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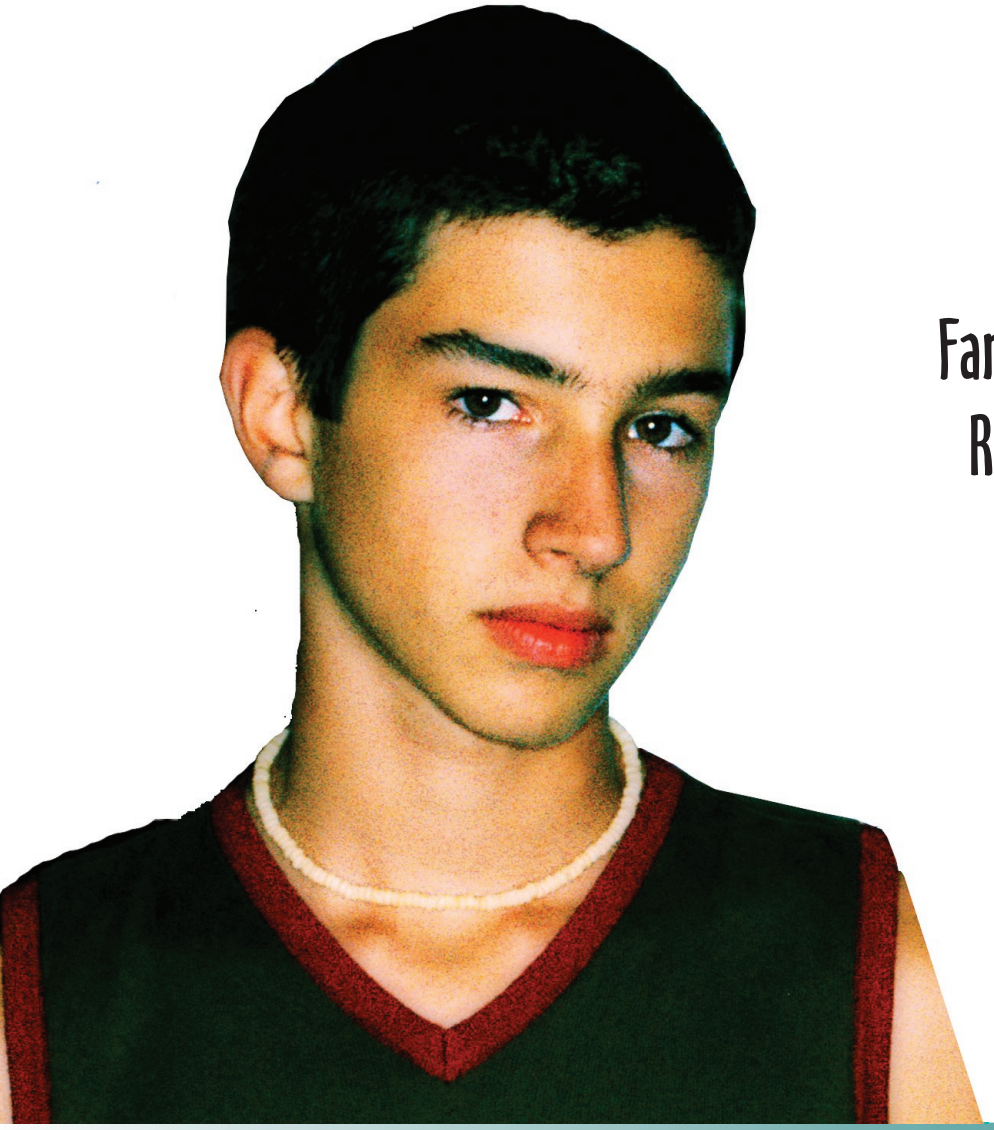
Boys Will Be Boys:



Understanding the Impact of Child Maltreatment and Family Violence on the Sexual, Reproductive, and Parenting Behaviors of Young Men

By Abby Kahn and Pat Paluzzi

Healthy Teen Network
MAKING A DIFFERENCE IN THE LIVES OF TEENS AND YOUNG FAMILIES

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Healthy Teen Network (formerly the National Organization on Adolescent Pregnancy, Parenting, and Prevention) is a national membership organization devoted to making a difference in the lives of teens and young families. Healthy Teen Network was founded on the belief that youth can make responsible decisions about their sexuality and reproductive health when they have complete, accurate, and culturally relevant information, skills, resources, and support. Healthy Teen Network serves as a leader, a national voice, and a comprehensive educational resource to professionals working in the area of adolescent reproductive health – specifically teen pregnancy prevention, teen pregnancy, teen parenting, and related issues.

This report is available on the Healthy Teen Network Web site at **www.HealthyTeenNetwork.org**. To order additional copies, contact:

Healthy Teen Network
509 2nd St, NE, Suite 200
Washington, DC 20002
Phone: (202) 547-8814
Fax: (202) 547-8815
Email: **HealthyTeens@HealthyTeenNetwork.org**
Web: **www.HealthyTeenNetwork.org**

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A Call to Action

Regardless of whether we raised our own boys, were raised with them, or grew up around them, we have all heard the phrase, *Boys will be boys*. It is often given as a tongue in cheek response to aggressive or "boyish" behavior; the kind of rough housing or bullying more often tolerated or even encouraged among boys than girls. While our personal familiarity with boys shows us that they are every bit as emotional as girls, sadly, we also get a close up view of how society discourages sensitivity among young boys and how signs of tenderness may result in taunts or worse, teaching our sons what it means to be boys, and eventually men.

Such a strict and outmoded definition of masculinity serves as one major barrier to boys and young men who seek the opportunity to disclose abuse, discuss their experiences, and receive treatment for dealing with their experiences. This lack of disclosure masks the very real problem of exposure to child maltreatment and family violence among males and permits all of us to continue to use the same narrow lens to view males as solely perpetrators and never survivors of violence.

Research tells us that boys are in fact exposed to child maltreatment and family violence at rates similar to girls, suffer different types of violence than girls, and experience their own gender-specific responses. These young male survivors are prone to certain sexual, reproductive, and parenting behaviors because of their exposure, including higher rates of pregnancy and sexually transmitted diseases, including HIV infection, perpetrating violence among their own families, and more.

The problem is clear - what we lack is the public attention to this issue as it affects boys and young men.

In October 2001, Healthy Teen Network (then the National Association on Adolescent Pregnancy, Parenting and Prevention) and the Center for Assessment and Policy Development published a report - *Interpersonal Violence and Adolescent Pregnancy: Prevalence and Implications for Practice and Policy* - exploring research related to this issue among young women.

Now it's the boys' turn.

With this report, Healthy Teen Network hopes to complete the call to action to address the complex public health issue of child maltreatment and family violence as it affects the future sexual, reproductive, and parenting behaviors of those in our youngest families. Please join us in fighting abuse among all our children so that they may grow into healthy adults, nurture healthy families, and break the cycle of abuse.

Thank you,

Patricia Paluzzi, CNM, DrPH
President and CEO
Healthy Teen Network

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Introduction

Boys Will Be Boys – It is a common refrain, one often heard when boys engage in aggressive play, resort to violence to settle conflicts, use drugs or alcohol, or display sexually aggressive or inappropriate behavior. For some young boys, these negative and risky behaviors develop into bigger problems in adolescence and adulthood. While we may postulate many reasons for boys' behavior, one that is often not given enough consideration is the effect of exposure to child maltreatment and family violence. Exposure to child maltreatment and family violence is linked with certain behavioral outcomes in males. These include higher rates of adverse and/or health compromising sexual behaviors among adolescent and adult males, including sexual violence perpetration (Borowsky, 1997), having multiple partners (Nagy, 1994), condom non-use (Van Dorn, 2005), contracting a sexually transmitted infection (STI) including HIV/AIDS, involvement in a teen pregnancy (Saewyc, 2000), and abusive parenting behaviors (Newcomb, 2000).

As the second in a set of briefing papers on the effects of child maltreatment and family violence on adolescent behavior, this paper concerns itself with the impact of physical, sexual, and psychological abuse, and exposure to family violence on the sexual, reproductive, and parenting behaviors of young men. Healthy Teen Network believes it is time to expand our thinking with regard to males and violence, to let go of outdated and harmful stereotypes and misperceptions about masculinity and male gender identity, and to begin to work toward a society that recognizes young men's real potential as agents of sexual, reproductive, and public health. With this paper, Healthy Teen Network hopes to educate and stimulate further discussion among the people often challenged by these issues, including practitioners, policymakers, advocates, and educators.

Healthy Teen Network intentionally uses the term 'survivor' rather than 'victim' when speaking of those previously exposed to maltreatment because it connotes resilience. The term 'victim' can imply helplessness, and Healthy Teen Network believes that anyone who experienced maltreatment and is still functioning is clearly a survivor.

The Scope of the Problem

Child maltreatment is a serious problem. However, the quality of national surveillance data on child maltreatment is poor (Hussey, 2006). Much of the data available, such as the National Child Abuse and Neglect Data System or the National Incidence Study, are based on investigations by state and local child protective services agencies. For instance, in 2004, according to national records, 872,000 children were the subjects of substantiated cases of abuse and neglect. For every 1000 children, 2.1 were physically abused, 1.2 were sexually abused, 0.9 were psychologically abused, and 7.4 were the victims of neglect (DHHS, 2006). However, because these data only include cases reported to authorities, they do not take into account the many cases of abuse known only to the perpetrator and the survivor, thus skewing the image of the general prevalence of such maltreatment.

National Surveys: Our best estimates of the prevalence of child maltreatment and family violence come from studies using large, national samples that cut across social groups. The National Longitudinal Study of Adolescent Health (Add Health) provides slightly more representative figures for the prevalence of child maltreatment and family violence against both males and females. Collected between 1994 and 1995, the study states the rate of supervision neglect for both males and females as 41.5 percent; physical assault at 28.4 percent; physical neglect at 11.8 percent; and sexual abuse involving physical contact at 4.5 percent (Hussey, 2006). According to this same study, males were 1.25

times as likely to experience supervision neglect, 1.78 times as likely to experience physical neglect, 1.1 times as likely to experience physical assault, and 0.82 times as likely to experience contact sexual abuse as their female counterparts (Hussey, 2006).

In the Adverse Childhood Experiences (ACE) Survey (1998), men reported their experiences of maltreatment before the age of 18 at the following rates:

29.9%– Physical Abuse
16% – Sexual Abuse
7.6% – Emotional Abuse
11.5% – Witnessed Family Violence against Mother

In another seminal study conducted by telephone in 1985, 16 percent of adult men nation-wide reported having experienced some type of sexual abuse in their lifetime (Finkelhor, 1990). According to a third national, school-based study of adolescent boys, 12 percent reported having ever experienced physical abuse (Schoen, 1998).

Non-National Surveys: The Adverse Childhood Experiences (ACE) Survey reports the prevalence of different types of abuse by the survivor's gender. Between 1995 and 1997, men reported their experiences of maltreatment before the age of 18 at rate of 29.9 percent for physical abuse; 16 percent for sexual abuse; 7.6 percent for emotional abuse; 10.7 percent for physical neglect; 12.4 for percent emotional neglect; and 11.5 percent for family violence against the mother (Felitti, 1998).

According to a study conducted among randomly identified Canadian young men, 15.5 percent reported unwanted sexual contact before the age of 17 (Bagley et al., 1994), and according to self-reports from the National Youth Survey, 3.2 percent of males ages 11-17 admitted to perpetrating a sexual assault (Elliot, 1995).

Convenience and Population-Based Surveys: Prevalence data from studies of boys and men in less widely representative populations vary greatly. According to the results of the Minnesota Student Survey, in 1992, six percent of sexually experienced male respondents reported a history of any type of sexual abuse, and in 1998, the figure was nine percent (Saewyc, 2004) In this same study, in 1992 sexual violence perpetration by adolescent males was reported by 4.8 percent of the study population (Borowsky, 1997). In their review of studies, Holmes & Slap (1998) found that a history of sexual abuse was reported by five percent of a sample of homeless men (Koegel et al., 1995); 34 percent of men who have sex with men being treated at a sexually transmitted disease clinic; and 39 percent of juvenile sex offenders (Bartholow et al., 1994).

Child maltreatment is defined as any act or failure to act by a parent, caregiver, or other responsible person as defined under state law that results in physical abuse, neglect, medical neglect, sexual abuse, emotional abuse, or other that presents an imminent risk of serious harm to a child (DHHS, 2004).

In sum, available research tells us that between 0.21 and 29.9 percent of young men experience physical abuse at some point in their lifetime; between 0.12 and 39 percent experience sexual abuse; between at 0.09 and 7.6 percent experience emotional or psychological abuse; and around 11.5 percent witness family violence in the home. As disturbing as these figures are, this is just the tip of the iceberg. Each year, thousands of cases of maltreatment go unreported and uninvestigated, and countless maltreated children go untreated. Because violence against young men has not traditionally been a focus of researchers' or public attention, there is a general dearth of reliable and current data with which to describe this issue. Until this changes, the reliability of prevalence data will always be limited, and the numbers for maltreatment against males will remain especially cloudy.

Methodological Issues

Certain methodological issues, such as the lack of common definitions and rigorous study designs, cloud the maltreatment literature and make generalizations and comparisons across studies difficult. Few studies are prospective and utilize a random assignment for intervention because of the associated ethical issues when dealing with child maltreatment.

Terms such as maltreatment, abuse, and violence are often interchanged, and not consistently defined. Researchers often rely on data gathered from studies that use varied definitions of these common terms, making comparisons across research findings difficult. For example, when one study defines "sexual abuse" as forced intercourse, while another defines it as unwanted sexual contact, the second will likely report higher rates because of the more general criteria.

Family violence is the use of abusive behavior among people who are married, living together, or have an on-going or prior intimate relationship (DHHS, 2004).

Hopper (1996) outlines several important methodological issues to consider when dealing with prevalence rates. First, the population from which the research sample is drawn affects the responses the survey will elicit. For example, a sample of male adolescent juvenile sex offenders will probably report higher rates of sexual abuse than a school-based sample of adolescent boys. Another methodological issue has to do with the way questions are asked. Studies that use questions that present possible abuse experiences and require only a "yes" or "no" answer are more likely to report lower rates of abuse among their samples than if the survivor is allowed to describe his own experience. Third, a survivor may not label his experience as "abuse," especially if it does not involve physical contact, thus he may not report it if the researcher asks about abuse only. Finally, the more questions asked, the more likely the survivor will remember and report the abuse. Often it can be very painful to admit the experience of abuse, therefore giving the survivor more opportunities within a survey to speak up can result in higher rates of reporting.

The type of research design used in a study also affects reported results. Prevalence rates differ according to whether reports were gathered in face-to-face versus telephone interviews, in computerized or paper questionnaires. As well, many studies are retrospective and examine the personal histories of adult males who exhibit adverse or health compromising sexual behaviors, as opposed to prospective and longitudinal studies of child survivors of maltreatment through adolescence and adulthood (Lavoie, 2002). In such instances, subjects are asked to remember in detail the conditions of their abuse, which often elicit accounts affected by recall bias after so much time has passed.

Often, when researchers do survey adolescents, the studies are conducted among populations outside of the mainstream, such as youth in the juvenile justice system (Prentky, 2005), youth in clinical settings (Wherry, 1995), or runaway and/or homeless youth (MacKeller, 2000). Such data do not provide an accurate representation of the prevalence of child maltreatment and family violence among boys within the generalized population that may be better studied using a national or school-based sample including a cross-section of many different sub-populations of young men.

Given these constraints, Healthy Teen Network included research findings in this paper as identified in peer-reviewed, academic literature among studies based in the United States and Canada and reported in the past fifteen years, with notable exceptions. In light of the unique considerations male victimization presents for study, prevention, diagnosis, and treatment, such data are confusing at best and misleading at worst. One thing researchers do agree on, however, is that maltreatment and violence against young men is a national problem that must be given its due attention to prevent serious public health issues for males and females.

The Male Experience of Child Maltreatment and Family Violence

The male experience of child maltreatment and family violence is unique from that of female survivors in several significant ways. The gendered socialization that males undergo differentially affects the types of maltreatment males are exposed to, their psychological effects, and the resulting behavioral sequelae. First, the specific type and form of abuse children experience varies by gender. For example, it has been shown that males are the victims of beatings and physical punishment more often than females, while females are at higher risk of infanticide, sexual abuse, neglect, and being forced into prostitution (World Health Organization, 2002). As well, sexually abused males are more often forced to participate in non-penetrative sex acts, while females are more often subject to forced vaginal intercourse (Raj, 2000).

Possibly the most troubling aspect of the male experience of child maltreatment and family violence is that male survivors tend to report their victimization less frequently than females.

Second, the gender of the perpetrator has also been shown to significantly influence how a male child is affected in cases of witnessing family violence. When a father perpetrates physical and/or psychological abuse against a mother, male child witnesses show a greater tendency to develop certain conditions, such as internalizing (depression, disordered eating, etc.) and externalizing behaviors (binge drinking, fighting, etc.) and post-traumatic stress disorder (PTSD), than their female counterparts (Diamond, 2004). It may be useful to consider how growing up witnessing family violence from an adult male in the home could affect a young boy's ideas about interpersonal relationships, and how this may carry over into his own behavior in relationships in adolescence and adulthood.

Possibly the most troubling aspect of the male experience of child maltreatment and family violence is that male survivors tend to report their victimization less frequently than females. According to one national, school-based survey, nearly half (48 percent) of abused males had not talked to anyone about their abuse compared with 29 percent of abused females (Schoen, 1998). One reason that male survivors report their victimization less often is that society reinforces the notion that boys and young men should be able to protect themselves from harm and not talk about painful experiences. Thus, male survivors may interpret their experiences of maltreatment as a failure to protect themselves and reporting it as a public admission of this failure (Holmes & Slap, 1998). Male survivors may also fear the loss of their independence or other negative repercussions from disclosing their abuse (Holmes & Slap, 1998). Male survivors may fear that if law enforcement or Child Protective Services intervenes and they are removed from their home and placed in a facility or in foster care, then they somehow failed to "be a man" and to manage their problems independently.

Another reason why males may not report their experiences of sexual abuse is that, in many places in the world, such victimization holds the social stigma of being associated with homosexual behavior. Because the majority of perpetrators of child sexual abuse are also male, the experience may be especially traumatic to young males' developing gender identities. When a boy is victimized by another man, it may lead to confusion about his own sexual orientation. In a society that does not wholly accept homosexuality, fear of

being gay can add to the psychological trauma of sexual victimization for a male survivor. It is because of such social and cultural expectations put on men in combination with the glaring lack of understanding of male victimization that male survivors face unique challenges in their recovery.

Related Risk Factors

Maltreatment alone is harmful, but when combined with other negative experiences, it can be even more damaging. Additional factors in the lives of male survivors that may affect whether they engage in adverse or health compromising sexual, reproductive, and parenting behaviors include substance abuse among family members, illegal drug use, steroid use, alcohol use, gang membership (for any duration), unstructured time spent "hanging out," community connectedness, and emotional health and suicide risk (Borowsky, 1997).

Other social and familial factors may create a stressful and adverse developmental environment that can add to the traumatizing effects to child maltreatment, exacerbating the effects on these young men's sexual, reproductive, and parenting behaviors. If a young man has a history of sexual abuse, other variables in his life can work together to compound the likelihood that he will exhibit adverse behaviors – in particular, sexual violence perpetration – as a result (Borowsky, 1997). Research has shown that while – alone – poverty, unemployment, parental substance abuse, parental imprisonment, homelessness, and parental mental illness may not be significantly related to adverse sexual, reproductive, and parenting behaviors, these variable are significantly related to adverse mental health outcomes among males survivors (Turner, 2005). Structural and socio-demographic variables also influence how young men are differently affected by maltreatment. For instance, according to Turner (2005), racial and ethnic minorities, children in low income households whose parents have attained lower levels of education, and children living with a single parent or stepparents experience more types of maltreatment.

According to Finkelhor (2005), the risk of long-lasting adverse effects is the greatest in those cases where child maltreatment is more a chronic condition than a traumatic event. In fact, the vast majority of survivors who later experience adverse mental health effects also experienced multiple victimizations (Finkelhor, 2005).

Three important factors that influence not just the occurrence but the severity of adverse outcomes for the survivor include the age at which the maltreatment began and its frequency or duration (Finkelhor, 2005); the invasiveness of the abuse (penetration versus oral sex, fondling, exhibitionism, etc.); and the victim's relationship to the abuser (family member versus stranger) (Hopper, 1996). The earlier abuse is initiated and the longer the duration, the greater the adverse effects on the survivor later in life. According to Finkelhor (2005), the risk of long-lasting adverse effects is the greatest in those cases where child maltreatment is more a chronic condition than a traumatic event. In fact, the vast majority of survivors who later experience adverse mental health effects also experienced multiple victimizations (Finkelhor, 2005). When physically and sexually aggressive behavior starts in childhood – as a result of maltreatment – it is harder to reverse and is more likely to persist than when the behaviors begin in adolescence (Garbarino, 1999). Research tells us in most cases the first experience of child sexual abuse occurs before the onset of puberty. And while there is no definite age threshold at which the effects of abuse becomes irreversible, we do know the earlier abuse starts, the harder it is to heal.

Researchers have also found that child maltreatment and stress from such trauma in the early stages of development can cause permanent neurological damage to the developing brain in ways that affect behavior (Anda 2005; Prentky, 2005). According to a review of

"Childhood abuse and exposure to domestic violence can lead to numerous differences in the structure and physiology of the brain that expectedly would affect multiple human functions and behaviors" (Anda et al, 2005).

the neurobiological effects of adverse childhood experiences, child maltreatment and exposure to domestic violence can lead to numerous differences in the structure and physiology of the brain that expectedly would affect multiple human functions and behaviors (Anda, 2005). Thus, added to the already hormone-affected state of mind the average adolescent functions within, such damage to the developing brain may increase the likelihood of engaging in aggressive or otherwise adverse sexual behaviors (Prentky, 2005).

The Impact on Psychological Health

Child Physical and Sexual Abuse: Much of the literature devoted to studying the effects of early exposure to child maltreatment focuses on the immediate psychological effects on survivors, such as the diminished ability to form secure attachments to others (Lussier, 2005), depression (Van Dorn, 2005), and feelings of social isolation (Elliot, 2005). It has been hypothesized that adverse childhood experiences, especially sexual abuse, may impair a child's ability to form a secure attachment with parents and peers, which may lead him to seek alternative ways to fulfill emotional needs that can manifest in adverse, health compromising, and often criminal sexual behaviors (Lussier, 2005). This hypothesis is supported by the fact that adults with sexual preferences for children, such as child molesters, report higher rates of exposure to child maltreatment and family violence (Lussier, 2005).

Psychological Abuse and Witnessing Family Violence: Early exposure to child maltreatment and family violence may include a wide range of experiences, not all of which involve direct bodily harm. Although psychological abuse may be perceived as a relatively less harmful form of aggression, it can be just as damaging as other forms of abuse. Psychological abuse relies on fear, often with the threat of force. It occurs more frequently and for a longer duration than either physical or sexual abuse, and it most often goes unreported and unabated.

Psychological abuse and witnessing family violence have been hypothesized to contribute to subsequent emotional/psychological, social, and even medical problems. One study demonstrated that witnessing both physical and psychological forms of intimate partner violence as a child, in the absence of direct forms of child abuse, increases the likelihood of developing psychopathologies, such as post-traumatic stress disorder (Diamond, 2004). Often, when interparental violence occurs, the parents' relationship with the child deteriorates. According to one study (Diamond, 2004), the father may become distant, and the mother may demonstrate erratic behaviors with regard to the child, such as inconsistent discipline, as a result of the stressful environment in which they live. This may contribute to the child's emotional insecurity which may lead to greater psychological disorders later (Diamond, 2004).

Rejection and Neglect: Parental rejection and neglect have also been shown to contribute to problems for male survivors later in life. Garbarino (1999) makes plain the relationship between emotional rejection and neglect and subsequent psychological and behavioral outcomes in males, stating "shame at abandonment begets covert depression, which begets rage, which begets violence." Maltreatment need not involve physical contact to be damaging.

All types of maltreatment have a damaging impact on the mental health of young male survivors. Among other things, exposure to child maltreatment or family violence may affect a child's self-esteem and how much he values his own health (Santelli, 1998) as well as his future orientation, or the idea that the future holds no promise for him (Garbarino, 1999). An extreme lack of confidence in the future, terminal thinking, and the feeling that the future is over for them may lead survivors of child maltreatment and family violence to engage in health compromising behaviors that put their long-term well being in jeopardy, such as having multiple sexual partners and not using contraceptives.

The Impact on Sexual, Reproductive, and Parenting Behaviors

Exposure to child maltreatment or family violence in childhood increases the likelihood that young men will engage in behaviors that put them at greater risk for adverse reproductive health outcomes later in life, such as contracting an STI, including HIV/AIDS, and involvement in a teen pregnancy (Saewyc, 2004; Raj, 2000).

Sexual Behavior: Among male survivors, sexual initiation at a young age, whether recognized as abuse or not, has been shown to increase the risk of subsequent adverse and/or health compromising sexual and reproductive outcomes, as well as abusive behaviors within intimate or family relationships (Widom, 1996; Zierler, 1991; Santelli, 1998; Nagy, 1994). According to one study, male survivors of child sexual abuse are more likely to engage in sex with more lifetime partners, as well as engage in prostitution, often after running away from home and/or to support a habit of substance use (Widom, 1996; Zierler, 1991). Early initiation of sexual activity can lead to casual sex with multiple sexual partners, with those males who were youngest at the time of first sex reporting the most lifetime sexual partners (Santelli, 1998). Another study suggests that survivors of early exposure to child sexual abuse may report more liberal attitudes toward sex, the belief that it is okay to have multiple partners, and that it is not okay to say "no" to sex (Nagy, 1994).

Research has found that the experience of child maltreatment and family violence is a strong predictor that adolescent males will perpetrate acts of violence, including dating violence (Lavoie, 2002), domestic or intimate partner violence (Lavoie, 2002; Tilley & Brackley, 2005), as well as sexual violence not specific to intimate relationships in the form of rape, child molestation, and/or verbal coercion (Borowsky, 1997; Krug et al., 2002). For example, one study found a direct relationship between the use of harsh parenting practices, defined by various acts of physical and verbal abuse, and dating violence among adolescents aged 16 or older (Lavoie, 2002). According to another study, adolescent males with a history of sexual abuse were more than twice as likely to perpetrate sexual violence as their non-abused peers (Borowsky, 1997). Again, a retrospective study found that adult men are more likely to commit rape when they have a history of child sexual abuse, witnessed family violence as a child, and/or grew up in a family environment characterized by physical violence and few resources (Krug et al., 2002). In a study of incarcerated adult male rapists, 76 percent had experienced some type of child maltreatment or family violence, and over half of those had, in adolescence, reenacted their own experiences as perpetrators (Burgess, 1988; McCormack, 1992).

Reproductive Health Outcomes: Exposure to child maltreatment or family violence during childhood increases the likelihood that young men will engage in behaviors that put them at greater risk than their non-abused peers for adverse reproductive health outcomes later in life, such as contracting an STI, including HIV/AIDS, and involvement in a teen pregnancy (Saewyc, 2004; Raj, 2000). According to one study, adolescent males with a history of child sexual abuse were more likely to report having had an STI (Saewyc, 2004). Male survivors of sexual abuse perpetrated by a non-family member only were twice as likely

to report having had an STI, and survivors of both incest and extra-familial sexual abuse were seven times as likely (Saewyc, 2004). As well, men who report early abuse have higher HIV/AIDS rates not explained by intravenous drug use than those with no history of victimization (Dube, 2005; Zierler, 1991). These findings reflect the tendency in male survivors to engage in health compromising sexual behaviors that put them at risk for adverse reproductive health outcomes.

When parents use harsh parenting practices involving corporeal punishment and this is tolerated within the family environment, the risk may increase that children grow up to accept this as normal and reenact these forms of abuse in their own families.

Exposure to child maltreatment, specifically sexual abuse, among young men has also been linked to higher rates of involvement in a teen pregnancy than among their non-abused peers (Saewyc, 2004). As well, the likelihood that a male will become involved in a teen pregnancy increases even more when two or more forms of abuse are present. According to one study, adolescent males who had experienced both incest and extra-familial sexual abuse were the most likely to be involved in a pregnancy (Saewyc, 2004). Even though females are more than four times as likely to report sexual abuse, male survivors are more likely to be involved in a pregnancy than their abused female counterparts (Saewyc, 2004).

Researchers have proposed reasons why male survivors of sexual abuse have higher rates of involvement in a teen pregnancy than female survivors (Saewyc, 2004). One author suggests that male survivors tend, more than their abused female peers, to come from "dysfunctional family environments," characterized by substance abuse and/or family violence, and that lack an emotional support system (Lynskey, 1997). Often, male survivors turn to drugs and alcohol and/or run away, which increases the chances of engaging in health compromising sexual behaviors and becoming involved in a pregnancy. Culturally prescribed gender expectations may prevent males from processing their experiences of maltreatment in healthy ways. In a society that expects men to be dominant, producing a child can be a way to reestablish a sense of masculinity and virility that are questioned through victimization. It has also been suggested that, in a society that fears homosexuality in any form, impregnating a female may alleviate some of the gender identity confusion caused by sexual abuse in which the perpetrator is also male (Saewyc, 2004; Lew, 2004).

Parenting Behaviors and Attitudes: The family environment in which a survivor grows up affects the subsequent parenting behaviors and attitudes he will exhibit. Parents who have a developmental history characterized by child maltreatment and family violence are often predisposed to maltreat their own children later in life (Newcomb, 2000). When parents use harsh parenting practices involving corporeal punishment, and this is tolerated within the family environment, the risk may increase that children grow up to accept it as normal and reenact these forms of abuse in their own families. For example, child sexual abuse in boys and young men has been shown to contribute to poor parenting behaviors later, specifically emotional rejection of their own children (Newcomb, 2000). As well, early experiences of physical abuse can lead fathers to physically neglect their children (Newcomb, 2000). Thus, boys' and young men's exposure to child maltreatment or family violence has been linked to their perpetration of family violence and the replication of abusive parenting styles and attitudes as fathers.

Related Sequelae

Exposure to child maltreatment and family violence has been linked to sequelae other than sexual, reproductive, or parenting behaviors. These related sequelae may include depression, anger, and anxiety (Finkelhor, 2005); antisocial and (non-sexual) aggressive behavior (Moe et al., 2004; Garbarino, 1999); and disordered eating, running away, and suicidal behavior (Kaplan, 1999). For example, in survivors of physical abuse, an indirect link has been established between physical abuse during childhood and adolescence, negative beliefs about oneself, and suicidal behavior (Kaplan, 1999).

Survivors of child maltreatment often become involved in substance abuse. Substance abuse has been proven to increase the likelihood of sexual risk-taking, having multiple partners, prostitution, teen pregnancy, and contracting an STI including HIV/AIDS (Widom, 1996; Dube, 2005; Saewyc, 2004). According to one study, adolescent males with a history of sexual abuse reported using illegal drugs and/or alcohol at last intercourse significantly more often than their non-abused peers (Nagy, 1994). Among a sample of HIV positive men, those with a history of child sexual abuse were more than 12 times as likely to have injected intravenous drugs during a period in their adolescence after the abuse was initiated as opposed to their non-abused peers (Holmes, 1997).

Exposure to child maltreatment and family violence can also cause adverse mental health outcomes (Turner, 2005). Victimization and other adverse experiences in childhood have been shown to be associated with internalizing behaviors, including depression, and externalizing behaviors, including anger and anxiety (Turner, 2005). Sometimes the immediate response to or mechanisms used to cope with experiences of maltreatment – not the actual abusive experience(s) – may be most directly responsible for young men's subsequent behavioral problems.

While this paper does not devote itself to exploring these other sequelae in depth, Healthy Teen Network believes they must be taken seriously because of their relationship to the sexual, reproductive, and parenting behaviors that can result from exposure to child maltreatment and family violence. The personal, familial, and social factors that add context to the abusive experience – as well as the characteristics of the abusive act itself – together shape the likelihood of developing potentially long-lasting effects in the survivor.

Reframing the Issue of Violence against Young Men

Despite the constraints on data collection and analysis, we know that young men experience child maltreatment and witness family violence and that the effects are similarly damaging to those of female survivors. We know that some male survivors go on to engage in behaviors that put them at risk for adverse sexual, reproductive, and/or parenting outcomes. And we know that, because of certain societal standards, males face unique challenges in the prevention, diagnosis, and treatment of abuse.

There is growing attention among professionals on the unmet sexual and reproductive health needs of men. For example, within the last decade, Title X – the section of law which provides funding to family planning services, historically for women – has allowed clinics to use these funds to offer related services to men. As well, in 2000, the Urban Institute published a paper calling for a national initiative, spearheaded by the Surgeon General's Office, to refocus the field of public health around young men's sexual and reproductive health and development (Sonenstein, 2000).

However, the issue of child maltreatment and family violence among young men still lacks societal resonance and substantive research attention. While the field of male sexual and reproductive health grows, Healthy Teen Network believes an effort to shift the paradigm concerning males and exposure to violence must occur. This means changing our lens to include males as survivors; allowing males the opportunity to disclose abuse, past and present, without fear of retribution, unfair labels and/or accusations; and offering the same support and treatment we offer female survivors.

As the literature tells us, young men are exposed to maltreatment and suffer similar yet gender-specific outcomes along with their female counterparts, which absolutely affect their ability to develop healthy sexual habits, form healthy intimate relationships, and be positive and effective parents. We must be sure to recognize the risk among young men for child maltreatment and family violence as we build a body of research to better understand how to prevent maltreatment and violence, and then develop and assess models of intervention.

The Ecological Model comprises a system of interacting risk and protective factors that influence the development of a social phenomenon, such as violence against young men. The four domains in the system are:

- *Individual*
- *Family*
- *Community*
- *Society*

(Garbarino, 1976)

Implications for Research

Researchers have begun to acknowledge the significance of certain risk as well as preventative factors that influence the occurrence of child maltreatment and family violence and subsequently affect survivors' emotional well being and behavior. Violence does not develop in men as individuals, but as members of families living in chaotic environments characterized by violence and mediated by substance abuse, gender inequalities, financial problems, and emotional dysfunction. Thus, children who grow up surrounded by violence and dysfunction are prone to transfer that chaos into their intimate relationships and subsequent families in the form of intimate partner violence and child maltreatment.

The US Advisory Board on Child Abuse and Neglect stated that only a universal system of early intervention, grounded in the creation of caring communities could provide an effective foundation for responding to the child abuse crisis in this country (DHHS,

1995). They endorse an ecological model (Garbarino, 1976) – which considers personal, familial, community, as well as social characteristics and influences – as the only truly effective approach to prevent and treat the effects of interpersonal violence.

Further honing the ecological model, researchers Tilley & Brackley (2005) propose the Violent Families Paradigm, which suggests a family centered approach to prevention and treatment based on the premise that the family is the most immediate source of risk for abuse and where prevention and treatment must be focused to be effective. Following this, the family can be targeted with unique interventions that promote health and stability, including substance abuse treatment, financial literacy, and improving access to education and healthcare services, in addition to developing healthy behavioral alternatives to violence.

Healthy Teen Network proposes the following directions for research on the impact of violence on young men:

1. Study and document the prevalence of child maltreatment and exposure to family violence among young men.
2. Explore the unique impact of child maltreatment and family violence on young male's psychological health.
3. Explore the effectiveness of interventions targeting the four domains in the Ecological Model as well as family centered approaches to violence prevention.
4. Develop and evaluate male-specific treatment interventions.

While more research is still needed to better identify and understand young men as survivors of abuse, Healthy Teen Network proposes that the field can start shifting the framework now by directing attention to the question of how best to address prevention and rehabilitation among male survivors. Researchers can play an integral role in fostering acceptance of male victimization by developing and testing male-specific and gender-inclusive interventions.

The Violent Families Paradigm suggests a family-centered approach to prevention and treatment based on the premise that the family is the most immediate source of risk for abuse and where prevention and treatment must be focused to be effective (Tilley & Brackley, 2005).

Implications for Program Interventions

Unfortunately, few prevention and/or treatment modalities currently exist for addressing child maltreatment and family violence or the adverse sexual, reproductive, and parenting behaviors attributed to the experience of abuse among young male survivors. While a variety of individual therapy techniques show some effect on treatment for the trauma of enduring abuse, few have been evaluated, replicated, and proven effective. One prevention intervention - extended home visitation via the Nurse Family Partnership Model – has been evaluated using a randomized controlled design and has shown to reduce child maltreatment among the women it serves (Olds, 1986). As well, Alicia Lieberman's work has shown some promise in support of parent-child psychotherapy as a therapeutic intervention to reduce the adverse psychological effects of witnessing family violence among infants and toddlers and their mothers (Lieberman, 2005). However, neither of these interventions is targeted for adolescents nor male survivors of maltreatment. Likewise, there are few STI and HIV prevention, or teen pregnancy prevention programs designed for young men, let alone male survivors of abuse, that have been evaluated, replicated, and proven effective.

Healthy Teen Network believes that a comprehensive child maltreatment and family violence prevention and treatment program interevention would address factors at the individual, family, and community levels.

Despite the lack of research to support effective program interventions, Healthy Teen Network endorses ecological and family-based treatment models, as they respect what we do know about the development of violence and young men's behavior. Healthy Teen Network believes that a comprehensive child maltreatment and family violence prevention and treatment program intervention would address factors at the individual, family, and community levels:

1. Individual: Healthy Teen Network proposes that efforts to recognize and follow up on individual cases of child maltreatment are crucial to the subsequent mental, physical, sexual, and reproductive health of male survivors. According to one study, among survivors of child sexual abuse cases that were validated by a protective services unit, only 56 percent were referred for mental health treatment, and of those, only half ever actually received care (Pierce, 1985). Again, we can see the challenges male survivors are up against. The sooner cases of child maltreatment and family violence can be diagnosed and treated, the better the chances for a full recovery for adolescent and adult survivors.

2. Family: Healthy Teen Network believes that the cycle of abuse can most effectively be broken at the family level. Families that abuse their members produce individuals who go on to abuse others. Research exists that suggests the intergenerational cycle of abuse can be broken. According to one study, formerly abused mothers who underwent therapy and who were supported in relationships with other adults during childhood were less likely to abuse their own children (Egeland, 1988). As well, parent-child therapy aims to reestablish a bond within the family broken by family violence (Lieberman, 2005). While there are no data for therapeutic interventions among formerly abused fathers, these remain promising directions for secondary prevention among survivors.

3. Community: To effectively address child maltreatment and family violence at the community level, Healthy Teen Network believes that social service agencies and community-based organizations must work together. Community groups can do many things to educate and inform people about the prevalence of child maltreatment and family violence against boys and young men, as well as its lasting psychological and behavioral effects and public health relevance. Community interventions that help at-risk families build their social capital may also help them avoid some of the pitfalls that can lead to parents maltreating their children and intimate partners perpetrating violence against one another. Creating components within the community that stabilize adolescents' lives may prevent and/or ameliorate some of the psychological trauma caused by child maltreatment and family violence and prevent the development of adverse and health compromising behavioral outcomes.

4. Society: Above all, Healthy Teen Network believes that prevention and treatment program interventions will only be truly effective once we shift the lens through which we view males and violence from a criminal justice issue to a public health issue. To truly help survivors of child maltreatment and family violence overcome the trauma of victimization and its potential adverse effects, we must move away from the tendency toward incarceration and demonization, and move toward prevention and rehabilitation.

FIRST STEPS: In this vein, professionals in the field can take some first steps to respond more effectively to the needs of male survivors. We can:

1. Educate those who come in contact with young men about the rates of exposure and effects of maltreatment on male sexual, reproductive, and parenting behaviors.
2. Train school nurses, clinical providers, teachers, health educators, pediatricians, and others to increase their awareness of the unique needs of male survivors and to respond appropriately.
3. Review and revise clinical protocols and procedures to ensure that young men are equally assessed for a history of abuse if they demonstrate warning signs in their sexual, medical, and behavioral histories when they present for care at health departments, school-based centers and other clinical sites that serve males.
4. Extend services to young men and teen fathers within existing programs, such as home visitation, that serve at-risk girls and young mothers, so that they also receive the benefit of screening for signs of abuse and adverse or health compromising behaviors and can be offered available treatment options.

By increasing awareness of violence against young men, we will eventually create safe spaces for them to disclose their maltreatment history and seek treatment. Once males feel increasingly able to disclose their past without the stigma of feeling less like "men," they will be more likely to seek treatment. And once our society becomes aware of the issue, and research has laid a path toward effective interventions, we *must* tackle the lack of services designed specifically to address the unique needs of male survivors. Hopefully, soon we should be able to offer them effective program interventions and resources to support them through their recovery.

Implications for Policy

Healthy Teen Network believes that child maltreatment and family violence prevention initiatives are most effective when all of the parts of the social ecology – government agencies, social service and healthcare providers, community-based organizations, families, and concerned individuals – take the initiative to address violence against and among young men. However, it is the societal and cultural levels where the most profound change can and must occur. Abuse is a social phenomenon, and as long as our society reinforces stereotypes of males solely as perpetrators and females as victims, male survivors of child maltreatment and family violence will lack parity with their female counterparts in efforts to develop and access prevention and treatment resources tailored to their specific needs. Young men will continue to be passed over as potential beneficiaries of program interventions, and society will carry on the cycle of violence in the next generation because our policies fail to address the root causes of violence.

Healthy Teen Network proposes action steps in the following five areas to serve as starting points to reframe the issue of male exposure to child maltreatment and family violence with the goal of eliminating barriers to recovery for male survivors:

1. Awareness: Healthy Teen Network recommends widespread efforts to:
   - Increase awareness about the prevalence of physical, sexual, emotional, and intimate partner abuse, and neglect experienced by boys and young men.
   - Work toward a society where males can recognize all types of maltreatment, speak safely about their experiences, and receive adequate support and treatment to prevent unhealthy sequelae.

2. **Education**: Healthy Teen Network encourages advocacy efforts around public policy that promotes mandated training – including continuing education as part of medical recertification – and educational activities for all educators, service providers, parents, teachers, and children to better identify male survivors of child maltreatment and/or family violence.

3. **Support Systems**: Healthy Teen Network recommends creating services and support systems – which include science-based programs, interventions, and social services – for males and their families, specifically to:
   - Increase primary (geared toward the abused) and secondary (the abuser, home environment, etc.) prevention resources to curb initial maltreatment.
   - Improve identification strategies of males who experience maltreatment.
   - Create better treatment/therapy options for survivors of maltreatment.
   - Implement treatment therapies as soon as maltreatment is discovered and provide support.

   Healthy Teen Network recommends that support systems for adolescents who have experienced child maltreatment and/or family violence build on and reinforce their strengths and resilience with strategies focused on acknowledging and recovering from trauma and victimization.

   Healthy Teen Network recommends increased interventions for male youth who have experienced maltreatment and/or family violence, such as mental health services, physical health care, clinics and other resources that cater to adolescent males.

4. **Behaviors**: Healthy Teen Network recommends all adolescents be taught – through comprehensive sexuality education in public schools, community-based after school programs, and other settings – about healthy relationships, open communication, positive sexuality, and safe sexual behaviors.

   Healthy Teen Network recommends increasing the number of parenting classes and resources for fathers, including how to be an involved father and how to be in healthy, violence-free relationships, both with their child(ren) and the co-parent(s) of their child(ren).

5. **Funding**: Healthy Teen Network recommends increasing funding streams to:
   - Conduct research on the impact of abuse on the sexual, reproductive, and parenting behaviors of adolescent males.
   - Improve treatment services, resources, and interventions for abused males.
   - Provide safe alternative living environments for males if their current residence is not an option.
   - Advocate on behalf of male survivors.

Healthy Teen Network believes that the action steps proposed here need to originate at the Federal level with implementation at the state and local levels. A movement to truly integrate young men into the public health system – moving away from "Maternal and Child Health" and toward "Family Health" – is a necessary step toward increasing possibilities for assessing and responding to these newly defined needs of young male survivors of abuse. To realize this new framework around violence against young men as a public health issue, male survivors need a voice at the highest level of policy-making advocating for them and working to ensure that – nationwide – all survivors have the same supports.

Conclusion

We should now be able to recognize that male survivors of child maltreatment and family violence experience unique disadvantages and face special challenges in their recovery. And yet, it is evident that male survivors' needs are not being met in terms of recognition, treatment, and support, and consequently, it is impacting their behavior and health as adolescents and adults.

Healthy Teen Network calls upon professionals in the United States to help foster a change in thinking around child maltreatment and family violence as social phenomena and masculinity as a social concept. Professionals in the field must be sensitive to this new vision as they diagnose, treat, and manage the sequelae of child maltreatment and family violence among male survivors. Healthy Teen Network again urges the field to embrace and pursue the steps outlined in this paper in order to reframe the issue of violence against young men using a public health approach.

Boys Will Be Boys – that is, as long as we, both as individuals and a society, continue to reinforce a version of male gender identity that breeds negativity and violence among boys and young men. As long as we continue to punish the abuser while ignoring the abused, we will fail to prevent violence and instead add to the trauma male survivors have already been dealt. We must find a way to teach boys that to "be a man" does not mean ascribing to outdated and harmful notions of masculinity but to be respectful as an individual and respected as a member of the community.

There is much to be done to change the way society views men – and how men view themselves – and this change will not happen over night. But paradigm shifts do occur, and they usually begin when concerned individuals take the lead in calling for action. Let each of us strive to ensure that every young man has the opportunity to feel accepted and supported, to reach his potential, and to live a full, healthy, and rewarding life – for we are all affected.

References

1. Anda, R.F., Felitti, V.J., Chapman, D.P., Croft, J.B, Williamson, D.F., Santelli, J. et al. (2001). Abused Boys, Battered Mothers, and Male Involvement in Teen Pregnancy. *Pediatrics, 107*.
2. Anda, R.F., Felitti, V.J., Bremner, J.D., Walker, J.D., Whitfield, C.H,. Perry, B.D. et al. (2005). The Enduring Effects of Abuse and Related Adverse Experiences in Childhood. *European Archives of Psychiatry and Clinical Neuroscience, 256*, 174-186.
3. Bagley, C., Wood, M., & Young, L. (1994). Victim to Abuser: Mental health and Behavioral Sequels of Child Sexual Abuse in a Community Survey of Young Adult Males. *Child Abuse and Neglect, 18*(8), 683-697.
4. Bartholow, B.N., Doll, L.S., Joy, D., Douglas, J.M., Bolan, G., Harrison, J.S. et al. (1994). Emotional, Behavioral, and HIV Risks Associated with Sexual Abuse among Adult Homosexual and Bisexual Men. *Child Abuse and Neglect, 18*, 747-761.
5. Borowsky, I.W., Hogan, M., & Ireland, M. (1997). Adolescent Sexual Aggression: Risk and Protective Factors. *Pediatrics, 100*(6),1-8.
6. Burgess, A.W., Hazelwood, R.R., Rokous, F.E., Hartman, C.R., & Burgess, A.G. (1988). Serial Rapists and Their Victims: Reenactment and Repetition. *Annals of the New York Academy of Sciences*, (528), 277-295.
7. Department of Health and Human Services. (2004). *Child Maltreatment 2004*.
8. Diamond, T. & Muller, R.T. (2004). The Relationship between Witnessing Parental Conflict during Childhood and Later Psychological Adjustment among University Students: Disentangling Confounding Risk Factors. *Canadian Journal of Behavioural Science, 36*(4), 295-309.
9. Dube, S.R., Anda, R.F., Whitfield, C.L., Brown, D.W., Felitti, V.J, Dong, M. et al. (2005). Long-Term Consequences of Childhood Sexual Abuse by Gender of Victim. *American Journal of Preventive Medicine, 28*(5), 430-438.
10. Egeland, B., Jacobvitz, D., & Sroufe, L.A. (1988). Breaking the Cycle of Abuse. *Child Development, 59*(4), 1080-1088.
11. Elliot, D. (1995). *National Youth Survey*. Boulder, CO: Behavioral Research Institute.
12. Elliott, G.C., Cunningham, S.M., Linder, M., Colangelo, M., & Gross, M. (2005). Child Physical Abuse and Self-Perceived Social Isolation among Adolescents. *Journal of Interpersonal Violence, 20*(12), 1663-1684.
13. Felitti, V.J, Anda, R.F., Nordenberg, D., Williamson, D.F., Spitz, A.M., Edwards, V. et al. (1998). Relationship of Childhood Abuse and Household Dysfunction to Many of the Leading Causes of Death in Adults. *American Journal of Preventative Medicine, 14*(4), 245-258.
14. Finkelhor, D., Hotaling, G., Lewis, I.A., & Smith, C. (1990). Sexual Abuse in a National Survey of Adult Men and Women: Prevalence, Characteristics, and Risk Factors. *Child Abuse and Neglect*.
15. Finkelhor, D. (1994). The International Epidemiology of Child Sexual Abuse. *Child Abuse & Neglect, 18*,409-417.
16. Finkelhor, D., Ormrod, R.K., Turner, H.A., & Hamby, S.L. (2005). Measuring Poly-Victimization Using the Juvenile Victimization Questionnaire. *Child Abuse & Neglect, 29*, 1297-1312.
17. Flanagan, A.Y. (2002). *What Health Professionals Need to Know*. Retrieved from www.NursingCEU.com.
18. Garbarino, J. (1976). A Preliminary Study of Some Ecological Correlates of Child Abuse: The Impact of Socioeconomic Stress on Mothers. *Child Development, 47*(1), 178-185.
19. Garbarino, J. (1985) *Adolescent Development: An Ecological Perspective*. Columbus, OH: Charles E. Merrill.

20. Garbarino, J. (1999). *Lost Boys*. New York, NY: Anchor Books.
21. Holmes, W.C. (1997). Association Between a History of Childhood Sexual Abuse and Subsequent, Adolescent Psychoactive Substance Use Disorder in a Sample of HIV Seropositive Men. *Journal of Adolescent Health, 20*, 414-419.
22. Holmes, W.C. & Slap, G.B. (1998). Sexual Abuse of Boys: Definition, Prevalence, Correlates, Sequelae, and Management. *Journal of the American Medical Association, 280*(21), 1855-1862.
23. Hussey, J.M., Chang, J.J., & Kotch, J.B. (2006). Child Maltreatment in the United States: Prevalence, Risk Factors, and Adolescent health Consequences. *Pediatrics, 118*(3), 933-942.
24. Kaplan, S.J., Pelcovitz, D., Salzinger, S., Mandel, F., Weiner, M., & Labruna, V. (1999). Adolescent Physical Abuse and Risk for Suicidal Behaviors. *Journal of Interpersonal Violence, 14*(9), 967-988.
25. Koegel, P., Melamid, E., & Burnam, A. (1995). Childhood Risk Factors for Homelessness among Homeless Adults. *American Journal of Public Health, 85*, 1642-1649.
26. Krug, E.G., Mercy, J.A., Dahlberg, L.L., & Zwi, A.B. (Eds.) (2002). *World Report on Violence and Health*. Geneva: World Health Organization.
27. Lavoie, F., Hebert, M., Tremblay, R., Vitaro, F., Vezina, L. & McDuff, P. (2002). History of Family Dysfunction and Perpetration of Dating Violence by Adolescent Boys: A Longitudinal Study. *Journal of Adolescent Health, 30*, 375-383.
28. Leiderman, S. and Almo, C. (2001). *Interpersonal Violence and Adolescent Pregnancy: Prevalence and Implications for Practice and Policy*. Washington, DC: Healthy Teen Network.
29. Lew, M. (2004). Adult Male Survivors of Sexual Abuse: Sexual Issues in Treatment and Recovery. *Contemporary Sexuality, 38*(11), i-viii.
30. Lieberman, A. et al. (2005). Preschooler Witnesses of Marital Violence: Predictors and Mediators of Child Behavior Problems. *Developmental Psychopathology, 17*(2), 385-96.
31. Lieberman, A. et al. (2005). Toward Evidence-Based Treatment: Child-Parent Psychotherapy with Preschoolers Exposed to Marital Violence. *Journal of American Academy of Child and Adolescent Psychiatry, 44*(12), 1241-8.
32. Lussier, P., Beauregard, E., Proulx, J., & Nicole, A. (2005). Developmental Factors Related to Deviant Sexual Preferences in Child Molesters. *Journal of Interpersonal Violence, 20*(9), 999-1070.
33. Lynskey, M.T.; Fergusson, D.M. (1997). Factors Protecting Against the Development of Adjustment Difficulties in Young Adults Exposed to Childhood Sexual Abuse. *Child Abuse and Neglect, 21*(12), 1177-1190.
34. MacKellar, D.A., Valleroy, L.A., Hoffmann, J.P., Glebatis, D., LaLota, M., McFarland, W. et al. (2000). Gender Differences in Sexual Behaviors and Factors Associated with Nonuse of Condoms among Homeless and Runaway Youth. *AIDS Education and Prevention, 12*(6), 477-491.
35. McCormack, A. et al. (1992). An Exploration of Incest in the Childhood Development of Serial Rapists. *Journal of Family Violence*, (7), 219-228.
36. Moe, B.K., King, A.R., & Bailly, M.D. (2004). Retrospective Accounts of Recurrent Parental Physical Abuse as a Predictor of Adult Laboratory-Induced Aggression. *Aggressive Behavior, 30*(3), 217-228.
37. Nagy, S., Adcock, A.G., & Nagy, M.C. (1994). A Comparison of Risky Health Behaviors of Sexually Active, Sexually Abused, and Abstaining Adolescents. *Pediatrics, 93*(4), 570-575.
38. Newcomb, M.D. & Locke, T.F. (2001). Intergenerational Cycle of Maltreatment: a Popular Concept Obscured by Methodological Limitations. *Child Abuse and Neglect, 25*, 1219-1240.
39. NiCarthy, G. (1991). In Levy, B. (Ed.) *Dating Violence: Young Women in Danger*. Seattle: Seal Press.

40. Olds, D.L., Henderson, Jr., C.R., Chamberlin, R., & Tatelbaum, R. (1986). Preventing Child Abuse and Neglect: A Randomized Trial of Nurse Home Visitation. *Pediatrics, 78*(1), 65-78.
41. Parke, R.D. (1982). Theoretical Models of Child Abuse: Their Implications for Prediction, Prevention, and Modification. In R.H. Starr (Ed). *Child Abuse Prediction: Policy Implications* (Chapter 2). Cambridge, MA: Ballinger Publishing Company.
42. Pierce, R. & Pierce, L.H. (1985). The Sexually Abused Child: A Comparison of Male and Female Victims. *Child Abuse and Neglect, 9*, 191-199.
43. Prentky, R.A. (2006). Risk Management of Sexually Abusive Youth: A Follow up Study. *US Department of Justice*.
44. Raj, A., Silverman, J.G., & Amaro, H. (2000). The Relationship between Sexual Abuse and Sexual Risk among High School Students: Findings from the 1997 Massachusetts Youth Risk Behavior Survey. *Maternal and Child Health Journal, 4*(2), 125-134.
45. Richardson, M.F., Meredith, W., & Abbot, D.A. (1993). Sex-typed Role in Male Adolescent Sexual Abuse Survivors. *Journal of Family Violence, 8*, 89-100.
46. Saewyc, E.M., Magee, L.L., & Pettingell, S.E. (2004). Teenage Pregnancy and Associated Risk Behaviors among Sexually Abused Adolescents. *Perspectives on Sexual and Reproductive Health, 36*(3), 98-105.
47. Santelli, J.S., Brener, N.D., Lowry, R., Bhatt, A., & Zabin, L.S. (1998). Multiple Sexual Partners among US Adolescents and Young Adults. *Family Planning Perspectives, 30*(6), 271-275.
48. Schoen, C., Davis, K., DesRoches, C., & Shekhdar, A. (1998). *The Health of Adolescent Boys: Commonwealth Fund Survey Findings*. The Commonwealth Fund.
49. Sonenstein, F. (Ed.) (2000). *Young Men's Sexual and Reproductive Health: Framework Recommendations*. Washington, DC: The Urban Institute.
50. Tilley, D.S. & Brackley, M. (2005). Men who Batter Intimate Partners: A Grounded Theory Study of the Development of Male Violence in Intimate Partner Relationships. *Issues in Mental Health Nursing, 26*, 281-297.
51. Turner, H.A., Finkelhor, D., & Ormrod, R. (2005). The Effect of Lifetime Victimization on the Mental Health of Children and Adolescents. *Social Science & Medicine, 62*, 13-27.
52. US Department of Health and Human Services (DHHS), Administration for Children and Families. (1995). *A Nation's Shame: Fatal Child Abuse and Neglect in the United States*. Washington, DC: US Advisory Board on Child Abuse and Neglect.
53. US Department of Health and Human Services (DHHS), Administration on Children, Youth and Families. (2006). *Child Maltreatment 2004*. Washington, DC: US Government Printing Office.
54. Van Dorn, R.A., Mustillo, S., Elbogen, E.B., Dorsey, S., Swanson, J.W., & Swartz, M.S. (2005). The Effects of Early Sexual Abuse on Adult Risky Sexual Behaviors among Persons with Severe Mental Illness. *Child Abuse and Neglect, 29*, 1265-1279.
55. Wherry, J.N., Jolly, J.B., Feldman, J., Adam, B., & Manjanatha, S. (1995). Child Sexual Behavior Inventory Scores for Inpatient Psychiatric Boys: An Exploratory Study. *Journal of Child Sexual Abuse, 4*(3), 95-105.
56. Whipple, E. (1989). *The Role of Parental Stress in Abusive Families* (Dissertation). University of Washington.
57. Widom, C.S., & Kuhns, J.B. (1996). Childhood Victimization and Subsequent Risk for Promiscuity, Prostitution, and Teenage Pregnancy: A Prospective Study. *American Journal of Public Health, 86*(11), 1607-1612.
58. World Health Organization. (2002). *World Report on Violence and Health: Summary*.
59. Worling, J.R. & Curwen, T. (2000). Adolescent Sexual Offender Recidivism: Success of Specialized Treatment and Implications for Risk Prediction. *Child Abuse and Neglect 24*(7), 965-982.
60. Zierler, S., Feingold, L., Laufer, D., Velentgas, P., Kantrowitz-Gordon, I., & Mayer, K. (1991). Adult Survivors of Childhood Sexual Abuse and Subsequent Risk of HIV Infection. *American Journal of Public Health, 81*(5), 572-575.
61. Zolotor, A.J. & Runyan, D.K. (2006). Social Capital, Family Violence, and Neglect. *Pediatrics, 117*, 1124-1131.

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