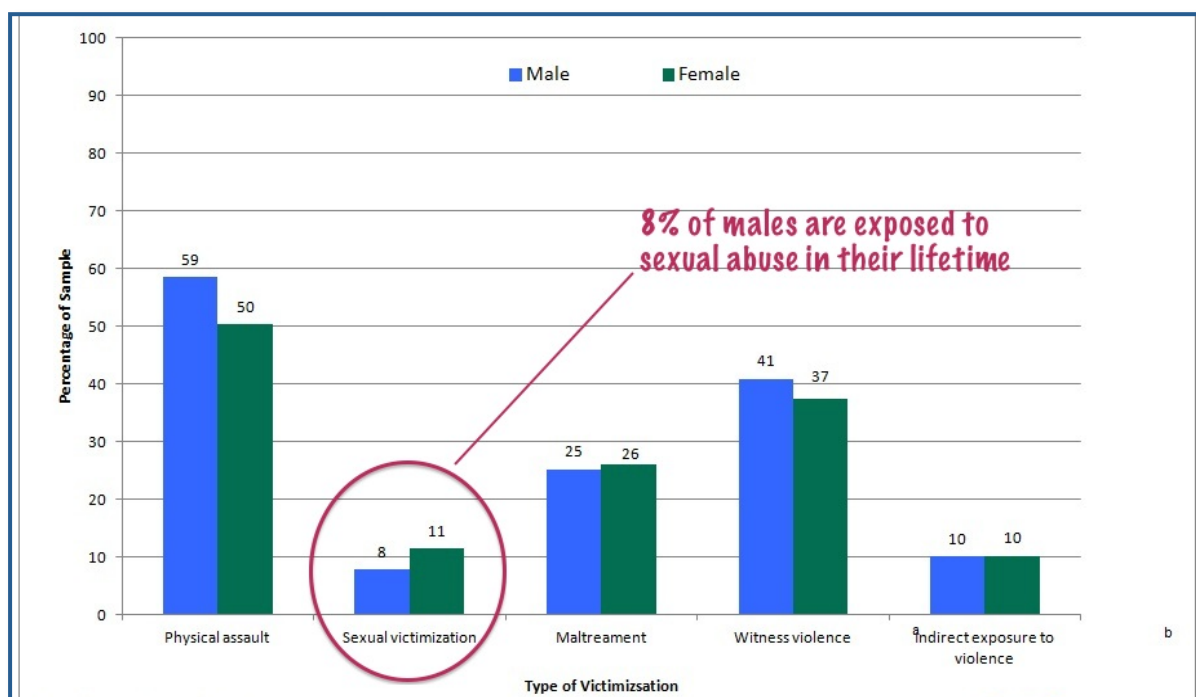
⁶ Physical Abuse: maltreatment referring to physical acts that caused or could have caused physical injury to a child.⁴⁶

⁷ Psychological Maltreatment: acts or omissions, other than physical abuse or sexual abuse, that caused or could have caused, conduct, cognitive, affective, or other behavioral or mental disorders. Frequently occurs as verbal abuse or excessive demands on a child’s performance.⁴⁶

⁸ Medical Neglect: a type of maltreatment caused by failure of the caregiver to provide for the appropriate health care of the child although financially able to do so, or offered financial or other resources to do so.⁴⁶

penetration in terms of oral, anal or vaginal intercourse or attempted intercourse”.¹⁰ Varying definitions is one of three common issues in calculating prevalence through CSA reporting; the other two are: many cases never get reported, and those that are must meet certain standards to qualify as CSA; and time periods in which statistics are reported differ.^{10,84-86} Definitions vary in the forms of SA included and in the age of the perpetrator: some only include contact SA, while others incorporate non-contact SA, and some only consider adults (18 years plus) to be perpetrators, while others include adolescents (14-17 years) who are 3 or more years older than the victim. In the rare cases where CSA is reported, it is investigated by professionals who must follow guidelines and meet certain criteria to substantiate a case.^{2,6,8,10,52,59,62} Where standards vary, reported and substantiated cases vary. Another issue is that different sources report prevalence and incidence for different time periods: children abused in the last year, abused in their lifetime, ever abused, adults abused as children, etc.⁵⁹ This means prevalence may not represent the present, but could refer to a point in the past. To give a full picture of the scope of the problem, I cite prevalence and incidence from multiple sources.

Figure 9: US Children’s Lifetime Exposure to Violence: Percentage Victimized by Child’s Gender, 2011⁸⁰



According to a National Survey from 2011, 10% of all children (8% boys and 11% girls) experience SA in their lifetime,⁸⁰ (Figure 9). According to Finkelhor’s National Samples, 5.6% of children experience SA in their life, 27% of which are 14-17 years-old (20% boys; 35% girls).^{81,87}

3.1.3.1 CSA Risk Factors

Risk factors identified for CSA include age, gender, family structure, parental behavior,^{48,88} socioeconomic status (SES),⁴⁸ and neighborhood environment.^{14,89} Generally, girls are at higher risk than boys; but, males are often underrepresented in CSA studies due to underreporting and stigma.^{1,6,9,25} Regarding age, multiple studies analyzed in Black et al.’s⁹⁰ CSA review indicate children 13-17 years are at greatest risk, while other studies suggest vulnerability of SA is greatest for boys seven to 13 years. However, most sexually abused boys do not disclose until adolescence, and victims younger than seven are often missed due to age at the time of abuse or tendency to repress the memory in adulthood.^{64,91} As for family structure, children living with a single parent and/or one biological parent (Figure 10) are at greater risk for CSA.^{59,64,90} Although, this is regularly linked to “parental inadequacy, unavailability, conflict, and poor parent-child relationship,” as poorly supervised children are more vulnerable to their

Figure 10: US Incidence of Harm Standard Abuse by Family Structure and Living Arrangement, 2010⁵¹

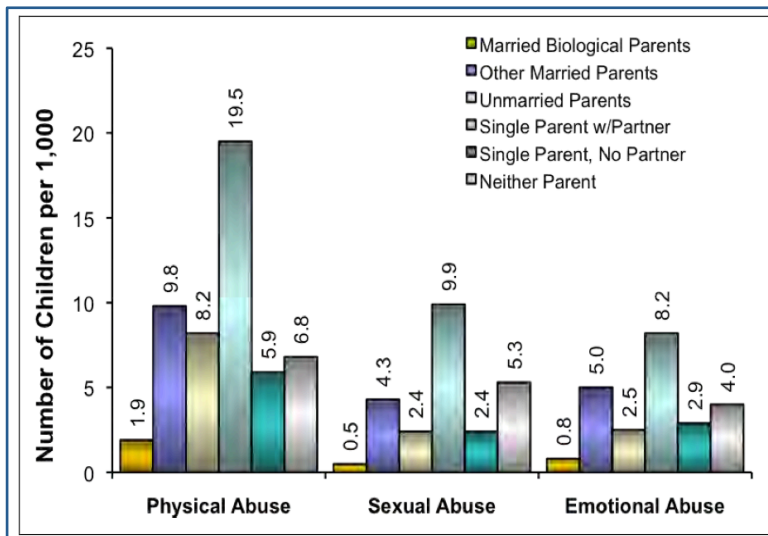
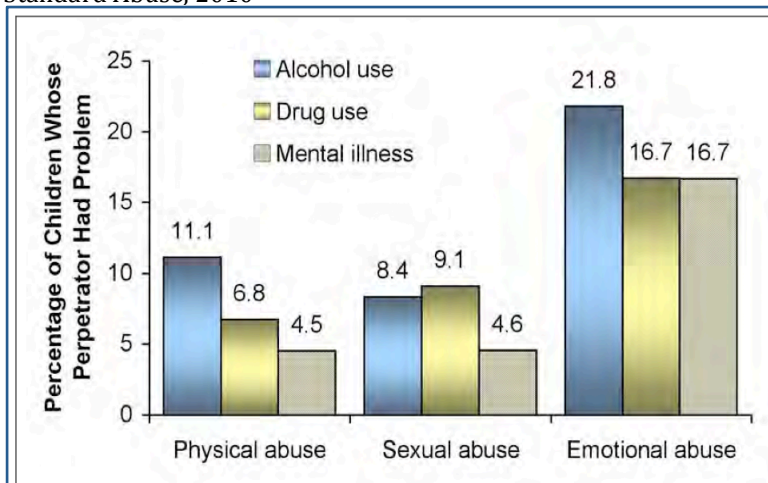


Figure 11: Perpetrator Problem in Specific Categories of Harm Standard Abuse, 2010⁵¹



surroundings.^{59,64} Additionally, children living with parents who have a history of CSA and/or volatile behavior related to alcohol and drug abuse,⁴⁸ poor health, or DV are at increased risk of CSA^{88,89} (Figure 11). These factors also lead to neglect, and physical or psychological abuse, which, in turn, makes a child more vulnerable to an abuser’s duplicitous offers of attention.^{59,64,90}

Moreover, single-parenthood and unstable family structure are often associated with poverty, which is linked to high-crime neighborhoods. Thus, individuals of low SES and/or living in dangerous communities are at an increased risk of CSA.^{10,14,48, 59,64,89,90} Black and colleagues⁹⁰ review suggests poverty is significantly associated with CSA, and children sexually abused by someone in the family are more likely to have parents that work blue-collar jobs.

Keeping this context in mind, I now describe the negative effects sexually abused boys face within the US.

3.2 Effects of Child Sexual Abuse on Boy Victims in the US

Boys who experience CSA are at increased risk for numerous negative physical, mental, behavior, and social consequences. CSA among boys can result in adverse feelings regarding low self-esteem, powerlessness, self-blame, anger, betrayal, shame and confusion regarding sexual identity. It can lead to negative psychological consequences such as anxiety, depression, post-traumatic stress disorder (PTSD), antisocial personality disorder, dissociation and emotional avoidance. CSA can result in social repercussions arising from learning impairments, poor academic performance and school dropout. It can also results in behavioral disorders around sexual dysfunction and dissatisfaction, obsessive compulsiveness, paranoia, gender-role confusion, hyper-sexuality and –masculinity, and perpetration of SV. Lastly, CSA can lead to many negative health outcomes like alcohol and substance abuse, increased STIs, eating and sleeping disorders, and self-harm or suicide.^{4,10,14,52,55-57,64,88,89,92-103}

Notwithstanding, CSA impacts vary depending on genetic make-up and severity of abuse. Individuals with certain genetic factors known as “plasticity alleles,” have been found to be more vulnerable to their environment, for good or bad.¹⁰⁴ Barns and Jacobs¹⁴ demonstrate how genetic-environment interactions “between a dopamine risk scale and exposure to neighborhood disadvantage and county-level violent crime rates” increase the likelihood for an

individual to behave violently. Research also implies genetic factors influence one's vulnerability or resistance to developing a mental disorder after CSA; if the developmental environment is threatening and violent, then the expression of genes resemble negative psychological consequences, but if CSA is countered with a protective, loving and safe developmental environment, these genes can be inhibited from surfacing.^{10,14,90} Additionally, it has been found that severe child maltreatment can trigger the expression of certain genes related to antisocial conduct later in life.¹⁴

Severity of abuse, determined by age of onset, frequency and duration of victimization, type of SA, and victim's relationship to the perpetrator, can also impact CSA outcomes.^{10,89,103} A victim whose SA starts from an early age has increased odds of revictimization as an adolescent and adult.^{2,89} However, Finkelhor notes difficulties in assessing the effect of this variable because of its correlation with frequency and duration, and relationship of the victim to perpetrator.^{10,103} Still, regarding frequency, research indicates that one experience of SA in childhood is associated with further CSA and other types of child maltreatment like neglect and emotional abuse; as a result, greater emotional and behavioral negative outcomes, in addition to increased suicide attempts, have been associated with greater frequency of CSA.^{10,59,87} Similarly, duration of abuse significantly affects psychological disorder outcomes among victims, as certain studies show longer duration of abuse is linked to self-blame and depression,¹⁰³ and thus, more psychological problems and suicidal behavior.¹⁰

Furthermore, type of CSA can greatly impact the effects an abused child experiences. Graver forms of CSA, such as intercourse, penetration and use of force, are related to poorer mental health outcomes, earlier onset of alcohol abuse, increased odds of suicide, and distorted sexual and relational development in comparison to non-contact (verbal harassment, stalking, flashing) and non-penetrative contact abuse (kissing, touching, fondling).^{56,89,95} It is speculated that "more severe forms of [SA] may inflict a deeper wound by reinforcing helplessness, powerlessness, and self-blame".⁹⁵ Some research suggests victims experience worse outcomes when perpetration is intra-familial, while others argue otherwise; incestuous abuse by a father or stepfather shows more traumatic effects than abuse by others, for parental abuse "involves greater betrayal and loss of trust," and tends to occur more frequently, over a greater span of time. Additionally, abuse by a paternal figure is often less conceivable by the perpetrator's partner when a child reports.^{98,103} On the other hand, one meta-analysis argues no significant association exists between intra-familial perpetration and mental disorders. More research must be done considering the array of negative outcomes that can result from intra-familial CSA.¹⁰ Regardless, CSA's consequences range between short and long-term impacts with a varying degree of manifestations. CSA affects victims on a personal, relational and social level, which can influence one's sense-of-self and belonging. Along the next element of the SIT, I will now explore how CSA affects boys' self-esteem.

3.2.1 CSA and Self-esteem

The SIT's foundation of needing to belong and build one's self-worth explains why people seek to identify with various social groups they categorize as valuable.^{71,74-76} In the context of children, there is an exceptionally high need for acceptance and belonging due to their developmental state and their vulnerability to surroundings.^{59,64} Consequently, CSA is seen to affect victims' self-esteem in various ways. Self-esteem is the belief in one's self-worth and confidence in one's abilities.¹⁰⁵ Many sexually abused children interpret their experience as a consequence of "bad" behavior and end up internalizing the event, believing they are inherently bad.¹⁰² When interviewed about their experience of CSA, men described their internalization as: feeling inferior, being unacceptable, feeling insignificant, and being unlovable.^{96,102} Male survivors express loss of self-respect and profound self-hatred, indicating a severely impaired self-esteem.^{96,102} Likewise, when boys define their experience of SA as "horseplay" or "experimentation," their self-esteem is similarly affected, leading to serious psychological disorders and suicidal behavior.⁵²

“When you’re being abused, you don’t have self-respect, you can’t look people in the eye. You feel dirty. It feels like you don’t belong. You feel like you’re not as good as anyone else. You feel like you don’t deserve anything.” – quote by participant from qualitative study.⁹¹

Another way CSA distorts boys’ self-esteem is through a feeling of powerlessness, leaving the victim with a lack of confidence in his own capacities.^{10,95,106,107} Lisak¹⁰² describes this as “one of the most crucial aspects of the experience of abuse, a fundamental loss of control: over one’s physical being, one’s sense-of-self, one’s sense of agency and self-efficacy, and one’s fate”. Accordingly, CSA survivors face feelings of discomfort in social situations, describing a sense of separation and isolation; male CSA survivors express how alienation from others deprives them of validating relationships and development of interpersonal skills.¹⁰² Additionally, through development, boys assimilate the understanding that *real* men are independent, in control, and self-sufficient as opposed to needy.¹⁰⁰ This loss of power confronts boys with feelings of emasculation.¹⁰⁶ Furthermore, this inferiority-complex can lead to learning deficiencies and other academic problems, which affects their chances at graduating or going to college.^{15,88,89}

A victim’s impaired self-perception also inhibits disclosure of abuse. Collin-Vezina and colleagues⁹¹ identified self-blame and shame as two of the most critical barriers to disclosing CSA. Similarly, when children do disclose and the abuse is not properly acknowledged through protective and supportive behavior, it can exacerbate a child’s poor self-esteem by reinforcing his feelings of self-worthlessness.^{98,108} Moreover, stoic reactions by non-abusive parents magnify boys’ vulnerability to revictimization by creating “emotionally deprived [and] needy” children,⁶⁴ which further increases victims’ risk of developing unstable relationships, insecure attachment, and intimacy issues, fueling a vicious cycle of low-self-esteem.^{88,99,100}

Following the SIT, this next section outlines how need for self-esteem affects male CSA victims’ social categorization process, and how society’s response to disclosure of CSA by males and male CSA in general influences social categorization.

3.2.2 Social Response & Categorization

Society’s response to disclosure and CSA in general has serious affects upon boy victims and survivors of CSA. In 2002, WHO⁸ revealed SV against males is not treated or acknowledged as an equally severe offence as SV against women, and according to Holmes and Slap,¹⁰¹ male CSA cases are less prosecuted than female cases.²⁵ It has also been demonstrated that when boys disclose as children they face more traumatic outcomes than disclosing as adults.⁹⁴ Negative responses to disclosure include: disbelief by parents/guardians, or blame and punishment for causing a family feud; gossip; social stigmatization; rejection; and labeling as a homosexual, pedophile and possible perpetrator.^{91,100,101} Society’s response to and beliefs about male CSA further inhibits victims from disclosing and overcoming their experience. First, society grants little credibility to children, and those who wish to speak out have little knowledge around existing CSA services. Second, discussions around sexuality at home and school remain taboo, which closes the line of communication with children who may be victims and ignores all possibilities of CSA. In a 2015 study, men explain not understanding ‘normal’ or abnormal sexuality as children, and lacking knowledge about sex, incorrect behavior and abuse, or where to access such information.⁹¹ Third, hegemonic masculinity promoted socially and culturally leads to minimal acceptance and stigmatization of males sexually victimized by men, and those victimized by women experience these repercussions to an even greater extent.^{5,96,100,106,109} Lastly, the racial inequalities and stereotypes that permeate the US exacerbate victim-blaming and unfavorable reactions to certain groups of CSA survivors, which is subsequently internalized by different races/ethnicities. For example, Black men are less likely to admit being affected by CSA than White or Latino men.^{91,96}

These factors contribute to the way boys make sense of social categories they are born into and the value they place on those categories. When boys go through categorization they also pass through a process called social-comparison, where one classifies people they see as similar in the same category, making up an “in-group,” and people they see as different classified as an “out-group,” (refer back to Figure 2). The SIT predicts that social categorization leads people to accentuate similarities they perceive between them and fellow in-group members, and differences between them and out-group members. By doing so, people heighten positive characteristics of their in-group and negative characteristics of the out-group, which ultimately serves to enhance their self-esteem.⁷⁶ Yet, for male CSA survivors who experience negative social reactions in a predominantly hegemonic culture, they struggle to identify with the social categories they perceive as desirable, and categorize themselves within a group they do not wish to associate with: CSA victims. As this group is a social minority, boys believe they are actually part of society’s “out-group,” while wishing to be part of society’s “in-group.” They then overcompensate to fit into the hegemonic male “in-group.” This culturally accepted masculinity framed by characteristics such as self-sufficiency, control, protection, power, stoicism, virility, aggression, and economic success, can become exceptionally problematic for male CSA victims.^{96,106,109} Because of their desire to socially categorize as men, CSA victims occasionally act out in hypermasculine behavior, exhibiting hyper-aggressiveness, over-control, emotional apathy, and violence or SA. This is common, as SA is not usually about sexuality or pleasure but purely about power.^{5,6,15,95,100,106}

*“These men described, often with remarkable eloquence, their struggle to reconcile the experience of sexual victimization with the demands which their culture places on them to be “masculine.” Masculinity, as defined by cultural norms, rejects vulnerability, passivity and helplessness, psychological states which comprise the very core of the experience of sexual victimization”.*¹⁰²

I will now analyze the affects of social categorization on male CSA survivors’ personal and social-identities.

3.2.3 Personal & Social-identity

As is visible in the struggles associated with social categorization, male CSA victims have an equally difficult time defining their personal and social-identities. The US does not typically accept the idea of male victims.^{52,109} “If men aren’t to be victims, . . . then victims aren’t men”.¹⁰⁰ This connection, linked to hegemonic masculinity, stems from the gender norms assigned by society. Since gender dictates roles, behaviors, characteristics and values ascribed to men, these ideals influence how men view themselves individually, within their interpersonal and social relationships, and in societal structures and policies.^{5,92} Therefore, males who abide by society’s ascribed gender roles deduce that being a victim means being un-masculine. Hence, CSA can significantly disturb a survivor’s development of masculine identity.^{55,106,110}

Men who experience CSA are confronted with pressure from family, friends and society to exhibit traditional masculinity while confronting the repercussions of abuse.¹⁰⁶ From a young age, before reaching puberty, victims describe feelings of “masculine inadequacy”.¹⁰² One victim describes, “Deep down if I were a real man I should have been able to stop the abuse”.⁵² Yet, instead of understanding and resolving this internal struggle, some men attempt to compensate by aggressively reasserting their masculinity or by seeking reassurance from “masculine” institutions like the armed forces.^{55,102,103}

Nevertheless, a plethora of factors, both personal and social, influence the degree to which gender expectations affect an individual who experiences CSA, and depending on the context, men may enhance or diminish their self-esteem by conforming or not conforming to these gender norms.⁹⁵ For example, Hispanic and Black men come from cultures emphasizing

traditional masculinity more than White culture. Black-masculinity stresses pride, control and physical strength; Hispanic-masculinity accentuates machismo and *caballerismo*, which values interpersonal dominance, control and family responsibility. Consequently, men from these cultures feel more pressure to conform to gender roles than White men.^{96,106} Payne and colleagues⁹⁶ demonstrate how these different factors play a role in CSA victim response: Black and Hispanic men who experienced CSA make more statements than their white counterparts regarding shame, guilt, regret, and confusion about sexual identity. If abused by a man, these boys may question why they were “chosen...as a sexual target, and whether having been chosen means [they are] ‘truly homosexual’”.¹⁰⁰ Hispanics express more anger, fear, communication issues, and emotional struggles, while Blacks speak least about anxiety and fear, but most about hyper-sexuality and substance abuse. Schraufnagel et al.⁵⁶ found boys who isolate themselves as a result of CSA favor anti-social peer-groups, engaging in anti-social activities like underage drinking and substance abuse to increase their self-esteem. Meanwhile, White men express self-hatred and low self-esteem most openly in comparison to Blacks and Hispanics.⁹⁶ Sexually abused boys/men hope to remain in line with “in-group” gender norms, while coping with abuse, and group and cultural norms clearly influence victims’ response to CSA and their attempts to reassert self-esteem.

Finally, having critically assessed the effects of CSA on males through the lens of the SIT, I now discuss what male CSA victims need to fulfill their desire for belonging and appreciation.

3.2.4 Discussion: Male CSA Victims’ Needs (Self-esteem and Personal/Social-Identity)

Sexually abused boys need reassertion and validation of self-worth; a supportive family with nurturing parents; an open dialogue at home and school around sexuality and abuse; a compassionate and conscious macro-environment that discourages stigma and victim-blaming; an accessible social system that listens to and believes children; and tools to understand, deconstruct, and renegotiate gender identity and socialization.^{7,15,53,88,91,106,111,112}

Research suggests that high-self esteem can serve as a protective factor against psychological disorders and negative outcomes of CSA.⁸⁸ For this reason it is imperative that family members, especially parents, be supportive and nurturing. Evidence shows affectionate parent-child relationships significantly lower the odds of CSA victims displaying aggressive behavior and help CSA survivors develop better intimate relationships in the future.^{7,53} Furthermore, low-self-esteem inhibits empathy, which contributes to SV perpetration.⁷ To avoid future perpetration, developing self-esteem among male CSA survivors should be made a priority.

As relational connections with family, friends, and fellow CSA survivors show great improvement in discussing survivors’ experiences and advancing in recovery,¹⁰⁶ strong interpersonal relationships are key in reducing future perpetration among sexually abused boys. Schools also show potential as a safe haven for CSA victims. If surrounded by good friends and teachers who serve as supportive and positive role-models, boys can cultivate hope for their future.^{15,113} Therefore, schools need to raise CSA awareness, address stigma, and provide an outlet for children to disclose.^{15,91}

Similarly, resilient CSA survivors stress the importance of tools for renegotiating traditional gender roles in order to resist aggressive, hyper-masculine and abusive behavior.^{106,111} Research demonstrates how sexually abused boys juggle prescribed masculinity and their victimization history simultaneously; their survival depends upon the ability to negotiate or reject these norms.⁹⁵ Furthermore, families accepting of gender-nonconforming behavior “contribute to positive self-esteem, increased social support, life satisfaction, and overall health in early adulthood, and [serve] as a protective factor against depression and suicidality”.⁹² It is clear that interventions need to stress the importance of gender-transformation and nonconformity.

Lastly, boy and male survivors from diverse ethnic/racial backgrounds may need different responses to overcome SA. As depicted above, White, Black and Hispanic-men are affected differently by victimization as a result of cultural upbringing and environment.^{96,106} Survivors should be provided with a corresponding response to address their particular concerns.

Having assessed the needs of male CSA survivors, I will now examine the US' CPS program and response to male CSA.

3.3 Child Protective Services in the US

I first describe CPS at the national level, as it is overseen federally. Then, I describe CPS in Pennsylvania and Georgia, as services vary by state in terms of funding, policies and stakeholder interests.

Each state's administrative structure differs. State central offices, county offices or a mix of both are responsible for responding to claims of CA and neglect, including CSA. Yet, cases of abuse only come to CPS' attention when reported, and claims are only accepted when the source is one the state deems credible. Most states mandate reporting by professionals who work with or encounter children in their jobs. Some, but not all, states accept additional reporting sources, such as victims, family members or anonymous persons.^{46,114} Some, but not all, state referrals/reports are followed by an investigation. Those indicating "low or moderate risk of maltreatment" receive an alternative response (sometimes called differential response), which typically includes voluntarily accepted CPS services that focus on family needs. Meanwhile, the investigation process has two objectives: to establish if a child was or is at-risk of being maltreated; and to identify if services are needed and which services should be provided.⁴⁶ If a report is investigated, it results in determining the disposition of the alleged maltreatment. The most common dispositions are: substantiated (or founded), meaning the report of abuse is recognized and supported by state law or policy; or unsubstantiated (unfounded), meaning there is not enough evidence according to state law to determine CA or risk of abuse.⁴⁶

Each state program has unique statutes and policies that delineate state response to CA accusations, and definitions of child maltreatment and its sub-types.⁴⁶ Policies also outline time guidelines for beginning response to screened-in reports. Nationally, response-time refers to the amount of time CPS takes to meet in-person with the alleged victim after receiving a referral about their case. Depending on the state, CPS has either one timeframe to respond to all reports or multiple timeframes to respond to "high-priority" reports within 24 hours versus low-priority reports within a few days; average state response-time in 2013 was 2.7 days.⁴⁶ Each state's response-time also depends on its human resources, and considering the complexity of cases and the workload of CPS staff, there is increasing attention to how CPS addresses workforce challenges and shortages, but this is beyond the scope of this study.¹¹⁵ Generally, states have different groups of people assigned to screening, investigations and alternative response, but some states have one person that performs all or a combination of the tasks per referral; the 2013 Child Maltreatment report⁴⁶ indicates that one CPS employee responds to about 68 cases per year.

A comprehensive overview of national CPS referrals, screenings, reports and response from 2013 can be found in Appendix B. To better depict how states vary, I discuss Pennsylvania and Georgia CPS program structures and their response to CSA in the following sections.

3.3.1 CPS in Pennsylvania and Georgia

Between 2009 and 2013, Pennsylvania's CPS provided approximately 23,000 investigations or differential responses to victims of CA and neglect each year, with an overall workforce of about 2,800 caseworkers.⁴⁶ In comparison, Georgia provided four times more (~80,000) investigations or differential responses yearly with half (1,408) the amount of caseworkers,⁴⁶ and in 2013 alone, Georgia conducted 114,000 investigations or differential responses. While

Georgia has a lot more referrals to respond to than Pennsylvania, they mainly comprise of neglect (67% per year), while Pennsylvania’s CPS referrals predominantly regard CSA (68% per year).⁴⁶ Reasons for these differences are not entirely clear; however, some explanations may stem from each state’s CPS structure, abuse definition, policies and statutes, workforce and available services. These defining characteristics of Pennsylvania and Georgia’s CPS programs are outlined below (Table 3).

Table 3: Pennsylvania and Georgia’s CPS Defining Characteristics

	Pennsylvania	Georgia
CA definition	<p>(i)An act or failure to act by a perpetrator, which causes non-accidental or imminent risk of serious physical or mental injury to, or SA or sexual exploitation of a child under 18 years.</p> <p>(ii)Serious physical neglect constituting of prolonged or repeated lack of supervision or failure to provide essentials of life, including adequate medical care, which endangers a child’s life or development or impairs the child’s functioning.¹¹⁶</p>	<p>(i)Physical injury or death inflicted upon a child by a parent or caretaker thereof by other than accidental means; provided, however, that physical forms of discipline may be used as long as there is no physical injury to the child</p> <p>(ii)Neglect or exploitation of a child by a parent or caretaker</p> <p>(iii)Sexual abuse or exploitation of a child¹¹⁷</p>
CSA definition	<p>CSA: "The employment, use, persuasion, inducement, enticement or coercion of a child to engage in or assist another individual to engage in sexually explicit conduct or simulation of sexually explicit conduct for the purpose of producing visual depiction, including photographing, videotaping, computer depicting and filming; or rape, sexual assault, involuntary deviate sexual intercourse, aggravated indecent assault, molestation, incest, indecent exposure, prostitution, SA or sexual exploitation, if the offense is committed against a child."¹¹⁶</p> <p>Perpetrator: "a person who has committed CA and is a parent of a child, a person responsible for the welfare of a child, an individual residing in the same home as the child (the individual must be 14 years of age or older), or a paramour of a child’s parent".⁴⁶</p>	<p>CSA: "a person's employing, using, persuading, inducing, enticing, or coercing any minor who is not that person's spouse to engage in any act which involves: sexual intercourse, including genital-genital, oral-genital, anal-genital, or oral-anal, whether between persons of the same or opposite sex; bestiality; masturbation; lewd exhibition of the genitals or pubic area of any person; flagellation or torture by or upon a person who is nude; condition of being fettered, bound, or otherwise physically restrained on the part of a person who is nude; physical contact in an act of apparent sexual stimulation or gratification with any person's clothed or unclothed genitals, pubic area, or buttocks or with a female's clothed or unclothed breasts; defecation or urination for the purpose of sexual stimulation; or penetration of the vagina or rectum by any object except when done as part of a recognized medical procedure".^{117,118} Georgia does not have an exact definition of a perpetrator.</p>
Administrative Structure	<p>State-supervised and county-administered: each county is solely responsible for responding to and investigating CSA claims.¹¹⁹ State Central Office maintains the hotline, screens & determines the need for response, and assigns cases to their corresponding county.¹¹⁴</p>	<p>State-supervised and county-administered: the Division of Family and Children Services (DFCS) is held responsible for the administration and management of CPS, but Georgia holds county or local offices accountable for all major CPS functions.^{114,120}</p>
Mandatory Reporters	<p>Licensed physicians & practical nurses; registered nurses & hospital personnel engaged in admission, examination, care or treatment; dentists, osteopaths, optometrists, chiropractors, & podiatrists; medical examiners & mental health professionals; coroners & funeral directors; Christian Science practitioners; member of the clergy; school administrators, teachers, & nurses; social service workers; day-care facility employees or any other child-care or foster-care employee; peace or law enforcement officers.¹¹⁶</p>	<p>Licensed physicians, physician assistants, interns, or residents; hospital or medical personnel; reproductive health care facility or pregnancy resource center personnel and volunteers; dentists & podiatrists; registered professional nurses or licensed practical nurses; licensed psychologists & their interns; professional counselors, social workers, or marriage/family therapists; school administrators, guidance counselors, substitute-teachers, social workers, or psychologists; child welfare agency, child-counseling & child service organization personnel; and law enforcement employees.^{117,118}</p>
Accepted Reports	<p>Pennsylvania accepts reports from all sources.¹¹⁴</p>	<p>Georgia only accepts reports from anonymous persons.¹¹⁴</p>

	Pennsylvania	Georgia
Screening	Pennsylvania screens-in and investigate every referral of child maltreatment. ⁴⁶	Georgia does not screen-in all reports, but decides whether the report is worthy of an investigation based on the child’s age (0-17), suspected maltreatment, and a known/suspected perpetrator. All reports are referred to local law enforcement, and screened-out reports are assessed by supervisors. ¹²⁰
Alternative Response	Screened-in referrals that do not meet CPS child abuse definitions, take a differential response . ⁴⁶	Screened-out referrals take a differential response to prevent CA among vulnerable families by supporting their identified needs. ¹²⁰
Response-Time	Pennsylvania does not generally report response-time; yet, state mandates county-agencies open an investigation immediately in an emergency , where protective custody is urgently needed, and if CPS does not detect an emergency, investigation is required to open within 24 hours of the referral. ⁴⁶	Response-time statewide is within 24 hours for all investigations , unless assigned to Family Support Division; then, response-time is within five workdays . DFCS determines investigation response-time after an initial interview and assessment of present danger; if a child’s safety is at risk, then DFCS requires initiation of investigation and safety-plan. ¹²⁰
Work-force	Each county-agency is staffed by caseworkers who specialize in either investigations or general protective service assessments, or caseworkers who do both. ⁴⁶	
Possible Dispositions	(1) Founded : “there is judicial adjudication that the child was abused”; (2) Indicated : report is supported by substantial evidence from medical exams, CPS findings, and/or a confession; (3) Unfounded : “there is a lack of evidence that the child was abused”; and (4) Pending : report could not be completed within 30 days due to initiated juvenile/criminal court action. ^{46,119}	(1) Substantiated : “a preponderance of evidence supports the allegation”; (2) Unsubstantiated : where “there is either no evidence or not a preponderance of the evidence to support the allegations”. ¹²⁰ Each investigation also entails a Risk Assessment , which indicates whether the case is open/closed: (1) Open : case is open for CPS services or placement of children; (2) Closed : case displays no significant risk factors for services or placement. ¹²⁰

With Pennsylvania and Georgia’s CPS context described above, I will now look specifically at their response to CSA. It is crucial to note that neither Georgia nor Pennsylvania’s CPS programs report sex-disaggregated data among type of maltreatment or a sex-specific response for abused boys and girls. Therefore, when analyzing their response to male CSA, I base my findings on a general CSA protocol, assuming this response applies to both girl and boy victims.

3.3.2 Pennsylvania’s Response to CSA

Pennsylvania has one of the first developed CA medical programs nationwide; stemming from Pittsburgh Children’s Hospital in 1960, Pennsylvania’s Children’s Advocacy Center (CAC) plays a major role in CSA cases throughout the state.⁵⁰ Once CSA cases are founded or indicated, CPS works closely with CACs to provide services to victims.^{121,122} Since investigation and prosecution of sex crimes tend to be complex and obscure due to missing evidence and power dynamics between the perpetrator and the child, CACs facilitate the process.¹¹⁶ They have been pronounced “the single most important tool in the investigation of [CA]” to manage the various challenges within the criminal justice and child protection systems; CACs have had a 100% success rate with prosecuting CSA cases in Pennsylvania.^{116,121,122} CAC’s primary purpose is to provide a coordinated response to alleged CA cases, through a child-focused and facility-based program. CACs are founded on multidisciplinary teams (MDT) comprised of CAC and CPS caseworkers, law enforcement personnel, medical and mental health professionals, prosecutors, and victim advocates. Together, the MDT provides “forensic interviews ⁹, medical [and mental

⁹ Forensic interview is: a structured conversation with a child that may be a victim of physical or sexual abuse intended to gather information about the possible event(s) around their experienced or witnessed abuse; it is a single session (often recorded) that is conducted by professionally trained forensic interviewers who use a supportive and non-leading technique.¹²³

health] evaluations, therapeutic interventions, victim support and advocacy, team case reviews and a system for case tracking".^{116,121} Pennsylvania CACs also collaborate with hospital sexual assault nurse examiners who specialize in pediatric SV.

Nevertheless, only 20 CACs exist throughout 67 counties.¹¹⁶ Geographical inaccessibility and volatile funding creates barriers to reaching all CSA victims statewide. Many children are thus not provided medical exams needed for their case or are given an exam by professionals who lack training in CSA indicators and injuries. Furthermore, as CSA can be ambiguous, CAC's role is important for successful prosecution, especially through recorded forensic interviews (FIs). The non-leading and neutral techniques used by forensic interviewers are conducted in a child-friendly, comfortable, private environment using toys or games, which provide critical evidence needed for such cases.^{121,122} It has been found that defendants faced with these tapes often give-in, pleading guilty to crimes they previously denied, and saving children from the trauma of testifying in court. For this reason, it is vital that FIs be correctly conducted. State policies even recommend that Pennsylvania State and Municipal Police departments train staff on the efficacy of FI for CSA.^{116,121}

An Overview of Pennsylvania's Male Child Sexual Abuse (2013)¹¹⁹

- CSA has consistently been the most prevalent type of abuse in Pennsylvania
- 53% of all substantiated reports in 2013 were due to CSA
- 20% (358) of all substantiated CSA reports affected boys
- 64% (2,658) of substantiated injuries were sexual
- 64% (1,710) of sexual injuries were caused by sexual assault
- 16.5% of sexual injuries were inflicted by fathers
- 26% of sexual injuries were caused by "other" family members
- 17% of sexual injuries were committed by babysitters and 85% of injuries that babysitters committed were sexual

Pennsylvania also takes a proactive public health approach, ensuring CSA prevention activities target various socio-ecological levels. For primary prevention of CSA, Pennsylvania provides education on healthy relationships, CSA risk factors, protective policies, and action against SA. They also undertake advocacy and action to make societal changes around the norms that support CSA.¹¹⁶ For secondary prevention, the state offers CSA screening and response classes for parents, educators and physicians; awareness campaigns around available services for CSA survivors; and CSA stigma reduction activities. Finally, for tertiary prevention, Pennsylvania provides services aimed to reduce recurrence among survivors by working with perpetrators to prevent future abuse and by offering rehabilitation services for victims to diminish long-term negative effects. Pennsylvania claims their most effective CSA prevention programs are long-term and involve both parents and children in a meaningful manner via modeling, group discussion, and role-play techniques.¹¹⁶

*"Changing the behavior of adults and communities, rather than the behavior of children, is the ideal way to prevent child sexual abuse."*¹¹⁶

3.3.3 Georgia's Response to CSA

Georgia's 2014 Protection of Children protocol states all CSA cases be referred to a CAC for an interview and treatment.^{117,118} Similar to Pennsylvania, Georgia's DFCS considers CACs an essential component to conducting joint investigations, especially with the help of MDTs.¹¹⁷ In Georgia's CACs, as in Pennsylvania, FIs are videotaped and conducted in a developmental, cultural and linguistic-sensitive manner. Additionally, interviews are non-leading and unbiased to ensure credibility in court.¹¹⁷ After FIs, Georgia requires MDTs, structured parallel to those in Pennsylvania, to offer recommendations around the child's medical needs and referral for treatment. Each professional within the MDT brings their understanding of the case forward to best respond to and support CSA victims and their families. Full-disclosure is expected within the MDT to facilitate each represented agency's responsibilities regarding the case.¹¹⁷

If the MDT recommends a child be referred for treatment, the CAC or other trained child therapists provide the necessary counseling. Generally, CACs use Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) for CSA rehabilitation, as it is considered the most effective treatment for traumatized and sexually abused children.¹¹⁷ This approach stresses the involvement of both the victimized child and his/her parents. Throughout the process, a therapist meets with the child and parents separately, and then together.¹¹⁷ Georgia's TF-CBT objectives are to help children and their parents learn about CSA and trauma in comparison to healthy sexuality; develop healthy and effective coping mechanisms as well as body safety skills; work through consequential negative thoughts, feelings, and behaviors; and process the traumatic experience in a therapeutic manner. Additionally, certain CACs offer Play Therapy, which is a technique using games, art, toys and creativity to enable communication and recovery among CSA survivors.¹¹⁷

Georgia has only 49 CACs, which aim to serve 159 counties. When there are no local CACs, children and their families are referred to other mental health providers who have experience in CSA and are appropriate for the child's needs and family's financial means.¹¹⁷ If a family declines treatment or refuses to cooperate, and the provider thinks this behavior poses a continued risk for the child, then another referral is made to CPS.¹¹⁷

3.3.4 Discussion: Addressing Self-esteem and Identity in CPS (Pennsylvania vs. Georgia)

Looking at Pennsylvania and Georgia's response to CSA, a few interventions stand out regarding self-esteem and identity. First, by taking a differential response for children at low or moderate risk of maltreatment, Pennsylvania and Georgia contribute to strengthening family structures and relationships. This can ultimately build children's sense of security, identity and self-esteem before CSA even occurs.^{46,53,92,108,114} Additionally, Pennsylvania's preventive efforts of advocacy and action against social norms supportive of CSA, education around healthy relationships, and awareness activities for reducing CSA stigma indirectly help male CSA survivors build a positive personal and social-identity and consequently a good self-esteem.^{55,91,92,95} Second, both Pennsylvania and Georgia's use of CACs and MDTs throughout CSA investigations help diminish sexually abused children's self-blame and -hatred by providing a culturally, developmentally and linguistically-compassionate environment.^{124,125} Furthermore, Georgia's CAC model, which incorporates parents in children's TF-CBT and helps the child and parent work through negative thoughts, feelings, and behaviors, fortifies the parent-child relationship and addresses poor self-esteem resulting from abuse. All of these eventually help the child develop a positive personal-identity.^{53,55,92,95,108}

Nevertheless, as CSA response interventions are neither described explicitly nor directly targeted toward male CSA victims, it is difficult to conclude just how each intervention addresses specific identity or self-esteem issues among boys. For example, though Pennsylvania describes changing societal structures and cultural norms supportive of CSA as prevention, the state fails to outline strategies needed to achieve this or if they even target hegemonic masculine norms.¹¹⁶ As most CSA reports affect girls,⁴⁶ their response may focus predominantly on girls. Additionally, since type of maltreatment and sex is not racially disaggregated, response may not sufficiently take culturally specific backgrounds into account. If they do, it is not clear how or when they do so.

Furthermore, it is curious that CSA demographics indicate Blacks are mostly affected, but Whites predominantly perpetrate.^{46,47} Meanwhile, intra-familial CSA is more common than extra-familial CSA.^{46,59,119} If Blacks are at highest risk of CSA, then their corresponding Black parents/guardians or family members would presumably be the perpetrators, but somehow, the statistics do not match up. This may be due to bias in reporting, racial-profiling or prejudice.^{30-32,47} Although state laws prohibit retaining racial/ethnic related information

regarding CA victims or perpetrators,⁴⁶ I believe there may be reasonable cause to do so. If we do not know the details of victims or perpetrators of CSA, we cannot know their circumstances, needs, or motives to adequately intervene. Most importantly, cultural awareness and sensitivity should be an integral part of CPS, CACs and corresponding organizations.⁴⁷ Only when aspects of a victim's identity are addressed will CSA survivors be able to heal and develop positive personal and social-identities.

Next, I examine interventions that have been proven effective or shown promise for treating male CSA.

3.4 Most effective male CSA interventions

The majority of CSA treatment methods aim to achieve one or multiple of the following objectives: symptom relief; de-stigmatization; improved self-esteem; and/or recurrence prevention.¹²⁶ Before beginning treatment for sexually abused boys, it is fundamental to assess their environment for persisting violence such as IPV, DV or other forms of maltreatment, for this can hamper the progress of treatment and exacerbate the repercussions of CSA.^{59,64,90,127,128} Various CSA treatments exist, and while some have been tested extensively, others are promising but tested insufficiently. Below, I address the most promising treatments based on numerous reviews and meta-analyses.

3.4.1 Types of Interventions

Cognitive Behavioral Therapy (CBT) is one of the only evidence-based treatments that exist for dealing with sexual trauma, stigma, powerlessness and feelings of betrayal.¹²⁷ It normally consists of a combination of child therapy, and training or counseling for parents of sexually abused children. The treatment focuses on parent-child communication, cognitive-education, psychological reframing, and parent-management skills.^{125,129} Common themes addressed within children's sessions are: safety and avoidance; coping with and processing the abuse; relaxation techniques; self-awareness; and identifying inappropriate behavior.¹²⁹

Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) is a method that employs CBT and stress management techniques originally used for treating adults with depression, anxiety and fear. Modified to treat children demonstrating symptoms associated with PTSD as a result of SA and trauma, TF-CBT commonly incorporates child and parent relaxation training; self-soothing activities; emotional distress communication and management techniques; self-blame deconstruction and self-worth affirmation activities; and parental education for addressing child behavioral difficulties.¹²⁶

Group Therapy, incorporating family or other CSA survivors, has been shown as the most effective treatment for sexually abused children within one meta-analysis.¹³⁰ Family therapy is particularly effective when elements of child-support and empathy are included, as this gives non-offending family members the skills to adequately support the sexually abused child and provides the child with family acceptance, feeling acknowledged and understood.¹³⁰

Concurrently, some speculate individual therapy, including CBT, supportive therapy¹⁰, and art therapy¹¹, provides a more comfortable atmosphere than group therapy for children to discuss depression and anxiety, and work through psychological distress.¹³⁰

The 3-phase treatment modality is a method used for CSA victims suffering from Dissociative Identity Disorder (DID)¹² aiming to: relieve symptoms through cultivation of self-confidence

¹⁰ Supportive therapy is any method of treatment that aims to alleviate symptoms or help a person cope with their symptoms as opposed to change their character structures¹³¹

¹¹ Art therapy is a method using art media and creativity in order to explore a patient's feelings, reconcile conflicting emotions, create self-awareness and improve self-esteem, cultivate social skills, manage behavioral challenges, and reduce anxiety^{132,133}

and control; help the child confront and cope with aftereffects of trauma; and strengthen identity through restructured thinking of the self and abnormal developed identities.¹²⁶ The treatment consists of three phases: first, the therapist negotiates with the dissociative-developed identities to moderate aggressive and volatile behavior; second, the therapist and child work through traumatic memories, so the child can make sense of the experience and learn to cope with it as a part of his personal history; and third, the child works on strengthening his ability to integrate his dissociated identity into his prominent ego-state.¹²⁶

3.4.2 Determinants of Success within Interventions

Each type of treatment's success or effectiveness is determined by its ability to reduce negative consequences resulting from CSA or increase resiliency for dealing with CSA. Studies of CBT demonstrate effectiveness in: reducing children's fear, anxiety, depression, and PTSD symptoms; enhancing children and parents' coping abilities; and decreasing children's sexually aberrant and emotionally problematic behavior.^{127,129,130,134-136} When conducted as family therapy, CBT shows significant improvement in anxiety and fear.^{125,136,137} Individual CBT has also demonstrates promising results for reducing PTSD symptoms and anxiety among sexually abused children with heightened anxiety.^{130,137} Nevertheless, some studies show conflicting evidence in CBT's efficacy for reducing children's depression and behavioral problems.^{129,135}

Analyses of TF-CBT indicate that among CSA survivors, TF-CBT can significantly improve: PTSD symptoms like re-experience, avoidance, and hyper-vigilance;¹³⁸ behavioral problems,¹²⁷ including dissociative symptoms and hyper-sexuality; mental health outcomes such as depression, anxiety, shame, and guilt;^{125,138} and caregiver-child relationships.¹³⁸ Among parents who participate in TF-CBT, results revealed significantly reduced depression and abuse-specific anguish, and increased supportive behavior toward children and positive parenting practices.^{125,138} When compared to a control-group, participants exposed to TF-CBT show lower distress symptoms, and significantly improved depression, PTSD symptoms, and sexualized or internalized behavior than participants receiving other treatments.^{125,126} TF-CBT also shows superior outcomes to play therapy. When combined with supportive therapy, TF-CBT shows the most improvement in psychological health.^{125,127} Still, one meta-analysis classified a few of the studies indicating positive psychological outcomes for sexually abuse children as methodologically flawed.¹²⁷ More testing needs to be done to ensure this method is as promising as it currently appears.

Group and Family Therapy effectiveness, as compared to child-only treatment, results in better outcomes regarding PTSD, externalized and internalized behavior, and hyper-sexuality.^{136,137} It has been demonstrated that CSA survivors who find an accepting environment to heal within a family or family-like group will gain a feeling of belonging, identity and self-worth, which is in line with Tajfel's SIT⁵⁸

Parallel, individual therapy, whether conducted through CBT, supportive therapy or art therapy, has been found most effective in helping sexually abused children express their emotional reactions, especially since these methods provide a safe space to discuss the abuse and cultivate new forms of expression.^{127,130} One review of therapeutic approaches for adult survivors of CSA shows both individual and group therapy decrease depression, psychiatric distress and trauma-related symptoms.¹³⁹

The 3-phase treatment modality method helps children face their grief and loss while investing in the present in attempt to lessen their reliance on dissociative mechanisms.¹²⁶ This treatment appears especially promising for male CSA victims who have a high tendency to exhibit

¹² DID is a condition often seen in sexually abused children who attempt to dissociate themselves from the traumatic event and, as a result, develop two different identities that occasionally take control of the child's behavior, accompanied by amnesia.¹²⁶

dissociative behavior, yet few studies exist on the treatment's effectiveness.^{52,88,100,102,126} Further studies should be conducted with male CSA survivors in particular.

Each treatment method has its strength for addressing specific issues. Therefore, a combination of methods may be best employed for targeting certain psychological and behavioral adversities.¹²⁷ For depression and sexualized behavior, combining CBT, play therapy and supportive therapy; or conducting CBT or supportive therapy alone, shows best results. For improved self-esteem, combining CBT and play or art therapy, or using CBT on its own provides statistically significant positive outcomes.^{125,127,133,136,137} For behavioral problems, best results are seen with supportive therapy provided in conjunction with CBT, followed by CBT combined with play therapy and supportive therapy, and CBT by itself. For psychological distress, optimal results have been achieved by CBT and individual treatment. For social performance skills, play therapy demonstrates best outcomes.¹²⁷ Overall, CBT combined with supportive therapy, or play therapy shows the best effects for treating sexually abused children.¹²⁷

3.4.3 Discussion: Best interventions for Male Self-Esteem and Identity

Characteristics identified as essential factors for a successful response to sexually abused boys' self-esteem and identity are: immediate attention to psychological suffering and ensured safety;^{125,129} longer-lasting therapy with enduring results;¹³⁰ acknowledgement and minimization of additional child and family hardships;¹²⁹ and provision of tools to deconstruct and renegotiate gender-roles.¹⁰⁶

According to these findings, the ideal responses to male CSA would be those geared toward developing solid interpersonal relationships, a positive sense-of-self and a healthy identity, as predicted in the SIT. TF-CBT, through individual, family and group therapy seems to address many aspects that contribute to building a child's self-esteem and identity. CBT or TF-CBT are most often praised for responding to CSA; however, this may be merely due to the fact that they are the most extensively-tested forms of treatment to date.^{125,127,129,130,134-136,138} Still, a standardized treatment cannot yet be identified, as many methods lack sufficient experimental testing. It is also difficult to identify whether CBT and TF-CBT are as optimal for sexually abused boys as for girls. Meanwhile, the 3-phase treatment modality shows promise for male CSA survivors as it caters to dissociation, which is more commonly experienced among male than female CSA victims.^{52,88,100,102} Findings from a meta-analysis of psychological treatments for sexually abused children¹²⁷ further supports sex-specific treatment, as it may provide most effective results among males since boys face unique challenges in forming healthy identities.

3.5 Opportunities for Improving Child Protective Services in Georgia and Pennsylvania

3.5.1 CPS and CAC

Having looked at promising treatments for sexually abused boys, and CPS in Georgia and Pennsylvania, I have identified multiple opportunities within CPS to strengthen their response to male CSA.

First, state definitions of CSA and perpetrators need to be unified. If definitions are unified, reporting is unified, and comparison of CSA incidence and prevalence between states becomes a realistic possibility. As mentioned in 3.1.3, varying definitions of CSA affect levels of reporting and make it difficult to know whether CSA prevalence is *actually* higher or simply appears so due to reporting.^{10,84-86}

Second, CPS must strengthen its workforce to ensure sufficient staff support and a feasible caseworker to child ratio. Without an adequate workforce, it is difficult to assess why CSA prevalence differs.⁴⁶ Perhaps CSA reports are less substantiated in Georgia due to a lack of

human resources, or perhaps they are more substantiated in Pennsylvania because of sufficient human resources.

Third, CPS should standardize mandatory and accepted reporting, screening, and response-time procedures across states. Additionally, standardized policies should be structured around strategies to expand referred and accepted sex-disaggregated maltreatment reports with greater awareness toward *male* CSA in order to use financial and human resources most effectively. We know CSA is underreported in general and specifically among boys, so CPS must create an environment sensitive to male CSA that encourages and accepts referrals/reports concerning them. One study discovered that CPS substantiated fewer CSA cases, even when MDTs found probable cause for abuse, if the child was White, in his/her older years, had STI testing, or was less likely to disclose the abuse.¹⁴⁰ Meanwhile, CPS substantiated CSA cases more often when the child was female and in her teens; displayed speech impediment and lacked sexualized behavior; had a history of CSA; and disclosed CSA.¹⁴⁰ Furthermore, when interviewed, CPS caseworkers generally displayed more skepticism about CSA allegations and were more concerned with false accusation than were MDT members.¹⁴⁰ This shows that the CPS system and its caseworkers may lack a sex- and racially-sensitive response. If so, this could be an opportunity for improvement

Fourth, CAC's partnership fortifies CPS' response to CSA. Studies comparing CAC outcomes with non-CAC community outcomes show that communities with CACs have more coordinated investigations, increased involvement from law officials, better access to medical exams and referrals for psychotherapy, increased removal of children from homes, more prosecution of offenders, and greater satisfaction from family members.^{50,140} However, it should be noted that these are proxy measures, and just because CACs demonstrate better outcomes among these measures does not prove they reach sexually abused boys, or that they translate, for example, to *actual* medical exams or *received* psychotherapy. Studies indicate this as a serious downfall within CPS' system, as sexually abused children only occasionally follow-through with mental health referrals and the majority of children not receiving treatment are Black.¹³⁴

Finally CPS should strengthen its response by following-up on sexually abused children referred to psychotherapy. CPS must ensure that abused children receive treatment or understand why they do not. By doing so, CPS can focus on working more closely with children and families less likely to follow-through until arriving at a solution.¹³⁴

3.5.2 Discussion: Strengthening Self-Esteem and Identity

Upon review of these findings, I believe CPS and CAC's main opportunity to address self-esteem and identity among male CSA lies predominantly within their workforce and their therapeutic treatment methods. Sexually abused boys' first point of contact is a caseworker. It is therefore essential that CPS assure its caseworkers adequate training and support to interact with clients in a compassionate, neutral, gender- and racially-sensitive manner. To better target their responses, CPS should also attend to sexually abused boys' demographics and sociocultural backgrounds in their strategy design and program planning. By doing this, they can gain insight into boys' self-esteem and identity needs.

Additionally, as CACs provide warm and child-friendly environments specific to CSA victims, it is preferable to refer sexually abused boys to these facilities. Still, CACs remain insufficient to serve the entire state, so it should be made a priority to place them in locations that are most affected by CSA and gradually scale-up. CAC professionals' responses can also be strengthened by prioritizing protective factors that reduce recurrence: increased self-esteem, social support, and nourishing relationships, for these all contribute to a positive personal and social-identity.⁸⁸

3.6 Limitations

Due to the scope of this study, I encountered many limitations. As Georgia and Pennsylvania vary in many aspects, comparability of reports between states proved difficult. By having different definitions of CSA and perpetrator, mandated and accepted reporters, screening-in protocol, response-time, and human resources, it is difficult to determine whether CSA state prevalence is actually higher in Pennsylvania or if it just appears so due to reporting differences, policies, or manpower.

The fact that CPS does not disaggregate data by sex and type of maltreatment, race, or sex *and* type of maltreatment also makes it difficult to draw conclusions regarding male CSA victims' needs, generally or specifically. Since states have statues prohibiting race-disaggregated data, it is impossible to recognize differences in risk and incidence among each race/ethnicity. As seen in the findings from 3.2, boys from different races or cultural backgrounds experience the repercussions of CSA differently, warranting different responses. Consequently, I believe this type of disaggregated data is essential. Without knowing what race is most affected by male CSA, steps cannot be taken to formulate the most effective response for those most affected. Additionally, few studies exist to date that look at the impact of race on male CSA, let alone the impact of race on CSA treatment methods, which further limits my research findings.¹³⁹

Similarly, CPS reports a general response to CSA, not a sex-specific one, which makes it challenging to know whether their *actual* response differs between boys and girls. This makes measuring the effectiveness of their response to sexually abused boys practically impossible.

Reports, particularly protocols and procedures on paper, do not always translate in reality. This is an overarching limitation for my thesis. I acknowledge that these findings may not be an accurate representation of CPS' reality in Georgia or Pennsylvania. Future research could be strengthened through conducting qualitative interviews with male CSA survivors, CPS caseworkers, and CAC employees.

Finally, studies regarding males CSA are less well-tested. This is a particularly salient problem when looking at CSA therapy treatments. Most treatments are tested with CSA female survivors and not males. While my literature review includes some studies conducted with males, most are based on outcomes regarding females. This can have serious implications for determining best CSA treatment among sexually abused boys, as males face particular adversities regarding masculinity that differ from females. Furthermore, studies that measure treatment efficacy are often designed in a structurally weak manner with pre/post-evaluation rather than a control-group.^{127,130,138} These studies are also not conducted over a long enough period of time, nor are they followed-up past one year,^{125,129,139} making it difficult to determine whether these treatments have long-lasting or sustainable effects to prevent future perpetration.

4 Conclusion

It is imperative that more people become aware of male CSA's reality, and behavioral, social, and health implications. Males are too often overlooked as victims due to social norms and perceptions around masculinity. It is time society acknowledges the severity of boys' suffering and adversities, especially if we ever hope to end the cycle of gender-based and sexual violence. Gender norms must be transformed to promote a gender-equitable society. While this shift occurs, all males must be given tools to renegotiate or refuse norms they are born into and are expected to adopt. Without these tools, sexually abused boys will continue to suffer the consequences of a disabled self-esteem, muddled identity, and risk for recurrence, while women and girls bear the brunt of this violent cycle.

My findings suggest that male CSA victims must be provided with:

- an open dialogue at home and in schools around sexuality and abuse;
- a supportive family response and nurturing parents;
- a compassionate and conscious environment, discouraging stigma and victim-blaming;
- an accessible social system responsive to children;
- reassertion and validation;
- tools to understand and deconstruct gender-identity and socialization.

4.1 Recommendations

4.1.1 For the US Government

To fulfill male CSA victims' needs, the federal government must first acknowledge male victims and include them in the "1 is 2 Many¹³" campaign and Violence Against Women's Act. The US has made great strides in their fight to end VAWG, yet they seem to ignore a key group of players: perpetrators. One must understand the cycle of violence to break it. Still, the US has yet to recognize boy and male victims as key participants in this fight. It is only when those at risk of becoming perpetrators are identified, loved, accepted, and in recovery, that we can break the cycle.

4.1.2 For CPS & CAC

Similarly, child protection agencies must make efforts to acknowledge male CSA, but most specifically CPS needs to make male CSA a priority.

CPS and CACs should take a holistic approach in reducing individual, relational and socially persisting risk factors in response to CSA rather than simply treating resulting symptoms. A particular emphasis should be placed upon the relationships and family structure within which the boy is raised, as this will have the most protective or debilitating consequences in addressing his need for belonging and sense-of-worth. Most importantly, in working with families, CPS and CACs can reduce the risk of future perpetration and violent behavior among sexually abused boys if they:

- identify the perpetrator and the type of abuse committed to allocate appropriate responsibility;
- make corresponding apologies;
- reduce self-blame among the victim;
- work to diminish denial, minimization and accusation, so the victim's externalized response

¹³ The 1 is 2 Many campaign was initiated by the Office of the Vice President to commemorate the 20th anniversary of the Violence Against Women's Act. It focuses on reducing dating violence and sexual assault targeting women 16-24 years, and only briefly mentioning boys/males.²⁵

- and feelings of guilt and shame are abated;
- cultivate assertion and address power dynamics within the family to restore balance and reestablish proper authority;
- correct boundaries to prevent victims from identifying with or role-modeling the perpetrator;
- adequately address loss and grief, so children removed from homes can better manage the process of dissociating from their aggressor.⁵⁸

Additionally, CPS should ensure their program planning and strategy design considers demographics of boys most affected by CSA, as it may provide insight into aggravating factors around ideas of masculinity, violence and perpetration.

Nevertheless, a particular focus should always be placed on increasing protective factors like positive self-esteem, healthy interpersonal relationships, and social support and acceptance, despite the survivor's background. CACs, more so than CPS, should aim to address these factors, as they tend to work most with CSA victims post-abuse.

Likewise, CACs should further test the efficacy of their approach to ensure optimal results are achieved with their limited financial and human resources.

Lastly, CACs should standardize benchmarks to address and strengthen boys' self-esteem, relationships, and identity, considering their impact and importance.

4.1.3 For Researchers

There are many questions left unanswered around male CSA demographics, racial impact, effective treatment, and CPS response.

Further studies should be conducted on male CSA victim and perpetrator demographics, specifically regarding race and relationship.

Considering the difference seen between Black, White and Hispanic CSA survivors, more research should be conducted on how race/ethnicity impacts sexually abused boys.¹²⁷

Additional research must be done regarding various therapy methods focusing on males since some findings indicate sex-specific treatments may be most effective.

CBT and TF-CBT trials regarding CSA need follow-up past one year and should include review sessions with survivors and their families to ensure sustainable results. Treatment trials should also have standardized forms of evaluation in order to compare and contrast efficacy across trials.^{129,137}

Finally, CPS' response to CSA should be disaggregated by sex and race. Brink et al.'s¹⁴⁰ study demonstrates that more female, non-White cases are substantiated than White-male cases. This suggests that perhaps CPS' response to CSA referrals plays a major role in unsubstantiated male CSA cases.

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Appendices

Appendix A: A Brief Overview: US National and State History

US history is relatively new in documentation, even though, Native-Americans inhabited the land for thousands of years before its “discovery” in 1492. In the 1600s, European Colonists invaded the country, introduced slavery, and prompted the legalization of slavery in every American colony by mid 1700.³⁹ Still, society’s views on the issue differed due to moral and religious beliefs, and in early 1800, slavery abolitionists in the north advocated to ban the international slave trade until succeeding in 1808.³⁹ (IHA 2014)

Before this, the country claimed its independence from Britain in 1776, and when it was officially declared “The United States of America”, it only consisted of thirteen states, including Georgia and Pennsylvania.¹⁴¹ Philadelphia, Pennsylvania was considered the largest city at the time and became the hub for the US’ independence.¹⁴¹ The country, built on ideals of liberalism, was guided by republican principles granting power to the people through a decentralized governments.¹⁴² The US Constitution solidified these ideals in 1789, delineating the role of central government, state government and taxation.¹⁴²

However, in the late 1850s, this dispersed power separated states on issues like slavery: northern states, influenced by ideas surrounding “equality of men” and an under-reliance on slave production, abolished it; Pennsylvania was the first state to abolish slavery in 1780.³⁹ Meanwhile, southern states, dependent upon slave labor with the cotton boom, fought to preserve it; Georgia was especially pro-slavery and economically depended on slave labor due to the local invention of the cotton gin. In 1842, Georgia went to extremes to deny free Blacks US citizenship, despite that 44% of their population comprised of Black slaves by 1860.³⁹ This divide contributed to the American Civil War, which culminated in the Emancipation Proclamation, granting freedom to 3 million slaves.³³ Still, Georgia’s confederate leaders rescinded Black men’s right to vote and formed the second movement of Ku Klux Klan, an organization that sought to control and segregate Blacks. Over time, Blacks moved to northern and western states in search of safer environments and more opportunities.³⁹

Meanwhile, from 1870 to 1900, the US expanded to the west, invading Native-American territory. In 1890, Pennsylvania led the nation’s industrial revolution, employing thousands of Black and European emigrants.³⁹ This time period increased chaos in the workplace and brought men to seek refuge at home, which contributed to defining the roles of workingmen and domestic women.

*“A **TRUE MAN** was concerned about success and moving up the social ladder. He was aggressive, competitive, rational, and channeled all of his time and energy into his work. A **TRUE WOMAN**, on the other hand was virtuous. Her four chief characteristics were piety, purity, submissiveness and domesticity”.³⁹*

Inspired by the Civil War, women’s suffrage made strides in property and child custody rights but little advancement in the right to vote, which was not achieved until 1920.¹⁴³

The following decade marked prosperity in the US until the stock market crash of 1929, which instigated the Great Depression.³⁷ The nation’s high unemployment rates and economic loss particularly affected Pennsylvania’s industrialized economy. Enacted to revive the country, the New Deal of 1933 reshaped social welfare and initiated the child welfare program we have today: It created programs to support unemployed populations; it created labor unions to protect the employed; it instated the Securities Act to avoid another market crash; it provided food stamps for the poor, but most importantly, it launched the Social Security program, which

evolved from worker retirement benefits to all aspects of social welfare, including child welfare..^{37,38}

From 1939-1945, the United State's involvement in World War II stimulated production within the country, leading to employment, economic stability, and new job opportunities among women and Blacks in both Georgia and Pennsylvania. In 1947, the Cold War began and space innovations launched the Space Race¹⁴, leading to the US federal government's investment in education and research.³⁹

Soon thereafter, the Civil Rights and Women's Rights Movements strove toward equality for Blacks, Native-Americans, Mexican-Americans and women across the nation.³⁹ Martin Luther King, Jr. placed Georgia at the forefront of Civil Rights, achieving unprecedented results; nonetheless, issues of racial segregation and inequality remain remarkably present in present day.³⁰⁻³² Similarly, Women's Rights gained momentum in 1963, leading to: federal laws equalizing employment, education opportunities, and ending pregnancy discrimination; state laws that sought to end spousal abuse and marital rape; and Supreme Court rulings that expanded women's access to contraceptives and abortion.³⁴⁻³⁶ Still, women today are valued less than men,⁵ have less decision-making power and limited access to birth-control and abortion.

Over the years, Georgia has become a leader in public health, headquarters to Center for Disease Control and Prevention, and a center for finance, insurance and real estate companies. Pennsylvania now focuses on service industries and is a leader in technology, education and healthcare. Nationally, Georgia ranks 10th and Pennsylvania 6th in US gross domestic product.¹⁴⁴

¹⁴ Space Race was a race between the Soviet Union and the US to achieve spaceflight abilities; i.e. first to land on the moon³⁹

Appendix B: CPS Statistics at a Glance (2013)⁴⁶

