

AN ABSTRACT OF THE THESIS OF

Ruth N. Owens-Lewis for the Master of Science Degree
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Title: TREATMENT AVAILABILITY IN KANSAS MENTAL HEALTH
CENTERS OF MALE VICTIMS OF INCEST.

Abstract approved: Cooper B Holmes

The present study investigated the treatment availability of male incest victims in Kansas community mental health centers. Directors in Adult Outpatient and Children Services were asked to complete and return a survey questioning treatment availability for victims of incest. The return rates for the adult and children surveys were 21 out of 30 (70%) and 22 out of 30 (73%) respectively.

An interaction was found between age and gender in treatment availability. The results of the study indicate that a greater percentage of females are treated at mental health centers than males, and, specifically a greater percentage of females are treated for incest than males in this population. No differences were found in screening for incest on intake. However, significantly more mental health centers were found to provide females rather than males with separate specific treatment programs for incest and more sexually abused females received treatment than did sexually abused males. Center directors responded that specific group treatment programs for victims of incest were equally available.


TREATMENT AVAILABILITY IN KANSAS MENTAL
HEALTH CENTERS FOR MALE VICTIMS OF INCEST

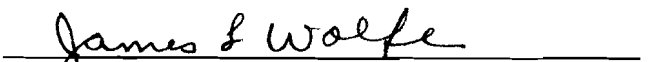
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Finally, this manuscript is dedicated to my parents. During their life, they have served as loving examples of those whose lives are quite meaningful, and who taught that children are our most precious gift.

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CHAPTER 1

LITERATURE REVIEW

Incest in our society produces social and personal problems which require victims to seek professional mental health (Ruch & Chandler, 1982). Baye (1984) stated that incest occurs in all types of families--whites, blacks, rich, poor, educated, or illiterate. Bockelheide (1978) noted that "the incest taboo" is a characteristic of almost every culture. Boatman, Korkan, and Schultz (1981) also commented that with incest, the innocent victim is the one who suffers and deals with keeping the secret. In the past 15 years, the extent of the emotional and psychological distress caused by incest victims has been increasingly revealed.

Swift (1977) noted that incest remains one of our society's most underreported crimes. Swift further reported that the incidence of sexual abuse of boys is less documented than for girls. The taboos of our society encourage or traumatize boys more than girls into remaining silent. Incest or sexual abuse manifests itself in boys somewhat differently and less identifiably than it does in girls. Health care professionals are reluctant to discuss, treat, or attempt to induce a reluctant and suspected male victim into disclosing sexual abuse, and in particular, incest. Transforming the natural nuclear family into a stepparent family may be a contributing factor, as

suggested by Perlmutter, Engel, and Sager (1982).

Berliner and Stevens (1982) found that while the general expectations of society demand that social workers aggressively seek out, confront, and treat those families in which incest exists, or is thought to exist, many social workers are reluctant to become involved in the treatment and prevention of child sexual abuse. This includes mental health professionals who are trained and empowered to provide the skills and healing climate needed for the treatment of the child and the family.

de Young (1982) further noted that many clients seek psychiatric help without revealing the incestuous act. Gelinas (1983) reported that treatment often proves to be effective only when the abuse surfaces.

In 1987, Kohn reported that one out of every six Americans was sexually victimized as a child. He stated that of these Americans, at least 25% to 30% of the females, and 10% to 16% of the males had experienced abuse ranging from fondling to intercourse. Often sexual abuse goes unreported and untreated because victims are unwilling or not able to talk about such painful experiences.

In 1977, Swift noted that societal attitudes may play an important role in the identification of victims and lack of treatment for males. For example, Swift noted that this society traditionally accepts females but not males seeking treatment.

The responsibility of identifying abuse victims rests with of health care providers. Although, school counselors, nurses, and physicians all have articles in their professional journals indicating a need to take assertive and protective action, two-thirds of an anonymous mail survey of 300 general practitioners and pediatricians in Seattle felt reporting the abuse would be harmful (James, Womack, & Stauss, 1978). In addition, the differences in vocabulary terms used by the health care and legal professions may further obscure the identification and treatment of incest victims (Adams & Roddey, 1981).

Johnson (1983) discussed the physician's role in recognizing incest patterns and arranging appropriate therapy when incest is expected. He admonished physicians to look beyond depression, drug abuse, promiscuity, seizures, enuresis, anorexia, and insomnia to determine the possibility of incest as an underlying cause.

In 1981, Geiser reported that less than a quarter of incest victims appear to be unaffected by the abuse. The remaining victims display psychological trauma such as sleep or eating disorders, anxiety, hyperactivity, learning problems, overt sexual acting out or preoccupation with sexual matters. In addition, trust, self-esteem, competency, and personal integrity are impaired. A study of 26 male and female incest victims, aged 13 to 18, revealed common traits of delinquency, chronic rule

violation, substance abuse, running away, a low tolerance of frustration, depression, and hostility toward authority figures (Fisher, 1983).

In some cases, the effects of childhood incest consistently carry over into adulthood, regardless of gender. Gelinas (1983) noted that in adulthood, victims commonly suffer from traumatic neurosis, relational imbalances, intergenerational risk, and problems of loyalty and power. Victims may, as adults, feel guilty, sexually confused and ashamed. Suicide, depression, and difficulty in establishing trusting relationships are also cited as common reactions (Daugherty, 1984). Boatman, Korkan, and Schultz (1981) also indicated damaged self-esteem, guilt, anger, and countertransference. More to the point, those who have studied the effects of incest in children of both sexes indicate common manifestations in victims as children, and later as adolescents and adults (Landis, 1956).

Incest is a matter of power, control, deceit, and betrayal by a family member (Baye, 1984). Baye further defined incest as a crime against the young, weak, innocent, trusting, and dependent family member; the most powerful person against the most powerless in the family. Baye (1986) said, "It is the very power that adults have over children that results, too often, in children's being unwilling accomplices in the act of incest" (p. 144).

According to Summit (1983), after the incident an accommodation syndrome develops in the victims consisting of secrecy, helplessness, entrapment, delayed disclosure, and retraction of disclosure.

Children learn the definition of right and wrong through the parameters set by adults. The ability of children to identify child sexual abuse increases the likelihood of stopping it and helping the child overcome its negative effects (Brassard, Taylor, & Kehle, 1983). Incestuous families, however, may appear to be well-adjusted, each member of the family supporting a facade creating a conspiracy of silence surrounding the abuse (Cohen, 1983). Cohen further stated that fathers usually appear to be overinvested and in the control of their family members by using threats, intimidations, or seduction, while mothers are passive and emotionally distant from the rest of the family.

Ney (1987) postulated that childrens' responses to incest fit into ten categories: identification with the aggressor, neurotic adoption, guilt, folie a deux (madness for two), depression, apathy, revenge, rebellion, search, and precocious development. de Young (1982) noted in a study of 45 paternal incest victims ages seven to thirty-eight years old, other responses include a high incidence of self-destructive, injurious behavior.

Father-son incest is rarely reported and the least

ommon of incest patterns, due in part to a social stigma attached to incestuous and homosexual experiences (Langsley, Schwartz, & Fairbairn, 1968; Swift, 1977; Vander Mey, 1988). Fathers engaging in incestuous acts with their children often experience unfulfilled sexual needs and rationalize these needs to defeat the child's resistance (Frude, 1982). Viewing incest as meeting primary sexual needs could lead to changes in the management of incest to include men as well as womens. Whether male incest victims seek individual or group counseling may depend on several variables, such as availability, financial stability, social stigma, the individuality of the case, and family pressure.

MacDonald (1986) and Dixon, Arnold, and Calestio (1987) have attempted to estimate and report the extent of male child sexual abuse to the psychological community in order to ascertain the need for treatment for these males. It is imperative that treatment programs be designed and made widely available to males.

According to MacDonald (1986), male incest is more prevalent than previously thought. Swift (1977) reported a survey of 1,800 college students and found that approximately 30% of the males reported at least one or more childhood sexual experiences with an adult. Forty percent of these reported three or more sexual experiences, and as many as 80% of these males reported their

experiences involved homosexual advances including but not limited to father-son incest.

Swift (1977) further reported that in a survey conducted in a mental health center over half of the cases involving adult male victims who were sexually abused as children were involved in incest. This survey noted that 33% of the child caseload dealt with young males but failed to report the percentage of incest cases in treatment.

Many times, therapy includes treating the family of the incest victim. Ney (1987) identified clear, common stages of treatment for incest: realization, protest, guilt, despair, re-evaluation of relationships, reconciliation, and reconstruction. According to Finkelhor (1986), several preconditions of incestuous abuse need to be considered for treatment: 1) the potential offender had some motivation to abuse the child; 2) the offender must overcome internal and external inhibitions to act on that motivation; and 3) the offender must undermine or overcome the child's resistance to the abuse. These are among the many issues that be addressed through therapy.

In 1984, Furniss reported that treatment of the incestuous family should include at least one or two conjoint family sessions where facts can be established. Following the initial family intake session, goals can be established for the family which include: the perpetrator, not the child, accepting the sole responsibility for the

sexual act; parents agreeing on the amount of day-to-day care of the child with family separations discussed openly; and perpetrator and the victim receiving therapy together.

Children have been sexually exploited throughout the centuries. In 1977, Swift noted that this issue had not been systematically studied, and the research literature was extremely limited. Children continue to be victimized, and the dearth of research hampers the amount of screening and treatment availability for male victims of incest.

Incest victims may be helped by routine inquiry of past history of incest and subsequent counseling or therapy (Jacobson & Richardson, 1987), although assistance appears to be more widely available for females than males (Swift, 1977; Vander Mey, 1988). Since availability of treatment for males is not well known, the present study focused this issue by surveying community mental health centers in Kansas.

CHAPTER 2

METHOD

Sample

Directors of adult and children services of the 30 community mental health centers in Kansas were chosen to participate in this study. Community mental health centers, as defined by the Kansas Statutes Annotated 19-4002 (1988), are non-profit organizations, created with state and federal funding for the purpose of providing mental health counseling, evaluation, and identification of mentally retarded individuals residing in the community.

Kansas was chosen to be representative of the Midwest geographic region. Directors of adult and children services in each mental health center were asked to complete a survey. This made a total of 60 subjects. A minimum of 30 surveys was required for this study (15 adult services, 15 children's services). The return rates were 21 for adult services and 22 for children's services.

Instrument

The 60 directors were asked to complete a survey consisting of 10 items to be answered as an estimated percentage basis or as yes/no. The survey (see Appendices A and B) included questions concerning specific treatment programs for victims of incest in individual therapy and group therapy. The survey inquired whether or not routine screening for incest is part of the intake for male as well

as for female clients.

Procedure

Each packet contained a cover letter (see Appendix C) detailing the reason for the study and the administration of the instrument. Subjects were given a guarantee of confidentiality in that names were not used. A copy of the appropriate survey (see Appendices A or B) for either adult or children service directors was enclosed along with a self-addressed, stamped, return envelope. Subjects were informed that the final results of the study would be made available to them at the completion of the study.

Upon completion of the survey, the subjects returned the instrument to the researcher. If subjects failed to respond within two weeks after having received the survey, a follow-up letter (Appendix D) was sent requesting that the survey be completed and returned. If no responses was received within three weeks after the first contact, the subject was considered a non-respondent.

CHAPTER 3

RESULTS

Data Collection

The surveys were mailed to each of the mental health centers in May, 1990. Included were instructions that the subjects were to complete the surveys and return them by mail to the examiner in the envelope provided. Those mental health centers not returning the surveys in two weeks, were sent a second survey. The return rates for the adult and children surveys were 21 out of 30 (70%) and 22 out of 30 (73%) respectively. After these responses were received, statistical analyses were carried out on the data.

The data from Items 1 and 2 were analyzed with a 2 (Gender: male or female) x 2 (Age: child or adult) analysis of variance. A significant main effect for Gender was obtained, $F(1, 83) = 12.36, p < .0001$. Female clients ($M = 54.43\%$) composed a significantly higher percentage of yearly caseloads than males ($M = 45.34\%$). There was also a significant Gender x Age interaction $F(1, 83) = 18.69, p < .0001$. Fisher's Least Significant Difference (LSD) test was used to analyze the means. The results appear graphically in Figure 1. No significant differences were found when men and women, boys and girls, men and girls, and women and boys were compared by Fisher's LSD.

Responses to Items 3 and 4 were also analyzed by a 2

(Gender) x 2 (Age) analysis of variance. This analysis produced a significant main effect for gender $F(1, 83) = 32.45$, $p < .0001$. Female clients ($M = 32.52\%$) were again found to compose a significantly higher percentage of yearly caseloads than males ($M = 10.00\%$). There was no significant main effect for Age nor interaction for Gender x Age.

Questions 5 through 10 were analyzed using the Chi-square test of independence. This test was used to examine the null hypothesis that treatment availability was the same for men, women, boys, and girls in Kansas community mental health centers. Each test compared adults and children, males and females, and the interaction.

Questions 5 and 6 dealt with whether or not mental health centers routinely screen for incest upon intake. No significant differences were found.

Whether or not individual centers provide separate specific treatment programs for victims of incest was addressed by Questions 7 and 8. No significant difference was found in the provision of such treatment programs when children and adults were compared, nor when men, women, boys, and girls were compared. However, there was a significant difference in the provision of treatment programs when males and females were compared, $\chi^2(1) = 7.86$, $p < .001$. More health centers provided women than men with separate specific treatment programs for incest.

In Question 9, the surveyed centers were asked if they provide specific group counseling for sexually abused subjects. As in Questions 7 and 8, there were no significant differences in comparisons between adults and

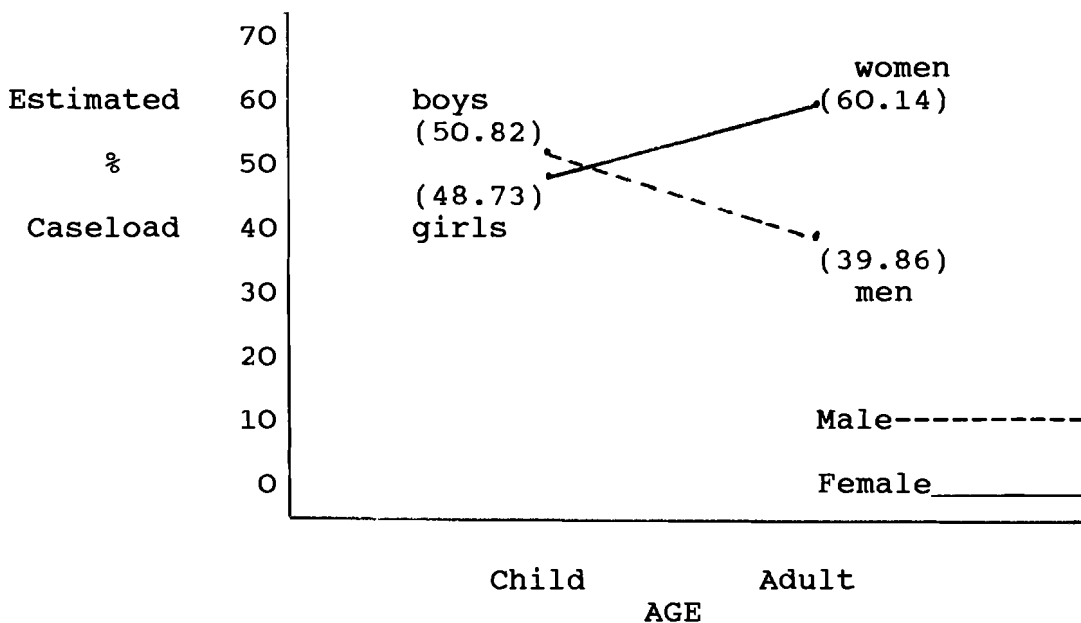


Figure 1. Interaction of Means on Items 1 and 2 Between Gender x Age for Yearly Caseloads in Kansas Community Mental Health Centers.

children, and among men, women, boys, and girls. However, there was a significant difference in the availability of group counseling when men and women were compared, $\chi^2(1) = 15.08, p < .001$. More centers provide specific group counseling for sexually abused women than for sexually abused men. Whether or not the surveyed centers provide specific group treatment programs for victims of incest was addressed in Question 10. No significant differences were obtained.

CHAPTER 4

DISCUSSION

The present study focused on screening, intake, and availability for victims of incest in Kansas community mental health centers because treatment availability for men is not well known. Results indicate that a greater percentage of women are treated at mental health centers than men and, specifically, a greater percentage of women are treated for incest than men in this study.

There were no differences found as to whether or not mental health centers screen for incest upon intake. As indicated by Perlmutter, et al. (1982), this may be a result of the reluctance of mental health professionals to become involved in the treatment and prevention of incest. These health care professionals need to take more assertive and protective action with regard to victims of incest.

In particular, mental health care professionals need to overcome their reluctance to approach this subject. They need to look beyond the outward symptoms of depression, drug abuse, promiscuity, seizures, enuresis, anorexia, and insomnia to determine if incest is the underlying cause (Johnson, 1983). Improved screening measures on their part would be beneficial in helping them to achieve this end.

No comparable differences for males and females and adults and children in screening clients existed on intake

for incest. Neither gender nor age seemed to affect the frequency with which Kansas community mental health centers screened for incest.

Though no differences were found in screening taking place, significantly more mental health centers provided females rather than males with separate specific treatment programs for incest and more sexually abused females received treatment than did sexually abused males. Perhaps male victims who do admit to a history of incestuous abuse decline treatment more often than female victims. The estimated caseload for adult females is substantially greater than males, suggesting greater male fears of the social stigma concerning such experiences. Male victims who have experienced incest may be expressing their reticence to being stigmatized. As Ney (1987) postulated, this is unfortunate because the treatment of these individuals may lead, at last in part, to the successful resolution of symptoms related to these abuses.

A second probable reason for the disparity in treatment availability may be that females are more likely to admit to being the victims of incestuous relations. This line of reasoning concurs with Swift (1977) who noted that the taboos of our society encourage or traumatize males more than females into remaining silent. Since females, as victims of incest, are less likely to be socially stigmatized by admissions of being the victims of

incest, they may be more inclined to come forward for treatment than males.

Center directors responded that specific group treatment programs for victims of incest were equally available. Upon analysis of their responses, no significant differences were found for any of the parameters addressed. This concurs with Swift's 1977 finding that societal attitudes may play a part in treatment availability.

Center directors were also asked how they define the term "incest." In general, they described incest as being the sexual contact between family members including parents, step-parents, brothers, sisters, grandparents, aunts, and uncles. It should be noted that first cousins were not listed. They described incestuous behaviors as ranging from touching and fondling to intercourse.

Directors from children's services, unlike those of adult services, included in their definitions that an age difference of approximately five years usually exists between family members in the case of incest. The majority of these cases involved an adult in a parental role and child incest. Directors of the children's services may have indicated this age difference because they were more aware of this adult/child incest pattern.

The lack of available treatment programs for male victims of incest in Kansas community mental health centers

has not been well researched in the past. It is suggested that future studies take a closer look at the effects that court system referrals may have in the identification of the perpetrators and the victims of incest. This may lead to increased treatment availability for those individuals involved. It is imperative that mental health providers make treatment for male victims of incest easily accessible for those who need it.

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APPENDIX A

FORM FOR ADULT SERVICES

1. Estimate of percentage of yearly center adult caseload that are males. _____
2. Estimate of percentage of yearly center adult caseload that are females. _____
3. Estimate of yearly center caseload of adult females that are victims of incest. _____
4. Estimate of yearly center caseload of adult males that are victims of incest. _____
5. Do you screen, on intake, adult females for incest?
Yes _____ No _____
6. Do you screen, on intake, adult males for incest?
Yes _____ No _____
7. Does your center provide a separate specific treatment program for adult female victims of incest?
Yes _____ No _____
8. Does your center provide a separate specific treatment program for adult male victims of incest?
Yes _____ No _____
9. Does your center provide specific group counseling of sexually abused adult clients?
Females: Yes _____ No _____
Males: Yes _____ No _____

10. Does your center provide a specific treatment program for adult incest victims?

Group Therapy?

Males_____ Females_____

11. How do you specifically define incest?

APPENDIX B

FORM FOR CHILDREN'S SERVICES

1. Estimate of percentage of yearly center children's caseload that are boys. _____
2. Estimate of percentage of yearly center children's caseload that are girls. _____
3. Estimate of yearly center caseload of girls that are victims of incest. _____
4. Estimate of yearly center caseload of boys that are victims of incest. _____
5. Do you screen, on intake, girls for incest?
Yes _____ No _____
6. Do you screen, on intake, boys for incest?
Yes _____ No _____
7. Does your center provide a separate specific treatment program for female child victims of incest?
Yes _____ No _____
8. Does your center provide a separate specific treatment program for male child victims of incest?
Yes _____ No _____
9. Does your center provide specific group counseling of sexually abused children?
Girls: Yes _____ No _____
Boys: Yes _____ No _____

10. Does your center provide a specific treatment program for child incest victims?

Group Therapy?

Girls _____ Boys _____

11. How do you specifically define incest?

APPENDIX C

Dear Director:

I am completing requirements to earn a Master of Science degree from Emporia State University at Emporia, Kansas. I am interested in a study regarding the screening and treatment for incest victims in Kansas mental health centers. This study will produce data that could be used by interested individuals, groups, or organizations regarding the utilization of mental health professionals employed by community mental health centers in Kansas.

I will appreciate your assistance in an inquiry into the subject by completing the enclosed questionnaire and returning it to me prior to May 18, 1990, in the pre-addressed, stamped envelope enclosed. The average time needed to complete the questionnaire is 15 minutes.

My commitment to you is to send a summary of the study's result. Thank you for your cooperation.

Sincerely,

Ruth N. Owens-Lewis

Enclosures

APPENDIX D

May 19, 1990

Dear Director:

About two weeks ago, I wrote you seeking your opinion on the screening and treatment availability for incest victims at Kansas mental health centers. As of today, I have not yet received your completed questionnaire.

I am writing to you again because of the significance each questionnaire has to the usefulness of this study. In order for the results of this study to be truly representative of the opinions of each director of these mental health centers, it is essential that each person in the sample return their questionnaire.

In the event that your questionnaire has been misplaced, a replacement is enclosed. Please fill it out and return it to me in the enclosed self-addressed, envelope as soon as possible. If you have already completed and returned it to me please accept my sincere thanks.

Your cooperation is greatly appreciated.

Cordially,

Ruth N. Owens-Lewis
Masters Candidate
Emporia State University

Enclosure