

Childhood Abuse and Family Sexual Attitudes in Sexually-Compulsive Males: A Comparison of Three Clinical Groups

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The study examined the backgrounds of 15 males undergoing treatment for compulsive sexual behavior (CSB). Researchers used a self-report questionnaire and focused on the areas of childhood sexual, physical, and emotional abuse—and sexual attitudes within the family of origin. Findings were compared to 33 males undergoing treatment for chemical dependency or psychogenic sexual dysfunction. Results show that the CSB group reported significantly more sexual abuse in childhood than either of the other two groups. The CSB group also reported significantly more restrictive sexual attitudes within the family of origin than the chemical dependency group. The sexual dysfunction group did not differ significantly from either group. No difference in reported childhood physical or emotional abuse was found among the three groups. The results lend support to the view that sexual abuse and restrictive sexual attitudes are important early developmental correlates of CSB.

This study examined the early developmental correlates of compulsive sexual behavior (CSB) in an effort to understand its etiology. CSB, as defined here, is a symptom of an underlying obsessive-compulsive disorder, driven by anxiety reduction mechanisms that provide temporary relief for psychological distress. The behavior, however, ultimately produces greater distress, as it becomes part of a compulsive cycle in which negative consequences for sexual behavior and repeated failed attempts to change behavior are often experienced. This study focused on the early development correlates of CSB, since, in the researchers' view, the development of valid treatment approaches must begin with an accurate conceptualization of the problem. The study examined the backgrounds of males who present for treatment of CSB and then compared the findings to the backgrounds of males undergoing treatment for chemical dependency and psychogenic sexual dysfunction in the areas of childhood sexual, physical, and emotional abuse—and restrictive sexual attitudes within the family of origin. The sexually compulsive sample was confined to male individuals with non-criminal problematic sexual behavior.

THEORIES OF ETIOLOGY

Coleman suggests that sexually compulsive individuals have a history of childhood abuse that leads to the

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development of a shame-based personality.¹ The shame and associated anxiety or depression are symptoms of an underlying obsessive compulsive disorder. Carnes supports the view that sexually compulsive individuals have suffered childhood abuse. His research shows that 81% of respondents to a national survey of "recovering sex addicts" reported childhood sexual abuse, 97% reported emotional abuse, 72% reported physical abuse.²

The child responds to this trauma by developing feelings of shame. Brown has described shame as a perception of "total failure of self."³ The feeling grows out of a misperception by the child that he or she was the cause of the abuse or neglect within the family of origin, a consequence of the lack of established boundaries between parent and child in the egocentric stage of childhood.^{4,5} Abusive experiences in childhood almost inevitably interfere with the process of healthy attachment to and separation from parents, which underlies the development of self esteem and effective interpersonal functioning. The child attempts to identify with parents who are abusive, but he or she internalizes shame and fails to develop the secure foundation that aids effective separation.^{6,7} The abuse, therefore, leads to low self-esteem and poor interpersonal functioning. Faced with the psychological pain and anxiety that accompanies low self-esteem and loneliness, individuals are vulnerable to any agent that causes physical or psychological changes that temporarily distract them from pain or serve as an anxiety reduction mechanism.⁸ The agent fails to resolve the real problem; and the shame, low self-esteem, and anxiety return, prompting a renewed need to engage in the behavior. The out-of-control sense results in greater feelings of shame. In addition, preoccupation serves as a barrier to building and maintaining intimacy. The cycle of compulsive behavior, therefore, is both a result and a cause of intimacy dysfunction and feeds the intergenerational cycle of intergenerational dysfunction in an individual's family.⁹

Why might an individual be drawn to sexual behavior as an anxiety reduction mechanism rather than to other forms of behavior? Coleman suggests that shame is frequently linked with sexuality in sexually compulsive individuals, that shameful sexual attitudes are often learned early in the family, and that acting-out sexual behavior can become an expression of shame.¹⁰ The development of sexual shame is sometimes linked to the pairing of shaming experiences with sexual ones, as in sexual abuse or condemnation of normal sexual play or masturbation. But it also can be more subtly linked to multi-generational attitudes about sexuality and touch, lack of information, and highly restrictive religious beliefs.¹¹ In addition, powerful sociocultural messages portray sex as the

key to success, love, and happiness—and they can feed the compulsive cycle.

In addition to psychological and sociocultural factors that contribute to obsessive-compulsive behavior, a neurological basis may exist for the disorder. Biological factors may be precursors or signs of some form of obsessive-compulsive disorder and may manifest themselves both in behavior and neuroanatomic abnormalities.¹² Although its origins are undoubtedly complex, the etiology of CSB seems to involve a combination of 1) abuse and neglect in the family of origin; 2) the existence of sexual shame in the compulsive individual, which is rooted in abuse and highly restrictive sexual attitudes in the family of origin; and 3) sociocultural and biological influences.

In addition, individuals are often susceptible to more than one type of "fix" for their psychological distress. Coleman suggests that chemically dependent individuals may show a higher incidence of CSB than others.¹³ Carnes reports that 42% of the respondents to a survey of sexually compulsive individuals report chemical dependency and 38% report eating disorders.¹⁴ Alcohol may be used to anesthetize pain about other kinds of behavior such as CSB,¹⁵ or it may enable individuals who feel shameful about their sexuality to temporarily feel confident enough to have sex.¹⁶ Chemically dependent individuals can develop sexually compulsive patterns before treatment or replace alcohol with compulsive behavior of some type after treatment. If the underlying intimacy difficulties are not addressed among chemically dependent or sexually compulsive individuals, the individual may simply substitute symptoms. Unfortunately, as Carnes suggests, the chemical dependency field often continues to assume that problematic sexual behavior will change when a client gains sobriety. It may, in fact, sometimes worsen.¹⁷

RELATIONSHIP BETWEEN COMPARISON GROUPS AND DEPENDENT VARIABLES

The study compared sexually compulsive males to a group of chemically dependent males and a group of males with psychogenic sexual dysfunction. In order to formulate hypotheses about how the CSB group might compare to these other groups in the areas of sexual, physical, and emotional abuse—and restrictive sexual attitudes in the family of origin—it is necessary to review the literature that addresses the relationship of chemical dependency and psychogenic sexual dysfunction to the relevant variables.

Childhood sexual abuse. The literature shows that between 15% to 38% of women and 5% to 16% of men from non-clinical populations have been sexually victimized as children,^{18,19} although some studies show the figures ranging from 6% to 62% for women and from 3% to 31% for men.^{20,21} Methodological differences among studies appear to account for the wide variance in findings. Studies that interview subjects and use multiple questions to help assess for abuse yield higher reports, at least in studies that have examined women.²² The most thorough studies in terms of sampling techniques, sample size, and careful definition of sexual abuse, use multiple questions to assess for abuse and tend to yield results between 15% to 38% for women and 5% and 16% for men.²³⁻²⁷ The sexual abuse of women has been studied much more frequently than the sexual abuse of men; few clinical or empirical studies have been published on male victims.²⁸

Studies have, on average, found a greater prevalence of childhood sexual abuse among chemically dependent populations. Studies show a 20% to 75% occurrence for women.²⁹⁻³⁸ Only one published prevalence study was found that examined childhood sexual abuse among chemically dependent men, and it reported that 42% of an inpatient population of teenage males reported childhood sexual abuse.³⁹ One article referred to an unpublished survey showing that 25% of the chemically dependent men studied reported childhood sexual abuse.⁴⁰ Several recent studies have directly compared the prevalence of sexual abuse between chemically dependent and non-chemically dependent women, and each study has found significantly higher levels of sexual abuse in the chemically dependent group.⁴¹⁻⁴⁵ However, no studies were found that directly compared the prevalence of sexual abuse between chemically dependent and non-chemically dependent men. Therefore, although it appears that the prevalence of sexual abuse is clearly higher among chemically dependent women than among non-chemically dependent women, we can only speculate at this point that the prevalence may be higher among chemically dependent men than non-chemically dependent men.

Kaplan,⁴⁶ and Masters and Johnson⁴⁷ cite sexual abuse as only a rare factor in the etiology of sexual dysfunction. No studies were found that cited any of the forms of childhood abuse—sexual, physical, or emotional—as factors that distinguish sexually dysfunctional males or females from non-clinical males or females. Performance anxiety, lack of communication with partner, rigid sexual attitudes, and lack of sexual information are the most frequently cited factors.⁴⁸⁻⁵² Therefore, it is expected that males with psychogenic sexual dysfunction show prevalence rates fairly close to a non-clinical population, although there is no direct empirical evidence to support this assumption.

Childhood physical abuse. Prevalence data for physical abuse among chemically dependent samples were found in only three studies. Covington and Kohen report that 52% of the alcoholic women studied reported physical abuse, although they did not distinguish between abuse suffered during childhood and adulthood.⁵³ Schaefer, Sobieraji, and Hollyfield studied 100 chemically dependent men using a questionnaire with specific behavioral indicators of childhood physical abuse. They found that 31% of subjects had been abused in childhood.⁵⁴ In a study that looked at physical abuse in a mixed-sex sample of 178 residential alcohol/drug addicts, Cohen and Densen-Gerber reported that 35% of the sample were physically abused by a male parent, and 24% by a female parent, although the extent of the overlap between these two statistics was not reported.⁵⁵ Two studies compared prevalence of physical abuse between a chemically dependent and a non-chemically dependent sample. Miller, Downs, and Gondoli report that significantly more of the chemically dependent females in their study were physically abused as children than were the non-chemically dependent, non-clinical females—although prevalence data were not reported.⁵⁶ Covington and Kohen did not find significant differences in the amount of reported physical abuse between chemically dependent women reported physical abuse.⁵⁷ No studies compared male chemically dependent and non-chemically dependent samples. Therefore, the literature only partially supports the hypothesis that there is more physical abuse in the background of chemi-

cally dependent women than non-chemically dependent women; and it does not address the question of physical abuse in the background of chemically dependent versus non-chemically dependent men. However, prevalence data suggests that more physical abuse occurs in the background of chemically dependent men than in non-chemically dependent men.

No published studies were found that address the prevalence of physical abuse among males with psychogenic sexual dysfunction, and physical abuse is not cited among experts as an etiological factor in the development of sexual dysfunction.^{58,59} Therefore, it is expected that sexually dysfunctional males will reflect prevalence rates that are fairly close to a non-clinical population for physical abuse.

Childhood emotional abuse. No published studies were found that investigated the prevalence of childhood emotional abuse among non-clinical samples, chemically dependent samples, or sexually dysfunctional samples. However, all kinds of family dysfunction have been theoretically linked with chemical dependency, including emotional abuse,^{60,61} although emotional abuse is not cited among experts as an etiological factor in the development of sexual dysfunction.^{62,63}

Restrictive sexual attitudes. Although many studies have investigated the physiologically based sexual difficulties associated with chemical dependency, only one published study was found that investigated the sexual attitudes of a male chemically dependent sample compared to a non-chemically dependent sample. This study found no difference in sexual attitudes, except for a lesser degree of sexual satisfaction among the chemically dependent sample.⁶⁴ However, restrictive sexual attitudes have sometimes been theoretically linked with the general relationship difficulties suffered by many chemically dependent individuals.⁶⁵ Overall, the literature that addresses the relationship between chemical dependency and restrictive sexual attitudes is scanty and inconclusive.

Much theoretical speculation has linked restrictive sexual attitudes to male psychogenic sexual dysfunction. However, the definition of restrictive sexual attitudes has more often meant rigid sex role stereotyping, focus on coitus as the central feature of sexual encounters, and exaggerated notions about what constitutes adequate sexual performance.⁶⁶⁻⁶⁹ It has less often meant belief that sex is inherently wrong or only acceptable under certain very narrow conditions, as it is defined in this study. Studies that have examined sexual attitudes before and after successful sex therapy for male psychogenic sexual dysfunction have found positive changes in sexual attitudes, including decreased sex-role stereotyping, decreased negativity toward sex in general, and decreased negativity toward masturbation.⁷⁰⁻⁷²

Studies that have compared sexual attitudes between males with psychogenic sexual dysfunction and non-clinical males or males with organic sexual dysfunction have found mixed results. Two such studies found some difference in amount of sexual knowledge but no other difference in sexual attitudes.^{73,74} One study found significant differences between males with psychogenic sexual dysfunction and non-clinical males in the belief in rigid myths about sex roles and sexual performance.⁷⁵ No studies were found that examined sexual attitudes in the family of origin. So, although the literature seems to support the notion that re-education about sexual attitudes can be effective sex therapy for males with psychogenic sexual

dysfunction, it is less clear whether these sexual attitudes can actually distinguished males with psychogenic sexual dysfunctions from other males. Even if these sexual attitudes are clearly linked with sexual dysfunction, it is unclear whether restrictive sexual attitudes, as they are defined in this study, are linked with sexual dysfunction.

Based on this review of literature, the following hypotheses seem warranted. It is hypothesized that there will be a greater amount of childhood sexual, physical and emotional abuse among subjects from the CSB group and the chemical dependency group than among subjects from the sexual dysfunction group. The literature does not suggest a clear hypothesis about differences in the amount of restrictive sexual attitudes within the family of origin among the three clinical groups. Therefore, no hypothesis will be offered. Rather, the study will ask the question of whether there are differences among the three groups.

METHOD

The study examined 48 men between the ages of 18 and 73 who were undergoing treatment in a group therapy setting for one of three clinical issues: 1) chemical dependency (CD), 2) CSB, or 3) sexual dysfunction (SD).

The CD group consisted of 24 men in inpatient group therapy at Golden Valley Health Center, Golden Valley, MN. Individuals in the group began treatment between April 1986 and September 1986.

The CSB group consisted of 15 men in inpatient group therapy at Golden Valley Health Center who began treatment between October 1985 and September 1986. The SD group consisted of nine men in outpatient group therapy at the Program in Human Sexuality, University of Minnesota, Minneapolis, who began treatment between October 1985 and March 1986. All participation in group therapy for the three groups was voluntary.

MEASURES, INSTRUMENTS, AND PROCEDURES

Independent variable. The independent variable in this study was the clinical category of each of the three groups chosen for comparison. Subjects had presented themselves for group therapy for one of the three clinical groups. Although different subjects began treatment at different times during the study period, they all filled out the questionnaire within the first two weeks of the treatment program as part of an initial assessment and evaluation. All members of the groups who began treatment during the study period were administered the questionnaire, but only some of the members were retained in the samples studied.

All members of the CD group who considered themselves sexually compulsive or who had received treatment for CSB—or who had been arrested or legally apprehended for inappropriate sexual behavior—were excluded. All members of the CSB group who considered themselves to be chemically dependent (in addition to sexually compulsive) or who had undergone previous chemical dependency treatment were excluded. The goal was to limit the sexually compulsive sample to individuals with non-criminal problematic sexual behavior. All members of the SD group who considered themselves chemically dependent or sexually compulsive—or who had undergone treatment for either disorder—were excluded. The nature of the sexual dysfunctions in this group included psychogenic erectile dysfunction and premature ejacula-

tion. The possibility that some of the members of the CD or CSB group might show symptoms of sexual dysfunction was not controlled for, and, in fact, would be expected to occur.

Dependent variable. The dependent variables—childhood sexual, physical, and emotional abuse, and restrictive sexual attitudes in the family of origin—were measured by a self-report questionnaire. The twenty-page questionnaire consisted of several scales for various exploratory research studies being undertaken at the Program in Human Sexuality, Minneapolis. For purposes of this study, the questionnaire consisted of demographic information, three questions regarding chemical dependency, four questions regarding CSB, five questions regarding sexual offenses, three questions that addressed the issue of sexual and physical and emotional abuse during childhood, and 11 items that addressed restrictive sexual attitudes within the family of origin.

Respondents were provided the opportunity on the restrictive sexual attitudes items to mark whether they, their mother, and their father would have agreed with certain statements about sexuality that might have applied when the respondent was age 13 or younger (e.g., "masturbation is unhealthy," "sex is dirty," and "sexual relations between person of the same sex are abnormal").

Analysis. Data were analyzed using the one-way analysis of variance (ANOVA), with the significance level set at .05. When the ANOVA yielded significant results, the three groups were compared to each other using Fisher's LSD, with the significance level again set at .05. Demographic data were analyzed with chi square, with the exception of age, which was analyzed with ANOVA. The significance level in both cases was set at .05.

RESULTS

Demographics. There were no significant differences between groups on the demographic variables of relationship status, sexual orientation, racial background, size of community while growing up, religion practiced in family of origin, or religion practiced now. There were, however, significant differences on the variables of age, education, occupation, and number of parents in the home while growing up. The CSB group was significantly older (mean age of 45.9) than the CD group (mean age of 34.0); the SD group (mean age of 37.4) did not significantly differ from the other two.

The CD group had significantly less education than either of the other two groups; 50% had at least some college, compared to 80% in the CSB group and 100% in the SD group. Similarly, the CD group reported a significantly lower level of employment than either of the other two groups; 70% were employed in technical, skilled, and semi-skilled labor occupations, compared to 28% in the CSB group and 12% in the SD group. These latter two groups tended to report a greater number of occupations in managerial and professional occupations. The CSB group also reported a significantly different home situation while growing up than did the other two groups; 100% reported that both parents were in the home, compared to 78% of the SD group and 54% of the CD group.

Childhood sexual abuse. The results of the ANOVA for the childhood sexual abuse item yield an F of 3.5212 and a probability of .0380, and the hypothesis of no difference among groups is rejected. Group means are 4.40 for the CSB group, 4.89 for the SD group, and 4.88 for the

CD group, with 5 equalling "never abused" and 1 equalling "very frequently abused" on the questionnaire for the sexual, physical, and emotional abuse items. Comparisons between the three clinical groups using Fisher's LSD show significantly higher sexual abuse in the CSB group than in the SD and the CD groups. No significant differences were found between the CD group and the SD group. Prevalence data (See Table 1) show that 46.7% of the CSB group reported sexual abuse in childhood; 8.3% of the CD group reported such abuse; and 11.1% of the SD group reported such abuse.

Table 1 Prevalence Data For Childhood Sexual Abuse

Group Number	1	2	3
Clinical Group	Compulsive Sexual Behavior	Sexual Dysfunction	Chemical Dependency
N	15	9	24
N reporting sexual abuse*	7	1	2
N reporting no sexual abuse**	8	8	22
% reporting sexual abuse	46.7%	11.1%	8.3%

*Answered "frequently," "occasionally," or "rarely" to the question, "Were you sexually abused as a child?"

**Answered "never" to the question, "Were you sexually abused as a child?"

Childhood physical abuse. Results of the ANOVA yield an F of 1.863 and a probability of .167, and the hypothesis of no difference among groups is accepted. Group means are 4.14 for the CSB group, 4.78 for the SD group, and 4.67 for the CD group. Prevalence data (see Table 2) show that 50% of the CSB group reported physical abuse in childhood, 16.7% of the CD group reported such abuse, and 11.1% of the SD group reported such abuse, although these differences were not significant.

Table 2 Prevalence Data For Childhood Physical Abuse

Group Number	1	2	3
Clinical Group	Compulsive Sexual Behavior	Sexual Dysfunction	Chemical Dependency
N	14	9	24
N reporting physical abuse*	7	1	4
N reporting no physical abuse**	7	8	20
% reporting physical abuse	50.0%	11.1%	16.7%

*Answered "frequently," "occasionally," or "rarely" to the question, "Were you physically abused as a child?"

**Answered "never" to the question, "Were you physically abused as a child?"

Childhood emotional abuse. Results of the ANOVA yield an F of 2.187 and a probability of .124, and the hypothesis of no difference among groups is accepted. Group means are 3.33 for the CSB group, 4.44 for the SD group, and 3.92 for the CD group. Prevalence data (see Table 3) show that 80% of the CD group reported such abuse, and 33.3% of the SD group reported such abuse, although these differences were not significant.

Restrictive sexual attitudes scale The restrictive sexual attitudes scale was a summation of 33 scores (11 items x 3 scores/items) addressing sexual attitudes within the family of origin. An internal consistency analysis of the 33 scores, computing Cronbach's coefficient alpha, yielded a reli-

ability coefficient of .8673, justifying the summation of the items into a scale. No hypothesis was formulated with respect to the restrictive sexual attitudes scale. However, data from this scale were analyzed and the results of the ANOVA yield an F of 7.9591 and a probability of .0011, indicating that a hypothesis of no difference between the three groups on this scale would have been rejected. Group means are 17.87 for the CSB group, 14.22 for the SD group, and 11.50 for the CD group. Comparison of the three groups to one another using Fisher's LSD shows that the amount of reported restrictive sexual attitudes in the family of origin was significantly higher in the CSB group than in the CD group. Although the mean for the SD group lay between the higher mean for the CSB group and the lower mean for the CD group, no significant differences were found between the CSB group and the SD group—or between the CD group and the SD group.

Table 3 Prevalence Data For Childhood Emotional Abuse

Group Number	1	2	3
Clinical Group	Compulsive Sexual Behavior	Sexual Dysfunction	Chemical Dependency
N	15	9	24
N reporting emotional abuse*	12	3	12
N reporting no emotional abuse**	3	6	12
% reporting emotional abuse	80.0%	33.3%	50.0%

*Answered "frequently," "occasionally," or "rarely" to the question, "Were you emotionally abused as a child?"

**Answered "never" to the question, "Were you emotionally abused as a child?"

Data on the complete scale do not distinguish among family members. They simply provide a composite of attitudes within the family. Given the finding of significantly more restrictive family attitudes in the CSB group than in the CD group, the question about whose attitudes were restrictive within the family of sexually compulsive individuals remains unanswered. In order to begin speculating about this question, three subscales were formed and called RSAS-F (father), RSAS-M (mother), and RSAS-R (respondent). An internal consistency analysis of each of the three subscales (11 items each), computing Cronbach's coefficient alpha, yielded reliability coefficients of .7978, for RSAS-R, justifying the creation of each of the subscales. Each subscale was subsequently used to analyze for differences between treatment groups using one-way ANOVA. The results of these three ANOVAs suggest that significant differences between groups may exist for RSAS-M and RSAS-R, but not for RSAS-F. Comparisons of the three clinical groups using Fisher's LSD for the RSAS-M and RSAS-R subscale yield differences between groups that are exactly the same as the differences between groups on the overall scale.

DISCUSSION

Although a greater incidence of abuse or restrictive sexual attitudes in the background of sexually compulsive individuals, as compared to other groups, does not prove the etiological role of these factors in the development of CSB, it certainly does not contraindicate such a role, and it opens the discussion on the relationship between these factors and CSB.

Childhood sexual abuse. Overall, the results of this study indicate that there is a greater prevalence of sexual abuse among sexually compulsive males than among sexually compulsive males than among sexually dysfunctional males. This finding is supported by theory. In addition, the results indicate that there is a greater prevalence of sexual abuse among sexually compulsive males than among chemically dependent males. The prevalence of sexual abuse is highest among sexually compulsive males than among either of the other groups studied. Indeed, childhood sexual abuse appears to be a very significant problem within the sexually compulsive sample, with almost 50% reporting abuse (see Table 1).

The finding of no difference between the CD group and the SD group is surprising and implies that the prevalence of sexual abuse for chemically dependent males and sexually dysfunctional males is similar to the prevalence for non-clinical males. Indeed, the prevalence of sexual abuse among both of these groups was similar to what would be expected in a non-clinical group, based on available prevalence studies for men.^{76,77} Although prevalence studies have suggested that sexual abuse is higher among chemically dependent males than among non-clinical males, direct research comparison between groups has so far not been undertaken. It should be noted that chemically dependent individuals who also reported CSB were eliminated from the chemically dependent sample, which has not been done in other studies that have explored the sexual abuse history of chemically dependent men. Potential differences between subgroups of chemically dependent men—those who are also sexually compulsive and those who are not—offer an interesting and important domain for further research.

Childhood physical abuse and childhood emotional abuse. Although no significant differences in the amount of physical or emotional abuse were found among groups, the means were in the direction predicted for both variables. It appears quite possible that there is a difference in the prevalence of physical and emotional abuse among the three groups that did not show up in this study because of sample size. The prevalence data presented here suggested the possibility that with larger sample size, physical and emotional abuse may be reported more in CSB groups than in either of the other two—and that they may be reported more in CD groups than in SD groups. Nonetheless, with the present sample sizes, sexual abuse was found to be significantly higher in the CSB group than in the other two groups, whereas physical and emotional abuse were not.

Therefore, it may be concluded that the presence of childhood sexual, physical, and emotional abuse distinguishes CSB from the other two groups to a greater extent than the presence of physical or emotional abuse, even in physical and emotional abuse are found to have differing prevalence among the three groups in the results of further research. This finding is supported by theory which suggests that sexual shame may be an important etiological factor in the development of compulsive sexual behavior. Sexual abuse represents just the kind of pairing of a shaming experience with a sexual one that may underlie the development of sexual shame.

Restrictive sexual attitudes. The results tentatively indicate that there is greater restrictiveness of sexual attitudes within the family of origin of sexually compulsive males than of chemically dependent males, and, conse-

quently, that restrictive sexual attitudes may be of significant importance in the understanding of the development of male CSB. Further research is needed to compare CD groups to non-clinical groups in order to rule out the possibility that restrictive attitudes are also of significant importance in understanding chemical dependency. It is unclear at this point whether restrictive sexual attitudes are important in the understanding of male psychogenic sexual dysfunction, since the mean on the scale for this group fell between the mean for the CD group and the CSB group and could not be significantly distinguished from either of the two groups statistically. It is possible that with larger samples, the SD group would either cluster with one of the other two groups, with a greater or a lesser amount of restrictive sexual attitudes in the family of origin—or that it would distinguish itself from both groups with an amount in the middle. Further research with larger samples is clearly needed.

In order to examine which family members were reported to have more restrictive sexual attitudes in the CSB group when compared to the CD group, the restrictive sexual attitudes scale was divided into three subscales. Results indicate that sexually compulsive individuals report that they and their mother had more restrictive sexual attitudes than chemically dependent individuals report they and their mothers had. It must be pointed out that although differences between groups were not found to be significant for the RSAS-F subscale, the mean for the CSB group was highest, the SD group was next highest, and the CD group was lowest. Therefore, it is possible that differences would be found on this subscale with larger samples and that the pattern of differences would be similar to the pattern found for the other two subscales. In other words, although the attitudes of the subjects and their mothers appear to discriminate the groups—whereas the attitudes of their fathers do not—it is quite possible that the attitudes of their fathers would also discriminate the groups with larger samples. Given the number of subjects in this study, it is important not to conclude without further research that these findings are meaningful. It must also be noted that post-hoc analysis of data may only form hypotheses for future research; it must not be mistaken for conclusive results. In addition, it must be noted that the restrictive sexual attitudes scale measures perceptions of individuals about their families and cannot be interpreted as completely valid indicators of actual conditions in the family. However, perceptions of family sexual attitudes are clearly important to individual development, regardless of accuracy.

Limitations. The small sample size makes it necessary to consider all conclusions in this study as tentative, and further research with larger samples will be important conclusions reached in this study.

Sexual abuse, physical abuse, and emotional abuse were not defined for subjects filling out the questionnaire, leaving the interpretation of terms up to the subject. Emotional abuse, in particular, has very little agreed-upon meaning among professionals and the general public. Although all three groups responded under the same conditions, the study is susceptible to the possibility that different groups interpreted the questions differently because of non-random assignment of subjects to groups.

The study dealt with convenience samples, two of which were inpatient and one of which was outpatient, making group differences an alternative hypothesis to explaining

results and limiting generalizability of the results.

The known validity of the restrictive sexual attitudes scale is limited to face validity. It is impossible to objectively verify at this time, therefore, that what is being measured is the construct of restrictive sexual attitudes as it is interpreted in this study. Self-report data always rely on the memory, honesty, and interpretation of the subject, making "what really happened" during the childhood of these subjects virtually impossible to know.

Recommendations. Clearly, more research with larger samples is needed to examine the questions posed in this study and to attempt to replicate the findings regarding sexual abuse and restrictive sexual attitudes. It will be important in such research to control for factors such as subject age and number of parents in the home while growing up that could confound the factors. Research with larger samples is also needed to further investigate physical and emotional abuse as factors that may be important to understanding CSB. In order to learn about a broader population of sexually compulsive individuals, studies are needed with samples of 1) outpatient sexually compulsive males, 2) samples of outpatient and inpatient sexually compulsive females, 3) samples of sexually compulsive males who commit sex-related offenses, and 4) samples of sexually compulsive individuals with multiple compulsive behaviors.

Overall, the results of this study help support the existence of the problem of CSB. If those individuals who are seeking help for compulsive sexual behavior have a greater amount of sexual abuse in their past than others and have learned restrictive sexual attitudes in their families, it becomes more difficult to say that these individuals simply have sexual practices that are "out of step" from the rest of society—and that the problem lies in society's labeling deviant. Clearly, clinicians working with sexually compulsive individuals need to be aware that sexual abuse and restrictive sexual attitudes may underlie the presenting behavior problem and that many of these individuals may require help for these issues, as well as help to control the sexual behavior that is problematic for them.

The results of this study also lend support to the theoretical position that sexual abuse and restrictive sexual attitudes in the family of origin may be important etiological factors in the development of CSB. As the results of this study are correlational, they certainly cannot pinpoint the cause of CSB. However, they indicate that further investigation is needed to understand these factors as potentially important in the development of CSB.

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