Evaluation of the Effectiveness of an Educational Presentation in Increasing Chemically Dependent Males’ Report of Sexual Abuse

Linda L. Hand
EVALUATION OF THE EFFECTIVENESS OF AN EDUCATIONAL PRESENTATION IN INCREASING CHEMICALLY DEPENDENT MALES' REPORT OF SEXUAL ABUSE

by

Linda L. Hand

A Thesis
Submitted to the Faculty of The Graduate College in partial fulfillment of the requirements for the Degree of Master of Arts Department of Psychology

Western Michigan University
Kalamazoo, Michigan
December 1988
EVALUATION OF THE EFFECTIVENESS OF AN EDUCATIONAL PRESENTATION IN INCREASING CHEMICALLY DEPENDENT MALES' REPORT OF SEXUAL ABUSE

Linda Hand, M.A.
Western Michigan University, 1988

Research has demonstrated several factors among sexually abused males such as males sexually abused as children becoming adult sexual abusers; one in four males reporting sexual abuse; and adult emotional trauma, drug abuse, and sexual dysfunction. To break this abuse pattern, we need to focus on increasing males' reports of sexual abuse and initiating treatment.

The present study evaluated the effectiveness of an oral educational presentation in increasing males' reports of sexual abuse. It also sought prevalence information and treatment needs. Subjects were 51 males from three chemical dependency treatment centers. One control and four experimental groups were used. The independent variable was the one-hour oral presentation and the dependent variable a "yes" response to a questionnaire question, "Were you ever sexually abused?"

Results did not demonstrate a statistically significant difference. However, increases in reporting in the direction hypothesized were noted.

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.
ACKNOWLEDGMENTS

I would like to extend my grateful appreciation to Dr. David Holland of Kalamazoo for his personal concern and for the hours of valuable assistance in preparation of the questionnaire and oral presentation.

Thanks must also go to the participating treatment centers: Gateway Villa, 900 Myrtle House, and Borgess Midwest Recovery; their clinical directors, Jane Nelson-Holmes, Dr. Robert Perra, and David Russell; and their clinical staff. Without their support and acceptance of highly controversial material, this research could not have been conducted. This displays their continued effort to serve their clients in a holistic manner.

My most humble thanks must go to the pre-test clients who had the courage to share openly their fears, hopes, needs, and advice, which were used extensively in the preparation of the oral presentation. Thanks must go as well to all of the substance abuse clients who participated and helped further research in this area.

Appreciation is extended to Drs. Robertson, Koronokas, and Lyon, my thesis committee members, for
their patience and constructive advice.

A few others need "honorable mention" and special gratitude acknowledged, for, without their emotional support, I could never have accomplished this undertaking: my son, Lyle, and daughter, La Donna, and very special friends, Kendra, Abbas, Sheryl, Anne, and Bernie!

Linda L. Hand
INFORMATION TO USERS

The most advanced technology has been used to photograph and reproduce this manuscript from the microfilm master. UMI films the text directly from the original or copy submitted. Thus, some thesis and dissertation copies are in typewriter face, while others may be from any type of computer printer.

The quality of this reproduction is dependent upon the quality of the copy submitted. Broken or indistinct print, colored or poor quality illustrations and photographs, print bleedthrough, substandard margins, and improper alignment can adversely affect reproduction.

In the unlikely event that the author did not send UMI a complete manuscript and there are missing pages, these will be noted. Also, if unauthorized copyright material had to be removed, a note will indicate the deletion.

Oversize materials (e.g., maps, drawings, charts) are reproduced by sectioning the original, beginning at the upper left-hand corner and continuing from left to right in equal sections with small overlaps. Each original is also photographed in one exposure and is included in reduced form at the back of the book. These are also available as one exposure on a standard 35mm slide or as a 17" x 23" black and white photographic print for an additional charge.

Photographs included in the original manuscript have been reproduced xerographically in this copy. Higher quality 6" x 9" black and white photographic prints are available for any photographs or illustrations appearing in this copy for an additional charge. Contact UMI directly to order.

UMI

University Microfilms International
A Bell & Howell Information Company
300 North Zeeb Road, Ann Arbor, MI 48106-1346 USA
313/761-4700  800/521-0600

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.
Evaluation of the effectiveness of an educational presentation in increasing chemically dependent males' report of sexual abuse

Hand, Linda L., M.A.
Western Michigan University, 1988

Copyright ©1988 by Hand, Linda L. All rights reserved.
# TABLE OF CONTENTS

ACKNOWLEDGMENTS ........................................... 11  
LIST OF TABLES ............................................. v  
INTRODUCTION ............................................. 1  
METHOD .................................................... 10  
  Subjects ............................................... 10  
  Setting ............................................... 11  
  Materials ............................................ 11  
  Procedure .......................................... 12  
  Analysis of Data ..................................... 15  
  Validity ............................................ 15  
  Reliability ........................................ 16  
RESULTS ................................................... 18  
DISCUSSION ............................................... 21  
ADDITIONAL CLINICALLY SIGNIFICANT DATA ............... 24  
REFERENCES ............................................ 26  
APPENDICES .............................................. 29  
  A. Oral Presentation .................................. 30  
  B. Questionnaire Survey Form ....................... 40  
  C. Informed Consent Handout ......................... 49  
  D. Data Recording Form ................................ 53  
  E. Tabulated Data on Actual Findings to  
     Questionnaire Questions of Clinical  
     Significance .................................... 55  
BIBLIOGRAPHY ............................................ 59

iv

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.
LIST OF TABLES

1. Group Numbers and Percentages of Answers to Question Five of the Questionnaire - Were You Sexually Abused? ......................... 20
INTRODUCTION

The purpose of this study was to evaluate the effectiveness of an educational presentation in increasing reports of sexual abuse among males in residential treatment for chemical dependency. Another goal of the study was to provide information to the agencies and participants involved in the study and to health care professionals in general regarding the prevalence of male sexual abuse and the needs of sexually abused males.

Studies on sexual abuse have focused almost exclusively on the female population. Male sexual abuse has received scant attention from mental health professionals and has remained a lightly mentioned topic in the literature. The few studies that have been published suggest that possibly one in four males are victims of sexual abuse. For instance, Wathey and Densen-Gerber (1976) reported 25% of the males in a residential substance abuse treatment center had experienced some type of incestuous activity. Ledray (1984) reported the same percentage among males in treatment at an outpatient clinic. Bess and Janssen (1982) found similar results at a psychiatric walk-in evaluation center in which 31% of the 32 patients
interviewed at random disclosed an incestuous history. In addition to the significant incidences of sexual abuse among males, other findings that underscore the need for research in this area include the following:

1. There is a repetitive pattern of males sexually abused as children becoming adult sexual abusers (Groth, 1979; Seabloom, 1979; Serrill, 1974).

2. Sexually abused children suffer short and long-term effects, such as physical and emotional trauma often resulting in extensive psychiatric care (Adams-Tucker, 1982; Dixon, Arnold, & Calestro, 1978; Ellerstein & Canavan, 1980; Johnson & Shrier, 1985; Medicott, 1967; Nasjleti, 1980; Showers, Farber, Joseph, Oshins, & Johnson, 1983).


4. Alcohol is a significant factor in a high number of sexual abuse crimes (Goldberg, 1977; Pierce & Pierce, 1985; Virkkunen, 1974).

5. Sexually abused males display a higher than normal incidence of sexual dysfunction (Bess & Janssen, 1982; Johnson & Shrier, 1985).

6. Males often do not report sexual abuse
(Finklehor, 1979; Groth & Burgess, 1980; Landis, 1956; Nasjleti, 1980).

With respect to the first finding, a repetitive pattern of males sexually abused as children becoming adult sexual abusers has been demonstrated. Groth's (1979) interviews with 348 male sex offenders revealed that one-third had been sexually abused as children. Serrill's (1974) study of 150 imprisoned male sexual offenders found 75% of them reporting sexual abuse histories. Seabloom (1979) estimated that 100% of the sex offenders he interviewed reported childhood sexual abuse.

With respect to the second finding, Adams-Tucker (1982) reported physical and emotional trauma accompanied by suicidal and homicidal ideation in 28 sexually abused children (both female and male) which resulted in long-term psychiatric care. Mendicott (1967) describes three cases of homosexual incest. As adults, these three male incest victims displayed both neurotic and psychotic symptoms and one committed suicide. Dixon et al. (1978) found homicidal and/or suicidal ideation in four out of six sexually abused patients, with the incest victims reporting homicidal ideation toward their abusing fathers. Three of the patients also reported a history of self destructive-ness as well. In a study by Ellerstein & Canavan
(1980), 8 out of the 16 male victims of sexual abuse were found to suffer perianal abrasions, anal hematomas, and under the skin hemorrhages.

De Jong, Emmett, & Hervada (1982) researched 416 sexual abuse cases at an emergency room crisis center. Of the 416 patients, 72, or 17.39%, were male. Evidence of trauma was present in all 72 male patients. Hospitalization was required for 13 patients, one for severe psychotic problems and three for extensive physical trauma. Violence was reported by the victim 55.6% of the time for males compared to 31.7% of the time for females. Male victims were generally younger than females when abused and were subjected to more violence and evidenced more trauma than their female counterparts.

Regarding the third finding, researchers have found a higher incidence of drug abuse occurring in persons with histories of being sexually abused. Cohen & Densen-Gerber (1982) studied 178 adult patients at a residential alcohol and drug abuse treatment center and found 33% of the 178 patients (females) had experienced child sexual abuse. Male percentages were unlisted, but a statement noted that male sexual abuse including incest was significantly lower compared to females. The authors also found that sexual abuse, violence, and neglect were listed
by patients as primary factors in their abuse of substances. Weber (1977) reported that 70% of the 599 cases of chemically dependent adolescents (both male and female) reported some form of family sexual abuse. Similar findings by Benward & Densen-Gerber (1975) report 44% of their female population of 118 chemically dependent patients admitted to being victims of incest. Bess & Janssen (1982) report a higher incidence of drug abuse at present and in past histories in patients with sexual abuse histories than in the general clinical population at a psychiatric walk-in evaluation unit.

Studies of sexual abuse have demonstrated correlations between parental alcoholism and incest (Bess & Janssen, 1982; Pierce & Pierce, 1985; Virkkunen, 1974). Virkkunen (1974) found that in 49% of the 45 cases of incest (female), the abuser was alcoholic. Pierce and Pierce (1985) report that of 205 substantiated cases of sexual abuse (male and female), 45 cases were incest by alcoholic fathers. A triad of incest, parental alcoholism, and parental child abuse emerged from the study by Bess & Janssen (1982).

With respect to the fourth finding, alcohol is a factor in a number of sexual crimes. Of the 45 cases of incest reported by Virkkunen (1974), 49% of the
male abusers were alcoholic. Rada (1976) studied 203 cases of male child molesters and found 52% rated as alcoholic. The definition of "alcoholic" was vague. However, 49% reported they were drinking heavily when they committed the crime. The same researcher in 1975 reported 50% of the 77 male rapists in a prison setting stated they were drinking heavily when they attacked their victims.

The fifth finding reveals a significantly higher rate of sexual dysfunction reported by male victims of sexual abuse. Bess & Janssen (1982) found 70% of incest subjects reporting a history of adult sexual impairment compared to 18% of non-incest subjects. Of the 40 adolescent males studied by Johnson & Shrier (1985), 25% reported sexual dysfunction compared to 5% of the control group of non-victimized males. Furthermore, 60% stated the abuse impacted significantly on their lives and only six of the 40 had previously reported the abuse. In the Bess & Janssen (1982) study of five males reporting homosexual childhood incest, four of the five males reported a homosexual preference as adults.

With respect to the sixth finding, common in the literature is the lack of reporting of male sexual abuse. Nasjleti (1980) states gender-specific cultural roles keep males from reporting molestations.
It was found that boys report both extreme fear of being labeled homosexual and shame stemming from helplessness as well as fear of retribution from the abuser. Landis (1956) found 17% of the sexually abused males compared to 43% of sexually abused females had reported the abuse to their parents. No explanations were offered. Groth & Burgess (1980) revealed that men often fear being labeled a homosexual and, therefore, do not report the abuse. The study also identified an offender strategy of getting the victim to ejaculate, thereby leaving the victim confused about his part in the offense and his own sexuality in question. It was also noted that in some states there is punishment toward the victim as well as the offender for participating in the illegal act of "sodomy." The legal system also allows the sexual lifestyle of a male victim to be used as a defense in some states. This deters gay men from reporting male sexual abuse or rape.

Other reasons males fail to report may be due to the fact that healthcare clinicians do not assess sexual abuse histories (Bess & Janssen, 1982). Social taboos also keep spontaneous reports at a minimum, especially in the area of homosexual incest (Nasjleti, 1980).

Many of the studies on sexual abuse, especially
male sexual abuse, suffer from weaknesses such as a small number of reported cases, or memory reliance which may be inaccurate, such as in the case of retrospective surveys, interviews with sexual offenders, and self-reports.

Given the amount of knowledge, or more appropriately, the lack of knowledge, when compared to the literature on sexual abuse of females, it is imperative to begin exploring methods to: (a) increase the incidence of reporting male sexual abuse, (b) identify possible areas sexually abused males may predominate, and (c) explore treatment needs and requests of sexually abused males.

Research definitions of male sexual abuse suffer from lack of specificity and standardization. In an attempt to remove these weaknesses from the present study, the definition of male sexual abuse was derived from Jones (1982) and the Michigan Compiled Laws (1979) concerning criminal sexual conduct. For the purpose of this study, male sexual abuse was defined as a situation which included one or more of the following:

1. A sexual act forced upon a male to gain sexual arousal or gratification for the abusing person.

2. Sexual act of any kind: vaginal or anal
intercourse, fondling of the genitalia, oral sex, or exhibitionism in which the participation of the male was obtained via bribery, threats, or misleading information about acceptable sexual behavior.

3. Any sexual act that is legally prohibited because of: (a) age, such as adult/child under 13, (b) family relationship, such as blood relative or person residing in the same household as the victim, and (c) position of authority over the victim.

Based on the assumption that education and discussion of a taboo subject would make it easier for a male to admit to a sexual abuse history, the hypothesis was that there would be a significant increase in the number of "yes" responses in the intervention groups receiving the oral presentation compared to the control group receiving no presentation prior to the administration of the questionnaire.
METHOD

Subjects

Subjects were 51 males, ranging in age from 21 to 54 with a mean age of 33, recruited from three 14-28 day in-patient treatment centers for chemical dependency located in lower southwest Michigan. The subjects were of diverse occupational and ethnic origins. Marital status breakdown found the following: single--18, married--21, separated--2, and divorced--10. Participating treatment centers were: Gateway Villa of Kalamazoo, Michigan; Borgess Hospital's Midwest Recovery Program of Kalamazoo, Michigan; and Myrtle House of Sturgis, Michigan. Gateway Villa was used more extensively than the other centers due to ease in obtaining time for group data collection.

Five groups comprised the study: one control group from Gateway Villa (GVC) n=13, and four experimental groups: IV1 n=9, IV2 n=8, IV3 n=13, and IV4 n=10.

Subjects were asked to participate by the experimenter in a group study. Participation in the questionnaire survey was voluntary. Eligibility for the study required participants to have resided in the facility for at least five days to assure detoxifi-
cation of all drugs. Some participants were in their last few days of their 28-day treatment while others were at or near the five-day minimum eligibility requirement. Eligibility also required participants to be literate. Literacy was ascertained by the primary therapist or intake worker at the facility during the normal assessment interview and was double checked by the experimenter prior to administration of the questionnaire and the educational presentation. This did not present a problem as there were no illiterate residents in the subject pool.

Setting

The setting for the oral presentation and administrations of the questionnaire at each treatment facility was a regular group lecture room. The rooms were quiet, private, and familiar surroundings to each participant. Chairs were set in semicircle fashion with the experimenter in front of the participants, allowing for good eye contact and full view of visual aids.

Materials

The content of the oral presentation included: (a) the definition of male sexual abuse, (b) prevalence, (c) characteristics of sexual abusers, (d)
the secrecy around abuse, and (e) possible effects on
the victim. It closed with possible ways to aid
victims still suffering from male sexual abuse (see
Appendix A--Oral Presentation).

During the presentation, content information was
displayed on a white paper flip chart with black
lettering. The flip chart was located at the side of
the experimenter in full view of all participants.
The visual aid was used to ensure standardization of
the educational material and participant contact with
the content of the presentation.

The questionnaire was a six-page handout
containing 34 multiple choice items designed to elicit
personal information on male sexual abuse (see
Appendix B--Questionnaire). It was developed by the
author after collaboration with Dr. David Holland, a
local sex therapist, a review of the legal literature
on sexual abuse, and incorporation of demographic
information and appropriate elements from the review
of literature.

Procedure

The independent variable was the one-hour oral
presentation on various issues related to male sexual
abuse. The dependent variable was the response to
question 5 of the 34-item questionnaire asking:
"Referring to the definition of sexual abuse on page 1, have you ever been sexually abused?"

Due to the nature of the material requested by the questionnaire and its likely emotional impact, all participants received the educational component. The control group received it following the administration of the questionnaire, and the intervention groups prior to administration of the questionnaire. Thirty days elapsed between groups to assure a new sample of participants.

All oral presentations were given by the experimenter. Prior to the presentation, participants were introduced to the experimenter by their respective staff personnel and given information about the relevance of the presentation.

Protocols for the groups are described below:

Control group:
1. Experimenter introduced to participants
2. Research relevance reviewed
3. Informed consent forms distributed, read aloud, reviewed, and questions answered
4. Participants invited to participate by picking up and completing a questionnaire and returning it within one hour to the experimenter
5. Questionnaires collected by experimenter
6. All group members received oral presentation
7. Question and answer period

Intervention group:

1. Experimenter introduced to the participants
2. Research relevance reviewed
3. Oral presentation delivered
4. Question and answer period
5. Informed consent forms distributed, read aloud, reviewed, and questions answered
6. Participants invited to participate by picking up and completing a questionnaire and returning it to the experimenter within one hour
7. Questionnaires collected by experimenter

The experimenter read the informed consent form aloud to the participants as they followed along on a personal copy (see Appendix C--Informed Consent Form). Questionnaires were distributed in manila envelopes and participants were asked to complete them without assistance in total privacy to ensure confidentiality.

Data from the questionnaires were then entered onto a data recording form by individual treatment groups (see Appendix D--Data Recording Form). The recording form was a standard-sized sheet of white paper divided into 30 columns lengthwise representing participants' identifying numbers. Along the left edge of the form, 156 rows represented each possible answer on the questionnaire. The numbers of the rows
corresponded to the same numbers on the questionnaire. Sensor sheets were prepared and read by Testing Services into the computer at Western Michigan University for data analysis.

Analysis of Data

A group design was employed to assess the treatment effects of the oral presentation. The control group (GVC) completed the questionnaire without the oral presentation and the four intervention groups completed the questionnaire following the oral presentation. Chi square analysis was used to compare group data.

Validity

Content validity and question clarity of the questionnaire were determined by pretesting the questionnaire with ten known sexually-abused clients who had previously completed treatment at Gateway Villa. Clients were asked to verify that the questions on the questionnaire were clear and easily answered. They were instructed to circle any unclear question and state what was not understood. Questions were then reworded and retests given until all questions were clearly understood by all 10 participants.
Reliability

Since the instrument was designed by the experimenter, reliability of the questionnaire was verified by having all participants of one intervention group from Gateway Villa complete the questionnaire twice with a lapse of five days between presentations.

Eleven questionnaires were returned; six respondents answered questions 1-9 (21 possible responses). All six responded exactly the same on every response for both administrations. They discontinued responses after question 9 as they did not report being sexually abused.

Three respondents reported sexual abuse and answered all 34 questions (123 possible responses). Two of the respondents answered exactly the same on all responses on both administrations. One respondent omitted a single response to one question on the second administration. All other questions and responses were exactly the same for the third respondent. Two participants left treatment before the second administration.

Accuracy of recorded data was ascertained by coding the testing sheets from the written questionnaires and comparing the totals to totals on the data recording forms which were also taken.
directly from the questionnaires.

Built-in consistency questions (questions 10, 18, 20, and 23) were used to detect random responses. No random responses were observed.
RESULTS

Rates of participation ranged from 91.7% (one not returned) GVC, 86.7% (two not returned) IV3, 83.3% (two not returned) IV4, 90% (one not returned) IV1, to 100% IV2. Only one participant questionnaire was eliminated from the results due to failure to meet the requirement of being in treatment for at least five days to allow detoxification of drugs. Sexual abuse was reported by 13 (25.5%) of the 51 subjects.

Of the three treatment centers, participants in one intervention group (IV3) in one center had previous contact with the experimenter. Therefore, data were analyzed individually by intervention groups to control for this variable. However, no statistically significant differences were found between groups (Chi square = 3.01, 2 df, p=.2219).

The major outcome measure employed in the study to assess an increase in treatment effect was an affirmative answer to question 5 of the questionnaire, "have you ever been sexually abused?" No statistically significant difference was found between the control and intervention groups using a Chi square analysis of data at a .05 level of significance (Chi square = 1.037, 1 df, p=.3084).

18
Table 1 shows the numbers as well as percentages of subjects' answers to question 5 of the questionnaire. Data suggest an increase in each treatment group in the direction hypothesized, from 9.1% (control) to 23.1%, 22.2%, 30.0%, and 50.0%, respectively, for individual treatment groups.

Additional statistical analysis was done by performing Chi square analysis on question 3, "was there drug abuse in the home the subject was raised in". A statistically significant relationship was found (Chi square = 12.00, 1 df, p=.0005, using a Yates correction).
<table>
<thead>
<tr>
<th>Group</th>
<th>Answers</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>IV1 (n=9)</td>
<td>7</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td></td>
<td>77.8%</td>
<td>22.2%</td>
<td></td>
</tr>
<tr>
<td>IV2 (n=8)</td>
<td>4</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td></td>
<td>50.0%</td>
<td>50.0%</td>
<td></td>
</tr>
<tr>
<td>IV3 (n=13)</td>
<td>10</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td></td>
<td>76.9%</td>
<td>23.1%</td>
<td></td>
</tr>
<tr>
<td>IV4 (n=10)</td>
<td>7</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td></td>
<td>70.0%</td>
<td>30.0%</td>
<td></td>
</tr>
<tr>
<td>Subtotals (n=40)</td>
<td>28</td>
<td>12</td>
<td></td>
</tr>
<tr>
<td></td>
<td>70.0%</td>
<td>30.0%</td>
<td></td>
</tr>
<tr>
<td>GVC (n=11)</td>
<td>10</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td></td>
<td>90.0%</td>
<td>9.1%</td>
<td></td>
</tr>
<tr>
<td>TOTALS (n=51)</td>
<td>38</td>
<td>13</td>
<td></td>
</tr>
<tr>
<td></td>
<td>74.5%</td>
<td>25.5%</td>
<td></td>
</tr>
</tbody>
</table>
DISCUSSION

The present research sought to evaluate the effects of an educational oral presentation on increasing reports of sexual abuse of males in treatment for substance abuse. The hypothesis that an oral educational presentation would increase the reporting rate of sexual abuse of males was not confirmed. However, the data did display a trend in the direction hypothesized and it is possible that with a larger pool of subjects, an educational presentation may prove to be a useful tool in increasing males' verbal reports of sexual abuse. It is the task of future research to explore this possibility as well as to test this hypothesis with other clinical populations. It seems likely to the author that other areas where clients are seeking help for emotional traumas, sexual dysfunction, or substance abuse may be a good place to begin questioning routinely for a history of sexual abuse and current sexual problems.

A limitation of the study lies in the self-report tool--the questionnaire. There is a risk that problems may exist with self reports which rely on memory which can be distorted by time. Communication
problems may exist in that the definition of sexual abuse may not mean the same to all participants. To avoid this, the definition that participants were asked to use was printed in capital letters at the beginning of the questionnaire. Additionally, during the oral presentation, each intervention group received examples of the categories listed in the definition. It was anticipated that these measures would create a common frame of reference. It should also be noted that, especially with males, there is a strong bias toward under-reporting of sexual abuse due to fear, shame, and guilt (Clark & Tifft, 1973; Finklehor, 1979; Nasjleti, 1980).

In order to deal with strong fear, guilt, and shame issues, a more potent intervention than a one-hour group educational presentation may be needed. However, it is noteworthy that all subjects in the study, when asked if the presentation was helpful in getting them to reveal sexual abuse histories, reported that it was "helpful" and 67% reported that it was "very helpful." Even with these limitations, the study indicates a need for sexual abuse and sexual problem areas to be included as a routine component of the assessment interview at substance abuse treatment centers.

The present study found 25.5% of the
participating subjects reporting sexual victimization, a finding that concurs with incidence rates of 25% found by Wathey & Densen-Gerber (1976), and findings by Parents United (a national self-help group) of one in four males who are sexually victimized before the age of 18. The present study also concurs with Bess & Janssen (1982) in finding parental alcoholism positively correlated with subjects reporting sexual abuse.
ADDITIONAL CLINICALLY SIGNIFICANT DATA

Additional clinically significant data obtained from subjects reporting sexual abuse are summarized below. The author believes they clearly indicate a need to thoroughly assess sexual abuse histories and sexual problems in males seeking treatment for substance abuse.

Age of first abuse ranged from 4 to 25 years. Modal ages were 4, 7, 10, and 12 with two reports for each modal age.

Abusers were older friends (6), uncles (2), babysitters (2), stepfather (1), brother (1), friend's father (1), and neighbor (1). All abusers except one were male. Seven out of thirteen sexually abused subjects reported their abusers to be under the influence of alcohol or drugs at the time the abuse occurred. Three reported this to be true one time; two reported this to be true three times; one stated it was true in the four times he was abused; and one reported 9+ abuses and, each time, the abuser was under the influence of alcohol or drugs.

Only 5 (39%) of the 13 victims reported the abuse and none reported it to physicians, teachers, clergy, or police. For those victims not reporting abuse,
shame and various kinds of fear were the reasons given.

Seven (54%) of the 13 victims reported some permanent emotional damage as a result of the abuse. Damage included the following: 3 (23%) had problems with impotency, 4 (31%) had problems with premature ejaculation, 6 (46%) were fearful of having sex, and 5 (39%) were fearful of homosexuality.

Six victims (46%) reported abusing another person sexually. One hundred percent of the pretest respondents also reported abusing another person sexually.

Forty-three out of fifty-one respondents reported never having been questioned regarding sexual abuse histories even though 45% reported being in treatment for chemical dependence two or more times. Not surprising for this population is the finding that 77% acknowledged that they used drugs to cope with the effects of sexual abuse. Sadly, one half indicated some permanent emotional damage from the abuse.

Tabulated data in Appendix E represent the actual findings on various other questions of clinical significance.
REFERENCES


Holland, D., Ph.D., Professional Interview. 4/14/87. Kalamazoo, MI.


APPENDICES
Appendix A

Oral Presentation
I. WHAT IS MALE SEXUAL ABUSE?

A Situation which includes one or more of the following aspects:

A. Sexual act forced upon a male to gain sexual arousal or gratification for the abusing person

B. Sexual act of any kind, such as intercourse (vaginal or anal), fondling of the genitalia, exhibitionism, or oral sex in which the participation of the male was obtained via bribery, threats, or misleading information about acceptable sexual behavior.

C. Any sexual act that is legally prohibited because of:

1. Age (such as adult/child under 13)
2. Family relationship (such as blood relative or person residing in the same household as the victim - incest)
3. Position of authority over the victim

II. HOW OFTEN DOES IT HAPPEN?

Johnson & Shrier (1985) in a six-year study at an adolescent medical clinical questioned all males about sexual abuse in their past. 40 of 3000 males reported sexual abuse.
Groth (1977) reports that in a study by the Oakland County Homicide Task Force in 1976 which reviewed police records, 17% of the child sexual abuse victims were male.

Landis (1956) found that out of 1800 college students surveyed, 30% of the males had had childhood sexual advances, usually homosexual in nature.

Pierce & Pierce (1985) analyzed 205 cases of reported child sexual abuse from 1976-1979 at the Illinois Department of Children and Family Services. They found that 12% of the 205 cases were male (males tended to be abused younger than females and experienced at least three or more sexual acts 92% of the time compared to females at 48% of the time).

Serrill (1974) studied 150 males imprisoned for sexual offenses in which 75% of them reported being sexually abused as children.

Groth (1979) interviewed 348 male sexual offenders in which 33% said they had been sexually abused as children.

Seabloom (1979) estimated that 100% of the male sex offenders he worked with were sexually abused as children.

III. WHO DOES THE ABUSING?
A. **Males**

Pierce & Pierce (1985) reports that out of 205 substantiated cases of sexual abuse reported via a sexual abuse hotline, 93% of the abusers were males (for male victims, in 20% of the cases, natural fathers were the abusers and in 28% of the cases, stepfathers were the abusers).

B. **Previous Victims of Sexual Abuse**

Groth's (1979) study of convicted sexual offenders found 33% of the 348 abusers to have been abused as children. Serrill (1974) studied 150 males imprisoned for sexual offenses and found 75% of them as sexually abused children. Seabloom (1979) estimated that 100% of the sex offenders he worked with were sexually abused as children.

C. **Alcoholics or Persons Abusing Alcohol**

Pierce & Pierce (1985) found that of 205 substantiated cases of sexual abuse, 45 cases were incest by alcoholic fathers. Virkkunen (1974) found that in 49% of the 45 cases of incest he studied, the abuser was alcoholic. Rada (1976) studied 203 male child molesters
and found that 49% of them had been drinking heavily at the time the abuse occurred (50% were rated as alcoholics).

Rada (1977) again found of 77% imprisoned male rapists, 50% were drinking at the time the rape occurred and 35% were alcoholic.

Carmen, Richer, & Mills (1984) found that 38 adults in an in-patient psychiatric unit stated they were sexually abused as children and 40% of their parents were alcoholics.

D. Emotionally Disturbed Persons

Pierce & Pierce (1985) found that of 205 substantiated cases of sexual abuse, 35% of the time the abusers were found to be emotionally disturbed and needed referral to mental health clinics (40% when only male abuse was considered).

IV. WHY ISN'T IT TALKED ABOUT MORE?

A. Social Taboos Involved of Incest and Homosexuality

B. Men Don't Report

Nasjleti (1980) reports this is due to several reasons:

1. shame (not being in control)
2. fear of physical harm (which accompanied male sexual abuse more often than female
sexual abuse)

3. difficult for a male to admit helplessness and vulnerability (feelings of being "weak")

4. fear of being labeled a homosexual (abuser is most often a male and may cause the victim to reach orgasm and tell the victim he wanted the abuse to happen or the victim may experience pleasure from stimulation in the case of genital fondling or oral sex, which is a natural biological reaction to stimulation)

5. if abused by a female, he may not feel he will be believed as society tends to believe sexual experiences are always pleasurable to a male

6. if abused by a mother, males often fear for their mental stability, often fearing this was a mental illness

Groth (1980) also found reasons such as:

1. men were expected to be able to defend themselves

2. fear that their sexuality may come into suspect (homosexuality label)

3. embarrassment and shame
4. often brought to ejaculation which left the victim confused about whether or not he really wanted or enjoyed the rape and also a fear that this may affect the credibility of his story should he tell someone

5. some states have laws that make both the victim and the abuser guilty of sodomy offenses

C. Professionals Do Not Ask

1. difficulty conversing about taboo topics
2. personal bias that male sexual abuse does not happen
3. difficulty knowing what to do with information once it has been reported to them
4. questions of sexual abuse are often not part of routine social history taking

V. POSSIBLE EFFECTS ON THE VICTIM

A. Possibly Become Sexual Abusers Themselves
(see research listed by Groth (1979), Seabloom (1979), and Serrill (1974)).
B. **Sexual Dysfunction**

Bess & Janssen (1982) studied 32 adults on a walk-in psychiatric unit of a metropolitan hospital during July and August 1977 and found nearly one third were sexually abused (incest) as children. Five of these were male and a significant number of these males reported homosexual adjustment as adults. Johnson & Shrier (1985) studied males at an adolescent medical clinic finding 40 sexually abused. 25% of these males reported sexual dysfunctions such as decreased sex drive, premature ejaculation, failure to get an erection, and failure to ejaculate. They also found, when comparing them to non-sexually abused males, that abused males had chosen homosexuality as a sexual preference seven times as often as non-abused males. They chose bisexuality six times more often than non-abused males.

C. **Emotional/Physical Trauma**

Groth (1980) found that 64% of the 14 sexually abused males were sodomized as children (sodomy often causes anal tearing in children).

Bess & Janssen (1982) also found 60% of the 5
males sexually abused in the study to have been sodomized.

Carmen, Reiker, & Mills (1984) studied 188 adults who had been discharged from an inpatient psychiatric unit and found that 15 had been sexually abused and 23 physically and sexually abused.

Adams-Tucker (1982) studied 28 sexually abused children (22 girls and 6 boys aged 2 1/2 to 15 1/2 years). All of the children were symptomatic and all but one boy suffered considerably and were given psychiatric referrals.

D. Possible Victim Drug/Alcohol Abuse

Cohen & Densen-Gerber (1982) studied patients at alcohol and drug abuse treatment centers and found that, since 1973, Odyssey's patient charts have reported a high rate of child sexual abuse and violence which seemed to be the primary factors patients reported to have caused them to use drugs by minimizing dysphoria, creating euphoria, or helping them make it through the day.

Benward & Densen-Gerber (1975) found that 44% of 118 female patients in treatment for chemical dependency were incest victims.
Bess & Janssen (1982), in a study of 32 adults at a walk-in psychiatric unit during July and August of 1977 (10 sexually abused - incest), found that both the incest and non-incest subjects showed a higher incidence of drug abuse at present or in their past than the general population at the walk-in unit. Weber (1977) reported that 70% of the 599 cases of chemically dependent adolescents reported some form of family sexual abuse.

VI. WHAT WILL HELP THE VICTIMS OF MALE SEXUAL ABUSE?

A. **Education**
   media awareness, clinician awareness, and self-help materials

B. **Willingness to Admit**
   knowledge that one is not alone in suffering or questioning, catharsis of venting, knowledge that it is not the victim's fault, release of guilt and shame

C. **Supportive Therapy**
   vent, reduce fear, guilt and shame, rebuild self worth and self image via individual therapy, self help materials, books on subject and group therapy sessions
Appendix B

Questionnaire Survey Form
QUESTIONNAIRE

The following pages reflect a series of personal questions about sexual abuse as it is defined below. Thank you for taking your time and effort to make research on this difficult topic possible.

MALE SEXUAL ABUSE IS DEFINED AS:

A situation which includes one or more of the following aspects:

1) Sexual act forced upon a male to gain sexual arousal or gratification for the abusing person

2) Sexual act of any kind, such as intercourse (vaginal or anal), fondling of the genitalia, oral sex, or exhibitionism in which the participation of the male was obtained via bribery, threats, or misleading information about acceptable sexual behavior.

3) Any sexual act that is legally prohibited because of:

(a) age (such as adult/child under 13)
(b) family relationship (such as blood relative or person residing in the same household as the victim - incest)
(c) position of authority over the victim

Have you completed detox or been in treatment for at least five days?  yes ______  no _______

1. How old are you?  ______

2. What is your marital status?
   (2a) ______ Single
   (2b) ______ Married
   (2c) ______ Separated
   (2d) ______ Divorced
   (2e) ______ Wife deceased

3. Did anyone living in the home(s) in which you were raised abuse or have a problem with or abuse alcohol or other drugs?
   (3a) yes ______ (3b) no ______

4. If you answered yes to question 3, please specify
who abused alcohol or drugs (please check all that apply):

(4a) ________ Mother
(4b) ________ Father
(4c) ________ Sibling (sister/brother)
(4d) ________ Other - please list all others who lived with you and abused alcohol or drugs and their relationship to you below:

5. Referring to the definition of sexual abuse on page 1, have you ever been sexually abused? (5a) yes ________ (5b) no ________

6. How many times have you received treatment for substance abuse or other emotional problems whereby you have interacted with a therapist, counselor, doctor, or other healthcare professional? (please check only one)

(6a) ________ first time
(6b) ________ second time
(6c) ________ third time
(6d) ________ more than three times

7. How many of the times in question #6 were you ASKED if you were sexually abused? ________

8. If you were asked (question 7 above), did you admit to being sexually abused? (8a) yes ________ (8b) no ________

9. If you answered no to question 8 and you were sexually abused, please explain why you did not admit by checking all reasons that apply and adding any additional under the "other" column.

(9a) ________ asked by a female therapist/medical worker
(9b) ________ asked by a male therapist/medical worker
(9c) ________ ashamed
(9d) ________ afraid of what would happen to me
(9e) ________ afraid of what would happen to the abuser
(9f) ________ afraid I would be blamed
(9g) ________ other - list below

IF YOU ANSWERED NO TO QUESTION FIVE, PLEASE STOP HERE;
IF YOU ANSWERED YES TO QUESTION FIVE, PLEASE CONTINUE

10. How many times were you sexually abused? (please check only one)
(10a) ________ Once
(10b) ________ 2 - 3 times
(10c) ________ 4 - 10 times
(10d) ________ More than 10 times

11. How old were you when the FIRST abuse occurred?___

12. Please estimate the age of the person who abused you. (list all if more than one)
   (12a) ________
   (12b) ________
   (12c) ________

13. Please place a check by any person listed below who sexually abused you and add any who are listed in the "other" column.
   (13a) ________ Father
   (13b) ________ Mother
   (13c) ________ Brother
   (13d) ________ Sister
   (13e) ________ Older friend (how many years older? ________)
   (13f) __________________________________________________
   (13g) __________________________________________________

14. Referring to the definition of Male Sexual Abuse, please check as many of the following abuses that you suffered. Please list under the "other" column any that are not listed and occurred.
   (14a) ________ Genital fondling - done to my body
   (14b) ________ Genital fondling - forced/coerced into doing it to another
   (14c) ________ Oral/Genital contact - done to my body
   (14d) ________ Oral/Genital contact - forced/coerced into participating
   (14e) ________ Vaginal Intercourse - forced/coerced into participating
   (14f) ________ Anal Intercourse - done to my body
   (14g) ________ Anal Intercourse - forced/coerced into doing it to another
   (14h) ________ Forced to watch sexual relations of others
   (14i) __________________________________________________
   (14j) __________________________________________________

15. How did the person abusing you get you to cooperate with him/her? (please check all that apply)
   (15a) ________ Threatened me
16. Check as many of the following as you experienced when you were sexually abused. List any others in the "other" column.
(16a) ________ Fear
(16b) ________ Anger
(16c) ________ Shame
(16d) ________ Shock
(16e) ________ Interest/Curiosity
(16f) ________ Pleasure
(16g) ________ Physical Pain
(16h) ________ Rage
(16i) ________ Betrayal
(16j) ________ Dirty/Unclean
(16k) ____________________________ Other - please list below

17. How many of the times you were sexually abused was the person(s) abusing you under the influence of alcohol or other drugs? ________

18. Did you ever tell anyone that the abuse occurred?
(18a) yes ________ (18b) no ________

19. If you answered yes to question 18, please check whomever you told about the abuse. (you may check more than one)
(19a) ________ Father
(19b) ________ Mother
(19c) ________ Sibling (sister/brother)
(19d) ________ Counselor
(19e) ________ Friend
(19f) ________ Doctor
(19g) ________ Teacher
(19h) ________ Police Officer
(19i) ________ Minister/Priest/Rabbi or other clergy
(19j) ____________________________ Other - please list below
(19k) ____________________________

20. Please check the reactions of the persons you told in question 19. You may check more than one and list any not listed under the "other" column.
(20a) ________ Supportive
(20b) ________ Angry
21. If you answered no to question 18, please check any reasons why you did not report the abuse. (you may check more than one and list any that are not listed in the "other" column)

(21a) ________ Too ashamed
(21b) ________ Fear that I would be labeled a homosexual
(21c) ________ Brought to ejaculation or received pleasure and feared that meant I wanted it to happen
(21d) ________ Did not think anyone would believe me
(21e) ________ Fear that I would be physically injured
(21f) ________ Fear that people would not think I was a "man" or did not try to fight back
(21g) ________ Fear I caused it to happen
(21h) ________ Fear I would be blamed
(21i) ________ Believed males could not be raped
(21j) ________ Other - please list below

22. Please circle the extent of emotional damage you felt you suffered from the sexual abuse experience(s). (please circle only one number reflecting the overall effects of the abuse if it occurred more than once)

<table>
<thead>
<tr>
<th>No damage</th>
<th>Temporary damage (suffered for awhile)</th>
<th>Permanent damage (still suffering)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>

(22a) (22b) (22c) (22d) (22e)

23. How long did it take you to get over it?

(23a) ________ A few hours
(23b) ________ A few days
(23c) ________ A few months
(23d) ________ A few years
(23e) ________ Not over it yet
(23f) ______ Not bothered by it at all

24. Have you ever used alcohol or other drugs to deal with the thoughts of your sexual abuse experience?
   (24a) yes ______ (24b) no ______

25. Have you ever thought about, planned, or attempted suicide because you were sexually abused?
   (25a) yes ______ (25b) no ______

26. Have you ever been fearful of your sexuality because of the sexual abuse?
   (26a) yes ______ (26b) no ______

27. Current sexual preference:
   (27a) ______ Heterosexual (male/female)
   (27b) ______ Homosexual (male/male)
   (27c) ______ Bisexual (both male/female & male/male)
   (27d) ______ Asexual (do not prefer sex with either partner)

   If you checked "asexual", please specify how long you felt this way (number of years) ____________

28. Please check as many of the following that you consider a problem currently or you have had as a problem in your past that you feel resulted from the sexual abuse.
   (28a) ______ Impotency (unable to have sex)
   (28b) ______ Premature ejaculation
   (28c) ______ Fear of having sex
   (28d) ______ Fear of homosexuality
   (28e) ______ Abuse of another person sexually
   (28f) ______ Other - please list below
   (28g) ______ None of the above

29. Would you like to receive further professional help for sexual abuse?
   (29a) yes ______ (29b) no ______

30. Please list the areas you feel you need help in currently. (you may check more than one)
   (30a) ______ Impotency
   (30b) ______ Abusing others
   (30c) ______ Premature ejaculation
   (30d) ______ Fears about sex
   (30e) ______ Fear of homosexuality
   (30f) ______ Other - please list below
   (30g) ____________________________________________
31. What type of help would you prefer to receive? (you may check more than one)
   (31a) ________ Reading material - explaining sexual abuse
   (31b) ________ Self help books on how to deal with sexual abuse
   (31c) ________ Individual therapy with a female therapist
   (31d) ________ Individual therapy with a male therapist
   (31e) ________ Group therapy with other abused males
   (31f) ________ Group therapy with both males and females who have been sexually abused

   IF YOU SAT THROUGH A LECTURE BEFORE YOU RECEIVED YOUR QUESTIONNAIRE, PLEASE ANSWER THE LAST THREE QUESTIONS. IF YOU DID NOT, STOP HERE.

   THANK YOU FOR YOUR HONEST ANSWERS!!!!!!!!!!!

32. Would you have answered this questionnaire differently if the presenter would have been a male?
   (32a) yes ________ (32b) no ________
   If you answered yes, please explain:
   ____________________________________________

33. Would you prefer to have this information presented by a male?
   (33a) yes ________ (33b) no ________

34. How helpful was the presentation in getting you to learn about, admit to being sexually abused, or answer questions about male sexual abuse? (please circle only one number)

   Not Helpful Somewhat Very
   At All Helpful Helpful

   1 2 3 4 5
   (34a) (34b) (34c) (34d) (34e)
THANKS FOR TAKING YOUR TIME TO ANSWER THESE QUESTIONS AND HELP WITH RESEARCH IN THE AREA OF MALE SEXUAL ABUSE
Appendix C
Informed Consent Handout
You have just listened to a lecture concerning the sexual abuse of males. I would now like to ask you to take part in a questionnaire survey on the same topic. To help you with the decision, let me give you a little more information about the research survey. The questionnaire will cover much of the same material you have just been presented. It will ask about the material and how it relates to you personally. Some of your answers may involve reporting unlawful acts (incest). Please understand that this information will not be reported to the police or be disclosed to anyone other than the experimenter, Linda Hand.

Since it is believed that many males suffer in silence from sexual abuse and people who have abused substances have been found to have been sexually abused, you are being asked to help me gain information in this area. It will provide necessary knowledge for potential treatment techniques for sexually abused males.

Few researchers have investigated this area and if we are to help males with the problem of sexual abuse, accurate information is needed on how often it happens, what problems it causes, and how, as males, you would like to receive help. Your answers in this area are very important. They could possibly help you
and/or others in your own family.

You will not be asked to write your name on the questionnaire. It will remain totally anonymous.

With all this in mind, I hope you decide to participate. Remember that you are under no obligation to complete the form. It is not a requirement of the substance abuse program you are currently in. You will not be penalized if you decide not to participate. Furthermore, if there are any questions you choose not to answer even if you do participate, feel free to do so. I do hope, however, that you choose to answer all questions as that would be of most benefit to the research. Please complete the questionnaire in total privacy and return it to the experimenter in the envelope provided within one hour after the presentation.

If you agree to participate, you will be one of approximately 100 participants in this questionnaire survey distributed in three lower Michigan substance abuse treatment centers. PLEASE REMEMBER, ANY INFORMATION PROVIDED BY YOU IN THE QUESTIONNAIRE INCLUDING THE OCCURRENCE OF UNLAWFUL ACTS WILL REMAIN CONFIDENTIAL AND WILL NOT BE SEEN BY ANYONE EXCEPT THE EXPERIMENT, LINDA HAND. YOUR PRESENCE IN A SUBSTANCE ABUSE TREATMENT CENTER WILL ALSO REMAIN CONFIDENTIAL.

Results of the research will be made available at
your treatment center office within 90 days and may be picked up at your convenience.

THANK YOU FOR YOUR COOPERATION AND TIME AND PARTICIPATION!!!
Appendix D

Data Recording Form
<table>
<thead>
<tr>
<th>Treatment Center</th>
<th>Group - Control / Experimental</th>
</tr>
</thead>
<tbody>
<tr>
<td>Question Number</td>
<td>Participant Number</td>
</tr>
<tr>
<td>1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30</td>
<td>Total</td>
</tr>
</tbody>
</table>

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.
Appendix E

Tabulated Data on Actual Findings to Questionnaire Questions of Clinical Significance
Tabulated Data on Actual Findings to Questionnaire
Questions of Clinical Significance

Clients reported being in treatment the following number of times:

<table>
<thead>
<tr>
<th>Number</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>1st time in treatment</td>
<td>28</td>
</tr>
<tr>
<td>2nd time in treatment</td>
<td>15</td>
</tr>
<tr>
<td>3 or more times in treatment</td>
<td>8</td>
</tr>
</tbody>
</table>

Persons reporting they used drugs to deal with the sexual abuse: 10 77%

The extent of emotional damage reported:

- none: 3 23%
- temporary: 3 23%
- some permanent: 2 15%
- permanent: 5 39%

Length of time taken to recover:

- few years: 3 23%
- not over it yet: 7 54%
- not bothered by it: 2 16%

Reported effects of the abuse: (respondents could check more than one)

- abused another person sexually: 6 46%
- thoughts of suicide: 1 8%
- fear of sexuality: 9 70%
- problems with impotency: 3 23%
- premature ejaculation: 4 31%
- fear of homosexuality: 5 39%

Reasons for not reporting: (respondents could check more than one)

- shame: 9 69%
- fear of being labeled homosexual: 6 46%
- fear that the pleasure meant I wanted it to happen: 5 39%
- fear of physical injury: 6 46%
fear I would be blamed  4  31%
fear others would think I did  not fight it  3  25%
fear I caused it  4  31%
enjoyed it (abused by female babysitter)  1  8%

Types of abuse:
(respondents could check more than one)

- genital fondling to victim  10  77%
- genital fondling to abuser  5  39%
- oral sex to victim  7  54%
- oral sex to abuser  7  54%
- vaginal intercourse  2  16%
- anal intercourse to victim  4  31%
- anal intercourse to abuser  3  23%

Cooperation was obtained by:

- force  7  54%
- threats  2  16%
- promised favors  5  39%
- unknown wrongness  6  46%
- enjoyed it (female babysitter)  1  8%

Reactions to the abuse:
(respondents could check more than one)

- fear  10  77%
- anger  7  54%
- shame  10  77%
- shock  4  31%
- curiosity  2  16%
- pleasure  5  39%
- physical pain  6  46%
- rage  2  16%
- betrayal  3  23%
- felt dirty  10  77%

Responses to the abuse reports were:

- anger  3  23%
- support  3  23%
- violence to abuser  1  8%
- shock  1  8%

Personal requests for help:
### Professional Help

<table>
<thead>
<tr>
<th>Help</th>
<th>Count</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Professional help</td>
<td>6</td>
<td>46%</td>
</tr>
<tr>
<td>Help with abusing others sexually</td>
<td>6</td>
<td>46%</td>
</tr>
<tr>
<td>Help with fears of sex</td>
<td>5</td>
<td>39%</td>
</tr>
<tr>
<td>Help with fears of homosexuality</td>
<td>5</td>
<td>39%</td>
</tr>
</tbody>
</table>

### Types of Help Requested:

<table>
<thead>
<tr>
<th>Type</th>
<th>Count</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reading material/self help books</td>
<td>9</td>
<td>69%</td>
</tr>
<tr>
<td>Individual therapy with female</td>
<td>5</td>
<td>39%</td>
</tr>
<tr>
<td>Individual therapy with male</td>
<td>0</td>
<td>---</td>
</tr>
<tr>
<td>Group therapy with males only</td>
<td>2</td>
<td>15%</td>
</tr>
<tr>
<td>Group therapy with males and females</td>
<td>1</td>
<td>8%</td>
</tr>
</tbody>
</table>

### Help Received from Oral Presentation:

<table>
<thead>
<tr>
<th>Type</th>
<th>Count</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not helpful at all</td>
<td>0</td>
<td>---</td>
</tr>
<tr>
<td>Helpful</td>
<td>2</td>
<td>17%</td>
</tr>
<tr>
<td>Somewhat helpful</td>
<td>2</td>
<td>17%</td>
</tr>
<tr>
<td>Very helpful</td>
<td>8</td>
<td>67%</td>
</tr>
</tbody>
</table>


Bucklin, D., (personal communication, May 1, 1987).


Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.


Holland, D., (personal communication, April 14, 1987).


Showers, J., Farber, E.D., Joseph, J.A., Oshins, L., &


