

OBSTACLES TO THE RECOGNITION OF SEXUAL ABUSE AND DISSOCIATIVE DISORDERS IN CHILD AND ADOLESCENT MALES

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ABSTRACT

Previous studies are reviewed which describe difficulties in diagnosing dissociative disorders in general, in children, and in males. Five cases are presented in which males from eight to fourteen years of age were diagnosed as having dissociative disorders after significant delays. In three cases, evaluation did not take place until years after substantiation of child abuse. In one case the child was reabused and in three cases the index victim reabused another child before the dissociative disorder was recognized. Delay in evaluation and diagnosis occurred despite the presence of documented sexual abuse in all cases and typical symptoms including amnesic periods, sudden shifts in behavior and emotion, denial of witnessed behavior, and somnambulistic or trance states. Three patients had at least one first degree relative with a dissociative disorder. Obstacles to recognition included denial of sexual abuse and symptoms by the boys themselves and their families and therapists; other problems included family dysfunction, and the patients' self-isolation. In these cases some qualities of the dissociative systems mitigated against recognition including: 1) the presence of a secret-keeping alter that shielded all victimization memories; and 2) hypermasculine traits in the host including aggressivity and stoicism, which were perceived as hypernormal rather than as resulting from dissociative fragmentation.

INTRODUCTION

This article reviews the difficulties in diagnosing dissociative disorders in general and in children and males in particular. Five cases are described in which the accurate diagnosis of sexually abused child and adolescent males was delayed significantly. The cases illustrate that recognition of

both the victimization history and the dissociative symptoms are obstructed by cultural myths about the invulnerability and aggressivity of males. These obstacles function at every level—intrapsychically, intrafamilially and within therapeutic settings—to facilitate denial of the abuse history and the dissociative symptoms.

Difficulties in Diagnosing Dissociative Disorders

Dissociative disorders are difficult to diagnose for several reasons: they tend to have a fluctuating course and a varied clinical presentation, to share symptoms with other more common psychiatric disorders, and their overt symptomatology is subtle (Kluft, 1985). Additionally, many patients seek to hide their dissociative symptoms due both to conscious and unconscious motivations such as fear that examining these defenses may attenuate their effectiveness (Franklin, 1990).

Diagnosis in Children

Identification of dissociative disorders in children is even more difficult. Although dissociative disorders begin to develop early in life, with the foundation having been laid in the preschool years (Peterson, 1990; Kluft, 1990), and patients usually describe symptom onset prior to age six, most cases of multiple personality are not diagnosed until ages twenty to forty with only 11% of MPD cases diagnosed before the age of twenty (Peterson, 1990, Putnam 1991). Some of this time lag may be attributed to the child's fear of injury. Waiting until one is older and stronger to reveal one's victimization seems to afford some sense of psychological protection and safety (Nasjleti, 1980).

Clinical study of childhood dissociative disorders has until very recently lagged behind research on those disorders in adulthood (Kluft, 1990; Peterson, 1991). Skepticism on the part of child psychiatrists may reduce diagnostic frequency. Memory disturbances are particularly difficult to assess in young children because of their inability to estimate duration or to temporally sequence events (Putnam, 1991). The existence of normal dissociative phenomena varying in range and intensity at different developmental stages of childhood and adolescence, the necessity of using adult *DSM-III-R* diagnostic criteria for diagnosing children, clinical presentations which are frequently obfuscated by comorbid psychiatric conditions, and the dearth of longitudinal studies delineating the natural course of dissociative disorders from inception through adulthood are additional factors which contribute to an even greater difficulty in diag-

nosing dissociative disorders in children and adolescents than in adults (Ross, Ryan, Anderson, Ross, & Hardy, 1989; Peterson, 1991; Putnam, 1991).

Diagnosis in Males

There is evidence for reluctance on the part of both male children and male adults to report victimization experiences, especially those of a sexual nature, and this may extend to the reporting of dissociative symptoms. The concept of masculinity in both historical and present-day contexts equates maleness with invulnerability. In our culture, male children are raised to be more aggressive, physically and psychologically, and more independent than female children (Nasjleti, 1980). "Among the things males are denied are: being dependent on others, being spontaneous in the expression of feelings, being passive toward aggressiveness other than that from females, or permission to ask for nurturance" (Nasjleti, 1980, p. 270). The idea of male victims of sexual abuse challenges such traditional views of masculinity. Victims themselves tend to minimize and deny (Lesnik-Oberstein, 1983; Kaufman, 1984; Green, 1988) and society and families reinforce this denial because of its concordance with their expectations of males (Kaufman, 1984; Zaglifa, 1984; Wilbur, 1986; Green, 1988; Vander Mey, 1988). The mythological strength associated with maleness has led society to expect men to be indestructible both mentally and physically. A male abuse victim must have allowed himself to be abused. If he complains (that is, reveals) his victimization, he further compounds his weakness.

Obstacles to Disclosure of Sexual Abuse in Males: Cultural Permissions and Taboos

Reporting of the sexual abuse of boys who have been victimized by females is still hindered by the myth that this is an act of lucky seduction, a rite of passage which allows entry into the world of heterosexual sexuality (Nasjleti, 1980; Zavodnick, 1989), leading male children and adolescents, themselves, to be less likely to recognize sexual abuse by a female as aberrant behavior (Dimock, 1988). Although few professionals profess the belief that sexually molested boys "are not really abused, they're lucky" (Zaglifa, 1984), the still-prevalent belief that males are less traumatized may be a legacy of that traditional view (Brooks, 1985; Conerly, 1986; Deitz, 1986; Green, 1988; Rogers and Terry, 1984).

However, most perpetrators, regardless of the victim's gender, are male (Briere, Evans, Runtz, & Wall, 1988; Zavodnick, 1989). Finkelhor, Hotaleng, Lewis, & Smith (1990) found that 83% of the perpetrators of sexual abuse against boys were men. Male children are usually abused by known adolescent or adult males (Dimock, 1988). The male child or adolescent may equate revealing male-male sexual abuse with being labelled as a homosexual. Indeed, he may believe himself to actually have become a homosexual, particularly if he experienced anything positive from the abuse, ranging from special attention and privileges to erotic arousal (Nasjleti, 1980; Friedrich, Berliner, Uguiza, & Beilke, 1988; Zavodnick, 1989). When male-male sexual abuse involves father-son or stepfather-stepson incest, the literature describes

serious psychopathological sequelae including depression, psychosis, or suicide (Kaslow, Haupt, Arce, & Werblowsky, 1981). Male-male incest may be underreported due to its violation of both the homosexuality taboo and the incest taboo (Kaslow et al., 1981; Vander Mey, 1988; Williams, 1988; Watkins & Bentovim, 1992). Williams (1988) believes there is a subgroup of perpetrator fathers who, fearful of expressing their homosexuality outside of the family, practice their homosexual preferences intrafamilially by abusing a son. This realistic component of becoming the homosexual partner of the father who usually functions as the primary male role model for his male children may further confuse the gender orientation of the victim of father-son incest. In fact, some studies indicate that male victims are indeed more likely to practice homosexuality outside the family than are non-victim males (Williams, 1988; Dimock, 1988). Relationship difficulties extend to both male-male and male-female relationships as these victims tend to sexualize any male-male interactions, thereby depriving themselves of the support of same-sex relationships (Dimock, 1988; Watkins & Bentovim, 1992).

Obstacles to Disclosure of Sexual Abuse in Males: Differences in Symptoms and Course in Male and Female Victims

Childhood sexual victimization in both males and females is associated with subsequent psychological, and particularly sexual, dysfunction. Briere, et al. (1988) hypothesize that males are more traumatized by their abuse than females, having later onset of symptomatology, a pattern seen in those females who were more severely abused. This may be explained in part by the finding that males experience more threats and more physical force by the perpetrators in order to insure compliance (Vander Mey, 1988). In addition, male victims are more likely to live in homes where other siblings are also being abused (Vander Mey, 1988). Since male victims tend to experience more severe abuse, are more traumatized by their abuse, and are generally one of multiple victims within a family, one would predict that the mental health community would have a higher index of suspicion both for sexual abuse in symptomatic males and for those symptoms associated with severe abuse, such as dissociative disorders. This, however, is not the current practice as evidenced by the significant under-reporting of these phenomena in males (Peters, Wyatt, & Finkelhor, 1986; Risin and Koss, 1987; Mann, 1987; Zavodnick, 1989; Friedrich et al., 1988; Finkelhor et al., 1990; Watkins & Bentovim, 1992).

Abused boys appear to have more aggressive behavior than abused girls (Friedrich et al., 1988; Watkins & Bentovim, 1992). This may lead evaluators away from considering dissociative diagnoses and towards diagnosing sexual or impulse control disorders. Male adolescents with MPD have more antisocial traits than a comparable group of female adolescents. Adult male psychiatric inpatients with a history of abusive childhoods are more likely than a comparable group of females to become physically aggressive when angered. There is evidence in the literature that having been a victim of sexual abuse can predispose one to then become a perpetrator of such abuse (Freeman-Longo, 1986; Vander Mey, 1988;

Friedrich et al., 1988) thereby paralleling the hypothesized cycle in childhood physical abuse (Goodwin, McCarty, Divasto, 1981; Watkins & Bentovim, 1992). Some studies report that the majority of adolescent and adult men who are sex offenders were victims of sexual abuse in childhood, the victim-to-victimizer transformation increasing in likelihood if the original victimization was of long duration and perpetrated by multiple people on multiple occasions (Freeman-Longo, 1986; Friedrich et al., 1988). Other studies indicate that males who sexually abused their younger brothers typically were sexually abused by their fathers. Also, fathers who sexually abuse their sons have been found to have been physically or sexually abused in childhood themselves (Vander Mey, 1988). Some rapists and incestuous fathers describe eroticized or sexualized relationships with their mothers (Nasjleti, 1980). Thirty-seven percent of males who were identified as having sexually compulsive behavior reported childhood sexual abuse (Dimock, 1988). Unfortunately, it is this same action-orientation that makes accurate diagnosis so urgent that obscures the victimization history and dissociative episodes that are critical to diagnostic accuracy.

CASE STUDIES

These five cases were diagnosed in the child/adolescent case load of a rural Mental Health Center in a two-year period in the late 1980s. Four were referred by Child Protective Services. All were initially diagnosed as conduct disorder with dissociative symptoms appearing within the first 10 sessions. All were treated (by D.M.) for dissociative disorder for periods ranging from 8 to 30 months.

The patients' names have been changed to insure confidentiality.

Case #1:

Brad was eight years old when he was referred for an outpatient evaluation by his parent subsequent to being suspended from school because of episodes of violence toward peers, teachers, and school property. These episodes were interspersed with periods of pleasant behavior.

Brad's academic performance showed a wide variability, coinciding with changes in his behavior. Although Brad was in the fourth grade, his math and reading skills ranged from a second-grade level to language skills equivalent to twelfth grade performance and college-level mathematics. His WISC-R full scale IQ, assessed on clinical admission, was 144. Eleven months later, during a difficult time for Brad, a repeat WISC-R showed a full scale IQ of 87.

Play therapy was instituted, emphasizing projective tasks in painting and drawing and play with puppets and dolls. During one session, Brad identified a doll as "the Break-Dancing Monster—just like my friend." He described an imaginary companion who spent time with him during non-problematic times and who, it appeared, provided nurturance and protection when needed.

By the fifth session Brad had settled into the therapy process and the Rorschach was administered. Brad provided 53 responses to the ten cards; his initial response to Card

IV was, "It's a great big guy with water—or this white stuff—coming down on the little kid." When questioned about this, Brad shrugged off inquiry by saying that the Break Dancing Monster knew all about it. That evening, Brad ran away from home.

The next day, Brad's mother reported that he had been returned by the police late the previous evening and that he was unable to remember running away and had no recall of his previous session. His mother agreed to bring him to the clinic that afternoon. In that session, Brad appeared different in several ways: his voice was deeper, his speech was articulated more slowly, and he seemed to have a slight southern accent. His drawings lacked the complexity of technique and content that had been so consistent in previous sessions. He appeared to be ill at ease with the therapist.

Suddenly, he accused the therapist of having abrogated their trust: He shouted, "You cheated! You weren't supposed to know about me and you cheated me so I would have to let you know me." He identified himself as the Monster and agreed, with surprisingly little urging, to come to Brad's sessions along with Brad.

The next day the Monster disclosed events that occurred over one year's time in which a man down the street had bribed Brad into lying on the man's couch while the man fondled Brad's genitals, coerced Brad into fondling his genitals and then ejaculated onto Brad's genitalia. A retrospective investigation revealed a definite correlation between Brad's deterioration of behavior and the episodes of abuse.

When Brad's mother was told that a report would have to be made, she withdrew him from therapy. Brad ran away from home twice over the next four months and his vacillating school performance increased in frequency and intensity. His mother brought him back to therapy when he was accused at school of reaching under a little girl's dress and fondling her.

Brad's mother reported that she had withdrawn him from therapy because, after learning of Brad's abuse, she took him to the family physician who told her that "boys are never molested—it couldn't have happened." She reported that she believed the physician and concluded that the therapist had fabricated the abuse. It was easier, she said, to bring Brad back into therapy after he had inappropriate sexual behavior toward his classmate. When Brad convinced his mother that the abuse really had happened (the perpetrator was later arrested and confessed to molesting Brad and other children) she sought help from her own therapist. During these sessions, her own dissociated prior sexual abuse was uncovered.

During the first session of the resumed therapy, Brad allowed the Monster to emerge. The Monster went over the story of his sexual abuse and was pleased by the therapist's praise for having the strength to remember what happened and take the action to help Brad feel safe. The Monster said to the therapist that eventually "both of us will come to see you at the same time."

Within six months, Brad's behavior and school performance stabilized, his previous discontinuity of time steadily diminished, and he limited his running away from home

to walks to the corner pay phone which he used to call the therapist when he needed to talk. Brad's treatment was interrupted by his acceptance at a therapeutic high school. He entered college but in his first year acquired a substance abuse diagnosis and a criminal record. He continues part-time college work as well as court-mandated treatment. His mother was judged negligent both in her care of Brad and his younger siblings and remains in treatment for a major dissociative disorder.

Case #2:

Bob was a six foot tall, well-developed 14-year-old when his social service worker brought him to the clinic because he had been charged with the sexual abuse of a thirteen-year old girl. He had a history of having been psychiatrically hospitalized at ages seven and ten at the urging of his family physician who had diagnosed him as schizophrenic.

He was initially hostile and uncooperative with the therapist. In the fifth session, however, when Bob entered the office he appeared markedly different from previous sessions. He was quiet, frightened, and confused. He seemed unfamiliar with both the office and with the therapist. He referred to himself as "Bobby" and stated that he was six years old. He described Bob's alleged female victim as being a playmate of similar age who, he said, "told me all about what her grandpa did to her and I told her what the babysitter did to me." He tearfully related several incidents in which a teenage male babysitter had sodomized him. Subsequent therapy sessions focused on the Bob alter becoming familiar with the Bobby alter, with Bobby's sharing the knowledge of the abuse with Bob (through playing tape recordings of Bobby's sessions for Bob), and a gradual fusion of the two alters. Bob was brought to his sessions by his caseworker. His parents refused to come to sessions with him because they refused to believe that the abuse at age six had actually occurred. Prior psychiatric records revealed that Bob's abuse had been reported and substantiated at age seven, but never had been connected with his psychiatric problems. Bob continued living in the foster home where he did well, and entered technical college.

Case #3:

Jack was a twelve year old boy who had been removed from a dysfunctional home by Social Services because of sexual abuse by an older brother and chronic truancy which had continued for more than a school year. Two months after his placement in a treatment foster home, the foster father discovered Jack attempting to sodomize a younger child in the home.

Jack presented evidence of alter states in his very first session. At times he appeared to be his actual age but episodically he experienced a sudden switch to markedly immature behavior, calling himself Johnny at these times. He also displayed amnesic barriers between these states and loss of time during the initial two-hour interview.

During a therapy session, Johnny emerged angrily, saying he was "doing to the foster brother what Jimmy and Kevin (Jack's older brothers) did to me." He reported some aware-

ness of what had occurred in therapy sessions with both alters.

His parents persisted in their denial of the sexual abuse. This was more easily understood when, a year after beginning therapy, Jack disclosed that his father had sexually abused him for several years. The Jack alter contained the information about the father's abuse and the Johnny alter contained the information about the brothers' abuse. The two personalities remained disparate, as did the knowledge of the different sources of the abuse.

Parental rights were terminated and he was adopted by the foster parents with whom he was placed by Child Protective Services. The foster parents withdrew Jack from therapy for awhile, then requested that therapy resume with a different therapist because they did not believe in Multiple Personality Disorder. Jack apparently did well for a time, but at the age of 18 he was convicted of sexually abusing a 13-year old boy. He is currently serving a five-year prison term.

Case #4:

Chip was eight years old and was the near-victim of Jack as described, above. Chip adamantly denied that the incident occurred. He was described by the foster father as being a difficult child because of his sleepwalking. It was discovered that these somnambulistic episodes were the medium for the emergence of a frightened, angry alter who spoke in neologisms. This somnambulistic alter described the frequent sodomization perpetrated by his step-uncle which had occurred before Chip entered foster care. Chip had entered foster care because of physical abuse by his father, truancy and running away. The sexual abuse had been known only to the somnambulistic alter. Once the somnambulistic alter could share with Chip (the waking alter) the prior sexual abuse, Chip could become aware, too, of the more recent abuse in foster care. Chip's mother had been diagnosed as having a dissociative disorder and was in treatment in another state. Within a year of diagnosis Chip was kidnapped from foster care by his alleged perpetrator and has not been traced.

Case #5:

Rick was nine years old when he began therapy, referred by his school because "he keeps spacing out during class, he doesn't do any of his work and he has no friends." "Some days," the school psychologist reported, "he does brilliant school work and other days he acts almost retarded." Earlier in that school year, Rick had been treated by two school psychologists, each without the other's knowledge, and had very different test score profiles.

His parents had divorced when he was two. He had lived with his mother until he was seven at which time his father gained custody after learning that the mother and her friends had been sexually abusing Rick for several years. The abuse consisted of his mother's fellating him while she or her friends inserted objects into his anus.

For more than a year in therapy, Rick denied having been abused. When one of his projective paintings was suggestive of abuse, Rick answered questions by saying, "You have to ask him." It turned out that "Him" was the name of an alter personality state. Another, called "It," was also iden-

tified. Shortly after the alters were identified, Rick's father withdrew him from therapy. He continued to begin and then withdraw from therapy and he continued to have problems in school. During this year, his mother and his paternal grandmother were diagnosed with Multiple Personality Disorder.

Rick's school problems ceased in high school and he became a wrestling champion. He has not yet returned to therapy.

DISCUSSION

This report describes five young males, ages eight to fourteen years, diagnosed as having dissociative disorders. In all cases, significant delays occurred between onset of symptoms and appropriate diagnosis and treatment. All five had obvious symptomatology: amnesic periods, inconsistent learning behavior and performance, lying (in particular, denial of observed behavior), active fantasy life, trance-like states, evidence of multiple ego states, sexual misbehavior and aggression, a history of running away, self-mutilative or self-defeating behaviors, affective symptoms, multiple diagnoses, and post-traumatic symptoms, all consistent with a diagnosis of dissociative identity disorder (Peterson, 1990; Putnam, 1991). All five had documented severe sexual abuse corroborated by legal judgements. Three (cases 3, 4, & 5) had significant delays between substantiation of abuse and evaluation. In three (cases 1, 4, & 5) there was a family history of multiple personality or other dissociative disorder. In cases one and five, inconsistencies in psychological testing were observed. Despite the severity of both symptoms and stressors, and despite legal intervention, one boy was reabused (case 4), three reabused others (cases 1, 2, & 3), and three sustained at least one incomplete or aborted evaluation before definitive diagnosis occurred (cases 1, 2, & 5).

In these cases, resistance to recognition was found in children, their families, and in the professionals with whom they came in contact. The dissociated alters, themselves, represented an intrapsychic form of defense against the acknowledgment of the sexual abuse. At all levels there existed a great reluctance to accept victimization as part of male experience. Parents actively sabotaged evaluation and treatment, probably reflecting the high level of dysfunction present in the families of these children and adolescents (Tyson, 1992). Although several studies define an unhappy family life as a powerful risk factor for both intra-familial and extrafamilial sexual abuse (Finkelhor et al., 1990), professionals in these cases often accepted rather passively the family's viewpoints, which tended to minimize the severity both of symptoms and of environmental adversity. The chilling example of the child kidnapped from foster care by the alleged perpetrator illustrates the grave dangerousness which must be appreciated in these situations. Yet, when obstacles appeared, professionals often failed to pursue these cases as actively as warranted by these real dangers. This may be a reflection of society's reluctance to address the issue of sexual abuse in male children and adolescents.

Most males are taught from early childhood to keep secret their emotional and physical vulnerability (Dimock, 1988).

Little boys learn early that they are not supposed to be victims (Wilbur, 1986). These boys engaged in intensive efforts to deny their victimization. The young men covered their fears with aggression and isolated themselves from all relationships. Four had elaborated a "secret-keeping" alter who remembered the details of the sexual abuse and acted as a nurturant companion to the host, responding to knowledge of his own victimization with a level of acceptance that the parents were unable to provide. This "secret-keeping" alter, while acting as a guardian of the guilty secret (Goodwin, 1986), also was a protector against further abuse.

In these male dissociators, often only the "secret keeping" alter held the memories of the abuse. In most female dissociators described in case studies, parts or all of the abuse are known by multiple alters (as seen in our case 3). If these preliminary findings reflect actual gender differences, this would explain some of the difficulty in diagnosing victimization in dissociative males as the memories are less accessible. In addition, females tend to exhibit hyperfeminine and hypercompliant behavior which may lead both to revictimization and to the diagnosis of depression and other psychiatric disorders; mental health clinicians tend to see even normal females as less healthy than males or gender-unspecified adults (Broverman, Vogel, Broverman, Clarkson, & Rosenkrantz, 1972). Additionally, their violence is more self-directed, all of which results in a higher probability that victimized females with dissociation will at least come to the attention of the mental health system (Kluft, 1985). The dissociative males in this study tended to exhibit hypermasculine behavior including physical aggressivity, sexual aggressivity, and stoicism confirming previous findings (Kluft, 1985; Perry, 1993). All five boys presented with conduct problems and 3 had juvenile records. Two had acquired criminal records by early adulthood. The criminal justice system, even more than the mental health system, is burdened both by the general prejudices described above against male victimization and by the difficulties in diagnosing dissociation in males.

Violence prevention is a particularly compelling reason for the advocacy of accurate diagnosis and appropriate treatment of sexually abused male children and adolescents. Children diagnosed with these disorders will have produced fewer victims of their aggressive dyscontrol and are more easily treated than adults. Treatment is usually shorter in duration (Kluft, 1990). In addition, "when we consider the arduous and painful lives that most adults with MPD have endured, the extensive treatment that many MPD patients require to achieve recovery, and the many years of ineffective treatment that most of them have received before they were diagnosed correctly, the socioeconomic and public health consequences of failing to detect and treat MPD and dissociative disorders in children became painfully apparent" (Kluft, 1990, p. 1). This is truly a psychiatric intervention that can provide primary as well as secondary and tertiary prevention. ■

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