EVALUATION OF A MULTI-COMPONENT INDIVIDUAL TREATMENT INTERVENTION FOR ADULT MALES WITH HISTORIES OF SEXUAL ABUSE: A MULTIPLE-BASELINE APPROACH

BY

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A Thesis
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Abstract

The recognition of male sexual abuse as a growing problem with potentially numerous debilitating effects has underscored the need to develop effective treatment interventions for this population. In the present study, five adult males who experienced childhood sexual abuse were involved in an individual treatment program which focused on abuse-related issues, specifically self-blame, anger, and anxiety. Each participant completed daily self-blame, anger, and anxiety ratings as well as bi-weekly self-monitoring measures on depression and self-esteem. Pre-, post-, and follow-up data on depression, self-esteem, self-blame, anger, and anxiety were also collected through self-report questionnaires. A multiple-baseline design was used to evaluate each participant's treatment experience. Overall findings indicated that most participants reported clinically significant long-term reductions in self-blame, anger, and anxiety as a result of their involvement in the sexual abuse treatment program. An important finding concerned the improvements in most participants' feelings of depression and self-esteem, which were not explicitly targeted during the treatment program. Results of the study suggest that adult males benefitted from their involvement in an abuse-focused individual treatment program. The study also represented an important step in the development of systematic research in treatment outcome, particularly for a population of individuals which has been relatively neglected in the clinical and research literature. It would seem important to continue refining efforts to employ multiple-baseline designs to evaluate treatment for sexually abused individuals. In particular, careful consideration must be given to such issues as the operationalization and measurement of dependent variables as well as the interdependence which commonly occurs among these variables.

Evaluation of a Multi-Component Individual Treatment Intervention for Adult Males With Histories of Sexual Abuse: A Multiple-Baseline Approach

Prevalence

Until recently, the study of male sexual victimization was relatively neglected as it was commonly believed that abusive sexual activity involving boys was infrequent and did not have a significant impact on later development (Crowder, 1995; Friedman, 1994; Hunter, 1991; Watkins & Bentovim, 1992). Since the mid 1980s, there has been growing recognition of the importance of more systematic investigation involving male child and adolescent victims of sexual abuse (Dhaliwal, Gauzas, Antonowicz, & Ross, 1996). Bagley and Thurston (1996) estimated that between 10 to 15% of males will experience at least one incident of sexual abuse prior to 16 years of age. If one applies this prevalence rate to the Canadian population, statistics would suggest that approximately 2 million males have been sexually abused and that .7 million boys will experience sexual victimization by late adolescence (Violato & Genuis, 1993). While these figures are staggering, it should be noted that there are roughly three to four times as many cases of sexual abuse than are actually disclosed or reported (Crowder, 1995; Violato & Genuis, 1993).

Factors affecting the reporting of male childhood sexual abuse. There is evidence suggesting that the most under-reported cases of sexual abuse are those involving males (Brannon, Larson, & Doggett, 1989). A number of factors may explain the relatively little attention which has been given to male victims of sexual abuse. First, in terms of prevalence rates, Finkelhor and Baron (1986) noted that the average ratio of sexually abused girls to boys is 2.5:1. Thus, the study of sexually abused females may have warranted more attention in the past

because girls appear to be at greater risk for sexual victimization than boys. Also, the limited exposure to males who have experienced sexual abuse may have made it difficult to recognize these individuals as a population in need of investigation (Holmes, Offen, & Waller, 1997; Urquiza & Keating, 1990). Dhaliwal et al. (1996) added that many professionals in such areas as mental health, medicine, education, and child protection may deny the existence of male sexual abuse, may be reluctant to deal with male victims, or may minimize the negative effects of male sexual victimization.

Second, the reluctance of males to disclose abuse experiences has also contributed to the under-estimation of the prevalence and seriousness of male sexual abuse. Sexually victimized males may struggle with the male ethic of self-reliance, which holds that it is unmasculine to seek help (Cermak & Molidor, 1996; Crowder, 1995; Dimock, 1988; Dhaliwal et al., 1996; Finkelhor, 1979, 1984; Meiselman, 1990; Schwartz, 1994). Hack, Osachuk, and De Luca (1994) stated that a "society that traditionally rewards stoic and independent behavior in young boys does not encourage disclosure of victimization" (p. 218). As a result, boys who experience sexual abuse may often believe that their victimization occurred because of their own weakness and failure as males (Ryan, Lane, Davis, & Isaac, 1987).

Third, the stigma of homosexuality, associated with the finding that most boys are abused by male perpetrators, may also contribute to males' reluctance to report sexual victimization (Cermak & Molidor, 1996; Dimock, 1988; Dhaliwal et al., 1996; Finkelhor, 1979, 1984; Hunter, 1991; Meiselman, 1990; Schwartz, 1994; Sheldon & Sheldon, 1989). For a boy, disclosing that he was sexually abused by another male may be synonymous to admitting that he himself is homosexual (Nasjleti, 1980), despite research findings that the majority of male

sexual offenders are attracted to both male and female children (Hack et al., 1994).

Fourth, Finkelhor (1984) noted that, compared with girls, boys are usually permitted to engage in more independent and unsupervised activity. Thus, they may be more hesitant to report sexual abuse for fear of losing their independence and freedom. This finding may be particularly relevant in cases where the abuse was committed by an individual outside of the home (Dimock, 1988; Finkelhor, 1979, 1984; Meiselman, 1990).

Fifth, males may be less likely to clearly label their childhood sexual activity with an older individual as abusive. Holmes et al. (1997) reported that the fact that males often respond in a clearly visible physiologically manner (e.g., erection, ejaculation) may contribute to their perception of the abuse as something which they desired and encouraged. In addition to this "myth of complicity" (Gerber, 1990), there is the finding that "boys may have been successfully 'groomed' by the abuser - the sexual abuse may be preceded by (and coupled with) affectionate real or substitute parenting, attention, and rewards. Males with these experiences may find it hard to acknowledge the abusive nature of the relationship" (Holmes et al., 1997, p. 76).

Sixth, the characteristics of sexual offenders may be a factor related to the under-reporting of male sexual victimization. Many boys are sexually abused by individuals who are not much older than themselves (e.g., babysitter, older sibling) and so the incident may simply be dismissed as inappropriate sex play or sexual experimentation (Finkelhor, Hotaling, Lewis, & Smith, 1990; Gordon, 1990; Holmes et al., 1997; Hunter, 1991; Rogers & Terry, 1984; Ryan, 1986). In addition, society views youthful male sexuality as a positive experience and, as such, sexual activity between a boy and an older woman may not be perceived as serious and traumatic (Dhaliwal et al., 1996; Finkelhor, 1984; Holmes et al., 1997; Jennings, 1993). In such

instances, males may minimize the impact of their childhood sexual abuse, which may further contribute to their reluctance to disclose abuse or, when a disclosure is made, to describe the sexual experience in either neutral or even positive terms (Draucker, 1992; Meiselman, 1990). Bagley and Thurston (1996) stated that approximately 20% of boys who engaged in sexual activity with an older woman reported the experience to be either non-threatening or pleasurable.

Effects of Childhood Sexual Abuse

While males may portray their childhood sexual victimization in neutral or positive terms, one must not assume that they have not been negatively affected by these sexual experiences (Crowder, 1995). In fact, the numerous initial and long-term negative consequences associated with childhood sexual abuse have been well documented in the clinical and research literature (Beitchman, Zucker, Hood, daCosta, & Akman, 1991; Beitchman, Zucker, Hood, daCosta, Akman, & Cassavia, 1992; Briere, 1988, 1992; Browne & Finkelhor, 1986; Friedrich, 1988; Kendall-Tackett, Williams, & Finkelhor, 1993; Mendel, 1995). Kendall-Tackett et al. (1993) reviewed 45 recently published empirical studies on the initial impact of sexual abuse on male and female children. Compared with non-abused children, those who had experienced sexual abuse exhibited numerous detrimental effects, including greater fears and nightmares, general posttraumatic stress disorder, lower self-esteem, internalizing behaviour problems (e.g., withdrawal, depression, regressive behaviours such as enuresis and temper tantrums), externalizing behaviour problems (e.g., cruelty, delinquency, aggression), sexually inappropriate behaviour, and self-injurious behaviour. The study concluded that, for virtually every variable which was examined, sexually abused children were more symptomatic than children who had

not reportedly experienced sexual victimization.

Initial negative effects of childhood sexual abuse, such as those reported by Kendall-Tackett et al. (1993), may frequently extend into adolescence and adulthood. Among adult males with histories of childhood sexual abuse, common long-term effects range from low self-esteem, depression, guilt, anxiety, and anger to problems with substance abuse, interpersonal relationships, male gender identity, sexual orientation, and offending behaviour (Bagley, Wood, & Young, 1994; Black & DeBlassie, 1993; Brown, 1990; Bruckner & Johnson, 1987; Cermak & Molidor, 1996; Crowder, 1995; Cruz & Essen, 1994; Dimock, 1988; Genuis, Thomlison, & Bagley, 1991; Lew, 1988; Lisak, 1994; Myers, 1989; Nice & Forrest, 1990; Sanderson, 1995; Singer, 1989; Urquiza & Capra, 1990; Violato & Genuis, 1993). With regard to psychiatric diagnoses, Schulte, Dinwiddie, Pribor, and Yutzy (1995) administered a standardized diagnostic instrument to sexually abused males who were seeking psychological treatment. Results revealed high lifetime prevalence rates for a wide variety of psychiatric disorders, most notably substance abuse, mood disorders, anxiety disorders, and somatoform pain disorder. Also, it appeared that most sexually abused males met the criteria for multiple psychiatric diagnoses. In examining the results of this study, it should be noted that there was an absence of a control group, which poses difficulties for the generality of findings.

Sexually abused males and females. The area of sexual abuse involving males has only recently begun to receive increased public attention and systematic investigation. As such, the empirical and clinical literature on males who have experienced sexual victimization, including research comparing sexually abused males and females, is relatively limited. Given these limitations, Finkelhor's (1990) update of the childhood sexual abuse research literature found

that the responses of boys and girls to their sexual abuse experiences were relatively similar, despite some gender differences in the nature of the abuse. Even during adulthood, sexually abused males and females reported either highly similar abuse-related problems or revealed a small number of differences in externalizing and internalizing behaviour problems. Specifically, sexually abused males tend to exhibit slightly more externalizing behaviour problems (e.g., aggression), while sexually abused females display slightly more internalizing behaviour problems (e.g., depression). Related to this finding, the review (Finkelhor, 1990) revealed that males were more likely to have substance abuse disorders whereas females were more likely to have affective and anxiety disorders. In reflecting on the overall results of his literature review on sexually victimized males and females, Finkelhor (1990) concluded that "it is somewhat remarkable, given the importance of gender in the realm of sexuality, more differences have not shown up on the behavioral and symptomatic level" (p. 326).

An often-cited empirical study by Briere, Evans, Runtz, and Wall (1988) also concluded that there were few differences among sexually abused adult males and females with respect to psychological symptomatology. Males and females who had experienced sexual abuse during childhood completed a symptom checklist, and no statistically significant differences were found. Additionally, compared with non-abused individuals, both males and females with histories of sexual abuse reported significantly more problems with anxiety, depression, anger, sleep, and dissociation. Interestingly, males in the study reported less extensive sexual abuse, compared with sexually abused females. In an attempt to explain the relationship between the nature of sexual abuse experiences and psychological symptomatology, the researchers (Briere et al., 1988) speculated that (a) childhood sexual abuse may have an equivalent impact on males

and females, despite any differences in the nature of the abuse, or (b) sexually abused males may experience more trauma, given that their less severe abuse experiences resulted in levels of psychological symptomatology that were comparable to those of females, who had experienced more severe childhood sexual abuse. While these hypotheses may warrant further examination, it seems important to keep in mind that data regarding childhood sexual abuse were gathered through individuals' self reports. As such, one must remain cognizant of issues related to individual biases and distortions in recall.

Finally, Stein, Golding, Siegel, Burnam, and Sorenson (1988) investigated the presence of psychiatric diagnoses among a community sample of sexually abused and non-abused adults. Findings showed that adult males with histories of sexual abuse had higher rates of externalizing-type lifetime and current psychiatric disorders, such as drug abuse/dependence. In contrast, sexually abused adult females had higher lifetime prevalence rates for all psychiatric disorders (except antisocial personality disorder) as well as higher current prevalence rates for affective disorders, major depression, and anxiety disorders. Stein et al. (1988) interpreted their findings by noting that the gender differences may be the result of (a) the small number of males who participated in the study or (b) the differences in the nature of the sexual abuse among males and females which, incidentally, were not reported in the study.

While the research comparing sexually victimized males and females is scarce, it would appear that, overall, childhood sexual abuse may negatively affect individuals in similar ways, regardless of the victim's gender. In instances where gender differences exist, it seems that sexually abused males may exhibit slightly more externalizing behaviour problems (e.g., aggression, substance abuse) while sexually abused females may display slightly more problems

of an internalizing nature (e.g., depression, anxiety). One unequivocal conclusion regarding childhood sexual abuse is that it appears to be associated with numerous detrimental initial and long-term consequences for both male and female victims.

Depression. As previously mentioned, sexually abused adult males generally experience slightly more externalizing behaviour problems than females. Nonetheless, internalizing behaviour problems are frequently reported by males who have been sexually abused. In fact, feelings of depression appear to be one of the more commonly reported long-term consequences of childhood sexual abuse (Bagley et al., 1994; Kendall-Tackett et al., 1993; Ratican, 1992; Stein et al., 1988; Urquiza & Capra, 1990; Watkins & Bentovim, 1992). In an attempt to explain the development of depression, Pescosolido (1988) noted that individuals experience varying intensities of sadness over their sexual victimization. In addition, they may feel helpless to stop the abuse, particularly in cases of sexual activity involving a family member over a long period of time. As the duration and frequency of abuse increases and if no psychological intervention is made available to the victim, it is posited that the individual's sadness evolves into depression.

The clinical literature on sexual abuse devotes much attention to the area of depression with respect to adult survivors (Briere, 1992). Additionally, the few empirical studies which have been conducted with sexually abused adult males further validate clinical findings of depression. In an empirical study which asked adult males to complete symptom checklists (Briere et al., 1988), results revealed a statistically significant difference on the depression subscale. Specifically, sexually abused males indicated a higher level of depression, compared with males who did not disclose a history of childhood sexual abuse. In addition, compared with the non-abused group, sexually abused males indicated a higher incidence of previous suicide

attempts. Ratican (1992) further elaborated on these findings by noting that, even compared with non-abused but depressed individuals, sexual abuse survivors appear to be more suicidal and self-destructive. Bagley et al. (1994) conducted a survey on the mental health and behavioural effects of sexual abuse among adult males. Results indicated that childhood sexual abuse was significantly linked with various indicators of poor mental health, including depression. Also, the study found that one-fifth of the sexually abused males were currently experiencing a serious form of depression and that one-third had attempted suicide or had made a suicidal gesture.

Guilt and self-blame. Guilt and self-blame have been found to be common negative effects of childhood sexual abuse. Attributions of blame by sexually abused individuals may have a number of short- and long-term implications for psychological functioning (Hunter, Goodwin, & Wilson, 1992). In a sample of sexually abused women, Hoagwood (1990) reported that self-blame was significantly correlated with feelings of depression and low self-concept. While such data are currently unavailable for adult male survivors, one may expect to find similar results given that, overall, males and females appear to respond in a similar manner to childhood sexual victimization (Briere et al., 1988; Finkelhor, 1990).

It has been suggested that self-blame may, at times, fulfill certain psychological needs. For instance, individuals may assume some responsibility for their sexual victimization in order to maintain some level of perceived control over their lives and to ward off feelings of helplessness and powerlessness. Additionally, sexually abused individuals may blame themselves as a result of their need to believe in a just world, where bad things do not randomly happen to individuals (Briere, 1996; Hoagwood, 1990; Janoff-Bulman, 1979). Feinauer and Stuart (1996) explored this hypothesis by asking a large randomly selected sample of women to

complete questionnaires related to abusive childhood sexual experiences, attributions of blame (e.g., self, fate, self and fate), and current level of psychological functioning. Results revealed that women who placed greater blame on themselves for the sexual abuse also reported a greater number of psychological symptoms, whereas women who blamed the perpetrator experienced fewer symptoms (e.g., anxiety, depression). The authors concluded that blaming oneself for sexual abuse is not a "healthy" way of making sense of the experience and may, in fact, be associated with greater impairment in psychological functioning. Several issues related to the study seem worthy of further elaboration. First, Feinauer and Stuart (1996) did not directly assess perpetrator blame. Rather, they assumed that participants who blamed neither themselves nor fate for the sexual abuse must have blamed the perpetrator. However, it is also possible that these individuals simply did not experience any feelings of blame. Second, the distinction between responsibility for the abuse versus responsibility for recovery seems crucial. The authors stated that if "the key element in recovery is a sense of personal power and efficacy in the recovery process, the separation of blame for the event from responsibility for recovery is vital. In making this separation, one may clearly be empowered by placing blame for the abuse where it appropriately belongs, while placing responsibility for recovery primarily upon oneself" (Feinauer & Stuart, 1996, p. 38). Mendel (1995) provided additional empirical support for the view that sexually abused individuals are not negatively affected by efforts to affirm their blamelessness. Interviews of a large clinical sample of sexually abused adult males suggested that these individuals experienced a great sense of relief through accepting that they were not responsible for their sexual victimization.

Among sexually abused males, guilt and self-blame appear to be almost universal

feelings (Brown, 1990; Crowder, 1995; Lisak, 1994; Myers, 1989). Clinical reports offer several explanations for the strong feelings of guilt and self-blame that many individuals experience over their childhood abuse. First, as children, sexually abused males were often told by the offender that they were to blame for the abuse (e.g., they may have accepted gifts or bribes from their abuser). Significant others may have also given sexually abused males the message that they were responsible for the abuse (e.g., males may have been punished when they disclosed the abuse to a significant other). Finally, there are a variety of reasons why males may blame themselves for their childhood sexual abuse. Males who responded physiologically with pleasure or arousal during the abuse may conclude that they had enjoyed and sought the experience. Also, males who identified positive aspects associated with the abuse (e.g., attention or affection) may believe that, as children, they had instigated or desired the experience (Draucker, 1992; Gil, 1988; Napier-Hemy, 1994; Ratican, 1992; Sanderson, 1995). In other instances, abused males may not necessarily blame themselves for initiating the sexual activity but rather, for not being able to defend themselves against the offender (either through physical means or through disclosure to a trusted adult). The issue of failing to protect oneself may be particularly salient among individuals whose abuse (a) occurred over a long period of time, (b) began at a later age (e.g., adolescence), and (c) did not involve physical coercion (Draucker, 1992).

While the clinical literature has devoted much attention to issues of guilt and self-blame among sexually abused males, research is only now beginning to validate anecdotal findings. In an attempt to cross-validate clinical findings on the psychological effects of childhood sexual abuse, Lisak (1994) conducted a content analysis of interviews with 26 sexually abused males and identified self-blame as a common theme. Sources of self-blame stemmed from males'

attributions of adult capabilities to their childhood selves as well as beliefs that there was something inherently wrong with them which must have instigated the abuse. Mendel's (1995) interviews with victimized males suggested that they felt "deficient, unmanly, and incompetent because they could not provide themselves with adequate protection against the abuse. The sense of self-blame is exacerbated by the myth that males are constantly and indiscriminately sexually willing. The message to the male victim is not simply that if he was abused he must not be a man, but also that if he is a man he must not have been abused" (p. 206). A study (Hunter et al., 1992) examining attributions of blame among sexually abused individuals also revealed some interesting findings. In particular, the hypothesis of an inverse relationship between self-blame and molester blame was not supported for adult males, who simultaneously internalized and externalized responsibility for the sexual abuse. The authors viewed these findings as indicative of males' lack of clarity regarding victim-perpetrator boundaries as well as their heightened sensitivity to issues of autonomy and control.

Self-esteem. Many adult males who have been sexually abused struggle with feelings of low self-esteem (Blanchard, 1986; Hunter, 1991; Myers, 1989; Watkins & Bentovim, 1992). Male survivors often internalize the "badness" of the experience and interpret their role in the abuse from a child's perspective, believing that something bad happened to them because they were somehow bad (Draucker, 1992; Lisak, 1994). Sexually abused individuals may feel that they deserved what happened to them because of something they may have said or done or because of their inherent unacceptableness or worthlessness (Gil, 1988; Lisak, 1994). As well, Briere (1996) noted that some features of sexual abuse may be more strongly associated with negative self-perceptions. In particular, "there is often a 'conspiracy of silence' surrounding

sexual abuse, invoked both by the abuser in the interests of self-protection and the reactions of society to abuse disclosures. Such secrecy conveys to the abuse victim the notion that she or he was involved in a shameful act and was, in fact, a guilty coconspirator" (p. 15-16).

While empirical studies of self-esteem among sexually abused males are presently limited, research has suggested that males with histories of sexual abuse score significantly lower on measures of self-esteem and self-concept than males with no reported history of abuse (Urquiza & Capra, 1990). In a review of the male childhood sexual abuse literature, Violato and Genuis (1993) concluded that sexual victimization may negatively affect a child's self-esteem, both on an initial as well as long-term basis. Lisak's (1994) study of male survivors found that their low self-esteem was expressed in numerous ways, such as feelings "of inferiority, of insignificance, of being unacceptable and unlovable. Some men described this sense of badness in terms akin to 'infection,' as though the abuse was in them, an indelible and eternally bad part of themselves" (p. 541).

Anger. One emotion that males seem able to easily identify and express is anger at having been a victim of sexual abuse (Crowder, 1995; Draucker, 1992; Lisak, 1994; Singer, 1989; Violato & Genuis, 1993). Crowder (1995) stated that "anger is a feeling that most men have cultural permission to express; it often becomes a unidimensional expression of feeling that consumes all other emotions" (p. 87). It seems important for sexually abused individuals to express their feelings of anger because (a) they may have a number of valid reasons to feel angered by the injustice of their sexual victimization; (b) they often did not have a chance to express their anger during the time of their abuse; and (c) they may have developed negative associations to their anger, as a result of others' reactions to their expressions of anger (Briere,

1996). While it appears critical to acknowledge feelings of anger, it is also important to keep in mind that male survivors who focus almost exclusively on their anger may be attempting to suppress other emotions which may be too painful to express, such as fear or loneliness (Blanchard, 1986; Napier-Hemy, 1994). Blanchard (1986) noted that male survivors often associate their abusive experiences with feelings of weakness and vulnerability. As a result, they may attempt to cope with their sexual abuse by repressing all emotions which may suggest weakness or vulnerability (e.g., sadness, fear) and, instead, developing an angry demeanour suggestive of invulnerability, power, and control. Clinical observations have shown that male victims often direct their anger towards (a) themselves for allowing the abuse to occur and for not protecting themselves; (b) the perpetrator for taking advantage of their childhood vulnerability; or (c) individuals whom they feel should have prevented the abuse, such as parents (Dhaliwal et al., 1996).

In Bruckner and Johnson's (1987) description of a group treatment program for sexually abused males, they noted that dealing with abuse-related anger was a surprisingly intense component of the intervention. Males' feelings of anger were associated with a variety of abuse issues, including their family of origin, the offender, their sense of isolation, and their lack of power. In addition, sexually abused males expressed their anger through fantasies of revenge, concrete plans for carrying out their fantasies, and in some cases, actual implementation of their plans for retribution. Crowder (1995) stated that revenge fantasies provide invaluable information about males' reactions to their sexual victimization experience. However, she also added that abused males may have difficulty disclosing their fantasies because of overwhelming feelings of guilt and shame over the intensity and extent of their anger.

Anxiety. Berliner and Wheeler (1987) noted that anxiety is characterized by physiological symptoms (e.g., increased heart rate, sweating), subjectively experienced feelings (e.g., of tension and worry), and specific behaviours (e.g., attempts to avoid or confront anxiety-provoking stimuli). The presence of anxiety among sexual abuse survivors has been documented in the clinical and research literature (Bagley et al., 1994; Blanchard, 1986; Briere, 1992; Lisak, 1994; Nice & Forrest, 1990; Urquiza & Capra, 1990; Watkins & Bentovim, 1992). Several authors (Briere, 1992; Ratican, 1992) have reported that the threatening and disruptive nature of childhood sexual abuse may lead to lasting feelings of fear and anxiety among adult survivors. In their study of sexually abused adult males, Briere et al. (1988) found that, compared with non-abused males, there was a significantly higher level of anxiety reported by males who had experienced sexual victimization. In a more recent study which employed the same symptom checklist as Briere et al. (1988), the results also revealed a statistically significant relationship between male childhood sexual victimization and elevated levels of anxiety during adulthood (Bagley et al., 1994).

Individuals who are struggling with intense feelings of abuse-related anxiety may exhibit the following characteristics: (a) hypervigilance to danger in their environment, regardless of whether a threat actually exists; (b) preoccupation with control and the belief that any loss of control may result in danger to the self; and (c) misinterpretation of interpersonal situations as threatening, even though they may be objectively neutral or positive (Briere, 1992, 1996). In addition to these characteristics, abuse-related anxiety and fear may also manifest itself through sexual dysfunction. Individuals who have experienced sexual abuse may have come to associate sexual stimuli with a sense of personal invasion or feelings of pain. Consequently, they may

experience overwhelming feelings of anxiety during sexual contact, which may lead to such difficulties as reduced sexual arousal, erectile dysfunction, or pain during intercourse (Briere, 1992).

According to Nice and Forrest (1990), adult males who have been sexually abused may attempt to cope with their anxiety and fear through the development of addictive behaviours. Empirical evidence has shown that, compared with sexually abused females, a powerful impact of sexual victimization on male survivors is the development of substance abuse addictions (Finkelhor, 1990; Stein et al., 1988). While alcohol and drug addictions are frequently noted in the literature, it is also important to keep in mind that addictions may assume a variety of other forms, ranging from food, sex, and gambling to compulsive work and exercise habits (Crowder, 1995). It has been suggested that addictions may provide sexually abused males with temporary relief from emotions perceived as overwhelming or intolerable and, as such, may be an attempt on the part of the individual to self-medicate (Briere, 1992; Crowder, 1995; Napier-Hemy, 1994).

Sexuality issues. There appears to be a pervasive concern among male survivors about the impact of their childhood sexual abuse on their sexual identity and orientation (Dimock, 1988; Hunter, 1991; Lisak, 1994; Myers, 1989; Ratican, 1992; Urquiza & Capra, 1990). In his content analysis of interviews with sexually abused males, Lisak (1994) reported that many individuals expressed a strong fear of homosexuality, related to concerns that they are or have the potential to be homosexual. Much of this apprehension may be traced to the nature of the sexual abuse experience, particularly the finding that sexual offenders against boys are overwhelmingly male (Draucker, 1992; Jehu, 1991; Pescosolido, 1988; Violato & Genuis,

1993). Pescosolido (1988) stated that, for a male who became physiologically aroused through genital stimulation by an older male, it "becomes difficult and almost emotionally impossible for the victim to deny the physical reactions usually associated with sexual pleasure and arousal. Accordingly, the victim is left to question his sexual orientation, asking himself, 'Why else do these physical responses occur?'" (p. 90-91). In addition, sexually abused males often believe that the abuse occurred because of their perceived feminine attributes. For instances, they may attribute their sexual victimization to their slight build, lack of muscle, soft voice, warm and friendly personality, or "sissy" shorts (Rogers & Terry, 1984).

Several authors (Bruckner & Johnson, 1987; Dimock, 1988; Draucker, 1992; Meiselman, 1990; Napier-Hemy, 1994) have found that male survivors may develop compensatory behaviours as a means of coping with their fear of homosexuality. Sexually abused males may avoid forming friendships with other males or may even engage in anti-homosexual activities. Other male survivors may strive to prove their worth and adequacy as men through excessive sexual activity, thereby developing such problems as hypersexuality, compulsive sexual behaviours (e.g., masturbating several times a day), or aggressive sexual behaviours. According to several authors (Briere, 1996; Mendel, 1995; Ratican, 1992), sexually abused men may also exhibit excessive sexual activity because they have learned, through their victimization, that sex is the only way in which to express affection or gain intimacy. Briere (1996) described the cycle of compulsive sexual activity as one in which male survivors may "(a) seek out sexual contact as a way to gain nurturance, support, and validation; (b) find such superficial contact unsatisfying after the initial excitement has faded and the person involved appears to make excessive demands (e.g., for intimacy or relationship); leading to (c) a search for new, 'better' partners" (p.

26).

Another common sexuality issue for adult males who have experienced childhood sexual abuse is fear of engaging in sexually inappropriate behaviour (Bruckner & Johnson, 1987; Singer, 1989; Meiselman, 1990; Violato & Genuis, 1993). Crowder (1995) suggested that sexually abused males may have developed "contaminated" sexual arousal patterns as a result of their childhood victimization. Specifically, males who experienced physiological arousal or orgasm during incidents of abuse may have created abuse-related masturbatory fantasies and, as a result, an association may have been formed between sexual arousal and fantasies of abuse. The clinical and research literature suggests that having experienced childhood sexual abuse may increase the likelihood that males will commit later sexual offenses (Blanchard, 1986; Violato & Genuis, 1993). Friedrich (1988) compared samples of sexually abused children, psychiatric outpatient children, and non-abused children on a behaviour checklist, which was completed by mothers or mother figures. On items related to sexual behaviour (e.g., "plays with own sex parts in public," "behaves like opposite sex"), sexually abused children scored significantly higher than both psychiatric outpatient as well as non-abused children. In an empirical study which compared various groups of sexually abused adult males (Romano & De Luca, 1996), the prevalence rate of childhood sexual abuse among sexual offenders was approximately two times greater than among males who had committed offenses of a non-sexual nature and three times greater than among males who had not committed any known offenses. Keeping these findings in mind, it also seems important to remember that a number of factors, in addition to childhood sexual victimization, may also contribute to the development of sexual offending behaviour. The literature suggests that sexual offenders who were sexually abused

during childhood often experienced additional forms of abuse (e.g., physical, neglect). As well, it appears that sexual offenders, regardless of whether they have a history of sexual abuse, generally come from multi-problem homes that often include family pathology and violence (Dhaliwal et al., 1996).

Research considerations in the study of childhood sexual abuse effects. Empirical studies on childhood sexual abuse have proliferated over the past few years. While there appears to be a relative lag in the literature on sexually abused males, the inclusion of this population in research studies and clinical reports is beginning to increase. As with any field of study, there exist limitations of which one must be aware, particularly when interpreting research data and arriving at conclusions about the findings. With regard to the operationalization of childhood sexual abuse, research studies often employ a variety of different definitions (Briere, 1992a; Crowder, 1995; Hunter, 1991; Tong, Oates, & McDowell, 1987). The type of abuse (e.g., intrafamilial versus extrafamilial), nature of the sexual activity (e.g., contact versus non-contact), and age of the offender (e.g., peers versus individuals who are at least five years older than the victim) represent only several of the many important variables which comprise the definition of childhood sexual abuse. The fact that many studies are based on disparate definitions indicates that one must exercise caution when considering such issues as prevalence rates, abuse-related effects, and treatment strategies (Dhaliwal et al., 1996; Tong et al., 1987).

With regard to participant samples, several authors (Crowder, 1995; Dhaliwal et al., 1996; Mrazek & Mrazek, 1981; Tong et al., 1987) have noted a lack of standardization, meaning that some studies focus on non-clinical populations (e.g., university students) while others concentrate on clinical populations (e.g., individuals in treatment, sexual offenders). Also, a

great deal of past research has focused almost exclusively on females with histories of childhood sexual abuse (Hunter, 1991; Tong et al., 1987). While results from these studies are important, one must also be cognizant of the limits to generality. For example, university students are not usually representative of the general population in terms of social class, ethnicity, intelligence, and personal motivation (Mrazek & Mrazek, 1981; Tong et al., 1987).

Overall, the research literature on the long-term effects of childhood sexual abuse is based largely on findings from retrospective studies of adults, which may be limited in their accuracy and validity (Briere, 1992a; Finkelhor & Baron, 1986; Mrazek & Mrazek, 1981; Seghorn, Prentky, & Boucher, 1987). Briere (1992a) noted that some individuals may not remember much of their sexual abuse or may even have no recollection of childhood sexual victimization. As well, "age-specific socialization may influence subjects' willingness to report sexual abuse. Individuals who grew up in an earlier era, for example, may be more prone to suppress or deny abuse experiences by virtue of the greater secrecy and stigmatization associated with sexual victimization in previous decades" (Briere, 1992a, p. 197). On the positive side, Kendall-Tackett et al. (1993) observed that since the mid 1980s, there has been a substantial increase in the number of research studies focusing specifically on sexually abused children. Studies of sexually abused children are important not only in addressing some of the difficulties of retrospective research but also in providing possible validation of findings from studies conducted with adults who have been sexually abused.

Finally, methods of data collection have varied considerably across studies. While some research utilizes clinical material from therapy sessions or reports from social services agencies, other research is based on self-report questionnaires, psychiatric interviews, or telephone surveys

(Crowder, 1995; Mrazek & Mrazek, 1981). In addition, studies sometimes lack a comparison group so that there is no basis for data comparison, which may significantly limit the validity of research findings (Hunter, 1991; Mrazek & Mrazek, 1981). The interested reader is referred to Briere (1992a) for a more detailed examination of methodological issues relevant in the investigation of sexual abuse effects.

Characteristics of Childhood Sexual Abuse Experiences

The characteristics of individuals' childhood sexual abuse experiences, including similarities and differences between males and females, have received considerable attention in the clinical and empirical literature. As well, research has been conducted on the relationship between various sexual abuse characteristics and the amount of psychological distress (e.g., depression, low self-esteem) experienced by abused individuals. Thus, it would appear important to review several of the characteristics (e.g., age of abuse onset, nature of the sexual activity, and offender profiles) in order to gain a more comprehensive understanding of sexual abuse effects and treatment implications.

Age of abuse onset. Overall, the literature seems consistent in suggesting that most sexual abuse experiences begin between the ages of 7 and 10 years (Gonsiorek, Bera, & LeTourneau, 1994; Mendel, 1995). Findings from retrospective studies appear to indicate that the average age of abuse onset is slightly higher for males than females (Finkelhor et al., 1990; Gordon, 1990; Hunter, 1991; Kendall-Tackett & Simon, 1992). One such study (Hunter, 1991) found the average age of onset to be 8.1 years for male children and 7.1 years for female children. However, these findings did not reach statistical significance. In a national survey of adult males and females who experienced childhood sexual abuse (Finkelhor et al., 1990), there

also was no statistically significant gender difference in age of abuse onset, with the median age of onset identified as 9.9 years for boys and 9.6 years for girls. A more recent study (Kendall-Tackett & Simon, 1992) also reported no difference in age of onset for sexually abused adult males and females.

Contrary to retrospective research, the overall impression from studies which rely on reported cases seems to be that the mean age of abuse onset is lower for males than females (Pierce & Pierce, 1985; Stephens, Grinnell, & Krysik, 1988; Thomlison, Stephens, Cunes, Grinnell, & Krysik, 1991). Pierce and Pierce (1985) compared substantiated cases of sexual abuse involving male and female children and found that boys were significantly younger when their abuse began (mean age of 8.6 years), compared with sexually abused girls (mean age of 10.6 years). In a more recent Canadian study which also reviewed substantiated cases of childhood sexual abuse (Thomlison et al., 1991), the mean age of onset for males was lower than that for females. However, the results did not achieve statistical significance.

In attempting to explain the discrepant results regarding age of abuse onset, Finkelhor (1984) suggested that data from reported cases may be more reflective of the manner in which sexual abuse is discovered by professionals, rather than the actual age at which the abuse began. In particular, male children are more often the victims of extrafamilial abuse while female children are more frequently abused by family members (Finkelhor, 1984; Finkelhor et al., 1990; Gordon, 1990; Hunter, 1991; Knudsen, 1991; Rogers & Terry, 1984; Thomlison et al., 1991; Tong et al., 1987). Contrary to intrafamilial abuse, extrafamilial sexual abuse typically has a shorter duration and is discovered sooner because the family (especially parents) is not involved in keeping the abuse a secret. Consequently, boys may be younger than girls when the

sexual abuse is discovered and when it comes to the attention of appropriate authorities (Finkelhor, 1984). Additionally, Pierce and Pierce (1985) stated that, as boys become older, they may be less inclined to disclose sexual victimization for fear of jeopardizing their masculinity. This observation may also help explain the general findings that age of abuse onset for males is higher in retrospective studies and lower in studies based on substantiated cases.

The empirical literature on the relationship between age of onset and severity of psychological distress is equivocal (Kendall-Tackett et al., 1993; Urquiza and Capra, 1990; Violato & Genuis, 1993). Trends in the data seem to suggest that sexual abuse at a younger age may be associated with greater psychological trauma (Briere, 1992; Browne & Finkelhor, 1986; Crowder, 1995; Mendel, 1995). In a review of recent empirical research, Kendall-Tackett et al. (1993) concluded that the different results may be due to examining age of onset in isolation of other abuse variables and suggested that it be integrated into a comprehensive model of childhood sexual victimization. Thus, in order to properly evaluate the effects of age of onset on severity of outcome, other abuse-related variables (e.g., nature of the sexual activity, relationship to the offender, and duration of the abuse) must be carefully considered (Beitchman et al., 1992).

Relationship to the sexual offender. The finding that male children are more likely to experience extrafamilial sexual abuse while female children are more likely to be sexually abused by family members is well documented in the literature (Finkelhor, 1984; Finkelhor et al., 1990; Gold, Elhai, Lucenko, Swingle, & Hughes, 1998; Gordon, 1990; Hunter, 1991; Knudsen, 1991; Rogers & Terry, 1984; Thomlison et al., 1991; Tong et al., 1987). Gold et al. (1998) administered structured clinical interviews to 305 individuals seeking outpatient psychotherapy services and found that men were more likely to have been sexually abused by

non-family members while women were over 2 ½ times more likely to have experienced intrafamilial sexual abuse. Faller's (1989) comparison of a clinical sample of sexually abused children also showed that, compared with girls, boys were more likely to experience sexual victimization outside the home. However, the study's findings also suggested that about 63% of the boys had been sexually abused by a family member, although this percentage was significantly lower than that for sexually abused girls (89%). A more recent investigation (Kendall-Tackett & Simon, 1992), which compared the sexual abuse experiences of treatment-seeking adults, appeared to validate some of the results presented by Faller (1989). This study also found that males were more likely to have experienced extrafamilial sexual abuse (e.g., friend of the family) while females were more likely to have been sexually abused by a family member (e.g., stepfather). In addition, the study reported that, surprisingly, the rate of sexual abuse by natural fathers was about equal for both males and females. These findings, along with those of Faller (1989), indicate that intrafamilial abuse involving male children warrants further careful investigation because it may not be as rare as once believed.

The literature suggests that children who have a close relationship with their offender, as would be more often the case with intrafamilial abuse, may experience greater psychological distress (Beitchman et al., 1992; Browne & Finkelhor, 1986; Conte & Schuerman, 1987; Crowder, 1995; Kendall-Tackett et al., 1993; Mendel, 1995). Mendel's (1995) study of the relationship between abuse characteristics and later psychological functioning among adult males revealed that sexual abuse involving a close relative was one of the most powerful predictors of later psychological disturbance. Crowder (1995) noted that intrafamilial abuse may lead to a greater sense of loss, grief, and betrayal in a child because the intensity of interaction

between a child and a family member is generally greater. In a review of the empirical literature (Browne & Finkelhor, 1986), it was concluded that there were a greater number of negative effects resulting from sexual abuse experiences involving fathers or father figures. It should be noted, however, that the study only focused on the empirical literature involving female children (due to the lack of research on sexually abused male children at the time).

Characteristics of offenders. Existing research, including both retrospective studies and studies based on reported cases of sexual abuse, has generally found a smaller age difference between boys and their offenders, compared with girls and their offenders (Finkelhor et al., 1990; Gordon, 1990; Hunter, 1991; Reinhart, 1987; Stephens et al., 1988; Thomlison et al., 1991) A national survey of adult survivors of childhood sexual abuse (Finkelhor et al., 1990) revealed that male children are at greater risk of being sexually abused by older adolescents or, in the case of intrafamilial abuse, by slightly older siblings or cousins. On the other hand, the greatest risk for female children is sexual victimization by a relative who is at least 10 years older than the child. In Gordon's (1990) comparison of adult survivors of childhood sexual abuse, there were statistically significant differences between the victim's gender and the age of the sexual offender. Compared with females, sexually abused males were more frequently victimized by individuals who were five or less years older than themselves. In contrast, sexual offenders were significantly older than their female victims (i.e., 11 or more years older).

Turning to the relationship between age of the offender and psychological trauma, several authors (Briere, 1992; Finkelhor, 1979) have suggested that sexual victimization involving individuals who are substantially older than the child may be associated with a greater number of negative effects. Currently, however, empirical findings to validate this hypothesis

are limited.

Concerning the gender of sexual offenders, the research literature reports that the majority of childhood sexual abuse is committed by males (Faller, 1989; Finkelhor, 1979, 1984, 1990; Finkelhor et al., 1990; Gordon, 1990; Hack et al., 1994; Stephens et al., 1988; Thomlison et al., 1991). In Finkelhor et al.'s (1990) national survey of adult males and females who experienced childhood sexual abuse, findings revealed that 83% of the offenders against boys and 98% of the offenders against girls were males. Studies based on substantiated cases of childhood sexual abuse have also shown similar findings (Gordon, 1990; Thomlison et al., 1991). For example, one Canadian study (Thomlison et al., 1991) examined reported cases of sexual abuse and found that 98% of offenders for both boys and girls were males.

While Finkelhor (1979) noted that children who were sexually abused by male offenders generally exhibited greater negative effects, it is difficult to evaluate the effects of sexual abuse involving female offenders because of the limited information available on this population. One recent study of sexually abused males (Mendel, 1995) provided some data on the impact of sexual abuse as a function of the offender's sex. In particular, males who were sexually abused by male and female perpetrators reported the most psychological disturbance on a variety of outcome measures (e.g., self-worth, psychiatric symptomatology, sexual difficulties). This group was followed by males who reported childhood sexual victimization involving males only, while males who were abused by females only reported the highest level of psychological functioning. Mendel (1995) hypothesized that the greater psychological disturbance among males who were sexually abused by males only (compared with those who were abused by females only) may be related to (a) the finding that sexual abuse by males generally involves more severe and intrusive

activity than abuse by females and (b) the stigma of homosexuality and the victim's resulting feelings of concern regarding his masculinity. Similarly, the finding that males who were abused by females only reported the highest level of psychological functioning may be related to their (as well as society's) perception of the sexual activity. Specifically, Gordon (1990) reported that, because females are generally viewed as nurturers, it is less likely that their actions will be perceived as sexually abusive. In addition, the fact that males are generally encouraged to have early sexual experiences with females may also contribute to the decreased likelihood that females will be perceived as sexual perpetrators.

As mentioned, the literature on female sexual offenders is presently limited. The few studies that have examined prevalence rates have focused on clinical samples, particularly sexual offenders with histories of childhood sexual victimization. In such studies, the rates of sexual abuse by female offenders have ranged from 13% (Langevin, Wright, & Handy, 1989) to 27% (Romano & De Luca, 1996). While the prevalence of female sexual abuse is currently unknown, Jennings (1993) stated that it is not as high as that of sexual abuse involving male offenders and probably ranges somewhere between 1 and 20%. Several authors (Mendel, 1995; Rudin, Zalewski, & Bodmer-Turner, 1995) have indicated that the under-reporting of female sexual offenders may be due to difficulties in collecting accurate data as well as the fact that male victims have been less likely than female victims to disclose childhood sexual abuse. This latter point was demonstrated in a study (Johnson & Shrier, 1985) which interviewed males at an adolescent medicine clinic for the presence of sexual abuse. Results revealed that adolescents who were identified as having been sexually abused appeared to be experiencing more sexual dysfunction and psychological trauma, compared with non-abused clinic adolescents. Despite

their distress, none of the sexually abused adolescents had reported their victimization experiences to either a mental health, social service, or criminal justice agency prior to the study. In addition, throughout the course of the study, Johnson and Shrier (1985) stated that a number of the adolescent males disclosed having had a sexual experience with an older adolescent or adult female but that they did not perceive the experience as negative or abusive. In fact, it seems that sexual activity between a young male and an older female is frequently perceived as less representative of childhood sexual abuse than a sexual experience between a young female and an older male. Also, there appears to be a societal perception that a male who is sexually abused by a female will not experience as much psychological trauma as a female whose sexual victimization involves a male offender (Jennings, 1993). It seems critical to keep in mind that, while society (and even males themselves) may view their sexual experiences with older females as positive, sexually victimized males may, nonetheless, experience a significant number of negative abuse-related effects.

Duration and frequency of sexual abuse. In a retrospective study of sexually abused adults, Kendall-Tackett and Simon (1992) found that the duration of abuse was significantly shorter for boys (average of 3.91 years) than for girls (average of 5.6 years). Thomlison et al. (1991) reviewed reported cases of childhood sexual abuse and also found that the average duration of abuse was shorter for boys than girls. Several explanations have been offered for the shorter duration of sexual abuse among male children. First, because boys are more often the victims of extrafamilial abuse, the duration may be shorter because offenders from outside the home do not have as much continual access to their victims. Second, male children may experience greater physical trauma because of force or type of sexual activity (e.g., anal

penetration) and, as such, may require immediate medical intervention. Third, as boys grow and become more physically strong, they may be able to stop their offender and therefore end the sexual abuse at an earlier age (Finkelhor, 1984; Pierce & Pierce, 1985).

While it seems reasonable to expect that abuse of a longer duration will result in a greater negative impact on the victim, Beitchman et al. (1991) stated that there has not been much empirical investigation of this hypothesis. In one review of the research literature on childhood sexual abuse (Browne & Finkelhor, 1986), the relationship between duration of sexual abuse and extent of psychological trauma remained unclear. It was suggested that, because duration is closely linked with other abuse variables (e.g., age of onset, relationship to the offender, nature of the sexual activity), "some of the contradictions may be cleared up when we have better studies with well-defined multivariate analyses that can accurately assess the independent effect of duration" (Browne & Finkelhor, 1986, p. 73). Nonetheless, Mendel's (1995) study of sexually victimized males revealed that sexual abuse of a long duration was strongly correlated with poor self-worth, psychiatric hospitalization, and the use of prescription medication.

The findings on gender differences in the frequency of sexual abuse are limited. However, several studies (Finkelhor et al., 1990; Gordon, 1990; Thomlison et al., 1991) have reported no differences in the frequency of sexually abusive activities among males and females, which has ranged from a single incident to multiple occurrences. While frequency rates among boys and girls show variability, the literature (Beitchman et al., 1991, 1992; Briere, 1992; Crowder, 1995; Friedrich, Urquiza, & Beilke, 1986; Kendall-Tackett et al., 1993; Tsai, Feldman-Summers, & Edgar, 1979) does suggest that boys and girls who experience frequent sexual abuse

may have more negative effects.

Nature of the sexual activity. Vander Mey's (1988) review of the research literature revealed that, compared with females, male children are forced to engage in sexual activities which require more contact (e.g., masturbation, oral sex). Thomlison et al. (1991) also reported that males experienced more severe forms of sexual contact (e.g., intercourse, oral sex) than females. In a more recent study (Kendall-Tackett & Simon, 1992), there were no gender differences in the incidence of oral sex and fondling below the waist. It should be noted, however, that females reported significantly more instances of fondling above the waist while males indicated significantly more instances of anal intercourse. Finally, Violato and Genuis' (1993) review of the literature concluded that, compared with females, males appear to experience a greater variety and number of sexually abusive events. However, penetration (defined as anal intercourse for males and anal or vaginal intercourse for females) appears to occur at approximately equal rates for both males and females. Gold et al.'s (1998) interviews of sexually abused individuals appeared to clarify some of the equivocal findings pertaining to the nature of the sexual activity. The authors found that, while there were no gender differences in oral sex performed on the perpetrator, males were more likely to have had oral sex performed on them by the perpetrator. Also, with regard to the higher frequency of anal intercourse among males, Gold et al. (1998) stated that this finding may be due to anatomical differences. In fact, when vaginal intercourse and anal intercourse (as well as anal penetration with objects) were considered as one category, the differences between males and females were no longer significant. Research on the relationship between the nature of the sexual activity and psychological distress clearly indicates that abuse involving more invasive acts is associated

with greater negative impact (Beitchman et al., 1991, 1992; Briere, 1992; Browne & Finkelhor, 1986; Kendall-Tackett et al., 1993; Tsai et al., 1979). In an empirical study of adult males who were sexually abused during childhood, findings suggested that more invasive sexual activity was associated with increased psychiatric symptomatology as well as decreased feelings of self-worth (Mendel, 1995).

Means of engagement. Overall, the literature suggests that physical force, as a means of engaging children in sexual activity, is more frequently employed with male, as opposed to female, children (Knudsen, 1991; Pierce & Pierce, 1985; Rogers & Terry, 1984; Vander Mey, 1988; Violato & Genuis, 1993). Pierce and Pierce (1985) reviewed substantiated cases of childhood sexual abuse and reported that, compared with females, the use of force and threats was found to occur significantly more often among male survivors of childhood sexual abuse. In addition, the literature consistently reveals a higher degree of psychological distress among individuals whose sexual abuse experiences involved force or the threat of force (Beitchman et al., 1991; Briere, 1992; Browne & Finkelhor, 1986; Conte & Schuerman, 1987; Crowder, 1995; Finkelhor, 1979; Kendall-Tackett et al., 1993; Watkins & Bentovim, 1992).

Physical abuse. Compared with female children, the occurrence of concurrent physical abuse is more commonly reported among males who have experienced sexual abuse (Finkelhor, 1984; Vander Mey, 1988; Watkins & Bentovim, 1992). It appears crucial to investigate the presence of physical abuse among individuals who have disclosed childhood sexual victimization because of its many possible negative repercussions. Briere and Runtz (1988) found that initial effects of physical abuse may include increased anger and aggression, academic problems, and interpersonal difficulties, while long-term consequences may include

lower self-esteem, greater likelihood of criminal activity, and higher numbers of psychological symptoms and sexual problems. Mendel (1995) also reported that adult males who experienced childhood sexual and physical abuse were more likely to have attempted suicide than males who had only experienced sexual abuse.

Family environment. There is much literature related to the family characteristics of sexually abused children. While a review of this area was not undertaken for purposes of the present study, it seems important to briefly mention several findings that have been more commonly reported in the literature. Black and DeBlassie (1993) stated that research has shown that sexually abused children tend to perceive their families as less capable of problem solving and of establishing and maintaining appropriate role boundaries. As well, families of sexually abused children seem to possess a greater level of general dysfunction and pathology. In a review of the research on adult outcomes of childhood sexual abuse (Bagley & Thurston, 1996), several interesting results were reported. In particular, a family climate characterized by secrecy, communication and attachment problems, other forms of abuse (e.g., emotional, physical), and feelings of shame and guilt on the part of the victim was found to be associated with greater psychological impairment among victims. In addition, the family's reaction to the disclosure of sexual abuse was found to be critical. Bagley and Thurston (1996) stated that "a warm, loving, accepting, and sexually open family can minimize the harms resulting from abuse. Likewise, a family which accepts the victim without blame following revelation of CSA [childhood sexual abuse] is likely to contribute to good mental health in the victim" (p. 220).

Summary. Age of abuse onset shows equivocal findings for male and female children. While some studies have concluded that boys are relatively older at the time when their abuse

occurs, other research has found that boys are younger than girls at the time of their abuse. However, it has been suggested that the latter finding may be a reflection of the nature of the abuse (i.e., the shorter duration of extrafamilial abuse) and the increased likelihood that older boys will not disclose sexual victimization. The overwhelming majority of sexual offenders against boys and girls are males. While male children are more likely to be sexually abused by non-family members who are not much older than themselves, female children appear to experience a greater amount of sexual victimization by older family members.

There does not seem to be a gender difference in the frequency of childhood sexual abuse, but the sexual victimization of male children does seem to be of a relatively shorter duration. With regard to the nature of sexual abuse, findings tentatively suggest that, compared with girls, boys experience a greater number and variety of sexually abusive activities. Additionally, sexually abused male children may experience more physical force by offenders as a means of compliance and may also be at higher risk for concurrent physical abuse.

Treatment Approaches for Adult Males Who Have Experienced Sexual Abuse

In recent years, the growing realization that the sexual abuse of male children is a serious problem has highlighted the need to develop effective treatment interventions for this population (Hack et al., 1994). The numerous negative effects which may result from childhood sexual abuse and the increased risk of psychological trauma associated with certain characteristics of males' victimization experiences further point to the need for effective treatment. Given the clinical and empirical findings, Jehu (1991) stated that "there is ample justification for substantial professional attention to the problems and treatment of male victims" (p. 230).

Since the late 1980s, writings on the treatment of adult males have appeared on a more

regular and consistent basis in the literature. Individual and group therapy appear to be the most commonly reported treatment modalities for adult males who were sexually abused during childhood. Overall, the literature seems to indicate that many of the difficulties with which sexually abused males struggle are similar to those of female survivors. The one exception, however, appears to be that therapy with sexually abused males may need to pay closer attention to issues of sexual identity and sexual offending behaviour (Jehu, 1991). Given the number of similarities between adult male and female sexual abuse survivors, the present discussion of treatment approaches, components, and interventions will focus exclusively on males who have experienced sexual abuse.

Individual treatment. Pervasive societal beliefs about male gender identity, sexuality, and victimization have undoubtedly contributed to the reluctance of males to obtain mental health services for their childhood sexual abuse (Draucker, 1992; Lew, 1988). If and when adult males seek treatment, the initial presenting problems are typically of a behavioural nature (e.g., the negative consequences of aggression). Thus, male clients may not directly reveal their history of abuse to a clinician but may present with issues that the literature has identified as being associated with childhood sexual victimization. In such instances, it would seem important for a clinician to be alert to the possibility of abuse and, in fact, to assess whether a male client has been sexually abused. If a history of childhood sexual abuse is established, it would seem critical that the clinician then address abuse-related issues as part of the treatment program (Draucker, 1992).

When pursuing treatment for the first time, it is common for sexually abused adult males to engage in individual therapy. Crowder (1995) noted that, initially, most clinicians recommend

individual work because it appears to provide the greatest sense of safety for clients, thereby enabling them to begin addressing sexual abuse issues. Individual sessions also provide male clients with an opportunity to develop familiarity with both their therapist and the therapeutic process. Additional benefits of individual therapy are that it allows the therapist to thoroughly assess the client's skills and deficits and permits the client to develop a safe and trusting relationship with another adult (Dimock, 1988). These features are essential for effective individual treatment, and they may serve as important prerequisites for future possible participation in an abuse survivors group (Crowder, 1995).

Group treatment. The sexual abuse treatment literature has focused much attention on the integration of individual and group approaches. Ideally, a combination of individual and group therapy seems important to help male survivors address problematic feelings, thoughts, and behaviours associated with their childhood sexual victimization (Singer, 1989). As mentioned, individual therapy plays a critical role in the recovery process for sexually abused males, as it provides a safe environment to begin exploring the victimization experience and to work on abuse-related issues (Friedman, 1994). Most professionals, however, would seem to agree that individual work may be further enhanced through participation in group treatment, which is often seen as the second stage in the recovery process of sexual abuse (Crowder, 1995; Dimock, 1988). Gonsiorek et al. (1994) stated that the effectiveness of group treatment lies in its ability to provide education about childhood sexual abuse, to offer a supportive environment, and to function as a "social laboratory" in which interpersonal difficulties may be examined.

One suggestion concerning group treatment is that it be provided to supplement individual therapy. This adjunctive role of group therapy appears to be the result of some

clinicians' concerns about whether survivors of abuse can obtain sufficient attention and support to meet their individual needs in a group setting (Briere, 1996; Cruz & Essen, 1994; Jehu, 1991). When group treatment is conducted in conjunction with individual therapy, issues that arise in group may then be more fully explored in a one-to-one therapeutic setting in which time constraints are not as significant an issue (Sanderson, 1995). It is often the case that individual therapy is more frequent as male survivors make the adjustment to group but that, as group sessions progress, the frequency of individual therapy sessions decreases (Dimock, 1988).

Bruckner and Johnson (1987) have proposed that some male survivors may be referred for group treatment, in addition to individual therapy, if they have reached an impasse in their individual work. An example of a therapeutic impasse may be if adult males continue to struggle with feelings of isolation and the perception that the abuse experience was unique to themselves. Another recommendation regarding the use of different treatment modalities is that male survivors first be treated in individual therapy and then, if possible, be referred to a group for adult survivors of sexual abuse (Bruckner & Johnson, 1987).

Benefits and limitations of individual and group treatment. While there seems to be some debate among professionals about whether group treatment should occur concurrently with or following individual therapy, there does appear to be consensus about the importance of incorporating a group component in the treatment of males who have experienced childhood sexual abuse. A number of authors (Cahill, Llewelyn, & Pearson, 1991; Crowder, 1995; De Luca, Boyes, Furer, Grayston, & Hiebert-Murphy, 1992; Jehu, 1991; Lew, 1988; Sanderson, 1995; Singer, 1989) have outlined the many benefits of group treatment, such as helping to reduce individuals' feelings of alienation and isolation by normalizing their abuse experiences.

When male survivors join a group, there is the opportunity to explore similar issues with other individuals, which may enhance group cohesiveness and further help males develop trusting relationships (Briere, 1996; Draucker, 1992). For many males who have experienced childhood sexual abuse, a group may represent their first opportunity to talk with other males about having been vulnerable and hurt by the actions of trusted others (Jehu, 1991; Singer, 1989). Sanderson (1995) noted that survivors are often better able to accept positive messages about not being responsible for the abuse when they are conveyed by individuals who have shared a similar experience and can offer validation of the survivor's thoughts and feelings.

Groups may provide sexually abused males with an opportunity to experience a social setting where there is respect for personal boundaries and where they may practice new interpersonal skills (Cahill et al., 1991; Crowder, 1995; Cruz & Essen, 1994; De Luca et al., 1992). Through interactions with other group members, males may learn more appropriate ways of resolving conflict, satisfying their needs, giving and receiving non-sexual affection, and increasing their social support systems (Crowder, 1995; Cruz & Essen, 1994). Additionally, group therapy may be a more cost-effective modality of treatment, compared with individual therapy (De Luca et al., 1992). Unlike individual treatment, the time constraints of short-term, time-limited groups may provide a strong motivation for male survivors to explore specific issues and set goals that they wish to attain (Lew, 1988). Also, the format of a time-limited group may make it easier for males who only wish to commit themselves to short-term treatment (Sanderson, 1995).

While there are many benefits associated with participation in a group treatment program, there are also several limitations which would demonstrate the importance of an

individual therapy component. Unlike individual therapy, which may be of long-term duration, short-term, time-limited groups make it impossible for males to address all aspects related to their childhood sexual abuse (Crowder, 1995). According to Singer (1989), short-term group therapy is "not adequate in helping them [males] to identify the emotional and behavioral symptoms, recognize the negative messages from the past, and develop ways to alter the feelings and behavior that work against them" (p. 470). Unlike group therapy, individual treatment can explore a variety of issues and evolve gradually according to the client's individual pace (Lew, 1988). Thus, a further limitation of group treatment is that it cannot be completely tailored to the needs and wishes of its members, which may cause them to feel as though they have little control over the course of the group process (Draucker, 1992). Finally, some males with histories of sexual abuse may find it difficult to listen to the experiences of other individuals and may become overwhelmed with the whole issue of sexual abuse. This point underscores earlier statements about the importance of having group participation occur either in conjunction with individual work or after the termination of individual therapy (Cahill et al., 1991; Sanderson, 1995).

Treatment Issues and Interventions

The sexual abuse literature has addressed several important issues and components of treatment for adults who have experienced childhood sexual abuse. Both individual and group treatment modalities have been examined, particularly with respect to specific interventions and activities which may be employed to address important abuse-related issues. It should be noted that the majority of writings are based on professionals' own clinical work with adult male survivors of sexual abuse.

Safety. Issues surrounding a client's sense of safety are significant in therapy, and it is imperative that clinicians ensure the safety of the therapeutic process to the best of their ability. Without a sense of safety, it seems unlikely that male clients will feel comfortable enough to examine highly personal and sensitive abuse-related issues, and as such, the efficacy of treatment will be compromised. One important way of increasing therapeutic safety may be through the establishment of ground rules, such as those pertaining to client confidentiality and regular attendance (Crowder, 1995).

The establishment of ground rules seems particularly important in group treatment because a client may feel quite vulnerable as he begins to share his victimization experiences with a number of other individuals. Issues involving active participation, expression of feelings, boundaries (e.g., social contact outside of the group), and withdrawal from the group are commonly addressed in group therapy programs (Briere, 1996; Crowder, 1995; Jehu, 1991). With respect to the issue of socializing outside of group, various views have been expressed. Friedman (1994) noted that a number of male survivors experience difficulties related to boundaries and sexuality and consequently, may sexualize their friendships with group members. Thus, he concluded that social contacts outside of group sessions should be discouraged by group facilitators. Draucker (1992), on the other hand, stated that the advantages and disadvantages of contact outside of group should be explored with participants and that, ultimately, participants need to make their own choices regarding the issue.

Disclosure of childhood sexual abuse. One important issue for sexually abused males is disclosure of the sexual abuse experience, which seems to be a prerequisite for any form of treatment (Black & DeBlassie, 1993). Crowder (1995) stated that "acknowledging to himself

that he was sexually abused as a child is the first step a survivor must take to heal from this experience" (p. 50). Disclosure is a particularly challenging therapeutic issue because there is a tendency among males to minimize the abusive aspects of early sexual experiences (Meiselman, 1990). It may also be difficult for males to disclose sexual abuse by another male because of concerns related to sexual orientation (Bruckner & Johnson, 1987). As such, relating details of their abuse and accepting the fact that they were sexually abused constitutes a major achievement for males in therapy and may lead to considerable feelings of relief (Sanderson, 1995).

In order to address the issue of disclosure, it may be necessary for clinicians to elicit specific details of the abuse as well as to explore feelings related to any previous disclosure experiences, both positive and negative (Bruckner & Johnson, 1987). There are a variety of ways in which to help male clients disclose their victimization experiences. As an initial step in beginning to talk about and release emotions related to the sexual abuse, some clients may find it helpful to bring photographs of themselves as well as the offender before, during, and after the abuse (Draucker, 1992; Sanderson, 1995). Clinicians may also ask clients to construct an image of their family and their position in the family through the arrangement of various objects. The placement of objects may then be used to begin exploring the roles of individual family members, after which the focus may move to the abusive experience and its effects on survivors' feelings toward family members (Bruckner & Johnson, 1987). Another method of addressing the issue of disclosure may be to have male clients develop "sexual abuse autobiographies" in which they journal their own victimization experiences. Specifically, sexually abused males may be encouraged to write about their perpetrators, the duration and frequency of their abuse, the

manner in which they were groomed for the abuse, the specific sexually abusive activities, their negative and positive reactions to the experience, and whether they told anyone about the experience. Parts of the autobiography may then be shared in therapy (Crowder, 1995). According to Dahlheimer (1990), this activity may (a) help survivors end the denial about their past abuse, (b) validate the experience and its negative consequences, and (c) help male survivors gain a better understanding and different perspective of their sexual victimization experiences.

Crowder (1995) has devoted much attention to the issue of dealing with disclosure through the use of the inner child metaphor. The rationale behind inner child work is that clients may develop more self-loving ways when they begin to see the "child" part of themselves as having been traumatized and mistreated. According to Crowder (1995), most inner child work may be appropriately undertaken through the use of guided imagery or visualization. With this method, the therapist induces deep relaxation and leads the client into a visualization, in which he is asked to get in touch with his child just before the abuse began. Afterwards, the client may be instructed to have the child either tell the client something that is upsetting to him or to tell the adult client about his state of well-being. Prior to leaving the imagery, the client may be asked to respond to the child, either verbally or silently, and to ensure that the child is feeling safe and protected. An important aspect to keep in mind prior to undertaking a visualization exercise is that clients need to establish adult "anchors." Clients may think about a symbol or touch an object (e.g., wedding ring) if they begin to feel anxious during the guided imagery activity. Another important point raised by Crowder (1995) is that the inner child metaphor may initially be difficult for males to accept because being childlike is often seen in a negative light.

In such instances, it is suggested that the therapist ask clients to use the image of a little girl during the visualization, as sexually abused males may experience compassion for a girl more easily than they may for a boy.

Abuse-related affect. Many males grow up with messages that the expression of feeling is a sign of vulnerability and powerlessness. These are features which are not typically associated with masculinity. As a result, it may be difficult for males who have experienced childhood sexual abuse to identify and explore abuse-related feelings. Males may fear that they will not be able to control their feelings if they begin to address their abuse and the emotional impact it has had on them (Crowder, 1995; Schwartz, 1994). In order to effectively deal with their past experiences of abuse, it seems crucial to help male clients learn to label their feelings and to develop skills for handling their emotions. Mendel (1995) stated that males will only be able to fully work through their sexual abuse experience once they have identified, accepted, and integrated feelings of helplessness, sadness, pain, and vulnerability.

As mentioned, many sexually abused adult males may need to develop a vocabulary for the identification of their different emotions. This work may involve therapists informing clients about the continuum of emotions and the fact that they are capable of experiencing varying degrees of feelings. Clients may be asked to observe other individuals and the different ways in which people express their emotions. As well, some time may be spent exploring the various ideas and beliefs that survivors hold with respect to men and emotional expression (Crowder, 1995). There are a variety of techniques which may help to increase the affective expression of males who have been sexually victimized. As an initial exercise, clients may be asked to draw the house in which they were abused as a way of exploring the many feelings associated with the

sexual abuse experience (Sanderson, 1995). A common activity involves the gestalt empty chair technique, in which clients imagine that someone they wish to talk to, such as the offender, is sitting in an empty chair. Clients may then begin a dialogue with this individual, paying particular attention to the impact that the sexual abuse has had on them. This exercise may be particularly useful for clients who are either unable to confront their offender or who wish to prepare themselves for a future confrontation (Ratican, 1992; Sanderson, 1995). Initially, it may be difficult for clients to begin the dialogue, and, in such instances, the clinician may suggest that clients write a letter to the offender and then begin by reading this letter aloud (Crowder, 1995; Ratican, 1992).

Guilt and self-blame. Therapy may be particularly valuable in decreasing male survivors' feelings of responsibility for the sexual abuse (Brown, 1990; Lisak, 1994), According to Draucker (1992), many sexually abused adult males blame themselves for instigating the abuse, failing to protect themselves against the offender, or not telling anyone about the abuse. In exploring beliefs about lack of disclosure, it may be important to have male clients consider their childhood assumptions regarding the consequences of disclosure, such as punishment or family break-up. Also, clinicians may need to inform survivors that disclosure would have required the availability of supportive receptive significant others and may encourage survivors to examine whether these conditions were present during the time of their abuse (Draucker, 1992). It may also be important for clinicians to provide information about the prevalence and effects of childhood sexual abuse and to stress that the perpetrator (not the victim) was responsible for the abuse. This sharing of information gives clinicians the opportunity to normalize the individual's sexual abuse experience and to help him understand his current

thoughts, feelings, and behaviour within the context of his childhood victimization (Briere, 1996).

Hunter et al. (1992) reported that examination and correction of erroneous self-blame cognitions is an integral component of most sexual abuse treatment programs. A common approach to address issues of guilt and self-blame is cognitive restructuring (Draucker, 1992; Ratican, 1992; Schwartz, 1994). Clinicians typically begin the process of cognitive restructuring by explaining that it is based on the principle that beliefs influence feelings and that distorted beliefs may lead to distressing feelings along with behavioural or emotional difficulties. The next stage is to help clients identify the thoughts and beliefs that they have when feeling distressed. The last stage in cognitive restructuring involves helping clients recognize distortions in their beliefs (e.g., all-or-none thinking, overgeneralization) and exploring alternative beliefs. These alternative beliefs may be generated by having clients examine factual information about their abuse, analyze the evidence that supports or disproves a belief, and shift from a subjective to a more objective perspective (Draucker, 1992). One difficulty with cognitive restructuring is that sexually abused males' feelings of guilt are often resistant to cognitive challenges. Guilt may serve a protective function for survivors by preventing them from being overwhelmed by feelings of powerlessness and lack of control. In such instances, Draucker (1992) suggested that it may be important for therapists to acknowledge clients' feelings of guilt and to suggest that such feelings generally decrease as clients begin to feel better. Such statements may help clients feel that they have control over their emotions and that they may choose whether or not to have particular feelings.

Anger. Among adult males with histories of childhood sexual abuse, anger is an abuse-

related affect which seems to be easily identified and expressed. In order to discover and explore feelings that may underlie anger, sexually abused males may initially need to focus on fully expressing their angry feelings (Crowder, 1995; Dimock, 1988). When addressing the issue of anger, overall therapeutic goals may include identifying the source and direction of anger, validating clients' rights to feel angry, externalizing rather than internalizing anger, accepting and supporting these intense feelings, and learning constructive ways of expressing anger (Jehu, 1991). One appropriate way of externalizing feelings of anger is through the activity of letter writing. Writing letters may permit male clients to release their feelings of anger and to begin expressing more difficult feelings, such as grief, loss, and powerlessness (Draucker, 1992; Ratican, 1992; Sanderson, 1995). These letters, which are often unsent, may be addressed to either living or deceased significant individuals (e.g., client's parents, offender, or other family members). A client's letter to his offender should confront him or her with the impact that the abuse has made on his life. As well, the client is encouraged to relate his feelings about the abuse in the letter so as to dispel any beliefs that the offender may possess regarding the victim having enjoyed or wanted the abuse to occur. The letter may also convey the client's feelings toward the offender and, if possible, what it is he wishes the offender to do (Singer, 1989).

Related to their intense feelings of anger, Crowder (1995) noted that many sexually abused adult males have powerful revenge fantasies involving "getting even" with their offender. It is important to explore these fantasies in therapy, perhaps through such valuable tools as role playing and imagery work (Bruckner & Johnson, 1987). One approach that has been used in therapy is to have clients draw or symbolically act out their fantasies of retribution in order to release their intense feelings of anger and rage. A symbolic enactment that appears to be

effective involves covering an old cardboard box with reminders of the abuse and the offender and then having the client destroy it by stomping all over the box (Crowder, 1995). As mentioned, role playing is a valuable technique that may help survivors release their emotions, explore their sexual victimization experiences, and examine the possibility of a future confrontation with a significant other. As a method of exploring emotions, role plays may involve having clients assume a variety of roles, such as that of the abused child, the offender, or a non-offending significant individual, such as a parent. One word of caution is that role plays may be extremely powerful, and as such, therapists need to properly prepare their client and tailor the role plays in order to give the client a sense of control over the process (Sanderson, 1995). When using role plays to assist clients who wish to prepare for a future confrontation with a significant other, therapists may need to first evaluate whether clients are psychologically ready for such a confrontation by evaluating the progress they have made with such issues as denial, minimization, and self-blame (Draucker, 1992). It also appears crucial for therapists to prepare clients for the possible consequences of a confrontation, including the relative benefits gained from such an action as well as possible negative ramifications (Draucker, 1992; Sanderson, 1995).

Anxiety. There are several therapeutic interventions which may be employed to address male survivors' feelings of anxiety. Most of the interventions aimed at reducing anxiety are subsumed under the heading of stress management and involve cognitive-behavioural and behavioural procedures. Such procedures may include relaxation training, thought stopping, guided self-talk, in vivo exposure to anxiety-provoking situations, and cognitive restructuring to correct distorted beliefs which may exacerbate feelings of anxiety (Jehu, 1991). Sanderson

(1995) elaborated on several behavioural techniques which may be employed in the treatment of childhood sexual abuse. Therapists may help sexually abused clients develop effective grounding techniques, which are defined as behaviours in which individuals engage in order to feel more in the "here and now" when feelings of anxiety become too overwhelming. Examples of grounding techniques may include touching oneself, focusing attention on a specific object, or deep breathing.

Relaxation training may also be an especially useful intervention for adult survivors of sexual abuse, particularly because their hypervigilance seems to severely limit their ability to feel calm and rested. Once clinicians have explained the rationale behind progressive muscle relaxation training, they may then lead the client in a relaxation exercise, which involves briefly tensing and relaxing various muscle groups throughout the body. In order for relaxation training to be optimally effective, clinicians may need to stress the importance of practice outside of therapy sessions. In fact, it has been recommended that clients practise relaxation training twice daily in order to achieve mastery within one to two weeks (Davis, Eshelman, & McKay, 1988).

The literature has also identified distraction and thought stopping as a common procedure to reduce individuals' feelings of anxiety (Cautela & Wisocki, 1977; Jehu, 1991; Sanderson, 1995). Therapists may begin by helping sexually abused adult clients identify anxiety-provoking thoughts and then explain the manner in which thoughts may lead to anxiety and maladaptive behaviours, such as addictions or even sexual dysfunctions. The thought stopping procedure involves asking clients to think about anxiety-provoking thoughts and then having the clinician loudly say "Stop!" which will presumably distract clients from these problematic thoughts. Eventually, clients are taught to stop themselves, using the same or similar

phrases, when they begin to have anxiety-provoking thoughts (Cautela & Wisocki, 1977).

Sexual identity. Regarding the issue of sexual identity, there are a number of approaches which may be employed in treatment interventions. Bibliotherapy is often used to ensure that clients have a basic understanding of male sexuality (Bruckner & Johnson, 1987). Education seems to play a major role in examining sexual identity issues. Most males who have been sexually abused require some exploration of the ways in which their victimization may have affected their beliefs about their own sexual identity. It may be important for clinicians to inform survivors that they are not "made" homosexual by any kind of childhood sexual experience and that sexual victimization experiences do not lead to the development of any particular sexual identity (Dimock, 1988; Meiselman, 1990). When examining sexual identity issues, a crucial therapeutic component involves addressing the fact that many males responded physically with pleasure or arousal during the victimization experience. Such responses may have led to conclusions that, as children, survivors must have enjoyed and sought the experience. Reframing the issue of sexual responsiveness from an adult perspective involves educating survivors (perhaps through bibliotherapy and reassurances from the therapist) that physiological reactions to sexual stimulation are natural and expected responses (Draucker, 1992).

Draucker (1992) noted that sexually abused males may externalize their feelings through inappropriate sexual actions, such as hypersexuality or compulsive sexual behaviours. A combination of insight-oriented, cognitive, and behavioural techniques may be implemented to address these issues. Initially, it may be important for male clients to gain an understanding of the way in which their current sexual difficulties are related to their sexual abuse experience. Subsequently, the misconceptions regarding sex roles and sexuality may need to be examined

through the use of cognitive challenging or restructuring. Finally, therapists may suggest the implementation of several behavioural changes, such as avoiding triggers of the abuse experience during sexual activity (e.g., the smell of alcohol), finding a place for sexual activity that does not resemble the place where their childhood victimization occurred, and learning to say no or to end sexual activities with one's partner in a non-rejecting manner (Draucker, 1992).

While many males who have experienced childhood sexual abuse have not offended against another individual, they are, nonetheless, often concerned about this possibility (Bruckner & Johnson, 1987). In his interviews with male survivors, Mendel (1995) found that the most salient issue involved the fear of sexually perpetrating against another person. Clinicians may need to assist clients in understanding the origin of their fears by exploring fantasies that survivors may have created during their victimization experiences. Although perpetrating behaviour may be more probable among abused males, it is imperative that therapists inform survivors that individuals who work through abuse-related issues and feelings (e.g., vulnerability, loss, pain, helplessness) and who develop satisfying relationships with others may greatly diminish their chances of continuing the cycle of abuse (Draucker, 1992; Mendel, 1995). In addressing the issue of sexual offending, therapists may need to help clients examine their current lifestyles to assess the possibility of abusing children and then to learn ways of taking control of their behaviours and making changes to ensure that this possibility does not occur (Crowder, 1995; Draucker, 1992). Such changes may involve the cognitive technique of thought stopping, which may enable male clients to gain control of their fear-related thoughts or deviant fantasies. As well, if clients have used abuse-related fantasies to reinforce their sexual arousal, it seems critical that therapy assist them in developing more appropriate fantasies in

order to diminish the possibility that sexual offending behaviour will occur (Crowder, 1995).

In working with males who have a history of sexual abuse, Meiselman (1990) stressed that clinicians must be aware of their legally mandated reporting requirements in cases where clients disclose current or recent sexual offenses. It seems important for therapists to respond to such disclosures calmly and non-judgmentally and to inform clients that, while the behaviour is unacceptable, therapists will not reject them and will help them deal with the issue (Draucker, 1992). While certain instances of abuse (e.g., ongoing abuse) will need to be reported, other sexually abusive actions (e.g., abuse that occurred during childhood or adolescence) may not necessarily need to be reported. In either case, an important therapeutic goal will involve helping survivors accept responsibility for their offending behaviours. The empty chair technique, in which survivors speak with their victims, acknowledge the offense and its consequences, apologize and ask for forgiveness, and share their own abuse experience, may be a powerful technique in helping clients accept responsibility and deal with feelings of guilt related to the offending behaviour (Draucker, 1992; Ratican, 1992).

Evaluation of Treatment Approaches With Sexually Abused Adult Males

Research on the impact of male childhood sexual abuse and clinical writings of treatment approaches for male survivors have recently begun to emerge. However, there still remains a paucity of information related to the effectiveness of various treatment interventions (Cahill et al., 1991; Crowder, 1995; Dhaliwal et al., 1996; Hoier, 1991; Jehu, 1991). Jehu (1991) stated that "with few exceptions, the current knowledge base for the provision of therapy to previously sexually abused men and women contains little information on feasible, acceptable, and effective treatment packages for the wide range of problems presenting in these client groups"

(p. 255).

In her survey of various therapists knowledgeable in the area of childhood sexual abuse, Crowder (1995) found that most employed informal methods (such as asking clients for feedback on therapy sessions) to evaluate the efficacy of their therapeutic work. In addition, "changes such as a reduction in PTSD symptoms or in trauma-based intrusive memories, increased self-awareness, affective improvements, and cognitive restructuring are used to measure the success of the therapy. Client satisfaction and life changes, achievement of identified goals, and improved work or relationship functioning are other indicators of improvement" (p. 67). With regard to formal evaluation methods, they appear to be an under-utilized resource in clinical work with abuse survivors, and the small number of therapists who use formal testing typically administer standardized psychological tests on a pre- and post-treatment basis. Commonly administered psychological instruments include those assessing abuse-related psychological symptoms, self-esteem, depression, and personality functioning (Crowder, 1995).

Cahill et al. (1991) reviewed individual and group treatment approaches for adults who were sexually abused during childhood. It should be noted that the study focused almost exclusively on females, as there was virtually no treatment outcome research available on sexually abused adult males. The authors noted that some empirical research has employed self-report consumer satisfaction questionnaires in order to evaluate treatment effectiveness, and the following results have been reported: (a) increased self-esteem was consistently found; (b) the sharing of feelings with supportive individuals was identified as the most helpful component of therapy; (c) decreased feelings of isolation, guilt, and shame; and (d) individuals reported feeling

better able to protect themselves. Cahill et al. (1991) also concluded that, among sexually abused adult females who participated in group treatment, predictors of positive outcome may include having a supportive relationship outside of group, being motivated and expecting a positive outcome, and being involved in individual therapy prior to or concurrently with group.

In sum, it would seem that efforts to systematically evaluate treatment interventions for childhood sexual abuse are being undertaken. Nonetheless, it is recommended that improved standardized methods for assessing treatment outcome, in addition to anecdotal information, be further developed (Crowder, 1995; Sanderson, 1995). Additionally, as psychological investigation of sexually abused adult males continues, it is hoped that research may establish finer discriminations between the efficacy of various forms of treatment (i.e., individual versus group therapy) and may identify the components and issues which are essential for effective treatment of adult male survivors (Cahill et al., 1991).

Comparison of Single-Case and Between-Group Designs in Treatment Outcome Research

Overview. Single-case and between-group designs represent two diverse methods which have been used in treatment outcome research. At their most basic level, between-group designs include two groups of individuals, specifically an experimental group and a comparison or control group. Random assignment of individuals is typically employed in order to produce groups which are equivalent on factors which may be related to the independent variable (i.e., the treatment intervention) or which may affect group differences on measures of the dependent variables. The rationale for using randomization is to better ensure that any differences between groups are the result of the treatment intervention and not other extraneous variables (Kazdin, 1992). In between-group research, the experimental group is exposed to one or more treatment

interventions or variations of a treatment. The comparison group is treated exactly the same way as the experimental group except that participants in the comparison group do not receive the treatment intervention. The purpose of the comparison group is to control for the impact of extraneous variables so that differences between groups may be considered to reflect the effect of the experimental manipulation (Kazdin, 1992; Sanderson & Barlow, 1991).

With regard to single-case research designs, a common misconception is that these designs are synonymous with case studies. This misconception has resulted in several erroneous conclusions about single-case research, namely that such research employs only one participant and lacks internal validity (Aeschleman, 1991). Contrary to these assumptions, a single-case design is an "experimental procedure in which the researcher systematically controls the experience of a single organism in order to determine the identity and power of the variables controlling a particular behavior" (Callahan & Ziegler, 1980, p. 176). One of the core features of single-case designs is the pre-intervention or baseline period during which the investigator measures the natural occurrence of a behaviour, often in terms of its frequency, duration, or intensity. The baseline period is critical in single-case research because experimental effects are contrasted to baseline functioning, and conclusions about the efficacy of a treatment intervention are based on this comparison (Callahan & Ziegler, 1980). Typically, single-case designs employ one to a few individuals (although a large number of individuals may be studied), and the dependent measures are assessed continuously over the duration of the study. As well, the manner in which the components of the treatment intervention are implemented is largely determined by examining the pattern of data for individual participants (Kazdin, 1992).

Advantages of single-case research in treatment outcome studies. While the between-

group design continues to be the more frequently employed research approach, single-case designs have much to offer in furthering our knowledge of treatment effectiveness. Concerning the issue of design structure, it would appear that single-case research designs offer more flexibility than pre-determined between-group designs. In other words, the details (e.g., length of treatment, treatment strategies) of a between-group design are entirely mapped out prior to the intervention and then simply carried out (Hayes, 1981). While single-case research also requires much planning prior to the intervention, these designs appear to be more adaptive and interactive in nature, meaning that the investigator makes only tentative decisions about such issues as treatment length and strategies. The client's data are closely monitored over the course of the research study, and alterations to the design and length of various experimental conditions are then made accordingly (Galassi & Gersh, 1991). It should be noted that the option to change features of the design is also available to between-group researchers, but the distinction seems to be that design flexibility is an essential characteristic of single-case research (Gettinger & Kratochwill, 1987). The important benefit of design flexibility is that investigators have the ability to make alterations to the treatment intervention in order to more closely tailor it to the needs of the client. The emphasis on closely monitoring the needs of clients may help in furthering knowledge about effective treatment variables and may lead to the development of more beneficial treatment packages (Galassi & Gersh, 1991; Wilson & Heward, 1988).

Turning to the issue of assessment, between-group designs typically gather information on the dependent variable prior to and following the completion of the treatment study. On the other hand, assessment in single-case designs occurs on a continuous basis as a means of closely examining individual functioning in response to various components of the research study

(Galassi & Gersh, 1991). According to Wilson and Heward (1988), one of the major advantages of repeated measurement is that it serves to detect and control for extraneous variables which may interfere with the interpretation of treatment effects. In contrast, between-group designs, which employ only a few widely spaced measurements of the dependent variable, may not be sensitive enough to detect variability in individual responding over the course of the study. Thus, it would seem that the emphasis of single-case research on individual variability may result in better experimental control and may lead to firmer conclusions about the relationship between the treatment intervention and its effects on individual functioning (i.e., internal validity will be increased).

Consideration of evaluation criteria may also demonstrate the advantages of a single-case approach to treatment outcome research. Overall, it may be stated that between-group research focuses on statistical methods to evaluate statistical significance while single-case research focuses mainly on visual inspection to evaluate the clinical significance of treatment effects (Galassi & Gersh, 1991). (However, it should be noted that statistical analysis of single-case data is also readily available). Visual inspection, which refers to visually examining clients' graphed data in order to reach conclusions about the effects of an intervention, possesses a greater likelihood of detecting effects which have practical or clinical significance for an individual, as opposed to those which only exhibit statistical significance (Bryan, 1987; Kazdin, 1982). Several authors (Kazdin, 1982; Lambert, 1994) have noted that research findings which focus exclusively on statistically significant changes may not be important at a clinical level. In other words, the changes may not make much of a difference in the individual's everyday life and, as such, may not be important or relevant. As well, statistically significant changes may not offer

much information on the impact of treatment interventions on specific individuals (Lambert, 1994). In single-case research, clinical significance may be determined by examining the degree to which a treatment intervention returns individuals to normative levels of functioning, the extent to which improvement is perceived by the individual as well as by significant others in the individual's everyday life, and whether the presenting problem has been eliminated (Kazdin, 1990).

Related to the issue of evaluation criteria is the types of errors which may be committed as a result of the decision-making methods in single-case and between-group research. Type 1 errors occur when an independent variable is accepted as having an effect on the dependent variable when in fact, it has no effect. Type 2 errors are committed when an independent variable is rejected as not having an effect on the dependent variable when in fact, it does have an effect (Kazdin, 1982; Wilson & Heward, 1988). It appears that single-case designs have a higher probability of committing Type 2 errors, while the risk of a Type 1 error is higher in between-group research. The reason that between-group designs produce more Type 1 errors is because statistical analyses are not capable of discriminating between variables that produce a socially significant (i.e., clinical) change versus those that have a statistically significant effect. Therefore, there is a greater risk of accepting variables whose true effect may be statistically significant but also socially insignificant (Wilson & Heward, 1988). In contrast, the focus of single-case research on visual analysis may provide a "higher level of discrimination than would be possible through the use of a statistically set point of acceptance or rejection. As a result, single-case research designs identify fewer variables, but these variables are typically more robust or powerful" (Wilson & Heward, 1988, p. 149).

Additional advantages of employing single-case designs in treatment outcome research involve ethical and practical issues. When conducting research in an applied setting, a single-case approach may provide clinicians with a realistic research strategy which can easily be incorporated into their daily clinical work. On the other hand, attempting to design a between-group treatment outcome study may result in several problems, such as collecting large client samples and forming randomized and equivalent experimental and comparison groups (Hersen & Barlow, 1976). In addition to these practical difficulties, several ethical concerns may be raised when using a between-group design to evaluate treatment efficacy. For instance, the treatment of psychologically distressed individuals may be delayed for lengthy periods of time until a large enough sample has been collected. Also, a treatment intervention may be withheld from certain clients who are in dire need of psychological services because these clients are serving as a comparison group in the research study.

Summary. The use of a single-case design in conducting research on treatment effectiveness has many benefits. The flexibility of a single-case design structure allows treatment to be tailored to meet the specific needs of the client, which may result in more effective and efficient treatment interventions. The continuous assessment of the client and close monitoring of extraneous variables increases internal validity. As well, the emphasis of single-case research on visual inspection results in the identification of powerful treatment interventions which make clinically significant differences in an individual's everyday functioning. Finally, a single-case research approach offers a practical and ethical way of conducting research in an applied setting.

Purpose of the Present Study and Expected Findings

There are a variety of arguments in support of increasing treatment efforts and treatment outcome research on adult males who have experienced childhood sexual abuse. The reported prevalence and incidence rates of sexual abuse involving male children are alarming, particularly when one considers that these rates most likely represent under-estimates of the actual extent to which boys are sexually victimized. There are numerous initial and long-term negative effects which appear to be related to the sexual abuse of male children, including low self-esteem, depression, self-blame and guilt, anger, and anxiety. Additionally, the elevated risk of psychological trauma associated with certain characteristics of males' victimization experiences (e.g., use of physical force, invasive sexual activities) further point to the need for effective treatment interventions.

While there is ample justification for developing and evaluating treatment programs for adult males who have been sexually abused, the literature in this area is relatively limited. Most of the published reports on the treatment of sexually abused adult males consist of clinical impressions based on therapeutic work with this population. While these anecdotal reports have merit, they require systematic empirical validation. Thus, the purpose of the present study was to empirically evaluate the effectiveness of an individual treatment program for adult males with histories of childhood sexual abuse. Based on the research and clinical literature, it was expected that sexually abused adult males who participated in the intervention would experience improvements in psychological adjustment and functioning over the course of individual treatment. In particular, the following results were expected:

(1) Compared with pre-treatment assessment, participants' scores on the self-esteem measure

would increase while their scores on measures of depression, self-blame, anger, and anxiety would decrease at post-treatment and follow-up assessment sessions.

(2) Over the course of the research study, the self-monitoring measures would show increases in (a) the number of pleasant activities in which participants engaged and the perceived enjoyability of these activities and (b) participants' self-concept scores.

(3) Participants' daily self-ratings of self-blame, anger, and anxiety would decrease in response to treatment interventions which focused specifically on these issues, and these decreases would persist throughout the course of the research study.

(4) Significant others' weekly ratings of participants' feelings of self-blame, anger, and anxiety would show decreases in response to treatment interventions which focused specifically on these issues, and these decreases would persist throughout the course of the research study.

Method

Participants

Seven adult males who experienced childhood sexual abuse were originally recruited for the present study. One participant terminated treatment halfway through the program, while another participant moved to a new city towards the end of the treatment program. The remaining five participants will be referred to as Steven, Samuel, Stan, Scott, and Sean in order to protect their identity and maintain confidentiality. The average age of participants was 33 years, with ages ranging from 23 to 37 years. Each participant disclosed at least one incident of childhood sexual abuse, which was defined as sexual contact prior to 16 years of age with an individual who was at least five years older than the child. In instances where the age difference was less than five years, the experience was considered sexual abuse if (a) the individual

indicated that he did not consent to the experience, (b) some degree of coercion was used to engage the child in the sexual activity (e.g., physical force), and (c) the offender was in a position of relative power (e.g., caregiver, authority figure) over the child (Finkelhor, 1984; Risin & Koss, 1987; Violato & Genuis, 1993).

Participants were recruited through notices which were sent to various mental health agencies (e.g., Psychological Service Centre, Elizabeth Hill Counselling Centre). The notices provided information about the purpose of the research study, the content and format of the individual treatment program, and inclusionary as well as exclusionary participant criteria (see Appendix A). Similar information pertaining to the research study was also posted on notice boards around the University of Manitoba and in local newspapers. Individuals who expressed an interest in the research study underwent a brief screening process in order to ensure that they met the following requirements: (a) they disclosed at least one incident of childhood sexual abuse; (b) they were in a living arrangement which did not include the offender; (c) they were able to talk about the abuse experience at some length; (d) they were not suffering from a psychotic disorder; (e) they were not struggling with a severe alcohol or drug addiction; (f) they were not experiencing acute post-traumatic symptoms; (g) they appeared to possess an average level of intellectual functioning; and (h) they were not suffering from a specific phobia (Draucker, 1992; Lew, 1988; Saxe, 1993).

Therapist and Supervision

A doctoral-level female graduate student in the Clinical Psychology program at the University of Manitoba served as the therapist for participants involved in the research study. This individual, along with the assistance of another doctoral-level female graduate student in

the Clinical Psychology program, also conducted the pre-, post-, and follow-up assessment sessions with participants as well as scored the psychological measures and homework assignments. Individual supervision sessions were held on a weekly basis with a registered clinical psychologist whose area of specialty is childhood sexual abuse.

Materials

Clinical interview. A modified version of Hunter's (1990) intake interview for sexually abused males was used in the present study. The interview assesses a variety of areas related to sexual victimization, including family and social history, behavioural history, sexual and sexual abuse history, and abuse reactive behavioural history. Socio-demographic data as well as information pertaining to any childhood physical abuse experiences were also collected (see Appendix B).

Self-Report Measures

Beck Depression Inventory. The present study assessed the intensity of cognitive, affective, behavioural, and somatic aspects of depression through the use of the revised Beck Depression Inventory (BDI; Beck, Rush, Shaw, & Emery, 1979). The BDI consists of 21 items, each of which contains four statements describing depressive symptoms which are rated from 0 to 3 in terms of increasing intensity. Individuals are asked to choose the statement which best describes the way they have been feeling over the past week (see Appendix C). The total score is derived by summing the ratings for each of the 21 items. Scores range from 0 to 63, with higher scores indicating a higher level of depression. The following clinical cut-off scores have been established for the BDI: none or minimal depression is less than 10; mild depression is 10-16; moderate depression is 17-29; and severe depression is 30-63 (Beck & Steer, 1993). It has been

suggested that a 10-point decrease in score on the BDI from pre- to post-treatment represents a clinically significant change. However, no specific studies on this issue have been conducted (Katz, Katz, & Shaw, 1994).

In a 25-year review of research conducted on the psychometric properties of the BDI, Beck, Steer, and Garbin (1988) concluded that the BDI is a reliable and valid instrument for assessing the intensity of depression in psychiatric and non-psychiatric samples. The meta-analysis yielded a high mean internal consistency estimate (alpha = .87), and test-retest reliability correlations were greater than .60. The concurrent validity of the BDI with regard to a variety of other measures of depression was found to be high, and the BDI also demonstrated strong construct validity, meaning that it detected relationships between physiological, behavioural, and attitudinal variables which may be associated with depression (Beck et al., 1988; Katz et al., 1994). Johnston and Page (1989) conducted a study in which the BDI was one of several measures administered to males and females in various age categories. Results indicated that, among male university students whose average age was 21.47 years, the overall depression level was minimal ($\underline{M}$ = 8.35, $\underline{SD}$ = 7.31).

Self-Esteem Scale. Rosenberg's (1965) Self-Esteem Scale is a unidimensional measure which places individuals along a single continuum from high to low feelings of self-worth. It includes 10 items which are rated along a 4-point scale ranging from 1 (strongly agree) to 4 (strongly disagree; see Appendix D). Scores range from 10 to 40, with higher scores indicating lower levels of self-esteem. In a study (Higgins & McCabe, 1994) which examined the relationship between childhood sexual abuse, family violence, and adult adjustment among women, findings revealed that non-abused females had a mean score of 22.80 on the Rosenberg

Self-Esteem Scale (SD = 7.06). Normative data on a sample of non-abused adult males could not be found.

Hoagwood (1990) reported test-retest reliabilities ranging from .85 to .92. In terms of convergent validity, which measures the correlation of the Self-Esteem Scale with different scales that assess the same concept (i.e., self-esteem), Silber & Tippett (1965) sampled 44 university students, seven of whom were involved in psychiatric treatment. They found the correlation to range from .56 to .83.

The Blame Scale. The present study used Hoagwood's (1990) Blame Scale to examine blame beliefs related to childhood sexual victimization experiences (see Appendix E). The measure consists of 20 items, the majority of which are rated along a 6-point scale from 1 (not at all) to 6 (completely). While the Blame Scale asks individuals about feelings of blame both as a child and as an adult, the present study focused on current perceptions of blame related to the sexual abuse. Therefore, 11 questions were used to assess abuse-related feelings of blame in terms of their intensity, direction (i.e., directed towards self, abuser, parents), and type (i.e., characterological versus behavioural). In the present study, particular attention was given to questions related to the amount of blame towards the abuser and the two types of self-blame. With regard to type of self-blame, behavioural self-blame "is control related, involves attributions to a modifiable source (one's behavior), and is associated with a belief in the future avoidability of a negative outcome. Characterological self-blame is esteem related, involves attributions to a relatively unmodifiable source (one's character), and is associated with a belief in personal deservingness for past negative outcomes" (Janoff-Bulman, 1979, p. 1798).

Test-retest reliability data were gathered over a two-week period in a sample of 31

women who had reported a history of childhood sexual abuse. The Pearson correlation coefficient (alpha = .97) indicated excellent reliability for the Blame Scale. In order to establish the content validity of the Blame Scale, two clinical psychologists experienced in the treatment of sexually abused children rated the appropriateness of items along a 5-point scale from 1 (completely inappropriate) to 5 (very appropriate). Only those items whose combined ratings were greater than or equal to 4 were retained in the measure (Hoagwood, 1990). Presently, there are no established norms for adult males who have experienced childhood sexual abuse.

Multidimensional Anger Inventory. In order to investigate various dimensions of anger, the Multidimensional Anger Inventory (MAI; Siegel, 1985) was used in the present study. The self-report measure includes 38 items, rated along a 5-point scale from 1 (completely undescriptive) to 5 (completely descriptive). Scores range from 38 to 190, with higher scores indicating a higher level of overall anger. The MAI is designed to assess frequency, duration, magnitude, mode of expression, hostile outlook, and range of anger-eliciting situations (see Appendix F). The MAI provides an overall anger score as well as the following five subscales: General Anger (includes items about the frequency, duration, and magnitude of anger); Range of Anger-Eliciting Situations; Hostile Outlook (includes items pertaining to negativism, resentment, and suspicion); Anger-In/Brooding (includes items reflective of anger suppression and feelings of brooding and guilt); and Anger-Out/Brooding (includes items about the overt expression of angry feelings and feelings of brooding and guilt related to the response; Siegel, 1985). In a study which administered the MAI to male and female participants, Siegel (1985) reported an overall anger score of 110.57 for a sample of 73 university males and an overall anger score of 100 for a sample of 288 male factory workers. For purposes of the present study,

only participants' overall anger scores were examined.

Psychometric data for the MAI were collected in samples of male and female university students as well as in a sample of male factory workers. Concerning reliability, test-retest Pearson correlations were .75 for the university sample over a 3- to 4-week interval. The MAI also demonstrated a high degree of internal consistency, with an overall alpha coefficient of .84 for university students and .89 for male factory workers. Validity for the MAI was supported through its significant correlations with measures designed to assess similar dimensions of anger and its low correlations with measures examining conceptually dissimilar dimensions (Siegel, 1986).

State-Trait Anxiety Inventory. In the present study, the State-Trait Anxiety Inventory (STAI-Form Y; Spielberger, Gorsuch, Lushene, Vagg, & Jacobs, 1983), a widely used measure in clinical and research settings, was employed to examine situational and trait anxiety. Trait anxiety "refers to an underlying vulnerability, a general tendency to experience anxiety symptoms in non-dangerous situations. This trait is thought to show a normal distribution in the general population and is relatively resistant to modification. State anxiety, on the other hand, is conceptualised as a discrete response to a specific, threatening situation" (Creamer, Foran, & Bell, 1995, p. 478). Contrary to individuals who have low trait anxiety levels, high trait anxiety individuals would be expected to respond to perceived threats with more frequent and intense increases in state anxiety (Spielberger & Sydeman, 1994).

The STAI includes 40 items, with 20 items related to state anxiety and 20 items pertaining to trait anxiety (see Appendix G). The state anxiety items are rated along a 4-point scale from 1 (not at all) to 4 (very much so), and the trait anxiety items are rated along a 4-point

scale from 1 (almost never) to 4 (almost always; Spielberger et al., 1983). Scores range from 20 to 80, with higher scores indicating higher levels of state and trait anxiety. Creamer et al. (1995) administered the STAI to over 300 male and female university undergraduate students. The mean state anxiety score was 38.5 (SD = 10.7), and the mean trait anxiety score was 40.4 (SD = 10.7). The data were not presented separately for males and females.

Psychometric information on the STAI was collected from a representative sample of over 5 000 individuals. Test-retest reliability coefficients over a 60-day period ranged from .65 - .68 for trait anxiety and .36 - .51 for state anxiety. It should be noted that the low reliability coefficients for state anxiety items are expected because these items assess changes in anxiety arising from situational stress. Internal consistency for both the trait and state anxiety scales was high, with a median alpha coefficient of .90 for trait items and .93 for state items. With regard to validity, the STAI demonstrated good construct validity by discriminating between non-psychiatric patients and psychiatric patients in whom anxiety was a major symptom. In addition, the trait subscale of the STAI correlated highly with other measures of trait anxiety, revealing good concurrent validity. There is also evidence of adequate convergent and divergent validity (Spielberger et al., 1983; Spielberger & Sydeman, 1994).

Client Satisfaction Questionnaire. The Client Satisfaction Questionnaire (CSQ; Larsen, Attkisson, Hargreaves, & Nguyen, 1979) was used in the present study to collect general information related to social validity and consumer satisfaction with treatment interventions. The scale includes eight items which are rated along a 4-point scale in order of increasing satisfaction. Scores which range from 8 - 20 are classified as low satisfaction, while those ranging from 21 - 26 are classified as medium satisfaction. High satisfaction is defined as scores

which range from 27 - 32 (Larsen et al., 1979). The average total score among a large sample of individuals seeking psychological services was found to be 27.09 (SD = 4.01; Nguyen, Attkisson, & Stegner, 1983). In addition to the global evaluation provided by the CSQ, more specific questions were added to examine satisfaction with various components of the individual treatment program (see Appendix H).

In samples of over 3 000 male and female outpatient clients, the overall alpha coefficients ranged from .86 to .94, indicating a high degree of internal consistency (Nguyen et al., 1983). At a 4-week follow-up assessment, clients' scores on the CSQ showed a significant positive correlation with their self-ratings of global improvement and significant negative correlations with their self-ratings of depression and anger. Therapists' ratings of client improvement following treatment revealed significant negative correlations between client satisfaction and therapist ratings of anxiety, thought disturbances, and interpersonal problems. Finally, therapists' satisfaction with their own clinical work showed a statistically significant positive correlation with client satisfaction ratings, and therapists' estimates of client satisfaction showed a significant positive correlation with actual client satisfaction ratings. This latter finding provides some evidence for the concurrent validity of the CSQ (Larsen et al., 1979).

Feedback questionnaires. Upon completion of the individual treatment program, participants were asked to respond to the six following questions: (a) What were your overall impressions about the treatment program? (b) Did you find any parts of the treatment program particularly helpful to you? If so, what were they? (c) Did you find any parts of the treatment program not helpful to you? If so, would you please comment on what would have made them more helpful; (d) How do you feel the treatment program has affected you? How do you feel the

program will continue to affect you on a more long-term basis? (e) At this point in time, what issues do you feel you need to continue exploring for yourself? and (f) Were your expectations of the treatment program met? If so, how? If not, would you please comment on how we could have met some of your expectations. At the 1- and 6-month follow-up assessment sessions, participants were asked to describe any positive and/or negative changes which they may have noticed over the specified time period. It should be noted that these questions were developed by the principal investigator in order to obtain qualitative information related to participants' subjective experience of the sexual abuse treatment program.

Self-Monitoring Measures

Pleasant Events Schedule. MacPhillamy and Lewinsohn's (1976) Pleasant Events Schedule (PES) is a behavioural inventory which assesses the amount of external positive reinforcement that an individual receives. The instrument contains 320 events, each of which is rated twice along a 3-point scale. First, the individual indicates the frequency of occurrence of each event over the last month in terms of 0 (not happened), 1 (happened a few times; 1-6 times), and 2 (happened often; 7 or more times). The individual then rates each of the items again regarding their subjective pleasantness or enjoyability in terms of 0 (not pleasant), 1 (somewhat pleasant), and 2 (very pleasant). The PES provides the three following scores: Activity Level is derived from the sum of the frequency ratings; Reinforcement Potential is derived from the sum of the pleasantness ratings; and Obtained Reinforcement is defined as the product of the frequency and pleasantness ratings for each item (MacPhillamy & Lewinsohn, 1976). In the present study, participants' Activity Level and Reinforcement Potential scores were examined separately. This decision was based on Rose and Staats' (1988) suggestion that the

"frequency of occurrence of pleasant events is part of the individual's environmental circumstances (although frequency will also depend upon the individual's behavioral competence, an aspect of the language-cognitive and sensory-motor repertoires). The strength of pleasantness ratings, on the other hand, measure aspects of the emotional-motivational personality system of the individual. Using the product of these two measures to get a total score combines factors that should be separately considered since they arise in different circumstances and have independent effects upon the individual" (p. 490-491).

In summarizing the psychometric data of the PES, Rehm (1988) reported test-retest reliabilities of .85 for Activity Level, .66 for Reinforcement Potential, and .72 for Obtained Reinforcement. The author also indicated the following alpha internal consistency coefficients: Activity Level = .96; Reinforcement Potential = .98; and Obtained Reinforcement = .97. The PES has also demonstrated good validity in that the three scores were capable of statistically differentiating between depressed individuals versus psychiatric and non-psychiatric individuals (Rehm, 1988). In other words, there appears to be a relationship between the manner in which individuals endorse items on the PES and their activity level as well as the degree to which they are experiencing depressive symptoms. In particular, findings showed that an individual's perceived enjoyability of events (i.e., reinforcement potential), rather than their actual frequency (i.e., activity level), is more strongly correlated with depression level (Rose & Staats, 1988). Following extensive testing of the psychometric characteristics of the PES, MacPhillamy and Lewinsohn (1982) concluded that the instrument possesses acceptable reliability as well as concurrent, predictive, and construct validity.

The use of the PES has ranged from a daily to monthly basis (Rehm, 1988). For purposes

of the present study, the PES was administered every two weeks. An abridged version of the PES, containing 49 items which have been shown to be particularly relevant for depressed individuals, was employed (see Appendix I). These items appear to fall into three different categories: (a) social interactional behaviours (e.g., "being with happy people"); (b) feelings and activities that are presumed to be incompatible with feelings of depression (e.g., "laughing"); and (c) activities that are presumed to lead to feelings of adequacy, competence, and independence (e.g., "doing a job well," Lewinsohn & Graf, 1973).

"How I see myself now" Scale. In order to monitor various components of self-concept, the "How I see myself now" scale (Burt & Katz, 1987) was administered every two weeks over the course of the research study (see Appendix J). This adjective checklist is composed of self-descriptive items which are rated along a 7-point scale from 1 (never) to 7 (always). Burt and Katz (1987) identified the six following factors of the scale: Angry/Needy/Lonely; Independence/Competence; Mental Health; Trust; Help; and Guilt/Blame. For purposes of the present study, only the overall self-concept score was examined. Test-retest reliability coefficients for the six factors range from .53 to .82, while the range of internal consistency reliabilities is .68 to .77 (Burt & Katz, 1987).

Self-Rating and Significant Other Measures

Throughout the research study, participants completed daily self-rating measures on their levels of self-blame, anger, and anxiety related to their childhood sexual abuse. Each measure was rated along a 10-point scale from 1 (none) to 10 (as much as you can imagine; see Appendix K). Participants were asked to complete the three daily self-ratings in the evenings and to assign an overall average rating which best described their day. In addition, participants were asked to

briefly write down what contributed most to their daily ratings. Data for the previous week were collected prior to the start of the next session. The present study planned to collect similar ratings (on a weekly basis) from participants' significant others. However, various circumstances did not permit such data to be gathered (i.e., participants were not in an intimate relationship or were involved in a new, casual, or unstable relationship).

Experimental Design

A multiple-baseline design across behaviours was employed in the present study. This design was replicated across five separate adult males who disclosed a history of sexual abuse. Replication was crucial as it represents the key component to evaluating the generality of treatment effects across individuals. The three target behaviours in the multiple-baseline design included (a) self-blame related to the sexual abuse experience, (b) abuse-related anger, and (c) anxiety associated with childhood sexual victimization. Please refer to Appendix L for an illustration of the multiple-baseline across behaviours design. It should be noted that the graphed data points represent hypothetical results.

In the present study, each participant was asked to complete daily self-ratings on their levels of self-blame, anger, and anxiety prior to the treatment intervention. These daily self-ratings constituted baseline data (i.e., current level of functioning) for the participant's three target behaviours. Once the self-ratings for the three behaviours achieved stability, the treatment intervention was applied to the first behaviour (i.e., self-blame). It should be noted that stability was defined as the absence of a slope or trend in the data, a slope or trend in the direction opposite from that which the treatment was expected to produce, or relatively little variability in the data (Kazdin, 1982). A further point regarding a multiple-baseline design is that it may result

in prolonged baselines. In other words, a great deal of time may elapse before a treatment intervention is introduced to a specific target behaviour. Because of clinical and ethical concerns related to delaying treatment for an extended period of time, it may have been necessary to implement treatment following a minimum of three ascending data points for any one of the specified behaviours (Kazdin, 1982).

While treatment focused on the participant's feelings of self-blame, daily self-ratings on self-blame, anger, and anxiety continued to be gathered. In order to evaluate whether the treatment intervention on self-blame was effective, it was expected that the participant's self-blame ratings would decrease while his anger and anxiety ratings would remain at baseline levels. According to several authors (Callahan & Ziegler, 1980; Gettinger & Kratochwill, 1987), if behavioural change occurs only when a specific intervention has been introduced, then experimental control has been demonstrated and conclusions about the effectiveness of the intervention may be drawn. With regard to this point, it seems important to mention that the time period (i.e., latency) between the implementation of a treatment intervention and changes in self-ratings may have been longer in the present study. This expectation was based on the nature of the dependent variables (i.e., individual's *perceptions* of self-blame, anger, and anxiety rather than actual *behaviour*) as well as the course of therapy (i.e., prior to reporting increased feelings of well-being, individuals often report feeling worse as they begin to directly address their difficulties in a therapeutic setting; Briere, 1996).

Once the participant's self-ratings of self-blame, anger, and anxiety again achieved stability, treatment was then introduced to the second behaviour (i.e., anger). At this point, it was expected that (a) the participant's anger self-ratings would decrease, (b) self-ratings of anxiety

would remain at baseline levels, and (c) self-blame ratings would continue to remain at their decreased levels. Finally, once stability was again achieved for the three behaviours, the treatment was introduced to the third behaviour (i.e., anxiety). At this point, the following results were expected: (a) the participant's self-ratings of anxiety would decrease and (b) self-blame and anger ratings would continue to remain at their decreased levels. Repeatedly demonstrating that target behaviours change only in response to the introduction of a specific treatment intervention was expected to effectively establish that the treatment (rather than extraneous variables) was responsible for the changes in the participant's behaviours (Kazdin, 1982).

Procedure

Pre-baseline/Pre-treatment. For those participants who successfully completed the telephone screening process, an assessment session was scheduled at the Psychological Service Centre, located at the University of Manitoba. During the session, each participant met with his therapist (a doctoral-level female graduate student in the Clinical Psychology program) who further elaborated on the nature of the research study as well as on the content and format of the treatment package. The assessment session also gave participants the opportunity to address any concerns related to the treatment program.

Participants were asked to sign a consent form giving permission to be observed, evaluated, and treated in an individual therapy program. As well, the form asked for participants' written agreement to complete all homework assignments over the course of the research study and to attend all scheduled therapy sessions (see Appendix M). Clinical interviews were conducted with each participant, who also completed the following self-report measures: Beck Depression Inventory (Beck et al., 1979), Self-Esteem Scale (Rosenberg, 1965), Blame Scale

(Hoagwood, 1990), Multidimensional Anger Inventory (Siegel, 1985), and State-Trait Anxiety Inventory (Spielberger et al., 1983).

Baseline. During the baseline period, participants completed daily self-ratings on the levels of their self-blame, anger, and anxiety. In addition, they completed the two self-monitoring measures, namely the Pleasant Events Schedule (MacPhillamy & Lewinsohn, 1976) and the "How I see myself now" Scale (Burt & Katz, 1987), at the end of the baseline period. The length of the baseline period depended upon a stable pattern of performance for participants' self-ratings of self-blame, anger, and anxiety. As previously mentioned, prolonged baselines may be problematic, and in such instances, treatment was implemented following three ascending data points for any of the specified behaviours (Kazdin, 1982).

Treatment. In the present study, a multi-component treatment package was developed (based on the childhood sexual abuse literature) to address issues related to clients' experiences of childhood sexual victimization (see Appendix N). In examining self-blame, the goals of treatment were (a) to explore the nature of the sexual abuse which contributed to the client's feelings of self-blame, (b) to correct misinformation and myths through the provision of education about sexual abuse, (c) to assist the client in challenging and correcting his misconceptions about sexual abuse, and (d) to help him develop a realistic perception of his sexual abuse experience. Concerning anger, treatment goals included helping the client (a) to identify targets and causes of his abuse-related anger, (b) to express feelings of anger in socially acceptable and non-self-defeating ways, (c) to examine revenge fantasies, and (d) to prepare for a possible future confrontation with his offender. Finally, the goals of treatment with regard to anxiety were (a) to increase the client's understanding of the relationship between his childhood

sexual abuse and current feelings of anxiety, (b) to challenge the validity of the client's anxiety-provoking thoughts and beliefs, and (c) to teach the client cognitive and behavioural strategies to reduce his feelings of anxiety. While individual therapy sessions were structured, modifications to the treatment program were made to accommodate the needs of the client. It should be noted that any changes made to the treatment intervention program were carefully documented. Throughout the research study, clients were asked to complete daily self-ratings on their levels of abuse-related self-blame, anger, and anxiety. Also, the two self-monitoring measures (i.e., PES and "How I see myself now" Scale) were completed by clients on a bi-weekly basis. .

Post-treatment. Shortly following the completion of the individual treatment program, clients were again asked to complete the self-report questionnaires and the two self-monitoring measures. In addition, clients completed the Client Satisfaction Questionnaire (Larsen et al., 1979) and a feedback questionnaire.

Follow-up. One- and 6-month follow-up assessment sessions were scheduled following the termination of the individual treatment program. During these assessment sessions, clients were again asked to complete the self-report questionnaires, self-monitoring measures, and brief feedback questionnaires.

Generalization. In order to extend therapeutic gains beyond actual therapy sessions, the present study incorporated various generalization promotion strategies. First, the use of a multi-component treatment program, which included a variety of approaches (e.g., role plays, bibliotherapy, relaxation training), may have increased the possibility of generalization of treatment effects (Stokes and Baer, 1977). Second, the use of prompting, positive reinforcement, and feedback have been identified as strategies associated with successful generalization of

intervention effects (Chandler, Lubeck, & Fowler, 1992). In the present study, these strategies were employed over the course of individual treatment to assist clients in making positive changes, to strengthen the positive changes that clients achieved in therapy, and to give clients feedback about their progress in sessions. Finally, the treatment program helped clients learn to "cue their potential natural communities to reinforce their potential behaviors" (Stokes & Baer, 1977, p. 364). In other words, attention focused on facilitating clients' ability to communicate with important individuals in their lives about what they need to maintain their therapeutic benefits (e.g., validation, praise, support).

The generalization of therapeutic benefits was evaluated in several ways. In order to examine the generality of results over time (i.e., maintenance), 1- and 6-month follow-up assessment sessions were scheduled. Additionally, the present study gathered bi-weekly data related to depression and self-concept through the Pleasant Events Schedule (MacPhillamy & Lewinsohn, 1976) and the "How I see myself now" Scale (Burt & Katz, 1987) respectively. As well, the study collected pre-, post-, and follow-up information on depression and self-esteem through the Beck Depression Inventory (Beck et al., 1979) and the Self-Esteem Scale (Rosenberg, 1965) respectively. These data provided information about the generality of therapeutic benefits to areas that were not specifically targeted in the treatment program.

Treatment integrity. Treatment integrity is comprised of two components, namely procedural reliability and compliance (Gutkin, Holborn, Walker, & Anderson, 1992; Vermilyea, Barlow, & O'Brien, 1984). The assessment of treatment integrity is crucial for several reasons: First, the validity of research results is greatly increased through the demonstration of treatment integrity and experimental control. Second, errors in treatment procedure may be more quickly

detected and corrected, and modifications to the treatment program may be made in order to increase or maintain clients' therapeutic gains (Vermilyea et al., 1984).

With regard to the first component of treatment validity, the present study evaluated the extent to which the individual treatment program was administered as planned by conducting procedural reliability checks. A detailed outline of the treatment program, including the issues that would be covered in sessions and the activities that would be used to address these issues, was developed for purposes of the present research study. Two psychology students from the University of Manitoba were recruited as raters to assess procedural reliability. They were provided with the detailed treatment outline and were given instructions about session content, implementation procedures, and scoring method. In order to minimize the chances of rater drift (i.e., the decreased reliability of ratings over time as the task becomes more familiar), regular and on-going contact was maintained with the raters throughout the course of the treatment program.

Following each individual therapy session, the raters reviewed the videotaped session and scored the therapist's adherence to the treatment outline, using a checklist developed for this purpose (see Appendix O). It seems important to note that the raters did not interact with one another and completed the checklists independent of one another. The following scoring procedure, adapted from Welch and Holborn (1988), was employed: A value of 1 was assigned if a treatment procedure specified in the outline occurred, and a value of 0 was assigned if a specified treatment procedure did not occur. In cases where the student observers were uncertain about whether a treatment procedure occurred as specified in the outline, a score of ½ was assigned. Procedural reliability was calculated by dividing the obtained score by the total score

specified in the outline and then multiplying by 100. A procedural reliability score was calculated for the overall treatment program as well as for each of the three components of treatment (i.e., self-blame, anger, and anxiety). It should be noted that decisions about when to introduce the next component of treatment was based on clients' self-rating measures. As such, not all of the procedures in the treatment outline may have been completed. In terms of procedural reliability, the raters were instructed to focus on whether the order of procedures had been followed and not whether all of the procedures had been completed. Results showed that both raters reported 100% therapist adherence to the procedures outlined in the treatment program. Given this finding, it would follow that there was complete agreement between the raters with respect to their procedural reliability checks.

Compliance, which refers to clients' adherence to the requirements of the treatment program, was ensured through several procedures. During the assessment session, clients were asked to sign a written contract in which they acknowledged the importance of homework assignments, conceded to complete all assignments on time, and agreed to attend scheduled therapy sessions. Another procedure to ensure compliance consisted of clients contacting the therapist the evening prior to their therapy session in order to report their self-ratings during the period following their last scheduled appointment.

Data Analyses

In the present study, data for each of the five participants were individually analyzed. These data included each participant's self-report, self-monitoring, and self-rating measures. Separate analyses provided the opportunity to consider each participant's childhood sexual abuse experience and to carefully examine his involvement in the individual treatment program. Thus,

it was possible to delineate in detail the treatment interventions which were and were not effective, the participant's response to various components of the treatment program, and additional issues and concerns which the participant raised during therapy sessions. Individual analyses were proceeded by global consideration of the results for the five participants. Examination of overall results allowed for more general conclusions to be made about the effectiveness of an individual treatment program for adult males who have experienced childhood sexual abuse.

Self-report measures. Each participant's scores at pre-treatment, post-treatment, and follow-up assessment were examined for clinical significance. Criteria for clinical significance included (a) the extent to which the participant perceived an improvement in his functioning after treatment, (b) whether the presenting problem was eliminated following the treatment intervention, (c) whether the participant's scores following treatment fell below established clinical cut-off scores, (d) whether the participant's scores after treatment represented high end-state functioning, or (e) whether the participant's scores following treatment reached normative levels of functioning (Beutler & Hill, 1992; Jacobson & Truax, 1991; Kazdin, 1990). Regarding the last criterion, scores were considered to have reached normative levels if they fell within one standard deviation of the mean for the population used to construct the dependent measure. It should be noted that this criterion is more conservative than that proposed by Jacobson and Truax (1991), who defined the normative range as extending to two standard deviations from the mean of the normative population.

In addition to the *level* of scores at post-treatment and follow-up assessment sessions, the *amount of change* in scores over the course of the treatment intervention was also examined for

each participant. The importance of these two aspects of clinical significance was captured by Beutler and Hill (1992), who stated that methods of examining the level of scores "are promising but do not take into account the amount of change experienced. Thus, very disturbed clients who make large changes may be counted as less successful than less disturbed clients making more modest changes. Both assessing the amount of change and comparing posttreatment and normative indexes of severity should be encouraged to capture the relative strengths of both of these procedures" (p. 207).

Self-monitoring measures. The bi-weekly self-monitoring scores collected over the course of the treatment intervention were graphed (using line graphs) and visually inspected for each participant. As with the self-report data, both the level of each participant's scores at post-treatment and follow-up as well as the amount of change in scores were examined. Based on the psychometric information available for the two self-monitoring measures, it was decided that the criterion for clinical significance would be whether the participant's scores after treatment represented high end-state functioning. For purposes of the present study, a score falling within the upper 30% range of all possible scores was defined as high end-state functioning. Also, based on visual inspection of the change in slope, the present study considered a 30% (or greater) change in score to be clinically significant.

Self-rating measures. Each participant's self-ratings of self-blame, anger, and anxiety over the course of the treatment program were graphed (using line graphs). Visual inspection was used to evaluate whether clinically significant changes in self-blame, anger, and anxiety were achieved in response to treatment interventions aimed at these specific behaviours. In addition to the amount of change in each participant's self-ratings throughout treatment, the

level that self-ratings reached at various stages of the program was also examined. The following criteria were used during visual inspection: (a) changes in means across treatment phases examines shifts in the average rate of performance; (b) changes in level examines shifts or discontinuous performance between treatment phases; (c) changes in trend/slope examines systematic increases or decreases in performance over time; and (d) latency of change examines the amount of time between the onset or termination of a phase and changes in performance (Kazdin, 1982; Parsonson & Baer, 1978).

Visual inspection of each participant's self-ratings data was supplemented with a descriptive statistic known as effect size. Given the novel and unique nature of the present study, the inclusion of descriptive statistical analyses seemed valuable because of the following characteristics: (a) the possibility of unstable baselines; (b) the investigation of a relatively new research area; (c) the likelihood of increased intrasubject variabiltity; and (d) the potential for small changes to be important (Kazdin, 1982). The American Psychological Association (APA) encourages researchers to include effect size information in the presentation of results (APA, 1994). An effect size "is a number that describes the extent to which an effect is present in a sample of data. The effect size simply represents the strength of the relationship between two sets of variables. The larger the value of an effect size, the greater the degree to which the phenomenon being studied is manifested in the sample of data" (Kromrey & Foster-Johnson, 1996, p. 77). Thus, effect sizes focus on the strength of the relationship between treatment interventions and the dependent measures, rather than on the testing of null hypotheses (Kromrey & Foster-Johnson, 1996).

Different effect size formulas were used depending on the nature of the data and the type

of effect to be described. In the present study, the following four formulas for effect sizes were employed: changes in the level of self-ratings (i.e., mean shift); changes in the variability of self-ratings; changes in the trend/slope of self-ratings; and changes in the level of self-ratings when the data show a trend/slope (Kromrey & Foster-Johnson, 1996). For changes in the level of self-ratings, the values of 0.2, 0.5, and 0.8 were used to describe small, medium, and large effect sizes, respectively. For the three remaining effect size formulas, the values of small, medium, and large effects were given to values of 0.02, 0.15, and 0.35, respectively (Cohen, 1992).

Results

Steven: Background History and Treatment Findings

Background Information

Steven was a single, unemployed male in his mid-thirties who experienced sexual abuse by his father throughout his childhood and adolescence. While Steven had memories of physical contact involving fondling, he was unable to recall other details of the sexual activity. However, Steven remembered engaging in non-contact activities with his father which included watching one another masturbate. Steven reported that his mother also behaved in sexually inappropriate ways and that she was often scantily clad or naked around him. There were instances in which Steven remembers his mother asking him to sleep with her, usually following frequent episodes where Steven's father would become enraged and physically violent towards his son. At the time of the intake interview, Steven maintained regular (albeit limited) contact with his parents. Steven had never confronted his parents about the sexual abuse because he reported feeling helpless and powerless in the presence of his father. According to Steven, his siblings ended their contact with him several years ago following attempts to disclose his sexual abuse to them.

Steven had a long history of involvement with mental health professionals to address difficulties ranging from anxiety, panic attacks, and depression to problems with personality functioning and interpersonal relationships. Throughout most of the sexual abuse treatment program, Steven did not have any additional therapeutic contact. However, towards the end of the program, Steven had resumed his involvement in long-term individual therapy with a psychiatrist. With regard to the sexual abuse treatment intervention, Steven was seen on a mostly twice weekly basis for 19 sessions over a period of approximately four months.

Self-Report Data

Beck Depression Inventory. Prior to the sexual abuse treatment program, Steven's score fell in the upper range of the "moderate depression" category (see Figure 1, page 268). His depression score dropped significantly following the intervention and was classified as "minimal" at both post-treatment and 1-month follow-up. It should be noted that a minimum 10-point decrease in score was considered clinically significant (Katz et al., 1994). While Steven's score showed a slight increase by 6-month follow-up, it was still well-within the clinical cut-off for "mild depression" and within the normative range for a sample of male university students ($M = 8.35$, $SD = 7.31$; Johnston & Page, 1989).

Self-Esteem Scale. As shown in Figure 2 (page 269), Steven's pre-treatment score indicated low feelings of self-esteem. He reported a clinically significant improvement (i.e., a change of at least one standard deviation from the normative mean) in self-esteem at post-treatment, and Steven's score was well-within the normative range for a sample of non-abused adult females ($M = 22.80$, $SD = 7.06$; Higgins & McCabe, 1994). (It should be noted that normative data for non-abused adult males could not be found). Steven's self-esteem gains

dissipated over time, and by 6-month follow-up, his score had returned to its pre-treatment level.

The Blame Scale. The amount of blame directed towards the individual who sexually abused Steven showed minimal variation over time. At pre-treatment, Steven reported "some" amount of blame towards his abuser. While the amount of abuser blame decreased slightly by post-treatment, it showed increases throughout the follow-up sessions. At 6-month follow-up, Steven reported "a lot" of blame towards his abuser (see Figure 3, page 270).

Steven's characterological self-blame score showed a clinically significant decrease from pre- to post-treatment. It should be noted that the present study defined clinical significance as a minimum 2-point change in the amount of blame. At pre-treatment, Steven reported experiencing "some" blame for the kind of person he was with respect to the sexual abuse. Upon completion of the sexual abuse treatment program, Steven reported "very little" characterological self-blame. However, his score increased over time and, by 6-month follow-up, it had returned to its pre-treatment level.

Behavioural self-blame showed clinically significant decreases over time. At pre-treatment, Steven reported "a lot" of behavioural self-blame, but at the time of the post-treatment session, he reported "very little" blame for his actions related to the sexual abuse. While the amount of behavioural self-blame fluctuated slightly over the month following treatment termination, it returned to its low level by 6-month follow-up.

Multidimensional Anger Inventory. As shown in Figure 4 (page 271), Steven's overall anger score showed a clinically significant decrease (i.e., a minimum 15-point difference) from pre- to post-treatment. Following termination of the sexual abuse treatment program, Steven's score was nearly identical to that reported for a sample of university males ($M = 110.57$; Siegel,

1985). While Steven's overall anger score increased slightly over the course of follow-up assessment sessions, it still remained well-within the normative range.

State-Trait Anxiety Inventory. Prior to the sexual abuse treatment program, Steven's state anxiety score was moderately high, and it returned to its pre-treatment level by 6-month follow-up (see Figure 5, page 272). However, it should be noted that Steven reported considerable decreases in state anxiety upon completion of treatment and during the month following termination. Thus, post-treatment assessment revealed a clinically significant decrease (i.e., a change of at least one standard deviation from the normative mean) in Steven's state anxiety score, which fell within the normative range for a sample of university students ($M = 38.5$, $SD = 10.7$; Creamer et al., 1995). However, as mentioned, these changes were not maintained by 6-month follow-up.

Steven's trait anxiety scores revealed much fluctuation over time. At post-treatment, the amount of change in Steven's trait anxiety score reached clinical significance (i.e., a change of at least one standard deviation from the normative mean), and his score fell within the range identified for the normative sample of university students ($M = 40.4$, $SD = 10.7$; Creamer et al., 1995). While there was a sharp increase in trait anxiety at 1-month follow-up, Steven's longer-term follow-up score was significantly lower than that reported prior to the treatment intervention, and it fell within the normative range.

Self-Monitoring Data

Pleasant Events Schedule. Steven's scores for the Activity Level category of the PES showed steady increases from pre-treatment to the seventh assessment session (see Figure 6, page 273). After this point, the scores revealed a more fluctuating pattern, although none of the

scores approached pre-treatment or initial levels. In fact, Steven's Activity Level score showed a clinically significant increase of 55% from pre- to post-treatment. (It should be noted that the present study defined clinical significance as a minimum 30% change in scores. Also, percentage change was calculated by subtracting the pre-treatment score from the post-treatment score and then dividing by the post-treatment score). While there was a slight decrease in Steven's score at 6-month follow-up, there still remained a significant 47% increase over the pre-treatment level. By the time of the longer-term follow-up session, Steven's Activity Level score fell in the middle range of all possible scores.

Steven's scores for the Reinforcement Potential category showed greater variability, with a considerable decrease following the pre-treatment session and a considerable increase following the fifth assessment session. The scores revealed an abrupt pattern of change, although scores from the second to fifth assessment sessions and from the sixth to 6-month follow-up assessment sessions demonstrated fairly stable trends (except for a larger increase at post-treatment). Steven's Reinforcement Potential score increased significantly by 35% from pre- to post-treatment and fell at a high level. While Steven's score at 6-month follow-up remained considerably higher than scores obtained during initial assessment sessions, it had almost returned to its moderate pre-treatment level.

"How I see myself now" Scale. As shown in Figure 7 (page 274), Steven's self-concept scores showed a fairly stable pattern, although there was an observable increase by the sixth assessment session and an observable decrease by 1-month follow-up. Steven's score reached its highest level at post-treatment, where it demonstrated a significant increase of 34% from pre-treatment. (It should be noted that the present study defined clinical significance as a minimum

30% change in scores). However, additional follow-up sessions revealed a steady decrease in self-concept scores, with the 6-month follow-up score returning to its moderate pre-treatment level.

Self-Ratings

Baseline period. The duration of Steven's baseline period was 13 days. During this time, Steven's mean self-blame scores showed an increasing trend, although there was much variability in the range of his daily scores (see Figure 8, page 275). Anger mean scores followed a similar pattern as those for self-blame, with Steven's daily self-ratings showing much variability particularly during the first few days of baseline. Steven's anxiety means revealed a more stable trend with several peaks and valleys in daily scores. Table 1 (page 260) presents the overall mean scores for self-blame, anger, and anxiety over phases of the sexual abuse treatment program. Steven's overall mean self-blame score during baseline was 5.4, while that of anger was slightly higher at 5.8. Steven's anxiety scores revealed the lowest overall mean of 4.1 during the baseline period.

Self-blame phase. This phase of the sexual abuse program involved four treatment sessions over a period of 28 days. Overall, Steven's self-blame scores showed a change in slope from the baseline period. In contrast to the increasing baseline slope, Steven's self-blame scores revealed a declining trend over the course of the self-blame phase, with stability between the second and third self-blame means. Table 1 indicates that there was a moderate decrease in Steven's overall mean self-blame score from baseline (5.4) to the self-blame treatment phase (4.6). The effect size for Steven's self-blame ratings during baseline compared with those during the self-blame phase was calculated for a change in slope and was found to be $f^2 = 0.21$. This

value represents a medium decrease in Steven's self-blame scores during the self-blame treatment phase (compared to the baseline period).

Steven's anger scores during the self-blame treatment phase showed a large drop between the second and third anger means. The effect size for Steven's anger ratings prior to the self-blame phase compared with those during the self-blame phase was calculated for a change in slope and was found to be $f^2 = 0.32$. This value represents a large decrease in Steven's anger scores during the self-blame treatment phase (compared to the period before the self-blame phase was implemented). However, overall means indicate minimal change in Steven's anger from baseline (5.8) to the self-blame treatment phase (5.6; see Table 1).

Steven's anxiety scores during the self-blame treatment phase revealed no change in slope from the period prior to the treatment phase (i.e., baseline). Table 1 indicates that there was a considerable increase in Steven's overall mean anxiety score from baseline (4.1) to the self-blame treatment phase (5.2). The effect size for Steven's anxiety ratings prior to the self-blame phase compared with those during the self-blame phase was calculated for a change in mean and was found to be $d = 0.80$. This value represents a large effect size and indicates that the level of Steven's self-reported anxiety during the self-blame phase was eight tenths of a standard deviation higher than during baseline.

Anger phase. This phase of treatment included eight sessions conducted over a 38-day period. Overall, Steven's mean anger scores revealed a slowly declining trend over the course of the anger phase. Although there was much variability in Steven's daily anger self-ratings throughout most of the phase, it began to decrease toward the end of the anger treatment phase. Table 1 indicates that there was a considerable decrease in Steven's overall mean anger score

during the anger treatment phase (4.5), compared to the entire period prior to the phase (5.7). The effect size for Steven's anger ratings prior to the anger treatment phase (i.e., baseline) compared with those during the anger phase was calculated for a change in slope and was found to be $f^2 = 0.11$. This value represents a small to medium decrease in Steven's anger scores during the anger treatment phase (compared to the baseline period).

Steven's self-blame means during the anger treatment phase showed overall stability with minor fluctuations in daily scores. Table 1 indicates a considerable drop in Steven's overall mean self-blame from the self-blame phase (4.6) to the anger phase (2.7). The effect size for Steven's self-blame ratings during the self-blame treatment phase compared with those during the anger treatment phase was calculated for a change in slope and was found to be $f^2 = 0.23$. This value represents a medium to large decrease in Steven's self-blame scores during the anger phase (compared to the self-blame phase).

Steven's anxiety scores during the anger treatment phase revealed an overall declining trend from the period prior to the treatment phase (i.e., baseline). However, anxiety means showed an increase during the early part of the anger treatment phase and some stability between the third and fourth anxiety means. Table 1 indicates that there was a small decrease in Steven's overall mean anxiety score during the anger treatment phase (4.0), compared to the entire period prior to the anger phase (4.6). The effect size for Steven's anxiety ratings prior to the anger phase compared with those during the anger phase was calculated for a change in slope and was found to be $f^2 = 0.27$. This value represents a medium to large decrease in Steven's anxiety scores during the anger treatment phase (compared to the baseline period).

Anxiety phase. The anxiety phase of the sexual abuse program included seven treatment

sessions over a period of 39 days. Mean anxiety scores peaked during the middle of the treatment phase, which was due mostly to several high daily scores. After this point, Steven's anxiety means decreased, and there was only minor fluctuation in his daily self-ratings. Table 1 shows a large decrease in Steven's overall mean anxiety score from baseline (4.4) to the anxiety treatment phase (3.1). The effect size for Steven's anxiety ratings during baseline compared with those during the anxiety treatment phase was calculated for a change in mean and was found to be $\underline{d} = -0.68$. This value represents a medium to large effect size and indicates that the level of Steven's anxiety scores during the anxiety phase was close to seven tenths of a standard deviation lower (compared to the baseline period).

Steven's self-blame scores during the anxiety phase of treatment continued to show stability with only minor fluctuations in daily self-ratings. Table 1 indicates a small decrease in Steven's overall mean self-blame during the anxiety phase (2.2), compared with the previous anger phase (2.7). The effect size for Steven's self-blame ratings during the previous anger phase compared with those during the anxiety phase was calculated for a change in variability and was found to be $\underline{f}^2 = 0.53$. This value represents a large reduction in the amount of fluctuation in Steven's self-blame scores during the anxiety phase (compared to the previous anger treatment phase).

Steven's anger scores during the anxiety treatment phase revealed stability, and his daily self-ratings decreased in both their intensity and range. Table 1 shows a considerable decrease in Steven's overall mean anger from the anger phase (4.5) to the anxiety phase (2.3). The effect size for Steven's anger ratings during the anger phase compared with those during the anxiety phase was calculated for a change in slope and was found to be $\underline{f}^2 = 0.29$. This value represents a

medium to large decrease in Steven's anger scores during the anxiety treatment phase (compared to the anger phase).

Significant Other's Weekly Ratings

Throughout the course of the sexual abuse treatment program, Steven was not involved in an intimate relationship with another individual. As such, no data on Steven's feelings of self-blame, anger, and anxiety, as perceived by a significant other, were collected.

Client Satisfaction Questionnaire

At post-treatment, Steven's score of 31 indicated a high level of consumer satisfaction with the sexual abuse treatment program. With regard to the self-blame component of treatment, Steven found the exploration of sexual abuse myths to be particularly helpful. Writing a letter to his abuser was reported to be especially helpful for Steven during the anger component, while relaxation training during the anxiety treatment component was cited as particularly beneficial for Steven. It should be noted that the CSQ was not completed by a significant other as Steven was not involved in an intimate relationship during the time of treatment.

Feedback Questionnaires

Steven provided much feedback concerning the sexual abuse treatment program. His overall impressions were highly positive and focused on the therapeutic relationship. Steven wrote that "the therapist was willing and able to listen to my story, respond empathically and yet not get pulled into some of the feelings of anxiety and fear I have that for me can be quite paralyzing. This gave me the confidence to be more open and trusting. With the therapeutic alliance that I felt was established, I felt freed up to challenge myself given that I did not feel I had to 'protect' the therapist from 'bad or negative' feelings."

Steven identified the letter-writing exercise as particularly helpful for him because it provided him with an opportunity to "tell his story" and to process powerful emotions underlying anger (i.e., loss, abandonment, and lack of boundaries). While Steven did not identify any parts of the treatment program which were not helpful, he commented that exploring issues of abandonment would have also been beneficial for him. However, Steven qualified this statement by adding that this issue would have been highly difficult for him and would have probably led to dissociative responses on his behalf.

With regard to the impact of the intervention, Steven responded that the treatment program "has given me the confidence to begin to explore ideas such as going back to university and making plans for the future. It has also allowed me to once again begin to entertain the idea of forming intimate alliances with other people." Steven also stated that, as a result of the program, he feels he will be able to continue exploring his potential as well as his future possibilities. Steven identified the following issues as requiring further exploration: exploring ambivalent feelings about resuming sexual relations; trusting significant individuals in his life; and allowing himself to behave in a manner which meets his expectations and abilities.

Steven reported that his expectations of the treatment program increased as his trust in the therapist strengthened. He again reiterated the importance of the therapeutic relationship by stating that it "was an intrinsic part of the process that made this program a success for me." Steven also noted that it would have been useful to have a longer period of time to address termination issues, particularly his strong and positive feelings about the therapeutic relationship.

At 1-month follow-up, Steven reported that he noticed becoming more anxious. He

attributed his increased anxiety to having encountered some difficulties in implementing some of his university plans, resulting in more self-examination and, at times, self-deprecation. Feedback at 6-month follow-up suggested that Steven was continuing to make positive changes, albeit not without some difficulty. Steven reported behaving more assertively and confronting individuals more directly when he feels that he has not been fairly treated. With regard to the treatment program, Steven stated that the relaxation training has continued to be helpful in reducing his feelings of anxiety and stress. He also identified the letter-writing exercise as having been a powerful tool for further exploration of his feelings towards his abuser.

Samuel: Background History and Treatment Findings

Background Information

Samuel was an employed male in his early thirties who was involved in a conflictual "on-again, off-again" relationship which resulted in the birth of a child. Samuel also had two children from a previous relationship. All the children were in foster care because they had reportedly witnessed domestic violence between Samuel and his female partners. Samuel had infrequent contact with his children, although he was actively involved with child protection to arrange additional visits. At the time of the treatment program, Samuel was on probation because of his violent behaviour but there were no charges pending.

Samuel was sexually abused as a pre-schooler by a middle-aged man who was a family acquaintance. The sexual activity, which involved fondling and mutual oral sex, occurred at the home of Samuel's grandparents who minded him while his parents worked. Samuel's sexual abuse lasted for approximately one year, during which time the offender reportedly used bribes and threats to ensure that Samuel would not disclose the sexual activity. Samuel first disclosed

his sexual abuse several years ago to a helping professional, and since that time, he had been struggling over whether to reveal the abuse to his mother. (It should be noted that Samuel was an only child whose father died at an early age). At the time of the intake interview, Samuel was also experiencing a number of other difficulties, including impaired anger management, past physical violence, relationship conflicts with his partner, alcohol abuse, and excessive focus on sexual activity. Samuel had past involvement in a program for domestic violence, and he also had infrequent contact with Alcoholics Anonymous. While he had addressed some of his sexual abuse issues with individuals in the helping profession, there had been no consistent or long-term therapy involvement prior to the treatment program. Throughout the course of the sexual abuse program, Samuel did not have additional therapeutic contact. He was seen on a mostly weekly basis for 17 sessions over a period of approximately four months.

Self-Report Data

Beck Depression Inventory. At pre-treatment, Samuel's score fell in the middle range of the "moderate depression" category (see Figure 9, page 276). His depression score showed a gradual decrease over the course of the treatment program, falling in the "mild" range at post-treatment and in the "minimal" range by 1-month follow-up. While Samuel's score increased slightly at 6-month follow-up, it still remained within the "minimal depression" category. Overall, the findings suggested that, while the amount of change in Samuel's depression score was not clinically significant by post-treatment, it did achieve clinical significance by 6-month follow-up. At the time of the longer term follow-up, Samuel's depression level was minimal and approximated the mean identified for the normative sample of male university students ($\underline{M}$ = 8.35; Johnston & Page, 1989).

Self-Esteem Scale. Samuel's scores showed slight declines from pre-treatment through to 1-month follow-up, indicating a small improvement in his feelings of self-esteem (see Figure 10, page 277). However, the changes in Samuel's scores were minimal and, by 6-month follow-up, his self-esteem score had almost returned to its pre-treatment level. While the amount of change in Samuel's self-esteem score was not clinically significant, the level of his self-esteem at 6-month follow-up was almost identical to the normative mean for a sample of non-abused adult females ($M = 22.80$; Higgins & McCabe, 1994).

The Blame Scale. As shown in Figure 11 (page 278), the amount of blame directed towards the individual who sexually abused Samuel showed little variation over the course of the sexual abuse treatment program. Samuel reported "a lot" of blame towards his abuser at pre-treatment. The score increased slightly by post-treatment, with Samuel indicating that he "completely" blamed his abuser. The amount of abuser blame continued to remain at this high level at both 1- and 6-month follow-up.

Samuel's characterological self-blame score showed a clinically significant decrease from pre-treatment (when he reported "a lot" of blame for the kind of person he was with respect to the sexual abuse) to post-treatment (when he blamed himself only "slightly"). Characterological self-blame continued to decrease following post-treatment and then showed a stable pattern at 1- and 6-month follow-up. In particular, Samuel indicated experiencing "very little" characterological self-blame at follow-up sessions.

Behavioural self-blame also showed a clinically significant decrease from pre- to post-treatment. While initially reporting "some" blame for the way he acted during the time of his sexual abuse, Samuel did not indicate any feelings of behavioural self-blame at post-treatment.

Samuel continued to report an absence of behavioural self-blame at the two follow-up sessions.

Multidimensional Anger Inventory. Samuel's overall anger score decreased gradually over the course of the treatment program and then showed a stable pattern at both 1- and 6-month follow-up (see Figure 12, page 279). While the decrease in Samuel's overall anger was not clinically significant from pre-treatment to 6-month follow-up, his anger level at long-term follow-up was almost equal to that of the normative university sample (M = 110.57; Siegel, 1985).

State-Trait Anxiety Inventory. Samuel's state anxiety score was in the middle range prior to treatment, and it showed a steadily declining trend over the course of the post- and follow-up assessment sessions (see Figure 13, page 280). Six-month follow-up revealed a clinically significant decrease in Samuel's reported level of state anxiety. At 6-month follow-up, Samuel's score fell within the normative range for a sample of university students (M = 38.5, SD = 10.7; Creamer et al., 1995). The changes in Samuel's trait anxiety scores also revealed a decreasing trend, although there was a slight increase from 1- to 6-month follow-up. The decline in Samuel's trait anxiety from pre-treatment to 6-month follow-up was clinically significant, with the reported level of trait anxiety approximating the normative mean for a university sample (M = 40.4; Creamer et al., 1995).

Self-Monitoring Data

Pleasant Events Schedule. From pre-treatment to the ninth assessment session, Samuel's scores for the Activity Level category of the PES showed an overall increasing trend with slight fluctuations (see Figure 14, page 281). Following the ninth assessment session, Samuel's scores declined steadily over post-treatment and 1-month follow-up. However, by 6-month follow-up,

Samuel's score had increased significantly and had reached a level equal to that of the ninth assessment session. Compared to pre-treatment, Samuel's Activity Level score at 6-month follow-up was at a moderately high level and represented a clinically significant 35% increase.

There was greater variability in Samuel's scores for the Reinforcement Potential category of the PES. Overall, scores showed an increasing trend until the sixth assessment session, after which point the scores steadily declined until the ninth assessment session. At post-treatment, Samuel's Reinforcement Potential level showed a minimal increase from pre-treatment, and this level was generally maintained at the 1- and 6-month follow-up sessions. While Samuel's score at 6-month follow-up was almost equal to that at pre-treatment, it should be noted that his score prior to the intervention was already at a moderately high level.

"How I see myself now" Scale. As shown in Figure 15 (page 282), the overall pattern of Samuel's self-concept scores was that of stability, with his 6-month follow-up score revealing only an 18% increase from pre-treatment. By longer-term follow-up, his self-concept score fell at a moderately high level. Despite the overall stable trend, there were several periods of moderate variability. In particular, Samuel's self-concept score increased from the second to third as well as from the fifth to sixth assessment sessions. In contrast, his scores showed a marked decline from the sixth to seventh assessment sessions.

Self-Ratings

Baseline period. Samuel's baseline period lasted 31 days, during which time his mean self-blame scores rose initially and then showed an overall stable pattern. Most of Samuel's daily self-blame scores ranged from 5 to 7, although there were several peaks towards the middle to latter half of the baseline period (see Figure 16, page 283). Anger mean scores showed an

oscillating trend with much variability in daily self-ratings. An interesting observation was the steady decrease in Samuel's daily anger self-ratings during the middle portion of the baseline period. (It should be noted that the declining slope was partly responsible for the lengthy baseline period, as it was necessary to postpone treatment until Samuel's anger self-ratings began to rise again). Samuel's anxiety means showed initial stability followed by a large drop. Despite the initial stability, the intervention could not have begun as it was necessary to wait for Samuel's daily anger self-ratings to increase. In addition, given that anxiety represented the final phase of the treatment program, there was less concern about the decrease at the end of baseline. Table 2 (page 261) presents the overall mean scores for self-blame, anger, and anxiety over phases of the sexual abuse treatment program. Samuel's overall mean self-blame score during baseline was 6.1, while that of anger was slightly lower at 5.6. Samuel's anxiety scores revealed the lowest overall mean of 5.2 during the baseline period.

Self-blame phase. This phase of the sexual abuse treatment program consisted of three sessions over a period of 26 days. Overall, Samuel's self-blame means showed a declining trend except for a slight increase between the second and third mean scores. As well, there was a dramatic drop in self-blame mean upon the introduction of the self-blame treatment phase (see Figure 16). Table 2 shows a considerable decrease in Samuel's overall mean self-blame score from baseline (6.1) to the self-blame treatment phase (3.1). The effect size for Samuel's self-blame ratings during baseline compared with those during the self-blame phase was calculated for a change in level when the data show a trend and was found to be $\underline{f}^2 = 0.18$. This value represents a medium decrease in Samuel's self-blame scores during the self-blame treatment phase (compared to the baseline period).

Samuel's anger scores during the self-blame phase of treatment showed a reduction in variability from the period before the phase was implemented (i.e., baseline). While the means revealed an overall increasing trend, there was a dramatic drop between the third and fourth anger means. Table 2 indicates that there was a small decrease in Samuel's overall mean anger from baseline (5.6) to the self-blame treatment phase (5.0). The effect size for Samuel's anger ratings prior to the self-blame phase compared with those during the self-blame phase was calculated for a change in variability and was found to be $f^2 = 0.74$. This value represents a very large reduction in the amount of fluctuation in Samuel's anger scores during the self-blame treatment phase (compared to the period before the self-blame phase was implemented).

Samuel's anxiety scores during the self-blame treatment phase revealed a dramatic increase between the second and third means and then a dramatic decrease between the third and fourth means. Table 2 shows a considerable drop in Samuel's overall mean anxiety score from baseline (5.2) to the self-blame treatment phase (3.2). The effect size for Steven's anxiety ratings prior to the self-blame phase compared with those during the self-blame phase was calculated for a change in slope and was found to be $f^2 = 0.02$. This value represents a small decrease in Samuel's anxiety scores during the self-blame treatment phase (compared to the baseline period).

Anger phase. This phase of treatment included nine sessions over a 72-day period. It should be noted that there were a relatively large number of missing data points due to Samuel having misplaced his daily self-rating forms. Means showed an initial increasing trend followed by a decreasing slope. Samuel's daily anger self-ratings revealed some instances of high variability, but overall, they seemed to cluster within the 2 to 5 range (see Figure 16). Samuel's

anger scores showed a considerable decrease in overall mean score during the anger treatment phase (3.8), compared to the entire period prior to the phase (5.3; see Table 2). The effect size for Samuel's anger ratings prior to the anger treatment phase (i.e., baseline) compared with those during the anger phase was calculated for a change in mean and was found to be $\underline{d} = -0.77$. This value represents a large effect size and indicates that the level of Samuel's self-reported anger during the anger phase was close to eight tenths of a standard deviation lower than during baseline.

Samuel's self-blame scores during the anger phase of treatment revealed stability with a virtual lack of variability in the data. Table 2 shows a considerable decrease in Samuel's overall mean self-blame from the self-blame phase (3.1) to the anger phase (1.0). The effect size for Samuel's self-blame ratings during the self-blame treatment phase compared with those during the anger treatment phase was calculated for a change in slope and was found to be $\underline{f}^2 = 0.12$. This value represents a small to medium decrease in Samuel's self-blame scores during the anger phase (compared to the self-blame phase).

Samuel's anxiety scores during the anger treatment phase showed much variability. There was a noticeable increase in mean anxiety scores with just a minimal decrease between the fourth and fifth anxiety means. Table 2 reveals minimal change in Samuel's overall mean anxiety during the anger phase (3.9), compared to the entire period before the anger phase was implemented (4.2). The effect size for Samuel's anxiety ratings prior to the anger phase compared with those during the anger phase was calculated for a change in level when the data show a trend and was found to be $\underline{f}^2 = 0.03$. This value represents a small increase in Samuel's anxiety scores during the anger phase (compared to the baseline period).

Anxiety phase. The anxiety phase of the sexual abuse program included five sessions over a period of 28 days. Mean anxiety scores showed minor fluctuations throughout the treatment phase, and Samuel's daily self-ratings remained at a relatively low level (see Figure 16). As shown in Table 2, Samuel's anxiety scores showed a considerable drop in overall mean during the anxiety treatment phase (2.7), compared to the entire period prior to the implementation of the phase (4.1), known as baseline. The effect size for Samuel's anxiety ratings during baseline compared with those during the anxiety phase was calculated for a change in mean level and was found to be $\underline{d} = -0.64$. This value reveals a medium to large effect size and indicates that the level of Samuel's self-reported anxiety during the anxiety phase was about six tenths of a standard deviation lower than during baseline.

Samuel's self-blame scores during the anxiety treatment phase revealed the elimination of self-blame as a problem. Table 2 shows no change in Samuel's overall mean self-blame during the anxiety phase, compared with the previous anger phase. With regard to Samuel's anger scores during the anxiety treatment phase, one notices minor variability in his daily self-ratings. As well, Table 2 indicates that there was a considerable decrease in Samuel's overall mean anger from the anger phase (3.8) to the anxiety phase (1.8). The effect size for Samuel's anger ratings during the anger phase compared with those during the anxiety phase was calculated for a change in mean and was found to be $\underline{d} = -0.87$. This value represents a large effect size and indicates that the level of Samuel's self-reported anger during the anxiety phase was about nine tenths of a standard deviation lower than during the anger phase.

Significant Other's Weekly Ratings

At the time that the treatment program began, Samuel was involved in a highly

conflictual and unstable relationship of several years' duration. There had been numerous break-ups and reunions over the years, and Samuel ended the relationship shortly after the start of therapy. Thus, there were no data on Samuel's feelings of self-blame, anger, and anxiety as perceived by a significant other.

Client Satisfaction Questionnaire

At post-treatment, Samuel's score of 28 indicated a high level of consumer satisfaction with the sexual abuse treatment program. Concerning the self-blame component of treatment, Samuel found the activity which examined the differences between children and adults helpful in understanding his vulnerability as a child. Turning to the anger component, Samuel reported that it was helpful "learning to talk out my anger with someone and recognizing physical symptoms of anger and how to diffuse it." Finally, relaxation training during the anxiety treatment component was identified by Samuel as being particularly beneficial. It should be noted that the CSQ was not completed by a significant other as Samuel's relationship with his partner was inconsistent and ended towards the beginning of the treatment program.

Feedback Questionnaires

Overall, Samuel's impressions about the treatment program were positive, and he stated feeling that the therapist was highly supportive and flexible. Samuel focused on the self-blame work as being particularly helpful for him and listed the following improvements: learning about the nature of child sexual abuse and who is responsible; learning about why he behaved in the manner he did as a child; and no longer blaming himself for the abuse. Samuel did not mention any parts of the treatment program that were unhelpful.

With regard to the impact of the intervention, Samuel stated that his feelings of self-

blame have "vanished." He identified several areas as requiring further exploration, namely non-abuse-related anger, low self-esteem, anxiety related to meeting new people, and negative views of women. Samuel's expectations of the treatment program were met, although he acknowledged not being completely certain of what the intervention would involve when he began the program.

At 1-month follow-up, Samuel reported a considerable improvement in the relationship with his mother. He stated that "since I have told her about my past sexual abuse, she is definitely more supportive of me by not putting me down and making more positive statements to me. This caught me off guard a bit but it is bringing us closer. I am grateful this is happening." A negative change which occurred over the time period involved Samuel being laid off from his job, which he said was difficult because he missed the daily contact with his co-workers. Feedback at 6-month follow-up generally remained positive. Samuel's relationship with his mother continued to improve, and he no longer experienced guilt and shame over the childhood sexual abuse. Samuel also reported an increase in his self-confidence, assertiveness, and trust in people. One problem identified by Samuel involved an increase in unprotected sexual activity with a number of partners. Samuel stated, "I am feeling lonely quite often. I also feel needy but do not know what this need is. I have tried to fill this need sexually. This seems to be getting worse almost by the week, and the sexual relations seldom are fulfilling. Something seems to be lacking in my life."

Stan: Background History and Treatment Findings

Background Information

Stan was a single, unemployed male in his late thirties who was sexually abused for

several months during early childhood. Stan recalled instances of fondling, oral sex, and attempted intercourse with his older brother. There were also numerous attempts by his brother's friends to engage Stan in sexual activity, including intercourse. Stan ended his relationship with his brother many years ago but maintained regular contact with his parents. While Stan disclosed his sexual victimization to his mother several years ago, his father remained unaware of the abuse. Stan reported that the decision not to tell his father was based on concerns related to his poor physical health.

At the time of the intake interview, Stan identified a number of abuse-related difficulties, including depression, anxiety, and social isolation. The near absence of intimate opposite-sex relationships during Stan's lifetime was particularly problematic for him. Stan had participated in a sexual abuse group therapy program several years ago. As well, he was in the final stages of a short-term social phobia group at the time of intake. With regard to the sexual abuse treatment intervention, Stan was seen on a mostly twice weekly basis for 21 sessions over a period of about four months.

Self-Report Data

Beck Depression Inventory. At pre-treatment, Stan's score fell at the upper limit of the "moderate depression" category (see Figure 17, page 284). His score showed an abrupt and clinically significant drop following the intervention and was classified as "minimal" at post-treatment. Stan's depression score continued to remain at a minimal level throughout 1- and 6-month follow-up. The findings suggested that Stan's depression score demonstrated a clinically significant improvement from pre-treatment to post-treatment and through to follow-up sessions. Also, Stan's depression level at 6-month follow-up was minimal and was within the normative

range for a sample of male university students (M = 8.35, SD = 7.31; Johnston & Page, 1989).

Self-Esteem Scale. As shown in Figure 18 (page 285), Stan's self-esteem score prior to treatment indicated moderately low feelings of self-worth. There was a clinically significant improvement in Stan's self-esteem score at post-treatment, and this improvement was generally maintained at both 1- and 6-month follow-up. By long-term follow-up, Stan's level of self-esteem was well-within the normative range for a sample of non-abused adult females (M = 22.80; SD = 7.06; Higgins & McCabe, 1994).

The Blame Scale. The amount of blame directed towards the individual who sexually abused Stan showed a clinically significant increase from pre-treatment (where Stan reported "some" amount of blame) to post-treatment (where Stan reported blaming his abuser "completely"). While the amount of abuser blame decreased slightly by 1-month follow-up, it returned to its high post-treatment level by 6-month follow-up (see Figure 19, page 286).

Stan's characterological self-blame score decreased significantly from pre- to post-treatment. Prior to the treatment intervention, Stan reported experiencing "a lot" of blame for the kind of person he was with respect to the sexual abuse, but he indicated "very little" characterological self-blame at post-treatment. However, Stan's score increased over the follow-up sessions and, by 6-month follow-up, he reported experiencing "some" characterological self-blame.

Behavioural self-blame showed a clinically significant decrease over the course of the treatment program. At pre-treatment, Stan indicated "a lot" of blame for the way in which he acted during his sexual abuse, but at post-treatment and 1-month follow-up, he reported no such feelings. At 6-month follow-up, Stan's behavioural self-blame score had increased slightly but

continued to remain at a low level (i.e., he reported "very little" blame for his actions).

Multidimensional Anger Inventory. As can be seen in Figure 20 (page 287), Stan's overall anger score decreased by a clinically significant amount from pre- to post-treatment. While there was a minimal increase in anger at 1-month follow-up, Stan's overall anger score continued to drop by the time of the 6-month follow-up assessment. Thus, it would seem that the change in Stan's anger achieved clinical significance at both post-treatment and 6-month follow-up, at which time his score reached a level that was lower than that identified for a normative male university sample (M = 110.57; Siegel, 1985).

State-Trait Anxiety Inventory. Prior to the treatment intervention, Stan's state anxiety score was moderately high (see Figure 21, page 288). At post-treatment, his state anxiety score showed a sharp and clinically significant decrease, falling below the normative range for a sample of university students (M = 38.5, SD = 10.7; Creamer at al., 1995). Over the course of the follow-up sessions, Stan's state anxiety score increased. However, by 6-month follow-up, Stan's state anxiety score remained significantly lower than pre-treatment and was at a level that was well-within the normative range.

Stan's trait anxiety scores declined significantly from pre- to post-treatment. Trait anxiety continued to decrease slightly by 1-month follow-up but then increased slightly by 6-month follow-up, returning to its post-treatment level. Stan's long-term follow-up score showed a clinically significant drop from that reported prior to the intervention, and his score was well-within the range identified for the normative sample of university students (M = 40.4, SD = 10.7; Creamer et al., 1995).

Self-Monitoring Data

Pleasant Events Schedule. Stan's scores for the Activity Level category of the PES showed an overall increasing trend. The scores showed stability until the third assessment session, after which time there occurred a relatively large increase in Stan's score. Stability was maintained until the seventh assessment session, after which time Stan's scores showed a steady increase through to post-treatment (see Figure 22, page 289). By post-treatment, Stan's Activity Level score had shown a significant increase of 38% from pre-treatment, and the level remained in the middle range of all possible scores. There was a sharp increase in Stan's score at 1-month follow-up, and this increase was maintained through to 6-month follow-up. In fact, Stan's Activity Level score at 6-month follow-up was 58% greater than his pre-treatment score and fell at a high level.

Stan's scores for the Reinforcement Potential category of the PER showed an overall slowly increasing pattern with minor variability. There was a steady increase in scores until the third assessment session. Stan's scores were fairly stable from the third session until 6-month follow-up, except for a small decline at the seventh assessment session. Stan's Reinforcement Potential score increased by 23% from pre- to post-treatment (falling in the upper range of scores) and by 19% from pre-treatment to 6-month follow-up (again falling in the upper range of scores). While the amount of change in scores is not clinically significant, it seems important to note that Stan's scores fell within the upper range of all possible scores. As well, Stan's Reinforcement Potential score at pre-treatment was already at a relatively high level.

"How I see myself now" Scale. As shown in Figure 23 (page 290), Stan's self-concept scores showed a steadily increasing trend until post-treatment. There was a clinically significant

44% increase in Stan's score from pre- to post-treatment, with his level falling in the moderately high range. The two follow-up sessions revealed that Stan's self-concept scores were maintained at a moderately high level. In fact, Stan's 6-month follow-up score showed a significant increase of 42% from the pre-treatment level.

Self-Ratings

Baseline period. Stan's baseline period lasted 25 days, during which time his mean self-blame scores showed minor fluctuation with an overall stable slope (see Figure 24, page 291). Anger mean scores revealed an overall increasing trend with a moderate range of variability in daily self-ratings. Stan's anxiety means showed a relatively stable pattern with most daily self-ratings within the 7 to 8 range. Table 3 (page 262) presents the overall mean scores for self-blame, anger, and anxiety over phases of the sexual abuse treatment program. Stan's overall mean self-blame score during the baseline period was 6.6, while that of anger was slightly lower at 5.9. Stan's anxiety scores revealed the highest overall mean of 7.1 during baseline.

Self-blame phase. This phase of the treatment program involved seven sessions over a 36-day period. Stan's self-blame scores showed a steadily decreasing trend from the baseline period. Overall daily ratings alternated between periods of stability and slight peaks, with the levels of each decreasing over the treatment phase (see Figure 24). Table 3 reveals a considerable drop in Stan's overall mean self-blame score from baseline (6.6) to the self-blame treatment phase (4.8). The effect size for Stan's self-blame ratings during baseline compared with those during the self-blame phase was calculated for a change in slope and was found to be $f^2 = 0.39$. This value represents a large decrease in Stan's self-blame scores during the self-blame treatment phase (compared to the baseline period).

Stan's anger scores during the self-blame treatment phase revealed moderate variability in daily self-ratings. There was a large increase between the first and second mean anger scores followed by overall stability for the remainder of the self-blame phase. Stan's overall mean anger during the self-blame phase (6.1) showed a minimal increase from baseline (5.9; see Table 3). The effect size for Stan's anger ratings prior to the self-blame phase compared with those during the self-blame phase was calculated for a change in level when the data show a trend and was found to be $f^2 = 0.02$. This value reveals a small decrease in Stan's anger scores during the self-blame treatment phase (compared to the period before the self-blame phase was implemented).

Stan's anxiety means during the self-blame phase of treatment showed a slight declining trend with some variability in daily self-ratings. Table 3 indicates that there was a considerable decrease in Stan's overall mean anxiety score from baseline (7.1) to the self-blame treatment phase (5.7). The effect size for Stan's anxiety ratings prior to the self-blame phase compared with those during the self-blame phase was calculated for a change in slope and was found to be $f^2 = 0.04$. This value reveals a small decrease in Stan's anxiety scores during the self-blame treatment phase (compared to the baseline period).

Anger phase. This phase of treatment included six sessions over a period of 42 days. Overall, Stan's anger scores revealed a declining trend over the course of the anger phase. There was a slight initial increase in anger means followed by a decreasing pattern. Stan's daily anger ratings revealed a fluctuating pattern over the course of the treatment phase (see Figure 24). Table 3 shows a considerable drop in Stan's overall mean anger score during the anger treatment phase (4.2), compared to the entire period prior to the phase (6.0). The effect size for Stan's

anger ratings prior to the anger treatment phase (i.e., baseline) compared with those during the anger phase was calculated for a change in slope and was found to be $f^2 = 0.28$. This value reveals a medium to large decrease in Stan's anger scores during the anger treatment phase (compared to the baseline period).

Stan's self-blame scores during the anger treatment phase continued to show small decreases with minor fluctuations in daily scores. Table 3 indicates a dramatic drop in Stan's overall mean self-blame from the self-blame phase (4.8) to the anger phase (1.8). The effect size for Stan's self-blame ratings during the self-blame treatment phase compared with those during the anger treatment phase was calculated for a change in level when the data show a trend and was found to be $f^2 = 0.03$. This value represents a small decrease in Stan's self-blame scores during the anger phase (compared to the self-blame phase).

Stan's anxiety scores during the anger treatment phase showed an increasing slope until the middle of the phase, followed by an overall decreasing trend. Daily anxiety ratings showed some degree of variability, mostly ranging from 3 to 6. Table 3 indicates that there was a considerable decrease in Stan's overall mean anxiety score during the anger treatment phase (4.2), compared to the entire period prior to the anger phase (6.4). The effect size for Stan's anxiety ratings prior to the anger phase compared with those during the anger phase was calculated for a change in level when the data show a trend and was found to be $f^2 = 0.02$. This value represents a small decrease in Stan's anxiety scores during the anger treatment phase (compared to the baseline period).

Anxiety phase. The anxiety phase of the treatment program included eight sessions over a period of 34 days. Mean anxiety scores showed initial stability followed by a slight declining

pattern. There was minimal variability in Stan's daily anxiety ratings throughout most of the treatment phase (see Figure 24). Table 3 shows a considerable decrease in Stan's overall anxiety mean from baseline (5.7) to the anxiety treatment phase (3.3). The effect size for Stan's anxiety ratings during baseline compared with those during the anxiety phase was calculated for a change in level when the data show a trend and was found to be $\underline{f}^2 = 0.01$. This value reveals a very small decrease in Stan's anxiety scores during the anxiety phase (compared to the baseline period).

Stan's self-blame scores during the anxiety treatment phase showed the absence of self-blame as a problem. Table 3 indicates that there was a decrease in Stan's overall mean self-blame during the anxiety phase (1.0), compared with the previous anger phase (1.8). The effect size for Stan's self-blame ratings during the previous anger phase compared with those during the anxiety phase was calculated for a change in slope and was found to be $\underline{f}^2 = 0.32$. This value represents a large decrease in Stan's self-blame scores during the anxiety treatment phase (compared to the anger phase).

Stan's anger scores during the anxiety treatment phase showed relative stability, although there was a small decrease between the third and fourth mean anxiety scores. Table 3 reveals a dramatic drop in Stan's overall mean anger from the anger phase (4.2) to the anxiety phase (1.9). The effect size for Stan's anger ratings during the anger phase compared with those during the anxiety phase was calculated for a change in level when the data show a trend. The calculation revealed no change in Stan's anger scores during the anxiety phase (compared to the anger phase).

Significant Other's Weekly Ratings

Over the course of the sexual abuse treatment program, Stan was not involved in an intimate relationship with another individual. Thus, no data were collected on Stan's feelings of self-blame, anger, and anxiety, as perceived by a significant other.

Client Satisfaction Questionnaire

At post-treatment, Stan's score of 31 indicated a high level of consumer satisfaction with the sexual abuse treatment program. During the self-blame component of treatment, Stan stated that dispelling sexual abuse myths and "realizing it was my environment and not me that allowed the abuse to happen" were particularly helpful. Writing a letter to his abuser and exploring emotions that may underlie anger were identified as being especially beneficial for Stan during the anger treatment component. Finally, Stan reported that the cognitive restructuring activity and thought stopping procedure helped him to better cope with his feelings of anxiety.

Feedback Questionnaires

Stan's overall impressions about the sexual abuse treatment program were highly positive, and he stated that the intervention allowed him to discover "many helpful insights about myself." Stan reported that the entire treatment program was helpful and identified the following exercises as being particularly useful: dispelling sexual abuse myths; gaining an awareness of factors that contributed to the manner in which he coped with his abuse; examining emotions that may underlie anger; writing a letter to his offender; learning the thought stopping procedure; and engaging in the cognitive restructuring activity.

With regard to the impact of the sexual abuse intervention, Stan responded that "it has

given me hope. I have seen changes, welcoming changes that will forever be a part of me. I can never return, revert to the way I was before." He stated that he needed to continue working on developing more personal relationships with others and "to keep putting my trust in others and feel secure in the knowledge that intentional hurt is a rare occurrence." Finally, Stan reported that the treatment program exceeded his expectations and explained that "to know a measure, however small...of comfort, self-worth, the ability to dare trusting one's own judgement..."

At 1-month follow-up, Stan reported an increase in feelings of self-worth, minimal feelings of self-blame and anger, and decreased feelings of anxiety. Stan had also made a positive step by developing an intimate relationship with a woman. He reported, "I have discovered and confirmed that I can be viewed as sexually attractive and loved by another. I have discovered and confirmed that I can view as sexually attractive and love another and feel comfortable doing so...at times small feelings of fear, but for the most part, feelings of 'rightness' and a sense of belonging...the small scary feelings are probably related to travelling uncharted territory." Some of the negative changes identified by Stan over the month included having little confidence in his ability to find employment and feeling some anxiety over whether the positive changes he had made would continue.

Feedback at 6-month follow-up revealed that Stan's commitment to his intimate relationship was growing, and he and his partner were making long-term plans to become married. As well, he was continuing to find the self-dialogue and relaxation exercises helpful in managing his anxiety. Anger and self-blame were no longer important issues for him. With regard to negative changes over the six months, Stan stated that he had experienced flashbacks of his sexual abuse during times of sexual activity with his partner. He said he was struggling

with ways to effectively deal with the flashbacks but stated that his partner had remained supportive of him.

Scott: Background History and Treatment Findings

Background Information

Scott was a single, employed male in his early twenties who was sexually abused by a number of individuals throughout his childhood and adolescence. The first abusive experience began during middle childhood while Scott was living in a foster home. The sexual activity occurred over a period of several months and involved a young male adult who also resided in the foster home. Scott remembered engaging in fondling and oral sex activities on an almost daily basis as well as being exposed to pornographic material. At approximately the same time and over the course of a two-year period, Scott became involved in fondling activity with his older sister and her friends. Finally, Scott reported two episodes of fondling and oral sex during mid-adolescence. The sexual activity involved a young male adult whom Scott had perceived as a friend.

Scott had recently disclosed his sexual abuse to his parents, who separated prior to his birth. Scott's mother was remarried from the time of his early childhood to his early adolescence, after which time the couple divorced. It was during this time that Scott was placed in foster care for several months following allegations that his step-father sexually abused his sister. A significant negative event for Scott was the return of his step-father to the home after his release from prison for his sexual assault charge. Scott felt enormous anger toward his mother for exposing him to his step-father's physical abuse and for creating a family atmosphere in which the sexual and physical abuse were kept secret. At the time of the intake interview,

Scott was living with his mother and her new husband. He maintained a close relationship with his sister but had limited contact with both his biological father and step-father.

Scott reported no previous therapeutic involvement for issues related to his sexual abuse. However, he was involved in an on-going group for depression. Other difficulties identified during the intake interview included struggles with alcohol and drug use (which Scott identified as a way to cope with abuse-related feelings), social isolation related to mistrust of others and fear of making himself vulnerable, and lack of assertiveness. With regard to the sexual abuse treatment program, Scott was seen on a mostly twice weekly basis for 18 sessions over a period of approximately three months.

Self-Report Data

Beck Depression Inventory. Prior to the sexual abuse treatment program, Scott's score fell in the "severe depression" category (see Figure 25, page 292). At post-treatment, his score demonstrated a clinically significant drop and was classified as "mild." Scott's score showed an increase at 1-month follow-up and fell within the "moderate depression" category. By 6-month follow-up, Scott's score declined slightly and, while it was still classified as "moderate," it was at the clinical cut-off point between mild and moderate depression. Thus, the findings suggested that the amount of change in Scott's depression score achieved clinical significance from pre- to post-treatment as well as from pre-treatment to 6-month follow-up. However, Scott's level of depression at long-term follow-up was moderate and fell just outside the normative range for a sample of male university students (M = 8.35, SD = 7.31; Johnston & Page, 1989).

Self-Esteem Scale. Scott's pre-treatment score revealed low feelings of self-esteem (see Figure 26, page 293). At post-treatment, Scott reported a clinically significant improvement in

self-esteem, and these improvements were maintained at the two follow-up assessment sessions. At 6-month follow-up, Scott's self-esteem score was well-within the normative range for a sample of non-abused adult females (M = 22.80, SD = 7.06; Higgins & McCabe, 1994).

The Blame Scale. The amount of blame directed towards the individuals who sexually abused Scott remained at the same high level over the course of the treatment program and at follow-up sessions. As shown in Figure 27 (page 294), Scott reported blaming his abusers "completely" prior to treatment, upon completion of the treatment program, and at 1- and 6-month follow-up. Scott's characterological self-blame score showed a slight decrease from pre- to post-treatment. At pre-treatment, he reported experiencing "a lot" of blame for the kind of person he was with regard to the sexual abuse, but Scott later reported "some" characterological self-blame by the end of the treatment program. At both 1- and 6-month follow-up, Scott continued to indicate "some" characterological self-blame. Findings for behavioural self-blame showed the same pattern as that for characterological self-blame. At pre-treatment, Scott indicated "a lot" of blame for the way he acted during the time of his sexual abuse, and he later reported "some" blame for his actions at post-treatment. Scott continued to report "some" behavioural self-blame at the two follow-up sessions.

Multidimensional Anger Inventory. Figure 28 (page 295) shows that, prior to the treatment intervention, Scott's overall anger score was considerably high. There was a slight decrease in Scott's anger following treatment termination, and this level was maintained at 1-month follow-up. There was a clinically significant decrease in Scott's overall anger score at 6-month follow-up. While the amount of change reached clinical significance, Scott's overall anger score remained at a level higher than that reported for a normative male university sample

(M = 110.57; Siegel, 1985) at 6-month follow-up.

State-Trait Anxiety Inventory. Prior to the sexual abuse treatment program, Scott's state anxiety score was considerably high (see Figure 29, page 296). However, scores revealed a steadily declining slope at post-treatment and through the two follow-up sessions. While the amount of change from pre- to post-treatment and to 6-month follow-up reached clinical significance, the level remained outside the range for the normative sample of university students (M = 38.5, SD = 10.7; Creamer et al., 1995).

At pre-treatment, Scott's trait anxiety score virtually reached the highest possible level but decreased by a clinically significant amount at post-treatment and follow-up sessions. However, it should be noted that the level of his trait anxiety at all three assessment sessions remained above the range identified for the normative sample of university students (M = 40.4, SD = 10.7; Creamer et al., 1995).

Self-Monitoring Data

Pleasant Events Schedule. Scott's scores for the Activity Level category of the PES showed minimal variation from pre-treatment to 1-month follow-up (see Figure 30, page 297). There was only an 8% increase from pre- to post-treatment and an 11% increase from pre-treatment to 1-month follow-up. Scores at both post-treatment and 1-month follow-up were slightly above the middle range of all possible scores. While Scott's Activity Level scores were stable throughout most of the assessment sessions, there was a moderate decline at 6-month follow-up. In particular, Scott's score showed a 19% decrease from pre-treatment to 6-month follow-up and fell slightly below the middle range of scores.

Scott's scores for the Reinforcement Potential category showed greater variability. There

was a considerable increase after pre-treatment followed by a considerable decrease after the second assessment session, returning Scott's score to a level lower than that prior to treatment. However, Scott's score showed another dramatic increase following the third assessment session and then was relatively stable until post-treatment, at which time his Reinforcement Potential score had almost returned to its relatively low pre-treatment level. Following post-treatment, Scott's scores showed a rapidly increasing slope. By 6-month follow-up, Scott's Reinforcement Potential score had shown a clinically significant increase of 46% from its pre-treatment level and remained just slightly above the middle range.

"How I see myself now" Scale. As can be seen in Figure 31 (page 298), Scott's self-concept scores revealed an increasing trend until 1-month follow-up. At post-treatment, his score showed a clinically significant increase of 44% from pre-treatment. At 1-month follow-up, Scott's score had increased by 48% from its pre-treatment level. While Scott's self-concept score decreased by 6-month follow-up, it still remained at a level that was significantly higher (i.e., by 35%) than pre-treatment.

Self-Ratings

Baseline period. The duration of Scott's baseline period was 13 days. During this time, his mean self-blame scores showed a fairly stable trend, and there was not much variability in his daily self-blame ratings (see Figure 32, page 299). Similar to the self-blame means, anger mean scores also revealed a fairly stable trend. Scott's mean anxiety scores revealed an increasing trend, mirroring the overall pattern of his daily anxiety self-ratings. Table 4 (page 263) presents the overall mean scores for self-blame, anger, and anxiety over phases of the sexual abuse treatment program. Scott's overall mean self-blame score during baseline was 5.3.

His overall anger mean during the baseline period was the highest at 6.3, while that of anxiety was 5.6.

Self-blame phase. This phase of the sexual abuse program included five treatment sessions over a period of 33 days. Scott's mean self-blame scores revealed a decreasing slope with moderate variability in daily self-ratings (see Figure 32). His mean scores stabilized toward the end of the self-blame treatment phase. Table 4 indicates that there was a considerable decrease in Scott's overall mean self-blame score from baseline (5.3) to the self-blame treatment phase (4.0). The effect size for Scott's self-blame ratings during baseline compared with those during the self-blame phase was calculated for a change in slope and was found to be $\underline{f}^2 = 0.06$. This value reveals a small decrease in Scott's self-blame scores during the self-blame treatment phase (compared to the baseline period).

Scott's anger scores during the self-blame treatment phase revealed stability with minor variability in daily scores, which ranged from 5 to 7. Table 4 reveals no change in Scott's overall mean anger (6.3) during baseline and the self-blame treatment phase. The effect size for Scott's anger ratings prior to the self-blame phase compared with those during the self-blame phase was calculated for a change in variability and was found to be $\underline{f}^2 = 0.70$. This value indicates that there was a large reduction in the amount of fluctuation in Scott's anger scores during the self-blame treatment phase (compared to the period before the self-blame phase was implemented).

Scott's anxiety scores during the self-blame treatment phase showed a slightly declining trend which then began to increase toward the end of the phase. Despite the slight decline, Table 4 indicates that there was an increase in Scott's overall mean anxiety score from baseline (5.6) to the self-blame treatment phase (6.6). The effect size for Scott's anxiety ratings prior to the

self-blame phase compared with those during the self-blame phase was calculated for a change in slope and was found to be $f^2 = 0.17$. This value represents a medium decrease in Scott's anxiety scores during the self-blame treatment phase (compared to the period before the phase was implemented).

Anger phase. This phase of treatment included ten sessions conducted over a 45-day period. Scott's mean anger scores showed stability for most of the anger treatment phase, and daily self-ratings remained at a relatively high level. However, there was the emergence of a decreasing pattern toward the end of the phase (see Figure 32). Table 4 shows no change in Scott's overall mean anger score (6.3) during both the anger treatment phase as well as the entire period prior to the phase. The effect size for Scott's anger ratings prior to the anger treatment phase (i.e., baseline) compared with those during the anger phase was calculated for a change in level when the data show a slope and was found to be $f^2 = 0.08$. This value represents a small to medium decrease in Scott's anger scores during the anger treatment phase (compared to the baseline period).

Scott's self-blame scores during the anger treatment phase revealed a mostly stable slope with slight decreases toward the end of the phase. Table 4 indicates that there was a dramatic decrease in Scott's overall mean self-blame from the self-blame phase (4.0) to the anger phase (1.8). The effect size for Scott's self-blame ratings during the self-blame treatment phase compared with those during the anger treatment phase was calculated for a change in level when the data show a trend and was found to be $f^2 = 0.03$. This value reveals a small decrease in Scott's self-blame scores during the anger phase (compared to the self-blame phase).

Scott's anxiety scores during the anger treatment phase showed minimal fluctuation

throughout most of the treatment phase. However, there was a more consistent decline in anxiety means toward the end of the anger phase. Table 4 reveals a slight increase in Scott's overall mean anxiety score during the anger treatment phase (6.4), compared to the entire period prior to the anger phase (6.1). The effect size for Scott's anxiety ratings prior to the anger phase compared with those during the anger phase was calculated for a change in slope and was found to be $\underline{f}^2 = 0.12$. This value represents a small to medium decrease in Scott's anxiety scores during the anger treatment phase (compared to the baseline period).

Anxiety phase. The anxiety phase of the sexual abuse treatment program included three sessions over a period of 11 days. Scott's anxiety scores revealed an absence of variability. Table 4 indicates that there was a considerable decrease in Scott's overall mean anxiety score from baseline (6.3) to the anxiety treatment phase (5.0). The effect size for Scott's anxiety ratings during baseline compared with those during the anxiety phase was calculated for a change in mean and was found to be $\underline{d} = -1.32$. This value reveals a very large effect size and indicates that the level of Scott's self-reported anxiety during the anxiety phase was more than one standard deviation lower than during baseline.

Scott's self-blame scores during the anxiety treatment phase showed the elimination of self-blame problems. Table 4 indicates that there was a moderate decrease in Scott's overall mean self-blame during the anxiety phase (1.0), compared with the previous anger phase (1.8). The effect size for Scott's self-blame ratings during the previous anger phase compared with those during the anxiety phase was calculated for a change in slope and was found to be $\underline{f}^2 = 0.02$. This value reveals a small decrease in Scott's self-blame scores during the anxiety treatment phase (compared to the previous anger phase).

Scott's anger scores during the anxiety treatment phase showed an absence of fluctuation and a stable slope. There was a considerable decrease in Scott's overall mean anger from the anger phase (6.3) to the anxiety phase (5.0; see Table 4). The effect size for Scott's anger ratings during the anger phase compared with those during the anxiety phase was calculated for a change in mean and was found to be $\underline{d} = -1.58$. This value reveals a very large effect size and indicates that the level of Scott's anger scores was slightly over one and a half standard deviations lower during the anxiety treatment phase (compared to the anger phase).

Significant Other's Weekly Ratings

At the start of the sexual abuse treatment program, Scott was not involved in an intimate relationship. Towards the middle portion of the program, Scott began a relationship with a woman. Because the relationship was very new and only began halfway through the treatment program, no data were collected by Scott's partner. It should also be noted that the relationship became conflictual towards the end of the program and had ended by the time of 1-month follow-up.

Client Satisfaction Questionnaire

At post-treatment, Scott's score of 22 indicated a medium level of consumer satisfaction with the sexual abuse treatment program. With regard to the self-blame component of treatment, Scott stated that examining the differences between a child and adult was particularly helpful. He said this exercise helped in "understanding my abilities and inabilities as a child. Learning about my mental and physical capabilities and limits." Identifying and examining feelings that may underlie anger was reported to be especially helpful for Scott during the anger component. Finally, Scott stated that the thought stopping procedure and progressive muscle relaxation

exercises were beneficial in helping him cope with his feelings of anxiety. It should be noted that the CSQ was not completed by a significant other as Scott was not involved in any stable, long-term intimate relationship at the time that the treatment program began.

Feedback Questionnaires

Scott's overall impressions of the sexual abuse program were that it is "still an early science that needs more structure." However, he identified the overall self-blame component as having been particularly helpful in providing an understanding of where the responsibility for his childhood abuse should be placed (i.e., with his offenders). Scott also suggested that the thought stopping procedure may have been helpful to counter self-blame thoughts and so could have been introduced during the self-blame treatment component (rather than only during the anxiety component). In addition, Scott stated that "the paper work could have focused on how sexual abuse has affected life areas such as finances, religion, psychological life area, sexual life area, physical life area, social life area." It would seem, from this statement, that Scott would have preferred a more general focus on the many ways in which sexual abuse has affected the various areas of his life.

With regard to the impact of the treatment intervention, Scott reported that "it has taught me a lot about why I am who I am and that I have a right to feelings and to express them. Also, I know now to address issues early and that these issues must be addressed or they will not be resolved." While Scott identified several positive changes as a result of the program, he also acknowledged that he needs to continue exploring anger issues (as they relate to his mother, father, and abusers) and to learn ways of coping with his long-standing and overwhelming feelings of anxiety. Finally, in terms of his expectations of the treatment program, Scott said, "I

would have liked to learn a lot more about cognitive behavioral therapy with respect to my abuse. It is very important for a survivor to learn how to re-structure thoughts that are anxiety provoking or provoke anger."

At 1-month follow-up, Scott reported remaining concerned about his levels of anger and anxiety. He said he purchased a self-help program which focused on coping with anxiety. He explained that "the program is based completely on cognitive behavioral therapy. The student learns to recognize and unlearn old habits that lead to anxiety and panic. The student also learns self-respect, relaxation, and how to recognize signs of unproductive thoughts and anxiety provoking thoughts or obsessive thinking. I am in my third week and so far no great changes but I still believe in the program and will see it through to the end."

Feedback at 6-month follow-up suggested that Scott was continuing to work on the anxiety self-help program but was struggling with trying to "break negative thought patterns." He also said he was continuing to explore feelings that may underlie anger as a way to decrease his level of anger. Scott reported attempting to be more physically active, more positive and optimistic, and less upset by events that occur in his life. Scott stated that these attempts have been met with some success but that he is having a difficult time trying to be less critical of himself and others. Despite his struggles, Scott remained hopeful and stated, "I have a strong desire to change and continue changing so I will become free of the bonds that have tied me down so long."

Sean: Background History and Treatment Findings

Background Information

Sean was a single, unemployed male in his mid-thirties who experienced sexual abuse by

his mother during early adolescence. Sean remembered engaging in fondling activity with his mother on several occasions. He also described growing up in a highly sexualized environment in which individual boundaries were not respected. For instance, his mother and step-father reportedly would walk around naked in the home and engage in sexual activity in front of Sean. While Sean recalled the sexual abuse experience with his mother, he also had partial memories and nightmares involving what he perceived to be sexual activity with other family members (i.e., maternal grandparents). Sean described these memories as "being small and someone big is with me that I can't identify and something is happening that I can't control. I feel powerless, helpless, and small. It's confusing and I'm not happy. I'm anxious and scared." At the time of the intake interview, Sean had no contact with his biological parents, who divorced when he was a young adolescent. Sean also had no contact with his step-father, who married his mother shortly after the divorce. According to Sean, he ended his relationship with his mother and step-father several years ago after attempts to confront them about the sexually inappropriate activity were met with denial.

Sean had been involved in fairly extensive therapeutic work prior to his participation in the sexual abuse treatment program. He was involved in previous individual therapy for abuse-related issues and had also participated in a self-esteem and assertiveness group. As well, Sean had on-going contact with a psychiatrist in order to monitor his anti-depressant medication. Other difficulties identified during intake involved Sean's limited support system, high suicidal ideation, and lack of adult sexual relationships. Sean was seen on a mostly twice weekly basis for 25 sessions over a period of approximately three and a half months.

Self-Report Data

Beck Depression Inventory. Prior to the sexual abuse treatment program, Sean's score was at the upper limit of the "mild depression" category (see Figure 33, page 300). By post-treatment, his depression score showed a clinically significant decline and was classified as "minimal." Sean's score rose dramatically by 1-month follow-up and fell in the lower range of the "moderate depression" category. However, Sean's score showed another drop by 6-month follow-up, falling at the lower limit of the "mild depression" category. The results suggested that the amount of change in Sean's depression score was clinically significant from pre- to post-treatment but was not maintained through to 6-month follow-up. However, by 6-month follow-up, Sean's depression level was mild and fell well-within the normative range for a sample of male university students ($M = 8.35$, $SD = 7.31$; Johnston & Page, 1989).

Self-Esteem Scale. Figure 34 (page 301) shows that Sean's pre-treatment score indicated low feelings of self-esteem. While Sean reported some improvement in self-esteem at post-treatment, the change appeared temporary. By 1-month follow-up, Sean's self-esteem score had returned to its pre-treatment level, and this level was maintained through to the 6-month follow-up assessment session.

The Blame Scale. The amount of blame directed towards the individual who sexually abused Sean remained relatively stable over time. Prior to the treatment program, Sean reported "a lot" of blame towards his abuser. At post-treatment, the amount of abuser blame increased slightly, with Sean indicating that he blamed his abuser "completely" for the sexual victimization. Sean continued to place complete blame on his abuser at both the 1- and 6-month follow-up sessions (see Figure 35, page 302).

Sean's characterological self-blame score showed a clinically significant decrease from pre- to post-treatment. Prior to treatment, he reported experiencing "a lot" of blame for the kind of person he was with regard to the sexual abuse, but Sean later indicated "slight" characterological self-blame upon completion of the sexual abuse program. However, Sean's characterological self-blame score gradually increased over time and, by 6-month follow-up, it had returned to its high pre-treatment level.

Behavioural self-blame showed virtually no variability over time. At both pre- and post-treatment, Sean reported experiencing no blame for the way in which he acted as it related to the sexual abuse. While the amount of behavioural self-blame increased to "very little" by 1-month follow-up, it returned to its pre-treatment level by 6-month follow-up.

Multidimensional Anger Inventory. As shown in Figure 36 (page 303), Sean's overall anger score revealed a clinically significant decrease at post-treatment but then gradually increased throughout the two follow-up sessions. Following treatment termination, Sean's score was below the mean reported for a normative sample of male university students (M = 110.57; Siegel, 1985). By 6-month follow-up, Sean's overall anger score continued to remain within the normative range, despite its increase from the pre-treatment level.

State-Trait Anxiety Inventory. Prior to the sexual abuse treatment program, Sean's state anxiety score was in the middle range, and it dropped by a clinically significant amount by post-treatment. At this time, Sean's state anxiety level fell at the lower end of the normative range for a sample of university students (M = 38.5, SD = 10.7; Creamer et al., 1995). However, there was a sharp increase in Sean's state anxiety score at 1-month follow-up, and this moderately high level was maintained through to 6-month follow-up (see Figure 37, page 304).

At pre-treatment, Sean's trait anxiety score was considerably high but there was a clinically significant decline by post-treatment, where the level of reported trait anxiety was well-within the normative range for a sample of university students ($\underline{M}$ = 40.4, $\underline{SD}$ = 10.7; Creamer et al., 1995). Following post-treatment, Sean's trait anxiety score increased and returned to its pre-treatment level by 6-month follow-up. Therefore, it would appear that there was no long-lasting clinically significant improvement in Sean's trait anxiety, which was above the range identified for the normative sample.

Self-Monitoring Data

Pleasant Events Schedule. Sean's scores for the Activity Level category of the PES showed fairly steady increases from pre- to post-treatment (see Figure 38, page 305). By post-treatment, his Activity Level score demonstrated a clinically significant 44% increase from pre-treatment and was in the upper range of scores. However, there was a considerable decline in score by 1-month follow-up, and the declining trend was maintained through to 6-month follow-up. At this time, Sean's Activity Level score had returned to a point nearly identical to that at pre-treatment.

At pre-treatment, Sean's score for the Reinforcement Potential category was moderately high, and it rose abruptly by the first assessment session. The scores showed some variability until the fourth assessment session, after which time there was a relatively stable trend through to post-treatment. By post-treatment, Sean's Reinforcement Potential score had shown a clinically significant 30% increase from its pre-treatment level and was at an extremely high level. There were minor fluctuations at the two follow-up sessions. While the Reinforcement Potential score dropped slightly by 6-month follow-up, it continued to remain at a high level that

was 26% greater than the pre-treatment level.

"How I see myself now" Scale. Figure 39 (page 306) indicates that Sean's self-concept scores demonstrated a virtual lack of slope. The highest score occurred at post-treatment, but it revealed only a 19% increase in self-concept from pre-treatment. However, it should be noted that the level was moderately high. Sean's self-concept score decreased slightly by 1-month follow-up, and this level was maintained through to 6-month follow-up. By the time of the longer-term follow-up session, Sean's self-concept score had returned to a point which was approximately equal to that at pre-treatment.

Self-Ratings

Baseline period. The duration of Sean's baseline period was 27 days. During this time, self-blame ratings showed peaks and valleys ranging from 1 to 8. Sean's self-blame means showed an initial decrease followed by a noticeable increasing trend (see Figure 40, page 307). Anger means showed a dramatic increase during the initial portion of the baseline period, followed by relatively stable scores which centered around a mean level of 7.5. Sean's daily anger self-ratings revealed greater initial variability but then fell within a higher and narrower range for the rest of the baseline period. Turning to Sean's anxiety means, there was an initial increase followed by a gradually decreasing trend. Daily self-ratings remained fairly high and showed a moderate range of variability. Despite the decreasing pattern for anxiety, the treatment intervention was started because the baseline period had lasted a relatively long time, and anxiety was the final behaviour to be addressed in treatment so there would be enough time for anxiety to increase again. Table 5 (page 264) presents the overall mean scores for self-blame, anger, and anxiety over phases of the sexual abuse treatment program. Sean's overall mean self-

blame score was the lowest at 4.3, while that of anger was the highest at 6.7. Sean's anxiety mean score fell at 6.3 during the baseline period.

Self-blame phase. This phase of the sexual abuse program involved seven treatment sessions over a 28-day period. Overall, Sean's self-blame scores showed a declining trend from the increasing baseline slope. Initially, Sean's self-blame means showed minimal decreases but then revealed large decreases until the end of the treatment phase (see Figure 40). Despite the decreases, Table 5 indicates that there was an increase in Sean's self-blame ratings from baseline (4.3) to the self-blame treatment phase (5.6). The effect size for Sean's self-blame ratings during baseline compared with those during the self-blame phase was calculated for a change in slope and was found to be $f^2 = 0.20$. This value reveals a medium decrease in Sean's self-blame scores during the self-blame treatment phase (compared to the baseline period).

Sean's daily anger scores during the self-blame treatment phase showed some fluctuation but his anger means were fairly stable. Table 5 shows a considerable increase in Sean's overall mean anger from baseline (6.7) to the self-blame treatment phase (8.1). The effect size for Steven's anger ratings prior to the self-blame phase compared with those during the self-blame phase was calculated for a change in slope and was found to be $f^2 = 0.10$. This value represents a small to medium increase in Sean's anger scores during the self-blame treatment phase (compared to the period before the self-blame phase was implemented).

Sean's mean anxiety scores during the self-blame treatment phase showed stability. There was a reduction in data variability from the period prior to the treatment phase (i.e., baseline). Table 5 indicates that there was a small decrease in Sean's overall mean anxiety score from baseline (6.3) to the self-blame treatment phase (5.9). The effect size for Sean's anxiety

ratings prior to the self-blame phase compared with those during the self-blame phase was calculated for a change in variability and was found to be $f^2 = 1.78$. This value represents a very large reduction in the amount of variability in Sean's anxiety scores during the self-blame treatment phase (compared to the baseline period).

Anger phase. This phase of treatment involved 10 sessions over a period of 49 days. Sean's mean anger scores remained stable until the middle portion of the treatment phase. After this point, mean scores revealed a steadily declining pattern. Overall, Sean's daily anger self-ratings showed only some fluctuations, although there were several instances of considerable drops. Table 5 reveals a considerable decrease in Sean's overall mean anger score during the anger treatment phase (6.4), compared to the entire period prior to the phase (7.4). The effect size for Sean's anger ratings prior to the anger treatment phase (i.e., baseline) compared with those during the anger phase was calculated for a change in slope and was found to be $f^2 = 0.76$. This value represents a very large decrease in Sean's anger scores during the anger treatment phase (compared to the baseline period).

Sean's self-blame means during the anger treatment phase showed stability compared to the self-blame treatment phase. While there were some peaks and valleys in Sean's daily self-blame ratings, they generally fell within the 2 to 4 range of scores. Table 5 indicates that there was a dramatic decrease in Sean's overall mean self-blame from the self-blame phase (5.6) to the anger phase (2.7). The effect size for Sean's self-blame ratings during the self-blame treatment phase compared with those during the anger treatment phase was calculated for a change in slope and was found to be $f^2 = 0.10$. This value represents a small to medium decrease in Sean's self-blame scores during the anger phase (compared to the self-blame phase).

Sean's anxiety scores during the anger treatment phase revealed a reduction in data variability from the period prior to the treatment phase (i.e., baseline). Mean anxiety scores showed slight increases for most of the phase, although there was a decrease between the fifth and sixth means. Table 5 indicates that there was no change in Sean's overall mean anxiety score (6.1) during both the anger treatment phase and the entire period prior to the anger phase. The effect size for Sean's anxiety ratings prior to the anger phase compared with those during the anger phase was calculated for a change in variability and was found to be $f^2 = 1.18$. This value reveals a very large reduction in the amount of variability in Sean's anxiety scores during the anger treatment phase (compared to the baseline period).

Anxiety phase. The anxiety treatment phase included eight sessions over a period of 32 days. Overall, Sean's mean anxiety scores showed a declining trend from the entire period prior to the implementation of the anxiety treatment phase (i.e., baseline). Initially, mean scores remained fairly stable but then revealed considerable reductions toward the end of the treatment phase. Table 5 shows a large decrease in Sean's overall mean anxiety score from baseline (6.1) to the anxiety treatment phase (5.3). The effect size for Sean's anxiety ratings during baseline compared with those during the anxiety phase was calculated for a change in slope and was found to be $f^2 = 0.32$. This value reveals a medium to large decrease in Sean's anxiety scores during the anxiety phase (compared to the baseline period).

Sean's self-blame scores during the anxiety treatment phase showed a reduction in data variability from the previous anger phase. Self-blame means continued to remain low and to show stability. Table 5 indicates that there was a small decrease in Sean's overall mean self-blame during the anxiety phase (2.1), compared with the previous anger phase (2.7). The effect

size for Sean's self-blame ratings during the previous anger phase compared with those during the anxiety phase was calculated for a change in variability and was found to be $f^2 = 1.92$. This value represents a very large decrease in the amount of fluctuation in Sean's self-blame scores during the anxiety phase (compared to the previous treatment phase).

Sean's anger means during the anxiety treatment phase showed overall stability with some fluctuation in daily self-ratings. Table 5 shows a dramatic drop in Sean's overall mean anger from the anger phase (6.4) to the anxiety phase (3.1). The effect size for Sean's anger ratings during the anger phase compared with those during the anxiety phase was calculated for a change in slope and was found to be $f^2 = 0.21$. This value reveals a medium decrease in Sean's anger scores during the anxiety treatment phase (compared to the anger phase).

Significant Other's Weekly Ratings

During the course of the sexual abuse treatment program, Sean was not involved in an intimate relationship with another individual. Thus, no data on Sean's feelings of self-blame, anger, and anxiety, as perceived by a significant other, were obtained.

Client Satisfaction Questionnaire

At post-treatment, Sean's score of 32 indicated a high level of consumer satisfaction with the sexual abuse treatment program. With regard to the self-blame treatment component, Sean found all of the activities helpful and stated that the information and learning from these activities seemed to "come together for me when expressed by the collage," which was constructed during the anger component. Turning to the anger treatment component, writing a letter to his abuser was reported to be especially beneficial for Sean. As well, he noted that constructing a collage and exploring the manner in which anger masks a wide range of other

feelings were powerful exercises. Finally, Sean reported a number of helpful activities during the anxiety treatment component, namely the cognitive restructuring exercise, thought stopping procedure, and progressive muscle relaxation.

Feedback Questionnaires

Sean provided much feedback about the sexual abuse treatment program. His overall impressions were highly favourable, and he stated being extremely pleased with treatment. Sean identified the therapeutic relationship as the most helpful aspect of the treatment program. He wrote, "I felt comfortable, safe, and trusting with you. At all times you provided support and showed compassion for me, my experiences, and the ways I tried to cope with the hurt and sadness. Your compassion was reassuring and an affirmation of care. I was also deeply touched by your willingness to create a treatment program specific to the needs of male survivors. I have often felt like a statistical anomaly, someone who slipped through the cracks and was simply being left behind. That you reached out to someone like me touches my heart in a way that I can never adequately express." While Sean did not identify any parts of the treatment program as being unhelpful, he stated that he would have benefitted from more unstructured time in order to explore in greater detail some of the issues that arose from the more structured activities.

With regard to the impact of the intervention, Sean reported having gained a greater awareness of abuse-related issues, such as the manner in which anger can sometimes cover up more painful emotions of hurt and loss. Sean also stated, "I am feeling much better about myself as a person and have a greater degree of self-acceptance. I am also feeling noticeably much less depressed and more happy about myself as a person. I am much better prepared to meet the remaining challenges of my abuse and to move on to enjoy life to the fullest possible extent." As

a result of the treatment program, Sean stated the need to continue exploring two areas, namely his difficulties related to sexual intimacy (e.g., trust, vulnerability, body image) as well as his fragmented memories and nightmares of possible, additional sexually abusive experiences. Sean did not report having any expectations of the treatment program prior to its commencement. However, he stated finding the program an enlightening, positive, and meaningful experience.

At 1-month follow-up, Sean continued to find the relaxation exercise to be helpful in coping with anxiety. However, Sean reported feeling highly depressed and having little interest in anything. He said he often thinks about disappearing and finding a place where he could live all by himself or ending his life. (It should be noted that, after receiving this feedback from Sean, he was notified and encouraged to contact his psychiatrist as well as additional mental health services).

Feedback at 6-month follow-up indicated that Sean had made several improvements since the previous follow-up session. In particular, the frequency and intensity of his nightmares (of what he perceived to be additional sexual abuse experiences) and accompanying fear declined considerably. He was also involved in a group program for depression and maintained regular contact with his psychiatrist as well as a counsellor. However, Sean continued to struggle with strong feelings of unhappiness with his life. He elaborated on his feelings by noting that "it is not a crisis or dramatic event - just a slow unfolding in which I am like a bystander watching my life go through its motions and play itself out. In some sense I am quite detached from it all." In addition, Sean stated that he is re-experiencing strong feelings of anger and violent daydreams, which he attributes to attempts being made by his mother and step-father to contact him.

Overall Findings For the Five Participants

Self-Report Data

Beck Depression Inventory. Four participants (Steven, Stan, Scott, Sean) made clinically significant improvements in depression from pre- to post-treatment. Three of the four participants (Steven, Stan, Sean) scored in the "minimal depression" category, while Scott scored in the "mild depression" category. All four participants were within the normative range. It should be noted that, while the amount of change in Samuel's depression score was not clinically significant, his depression level was mild and just outside of the normative range.

By 6-month follow-up, four participants (Steven, Samuel, Stan, Scott) showed clinically significant improvements in self-reported feelings of depression from pre-treatment. Two participants (Samuel, Stan) scored in the "minimal depression" category, Steven scored in the "mild depression" category, and Scott scored in the "moderate depression" category. Three participants (Steven, Samuel, Stan) fell within the normative range of depression scores, while Scott fell just outside of the normative range. It should be noted that, while the amount of change in Sean's depression score did not remain clinically significant by 6-month follow-up, his depression level was mild and within the normative range.

Self-Esteem Scale. Three participants (Steven, Stan, Scott) showed a clinically significant increase in self-esteem from pre- to post-treatment. However, all five participants had self-esteem scores that fell within the normative range. By 6-month follow-up, two participants (Stan, Scott) continued to show clinically significant improvements in self-esteem from pre-treatment. Three participants (Samuel, Stan, Scott) scored within the normative range of self-esteem scores.

The Blame Scale. Only Stan showed a clinically significant increase in his amount of abuser blame from pre- to post-treatment and through to 6-month follow-up. However, post-treatment revealed that four participants (Samuel, Stan, Scott, Sean) placed complete blame for their sexual victimization on the abuser, and by 6-month follow-up, all five participants placed complete or almost complete blame on the abuser.

Turning to characterological self-blame, four participants (Steven, Samuel, Stan, Sean) reported clinically significant decreases from pre- to post-treatment. Two of the four participants (Steven, Stan) scored at the "very little" level. By 6-month follow-up, only Samuel continued to show a clinically significant decrease from pre-treatment, arriving at a level where he indicated "very little" characterological self-blame.

Turning to behavioural self-blame, three participants (Steven, Samuel, Stan) reported decreases from pre- to post-treatment that achieved clinical significance. All three participants reached a level where they indicated "very little" or no behavioural self-blame. At post-treatment, it should be noted that Sean also reported an absence of behavioural self-blame. By 6-month follow-up, the same three participants maintained a clinically significant decrease in behavioural self-blame from pre-treatment, with all indicating "very little" or no behavioural self-blame. As well, Sean continued to report an absence of behavioural self-blame.

Multidimensional Anger Inventory. Three participants (Steven, Stan, Sean) showed a clinically significant decrease in overall anger from pre- to post-treatment, with all three endorsing a level of anger that fell within the normative range. It should be noted that Samuel also scored within the normative range of overall anger. By 6-month follow-up, three participants' (Steven, Stan, Scott) overall anger scores showed a clinically significant decrease

from pre-treatment. These participants, along with Samuel, had levels of overall anger that fell within the normative range.

State-Trait Anxiety Inventory. With regard to state anxiety, four participants (Steven, Stan, Scott, Sean) reported a clinically significant decrease from pre- to post-treatment. Three of the four participants (Steven, Stan, Sean) had scores which fell within the normative range. It should be noted that Samuel also scored within the normative range. By 6-month follow-up, three participants (Samuel, Stan, Scott) made clinically significant improvements in state anxiety, and two participants' (Samuel, Stan) scores were within the normative range.

Turning to trait anxiety, four participants (Steven, Stan, Scott, Sean) indicated decreases from pre- to post-treatment that achieved clinical significance. Three of the four participants (Steven, Stan, Sean) had scores that fell within the normative range. By 6-month follow-up, four participants (Steven, Samuel, Stan, Scott) showed clinically significant decreases in self-reported trait anxiety. Three of the four participants (Steven, Samuel, Stan) scored within the normative range.

Self-Monitoring Data

Pleasant Events Schedule. With regard to Activity Level, three participants (Steven, Stan, Sean) indicated a clinically significant increase, but only Sean reported a level that was in the upper range of scores. By 6-month follow-up, three participants' (Steven, Samuel, Stan) scores reached clinical significance, but only Stan's score fell at a high level.

Turning to Reinforcement Potential, two participants (Steven, Sean) indicated a clinically significant increase. These participants, along with Stan, had scores which were at the high level of all possible scores. By 6-month follow-up, only Scott reported a clinically

significant improvement in Reinforcement Potential. However, two participants (Stan, Sean) had scores that fell at the high level.

"How I see myself now" Scale. Three participants (Steven, Stan, Scott) reported clinically significant increases in self-concept. Two participants (Stan, Sean) had scores that fell at a moderately high level. By 6-month follow-up, two participants (Stan, Scott) continued to indicate clinically significant increases in self-concept, but only Stan's score fell at a moderately high level.

Self-Ratings

Baseline period. The average length of baseline for the five participants was 24 days (range from 13 to 36 days). Anger showed the highest overall mean for three participants (Steven, Scott, Sean). Samuel's highest overall mean during baseline was for self-blame, while Stan's highest overall mean was for anxiety. Anxiety showed the lowest overall mean for two participants (Steven, Samuel), while self-blame was the lowest overall mean for two other participants (Scott, Sean). Stan's lowest overall mean during baseline was for anger.

Self-blame phase. The average number of sessions for the five participants was 5 (range from 3 to 7) over a 30-day period (range from 26 to 36 days). Only two participants (Stan, Sean) completed all the activities in the self-blame treatment phase. The three remaining participants ended the treatment phase after examination of sexual abuse myths and misinformation. Concerning overall mean self-blame scores, all five participants showed moderate to large decreases from baseline to the self-blame treatment phase. Turning to effect sizes, four participants' (Steven, Stan, Scott, Sean) data showed a change in slope during the self-blame treatment phase, compared to the baseline period. Two of the four participants (Steven, Sean)

reported a medium decrease. Stan's effect size showed a large decrease, while Scott's effect size revealed a small decrease. Samuel's self-blame scores during the self-blame treatment phase showed a medium reduction in variability, compared to baseline.

Turning to anger scores during the self-blame treatment phase, overall anger means revealed that two participants (Steven, Samuel) experienced decreases from baseline to the self-blame treatment phase. Stan reported a small increase in overall anger mean, while Sean reported a considerable increase. Scott's overall mean anger score showed no change from baseline to the self-blame treatment phase. Turning to effect sizes, two participants' (Steven, Sean) anger data showed a change in slope during the self-blame treatment phase, compared to the baseline period. Steven reported a large decrease, while Sean's effect size showed a small to medium decrease. Two participants' (Samuel, Scott) data showed a large reduction in variability from baseline to the self-blame phase, while Stan indicated a small decrease in the level of anger when the data show a trend.

Turning to the overall mean anxiety scores from baseline to the self-blame treatment phase, two participants (Steven, Scott) reported considerable increases while two participants (Samuel, Stan) reported considerable decreases. Sean reported only a small decrease in overall anxiety during the self-blame phase, compared to baseline. Concerning effect sizes, three participants' (Samuel, Stan, Scott) anxiety data showed a change in slope during the self-blame treatment phase, compared to the baseline period. Two of the three participants (Samuel, Stan) reported a small decrease, while Scott's effect size showed a medium decrease. Sean's data showed a large reduction in variability from baseline to the self-blame phase, while Steven indicated a large increase in overall anxiety mean during the self-blame phase.

Anger phase. The average number of sessions for the five participants was 9 (range from 6 to 10) over a 49-day period (range from 38 to 72 days). None of the participants completed all the activities during the anger treatment phase. Four participants (Steven, Samuel, Stan, Scott) ended the anger phase after examining ways of expressing anger constructively and safely. Sean completed the anger phase after exploring revenge fantasies through the construction of an abuse collage. Regarding overall mean anger scores, four participants (Steven, Samuel, Stan, Sean) reported considerable decreases from baseline to the anger treatment phase, while Scott's overall anger mean did not change. Turning to effect sizes, three participants' (Steven, Stan, Sean) data showed a change in slope during the anger treatment phase, compared to the baseline period. Steven reported a small to medium decrease, while Stan reported a medium to large decrease. Sean's effect size showed a large decrease in anger scores during the anger treatment phase. Samuel reported a large decrease in overall anger mean from baseline to the anger treatment phase, while Scott's effect size for a change in anger level when the data show a trend was small to medium.

Turning to self-blame scores during the anger treatment phase, all five participants reported considerable decreases in overall self-blame means from the self-blame treatment phase to the anger treatment phase. Turning to effect sizes, three participants' (Steven, Samuel, Sean) self-blame data showed a change in slope during the anger treatment phase, compared to the self-blame phase. Two of the three participants (Samuel, Sean) reported a small to medium decrease, while Steven's effect size showed a medium to large decrease. The two remaining participants (Stan, Scott) indicated a small decrease in the level of self-blame when the data show a trend.

Turning to the overall mean anxiety scores from baseline to the anger treatment phase, two participants (Steven, Samuel) reported small decreases while Stan reported a considerable decrease. Scott's data indicated a small increase in overall anxiety while Sean's overall anxiety mean did not change from baseline to the anger treatment phase. Concerning effect sizes, two participants' (Steven, Scott) anxiety data showed a change in slope during the anger treatment phase, compared to the baseline period. Scott reported a small to medium decrease, while Steven's effect size showed a medium to large decrease. Two other participants (Samuel, Stan) reported a change in anxiety level when the data show a trend. While Samuel's data showed a small increase in anxiety level, Stan's effect size showed a small decrease in anxiety level. Finally, Sean's data showed a large reduction in anxiety variability from baseline to the anger phase.

Anxiety phase. The average number of sessions for the five participants was 6 (range from 3 to 8) over a 29-day period (range from 11 to 39 days). All five participants completed all of the activities in the anxiety treatment phase. Regarding overall mean anxiety scores, all five participants reported large decreases from baseline to the anxiety treatment phase. Turning to effect sizes, two participants reported a change in overall anxiety mean that was medium to large (Steven) and large (Scott). Data for two other participants (Samuel, Stan) indicated a change in anxiety level when the data show a trend. Samuel reported a medium to large decrease in anxiety level, while Stan's effect size for a change in level when the data show a trend was small. Finally, Sean reported a change in anxiety slope during the anxiety treatment phase, compared to the baseline period. His effect size indicated a medium to large decrease.

Regarding overall mean self-blame scores during the anxiety treatment phase, two

participants (Steven, Sean) reported small decreases from the previous anger treatment phase while two other participants (Stan, Scott) reported moderate decreases. Samuel's overall self-blame mean did not change from the anger to the anxiety treatment phase. Turning to effect sizes, two participants' (Stan, Scott) self-blame data showed a change in slope during the anxiety treatment phase, compared to the previous anger phase. Stan reported a large decrease, while Scott's effect size showed a small decrease. Two other participants (Steven, Sean) reported a large reduction in self-blame variability during the anxiety treatment phase. Finally, an effect size for Samuel was not calculated as his data remained the same from the anger treatment phase to the anxiety treatment phase.

With regard to overall mean anger scores during the anxiety treatment phase, all five participants reported large decreases. Turning to effect sizes, two participants' (Steven, Sean) anger data showed a change in slope during the anxiety treatment phase, compared to the previous anger phase. Sean reported a medium decrease, while Steven's effect size showed a medium to large decrease. Two other participants (Samuel, Scott) indicated a large decrease in overall anger mean from the anger treatment phase to the anxiety treatment phase. Finally, Stan's effect size for a change in anger level when the data show a trend was negligible during the anxiety treatment phase.

Significant Other's Weekly Ratings

No data were collected by significant others for any of the participants. Three participants (Steven, Stan, Sean) were not involved in an intimate relationship during the duration of the sexual abuse treatment program. The two remaining participants (Samuel, Scott) were involved in relationships that were neither long-term nor stable.

Client Satisfaction Questionnaire

Four participants (Steven, Samuel, Stan, Sean) reported a high level of consumer satisfaction with the sexual abuse treatment program, while Scott's level of satisfaction was medium. Regarding the specific treatment components, two participants (Steven, Stan) stated that exploration of sexual abuse myths was particularly beneficial. Two other participants (Samuel, Scott) reported that examination of the differences between a child and an adult (or older person) was especially helpful, while Sean stated that all of the self-blame exercises were equally helpful. Turning to the anger phase, three participants (Steven, Stan, Sean) identified the letter writing activity to be especially beneficial. Two participants (Stan, Scott) also found exploration of the emotions underlying anger to be helpful. Samuel reported that all of the anger-related activities were helpful in helping him learn how to recognize and express anger in an appropriate manner. Finally, with regard to the anxiety treatment phase, four participants (Steven, Samuel, Scott, Sean) reported that the progressive muscle relaxation activity was helpful. (It should be noted that Stan had already learned this technique in an anxiety group in which he had previously participated). Three participants (Stan, Scott, Sean) also found the thought stopping procedure to be beneficial in managing their anxiety.

Discussion

The present study examined the two clinically important areas of childhood sexual abuse and treatment effectiveness. Through its focus on sexually abused males, the study aimed to elucidate important treatment considerations for this (until recently) relatively neglected population and to evaluate the utility of a treatment program for their abuse-related issues. Overall findings suggested that the treatment program shows promise in effectively addressing

some of the important issues surrounding an individual's past sexual victimization. In the present section, the global findings for all five participants will be considered. Each participant's progression through the sexual abuse treatment program will then be individually evaluated. Finally, there will be an examination of the benefits and limitations of the present study, along with clinical and future research recommendations in the area of sexual abuse.

Summary and Implications of Overall Findings

Self-blame. Interventions introduced during the self-blame treatment phase appeared to have made an impact in decreasing all participants' levels of guilt and responsibility over their childhood sexual abuse. The interventions which were particularly helpful included an exploration of the ways in which the offender engaged the participant in the sexual activity and made him feel responsible for the abuse as well as an examination of sexual abuse myths, especially those related to masculinity and sexual orientation, physiological arousal to the sexual activity, and lack of disclosure. While the self-blame interventions contributed to a reduction in some participants' feelings of anger and anxiety, the changes were typically not as considerable as those for self-blame. Theoretically, the overall findings suggest that, while feelings of self-blame, anger, and anxiety are not completely independent of one another, they are, nonetheless, distinct enough to show differential responses to specific treatment interventions. Clinically, the findings imply that individuals may generalize some benefits from self-blame interventions to other areas of functioning, but the benefits most probably will not be as considerable or long-lasting as those for self-blame. At a research level, the overall findings indicate that the present study met the requirements of a multiple-baseline across behaviours design, at least for the self-blame phase of treatment.

Six months after the treatment program had ended, most participants appeared to experience minimal feelings of responsibility for their childhood actions during the time of their sexual abuse. However, some of the participants continued to struggle with feelings of characterological self-blame. Clinically, these findings imply that it may be easier for individuals to understand that their childhood actions were not responsible for their sexual abuse than to accept that they were not sexually abused because of who they were as children (i.e., their character). Another clinical implication, based on the present study's overall results, is that there may not necessarily be an inverse relationship between abuser blame and self-blame. While all participants placed complete blame for their sexual victimization on the abuser, most still continued to report some degree of self-blame. Similar results were reported by Hunter et al. (1992), who concluded that there is a lack of clarity among males about victim-abuser boundaries as well as an excessive concern with issues of control and independence.

Anger. It would appear that the anger treatment phase made an impact in reducing the level of anger for most of the participants in the present study. Interventions that seemed to be particularly beneficial included the empty chair activity in which participants composed and read aloud a letter to their offender and the exploration of emotions that may sometimes underlie anger and rage. The anger-related interventions also appeared to slightly lower some participants' feelings of self-blame and anxiety, although these improvements were not as dramatic as those for anger. Thus, while there seemed to be some interdependence between self-blame, anger, and anxiety, the requirements of the multiple-baseline design were still maintained.

Most participants continued to experience lowered feelings of anger even months

following the completion of the sexual abuse treatment program. Keeping in mind the finding that males often "bury" more difficult feelings with anger, which then becomes an all-encompassing emotion (Blanchard, 1986; Crowder, 1995; Napier-Hemy, 1994), the fact that most participants in the present study reported a considerable decrease in anger seems important. At a clinical level, the findings imply that participants began to explore the more difficult feelings (e.g., sadness, hurt, loss, vulnerability) underlying their anger and that they were able to more clearly identify what they were feeling (i.e., what was and was not anger). In order for this development to occur, it seemed that participants first needed to fully express their anger and rage over the sexual victimization and to have these feelings validated in a supportive environment.

Anxiety. While most participants experienced a reduction in feelings of anxiety following the anxiety treatment phase, the changes did not appear to be in direct response to anxiety-related interventions. Nonetheless, it should be noted that the progressive muscle relaxation exercise did appear to make a small contribution to decreasing anxiety. During the anxiety phase of treatment, some participants also experienced lowered feelings of anger. However, the changes were not marked and were not in response to any specific anxiety-related intervention. Theoretically, the overall findings suggest some interdependence between feelings of anger and anxiety related to sexual abuse. Clinically, the overall findings imply that the treatment interventions during the anxiety phase were not highly effective in reducing participants' abuse-related anxiety. One of the difficulties appears to be related to the timing of the anxiety treatment phase. By the time participants progressed to the anxiety treatment phase, their levels of anxiety had decreased somewhat from pre-treatment. While the decreases were

not considerable, they, nonetheless, made it more difficult to notice dramatic changes in response to treatment interventions. At a research level, the overall findings suggest that the requirements of a multiple-baseline across behaviours design were not met for the anxiety phase of treatment.

While overall findings suggested that treatment interventions were not particularly helpful in reducing anxiety, it would appear that participants, nonetheless, reported reduced levels of anxiety six months after treatment had ended. These reductions seemed to occur with both situation-specific as well as the more underlying type of anxiety. Theoretically, the findings imply that state and trait anxiety may not be mutually exclusive types of anxiety but, rather, may affect one another. At a clinical level, decreased state anxiety seems important because it implies that, months after the end of treatment, participants still appeared to be experiencing less situational anxiety. One may speculate that having examined past abuse issues in a therapeutic setting not only affected participants' intrapersonal functioning but also had an impact on their experiences in the "outside world." It may be that there is a positive association between the amount of difficulty with which one struggles within oneself and that which one experiences in their environment. The finding of reduced trait anxiety also seems important, given that it is relatively difficult to modify (Creamer et al., 1995). It may be that, through exploration of the ways in which sexual abuse contributed to participants' heightened sensitivity to danger, they were eventually able to more realistically appraise situations and/or find alternative ways of coping with perceived danger.

Depression. Having been involved in the treatment program seemed to have had a positive impact on participants' feelings of depression, even though this area was not directly

targeted through the treatment interventions. This finding suggests that, for the majority of participants, the benefits derived from the sexual abuse treatment program generalized to an area not specifically addressed (i.e., depression), and these benefits also generalized over the long-term. At a theoretical level, these results imply that there is a relationship between depression and feelings of self-blame, anger, and anxiety. This positive correlation has, in fact, been demonstrated by several researchers (Feinauer & Stuart, 1996; Hoagwood, 1990). In terms of research, these results suggest that including depression with certain other behaviours (i.e., self-blame, anger, anxiety) in a multiple-baseline design may be problematic. Specifically, the strong relationship between these sets of variables may lead to problems of interdependence, which may make it difficult to draw clear conclusions about research findings. Finally, the findings imply that treatment for depressed individuals need not only focus on specific depression-related interventions but may also incorporate additional, more general clinical interventions. The findings also suggest that individuals may not necessarily be limited in the amount of benefit they derive from a structured sexual abuse treatment package that addresses only several specific issues, such as that employed in the present study.

Six months following the completion of the treatment program, most participants continued to engage in pleasurable activities at a frequency that was considerably greater than before the treatment program began. Theoretically, one implication of the finding concerning activity frequency may be that, as participants progressed through treatment and as their sense of shame and secrecy about the sexual abuse diminished, they felt more comfortable to increase their participation in outside activities and to re-establish social contacts. While the amount of enjoyment derived from activity did not appear to be dramatically affected by the sexual abuse

treatment program, one may speculate that, as individuals become more active (i.e., make a behavioural change), their associated feelings of pleasure and enjoyment will also eventually show an improvement (i.e., they will make affective and cognitive changes).

Research has shown that the frequency of activity, and especially the enjoyability of activity, is correlated with depression level (Rose & Staats, 1988). This relationship was certainly observed in the overall results of the present study. At a research level, these findings would appear to indicate a certain amount of concurrent validity between measures of depression and those of activity frequency and enjoyment.

Self-esteem. The treatment program appeared to have made a considerable long-term impact in improving feelings of self-worth for some of the participants. This finding is interesting because self-esteem was not an area that was specifically targeted through the sexual abuse treatment interventions. Thus, it would seem that there was some degree of generalization across behaviours and over time for feelings of self-worth. However, the effect was not dramatic. One implication is that, in order to have a greater impact on individuals' self-esteem, clinical interventions may need to be more specifically tailored to esteem-related issues. Also, given that self-esteem involves questions of basic identity and that sexual abuse often severely affects individuals' sense of identity, it may be reasonable to expect that a more lengthy and focused exploration of self-esteem issues is needed before any improvements are noticed. Research-related issues concern the nature of the self-esteem measure as well as the psychometric information used in the present study. The self-esteem questionnaire used in the study provided a unidimensional measure of self-worth. While this measure was satisfactory for purposes of the present study, it may be important to incorporate additional measures that assess

specific dimensions of self-esteem (e.g., feelings about one's physical, social, emotional, and sexual self). This added information may help clarify what aspects of self-esteem may and may not be affected by sexual abuse treatment interventions. Regarding psychometric data, conclusions about the clinical significance of self-esteem changes were based on information from a sample of non-abused adult women, as no such information could be located for non-abused adult males. While the literature suggests similarities in self-esteem among men and women, it may be important to establish norms specific to adult males.

Self-concept. Interventions during the sexual abuse treatment program appeared to have had a positive impact on some of the participants' self-concept. Hence, there was some degree of generalization across behaviours and over time. It is interesting to note that the same participants who reported a considerable increase in self-concept also reported a considerable increase in self-esteem. Theoretically, this finding implies a certain degree of conceptual similarity between the constructs of self-esteem and self-concept. Given the similarity, some of the clinical implications previously considered for participants' self-esteem may also be applicable for issues related to self-concept. At a research level, the present study looked at the overall self-concept score. It may also be important to consider the different subscales of the self-concept measure in order to further delineate what specific aspects of self-concept are and are not affected by sexual abuse treatment interventions.

Evaluation of Steven's Sexual Abuse Treatment Experience

Pre-treatment. Prior to treatment, Steven identified a number of factors as contributing to his feelings of self-blame, anger, and anxiety. His inability to end contact with his father as well as his perceived defensiveness around his parents seemed to result in intense feelings of guilt

and self-blame. Several of the reported reasons for Steven's anger included anticipation of his parents' visits, a sense of powerlessness in their presence, and "hatred of father." Finally, it seemed that much of Steven's anxiety was related to continual attempts to cope with the effects of his sexual abuse and to fears that he would one day "blow up" at his parents. In sum, it would appear that many of Steven's feelings of self-blame, anger, and anxiety were related to contact with his parents (and his father in particular) and to the fact that Steven felt highly conflicted about confronting his parents with the sexual abuse.

Treatment. As Steven began the treatment program, sessions focused on addressing the origins of his self-blame feelings, exploring issues of responsibility and power related to the sexual abuse, and examining sexual abuse myths. Interventions during this self-blame treatment phase seemed to result in a reduction of Steven's feelings of guilt and responsibility over his childhood sexual victimization. In particular, examination of the manner in which his father engaged him in sexual activity and made him feel responsible for the abuse seemed to contribute greatly to lowering Steven's feelings of self-blame. This intervention provided Steven with a better understanding of the many ways in which his father made him feel confused and helpless through the sexual abuse, physical punishment, inconsistent discipline, and power that he exerted over his son. Steven also reported beginning to understand the lack of choices that he had, as a child, regarding the sexual activity with his father.

Exploration of sexual abuse myths (e.g., same-sex abuse among males will result in the development of a homosexual orientation, physiological responses to sexual abuse imply that the child somehow wanted or enjoyed the experience) also seemed particularly helpful in lowering Steven's feelings of blame over his childhood sexual victimization. Regarding the myth that a

male who is sexually abused by another male will become homosexual, Steven's concerns were not centered around his sexual orientation per se but rather around the implications of this myth for his relationship with his father. More specifically, Steven stated that, if he accepted that his sexual orientation was determined by the sexual experience with his father, it would reveal yet another manner in which his father "wielded control over me." Through further examination of this myth, Steven eventually began to perceive his father more as a helpless and "pathetic" individual rather than someone who is powerful.

While the focus of sessions during the self-blame treatment phase was on feelings of guilt and responsibility for the abuse, Steven also seemed to experience some improvements in his abuse-related feelings of anger. In particular, exploring the differences between a child and an adult as a way of understanding issues of power and responsibility for sexual abuse seemed to have made an impact in lowering some of Steven's anger. This intervention seemed to provide Steven with an opportunity to tap some of the sadness underlying his anger, and he began to mourn the absence of a positive and loving relationship with his father. As well, Steven began to consider the possible intergenerational transmission of abuse by wondering whether his father (as well as other family members) may have also been victims of sexual abuse. It seems important to mention that, while Steven reported a decrease in his angry feelings, this improvement was not as great as that for Steven's self-blame. In addition, compared with anger, Steven reported more consistent decreases in his feelings of self-blame during the self-blame phase of treatment.

As Steven entered the anger treatment phase, sessions focused on abuse-related anger (e.g., toward whom does Steven feel anger, ways in which anger has and has not been helpful,

fears about expressing anger, feelings that underlie anger) and engaged Steven in activities which allowed him to express feelings of anger (e.g., writing a letter to the offender, identifying ways to express anger safely and constructively). Interventions during this treatment phase appeared to have made an impact in decreasing Steven's feelings of anger over his childhood sexual victimization. While Steven did not experience an immediate reduction in anger in response to treatment sessions, this finding is not unusual and points to the common therapeutic process of individuals often feeling worse before they get better (Briere, 1996). To elaborate further, Steven's primary method of coping with anger prior to treatment was through avoidance. Thus, he had had little opportunity to intensely examine and work through his abuse-related anger, which he did to a considerable extent during the anger treatment phase. Another important point concerning the initial lack of decrease in Steven's anger involved his ambivalence. In particular, Steven identified his anger as protective and stated, "it is my last line of defence against a flood of emotions."

Several interventions seemed to have made an important impact in alleviating Steven's feelings of anger over his sexual victimization. Exploring fears about expressing anger, identifying difficult feelings underlying anger (e.g., hurt, sadness, vulnerability), and reading a letter he had composed to his father were particularly powerful activities for Steven. Looking more closely at the letter-writing activity, Steven had the opportunity to express his anger without having to worry about his father's possible reaction. Unlike his usual feelings of helplessness around his father, Steven's experience during the letter-writing activity was that of reclaiming some sense of power and control over his own life. It also seems important to note that, shortly following the letter-writing exercise, Steven made the decision to discontinue

contact with his parents, whom he felt were "destructive to my mental well-being."

During the time that Steven was addressing his abuse-related anger, an important development occurred in the therapeutic relationship. Steven expressed ambivalence about continuing with the anger work because of concerns connected to "letting go" of his anger. He reported experiencing considerable fear and lack of control, and Steven commented that the therapist was pushing him to do something against his will. The therapist supported Steven's ambivalent feelings and accepted his anger towards her. Through further exploration, Steven was able to acknowledge that his anger was linked to concerns over whether the therapist would take advantage of his vulnerability should he examine his anger in greater detail. He also stated that it was easier to blame the therapist than to take responsibility for his own feelings. This particular interaction between Steven and the therapist appeared to have made a significant impact in decreasing his feelings of anger and in strengthening the therapeutic relationship.

While Steven experienced a considerable reduction in anger during the anger treatment phase, there also appeared to be some improvement in his feelings of anxiety. However, unlike Steven's decrease in anger, the improvement in his anxiety did not seem to be linked to any particular treatment intervention. In addition, the extent of Steven's anxiety reduction during the anger phase of treatment was not as great as that for his feelings of anger.

As Steven entered the final phase of treatment, sessions addressed the relationship between his sexual abuse experience and feelings of anxiety. As well, cognitive restructuring and behavioural (i.e., progressive muscle relaxation) techniques were introduced in order to help Steven cope with his anxious feelings. It would appear that, while Steven's anxiety decreased following this treatment phase, there was no one intervention that seemed to make more of an

impact in reducing his feelings of anxiety. Steven explained that it was more difficult to connect his anxiety to his sexual abuse experience because he had been struggling with intense anxiety since childhood, and these feelings had generalized to many other areas in his life. In addition, it seems important to note that, during the final stages of treatment, Steven was encountering a number of events which he perceived to be quite anxiety-arousing. Specifically, Steven had visited with his father following weeks of no contact, one of his close friends had died, and he was attempting to reduce his anti-anxiety medication (in conjunction with his psychiatrist).

Follow-up. Six months after Steven had completed the sexual abuse treatment program, he did not appear to be experiencing considerable problems of depression, anger, or anxiety. He also seemed to have clarified issues of responsibility and blame over his childhood sexual victimization. It would appear that these positive changes were occurring at a time when Steven was also gaining more enjoyment from his participation in community and social activities. While Steven had increased his involvement in enjoyable activities, he had also substantially decreased the amount of contact with his parents, whose "conspiracy of silence" over the sexual abuse led Steven to experience intense feelings of anger, conflict, and rejection.

Steven's lowered feelings of depression and increased enjoyability of activities seem consistent with research findings that the amount of pleasure one derives from activities is closely linked with depression (Rose & Staats, 1988). Hoagwood's (1990) study of sexually abused women found a correlation between self-blame and feelings of depression and low self-concept. Looking more closely at this finding, it seems important to maintain the distinction between behavioural and characterological self-blame. Over the course of the treatment program, Steven acquired an understanding of how he attempted to "make sense of a situation

that was out of control" by attributing sexually abusive incidents during childhood to his "bad" behaviour. This understanding seemed to help decrease Steven's sense of self-blame over his childhood behaviour, although not necessarily his sense of self-blame over the type of child that he was. Thus, it would appear that Steven's lowered sense of behavioural self-blame (rather than characterological self-blame) was more closely linked with his decreased feelings of depression. This idea is based on the work of Janoff-Bulman (1979), who noted that characterological self-blame is esteem-related and, as such, more closely related to self-concept and feelings of worth. The fact that Steven continued to struggle with both a sense of blame over the type of person he was as well as feelings of self-worth seems to offer some support for Janoff-Bulman's (1979) findings. However, it would seem that further exploration of the differential impact of characterological and behavioural self-blame on psychological functioning is required.

As previously mentioned, the treatment program seemed to have contributed to lowering Steven's feelings of anxiety, particularly his more underlying trait anxiety. This accomplishment would appear to be especially important given Creamer et al.'s (1995) statements that trait anxiety is relatively resistant to modification. While Steven's more situation-specific anxiety was relatively high after the end of the treatment program, several points must be considered. First, given that Steven had considerably increased his participation in activities at this point in time, it would seem to make sense that his chances of experiencing more anxiety would also increase. In addition, some of the situations with which Steven was dealing seemed especially anxiety-provoking. For example, he was seriously thinking about returning to his university studies which he had to abandon, in part, because of his overwhelming anxiety. As well, Steven continued to struggle with the future of his relationship with his parents and, in particular, with

his father.

Evaluation of Samuel's Sexual Abuse Treatment Experience

Pre-treatment. Prior to the start of the sexual abuse treatment program, Samuel identified several reasons for his self-blame, anger, and anxiety. Feelings of self-blame seemed related to Samuel not having avoided or stopped the sexual abuse (as a child) and to having enjoyed certain aspects of the sexual activity. Samuel also experienced much guilt over his excessive focus on sexual activity, which he perceived to be related to his childhood sexual experiences. Samuel reported a great deal of anger over the many ways in which he felt his sexual abuse had negatively impacted on his life (e.g., relationship difficulties, alcohol problems, "addiction to sex"). Finally, it would appear that much of Samuel's anxiety prior to treatment was linked to concerns over having to disclose and explore his sexual abuse experiences with the therapist.

Treatment. During the self-blame treatment phase, sessions addressed the origins of Samuel's self-blame feelings, explored issues of responsibility and power related to his sexual abuse experience, and examined sexual abuse myths. It would appear that these sessions contributed to decreasing Samuel's feelings of guilt and responsibility over his childhood sexual abuse. There were several interventions which seemed to be particularly helpful for Samuel. Examination of the ways in which the offender engaged Samuel in the sexual activity and attempted to free himself from responsibility for the abuse seemed to lower his self-blame feelings. Samuel reported beginning to understand how his childhood needs for attention, acceptance, and companionship were sometimes met by the offender. As well, Samuel reported that his offender often engaged him in sexual activity by presenting him with things which are difficult for children to resist (e.g., candy, playing games). Exploration of several sexual abuse

myths (e.g., the influence of same-sex abuse on masculinity and sexual orientation, the implications of having responded physiologically to the sexual activity) also seemed important in alleviating some of Samuel's self-blame surrounding his sexual victimization. Debunking the myth about physiological arousal during the sexual activity seemed particularly helpful for Samuel, who had equated his arousal with consent and enjoyment of the sexual abuse.

During the therapeutic work on sexual abuse myths, there was an important development which seemed to have made an impact on Samuel's sense of self-blame. Samuel disclosed that, since late adolescence, he had been involved in a sexual relationship with an older male. He described the relationship as abusive and stated that he "spaces out" during the sexual activity. Nonetheless, Samuel acknowledged that some of his needs were being met through the relationship (e.g., companionship, acceptance, attention). The therapist supported Samuel's highly difficult disclosure and used the opportunity to further explore his feelings about the relationship as well as similarities between the present sexual relationship and that which occurred during his childhood. Following the disclosure, Samuel seemed less conflicted about issues of self-blame, and he was able to begin "letting go" of his sense of guilt over the sexual activity. Nonetheless, Samuel still continued to struggle with issues of guilt and responsibility at various points throughout treatment. In particular, it seemed difficult for Samuel to examine his abuse from a child's perspective and to accept that the offender's lack of physical force (both when he was a child and with his more recent sexual relationship) did not imply that Samuel had consented to the sexual activity.

While sessions during the self-blame phase focused on issues of guilt and responsibility related to the sexual abuse, Samuel also experienced some reduction in his feelings of anger and

anxiety. The disclosure of his on-going sexual relationship with an older male seemed to be a powerful event that contributed to a lowering of both Samuel's anger and anxiety (as well as his self-blame). Following the disclosure, Samuel said that his clearer understanding of the nature of the sexual relationship was helping him to forgive himself. He also reported that "it felt good to talk about it [the on-going sexual relationship] and it was not as difficult as I thought it would be."

As Samuel progressed to the anger phase of treatment, sessions examined various aspects of abuse-related anger (e.g., towards whom does Samuel feel anger, ways in which anger has and has not been helpful, fears about expressing anger, feelings that underlie anger) and engaged Samuel in activities which allowed him to express his anger (e.g., writing a letter to the offender, identifying ways to express anger safely and constructively). Overall, interventions during the anger treatment phase made a considerable impact in decreasing Samuel's abuse-related anger. While Samuel did not report immediate decreases in his feelings of anger, this pattern of change seems common among individuals in therapy, who often experience an increase in symptom level prior to a decrease (Briere, 1996). Examination of the feelings underlying anger seemed to have resulted in an increase in Samuel's anger. This increase appeared to be related to his more intense focus on difficult issues which he had previously ignored. Samuel spoke about the sadness, fear, loneliness, and vulnerability that he often experiences in interpersonal situations. He also focused on the enormous frustration he feels at not being able to express his more "vulnerable side" to others and identified increased "feelings of anger towards my mom for not being there for me" and "angry at my abuser for the fact that I don't trust people now and am nervous around most people."

While Samuel's angry feelings initially increased during the anger treatment phase, it would appear that he later benefitted from some of the interventions that focused on abuse-related anger. Specifically, reading a letter he had composed to his childhood abuser seemed helpful in reducing Samuel's feelings of anger. Following this highly emotional intervention, during which time Samuel expressed many feelings of sadness and loss, he began to focus more attention on his "vulnerable side." Looking at the overall anger treatment phase, it would appear that earlier interventions helped Samuel to more readily identify and express anger about his childhood sexual abuse. Once Samuel had been given the opportunity to express his abuse-related anger, it seemed that he then felt safer and more prepared to begin the process of exploring emotions that are sometimes covered up by anger (i.e., his "vulnerable side").

While Samuel was working on issues related to his abuse-related anger, his level of anxiety seemed to increase and decrease considerably. He attributed much of his anxiety to thoughts about ending his sexual relationship with the older male as well as to plans about revealing his childhood sexual victimization to his mother. While Samuel seemed to experience increased anxiety during the contemplation of these issues, he later reported a decrease in anxiety after having made some difficult decisions. After much consideration, Samuel stated having ended his same-sex sexual relationship and feeling more confident about the decision to tell his mother about his childhood abuse.

As Samuel entered the final treatment phase, sessions focused on the relationship between his sexual abuse experience and feelings of anxiety. Cognitive restructuring and behavioural (i.e., progressive muscle relaxation) techniques were also introduced in order to help Samuel cope with his anxiety. The overall impact of sessions was on lowering Samuel's level of

anxiety, although there did not appear to be any one specific intervention that made more of an impact. During Samuel's work on abuse-related anxiety issues, he had disclosed his childhood sexual abuse to his mother. Following the disclosure, Samuel stated feeling more relaxed, and he expressed a wish to develop a closer relationship with his mother. Toward the end of the treatment phase, Samuel also began to express more concern over his sexualized and rigid views of women as well as his tendency to engage in an excessive amount of sexual activity with different partners. He expressed concern over his views of women and sex and stated feeling "confused and anxious about why I view women as good or bad and whether this comes from my abuse or other parts of my life."

Follow-up. Samuel's participation in the sexual abuse treatment program seemed to have contributed to a number of long-term positive changes. He did not appear to be experiencing many difficulties related to depression, self-blame, anger, or anxiety. Looking more specifically at Samuel's decreased level of anxiety, it would seem important to consider some of the situations he had confronted over the course of the treatment program. At the beginning of treatment, Samuel was struggling with a number of anxiety-provoking situations (e.g., highly conflictual and unstable relationship with his partner, on-going difficulties in setting up visits with his children, high alcohol consumption, start of a new job). It would appear that Samuel's gradual reduction in overall anxiety and, in particular situation-specific anxiety, was closely associated with his resolution of these highly difficult situations. Six months following the completion of the treatment program, Samuel had successfully ended his relationship with his partner and had made gains toward arranging more frequent visits with his children. Samuel was also engaged in steady employment, and he had increased his efforts to restrict his use of

alcohol. As Samuel began to resolve some of the more problematic situations in his life, he had also begun to experience an improved sense of self-worth and an increased level of participation in activities which he perceived to be highly enjoyable.

Samuel's increased feelings of self-worth, along with his lowered sense of self-blame and depression, appear consistent with previous research findings of a correlation between self-blame and depression and self-concept among sexually abused individuals (Hoagwood, 1990). Samuel's virtual lack of self-blame for both his actions during childhood as well as for the type of child he was seemed to be closely associated with his decreased depression and increased self-esteem. Six months after the treatment program had ended, Samuel had reached the point where he had "come to understand that it is the abuser who is responsible for his actions and that as a child I placed all my trust in adults. I also understand that the stimulation is pleasant and is a normal human reaction."

Evaluation of Stan's Sexual Abuse Treatment Experience

Pre-treatment. Prior to treatment, Stan attributed many of his self-blame feelings to his "naivete and stupidity" for engaging in sexual activity with his brother and for not ending the abuse immediately following the first episode. Stan even reported that he deserved to be sexually abused for "not knowing any better." Stan identified much anger toward his brother for his hurtful actions as well as toward himself for his inability to "get a handle on the experience and feel good about myself." Finally, it would appear that Stan's anxiety was related to feeling isolated, having no sense of belonging, lacking trust in others, and worrying about how people might hurt him.

Treatment. Stan began the treatment program by addressing the origins of his self-blame

feelings, exploring issues of responsibility and power related to his sexual abuse experience, examining sexual abuse myths, and identifying ways in which he could decrease his self-blame feelings. The interventions during the self-blame treatment phase appeared to play an important role in decreasing Stan's feelings of responsibility and blame for his childhood sexual abuse. While Stan was ultimately able to accept that he was not to blame for the sexual victimization, he experienced an on-going struggle between beginning to understand that he was not responsible but still feeling partly guilty for the abuse. His feelings of responsibility were linked to his lack of disclosure, his perceived passivity and gullibility, and the fact that he continued to seek out his brother's company even after the abuse began. At the same time, Stan reported beginning to understand that, as a child, he was not capable of labelling the sexual activity as abusive and that his upbringing encouraged him to be passive and accepting. He stated, "I was not taught to be pro-active. I was taught not to 'rock the boat' and to be a follower and to put others ahead of myself." Finally, some of Stan's ambivalence over "letting go" of his self-blame was connected to fear about what would replace his long-standing feelings of self-blame. While acknowledging the negative impact that self-blame had made on him, Stan also noted that "self-blame is familiar and not as anxiety-provoking as having to develop a new framework in which to view my sexual abuse."

The interventions which seemed to have an important impact in lowering Stan's feelings of self-blame were the exploration of ways in which his brother engaged him in sexual activity and made him feel responsible for the abuse as well as the examination of differences between a child and an older person who engages the child in sexual activity. Stan spoke about the bribes and threats of harm that his brother used to ensure that he would continue to secretly participate

in the sexual activity. Stan also explored how his upbringing contributed to feelings of doubt and self-blame by having taught him to be trusting of others and to put the needs of others ahead of his own.

During Stan's work in the self-blame treatment phase, he also appeared to experience a reduction in feelings of anger and anxiety. Examining the ways in which Stan's brother freed himself from responsibility and made him feel blamed for the abuse seemed to contribute to temporarily lowering Stan's feelings of anger. At times, it also seemed that Stan's lowered feelings of anger were due more to factors outside of the specific treatment interventions. For instance, Stan identified some of his decreased anger to feeling "too drained and apathetic" to be angry. Stan also reported, "what good is getting angry going to do? But I do have anger that does need release." Some of the reductions in Stan's anxiety seemed related to having explored the details of his sexual abuse in treatment and having "exposed" the secret. Stan also mentioned having spoken with a sexually abused friend, whose supportive response made him worry less about "what people would think if they knew I was abused."

As Stan entered the anger phase of treatment, sessions addressed abuse-related anger (e.g., towards whom does Stan feel angry, ways in which anger has and has not been helpful, fears about expressing anger, feelings that underlie anger) and engaged Stan in activities which allowed him to express feelings of anger (e.g., writing a letter to the offender, identifying ways to express anger safely and constructively). Interventions during this treatment phase made an impact in alleviating Stan's feelings of anger related to his childhood sexual abuse. Stan's exploration of the emotions which may underlie angry feelings (e.g., "sadness for being robbed of so much living," fear, hurt, self-pity, loneliness) seemed to be a particularly powerful

intervention. Stan spoke about a number of painful feelings, and he continued to work on identifying and understanding feelings which he had previously "lumped together" into the category of anger. The letter-writing intervention also appeared to contribute to a reduction in Stan's anger. While reading the letter he had composed, Stan released intense feelings of anger as well as associated feelings of grief and loss. He also made the decision to re-read his letter on a daily basis as a way of strengthening his "ability to discern between anger and a myriad of other emotions."

During the time that Stan was addressing issues related to his anger, he also seemed to experience a temporary decrease in anxiety. This decrease occurred following the letter-writing activity. Stan identified feeling "emotionally flat" after the activity, and he also contributed his lowered anxiety to having disclosed highly personal details of his sexual abuse and having felt accepted and validated by the therapist. During the anger treatment phase, there also continued to be small decreases in Stan's feelings of self-blame. He reported having made much progress in incorporating the self-blame work by "being able to acknowledge and truly feel that I could not have known this was abuse." He was also engaging in a number of activities geared specifically to decreasing self-blame feelings (e.g., viewing young children to gain a better understanding of their as well as his own vulnerability, using self-dialogue and affirming statements to remind himself that he was not responsible for the sexual abuse). While Stan experienced further reductions in self-blame during the anger treatment phase, they were not as pronounced as those for Stan's anger. Also, compared with self-blame, the decreases in Stan's feelings of anger seemed more closely connected to the interventions which were introduced during the anger treatment phase.

During the final anxiety phase of treatment, sessions examined the relationship between Stan's sexual abuse experience and his feelings of anxiety. As well, cognitive restructuring and behavioural (i.e., progressive muscle relaxation) techniques were introduced in order to help Stan cope with his anxious feelings. The decrease in Stan's overall feelings of anxiety during this treatment phase was considerable. While no one intervention made a considerable impact in reducing Stan's anxiety, he did appear to experience a greater reduction following the introduction of the thought stopping procedure. Stan was committed to practising what he perceived to be a highly effective procedure on a daily basis. He reported that, "while I don't have control over what others think, I do have the ability to exercise control over what I think."

While Stan continued to work on anxiety related to his childhood sexual abuse, he also seemed to experience further reductions in his feelings of anger. It would appear that the thought stopping procedure also contributed to Stan's decreased anger, although the extent of the decrease was not as great as that for anxiety. According to Stan, most of his lowered feelings of anger were due to continual work on identifying and examining feelings underlying anger (e.g., grief, fear). He also seemed to be "letting go" of the past and focusing more attention on present as well as future plans for himself.

Follow-up. It would appear that Stan continued to experience a number of improvements in his functioning months after the end of the treatment program. Feelings of depression, anger, and anxiety no longer appeared to be problematic for him, and he had almost completely resolved issues of responsibility and blame related to his childhood sexual victimization. Stan's sense of self-worth had improved, and he was engaging in more frequent social activities from which he derived much pleasure.

Stan's ability to derive enjoyment from activities may have played an important role in the reduction of his depressed feelings. This idea is based on Rose and Staats' (1988) finding that an individual's enjoyability potential is closely related to their feelings of depression. Stan's decreased sense of overall self-blame may have also been associated with his decreased depression as well as his increased feelings of self-worth, as previously reported by Hoagwood (1990). It seems interesting that, while Stan showed improvements in self-esteem and self-concept, he continued to experience a certain amount of blame for the type of person he was during the time of the sexual abuse. This finding seems surprising, given that characterological self-blame is more esteem-related (Janoff-Bulman, 1979) and, therefore, would be expected to show a negative correlation with measures of self-esteem. It may be that Stan needed to maintain some responsibility for his sexual victimization as a way of feeling some sense of control, as proposed by several authors (Briere, 1996; Hoagwood, 1990; Janoff-Bulman, 1979). This hypothesis may be particularly relevant for Stan, whose increases in abuser blame and decreases in behavioural self-blame were considerable. It may be that he needed to maintain some responsibility and sense of balance in light of these dramatic changes.

Stan's reduced level of underlying anxiety seems particularly meaningful, given both his long-standing problems in this area as well as the finding that trait anxiety is relatively resistant to modification (Creamer et al., 1995). Stan also reported reduced levels of more situation-specific anxiety. This reduction seemed related to a number of events which were occurring in his life six months after the treatment program had ended. In particular, Stan had developed an intimate and supportive relationship with a woman and was planning a long-term commitment with her. This development was particularly powerful for Stan, who had virtually no previous

intimate opposite-sex relationships. In addition, Stan was continuing to employ some of the anxiety-reducing exercises (e.g., relaxation exercises, self-dialogue) on a daily basis.

Evaluation of Scott's Sexual Abuse Treatment Experience

Pre-treatment. Before Scott began the sexual abuse treatment program, he reported a number of factors related to his feelings of self-blame, anger, and anxiety. Most of Scott's sense of self-blame seemed linked to the lack of disclosure of his childhood sexual victimization. Following his sister's allegations of sexual abuse by their step-father, Scott was reportedly questioned by child protection authorities regarding any sexual abuse which he may have also experienced. Scott stated that "even after it was explained to me [by child protection] that abuse was wrong, I still chose not to come forward at that time." Several of the reported reasons for Scott's anger included feeling that his youth and innocence were taken away and that his family did not protect him from the sexual abuse. As well, Scott experienced "hatred for my abusers for the fear they put into me." Finally, it appeared that some of Scott's anxiety was related to wanting to share abuse-related feelings with others but not doing so because of fear similar to that which he experienced as a child. He also reported much anxiety around issues of sexuality (e.g., feeling uncomfortable with his body, not deriving much pleasure from sexual activity).

Treatment. As Scott began the treatment program, sessions focused on addressing the origins of his self-blame feelings, exploring issues of responsibility and power related to his sexual abuse experience, and examining sexual abuse myths and misinformation. It would appear that Scott experienced a reduction in his feelings of self-blame as a result of the interventions during the self-blame treatment phase. During the initial portion of the treatment phase, Scott's self-blame feelings fluctuated between beginning to understand his relative

helplessness during the time of the sexual abuse but also feeling that he should have somehow known the sexual activity was wrong and should have informed someone of the abuse.

Scott experienced a more permanent decrease in self-blame feelings following an examination of the manner in which his offenders engaged him in sexual activity and made him feel responsible for the abuse. Scott identified the ways in which his offender in the foster home used threats of harm as well as toys to engage him in sexual activity. Scott also explored the manner in which the sexual abuse occurred within the context of a game, which made it difficult for him to clearly label the activity as abusive. With regard to his adolescent sexual abuse experience, Scott identified feeling entrapped because "I was afraid he [offender] would tell all my friends about the sexual experience and then I would be humiliated and embarrassed." Another intervention which seemed to play a role in reducing Scott's feelings of self-blame was the exploration of disclosure-related issues. Scott considered the way in which his family climate did not make him feel safe and supported enough to disclose his sexual abuse to any family member. Scott also examined the possible consequences of a disclosure (e.g., disbelief, minimization, punishment) which contributed to his decision not to tell anyone about the sexual victimization when he was younger.

During Scott's work on self-blame issues, he also seemed to experience some alleviation of anxiety. It would appear that the exploration of disclosure-related issues also contributed to some reduction in Scott's level of anxiety. However, the reduction was not as great as that for his feelings of self-blame. Scott continued to report much anxiety around issues of body image and sexual functioning. He stated, "I became addicted to sexual feelings and became dependent on the sexual excitement and release. To me it seemed normal to do these things in private and

yet at the same time caused so much anxiety because it was so obsessive." Scott also reported much anxiety over the fact that he engaged in sexual activity with same-sex individuals. He stated, "I know I am not a homosexual but I was performing oral sex on a male abuser!"

During the anger treatment phase, sessions addressed abuse-related anger (e.g., towards whom does Scott feel anger, ways in which anger has and has not been helpful, fears about expressing anger, feelings that underlie anger) and engaged Scott in activities which allowed him to express feelings of anger (e.g., writing a letter to the offenders, identifying ways to express anger safely and constructively). It would appear that the interventions during this phase of treatment had a minimal impact in lowering Scott's feelings of abuse-related anger. Scott continued to experience much anger toward his offenders (particularly his two male abusers) for "destroying" his self-respect and trust in people, for not having had to take responsibility for their actions, and for making him feel powerless and out of control. He also reported high levels of anger toward his mother for not providing him with a safe environment during his childhood and toward the child protection agency for placing him in a sexually abusive foster home.

Despite his overall high level of anger, Scott did appear to experience slight decreases following the letter-writing activity. While Scott read a letter he had composed to his offender in the foster home, he expressed a variety of feelings, including of anger, sadness, loss, powerlessness, and hurt related to his sexual victimization. At the same time, Scott expressed a great sense of relief at having finally been able to "break the silence" and share his feelings in a supportive and validating environment.

As Scott progressed to the final anxiety phase of treatment, sessions introduced cognitive restructuring and behavioural (i.e., progressive muscle relaxation) techniques in order to help

him cope with anxiety. While Scott's level of anxiety decreased considerably during this treatment phase, it did not appear that the interventions had any specific or direct impact in lowering his anxious feelings. Several factors need to be considered in light of these findings. Above all, the anxiety treatment phase was quite brief (i.e., three sessions) for several reasons. First, Scott became involved in the sexual abuse treatment program at a relatively late time. As such, there were serious time constraints which meant that some of the anxiety interventions were not introduced and that not much time could be spent on those interventions which were introduced during sessions. Second, many treatment sessions were devoted to abuse-related anger because there were many issues which Scott needed to address related to his intense feelings of anger over the sexual victimization. The lengthy focus on anger resulted in even less available time to address Scott's long-standing and extensive anxiety issues. Finally, another important consideration is that much of Scott's anxiety was related to issues around sexuality (e.g., sexual identity, body image, sexual dysfunction), which was not a primary component of the treatment program. Scott's anxiety was long-standing and extensive, and it had affected a number of areas in his life, such as his sexuality, body image, friendships, intimate relationships, and ability to communicate his needs in an assertive manner. While these issues were explored to some extent during sessions, they were not given the attention that seemed to be required by Scott. It would appear that more time was needed to adequately explore Scott's anxiety-related issues and that more focus would need to be given to issues dealing specifically with his sexual functioning and sexual identity. Given these various factors, it does not seem surprising that the interventions during this phase of the treatment program had a minimal effect.

Follow-up. Six months following the end of the treatment program, Scott's feelings of

self-worth had increased, and he seemed able to appropriately place responsibility for his sexual victimization on his abusers. His increased self-esteem seemed related to several factors. Briere (1996) noted that secrecy surrounding sexual abuse may be related to greater impairments in self-esteem. While there certainly was a "conspiracy of silence" surrounding Scott's sexual victimization for most of his life, he had begun to "break the silence." Scott had recently disclosed his experiences to his parents as well as to some trusted individuals. In addition, the treatment program had provided Scott with another opportunity to explore his sexual abuse in a validating and supportive environment.

While Scott made some gains in self-esteem, he continued to experience a number of difficulties in such areas as depression, self-blame, anger, and anxiety. It seems interesting that Scott reported improvements in his self-esteem while at the same time not reporting a decrease in his feelings of self-blame. This finding is in contrast to that of Hoagwood (1990), who reported a correlation between self-blame and feelings of self-worth. One may speculate that, for Scott, placing complete responsibility for the sexual abuse on his abusers was sufficient to have an impact on his sense of worth. It may also be that Scott needed to experience a certain amount of self-blame in order to maintain a sense of perceived control over his life (Briere, 1996; Hoagwood, 1990; Janoff-Bulman, 1979). To illustrate, Scott continued to report some self-blame even though he stated, "I understand that I was not capable of recognizing it [sexual activity] as abuse. I sought for any kind of attention I could get. I could not possibly ask to be abused. It is not in a child's mental ability to be so proactive as to instigate such activity."

As previously stated, Scott continued to experience considerable problems with self-blame, depression, anger, and anxiety even after the completion of the treatment program. While

Scott reported some improvement in these areas as a result of his participation in treatment, his high initial levels of psychological distress posed a number of difficulties for treatment effectiveness. With regard to the nature of his sexual victimization, Scott was abused by a number of trusted individuals over a long period of time. His sexual abuse occurred on a frequent basis and involved intrusive activities. As well, his family environment was such that Scott felt unable to disclose his abuse and to obtain the support and validation that he would have desperately required. All these characteristics of Scott's sexual victimization have been found to be correlated with increased levels of psychological disturbance and may have contributed to his high level of distress at pre-treatment (Beitchman et al., 1991, 1992; Browne & Finkelhor, 1986; Kendall-Tackett et al., 1993; Mendel, 1995). Second, Scott's family environment during childhood was characterized as chaotic, physically abusive, and secretive. These are characteristics which have all been shown to be associated with greater psychological impairment (Bagley & Thurston, 1996). Finally, Scott experienced long-standing feelings of anger toward his mother for not protecting him during childhood from the sexual abuse and for exposing him to a physically violent step-father. At the time that the treatment program began, Scott was living with his mother and her partner. While Scott experienced a number of conflictual feelings toward her, he did not feel that she would support his desire to talk about the past or his feelings about what he had endured during childhood.

Evaluation of Sean's Sexual Abuse Treatment Experience

Pre-treatment. Before the start of the sexual abuse treatment program, Sean's self-blame feelings seemed to greatly fluctuate. While Sean reported experiencing no blame because he knew that he did not provoke or instigate the sexual abuse in any way, he also stated feeling

concerned about the therapist's perception of him. Upon further exploration, Sean was able to acknowledge that he did, in fact, feel much self-blame over the sexual abuse. He identified several contributing factors to his feelings of self-blame, namely his inability to separate feelings of sex, sexual abuse, and guilt and his tendency to be aroused by incestuous fantasies. With regard to Sean's feelings of anger, it would appear that he experienced enormous anger toward his mother. He stated, "I'm feeling angered because I feel forced to have been physically and emotionally close (in a sexual sense) with my mother who I find repulsive and disgusting and weak. It makes me angry that my mother has no idea at all how much and to what extent she hurt me and its impact on my intimate relationships. I don't want to ever see her again." Finally, Sean reported a close link between his anxiety and his thoughts about the sexual activity with his mother, which resulted in both feelings of disgust as well as sexual arousal. As well, Sean attributed his anxious feelings to difficulties with forming sexual relationships with women.

Treatment. During the self-blame treatment phase, sessions addressed the origins of Sean's self-blame feelings, explored issues of responsibility and power related to his sexual abuse experience, examined sexual abuse myths, and identified ways in which he could decrease his self-blame feelings. Interventions during this phase of treatment had an overall effect in lowering Sean's feelings of self-blame over his sexual victimization experience. Examination of myths related to secret keeping and disclosure of the sexual abuse seemed to be a particularly powerful intervention for Sean. He explored the ways in which his strong childhood dependence on his mother made it highly difficult for him to "betray" her by revealing the sexual activity. He also stated that he enjoyed the positive aspects associated with the sexual activity, namely his mother's attention and affection.

Sean's examination of the ways in which he could continue to reduce his self-blame feelings over the sexual victimization also seemed helpful in further reducing some of his self-blame. Sean shared several compassion-filled messages that he had composed for himself and which focused on his inability (as a child) to be responsible for sexual activity with an adult. Sean reported realizing that it was his mother's responsibility to have protected him during childhood and not to have engaged him in sexual activity. He stated, "the fact that I needed affection and love and that my mother took advantage of this makes me feel responsible. If I didn't have these needs, then she wouldn't have abused me. Although I have difficulty accepting this part of myself, I can see it is OK to want these things, that it is normal for these needs. My mother is where the responsibility resides for the sex abuse."

While Sean continued to work on feelings of self-blame over his sexual abuse, an issue related to the therapeutic relationship also occurred. Specifically, Sean spoke about his desire to please the therapist and his perception that he was disappointing the therapist by not showing more rapid decreases in his feelings of self-blame. Some of the meaning underlying Sean's need to please the therapist was discussed in session (e.g., wanting to be liked and accepted, feeling that his lack of progress with self-blame would be detrimental for the therapist's research study). Following this exploration, Sean appeared relieved and reported feeling good about having openly confronted the issue in therapy.

As Sean entered the anger treatment phase, sessions examined various aspects of abuse-related anger (e.g., toward whom does Sean feel anger, ways in which anger has and has not been helpful, fears about expressing anger, feelings that underlie anger) and engaged Sean in activities which allowed him to express his anger (e.g., writing a letter to the offender,

identifying ways to express anger safely and constructively, making a collage). Interventions during this phase of treatment had an impact in decreasing Sean's feelings of anger over his childhood sexual abuse. While he did not immediately experience a reduction in anger, this finding is not surprising. The initial lack of change (and sometimes the initial worsening of symptoms) represents a common therapeutic process (Briere, 1996). As well, Sean reported much ambivalence about reducing his anger because, according to him, his anger motivated him to discontinue contact with his mother and step-father, which he felt was punishing to them.

As Sean began to explore his ambivalence, he also began to show an improvement in his angry feelings. Reading a letter he had composed to his mother appeared to be an important activity for Sean, who expressed enormous anger and sadness related to the loss of a healthy relationship with his mother. The letter-writing activity also seemed to offer Sean a validating experience in that his feelings about the sexual abuse were supported and accepted (in contrast to his reported disclosure experience with his mother and step-father). Following this intervention, Sean reported feelings of relief at having expressed his built-up anger in a supportive environment. Construction of a collage of sexual abuse reminders also appeared to be particularly helpful in reducing Sean's feelings of abuse-related anger. Sean reported that the "collage really deflated my anger. I was completely overwhelmed by feelings of sadness for myself as a boy who was molested and who was young and vulnerable and for myself who withdrew so much because of my hurt. I didn't expect to feel any of this or to connect and reidentify with myself when I was abused. It brought me back in touch with the heart of that boy." Thus, it would appear that the collage provided Sean with an opportunity to access emotions underlying anger and to experience some empathy for himself as an abused child.

While Sean experienced a decrease in anger during this treatment phase, it seems important to note that he continued to struggle with considerable feelings of anger and hatred toward his mother throughout treatment. As well, Sean continued to experience ambivalence about decreasing his feelings of anger because he felt his anger punished his mother and also allowed him to not deal with more difficult feelings. He stated, "I can feel myself hanging onto my anger, that it gives me some sort of satisfaction to do so but I have been thinking about this and asking myself exactly what is it that I am really getting out of this feelings because I do truly want to let go and move on. Today, though, it masks my hurt."

As Sean entered the final phase of treatment, sessions examined the relationship between his sexual abuse experience and feelings of anxiety. As well, cognitive restructuring and behavioural (i.e., progressive muscle relaxation) techniques were introduced in order to help Sean cope with his anxiety. It would appear that Sean experienced a decrease in his feelings of anxiety as a result of his work during this treatment phase. One intervention which made an important contribution in lowering Sean's anxious feelings was the cognitive restructuring exercise. Sean identified anxiety-provoking situations and accompanying thoughts, challenged these thoughts by examining supporting evidence and considering alternative interpretations, and explored possible consequences should the feared situation occur. Sean used this activity to examine his intense feelings of anxiety over a possible, future sexual relationship. He reported that the cognitive restructuring intervention was relieving because it introduced new ways of interpreting situations and thoughts which previously were highly anxiety-arousing. The progressive muscle relaxation intervention also appeared to be beneficial in improving some of Sean's anxiety. He was committed to practising the exercise on a daily basis and reported that it

was highly effective in reducing his feelings of worry and tension.

Follow-up. Sean appeared to be experiencing reduced feelings of depression and anger and increased enjoyability of activities six months after the sexual abuse treatment program had ended. As well, Sean seemed to have clarified most issues of blame and responsibility for his childhood sexual abuse. The areas of self-esteem, anxiety, and involvement in outside activities continued to remain problematic for Sean. While he seemed to have experienced considerable improvements in anxiety and activity participation immediately after treatment termination, these changes were not long-lasting. There are several points to consider in light of these findings. It may be that Sean required a more lengthy treatment intervention in order to better ensure that some of the gains he experienced in therapy would be better maintained. Related to this point, it seemed that many of Sean's difficulties related to his sexuality and sense of frustration, disappointment, and failure at not having experienced any satisfying sexual relationships during adulthood. Perhaps a more concentrated focus on these issues would have also helped to secure better maintenance of Sean's therapy gains.

Given these statements, it seems important to remember Sean's rather extensive therapeutic contacts prior to and following his participation in the present study's sexual abuse program. He had been involved in individual therapy to address abuse-related issues and in group therapy focusing on self-esteem and assertiveness. Sean also maintained contact with a psychiatrist who monitored his anti-depressant medication. Six-month follow-up revealed that Sean had regular contact with a psychiatrist as well as a counsellor and that he was involved in a group treatment program for depression. One may ask several questions when considering Sean's extensive involvement in individual and group treatment. Is there some underlying issue

for Sean that all these various interventions failed to address and that would have been the key to ensuring the maintenance of therapeutic gains once the intervention ended? What made Sean seem to continue requiring on-going involvement in treatment? What made it difficult for him to maintain the improvements he experienced in therapy and to make some of the long-desired changes in his life? One hypothesis concerns Sean's fragmented memories of additional abuse. It may be that part of Sean's on-going difficulties were related to fear, hopelessness, and frustration over trying (unsuccessfully) to make meaning of past, possible sexual victimization experiences. Another hypothesis concerns the meaning that Sean ascribed to his impairments in psychological functioning. Sean expressed ambivalence about feeling better because he felt that his difficulties served as continual reminders of the enormous hurt that his mother caused him. Sean also reported feeling that his continued struggles were somehow punishing to his mother and step-father, and these feelings provided him with a sense of control and power over them. As well, Sean's exclusive focus on anger allowed him to avoid dealing with other difficult feelings.

Benefits and Limitations of the Present Study

Given the relative lack of systematic research on the effectiveness of individual treatment for sexually abused adult males, it would appear that the present study has made an important contribution to the existing literature. Several unique and important features of the present study deserve to be considered. The use of a sexual abuse treatment manual allowed for better experimental control over extraneous variables which can compromise the validity of psychotherapy research efforts (Beutler & Hill, 1992). The calculation of effect sizes to augment visual inspection enabled more precise statements to be made about the study's findings. As well, the introduction of effect sizes seems in accordance with the American Psychological

Association's promotion of the effect size statistic in the behavioural literature (Kromrey & Foster-Johnson, 1996). Finally, the assessment of clinical significance seemed important in bridging the gap between research and clinical practice (Lambert, 1994).

Turning to the study's experimental approach, the use of a multiple-baseline across behaviours design presented both a number of benefits as well as limitations. On the positive side, the study's individualized approach to outcome assessment made it possible to more readily tailor treatment to individuals (as much as was possible within the framework of the sexual abuse treatment manual) and to more clearly identify those interventions which were effective in reducing feelings of self-blame, anger, and anxiety related to sexual victimization. The individualized approach and continuous assessment of individuals also allowed for tighter experimental control and, consequently, firmer conclusions about the study's findings. In addition, the study's use of a multiple-baseline design, with its emphasis on clinical significance, was invaluable. In particular, there was a greater chance of identifying treatment interventions that had practical significance and that would make a difference in the individual's everyday life. In light of these considerations, it would appear that a single-case approach lends itself well to treatment outcome research. Single-case designs seem especially useful in clinical settings concerned with the systematic evaluation of treatment efforts using small sample sizes.

While the use of a multiple-baseline approach strengthened the study's overall design and results, it also presented several limitations. In particular, at times it seemed difficult to "tease out" the specific effects of an intervention because changes occurred in all of the behaviours (i.e., self-blame, anger, anxiety), albeit to varying degrees. This interdependence among behaviours posed some difficulties for experimental control and treatment outcome

conclusions. As well, one of the concerns of a multiple-baseline design is with the latency of change once an intervention has been introduced. Specifically, it would seem that firmer conclusions can be drawn if a behaviour responds quickly to an intervention. In the present study, individuals did not generally demonstrate immediate and rapid decreases in self-blame, anger, and anxiety in response to specific treatment interventions. This finding is not surprising given both the nature of the behaviours which were being measured as well as the common therapeutic process of individuals often experiencing a worsening of symptoms prior to an amelioration. Nonetheless, issues surrounding latency of change pose some limitations to the conclusions which can be drawn from the results of the present study.

Given these consideration, the continued use of single-case designs in psychotherapy research of sexual abuse seems clear. However, the nature of difficulties commonly found among sexually abused individuals presents some unique challenges to the single-case approach. Unlike the visible and concrete behaviours that are more commonly used in behavioural research (e.g., hitting someone, pressing a lever, engaging in physical activity), it seems inherently more difficult to work with such constructs as depression and anger. As such, issues of interdependence, operationalization, and measurement must be carefully considered. For example, which constructs and behaviours will show the least amount of overlap with one another? What is the most accurate way of defining these constructs? How can one effectively and reliably measure these constructs?

Clinical and Future Research Recommendations

Based on the overall findings of the present study, the following recommendations appear important in clinical work with sexually abused adult males:

1. The exploration of issues related to self-blame and responsibility for the sexual experience seems to be highly beneficial for abused males, both on a short- and long-term basis. Gaining an understanding of the ways in which abusers used their power to "groom" victims as well as dispelling myths surrounding the implications of having been sexually abused are especially effective interventions. It appears important to note that self-blame feelings among sexually abused males may not completely disappear. However, the amount of self-blame, compared with the amount of responsibility males place upon their abusers, may be minimal.

2. It seems critical to explore males' feelings of abuse-related anger for several reasons: First, anger among sexually abused males is often so intense that it has a significant negative impact on other areas of functioning in the individual's everyday life. Second, there are usually a number of other feelings (e.g., sadness, loss, vulnerability) that underlie anger and that relate directly to the sexual abuse experience. One intervention which is particularly powerful in helping males express their anger and underlying emotions is to compose and read aloud a letter to the abuser describing the impact that the experience had and continues to have on the victim. It seems important to note that sexually abused males may only be ready to examine underlying emotions once anger has been fully explored and once a certain level of trust and safety has been established in the therapeutic relationship.

3. While problems stemming from high levels of anxiety are important to address in clinical work with sexually abused males, attempting to link such problems directly to the abusive experience may be difficult. For many males with histories of abuse, anxiety represents a long-standing problem which has often generalized to several areas of functioning. As such, pin-pointing the specific association between childhood sexual abuse and current feelings of anxiety

may be complex and unnecessary. Given these statements, it seems important, nonetheless, to present males with effective ways of managing their anxiety, perhaps through thought stopping procedures or progressive muscle relaxation. Such interventions appear effective in alleviating some of the situational problems arising from anxiety (e.g., meeting new people) as well as some of the more underlying, trait-like feelings of anxiety.

4. Being involved in a sexual abuse treatment program seems to greatly improve males' feelings of depression, and these improvements are generally long-lasting. Clinically, this finding implies that specific and direct interventions for depression do not have to necessarily be included in the treatment of sexually abused males. Similarly, feelings of self-worth also seem to improve for males after having participated in abuse-focused therapy. However, these gains are generally not as extensive as those for depression, suggesting that more focused interventions that deal specifically with self-esteem issues may be beneficial in treatment for abused males.

5. In clinical work with sexually abused adult males, interventions pertaining specifically to sexuality (e.g., sexual identity, difficulties with sexual functioning, sexual relationships, fears of sexual offending behaviour) must be incorporated. While these issues will undoubtedly arise during work on such areas as self-blame and anxiety, it seems important to include a separate component that addresses only these kinds of concerns, as they appear to be prevalent among males with histories of sexual victimization.

6. Equally important as the treatment intervention is the quality and strength of the therapist-client relationship. Throughout treatment, there will be times when the relationship seems strained, especially when those same interpersonal problems with which males struggle in their own lives (e.g., fear of vulnerability and subsequent hurt, intense need for approval) enter into

the therapeutic relationship. Such issues must be explored in an open and non-threatening manner because the success of a therapeutic intervention rests on the establishment of a safe and trusting alliance between the client and therapist.

Given the study's clinical implications, it is crucial to continue developing and refining treatment interventions for adult males with histories of childhood sexual abuse. The present study, through its use of a multiple-baseline design, made an important contribution toward furthering knowledge of issues that are particularly relevant for abused males and toward identifying effective interventions to address these issues. Such research efforts must be pursued so that we may more fully understand the needs of sexually abused males and then be in a position to better provide for these needs in a clinically effective manner.

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Appendix A: Participant Recruitment Letter

Psychological Service Centre
161 Dafoe Building
University of Manitoba
Winnipeg, Manitoba
Canada R3T 2N2
(204) 474-9222

Dear Colleague:

We are currently recruiting participants for an individual treatment program for adult males who experienced sexual abuse during childhood. A doctoral-level female student in the Clinical Psychology program at the University of Manitoba will serve as the therapist for the individual therapy program. On-going supervision of the treatment program will be conducted by a registered clinical psychologist who has much experience working in the area of childhood sexual abuse.

Males, aged 35 years or younger, who have disclosed sexual abuse by a family or non-family member are eligible to participate in the individual treatment program. Treatment will most likely commence in January 1997 and will consist of weekly one-hour sessions. Therapy termination may vary across participants and will be based on each participant's progress over the course of the individual treatment program. It is important that participants who express an interest in the treatment program meet the following requirements: (a) they have disclosed at least one incident of childhood sexual abuse; (b) they are in a living arrangement which does not include the offender; (c) they are able to talk about the abuse experience at some length; (d) they are not suffering from a psychotic disorder; (e) they are not struggling with a severe alcohol or drug addiction; (f) they are not experiencing acute post-traumatic symptoms; (g) they appear to

possess an average level of intellectual functioning; and (h) they are not suffering from a specific phobia.

The purpose of the present study is to evaluate the effectiveness of an individual treatment program for sexually abused adult males. As such, the treatment study incorporates a strong research component. Prior to beginning individual therapy, participants will undergo a clinical interview and will complete several self-report questionnaires related to depression, self-esteem, feelings of blame, anger, and anxiety. Following the assessment interview, participants will be required to complete daily self-ratings on their levels of self-blame, anger, and anxiety as well as bi-weekly self-monitoring measures on their feelings of depression and self-esteem. The self-rating and self-monitoring measures will be completed throughout the course of the individual treatment program. Additionally, weekly ratings on participants' levels of self-blame, anger, and anxiety treatment will be obtained from significant others. Upon termination of the treatment program, participants will again complete several self-report questionnaires in order to obtain further information concerning the effectiveness of the individual treatment program.

As mentioned, individual therapy sessions will be held on a weekly basis at the Psychological Service Centre. While a number of abuse-related areas will be explored throughout sessions, the treatment program will focus specifically on the issues of **self-blame**, **anger**, and **anxiety**. As such, these issues must be of particular importance for adult males who participate in the individual treatment program. A variety of therapeutic methods will be employed to address abuse-related issues, including psycho-education, cognitive restructuring, role plays, and behavioural techniques (e.g., progressive relaxation training). Participants' progress in therapy will be continuously assessed through self-report and self-monitoring

measures, and decisions related to treatment will be based on data from these measures.

If you require additional information about the individual treatment program, please feel free to contact us at the Psychological Service Centre. In the meantime, we thank you for your attention and look forward to hearing from you soon.

Sincerely,

Elisa Romano
Student Clinician

Dr. Rayleen V. De Luca
Supervising Clinician

Appendix B: Clinical Interview

Name of Client: _____

Interviewer: _____

Date of Interview: _____

Socio-Demographic Information

Date of birth: _____

Age: _____

Ethnicity: _____

Religion: _____

Marital Status:
_____ Single
_____ Living with partner
_____ Married
_____ Separated or divorced
_____ Widowed

If living with partner or married, list partner's age, occupation, and length of time living together or married:

_____

If separated, divorced, or widowed, list the length of time:

_____

List the names and ages of children (if any):

_____

List the names and relationships of people who currently live in your home:

_____

Education: _____

Occupation: _____

Annual income:
_____ $10 000 or below
_____ $10 000 - $20 000
_____ $20 000 - $30 000
_____ $30 000 - $40 000
_____ $40 000 - $50 000
_____ $50 000 or above

Family and Social History

Name of mother: _____

Living or deceased: _____

Occupation: _____

How would you describe your mother?

_____

How do/did you get along with your mother?

_____

Name of father: _____

Living or deceased: _____

Occupation: _____

How would you describe your father?

_____

How do/did you get along with your father?

_____

Parents' marital status: _____

Name and age of siblings and nature of the relationship:

How many friends do you have? How often do you see your friends? How close do you feel to your friends? Are most of your friends male or female?

Behavioural History

In general, what was your school experience like? How were your grades and relationships with teachers and peers? What did you like and dislike about school?

Were there any behaviours that people were worried about before the sexual abuse occurred?

Have you ever sought treatment before? If so, what was your subjective experience of therapy? Are you currently on any medication?

Sexual History

Where did you learn about sex and how old were you?

Was sex ever discussed at home? What was the attitude of your parents concerning sex? What messages about sex did you get at home?

Can you give me an idea of some of your sexual experiences (masturbation, sexual interaction with peers, homosexual experiences)?

Physical Abuse History

Have you ever been physically abused by a relative or non-family member? _____

If yes, age of onset: _____

Relationship with offender(s):

Number and age of offender(s):

Nature and extent:

_____

_____

Frequency and duration:

_____

Type of injuries incurred (if any):

_____

Sexual Abuse History

Age of onset: _____

Relationship with offender(s):

_____

Number and age of offender(s):

_____

Nature and extent:

_____

_____

Frequency and duration:

_____

Type of injuries incurred (if any):

_____

Where did the sexual abuse usually occur?

Do you think anyone else knew? Did you tell anyone about the abuse? How did people become aware of the abuse (if at all)? How did they react?

Did the sexual abuse ever come to the attention of the police or child welfare agencies?

Abuse Reactive Behavioural History

Did you notice any changes in the way you got along and interacted with others since the sexual abuse?

Do you feel that people started to treat you differently when they found out about the abuse?

Do you feel the abuse affected how you feel about being sexual with another person? How do you feel about your body?

Appendix C: Beck Depression Inventory

This questionnaire consists of 21 groups of statements. After reading each group of statements carefully, circle the number (0, 1, 2, or 3) next to the one statement in each group which **best** describes the way you have been feeling the **past week, including today**. If several statements within a group seem to apply equally well, circle each one. **Be sure to read all the statements in each group before making your choice.**

1. 0 I do not feel sad.
   1 I feel sad.
   2 I am sad all the time and I can't snap out of it.
   3 I am so sad or unhappy that I can't stand it.

2. 0 I am not particularly discouraged about the future.
   1 I feel discouraged about the future.
   2 I feel I have nothing to look forward to.
   3 I feel that the future is hopeless and that things cannot improve.

3. 0 I do not feel like a failure.
   1 I feel I have failed more than the average person.
   2 As I look back on my life, all I can see is a lot of failures.
   3 I feel I am a complete failure as a person.

4. 0 I get as much satisfaction out of things as I used to.
   1 I don't enjoy things the way I used to.
   2 I don't get real satisfaction out of anything anymore.
   3 I am dissatisfied or bored with everything.

5. 0 I don't feel particularly guilty.
   1 I feel guilty a good part of the time.
   2 I feel quite guilty most of the time.
   3 I feel guilty all of the time.

6. 0 I don't feel I am being punished.
   1 I feel I may be punished.
   2 I expect to be punished.
   3 I feel I am being punished.

7.	0	I don't feel disappointed in myself.
	1	I am disappointed in myself.
	2	I am disgusted with myself.
	3	I hate myself.
8.	0	I don't feel I am any worse than anybody else.
	1	I am critical of myself for my weaknesses or mistakes.
	2	I blame myself all the time for my faults.
	3	I blame myself for everything bad that happens.
9.	0	I don't have any thoughts of killing myself.
	1	I have thoughts of killing myself, but I would not carry them out.
	2	I would like to kill myself.
	3	I would kill myself if I had the chance.
10.	0	I don't cry any more than usual.
	1	I cry more now than I used to.
	2	I cry all the time now.
	3	I used to be able to cry, but now I can't cry even though I want to.
11.	0	I am no more irritated now than I ever am.
	1	I get annoyed or irritated more easily than I used to.
	2	I feel irritated all the time now.
	3	I don't get irritated at all by the things that used to irritate me.
12.	0	I have not lost interest in other people.
	1	I am less interested in other people than I used to be.
	2	I have lost most of my interest in other people.
	3	I have lost all of my interest in other people.
13.	0	I make decisions about as well as I ever could.
	1	I put off making decisions more than I used to.
	2	I have greater difficulty in making decisions than before.
	3	I can't make decisions at all anymore.
14.	0	I don't feel I look any worse than I used to.
	1	I am worried that I am looking old or unattractive.
	2	I feel that there are permanent changes in my appearance that make me look unattractive.
	3	I believe that I look ugly.

15. 0 I can work about as well as before.
1 It takes an extra effort to get started at doing something.
2 I have to push myself very hard to do anything.
3 I can't do any work at all.

16. 0 I can sleep as well as usual.
1 I don't sleep as well as I used to.
2 I wake up 1-2 hours earlier than usual and find it hard to get back to sleep.
3 I wake up several hours earlier than I used to and cannot get back to sleep.

17. 0 I don't get more tired than usual.
1 I get tired more easily than I used to.
2 I get tired from doing almost anything.
3 I am too tired to do anything.

18. 0 My appetite is no worse than usual.
1 My appetite is not as good as it used to be.
2 My appetite is much worse now.
3 I have no appetite at all anymore.

19. 0 I haven't lost much weight, if any, lately.
1 I have lost more than 5 pounds.
2 I have lost more than 10 pounds.
3 I have lost more than 15 pounds.

I am purposely trying to lose weight by eating less. Yes _____ No _____

20. 0 I am no more worried about my health than usual.
1 I am worried about physical problems such as aches and pains; or upset stomach; or constipation.
2 I am very worried about physical problems and it's hard to think of much else.
3 I am so worried about my physical problems that I cannot think about anything else.

21. 0 I have not noticed any recent change in my interest in sex.
1 I am less interested in sex than I used to be.
2 I am much less interested in sex now.
3 I have lost interest in sex completely.

Appendix D: Self-Esteem Scale

Please answer the following items according to how each one best describes you. Use the following scale:

1 = Strongly agree
2 = Agree
3 = Disagree
4 = Strongly disagree

1) I feel that I am a person of worth, at least on an equal plane with others. 1 2 3 4

2) I feel that I have a number of good qualities. 1 2 3 4

3) All in all, I am inclined to feel that I am a failure. 1 2 3 4 *

4) I am able to do things as well as most other people. 1 2 3 4

5) I feel I do not have much to be proud of. 1 2 3 4 *

6) I take a positive attitude toward myself. 1 2 3 4

7) On the whole, I am satisfied with myself. 1 2 3 4

8) I wish I could have more respect for myself. 1 2 3 4 *

9) I certainly feel useless at times. 1 2 3 4 *

10) At times I think I am no good at all. 1 2 3 4 *

* Reverse scored

Appendix E: The Blame Scale

Sometimes people feel that they are to blame for things that happen to them. The purpose of these questions is to get some information about how you feel now looking back at the sexual experience that occurred during childhood. Please try to remember as clearly as you can who you blame for the sexual abuse now. Please put your rating on the line next to the question.

1	2	3	4	5	6
Not at all	Very little	Slightly	Some	A lot	Completely

_____ 1. How much <u>now</u> do you blame yourself for the sexual abuse?

_____ 2. How much <u>now</u> do you blame the person who sexually abused you?

_____ 3. How much <u>now</u> do you blame your mother?

_____ 4. How much <u>now</u> do you blame your father?

_____ 5. How much <u>now</u> do you blame someone or something else?

(Please specify) _____

_____ 6. How much <u>now</u> do you blame yourself for the kind of person you are?

_____ 7. How much <u>now</u> do you blame yourself for what you did or how you acted?

8. If you blame yourself now, what is it about yourself that you blame? (That is, what quality or trait about yourself do you blame now?)

_____

9. Is this the same quality or trait that you blamed yourself for as a child or is it different?

a. the same
b. different

If different, what was it about yourself as a child that you blamed for the sexual abuse?

_____

10. If you have stopped blaming yourself for the sexual abuse, how long after the abuse ended did you do this?

_____

11. Why do you no longer blame yourself?

_____

Appendix F: Multidimensional Anger Inventory

Everybody gets angry from time to time. A number of statements that people have used to describe the times that they get angry are included below. Read each statement and write down the number that best describes you. There are no right or wrong answers.

1	2	3	4	5
Completely undescriptive	Undescriptive	Partly undescriptive and partly descriptive	Mostly descriptive	Completely descriptive

_____ 1. I tend to get angry more frequently than most people.

_____ 2. Other people seem to get angrier than I do in similar circumstances. *

_____ 3. I harbor grudges that I don't tell anyone about.

_____ 4. I try to get even when I'm angry with someone.

_____ 5. I am secretly quite critical of others.

_____ 6. It is easy to make me angry.

_____ 7. When I am angry with someone, I let that person know.

_____ 8. I have met many people who are supposed to be experts who are no better than I.

_____ 9. Something makes me angry almost every day.

_____ 10. I often feel angrier than I think I should.

_____ 11. I feel guilty about expressing my anger.

_____ 12. When I am angry with someone, I take it out on whoever is around.

_____ 13. Some of my friends have habits that annoy and bother me very much.

_____ 14. I am surprised at how often I feel angry.

_____ 15. Once I let people know I'm angry, I can put it out of my mind. *

_____ 16. People talk about me behind my back.

_____ 17. At times, I feel angry for no specific reason.

_____ 18. I can make myself angry about something in the past just by thinking about it.

_____ 19. Even after I have expressed my anger, I have trouble forgetting about it.

_____ 20. When I hide my anger from others, I think about it for a long time.

_____ 21. People can bother me just by being around.

_____ 22. When I get angry, I stay angry for hours.

_____ 23. When I hide my anger from others, I forget about it pretty quickly. *

_____ 24. I try to talk over problems with people without letting them know I'm angry. *

_____ 25. When I get angry, I calm down faster than most people. *

_____ 26. I get so angry, I feel like I might lose control.

_____ 27. If I let people see the way I feel, I'd be considered a hard person to get along with.

_____ 28. I am on my guard with people who are friendlier than I expected.

_____ 29. It's difficult for me to let people know I'm angry.

30. I get angry when:

_____ a. someone lets me down.

_____ b. people are unfair.

_____ c. something blocks my plans.

_____ d. I am delayed.

_____ e. someone embarrasses me.

_____ f. I have to take orders from someone less capable than I.

_____ g. I have to work with incompetent people.

_____ h. I do something stupid.

_____ i. I am not given credit for something I have done.

* Reverse scored

Appendix G: State-Trait Anxiety Inventory

A number of statements which people have used to describe themselves are given below. Read each statement and then circle the appropriate number to the right of the statement to indicate how you feel right now, that is, at this moment. There are no right or wrong answers. Do not spend too much time on any one statement but give the answer which seems to describe your present feelings best.

	Not at all	Somewhat	Moderately so	Very much so
1. I feel calm	1	2	3	4 *
2. I feel secure	1	2	3	4 *
3. I am tense	1	2	3	4
4. I feel strained	1	2	3	4
5. I feel at ease	1	2	3	4 *
6. I feel upset	1	2	3	4
7. I am presently worrying over possible misfortunes	1	2	3	4
8. I feel satisfied	1	2	3	4 *
9. I feel frightened	1	2	3	4
10. I feel comfortable	1	2	3	4 *
11. I feel self-confident	1	2	3	4 *
12. I feel nervous	1	2	3	4
13. I am jittery	1	2	3	4
14. I feel indecisive	1	2	3	4
15. I am relaxed	1	2	3	4 *
16. I feel content	1	2	3	4 *

	Not at all	Somewhat	Moderately so	Very much so
17. I am worried	1	2	3	4
18. I feel confused	1	2	3	4
19. I feel steady	1	2	3	4 *
20. I feel pleasant	1	2	3	4 *

A number of statements which people have used to describe themselves are given below. Read each statement and then circle the appropriate number to the right of the statement to indicate how you generally feel. There are no right or wrong answers. Do not spend too much time on any one statement but give the answer which seems to describe how you generally feel.

	Almost never	Sometimes	Often	Almost always
21. I feel pleasant	1	2	3	4 *
22. I feel nervous and restless	1	2	3	4
23. I feel satisfied with myself	1	2	3	4 *
24. I wish I could be as happy as others seem to be	1	2	3	4
25. I feel like a failure	1	2	3	4
26. I feel rested	1	2	3	4 *
27. I am "calm, cool, and collected"	1	2	3	4 *
28. I feel that difficulties are piling up so that I cannot overcome them	1	2	3	4
29. I worry too much over something that really doesn't matter	1	2	3	4
30. I am happy	1	2	3	4 *

	Almost never	Sometimes	Often	Almost always
31. I have disturbing thoughts	1	2	3	4
32. I lack self-confidence	1	2	3	4
33. I feel secure	1	2	3	4 *
34. I make decisions easily	1	2	3	4 *
35. I feel inadequate	1	2	3	4
36. I am content	1	2	3	4 *
37. Some unimportant thought runs through my mind and bothers me	1	2	3	4
38. I take disappointments so keenly that I can't put them out of my mind	1	2	3	4
39. I am a steady person	1	2	3	4 *
40. I get in a state of tension or turmoil as I think over my recent concerns and interests	1	2	3	4

* Reverse scored

Appendix H: Client Satisfaction Questionnaire

Please help us improve our program by answering some questions about the services you have received at the Psychological Service Centre. We are interested in your honest opinions, whether they are positive or negative. Please answer all of the questions. We also welcome your comments and suggestions. Thank you very much. We appreciate your help.

Please circle your answer.

1. How would you rate the quality of service you received?

4	3	2	1
Excellent	Good	Fair	Poor

2. Did you get the kind of service you wanted?

1	2	3	4
No definitely not	No not really	Yes generally	Yes definitely

3. To what extent has our program met your needs?

4	3	2	1
Almost all of my needs have been met	Most of my needs have been met	Only a few of my needs have been met	None of my needs have been met

4. If a friend were in need of similar help, would you recommend our program to him/her?

1	2	3	4
No definitely not	No I don't think so	Yes I think so	Yes definitely

5. How satisfied are you with the amount of help you received?

1	2	3	4
Quite dissatisfied	Indifferent or mildly dissatisfied	Mostly satisfied	Very satisfied

6. Have the services you received helped you to deal more effectively with your problems?

4	3	2	1
Yes they helped a great deal	Yes they helped somewhat	No they really didn't help	No they seemed to make things worse

7. In an overall, general sense, how satisfied are you with the service you received?

4	3	2	1
Very satisfied	Mostly satisfied	Indifferent or mildly dissatisfied	Quite dissatisfied

8. If you were to seek help again, would you come back to our program?

1	2	3	4
No definitely not	No I don't think so	Yes I think so	Yes definitely

9. Were the activities and exercises on self-blame helpful to you?

4	3	2	1
Yes they helped a great deal	Yes they helped somewhat	No they really didn't help	No they seemed to make things worse

Which activities were particularly helpful or unhelpful?

_____

10. Were the activities and exercises on anger helpful to you?

4	3	2	1
Yes they helped a great deal	Yes they helped somewhat	No they really didn't help	No they seemed to make things worse

Which activities were particularly helpful or unhelpful?

_____

11. Were the activities and exercises on anxiety helpful to you?

4	3	2	1
Yes they helped a great deal	Yes they helped somewhat	No they really didn't help	No they seemed to make things worse

Which activities were particularly helpful or unhelpful?

_____

Additional Comments: _____

Appendix I: Pleasant Events Schedule

This schedule is designed to find out about the things you have enjoyed during the past two weeks. The schedule contains a list of events or activities which people sometimes enjoy. You will be asked to go over the list twice, the first time rating each event on how many times it has happened in the past two weeks and the second time rating each event on how pleasant it has been for you. There are no right or wrong answers.

How often have these events happened in your life in the past 2 weeks?

Please answer this question by rating each item on the following scale:

0 - This has not happened in the past 2 weeks.

1 - This has happened a few times (1 to 6) in the past 2 weeks.

2 - This has happened often (7 or more) in the past 2 weeks.

Important: Some items will list more than one event; for these items, mark how often you have done any of the listed events. Since this list contains events that might happen to a wide variety of people, you may find that many of the events have not happened to you in the past 2 weeks. It is not expected that anyone will have done all of these things in 2 weeks.

1. Laughing	0	1	2
2. Being relaxed	0	1	2
3. Being with happy people	0	1	2
4. Eating good meals	0	1	2
5. Thinking about something good in the future	0	1	2
6. Having people show interest in what you have said	0	1	2
7. Thinking about people I like	0	1	2
8. Seeing beautiful scenery	0	1	2
9. Breathing clean air	0	1	2

10. Being with friends	0	1	2
11. Having peace and quiet	0	1	2
12. Being noticed as sexually attractive	0	1	2
13. Kissing	0	1	2
14. Watching people	0	1	2
15. Having a frank and open conversation	0	1	2
16. Sitting or being in the sun *	0	1	2
17. Wearing clean clothes	0	1	2
18. Having spare time	0	1	2
19. Doing a project in my own way	0	1	2
20. Sleeping soundly at night	0	1	2
21. Listening to music	0	1	2
22. Having sexual relations with a partner *	0	1	2
23. Smiling at people	0	1	2
24. Being told I am loved	0	1	2
25. Reading stories, novels, poems, or plays	0	1	2
26. Planning or organizing something	0	1	2
27. Going to a restaurant	0	1	2
28. Expressing my love to someone	0	1	2
29. Petting, necking	0	1	2
30. Being with someone I love	0	1	2

31. Seeing good things happen to my family or friends	0	1	2
32. Complimenting or praising someone	0	1	2
33. Having a coffee, tea, coke, etc., with friends	0	1	2
34. Meeting someone new *	0	1	2
35. Driving skillfully	0	1	2
36. Saying something clearly	0	1	2
37. Being with animals	0	1	2
38. Being popular at a gathering	0	1	2
39. Having a lively talk	0	1	2
40. Feeling the presence of the Lord in my life	0	1	2
41. Planning trips or vacations	0	1	2
42. Listening to the radio	0	1	2
43. Learning to do something new	0	1	2
44. Seeing old friends	0	1	2
45. Watching wild animals	0	1	2
46. Doing a job well	0	1	2
47. Being asked for my help or advice	0	1	2
48. Amusing people	0	1	2
49. Being complimented or told I have done well	0	1	2

Now please go over the list once again. This time the question is:

How pleasant, enjoyable, or rewarding was each event during the past 2 weeks?

Please answer this question by rating each event on the following scale:

0 - This was not pleasant. (Use this rating for events which were either neutral or unpleasant)

1 - This was somewhat pleasant. (Use this rating for events which were mildly or moderately pleasant)

2 - This was very pleasant. (Use this rating for events which were strongly or extremely pleasant).

Important: If an event has happened to you more than once in the past 2 weeks, try to rate roughly how pleasant it was on the average. If an event has not happened to you during the past 2 weeks, then rate it according to how much fun you think it would have been. Please rate every event and circle the number that best corresponds to your rating. The list of items may have some events which you would not enjoy. The list was made for a wide variety of people, and it is not expected that one person would enjoy all of them.

1. Laughing	0	1	2
2. Being relaxed	0	1	2
3. Being with happy people	0	1	2
4. Eating good meals	0	1	2
5. Thinking about something good in the future	0	1	2
6. Having people show interest in what you have said	0	1	2
7. Thinking about people I like	0	1	2
8. Seeing beautiful scenery	0	1	2
9. Breathing clean air	0	1	2
10. Being with friends	0	1	2

11. Having peace and quiet	0	1	2
12. Being noticed as sexually attractive	0	1	2
13. Kissing	0	1	2
14. Watching people	0	1	2
15. Having a frank and open conversation	0	1	2
16. Sitting or being in the sun *	0	1	2
17. Wearing clean clothes	0	1	2
18. Having spare time	0	1	2
19. Doing a project in my own way	0	1	2
20. Sleeping soundly at night	0	1	2
21. Listening to music	0	1	2
22. Having sexual relations with a partner *	0	1	2
23. Smiling at people	0	1	2
24. Being told I am loved	0	1	2
25. Reading stories, novels, poems, or plays	0	1	2
26. Planning or organizing something	0	1	2
27. Going to a restaurant	0	1	2
28. Expressing my love to someone	0	1	2
29. Petting, necking	0	1	2
30. Being with someone I love	0	1	2
31. Seeing good things happen to my family or friends	0	1	2

32. Complimenting or praising someone	0	1	2
33. Having a coffee, tea, coke, etc., with friends	0	1	2
34. Meeting someone new *	0	1	2
35. Driving skillfully	0	1	2
36. Saying something clearly	0	1	2
37. Being with animals	0	1	2
38. Being popular at a gathering	0	1	2
39. Having a lively talk	0	1	2
40. Feeling the presence of the Lord in my life	0	1	2
41. Planning trips or vacations	0	1	2
42. Listening to the radio	0	1	2
43. Learning to do something new	0	1	2
44. Seeing old friends	0	1	2
45. Watching wild animals	0	1	2
46. Doing a job well	0	1	2
47. Being asked for my help or advice	0	1	2
48. Amusing people	0	1	2
49. Being complimented or told I have done well	0	1	2

* Slightly modified wording

Appendix J: "How I see myself now" Scale

Please use the following scale to indicate how you see yourself now.

1	2	3	4	5	6	7
Never	Rarely	Sometimes	Half the time	Often	Usually	Always

_____ 1. self-confident

_____ 2. guilty *

_____ 3. accepting of others

_____ 4. fearful *

_____ 5. assertive

_____ 6. emotional relations are hard *

_____ 7. happy

_____ 8. trusting of women

_____ 9. angry *

_____ 10. needy *

_____ 11. able to ask for help or support

_____ 12. clear about my values

_____ 13. feel good about getting help or support

_____ 14. timid *

_____ 15. lonely *

_____ 16. trusting of friends

_____ 17. independent

_____ 18. in good shape

_____ 19. pushed around *

_____ 20. isolated *

_____ 21. competent

_____ 22. deserving praise

_____ 23. effective

_____ 24. trusting of strangers

_____ 25. strong

_____ 26. self-respecting

_____ 27. worthy of getting help or support

_____ 28. self-sufficient

_____ 29. vulnerable *

_____ 30. doing well

_____ 31. anxious *

_____ 32. trusting of men

_____ 33. clear about my needs

_____ 34. able to take care of myself

_____ 35. autonomous

_____ 36. depressed *

_____ 37. nervous *

_____ 38. in control of my life

_____ 39. sexual relations are hard *

_____ 40. trusting of myself

_____ 41. deserving of blame *

* Reverse scored

Appendix K: Daily Self-Rating Measures

Please complete the three daily self-rating measures in the evening and assign an overall average rating which best described your day.

Self-Blame

Overall, what was the average level of self-blame which you experienced today with respect to your childhood sexual abuse?

1	2	3	4	5	6	7	8	9	10
None				Somewhat					As much as you can imagine

In a word or sentence, write down what you feel contributed most to this rating?

_____

Anger

Overall, what was the average level of anger which you experienced today with respect to your childhood sexual abuse?

1	2	3	4	5	6	7	8	9	10
None				Somewhat					As much as you can imagine

In a word or sentence, write down what you feel contributed most to this rating?

_____

Anxiety

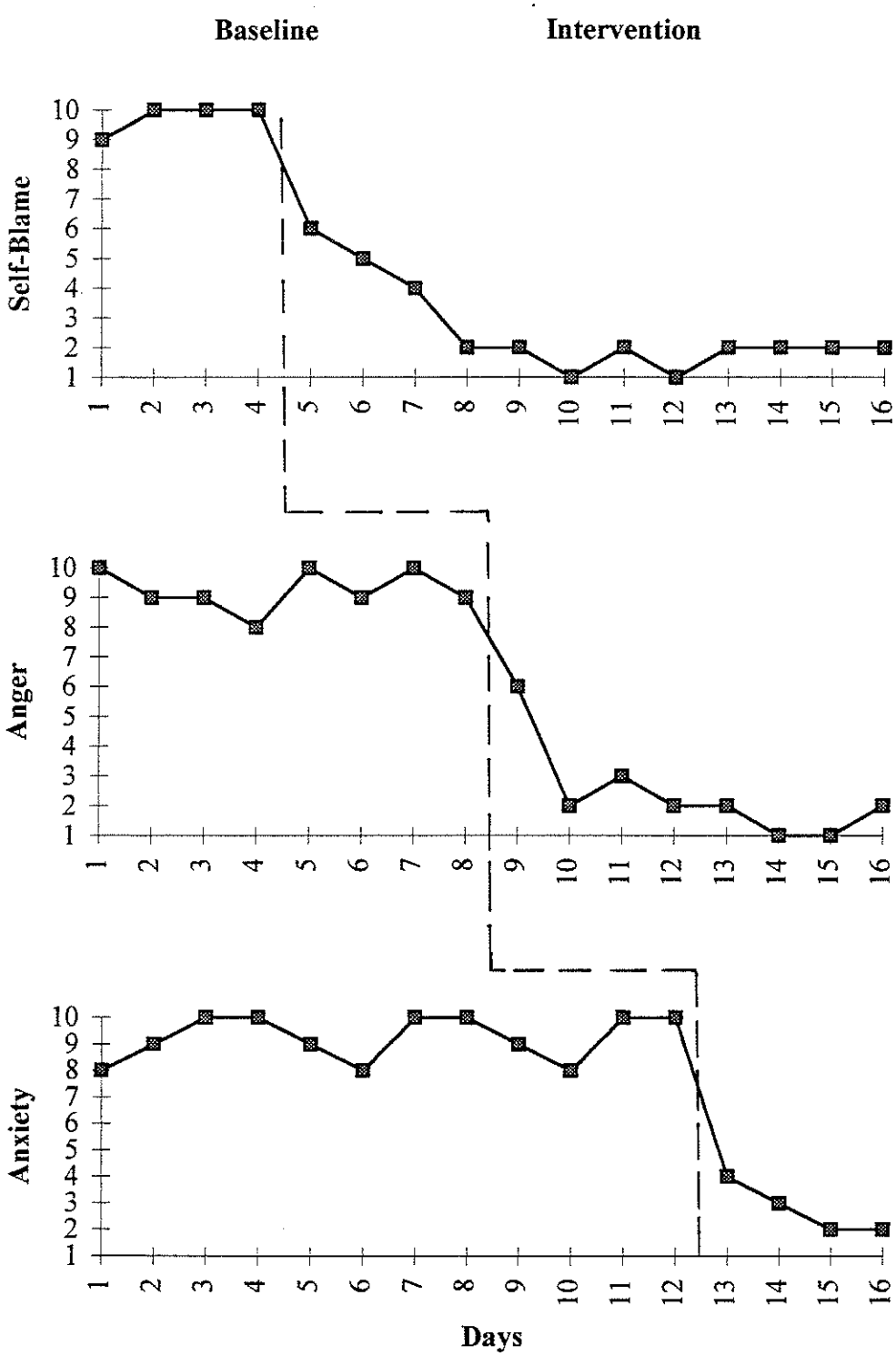
Overall, what was the average level of anxiety which you experienced today with respect to your childhood sexual abuse?

1	2	3	4	5	6	7	8	9	10
None				Somewhat					As much as you can imagine

In a word or sentence, write down what you feel contributed most to this rating?

_____

Appendix L: Illustration of a Multiple-Baseline Across Behaviours Design



Appendix M: Consent Form

In order to be more helpful to individuals who have experienced sexual abuse during childhood, we are conducting a study to examine the usefulness of an individual treatment program. Our goal is to explore which components of therapy seem the most beneficial so that we may develop treatment programs that most effectively meet the needs of males who have been sexually abused.

In order to receive the most benefits from treatment, it is important that you make a commitment to attend all scheduled therapy sessions as well as all assessment sessions prior to and following the completion of the individual treatment program. Your participation in the study will require that you agree to have all therapy sessions videotaped. These videotapes will be kept strictly confidential and will be used for supervision purposes as well as to ensure that the treatment procedures are being carried out as planned.

An important component of the study is obtaining information from participants about their progress in the treatment program. Your participation in the study will mean that you will be required to complete a set of questionnaires before and after treatment. Also, throughout the course of individual therapy, you will be asked to complete daily self-ratings and bi-weekly self-monitoring measures. The completion of these homework assignments is critical because the positive changes that you make in therapy depend considerably on the amount of work that you are willing to do. Significant others will also be asked to complete weekly ratings on the benefits that they believe you are achieving in therapy. This information is important because it helps us gain another perspective on the progress you are making during the treatment program.

The information that you and significant others provide will be confidential. If the results

of this study are published or presented in a professional forum, careful steps will be taken to ensure that all identifying data will be protected.

Your participation in the individual treatment program is completely voluntary. You are free to withdraw from the study at any time.

I understand that any information about me obtained through this research study will be kept strictly confidential. I have been informed about the nature and requirements of the study and I agree to participate. I also realize that I have the option to withdraw from the study at any point in time.

Name: _____

Signature: _____

Date: _____

Witness: _____

Elisa Romano, M. A.
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Appendix N: Outline of the Individual Treatment Program

Introduction to the Treatment Program

1. Explain the format of sessions and process of therapy

a. Weekly or twice weekly one-hour sessions

b. Sessions will be videotaped

c. The main components of the treatment package are self-blame, anger, and anxiety, which are commonly found among men and women who have experienced childhood sexual abuse.

d. There is no "quick fix" in therapy and there may actually be periods of stagnation or actual set backs as one begins to really work through and focus on difficult issues.

e. Does the client have any questions or comments?

2. Review confidentiality and ground rules

a. The client's right to privacy will be respected.

b. Limits to confidentiality include knowledge of abuse of children and feelings of wanting to harm oneself or another. In such cases, the appropriate steps need to be taken to ensure the safety of the client and others, such as contacting child welfare agencies or the police.

c. Other limits include legal involvement, supervision, and observation of videotape by psychology students for purposes of the research project.

d. Some ground rules include regular attendance and punctuality, which foster trust and safety in therapy. If a session needs to be cancelled, the client is asked to contact the therapist beforehand. Another ground rule is the completion of all homework assignments because the rate of progress in therapy depends largely on the amount of independent work that the the client is willing to do.

e. Does the client have any questions or comments?

3. Assignment of reading material

a. Give the client a copy of the booklet When Males Have Been Sexually Abused: A Guide For Adult Male Survivors (Napier-Hemy, 1994). Explain that the booklet provides an introduction to childhood sexual abuse and being involved in therapy. The booklet may be read at the client's leisure.

Self-Blame

1. Introduction to the self-blame component of therapy

a. Explain that feelings of self-blame and guilt sometimes protect individuals who have been sexually abused from being overwhelmed with feelings of powerlessness and lack of control. Acknowledge the client's feelings of self-blame and guilt and inform him that these feelings generally decrease as the client begins to address his childhood sexual abuse and begins to feel better (Draucker, 1992).

2. Begin to address the origins of self-blame feelings and explore the issues of responsibility and power as they relate to the client's sexual abuse experience.

a. Introduce the first exercise on self-blame, guilt, and responsibility in the following manner: "One of the most common things that happens to a child who has been sexually abused is that he feels guilty and ashamed of what has happened and often blames himself. The offender uses their power and position as a way of avoiding taking responsibility for their actions. I would like you to think back to your offender. How did the offender free themselves from responsibility for the sexual abuse and make you feel blamed? What did they say? How did they act?" Write down the client's responses on a flip chart and explore any responses that may require further explanation.

b. Introduce the second exercise in the following manner: "Often, the offender goes to a great deal of trouble and planning to engage the child in the sexual activity and to make sure that the abuse is kept a secret so that they are not caught or found out. I would like you to think back to your offender. How did they engage and entrap you and make you feel like you were responsible and to blame for the abuse? What sort of bribes, threats, etc. were used?" Write down the client's responses on a flip chart and explore any responses that may require further explanation.

c. Introduce the third exercise in the following manner: "I would now like to do an exercise to help understand why it was that you were able to be engaged and entrapped and made to feel that you were responsible and to blame for the sexual abuse. What I would like to do is look at the differences between a child and an adult (or older person) and to see who really had the responsibility and power. I will divide the flip chart into two columns, one labelled Child and the other labelled Adult (or Older Person). I would like you to give me some words to describe each one. For example, I can write the word 'little' under the Child column and the word 'big' under the Adult column. Can you think of any other words to help understand the differences between an adult and a child?" Write down the client's responses on a flip chart and explore any responses that may require further explanation.

(All these exercises were adapted from Saxe, 1993)

3. Examine the myths and misinformation about childhood sexual abuse which contribute to self-blame and utilize psycho-education and cognitive restructuring to correct the client's distorted beliefs.

a. Introduce the method of cognitive restructuring by explaining that it is based on the principle that beliefs influence feelings and that distorted beliefs may lead to distressing feelings.

b. Help the client identify some of their beliefs or myths which may be contributing to their feelings of self-blame. Some of these beliefs or myths may be derived from the client's responses to the previous exercises (see # 2a and2b). The following beliefs must be addressed as they are particularly relevant to sexually abused males and feelings of self-blame: the effect of sexual abuse on masculinity and sexual orientation; responding physiologically to the sexual activity with pleasure or arousal; failure to end the sexual abuse (perhaps through a lack of disclosure of the abuse).

c. Review each belief with the client in the following manner: ask the client to further explain their response; help the client to recognize distortions in their beliefs (e.g., using an adult perspective to interpret their childhood beliefs and actions related to the sexual abuse); and encourage the client to explore alternative beliefs by presenting psycho-educational information about childhood sexual abuse.

(Draucker, 1992; Meiselman, 1990; Schwartz, 1994)

d. With regard to masculinity and sexual orientation, psycho-education will involve informing the client that (1) childhood sexual abuse does not make someone homosexual or heterosexual, (2) most male offenders do not engage exclusively in same-sex abuse and are not homosexual, and (3) the sexual abuse of children is not about sexual identity but rather about power and control. Homosexual individuals are no more likely to sexually abuse children than heterosexual people (Dimock, 1988; Draucker, 1992; Meiselman, 1990; Nice & Forrest, 1990).

e. With regard to responding physiologically to the sexual activity, psycho-education will involve informing the client that the body naturally responds to touch and sexual stimulation, even during sexual abuse. The body can not tell the difference between sexual contact that is

good versus sexual contact that is bad and wrong. Also, a child needs and seeks attention and affection. If these basic needs are not met in healthy ways, a child will try to meet them in whatever ways are open to them (Draucker, 1992; Nice & Forrest, 1990).

f. With regard to secret keeping and not disclosing the sexual abuse, psycho-education will involve considering childhood assumptions about the consequences of disclosure (e.g., punishment or disbelief, family break-up, rejection by the offender). Also, the client may need to consider that telling others about the sexual abuse is a pro-active behaviour which is often simply not in the behavioural repertoire of a child. Finally, the client may need to consider that disclosure would have required receptive significant others, which may not have been available during the client's childhood (Draucker, 1992).

4. Explore ways in which the client can cope with feelings of self-blame.

a. Have the client write down a minimum of two compassion-filled messages that he can refer to when he begins to experience feelings of self-blame (Nice & Forrest, 1990).

b. Discuss reading material which may be helpful in further addressing the client's self-blame feelings (Bruckner & Johnson, 1987).

c. Ask the client to view photographs of himself at the time when the abuse was occurring or to observe children similar in age to when his sexual abuse began. In doing this exercise, encourage the client to remind himself that he was not capable of initiating or consenting to sexual activity, that he was physically small and dependent on others, and that adults were responsible for his safety and well-being (Draucker, 1992). If the client wishes, he may bring the photographs into session and engage the therapist in this exercise.

d. Examine ways in which the client may continue to maintain the positive changes which he has

made with regard to the issue of self-blame. In particular, ask the client to think of ways in which he can cue significant others in his life to support these changes.

Anger

1. Introduction to the anger component of therapy

a. Introduce the topic of anger as a universal issue with which everyone struggles and then ask the client to respond to the question "How do most people view anger?" Write down the client's responses on a flip chart and explore any responses that may require further explanation (Saxe, 1993).

2. Begin to address anger as it relates to the client's sexual abuse experience.

a. Introduce the topic of anger in the following manner: "Feelings of anger are commonly found among adults who have experienced childhood sexual abuse. For some individuals, anger is associated with violence, rejection, and a loss of control rather than being seen as a valid response to being abused. For these individuals, they may deny their angry feelings because of their fear of losing control. On the other hand, some adults who have been sexually abused are so immersed in their anger that they are often in a rage, lashing out at people in their lives, and may even be physically violent towards others."

b. Ask the client about whom he feels anger towards (e.g., offender, family of origin) and write down his responses on a flip chart. Also, ask the client "How have you seen anger as being helpful and not helpful with regard to your sexual abuse experiences?" On a flip chart, create two columns labelled Helpful and Not Helpful and write down the client's responses. Explore any responses that may require further explanation.

c. Introduce the topic of anger expression in the following manner: "Being able to feel anger and

express angry feelings is extremely important for adults who have been sexually abused. When an individual is angry and doesn't express it, he may end up feeling depressed, frustrated, and anxious. In order to feel emotionally healthy, an individual must be able to freely feel and express all his emotions, especially anger, without negative consequences. However, anger must be expressed constructively and safely."

d. Ask the client to respond to the question "What is your worst fear about expressing your anger?" Write down the client's responses and explore any responses that may require further explanation.

(All these exercises were adapted from Saxe, 1993)

e. In order to explore feelings which may underlie anger, explain to the client that anger is a feeling that most men have cultural permission to express. As such, anger often becomes an all-encompassing emotion. Ask the client to think of some emotions that may be covered up by anger and rage (e.g., powerlessness, sadness). Write down the client's responses on a flip chart. Explore the client's as well as society's beliefs about the male expression of feelings other than anger. Help the client challenge these beliefs about male emotional expression by examining whether they fit for him and his life (Crowder, 1995).

3. Engage the client in activities which focus on expressing abuse-related anger.

a. Explain that anger may be expressed in many constructive and safe ways and that one way which seems helpful for individuals who have been sexually abused is to write a letter to their offender. Inform the client that writing a letter may also help him to begin exploring more difficult feelings, such as those of grief, loss, and powerlessness, and that the letter does not need to be sent to the offender.

b. Write down the following instructions for the letter writing exercise on a flip chart: The letter should (1) confront the offender with the impact of the abuse on the client's life, (2) relate the client's feelings about the abuse, (3) convey the client's feelings toward the offender, and (4) if possible, state what the client wishes the offender to do (Draucker, 1992; Sanderson, 1995; Singer, 1989). Provide the client with some paper and a pencil and inform him that he will be given some time to construct the letter.

c. Guide the client in a gestalt empty chair activity, in which he imagines the offender sitting in a chair. Ask the client to read the letter to his offender. Process the client's experience of the exercise (Crowder, 1995; Jongsma & Peterson, 1995; Sanderson, 1995).

d. Have the client think of and write down other ways of expressing anger constructively and safely (e.g., physical activity, talking to friends, punching a pillow, taking a hot bath). If the letter writing exercise appeared helpful, the client may be encouraged to write additional letters to other individuals connected with the abuse, such as the client's parents or other family members (Singer, 1989).

e. Examine ways in which the client may continue to maintain the positive changes which he has made with regard to the issue of anger. In particular, ask the client to think of ways in which he can cue significant others in his life to support these changes.

4. Explore the client's revenge fantasies.

a. Inform the client that many males who have experienced childhood sexual abuse have revenge fantasies in which they imagine getting even with their offender. Explain that, while it may be difficult to talk about these fantasies, they are less likely to gain momentum and to be acted upon when they are spoken about rather than kept a secret.

b. In order to help the client release feelings of anger and rage related to the sexual abuse, a symbolic enactment exercise may be introduced. Bring in a large piece of paper and have the client construct a collage with reminders of the abuse and the offender by drawing or pasting material from magazines onto the paper. After, the client is asked to destroy the paper by tearing it up. Explore the client's feelings after the exercise has been completed (adapted from Crowder, 1995).

5. Help the client prepare for a future confrontation with a significant other. This component of therapy should only be implemented if the client expresses a desire for a confrontation and if the therapist feels that the client is psychologically ready for such a confrontation (i.e., client has worked through issues of denial, minimization, and self-blame).

a. The method of role playing is introduced to the client. Several role plays may be introduced, such as the client assuming the role of the sexually abused individual, offender, or non-offending significant other. Clients will need to be prepared for the possible consequences of a confrontation, including the relative benefits gained from such an action as well as possible negative ramifications (Draucker, 1992; Sanderson, 1995).

Anxiety

1. Introduction to the anxiety component of therapy

a. Explain that childhood sexual abuse is often a highly threatening and disruptive experience which may lead to strong feelings of anxiety and fear and that these feelings may resemble the same kind of anxiety and fear that the client felt as a child during the sexual abuse. Also, inform the client that individuals sometimes attempt to cope with these feelings through alcohol or

substance use or the development of other addictions. Also, it is important to mention that overwhelming feelings of anxiety may lead to problems in sexual functioning (Briere, 1992; Nice & Forrest, 1990).

2. Begin to address the client's experience of anxiety and the relationship between anxiety and the client's sexual abuse experience.

a. Ask the client to respond to several questions related to his feelings of anxiety and their association with his sexual abuse experience. Write down the client's responses on a flip chart and explore any responses that may require further explanation. The following questions will need to be explored with the client: (1) "What sorts of situations, thoughts, and beliefs make you feel anxious?" (2) "How do you know that you are feeling anxious or what kinds of symptoms do you experience (e.g., muscle tension, concentration difficulties)?" (3) "How are your current feelings of anxiety connected with your childhood abuse?" and (4) "What strategies do you use now (and what strategies did you use as a child) to cope with your anxiety?" (adapted from Jongsma & Peterson, 1995).

3. Introduce cognitive restructuring techniques to help the client cope with feelings of anxiety.

a. Review the method of cognitive restructuring by explaining that it is based on the principle that beliefs influence feelings and that distorted beliefs may lead to anxious feelings.

b. Help the client identify some of the thoughts or beliefs which may be contributing to their feelings of anxiety, fear, and worry. Some of these thoughts or beliefs may be derived from the client's responses to the previous exercises (see #2).

c. Review each thought with the client in the following manner: (1) ask the client to provide

evidence to support his thoughts. Help the client identify his use of faulty logic by correcting misinformation and encouraging the client to test out his hypotheses; (2) ask the client to examine his thoughts in alternative ways by considering more neutral and realistic interpretations. Such interpretations may involve the client challenging the belief that he is the focal point of events, gaining a broader perspective of events, and re-examining his attributions, particularly those of excessive personal control; and (3) ask the client to consider the consequences of a feared situation occurring. This component of cognitive work may involve helping the client to de-catastrophize consequences and to develop appropriate coping strategies. The client's responses may be written on a flip chart with columns labelled Situation, Anxiety-Provoking Thought, Questioning the Evidence, Alternative Interpretations, and Consequences (Beck, Emery, & Greenberg, 1985; Davis et al., 1988).

d. Present the thought stopping procedure (Cautela & Wisocki, 1973; Davis et al., 1988) by explaining the rationale and describing the procedure. The client may use previously identified anxiety-provoking thoughts in the thought stopping procedure. The therapist leads the client through the exercise.

e. The client is encouraged to practise the thought stopping procedure throughout the day for one week.

4. Introduce behavioural techniques to help the client cope with feelings of anxiety.

a. Present the progressive muscle relaxation method described by Bernstein and Borkovec (1973). This method involves explaining the rationale for the procedures and teaching the client how to tense the following muscle groups: arms; hands; face; neck; shoulders; chest; abdomen; buttocks; legs; and feet. Once the introduction has been completed, the therapist leads the client

in the progressive muscle relaxation procedure.

b. The progressive muscle relaxation exercise is audiotaped and given to the client, who is encouraged to practise the procedure daily for one to two weeks. He is also given some instructions concerning home practice (e.g., choosing a setting where interruptions will be minimized).

c. Examine ways in which the client may continue to maintain the positive changes which he has made with regard to the issue of anxiety. In particular, ask the client to think of ways in which he can cue significant others in his life to support these changes.

Termination of the Treatment Program

1. Address feelings associated with termination (e.g., sadness, loss, fear of the future).

2. Review of therapy

a. Review the client's progress and provide positive feedback on changes the client has made.

b. Present the client with a certificate acknowledging his successful completion of treatment.

3. Acknowledge the importance of the therapeutic relationship to both the client and therapist.

a. Share feelings about the relationship

b. Explore the client's future plans (Draucker, 1992).

c. Present the client with a copy of the handout entitled "Personal Bill of Rights" (adapted from Saxe, 1993).

4. Post-treatment

a. Plan for the post-treatment assessment session

Appendix O: Procedural Reliability Checklist

As you observe the videotaped therapy session, please complete your procedural reliability checks using the following scoring procedure:

If a treatment procedure specified in the outline has occurred, assign a value of 1.

If a treatment procedure specified in the outline has not occurred, assign a value of 0.

If you are uncertain about whether a treatment procedure has occurred as specified in the outline or it has only partially occurred, assign a value of 1/2.

Introduction to the Treatment Program

1. Explain the format of sessions and process of therapy

_____ a. Weekly or twice weekly one-hour sessions

_____ b. Sessions will be videotaped

_____ c. The main components of the treatment package focus on feelings of self-blame, anger, and anxiety, which are commonly found among men and women who have experienced childhood sexual abuse.

_____ d. There is no "quick fix" in therapy and there may actually be periods of stagnation or actual set backs as one begins to really work through and focus on difficult issues.

_____ e. Does the client have any questions or comments?

2. Review confidentiality and ground rules

_____ a. The client's right to privacy will be respected.

_____ b. Limits to confidentiality include knowledge of abuse of children and feelings of wanting to harm oneself or another. In such cases, the appropriate steps need to be taken to ensure the safety of the client and others, such as contacting child welfare agencies or the police.

_____ c. Other limits include legal involvement, supervision, and observation of videotape by psychology students for purposes of the research project.

_____ d. Some ground rules include regular attendance and punctuality, which foster trust and safety in therapy. If a session needs to be cancelled, the client is asked to contact the therapist beforehand. Another ground rule is the completion of all homework assignments because the rate of progress in therapy depends largely on the amount of independent work that the the client is willing to do.

_____ e. Does the client have any questions or comments?

3. Assignment of reading material

_____ a. Give the client a copy of the booklet When Males Have Been Sexually Abused: A Guide For Adult Male Survivors. Explain that the booklet provides an introduction to childhood sexual abuse and being involved in therapy. The booklet may be read at the client's leisure.

Self-Blame

1. Introduction to the self-blame component of therapy

_____ a. Explain that feelings of self-blame and guilt sometimes protect individuals who have been sexually abused from being overwhelmed with feelings of powerlessness and lack of control. Acknowledge the client's feelings of self-blame and guilt and inform him that these feelings generally decrease as the client begins to address his childhood sexual abuse and begins to feel better.

2. Begin to address the origins of self-blame feelings and explore the issues of responsibility and power as they relate to the client's sexual abuse experience.

_____ a. Introduce the first exercise on self-blame, guilt, and responsibility in the following manner: "One of the most common things that happens to a child who has been sexually abused is that he feels guilty and ashamed of what has happened and often blames himself. The offender uses their power and position as a way of avoiding taking responsibility for their actions. I would like you to think back to your offender. How did the offender free themselves from responsibility for the sexual abuse and made you feel blamed? What did they say? How did they act?" Write down the client's responses on a flip chart and explore any responses that may require further explanation.

_____ b. Introduce the second exercise in the following manner: "Often, the offender goes to a great deal of trouble and planning to engage the child in the sexual activity and to make sure that the abuse is kept a secret so that they are not caught or found out. I would like you to think back to your offender. How did they engage and entrap you and make you feel like you were responsible and to blame for the abuse? What sort of bribes, threats, etc. were used?" Write down the client's responses on a flip chart and explore any

responses that may require further explanation.

_____ c. Introduce the third exercise in the following manner: "I would now like to do an exercise to help you understand why it was that you were able to be engaged and entrapped and made to feel that you were responsible and to blame for the sexual abuse. What I would like to do is look at the differences between a child and an adult (or older person) and to see who really had the responsibility and power. I will divide the flip chart into two columns, one labelled Child and the other labelled Adult (or Older Person). I would like you to give me some words to describe each one. For example, I can write the word 'little' under the Child column and the word 'big' under the Adult column. Can you think of any other words to help understand the differences between an adult and a child?" Write down the client's responses on a flip chart and explore any responses that may require further explanation.

3. Examine the myths and misinformation about childhood sexual abuse which contribute to self-blame and utilize psycho-education and cognitive restructuring to correct the client's distorted beliefs.

_____ a. Introduce the method of cognitive restructuring by explaining that it is based on the principle that beliefs influence feelings and that distorted beliefs may lead to distressing feelings.

_____ b. Help the client identify some of their beliefs or myths which may be contributing to their feelings of self-blame. Some of these beliefs or myths may be derived from the client's responses to the previous exercises (see # 2a and2b). The following beliefs must be addressed as they are particularly relevant to sexually abused males and feelings of self-blame: the effect of sexual abuse on masculinity and sexual orientation; responding physiologically to the sexual activity with pleasure or arousal; failure to end the sexual abuse (perhaps through a lack of disclosure of the abuse).

_____ c. Review each belief with the client in the following manner: ask the client to further explain their response; help the client to recognize distortions in their beliefs (e.g., using an adult perspective to interpret their childhood beliefs and actions related to the sexual abuse); and encourage the client to explore alternative beliefs by presenting psycho-educational information about childhood sexual abuse.

_____ d. With regard to masculinity and sexual orientation, psycho-education will involve informing the client that (1) childhood sexual abuse does not make someone homosexual or heterosexual, (2) most male offenders do not engage exclusively in same-sex abuse and are not homosexual, and (3) the sexual abuse of children is not about sexual identity but rather about power and control. Homosexual individuals are no more likely to sexually abuse children than heterosexual people.

_____ e. With regard to responding physiologically to the sexual activity, psycho-education will involve informing the client that the body naturally responds to touch and sexual stimulation, even during sexual abuse. The body can not tell the difference between sexual contact that is good versus sexual contact that is bad and wrong. Also, a child needs and seeks attention and affection. If these basic needs are not met in healthy ways, a child will try to meet them in whatever ways are open to them.

_____ f. With regard to secret keeping and not disclosing the sexual abuse, psycho-education will involve considering childhood assumptions about the consequences of disclosure (e.g., punishment or disbelief, family break-up, rejection by the offender). Also, the client may need to consider that telling others about the sexual abuse is a pro-active behaviour which is often simply not in the behavioural repertoire of a child. Finally, the client may need to consider that disclosure would have required receptive significant others, which may not have been available during the client's childhood.

4. Explore ways in which the client can cope with feelings of self-blame.

_____ a. Have the client write down a minimum of two compassion-filled messages that he can refer to when he begins to experience feelings of self-blame.

_____ b. Discuss reading material which may be helpful in further addressing the client's self-blame feelings.

_____ c. Ask the client to view photographs of himself at the time when the abuse was occurring or to observe children similar in age to when his sexual abuse began. In doing this exercise, encourage the client to remind himself that he was not capable of initiating or consenting to sexual activity, that he was physically small and dependent on others, and that adults were responsible for his safety and well-being. If the client wishes, he may bring the photographs into session and engage the therapist in this exercise.

_____ d. Examine ways in which the client may continue to maintain the positive changes which he has made with regard to the issue of self-blame. In particular, ask the client to think of ways in which he can cue significant others in his life to support these changes.

<u>Anger</u>

1. Introduction to the anger component of therapy

_____ a. Introduce the topic of anger as a universal issue with which everyone struggles and then ask the client to respond to the question "How do most people view anger?" Write down the client's responses on a flip chart and explore any responses that may require further explanation.

2. Begin to address anger as it relates to the client's sexual abuse experience.

_____ a. Introduce the topic of anger in the following manner: "Feelings of anger are commonly found among adults who have experienced childhood sexual abuse. For some individuals, anger is associated with violence, rejection, and a loss of control rather than being seen as a valid response to being abused. For these individuals, they may deny their angry feelings because of their fear of losing control. On the other hand, some adults who have been sexually abused are so immersed in their anger that they are often in a rage, lashing out at people in their lives, and may even be physically violent towards others."

_____ b. Ask the client about who he feels anger towards (e.g., offender, family of origin) and write down his responses on a flip chart. Also, ask the client "How have you seen anger as being helpful and not helpful with regard to your sexual abuse experiences?" On a flip chart, create two columns labelled Helpful and Not Helpful and write down the client's responses. Explore any responses that may require further explanation.

_____ c. Introduce the topic of anger expression in the following manner: "Being able to feel anger and express angry feelings is extremely important for adults who have been sexually abused. When an individual is angry and doesn't express it, he may end up feeling depressed, frustrated, and anxious. In order to feel emotionally healthy, an individual must be able to freely feel and express all his emotions, especially anger, without negative consequences. However, anger must be expressed constructively and safely."

_____ d. Ask the client to respond to the question "What is your worst fear about expressing your anger?" Write down the client's responses and explore any responses that may require further explanation.

_____ e. In order to explore feelings which may underlie anger, explain to the client that anger is a feeling that most men have cultural permission to express. As such, anger often becomes an all-encompassing emotion. Ask the client to think of some emotions that may be covered up by anger and rage (e.g., powerlessness, sadness). Write down the client's responses on a flip chart. Explore the client's as well as society's beliefs about the male expression of feelings other than anger. Help the client challenge these beliefs about male emotional expression by examining whether they fit for him and his life.

3. Engage the client in activities which focus on expressing abuse-related anger.

_____ a. Explain that anger may be expressed in many constructive and safe ways and that one way which seems helpful for individuals who have been sexually abused is to write a letter to their offender. Inform the client that writing a letter may also help him to begin exploring more difficult feelings, such as those of grief, loss, and powerlessness, and that the letter does not need to be sent to the offender.

_____ b. Write down the following instructions for the letter writing exercise on a flip chart: The letter should (1) confront the offender with the impact of the abuse on the client's life, (2) relate the client's feelings about the abuse, (3) convey the client's feelings toward the offender and (4) if possible, state what the client wishes the offender to do. Provide the client with some paper and a pencil and inform him that he will be given some time to construct the letter.

_____ c. Guide the client in a gestalt empty chair activity, in which he imagines the offender sitting in a chair. Ask the client to read the letter to his offender. Process the client's experience of the exercise.

_____ d. Have the client think of and write down other ways of expressing anger constructively and safely (e.g., physical activity, talking to friends, punching a pillow, taking a hot bath). If the letter writing exercise appeared helpful, the client may be encouraged to write additional letters to other individuals connected with the abuse, such as the client's parents or other family members.

_____ e. Examine ways in which the client may continue to maintain the positive changes which he has made with regard to the issue of anger. In particular, ask the client to think of ways in which he can cue significant others in his life to support these changes.

4. Explore the client's revenge fantasies

_____ a. Inform the client that many males who have experienced childhood sexual abuse have revenge fantasies in which they imagine getting even with their offender. Explain that, while it may be difficult to talk about these fantasies, they are less likely to gain momentum and to be acted upon when they are spoken about rather than kept a secret.

_____ b. In order to help the client release feelings of anger and rage related to the sexual abuse, a symbolic enactment exercise may be introduced. Bring in a large piece of paper and have the client construct a collage with reminders of the abuse and the offender by drawing or pasting material from magazines onto the paper. After, the client is asked to destroy the paper by tearing it up. Explore the client's feelings after the exercise has been completed.

5. Help the client prepare for a future confrontation with a significant other. This component of therapy should only be implemented if the client expresses a desire for a confrontation and if the therapist feels that the client is psychologically ready for such a confrontation (i.e., client has worked through issues of denial, minimization, and self-blame).

_____ a. The method of role playing is introduced to the client. Several role plays may be introduced, such as the client assuming the role of the sexually abused individual,

offender, or non-offending significant other. Clients will need to be prepared for the possible consequences of a confrontation, including the relative benefits gained from such an action as well as possible negative ramifications.

Anxiety

1. Introduction to the anxiety component of therapy

_____ a. Explain that childhood sexual abuse is often a highly threatening and disruptive experience which may lead to strong feelings of anxiety and fear and that these feelings may resemble the same kind of anxiety and fear that the client felt as a child during the sexual abuse. Also, inform the client that individuals sometimes attempt to cope with these feelings through alcohol or substance use or the development of other addictions. Also, it is important to mention that overwhelming feelings of anxiety may lead to problems in sexual functioning.

2. Begin to address the client's experience of anxiety and the relationship between anxiety and the client's sexual abuse experience.

_____ a. Ask the client to respond to several questions related to his feelings of anxiety and their association with his sexual abuse experience. Write down the client's responses on a flip chart and explore any responses that may require further explanation. The following questions will need to be explored with the client: (1) "What sorts of situations, thoughts, and beliefs make you feel anxious?", (2) "How do you know that you are feeling anxious or what kinds of symptoms do you experience (e.g., muscle tension, concentration difficulties)?", (3) "How are your current feelings of anxiety connected with your childhood abuse?", and (4) "What strategies do you use now (and what strategies did you use as a child) to cope with your anxiety?"

3. Introduce cognitive restructuring techniques to help the client cope with feelings of anxiety.

_____ a. Review the method of cognitive restructuring by explaining that it is based on the principle that beliefs influence feelings and that distorted beliefs may lead to anxious feelings.

_____ b. Help the client identify some of the thoughts or beliefs which may be contributing to their feelings of anxiety, fear, and worry. Some of these thoughts or beliefs may be derived from the client's responses to the previous exercises (see #2).

_____ c. Review each thought with the client in the following manner: (1) ask the client to provide evidence to support his thoughts. Help the client identify his use of faulty logic by correcting misinformation and encouraging the client to test out his hypotheses; (2)

ask the client to examine his thoughts in alternative ways by considering more neutral and realistic interpretations. Such interpretations may involve the client challenging the belief that he is the focal point of events, gaining a broader perspective of events, and re-examining his attributions, particularly those of excessive personal control; and (3) ask the client to consider the consequences of a feared situation occurring. This component of cognitive work may involve helping the client to de-catastrophize consequences and to develop appropriate coping strategies. The client's responses may be written on a flip chart with columns labelled Situation, Anxiety-Provoking Thought, Questioning the Evidence, Alternative Interpretations, and Consequences.

_____ d. Present the thought stopping procedure by explaining the rationale and describing the procedure. The client may use previously identified anxiety-provoking thoughts in the thought stopping procedure. The therapist leads the client through the exercise.

_____ e. The client is encouraged to practise the thought stopping procedure throughout the day for one week.

4. Introduce behavioural techniques to help the client cope with feelings of anxiety.

_____ a. Present the progressive muscle relaxation method. This method involves explaining the rationale for the procedures and teaching the client how to tense the following muscle groups: arms; hands; face; neck; shoulders; chest; abdomen; buttocks; legs; and feet. Once the introduction has been completed, the therapist leads the client in the progressive muscle relaxation procedure.

_____ b. The progressive muscle relaxation exercise is audiotaped and given to the client, who is encouraged to practise the procedure daily for one to two weeks. He is also given some instructions concerning home practice (e.g., choosing a setting where interruptions will be minimized).

_____ c. Examine ways in which the client may continue to maintain the positive changes which he has made with regard to the issue of anxiety. In particular, ask the client to think of ways in which he can cue significant others in his life to support these changes.

<u>Termination of the Treatment Program</u>

_____ 1. Address feelings associated with termination (e.g., sadness, loss, fear of the future).

2. Review of therapy

_____ a. Review the client's progress and provide positive feedback on the changes that the client has made.

_____ b. Present the client with a certificate acknowledging his successful completion of the treatment program.

3. Acknowledge the importance of the therapeutic relationship to both the client and therapist.

_____ a. Share feelings about the relationship

_____ b. Explore the client's future plans.

_____ c. Present the client with a copy of the handout entitled "Personal Bill of Rights."

4. Post-treatment

_____ a. Plan for the It should be noted that decisions about when to introduce the next component of treatment will be based on clients' self-rating measures. As such, not all of the procedures in the treatment outline may be completed. In terms of procedural reliability, the student observer will be instructed to focus on whether the order of procedures has been followed and not whether all of the procedures have been completed. post-treatment assessment session

Table 1

Steven's Self-Blame, Anger, and Anxiety Response to Treatment Interventions

	Baseline	Self-Blame Interventions	Anger Interventions	Anxiety Interventions
Self-Blame Response	5.4	**4.6**	2.7	2.2
Anger Response	5.8	5.6	**4.5**	2.3
Anxiety Response	4.1	5.2	4.0	**3.1**

Note. Numbers represent overall mean scores ranging from 1 - 10. Higher values indicate higher levels of self-blame, anger, and anxiety.

Table 2

Samuel's Self-Blame, Anger, and Anxiety Response to Treatment Interventions

	Baseline	Self-Blame Interventions	Anger Interventions	Anxiety Interventions
Self-Blame Response	6.1	**3.1**	1.0	1.0
Anger Response	5.6	5.0	**3.8**	1.8
Anxiety Response	5.2	3.2	3.9	**2.7**

Note. Numbers represent overall mean scores ranging from 1 - 10. Higher values indicate higher levels of self-blame, anger, and anxiety.

Table 3

Stan's Self-Blame, Anger, and Anxiety Response to Treatment Interventions

	Baseline	Self-Blame Interventions	Anger Interventions	Anxiety Interventions
Self-Blame Response	6.6	**4.8**	1.8	1.0
Anger Response	5.9	6.1	**4.2**	1.9
Anxiety Response	7.1	5.7	4.2	**3.3**

Note. Numbers represent overall mean scores ranging from 1 - 10. Higher values indicate higher levels of self-blame, anger, and anxiety.

Table 4

Scott's Self-Blame, Anger, and Anxiety Response to Treatment Interventions

	Baseline	Self-Blame Interventions	Anger Interventions	Anxiety Interventions
Self-Blame Response	5.3	**4.0**	1.8	1.0
Anger Response	6.3	6.3	**6.3**	5.0
Anxiety Response	5.6	6.6	6.4	**5.0**

Note. Numbers represent overall mean scores ranging from 1 - 10. Higher values indicate higher levels of self-blame, anger, and anxiety.

Table 5

Sean's Self-Blame, Anger, and Anxiety Response to Treatment Interventions

	Baseline	Self-Blame Interventions	Anger Interventions	Anxiety Interventions
Self-Blame Response	4.3	**5.6**	2.7	2.1
Anger Response	6.7	8.1	**6.4**	3.1
Anxiety Response	6.3	5.9	6.1	**5.3**

Note. Numbers represent overall mean scores ranging from 1 - 10. Higher values indicate higher levels of self-blame, anger, and anxiety.

Figure Captions

Figure 1. Steven's depression scores over assessment sessions.

Figure 2. Steven's self-esteem scores over assessment sessions.

Figure 3. Steven's blame scores over assessment sessions.

Figure 4. Steven's overall anger scores over assessment sessions.

Figure 5. Steven's state- and trait-anxiety scores over assessment sessions.

Figure 6. Steven's mean activity level and reinforcement potential scores over assessment sessions.

Figure 7. Steven's mean self-concept scores over assessment sessions.

Figure 8. Steven's daily self-ratings and mean scores for self-blame, anger, and anxiety over the course of the sexual abuse treatment program.

Figure 9. Samuel's depression scores over assessment sessions.

Figure 10. Samuel's self-esteem scores over assessment sessions.

Figure 11. Samuel's blame scores over assessment sessions.

Figure 12. Samuel's overall anger scores over assessment sessions.

Figure 13. Samuel's state- and trait-anxiety scores over assessment sessions.

Figure 14. Samuel's mean activity level and reinforcement potential scores over assessment sessions.

Figure 15. Samuel's mean self-concept scores over assessment sessions.

Figure 16. Samuel's daily self-ratings and mean scores for self-blame, anger, and anxiety over the course of the sexual abuse treatment program.

Figure 17. Stan's depression scores over assessment sessions.

Figure 1. Steven's depression scores over assessment sessions.

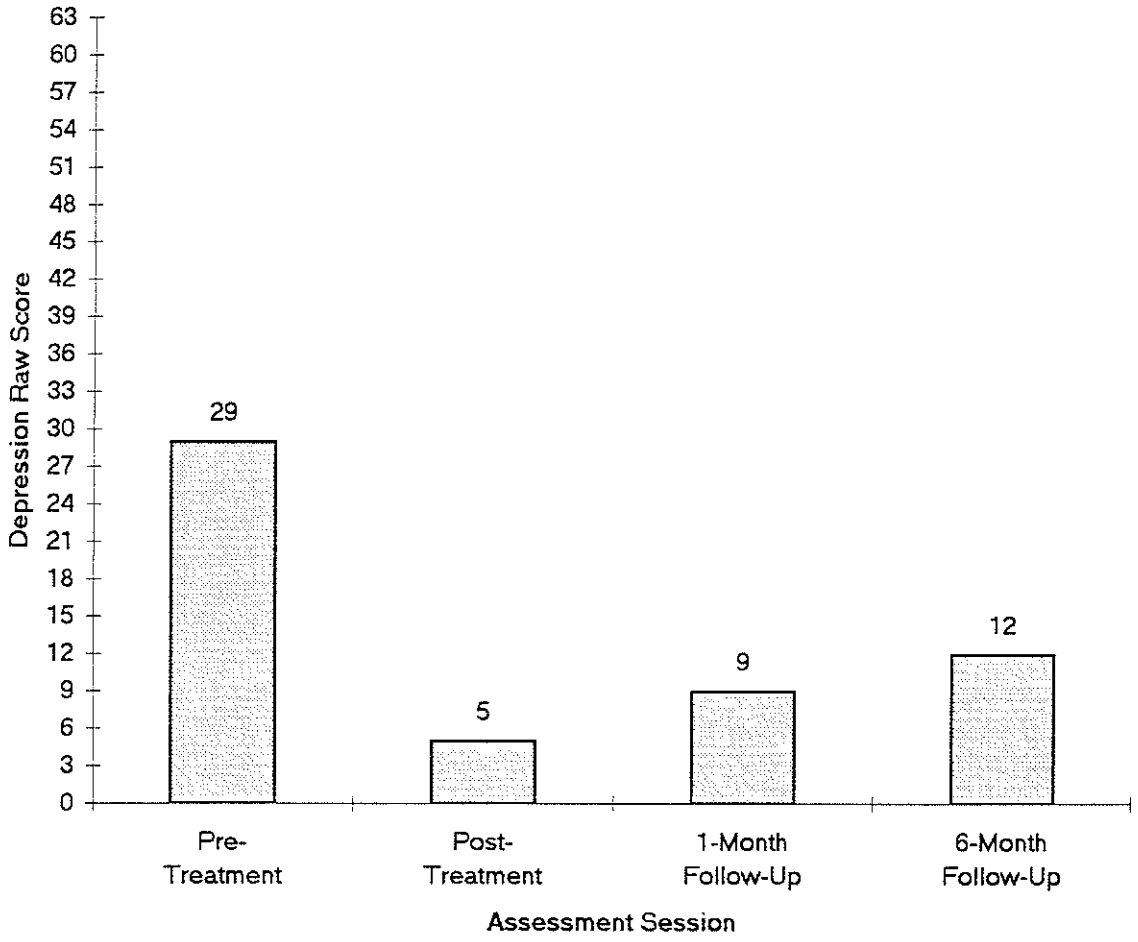
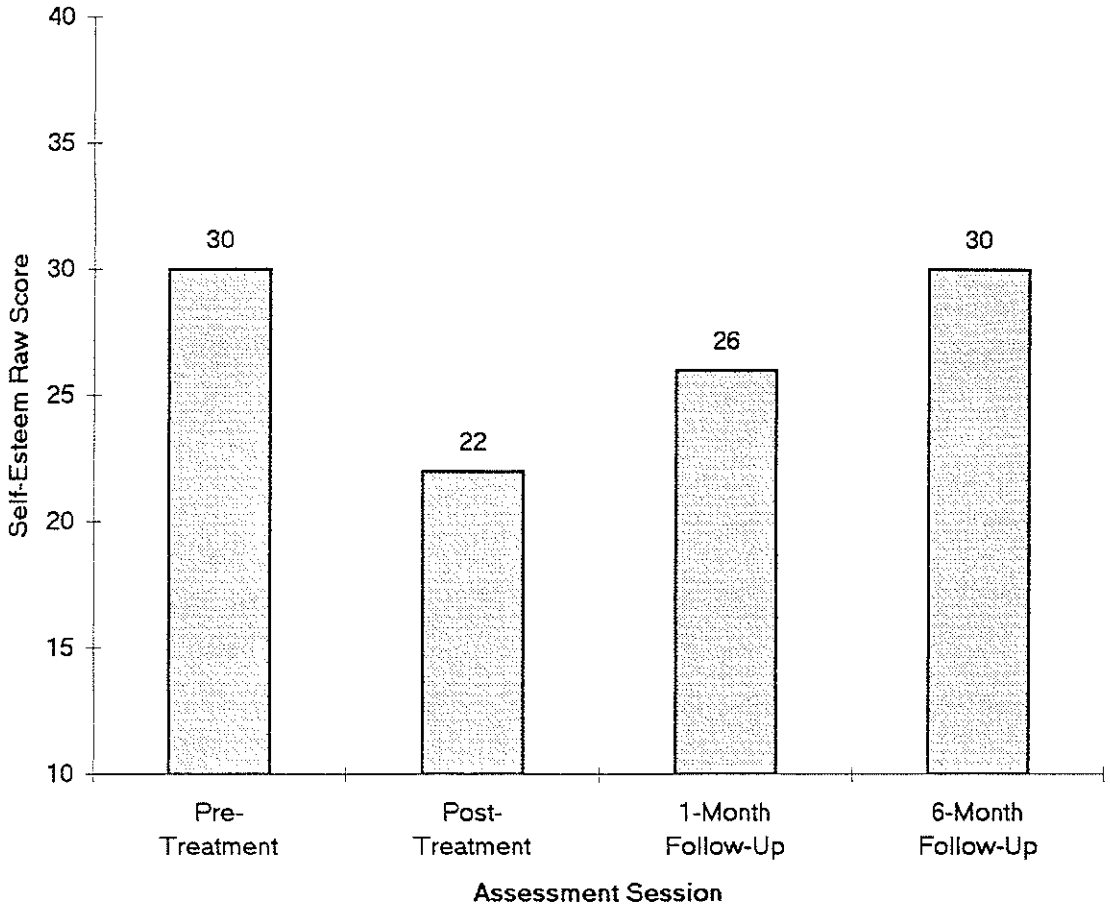


Figure 2. Steven's self-esteem scores over assessment sessions.



Note. Lower scores correspond to higher levels of self-esteem.

Figure 3. Steven's blame scores over assessment sessions.

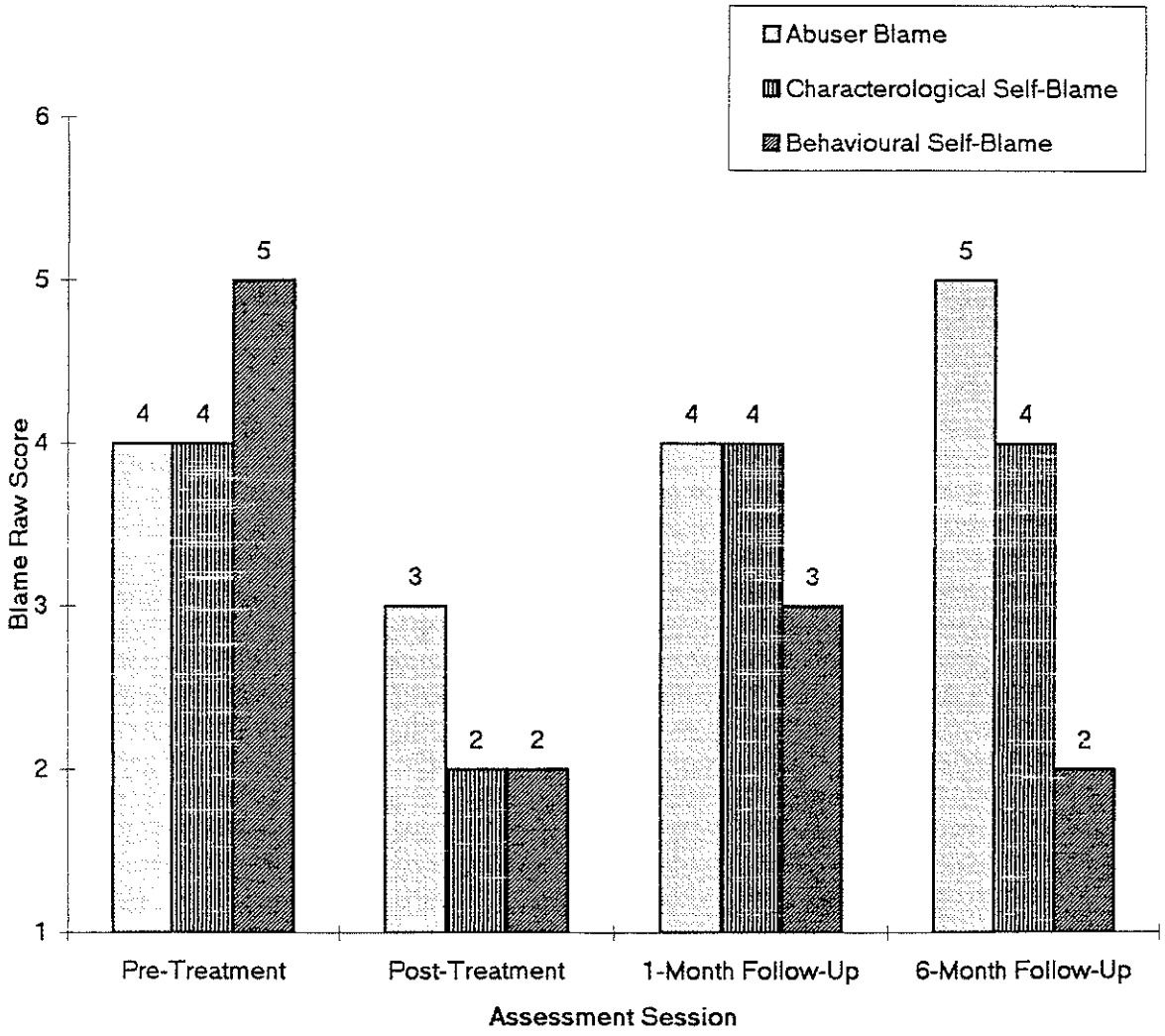


Figure 4. Steven's overall anger scores over assessment sessions.

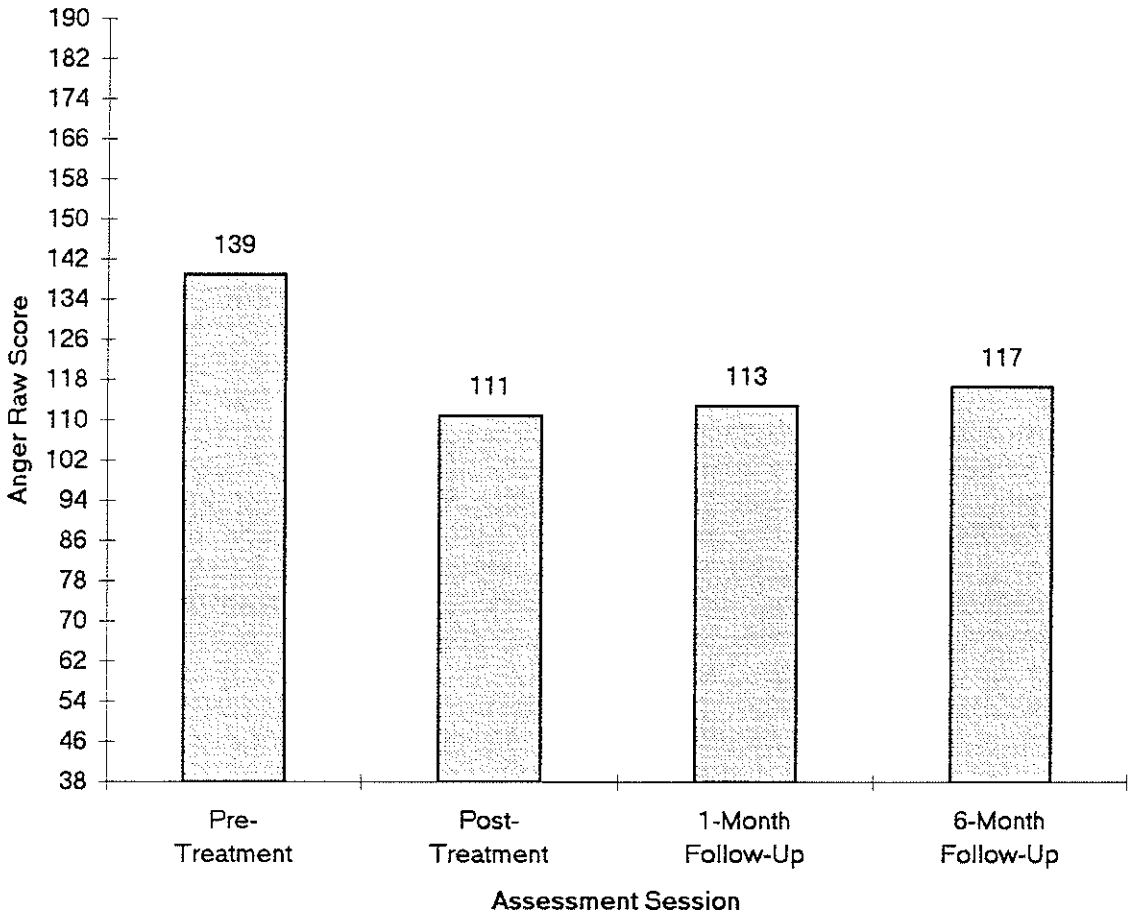


Figure 5. Steven's state- and trait-anxiety scores over assessment sessions.

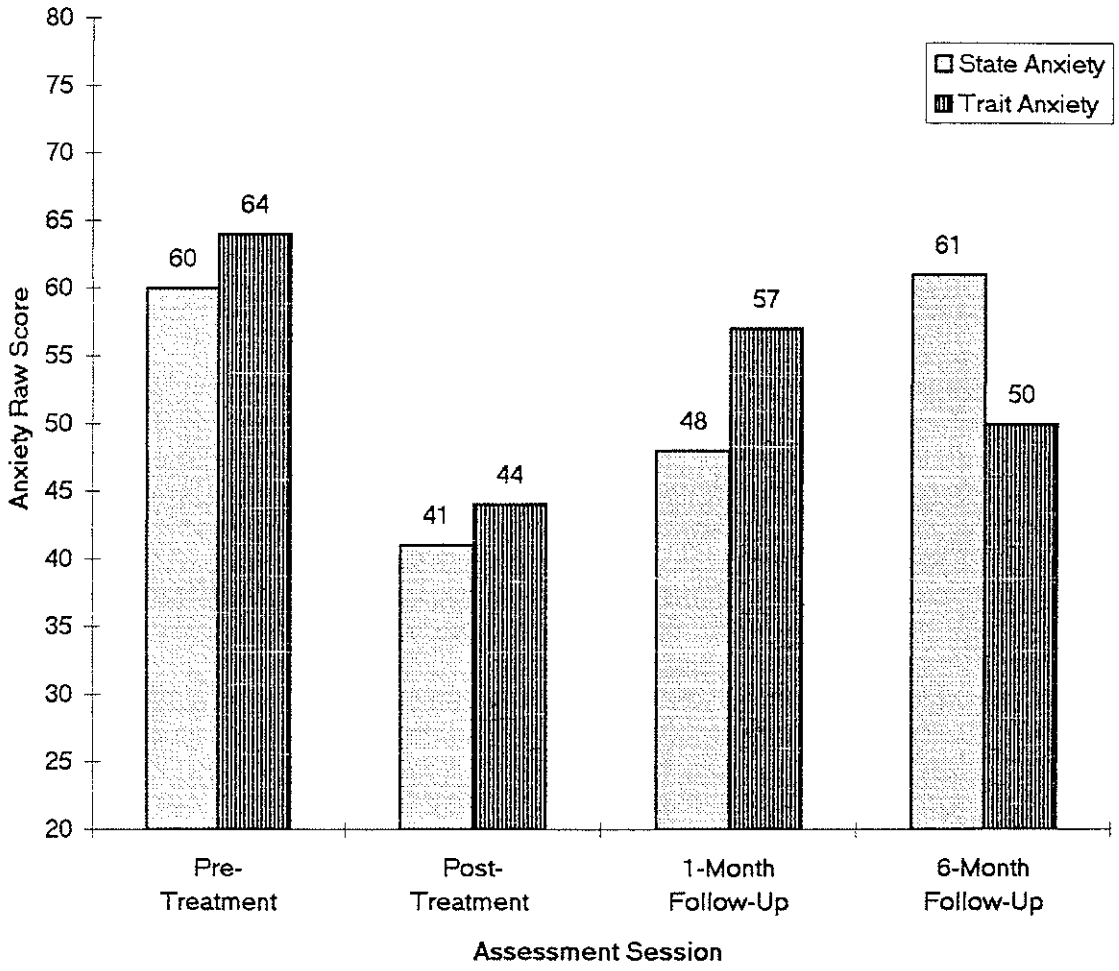


Figure 6. Steven's mean activity level and reinforcement potential scores over assessment sessions.

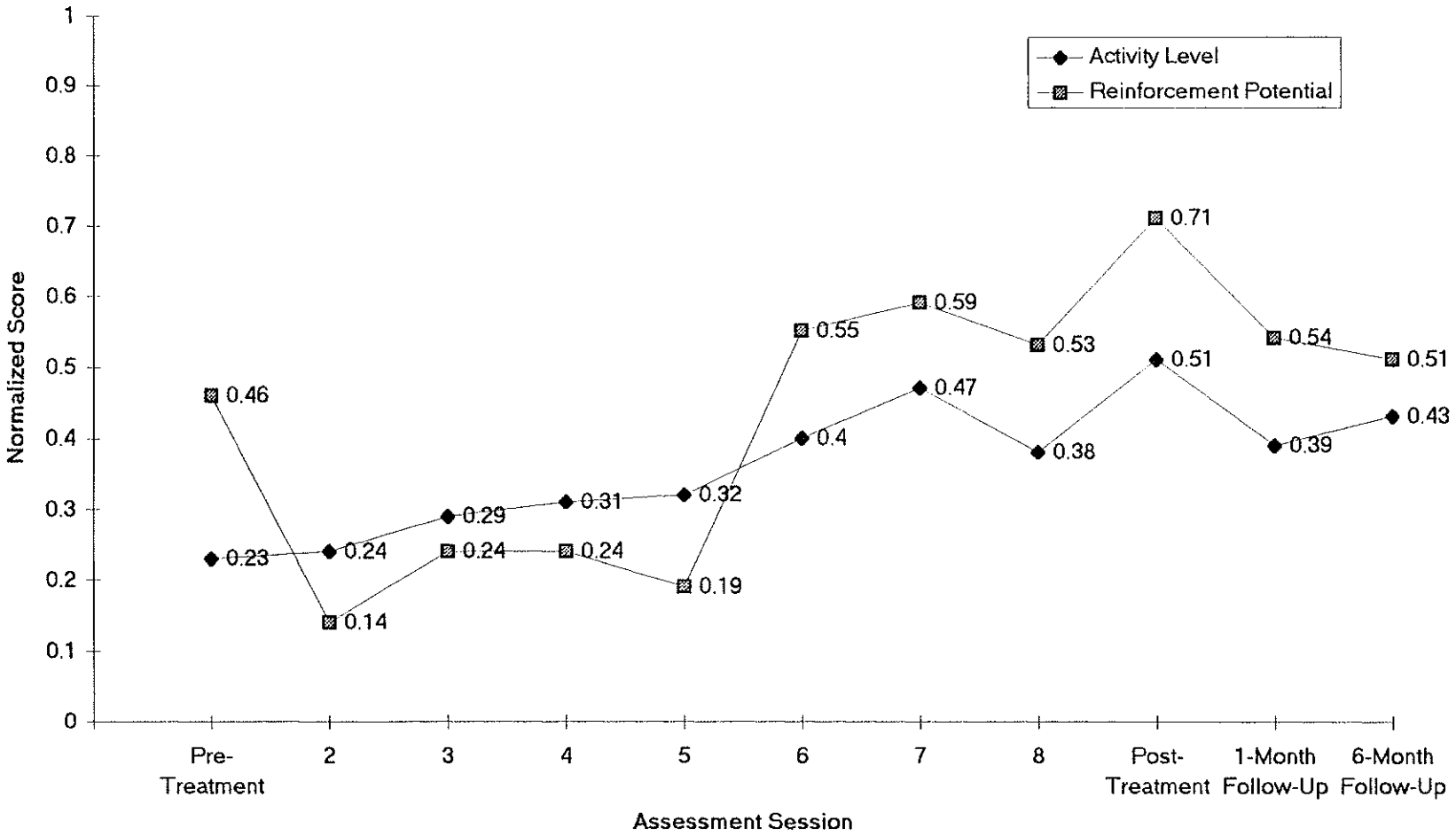


Figure 7. Steven's mean self-concept scores over assessment sessions.

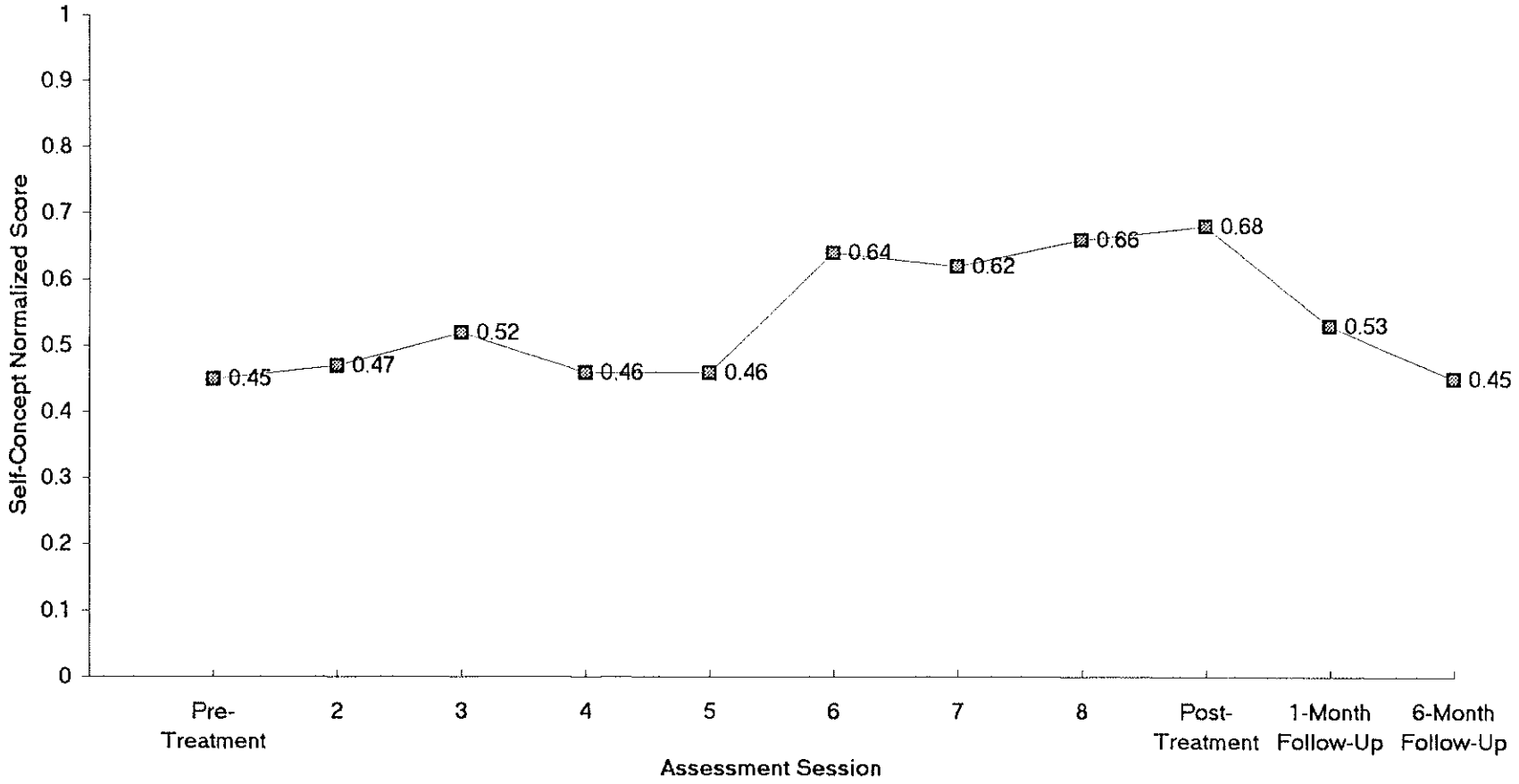
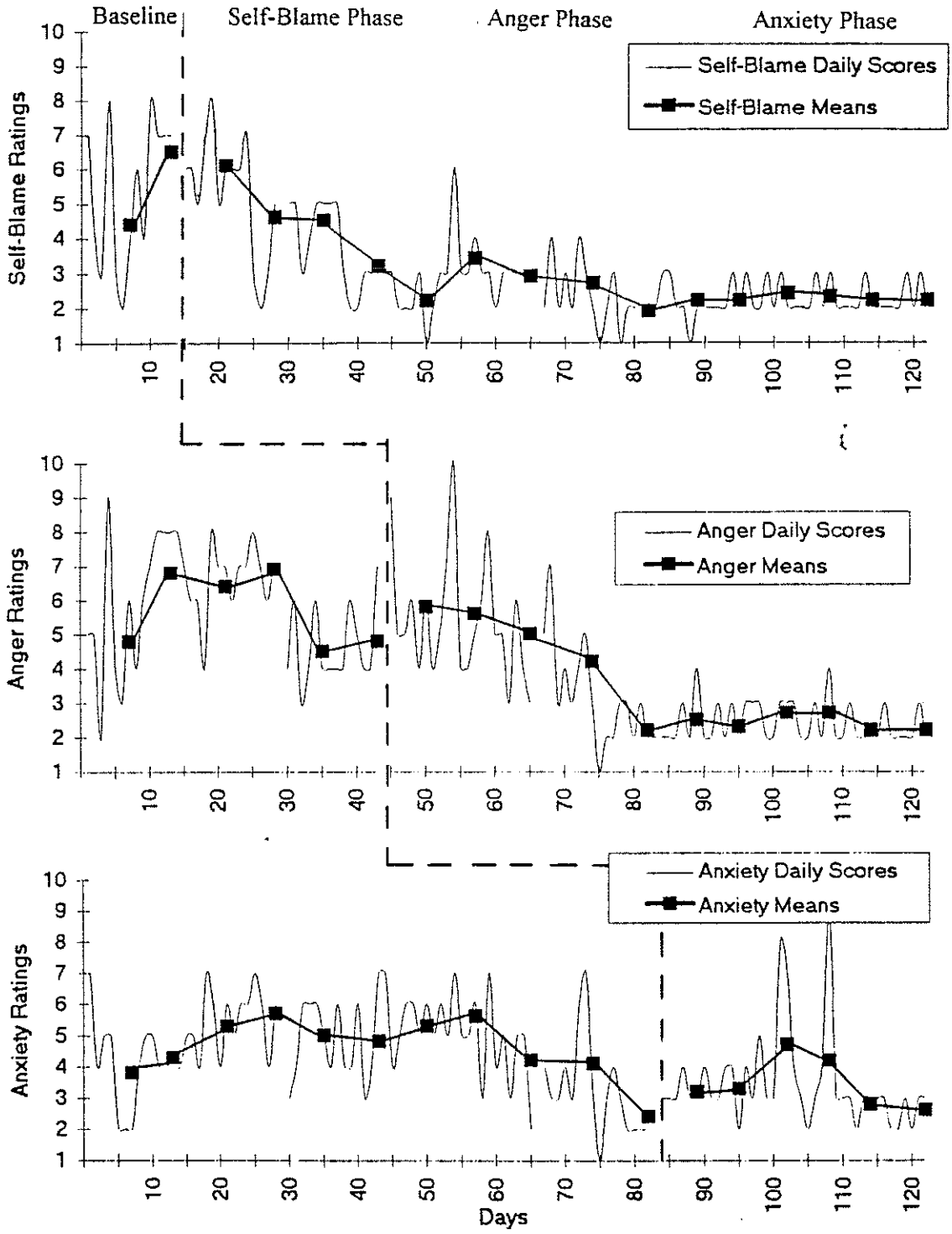


Figure 8. Steven's daily self-ratings and mean scores



Note. Means represent approximately 7-day intervals.

Figure 9. Samuel's depression scores over assessment sessions.

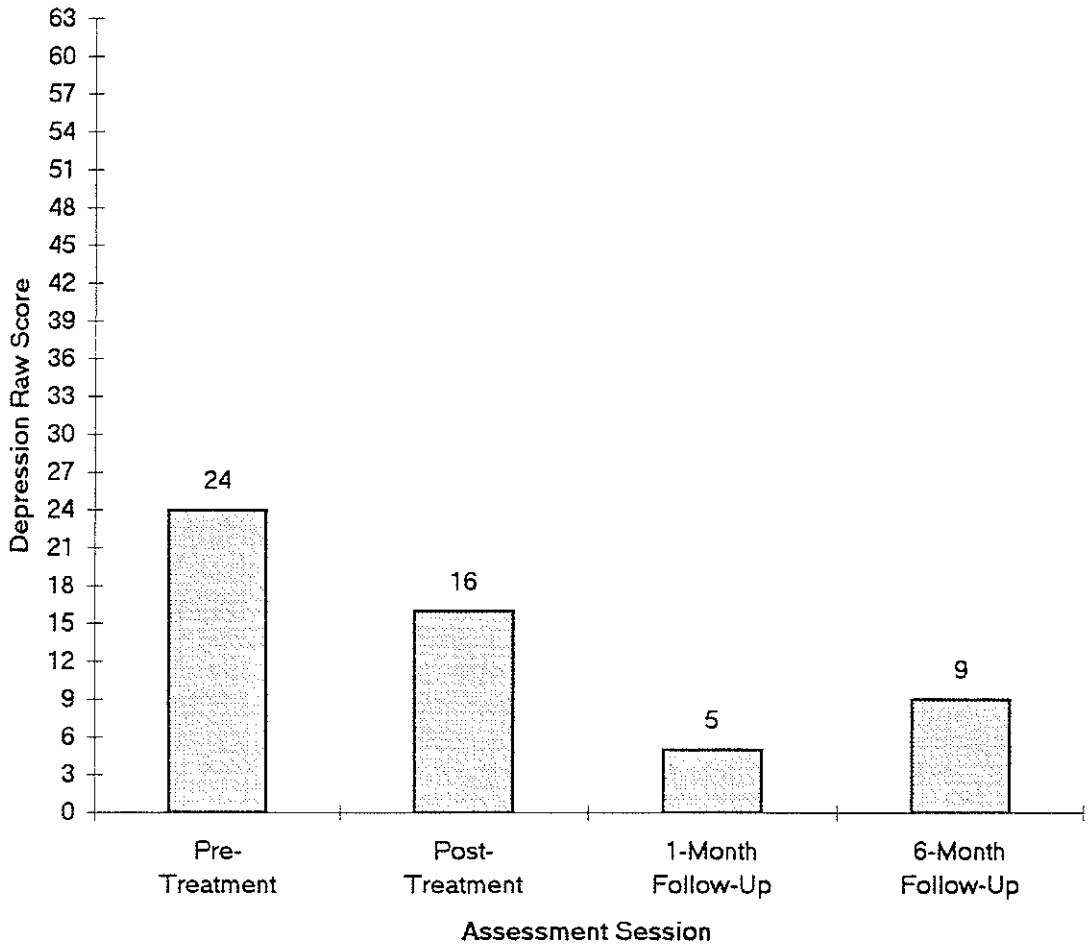
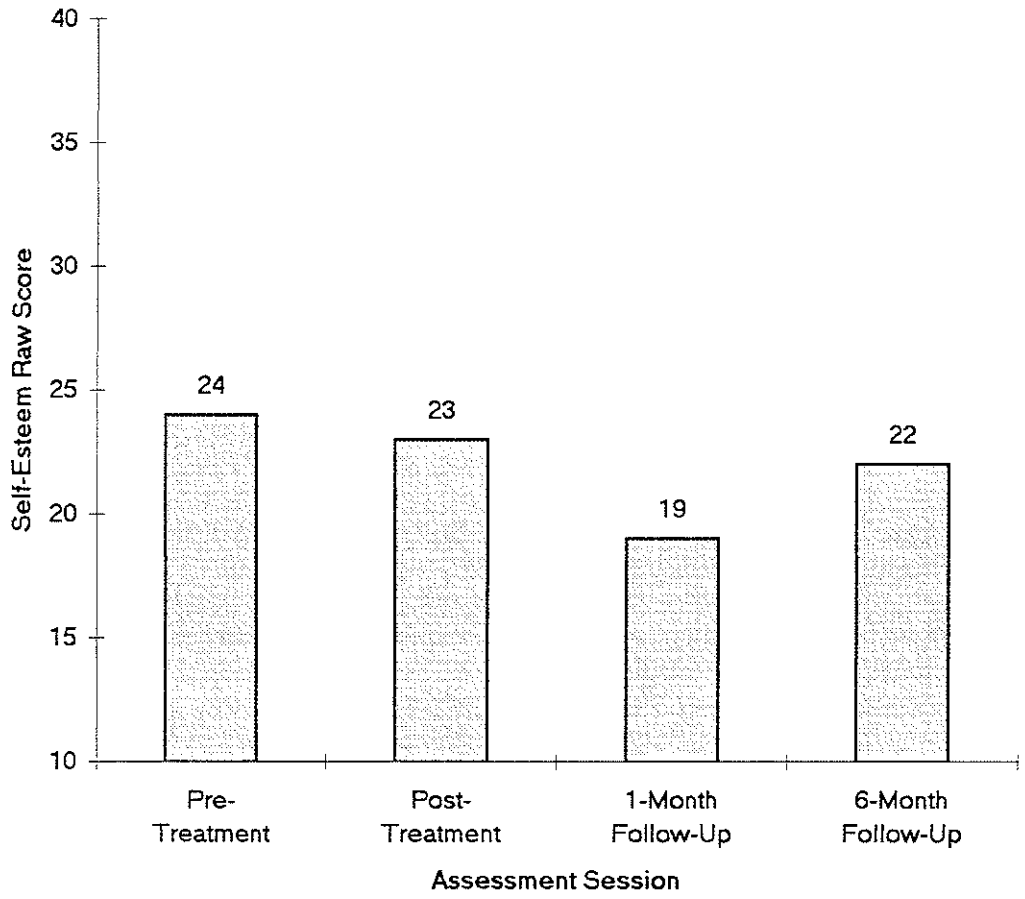


Figure 10. Samuel's self-esteem scores over assessment sessions.



Note. Lower scores correspond to highler levels of self-esteem.

Figure 11. Samuel's blame scores over assessment sessions.

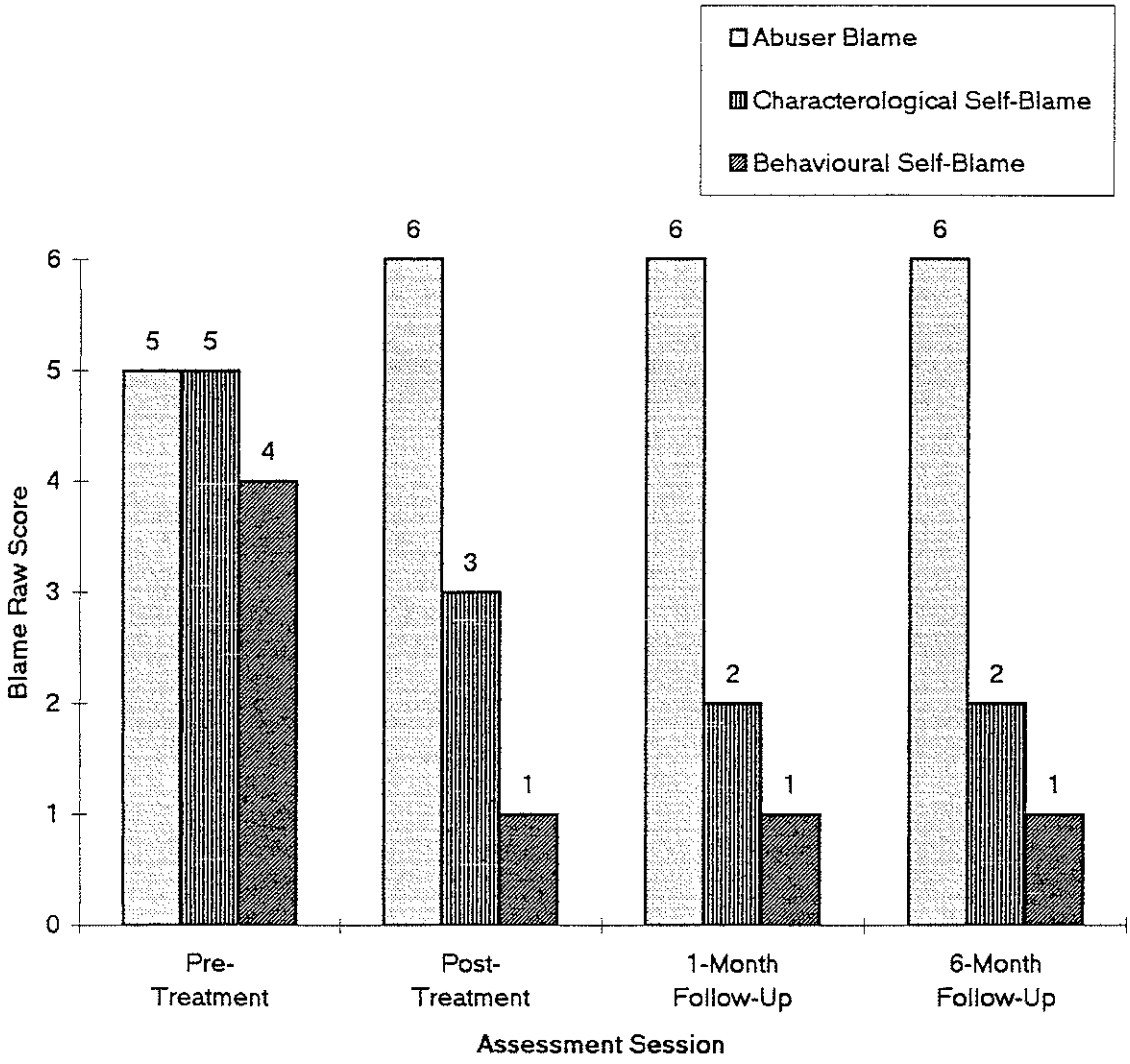


Figure 12. Samuel's overall anger scores over assessment sessions.

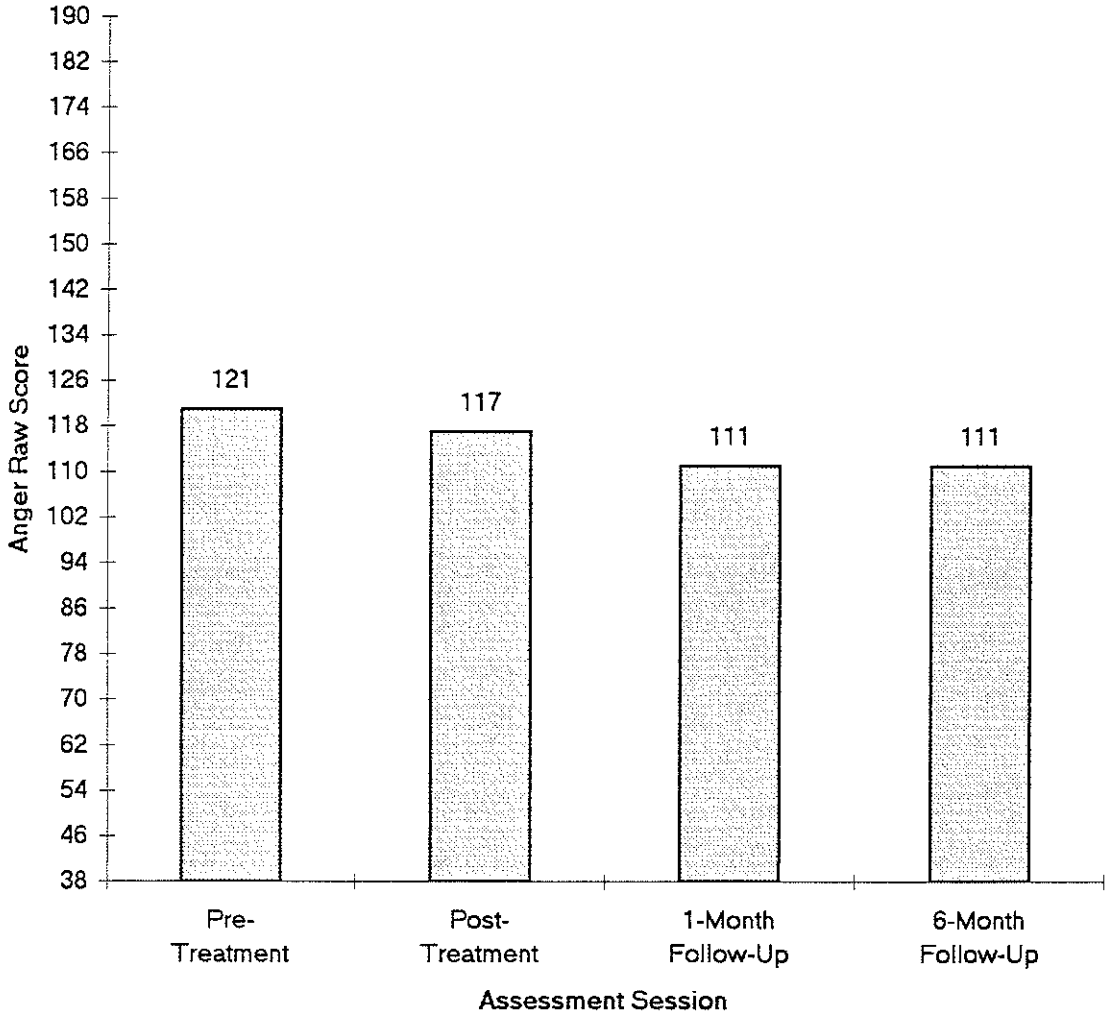


Figure 13. Samuel's state- and trait-anxiety scores over assessment sessions.

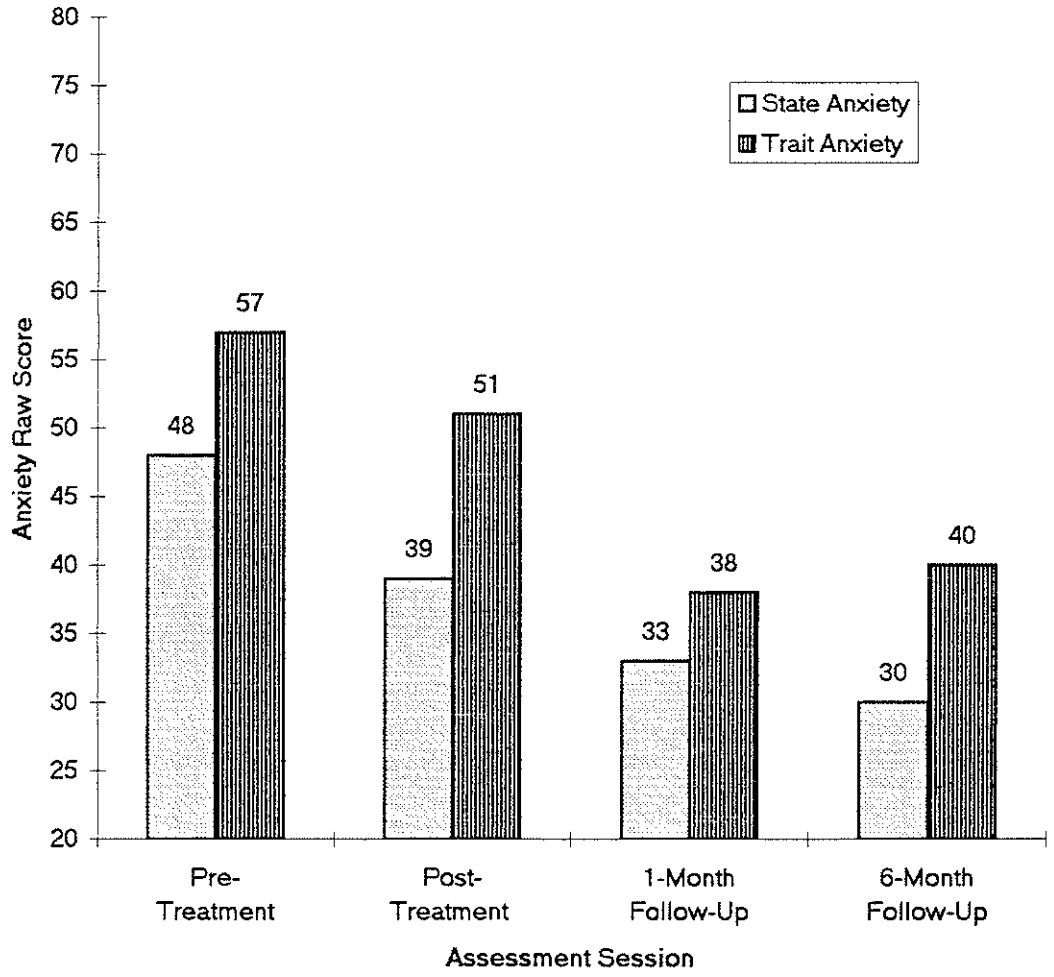


Figure 14. Samuel's mean activity level and reinforcement potential scores over assessment sessions.

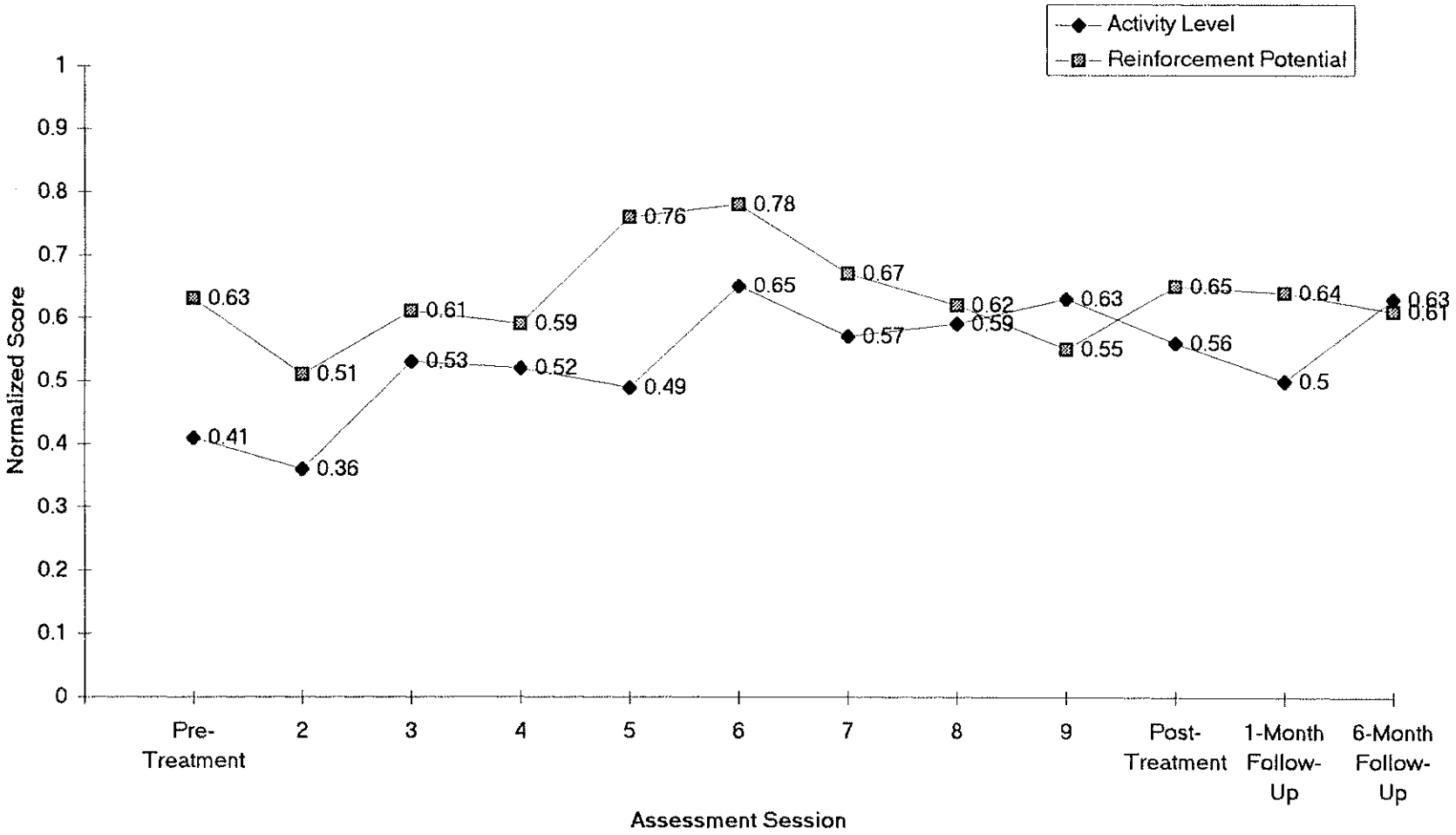


Figure 15. Samuel's mean self-concept scores over assessment sessions.

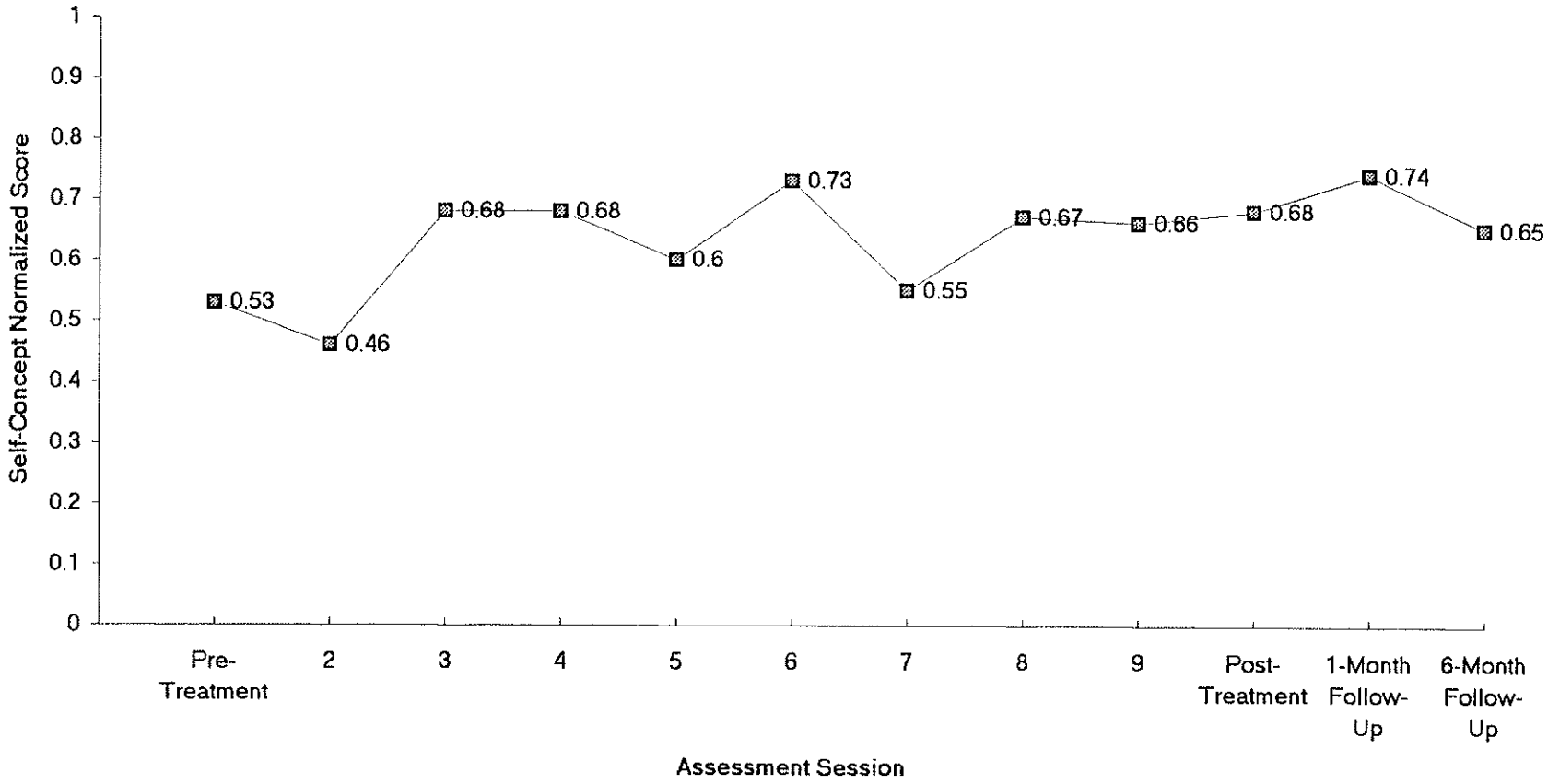
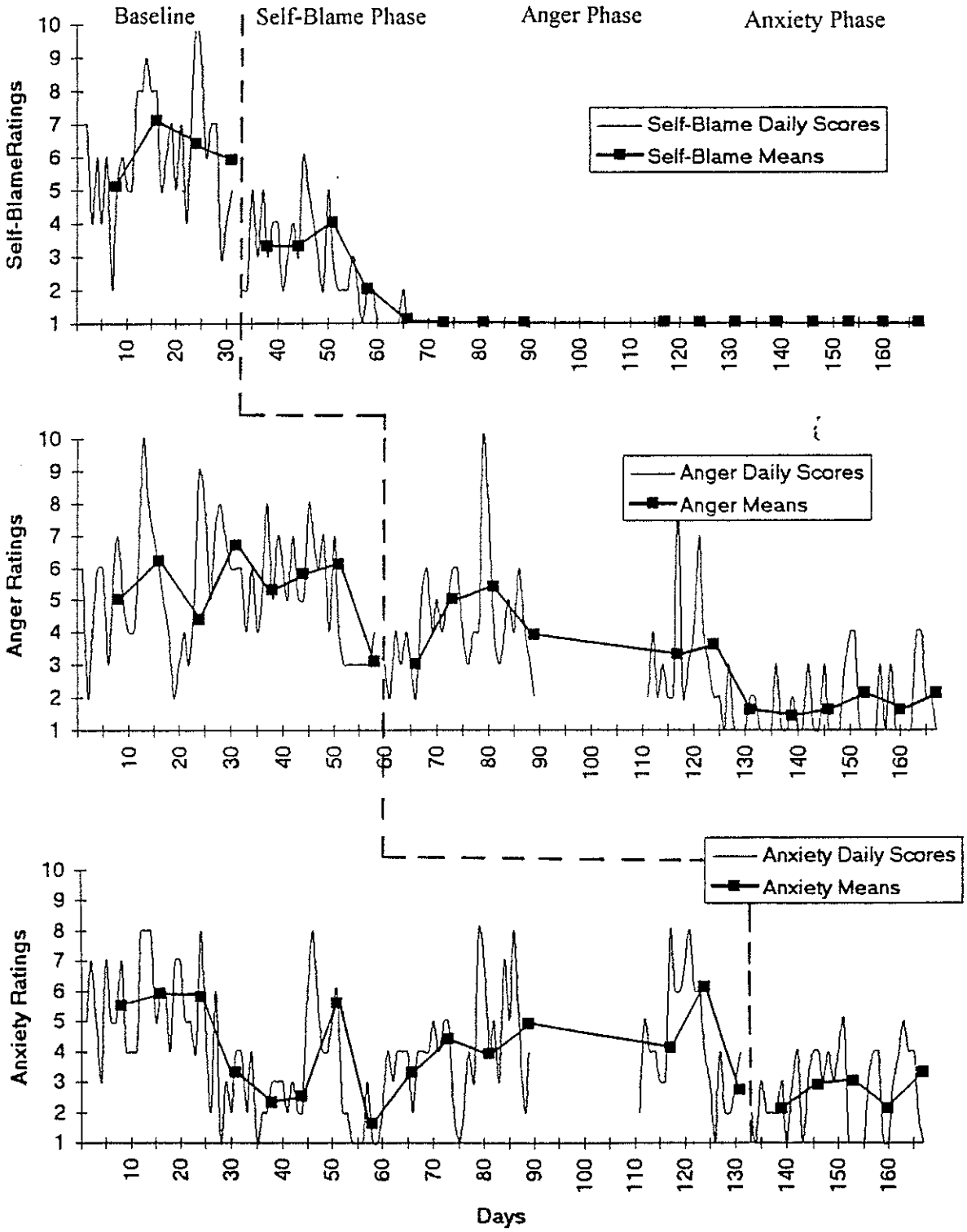


Figure 16. Samuel's daily self-ratings and mean scores



Note. Means represent approximately 7-day intervals.

Figure 17. Stan's depression scores over assessment sessions.

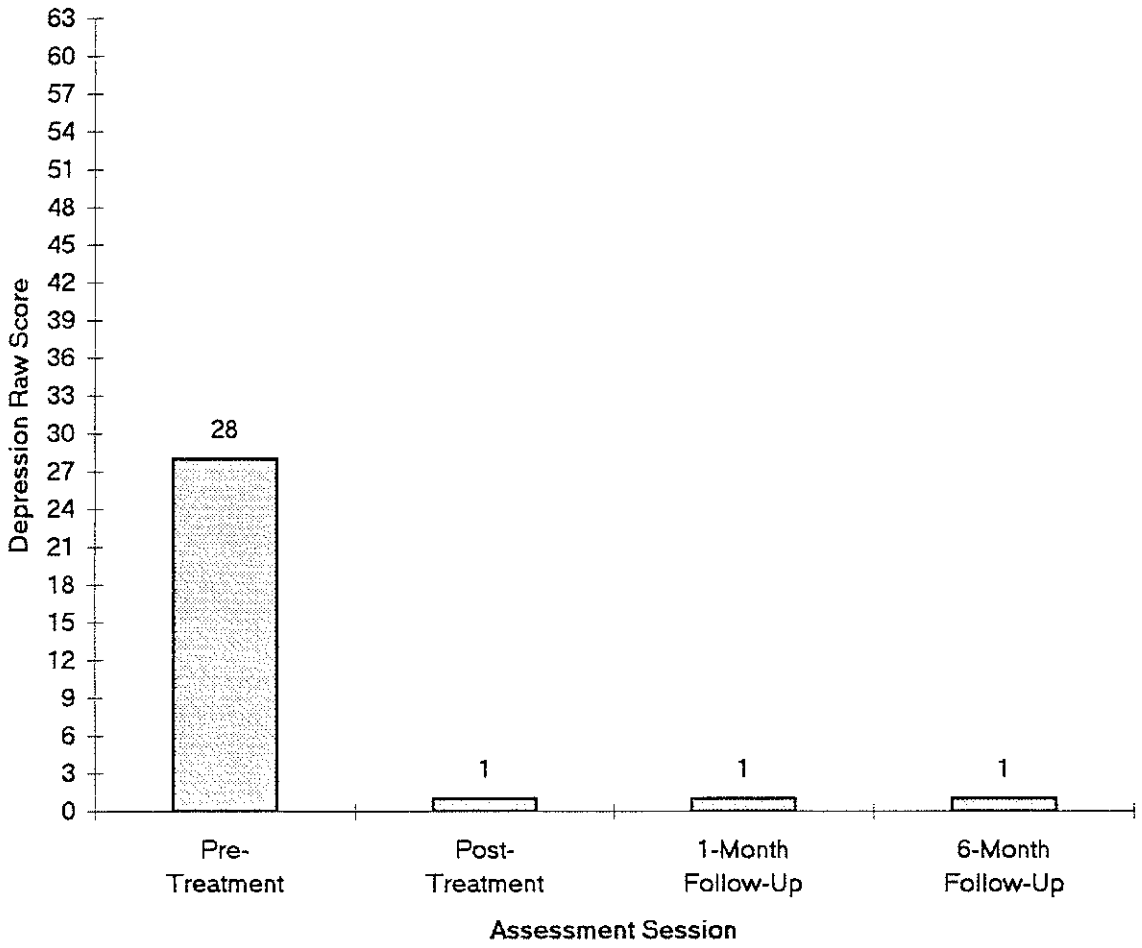
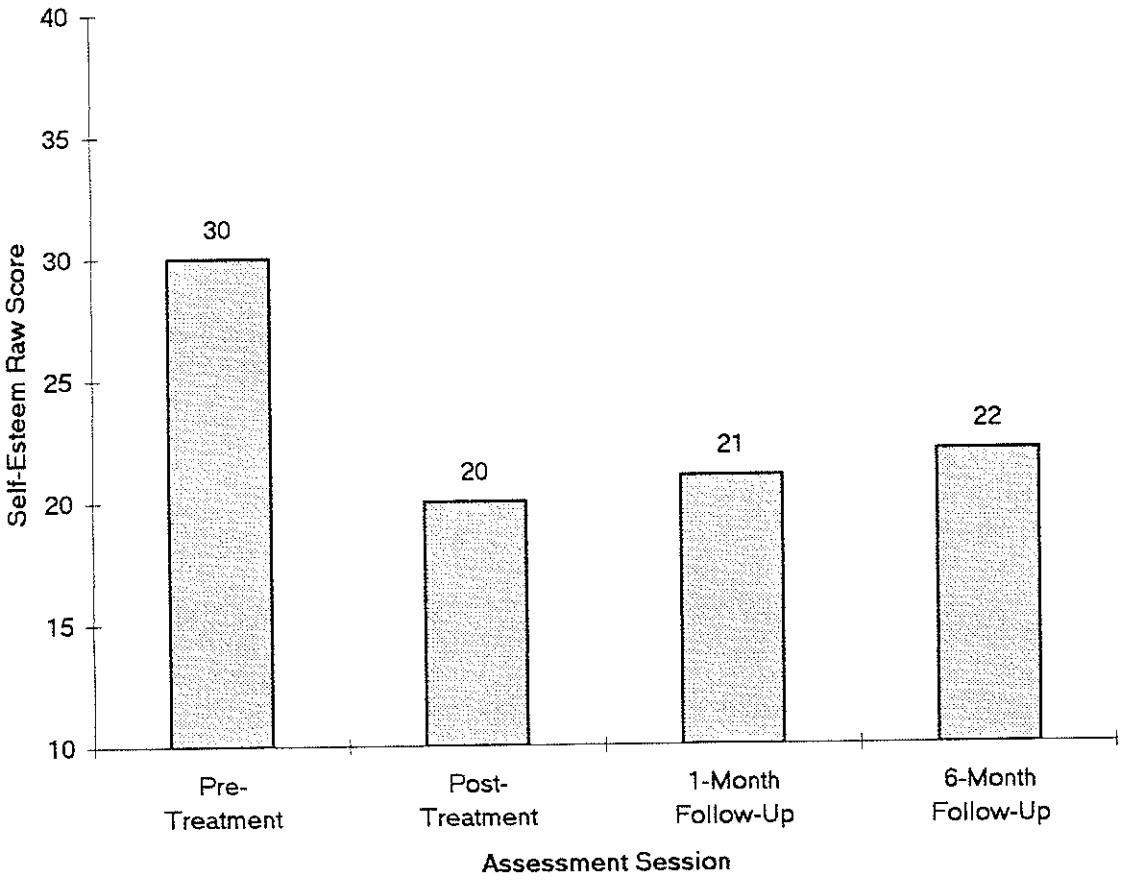


Figure 18. Stan's self-esteem scores over assessment sessions.



Note. Lower scores correspond to higher levels of self-esteem.

Figure 19. Stan's blame scores over assessment sessions.

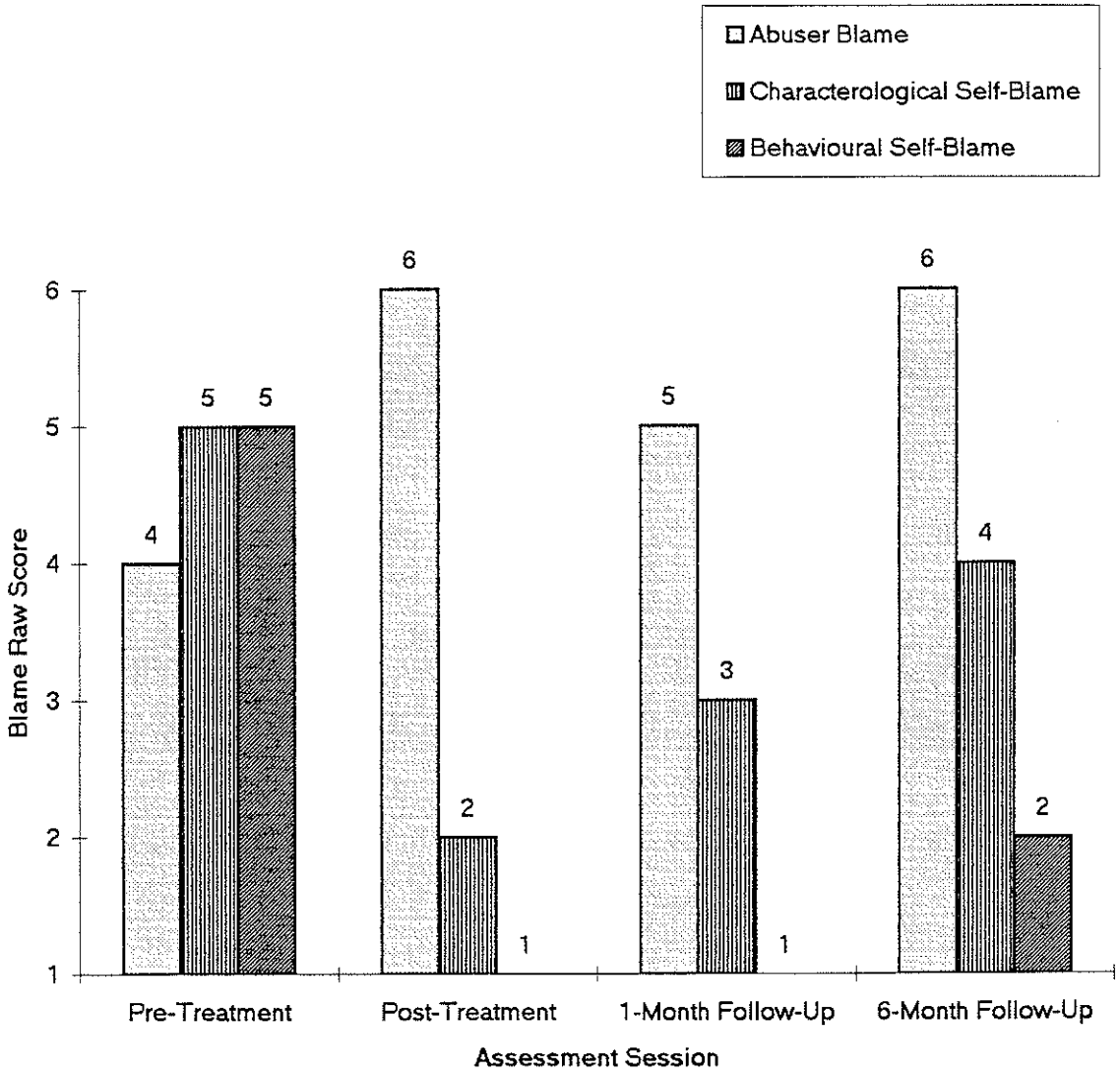


Figure 20. Stan's overall anger scores over assessment sessions.

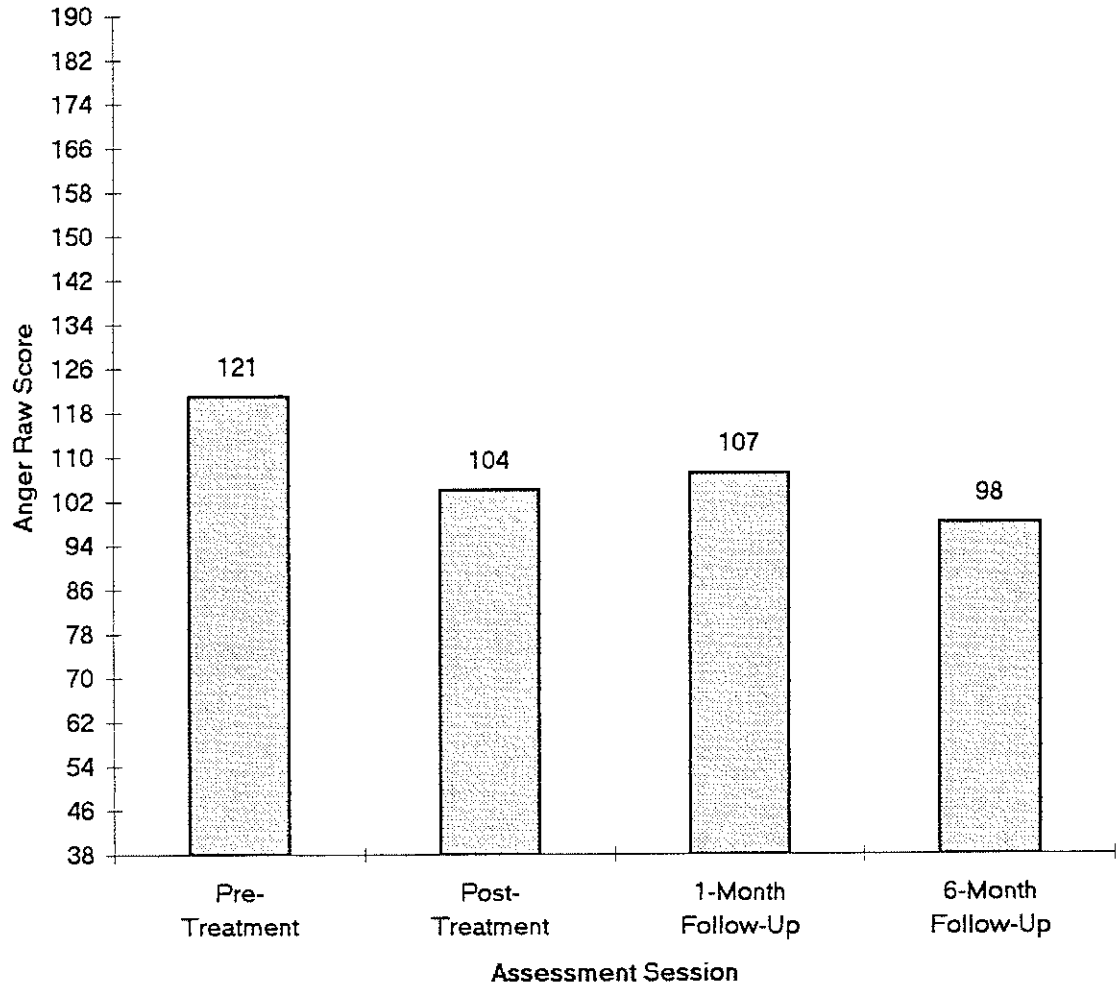


Figure 21. Stan's state- and trait-anxiety scores over assessment sessions.

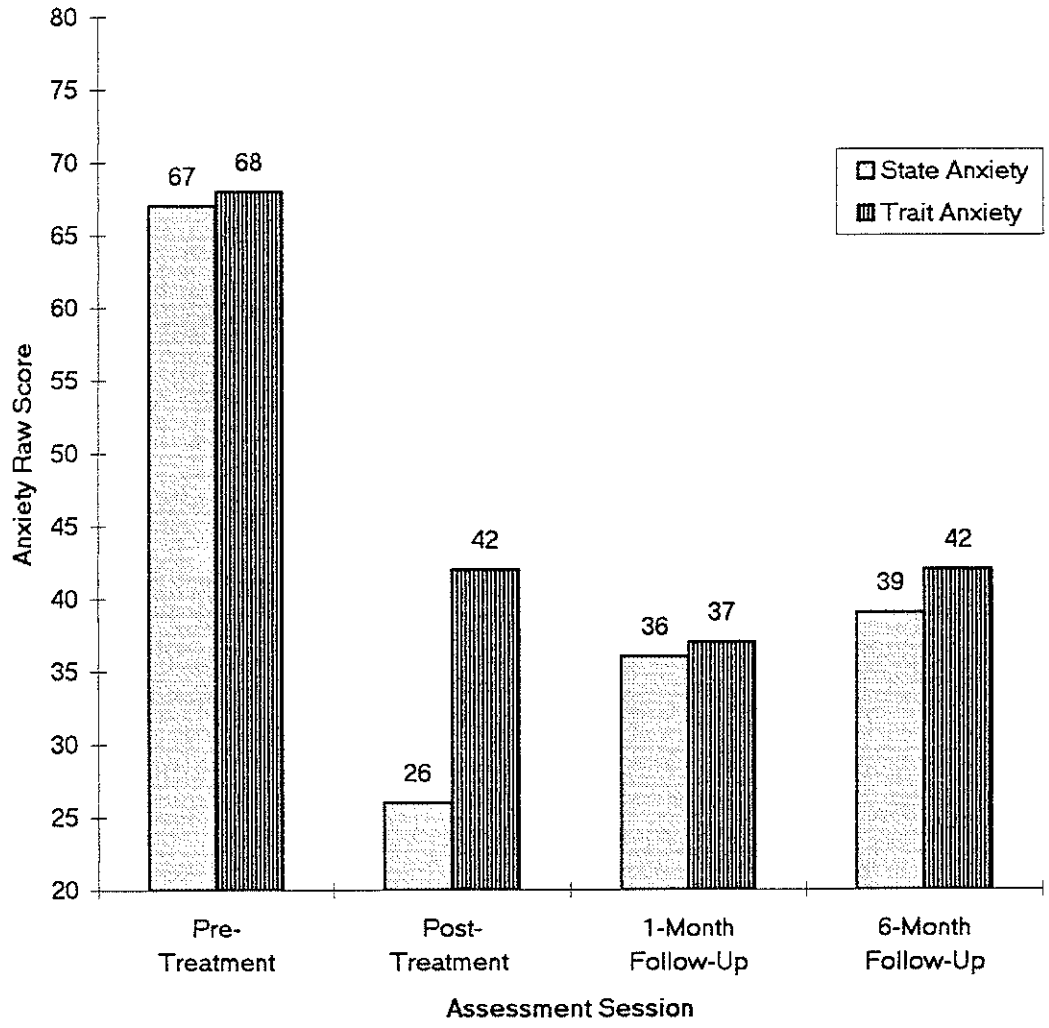


Figure 22. Stan's mean activity level and reinforcement potential scores over assessment sessions.

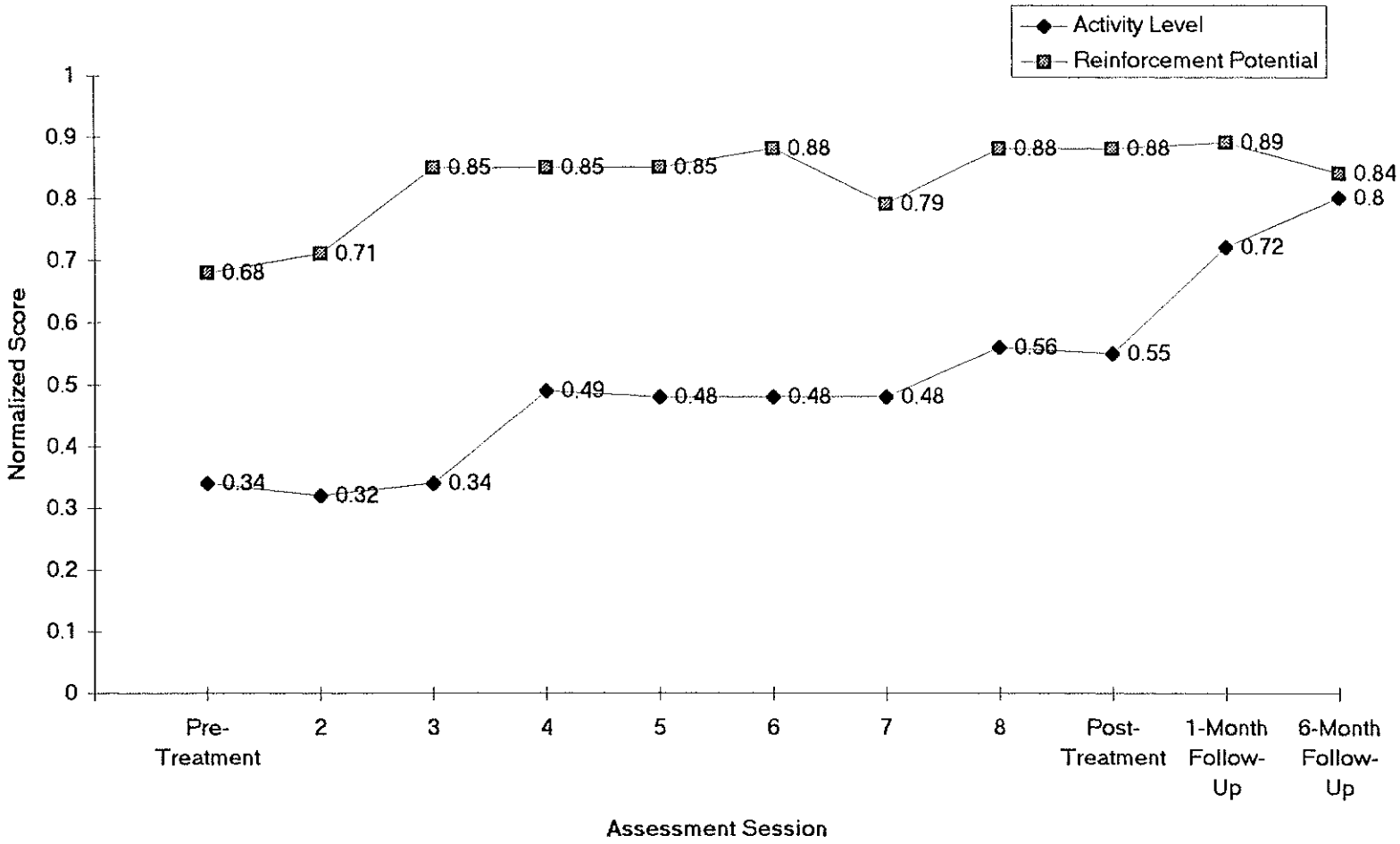


Figure 23. Stan's mean self-concept scores over assessment sessions.

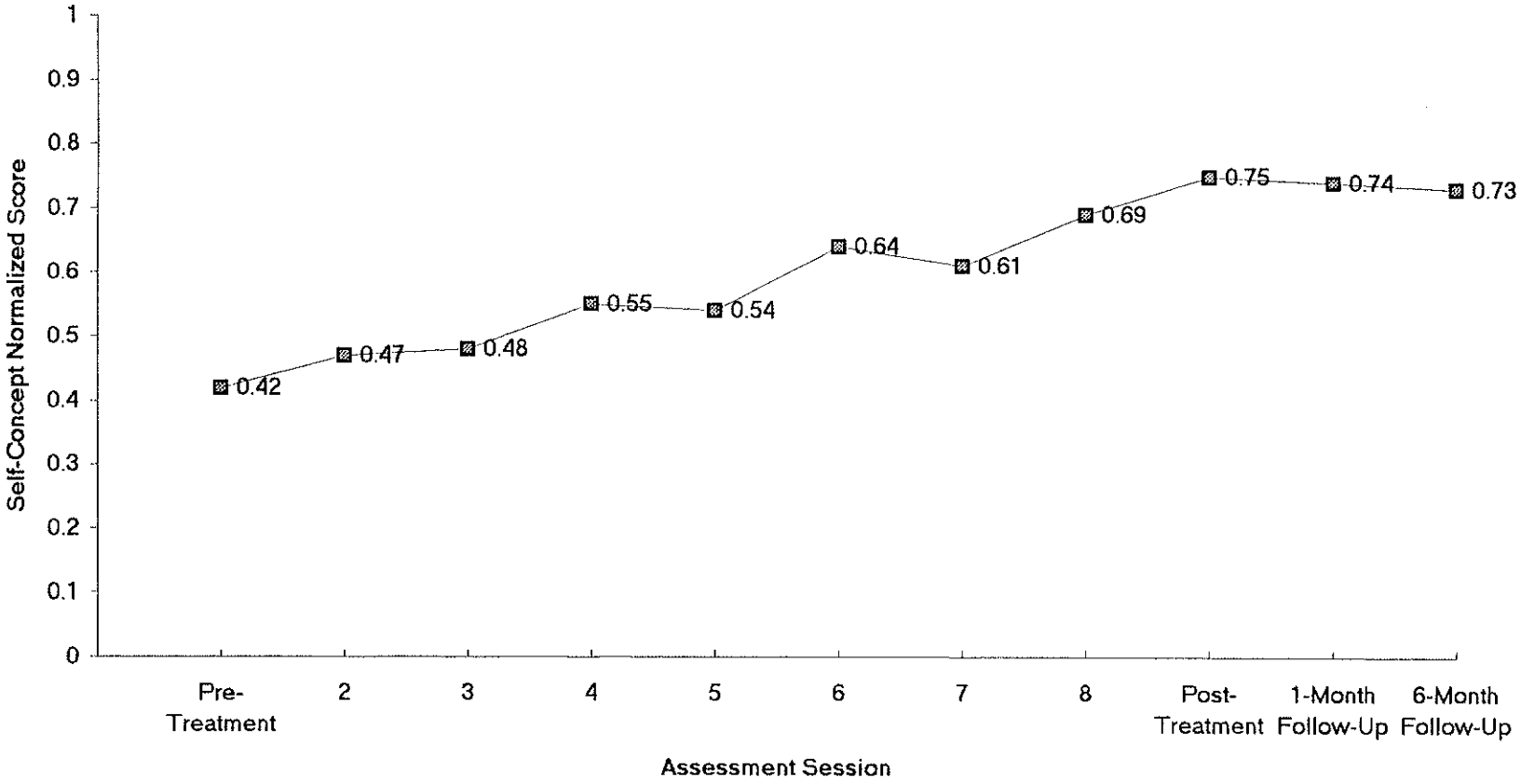
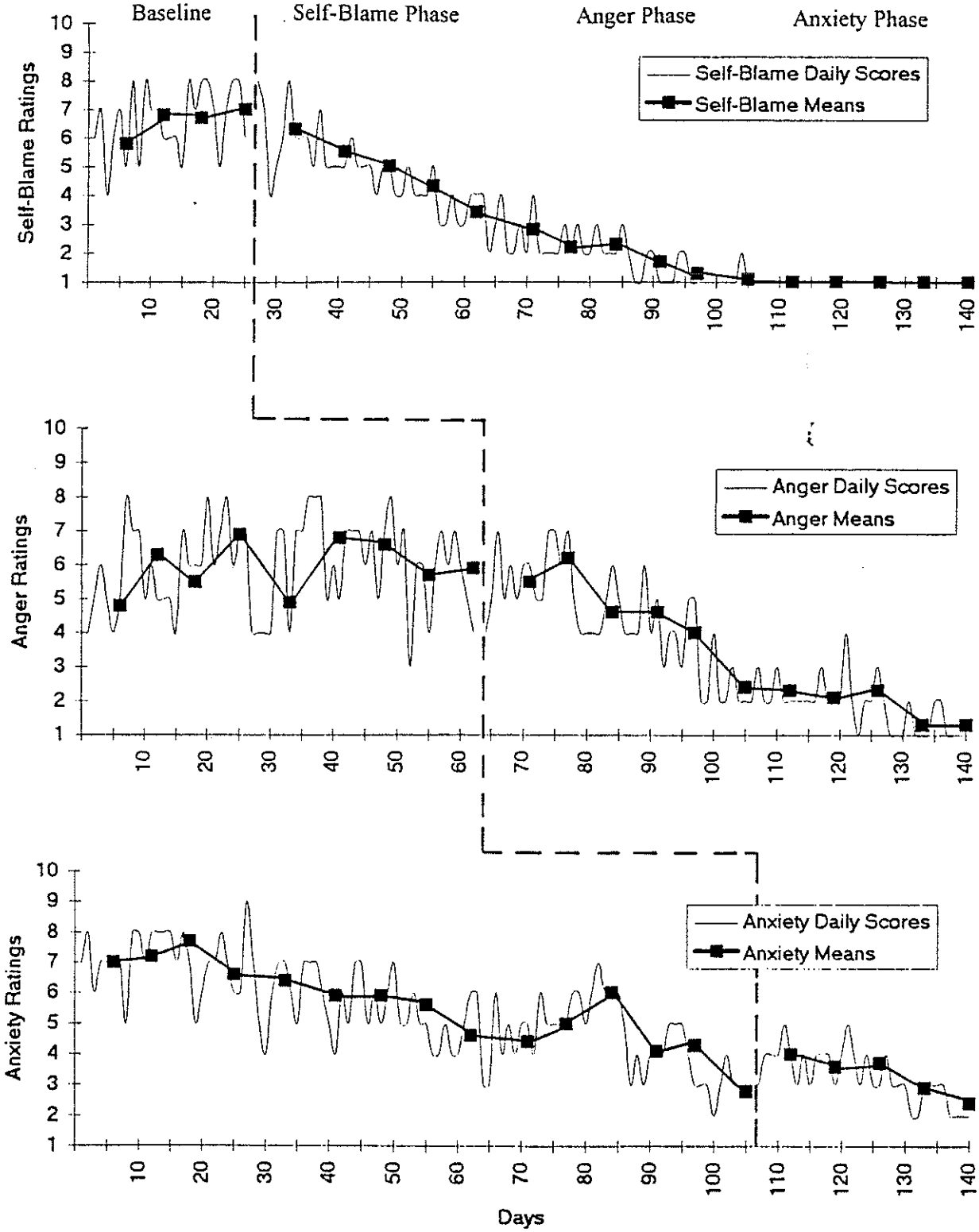


Figure 24. Stan's daily self-ratings and mean scores



Note. Means represent approximately 7-day intervals.

Figure 25. Scott's depression scores over assessment sessions.

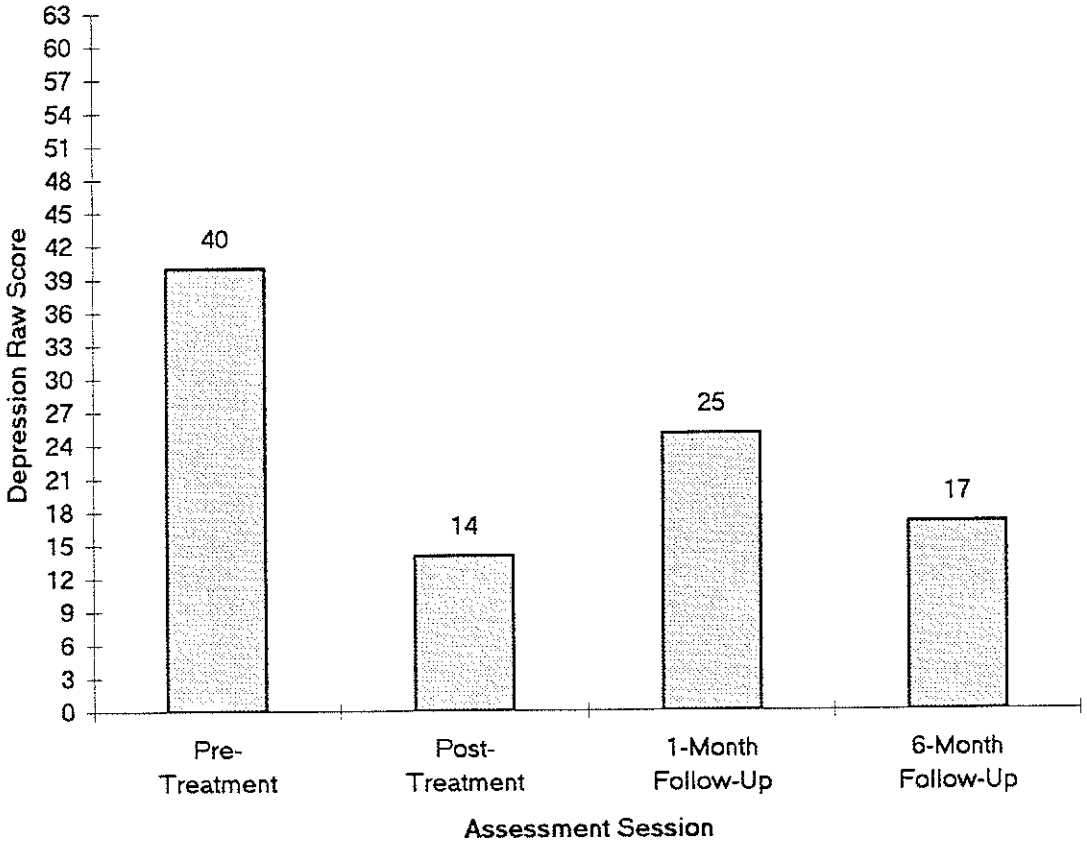
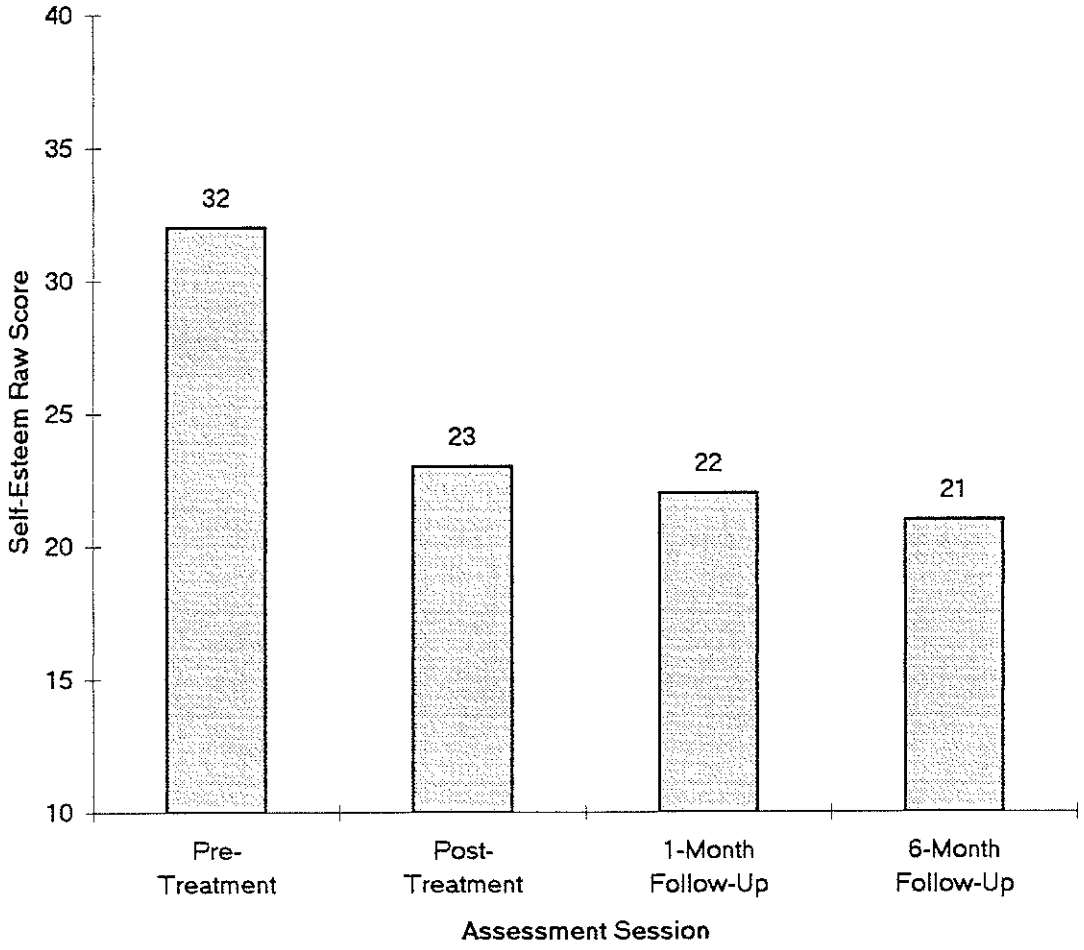


Figure 26. Scott's self-esteem scores over assessment sessions.



Note. Lower scores correspond to higher levels of self-esteem

Figure 27. Scott's blame scores over assessment sessions.

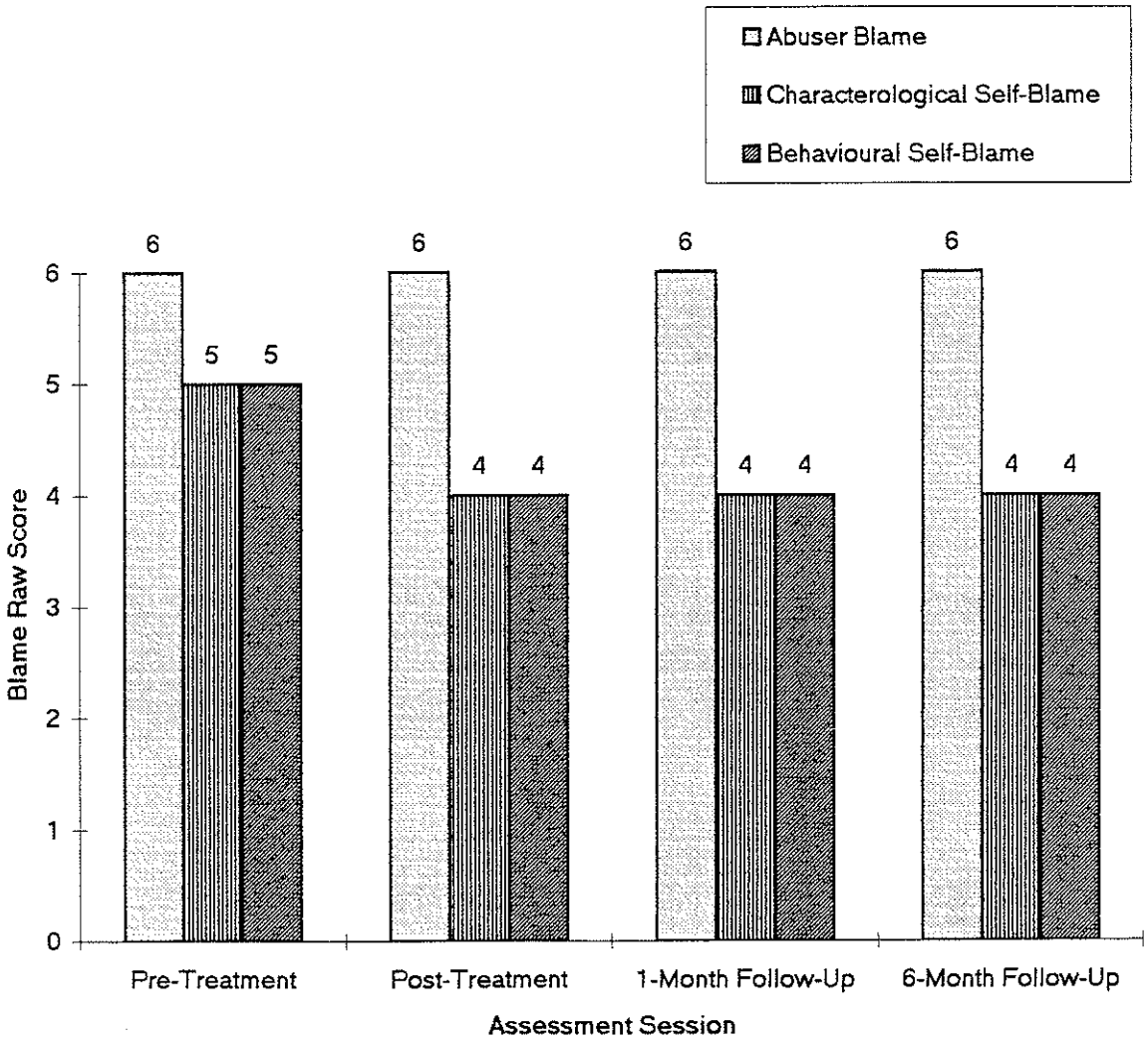


Figure 28. Scott's overall anger scores over assessment sessions.

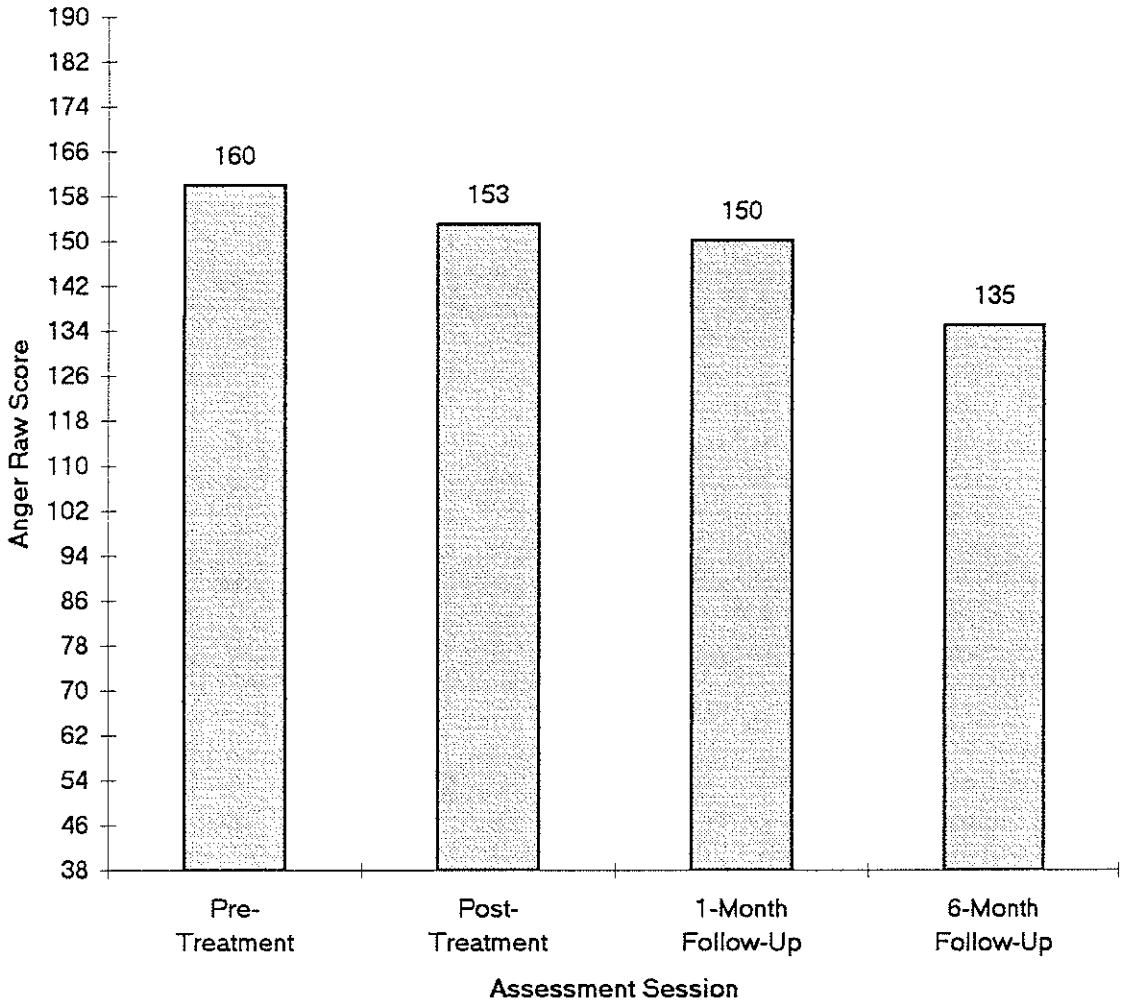


Figure 29. Scott's state- and trait-anxiety scores over assessment sessions.

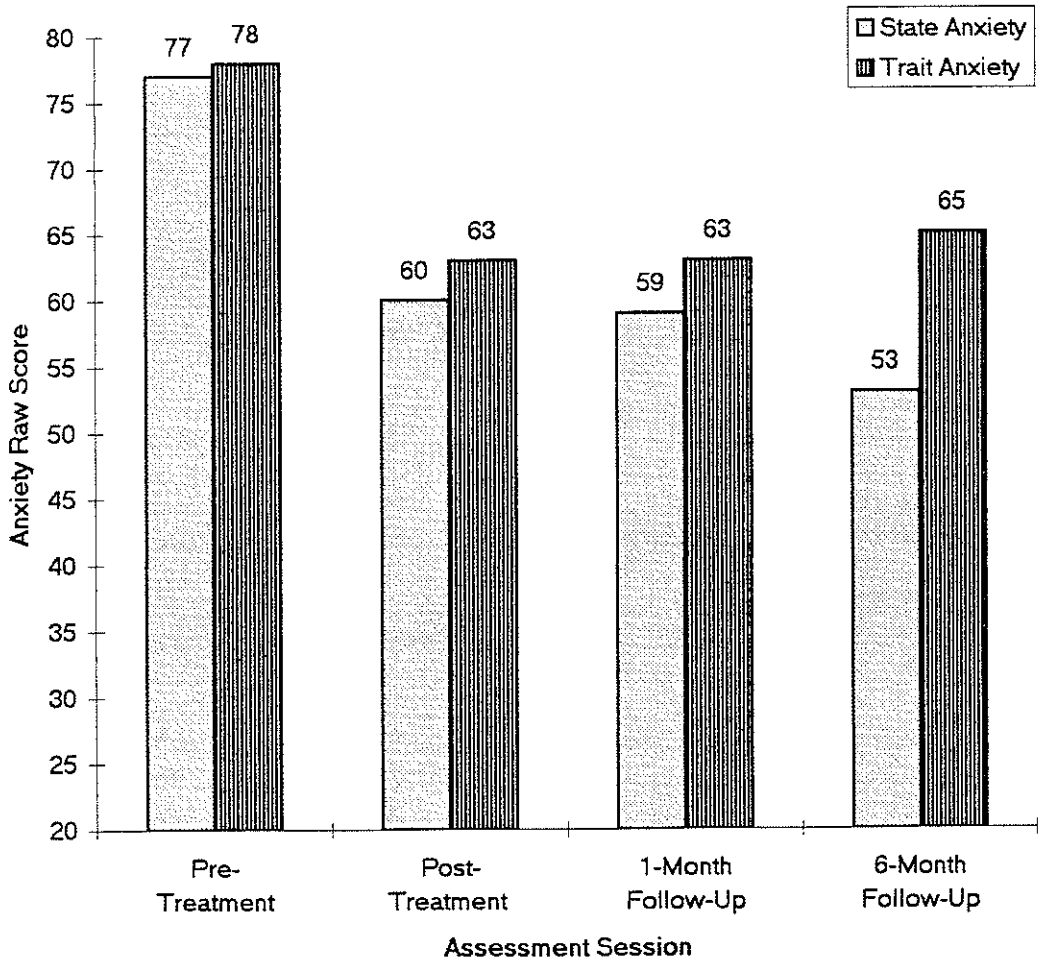


Figure 30. Scott's mean activity level and reinforcement potential scores over assessment sessions.

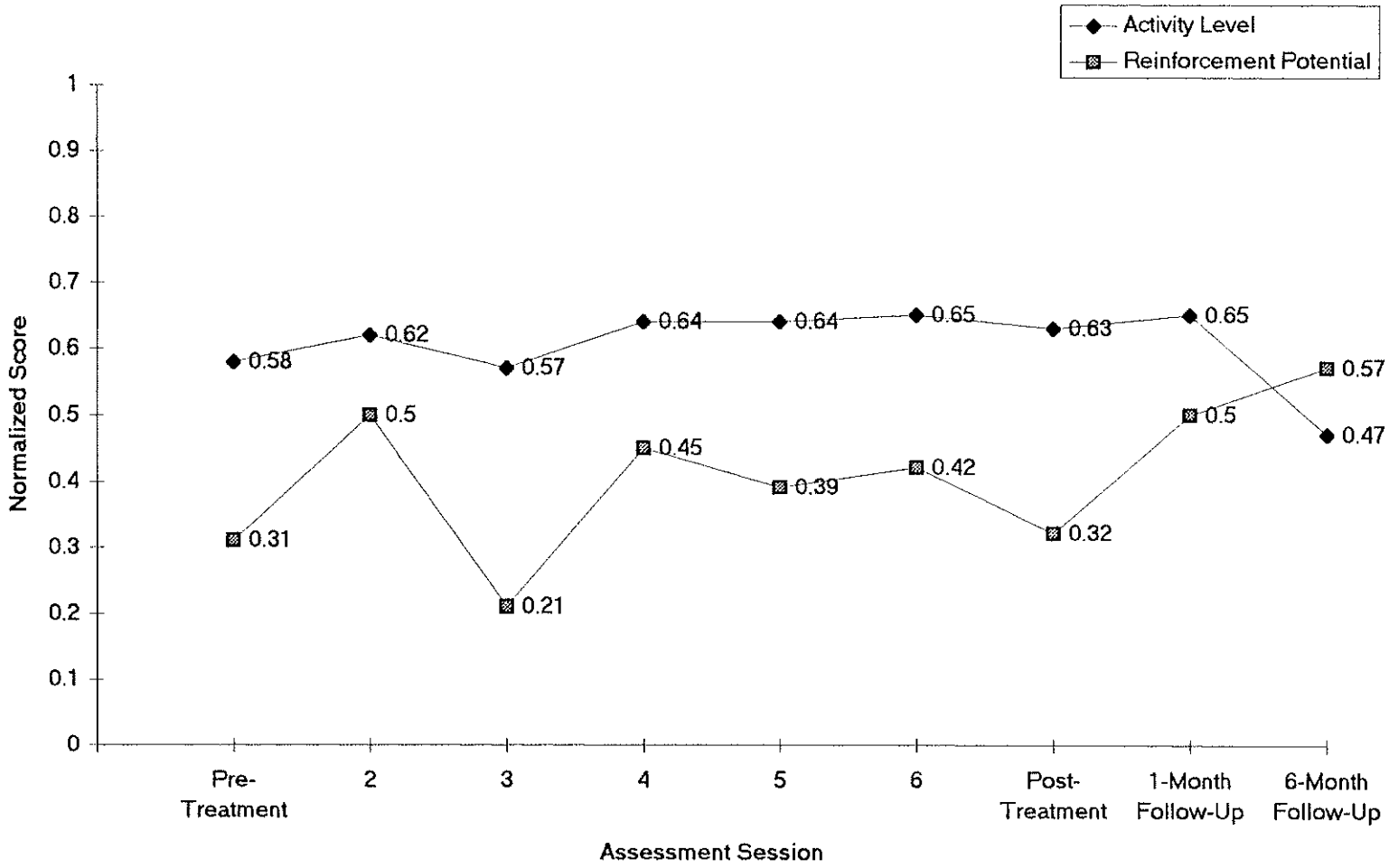


Figure 31. Scott's mean self-concept scores over assessment sessions.

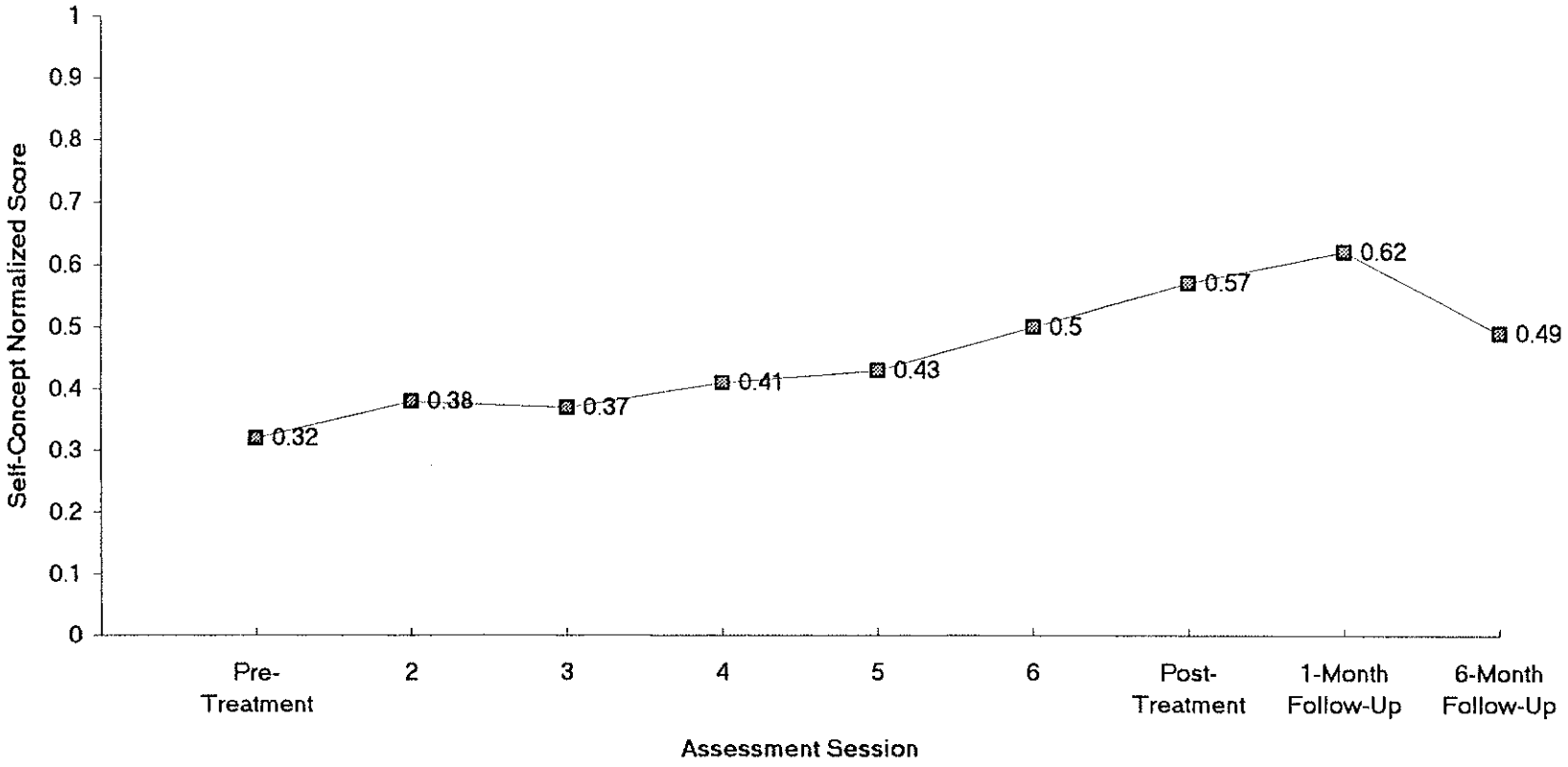
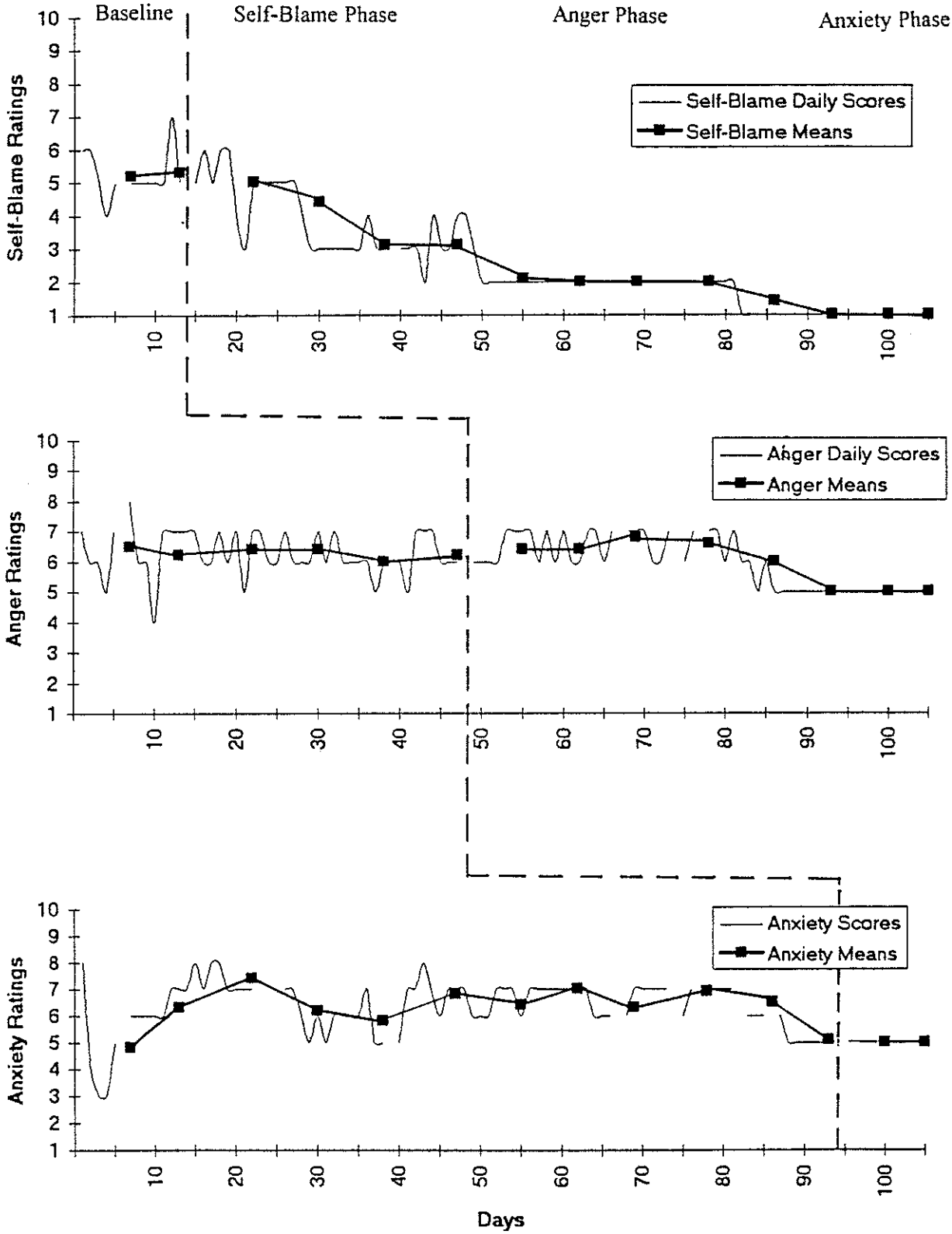


Figure 32. Scott's daily self-ratings and mean scores



Note. Means represent approximately 7-day intervals.

Figure 33. Sean's depression scores over assessment sessions.

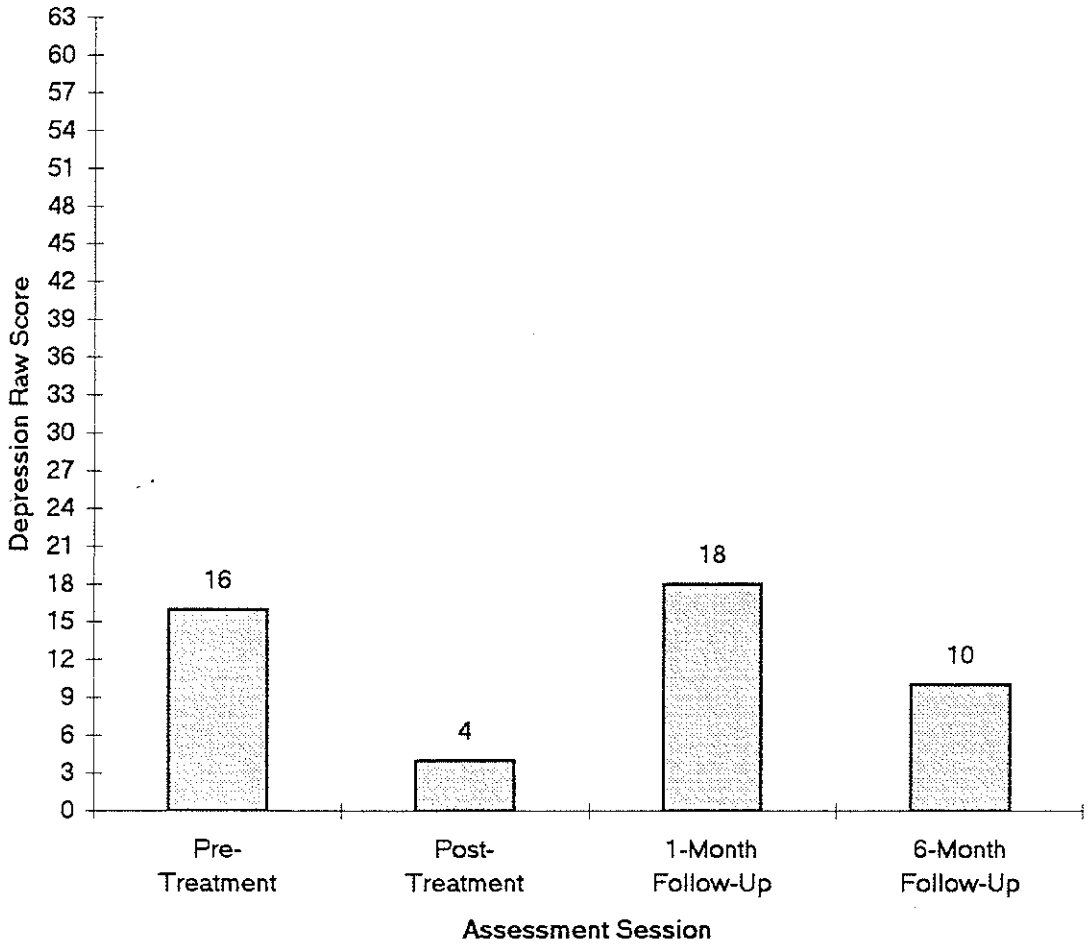
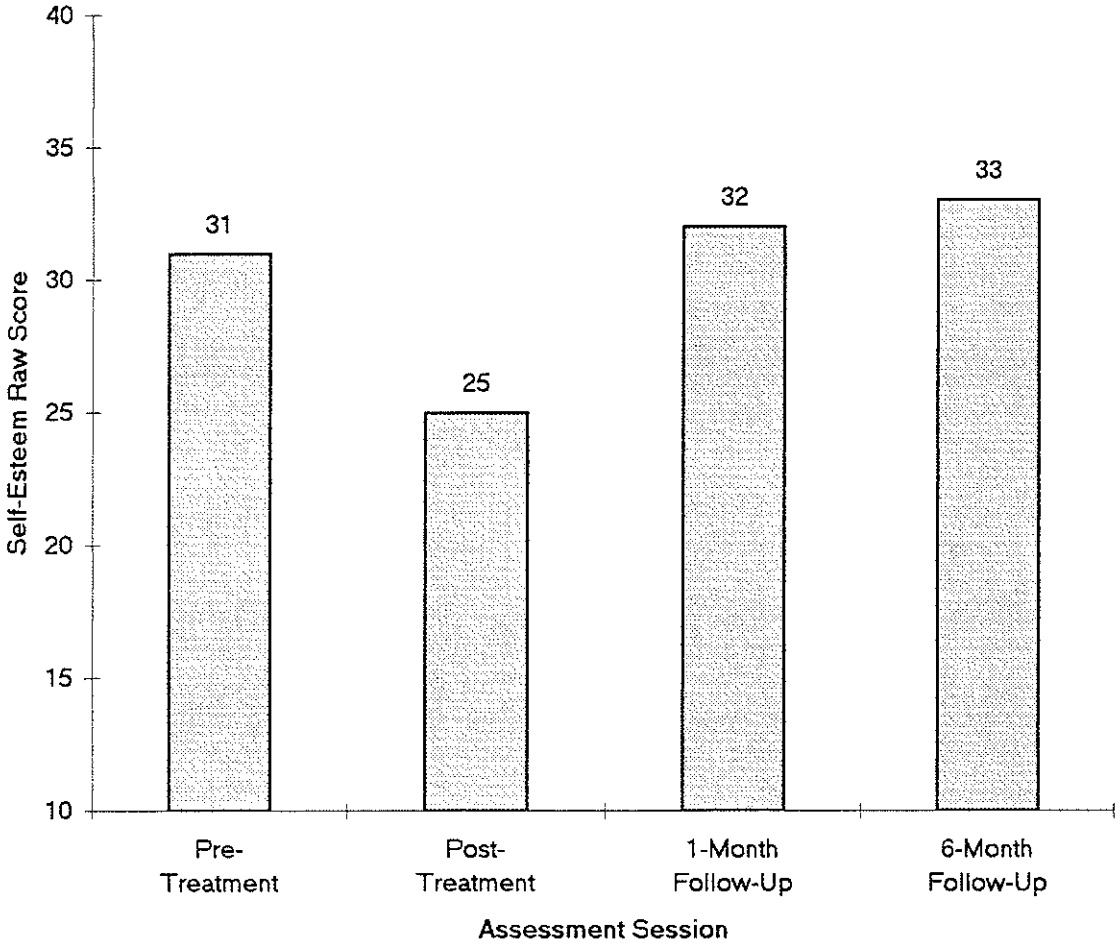


Figure 34. Sean's self-esteem scores over assessment sessions.



Note. Lower scores correspond to higher levels of self-esteem.

Figure 35. Sean's blame scores over assessment sessions.

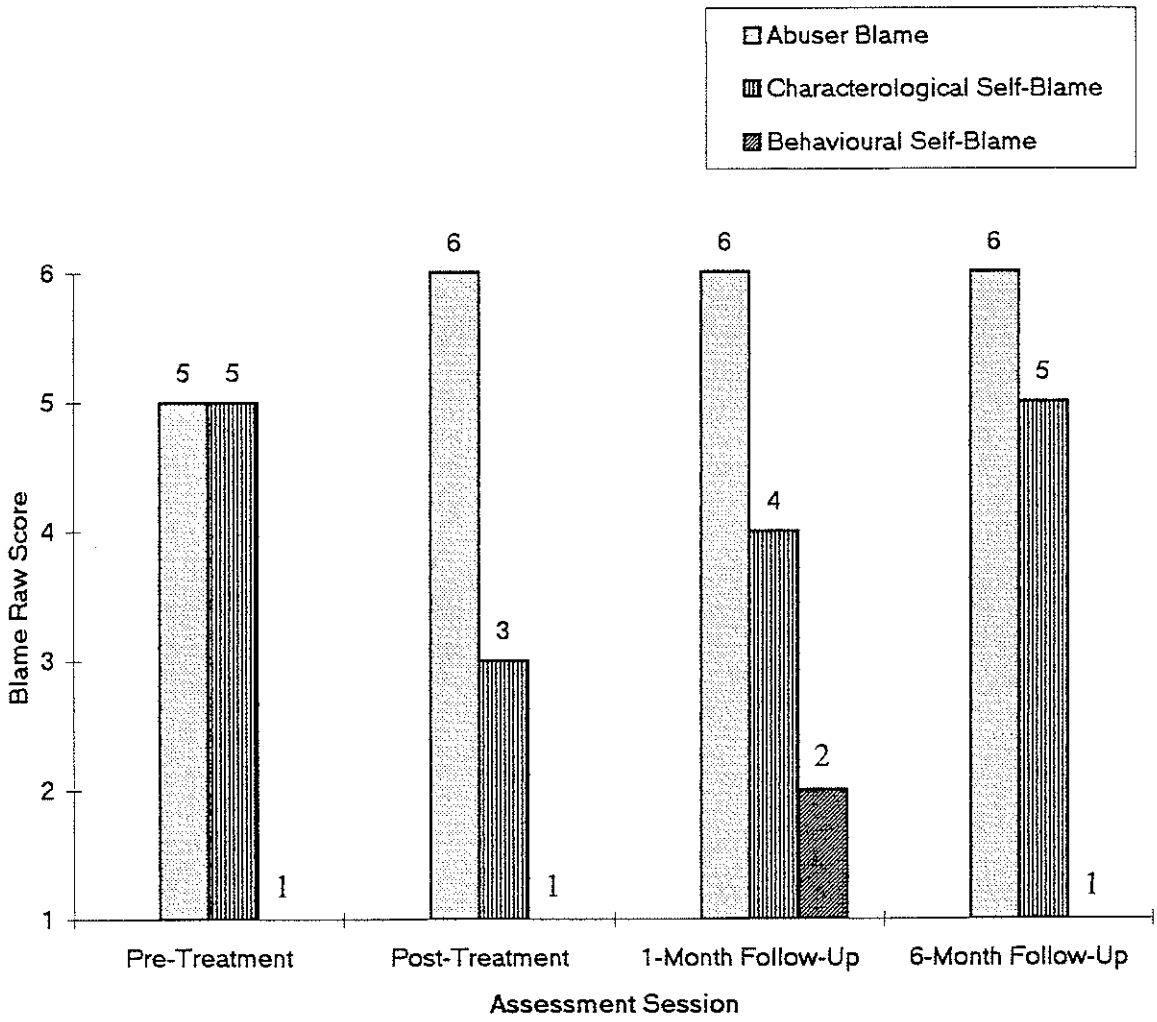


Figure 36. Sean's overall anger scores over assessment sessions.

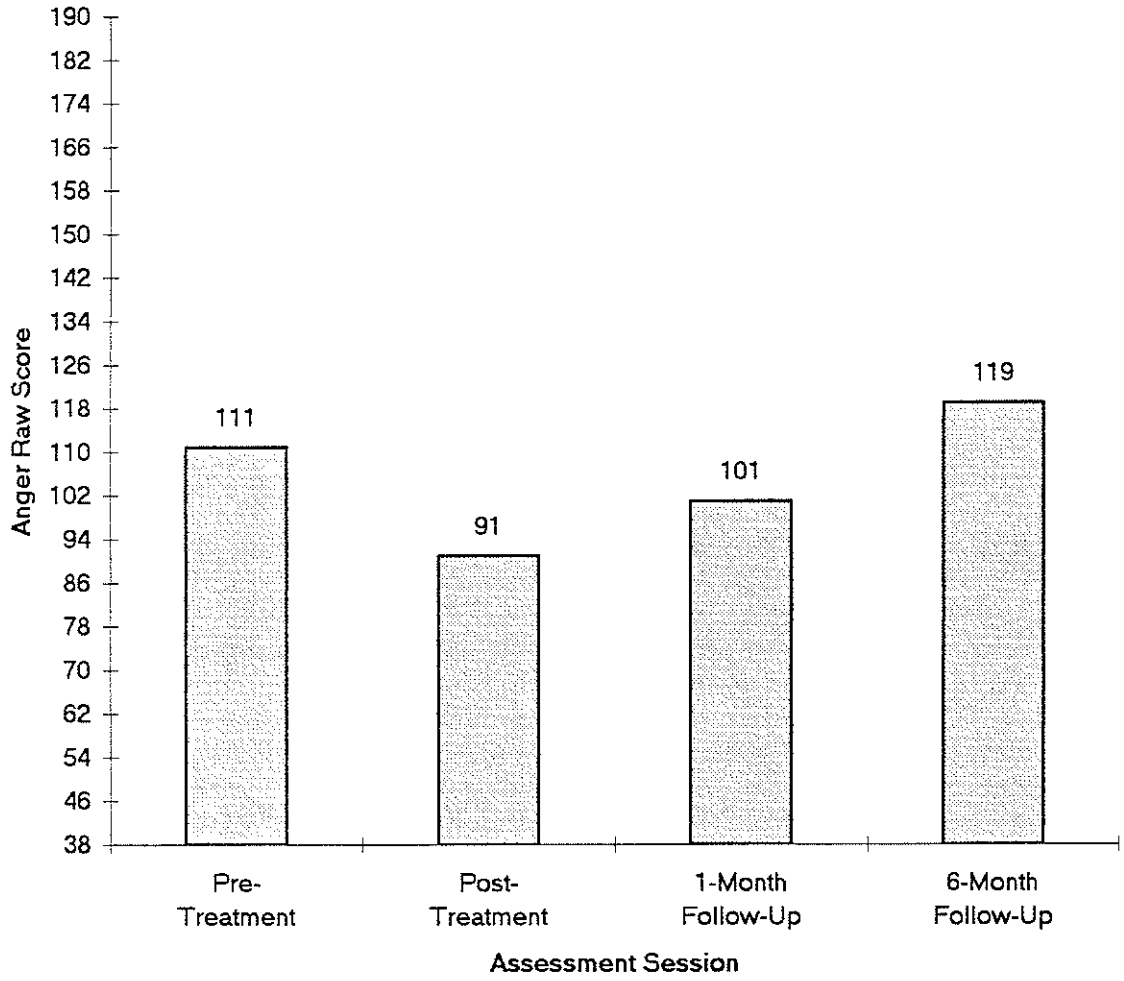


Figure 37. Sean's state- and trait-anxiety scores over assessment sessions.

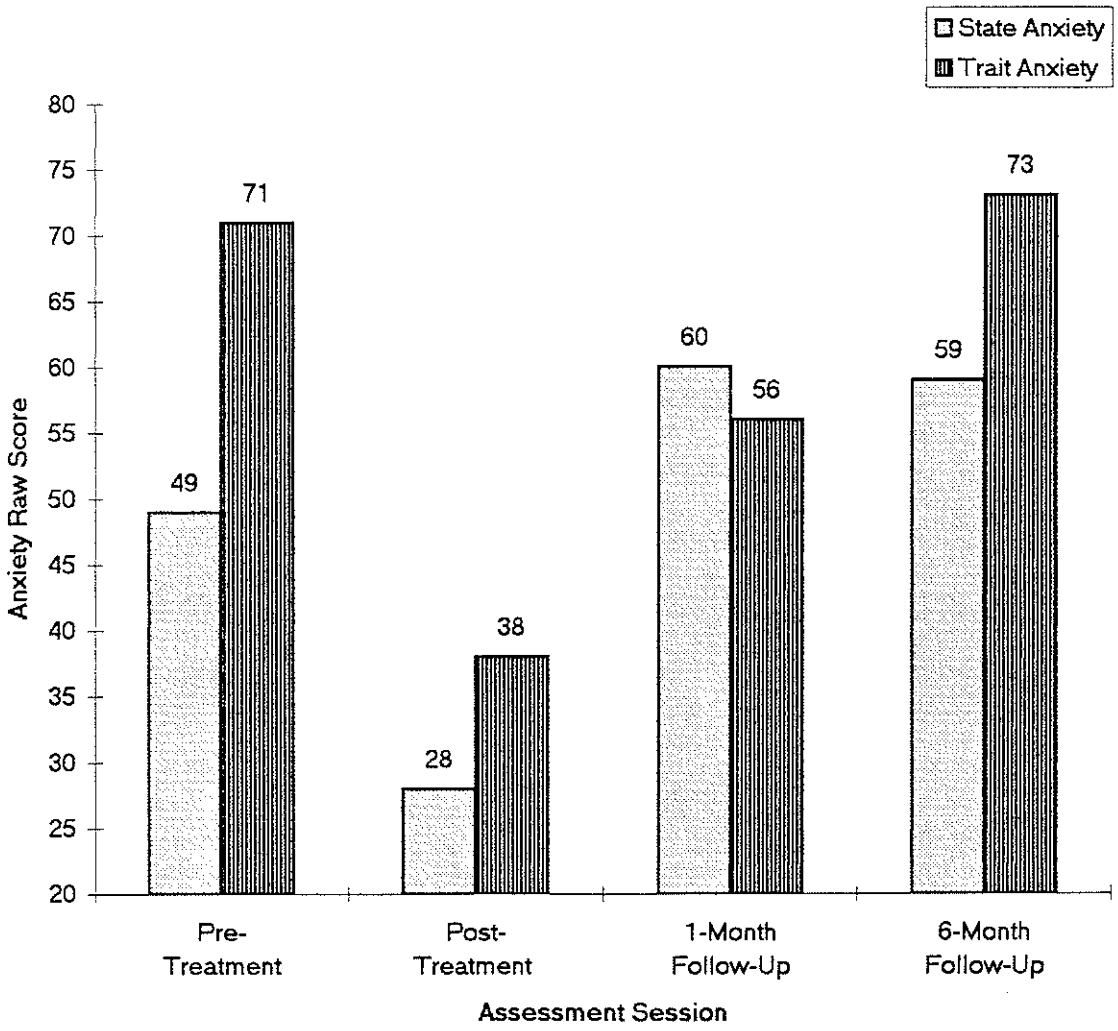


Figure 38. Sean's mean activity level and reinforcement potential scores over assessment sessions.

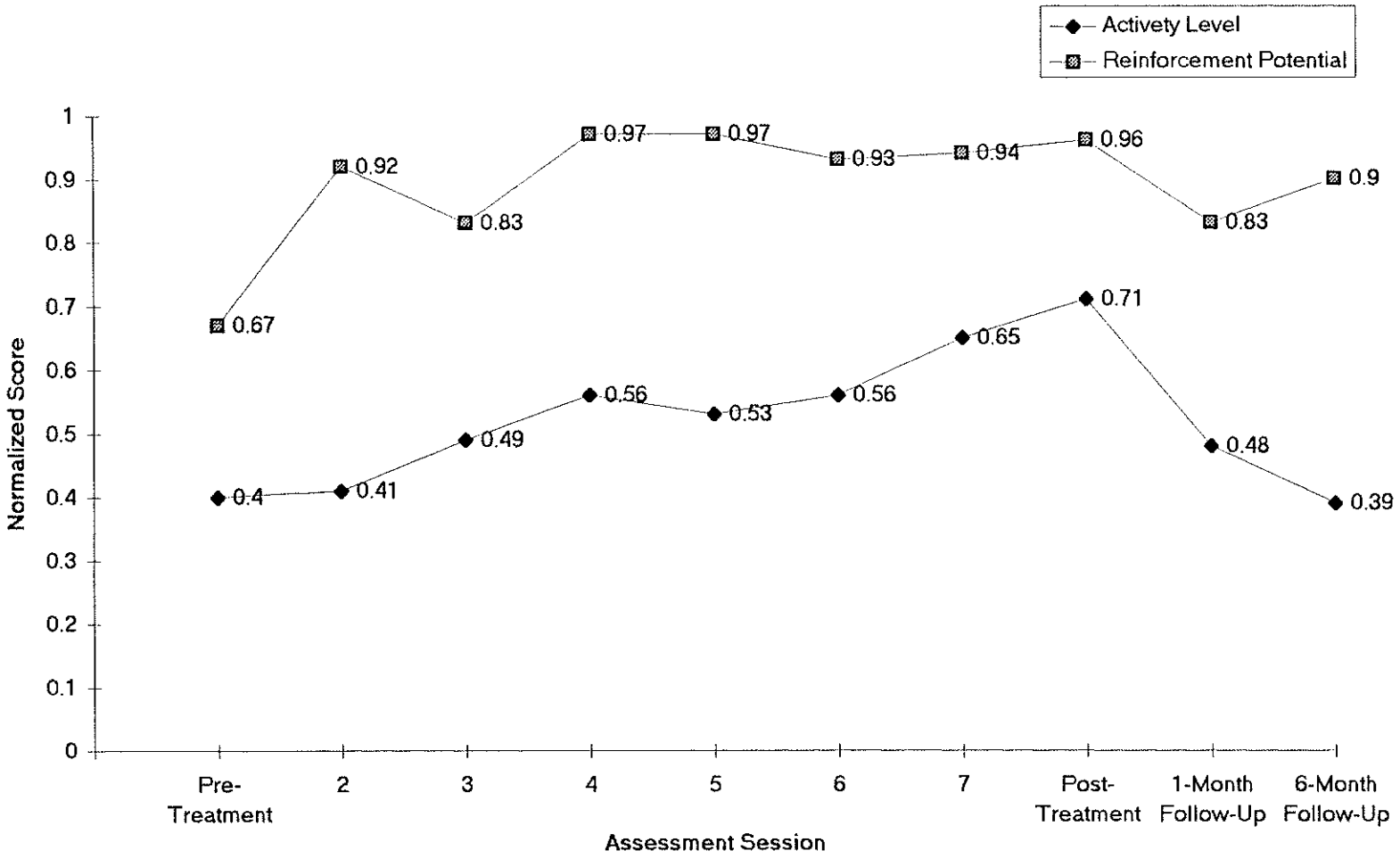


Figure 39. Sean's mean self-concept scores over assessment sessions.

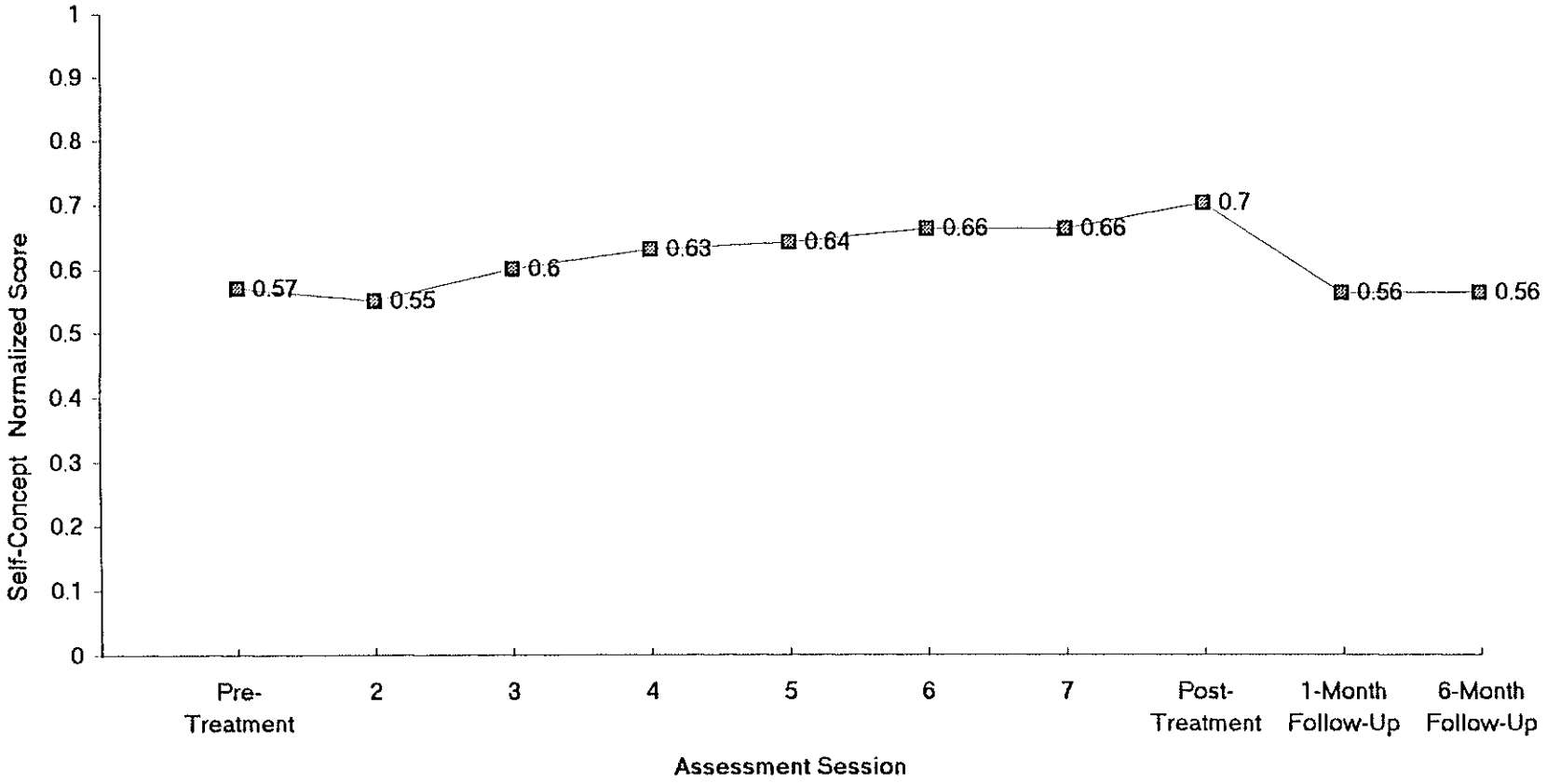
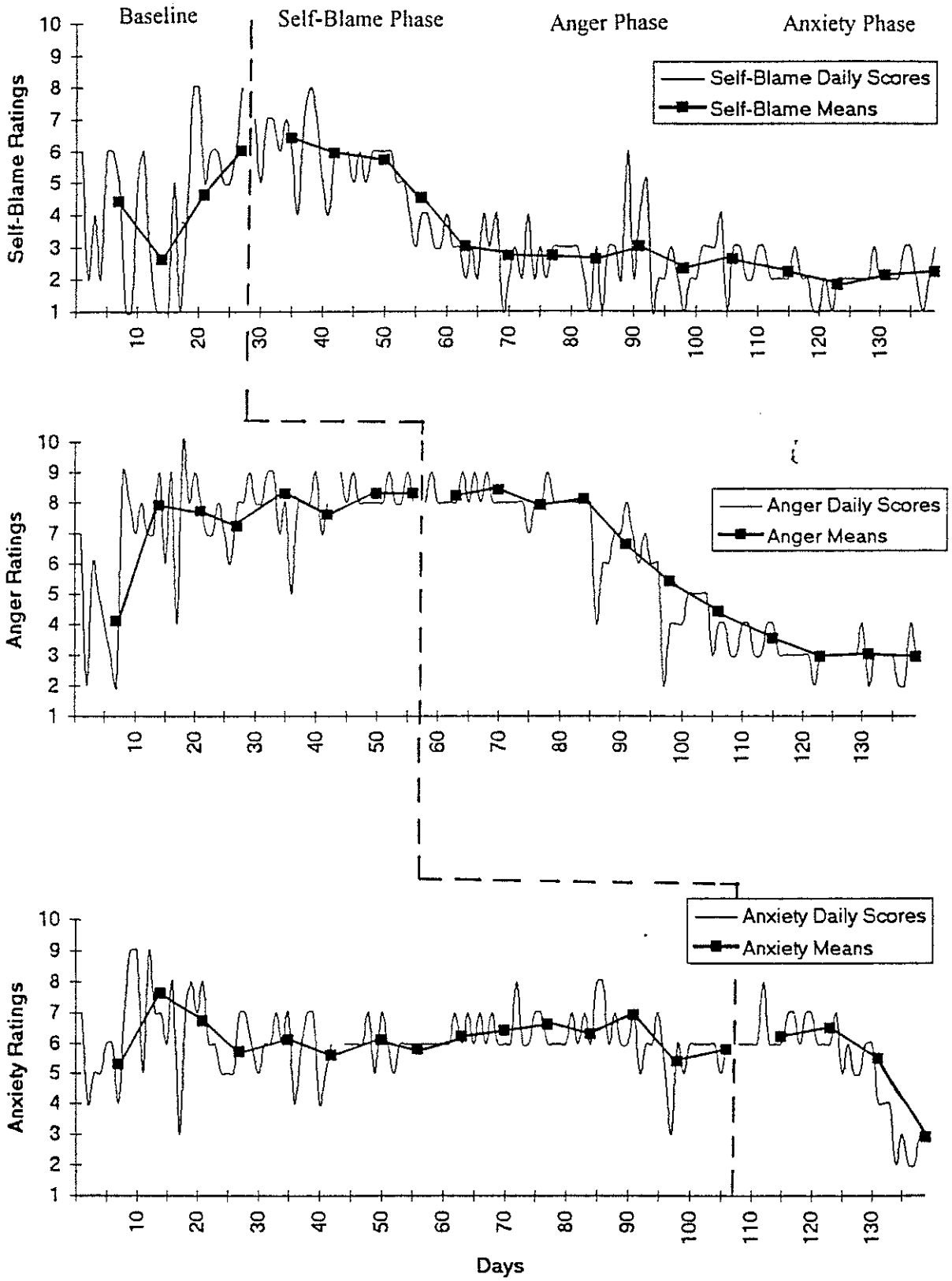


Figure 40. Sean's daily self-ratings and mean scores



Note. Means represent approximately 7-day intervals.