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Coping strategies as mediators of sexually risky behaviours of males who have experienced child sexual abuse

by

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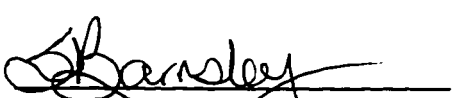

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The undersigned certify that they have read, and recommend to the Faculty of Graduate Studies and Research for acceptance, a thesis entitled Coping strategies as mediators of sexually risky behaviours of males who have experienced child sexual abuse submitted by Susan Barnsley in partial fulfillment of the requirements for the degree of Master of Science in Family Studies.

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ABSTRACT

The purpose of the present study was to test a model and to explore the relationship between child sexual abuse and sexually risky behaviours, with depression, suicidal ideation, alcohol and substance abuse acting as mediating variables. Subjects were 311 male students from the University of Alberta. Each student was asked to complete a packet which contained a 360 item student sexual behaviour survey. Results indicated that the model did not fit the data. However, two of the hypothesized direct relationships and one of the hypothesized indirect relationships were significant. The implications of the findings, particularly for future research, were discussed.

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CHAPTER I

INTRODUCTION

Child sexual abuse is illegal, prohibited by societal norms, and universally condemned by religious institutions (Roesler & Wind, 1994). It has been the subject of wide attention in the last fifteen years as researchers have sought to understand the dynamics involved (Browne & Finkelhor, 1986; Olson, 1990; Runtz & Schallow, 1997). Researchers have reported that during the past ten years prevalence rates in Canada and the United States suggest that 22-35% of females and 10-18% of males are likely to be sexually abused at least once before they reach their 18th birthday (Finkelhor, Hoatling, Lewis, & Smith, 1990; Geffner, 1992; Peters, Wyatt & Finkelhor, 1986; Russell, 1986). This recognition of the prevalence of child sexual abuse has led to the investigation of its aftermath, both immediate and long-term (Browne & Finkelhor, 1986; Classen, 1995).

In attempting to define what is considered sexual abuse, Banning (1989) stated that the language surrounding the definition of child sexual abuse is problematic. The definition of sexual abuse itself is fraught with difficulties depending on cultural values and beliefs (Banning, 1989). Researchers have struggled for many years seeking a manageable definition for childhood sexual abuse taking into consideration the range of possible sexual activities between children and adults (Banning, 1989; Boston, Morris & MacEachron, 1989; Browne & Finkelhor, 1986; Finkelhor, 1987). Although there is variability in the

definition of childhood sexual abuse, generally researchers agree that sexual abuse is any sexual contact, activity, or behaviour involving a child to which the child cannot give informed consent. Examples may include: fondling of the other's genitals by either the child or the adult, taking pornographic pictures of the child, exposing the adults genitals to the child, adult masturbation involving the child either as a witness or an active participant, oral sex performed on a child or by a child on an adult, or any form of penetration of the genitals or anus of the child with a penis, fingers, or any other object (Banning, 1989; Finkelhor, 1979; Fromuth & Burkhart, 1989; Genuis et al., 1991; Thomlison et al., 1991). Although the law in Canada suggests a two year age difference, current research suggests that there be at least a five-year age difference, thus avoiding cases of sexual experimentation between children (Banning, 1989; Boston et al., 1989; Finkelhor, 1979; Fromuth & Burkhart, 1989; Genuis, Thomlison & Bagley, 1991; Kondora, 1993; Thomlison, Stephens, Cunes, Grinnell & Krysik, 1991).

Researchers have reported that there is notable variability in the experiences reported by survivors of child sexual abuse which maybe the result of the broad social context within which sexual abuse occurs (Browne & Finkelhor, 1986; Edwards & Alexander, 1992; Finkelhor, 1990). This has lead researchers to examine other factors and life circumstances that could influence the presentation of symptoms and behavioural problems in adulthood (Browne & Finkelhor, 1986; Edward & Alexander, 1992; Wind & Silvern, 1994). Researchers have suggested that child sexual abuse causes major public health

problems that have many unhealthy personal and societal consequences (Browne & Finkelhor, 1986; Classen, 1995; Edward & Alexander, 1992; Wind & Silvern, 1994). These consequences may include the coping strategies that survivors[1] utilize to deal with the abusive experience. Examples of these coping strategies may include excessive alcohol use, substances use and risky sexual behaviour. Although coping mechanisms may provide essential boundaries, the problem is that many coping strategies survivors use have self-destructive aspects (Blume, 1990; Davis, 1991; Runtz & Schallow, 1997). Briere and Elliott (1994) found that survivors of child sexual abuse resort to a variety of methods to cope with the abusive experience, many activities used to cope with the pain, however, are problematic because they tend to be self-destructive or lead to further problems or both. Coping is defined as behavioural and/or cognitive strategies individuals use to manage the abusive experience (Drauker, 1995; Johnson & Kenkel, 1991; Lazarus & Folkman, 1984; Thoits, 1995; Zimrin, 1986). This institution of coping strategies is not only a reaction to stress, but also a major force that shapes the experiences of stress and its future results (Drauker, 1995; Johnson & Kenkel, 1991; Lazarus & Folkman, 1984; Thoits, 1995; Zimrin, 1986). Although researchers suggest that an appraisal of the effectiveness of

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Koss and Harvey (1991) reported that during the 1970s parties that were attacked without provocation were labelled "victims". They stressed that the intent of the term was to emphasize the criminal nature of the sexual abuse (Koss & Harvey, 1991). The word "victim" also carried negative connotations (Koss & Harvey, 1991). Bass and Davis (1988), Blume (1990) and Finney (1990) noted that during the 1980s the term of choice became "survivor". They said that by drawing the attention to the strength and resiliency of the men and women who had been sexually victimized, this term would focus on the active nature of the social and psychological struggle to recover (Bass & Davis, 1988; Blume, 1990; Finney, 1990).

coping strategies be made a person who has been sexually abused is not always able to make the connection between the abuse and the coping strategy until a much later time (Drauker, 1995; Johnson & Kenkel, 1991; Lazarus & Folkman, 1984; Thoits, 1995; Zimrin, 1986). This would leave a person unable to respond to and evaluate the effectiveness of their coping behaviour (Zimrin, 1986).

As the awareness of the sexual abuse of males has grown, so has the body of research studying various aspects of this problem and its after effects (Cermak & Molidor, 1996). Thus far, however, the research that has examined sexual abuse has focussed on female victims (Kempe & Kempe, 1984; Pierce & Pierce, 1985). That female victims with male perpetrators are consistently the clear majority is not disputed (Browne & Finkelhor, 1986, Olson, 1990). However, this has implication for male survivors of child sexual abuse because researchers and clinicians define the male experience from the perspective of the adult female rape victim (Boston et al., 1989; Lew 1988; Sepler, 1990). This results in researchers and clinicians focussing on issues of shame, guilt, powerlessness, and anger, all which are considered problems that female survivors deal with (Blume, 1990; Courtois, 1988; Gilgun, 1990; Olson, 1990). Boston et al. (1989) states that the concept of victimization is feminine in orientation. Therefore, because males are raised and socialized with an emphasis on mastery of self, environment and control of others, when they are confronted with situations beyond their control such as sexual abuse, it is

unlikely that they will respond by acknowledging to the powerlessness (Boston et al., 1989; Goldstein, 1987; Sepler, 1990). Males are unlikely to view themselves as victims in the feminine sense of the word. This has had repercussions for the research that has been conducted on male survivors. Gilgun (1990) reports that male sexual abuse victims are largely unknown, unidentified, under-reported and under-researched.

Therefore, in an effort to increase our understanding of the impact of child sexual abuse on the adult life of the male victim, the present study will focus on male students at the University of Alberta and explore their response to child sexual abuse. The purpose of this current study then, is to examine male survivors of child sexual abuse and their level of participation in sexually risky behaviours, and to examine the types of avoidant coping strategies, which are defined as suicide ideation, depression, alcohol and substance use, that they may utilize. Therefore, the question that will be addressed in this study is: Will male survivors of child sexual abuse participate in more sexually risky behaviours and exhibit more avoidant coping than males who have not experienced the same trauma?

Little research to date has examined the coping strategies and the sexually risky behaviours of male survivors to determine their impact (Gilgun, 1990). Thus, researchers, professionals and clinicians are unable to fully appreciate the impact of child sexual abuse on the adult lives of male survivors. It is with this understanding that Sepler (1990) recommended the development of

conceptual frameworks and models for the male survivor.

Therefore, based on this recommendation and in an attempt to develop a conceptual framework for the male survivor, this study will utilize coping theory. A presentation of the hypotheses and coping theory from which they are drawn will be presented a long with a review of the literature. However, it is necessary to establish the need for a framework that is suited to male survivors needs, therefore, the conceptual framework will be presented next.

CHAPTER II

CONCEPTUAL FRAMEWORK

Finkelhor (1984) stated that theories about child sexual abuse have been slow to appear. Nonetheless, Finkelhor (1984) recognized that the theories that have been proposed offered theoretical perspectives that might be applied to the problem of sexual abuse thereby explaining why individuals abuse immature children. Araji and Finkelhor (1986) report that many theories (i.e., family systems theory, feminist theory, and attachment theory) have helped researchers and clinicians understand some aspects of sexual abuse. They continue by reporting that these theories only identify one or at most a couple of factors that explain sexual abuse.

Family systems theory became a popular theory when society discovered that sexual abuse happened in all types of families. Family systems researchers suggested that this theory could be used to understand the family process. This would be accomplished by examining communication styles and conflict patterns that arise within the family structure. Asen, George, Piper and Stevens (1989) stated that the family process is understood to be the product of the system. The theory focuses on the relationships among the family members and less on the individual family member. Family systems theory views sexual abuse as a symptom and ignores the effect on the individual within the family structure and the societal impact. As Dinsmore (1991) reports family systems researchers believed that sexual abuse was a result of the "family system" gone

wrong. Coker (1991) in an attempt to reconceptualize family systems theory, suggested that this theory be structured with psycho-social development concepts to provide a framework by which the evolution of the abusive family could be described.

Dinsmore (1991) stated that the most noticeable aspect of this theory was the emergence of terms such as "comlicitius mother"; "distant and detached wife"; "the absent, disabled mother"; "the frustrated father". This theory appears to ignore power dynamics and the ramifications of this on the individual (Finkelhor, 1984). Family system theory implies that mothers were somehow to blame when fathers committed sexual abuse, and that fathers were "victims" who were attempting to meet their needs inappropriately (Coker, 1990; Courtois, 1988; Dinsmore, 1991). The family systems theory perspective holds the notion that each member of the family owns a piece of the problem, therefore, the sexually abused child as a member of the "family system" also deserved some of the blame (Dinsmore, 1991).

Though, family systems theory has been one of the most accepted theoretical developments in the field of mental health in generations (Courtois, 1988; Dinsmore, 1991; Finkelhor, 1984), there are serious problems with this theory. First, it appears to be victim blaming. Second, is the fact that mothers often take the blame for their partners' behaviour. In many cases the mother does not know that the abuse is occurring (Sirles & Franke, 1989). The family systems perspective also introduced two unhealthy biases into the field. First, it

has created strong theoretical interest in one form of sexual abuse, father-daughter incest, to the exclusion of all other forms (Courtois, 1988; Dinsmore, 1991; Herman, 1981). Other forms of sexual abuse, by older brothers, uncles, grandparents, not to mention abuse by non-family members such as neighbours, teachers, and friends, all of which are also common are not so easily explained using this theory. Spencer and Dunklee (1986) report that for males the majority of perpetrators were neighbours or acquaintances of the family. Kendall-Tackett and Simon (1992) and Russell (1984) also reported that there were significant differences between males and females with regard to the perpetrator. Males were frequently abused by friends of the family or extended family members (i.e. uncles, grandfathers). Second, family systems theory has discouraged interest in studies of offenders (Courtois, 1988; Dinsmore, 1991; Finkelhor, 1984). Family systems theory also, fails to account for the deviant behaviour of many survivors of child sexual abuse.

Courtois (1988) suggested that feminist theory offered insight into the issues regarding psychological development. Finkelhor (1984) stated that it was the result of feminist premise that sexual assault was endemic to our culture that prompted attention to sexual abuse in the first place. Feminism has proposed a variety of theoretical speculations about sexual abuse (Courtois, 1988; Dinsmore, 1991; Finkelhor, 1984).

The feminist view on the causes of sexual abuse are centred around male norms in our culture (Courtois, 1988). Feminism believes that sexual abuse

occurs as a result of the exaggerated extension of these norms (Courtois, 1988; Dinsmore, 1991). However, they do point out that not all men sexually abuse children. Feminism acknowledges that these norms account for socialization of males as aggressive, dominant, victorious, sexual and powerful and to see sexual involvement as an entitlement (Bolton et al., 1989; Courtois, 1988; Dinsmore, 1991; Finkelhor, 1984). Although feminism has tried to raise the conscious awareness of society, males are still taught to value achievement, and independence, and to exaggerate their sexual conquests (Bolton et al., 1989; Courtois, 1988; Dinsmore, 1991; Sepler, 1990). Herman (1981) has suggested that it is the result of the different socialization patterns that contribute to the problem of sexual abuse. Finkelhor (1984) has stated that as new insights develop concerning sexual socialization, they should be tested quickly to understand their application to sexual abuse.

Feminists challenge a main tenet of the psychoanalytic tradition, the oedipal theory, as a misconstruction. They argued that Freud's original theory (the seduction theory) was accurate and that its replacement was nothing short of a coverup which denied the reality of the abuse while excusing the perpetrators (Courtois, 1988; Dinsmore, 1991; Herman, 1981; Kahr, 1991).

Family systems theory and feminist theories tell us something about how and even why abuse occurs, regardless, as family systems theory fails to account for extrafamiliar abuse, feminism fails to account for abuse by women or the sexual abuse of males. While both family systems theory and feminist theory

are inadequate to explain the range of existing sexual abuse, each has made a huge contribution to the study of child sexual abuse. Family systems theory has taught us to consider the social context and feminist theory has shown us the critical issue of power inequities. Still, it is the issue of how the individuals cope with the trauma of the abusive experience that will be examined. It is recognized that the theories that have been utilized previously have attempted to deal with some components of sexual abuse, yet, little research has focussed exclusively on the male survivor and little attempt has been made to formulate and construct a theoretical model based on the male experience. In an attempt to rectify this situation, it will be necessary to alter existing models and develop a new framework for male survivors.

Therefore, in utilizing the stress and coping framework, it is hoped that some of the issues that male survivors experience will be addressed. Coping research in the field of family research has depended upon and drawn heavily cognitive psychological theories and sociological theories (McCubbin, Joy, Cauble, Comeau, Patterson & Needle, 1980). Holahan and Moos (1987) stated that the relationship between certain coping strategies and individual outcome have been clearly established, however, they report that little is known about the effects of maladaptive coping strategies. Himelein and McElrath (1996) concurred with this finding stating that little was known about the impact of maladaptive coping strategies and their impact on the different coping resources used by survivors of child sexual abuse.

Sexual abuse challenges individuals with affects and meanings that are complicated and overwhelming. These affects and meanings can present a significant coping challenge which can be disruptive and disturbing (Roth & Newman, 1993). Coping is defined as a pattern of responses either behavioural and/or cognitive that serve to control or reduce emotional distress in the face of some externally imposed life struggle (Drauker, 1995; Folkman & Lazarus, 1980; Johnson & Kenkel, 1991; Lazarus & Folkman, 1984; Thoits, 1995; Zimrin, 1986). Billings and Moos (1981) conceptualized coping strategies as being active or avoidant in nature. Active coping is defined as strategies aimed at having a direct influence on a stressful event, either behaviourally or cognitively (Kotchick, Forehand, Armistead, Klein & Wierson, 1996). Avoidant coping strategies are defined as behaviours and cognitions intended to draw attention away from the stressful event (Billings & Moos, 1987; Burt & Katz, 1987; Roth & Newman, 1993). Avoidant coping strategies may have adverse effects on the well-being of the individual, but can be adaptive in some situations, Suls and Fletcher (1985) report that avoidant coping can be helpful initially, but it becomes less effective over time. Avoidant coping has traditionally been associated with poorer individual adjustment in both children and adults (Holahan & Moos, 1991; Davis, 1991). Consistent with this argument, Drauker (1992) and Johnson and Kenkel (1991) found that female survivors of child sexual abuse who used avoidant coping strategies had poorer psychological adjustment. Roth and Newman (1993) report that avoidant coping strategies

minimize the emotional impact of an event, protecting the individual from becoming emotionally overwhelmed. For survivors of child sexual abuse, avoidant coping strategies facilitate a sense of control (Roth & Newman, 1993).

Male victims of childhood sexual abuse display a broad array of behaviours. These include social isolation, chronic depression, poor self-esteem, vague somatic complaints, substance abuse, self-injurious behaviour, and underlying resentment. Kondora (1993) stated that as child victims of child sexual abuse become adult survivors they create survival strategies that enable them to function as adults. However, the survival coping strategies have become dysfunctional (Blume, 1990; Davis, 1991). Therefore, when investigating how male survivors have coped and are coping with child sexual abuse, the strategies that male survivors have instituted to deal with their experience need to be examined. Blume (1990) reported that individuals need coping mechanisms to provide essential boundaries. The problem is that many coping strategies that survivors use have self-destructive aspects (Davis, 1990, 1991). They become entrenched patterns that the survivor turns to whenever he feels discomfort. The survivor may become addicted to gambling, drugs or alcohol, run away when anyone gets too close, or consistently ignore important problems that need to be dealt with (Blume, 1990; Davis, 1991). In this respect, survivors have developed coping strategies that allow them to survive the abusive experience (Blume, 1990; Davis, 1991).

Hypotheses

Therefore, based on the discussed theory and research the following hypotheses will be tested in the present study:

1) Child sexual abuse is positively related to depression and suicidal ideation.

2) Child sexual abuse is indirectly related to sexually risky behaviours through depression and suicidal ideation.

3) Child sexual abuse is positively related to sexually risky behaviours.

4) Child sexual abuse is positively related to alcohol use and substance abuse.

5) Child sexual abuse is indirectly related to sexually risky behaviours through alcohol and substance abuse.

6) There will be a relationship between depression, suicidal ideation and sexually risky behaviours.

7) There will be a relationship between alcohol use and substance abuse and sexually risky behaviours.

CHAPTER III

LITERATURE REVIEW

For the purpose of this research the following limitations have been placed upon the literature review. This study is not examining the perpetrators, type of abuse, length of abuse, whether force was used, disclosure of abuse, impact of therapy or the healing process. Therefore, when attempting to understand the development of coping strategies within the male survivor, the following review, will explore societal awareness of male sexual abuse, in the context of history to the present time period. This will be followed by an investigation of the prevalence rates for male survivors of child sexual abuse. The impact on the psychological well being of the survivor will be examined next, followed by behavioural symptoms and problems. This study will address the coping strategies that the survivor institutes to cope with the after effects of the sexual abuse. It is not possible to examine all the coping strategies that male survivors use to deal with the after effects of childhood sexual abuse, therefore, only a few will be explored in detail. To accomplish this it will be necessary to examine fantasy, depression, dissociation, multiple personalities as well as use of alcohol and drugs.

Historical Context

Briener (1990) stated that the prevalence of child abuse in the modern world is shocking. There are many that believe that child abuse is the product of our violent society and blame work, unemployment or television for causing child

abuse (Dinsmore, 1991). However, Briener (1990) and de Young (1982) report that child abuse has been prevalent in the majority of "civilized" nations for centuries. Kahr (1991) states that there are instances in history when adults were unable to cope with their erotic attraction to children. Kahr (1991) recounts that there is substantial documentation in poetry, and even in pottery, that Greek men of all ages would seduce and sodomize young boys on a regular basis. Kahr (1991) continues by stating that this activity proved so popular that it soon became widespread, ritualized, and socially acceptable; indeed, in certain classes, and at certain times, the practice became expected (Breiner, 1990; Kahr, 1991). Many parents sold their children into concubinage (DeMause, 1974a). Kahr (1991) continues to say that there is ample evidence to document the existence of incestuous behaviour and other forms of child sexual abuse throughout the last 3000 years, however, although the evidence is readily available, it has received scant attention.

The behaviour of the male Greeks toward their children is replete with atrocious brutality, most pre-pubescent boys became prey to the inappropriate lust of older men, a cycle which the boys upheld when they themselves grew older (Breiner, 1990; Kahr, 1991). Because the Romans sought much of their inspiration from Greek culture, there is ample evidence that they also imported many of the Greek sexual preferences (Breiner, 1990; Kahr, 1991). Table 3.1 shows the sexual activity and treatment of children in three ancient cultures.

Ancient Treatment of Children
Table 3.1

CULTURE	TREATMENT OF CHILDREN	SEXUAL ACTIVITY
GREEKS	- sexual abuse - physical abuse - infanticide - emotional abuse - performed castrations - left newborns to die if not wanted	- sexual freedom - isolated and sexually restricted women - men had extensive sexual freedom to abuse children - practice homosexuality - boy prostitutes
ROMANS	- sexual abuse - physical abuse - infanticide - emotional abuse - performed castrations - abandonment common - no legal protection	- extensive sexual activity allowed - pornography - sadism - debauchery
HEBREWS	- infrequent and episodic infanticide - educated both male and female children - care of the mother and the child central to culture	- sexual freedom prior to marriage for males - sexual activity was encouraged

Dinsmore (1991) and DeMausse (1991) report that the earlier in history one searches, the more evidence there is of universal sexual abuse. Table 3.2 presents a focus of the trends that have been detected thus far in the historical epidemiology of sexual abuse, covering a 300 year span. The table identifies four major periods in the history of the sexual abuse of children in the west. Table 3.2 is a general illustration of the more observable evolution that have occurred in the past 3000 years (Kahr, 1991).

Trends in Child Sexual Abuse[2]
Table 3.2

PERIOD	BEHAVIOUR
Ancient Period (comprising the time of the Greeks and the Romans)	both the Romans and the Greeks used children to relieve their sexual needs. The adults seduced and violated their children in an unashamed and socially acceptable manner
Medieval Period (rise of Christianity through to the Renaissance)	parents could no longer abuse their children with impunity. For the first time guilt became a predominant feature of psychic life and adults projected their sexual impulses onto the children
Early Modern (18th, 19th and early 20th Century)	sense of guilt and shame increased to such a degree that incest could no longer be regarded as an acceptable aspect of culture and instead it exploded on the pornographic scene and in the underworld unacknowledged in public, and hidden from "polite" society
The Late Modern (latter half of the 20th Century)	child sexual abuse has at last become the subject of widespread clinical and government concern and at time when both the abused children and the abusive adults are regarded as victims of a very pernicious cycle of cruelty and deprivation. Treatment and prevention have become more readily available.

In 1860, Tardieu, the dean of forensic medicine in France, published a treatise which detailed the epidemic proportions of the child sexual abuse problem. However, his ideas were scorned and people continued to label children as liars who were attempting to defame "innocent" adults (de Young, 1982; Summit, 1988). Freud attempted to show the occurrence of sexual abuse. Based upon the accounts of several of his female patients, Freud concluded that child sexual abuse was not only a real problem, but that the experiences had traumatic consequences for them as individuals, as well as years later as adults. However, it was due to the unwillingness of his colleagues to believe his

[2] Breiner (1990), Kahr (1991).

findings on sexual abuse, and together with the pressure exerted upon him by his peers, that he recanted his explanation and replaced it with his drive and Oedipal theories (Bagley & King, 1990; Courtois, 1988; Dinsmore, 1991; Herman, 1992; Kahr, 1991; Summit, 1988). Miller (1990) states that Freud did damage by recanting his findings. Researchers have posited many explanations for Freud's recanting (Bagley & King, 1990; Courtois, 1988; Dinsmore, 1991; Herman, 1992; Kahr, 1991; Masson, 1984; Miller, 1990; Summit, 1988). Masson (1984) argues that Freud's motivation to rescind was complex and included; "a fear of standing up for the least advantaged in society; ...a fear of the wrath of the more powerful men of the middle class elite whom Freud's patients were accusing of sexual abuse, and a desire to remain in the good graces of these men so that he could continue to practice his profession" (p.31).

Regardless, it took until the mid 1970s for acknowledgement of child sexual abuse to be realised. Nonetheless, it was not within the professional field that acknowledgement took place (Finkelhor, 1979). Books such as Armstrong's *Kiss Daddy's Girl*, Butler's *Conspiracy of Silence,* and Allen's *Daddy's Girl*, made people aware that something was drastically wrong. Around this time, the women's movement and the children's protection movements were forcing society to admit that the sexual victimization of children was a reality, and this reality had far reaching implications for the individuals involved (Dinsmore, 1991; Finkelhor, 1984).

Prevalence and Incidence

Although statistics on the incidence of child sexual abuse in the United States date back to 1929, it was not until the late 1970s and early 1980s that careful studies began to report with samples large enough to warrant careful statistical analysis (DeMausse, 1991). Estimates of the prevalence of childhood sexual abuse vary. Since the late 1970's the incidence of child sexual abuse among females has been estimated to range from 20% to 38% of the general population (Bagley & Ramsay, 1985; Faller, 1989; Herman, 1981; Hunter, 1991; McNulty & Wardle, 1994; Olson, 1990; Russell, 1983; Thomlison, Stephens, Cunes, Grinnell & Krysik, 1991; Wyatt & Powell, 1988). The most common findings suggest a range from 21-25% (Bagley & Ramsay, 1985; Faller, 1989; Hunter, 1991; Malmo & Laidlaw, 1993; Russell, 1983). The incidence of child sexual abuse among males has been estimated to range from 3% to 25% of the general population (Briere, Evans, Runtz & Wall, 1988; Genuis et al., 1991; Hunter, 1991; Malmo & Laidlaw, 1993; Olson, 1990). However, comprehensive surveys indicate that 10% of the adult male population report having been sexually abused as children (Briere et al., 1988; Genuis et al., 1991; Hunter, 1991; Olson, 1990).

The discrepancies in the statistics for the male population of survivors may be attributed to the method used in compiling them (DeMausse, 1991), or the lack of a common definition (Briere et al., 1988; Genuis et al., 1991). Collings (1995) reports that many nonclinical studies appear to have serious

design and measurement flaws. Cermak and Molidor (1996) suggest that the cause of discrepancies in the statistics may be the result of under-reporting by males survivors and by the professional community. Nevertheless, researchers maintain that the statistics for the male population are difficult to obtain, because the study of male sexual abuse is still in an exploratory stage (DeMausse, 1991; Finkelhor, 1984; Genuis et al., 1991). There is also evidence that males are far more reluctant to disclose and report the incidence of sexual abuse (Boston et al., 1989; Finkelhor, 1984). DeMausse (1991) reports that sexual abuse occurs earlier for males than for females and is therefore maybe more difficult for males to recall.

Psychological after effects

The relationship between early sexual abuse and later psychological problems is just now becoming clear. Recent evidence shows that among adult survivors of childhood sexual abuse, psychiatric morbidity appears to be significantly higher than among non-victimized populations (McNulty & Wardle, 1994). Researchers have indicated that the effects of childhood sexual abuse can still be seen through a number of maladaptive behaviours and symptomatology in adulthood (Lamb & Edgar-Smith, 1994).

The more common long-term psychological after effects of child sexual abuse appear to include; dissociative experiences (Blume, 1990; Briere & Runtz, 1988; Browne & Finkelhor, 1986; Courtois, 1988; Davis, 1990; Olson, 1990), suicidal tendencies (Banning, 1989; Blume, 1990; Faller, 1989; Herman, 1981;

Urquiza & Capra, 1990), multiple personalities (Blume, 1990; Coon, 1986; Coon & Sterne, 1986; Courtois, 1988; Davis, 1991; Putnam, 1989, Summit, 1988), low self-esteem (Blume, 1990; Davis 1990; Roth & Newman, 1992; Summit, 1983), feelings of anger (Bass & Davis, 1988; Blume, 1990; Davis, 1991; Faller, 1989), fantasy (Blume 1990; Courtois, 1988; Lew, 1988; Rauschenberger & Lynn, 1995), sexual dysfunction (Bass & Davis, 1988; Blume, 1990; Boston et al., 1989; David, 1990, Faller, 1989; Finkelhor, 1984; Fromuth, 1983; Kenzl, Traweger & Biebl, 1995), sexual identity problems (Lew, 1988; Olson, 1990), and anxiety (Blume, 1990; Browne & Finkelhor, 1986; Herman, 1981).

Although male survivors exhibit many of these psychological after effects, few studies have addressed these phenomenon in the male population (Boston et al., 1989; Cermak & Molidor, 1996; Collings, 1995). Therefore, little is known about what types of emotional reactions sexually abused males experience (Collings, 1995; Olson, 1990; Urquiza & Capra, 1990). However, these "symptoms" may reveal the many issues with which male survivors cope with (Boston, et al., 1989; Lew, 1988; Olson, 1990). In addition, these "symptoms" can portray the poor quality of adult life which can ensue after childhood sexual abuse. If left untreated during childhood or adolescent years, the after effects of child sexual abuse not only persist but can intensify during adult life (Boston et al., 1989; Lew, 1988; Olson, 1990).

Behavioural after effects

The chronic behavioural problems which have been linked to child sexual

abuse are alcohol and substance abuse (Blume, 1990; Briere, 1984; Courtois, 1988; Freeman-Longo, 1986; Lew, 1988; Maltz & Holman, 1987; Olson, 1990; Peters, 1988; Rohsenow, Corbett & Devine, 1988), self-destructive behaviours (Bass & Davis, 1988; Blume, 1990; Courtois, 1988; Herman, 1981; Olson, 1990; Rohsenow et al., 1988), anti-social behaviour (Friedrich, Beilke & Urquiza, 1988; Genuis et al., 1991; Olson, 1990; Zimrin, 1986) and increased aggression (Boston et al., 1989; Browne & Finkelhor, 1986; Friedrich et al., 1988).

There are several studies showing that males tend to respond to stressful and difficult situations in a behavioural or externalizing manner (Olson, 1990; Urquiza & Capra, 1990). Therefore, these "behaviours" may demonstrate the survivor's underlying need to "act-out" his abusive history rather than refocusing his attention, anger, and rage at the appropriate source (e.g. the perpetrator). If these "behaviours" are left untreated they may have devastating consequences for the male survivor in adulthood (Blume, 1990; Boston et al., 1989; Cermak & Molidor, 1996; Dimock, 1988; Lew, 1988; Olson, 1990).

To summarize the research conducted to date, studies of adults males who have been sexually abused as children are more likely than non-victimized males to display symptoms such as aggressive behaviour, anger, sexual dysfunction, anxiety, self-destructive behaviour and alcohol and drug abuse (Blume, 1990; Boston et al., 1989; Browne & Finkelhor, 1986; Courtois, 1988; Davis, 1990; Herman, 1981; Lew, 19888; Kinzl et al., 1995; Murphy, Kilpatrick, Amich, McMullan, Veronen, Paduhovich, Best, Villenponteaux & Saunders,

1988; Olson, 1990; Rohsenow et al., 1988).

Wishful thinking: Fantasy

Fantasy, daydreams, and imagination are fundamental to healthy psychological functioning. Indeed, it is widely believed that fantasy and imagination play a vital, adaptation-enhancing role in daily life (Rauschenberger & Lynn, 1995). Klinger (1990) postulates that fantasy and daydreaming reflect current concerns, help to regulate mood, provide self-relevant information and help to stimulate decision making. Nevertheless, fantasy and daydreaming have also been associated with psychological dysfunction and maladjustment (Rauschenberger & Lynn, 1995). Freud claimed, "happy people never make phantasies, only unsatisfied ones. Unsatisfied wishes are the driving power behind phantasies; every separate phantasy contains the fulfilment of a wish and improves an unsatisfactory reality" (Freud, 1962, p. 30). Rhue and Lynn (1987a) reported that fantasizing can become a means of coping with an intolerable environment. Blume (1990) has suggested that creating fantasy identities, friends, worlds, or alter egos are a means of escaping from an unsafe place. In addition to recreating their environments, child victims of childhood sexual abuse often recreate themselves, developing alter egos who offer a positive life alternative to their own (Blume, 1990). For many other children, running away from the abuse is not an option. They may be too young, too scared, physically incapable, or otherwise unable to leave home. These children figure out creative ways to distance themselves from the abuse while it

is occurring and after it has ended. Physically unable to get away from the abuse, they remove themselves psychologically (Blume, 1990; Courtois, 1988; Lew, 1988; Summit, 1983). As a child, the survivor learns to cope silently with terrors in the night. Bed covers take on magical powers against monsters, but they are no match for human intruders (Summit, 1983).

In sum, fantasizing is a coping strategy that is common to male survivors. It has been developed as a means of escape from a vicious reality. Many survivors talk of disappearing into the wall, or becoming part of the wallpaper (Martens, 1988; Summit, 1988; Wyatt & Powell, 1988). Rauschenberger and Lynn (1995) have suggested that when fantasy activities involve distortions of reality, or draw attention from present situations to serve as an avoidance manoeuvre, they become a liability rather than an asset.

Distancing/Detachment: Depression

According to Blume (1990) depression is a reaction to loss, real or imagined. It is a state of sadness and apathy, a condition where nothing matters. The survivor feels discouraged, disgusted, and despairing. It is an attitude in which one has lost all hope (Davis, 1990). A component of the depressive condition is designed to ward off unwanted feelings or memories (Blume, 1990; Boston et al., 1989; Lew, 1988). Martens (1988) states that feelings are a direct experience of oneself and the acknowledgement of feelings is a very painful process for the survivor. Depression is a double edged sword for the survivor. In one respect, it allow the survivor to cope because the numbness that is created

by depression controls the pain of the trauma to some extent. However, depression also affects the memories of the abuse and controls the thought process by numbing the survivor to the trauma that happened to him (Davis, 1991). Deep depression is a survival alternative, for the numb state it creates is like being "a little bit dead" (Blume, 1990, p 89).

In summary, male survivors have unconsciously used depression as a method of coping, as it tends to block out any sense of feeling. Feelings are a direct experience of oneself, the acknowledgement of feelings is a very painful process for the survivor (Martens, 1988). By the time the male survivor becomes an adult, this method of coping with feelings is fully operational and, sadly, usually quite dysfunctional (Blume, 1990; Boston et al., 1989; Courtois, 1988).

Dissociative Disorder and Multiple Personalities

Research has shown that many sexual abuse survivors suffer from dissociative disorders (Blume, 1990; Courtois, 1988; Davis, 1990). Dissociation is defined as a "psycho-physiological process whereby information-incoming, stored, or outgoing - is actively deflected from integration with its usual or expected associations" (West, 1967, p. 10). According to DSM-111-R, dissociative disorder is listed as a disturbance or alteration in the normally integrative functions of identity, memory or consciousness. Putnam (1989) defined dissociative disorders as "states of experience or behaviours wherein dissociation produces a discernable alteration in a person's thoughts, feelings, or actions, so that for a period of time certain information is not associated or

integrated with other information as it normally or logically would be" (p. 3-4). Courtois (1988) has described dissociative reactions as complex psychological mechanisms. Certain faculties, functions, feelings and memories are split off from the immediate awareness or consciousness and compartmentalized in the mind. Putnam (1989) also suggested that most dissociative disorders are traumatically induced. So in summary dissociative disorders appear to function in a way that keeps the individual from integrating painful and traumatic events (Courtois, 1988; Davis, 1991; Putnam, 1989).

Courtois (1988) reports that dissociating serves many purposes for the survivor of child sexual abuse. It provides a way out of an intolerable and psychologically contradictory situation. Dissociative disorders help to erect memory barriers to keep painful events and memories out of awareness and it even functions as a type of analgesic to prevent feeling pain (Blume, 1990; Courtois, 1988; Davis, 1991). Courtois (1988) reports that in the beginning the child may have used the dissociative mechanism spontaneously and sporadically, however, with repeated victimizations, the use of the dissociative mechanism had become chronic. She reports that as the child grows it becomes an autonomous process. Over time, however, Courtois (1988) reports that this "survival skill" may change from being functional to dysfunctional and get in the way of recovery.

Multiple Personalities (MP) is a more chronic form of dissociative disorders. Of all the coping strategies that survivors resort to for protection, MP

is the most inventive. According to DSM-111 MP is defined in the following manner:

1. Within the individual there must be the existence of 2 or more distinct personalities, each of which are dominant at a particular time.

2. The personality that is dominant at any particular time will determine how the individual behaves.

3. Each individual personality is complex and integrated with its own unique patterns and social behaviours (Summit, 1988).

Coon (1986) reports that the estimates of MP in males is difficult to determine. Males who exhibit MP usually escape detection because their "form" of MP differs from what is considered the "classic" presentation (Putnam, 1988). Putnam (1989) has suggested that the "classic" form is derived from the female experience. Bliss (1983) reported that male MP cases are missed because they are not seen in the mental health system and are more likely to be found in the criminal justice system. In a study conducted by Bliss and Larson (1985), it was found that there was a high rate of MP and dissociative disorders among convicted sexual offenders. Bliss and Larson (1985) report that male MP patients tend to high levels of sociopath and alcohol use.

The onset of MP occurs in childhood, although the condition may not be diagnosed until adolescence or early adulthood. Survivors with MP can divide or separate into fully functioning individuals with many talents (Blume, 1990; Coon, 1986; Courtois, 1988; Davis, 1991; Summit, 1988). The different

personalities have varying degrees of distinctness, they can be male or female, children or adults, they may have different sexual orientations, they also have unique skills and abilities, as well as different parentage. The personalities may even assign themselves proper names. Each of the personalities are fully functional and internally consistent and have played a role in protecting the survivor (Blume, 1990; Courtois, 1988; Davis, 1991; Putnam, 1989; Summit, 1988). The personalities are created by the individual to embody aspects of the child that they cannot face themselves. Each contain a part of the self, a certain set of memories (Davis, 1991).

Common alter personalities include fearful, dependent, child-like personalities, a reckless, promiscuous personality who acts out of forbidden aggressive sexual impulses, the claiming rational soothing protector (Courtois, 1988). Courtois (1988) reports that at least one personality, usually that of a child, contains the memory of the abuse. She continues by saying that the other personalities may be avengers or persecutors and may serve to deliberately humiliate other personalities.

Tension-reduction: Alcohol and substance abuse

A history of child sexual abuse is usually not investigated in alcoholics and substance abusers (Rohsenow et al., 1988). Although it has been reported previously that child sexual abuse has a strong and lasting impact on adults psychological and behavioural functioning, it is reasonable to expect that many survivors may turn to alcohol and/or drugs in an attempt to cope with these

effects (Blume, 1990; Briere, 1984; Browne & Finkelhor, 1986; Finkelhor, 1984; Olson, 1990; Rohsenow et al., 1988). Olson (1990) reports that the majority of the literature indicates that male survivors struggle with addictions. It is unusual to encounter a survivor of abuse who is not addictively or compulsively engaged in some form of numbing behaviour. Although, everyone, at times, has a need to numb to escape the pressures of life by diminishing the intensity of their feelings--the addict feels that ordinary life is so painful that, in order to survive, he must diminish or redirect all intense emotions (Lew, 1988). Therefore, chemical use and addiction serve as a coping strategy in an attempt to avoid pain (Blume, 1990; Boston et al., 1989; Lew, 1988). Conscious awareness is numbed as the survivor seeks to transport himself far from the horrible feeling of being out of control (Maltz & Holman, 1987). As the addiction numbs the pain it also creates a sense of aliveness or excitement for one who may feel "dead" inside (Blume, 1990).

Briere (1984) found that more male survivors of childhood sexual abuse, abused drugs or alcohol than the no abuse males. In a study conducted by Rohsenow et al. (1988) on adults males who had been admitted to a chemical dependency rehabilitation program, it was found that 42% admitted to having been sexually abused before the age of 16 by someone at least 5 years older. Although these researchers have investigated the relationship between sexual abuse, alcohol and drug addictions, they report that typically this is not investigated. Many of these researchers report that little data on male survivors

appears to be available with regard to alcohol and drug abuse (Olson, 1990; Rohsenow et al., 1988).

In summary, there appears to be a relationship between males who have experienced child sexual abuse and their over use of alcohol and drugs. However, the literature is not clear as to whether the child sexual abuse causes this over use or whether some other factor in conjunction with child sexual abuse is the reason for the problems. Nevertheless, this use of alcohol and drugs appears to be a means of dealing with the trauma that they have experienced. However, researchers who study alcoholism and chemical dependency have been slow to recognize that there may be a relationship between these addictions and child sexual abuse (Briere, 1984; Olson, 1990; Rohsenow et al., 1988).

In sum, the literature suggests that coping strategies are prevalent in the life of most male survivors. These strategies where instituted to protect the survivor from an intolerable and psychologically contradictory situation (Courtois, 1988). The problem is that many of these coping strategies have self-destructive aspects (Davis, 1990, 1991). They become entrenched patterns that the survivor turns to whenever he feels discomfort. Thus, based on coping theory it is expected that 1) males who have experienced child sexual abuse prior to the age of 16 will exhibit greater sexually risky behaviours, which are defined as promiscuous sexual behaviour, than males who had not experienced the same trauma, and 2) male students who have experienced child sexual

abuse will exhibit more avoidant coping strategies, which are defined for this study as depression, suicidal ideation, alcohol use and substance abuse. In an effort to address these issues the present study will a) use a nonclinical sample of adult males who have reported an abusive childhood sexual experience, b) compare this nonclinical sample of adult males students from the University of Alberta to a nonabused sample of male students from the same University.

CHAPTER IV

METHOD

Sample

The subjects of this current study were male and female students registered at the University of Alberta during the 1995 and the 1997 school year. The University of Alberta Student Sexual Behaviour Survey was administered to students in various faculties (see table 4.2) throughout the University between August 1995 and January 1997. The subjects where recruited by contacting the professors/instructors in various departments at the University of Alberta and obtaining permission to administer the survey. Several of the professors refused permission for their students to participate, citing the time requirement to complete the survey as the main factor (x=50minutes). The sample consisted of 1078 students (311 males, 767 females) enrolled full-time at the University of Alberta. Potential subjects were informed that the study examined student sexual behaviour. However, they were not told before they volunteered that the study consisted of specific questions on sexual abuse. Subjects completed the survey either in class time or in their own time. Obviously, this researcher makes no claim that this is a representative sample of the student population at the University of Alberta.

Procedure

Initially, the survey was administered during set class time, allowing for

the completion and return of the survey. No credit for completion or participation in survey was given. Some professors/instructors allowed the researchers to ask for participation within the class and then distributed the survey prior to class time and collect it at a specified time thereafter. This cut down the completion rate of the survey. The study protocol required that all the students be informed of the anonymous nature of the survey and that participation was completely voluntary. Two researchers would visit various classrooms and give a brief introductory speech informing the subjects of the nature of the study. Specifically, the subjects were informed that the study explored student sexual behaviour, looking at behaviour orientation, perceptions and attitudes. The subjects were notified that the survey had gone through the ethics review committee at the university. The subjects were given an envelope which included a survey, a score sheet and a pencil. Because of the anonymous nature of the survey, the subjects were reminded not to include their names. The subjects where also informed that if they found certain questions too intrusive they were to miss those questions out and continue with next set of questions. If the subjects did not want to do the survey at all, they were asked to put the survey, score sheets and pencil back into the envelope and return it to the researcher(s). Because of the sensitive nature of the survey the researchers had a list of telephone numbers of various services around the university put on an overhead that the subjects could write down at their convenience and call if

they found the survey caused problems or raised questions. Convenience sampling was utilized for this study.

During the month of November, 1995, several of the researchers spent a week at the Student Union Building at the University of Alberta in an attempt to obtain a more representative sample. This was enacted because it was not possible to gain access to the many departments at the University. Although random sampling would be the optimal method of collecting the information. This was not a viable option. Therefore, collecting data from the students who frequent the SUB during November of 1995 was considered a feasible alternative. However, it is recognized that only those students who went to the SUB during that particular week would be considered part of the sample. This in and of itself has serious ramifications for the generalizability of the results. The subjects from the SUB were asked to fill out the survey at a convenient time and return it via the campus mail to the address printed on the front of the envelope. There were 498 surveys given out during the week and 240 were returned completed. This represents a 48% completion rate. For those who participated during the week at the Student Union building it was necessary to include an extra slip of paper with the telephone numbers of Help Services around the campus.

The survey was distributed to approximately 2500 subjects, this includes subjects from classes and from the Student Union. Participation was voluntary.

Almost 57% waived participation. Of those who completed the survey, 71% (767) were female which represents 5.5% of the total full-time female student population, while 29% (311) were male which represents 2.6% of the total full-time male student population.

Instrument and Collection Techniques

Data was collected via the 360 item self-administered survey modified from one originally developed by Queen's University for the Canada Youth and AIDS Study. The survey focussed on: knowledge about AIDS and other sexually transmitted diseases, skills, personal context, demographics, religion, and behaviour orientation, self-esteem, perception measures, sexual behaviour measures as well as measures of risk-taking behaviours, childhood sexual abuse, both contact and non-contact forms, and sexual assault.

Child Sexual Abuse Questionnaire

Sexual abuse was assessed by a modification of the Finkelhor's (1979) Sexual Victimization of Children Survey. Child sexual abuse (CSA) was defined as: (a) non-contact behaviour occurring before the age of 16, with someone at least 5 years older than the subject; or (b) non-consensual sexual behaviour occurring before the age of 16, with someone at lest 5 years older than the subject. The non-consensual sexual behaviour ranged from sexual fondling to anal, oral and vaginal intercourse. Subjects were required to indicate the frequency on a 5-point scale ranging from "never" to "very often". Subjects who

reported a "non-consensual sexual activity" (the term "abuse" is not used in the questionnaire) prior to the age 16 with the perpetrator being at least 5 years older were considered to meet the criteria for sexual abuse (Boston et al., 1989; Finkelhor, 1979; Fromuth & Burkhart, 1989; Genuis et al., 1991; Kondora, 1993; Thomlison et al., 1991). Therefore, consistent with most CSA research, sexual experiences with peers were not included in the definition of sexual abuse (Kerns & Hastings, 1995).

Personal Contexts

The measures outlined in the Personal Contexts (gender, self-esteem, mental health scale, social integration/peer relationships, parent relationships) were considered separately in the context of the model. In the proposed model the personal contexts served as dependent variables with the CSA measures serving as independent variables, as well as independent variables with sexually risky behaviour variables serving as outcome variables. Also, in the proposed model the personal context variables are expected to mediate the effects of the CSA on sexually risky behaviours.

The item about gender was a simple indication of whether the subject was male or female. The mental health measure was a six-item scale that was used in the CYAS. Each of the items used a five-point Likert type response key "strongly agree", "agree", "uncertain/do not know", "disagree" and "strongly disagree". Cronbach's alpha was used as a measure of reliability of the scales

and was 0.83 for college/university students. This scale has proven to be a powerful measure (Doherty-Poirier & Munro, 1994).

Physical Environment

The measures outlined in Physical Environment (substance use) were considered. In the proposed model the Physical Environment variables served as dependent variables with the CSA measures serving as independent variables, as well as independent variables with sexually risky behaviour variables serving as outcome variables. Also, in the proposed model the Physical Environment variables are expected to mediate the effects of the CSA on sexually risky behaviours. The items are "How often do you use alcohol?" Subjects were asked to respond with "never", "on special occasions", "about once a month", "2-3 times a month", "once a week", "2-3 times a week", "every day". "Have you ever had so much alcohol that you were really drunk?" The response will simply be a number from 0 to more than 10, with "never" being considered for those students who have not been drunk. "How much alcohol do you usually drink at one time?" The response will be a statement from "none" to "5 or more drinks". "How often do you use other non-medical substances?" Subjects were asked to respond with "never", "on special occasions", "about once a month", "2-3 times a month", "once a week", "2-3 times a week", "every day". "Have you ever injected illegal drugs or steroids?" The response was simply "yes" or "no". "In the past two months have you injected illegal drugs or

steroids?". The response was "yes" or "no" (Doherty-Poirier & Munro, 1994; King et al., 1988).

Sexual Behaviours

There were ten major dependent variables in this study that acted as the outcome variables in this study. The measures outlined in Sexual Behaviours were considered. A single ordinal measure was constructed to represent a students risk avoidance behaviour. For this measure each subject was assigned a scored based on the level of risk suggested by their sexual behaviours. The approach to calculating this score was to examine each of the risk behaviours independently. A score was calculated for each of the vaginal sex, oral sex, anal sex, group sex, and sex with violence. This score will factor in number of partners, frequency of the activity. The actual items used are listed below: "How often have you had vaginal sex ever?", "How often have you had oral sex?", "How often have you had anal sex ever ?. "How often have you had group sex?" "How often have you had sex with violence?" "With how many people have you had vaginal sex?", "With how many people have you had anal sex?", "With how many people have you had oral sex?", For the items asking how often students engage in a particular behaviour, they are asked to respond indicating how many times. For the items regarding number of partners, students are asked to provide an actual number of partners. For the items asking about condom use, students were asked to respond with "always", "most of the time", "sometimes",

"occasionally", "never used a condom", "never had sexual intercourse". For the items asking about mutual sex experience, students were asked to respond with "I have not had engaged in sexual intercourse", "before 14 years", "14-16 years", "16-18 years old", "18-20 years old", "20-22 years old", "23 or older" (Doherty-Poirier & Munro, 1994 & King et al., 1988).

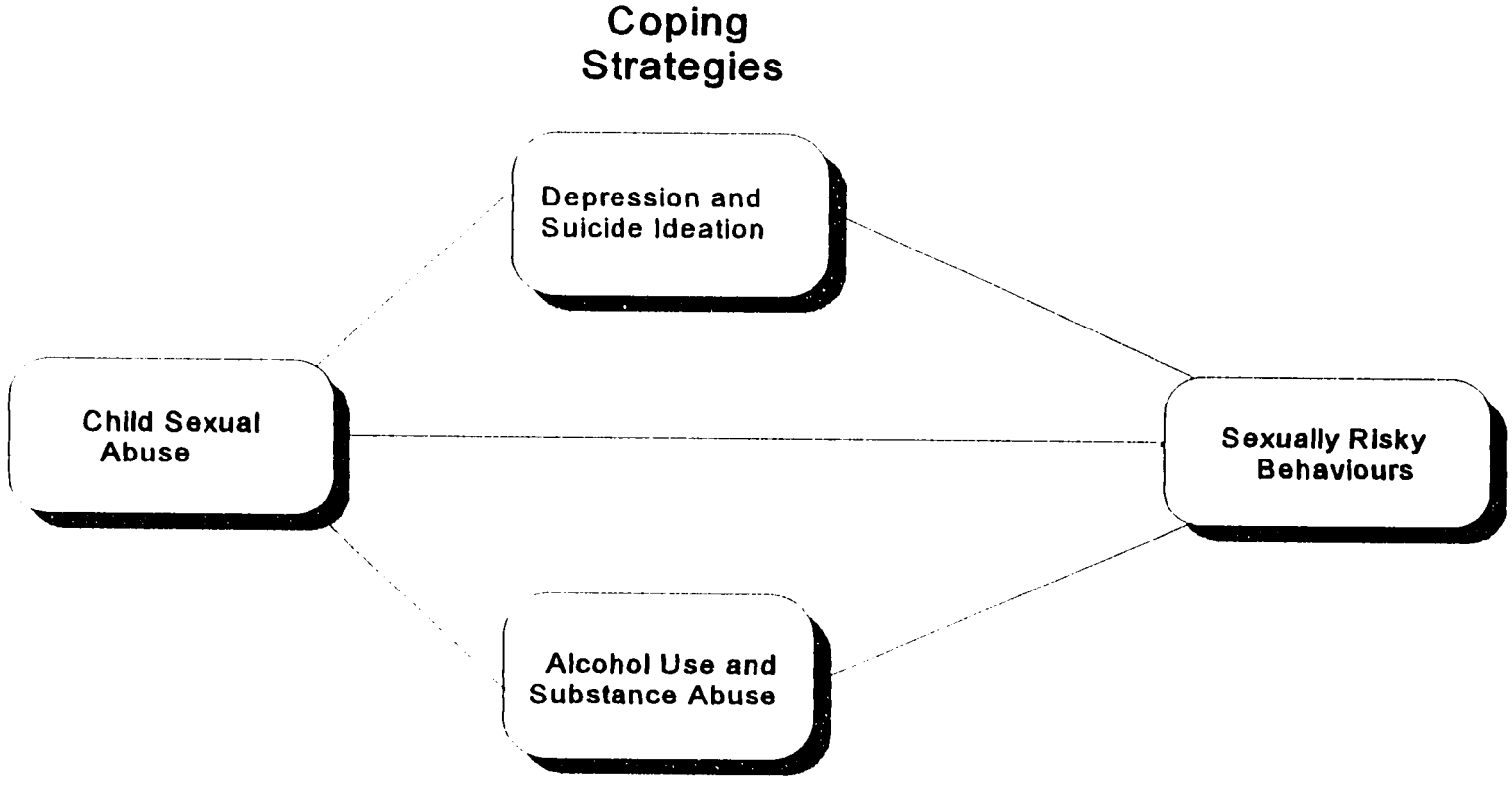
Coping Strategies
Depression and Suicide Ideation
Child Sexual Abuse
Sexually Risky Behaviours
Alcohol Use and Substance Abuse

Figure 1.

Data Analysis

To test whether males who have experienced sexual abuse prior to age 16 will exhibit more sexually risky behaviours than males who had not experienced the same trauma, frequency distributions, means and standard deviations will determine the prevalence and incidence of sexual abuse among the male population. One-way and two-way analysis of variance (ANOVA's) will be used to test all hypotheses of this study. ANOVA's will be conducted measuring the overall behaviour of the male survivors in comparison with the non-abused control group. Where the one-way ANOVA's are significant, Tukey-HSD post hoc tests will be used to determine which group is responsible for the significance. For the purpose of these analyses the dependent variable sexually risky behaviours are defined as promiscuous sexual activity.

Limitations

Although any research conducted in the area of the male survivor's and their response to trauma and stress would provided valuable insight into the individual and his adjustment, this study is limited in several ways. To assume that this study can develop a comprehensive understanding of the male survivors responses to the sexually abusive experience is unrealistic. First, only four coping strategies will be examined (i.e. depression, suicide ideation, alcohol use and substance use) in relation to the ten sexually risky behaviours. It would be preferable to examine all types of coping strategies but that is idealistic. Second, some factors will be left out of the examination. Family, social and

peers will not be examined in this study. The perpetrator, type of force used and onset and termination of the abuse are not factors that will be examined, either. This will limit the findings of this study considerably. Third, the data was not collected from a random sample, which limits the generalizability of the results. Fourth, a self-report survey was utilized and there is no way to verify the accuracy of the students self-reports. Therefore, it would be valuable to have additional information about their families, friends, and their sexual behaviour from another source. Fifth, other factors may be at work in the relationship between sexual abuse and sexually risky behaviours. For example, there is no information about the perpetrator, length of the abuse, the method used to elicit cooperation. Sixth, because this is a retrospective study and recall of childhood experiences may be influenced by a number of factors including repression.

Table 4.1

Distribution of Subjects by Gender

Gender	Frequency	Percentage
Male	311	29.0
Female	767	71.0
Total	**1078**	

Table 4.2

Percentage of Full-time Students by Faculty

Faculty	Percentage of full-time students in each faculty (n=26,130)	Percentage of students who completed the survey from each faculty
Agriculture, Forestry and Home Economics	5.1	0.65
Arts	19.4	0.72
Business	6.8	0.21
Education	11.1	0.22
Engineering	9.5	0.1
Medicine and Oral Health Sciences	4.6	0.11
Nursing	3.2	0.23
Rehabilitation Medicine	1.84	0.2
Science	18.4	0.4
Other	0.3	
Missing	1.1	

CHAPTER V

RESULTS

Completed questionnaires were returned by 1078 students, which represents a response rate of approximately 43%. Of the 1078 questionnaires returned, 767 (71%) were completed by female students and 311 (29%) were completed by male students. Five percent of the male subjects of this sample reported at least one type of invasive abuse (anal penetration or oral copulation), whereas 8.7% reported incidents of genital fondling without penetration or oral copulation, and 16.4% reported non-contact sexual b activity. For the purpose of this study recoding was used to categorize sexual abuse into three variables, non-contact and contact sexual abuse with no abuse subjects making the third category. The means and the standard deviations of the scores of no abuse, non-contact abuse, contact abuse subjects on the measures used in this study are compiled in table 5.1 to 5.3.

Tests of Hypotheses

Hypothesis # 1 - Child Sexual Abuse is positively related to depression and suicide ideation

To test the first hypothesis that CSA (child sexual abuse) was associated with the depression and suicide ideation, the latter variables served as dependent variables in a one-way analyses of variance (ANOVA), with the three categories (no abuse, non-contact abuse, contact abuse) as the independent variable. This was done to examine the relationship of abusive history on

depression and suicide ideation. As the first step in the analyses 2 (gender) x 3 (no abuse, non-contact abuse, contact abuse) were run with the dependent variables. No significant F Value was found between the three groups (see Table 5.4). Based on the results of the ANOVA's it is suggested that contact, non-contact and no abuse subjects did not differ with respect to either depression or suicide ideation. Therefore, it was not necessary to run further analysis on these variables.

In summary, there are no significant F Values between either depression or suicide ideation and CSA. So therefore, CSA is not significantly associated with depression or suicide ideation. Thus, it can be concluded that the first hypothesis was not supported.

Hypothesis # 2 - Child Sexual Abuse is indirectly related to sexually risky behaviours through depression or suicide ideation

To test the second hypothesis that CSA was indirectly related to sexually risky behaviours (i.e. with how many people have you had vaginal sex? With how many people have you had anal sex? With how many people have you had oral sex? How often have you had oral sex? How often have you had vaginal sex? How often have you had anal sex? How often have you had group sex? How often have you had sex with violence? When you had sexual intercourse, how often was a condom used? At what age did you experience your first mutually consenting sexual experience (vaginal, anal or oral intercourse)) through the factors of depression and suicide ideation. Of particular interest was

the interaction between CSA and the mediating variables of depression and suicide ideation. As a first step in the analyses with 2 (gender) as one factor x 3 (no abuse, non-contact abuse, contact abuse) as another factor x 1 (depression, suicide ideation) as another factor with each of the sexually risky behaviour as the dependent variables were run.

The main effect for the interaction in each of the ANOVA's were examined in order to understand the nature of the interaction. Each of the mediating variables will be taken separately. The first factor to be examined in conjunction with CSA was depression. The results of the analyses are presented in Table 5.5. One dependent variable showed significance, "how often have you had anal sex" was significant at the $p<.01$ level. To provide information on how the three groups (i.e. no abuse group, non-contact abuse, contact abuse group) differed, Tukey-HSD post hoc tests were used to determine which groups differed significantly. For "how often have you had anal sex?" the post hoc analyses are presented in Table 5.6. On most of the measures, the contact abuse - strongly disagree group did less well than all other groups except no abuse - strongly agree group. Males who reported contact abuse and low levels of depression were more likely to report often participating in anal sex. When examining the F for the main effect "I often feel depressed" none of the sexually risky behaviours were significant. No other variables showed trends toward significance.

The next factor to be examined was suicide ideation. The results of the

analyses are presented in Table 5.7. For the sexually risky behaviours, the interaction was significant for only one out of the ten behaviours. The dependent variable "when you had sexual intercourse, how often was a condom used?" was significant at the $p<.05$ level. The variable "how often do you have anal sex?" showed a trend toward significance. To determine which groups differed significantly the Tukey-HSD tests were used. The findings are presented in Table 5.8. The non-contact abuse - disagree group was significantly different from the non-contact - strongly disagree group. The non-contact abuse disagree group reported lower levels of suicide ideation but were more likely to have had sexual intercourse without a condom. When examining the F for the main effect for suicide ideation, two out of the ten sexually risky behaviour variables were significant, with the contact group having the higher means for those two dependent variables.

In summary, to test the second hypothesis, it was necessary to input the depression and suicide ideation factors separately along with the CSA variables with the sexually risky behaviour factors serving as dependent variables. This was done to ascertain the mediating effects of these two factors on sexually risky behaviours. Child sexual abuse was significantly related to sexually risky behaviours through both depression and suicide ideation. Those who had experienced contact abuse had significantly lower levels of depression, but were more likely to participate in anal sex than the other two groups, and those who had experienced non-contact abuse were significantly less likely to consider

suicide and less likely to wear a condom when having sexual intercourse than the other two groups. Thus, it can be concluded that the second hypothesis in principle was supported.

Hypothesis # 3 - Child Sexual Abuse is positively related to sexually risky behaviours

The third hypothesis was to examine whether CSA was positively related to sexually risky behaviours (i.e. With how many people have you had vaginal sex? With how many people have you had anal sex? With how many people have you had oral sex? How often have you had oral sex? How often have you had vaginal sex? How often have you had anal sex? How often have you had group sex? How often have you had sex with violence? When you had sexual intercourse, how often was a condom used? At what age did you experience your first mutually consenting sexual experience (vaginal, anal or oral intercourse)?). The latter variables served as dependent variables in a one-way analyses of variance (ANOVA), with the three categories (no abuse, non-contact abuse, contact abuse) as the independent variable. This was done to test the influence of abusive history on sexually risky behaviours. As the first step in the analyses 2 (gender) x 3 (no abuse, non-contact abuse, contact abuse) were run with the dependent variables. No significant F Value was found between the three groups and no trend toward significance were found (see Table 5.9). Therefore, it was not necessary to run further analysis on these variables.

In summary, there are no significant F Values between CSA and the

sexually risky behaviours. So therefore, CSA is not significantly associated with sexually risky behaviours. Thus, it can be concluded that the third hypothesis was not supported.

Hypothesis # 4 - Child Sexual Abuse is positively related to alcohol and substance abuse

The fourth hypothesis was to examine the relationship between CSA and alcohol and substance abuse (i.e. How often do you use alcohol? How often do you use other non-medical substances? Have you ever injected illegal drugs or steroids?). For the purpose of this study recoding was used to categorize how often do you use other non-medical substances and have you every injected illegal drugs or steroids into three variables, no=0, yes - non medical substances=1 (yes [nm]) and yes - non medical substances and injected drugs=3 (yes [nm&i]). The alcohol and drug variables served as dependent variables in a one-way analyses of variance (ANOVA), with the three categories (no abuse, non-contact abuse, contact abuse) as the independent variable. This was done to examine the relationship of abusive history on alcohol and substance use. As the first step in the analyses 2 (gender) x 3 (no abuse, non-contact abuse, contact abuse) were run with the dependent variables. No significant F Value was found between the three groups and no variables showed trends toward significance (see Table 5.10).

In summary, there are no significant F Values between either alcohol use or substance abuse and CSA. So therefore, CSA is not significantly associated

with alcohol use or substance abuse. Thus, it can be concluded that the fourth hypothesis was not supported.

Hypothesis # 5 - Child Sexual Abuse is indirectly related to sexually risky behaviours through alcohol and substance abuse

To test the fifth hypothesis that CSA was indirectly related to sexually risky behaviours through the alcohol and substance abuse variables mentioned previously. Of particular interest was the interaction between CSA and the mediating variables of alcohol and substance abuse. Each of the alcohol and substance abuse variables were taken separately. As a first step in the analyses with 2 (gender) as one factor x 3 (no abuse, non-contact abuse, contact abuse) as another factor x 1 (Alcohol use) as another factor were run with the dependent variables. The interaction term in each of the ANOVA's were examined in order to understand the nature of the interaction. Alcohol use was the first factor to be tested. The results of the analyses are presented in Table 5.8. One dependent variable showed a significant interaction at the $p<.01$ level, "how often do you have anal sex?". No other dependent variables showed any significance or trend toward significance. The Tukey-HSD post hoc test was used to determine which groups differed significantly from each other. The findings are presented in Table 5.11. The no abuse - every day group was significantly different from all but four of the groups. The no abuse - every day group was more likely to report more participation in anal sex than the other groups. When examining the F for the main effect for "how often do you use

alcohol?" nine out of the ten sexually risky behaviours were significant, with the contact group having the higher means in eight of the significant sexually risky behaviours variables.

In examining the substance abuse factor, the results of the analyses are presented in table 5.12. For the sexually risky behaviour variables, the interaction was significant for four out of the ten sexually risky behaviours. The dependent variable "with how many people have you had anal sex?" was significant at the $p<.01$ level. The dependent variables of "how many people have you had vaginal sex?", and "how often have you had anal sex?" were significant at the $p<.05$ level. "How often have you had sex with violence?" was significant at the $p<.001$ level. The dependent variable "use of condoms" showed a trend towards significance. The Tukey-HSD post hoc test was used to determine which groups differed significantly from each other. The findings from all four dependent variables are presented in tables 5.13 thru 5.16.

When examining the question "with how many people have you had anal sex?" the no abuse - yes (nm&i) group was significantly different from all the other groups. The no abuse - yes-inject group was more likely to report having had more partners than the other groups. When examining "with how many people have you had vaginal sex?" the no abuse yes (nm) group was significantly different from no abuse no group and the non-contact abuse no group. The no abuse yes (nm) group was more likely to report more partners than the other group. When examining "how often have you had anal sex?" the

no abuse yes (nm) group was significantly different from the no abuse no group. The no abuse yes (nm) group was more likely to report often being involved in anal sex more than the other group. The no abuse yes (nm&i) group also reported significant differences. This group was significantly different from the no abuse no group, the non-contact no group, and the contact yes (nm) group. The no abuse yes (nm&i) group was more likely than the other groups to report more involvement in violent sex. When examining the F for the main effect of substance abuse, six out of the ten sexually risky behaviour variables were significant, with the contact group having the higher means in all six cases.

In summary, to test the fifth hypothesis, it was necessary to input the alcohol use and substance abuse factors separately along with the CSA variables with the sexually risky behaviour factors serving as dependent variables. This was done to ascertain the mediating effects of these two factors on sexually risky behaviours. Child sexual abuse was significantly related to sexually risky behaviours through both alcohol use and substance abuse. Those who had not experienced sexual abuse were more likely to drink everyday and participated more often in anal sex than the other two groups. Those had not experienced sexual abuse and used drugs (nm) were more than likely to have more vaginal partners, and participate in anal sex more often than the other two groups. Those who had not experienced sexual abuse and used drugs (nm&i) had more anal partners and participated more often in violent sex than the other two groups. Thus, it can be concluded that the fifth hypothesis in principle was

supported.

Hypothesis # 6 - There will be a relationship between depression and suicide ideation and sexually risky behaviours

To test the sixth hypothesis that there would be a relationship between depression and suicide ideation and the sexually risky behaviours mentioned previously, both depression and suicide ideation served as independent variables in a one-way analyses of variance (ANOVA), with the sexually risky behaviours as the dependent variables. This was done to examine the relationship of depression and suicide ideation on sexually risky behaviours.

When examining depression there were no significant interactions, however, two variables showed trends towards significance. The dependent variables of "with how many people have you had anal sex?" and "with how many people have you had vaginal sex?" had trends toward significance (see Table 5.17).

When examining suicide ideation it was found that "with how many people have you had anal sex?" was significant at the $p < .05$ level and "how often have you had violent sex?" was significant at the $p < .01$ level. One other dependent variable, "with how many people have you had oral sex?" showed a trend towards significance (see table 5.18). The Tukey-HSD test was used to determine which groups differed significantly from each other. The findings for the two significant dependent variables are presented in table 5.19.

In examining "with how many people have you had anal sex?" the strongly

agree group was significantly different from the disagree group. The strongly agree group were more likely to have contemplated suicide and have more anal partners than the disagree group. In examining "how often have you had sex with violence?" the agree group was significantly different from the strongly disagree group. The agree group was more likely to have contemplated suicide and participated in violent sex than the disagree group.

In summary, there are no significant F Values between depression and sexually risky behaviours. So therefore, depression is not significantly associated with sexually risky behaviours. There were significant F Values between suicide ideation and sexually risky behaviours. Those who were more likely to consider suicide had more anal partners and participated in violent sex more often than the other groups. Thus, it can be concluded that for depression and sexually risky behaviours the hypothesis is not supported. However, for suicide ideation and sexually risky behaviours the hypothesis is supported.

Hypothesis #7 - There will be a relationship between alcohol use, substance abuse and sexually risky behaviours

To test the seventh hypothesis that there would be a relationship between alcohol use, substance abuse and the sexually risky behaviours mentioned previously, the alcohol and substance abuse variables served as independent variables in a one-way analyses of variance (ANOVA), with the sexually risky behaviours as the dependent variables. This was done to examine the relationship of alcohol and substance abuse on the sexually risky behaviour

variables. In exploring the independent variable alcohol use, the F Value was significant for eight out of the ten sexually risky behaviour variables. The results of the analyses are presented in table 5.20. The dependent variables of "with how many people have you had anal sex?", "how often have you had anal sex?", "how often have you had group sex?" and "how often have you had violent sex?" were all significant at the $p<.001$ level. The other four dependent variables were significant at the $p<.05$ level. The Tukey-HSD test was used to determine which groups differed significantly from each other. Although the dependent variables of "with how many people have you had oral sex?", "with how many people have you had vaginal sex?" and "at what age did you experience your first mutual sex experience?" had significant F Values, when the Tukey-HSD tests were run, none of the groups showed any significance. The findings for the other five dependent variables are presented in table 5.21.

In examining "with how many people have you had anal sex?" the everyday group was significantly different than all the other groups. The everyday group was more likely to have a drinking problem and to have more anal sex partners than the other groups. In considering "how often have you had anal sex?" the everyday group was significantly different than all the other groups. The everyday group was more likely to have a problem with alcohol and to participate in more oral sex than the other groups. In investigating "how often have you had group sex?" the everyday group was significantly different than all the other groups. The everyday group had problems with alcohol and was more

likely to participate in group sex than the other groups. In examining "how often have you had vaginal sex?" there was a significant difference between the on special occasions group and the once a week group. The on special occasions group was more likely to report more involvement in vaginal sex than the once a week group. When examining "how often have you had sex with violence?" the everyday group was significantly different than all the other groups. The everyday group was more likely to participate in sex with violence than the other groups.

For substance abuse, the F Value was significant for all ten sexually risky behaviour variables. The results of the analyses are presented in table 5.22. The dependent variables of "with how many people have you had anal sex?", "with how many people have you had oral sex?", "with how many have you had vaginal sex?", "how often have you had anal sex?", "how often have you had group sex?" and "how often have you had oral sex?" were all significant at the $p<.001$ level. While the dependent variables of "how often have you had vaginal sex?", "how often have you had sex with violence?" were significant at the $p<.01$ level. The other two dependent variables were significant at the $p<.05$ level. The Tukey-HSD test was used to determine which groups differed significantly from each other. The findings for all dependent variables are presented in table 5.23.

In examining "with how many people have you had anal sex?" the yes (nm&i) group was significantly different from all other groups. The yes (nm&i) group participated in drug use and had more anal sex partners than the other

groups. In examining "with how many people have you had oral sex?" the no group was significantly different from the yes (nm) group. Although the no group did not participate in substance use, they were more likely to have more oral sex partners than the yes (nm) group. In examining "with how many people have you had vaginal sex?" the no group was significantly different from the yes (nm) group. The no group was more likely to have more vaginal sex partners than the yes (nm) group. In investigating "how often have you had anal sex?" the yes (nm&i) group was significantly different than all the other groups. The yes (nm&i) group participated in more anal sex than the other groups. In considering "how often have you had group sex?" the yes (nm&i) group was significantly different than all the other groups. The yes (nm&i) group participated in more group sex than the other groups. In examining "how often have you had oral sex?" there was a significant difference between the no group and the yes (nm) group. The no group was more likely to participate in oral sex than the yes (nm) group. In analysing "how often have you had vaginal sex?" there was a significant difference between the no group and the yes (nm) group. The no group was more likely to participate in vaginal sex than the yes (nm) group. In examining "how often have you had sex with violence?" the yes (nm&i) group was significantly different than all the other groups. The yes (nm&i) group had problems with drugs and was more likely to participate in violent sex. In investigating "when you had sexual intercourse, how often was a condom used?" there was a significant difference between the no group and the yes (nm) group.

The no group was less likely to use a condom when having sexual intercourse. In examining "at what age did you experience you first mutual sex experience?" there was a significant difference between the no group and the yes (nm) group. The no group was more likely to be younger at the time of the first mutual sex experience.

In summary, to test the seventh hypothesis it was necessary to input the alcohol and substance abuse variables separately along with the ten sexually risky behaviour variables. There were significant F Values between both alcohol use and substance abuse and sexually risky behaviours. Those who drank alcohol everyday were more likely to have had more anal partners and to participate more often in anal, group and violent sex than the other groups. Those who drank alcohol only on special occasions participated more often in vaginal sex than the other groups. Those who took drugs (nm&i) had more anal partners and participated more often in anal, group and violent sex than the other groups. Those who did not take drugs had more oral and vaginal partners and participated more often in vaginal sex, were less likely to wear a condom when having sexual intercourse and were younger at the time of first intercourse than the other groups. Thus, it can be concluded that for alcohol use and substance abuse the seventh hypothesis, in principle was supported.

In this study it was hypothesized that CSA would have a direct effect on depression, suicide ideation, alcohol use and substance abuse and sexually risky behaviours and that CSA would have an indirect effect on sexually risky

behaviours through depression, suicide ideation, alcohol use and substance abuse. Overall, two of the direct hypotheses were supported and one of the indirect hypotheses was partially supported. These results will be discussed in the chapter VI.

TABLE 5.1

Mean and standard deviations of No abuse, Non-contact abuse, Contact abuse groups for Depression and Suicide ideation.

	Groups					
	No abuse n = 254		**Non-contact abuse n =26**		**Contact Abuse n =31**	
Variables	x	SD	x	SD	x	SD
Depression	2.56	1.09	2.38	1.02	2.46	1.14
Suicide	3.14	1.21	3.27	1.22	2.79	1.26

Table 5.2

Mean and standard deviations of No abuse, Non-contact abuse, Contact abuse groups for Substance Use

	Groups					
	No abuse n = 254		**Non-contact abuse n =26**		**Contact Abuse n =31**	
Variables	x	SD	x	SD	x	SD
Alcohol Use	2.85	1.56	2.50	1.50	2.69	1.54
Substance Abuse	.1466	.3544	.1923	.4019	.2308	.4297

TABLE 5.3
Mean and standard deviations of No abuse, Non-contact abuse, Contact abuse groups for Sexually Risky Behaviours

	Groups					
	No abuse n = 254		**Non-contact abuse n =26**		**Contact Abuse n =31**	
Variables	x	SD	x	SD	x	SD
Sexually Risky Behaviours						
How many people - Anal Sex	.40	1.20	.16	.47	.46	.76
How many people - Oral Sex	2.98	3.06	2.84	2.64	3.73	2.85
How many people - Vaginal Sex	2.84	3.17	2.68	2.76	3.88	3.10
How often - Anal	.38	.78	.27	.67	.58	.90
How often - Group	.13	.50	02	.20	.27	.67
How often - Oral	2.00	1.18	2.15	1.05	2.38	.85
How often - Vaginal	1.95	1.31	2.00	1.17	2.15	1.12
How often - Sex with Violence	.11	.50	.00	.00	.27	.60
Condom Use	2.52	1.80	2.17	1.66	2.54	1.42
Mutual Sex	2.27	1.88	1.85	1.71	2.19	2.23

Table 5.4

Results of the ANOVA analysis for Child Sexual Abuse and Depression and Suicide Ideation

	x	F	Sig.
Depression	2.54	.371	.690
Suicide	3.12	1.273	.282

Table 5.5

Results of the Two-Way ANOVA Analysis for Child Sexual Abuse, Depression and Sexually Risky Behaviours

Dependent Variables	F for Main Effect for Child Sexual Abuse	F for Main Effect for Depression	F for the Interaction
# of People - Anal Sex	.591	2.231	1.525
# of People - Oral Sex	.738	1.173	1.211
# of People - Vaginal Sex	1.203	2.287	.945
How often - Anal Sex	.966	.995	2.923**
How often - Group Sex	1.422	1.612	1.503
How often - Oral Sex	1.452	1.891	1.701
How often - Vaginal Sex	2.53	.685	.614
How often - Violent Sex	1.740	1.774	.875
Use of Condoms	.410	.148	.904
Mutual Sex	1.071	1.228	2.222*

*p<.05 **p<.01 ***p< .001

TABLE 5.6

Results of the Tukey-HSD Multiple Comparison Analysis for Child Sexual Abuse, Depression and "How often have you had anal sex?"

How often have you had anal sex?							
	No Abuse		Non-contact Abuse		Contact Abuse		F Value
Depression	x	n	x	n	x	n	
Strongly Agree	1.63	8					2.310**
Agree	2.56	48	.75	4	1.33	9	
Undecided	2.57	42	1.40	10			
Disagree	1.96	103	2.30	10	1.42	12	
Strongly Disagree	2.27	49	3.00	3	4.20[a]	5	

a. significantly different than all the other groups except no abuse - strongly agree
**p<.01

Table 5.7

Results of the Two-Way ANOVA Analysis for Child Sexual Abuse, Suicide and Sexually Risky Behaviours

Dependent Variables	F for Main Effect for Child Sexual Abuse	F for Main Effect for Suicide	F for the Interaction
# of People - Anal Sex	.657	2.910*	1.249
# of People - Oral Sex	.829	.967	1.044
# of People - Vaginal Sex	1.444	2.039	1.158
How often - Anal Sex	.852	1.726	1.694
How often - Group Sex	1.614	1.349	1.367
How often - Oral Sex	1.385	1.064	.690
How often - Vaginal Sex	.301	1.403	1.417
How often - Violent Sex	1.526	3.808**	.791
Use of Condoms	.279	1.182	2.342*
Mutual Sex	1.075	.980	.960

*p<.05 **p<.01 ***p< .001

TABLE 5.8

Results of the Tukey-HSD Multiple Comparison Analysis for Child Sexual Abuse, Suicide and Condom Use

Condom Use							
	No Abuse		Non-contact Abuse		Contact Abuse		F Value
Suicide	x	n	x	n	x	n	
Strongly Agree	2.40	5			2.67	3	1.990*
Agree	2.97	37			3.20	5	
Undecided	2.93	14			1.80	5	
Disagree	1.93	41	4.17[a]	6	2.57	7	
Strongly Disagree	2.53	129	1.36	14	2.30	10	

a. significant difference between the non-contact abuse - disagree group and non-contact abuse - strongly disagree group
*p<.05 **P<.01 *** p<.01

Table 5.9

Results of the ANOVA Analysis for Child Sexual Abuse and Sexually Risky Behaviours

Variables	x	F	Sig.
# of People - Anal Sex	.38	.579	.561
# of People - Oral Sex	3.04	.788	.456
# of People - Vaginal Sex	2.92	1.381	.253
How often - Anal Sex	.39	1.070	.344
How often - Group Sex	.14	1.433	.240
How often - Oral Sex	2.05	1.431	.241
How often - Vaginal Sex	1.98	.294	.745
How often - Violent Sex	.12	2.019	.135
Use of Condoms	2.49	.444	.642
Mutual Sex	2.23	.588	.556

Table 5.10
Results of the ANOVA Analysis for Child Sexual Abuse and Alcohol and Substance Use

Variables	x	F	Sig.
How often do you use alcohol	2.81	.687	.504
So much alcohol - really drunk	2.77	1.648	.194
Drink at one time	2.07	.711	.492
Substance Abuse	.1956	.965	.382

TABLE 5.11
Results of the Two-Way ANOVA Analysis for Child Sexual Abuse, Alcohol Use and Sexually Risky Behaviours

Dependent Variables	F for Main Effect for Child Sexual Abuse	F for Main Effect for Alcohol Use	F for the Interaction
# of People - Anal Sex	.622	12.665***	.595
# of People - Oral Sex	.832	2.434*	.369
# of People - Vaginal Sex	1.372	2.565*	.465
How often - Anal Sex	1.585	5.438***	2.512**
How often - Group Sex	1.432	6.248***	1.217
How often - Oral Sex	1.590	2.133*	.441
How often - Vaginal Sex	.367	2.422*	.516
How often - Violent Sex	2.431	6.431***	.619
Use of Condoms	.487	1.639	1.132
Mutual Sex	1.534	2.509*	1.329

*p<.05 **p<.01 ***p< .001

Table 5.12

Results of the Tukey-HSD Multiple Comparison Analysis for Child Sexual Abuse, Alcohol Use and "How often do you have anal sex?"

How often do you have anal sex?							
	No Abuse		Non-contact Abuse		Contact Abuse		F Value
Alcohol Use	x	n	x	n	x	n	
Never	.50	16			.60	5	3.618***
On Special Occasions	.32	37	.33	6	1.50	4	
About Once a Month	.35	37	.17	6	1.33	3	
2-3 times a month	.18	49	1.33	3	.00	6	
Once a Week	.33	46	.00	7	.25	8	
2-3 times a week	.56	34			.00	4	
Every day	2.25[a]	4					

a. significant difference between no abuse everyday group and all other groups except contact abuse never group, contact abuse on special occasions group and contact abuse about once a month group.

***p<.001

TABLE 5.13

Results of the Two-Way ANOVA Analysis for Child Sexual Abuse, Substance Abuse and Sexually Risky Behaviours

Dependent Variables	F for Main Effect for Child Sexual Abuse	F for Main Effect for Substance Abuse	F for the Interaction
# of People - Anal Sex	.374	48.061***	5.029***
# of People - Oral Sex	.557	11.629***	1.708
# of People - Vaginal Sex	.845	13.222***	3.172*
How often - Anal Sex	.611	11.051***	3.025*
How often - Group Sex	.822	32.771***	.536
How often - Oral Sex	1.209	5.877**	.505
How often - Vaginal Sex	.120	5.377**	1.855
How often - Violent Sex	1.500	17.828***	7.009***
Use of Condoms	.564	4.490	2.225
Mutual Sex	1.480	3.417*	.201

*p<.05 **p<.01 ***p< .001

TABLE 5.14

Results of the Tukey-HSD Multiple Comparison Analysis for Child Sexual Abuse, Substance Abuse and "With how many people have you had anal sex?"

With how many people have you had anal sex?

	No Abuse		Non-contact Abuse		Contact Abuse		F Value
Substance Abuse	x	n	x	n	x	n	
No	.27	187	.15	20	.50	18	18.115***
Yes (nm)	.59	32	.25	4	.43	7	
Yes (nm&i)	6.00[b]	3					

a. significantly different from all other groups.

TABLE 5.15

Results of the Tukey-HSD Multiple Comparison Analysis for Child Sexual Abuse, Substance Abuse and "With how many people have you had vaginal sex?"

With how many people have you had vaginal sex?

	No Abuse		Non-contact Abuse		Contact Abuse		F Value
Substance Abuse	x	n	x	n	x	n	
No	2.30	187	2.35	20	4.17	18	6.518***
Yes (nm)	5.34[a]	32	4.00	4	3.14	7	
Yes (nm&i)	6.67	3					

a. significant difference between the no abuse - yes (nm) group and the no abuse - no group and the non-contact abuse - no group

*p<.05 **p<.01 ***p<.001

Table 5.16

Results of the Tukey-HSD Multiple Comparison Analysis for Child Sexual Abuse, Substance Abuse and "How often have you had anal sex?"

How often have you had anal sex?							
	No Abuse		Non-contact Abuse		Contact Abuse		F Value
Substance Abuse	x	n	x	n	x	n	
No	.29	187	.25	20	.72	18	4.511***
Yes (nm)	.72[b]	32	.50	4	.29	7	
Yes (nm&i)	2.00[a]	3					

a. significant difference between the no abuse - yes (nm&i) group and the no abuse - no group and the non-contact abuse - no group and the contact abuse - yes (nm) group
b significant difference between the no abuse - yes (nm) group and the no abuse - no group
*p<.05 **P<.01 *** p<.001

TABLE 5.17

Results of the Tukey-HSD Multiple Comparison Analysis for Child Sexual Abuse, Substance Abuse and "How often have you had sex with violence?"

How often have you had sex with violence?							
	No Abuse		Non-contact Abuse		Contact Abuse		F Value
Substance Abuse	x	n	x	n	x	n	
No	.44	187	.00	20	.39	18	10.283***
Yes (nm)	.16	32	.00	4	.00	7	
Yes (nm&i)	2.00[a]	3					

a. significantly different from all other groups
*p<.05 **p<.01 ***p<.001

TABLE 5.18
Results of the ANOVA Analysis for Suicide Ideation and Sexually Risky Behaviours

Variables	No Abused x	Non-contact Abuse x	Contact Abuse x	F	Sig
# of People - Anal Sex	.40	.16	.46	2.868	.024*
# of People - Oral Sex	2.98	2.84	3.73	2.006	.094
# of People - Vaginal Sex	2.84	2.68	3.88	.846	.497
How often - Anal Sex	.38	.27	.58	1.816	.003**
How often - Group Sex	.13	.00	.27	1.251	.290
How often - Oral Sex	2.00	2.15	2.38	1.089	.362
How often - Vaginal Sex	1.95	2.00	2.15	1.392	.237
How often - Violent Sex	.11	.00	.27	4.098	.003**
Use of Condoms	2.52	2.17	2.54	1.231	.298
Mutual Sex	2.24	1.85	1.82	.888	.471

*p<.05 **p<.01 ***p<.001

TABLE 5.19

Results of the Tukey-HSD Multiple Comparison Analysis for Suicide and Sexually Risky Behaviours

	Suicide					
	Strongly Agree (n=8)	Agree (n=42)	Undecided (n=19)	Disagree (n=54)	Strongly Disagree (n=156)	F Value
Sexually Risky Behaviours	x	x	x	x	x	
With how many people have you had anal sex?	1.38[a]	.50	.79	.20	.31	2.868*
How often have you had sex with violence?	.50	.29[b]	.26	.11	.02	4.098**

a. significant difference between strongly agree and disagree
b. significant difference between agree and strongly disagree
*p<.05 **p<.01 ***p<.001

TABLE 5.20
Results of the ANOVA Analysis for Alcohol Use, and Sexually Risky Behaviours

Variables	No Abuse x	Non-contact Abuse x	Contact Abuse x	F	Sig
# of People - Anal Sex	.41	.16	.46	12.934	.000***
# of People - Oral Sex	2.99	2.84	3.73	2.480	.024*
# of People - Vaginal Sex	2.85	2.68	3.88	2.617	.018*
How often - Anal Sex	.38	.27	.58	5.011	.000***
How often - Group Sex	.14	.00	.27	6.220	.000***
How often - Oral Sex	2.00	2.15	2.38	2.113	.052
How often - Vaginal Sex	1.95	2.00	2.15	2.456	.025*
How often - Violent Sex	.12	.00	.27	6.368	.000***
Use of Condoms	2.50	2.17	2.54	1.609	.145
Mutual Sex	2.22	1.85	1.77	2.332	.033*

*p<.05 **p<.01 ***p<.001

TABLE 5.21
Results of the Tukey-HSD Multiple Comparison Analysis for Alcohol Use and Sexually Risky Behaviours

How often do you use Alcohol?								
	Never (n=21)	On Special Occasions (n=47)	About once a Month (n=46)	2-3 Times a Month (n=58)	Once a Week (n=61)	2-3 Times a Week (n=38)	Everyday (n=4)	F Value
Sexually Risky Behaviours	x	x	x	x	x	x	x	
With how many people have you had anal sex?	.38	.33	.33	.19	.36	.42	4.75[a]	12.934***
How often have you had anal sex?	.52	.43	.39	.22	.28	.50	2.25[a]	5.011***
How often have you had group sex?	.19	.00	.00	.12	.21	.00	1.50[a]	6.220***
How often have you had vaginal sex?	1.86	1.47[b]	1.98	1.91	2.25	2.21	3.00	2.456*
How often have you had sex with violence?	.14	.11	.13	.00	.15	.00	1.50[a]	6.368***

a. significantly different than all the other groups
b. significant differences between on special occasions and once a week
*p<.05 **p<.01 ***p<.001

TABLE 5.22
Results of the ANOVA for Substance Abuse and Sexually Risky Behaviours

Variables	No Abuse x	Non-contact Abuse x	Contact Abuse x	F	Sig
# of People - Anal Sex	.40	.17	.48	28.263	.000***
# of People - Oral Sex	2.93	2.67	3.76	6.471	.002**
# of People - Vaginal Sex	2.80	2.63	3.88	7.920	.000***
How often - Anal Sex	.37	.29	.60	4.527	.012*
How often - Group Sex	.14	.00	.28	13.788	.000***
How often - Oral Sex	1.97	2.21	2.36	3.204	.042*
How often - Vaginal Sex	1.94	2.04	2.12	2.936	.055
How often - Violent Sex	.12	.00	.28	10.200	.000***
Use of Condoms	2.52	2.17	2.56	2.388	.094
Mutual Sex	2.32	1.71	1.84	2.072	.128

*p<.05 **p<.01 ***p<.001

TABLE 5.23
Results of the Tukey-HSD Multiple Comparison Analysis for Substance Abuse and Sexually Risky Behaviours

	Substance Abuse			
	No (n=225)	Yes - Non Medical Substances (n=42)	Yes - Non Medical Substances and Injected Drugs (n=4)	F Value
Sexually Risky Behaviours	X	X	X	
With how many people have you had anal sex?	.28	.50	5.00[a]	46.571***
With how many people have you had oral sex?	2.60[b]	4.90	5.00	12.113***
With how many people have you had vaginal sex?	2.46[b]	4.93	5.50	13.661***
How often have you had anal sex?	.32	.60	2.00[a]	11.439***
How often have you had group sex?	.12	.00	2.00[a]	33.896***
How often have you had oral sex?	1.92[b]	2.55	2.75	17.476***
How often have you had vaginal sex?	1.85[b]	2.55	2.25	6.380**
How often have you had sex with	.00	.12	1.50[a]	5.516**
When you had sexual intercourse, how often was a condom used?	2.63[b]	1.83	1.50	4.343*
At what age did you experience your first mutual sexual experience?	2.36[b]	1.55	1.50	3.696*

a. significantly different than all the other groups
b. significant differences between no and yes - non-medical
*p<.05 **p<.01 ***P<.001

CHAPTER VI

DISCUSSION AND CONCLUSIONS

This chapter is divided into two sections. The results and interpretation of the findings presented in chapter V in conjunction with a summary of the findings as they relate to other studies are presented within the first section. Within the second and final section recommendations for future research in this area will be discussed.

Interpretation of Findings

The purpose of this study was to test a model. This model was developed specifically for male survivors, but drew on the conceptual framework of Folkman and Lazarus (1980) which used coping theory as a means of dealing with stressful life events. Coping theory was utilized to examine the relationship between CSA and sexually risky behaviours. The purpose was to determine whether males who been sexually abused used avoidant coping strategies (i.e. depression, suicide ideation, alcohol use, and substance abuse) as a means of dealing with their abusive experience.

Consistent with a portion of earlier studies, this study shows no clear relationship between a history of CSA and depression, suicide ideation, alcohol and substance abuse and sexually risky behaviours. While the data does not fit the proposed model it cannot be concluded that the relationships among the variables do not exist or that CSA is harmless (Fromuth, 1986). The reasons why these findings occurred will be discussed in the following section.

Hypothesis # 1 - Child sexual abuse is positively related to depression and suicide ideation

There was no significant difference between CSA on either depression or suicide ideation. So although there are no significant results to report for this hypothesis it is necessary to understand why this may have happened. This study examined the CSA variables independent of other variables and in relation to depression and suicide ideation. The results were not significant, possibly because CSA has been examined in isolation and not in combination with other factors. Researchers recently have begun to understand the need to examine CSA in combination with other factors such as family or social variables (Fromuth, 1986; Mullen, 1993; Runtz & Schallow, 1997). Nevertheless, although CSA was examined in isolation the findings are not altogether unusual.

Consistent with the findings of this study, Fromuth (1986) also found no significance between CSA and depression or suicide ideation in a group of university students. Her suggestion was that researchers focus on parental support which characterizes the home of the sexually abused individual in an attempt to understand the impact of CSA on the adult life of male survivors. Research conducted by Mullen (1993) also found no relationship between CSA and depression or suicide ideation. His conclusion was that any problems that have been found among individuals who have experienced CSA may be ameliorated within a university sample, citing that some effects like depression and suicide ideation may be repaired by academic, sporting or social success. It

is possible that this sample also had such effects alleviated by academic, social or sporting success. Brayden, Deitrich-MacLean, Dietrick, Sherrod, & Altermeier (1995) concluded their article by stating that there was still controversy regarding the extent to which sexual abuse itself is detrimental. Suggesting that it is sexual abuse in combination with other factors that accounts for the dysfunction and mental problems experienced by adult survivors. Several researchers have reported that when other factors are removed, there was no relationship between CSA and depression or suicide ideation (Briere & Runtz, 1990; Fromuth & Burkhart, 1988; Peters, 1988; Sedney & Brooks, 1984).

Conversely, there is empirical evidence in the literature suggesting a strong relationship between CSA and depression and suicide ideation (Blume, 1988; Lew, 1988; Runtz & Schallow, 1996) Browne and Finkelhor (1986) have reported that no effect or disturbance is universal. They recognize that there is variation in how survivors deal with their abusive experience. With regards to this variation, they report that many of the available clinical samples are based on men or women who have sought treatment and who's abusive experience has been reported, such samples could distort the outcomes that survivors experience as a result of their abuse. For male survivors there is still a stigma attached to admitting to an abusive experience. This means that they were victims and as Boston et al., (1989) reported the concept of victimization is feminine in orientation. So males are less likely to admit to being victimized. Browne and Finkelhor (1986) continue by reporting that those males who

present at clinics may be those who are most seriously affected by the abusive experience. These types of groups are the ones from which researchers have drawn their samples (Dimock, 1988; Olsen, 1990).

Hypothesis # 2 - Child sexual abuse is indirectly related to sexually risky behaviours through depression and suicide ideation

There was one significant relationship between CSA, depression and sexually risky behaviours. The influence of CSA was limited to an indirect effect through depression on only one of the dependent variables (i.e. "how often have you had anal sex?"). Males who had experienced the contact form of CSA, but who reported low levels of depression participated more often in anal sex than the other two groups. The finding that males who had been sexually abused had low levels of depression is contrary to prior research. Prior research suggests that depression is a psychological problem that many survivors deal with (Bartholow, Doll, Joy, Douglas, Bolan, Moss, Harrison, Moss & McKirnan, 1994; Dimock, 1988; Olson, 1990) however, as pointed out by Browne and Finkelhor (1986) no effect is universal and may be the result of interaction with other factors. For example, depression may have been alleviated within this sample as a result of academic success (Mullen, 1993). For many male survivors overcoming normal everyday experiences can be difficult, success in university would help to alleviate many negative feelings, including depression. If the survivor has experienced academic success, he may feel a sense of accomplishment in at least one area of his life.

In attempting to explain the reason why male survivors more often participate in anal sex, this may have something to do with the way male survivors view affection and sexual behaviour. Lew (1988) for instance, reports that for male survivors any display of affection have been inappropriately sexualized. This then leads to excessive and unsafe sexual behaviour (Lew, 1988). Lew (1988) reports that this is particularly true for male survivors who have experienced penetration of any kind. Male survivors begin to view this type of behaviour as normal, however, he does report that they may participate in it as means of distraction from their painful past. He continues by saying that there is a certain amount of excitement and even pleasure associated with the behaviour. In fact Briere and Runtz (1988) reported that males participated in some types of sexual behaviour as a means of developing close and intimate relationships and suggests that some males participate in certain behaviours as a means of dispelling any pain related to their abusive experience.

There was one significant relationship between CSA, suicide ideation and sexually risky behaviours. The influence of CSA was limited to an indirect effect through suicide ideation on only one of the dependent variables (i.e. "when you had sexual intercourse, how often was a condom used?"). Males who had experienced the non-contact form of CSA, but who report low levels of suicide ideation where less likely to wear a condom when having sexual intercourse. The findings that males who had been sexual abused had low levels of suicide ideation is consistent with prior research. However, much research that has

been conducted on suicide ideation in relation to CSA has consistently examined female survivors, this has resulted in what Ellis and Range (1991) term a feminine stereotypical behaviour. However, this does not mean that males who have experienced sexual abuse do not consider suicide (Lew, 1988). The results from this study simply mean that for this group, suicide ideation was not considered a viable option as a means of dealing with their abusive experience. The second part of the hypothesis was the use of condoms. There appears to be no research that has specifically looked at the relationship between suicide ideation and condom use. However, Lew (1988) gives a possible explanation for lack of condom use. Because male survivors have been inappropriately sexualized, this sexualization can lead to excessive and unsafe sexual practices. This may account for the findings of this study.

Hypothesis # 3 - Child sexual abuse is positively related to sexually risky behaviours

Contrary to the findings within this study, in one of the few studies that have examined male survivors (Bartholow, Doll, Joy, Douglas, Bolan, Moss, Hansen, & McKirnen, 1994), it was found that homosexual males who had experienced sexual abuse where more likely to participate in more risky sexual behaviours than those homosexual males who did not experienced sexual abuse. There are some important aspects to this study that need to be taken into account. First, this study included only homosexual men, who by the nature of their behaviour are assumed to be a highly risky group. Second, this study did

not have a comparison group of heterosexual men or another control group. Which means that any significance found in this study is limited specifically to the study. However, for this study, the Bartholow et al., (1994) shows that other factors may expedite a relationship between CSA and sexually risky behaviours, for example, drug use, family context.

While many researchers have examined the sexually risky behaviours of males they have, most frequently, not taken into account the man's sexual history (Boot, 1995; Des Jalais & Friedman, 1987). Thus, it is difficult to know whether the non-significant results reported in this study are characteristics of men from the various CSA groups or a result of a select group of males. More research is needed in this area.

Hypothesis # 4 - Child sexual abuse is positively related to alcohol use and substance abuse

There was no significant difference between CSA and either alcohol use or substance abuse. These findings may be interpreted as a need to examine alcohol use and substance abuse in conjunction with other variables. As suggested in other research it is often difficult to know exactly what is responsible for the relationships that have been found (Boston et al., 1989; Luster & Small, 1994; Rohsenow et al., 1988). This may be an indication that examining CSA in isolation with alcohol use and substance abuse is not an effective means of understanding the problems and issues of male survivors. Prior research has shown that male survivors often struggle with addictions

(Boston et al., 1989; Lew, 1988). However, as Rohsenow et al., (1989) has reported the relationship between CSA and alcohol use and substance abuse is tenuous at best.

Thus, it may be argued that CSA does not exist in a vacuum and that problems that people experience as a result of the experience often emerge within a matrix of social and family dynamics (Edwards & Alexander, 1996) or from a matrix of social and family disadvantages, that are often difficult to disentangle (Luster & Small, 1997; Runtz & Schallow, 1997). Mullen (1993) argues that CSA is not randomly distributed through the community and that emotional deprivation, physical misuse and sexual abuse tend to co-exist. Thus, there is a need for further research based on taking into account a broader range of intervening variables such as social and family dynamics.

Hypothesis # 5 - Child sexual abuse is indirectly related to sexually risky behaviours through alcohol and substance abuse

In considering the results of the second two-way ANOVA that examined the indirect relationship between CSA through alcohol and substance use and sexually risky behaviours, a discussion is required. As proposed earlier, to better understand the influence of the mediating variables the proposed model should be considered.

There were significant relationships between CSA, alcohol use and substance abuse and sexually risky behaviours. Males who had not experienced any form of CSA were more likely to participate in sexually risky behaviours.

Findings may have been influenced by selecting volunteers from a university course on sexuality which may have resulted in a higher incidence of some types of risky behaviours. Individuals with a propensity to act in a risky manner may take these types of courses to justify their risky behaviours. This could lead to erroneous conclusions and false assumptions (Beitchman et al., 1992). Consequently, there may be other factors that have inadvertently influenced the results of this study. Although, little research to date has examined the influence of CSA on sexually risky behaviours with the alcohol use and substance abuse acting as intervening variables, there have been a number of study that have examined alcohol use and substance abuse and sexually risky behaviours.

The association between alcohol use and substance practices and risky sexual behaviour have been well established in the empirical literature (i.e. Booth, 1995; Des Jarlais, Friedman, & Novick, 1989; Des Jarlais & Friedman, 1987; Fullilove et al., 1995). This study is consistent with prior research. Numerous studies have found that when males use alcohol and drugs they have more sexual partners regardless of the sexual activity (Booth, Watters & Chittwood, 1993; Lewis & Watters, 1991). These types of behaviours have seriously health consequences for those who participate.

Hypothesis # 6 - There will be a direct relationship between depression and suicide ideation and Sexually Risky Behaviours

There was no significant relationship between depression and sexually risky behaviours. However, there was a significant relationship between suicide

ideation and sexually risky behaviours. These result require further explanation. Non-significance may have been found between depression and sexually risky behaviours as individuals who experience depression are more likely to become withdrawn and isolated and less likely to be social. Becoming involved in sexually risky behaviours requires a certain amount of socializing, which may be difficult for someone who is experiencing depression. This finding is consistent with other research. Luster and Small (1994) report no relationship between depression and involvement in sexually risky behaviours, however, when examining suicide ideation they did find a relationship between suicide ideation and involvement in sexually risky behaviours. Students who report high levels of suicide ideation report having more sexual partners. However, Small and Kerns (1993) state that because their is no ordering of events it is difficult to know which came first. Luster and Small (1994) report that sexual risk taking was associated with other factors one of which is suicide ideation.

So consistent with prior research, this study shows that male students are not depressed, but who report high levels of suicide ideation are more likely to participate in risky sexual behaviour. However, it is difficult to know if they the suicide ideation comes before the sexual behaviour or is a result of the sexual behaviour. Longitudinal studies are needed to help clarify this relationship.

Hypothesis # 7 - There will be a direct relationship between alcohol use and substance abuse and Sexually Risky Behaviours

There was a significant relationship between alcohol use, substance

abuse and sexually risky behaviours. That male students would participate in sexually risky behaviours when they were under the influence of alcohol and/or drugs is not surprising. Alcohol use and substance abuse lower a persons inhibitions and they participate in activities that normally they would not consider. Thus, it would be more likely that males would participate in sexually risky behaviours. Fullilove et al., (1993) reported that males are more likely to participate in sexually risky behaviours when alcohol and substance abuse are present. Luster and Small (1994) concurred with finding, reporting that males who used drugs and drank alcohol were more likely to have five or more partners and to not use a condom when having intercourse. Neumark-Sztainer, Story, French, Cassuto, Jacobs and Resnick (1996) stated that some risky behaviours co-occurred and these included excessive drinking, drug use and sexually risky behaviours. However, all three studies indicate that other factors are also involved and that no one variable is responsible for the relationships that were found.

While the intent of this study was to examine the relationship between child sexual abuse and sexually risky behaviours, there is information that is not apparent from this study. Most males in this university sample who have experienced child sexual abuse are not suffering from depression, not abusing drugs and alcohol and have not attempted suicide. These male survivors have high levels of self-confidence and feel that others care about them. As Browne and Finkelhor (1986) report, no effect or disturbance is universal. For this

group of male survivors, it appears then, that they have dealt with their abusive experience in a positive manner.

Recommendations for Future Research

Another suggestion was actually put forth about 13 years ago (Tufts, 1984), has implications for a study such as this. According to Tufts (1984) some effects of CSA could be delayed. Although no sexually risky behaviours may be manifest in a sample of survivors at university, such effects may be yet to appear, and may manifest in studies of older survivors. Future research should look at clearly defined age groups (Tufts, 1984). For example, the outcomes of a sample of children cannot be compared to the outcomes of adolescents or of adults. Because of developmental issues, each group should be examined separately, only then will researchers have a firm understanding of effects of sexual abuse on each group and be able to hypothesize the possible outcomes that males experience. Second as Briere (1988) and Drauke (1993) both suggest, the very construct of CSA should be examined and an appropriate definition explicitly and precisely defined. It is essential that researchers examine CSA within the context of the home and other social environments. Scales should be constructed that include sexual abuse as well as the home and social context. Until that time, the results that we get from the clinicians and professionals who research CSA will continue to give contradictory findings, because of the many different scales that are often used to examine the after effects of CSA. It is understandable that it has taken so long for researchers to

examine other variables in conjunction with CSA. After all, it was only a few short decades ago that the reality of sexual abuse was forced into the spotlight by the women's movement. Prior to this time CSA was not considered a problem or an issue (Dinsmore, 1991). It has taken the clinical and professional community a little more time to understand that males also experience sexual abuse. Coping theory was put forward within this study in an attempt to understand how male survivors deal with their abusive experience. Given the non-significant findings in this study and its inconsistency with some previous studies, there is an obvious need for additional research in this area. Further, this study provides support for future research to consider the social and family context in relation to CSA.

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