

## **Boys in middle childhood placed in a clinic school: Experiences of sexual abuse**

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This study formed part of a larger research project, which aimed to develop an intervention strategy to support sexually abused boys in their middle childhood placed in a clinic school. The experiences of these boys were explored in this study. For the purpose of this study seven sexually abused boys in their middle childhood (9-12 years) placed in two clinic schools in Gauteng fitted the criteria for inclusion in the study and were selected through purposive sampling. Data were obtained through four in-depth interviews with each participant. These data were then thematically analysed. From the results it was clear that sexually abused boys placed in clinic schools exhibit intensified emotional reactions, as well as certain problems associated with male child sexual abuse. The intensified emotional reactions included a deep sense of sadness and helplessness, a sense of guilt and shame, a sense of dissociation and numbness, avoidance of situations associated with male child sexual abuse, fear of recurring incidents and the re-experiencing of the trauma. The problems associated with male child sexual abuse included concerns regarding own sexuality, difficulties in interacting with other people, dealing with anger and aggression, displaying self-destructive behaviour and difficulties to cope with schoolwork.

## **INTRODUCTION**

The main objective of a clinic school is to be a short-term alternative educational setting for learners with emotional and behavioural difficulties to become rehabilitated, change their problem behaviour and be integrated again into the mainstream educational setting as quickly as possible (Flick 2011:44) or by the time the learner reaches the age of twelve years (Els 2012). The main reason for referral to a clinic school is the learners' angry and externalising behaviour, which is often characterised by defiance, hyperactivity and aggression (Thomas 2010: 413). Learners with emotional and behavioural problems struggle to become integrated into the mainstream educational setting again (Flick 2011:4). According to Van Heerden (2012a), a possible reason for this may be the failure to resolve the learners' trauma effectively while they are placed in the clinic school. She is of the opinion that male child sexual abuse (hereafter referred to as MCSA) may add to the trauma of these learners, resulting in even more emotional and behavioural problems. Van Wyk (2013) mentioned the absence of intervention programmes that focus specifically on support of MCSA victims in clinic schools.

## **LITERATURE REVIEW**

Due to the limited attention given to MCSA in clinic schools the problem behaviour displayed by these learners often continues after their return to mainstream education and therefore contributes to the delayed integration of some learners into mainstream educational settings. According to Cyr, Mcduff and Hébert (2013: 210), as well as Phasha (2008:312) sexually abused children (boys or girls) who are effectively supported show higher adjustment levels compared to those abused individuals with low levels of support. Support for these children to address the trauma of MCSA while at the clinic school, might alleviate the emotional and behavioural problems to such an extent that they will be enabled to function in a mainstream educational setting. The need to support MCSA victims placed in a clinic school, urged the researchers to study MCSA as a phenomenon with the aim to develop an intervention strategy to support these MCSA victims.

For the purpose of this study the focus was on sexually abused boys aged nine to twelve years placed in the only two clinic schools with hostel facilities in Gauteng. These two schools are *Learner with Special and Educational Needs*

schools, which specifically focus on learners with behavioural and emotional problems. School A currently accommodates 45 boys, aged six to twelve years with severe emotional and behavioural problems (Els 2013) and School B currently accommodates 45 boys and 10 girls, aged six to twelve years (Van Wyk 2013). The social worker of School A and the principal of School B confirmed that many of these learners have been sexually abused and the trauma of the child sexual abuse (hereafter referred to as CSA) may contribute to their problem behaviour. The reality of CSA is further illustrated by the following findings.

Pereda, Guilera, Forns and Gómez-Benito (2009) found that South Africa appears to have the highest incidence of CSA globally. In a study done by Dunn (2008:37) it is stated that currently one in three children in South Africa will be sexually abused some time during their childhood.

Although most studies of CSA have focused on girls, sexual abuse of both boys and girls are common (Bullock & Beckson 2011:197; Parent & Bannon 2012:354). In a study undertaken in the residential areas of southern Johannesburg it was found that just as many boys as girls under the age of 15 years are sexually abused (Brookes & Higson-Smith 2004:111). According to current estimates roughly 14% of males experienced MCSA (Schraufnagel, Davis, George & Norris 2010:369). This percentage, however, may not be a true reflection of the reality either, due to low disclosure rates of MCSA (Maikovich-Fong & Jaffee 2010:435) and boys' way of suppressing emotions (Barker & Crenshaw 2011:location 1375; Haen 2011:7). Research on MCSA reveals that the long-term effects of CSA are equally damaging to girls and boys (Larsen, Sandberg, Harper & Bean 2011:436).

In studies which specifically focused on MCSA it became evident that the sexual abuse of boys in their middle childhood has serious effects. The victims of MCSA are at an increased risk of developing various mental illnesses and disorders (Maikovich-Fong & Jaffee 2010:435; Schraufnagel *et al.* 2010:369). MCSA victims may present with nightmares, major depression, post-traumatic stress disorder, antisocial personality disorder, hyperactivity, fear, anxiety disorders and aggression (Diamanduros, Cosentino, Tysinger & Tysinger 2012:134; Kiselica & Novack 2011: location 2810). MCSA victims can also show extreme forms of emotional and behavioural problems, like suicidal behaviour or becoming involved with some form of addiction like drug and/or alcohol abuse to suppress the memories of

the MCSA or to numb their feelings (Diamanduros *et al.* 2012:134; Lowenstein 2011: 296). O'Leary (2009:477) is of the opinion that the substances make it easier to control the associated distress of the MCSA.

MCSA victims also run the risk of developing sexually related problems (Diamanduros *et al.* 2012:134), which could range from the avoidance of anything related to sexuality by the MCSA victim (Ponton & Goldstein 2004:210), to the rejection of his genitals and the exhibition of sexual dysfunction, like hyper sexuality and confusion about sexual identity (Kiselica & Novack 2011:location 2810; Schraufnagel *et al.* 2010:370). A preoccupation with sex and excessive masturbation may occur in the victims of MCSA (Aucamp 2012; Pieters 2012). The feeling of guilt and shame is often present in MCSA victims. Often they struggle to trust and be in a close relationship with someone, because of their feelings of betrayal by a trusted person (Kiselica & Novack 2011:location 2810). The MCSA victim often start to think that all people are dishonest, malevolent and undependable (Van Heerden 2012a).

The research to date clearly highlights the need to develop support for MCSA victims. This study as part of a larger research project, aimed at developing an intervention strategy to support MCSA victims in their middle childhood placed in a clinic school. As a prerequisite for the development of the intervention strategy to support MCSA victims placed in a clinic school, a thorough understanding of their experiences of sexual abuse is required. However, no research that focused specifically on the experiences of sexual abuse of MCSA victims placed in a clinic school could be located on national or international level. Understanding their experiences became paramount to the development of the intervention strategy.

In order to understand the experiences of MCSA victims in clinic schools, they have to be incorporated in the research process as participants. For this purpose qualitative phenomenological research were used (Fouché & Schurink 2011: 307-327; Joyce & Sills 2010:17-27) in order to explore and describe the phenomenon of MCSA. This phenomenological method of inquiry implies that the participants were approached with genuine willingness to learn and an open mind, to discover their personal experiences of the phenomenon (Delport, Fouché & Schurink 2011:305). The researchers were open to new perceptions, perspectives, meanings, impressions and understanding of the phenomenon of MCSA (Maree & van der Westhuizen 2007:37). Since

this is an area where much needs to be done to improve support, the MCSA victims are the 'experts' of MCSA that must be consulted. This is a research with children, not about them or on them. Chan, Lam and Shae (2011:164) add that children in research should not be treated as objects or subjects to be counted or measured; rather, they should be regarded as active agents, as capable of enlightening us with their knowledge, thoughts, and why they hold certain views in ways they like and feel comfortable. Cashmore (2002:838) stated that this involvement could give them some sense of being active agents in relation to their own care. Jackson, Newall and Backett-Milburn (2013:1, 10) urged that neglected and abused children are a particularly vulnerable group whose voices have so often been ignored in the past. These children should therefore be involved and have some say in the decisions that are made about them. These authors urged that research of this matter is thus a necessity.

Considering the above-mentioned the research question addressed in this article is:

What are the experiences of boys in a clinic school who have been sexually abused?

The research aim for this part of the project was to explore and describe qualitatively, by means of a phenomenological strategy the experiences of sexually abused boys placed in a clinic school in Gauteng. Through studying the experiences of MCSA, the people involved in the MCSA victim's life may be supported to have a better understanding of the phenomenon of MCSA and support MCSA victims more effectively. The research is also intended to contribute to the development of an intervention strategy for the larger research project which specifically focuses on the support of sexually abused boys.

## **METHOD**

As already outlined, this article presents the first phase of a research project aimed at developing an intervention strategy to support MCSA victims in their middle childhood placed in a clinic school. The project consisted of three phases. During the first phase the experiences of MCSA of boys placed in a clinic school were explored and described. During the second phase the inputs from MCSA victims placed in a clinic school, social workers, psychologists, counsellors, teachers and child and youth care workers were obtained. These inputs were about what should be included in an intervention strategy to support MCSA victims. The third phase of the project consists of the development and implementation of this intervention strategy to support MCSA

victims placed in a clinic school. This third phase will include a pilot implementation of the intervention strategy and will be described in order to determine its feasibility and to make recommendations.

## **Research Design**

The experiences of MCSA of boys placed in a clinic school were explored and described. For this purpose qualitative research was undertaken (Fouché & Schurink 2011:307-327; Maltby Williams, McGarry & Day 2010:50). According to Joyce and Sills (2010:17) the phenomenological method of inquiry implies that researchers approach participants with a genuine willingness to learn and an open mind to discover their personal experiences of the phenomenon.

## **Participants**

To select the participants for the population with whom the in-depth interviews were conducted, non-probability sampling (Strydom 2011:231-232) was used and specifically purposive sampling (Strydom & Delpont 2011:392). The criteria for inclusion in this purposive sampling were sexually abused boys in their middle childhood (9-12 years), who attend clinic schools in Gauteng. Nine participants met the above set of criteria for inclusion in this study. Seven participants were willing to partake in the in-depth interviews.

The Ethical committee of the North-West University, Potchefstroom Campus (Ethical number: NWU-00060-12-A1), Gauteng Department of Education and the two different district offices in Johannesburg and Randfontein gave ethical approval for this study to be conducted. Informed consent and assent from the participants were obtained before participation. The procedures to be followed during the investigation were explained to all involved in this study, in order to avoid any deception of the participants. Participation was voluntary and any person could withdraw from the study at any time. The participants were informed about the use of a digital recorder during the interviews. Anonymity and confidentiality of all participants were ensured. All the participants from this population were already receiving counselling from a social worker or counsellors at the clinic schools and therefore the participants were referred to the school's social worker or counsellors if any secondary trauma or emotional harm occurred during the interviews or if they needed any further support. The participants got the opportunity at the end of each interview, to talk about their experiences and any misperceptions were rectified.

## Procedure

After the ethical approval for this research to be conducted was obtained, the two clinic schools in Gauteng were approached and the social workers at the two schools identified all the potential learners who fit the above-mentioned criteria. Each of the potential participants' parents were met privately to explain the aim of this study, what were expected of them and their children, answered questions about the participation in this study and obtained their written consent for their children to partake in this study. The social workers acted as mediators to discuss and explain this study to these learners. The mediators' role also included bringing together the primary researcher and the prospective participants, establishing the initial rapport with them as well as providing all the potential participants' details. Assent from the learners to participate were obtained and it was explained to them that their participation was voluntary, and that they could withdraw from the study at any time for whatever reason without any negative consequences.

## Data collection

In-depth interviews were conducted (Greeff 2011:341-374; Nolas 2011:23) with seven participants to gain knowledge and a better understanding of the experiences of MCSA and the meaning the participants make of that experience. Before the in-depth interviews were conducted, a relationship with the participants was built. This was done by means of talking in general about the participants' interests and hobbies, playing a board game and building a puzzle together. After the participant was at ease the first in-depth interview started. Data collection was done during this phase by means of a single open-ended question. This question was: "Tell me about your experiences of MCSA." This open-ended question was checked and evaluated by a social worker for its applicability. A pilot study of this open-ended question was conducted with one participant who also met the sampling criteria to make adjustments before the study was conducted with the remaining participants. Four interviews with each participant were conducted. The first interview was an in-depth interview to explore the participant's experiences of MCSA. The second interview was a creative session where the participant was able to show his feelings, emotions, perceptions and beliefs about MCSA by means of a collage. The

participants got the opportunity to explain and discuss their collage. A third interview was scheduled where it appeared further data could be obtained. During the fourth interview the participants' perception of what support they needed for the MCSA were explored.

Observations were also conducted during the in-depth interviews. Field notes were made and the participants actions were recorded while gaining in-depth insight into the manifestations of the child's body language, non-verbal cues and actions (Dewalt & Dewalt 2010). Field notes were written immediately after each interview to ensure that all observations and additional information were recorded. These observations were included in the field notes, and also gave an account of the prevailing circumstances during the interviews (Nieuwenhuis 2007:84).

## Data analysis

The qualitative narrative information that came from the four in-depth interviews with each participant was read, notes about observations were made during the interviews to be able to analyse the data. Themes and sub-themes were identified through thematic analysis. The steps as recommended by Schurink, Fouchè and De Vos (2011:403-419) were used to analyse the qualitative data.

Data collection and analysis was a coherent process. During the data collection process the transcribed data were checked to see what emerged from it and to identify ideas that needed to be followed up with the participants during the subsequent interviews. Possible themes were also identified during this process. Typologies needed to be developed, in which phenomena are classified in terms of their common characteristics in relation to other phenomena. The typologies needed to be mutually exclusive and any overlap between categories had to be eliminated (Schurink *et al.* 2011:403-419).

## Trustworthiness

The following key criteria of trustworthiness of Lincoln and Guba were included (Lincoln 1995:275-289; Nieuwenhuis 2007:80). These authors refer to four constructs, namely credibility, transferability, dependability and confirmability to ensure trustworthiness. The following table gives a clear explanation of the constructs mentioned and how they were implemented in this study.

**Table 1: Key criteria of trustworthiness of this study**

Strategy	Criteria	Application
Credibility	Prolonged engagement	Four interviews were scheduled with the participants to talk about their experiences of mcsa.
	Reflexibility	Field notes were written immediately after the interviews and were also analysed.
	Triangulation	Different data sources were used, like literature study, in-depth interviews, field notes and participant observations.
	Member checking	The understanding of the observed actions and behaviour by the participants of the mcsa participants were verified. During follow-up interviews the participants got the opportunity to comment on the findings and to assist with the interpretation of the data.
Transferability	Saturation	Data was collected until data saturation occurred.
	Dense description	Description of research methodology and checking of literature were done.
Dependability	Audit	Done by co-coder and expert study leader.
	Peer examination	Expert supervision was provided during this study.
Confirmability	Triangulation	Different data sources were used, like literature study, in-depth interviews, field notes and participant observations.
	Reflexibility	Field notes were written immediately after the interviews and were also analysed. These field notes gave more information about the participants' non-verbal cues.

## FINDINGS

**Table 2: Themes and sub-themes for this study**

Main themes	Sub-themes
<b>Theme 1</b> Intensified emotional reactions associated with MCSA	<b>Subtheme 1.1</b> A deep sense of sadness and helplessness <b>Subtheme 1.2</b> A sense of guilt and shame <b>Subtheme 1.3</b> A sense of dissociation and numbness <b>Subtheme 1.4</b> Avoiding situations associated with MCSA <b>Subtheme 1.5</b> Fear of recurring incidents <b>Subtheme 1.6</b> Re-experiencing of the trauma
<b>Theme 2</b> Problems associated with MCSA in boys	<b>Subtheme 2.1</b> Concerns regarding own sexuality <b>Subtheme 2.2</b> Difficulties in interacting with other people <b>Subtheme 2.3</b> Dealing with anger and aggression <b>Subtheme 2.4</b> Displaying self-destructive behaviour <b>Subtheme 2.5</b> Difficulties to cope with schoolwork

### Theme 1: Intensified emotional reactions associated with MCSA

Intensified emotional reactions in this study refer to the emotional responses that the participants relate to the incidents of MCSA. The participants in this study reported a deep sense of sadness and helplessness, on-going struggle with shame and guilt, a sense of dissociation and numbness, avoidance of situations associated with MCSA, fear of recurring incidents and re-experiencing of the trauma.

#### *Subtheme 1.1: A deep sense of sadness and helplessness*

The participants when talking about their experiences of MCSA emphasised how sad and helpless they felt during the incidents. In the statements below the intensity of these feelings of sadness is evident in the statements made by three participants:

When that rape happened to me, it felt like my heart was breaking apart and I did not know what to do. (Participant 3)

When I think and talk about the sexual abuse that happened to me, I am sad. (Participant 1)

I was crying while he raped me. (Participant 4)

Research supported this overwhelming feeling of sadness over their sexual victimisation (Asgeirsdottira, Sigfusdottirb, Gudjonssona, & Sigurdsson 2011:215; Olafson 2011:14). Ehlers (2013) mentioned that most MCSA victims feel an intense feeling of sadness over the MCSA. She is however of the opinion that often these sexually abused boys will not show these feelings, because of the gender role expectation that boys are tough and do not show emotions. This suppression of emotions by boys is also supported by Barker and Crenshaw (2011: location 1375) and Kiselica and Englar-Carlson (2011:location 1626). Helplessness is illustrated in these narratives:

He closed my mouth. I could not shout for help. (Participant 1)

I tried to get away from him (perpetrator), but I could not. I cried for my mother. (Participant 4)

I could not stop him from touching my private parts. He was stronger than me. (Participant 5)

This feeling of helplessness with MCSA victims is supported in a study done by Walker, Archer and Davies (2005:78), who reported that the

majority of victims said that they reacted with frozen fear and helplessness. In addition, Diamanduros *et al.* (2012:143) reported that the individual's response to the event most often is one of helplessness.

Participants furthermore reported that those close to them who had to witness these incidents were also deeply saddened and became helpless on-lookers. Some participants recalled the following:

There was a time when my dad did sexual stuff to me, even in front of my mom. He did not even care if she called the police. He was not scared anymore. My mom would go sit in front of the TV and start to cry. (Participant 2)

My dad always told my mom, whenever he wanted to do it (sexual abuse), he wants to have a dad-son talk with me, alone in the room and she must go out of the room. Then he would do all the wrong things with me, non-stop. He did this every day. Then he did the same thing, every day, every day, every day... I could not stop it. (Participant 2)

The prevalence of intense sadness and helplessness in boys, who have been exposed to MCSA, can be considered signs of childhood depression, as indicated by Van Emmenis (2013). The results therefore seem to confirm the findings of research by Alaggia and Millington (2008:266), as well as Kiselica and Novack (2011:location 2810) who found that MCSA victims can show signs of major depression. In a study done by Trask, Walsh and DiLillo (2011: 7) it is reported that sexually abused children display higher rates of depression than non-abused children with between 43% and 67% of children meeting diagnostic criteria for depression following CSA. This was confirmed by De Witt (2009:333) who stated that depression is common amongst CSA victims, where the victim can manifest very low levels of self-esteem, social withdrawal and little or no displays of emotion. During this depressive state the sexually abused child can show suicidal tendencies, poor eating patterns and disturbed sleep patterns, as a symptom of the depression.

#### *Subtheme 1.2: A sense of guilt and shame*

It was evident from the data that MCSA victims experienced guilt and shame about the incidents of MCSA as stated by these participants:

He asked me to have sex with him and then I said 'no' and then he forced me and raped me. Maybe I should have done something else. (Participant 3)

I am the wrong one. I should have stopped him. (Participant 5)

Participants showed a sense of guilt and partial responsibility for the MCSA, as illustrated by this narrative:

My mom always told me I must not go far and play in the yard. When my mom asked me if I was raped, I

said 'no', because I knew I did wrong by going out of the yard. (Participant 1)

The guilt and shame goes hand in hand with anger directed at the self:

I am angry with myself for watching those sex movies with my dad. I feel guilty and ashamed for watching that movies. (Participant 6)

The guilt and shame are furthermore related to the way in which the participants engaged with the perpetrators during the incidents of MCSA. Evidence indicate that participants in some instances allowed fondling to happen and therefore also tend to accept partial responsibility for what happened. The feeling of guilt and shame was also stated by the participant who recalled his frustration to be unable to stop the sexual abuse. He narrated the following:

I am a boy. I am supposed to be strong and fought the boy who touched me. (Participant 5)

A participant mentioned the intense shame he felt for allowing the fondling to happen. This is illustrated in the following:

My mom taught me not to allow anyone to touch my private parts and now this happened. I feel ashamed about the touching, because I should have stopped it. (Participant 7)

Research findings by Kiselica and Novack (2011:location 2810) indicate that MCSA victims show feelings of being "dirty", "ugly" and "no good". These findings are confirmed in this study. Dorahy and Clearwater (2012:156) furthermore reported that due to this extreme shame and guilt MCSA victims are often incapable of stopping the MCSA and to protect themselves from the abuse, as also indicated in this study.

The experience of MCSA challenges boys' sense of masculinity and, thus, their sense of identity, which causes shame and guilt in the MCSA victim (Aucamp 2012; Ehlers 2013). Many MCSA victims feel powerless because they were unable to stop the abuse and are embarrassed that they were unable to protect themselves and live up to their gender role by not doing enough to stop the MCSA (Dorahy & Clearwater 2012:156). To admit their victimisation is to indicate that they are weak, vulnerable, and emasculated (Diamanduros *et al.* 2012:133; Dorahy & Clearwater 2012:156).

#### *Subtheme 1.3: A sense of dissociation and numbness*

In this study the participants reported that due to the intense nature of the emotional reactions associated with the MCSA incidents, they tended to feel numb and dissociated from the situation. Participants explained as follows:

While the sexual abuse happened to me, it felt like I was in jail. I couldn't break free. It felt like it was not really me the abuse is happening to, but then I went

out of my own thoughts and it was as if I looked down at what was happening and saw that it was really me the sexual abuse is happening to. I felt so dead inside of myself. (Participant 4)

After the sexual abuse, I had to keep these feelings inside of myself. It was as if I was not feeling anything anymore. I had to do this, in order for no one to find out about the sexual abuse. (Participant 5)

Valente (2005:13) is of the opinion that dissociation can serve as a survival mechanism for the MCSA victim to distance himself from the abuse experience, in order to create psychic numbing as a way to repulse pain and humiliation. Diamanduros *et al.* (2012:146), as well as Dorahy and Clearwater (2012:156) also support this phenomenon of dissociation in MCSA victims.

#### *Sub-theme 1.4: Avoiding situations associated with MCSA*

In this study some of the MCSA victims narrated their experiences of avoidance of any stimuli associated with the sexual abuse. These avoidances ranged from hiding away from the perpetrator to refusal to visit the place where the abuse happened. This was illustrated by the following narratives:

Whenever my parents wanted to go to town, I used to hide under the car seats when we drove past the place where the sexual abuse happened. (Participant 4)

I used to go to the toilet a lot during night time, because I didn't want to be alone with him (perpetrator) in the same room. (Participant 5)

CSA has been associated with traumatic reactions that may include attempting to avoid situations or stimuli that remind them of the abuse (Diamanduros *et al.* 2012:143; Trask *et al.* 2011:7). Dissociation and alterations in consciousness can be seen as an automated strategy for either regulating feelings or becoming deeply absorbed in internal stimuli, including painful feelings and memories (Dorahy & Clearwater 2012:167). This way of coping with the MCSA was also supported by the MCSA victim who liked to avoid anything related to the MCSA. The participant narrated:

After the sexual abuse happened to me, I liked to sleep as a way not to think about the sexual abuse. (Participant 4)

#### *Sub-theme 1.5: Fear of recurring incidents*

It became clear that anxiety and fears form part of the experiences of the MCSA victims in this study. This is evident in the following narrative:

He raped me. I felt scared. (Participant 3)

I am afraid that he (perpetrator) might hear me talking about the sexual abuse. (Participant talks softly.) (Participant 5)

Some of the participants showed concerns for their own safety and a fear of the possibility that the MCSA could re-occur. A participant commented:

As a boy to be sexually abused, he forced you to do sexual stuff to him. Then whenever I see him, I am always scared and my heart is beating fast and I am always afraid. (Participant started to cry.) (Participant 3)

I am always scared and afraid that the rape can happen again. (Participant 4)

According to Diamanduros *et al.* (2012:134), as well as Kiselica and Novack (2011:location 2810) MCSA victims often show signs of fear and anxiety. In a study done by Trask *et al.* (2011:7) it is reported that the prevalence of anxiety disorders is significantly higher in CSA victims than in non-abused children (12% versus 3%).

#### *Subtheme 1.6: Re-experiencing of the trauma*

MCSA victims often re-experience the trauma of MCSA. Some of them responded during the in-depth interviews that especially during the night they have a lot of nightmares, think a lot about the MCSA and sex and therefore can't sleep properly. This was illustrated in the following narratives:

Sometimes when you want to sleep at night, you can't sleep, because you always think about the sexual abuse that happened. (Participant 4)

I dreamt yesterday night that boy came into this school. That thing... the rape... it happened again. (Participant seemed anxious and started to cry.) (Participant 3)

After the rape I could not sleep. I dreamt about the rape every night. (Participant 1)

Pieters (2012) and Trask *et al.* (2011:7) confirm that MCSA victims often re-experience the trauma of MCSA in the form of nightmares.

## **Theme 2: Problems associated with experiences of MCSA**

The participants in this study reported problems on the intrapersonal, interpersonal and behavioural levels of their lives that they associate with the experiences of MCSA. The problems specifically reported in this study relate to the development of their own sexual identity, the management of their anger, mistrust towards others, social withdrawal and scholastic achievement.

#### *Subtheme 2.1: Concerns regarding own sexuality*

It became evident that MCSA victims experience concerns regarding their own sexuality. Participants mentioned:

He called me a gay-boy, because of what happened between us. (Participant looked distressed and very angry.) (Participant 2)

Some children are teasing me and call me gay. (Participant 5)

The confusion about their own sexuality seems to be more serious if they ejaculated during the MCSA. Evidently participants question their own sexuality, especially when the perpetrator was male. The one participant recalled the incident:

My dad licked and sucked my private part. He did this licking and sucking of my private part until this white stuff (ejaculation) came from my private part. (Participant 2)

There is the risk for sexually abused boys to develop sexually related problems (Diamanduros *et al.* 2012:134; Parent & Bannon 2012:357), where the MCSA victim can avoid anything related to sexuality (Ponton & Goldstein 2004: 210), reject his genitals and exhibit sexual dysfunction, like hyper sexuality and confused sexual identity (Kiselica & Novack 2011: location 2810). Aucamp (2012) supported this feeling of vulnerability and questioning about the boy's own sexuality, sexual orientation and masculinity, if he experienced sexual arousal, an erection and equalling physical pleasure during the sexual abusive experience by a male.

Some participants indicated their fear of homosexuality because of the physical pleasure they experienced during the MCSA. This was stated by a participant:

He (perpetrator) told me, because I did not stop him while he played with my thing (penis), I actually enjoyed it. (Participant 5)

Van Heerden (2012b) confirmed if the MCSA victim was sexually stimulated by aspects of this sexual experience, he may feel he participated in or even invited the CSA. This creates great confusion inside the boy, who knows he was also repelled by the experience at the same time. Authors such as Gartner (2011) found that these feeling of guilt about the sexual pleasure he felt during the MCSA, may cause the MCSA victim to become ambivalent about any sexual pleasure.

MCSA victims often show sexualised behaviour, such as compulsive masturbation, especially when they think about the MCSA or experience an extreme emotional feeling, such as fear or anger (Aucamp 2012; Van Heerden 2012b). A participant stated:

I felt so bad when I woke up and realised that I dreamt about the sexual abuse. (Participant 4)

In a study done by Trask *et al.* (2011:7) it is reported that approximately 28% of CSA victims show highly sexualised behaviour which is one of the most widespread and troublesome problems reported following CSA. Pieters (2012) and Van Heerden (2012b) mentioned that a preoccupation with sex and excessive masturbation may occur in MCSA victims.

### *Subtheme 2.2: Difficulties in interaction with other people*

As far as their interaction with other people is concerned the participants reported that they experience feelings of mistrust in any adult or trusted person. Some of the participants reported mistrust in adults, as illustrated by this participant:

I trusted my dad to take care of me while my mom was at work. I was wrong to trust him. (Participant 6)

I told my child and youth care worker about the sexual abuse, but she didn't do anything about it. (Participant 5)

MCSA victims have much difficulty with trust and intimacy, because of their feelings of betrayal by a trusted person (Kiselica & Novack 2011: location 2810). The abuser wants to satisfy his own needs and misuses his age or authority to abuse a boy, resulting in the MCSA victim considering all people as dishonest, malevolent and undependable (Gartner 2011). Valente (2005: 10) is of the opinion that sexually abused boys have lost their belief in fairness, safety, privacy and trust.

This feeling of mistrust in the non-offending parent was also found in this study and one participant recalled:

My mom was not doing anything about the sexual abuse. (Participant 2)

Pieters (2012) also mentioned the mistrust these boys often show against the non-offending parent for not protecting the child against the MCSA.

The feeling of social withdrawal was present in most of the participants, as illustrated:

I just want to be alone... in the classroom and during break time. (Participant 4)

I don't want to play during break time. I just want to be alone and walk by myself. (Participant 7)

After the rape I didn't want to play with my friends. (Participant 3)

Thielmann (2010:location 42) supported this finding and reported that the shame resulting from the MCSA can limit the victim's social adjustment. According to Els (2012) and Gartner (2011) the sexually abused boy can confuse affection and friendship with sexual abuse and tenderness with desire. They may find it difficult to know the difference between sex, love, nurturance, affection, friendship and sexual abuse. It often happens that they will think normal interpersonal relationships are seductive and manipulative, or that exploitative situations are normal and acceptable.

*Sub-theme 2.3: Dealing with anger and aggression*  
Aggressive behaviour such as fighting and bullying was evident in the experiences of all the

participants and was illustrated in the following extracts:

Whenever I hit someone, I think of my father who abused me. Then I just want to kill these children that I fight with. (Participant 2)

I always bully the children and give them an excuse to hit me. (Participant 3)

To be sexually abused makes me angry and upset. Now when I grow up and I realised what my dad has done to me, it makes me even angrier. (Participant 2)

Trask *et al.* (2011:7) supported these findings and mentioned that externalizing problems, like aggression, are commonly reported among children with a history of CSA. Valente (2005:12) reported that MCSA victims have a two to four times higher risk than their normal counterparts of aggressive behaviour. MCSA victims often like to bully other children. The participants reported that the ability to bully somebody else, gave them the feeling of being in control of a situation, something they did not experience during the abusive situation. Parent and Bannon (2012:359) supported this finding of aggressiveness with MCSA victims. They are of the opinion that this aggressive behaviour actually constitute coping and survival strategies used to show that the victim conforms to masculine stereotypes.

#### *Sub-theme 2.4: Displaying self-destructive behaviour*

Participants reported self-destructive behaviour that includes suicide attempts, destructive thoughts, addictive behaviour and truancy. Suicidal attempts and self-destructive thoughts and behaviours were evident as an effect of the MCSA. Participants narrated their experiences:

I wanted to end my life. I took a chain and tried to hang myself in my room. (Participant 6)

I think about killing myself a lot. I was so angry with my mom for not letting me die. I wanted to die. (Participant 6)

After the rape I didn't want to live any more. (Participant showed no facial expression while talking about his suicidal ideation.) (Participant 3)

According to Valente (2005:14) these feelings of hopelessness, helplessness, futility, worthlessness and depression can be seen as warning signs for suicidal behaviours. MCSA victims show 1.4 to 1.5 times higher rates of attempting suicide than non-abused ones. Coohy (2010:857) supported the finding that MCSA victims are more likely to think about killing themselves or try to kill themselves than sexually abused girls. In a study done by O'Leary and Gould (2009:950) it was found that sexually abused men are ten times more likely to attempt suicide than the control group in their research. This suicidal behaviour

of MCSA victims was also supported by research done by Alaggia and Millington (2008:266), as well as Parent and Bannon (2012:357).

Another form of self-destructive behaviour is the involvement with some form of addiction. This was further illustrated in the following narratives of participants:

I remember the time when my dad took me to the bar with him. My dad's friends gave me alcohol to drink and forced me to lick and suck their private parts. The alcohol helped me not to think about what was really happening to me. (Participant 2)

When my dad gave me that alcohol to drink, it felt so funny. Actually while he was doing the sexual stuff with me, I was not feeling anything or thinking about anything at all. (Participant 2)

Valente (2005:14) found that during the sexual abuse, some boys may be given alcohol or other drugs as a way to increase their compliance with the sexual act. Later these boys learn that substances can help to dull feelings, numb their emotional pain and distress.

Running away from home or school is common in MCSA victims. This was illustrated in the following statements:

Every day when I saw him (perpetrator) at school, I wanted to run away. (Participant talked fast and show anxiousness.) (Participant 5)

My dad thinks I am homosexual, because of what happened to me. Now I just want to run away from home. (Participant 5)

I wanted to run away from home, whenever I saw them (perpetrators). (Participant 4)

MCSA victims are two to four times more likely to run away from home than non-abused boys (Valente 2005:12). They so desperately want to remove themselves from their abusive situation, that they do not mind the implications of their actions (Alaggia & Millington 2008:266; Barker & Hodes 2007:39).

#### *Subtheme 2.5: Difficulties to cope with schoolwork*

Scholastic problems form part of the aftermath of MCSA. A participant stated:

I used to destruct the classrooms. (Participant 6)

I could never sit still and do my school work. (Participant 4)

I refused to do any homework and I struggled to concentrate in the classroom. (Participant 1)

Children who have been abused show significant difficulties in dealing with all aspects of the school environment, including cognitive tasks, serious behaviour problems and are at extremely high risk of failure at school (Frederick & Goddard 2010:23). Research has found a correlation between poor school performance and MCSA (Alaggia & Millington 2008:266; Parent & Bannon 2012:357). The child is sometimes unable to give adequate attention in

class (De Witt 2009:328). This hyperactivity is actually a form of busyness, which can help the child to avoid the feelings of sadness, shame, confusion and being scared (Ellsworth 2007:26). Aside from the diagnosis of Attention Deficit Hyperactivity Disorder *per se*, studies have shown that sexually abused children are significantly more hyperactive than are non-maltreated children (Trask *et al.* 2011:7).

## DISCUSSION AND RECOMMENDATIONS

The research question addressed in this article was:

What are the experiences of boys in a clinic school who have been sexually abused?

To answer the above-mentioned research question qualitative phenomenological research were used (Fouchè & Schurink 2011:307-327), in order to hear the voices of the children in a clinic school regarding their experiences of MCSA. In this research the intervention strategy to support MCSA victims was specifically focused on boys placed in a clinic school. Seven participants from the two clinic schools in Gauteng were involved by means of four consecutive in-depth interviews with each participant.

In common with the findings of other research it was found that MCSA is a serious stressor. There were also commonalities with existing research regarding the increasing evidence of its adverse and potentially numerous debilitating and multifaceted consequences for the child's psycho-social growth and development (Pieters 2012; Van Heerden 2012a). Research consistently indicated the intensified emotional reactions associated with MCSA, which also correlated with this study. In common with the findings of previous research it was found that sadness (Asgeirsdottira *et al.* 2011:215; Olafson 2011: 14) and helplessness (Bullock & Beckson 2011: 201; Diamanduros *et al.* 2012:143) form part of the intensified emotional reactions of the MCSA victim. What differentiates this study from other research is that the in-depth interviews with the participants were done with South African boys, still in their middle childhood about their experiences of MCSA. Most other research was done with adult participants relating their retrospective accounts of MCSA in their childhood years. This is supported by Jackson *et al.* (2013: 1).

Research indicated that boys tend to suppress emotions and are reluctant to disclose emotions regarding the MCSA (Barker & Crenshaw 2011:location 1375; Haen 2011:7). In contrast to these findings the participants in this study openly discussed their emotions and reactions.

This could be due to the fact that these boys placed in a clinic school, were already receiving counselling on a weekly basis and were therefore used to discuss their experiences and emotions.

Previous research illustrated the feelings of guilt and shame which is most often present in MCSA victims. MCSA challenges boys' sense of masculinity and their sense of identity, which causes shame and guilt in the MCSA victim (Dorahy & Clearwater 2012:156). This correlates with the narratives in this study where MCSA victims narrated intense feelings of powerlessness because they were unable to stop the abuse, and embarrassment that they were unable to protect themselves and live up to their gender role by not doing enough to stop the MCSA.

In common with other research this study correlates a sense of dissociation and numbness as part of the experiences of sexually abused boys (Diamanduros *et al.* 2012:146; Dorahy & Clearwater 2012:156). Research indicated that MCSA victims often avoid situations associated with MCSA (Diamanduros *et al.* 2012:143; Trask *et al.* 2011:7). This avoidance of situations associated with MCSA was supported in this study. In previous research it is reported that MCSA victims often experience fears and anxiety (Diamanduros *et al.* 2012:134; Kiselica & Novack 2011:location 2810). This correlates with this study where the MCSA victims showed an intense feeling of fear for recurring incidents, where they show concerns for their own safety and a fear that the MCSA can re-occur. Research indicated that MCSA victims can re-experience the trauma of the MCSA (Alaggia & Millington 2008:266; Trask *et al.* 2011:7). In this study the MCSA victims often re-experience the trauma of the MCSA in the form of nightmares.

Research has shown the correlation between MCSA and concerns regarding own sexuality (Diamanduros *et al.* 2012:134; Parent & Bannon 2012:357). This correlates with the findings of this study. In this study this concern regarding own sexuality was particularly the case where the MCSA victim experienced physical pleasure during the MCSA. Previous research done by Trask *et al.* (2011:7) reported that approximately 28% of CSA victims show highly sexualised behaviour, like a preoccupation with sex and excessive masturbation or masturbation in public. In this study however the MCSA victims did not mention masturbation. This could be due to the sensitive nature of the topic and the feeling of boys that masturbation is wrong and will be punished if known to an adult.

Commonalities exist between previous research and this study regarding social interaction and

mistrust of MCSA victims. Research indicated that MCSA victims tend to mistrust (Kiselica & Novack 2011:location 2810) and tend to be socially isolated from others (Thielman 2010: location 42). This study correlates with research which indicated that MCSA victims have problems dealing with anger and aggression (Trask *et al.* 2011:7). In this study it was found that the ability to hurt somebody else, gives the MCSA victim the feeling of control of a situation and power over somebody else, which they did not experience during the abusive situation. Research mentioned self-destructive behaviour, which includes suicidal tendencies, addictive behaviour and truancy (Coohey 2010:857; Parent & Bannon 2012:357). In this study self-destructive behaviour was evident in the form of suicidal tendencies and truancy. The prevalence of addictive behaviour was however low. This could be due to the relative young age of the MCSA victims in this study. Research regarding the correlation between school functioning and CSA was supported in this study. MCSA victims have much difficulty coping with schoolwork, like concentration and destructiveness in the classroom.

The purpose of this study was to gain better understanding of the experiences of MCSA of sexually abused boys in their middle childhood placed in a clinic school in order to support these MCSA victims better.

Learners placed in clinic schools exhibit a wide range of emotional and behavioural problems. According to Van Wyk (2013) and Els (2012) both clinic schools have trained counsellors, but no intervention programme is in place to support MCSA victims with the intensified emotional reactions and the problems associated with MCSA. The development and implementation of such an intervention programme could support MCSA victims to deal better with the MCSA. If MCSA victims can be supported effectively, it may reduce the intensified emotional reactions and problems associated with MCSA. Subsequently this could assist in the re-integration of these learners into the mainstream educational setting.

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## REFERENCES

- Aucamp, L. 2012. Male child sexual abuse [personal interview]. 8 Sept, Pretoria.
- Alaggia, R & Millington, G. 2008. Male child sexual abuse: a phenomenology of betrayal. *Clinical social work*, 36:265-275.
- Asgeirsdottira, BB, Sigfusdottirb, ID, Gudjonssona, GH & Sigurdsson, JF. 2011. Associations between sexual abuse and family conflict/violence, self-injurious behavior, and substance use: the mediating role of depressed mood and anger. *Child abuse & neglect*, 35:210-219.

Research on the phenomenon of MCSA is limited compared to research on CSA in general and no research about MCSA in the context of a clinic school could be found. No intervention programmes to support the victims of MCSA, even outside the context of a clinic school could be located. It is therefore recommended that the results in this article be used to develop an intervention programme to support sexually abused boys in their middle childhood placed in a clinic school.

## LIMITATIONS

In the interpretation of the results presented in this article, some limitations should be taken into consideration. The article focused on the experiences of MCSA victims placed in a clinic school. The first limitation is that the findings are limited to a small sample of participants. Therefore the findings from this study cannot be generalised for the population of MCSA victims living in other residential settings. These findings are therefore not necessarily applicable beyond the scope of the project. A second limitation was the inclusion criteria which stated that the boys had to disclose the MCSA at a previous stage or their parents had to give a clear indication of such abuse. Because of low disclosure rates among MCSA victims it is possible that some potential participants were left out in this study.

## FINAL CONCLUSIONS

MCSA is a reality. Understanding the experiences of MCSA victims in their middle childhood placed in a clinic school will contribute to the development of an intervention strategy for the larger research project. This intervention strategy could possibly enable the people involved with these MCSA victims to support them more effectively. This support can help to relieve some of their emotional and behavioural problems, and subsequently enhance the process to integrate them into the mainstream educational system again as soon as possible.

- Barker, G & Crenshaw, DA. 2011. Honoring masculine strivings in individual psychotherapy with boys. In Haen, C. ed. *Engaging boys in treatment. Creative approaches to the therapy process* [Kindle ed.] Available from: <http://www.amazon.com> (Accessed 17 February 2012).
- Barker, J & Hodes, D. 2007. *The Child in Mind: a child protection handbook*. 3rd ed. London: Routledge.
- Brookes, H & Higson-Smith, C. 2004. Responses to gender-based violence in schools. In Richter, L, Dawes, A & Higson-Smith, C. eds. *Sexual abuse of young children in Southern Africa*. Cape Town: HSRC Press:110-129.
- Bullock, CM & Beckson, M. 2011. Male victims of sexual assault: phenomenology, psychology, physiology. *Journal of the American academy of psychiatry and the law*, 39:197-205.
- Cashmore, J. 2002. Promoting the participation of children and young people in care. *Child abuse & neglect*, 26:837-847.
- Chan, Y, Lam, GLT & Shae, W. 2011. Children's views on child abuse and neglect: findings from an exploratory study with Chinese children in Hong Kong. *Child abuse & neglect*, 35:162-172.
- Coohy, C. 2010. Gender differences in internalizing problems among sexually abused early adolescents. *Child abuse & neglect*, 34:856-862.
- Cyr, M, McDuff, P & Hébert, M. 2013. Support and profiles of nonoffending mothers of sexually abused children. *Journal of child sexual abuse*, 22:209-230.
- Delport, CSL, Fouchè, CB & Schurink, W. 2011. Theory and literature in qualitative research. In De Vos, AS, Strydom, H, Fouchè, CB & Delport, CSL. eds. *Research at grass roots: for the social sciences and human service professions*. 4th ed. Pretoria: Van Schaik:297-306.
- Dewalt, KM & Dewalt, BR. 2010. *Participant observation: a guide for fieldworkers*. 2nd ed. US: AltaMira Press.
- De Witt, M. 2009. *The young child in context: a thematic approach. Perspectives from educational psychology and socio-pedagogs*. Pretoria: Van Schaik.
- Diamanduros, T, Cosentino, CE, Tysinger, PD & Tysinger, JA. 2012. Theoretical perspectives of male sexual abuse: conceptualization of a case study. *Journal of child sexual abuse* 21(2):131-154.
- Dorahy, MJ & Clearwater, K. 2012. Shame and guilt in men exposed to childhood sexual abuse: a qualitative investigation. *Journal of child sexual abuse*, 21(2):155-175.
- Dunn, M. 2008. The HOOC board game as preventative measure against child sexual abuse within the South African context. *Child abuse research*, 9(2):37-48.
- Ehlers, L. 2013. Male child sexual abuse [personal interview]. 25 Jun, Pretoria.
- Ellsworth, L. 2007. *Choosing to heal. Using reality therapy in the treatment of sexually abused children*. London: Routledge.
- Els, R. 2012. Clinic schools [personal interview]. 21 Aug, Krugersdorp.
- Els, R. 2013. Clinic schools [telephonic interview]. 24 Apr, Pretoria.
- Flick, GL. 2011. *Understanding and managing emotional and behavioural disorders in the classroom*. Boston: Pearson.
- Fouchè, CB & Schurink, W. 2011. Qualitative research designs. In De Vos, AS, Strydom, H, Fouchè, CB & Delport, CSL. eds. *Research at grass roots: for the social sciences and human service professions*. 4th ed. Pretoria: Van Schaik:307-327.
- Frederick, J & Goddard, C. 2010. 'School was just a nightmare': childhood abuse and neglect and school experiences. *Child and family social work*, 15:22-30.
- Gartner, RB. 2011. *Talking about sexually abused boys, and the men they become*. Available from: [www.psychologytoday.com](http://www.psychologytoday.com) (Accessed 19 July 2012).
- Greeff, M. 2011. Information collection interviewing. In De Vos, AS, Strydom, H, Fouchè, CB & Delport, CSL. eds. *Research at grass roots: for the social sciences and human service professions*. 4th ed. Pretoria: Van Schaik:341-375.
- Haen, C. 2011. Boys and therapy. The need for creative reformulation. In Haen, C. ed. *Engaging boys in treatment. Creative approaches to the therapy process*. New York, NY: Routledge:3-40.
- Jackson, S, Newall, E & Backett-Milburn, K. 2013. Children's narratives of sexual abuse. *Child and family social work*, 18(2):1-11.
- Joyce, P & Sills, C. 2010. *Skills in Gestalt counselling & psychotherapy*. 2nd ed. London: Sage.

- Kiselica, MS & Englar-Carlson, M. 2011. Establishing rapport with boys in individual counseling and psychotherapy. A male-friendly perspective. In Kiselica, MS, Englar-Carlson, M & Horne, A. eds. *Counseling troubled boys. A guidebook for professionals* [Kindle ed.] Available from: <http://www.amazon.com> (Accessed 14 February 2012).
- Kiselica, MS & Novack, G. 2011. Promoting strength and recovery: counseling boys who have been sexually abused. In Kiselica, MS, Englar-Carlson, M & Horne, A. eds. *Counseling troubled boys. A guidebook for professionals* [Kindle ed.] Available from: <http://www.amazon.com> (Accessed 14 February 2012).
- Larsen, CD, Sandberg, JG, Harper, JM & Bean, R. 2011. The effects of childhood abuse on relationship quality: gender differences and clinical implications. *Family relations*, 60:435-445.
- Lincoln, YS. 1995. Emerging criteria for quality in qualitative and interpretive research. *Qualitative inquiry*, 1(3):275-289.
- Lowenstein, LF. 2011. The complexity of investigating possible sexual abuse of a child. *The American journal of family therapy*, 39:292-298.
- Maikovich-Fong, AK & Jaffee, SR. 2010. Sex differences in childhood sexual abuse characteristics and victims' emotional and behavioural problems: findings from a national sample of youth. *Child abuse & neglect*, 34(6):429-437.
- Maltby, J, Williams, G, McGarry, J & Day, L. 2010. *Research methods for nursing and healthcare*. New York, NY: Pearson Education.
- Maree, K & Van Der Westhuizen, C. 2007. Planning for a research proposal. In Maree, K. ed. *First steps in research*. Pretoria: Van Schaik:24-45.
- Nieuwenhuis, J. 2007. Qualitative research designs and data gathering techniques. In Maree, K. ed. *First steps in research*. Pretoria: Van Schaik:70-98.
- Nolas, S. 2011. Grounded theory approaches. In Frost, N. ed. *Qualitative research methods in psychology. Combining core approaches*. England: McGraw Hill:3-15.
- O'Leary, PJ. 2009. Men who were sexually abused in childhood: coping strategies and comparisons in psychological functioning. *Child abuse & neglect*, 33:471-479.
- O'Leary, P & Gould, N. 2009. Men who were sexually abused in childhood and subsequent suicidal ideation: community comparison, explanations and practice implications. *British journal of social work*, 39:950-968.
- Olafson, E. 2011. Child sexual abuse: demography, impact, and interventions. *Journal of child & adolescent trauma*, 4:8-21.
- Parent, S & Bannon, J. 2012. Sexual abuse in sport: what about boys? *Children and youth services review*, 34:354-359.
- Pereda, N, Guilera, G, Forns, M & Gómez-Benito, J. 2009. The prevalence of child sexual abuse in community and student samples: a meta-analysis. *Clinical psychology review*, 29:328-228.
- Phasha, TN. 2008. The role of the teacher in helping learners overcome the negative impact of child sexual abuse. A South African Perspective. *School psychology international*, 29:303-327.
- Pieters, L. 2012. Male child sexual abuse [email]. 28 Aug 2012.
- Ponton, L & Goldstein, D. 2004. Sexual abuse of boys by clergy. *Adolescent psychiatry*, 28:209-229.
- Schraufnagel, TJ, Davis, KC, George, WH & Norris, J. 2010. Childhood sexual abuse in males and subsequent risky sexual behavior: a potential alcohol-use pathway. *Child abuse & neglect*, 34(5): 369-378.
- Schurink, W, Fouchè, CB & De Vos, AS. 2011. Qualitative data analysis and interpretation. In De Vos, AS, Strydom, H, Fouchè, CB & Delport, CSL. eds. *Research at grass roots: for the social sciences and human service professions*. 4th ed. Pretoria: Van Schaik:397-423.
- Strydom, H. 2011. Sampling in the quantitative paradigm. In De Vos, AS, Strydom, H, Fouchè, CB & Delport, CSL. eds. *Research at grass roots: for the social sciences and human service professions*. 4th ed. Pretoria: Van Schaik:222-234.
- Strydom, H & Delport, CSL. 2011. Sampling and pilot study in qualitative research. In De Vos, AS, Strydom, H, Fouchè, CB & Delport, CSL. eds. *Research at grass roots: for the social sciences and human service professions*. 4th ed. Pretoria: Van Schaik:390-396.

- Thielmann, S. 2010. *Professional responses to male survivors of childhood sexual abuse: a literature review on current research and professional practice*. Available from: [www.nzmenshealth.org.nz](http://www.nzmenshealth.org.nz) (Accessed 19 July 2012).
- Thomas, G. 2010. Redrawing the front line. A play therapy service for meeting the psychosocial needs of children and families in school. In Drewes, AA & Schaefer, CE. eds. *School-based play therapy*. 2nd ed. New Jersey: John Wiley:407-433.
- Trask, EV, Walsh, K & DiLillo, D. 2011. Treatment effects for common outcomes of child sexual abuse: a current meta-analysis. *Aggression and violent behavior*, 16:6-19.
- Valente, SM. 2005. Sexual abuse of boys. *Journal of child and adolescent psychiatric nursing*, 18(1):10-16.
- Van Emminis, H. 2013. Male child sexual abuse [personal interview]. 5 Oct, Pretoria.
- Van Heerden, J. 2012a. Intervention strategies for male child sexual abuse [personal interview]. 24 May, Krugersdorp.
- Van Heerden, J. 2012b. Male child sexual abuse [personal interview]. 23 Aug, Krugersdorp.
- Van Wyk, M. 2013. Clinic schools [telephonic interview]. 24 Apr, Pretoria.
- Walker, J, Archer, J & Davies, M. 2005. Effects of rape on men: a descriptive analysis. *Archives of sexual behavior*, 34(1):69-80.