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Nonsexual Assaults to the Genitals in the Youth Population

David Finkelhor, PhD, Janis Wolak, JD

Objective.—To assess the frequency with which youth suffer nonsexual assaults to the genitals and their context and consequences.

Design.—Telephone survey with follow-up interview 1 year later.

Setting.—General population of the United States living in households with telephones.

Participants.—Random sample of 1042 boys and 958 girls aged 10 through 16 years.

Results.—A nonsexual assault to the genitals was experienced by 9.2% of the boys and 1.0% of the girls in the year prior to the initial interview and 9.1% of the boys and 2.2% of the girls in the year prior to the follow-up interview. Among the boys, about a quarter of the assaults involved some injury, but only one in 50 needed medical attention. The most common assailants were same-aged peers. The assaults occurred in a variety of contexts including gang attacks, peer fighting, bullying, and some situations in which girls retaliated against the genitals of harassing boys. Boy victims of nonsexual genital assault had significantly higher levels of posttraumatic and depression symptomatology than boys without such assaults..

Conclusions.—Nonsexual genital violence needs additional clinical and research attention. Youth should be educated about its possible consequences. Clinicians should ask about nonsexual genital violence when taking a history, particularly with youth who have experienced other kinds of assaults.

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A GREAT deal has been written in recent years about the epidemiology and impact of sexual assault on children and adolescents,[1] including the traumatic injuries such assaults can cause.[2-11] However, because sexual assault has generally been defined as behaviors undertaken with the goal of sexual gratification,[1] this literature has skirted an important and related kind of harm: assault to the genitals simply to hurt or injure, not to obtain sexual gratification. Although there has been virtually no research on nonsexual genital violence, there are reasons to believe such assaults might be fairly common. Anecdotal conversations with adults and young people suggest that many have recollections of such assaults, particularly in the course of fights with peers. Observational studies of preadolescent and early adolescent youth reveal that hostility among peers is often targeted toward the genitalia.[12,13] Parental disciplinary violence is known to result in genital injuries to young children,[14] and although it is not a common presentation, it occurs in an estimated 2% of cases referred for medical evaluation because of a suspicion of physical abuse.[15]

Unfortunately, the frequency and seriousness of nonsexual genital assaults in childhood may be obscured by cultural attitudes that make discussions of this subject difficult. These assaults affect a portion of anatomy that is very sensitive, both in a physical sense and in its social and psychological connotations. This sensitivity is reflected in recent observations about the harm that may be inflicted by abnormal genital care practices[16] or by medical procedures focused in the genital area.[17] Beyond any pain or tissue damage incurred, nonsexual genital assaults may provoke shame or embarrassment and may possibly affect developing children's feelings about their security, sexuality, and self-esteem, more so than other kinds of physical assaults. In view of these kinds of questions and the paucity of research, we explored the topic of nonsexual genital assaults as part of a larger study of the varieties of youth victimization.

METHODS

The National Youth Victimization Prevention Study was designed to gather information from a nationally representative sample of young people about experiences of violence, victimization, and sexual assault as well as exposure to violence prevention education.[18,19] Study staff, the employees of an experienced survey research firm specially trained to talk with youth, conducted telephone interviews with a nationally representative area probability sample of 2000 young people aged 10 through 16 years and their caretakers between May 1992 and February 1993. The sample was geographically stratified by region, with sample allocation proportionate to population distribution, but with no clustering or oversampling so it could be analyzed as a simple random sample. The sample was contacted through random-digit dialing. Telephone interviewing is a cost-effective methodology[20] that has been demonstrated to be comparable in reliability and validity

From the Family Research Laboratory, University of New Hampshire, Durham.

Corresponding author: David Finkelhor, PhD, Family Research Laboratory, University of New Hampshire, 126 Horton Social Science Center, Durham, NH 03824.

with in-person interviews, even for sensitive topics[21-24] and assessment of psychological symptomatology.[25,26] The methodology is also used to interview youth in the US National Crime Victimization Survey[27] and in a variety of other epidemiological studies of youth concerning violence exposure[28] and mental health morbidity.[29]

In each eligible household (one with at least one child aged 10 through 16 years), interviewers asked to speak with the primary adult caretaker, leaving the exact choice in multiadult households up to the adult who answered the call. In 66% of the households, the primary adult caretaker was the biological mother, in 26% it was the biological father, in 4% it was a stepparent, and in 4% it was a grandparent or other relative or guardian. This caretaker was interviewed for approximately 10 minutes on issues related to protecting children from violence and assaults. At the end, after mentioning the need to hear from children about their own experiences regarding violence prevention, the child interview portion of the study was described, and permission was requested to speak with the child or, in multichild households, the child with the most recent birthday. With caretaker consent, interviewers described the study to the child and obtained his or her verbal consent as well. Interviewers arranged to talk to the child at a time and under conditions when the child would be alone and undisturbed. The children, who were anonymous to interviewers at the time of first interview, were promised complete confidentiality. The study was conducted under supervision of the University of New Hampshire's Human Subject Committee, and the researchers obtained a certificate of confidentiality from the National Institute of Mental Health Office of Protection of Human Subjects.

The 2000 completed first interviews represented a participation rate of 88% of adults approached and 82% of children in the households where an interview was completed with an adult. About four fifths of the children we were unable to interview resulted from caretakers denying permission to interview children, and the rest were children who did not want to be interviewed. Nonparticipation was slightly greater among households with younger children (aged 10 and 11 years) and with parents who believed violence was not a problem in their community.

At the end of the study, all children were offered information about a national telephone hot line that provides assistance on victimization-related matters. Those who disclosed a situation of serious threat or ongoing victimization were recontacted by a psychologist member of the research team, trained in telephone crisis counseling, whose responsibility was to stay in contact with the child until the situation was resolved or brought to the attention of appropriate authorities.

The follow-up interview was conducted with much the same procedure as the first, including prior caretaker interview and consent. However, child interviewees were no longer anonymous since names had been obtained to facilitate recontact. Follow-up interviews occurred a mean of 15 months (range, 8 to 24 months) after the first interview. A total of 520 (26%) of the original sample were unavailable for reinterview, 360 of whom we were unable to locate and 160 who refused (115 parents and 45 children) to be interviewed. Sample attrition was more likely to come from lower-educated and black and Hispanic households, from families that had experienced a move in the year prior to the first interview, and from households in which children were not living with both biological parents or had experienced a previous sexual victimization.

The original sample of 1042 boys and 958 girls was comparable with US Census statistics for a population of this age: 10% black, 7% Hispanic, 3% from other races including American Indian and Asian, and the rest (80%) white. Fourteen percent came from families with annual incomes of less than $20 000. Fifteen percent lived with a single parent at the time of the survey, another 13% with a parent and a stepparent, 3% with a nonparental caretaker, and the remaining 69% with both biological parents. Attrition in the second interview plus 23 incomplete interviews left 772 boys and 685 girls, of whom 8% were black, 6% were Hispanic, 3% were other, and 84% were white. Fourteen percent were from families with incomes less than $20 000. Thirteen percent of those in the second interview lived with a single parent, 11% with a parent and a stepparent, 3% with a nonparental caregiver, and 73% with both biological parents.

Variables

In both interviews, children were asked 12 screener questions about victimizations they might have experienced, ranging from gang assaults to family assaults and sexual violence. Detailed information on all screener questions and data on various kinds of assaults have been published.[18] One of the screeners read: "Has there ever been a time when anyone intentionally tried to hurt your private parts by hitting you, kicking you there or trying to hit them with an object?" Children answering yes were then asked an extended series of questions about the nature of the assault, the context in which it occurred, and their reaction to it. A genital assault was defined as any nonsexual incident where a child reported that an assailant did hurt or intentionally tried to hurt his or her private parts. With respect to girls, an ambiguity in the question and a weakness in the design are that some girls may have interpreted "private parts" to include breasts as well as genitals. An injury was defined as a physical injury to any part of the body resulting from the genital assault. Thus, a bruise on a leg inflicted when an assailant was trying to kick a child's genitals was considered an injury resulting from genital assault.

Six additional questions asked respondents about incidents of sexual abuse. Examples include the following: "Has there ever been a time when an older person like an adult, an older teenager, a babysitter or someone like that tried to make you touch or look at their private parts?" "Has there ever been a time when someone your own age—a boy, a girl, or a group of them—tried to threaten, force, or trick you into doing something sexual that you didn't want to do?" Incidents included both contact and noncontact episodes.

Basic demographic information (race, family income, and type of metropolitan area) was gathered from caretakers. Children were asked about several personal characteristics including age, grade in school, family structure, delinquent assaultive behavior ("Since we last talked to you, not counting fights with brothers and sisters, did you beat someone up on purpose?"), and limiting physical conditions ("Do you have any conditions that limit the kinds of things you can do, like seeing, hearing or moving?").

Questions were asked about the impact of the assault ("Did you suffer any injuries, like any cuts or bruises? Did you bleed? Did you hurt the next day?") and about the receipt of medical attention ("Did you need to get medical attention like going to a doctor or a hospital?"). Children were asked to assess their own degree of fault in the incident ("Some people think that incidents like this happen because they were in the wrong place, with the wrong people, or doing the wrong things. Did you think that the incident was: mostly, partly, or not at all your fault?"). They were asked how upset they were after the incident (very, somewhat, or hardly at all), whether they were afraid they would be injured or killed during the incident (yes or no), who, if anyone, they reported the incident to, and whether the assailant was arrested.

Table 1.—Characteristics of Nonsexual Genital Assaults Experienced by Boys and Girls

Characteristic (n=Total No. of Boys; n=Total No. of Girls)	Boys, No. (%)	Girls, No. (%)
Grade (n=95; n=16)		
4	6 (6)	2 (13)
5	14 (15)	2 (13)
6	14 (15)	2 (13)
7	19 (20)	5 (31)
8	18 (19)	1 (6)
9	12 (13)	2 (13)
10	8 (8)	2 (13)
11	4 (4)	0
Type of blow (n=75; n=12)		
Hit	27 (36)	0
Kicked	32 (43)	1 (8)
Hit with object	6 (8)	0
Blow struck genitals (n=95; n=16)	45 (47)	1 (6)
Relationship to assailants (n=95; n=14)		
Family member aged ≥18 y	3 (3)	3 (21)
Family member aged <18 y	10 (11)	1 (7)
Acquaintance aged ≥18 y	7 (7)	2 (14)
Acquaintance aged <18 y	67 (71)	6 (43)
Stranger aged <18 y	7 (7)	2 (14)
Assailant age (n=93; n=16)		
Same age or <1-y difference	44 (47)	4 (25)
Older	37 (40)	11 (69)
Younger	12 (13)	1 (6)
Multiple assailants (n=95; n=16)	17 (18)	7 (44)
Sex of assailant(s) (n=95; n=16)		
Male	56 (59)	8 (50)
Female	38 (40)	7 (44)
Both	1 (1)	1 (6)
Location of assault (n=93; n=16)		
School	25 (27)	5 (31)
School grounds	13 (14)	5 (31)
Neighborhood	25 (27)	1 (6)
Home	16 (17)	5 (31)
Other	14 (15)	0
Time of day (n=90; n=15)		
Morning	8 (9)	3 (20)
Afternoon	48 (53)	8 (53)
Evening	26 (29)	2 (13)
Night	8 (9)	2 (13)
Episode frequency (n=94; n=16)		
Single	75 (80)	12 (75)
Series	19 (20)	4 (25)
Response to the question: Was this your fault? (n=94; n=16)		
Mostly	8 (9)	2 (13)
Partly	33 (35)	4 (25)
Not at all	53 (56)	10 (63)
Outcomes (n=95; n=16)		
Injured	22 (23)	1 (6)
Hurt next day	14 (15)	1 (6)
Bled	6 (6)	0
Needed medical care	2 (2)	1 (6)
Feared injury or death	16 (17)	4 (25)
Reported to		
Any adult	39 (41)	11 (69)
Mother	24 (25)	10 (63)
School authority	7 (7)	2 (13)
Police	4 (4)	0
Assailant arrested	4 (4)	0

Since the follow-up questions about nonsexual genital violence in the second interview were much more extensive and specific, the second interview sample alone was used for all of the analyses about the nature of these assaults. Data from the first interview were used only to make a supplementary prevalence estimate and to identify high-risk youth who were victimized prior to any victimization reported at the second interview. This dichotomous prior victimization variable indicated whether or not a child had reported a victimization (any physical assault or sexual assault by a family or nonfamily member) at the first interview.[18] A dichotomous prior genital assault variable was similarly constructed to indicate children who had reported genital assaults prior to the first interview.

The following two scales were used to assess possible psychological sequelae of the genital assault: (1) 15 items from the Post-traumatic Symptom Scale Self Report[30]; and (2) current level of depression, using 11 items from the Diagnostic Interview Survey for Children.[31]

Statistical Analysis

In conjunction with descriptive analysis, Pearson χ^2 tests were used to compare proportions, and analysis of variance, with F and Scheffe tests, was used to test for significant differences in means. Relative risk estimates were derived from cross-tabulations comparing boys who reported genital assaults with boys who did not report such assaults. Multiple regression was also used to test the association of genital assault with posttraumatic and depression symptomatology in boys.

In these regressions, factors that were empirically or theoretically related to symptomatology were included as controls, including the following: age, race (two dummy coded variables, one for white vs nonwhite and one for African American vs non–African American), parent educational level (a five-level ordinal scale ranging from some high school to some graduate school), family structure (a dummy coded variable, two biological parents vs others), type of metropolitan area (an ordinal variable, coded as large city, suburb, large town, small town, or rural area), prior victimizations (a dummy variable, yes or no), and the quality of the parent-child relationship. This latter was an eight-item scale (eg, "How often do you and [your parent(s)/the adult(s) you live with] have fun together?") that was summed to form an index (α=.71).

RESULTS

In the first interview, 9.2% of the boys (95% confidence interval [CI], 7.5% to 11.0%) and 1.0% of the girls (95% CI, 0.4% to 1.6%) said there had been a nonsexual assault directed at their private parts in the previous year. In the second interview, 9.1% of the boys (95% CI, 7.1% to 11.2%) and 2.2% of the girls (95% CI, 1.1% to 3.3%) indicated a similar such experience in the previous year. In calculating the annual rate for the second interview, children who had less than a 1-year interval between the first and the second interview were weighted by 12/m, where m was the number of months that had elapsed. In contrast to the disproportionate number of boys suffering genital violence, girls suffered more sexual abuse than boys in both interviews (at the first interview, 10.2% for girls vs 3.4% for boys; at the second interview, 10.2% for girls vs 2.7% for boys).[18] The sample of 95 boys and 16 girls analyzed included all children who had an episode between the first and second interviews and encompassed a few children who had an episode that fell outside the 1-year window used to calculate the prevalence estimate.

The largest percentages of boys reporting genital violence were the seventh and eighth graders, with the percentages declining rapidly for the children in grades 9, 10, and 11 (Table 1). Being kicked in the genitals was the most frequently reported event (43%), being hit the next most common (36%), and being hit with an object relatively uncommon (8%). Only about half the time (47%) did the blow actually strike the genital area, although all of the children stated that the blows were aimed at their genitals.

The assailants against boys were primarily other children, acquaintances younger than 18 years, but there were a few family members, including two parental assailants. Half of the assailants were the same age (within 1 year of age), but 40% were more than 1 year older and 13% were more than 1 year younger. Almost one in five (18%) of the assaults involved multiple assailants. Forty percent of the perpetrators of genital violence against boys were girls.

The assaults against boys tended to take place at school or around school, but more than a quarter took place in the child's neighborhood and another 17% at home. The afternoon was the most common time of day. Although most of the episodes were isolated events, 20% of the victims said the assault had been part of a series of such assaults, suggesting a context of bullying. When asked about responsibility for the episode, 9% of the boys said it was mostly their fault and 35% said it was partly their fault.

Almost a quarter of the nonsexual genital assaults against boys resulted in some injury, but most were not severe. Because the question was general, we do not know exactly what the injury was or whether it was to the genitals themselves or some adjacent portion of the anatomy. Fifteen percent said they still hurt the next day, 6% said they bled, and 2% were injured severely enough to need medical attention.

Most (59%) of these episodes against

Table 2.—Characteristics of Boys Who Did or Did Not Experience Nonsexual Genital Assault

Characteristic	Boys Who Were Assaulted, No. (%) (n=95)	Boys Who Were Not Assaulted, No. (%) (n=677)	Relative Risk Estimate	95% Confidence Interval
Race				
White	78 (82)	572 (85)	Not done	Not done
African American	10 (11)	40 (6)	Not done	Not done
Hispanic	5 (5)	43 (6)	Not done	Not done
Other	2 (2)	20 (3)	Not done	Not done
Family income <$20 000*	12 (14)	74 (11)	1.2	0.6-2.4
Urban or suburban residence	35 (37)	230 (34)	0.9	0.6-1.4
Lives with stepparent	23 (24)	71 (10)	2.7‡	1.6-4.6
Any prior victimizations†	63 (66)	257 (38)	3.2‡	2.0-5.1
Prior genital violence†	25 (26)	44 (6)	5.1‡	3.0-8.9
Limiting physical condition	15 (16)	41 (6)	2.9‡	1.5-5.5

*n=86 and 639 for boys who did and did not experience a nonsexual genital assault, respectively, due to missing data.
†Occurring during the year before the first interview.
‡$P<.001$.

boys did not come to the attention of an adult or a person in authority. A quarter were reported to mothers, 7% to school authorities, and 4% to police. Assaults involving injury were more likely than other genital assaults to be reported to an adult (64% vs 36%; $P<.02$), but even one third of these more serious episodes were not disclosed to adults.

Fewer girls reported a nonsexual assault to their private parts than boys (1.0% in the first interview and 2.2% in the second interview), making categorical breakdowns less reliable. It is noteworthy that of the assaults experienced by girls, half involved a female assailant and in almost half there were multiple assailants. However, few of the girls actually were struck in the course of the assault or reported any injury or need for medical care. Girls did tend to report their experiences to mothers and adults. The small number of girls made it impossible to analyze risk factors and effects of such assaults in the same way as for boys.

Boys reporting genital violence did not differ demographically from other boys (those not suffering a genital assault) in terms of their race, family income, or urban/rural residence (Table 2). They were somewhat more likely to live with a stepparent.

However, for boys, experiencing genital violence was associated with having been the victim of a prior assault of any sort. Boys who reported a violent assault, a sexual assault, a family or parental assault, or an earlier genital assault in the year prior to our first interview were 3.2 times more likely to report genital violence at the second interview. The risk was highest (5.1) for those reporting a previous nonsexual genital assault. Interestingly, another group of boys with generally higher rates of genital assault were those who reported some physically limiting condition, most frequently vision problems or asthma.

To get an additional perspective on the seriousness of nonsexual genital assaults, we examined the association between such assaults and the indicators of psychosymptomatology. Analysis of variance showed that boys who had experienced nonsexual genital violence had significantly higher levels of posttraumatic symptomatology (mean, 22.9 vs 19.2; $F[1,758]=40.9$; $P<.001$) and depressive symptomatology (mean, 4.2 vs 2.2; $F[1,734]=50.0$; $P<.001$) than boys not suffering such assaults. Regression analysis (Table 3) revealed a strong and significant association between nonsexual genital violence and posttraumatic and depression symptomatology, even when controlling for a variety of possibly confounding background and family factors, including age, parent education, family structure, race, metropolitan area, the quality of the parent-child relationship, or having experienced a prior victimization. There was also a clear dose-response relationship: boys who were afraid they would be injured or killed during the nonsexual genital assault manifested significantly more posttraumatic symptomatology than others (mean score on the posttraumatic symptom scale of 26.2 vs 22.3; $F[1,758]=24.5$; $P<.001$).

Recognizing that genital violence by girls against boys might be different in character from assaults among boys themselves and that fights among evenly matched friends (ie, similarly aged, familiar youth in one-on-one situations) might also be different from those where the victim was attacked by gangs, strangers, or much older children, we divided the boys' sample into three groups according to the identity of the assailant. The cases involving female assailants were put into one group and the episodes involving male assailants were put into two groups for those that did or did not involve either an unknown perpetrator, an older perpetrator (more than 18 months older), or multiple perpetrators.

This categorization gave us three groups of episodes that appeared quite different on certain important episode-related variables (Table 4). About a quarter of the episodes involved boys assaulted by older or unknown male perpetrator(s) or multiple assailants. These were the episodes that resulted in the most injury and the most upset to the boy. Fewer of these boys saw themselves at fault in any way. By contrast, when girls were assailants, there was significantly less injury or upset. Over half the time, the boys who had experienced nonsexual genital assaults by girls admitted being mostly or partly at fault. A third of the boys assaulted by girls admitted to having "beaten someone up on purpose" since their first interview, suggesting that they were themselves aggressively inclined. A third group, comprising a third of the episodes, involved genital violence at the hands of male peer acquaintances in one-on-one situations. These boys ranked somewhere between the other groups on levels of injury, upset, and being at fault for the episode.

COMMENT

Nonsexual assaults directed at the genitals appear to be relatively common for boys. Nearly one of 10 reported such an episode in the previous year. This was almost a quarter of the boys who reported any type of victimization. Nearly three times as many boys reported a violent assault on their genitals as reported a sexual assault.

While half of these assaults do not result in contact to the genitals and most do not leave lasting injury, a small number involve bleeding or pain that lasts into the next day. The 2% of victims who needed medical attention, when extrapolated to the nation's 12.5 million 10- to 16-year-old boys, translates into thousands of cases of possible relevance to medical professionals every year. Another concern is the finding that genital assaults were associated with marked elevations in posttraumatic symptomatology, even when controlling for other sources of trauma. It is noteworthy that those with more severe genital violence (those who, during the assault, feared they would be injured or killed) had a level of posttraumatic symptomatology that was a bit higher and statistically indistinguishable from the boys who had experienced sexual assault (mean score on the posttraumatic symptom scale of 26.2 vs 24.6).[32] These associations, and even the dose-response relationship, of

Table 3.—Regression of Boys' Posttraumatic and Depression Symptomatology on Genital Assault With Control Variables

Variable	Posttraumatic		Depression	
	β	*t*	β	*t*
Genital assault victim	2.01	3.49*	1.28	4.60*
Any prior victimization	1.00	2.55†	.66	3.53*
Quality of parent-child relationship	−.43	−9.31*	−.16	−7.36*
Lives with two biological parents	.77	1.80	.31	1.49
Age	−.14	−1.50	−.11	−2.42†
Parent educational level	−.11	−0.65	−.17	−2.20
African American	.63	0.66	.42	0.93
White	−.25	−0.38	.22	0.73
Type of metropolitan area	.07	0.53	.04	0.54
Adjusted R^2	.17		.16	

*$P<.001$.
†$P<.05$.

Table 4.—Reactions by Boys Who Experienced Nonsexual Genital Assault

Effect on Boy Who Was Assaulted	Characteristics of Assailant, No. (%)				
	Male				
	Older, Unknown, or Multiple (n=25)	Single, Peer, and Acquaintance (n=31)	Female (n=39)	χ^2	*P*
Injured	12 (48)	8 (26)	2 (5)	15.95	<.001
Upset	15 (60)	15 (48)	11 (28)	6.79	.03
Felt partly/mostly at fault	6 (24)	14 (45)	21 (54)	6.04	.05

course do not establish causation. But even if it means that such violence happens disproportionately to children traumatized from other sources, it does signal that these experiences are possibly less benign than they are sometimes characterized.

The episodes occur in a variety of contexts and should not be viewed in a stereotypical way. It would appear that some involve attacks or fights in which an assailant or several assailants are trying to inflict serious injury, pain, and humiliation. Other episodes may involve roughhousing among classmates in which the blows may not be intended to cause injury, even though they may. The fact that 40% of boys who experience genital assaults report that the perpetrators are girls suggests that some episodes involve situations in which girls may be trying to protect themselves from aggressive or sexually harassing boys and may kick or hit them in the genitals to try to compensate for inferior size or strength. The finding that 54% of boys assaulted by girls said the incident was mostly or partly their fault supports the possibility of provocation.

The fact that these episodes seem to peak around seventh and eighth grade suggests that to some extent they grow out of some of the tension surrounding pubertal changes. The higher risk to boys with physical impairments and a history of prior victimization also suggests that some may represent a form of bullying. The literature on bullying in this age group indicates that the harassment, hazing, and derogation often focus on sexuality and sexual anatomy.[12,13] Thus, nonsexual assaults may have a sexual component even if they are not for the purposes of direct sexual gratification.

Relatively few of the boys report their episodes to adults. Part of this may reflect the fact that boys who were misbehaving may not be eager to be interrogated about it. However, others may remain silent because they harbor some sense of shame or humiliation about such an assault and do not feel comfortable raising it with adults. The injuries and pain may not ordinarily be of such magnitude that they cannot be hidden or tolerated. It seems likely that even when these assaults require medical attention, boys may disguise their true etiology. All these factors may explain why the child health professionals we consulted when writing this article did not generally recall seeing many such cases (Desmond Runyan, MD, oral communication, February 15, 1995; John McCann, MD, oral communication, January 26, 1995; Jan Bays, oral communication, January 26, 1995; and Carole Jenny, oral communication, May 19, 1995), as has also been the case with the problem of wife abuse, another form of interpersonal violence whose shame has tended to obscure it from the view of health professionals.[33] This suggests a need for adults and professionals to explicitly ask and show some appropriate concern about such events.

This study is unfortunately not nearly so enlightening about the situation of girls. Only a small number of girls acknowledged a nonsexual assault to their private parts, most of these were attempts only, and some of the episodes may have involved breasts rather than genitals. One complexity for girls, however, concerns the way in which aggressive and sexual intentions may be confounded. Rapists are not infrequently trying to hurt and gain sexual gratification at the same time.[34] The distinction between sexual and nonsexual genital assaults may be difficult to make. Girls may also be more likely to interpret acts that target their genitals as sexual in intent whatever the actual motive of assailants. Thus, in understanding the situation of girls, the sexual and nonsexually motivated aspects of assaults against girls may need to be tabulated and analyzed conjointly. To do that, more detailed information needs to be gathered about the dynamics of the assault situation, the kinds of actions taken by assailants, and the elements by which victims interpret sexual and nonsexual intent.

The current study has some other unfortunate limitations as an exploratory examination of this issue. First, we did not gather enough detailed case histories and anecdotal material to fully document the contexts in which these assaults occur and the motivations of the assailants. Second, we had only limited and subjective information on injury. Third, we dealt only with a limited age range of victims, those aged 10 through 16 years. Nonsexual genital assaults are known to occur to younger children, but they happen under different contexts and with different motives, such as parental anger about toilet training, with correspondingly different effects.[35] Fourth, the sizable attrition rate, particularly among some vulnerable groups, meant that both the prevalence and the seriousness of the assaults may have been underestimated.

These limitations suggest some obvious avenues for further research. Badly needed is a study that recruits cases from clinical settings to find out more details of these assaults and more about the way such cases present to practitioners. It should also be a priority to explore further how to discuss and elicit reports of such experiences from children. More work needs to be done trying to create an empirically grounded typology of genital violence. Finally, it would be useful to know more about the physical and psychological sequelae of such violence. It is possible that the spe-

cial connotations associated with the genitals give such assaults the power to affect self-esteem, the sense of physical security, and the developing sexuality of youth in a way that is different from other assaults.

The fact that genital violence is quite common among boys, although not generally disclosed to adults, and yet in some cases can lead to damaging consequences, does hold some policy implications as well. For practitioners, it suggests that it may be advisable to ask about such episodes in history taking, particularly among young people reporting other experiences of assault. For researchers interested in violence and sexual assault, including those who gather some of the nation's most important crime victimization data such as the National Crime Survey, it may be important to include questions that tap experiences of nonsexual genital violence as well. It may also be wise to begin to include information on these kinds of assaults in violence prevention education programs that are targeted at young people so that they can come to appreciate their potential seriousness and also feel comfortable disclosing them.

Another arena that may benefit from some reevaluation in light of these findings is the media. An increasingly large number of movies, especially those aimed at youth audiences, have scenes in which genital violence is portrayed as an effective fighting technique (eg, *Three Ninjas*, *Wyatt Earp*, and *Jungle Book*) or used for comic relief (eg, *Dumb and Dumber* and *Wagons East*). This represents a change in norms in that such acts used to be considered signs of cowardice or in poor taste. The message that such violence is both legitimate, heroic, and humorous may encourage some children to try it and underestimate its potential harmfulness.

Genital violence to children appears to be a harm whose scope and seriousness have been underestimated. While it does not raise as many complex moral and therapeutic issues as are posed by sexual abuse, its neglect may in part be attributable to similar reasons—shame and social avoidance of issues related to sexuality. Genital violence should receive additional research and clinical attention.

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References

1. Finkelhor D. Current information on the scope and nature of child sexual abuse. *Future Child.* 1994;4:31-53.
2. Bays J, Jenny C. Genital and anal conditions confused with child sexual abuse trauma. *AJDC.* 1990;144:1319-1322.
3. Bays J, Chadwick D. Medical diagnosis of the sexually abused child. *Child Abuse Negl.* 1993;17:91-110.
4. Finkel MA. Anogenital trauma in sexually abused children. *Pediatrics.* 1989;84:317-322.
5. Herman-Giddens ME, Frothingham TE. Prepubertal female genitalia: examination for evidence of sexual abuse. *Pediatrics.* 1987;80:203-208.
6. Hobbs CJ, Wynne JM. Sexual abuse of English boys and girls: the importance of anal examination. *Child Abuse Negl.*1989;13:195-210.
7. Kerns DL, Ritter ML. Medical findings in child sexual abuse cases with perpetrator confessions. *AJDC.* 1992;146:494. Abstract.
8. McCann J, Voris J, Simon M. Genital injuries resulting from sexual abuse: a longitudinal study. *Pediatrics.* 1992;89:307-317.
9. Muram D. Child sexual abuse: relationship between sexual acts and genital findings. *Child Abuse Negl.* 1989;13:211-216.
10. Rimza ME, Niggemann EH. Medical evaluation on sexually abused children: a review of 311 cases. *Pediatrics.* 1982;69:8-14.
11. Spencer MJ, Dunklee P. Sexual abuse of boys. *Pediatrics.* 1986;78:133-137.
12. Evans C, Eder D. No exit: processes of social isloation in the middle school. *J Contemp Ethnogr.* 1993;22:139-170.
13. Fine GA. *Little League Baseball and Preadolescent Culture.* Chicago, Ill: University of Chicago Press; 1987.
14. Slosberg EJ, Ludwig S, Duckett J, Mauro AE. Penile trauma as a sign of child abuse. *AJDC.* 1978; 132:719-721.
15. Johnson CF, Showers J. Injury variables in child abuse. *Child Abuse Negl.* 1985;9:207-215.
16. Herman-Giddens ME, Berson NL. Harmful genital care practices in children. *JAMA.* 1989;261: 577-579.
17. Merritt K, Ornstein P. Children's memory for a salient medical procedure: implications for testimony. *Pediatrics.* 1994;94:17-23.
18. Finkelhor D, Dziuba-Leatherman J. Children as victims of violence: a national survey. *Pediatrics.* 1994;94:413-420.
19. Finkelhor D, Asdigian N, Dziuba-Leatherman J. The effectiveness of victimization prevention instruction: an evaluation of children's responses to actual threats and assaults. *Child Abuse Negl.* 1995; 19:137-149.
20. Weeks MF, Kulka RA, Lessler JT, Whitmore RW. Personal versus telephone surveys from collecting household health data at the local level. *Am J Public Health.* 1983;73:1389-1394.
21. Bajos N, Spira A, Ducot B, Messiah A. Analysis of sexual behavior in France (ACSF): a comparison between two modes of investigation: telephone survey and face-to-face survey. *AIDS.* 1992;6:315-323.
22. Bermack E. Effects of telephone and face-to-face communication on rated extent of self-disclosure by female college students. *Psychol Rep.* 1989; 65:259-267.
23. Czaja R. Asking sensitive behavioral questions in telephone interviews. *Int Q Commun Health Educ.* 1987;8:23-32.
24. Marin G, Marin B. A comparison of three interviewing approaches for studying sensitive topics with Hispanics. *Hispanic J Behav Sci.* 1989;11: 330-340.
25. Potts MK, Daniels M, Burnam A, Wells K. A structured interview version of the Hamilton Depression Rating Scale: evidence of reliability and versatility of administration. *J Psychiatr Res.* 1990; 24:335-350.
26. Wells K, Burnam M, Leake B, Robbins L. Agreement between face-to-face and telephone-administered versions of the depression section of the NIMH Diagnostic Interview Schedule. *J Psychiatr Res.* 1988;22:207-220.
27. Bureau of Justice Statistics. *Criminal Victimization in the United States, 1992.* Washington, DC: US Dept of Justice; 1994.
28. Hausman AJ, Spivak H, Prothrow-Stith D, Roeber J. Pattern of teen exposure to a community-based violence prevention project. *J Adolesc Health.* 1992;13:668-675.
29. Stewart WF, Linet MS, Celentano DD. Migraine headaches and panic attacks. *Psychosom Med.* 1989;51:559-569.
30. Foa EB, Riggs DS, Dancu CV, Rothbaum BO. Reliability and validity of a brief instrument for assessing post-traumatic stress disorder. *J Traum Stress.* 1993;6:459-473.
31. Shaffer D, Fisher P, Dulcan D, et al. *National Institute of Mental Health Diagnostic Interview Schedule for Children: Version 2.3 (DISC 2.3).* New York, NY: New York State Psychiatric Institute; 1992.
32. Boney-McCoy S, Finkelhor D. The psychosocial impact of violent victimization on a national youth sample. *J Consult Clin Psychol.* 1995;63:726-736.
33. Morrison LJ. The battering syndrome: a poor record of detection in the emergency department. *J Emerg Med.* 1988;6:521-526.
34. Groth NA. *Men Who Rape.* New York, NY: Plenum Press Inc; 1979.
35. Harley J, Kaufhold M, Reece R. Non-accidental injuries to the male genitalia. In: Program and abstracts of the San Diego Conference on Responding to Child Maltreatment; January 26, 1995; San Diego, Calif.