GROUP TREATMENT FOR ADULT MALES WHO WERE SEXUALLY ABUSED IN CHILDHOOD

By

David Sullivan

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A practicum submitted to the Faculty of Graduate Studies of the University of Manitoba in partial fulfillment of the requirements of the degree of

MASTER OF SOCIAL WORK

Abstract

This practicum describes a group intervention with adult male survivors of childhood sexual abuse. Treatment focused on the most common long-term consequences noted in the literature for this target population. The group was short-term, consisting of twelve two hour sessions. It was co-facilitated with a female therapist. The benefit of having a male and a female as group leaders proved to be immense for the group members.

There were four group treatment objectives. The intent was to provide a nurturing environment where members could experience non-competitive relationships and develop positive self-regard. Individual shame, guilt, and low self-esteem were hoped to be obviated through the breaking of the secret and sharing of common experiences and feelings with other group members. The intent was also to clarify gender confusion that may exist and improve members' masculinity self-concept. The final objective was to instill a sense of empowerment within the individuals.

An extensive literature review has been undertaken on the immediate and long-term consequences for males who have been sexually abused as children. A summary of the intervention is also provided. The evaluation of the intervention utilized a pretest posttest one group design in combination with a B design. Clinical significance was noted for all areas. Statistical significance was found for fifteen of seventeen scales measured at $p < .05$.

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Literature Review

The impact of sexual abuse for the male victim has been a neglected area of study. The amount of research and treatment services for this clinical population is stark when contrasted with the evolution of knowledge and treatment efficacy for the female victim (Jehu, 1988; Courtois, 1988; Rush, 1980; Meiselman, 1990; Briere, 1989). However, this is not to say the literature is deficient. Therapists have shared clinical observations and retrospective accounts of young male clients (Porter, 1986; Rogers & Terry, 1984). The opportunity exists to read of the devastation resulting from childhood sexual abuse from the perspective of adult male survivors. These publications most often chronicle personal experiences and serve to break down the secrecy and isolation for other male survivors (Hunter, 1990; Grubman-Black, 1990). Male survivors in therapy characterize their childhood as one fraught with many difficulties. They also attribute a disrupted lifestyle in later years to the sexual misuse they experienced as children (Groth & Burgess, 1980).

Why has so little attention been paid to the situation of the male victim of sexual abuse? One must first explore how society has come to understand the destructive aspects of sexual abuse. Child sexual abuse has been championed by the women's movement.

Their speaking out on the destructive effects of these sexual encounters has resulted in awareness of the issue. The movement has lent a deep and abiding support to the plight of the female victim. A result of this is that clinical information regarding the problem of sexual abuse quickly coalesced around one particular model. The framework that evolved was the female child victim and the adult male perpetrator. Father-daughter incest came to typify and explain the dynamics of sexual abuse. Some writers suggest such a theoretical framework explains the apparent lack of concern for the male victim (Jehu, 1988; Nielsen, 1983).

One cannot surmise that the sexual abuse of males is a rare occurrence and deserving of the erratic recognition it receives in the literature. Prevalence studies do not support such a hypothesis. Nor can one claim that the effects of the abuse are any less devastating for the male. Somehow however, these casualties of sexual abuse have eluded the attention of therapists and researchers. Another explanation for the lack of research on male sexual victimization is that most victims who have come forward for counselling have been females. As clinicians saw few male victims in their practice there was little pressure to understand the issue from the male victim perspective (Finkelhor, 1984).

No doubt other reasons exist for the lack of attention and knowledge on the sexual exploitation of males. Some of them will be exposed within this literature review. What needs to be recognized immediately is that male children are being sexually assaulted at alarming rates. Some people think that the male gender is a prophylactic against sexual abuse. This is not the case. Sandra Butler aptly describes the phenomenon of childhood sexual victimization as being relentlessly democratic regarding choice of victims (Butler,

1978). It occurs amongst every culture, race, class, religion, and gender.

Several practitioners believe that childhood sexual trauma has an equivalent impact on males and females, notwithstanding differences in severity or duration. (Briere et. al., 1988; p. 460). A review of these impact issues for male victims will be presented. The long-term consequences of childhood sexual victimization will be particularly detailed. As mentioned, there exists a paucity of available clinical information and empirical studies on the impact of sexual abuse for males (Briere, Evans, Runtz, & Wall, 1988; Bruckner & Johnson, 1987). Information on female sexual victimization, richer by comparison, will be included to augment a deeper level of understanding of the issues. Enlarging the scope of knowledge will expose effective treatment interventions in the healing process of childhood sexual victimization. Any matter peculiar to male victims will be highlighted as such. The same rule applies for material unique to female victims.

The last section of the literature review explores treatment models. This section also includes treatment issues that require special attention when working with adult male survivors. Before moving on though, the use of the words sexual abuse and sexual assault needs to be clarified by the writer. Both terms will appear in this document interchangeably. No discrimination is made between the nature and duration of the victimization. Nor do these words describe a relationship between the aggressor and the aggressed. However, the word incest does refer to sexual victimization where the perpetrator is related through blood or through marriage. Examples include step-brother, step-mother, or step-father as the offenders. It is realized that these terms may be different applications for some readers.

Definition of Childhood Sexual Victimization

Most definitions of child sexual abuse are either research driven or designed for legal purposes. Both perform useful functions. The research has contributed to the body of knowledge on child sexual abuse. Legal sanctions are one way society can express outrage at, and intolerance for, the commitment of such sexual aggressions. However, many definitions contain a hidden risk for the practitioner. The breadth of most definitions only permits exploration of limited interactions in the child's life. Usually they compromise inquiry of other associations in the growing child's world. This is a serious drawback for therapists and male clients engaged in the process of connecting past issues to adulthood functioning. Therapists should include sexual maturation when re-evaluating clients' childhood in connection to general dissatisfaction with present day life; otherwise a disservice can be done. Definitions of child sexual abuse usually do not look at this and herein lays their danger for the therapist.

To further illustrate the above points, various definitions of child sexual abuse will be presented. Addressed more thoroughly will be the abuse of sexuality model which expands the understanding of issues possibly facing males seeking counselling.

Researchers have used a variety of criteria to establish their definitions of what is a sexually assaultive experience. Demarcations have been made based on the gap in age between the perpetrator and the victim, the relationship between them, and whether there was use of force or any threats to harm. The type of sexual contact is also a variable in some studies. For the therapist and client though, there is a danger with any

of these definitions. Clinicians may be prone to provide circumscribed assessments and interventions based on the restrictive guidelines set up to define sexually abusive experiences for research purposes (Bolton, Morris & MacEachron, 1989; p. 17). Now to present some common definitions.

One of the first comprehensive treatment texts on child sexual abuse is titled Handbook of Clinical Interventions and Child Sexual Abuse. In it, sexual abuse is defined as "a sexual act imposed on a child who lacks emotional, maturational, and cognitive development. The ability to lure a child into a sexual relationship is based upon the all-powerful and dominant position of the adult or older adolescent perpetrator, which is in sharp contrast to the child's age, dependency, and subordinate position"(Sgroi, 1983; p. 9). The type of sexual contact could either be hands-on or hands-off violations.

A study investigating symptomatology of childhood sexual abuse amongst adult males and females used age and nature of contact as important criteria in its definition. Sexual abuse was defined as any hands on sexual contact experienced before the age of 16. The perpetrator had to be five or more years older than the victim (Briere, Evans, Runtz & Wall, 1988). Finkelhor's study on the sexual abuse of boys also used age differences to specify whether or not an experience was abusive (Finkelhor, 1981). Another study looking at prevalence of sexual abuse amongst boys employed a more extensive definition. This definition used three criteria. First, there had to exist a significant age discrepancy between the child and the other person. That is, the offender must be five or more years older for victims under the age of 12. The gap was eight or more years between the abuser and the victim in assaults where the victim was 13

years of age or older. The second gauge was that some form of coercion was used to force the participation of the victim. This coercion could be disguised in many ways. It could take the form of furnishing the victim with money, candy, or other gifts. Or it could be the blatant use of threats to hurt or punish. Further still, it could be the overt use of power or force over the victim. A third criteria was that the perpetrator was in a position of trust with the victim e.g., a babysitter or teacher (Risen & Koss, 1987; p. 311). All three criteria had to be met to define an experience as sexually exploitive.

It is difficult for society to accept the idea that coercion occurs in the sexual assault of males. The culturally endorsed male role in society is one in which the male is sexually aggressive, physically strong, and non-nurturing. He is the ready seducer. Any victimization experience is antithetical to his prescribed role. Sexual victimization can be an experience of emasculation for the male child. He did not protect himself. Consequently, he has let himself and others down if he does not avenge the hurt, preferably violently, and then forget about the assault. When he does not, he is branded a coward and scorned as unmanly (Lew, 1988; Geiser, 1979; Porter, 1986).

Amongst society there exists a reluctance to recognize boys as victims of sexual abuse. Society would prefer to portray these children as willing (eager?) participants in sexual encounters with adults (Jehu, 1988). This becomes even more apparent when the perpetrator is female. One writer exposes this with the following finding. "In 1979 a New Jersey Superior Court ruled that no woman could be prosecuted for *carnally abusing* a boy under the age of 16. The explanation given for this ruling is that *young girls can become pregnant; young boys cannot.* The court went on to note that a young girl who

suffers physical injury can also suffer an emotional or psychological trauma that might adversely affect her outlook on sexuality throughout her life; presumably boys are immune from that trauma" (de Young, 1982; p. 71).

Inherent in the conviction that males are physically strong is the belief that they cannot be victimized without physical force and struggle. In the absence of such a trail between the aggressor and the aggressed it is assumed that the victim must have wanted it to happen. When males are sexually victimized the spectre of misplaced responsibility rears itself; especially in situations where there is no overt evidence of a struggle from the victim. Instead of recognizing these exploitive, abusive experiences as such, society will contrive excuses and search for ways to blame the victim. In doing so, society does not have to define the experience as sexually abusive for the victim. Furthermore, by doing this, society will not need to concern itself with holding sexual aggressors accountable. The exploitive nature of such encounters are explained away with claims that the victims prostituted themselves or they were homosexual (Jehu, 1988; p. 299). Some people view the victim as having faltered with resisting physically as a *real boy would have done.* There are many other rationalizations used by people to defend the abuser.

The above examples typify the restrictive scope of research and legal definitions. These definitions are clinically very limiting and can lead to inaccurate identification of treatment themes. Strict adherence to rigid regulations delineating sexual abuse may result in many sexual aberrations going unnoticed. Most definitions lack focus on whether or not experiences were detrimental to the child's development and therefore,

practitioners may oversee or discredit some childhood encounters. A clinically driven definition such as the abuse of sexuality is more desirable. It examines childhood experiences in the context of how they influence one's view of the world.

The abuse of sexuality model is an expanded definition of child sexual abuse (Bolton et. al., 1989; pp. 17-29). It identifies from healthy through to pathological development of sexuality of an individual. The model addresses this development through the variables of any number of sexual expressions and experiences that may be met during childhood on to adulthood. The variables are scrutinized from the child's ability to understand what occurred. Table 1 represents the abuse of sexuality model. This paradigm is a continuum of environments-- from nurturing to abusive. The premise is that variations from the ideal increase the likelihood of the existence of sexual victimization in that environment. Each environment is depicted by events that shape opportunities to learn and experience one's developing sexuality. This model effectively eclipses the emphasis on who did what to whom. It allows for a focus on the causal variables and environmental factors. The clinician operating within such a theoretical understanding of sexual abuse will do more service to male clients as this model allows for a broader assessment. Males can define their experiences as sexually abusive based on their ability to understand what happened and not be forced to question the level of force used.

Table 1: The Abuse of Sexuality Model

Developmental Environment	*Degree of Victimization*
1. The ideal environment	
2. The predominantly nurturing environment	Nonabusive
3. The evasive environment	
4. The environmental vacuum	
5. The permissive environment	Abuse of sexuality
6. The negative environment	
7. The seductive environment	
8. The overtly sexual environment	Abuse of sexuality and sexual victimization

Bolton, F.G., Morris, L.A. & MacEachron, A.E. (1989). Males at risk: The other side of child sexual abuse. Newbury Park, CA: Sage; p.19.

The abuse of sexuality model describes an ideal environment. Children reared in this milieu will grow up in supportive, nurturing surroundings. In such homes, an understanding of the needs of the youngster by adults exists. Children are provided with necessary information regarding sexuality. However, most youngsters are reared in homes with an atmosphere that is a variation of this ideal environment. In recognition of this, the model constructs different hypotheses on outcomes for the child growing up in these situations. The model begins with a departure from the ideal milieu where the child receives minimal inappropriate sexual information. This progresses by varying degrees of inappropriate information and increasing inappropriate sexual activity. Open sexualized contact between the child and adult exists at the far end of the continuum.

The importance for the clinician to be operating with a clinically driven definition of what constitutes a sexual assault has been stressed. Exposed were the risks of practitioners simply adopting definitions that have been designed for legal or research purposes. Most of these definitions establish age, coercion, and nature of sexual contact to determine whether an encounter was sexually assaultive or not. The abuse of sexuality model provides a definition that is broader in its scope and this allows for investigation of many more variables. This is crucial in light of societal views on the male role.

Prevalence of Male Childhood Sexual Victimization

Problems inherent with the socialization of males have been intimated. Many researchers and practitioners assume that widespread under-reporting of sexual assaults

on males exists (Showers, Farber, Oshins & Johnson, 1983; Sebold, 1987; Kaufman, 1984). David Finkelhor, a noted researcher in the area of sexual abuse, believes the reporting of abuse, already subjugated to stifled numbers, has "deep seated roots in sex role stereotypes and homophobia that will not be easily changed short of a direct assault on these attitudes" (Finkelhor, 1984; p. 233). Males are less likely to identify experiences as abusive as long as being the victim of a sexual assault is a threat to their masculinity. The male child is thrust into a role in which he is typecast to be dominant, competitive, aggressive, and tough. With regard to sex and sexual performance, he should be active, knowledgeable, potent, and a successful seducer. He quickly realizes that if he does not meet these sex and gender role expectations than he does not measure up to the male role (Bolton et. al., 1990; pp. 11-14). With these points in mind, the reader is better prepared for critical interpretations of the following prevalence studies.

Several studies have included comparisons between genders when investigating child sexual abuse. One of the first audits completed was done in the state of New York during the 1960s. It found boys to be victims of sexual abuse on a ratio of one to every ten girl victims (De Francis, 1969). The literature reflects a trend of other studies tracking the proportion of victimization between girls and boys. At the end of the 1970's the ratio was believed to be three boys for every ten girls (Rush, 1980; p.175). Reports of male sexual victimization continued to increase into the 1980s (Blanchard, 1986).

Canada's most comprehensive study on child abuse was a national survey headed by Robin Badgely. This inquiry determined that one in every four males will likely be a victim of an unwanted sexual act before the age of 16. The survey also revealed that

one in three males will be a victim of an unwanted sex act at some point in their life. The comparison was one in every two females (Badgley, 1984; pp. 175-177). To clarify, this study included hands-off sexual transgressions such as obscene telephone calls and exposure as sexual victimization.

Another Canadian project gathered information from 89 adolescent male runaways who entered a shelter during the summer of 1984. Data collection was done by responses to a questionnaire which limited a sexual assault to three considerations. The study sample was queried on whether (1) Had he ever been sexually molested? (2) Had he ever had sex against his will? and (3) Had he ever been forced to view a sex act? Responses to the questioning revealed 38.2% had answered yes to at least one of the three questions (Janus, Burgess, & McCormack, 1987).

Finally, in the province of Manitoba, child sexual abuse showed the highest increase in reported assaults. Reports of incidence rose 108% between 1982 and 1986. When considering the climb in number of reports since 1979 the percentage is 289% (Manitoba Child Abuse Registry, 1987). Sexual abuse ascended most noticeably of all the reported cases of child abuse. In 1979 child sexual abuse represented 29% of all the cases. In 1986 child sexual abuse comprised 58% of reports. "However, a sign that these growth figures are conservative appeared once reporting system changes came into force in the fall of 1987. Registry figures rose dramatically in that year by another 83% to 1526 cases" (Wachtel, 1989; p. 8). These figures unfortunately, do not include a breakdown of the number of male children versus female children who have been sexually abused but do speak to the prevalence of the problem.

As researchers were noting a climb in the reporting of sexual assaults against male youths so were clinicians. Rogers and Terry conducted a comparison study of reactions of boy and girl victims of sexual abuse. They found one quarter of abused children to be male (Rogers & Terry, 1984). Black-Grubman is the author of Broken Boys/Mending Men. This book chronicles the difficulties and treatment needs of adult male survivors from a personal viewpoint. In this text the statement is made that one out every six males has been sexually victimized as a boy (Black-Grubman, 1990; p.136). The authors of The Courage To Heal, claim that one out of seven males will be sexually abused before he reaches age 18 (Bass, and Davis, 1988; p.20).

Many practitioners believe that accurate accounts of male sexual victimization are still unavailable. Some maintain the ratio of male to female victims more closely approximate 1:2; and may even be equal (Gieser, 1979; Porter, 1986). A study by the San Francisco Police Department's Youth Services Division during 1975-1976 revealed that of a total of 131 identified juvenile victims of sex offenses, nearly one third were males.

In closing, reasons why male sexual victimization is under-reported have been presented. First, it is unlikely that the male victim of a female perpetrator can define the experience as abusive (Lew, 1988). As well, the male victim will be hesitant to report the matter, regardless of the sex of the offender, should he believe his complaint will cause others to question his masculinity (James & Nasjleti, 1983; Grubman-Black, 1990). There is the belief that sexual violence may exceed physical abuse of children in its prevalence (Nielsen, 1983; p.139). However, professionals appear to lack awareness that

such brutality is such a rampant problem for boys (McFarlane, Waterman, Conerly, Dramon, Durfee & Long, 1986; Vander Mey, 1988; Mayer, 1983). "Stating that the largest annual increase in child abuse reporting occurred in the area of sexual abuse (54 percent), the American Humane Association (1986) notes also that since 1980 the percentage of male sexual victims (out of all child abuse victims) increased at a greater rate than female victims" (Porter, 1986; p.3). Could this be because finally there was recognition that such an event can occur for males?

Perpetrators of Sexual Abuse Against Males

Exactly who is it that sexually abuses children? Children are abused by fathers, step-fathers, uncles, brothers, and grandparents. They are also abused by neighbors, family friends, babysitters, teachers, and strangers. And sometimes they are abused by aunts and mothers (Bass & Davis, 1988; p. 20). The literature provides ample evidence to allow the generalized statement that boys are almost always assaulted by somebody of the same sex (Finkelhor, 1981; Dimock, 1988; Reinhart, 1987; Vander Mey, 1988; De Francis, 1969; Blanchard, 1986; Rogers & Terry, 1984); that the offender is usually somebody known to the family (Meiselman, 1990; Nielsen, 1983; Driver and Droisen, 1989; Showers et. al., 1983; Myers, 1989; Finkelhor, 1984; Risen & Koss, 1987; Walker, Bonner & Kaufman, 1988) and that the boy's perpetrator is most often adolescent (Dimock, 1988; Reinhart, 1987; Finkelhor, 1981; De Jong, Emmett, & Hervada, 1982). This far reaching statement will now be expanded on.

Perpetrators of same-sex assaults are chiefly heterosexual in their sexual orientation (Nielsen, 1983). "Sex becomes an instrument of control, retaliation, degradation, and punishment for the offender"(Groth and Burgess, 1980; p.809). Understanding this, it becomes clear that the offender is not motivated by sex. Nor does the act stem from the need of sexual release. It is false to believe the perpetrator commits these atrocities because the child wanted it. This is not to say that the offender may profess otherwise. Sexual infractions against children have been commonly defended with the comment 'the victim wanted it to happen'. The perpetrator will claim he knew this by the youngster's alleged sexually suggestive behaviors and innuendos. "The grossly seductive child who overwhelms the helpless adult with a degree of sensuality that cannot be ignored or denied and thereby stimulates a compulsive response from the adult that inevitably ends in a sexual relationship is a myth existing only in the minds of perpetrators and some defense attorneys....the attraction for the perpetrator is much more likely to be some combination of qualities that can best be termed childlike: immaturity; inexperience; defencelessness; and affectionate, trusting, confiding, playful behavior"(Sgroi, 1983; p.30)

Perpetrators of sexual abuse against boys are less likely to be family members. This is the opposite for girls (Nasjleti, 1980). Several studies on incest have found the number of boy victims to be significantly lower than girl victims. One finding was that one in every ten boys will have an incest experience. For girls it is one in every six females (Maltz, 1988). Researchers have found incest for boys as being a rare occurrence (De Francis, 1969; p.38). When it does occur, the perpetrator is most often

a young relative such as a brother or a cousin. This too, is dissimilar when a comparison is made to females. The female incest victim is usually abused by older relatives such as fathers, uncles and grandfathers (Reinhart, 1987; James & Nasjleti, 1983).

Can the statistics for male incest victims be a close proximate to actual numbers? One needs to remember the issues facing males when disclosing abuse. Father/son incest is rarely reported. Perhaps because it violates two moral codes: one against incest and one against homosexuality (Justice & Justice, 1979; Pierce, 1987). The exposed societal barriers and the silence surrounding the victimization of males tell readers little confidence can be placed in the estimates of incestuous abuse of males. It is possible that male incest victims may go undiscovered in the absence of sister victims (Vander Mey, 1988). The rarest form of incest noted in the literature is mother/son. Although mother/son incest does occur, it is far less frequent and less overt than the relationship between fathers and daughters. Most people regard it as the rarest and most taboo form of child abuse (Renvoize, 1982; p. 129). Despite this fact, there also exists a myth that the seduction of the male child by an older female is a positive sexual experience for the boy (Nasjleti, 1980; p. 271).

Now to address the statement that boys are most often assaulted by adolescents. Adolescent male sexual offenders and victims were engaged in a recent Canadian demonstration treatment project. Their retrospective accounts revealed that a majority had been assaulted by adolescent males (Campbell, Lussier, Vaughan-Jones, McCannell & Kuncewicz, 1992). A study embracing incarcerated adult male sexual offenders in three American states uncovered that 53% of the perpetrators had, by the age of fifteen

years, developed a proclivity for sexual abberations with young male children (Abel, Mittleman, & Becker, 1983). The medical records of sexual abuse victims presenting at a California hospital was used for data collection in an American study. Findings uncovered that 19% of the males were assaulted by adolescents. The figure for girls assaulted by adolescents was only 8% (Reinhart, 1987; p. 232).

To summarize, a review of several prevalence studies show that boys are most often sexually abused by adolescents of the same sex and who are known to the boy's family. The noted frequency with which boys are assaulted compared to girls has been increasing with recent studies. However, even these high numbers are probably conservative estimates of the actual incidence of abuse experienced by male children. Societal obstructions are at play in any reporting of child sexual abuse.

Nature of Sexual Assaults on Males

Child sexual abuse is a violation of power. The sexual offender is in a position of power over someone who is more vulnerable. The abuse of power takes on a sexual form, but it involves more than sex. "It involves a breach of trust, a breaking of boundaries and a profound violation of the survivor's sense of self" (Davies, 1991; p. 13). Reviewing patient records at a hospital serving urban and rural communities in Ohio and West Virginia, Showers et. al., noted that oral/genital contact was the most common form of abuse perpetrated (46.9%) against boys. The next frequent attack was anal intercourse, typifying the nature of assault for 40.7% of the male patients. At another

hospital, patient files of sexually abused boys identified attempted anal assault as the most serious act perpetrated for 78% (n = 110) of the sample. The next frequent complaint was fondling or exposure which was incurred by nine percent of the victims (Showers et. al., 1983).

It can be said that hospital records reveal distorted findings. Male victims using the services of crisis clinics or hospital settings conceivably are in distress, both emotionally or physically. Their anguish may have a relationship to the acts forced on them and therein lays the elevated number for violent acts performed on them. However, the findings of a descriptive study on the nature and prevalence of sexual assaults against males are very similar to that of findings from reviewing hospital records. This descriptive study was a national survey with a sample size of 2,972 males. One of the results of the survey was that 216 of these males were sexually victimized during childhood. Exhibition and fondling were the most serious incidents experienced by 34.7% of the subjects followed by attempted or actual penetration, for 30.7% (Risen & Koss, 1987; p. 315).

A comparison study between male and female victims found that the abuse experienced by boys frequently included multiple victims by the same offender (Blanchard, 1986; Abel et. al., 1983). Another difference noted in the study was the greater presence of threats and violence in the assault (Blanchard, 1986). The distinction noted by another investigation was that male incest victims came from homes where physical abuse also was occurring at a significantly higher rate (Pierce, 1987; p. 69).

Fifteen men participated in a research study on male rape. The mean age was

26.6 years for this sample. A finding from this group was that 60% (9) had been assaulted by more than one assailant. Another significant finding was the presence of brutality to be less for female rape victims then for male victims. Only 11% of the 100 female rape victims reported physical trauma compared to 53% of the men (Kaufman, 1984; pp.157-158). A similar finding on use of force was the case for the next study. Police reports of 12 male rape victims in Columbia, South Carolina revealed that force was utilized in all cases. The average age of the victim was 16.6 years and nine of them were under the age of 18. The perpetrators were adults (Forman, 1982).

Upon ending this section, a brief review shows that males are most often abused by somebody of the same sex. In comparison to female victims, the use of physical coercion may be more prominent for the male. However, in general, boys are assaulted in manners similar to girls (Showers et. al., 1983).

Consequences of Sexual Abuse for the Child

"For centuries, sexual behavior that violates the accepted societal norms has been a matter for social control and, in civilized societies, for legal control through criminal sanctions" (Whitaker & Wodarski, 1989; p. 50). However, society has dodged responsibility for supporting the victim in facing the aftermath of sexual abuse. One only needs to turn to victim services extant to conclude that society has not troubled itself past legal sanctions. Clinical wisdom and research experience shared by several writers reveal that victims are emotionally traumatized by the experience (Showers et. al., 1983; Janus,

1987; Maltz, 1988; Vander Mey, 1988; Bass & Davis, 1988; Briere et. al., 1988; Jehu, 1988; de Young, 1982; Hugaard & Repucci, 1988). The sexual assault of a child requires psychological, social, and cognitive adjustment to survive. It does not matter whether the duration of abuse is brief or over time, it still impacts on the victim (Hartman and Burgess, 1989).

However, factors do exist which influence the degree a child is affected. Negative results are most often the case when force was used to commit the assault (Pierce, 1987). Researchers point out that the overt use of coercion or exploitation results in more initial destructive consequences for the victims. The use of coercion and exploitation will also result in more long-term negative consequences (Rogers & Terry, 1984). There are writers who believe that coercion, manipulation, force, and violence are involved every time an adult sexually abuses a child (Hartman & Burgess, 1989; p. 119).

The trauma of a sexual assault involving coercion may be expressed through the manifestation of guilt in the victim for not resisting. Even when physical injury or harm is present, the victim is likely to hold the belief that he is responsible for the assault (Hugaard & Reppucci, 1988; pp. 64-65). Abusive acts of fondling or penetration (presumably requiring force on the part of the perpetrator) were found by researchers to cause extreme feelings of victimization. This was not so for hands-off assaults (Risen & Koss, 1987).

Included in contributing to the impact of abuse is the age of the victim at onset. Some researchers have found that younger children are more affected than victims who are older. Disturbances were noted in more abundance amongst females abused before

puberty (Meiselman, 1978). In a longitudinal study, women who were abused when they were prepubescent reported experiencing greater difficulty with long-term relationships than did women assaulted later in childhood (Courtois, 1979). On the other hand, there exists support for the opposite claim. There are writers who say the onset of abuse after puberty results in more contending symptoms for the victim. These individuals seeking treatment presented with a greater degree of discord in their lives than victims abused before puberty (Sedney & Brooks, 1984; Rogers & Terry, 1984; Renvoize, 1982; Haugaard & Reppucci, 1981).

Male and female victims differ on the average age at which abuse usually begins. Studies have ascertained the age to be younger for males. One particular investigation determined that males between the ages of six and 12 to be at eminent risk of sexual victimization (Renvoize, 1982; p.125). This was also the conclusion reached by Pierce and Pierce. Their results showed the median age for males as being 8.6 years. The median age for females was 10.6 years (Pierce & Pierce, 1985). The American Humane Association, examining available national statistics, saw a clustering at 8.46 years for boys and 12.4 years for girls (Finkelhor, 1984). Showers et. al., pioneering the research on sexual victimization of boys, tracked the lives of 81 male youths over a three year period. One of the findings of this study revealed a median of 7.89 years as the age when sexual abuse was initiated (Showers et. al., 1983).

It is difficult to comment on the significance of these studies. Whether the onset of abuse before puberty or after puberty results in more disastrous, lasting consequences for the victim has not been concluded by researchers. However, it is shown that males

tend to be younger in age than females when the abuse starts.

Prior emotional health is said to be a variable on the impact of sexual abuse although there is little rigorous investigation on the subject. Some argue that it is difficult to determine a child's emotional state before the assault. Incredible as it may seem, there are some who say victims of sexual abuse come from dysfunctional backgrounds anyway, and it is difficult to attach the victim's present struggles as a consequence of sexual assault. Regardless, good emotional health is thought to be an important ameliorating factor in the impact of a sexual assault (Haugaard & Reppucci, 1988). The reaction of others however, is more widely agreed upon as a formidable catalyst for resolving the trauma of the experience. Parental response was established as being a major factor on the impact of the abuse. Available social supports are also significant (De Francis, 1969; Newberger & De Vos, 1988; Burgess, Hartman, & McCormack, 1987; Driver & Droisen, 1989; Haugaard & Reppucci, 1988).

A summary of known factors impacting on severity of effects of sexual assault is presented in Table 2. This Table reflects the ideas of Christine Courtois, formulated from her clinical experiences with adult survivors and her academic acumen on the subject. The words sexual abuse and incest are used interchangeably in Table 2 as this was the intent of Courtois. A further elaboration on these accelerating factors follows the presentation of Table 2.

Table 2: Factors In Severity Of Effects

Duration and frequency

Incest which occurs more frequently and is of longer duration is believed to be more harmful than short-term, less frequent abuse.

Type of sexual activity

Sexual abuse involving penetration of any sort is considered to be more harmful than that involving other forms of sexual behavior.

Age at onset

The influence of the child's age at onset has been debated. Some researchers predict that the younger age at onset causes more damage. Others believe that a younger age provides some measure of insulation for the child and that the older child will be more damaged.

Age, gender, and relationship of the perpetrator

The more closely related the victim and perpetrator and the wider age difference between them, the greater the damage. Also, abuse perpetrated by a male is believed to be more damaging than that by a woman.

Passive submission or willing participation on the part of the child

The child who goes along with the wishes of the perpetrator, submits without struggle, or who willingly participates is theorized to suffer more negative effects in the long run.

Overt or disclosed incest with lack of assistance

The lack of assistance when the incest is known or disclosed is believed to be more damaging than incest which remains hidden.

Parental reaction and institutional response

Negative parental reactions upon discovery or reporting of incest are believed to cause further trauma for the child. Negative, stigmatizing response or ineffective assistance on the part of social service and law enforcement agencies contributes to trauma

Courtois, C. A., (1988). Healing the incest wound: Adult survivors in therapy. New York: W. W. Norton & Company, pp.115-116.

Now to turn and look at the immediate consequences of abuse for the child. The consequences identified here are shared by both male and female victims There will be a separate section devoted to consequences peculiar to males. A comprehensive summary of effects can be found in Table 3.

Feelings of guilt, anxiety, fear and rejection are the usual immediate results of sexual victimization. These feelings may manifest as disturbances in areas quite unrelated to sexual behavior (De Francis, 1969; Geiser, 1979). Examples of some of these unrelated behaviors are learning difficulties in school, nightmares, bed wetting, or aggressive behaviors towards others.

Some victims will endure feelings of guilt specific to the sexual aspect of the assault. They may have an acute sense of responsibility for the assault. This is due to the child's sense of pleasure from the physical aspect of the event. This may be the case for children who experienced natural physical responses or for whom the increased attention and warmth from the abuser made the sexual activity pleasurable (Haugaard & Reppucci, 1988).

The ability to trust and develop intimacy in relationships is also negatively affected by sexual abuse (Sebold, 1987). "Sexually stimulated children cannot develop the essential feeling of trust; their center is located outside themselves, and they are always ready to comply when something is expected of them" (Miller, 1986; p. 127). Issues of betrayal become apparent in therapy. This is especially so for the child who has been victimized by a trusted individual: one whom he is reliant on for care and well-being (Steele & Alexander, 1981; Maltz, 1988; Justice & Justice, 1979; Bolton et. al., 1990).

All of the previously noted effects encourages the development of low self-esteem for the victim. The stigmatization of being sexually abused, the negative connotations associated with this experience, and the later assimilation of these beliefs into one's self-concept will hurt self-esteem (Bolton et. al., 1990; Meiselman, 1987). The victim's self-esteem is attacked through the violation of his boundaries. He loses any sense of control and receives the message that he is not valued. He becomes humiliated and his real needs are ignored (Davies, 1991; p. 18).

An aftermath of sexual abuse that is often noted in the literature is depression. "Since the fact of abuse must be repressed for the sake of survival, all knowledge that would threaten to undo this repression must be warded off by every possible means, which ultimately results in an impoverishment of the personality and a loss of vital roots, manifested, for example, in depression" (Miller, 1986; p. 160). Effects of depression for the individual is often compounded by the failure to develop intimacy and an inability to trust others. As well the literature repeatedly highlights the likelihood of the victim holding a faulty sense of responsibility for the abuse.

Dissociation is being recognized more and more as an adaptive behavior to trauma. It is also a behavior which is frequently seen amongst victims of childhood sexual abuse. Knowledge of its substantive role in the process of surviving sexual assault is being understood through work with adults survivors. Dissociation is a normal reaction to an emotionally loaded situation. "Dissociative reactions are complex psychological mechanisms characterized by an alteration of normal integrated awareness and self-identity. Certain faculties, functions, feelings, and memories are split off from immediate

awareness or consciousness and compartmentalized in the mind, where they become separate identities" (Courtois, 1988; pp. 153-154). It represents an interruption in the further development of body and ego for the victim. Affective continuity with self, self-preservation and caring functions are sabotaged (Hartman and Burgess, 1989; pp. 96-119).

Several immediate effects of being sexually assaulted as a child have been presented. These effects represent psychological, social, and cognitive adjustments made by the victim resulting from the impact of the abuse. There are variables which influence the reverberations of sexual victimization for the victim. These factors have been identified as the amount of force used by the offender, the victim's prior emotional health, and the age of the victim. The reactions of others upon disclosure is also an important factor.

Table 3 is a compilation of consequences that male and female children experience during childhood. Some consequences listed are those which were identified in studies conducted the 1930s. The next section examines impact issues that are ordeals particularly for boy victims.

TABLE 3: Possible Immediate Consequences in Childhood

Problems in sexual adjustment:

Preoccupation with sexual matters; Increased masturbatory activities; Sudden rush into heterosexual activities; In prepuberty stage, premature and discrepant development of adolescent interests and independence; Despair regarding the inability to control sexual urges; Venereal diseases; Pregnancy; Impaired feminine identification: Acting out sexual delinquency, seemingly purposeless and not enjoyed; Promiscuity; Homosexuality; Prostitution; Molestation of younger children

Interpersonal problems:

Bewilderment concerning social relations; Frightened by contacts with adults: Hostile, dependent interactions with older women: Shocked by parental reaction to discovery of the assault: Increased affection seeking from adults: Running away from home; Homicidal ideation

Education problems:

Learning difficulties; Mental retardation; Truancy

Other psychological symptoms:

Loss of self-esteem; Personal guilt or shame; Nervous symptoms such as nail biting; Pessimistic or callous attitude; Obesity; Facade of maturity and capacity for responsibility; *Infantile stage* is prolonged or reverted to; Anxiety states and acute anxiety neuroses; Somatic symptoms; Sleep problems including nightmares; Impulsive behavior; Other behavior problems and delinquency: Tendency to with draw from activities of normal childhood; Depression; Suicidal ideation; Character disorder

Mrazek, P. A. & Mrazek, D. A. in Mrazek, P. B. & Kempe, C. H. (Eds.). (1981). Sexually abused children and their families. New York: Pergamon, p. 242.

Consequences of Sexual Abuse for Boys

It is claimed that childhood sexual victimization has an equivalent impact on males and females (Briere et. al., 1988). The consequences noted in the previous section are the ones shared by both sexes. However, there are impact issues that manifest in ways for boy victims that are separate from females. It is those effects which will be specifically addressed in this section. Some consequences can be seen amongst both sexes but the symptoms are different between the two sexes. "In a culture where male sexuality represents strength, superiority, dominance and success, in a world where the desired image is a male image, it is not surprising that a male child will react differently to a sexual experience than a female child. The male child knows that one day his sexuality will signify strength and superiority..." (Rush, 1980; p. 176).

Children suffer from *Damaged Goods Syndrome.* This is a phenomenon described in the Handbook of Clinical Interventions and Child Sexual Abuse (Sgroi, 1983). It characterizes feelings of being different from, or of less worth than others. Society may also negatively view the victim as different. At the root of being different is the belief that one is already used sexually because of the assault. Therefore, there is no need to protect or stop further sexual activity that is inappropriate to the child's age.

Another variation to the Damaged Goods Syndrome for boys occurs when the perpetrator is of the same sex. A possible consequence of this type of abuse often is expressed in gender confusion (MacFarlane, K., Waterman, J., Conerly, S., Dramon, L., Durfee, M., & Long, S., 1986; Haugaard & Tilly, 1988). The gender of the offender

introduces a homosexual theme to the assault (Blanchard, 1986). Sexual victimization by somebody of the same sex may lead a boy to conclude that he is homosexual, thereby eliminating his freedom to choose or determine his own sexual orientation as an older adolescent or adult. The boy victim may feel that the assault is confirmation of his homosexual status. This is often the case when the perpetrator is somebody he closely psychologically identifies with or who is an adult authority figure (Finkelhor, 1981; Pescosolido, 1988). Boys may also have internalized the notion that homosexuality is deviant and may also feel deviant therefore internalizing some responsibility for the offense (Rogers & Terry, 1984).

Victims of female perpetrators also may fear that their experience has injured their masculinity and thus made them homosexual (Meiselman, 1990; p.256). De Young investigated the reactions of six boys who were victims of female perpetrators. All the boys expressed fear, if even occasionally, that they are homosexual, or will have no choice but to become homosexual because of the sexual abuse (de Young, 1982; p.78).

Another effect shared but displayed differently between the sexes, is the recapitulation or re-enactment of the assault. This is referred in Sgroi's Handbook of Clinical Interventions and Child Sexual Abuse (1983) as Self-Mastery and Control. It is displayed as stylized sexual behavior in female victims. Often times people will incorrectly identify it as simply a seductive or sexually provocative child. While this consequence may occur amongst boys, usually it is displayed in sexually aggressive and/or assaultive behaviors. Some literature identifies it as the victim-turned-offender phenomenon (Finkelhor, 1981; Sebold, 1987; Johanek, 1988).

The male victim has experienced his gender as sexually, physically, and emotionally exploitive and assaultive. He often perceives himself as emotionally inadequate because he was the object of a sexual assault. Vulnerability, retribution, and identification with the aggressor become core issues (Pescosolido, 1988; pp.94-100). Being a victim may result in violent behaviors later in life for the male child. Reasons have been suggested for this although systematic evidence is currently lacking. Some reasons why the male victim develops an alleged tendency towards aggressive behavior have been suggested by writers. It may be an attempt to resolve doubts and confusion about their sexual identity. In this case, the victim emulates a stereotypical machismo image or over-identifies with such a person. This, apparently, serves to reassure the victim that his masculinity is still intact and to convince others of the same. Engaging in aggressive behavior may also serve to counter feelings of powerlessness that were evoked during the abuse and be a means of protection against any revictimization (Jehu, 1988; p.301).

Male victims are usually inclined to externalize their disturbance in more physically aggressive ways than females do. This difference is most apparent through sexual acting out. "The boy victim's increased risk for becoming a perpetrator has been explained largely as a result from the use of the ego defense mechanism of identification with the offender"(Meiselman, 1990; p.244). The trauma experienced by the male victim gets played out over and over as he victimizes others. This replay and repetition and reenactment of sexual acts on younger and weaker children provides the victim with a sense of mastery and superiority (Burgess et. al., 1987; p.1435, Driver and Droisen,

1989).

Another prevalent theme, and one that is unique to males, is the issue of masculinity. "Males who have been sexually victimized have not had that experience in the context of social training to be passive, ornamental, or a sex object. Victimization does not in any way support social notions of masculinity. Instead, males are encouraged from childhood to be strong, assertive, and aggressive - traits that are antithetical to the role of victim. Thus, a growing boy's sense of masculinity is often impaired by his abuse, since victimization implies weakness and being done to rather than doing to"(Briere, 1989; p. 154). This has also been identified as the crucial element which prohibits males from reporting their abuse or sharing their experience with others (Finkelhor, 1984; p. 162).

There is likely to be a sense of shame and guilt within the child due to his sexual response from the molestation (James & Nasjleti, 1983). In situations where the victim is the first to tell of the abuse he may experience guilt. The guilt experienced is a reaction to the victim's deduction that speaking out is a betrayal of the offender (Sgroi, 1983). In an earlier section there was mention made that parental reaction and available social supports play a part in the impact of the abusive experience. Generally, parents of sexually abused boys present at clinics with three common reactions. They may deny or minimize the event, blame the boy for the assault, or have unrealistic fears regarding the impact of the event on their son (Rogers & Terry, 1984). Parents may need to deny or minimize the occurrence to protect themselves against their own feelings concerning homosexuality. They will be preoccupied, especially the father, with a pronounced fear

that their son will grow up to be homosexual because he was sexually victimized by some one of the same sex (Jehu, 1988; p. 300). The inanity of such a conclusion by parents is exposed in the following quote. The "heterosexual rape of a female child will turn her against men and sex but, somehow the homosexual rape of a male child will turn the boy toward men and homosexuality" (Geiser, 1979; p. 77).

Feelings of shame and guilt are expressed in either passive or aggressive behaviors. A symptomatic response of passivity can be shown as withdrawal, regression, demonstrated fearfulness, clinging behavior, timidity, and uncertainty. An aggressive response can be seen in unmanaged anger, violent acting out, authority problems, rebelliousness, chemical abuse, and serious plots of revenge toward the offender. It also presents as school problems, the mistreatment of animals, or overcompensating demonstrations of maleness (Blanchard, 1986; p. 22).

Table 4 is a comprehensive listing of victim impact issues for boys. It is taken directly from Pescosolido's article in Vulnerable Populations Sexual Abuse Treatment for Children, Adult Survivors, Offenders, and Persons with Mental Retardation, volume 2. These impact issues are the gist of the author's seven year clinical experience in the evaluation, treatment, and consultation of hundreds of cases of male same-sex sexual abuse. The table lists ten issues: (a) gender identity confusion, (b) body imagery, (c) intimacy impairment with males, (d) intimacy impairment with females, (e) depression, (f) self-destructive behaviors, (g) traumatic rage, (h) aggression, (i) hypervigilence toward males, and (j) guilt.

TABLE 4: SAME SEX IMPACT ISSUES

Gender Identity Confusion

Preoccupation with teasing effeminate and/or gay peers; Younger boys express wish to cross-dress: Need to be perceived as hypermasculine; Physically aggressive behavior focused on overpowering peers; In mid to late adolescence, need to be perceived as hyperheterosexual, i.e., stud; Heightened/extreme homophobia; Sexual phobia

Body Imagery

Self-destructive behaviors/gestures emphasizing mutilation, disfiguring; Excessive preoccupation with physique, overly concerned with masculine physical presentation to world; Overt/covert exhibitionism of genitals and/or body; Excessive tattooing; Efforts to desexualize self through large-fitting clothing, covering up; Eating disorders (obesity, bulimia, anorexia)

Intimacy Impairment With Males

Overall apprehension in engaging with peers; Physical education distance-- refusal to participate, insidious yet too frequent excuses to participate (forgetting gym sneakers, fear of showering); Withdrawal/distance from participation in developmental peer activities (cub scouts, boy scouts, boys' club); Hypermasculine behavior/bravado; Consistent *ringleader-bully* behavior to vulnerable peers and younger children; Homophobia; Overinvolvement with younger boys; Avoidance of significantly older male children and/or adults

Intimacy Impairment With Females

In adolescence, physically aggressive to female peers; Outright disregard for girls (repeated obscene language); Fear of engaging with girls, social isolation; Creating fantasy of girl to be with; Immature behavior toward girls (in adolescence)

Depression

Clinging to nonoffending parent; Isolation from peers; Social withdrawal from male peers; Mood variations: depressed, irritable, agitated, flat, or blunt affect; Self-destructive gesturing; Regression to behavior reminiscent of younger age; Developmental delays to age at which abuse began

TABLE 4: continued

Self-Destructive Manifestations
Refer to behaviors listed for **Guilt**
Traumatic Rage
Firesetting or playing with matches; Sexually abusive to vulnerable peers and/or younger children; Sadistic, cruel, tormenting behavior directed at: younger children, vulnerable children, vulnerable peers, male and/or females; Encopresis; Violent, impulsive, assaultive, and/or homicidal behavior; Consistent disregard for the law, authority, and the rights of others; Sexually perverse behavior (e.g., bestiality, sadism, masochism
Aggression
Hypermasculine bravado; Consistent aggressive *ringleader-bully* behavior to vulnerable peers and younger children; Sexually abusive to vulnerable peers and/or younger children; Identification as sexually abusive
Hypervigilance Toward Males
Refer to behaviors listed for **Intimacy Impairment With Males**
Guilt
Superficial self-destructive behavior (e.g., self-scratching, hair pulling); Alcohol or drug abuse; Daredevil, reckless behavior; Self-mutilating behavior (e.g., nail and/or skin biting, picking at scalp, hair pulling, self-scratching, excessive tattooing, general disregard for physical care or well-being); Obsessive cleanliness; Disassociation and disregard for body; Body distortion/body image; Repeated *accidents* (falls with broken bones, car accidents); Self-destructive ideation

Pescosolido, Francis J., 1988. "Sexual Abuse of Boys by Males: Theoretical and Treatment Implications. Vulnerable Populations Sexual Abuse Treatment for Children, Adult Survivors, Offenders, and Persons With Mental Retardation. Vol. 2. Suzanne M. Sgroi (Ed.) Massachusetts: Lexington Books; D.C. Heath and Company. pp. 90-91.

In closing, there are three common reactions to the abuse that separate effects between boy and girl victims. The boy victim will experience confusion/anxiety over his sexual identity. There will likely be displays of inappropriate tries at asserting his masculinity which is something he perceives stolen from him. A third common reaction is recapitulation of the victimizing experience (Rogers and Terry, 1984; p.85). A comprehensive list of possible consequences that can affect a boy victim was just presented. The next section will be an examination of how these immediate consequences transpose to issues in adulthood.

Consequences of Childhood Sexual Victimization for Adult Males

The range of potential impact issues facing the sexually victimized male has been presented. These issues can result in the development of many adverse behaviors and negative effects for the victim in his adult years (Newberger & De Vos, 1988; Haugaard & Reppucci, 1988). "Childhood development is a series of tasks, sexuality development included. Distortions in these areas such as those introduced through aberrant sexual interactions, may contribute to confusion, delays in development, or overt sexual dysfunctions"(Bolton et. al., 1990; p.12). Any child who is sexually abused runs the risk of disturbances in adult sexual behavior and attitudes (de Young, 1982; p.73). It is these long-term consequences which will now be the focus of attention.

The long-term consequences extend to a host of emotional, interpersonal, and sexual problems experienced by adult survivors. The literature is substantial in its

documentation of how they effect the adult female survivor. Unfortunately, but for a few books containing clinical impressions and infrequent appearances of articles little is written on the effects for adult male survivors (Lew, 1988; Hunter, 1990; Grubman-Black, 1990; Bolton et. al., 1990; Briere et.al., 1988; Bruckner & Johnson, 1987). Knowledge gained in the areas of research and treatment with adult female survivors will be shared to enhance the understanding of issues faced by males. Finkelhor surveyed students enrolled in a New England state college. The results from this poll revealed males felt their sexual victimization was less negative in comparison to females. Specifically, only 38% of the males rated their sexual victimization experiences as being negative compared to 66% of the female respondents. The long-term effects of the experience were analyzed by measuring their impact on sexual self-esteem. When this was done it was found that males were just as affected as females, if not more so (Finkelhor, 1984; p.152).

It is suggested that sexual abuse during childhood may produce either chronic or delayed Posttraumatic Stress Disorder in later life. This is especially true when the sexual assault occurs within the family (Briere, 1989; p.6). The aftereffects of sexual abuse is similar to other traumatic life experiences. "Depending on the age of the victim, the severity of the trauma, the social support system, and the history of prior traumatization, psychological trauma may cause lasting alterations in the ways victims react to subsequent stress....It is often difficult to determine whether a person has integrated the long-term effects of psychological trauma: many victims make a successful adaptation during periods of life stability and social and physical well-being, only to have

a recurrence of symptoms when faced with major life stresses" (Van Der Kolk, 1988; p. 172-173). The victim's responses are adaptations made to survive the abuse. Several studies note the finding of post-traumatic stress reactions amongst victims. Chronic post-traumatic stress reactions were evident in young male children and adolescents involved in a sex ring. Investigators followed this sample for several years after disclosure. Their research uncovered high levels of anxiety, fears and intrusive thinking amongst the survivors (Burgess et. al., 1987; p.1433).

Post-traumatic stress reactions are the conscious and unconscious behaviors and emotions experienced by individuals who are battling stressful memories connected to a catastrophe in their life. Post-traumatic stress disorder is the clinical diagnosis for problems associated with trauma induced during the catastrophe and represented by the post-traumatic stress reactions (Courtois, 1988; p. 120).

Three men in a previously mentioned study on the rape of males had symptoms of chronic posttraumatic stress disorder. These symptoms were apparent in descriptions of recurrent memories of the sexual assaults coming into daily consciousness. The sample of fourteen male rape victims all sustained damage to their subjective sense of maleness or masculinity and had problems with self-esteem and self confidence. Three men also experienced occasional nightmares and intermittent *psychic-numbing*. Four men had histories that were suggestive of an acute Posttraumatic Stress Disorder. Twelve of the men used one or more of the following defenses; repression, denial, or normalization of the trauma (Myers, 1989).

The most frequent long-term consequences amongst adult survivors uncovered by

researchers are psychological distress and low self-esteem (Jehu, 1988; Briere, 1989; Bass & Davies, 1988; Forman, 1982; Lew, 1988; Bolton et. al., 1990; Gold, 1986). The initial impact of depression, guilt, feeling unworthy or damaged, and limited social skills all contribute to a lowered self-esteem (Sgroi, 1983). These persisting immediate reactions through childhood has chipped away at the survivor's self-esteem.

Other long-term effects for adult male survivors include poor interpersonal relationships and problems with intimacy (Courtois & Leehan, 1973; Pescosolido, 1989; Maltz, 1988; Bruckner & Johnson, 1987; Van Der Kolk, 1988; Grubman-Black, 1990; Porter, 1986; Lew, 1988; Sgroi, 1983; Dimock, 1988; Gordy, 1983; Deighton & McPeek, 1985). Poor interpersonal relationships are usually due to an inability to trust as a result of the sexual abuse. The boy who is assaulted by a significant adult male may grow up distrusting all males. This is more acute for the child who enjoyed a close relationship with the perpetrator. Avoidance or emotionally disengaging oneself in relationships may have been an effective coping mechanism in the past. However, its usefulness wanes and becomes detrimental to one's social and emotional development. The victim who is unable to trust others will lead an isolated life. His world will be void of significant or supportive people. It is this sense of isolation or alienation that was the most common complaint voiced by several male and female adult survivors (Courtois and Leehan, 1979).

Sexual dysfunctions is another repeatedly mentioned consequence in the literature (Meiselman, 1988; Dolan, 1991; Quadland, 1985; Myers, 1989; Steele & Alexander, 1981; Nielsen, 1983). Tsai's large clinical sample of female incest victims suffered

various sexual dysfunctions. Tsai concluded that this was the result of the sexually abusive childhood experience which lingers years after it has ended (de Young, 1982; p.57). The following quote is Tsai's explanation why this is so. "The pairing of the negative emotional response with the stimulus array constituting the molestation experience may produce a conditioned emotional response that is subjectively quite negative for the child. Then, through the process of stimulus generalization, these conditioned negative responses may later be elicited by sexual activities carried out even in a non-molestation situation and/or by other men with whom the women are intimately involved in their adult lives. Negative emotional reactions in these later situations, in turn, are likely to constitute or create, psychosexual problems" (Tsai, 1979; p. 415). Sexual compulsivity and difficulty with arousal are the two prominent tribulations for male survivors. Less frequent dysfunctions are impotence and premature ejaculation (Myers, 1989; Lew, 1988; Maltz, 1988; Hunter, 1990). First, an explanation of what is sexual compulsivity.

Sexually compulsive behavior is defined as a lack of control over one's sexual behavior. There are many ways sexual compulsivity is displayed. It can be observed in "preoccupation with sexual thoughts, compulsive masturbation, sexual acts with other men at pornographic bookstores and restrooms, and frequent and multiple partners" (Dimock, 1988; p.207). The sexually compulsive person is unable to identify, avoid, or refuse potentially abusive sexual partners and self-destructive sexual practices (Dolan, 1991). "Since childhood self-worth was associated with sexuality in relationships to the abuse perpetrators, it is not surprising that many sexual abuse survivors experience periods of

sexually compulsive behavior"(Dolan, 1991; p. 19). The adult survivor uses sexually compulsive behavior as a vehicle to regulate his internal emotional state (Herman, 1992). Those seeking treatment for compulsive sexual behavior often describe the behavior itself as not very satisfying sexually. They are often embarrassed or humiliated by their sexual activity, and may feel negative about themselves following a sexual experience. Compulsive sex is anxiety based. The sexual activity functions to reduce anxiety often related to issues of loneliness, low self-esteem, poor interpersonal relationships and fears of intimacy (Quadland, 1985; p.22).

A corollary to childhood sexual victimization is the distorted formation of associations with sexual activity (Steele & Alexander, 1981). "The child's first experiences of sexual arousal are linked with shame, disgust, pain, and humiliation. Abusive experiences with elements of affection and nurturing can result with the child growing up confused about the difference between affection and sex, intimacy and intrusion" (Davies, 1990; p.22). Maltz explains this as a conditioned response. The feelings of guilt, fear, shame and helplessness will go hand-in-hand with sexual arousal and stimulation (Maltz, 1988; p.147). "Sexual contact as an adult, even with a loving and reassuring partner, can inadvertently trigger physical flashbacks for the adult survivor of childhood sexual abuse"(Dolan, 1991; p.22).

Children often cope with abuse by forgetting it ever happened. This allows for the separating of one's intellect from one's feelings (Bass & Davies, 1988; pp. 22-23). However, "the consequences of a trauma are not eliminated by repressing it but are actually reinforced. The inability to remember the trauma, to articulate it (i.e., to be able

to communicate these earlier feelings to a supportive person who believes you), creates the need to articulate it through constant repetitions. The unresolved plight of being at someone else's mercy and being abused by a love object is perpetuated either in a passive or an active role, alternately in each"(Miller 1986; p. 161). Survivors are fragmented individuals. Many traumatized people gain some sense of control by shunning all situations, or even all emotions, associated with the trauma. The control sought is in interpersonal relationships. Thus, many of them avoid intimate relationships out of fear of another violation of an attachment (Van Der Klok, 1988; p.173).

Chronic depression is often described as a resulting consequence of sexual abuse (Steele & Alexander, 1981; Everstine & Everstine, 1989; Briere et.al., 1988). For the victim, the transition from childhood to adulthood may result in the manifestation of traditional clinical symptoms of depression. This is usually due to unresolved sexual trauma (Nielsen, 1983; p.141). Clinicians must consider the many negative affects the adult survivor has had to bear throughout his life and assess for the presence of depression.

Along with depression, clinicians need to assess risk of suicide amongst clients. The life histories of adult survivors of childhood sexual abuse who have not acted out sexually against others often are self-destructive. They have internalized their reactions. This population has a higher-than-average incidence of alcohol and drug abuse and other self-destructive acts ranging from self-mutilation to suicide (Porter, 1986; p.28). Briere and associates found that 55% of abused males in their study had a history of suicide attempts compared to only 20% of the non-abused males seeking treatment. "The

survivor often feels there's something bad, wrong, or dirty at his core. The sense of shame and self-loathing survivors feel is often hidden, but extremely deep. This self-hate is often expressed in two ways: the survivor tries to be perfect or good on the outside to make up for bad feelings on the inside and/or he acts out self-destructive feelings through suicidal feelings or suicide attempts, intentional self-injury, overindulgence in drugs, food, alcohol, unsafe sex, or seeking out dangerous people or situations" (Davies, 1991; p.18).

TABLE 5: SUMMARY OF LONG-TERM CONSEQUENCES

INTERPERSONAL CONSEQUENCES	Limited Social Skills Poor Interpersonal Relationships Problems with Intimacy Isolation and Alienation
EMOTIONAL CONSEQUENCES	Posttraumatic Stress Disorder Posttraumatic Stress Reactions Psychological Distress Low Self-esteem Chronic Depression Self-destructive behaviors
SEXUAL CONSEQUENCES	Lowered Sexual Self-esteem Sexual Compulsivity Difficulties with Arousal Impotence Premature Ejaculation

Table 5 is a compilation of the long-term consequences that have been discussed. It provides a summary to this section and reflects the corollary to childhood adaptations

of dissociative defenses, distress symptoms and self-destructive behaviors in adulthood. Now to explore the implications for treatment based on these identified long-term consequences.

Treatment Considerations and Components for the Adult Male Survivor

Based on past studies it is difficult to determine which long-term consequences are most distressing for male survivors. However, the results of the following study are probably worthy of strong consideration. This study was on attributional styles of survivors. Simply put, an attributional style is marked by internal, stable, global attributions for bad events. The findings of this examination was that survivors who reported psychological distress and low self-esteem were likely to display an attributional style of self-blame (Gold, 1986). Time has been devoted to examining society's prescribed role for males. The impact of being sexually victimized on one's masculinity in such a context has been addressed. Guilt for allowing the abuse to occur is a common consequence for the male survivor. Contributing to this guilt is the shame for failing to fulfil the male role. Guilt is also influenced by any pleasurable or physical responses that may have happened during the sexual assault.

Low self-esteem is a frequent consequence. Gender identity confusion, feelings of inadequacies, and isolation and alienation contribute to the survivor's damaged self-esteem. Depression and self-injurious behaviors can also be present (Briere et.al., 1988). Intimacy impairment due to hypermasculinity and the fear of not being seen as masculine

are issues highlighted in the literature along with sexual dysfunctions, particularly sexual compulsiveness. Identification with the aggressor and the victim-turned-offender continuum (recapitulation and repetitive sexually acting out) need to be identified as treatment issues as well. The male turns to various means to compensate for his sense of failure as a male. The sexual aggressor may be re-enacting his own abuse in an unconscious attempt to gain mastery and control over his own suffering.

There is little written describing treatment models for male survivors (Dimock, 1988). However, information is accessible on various interventions used with adult female survivors. What is known is a warning that the adult needs to understand and face past events and emotions or the survivor may try to negatively control the present and future (McCarthy, 1986; p.325). Cognitive restructuring is a valuable tool in working with survivors. It is an intervention "based on the premise that beliefs have a significant influence on feelings and actions. If the beliefs are distorted or unrealistic then feelings and actions are likely to be distressing and inappropriate. In this way distorted beliefs may contribute to many emotional and behavioral problems....To correct distorted beliefs it is necessary for clients to become aware of their beliefs, to recognize any distortions they contain, and to substitute more accurate alternative beliefs."(Jehu, 1988; p. 57). Cognitive restructuring involves the following techniques: awareness of one's beliefs, the recognition of any distorted beliefs, and the substitution of more accurate beliefs (Beck, 1976).

Cognitive restructuring may have merits in alleviating feelings of guilt and low self-esteem. The therapist would need to target the distorted beliefs concerning

responsibility for the abuse and of sexual orientation (Jehu, 1988). "The crucial aspect of abuse is not what occurred, but what impact it had on the survivor; how he explained it to himself and to others, and how it has affected his life" (Gil, 1983; p. 19). Treatment should focus on helping the victim make cognitive sense of the sexual assault (Pescosolido, 1988). Feelings are a dominant source of confusion for the abused male. Recovery of feelings is a major part of healing. One has to unlearn misinformation. Many men will not recognize their history of abuse (Lew, 1988). "They will tell about being sexually abused quite readily but insist on treating the incidents as trivial, perhaps even emphasizing the ways in which they either enjoyed the sexual activity or at least gratified their sexual curiosity about sexual functioning" (Meiselman, 1990; p.252).

Self-esteem issues are best addressed by developing an internal sense of worth. This is achieved through a process of identification and correction of dysfunctional attitudes held by the survivor. The victim needs to turn off self-criticism based on these attitudes and, instead, develop a more realistic internal self-evaluation system (Jehu, 1988; p. 81). Males need specific work on their masculine identity as victim status is so strongly identified with femininity. The implication of this for males is the entrenchment of doubts about whether they have lived up to their gender role. Adult male survivors believe they need to shore up their subjectively vulnerable masculine identity. Therapy needs to address masculinity and help the male victim to expand his definitions of manhood to allow more expression of individuality (Meiselman, 1990; pp.253-254).

Sgroi and Bunk (1988) assert that more similarities than differences exist in the emotional consequences of intrafamily and extrafamily abuse. This is in juxtaposition of

the views of many writers. Clinical experience with several hundred clients allow Sgroi and Bunk to identify the following issues as being the most common amongst people seeking treatment due to childhood sexual abuse. The notion of why the victim went along with the offender is a repeated theme amongst survivors. There is also a vagueness regarding what actually took place and what does it really mean. The other three issues pertain to confusion on why the victim kept the abuse a secret, is the victim damaged for life because of the experience and why is it so hard to remain connected to others.

There are a number of therapeutic tools that can be used to facilitate the survivor's understanding of the issues. A journal can be used to keep track of thoughts and feelings between sessions. Journalling provides an alternate medium of expression for those who have difficulty communicating orally. Reading first person accounts by other adult survivors serve to reduce feelings of isolation and loneliness (Faria & Belohlavek, 1984). A commonly known self-help book, The Courage to Heal (Bass and Davies, 1988) tells its readers that writing about being sexually abused provides an avenue to define reality. This is important for the survivor as so often their experiences had been denied, trivialized, or distorted.

Readings on sexual abuse and journaling may also have merit in aiding one to recognize his own feelings. Along with recognizing them is the expression of feelings. Such tools may prove crucial when working with male survivors. "Most men have learned to avoid experiencing and displaying emotions at all costs. They tend to describe events and their reactions to those events without using emotional terms" (Johanek, 1988; p.112). However, one emotion that often is available is anger. Anger is used to cover-

up for other feelings; especially hurt and fear (Dimock, 1988; p.215). It becomes a common response to abuse. However, many survivors have not been taught what to do with their anger. Anger is viewed as a *bad emotion.* As an abused child, the survivor has had violent, destructive examples of how to be angry. The survivor must learn constructive ways to express anger. If not, the hazard of violent or aggressive behaviors becoming responses to insignificant situations exists (Gil, 1983; p. 26). This would be particularly acute for males. Their anger may be misdirected toward self or innocent others (Grubman-Black, 1990).

To address issues of isolation, stigmatization, and inability to trust, group treatment is said to be highly beneficial. It is also practical in reducing shame (Briere, 1989; Pescosolido, 1988; Friedrich, Berliner, Urquiza & Belke, 1988; Herman & Schatzow, 1984; Cole & Barney, 1987; Bruckner & Johnson, 1987; Courtois & Leehan, 1979). Cognitive restructuring is not, in itself, enough to assist survivors in forgiving themselves and combat shame the way a group experience can. One must feel forgiven by one's peers to let go completely of the shame (Sgroi, 1988). Group treatment is also useful in obviating the problem of sexual compulsivity amongst male survivors. Members discover they are not alone with the problem. The shame associated with it and the isolation of speaking about it is lessened in group treatment. "Because of social attitudes about the problem, individuals tend to be isolated with it. Group provides a forum for developing intimacy which may reduce anxiety in group members and inhibition regarding ongoing relationships" (Quadland, 1985; p. 132).

Peer group therapy is believed to be the most effective clinical intervention to

assist adult survivors move through the stages of recovery in a timely fashion (Sgroi, 1988; Goodman & Scibelli, 1985). For male survivors, the group would be an opportunity to have a constructive experience of same-sex closeness, independent of exploitation or sexual stimulation (Pescosolido, 1988). It is important to realize though, that membership of any group can lessen, if not efface its therapeutic benefits. To ward against this, it is necessary to screen individuals for group membership. Individuals who are chronically unstable or currently in crisis should be screened out. Individuals abusing drugs or alcohol, or who are psychotic or suicidal, should also be screened out. With those points considered, one would have members who meet the minimal criteria for group participation (Briere, 1989; p. 144).

There are two types of group structure that are discussed in the literature. One is the process driven group that has a long-term format. The other is a time limited, structured group. Long-term groups most often addresses abuse issues in a psychodynamic style. Both group leader and members actively offer interpretive suggestions to the member presenting a problem at the moment.

Time limited and structured groups have the goal, at least partially, to provide education. Typically there is a predetermined number of meetings (six to 16), and each meeting covers a specific topic. Various techniques are utilized to present information and stimulate group involvement and discussion. The group usually begins with one or two introductory sessions, followed by a specific session for disclosure of abuse experiences, and than proceeds to consider issues about family of origin, parenting, assertiveness and sexuality (Meiselman, 1990). The advantage of short-term group is that

it is goal directed with a sharp focus on abuse-related issues (Briere, 1989). Having a focus to treatment is important. Adult survivors have had years of practice of avoiding confronting and dealing with their abuse (Goodman & Nowak-Scibelli, 1985).

Still, there are those who argue that individual therapy is advantageous over group therapy. Its strength lays in the client not having to share therapeutic time with the issues of others and, because of this, can have his own issues addressed specifically and intensely (Bolton et. al., 1990; p. 90). "The development of a trusting relationship in individual therapy helps clients make the transition into the group and also provides a context to work through transference issues resulting from feelings toward the abuser and other men who have had a negative impact in their lives" (Dimock, 1988; p. 212). It also allows for a thorough assessment.

Some consideration must be given to the gender of therapists engaging adult survivors in individual therapy. Gender of the therapist may be an important variable for some clients; for many it is less important than the knowledge, experience and skill level of the clinician (Bolton, 1990). The risk of power plays occurring during individual therapy exists. It is perhaps most obvious when the therapist is male. In such situations the client may present as passive or eager to please. Briere believes that clients may view the male therapist as a potentially dangerous father figure who must not be challenged, and who may require pacification. Therapeutic progress can be inhibited should this dynamic occur in counselling. For this reason, trust issues should be addressed frequently with acquiescent male clients, and tentative attempts at greater self determination should be reinforced. The opposite dynamic can also occur in therapy. There are those clients

who strive to dominate interactions with their male therapist. Such clients are frequently challenging, verbally aggressive, and likely to present a front of invulnerability. "These *hypermasculine* reactions usually represent compensations for fearfulness.... Specifically, the survivor who seeks to be *one up* hopes that a threatening or disinterested dismeanor will forestall therapist aggression or negative judgement, as well as in some instances, prove to the clinician that he is *still man* despite his molestation history" (Briere, 1989; p. 159).

In closing, the adult survivor challenges the therapist to understand the long and convoluted history of symptom formation and negative identity development (Meiselman, 1990; p. 61). Focus of treatment should hinge on changing the male's self image, sharing information on how child abuse occurs, and supporting the survivor to work through old feelings of depression, guilt, shame, and anger (Justice & Justice, 1979). Cognitive and affective mastery for the survivor hinges on the processing of key themes (Cole & Barney, 1987). "A male adult survivor usually sees the event through a male adult's eyes and evaluates himself accordingly. Assisting him in ignoring gender expectations and seeing the event through a child's eyes will bring him closer to accepting the experience as real and abusive" (Bolton et. al., 1990; p. 103). Education provided to male survivors on abuse dynamics will facilitate this. In particular, an explanation of the power differential between the adult offender and the child victim is required. The focus should be on the fact that males do not become victims because they are not manly. They are victimized because they were children without the knowledge, experience, and power that adults possess.

Summary

The review of the available literature on childhood sexual abuse tells of the indiscrimination with which children are sexually misused by older individuals. The frequency of victimization for boys is alarmingly high based on prevalence studies. This review has also exposed the lack of research and clinical acumen on interventions with adult male survivors. The aftermath of childhood sexual abuse is destructive and far reaching. The male child is emotionally traumatized when sexually assaulted and must undertake major psychological and behavioral adjustments to cope with the guilt, anxiety, fear, intimacy and trust impairment. As well, he is prone to experience confusion over his sexual identity and masculine role. The consequences can be the development of short and long-term dysfunctional behaviors and negative emotional and psychological effects. The most frequent long-term consequences noted are psychological distress and low self-esteem. Social indoctrination that males are not victims and could only be assaulted if they did not resist results in reticent survivors.

Implications for treatment suggest that cognitive restructuring is an effective tool to correct the distorted beliefs that are prevalent amongst survivors. This would be especially beneficial for males who hold deep rooted doubts about their gender role. Journalling and bibliotherapy facilitate the survivor's tracking and understanding his reality. It also is effective in identifying feelings connected to the abuse. The advantages of group work are crucial to the issues faced by survivors. Isolation, stigmatization, and inability to trust are effectively addressed by a therapeutic group experience. A limitation

of group work is a strength of individual counselling. This latter modality allows the client to have all the therapeutic time devoted to his issues. There are particular issues regarding therapist gender and counselling the adult survivor which suggest that therapeutic progress can rest with dynamics of trust and power.

Design and Implementation of Intervention

Practicum and Clinical Objectives

As stated earlier, clinical and academic understanding of sexual abuse has been based on the female victim's experience. From such a vantage point, the male is viewed in one light only-- that of the sexual assault perpetrator. An outcome of this paradigm has been the evolution of treatment services for the female victim and the male offender. Specific to males, there has been an advancement of sexual offender treatment. The formation of interventions for the male victim has clearly not kept pace. Therapists working with male survivors are left depending on the theory and interventions shaped to address the needs and issues converged on the female victim. It is a reckless assumption to believe that the same issues are visages for male victims. This becomes especially so when one examines the acculturation of males in our society.

The motivation to undertake this practicum was to build on my professional experience with adolescent male perpetrators and victims of sexual abuse. The personal objectives were similar: to enhance my theoretical knowledge on the area of initial and long-term effects of sexualized trauma amongst males and further develop my clinical skills. Group treatment was the chosen intervention to address the most frequently reported long-term effects of childhood sexual victimization.

The objectives of this group intervention were:

- To provide a nurturing environment where one can experience non-competitive relationships and develop positive self-regard.

- To obviate individual shame, guilt, and low self-esteem through the breaking of the secret and sharing of common experiences and feelings with other group members.

- To clarify gender confusion that may result from childhood sexual abuse and one's masculinity self concept.

- To instill a sense of empowerment within members.

Rationale for the Treatment Intervention

The profession of social work views group as a treatment modality designed to support individuals while enhancing their functioning as social beings. The social worker accomplishes this through structuring small groups where members can interact face-to-face (Garvin, 1981). "The social work group begins to address the internal and social factors influencing both the cognitive and affective dimensions which are crucial points to change" (Nosko & Wallace, 1988). Group is used as the primary instrument to reach individuals and help them grow and change (Trecker, 1970). To do this, the social worker structures group so that members mirror similar problems. The belief is that members will yield to the pressures of the other members and act or react in a manner that is considered to be acceptable to the group. The power of influence over an individual's thoughts and behaviors is strongly suggested in such a context (Hartford, 1971). The notion that group is the most effective vehicle for change amongst clients is

supported by reports from men participating in a group for batterers. They identified "the group process as effecting the greatest amount of change in their view of themselves" (Nosko & Wallace, 1988; p.35).

Group members will experience therapeutic benefits that are not as readily available with other interventions. Martin (1983), in his text on counselling skills, reviews the merits of group treatment that have been identified by writers on the subject. First, he notes that the client can witness the progress of others in the group and hear them tell of gains made in problems similar to his own. The individual discovers he is not unique or alone in having threatening thoughts and debilitating problems. Hope and commonality is offered to members of a group. One advantage to being in a group is that the client can select information from several other members. Each member provides information for the individual on various coping techniques. The result is a broader range of coping skills for the client from which he can select ones that are most helpful to him. Group, more than individual counselling, gives clients practice navigating interpersonal relationships in a safe environment. The group serves as a new microsociety with its own set of curative norms and values. Imitative learning occurs with the client learning from observing how the therapist interacts with group members. The client also has the chance to practice newly acquired social skills by being in reciprocal relationships with members (Martin, 1983).

These points are reiterated in contributions from other writers. Sheldon Rose reviewed literature on the subject and critically examined the application of group experience for individual change. He sees group as useful in dispelling the sense of

isolation that clients may feel with their problems. Group is effective in developing the ability to self-assess through members' feedback on behaviors that are annoying or unacceptable in the group. The client also receives feedback about cognitions that can be viewed as self-defeating or self-enhancing. The flip side to receiving feedback is giving feedback. This has the potential to enhance relationship skills as the client will have to tolerate the idiosyncrasies of the other members. In doing so, he must learn to wait while others explain their problems. He must also bear with what he may perceive as useless advice and tolerate major differences with other members. Opportunity exists for the member to deal with these differences and learn to offer critical feedback and advice in a tactful manner. The last point made by Rose is that the client can transfer his recently learnt skills to life situations (Rose, 1990).

Variables affecting the effectiveness of group have been noted in the literature review section. The group will be more successful if it is designed so that the group has a common, identifiable and meaningful purpose. The result is that members identify with each other easier and more quickly. This, in turn, facilitates less difficulty with communication, expression, and exposure of self to the group, and faster, more identifiable, problem-solving (Levine, 1967; pp.14-15). A closed group is one where membership is the same from the start of group to termination. Group with a consistent membership provides an experience where warm, trusting relationships can develop. Membership size is crucial. A group of no less than five and no more than nine members, promotes optimum interaction and intensity (Wickham & Cowan, 1986).

The duration of group can be a factor in treatment efficacy. Short-term groups

tend to minimize regression amongst clients. The strengths of the individual is highlighted by virtue of the specified time devoted to the problem. Short-term groups, by necessity, directly focus client's attention on the problem that led to the group establishment (Goodman & Scibelli, 1985; Herman & Schatzow, 1984). Short-term groups lend to an easier achievement of group cohesion. This seems to be established very early on in short-term groups and is probably due to the recognition of a time limit. It is assumed that clients will be less resistant to sharing emotionally important material. A short-term group is believed to reduce stress for the client. An ongoing group risks subjecting the client to an intense and disorganizing experience over a long period (Herman & Schatzow, 1984). In a comparative study of group treatment for men who batter it was found that twelve sessions were just as beneficial in bringing about desired change for clients as did the long-term groups (32 sessions). The investigators conclude that the clients may have worked harder when a deadline was closer. They also note that in the short-term groups the men were more likely to complete group treatment (Edleson & Syers, 1990).

Group membership is another variable that influences the effectiveness of this treatment modality. There are varied opinions in the literature on whether group composition should be homogeneous or heterogeneous. As stated, membership should be based on individuals sharing a common problem. If the purpose of the group is to provide information to clients on the presenting problem than a homogeneous membership is desirable. This is also true for those groups designed to provide education. The merits of a heterogeneous membership include the availability of varied perspectives, modelling,

and interactions. Heterogeneous membership is favoured for groups concentrating on new role behaviors or the exploration of interpersonal problems (Feldman & Wodarski, 1975). Another author claims the opposite to be true; arguing that the homogeneous group facilitates quicker establishment of trust and sharing amongst the members (Hartford, 1971). She believes it is because of this that homogeneous group are better suited to work on interpersonal relationship issues.

Membership selection should not be based solely on the function of the group. Group composition is usually further delineated by social factors that consider age, sex, ethnicity, intellectual capacities, race and social class. The individual's personality characteristics and capacities to relate to others and use the group experience have also been considered. The key point is not to have an individual member who is significantly different from other members or to have obvious fractions or cliques due to dissimilarities amongst the sub-groups. This type of composition is better suited for attitude changes amongst members regarding these blatant differences (Hartford, 1971). There is a danger in having a member who, because of a particular characteristic, is vastly different from the rest of the group. The individual's and group's functioning can be impaired as a result of the isolation that results (Wickham & Cowan, 1986).

Herman and Schatzow argue that selection of members should be based on motivation and positive expectations regarding group participation rather than other characteristics. They state that these two factors far outweigh other factors in predicting a successful treatment outcome (Herman & Schatzow, 1984; p.607).

Intake or screening interviews is a necessary component to group and is

recognized as a stage of group treatment (Rose, 1990; Levine, 1967; Hartford, 1971). Advice on how much time should be spent conducting these interviews was not clearly stated anywhere in the literature reviewed. However, one author cautioned group leaders on having more than three separate screening interviews (Levine, 1967). Should group leaders find themselves conducting repeated intake meetings with prospective group members it is likely the practitioner may be doing individual counselling and not an intake meeting. The client may become dependant on the counsellor and raise issues better addressed at group. Levine has outlined three major objectives for the individual intake interview. One goal is to assess, with the client, the individual's motivation for participating in group. Together, the client and interviewer explores the motivation as it compares to the purpose of the group and the goals of other members. Another focus of the intake interview is to help the client prepare for using the group as a treatment medium. The last major objective is to initiate a worker-member relationship (Levine, 1967; p.27).

An illustration of how generalities of group practice have been used in group work with adult survivors of sexual abuse will complete this section. Attention to selection of members and treatment themes will highlight the discussion. As well, benefits of group for this clinical population will be reevaluated.

Christine Courtois identifies several advantages to group work. The adult survivor experiences an identification and establishes a therapeutic alliance with other members. Like other writers on group practices, Courtois sees the involvement in a group for survivors as beneficial in that it challenges the individual's shamed and stigmatized sense

of self. The individual survivor will likely experience cognitive dissonance upon meeting and interacting with other survivors and realize he is not reprehensible or an unlovable creature. The individual will discover that survivors look and act like *normal people* (Courtois, 1988; p. 245). Other group practitioners have identified conquering feeling different or fearing that they are different from others because of the sexual abuse as a significant therapeutic gain resulting from group (Maltz & Holman 1987; Johanek, 1988; Gordy, 1983). Courtois believes that along with the survivor's recognition that he is no different from anybody else, he will gradually realize that what he thought were "character defects" are actually common reactions to sexual abuse. This occurs when the individual observes commonalities amongst members regarding the experience, its immediate and long-term consequences and coping mechanisms. Gordy (1983), in her group work with adult females also found this to be true as did Tsai and Wagner (1978) with their group experience with fifty women.

The idea of group being a microsociety is significant. Survivors can experience a safe, supportive, and consistent environment with group. This, in turn, facilitates exploration of interpersonal issues, especially betrayal and trust (Courtois, 1988). Group therapy allows the male survivor to have a constructive experience of same-sex closeness independent of exploitation or sexual stimulation (Pescosolido, 1988). Bruckner and Johnson describe the importance of support and identification with their own gender as a therapeutic need of male survivors. This issue was identified through their work in a pilot project for the treatment of adult male survivors. The need for comradery with others of the same-sex is something group can provide (Bruckner & Johnson, 1987).

Therapists comment on the advantage of group being a forum to practice newly acquired skills without threat of retaliation (Courtois, 1988; Sgroi, 1988; Gil, 1990). Courtois further states that membership in a treatment group symbolizes public acknowledgement of their experience. The telling of each member's experience is important. There is a "chaining effect" that can occur with the repeated disclosures by individual members at different times throughout the group process. This focus on the events of the sexual abuse serves to counter any denial, minimization, and repression that might be used by a particular member. The discussion of the issues by the group holds the potential to focus on aspects of the abuse which were previously unavailable to the survivor (Courtois, 1988; pp.246-249).

Literature on group therapy with adult survivors suggests that a closed, time-limited group is the best structure (Herman & Schatzow, 1984; Gordy, 1983; Gil, 1990; Sgroi & Bunk; 1988; Briere, 1989; Tsai & Wagner, 1978). Briere and Gordy believe that ten to twelve sessions are optimal. Tsai and Wagner structured four sessions for their group treatment although members and leaders felt that a longer time-limited group would have been more beneficial. Sgroi and Bunk believe that the unresolved issues of childhood sexual abuse are best addressed with the adult through sequential time-limited cycles of peer group counselling.

Short-term groups are goal oriented and have a sharp focus on abuse issues (Briere, 1989; p.148; Cole & Barney, 1987)). Bruckner and Johnson observed that the adult male survivors in their short-term group therapy readily focussed on sexual abuse related problems. They attributed this to the time limit (Bruckner & Johnson, 1987).

The ardent focus on sexual abuse issues makes the purpose of the group prominent to the members. This is something that is important when working with clients who have had years of practice at suppressing the issues. The short duration of this type of group avoids the development of intra-group conflicts and the habitual appearance of dysfunctional behaviors among the members.

Group leaders working with adult survivors offer suggestions for selecting group members. The intake interview should be done for the purpose of enabling the group facilitator to assess the motivation, issues, interpersonal skills and general suitability of each potential member (Courtois, 1988). Briere views screening of members necessary to determine specific strengths of individuals. In particular, one should evaluate individuals on impulse control and whether or not they have sufficient inner resources and few interfering factors to face the demands of group and experience its benefits (Briere, 1989; pp.144-145). The ability of the client to discuss their abuse is another necessary attribute for successful group membership. The client who is unable to do this at intake is likely to encounter the same difficulty in group (Sgroi, 1988; Gil, 1990).

To summarize this section it can be said that the merits of group as a treatment intervention is the process of identification and the formation of alliances among members, which are powerful phenomena for affecting change. In addition, the client is provided with a breadth of strategies due to the collective resources of a group. Group would seem to be a very suitable intervention for the sexual abuse survivor who is experiencing isolation and alienation. It is also a safe place to practice newly acquired skills. In peer groups, these practiced skills are easily transferred to daily living

situations. Argument has been made that short-term groups are just as effective as long-term groups. This is because of the sharp focus on treatment goals that is often brought on by the awareness of the limited time at hand.

Introduction to Intervention

This intervention was conducted at Klinic Community Health Center. Klinic's advancements of treatment acumen on sexual assault issues is widely known in the community. This agency provides a range of medical and counselling services and has a positive reputation for providing reliable services to female victims of sexual assault. Klinic has been a placement site for other University of Manitoba students from the faculties of psychology and social work. No doubt this contributed to the acceptance and comfort this student experienced while completing this practicum.

The practicum site had appropriate space for conducting group therapy. Group therapy is a regular treatment modality offered at this agency. The availability and ease of video taping used for clinical supervision was an enriching benefit to the student.

Short-term group therapy was offered to nine adult male survivors of childhood sexual victimization. Many definitions of childhood sexual abuse were provided in the Literature Review section of this report. Close attention was given to the suitability of these definitions for clinical practice. The definition offered within The Abuse of Sexuality Model (Bolton et. al., 1990) was felt to be the most workable in choosing a framework for this group intervention. This provided the most universal definition of a

sexually abusive experience based on the reality of the violation and not on prevalent interpretations that males could not be assaulted unless overt force was used.

The time frame for the intervention was twelve sessions occurring once a week in the evening. Each session was two hours in duration. Group membership was closed and members were expected to attend all twelve sessions. The student was available to clients between group sessions should any member request it.

The group was co-facilitated by a female therapist experienced in group therapy with adult female survivors. The student assumed primary responsibility for the development and execution of this intervention. The male/female genders of the co-therapists proved to be valuable over the course of therapy. This point is elaborated on later in the section on Clinical Observations.

The group process was semi-structured. Therapists were responsible for introducing topics and guiding discussion on five treatment themes. The format of the group was structured so that the themes were introduced sequentially. It was not expected, nor did it happen, that each idea would be introduced for a period of time, dropped, and another theme introduced. Rather, topics were introduced sequentially but discussion on the points blended throughout group. The five themes were disclosure, coping patterns used during childhood and present day, male sex-role socialization, intimacy, and trust.

Homework in the form of written assignments was assigned. These exercises were brought to group where they were discussed. Journaling was recommended but it was not expected that this be shared at group or with the facilitators. Some members

acknowledged keeping a journal during the course of group and reported it as useful in tracking memories or feelings that were evoked from session to session.

Group Selection and Composition

A letter was mailed to various social agencies and organizations explaining the purpose and structure of the group. Any man interested in joining initiated contact with Klinic. Referrals were only accepted if the individual himself inquired and expressed an interest in joining the group. The letter explained that group sessions would be video taped and the themes were outlined. The initial contact at Klinic was with the agency's Crisis program Intake worker who maintained a list of potential members. This person also answered any general questions these men may have had upon phoning.

The student contacted a total of twelve men and set a time for an intake interview. Attempts were also made to contact one other man who had initially been interested in joining but unfortunately a connection was not made until after commencement of group. One man declined an intake interview and withdrew his referral to group. He explained that some events had recently occurred and he was not ready to join a treatment group.

One individual intake meeting took place with each prospective client. Each meeting was approximately one and a half hours long. A brief overview of the agency and an explanation of the group occurred at the beginning of the interview. Any questions the men had were answered at this time as well. The purpose of this meeting was also explained to potential members as an opportunity for both parties to determine

if group was a suitable intervention to meet the survivor's needs. It was explained that consideration would also be given to the overall composition of the group. The individual himself might also decide he is not interested in participating after hearing about the group. Potential members were screened for the following criteria.

Reasons for screening out potential group members:

Individual is unable to control strong impulsive and aggressive tendencies.

Individual can tolerate neither the painful feelings arising in treatment nor the interpersonal demands of group interaction.

Individual disbelieves the reality of abuse in his life or others.

Individual cannot discuss his own abuse experience without an intense, uncontrollable anxiety, dissociative or depressive reaction (as opposed to the more occasional or moderate reaction).

Individual is chronically unstable.

Individual currently abusing drugs or alcohol.

Individual is psychotic.

Individual is suicidal.

Individual is a sexual offender

Reasons for accepting potential group members:

Individual is positively oriented towards a group experience and group process rather than ambivalent or resistant.

Individual can function reasonably well on a day-to-day basis and not be in a personal crisis at the time he joins group.

> *Individual has, if possible, an identified support system outside of group. For those in individual and/or simultaneous treatment, potential member may be required to give permission for the primary therapist to be contacted prior to the initiation of group therapy and during the course of therapy as the need arises.*

The intake interview was guided by a set of questions found in Appendix A. The choice of these questions was made because they addressed the issues identified in the literature.

Each potential member was asked to identify personal goals he had for the group experience. An informed consent form (Appendix B) was provided and individuals were told that this would be signed at the first group session. Each person also completed Klinic's data form which requests basic demographic information.

Selection was based on how the answers corresponded to the selection criteria. Individuals were informed by phone of the decision on membership to group. However, each individual was given a definite date by which he should expect an answer and was given telephone numbers where the student could be reached should he have any questions following the intake interview.

Nine of eleven potential members were selected for group. A decision was made not to accept one individual based on his extreme anxiety during the interview. He had difficulty responding to the questions and presented as angry throughout the interview. He rarely made eye contact. He acknowledged it was stressful to be around other people; that he very recently was separated from his wife and had lost his job. He was advised that individual counselling would better suit his needs at this time and he followed through with a self-referral to Klinic.

The other man not accepted into group had refused to come for a second intake meeting. After the initial meeting there were many unanswered questions with respect to his purpose for joining the group and whether he was currently using drugs. These left over questions were based on his inability to share what he hoped to accomplish at group and the many exaggerated, peculiar responses to questions. He did say that he had used numerous street drugs in the past but was not doing so presently. Because he was unwilling to participate in a second interview he was not accepted into group. By way of comment, each potential member was told at the beginning of intake meetings that there was the possibility of needing to meet a second time so that all the necessary information could be gathered.

Eight of the nine members completed the group process. Homogeneity of the group was based on all the members having been sexually assaulted during their childhood and their being able to identify difficulties in present relationships as a result of this experience. All had participated in some form of counselling although not necessarily related to their sexual victimization. All had been sexually assaulted by an adult or an older adolescent who was at least five years older then they were when the abuse occurred. There was no discrimination as to the sex of the offender or the number of perpetrators. The frequency or duration of the sexual abuse was not a factor in membership selection. Two group members had been sexually abused by their mothers. The rest of the members had been sexually victimized by males who were either related to them or known to them. Some members had clear recollections of being sexually assaulted while three had vague memories or hunches they had been abused by family

members.

Summary of Group Sessions

The twelve sessions were structured in distinct phases. In organizing these phases, consideration was given to theoretical concepts of group process. Treatment themes were introduced accordingly, with the beginning sessions being more structured and including an educational component. The purpose of these early sessions was to establish ground rules around safety, confidentiality, and attendance. This structure provided members with the opportunity to get to know one another and to become familiar with the weekly routine of group. Members were made aware of the following: each session would begin with "check in" and end with "check out", there would be a fifteen minute break during each session, and at each session the theme of the next session would be announced. Attention was also given to clarifying the objectives of group and the individual goals of members. The connection between individual and group goals was discussed, with particular emphasis placed on goal similarities amongst members.

The middle phase of group treatment provided members with an examination of coping strategies used in childhood as well as coping strategies used in their present adult lives. Sexuality was discussed as well as relationship difficulties that members had experienced.

The ending phase of group focussed on termination. The impact of ending for each individual was discussed. As well, members shared their thoughts on how to best

to celebrate the completion of group and say good bye.

Session 1.

One member was absent for this session. He had told the group leaders at the time of intake that a previous business commitment would prevent him from attending the initial session. The meeting began with an introduction of the facilitators, a review of the purpose of group, and an explanation of what was meant by "check in". Check in was described as a brief allotment of time given to each member at the beginning of each session. Individuals during check in would be asked to respond to a particular question posed to them by the facilitators. Individuals could also choose to pass and not say anything. The facilitators began the exercise by responding to the question "How it feels being here tonight?". Afterwards, the facilitators went around the circle and each member responded to the question. The only variation to this in following sessions was that members themselves would begin the exercise and, on occasion, suggest the check in topic.

The Informed Consent form (Appendix B), which had been read by members at the screening interview, was introduced again. The form was carefully reviewed with the group and members were asked to sign it, acknowledging their agreement with it.

Expectations were articulated and included group starting and ending on time and ground rules regarding confidentiality, physical outbursts and verbal put downs. Members were told that they were expected to attend all sessions. Any one unable to attend a particular session was asked to contact the facilitators and let them know that he

would not be coming to that particular session. Members were asked if there was any guidelines they believed would help facilitate their participation in group. The points that they raised were on confidentiality amongst members and not judging one another. For some members, the fear of being judged by others stemmed from a concern that their comments might offend certain members. These members had been either sexually assaulted by religious clerics or had been employed by a church or religious group. There was acknowledgement by members who were sexually assaulted by religious clerics that they held a great deal of anger directed towards a specific religion. However, the group members who were clergymen did not represent those specific religions. This seemed to be a key factor in putting members at ease. Members also stated that it was important for everyone to feel free enough to express themselves and not be encumbered because of others' occupations or beliefs. They pointed out that ground rules had been established to prevent personal attacks from occurring. Facilitators acknowledged that the members had shown courage in raising the issue in the first place and stated if such determination were to continue in group than it was less likely that the group would experience any major impasses. Discussion followed on what members would do if they saw each other outside of group. The questions posed were: should they say anything more than hello; what would they do if either person was with someone when they meet; and how should they introduce that person?

It was the facilitators' intent to review group goals once the rules were established. However, members did not believe that this was necessary and preferred to focus on individual goals. Parallels between individual objectives were obvious and the facilitators

bridged these similarities throughout the discussion.

The facilitators asked members whether or not they had ever experienced flashbacks. This was presented as not being uncommon for people attending such a group to experience feeling overwhelmed or a flooding of strong emotions. Those who had experienced flashbacks were asked what had been helpful for them when this had happened. The telephone to Klinic's crisis line was given and members were encouraged to phone whenever they needed to talk. Some members attested to having phoned the crisis line and also advocated the use of the number.

As part of the evaluation of treatment effectiveness, self-report measures were completed by members. Members completed this task positively. Client self-anchored scales were also a part of the evaluation. The facilitators explained the utility of such scales and how they are constructed to the members. Members were asked if they would be interested using self-anchored scales over the course of group. The student had prepared three self-anchored scales as examples of likely areas that members could use the scales for. The members quickly stated that they wanted to do these scales and did not feel a need to amend or change the scales that the facilitator had prepared.

The session ended with check out; an exercise similar to check in and done at the end of every session. The facilitators also suggested the possibility of circulating a self-care basket during the check out exercise. This was received positively as well. The members were told that the facilitators would put together such a basket for the next session and that afterwards the members would be responsible for replenishing the basket.

Session 2.

All group members were present for the second session. The member who was absent from the first session introduced himself. He was provided with an overview of what had taken place during the session he had missed. He had met briefly before the start of this session with the facilitators. They too, had provided him with an overview of the session he had missed. He also completed the self-report measures that the other group members had filled out.

This session began with check in. Members took this opportunity to express a desire to get on with a discussion of their experiences. They also acknowledged the need to do the many business items that were done at the last session. Some even stated that they appreciated the time spent clarifying rules and making clear what would be happening over the course of group. They felt less anxious about participating as a result of the established ground rules.

During check in one member mentioned having watched a television movie titled Liar Liar. He was curious as to whether any other member had watched it as well. The show's protagonist was a young girl and the story was about this girl's tribulations resulting from her disclosure of being sexually abused by her father. It turned out that other members had also watched the show. This led to a sharing of the story line with those who had not and a discussion about peoples' reactions. The facilitators sought for a connection between the movie and the members' experiences as children. The facilitators asked the group whether they recalled what happened when they told about their sexual victimization. In situations where someone else had disclosed, members were

asked if they remembered how they had felt at that time. These questions did not really lead to much deliberation. This may have been because it was too early on in the group process. Another reason might have been that members were experiencing other reactions which are described in the next paragraph.

As the discussion about the movie Liar Liar progressed three members shared that they had been sexually inappropriate as youths with younger siblings. The first member to reveal this said he feared group members might not want him to remain because of what he had done. There was almost a chain reaction, with two other members saying they too, had been sexually inappropriate, and held the same fear of being expelled by the group. A fourth member who, at the intake interview disclosed sexually inappropriate behavior with his sibling, was reticent during this discussion at group. Members did not respond to the fear that these three members expressed. Actually, members sat silently as these men disclosed. The facilitators told the group that each member had been screened and was deemed appropriate for group membership. It was also stated that no person believed to be sexually assaultive would have been admitted to group. In this way, the men received the message that sexual offending behavior was unacceptable but that they were accepted.

The theme of this second session was defining sexual abuse. The unplanned discussion at this session helped focus the group and generate people's thinking on what situations and acts defined sexual abuse. The facilitators assumed a participatory role during this brainstorming exercise. This was effective in that it served to motivate the members to respond to suggestions as opposed to offering suggestions. Some members

stated that they feared becoming an offender. This worry was the result of media claims or pieces they had read on sexual abuse stating that sexual offenders themselves, were victims of sexual abuse. The men also said they were confused with what was appropriate sexual interactions. They wanted to know if kissing or hugging their partners in front of their children was appropriate. Other points of confusion were whether or not fondling their partners in the presence of infants was okay, and at what age does the parent stop bathing or dressing in front of the child. One member asked if masturbation was normal.

Compiling an extensive list of definitions of sexual abuse concluded the exercise. The facilitators closed the activity with an educational piece on boundaries and guidelines of what constituted sexual abuse. Just as check out was to begin one member said he was feeling guilty that he had not said no to his offender. The facilitators asked whether or not anyone had said no to their offender and if they had, what had the consequence of their request been. Two shared that they had said no. For one, the result had been that the offender had stopped. For the other, the assault had continued.

The self-care basket holding comfort items such as food, reading material, and candles was circulated during check out. This, however, detracted from what people were saying. Therefore, all agreed it would be passed around at future sessions after check out.

Session 3.

All group members were present for session three. During check in three members said they had experienced some flooding of emotions and strong reactions following the

previous session. These were not the same members who shared that they had been sexually inappropriate with their siblings. The three men said they had intrusive memories about their sexual victimization. They were asked what they had done to regain control of their memories and help them cope with the reactions. Each had coped differently. One said he had taken time off from his place of employment. Another had immersed himself in his art and one said he had begun journalling.

The theme of this session was coping. Members were asked to recall ways they had survived the sexual abuse during childhood and what they use in their present lives. They were also asked not to screen what they said.

The men appeared more comfortable listing negative reactions and destructive ways of coping. The facilitators invited members to view what they had done as survival mechanisms. The facilitators put effort into reframing members' comments as adaptations to the abuse. They also pointed out that each member demonstrated resourcefulness by knowing what they had to do to survive the abuse. The similarities of coping patterns that members used was also pointed out.

The general theme of their coping strategies was not to be vulnerable or be obliging in relationships. Self-destructive behaviors included alcohol and drug abuse, suicide attempts, and self mutilation. Some members said they withdrew from people and stopped trusting any one. Also, some members said that they went out of their way to not anger any one. Member's description of how they cope today were extremely positive. They offered seeking therapy, increased self-awareness, the ability to block out the abuse, and increased self-acceptance as ways that they cope today. As well, members

quickly aligned with each other's present day coping strategies.

At this session one member shared that he had been disciplined at work by a female superior and this surfaced some troublesome issues for him. He did not label his reactions as coping strategies but spoke about always having held a disparaging view of females. This prompted acknowledgement of the same belief from another member. The facilitators intimated that their belief might be linked to their abuse. There was little reaction to this. The group did offer suggestions on how to handle interactions at work to the member.

Homework was assigned at the end of session. Members were asked to reflect on five questions on secrets (Appendix C) and told that the material will be reviewed at the next session. The self-anchored scales were also completed at this session.

Session 4.

All nine members were present for session four. At check in, members reported feeling good since the last session. They also said they had been looking forward to this session which was to be a continuation on coping.

Members were asked if they were aware of any additional coping strategies that they might had forgotten last session. Many identified an avoidance or mistrust in relationships with other men. The members viewed this as a most troublesome aftereffect of the sexual abuse. A couple members did say that they had a close male friend with whom they could talk about feelings and had told about their abuse. There were a couple members who said they even had difficulty talking about their sexual victimization with

their partners. They did not believe that their wives could appreciate the impact of that experience.

The overall feeling expressed at this session was anger. Members either denied that they ever felt anger or that they felt a great deal of anger but did not know what to do with this feeling. Since group began a couple of members noted that they had become less understanding around their families. They said they would become openly angry at the least provocation. All but one member said they had experienced this in relationships at one time or another. They attributed this anger to their belief that people could not fully understand what it was like for men who had been sexually abused. This was an interesting comment to the facilitators as several of the members' partners were themselves, victims of childhood sexual abuse.

The assigned homework was not reviewed at this session. The facilitators sought permission to put it off until the next session. This would allow time at this session for another exercise. The members agreed to both requests. The exercise consisted of introducing an assortment of play objects which included mechanical cartoon characters and plush animals. These objects were placed on the table in the centre of the group and the members were free to choose any object they desired. The members were asked to comment on what they had chosen and whether or not it represented anything about themselves. Three members elected not to participate. They said the exercise felt too artificial for them. Comments from the men who did participate were on personal characteristics. Examples of some of the comments made were: 'both sensitive and macho' or 'my personality does flip flops all the time depending on who I am with'.

Session 5.

Two members missed session five. One member telephoned to say he was out of town and that his return had been delayed. The other member told the group at the last session that he had a business trip conflicting with this session. This was his second missed session and both times had been for the same reason.

The focus of this session was feelings. The original outline to group had not included an entire session allotted to this theme. However, it was believed by the facilitators that the comments on feelings being experienced by members at the last session warranted such an amendment. The aim of this session was the recognition of feelings and the healthy expression of them.

The topic was easily introduced through issues brought to group by two members. Both had said that they had trouble expressing themselves to their partners. They went on to say that lately they were over-reacting to comments from their partners. This over-reaction led to an escalation in the amount of anger and disapproval expressed towards their partners. The facilitators directed the group to think of situations in the past were they too, had over-reacted. All but one member could recall situations. Several of the men felt that their anger had negatively interfered in interpersonal relationships. They said they had difficulty with either talking about or expressing feelings with other male peers. As the group continued to talk about feelings, obvious differences emerged amongst members. There were those who said they had great difficulty identifying any of their feelings. Other members spoke of strong reactions to events in their family of origin. These members felt let down by their parents. They felt that they had never

pleased their parents and that their parents had never given them positive recognition. The men believed that much of the anger they are experiencing today is a result of these issues. The men also talked about feeling guilty for causing their families a lot of grief. These members described negative behaviors that they had engaged in as youths. It was these behaviors that was the source of grief for the family. While the members had related the behaviors to a result of their sexual abuse, they had not spoken about it to their families.

The facilitators steered discussion so comparisons or similarities amongst members could be highlighted. Some advice giving by the facilitators occurred, especially for the member who talked about having trouble at work. The facilitators also directed conversation to an examination of how feelings were expressed in family of origins. Members were asked to conclude whether or not they recognized any similarities between this and how feelings are expressed in their present families.

The previously assigned homework about family secrets was reviewed. Not all members attempted it or brought it with them to this session. However, members readily discussed selected questions as a group. Questions were chosen either by the facilitators or by members. During the review of the homework some members acknowledged new revelations about rules in their family of origin. They also stated they were better able to understand why certain things happened and why some family members behaved in certain ways. These comments were recognized by the facilitators but time did not permit any elaboration of them.

Session 6.

One member was absent at session six. This was the same man who informed the facilitators that his return to the city had been delayed and was therefore, unable to attend the last session. He phoned just before this session was to begin and said he would be present at the next session.

This session's topic was disclosure. An exercise was used to help the members with the discussion. The topic was not intended to be a disclosure of the victimization but rather an identification by members on how they had been affected by their sexual abuse.

The members had been informed of this session's topic at the last session. At check in the men took extra time to share feelings of both anxiety and positive anticipation at the thought of making a public disclosure. The men participated in an exercise where they created lists under specific headings. The headings were printed on flip chart paper and tacked on to the walls in the group wall. The headings included Focus on the Offender, Degradation/Humiliation, Isolation, Told You Were Incompetent, Occasional Treats, Exhaustion, and Threats. Members were told that the headings had been borrowed from points mentioned by people who had experienced traumatic events. The headings were also indicative of techniques captors have used to brainwash prisoners.

Not every member wrote under each heading. Members said that they selected headings that were significant to them. The facilitators randomly picked comments under headings and asked whether or not the writer of the comment wanted to say anything about it. The facilitators also asked clarifying questions connected to the comments. The

other members were asked if they recalled similar feelings or actions happening to them.

Time allowed only for an examination of the headings Isolation and Exhaustion. Examples of comments under the heading Isolation were the belief that they were the only person to have been sexually abused, that there was no person they could tell about the abuse, that they felt like they did not belong anywhere, and that they were the only person to feel this way. Under the heading Exhaustion, members wrote about being depressed and always worried during childhood. More than one member wrote that they was scared of the next assault and never felt safe enough to sleep. Several commented on being tired due to thinking about the abuse on a daily basis.

The self-anchored scales were completed by the members at this session.

Session 7.

Two members were absent for session seven. One of these men was the member who had missed the previous two sessions. He did not contact any one to say he would not be present. The group asked that the facilitators contact him and express their wish that he return. They also asked that he be told that he was missed. The facilitators had no luck contacting him directly but did speak with his individual therapist. The therapist related that the member did not want to continue with group because he was feeling overwhelmed with too many memories about his sexual victimization. This member did not return to group.

The other absent member had missed three sessions to date. He did not contact any one to say he would not be at session seven.

This session was to be a follow-up to the previous session. However, at check in

two members spoke about being distressed about events that took place since the last session. The facilitators decided, with permission from the group, to spend this session's time talking about what happened for these two members.

One member was distressed over comments made by his wife. He felt that the comments vilified his involvement in this group. He felt unsupported by her because she said she was unsure whether he was addressing his own sexual abuse or that of his siblings. She also went to question whether or not he had been sexually abused as he had never been able to tell her about any details of his abuse. This member was assisted with identifying his feelings about his wife's comments at group.

The other member had announced at check in that one of his siblings was pressing charges against the father for sexual assault. The siblings were feuding with one another because of the sibling's actions. The member felt caught in the middle. He was concerned with the financial and emotional strain this ordeal would have on his father. The member also wanted to support the sibling. To complicate the situation for him, another sibling was threatening to take legal action against the member for circumstances that happened long ago. To stop any legal action against him, the member was told by the sibling that he must discredit the charges against father. As this member related to the group what had happened since the last session, members began to voice concern that they might be prosecuted for the sexual inappropriateness they had displayed as children. Again, some of the members spoke about their fear of becoming a sexual offender. The facilitators provided a brief educational piece on the etiology of the sexual offender. The facilitators pointed out the number of male victims in society and contrasted this with the

reported average number of victims each sex offender is alleged to have.

There was little time to discuss last session's exercise. Members were asked if they experienced any unsettling reactions to the exercise. No one said that they had and it was agreed that the exercise would be discussed further at the next session.

Session 8.

Eight members attended this session. The facilitators shared with every one that one member decided to withdraw from group. His reason for withdrawing was told to the group. He had asked that this be done. The members accepted this and were pleased that he was continuing in individual counselling. There was no further drop in membership over the course of group.

Content of this session was a continuation of the disclosure exercise from session six. The lapse from when the exercise was first done and this session might have contributed to what the facilitators interpreted as apathy on the part of the members. Discussion was quite stifled. There exists the other possibility that the headings being discussed at this session were not comfortable ones for the members. Only one member could acknowledge anything under the heading Occasional Treats. The heading attempted was Degradation/Humiliation. Several members commented that they believed it was their fault that the sexual abuse took place. Talking about this heading returned the conversation to an earlier topic. Members said they wished that they could explain to their parents why they were such 'trouble makers' when they were young. Members also spoke about feeling like they did not fit in any where. Overall, they said they felt insecure around peers.

The themes of sexuality and interpersonal relationships were also introduced at this session. Members were asked to brainstorm on what sexuality meant to them. The result was that members became stuck on listing anything other than sexual performance and masturbation. Interestingly, masturbation became the center of conversation during this exercise. Members spoke of their guilt over masturbating. They viewed the act of masturbating as wrong for two reasons. One was because of religious upbringing and the other reason was because of their sexual abuse. Feelings of anger were evident when members talked about the guilt they experienced. Members also said they felt guilty because they masturbated compulsively. Compulsive use of pornography and extremely promiscuous sexual behavior caused the men to feel guilty. Most men admitted to using pornography and saw it as a problematic in their relationships. They kept their use of it hidden from partners and found themselves progressing from reading Playboy and Penthouse magazines to frequently stopping at strip-tease bars. They also said their interest in pornography increased to the point where they could find satisfaction watching hard core videos or much more explicit reading materials. They described their use of pornography as addictive. No one said he still engaged in such behaviors although some said it might have been a year or so since they had ceased doing so.

The member who, at last session stated he was troubled by pressure from his siblings, was asked how he was feeling. He stated that it was no longer a problem. However, he did notice that he was snapping at his wife on occasion and that he had noticed experiencing an overall feeling of anger in his life. He attributed this to being that sexually abuse had affected his life.

Session 9.

Two members were absent from session nine. One of the facilitators was also absent due to illness.

The theme of this session was a continuation of sexuality. The group focussed on male sex-role expectations. Members talked about body image, sexual performance, and physical strength. At some point, each member spoke of holding a faulty belief about sex and how this belief caused them problems. The session was mostly one of values clarification and checking out how normal they compared to each other.

One member requested time at group. He was having difficulty trusting and relating to his partner. He stated that he did not know what to do and asked for feedback from the group. He said the stress he was experiencing was so bad that he was not going to come to this session. However, he said he realized that the group was his main support in his life. By way of background, this was the same member who said at a previous session that he felt vilified by his wife. At this session he said he could be quite controlling with his family and verbally expressing a great deal of anger at his wife. His anger, he said, was due to the lack of support he felt from his wife. He believed she was incapable of offering him any emotional support as she wanted all available support for herself. He had decided to go on a brief retreat and wanted to know if the group approved of his decision.

Members encouraged him to do whatever he felt necessary. A few members said they were reluctant to tell him what to do as they are resentful when others did it to them. They went on to say that for too long in their lives there were people telling them what

to do. The discussion ended with the member saying he would reflect on what he had heard and than decide whether or not to go on retreat.

The self-anchored scales were completed at this session.

Session 10.

One member was absent from session ten. This was the fourth session he had missed and all because of business commitments. The two previously absent members explained to the group why they had missed the session. One stated it was because he did not have any transportation. The other member had experienced a crisis. This was the same member who had been experiencing conflict with his sibling. Since the last session an allegation of physical assault was made against him. This was not done by one of his family members. The matter has been dropped and the member said his actions were misinterpreted by the individual. There was a lot of group discussion about what had happened.

Sexuality was this session's theme. Members talked about being frightened by the idea of being intimate with some one. They acknowledged that their sexual relations were not very rewarding. This included their present relationships. They viewed their sexual role as one of performer. The act of sexual intercourse or any physical contact for that matter, was for the purpose of sexual release; not comfort or intimacy. A couple of men talked about recently abstaining from sexual relationships with their partners. This was a marked change in their relationship. The men remarked that they had been abstaining for six to eight months in these relationships. As the men talked about this others began to acknowledge doing the same either in present or past relationships. Members said they

were relieved to hear of others talk of the same experience. Most members expressed fear of being misinterpreted because of their abstinence. They feared being viewed as less manly for not wanting sex and had kept this aspect of any relationship a guarded secret. The members said that they were concerned that other people may view them as less manly because of the sexual abuse. They attributed much of their earlier promiscuous behaviors as being related to this. One member verbalized the wish that he had been a girl when he was sexually assaulted. He said only girls are suppose to be sexually assaulted.

As this was the tenth session, the facilitators asked the group to think of how they would like to spend the final session. Their input would be solicited at the next session.

Session 11.

One member was absent at this session. The intent of this session was to conclude the discussion on sexuality and interpersonal relationships.

At check in one member stated that since last session he had physically assaulted his partner. He spoke at length about what happened. Two years ago, this member had been engaged in individual counselling that specifically addressed battering. However, he stopped attending the counselling sessions before therapy was completed. He went on to share that the most recent incident involved him grabbing his partner around the neck and shoving her. He said he did not strike her. He told the group that he was worried about his loss of control. Some members acknowledged having lost control in the past and becoming violent with their partners. Most members were silent during the discussion. The facilitators stressed that violence of any form was an unacceptable way

to express feelings. They, as well as some members, did say that they were pleased that he had taken responsibility and actions that considered his partner's feelings. Some of these actions were leaving the residence and not returning unless the partner gave him permission. The facilitators also gave the telephone numbers to Klinic's crisis line and domestic violence program.

The group discussed what they wanted to do at the final session. Homework was assigned for that session as well. Each member was given a sheet of paper with five questions (Appendix D). Members were asked to answer these questions and be prepared to answer them at the next session.

One member asked if other members would be interested in forming a self-help group. He had already found suitable space for this to happen. The facilitators suggested that the men think about this until the next session before making their decision.

Session 12.

All of the members were present for this final session. However, one member arrived one half hour late. This was the same member who, at the last session, said he physically assaulted his partner. The group was concerned when he was late and asked that the facilitators call him and tell him to join them. He arrived just as the facilitators were about to call.

This was the last session. The previous week it had been agreed that the facilitators would bring food and food was made available throughout the final session. One exercise was done at this session. This exercise had to do with leaving things behind and continuing on with a different perspective. The assigned homework had resulted in

some members expressing anger at being asked to do something that might re-open any pain on the final session. There were other members who did do the homework. They asked that they be allowed to share their responses to the questions with the group.

The self-report measures that were administered on the first session were again given to the group. The self-anchored scales were also completed at this session. There were additional forms given that asked for feedback on the group process. The members began an open discussion on what it was like to participate in this group. They made several positive comments on the sharing and honesty they witnessed amongst members. A couple of the men said they were surprised that sexuality was such a major issue for them. There was talk that other counselling that focused on spirituality and sexual abuse may be pursued. Others said they wished to take a break from any type of counselling for the next while.

The members talked about forming a self-help group that would meet every two weeks. All but one member said he was interested in participating. One member took responsibility for arranging the formation of the group and collected telephone numbers of those interested in joining.

Evaluation

The purpose of the evaluation design was to determine the efficacy of the group treatment implemented by the student. The group focused on long-term consequences of sexual abuse including low self-esteem, depression, interpersonal relationship difficulties, isolation and alienation. A case study method was selected to evaluate the group intervention. This approach included a pre-experimental one group pretest posttest design and a B design in which ongoing assessment occurred as the intervention was being implemented. The effectiveness of treatment was determined by desired changes noted in various measures. Standardized pencil and paper instruments were administered at beginning of group and at the end and provided information on a number of psychological characteristics.

Self-anchored scales and rating scales were also completed. Data collection from these instruments was repeated throughout treatment at pre-determined intervals. Kazdin (1981) argues that such time series measurements enhance the case study method of evaluation and strengthen the point of being able to draw inferences that the change detected was not the result of extraneous factors. He also points out that the magnitude of change and the number of cases showing change also strengthen inferences that these changes have resulted from the impact of treatment.

Client satisfaction with the services received was also evaluated. A modified form of the Consumer Satisfaction Questionnaire-8 (Larsen, Attkisson, Hargreaves, & Nguyen, 1979) was used. The modifications made were the addition of two questions (Appendix

E). As well, clients completed a survey designed by Klinic. It contains five open-ended questions allowing feedback on group counselling services (Appendix F).

Standardized Measures

Three standardized measurements were used. They were the Beck Depression Inventory (B.D.I.), The Rosenberg Self-Esteem Scale, and the Stait-Trait Anger Expression Inventory (STAXI). These instruments were selected because of their utility in tapping dimensions that were being targeted during treatment. The B.D.I. measures several dimensions of depression. Some of the dimensions which it monitors are self dislike, guilt, pessimism, social withdrawal, sadness, and sleep disorders which are often identified in the literature as symptoms experienced by survivors of childhood sexual abuse. The Rosenberg Self-Esteem Scale taps one dimension-- perception of self-worth in relation to others. Casualties of childhood sexual abuse often view themselves as being of less importance than people around them. The STAXI was selected because it measures the expression and experience of anger. The appropriate expression of anger is a factor in satisfactory interpersonal relationships.

It takes little time to complete all three instruments as the administration is straightforward and can be carried out in a group setting. Scoring these instruments is simple and requires very little time as well.

B.D.I.

The B.D.I., constructed by Aaron Beck (1978), is a well established 21 item instrument that measures the presence and degree of depression in individuals. Each item, representing different depression symptoms, consists of four or five statements. Numerical values of zero, one, two, and three are assigned to each statement to indicate degree of severity. The total score is obtained by adding up the highest scores for each of the 21 items. A low score is indicative of normal to mild depression. A high score is indicative of moderate to severe depression (Beck, 1978). Face validity and content validity appear to be quite high. Its utility as a clinical tool has demonstrated it to be sensitive to change (Corcoran & Fischer, 1987). This instrument was administered at the first group session and at the last session. Originally the B.D.I. was also intended for use as a clinical measure with clients who scored in the severely depressed range. The cutoff scores are listed below.

0-9	normal range
10-15	mild depression
16-19	mild-moderate depression
20-29	moderate-severe depression
30-63	severe depression

Rosenberg self-esteem scale.

This ten item Guttman scale was constructed by Rosenberg (1965). The instrument taps only one dimension of self-esteem; that is, self-acceptance where the individual believes simply that he is 'good enough'. Accordingly, the individual with high self-esteem respects himself for who he is, and not does not compare himself to others. He feels neither superior nor inferior to others (Rosenberg, 1965). A low score

on this instrument indicates high self-esteem and a high score indicates low self-esteem. This clinical tool was a pretest posttest instrument.

STAXI.

This 44 item instrument provides measures of the experience and expression of anger. The experience of anger is considered as having two parts -- state anger and trait anger. The expression of anger is seen as having three major parts: the expression of anger toward other people or objects in the environment; the expression of anger directed inward; and the extent the expression of anger is controlled. The instrument is organized into six scales and two subscales which are described by the following:

> **State-Anger** (S-Anger): A 10-item scale which measures the intensity of angry feelings at a particular time.
>
> **Trait Anger** (T-Anger): A 10-item scale which measures individual differences in the disposition to experience anger. The T-Anger scale has two subscales:
>
> > **Angry Temperament** (T-Anger/T): A 4-item T-Anger subscale which measures a general propensity to experience and express anger without specific provocation.
> >
> > **Angry Reaction** (T-Anger/R): A 4-item T-Anger subscale which measures individual differences in the disposition to express anger when criticized or treated unfairly by other individuals.
>
> **Anger-in** (AX/In): An 8-item anger expression scale which measures the frequency with which angry feelings are held in or suppressed.
>
> **Anger-out** (AX/Out): An 8-item anger expression scale which measures how often an individual expresses anger toward other people or objects in the environment.
>
> **Anger Control** (AX/Con): An 8-item scale which measures the frequency with which an individual attempts to control the expression of anger.

> **Anger Expression** (AX/EX): A research scale based on the responses to the 24 items of the AX/In, AX/Out, and AX/Con scales which provides a general index of the frequency that anger is expressed, regardless of the direction of expression (Spielberger, 1988; p.1).

Normative tables that convert the raw scores for each scale to percentile ranks and T scores are provided for both genders and their different age groups. Scale scores between the 25th and 75th percentile are within the normal range of experiencing or expressing angry feelings. A lifestyle where defense mechanisms such as denial and repression are consistently used as a primary means for coping with and avoiding anger can also be revealed with this instrument(Spielberger, 1988).

Self-Anchored and Rating Scales

These measures were used to tap the intensity of the problems of self-esteem and the expression of feelings. They also monitored relationship difficulties. Bloom and Fischer (1982) describe the utility of such scales in that they are able to evaluate the internal thoughts and feelings and their intensity. Because of their high face validity these measures are prone to reactivity.

Self-anchored scales.

Three examples of self-anchored scales (Appendix G) were constructed based on common client goals indicated at intake. These examples were shown to group members at the first session. Each scale had nine points, with each point representing a different degree of intensity of the problem. It was intended that client and therapist together

would construct as many as three self-anchored scales for each individual's use. However, all the members adopted the three scales constructed by the therapists. It should be noted that members were presented with the options of not using any self-anchored scales, constructing their own, or using any of the example scales. The three scales were: **Extent of Feeling Positive About Self, Relationships**, and **Extent Feelings Shared.** The anchored points for **Extent of feeling Positive About Self** were *can't identify anything positive about self* (1) and *there are many positive things about me* (9). The anchored points for **Relationships** were *no close relationships* (1) *and I can be open with those close to me* (9). The anchored points for **Extent Feelings Shared** were *can't put words to my feelings* (1) and *comfortably talk about my feelings* (9). Data from these instruments was collected at pre-determined intervals. A higher rating over time was the desired direction of change for each scale.

Therapists rating scales.

Two 9 point scales (Appendix H) were completed at the end of each group session by the therapists. These scales rated group members on two dimensions: (a) the extent to which client shares feelings, and (b) the extent to which client makes positive self statements. The points one, five, and nine, on the **Extent to Which Client Shares Feelings** scale were anchored with (a), never shares feelings; (b), shares feelings half the time; and (c), always shares feelings; respectively. Similarly the points one, five and nine on the **Extent to Which Client Makes Positive Self Statements** scale were anchored with (a), never says a positive self statement; (b), will say positive self statements; and (c), always says positive self statements. Bloom and Fischer warn of the

limited reliability and validity of such scales due to the fact that their utility is based on inferences made by the therapist completing the scale. However, they do point out that such scales have merit as a supplementary instrument to self-anchored and standardized scales (Bloom & Fischer, 1982). A higher rating over time was the desired direction of change for each scale.

Discussion

Analysis of the Data

The purpose of the data analysis was to determine whether or not there was significant change in client scores from the beginning to the end of group. A two-tailed t-test for paired samples was done to analyze the data from the instruments. The mean difference for scores at pretest and posttest are compared to determine change of client scores. The level of statistical significance is .05. The results analyzed are from the eight clients who completed treatment.

B.D.I.

The findings suggest that there was a significant reduction in depression from the scores at beginning of group to the scores at the end of group. The pretest mean of 19.5 (sd=11.51) was reduced to a posttest mean of 14.37 (sd=8.07). Further, this improvement was significant ($t=1.91$, $df=7$, $p < .05$). Clinically, this shift in mean scores suggests a shift from a moderate range of depression to a mild range of depression.

Rosenberg self-esteem scale.

A lowered score on this scale is indicative of improved self-esteem. The findings suggest that there was a marked increase in the degree of self-esteem amongst clients. The pretest mean of 25.37 (sd=3.16) was decreased to a posttest mean of 21.12 (sd=5.28). Further, this improvement of self-esteem was significant ($t=3.61$, $df=7$, $p < .05$).

STAXI.

Analysis of the data revealed statistical significance on seven scales of this instrument: S-Anger ($t=-3.5$, $df=7$, $p < .01$), T-Anger/T ($t=2.22$, $df=7$, $p < .05$), T-Anger/R ($t=-2.17$, $df=7$, $p < .05$), AX/In ($t=-3.98$, $df=7$, $p < .05$), AX/Out ($t=-2.0$, $df=7$, $p < 05$), Ax/Con ($t=2.8$, $df=7$, $p < .05$), and AX/EX ($t=-2.56$, $df=7$, $p < .05$). Table 6 contains the mean pretest and posttest scores as well as the percentile scores of each scale. The percentile scores reflect the percentage of respondents in the normative sample who scored lower than the group scores. Scale scores that fall within the 25th and 75th percentile are in the normal range (Spielberger, 1988). A discussion of each scale's pre- and posttest scores follows Table 6.

TABLE 6: MEAN SCORES OF STAXI

	PRETEST SCORES		POSTTEST SCORES	
	RAW	PERCENTILE	RAW	PERCENTILE
S-Anger	14.75 (sd=3.73)	93%	21.75 (sd=5.62)	98%
T-Anger	7.87 (sd=3.44)	>2%	9.87 (sd=2.53)	>2%
T-Anger/T	19 (sd=4.96)	<99%	15.12 (sd=3.14)	<99%
T-Anger/R	19 (sd=5.58)	<99%	31.12 (sd=10.76)	<99%
AX/In	13.62 (sd=4.9)	46%	21.5 (sd=5.73)	92%
AX/Out	7.25 (sd=3.2)	>1%	10.62 (sd=2.67)	19%
AX/Con	19.62 (sd=2.87)	12%	15.62 (sd=2.82)	2%
AX/EX	20.62 (sd=4.1)	65%	30.75 (sd=7.34)	95%

Elevated scores for the S-Anger scale indicate the men were experiencing relatively intense angry feelings. Both the pretest and posttest scores are extremely high (normative range is between the 25th and 75th percentile). The posttest score is an increase of five percent (98%) which suggests that the men were experiencing even more anger at the end of treatment than prior to beginning group.

Falling well below the normative range, the pretest and posttest scores for the Ax/Out and T-Anger scales suggest that the men generally experience, express, or

suppress relatively little anger. It is the elevated posttest score for the AX/In scale (92%) which provides the answer that the men **suppress** the angry feelings that they experience. "Persons with high AX/In scores frequently experience intense angry feelings but they are suppressed rather than expressed either physically or verbally" (Spielberger, 1988; p.5). The pretest score for the AX/In scale fell within the normative range at 46%.

The pretest and posttest scores for the two subscales, T-Anger/T and T-Anger/R are exceptionally high (<99%). The posttest raw score for T-Anger/T was a drop from its pretest score but still remained at a percentile greater than 99%. The T-Anger/R posttest raw score increased by 12.12 points. The desirable direction of change would have been a decrease. According to the professional manual for the STAXI, individuals with high scores on the subscales are quick-tempered and readily express their angry feelings. They are impulsive and lacking in anger control but they are not necessarily vicious and vindictive in attacking others. They are highly sensitive to criticism, perceived affronts, and negative evaluation by others, causing them to experience intense angry feelings.

The mean pretest score of the AX/EX scale fell within the normative percentile range (65%). However, there was a significant increase in the posttest score. The was not the desired direction that change was expected to occur. The posttest score was ranked at the 95 percentile. Persons with high AX/EX scores experience intense angry feelings.

The pretest score of 12% for the AX/Con scale decreased to a posttest score of 2%. This decrease of 10% was not the desired change to take place at the end of

treatment. People who rank above the normative range on this scale tend to invest a great deal of energy in monitoring and preventing the experience and expression of anger. Examining this scale's scores and the scores for the AX/IN and AX/EX scales it can be concluded that the men were suppressing intense angry feelings much more after the treatment intervention than they were before. Low scores on all scales except the S-Anger and T-Anger/T scales indicate excessive use of denial and repression according to the manual. However, the manual does not provide an interpretation of consideration for low scores for each of the six scales.

Self-anchored scales.

There was a slight, though not statistically significant increase in the expression of feelings. The mean pretest score of 5.12 (sd=1.88) increased to a mean posttest score of 6.37 (sd=2.2). The change was significant at p=.053 (t=-1.85, df=7). This would suggest that the men did not express their feelings to the degree they had wished to.

The mean pretest score of 5 (sd=2.27) on the scale tapping relationships increased to a mean posttest score of 6.62 (sd=1.19) and was statistically significant (t=-2.15, df=7, $p < .05$).

Statistical significance (t=-2.5, df=7, $p < .05$) was found the scale measuring the intensity of feeling positive about one self. The mean pretest score of 5 (sd=2.33) increased to a mean posttest score of 6.75 (sd=1.488). This increase would be consistent with the increase noted for the Rosenberg Self-Esteem scale.

Therapists rating scales.

There was a highly significant increase in observed positive self statements amongst clients. The pretest mean of 2.87 (sd=1.55) was increased to a posttest mean of 8.12 (sd=.83). The mean change was statistically significant (t=-9.98, df=7, p <.0001). While the increase is more marked than that felt by clients it is, none-the-less, a change in the same desired direction.

The observed increase in the frequency of feelings shared is also highly significant. The pretest mean of 4.25 (sd=2.05) was increased to a posttest of 7.75 (sd=1.67). The mean change was statistically significant (t=-7, df=7, p <.0001).

Consumer Feedback

There were two instruments used to obtain general consumer feedback on the intervention. One of these instruments was a modified version of the Client Satisfaction Questionnaire. Overall the clients were satisfied with the service they received. Only one of the men found the quality of service to be fair, while three reported it as excellent and four as good. The vast majority of participants said they received the kind of service they wanted, with only one man responding no, not really. All would recommend the program to a friend. All men responded as satisfied to overall satisfaction with the services (five reported mostly satisfied and two reported very satisfied). All reported that they would come back to the program - 50% "yes I think so" and 50% "yes definitely".

Two questions were added to this measure. One related to the benefit of a

male/female co-therapists which received a positive response (5 said it was definitely beneficial and 3 thought it was). The other question was whether or not the individual would chose group counselling for a similar problem given the option of individual or group. One man did not think that he would, four thought they would and three definitely would.

The Client Satisfaction Questionnaire also allowed for the men to make additional comments if they wished. One comment written by several was that having a male and female as co-facilitators was an excellent strength. One man identified that it created a sense of security for him due to his fear of men. Two other comments related to seeking further sexual abuse counselling which addressed spirituality.

The evaluation form used by Klinic provided richer direct feedback. Members identified feeling more comfortable with themselves and a realization that they were normal as a change that occurred since being in group. They enjoyed the sharing of experiences and openness amongst the members. Two men wished the group was longer in duration. There were two comments on the structure of the group. These comments were the opposite of each other. One individual thought the facilitators should have been more organized and the other member identified adherence to structure was a weakness of the facilitators. Lastly, two members wrote they had hoped that the group would have focussed specifically on exploring and discussing the actual nature of the sexual abuse experienced.

Clinical Observations and Conclusions

The results of the measures indicate that there was significant change during the course of the intervention. The mean scores for all the instruments are presented below in Table 7.

TABLE 7

SCALE	PRETEST MEAN	POSTTEST MEAN	SIGNIFICANCE		
			t-value	df	significance level
B.D.I	19.5	14.37	1.91	7	.O49*
R.S.E	25.37	21.12	3.61	7	.0045**
S-ANGER	14.75	21.75	-3.5	7	.005**
T-ANGER	7.87	9.87	-1.87	7	.O52
T-ANGER/T	19.0	15.12	2.22	7	.031*
T-ANGER/R	19.0	31.12	-2.17	7	.O335*
AX/IN	13.62	21.5O	-3.98	7	.025*
AX/OUT	7.25	10.62	-2.90	7	.0115*
AX/CON	19.62	15.62	2.80	7	.013*
AX/EX	20.62	30.76	-2.56	7	.019*
CLIENT RELSHPS	5.00	6.62	-2.15	7	.034*
CLIENT POS STAT	5	6.75	-2.5	7	.0205*
CLIENT FEELING	5.12	6.37	-1.85	7	.053
THER FEEL	4.25	7.75	-7.00	7	.000***
THER POS	2.87	8.12	-9.98	7	.000***

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

The repeated measures, which allows stronger inference that it was the intervention that brought about these changes, indicate significant enhancement of self-esteem. The feedback received from the men at the end of treatment was that they generally were feeling more positive about themselves. Another significant finding was that the men identified an increase in the number of positive relationships in their lives. These relationships were probably those established with the other group members. The comradery between members was something that was positively mentioned in the feedback from several men. During group sessions, the men spoke of difficulties they were experiencing in relationships with partners and at the work place.

The shifts in scores for the B.D.I., and the Rosenberg self-esteem scale suggests that at the end of group there was a marked decrease in depression and enhanced self-esteem amongst the men. This change may be strongly attached to the experience of feeling connected to others in the group. Individuals expressed feeling understood and not judged by the other members, and that for many, it was the first time they had experienced this. There is evidence in the literature that survivors feel isolated and alienated from others. This isolation is usually broken down when one is a member of a positive group and has opportunities to participate within this group. Previously, no support group of peers had existed for the men. There had been no forum available to them where they could discuss feelings and difficulties openly with others who shared similar experiences. The discussion at group served to normalize the reactions and feelings the men had as a result of their abuse.

The STAXI scores suggest that the men are experiencing intense feelings of anger

which are situationally determined. Rather than expressing these angry feelings the men are suppressing them. There were no posttest scores for the STAXI scales that fell within the normative percentile range. However, pretest scores for two scales (AX/In and AX/EX) did fall within the normative range. The elevated scores for the AX/In and AX/EX scales at the end of treatment indicate that members were suppressing angry feelings. The extreme high scores on the S-Anger and T-Anger/R scales indicate that the angry feelings experienced are situationally determined by perceived affronts and negative criticism from others.

These scores would be consistent to what was observed at group. Members did talk about difficulties with partners, employers, and family members. The difficulties stemmed from the members' feelings of being misunderstood or unappreciated. All but one member acknowledged that they often felt angry. The one member who said he never felt angry later in group recanted his claim. He explained that anger to him is a very scary emotion. He recalled that when he was a child his offenders expressed a great deal of anger at him before sexually assaulting him. He also recalled people being angry at him following the assault. For this member, expressing angry feelings meant getting hurt.

This may be a plausible explanation as to why the members suppress their angry feelings. Other members talked about going out of their way to please their parents so as not to make them angry. They described this as a way to protect themselves against being seen as different because of the sexual abuse. However, they also said that they never felt as if they measured up to their family's expectations and, consequently, they

still experience guilty feelings. They saw themselves act out in ways that caused hardships for their parents and siblings. This compounded their fear of being viewed as different from other people.

A further explanation of why these men are likely suppressing their feelings of anger is their fear of what they, themselves, may do if they began expressing anger. One member in particular was clear on what he feared would happen. He spoke of having an incredible amount of rage towards his victimizer and believed he would be unable to stop himself from physically hurting the abuser. Three other members feared what they, too, might do if they were to express their anger. These were the same members who told about physically expressing their anger at their partners over insignificant events. Other members either denied ever expressing anger or said they were troubled with the intensity and depth of their anger and, therefore, could not feel safe enough to express themselves.

Two case studies will now be presented to provide more detail and thereby, strengthen inferences on the data. The discussion of the case studies is comprised of data from the instruments and clinical observations.

Case Study 1

Client A is in his late thirties, is employed full time, and is in a common law relationship. He has a history of drug and alcohol abuse and recalls first abusing alcohol at the age of twelve. He has been sober for over three years now. He has children from a previous long term relationship. He has a history of depression and was hospitalized

for this when he was an adult. He did not report any past suicide attempts or ideation.

Client A has received individual, family and group counselling for various issues including childhood sexual abuse. He was in individual counselling at the time he joined the group at Klinic. He describes his parents as detached and unemotional, who would humiliate or shame him as a child. He has very little contact with his siblings as they either deny he was sexually abused by his parents or that he was responsible for it happening.

At intake he identified feeling ashamed and responsible for his sexual victimization. He also shared that when he was an adolescent he had sexually misused a male child on one occasion. The event involved touching the other boy's penis. He was sexually promiscuous during his late adolescence and early adulthood.

Client A had missed four of the twelve group sessions. He was one of the most vocal and empathetic members of the group. Table 8 contains the scores on his self-anchored scales. These were nine point scales, with a range from one being the least desirable, to nine, the most desirable response. The fifth point was the midpoint and indicated a neutral response to either end of the scale. Client A placed himself higher on the initial completion of the scales than he did on the following times. The exception to this was on the forth time completing the **Extent Feelings Shared** scale.

The Therapist rating scales are also shown in Table 8. These scores show an increase over time on both scales. There was a significant increase in scores for the therapist's rating scale **Extent to Which the Client Makes Positive Self Statements.** Client A's self-anchored scale score on **Extent of Feeling Positive About Self** shows a

slight decrease. However, he had rated himself at the ninth point on this scale and than at the eighth point on the last three times he completed the scale.

During group, there was a noticeable increase in the number of positive self statements made by client A. Initially, the facilitators' observations were ranked at the midpoint on that scale, with a gradual climb over the course of the group sessions. This group member often normalized other members' feelings or reactions. He did this with statements that he had similar feelings or reactions and has come to realize that there was nothing wrong with him; it was the abuser who had the character defects. While he could make these statements he also struggled with responsibility for his abuse. This was a difficult area for him to explore. He did acknowledge that his belief that he was not responsible for the sexual abuse was fragile, and something he has just recently begun to realize.

There were other events that occurred for him while he was attending group. He had ended a six month long common law relationship. He expressed some anxiety about the impact that this might have on him. He related that in the past when he had ended relationships he either became depressed or extremely promiscuous. He did not want either to happen this time. He believed that by coping in healthier ways he would have made significant gains. However, he also questioned why it was that he was unable to establish healthy relationships, noting that all his previous long term relationships were dysfunctional.

TABLE 8: Client A

SELF-ANCHORED SCALES

January 19, 1993	9*	9**	8***
February 2, 1993	7*	8**	6***
February 23, 1993	8*	8**	7.5***
March 16, 1993	8*	8**	9***
April 13, 1993	8*	8**	7.5***

*Extent of feeling positive about self **Relationships ***Extent feelings shared

THERAPIST RATING SCALES

January 19, 1993		
January 26, 1993	**7***	**5****
February 2, 1993	**6***	**6****
February 9, 1993	**6***	**5****
February 16, 1993		
February 23, 1993	**7***	**6****
March 2, 1993		
March 9, 1993	**8***	**8****
March 16, 1993	**7***	**8****
March 23, 1993		
March 30, 1993	**9***	**9****
April 13, 1993	**9***	**9****

*Extent to which client shares feelings **Extent to which client makes positive self statement

The pretest score of 24 for the Rosenberg Self-Esteem scale shifted in the desired direction to a posttest score of 18, indicative of improved self-esteem. Again, this is something that the scores for the therapist rating scale showed.

The pretest score of 11 for the B.D.I. increased to a posttest score of 13. This elevated score is still within the cutoff range established for mild depression. Table 9 is an illustration of client A's pretest and posttest scores for the B.D.I. and the Rosenberg Self-Esteem scale. The mean scores of the group, presented in parentheses, are also contained in Table 9. To note, client A's scores were consistently lower than the mean scores for the group.

TABLE 9: Client A SCORES ON THE B.D.I. & ROSENBERG SELF-ESTEEM

	B.D.I.	Rosenberg Self-Esteem
PRETEST	11 (19.5)	24 (25.37)
POSTTEST	13 (14.37)	18 (21.12)

Client A reported that he experienced a sense of belonging with the other members and believed this to be very valuable. He also said that he did not know anyone's name at group except for the facilitators but it was inconsequential to the felt closeness he had with the members. Another significant part of the group for him was the realization that

there were other men experiencing the same difficulties with relationships and sexuality. He felt that listening to them talk helped him feel hopeful with his own struggles.

Client A's STAXI pretest and posttest scores are represented by their percentile rank in Table 10. The mean pretest and posttest scores of the group is also presented according to percentile rank in parentheses in Table 10. Client A's posttest scores show an increase from within the normal range to the high range for the T-Anger/R and AX/In scales. Persons with high T-Anger/R scores are highly sensitive to criticism, perceived affronts and negative evaluation by others. The elevated AX/In score suggests client A may frequently experience intense angry feelings but suppresses them. The guide to interpreting the scores also suggest that elevated scores for S-Anger, T-Anger, and AX/In reflects chronic anger.

TABLE 10: Client A

	PRETEST	POSTTEST
S-Anger	93% (93%)	93% (98%)
T-Anger	76% (>1%)	85% (1%)
T-Anger/T	69% (<99%)	69% (<99%)
T-Anger/R	64% (<99%)	83% (<99%)
AX/In	56% (46%)	85% (92%)
AX/Out	2% (<1%)	2% (19%)
AX/Con	6% (12%)	20% (2%)
AX/EX	91% (65%)	91% (95%)

The posttest score on the T-Anger scale for client A is markedly different from the group mean score. The high score is characteristic of individuals who experience difficulty with chronic anger. According to the scores on the STAXI, client A is likely to suppress feelings of anger (Spielberger, 1988). The background presented on client A revealed a history of depression and which resulted in hospitalization. Client A was

in individual counselling during group where he was addressing childhood issues, including his sexual abuse. He said his embarrassment and guilt resulting from his abuse are major blocks. While one of the most empathic and vocal members at group, he was very guarded when addressing his own issues. When he spoke directly about it he would express sadness and shame. The humiliation and lack of love he experienced from his family of origin are issues that are particularly shameful for him and, outside of acknowledging these feelings, were too painful for him to discuss. On more than one occasion he talked about being angry at his parents for teaching him that his worth was only sexual; that is, how well he could sexually please someone. He states that this belief will still surface from time to time for him.

Client A also spoke about feeling robbed of his childhood because of the sexual abuse. A part of the group process that held special meaning for him was the self-care basket circulated at the end of each group session. He could not recall a time when some one else was concerned about his well-being or had told him to take care of himself. To him, the self-care basket was a message that he was worthy of being taken care of.

These descriptive comments made about client A would suggest that he holds anger which is far reaching and rooted in issues he has with his family of origin. An observation on the experience of group for this member would be the significance of the normalization of many of his feelings and reactions resulting from the abuse. This was something that he too, commented on.

Case Study 2

Client B is a self-employed, single male who has a history of suicide attempts and depression. He was hospitalized during his teen years for attempted drug over dose. His father died when client B was still a child and he feels this may contribute to him always being a withdrawn person.

His parents were devout Roman Catholics and he was raised in a strict religious home. Client B was assaulted by a member of the clergy on one occasion. When he told his parents about it he was told to be quiet and not talk about it. Client B also reported being physically abused by an extended member of the family.

Client B has had numerous brief sexual relationships. At intake he said he was troubled with not being able to sustain these relationships. His partners have said that he was not sexually satisfying or exciting and that is why the relationships have ended. His personal goals for group was to be self confident and feel better about himself, feel accepted by other males, and to learn to trust. He also saw the group as an opportunity to determine whether his depression is linked to his sexual abuse or because of his father's death.

Client B attended all twelve group sessions. He was a silent observer for the most part but did participate whenever questions or remarks were directed to him. This was his first counselling experience, except for a brief intervention when he was hospitalized for the suicide attempt. There was a significant change on all of his measures. The self-anchored scales (Table 11) scores shifted in the desired direction over time. This is also

the case for the therapist rating scales. The posttest scores for the B.D.I. and the Rosenberg self-esteem scale reflect a decrease from the pretest scores. This change is indicative of improvement for both scales. Table 12 presents the pretest and posttest scores for both of these scales. Table 12 also contains the corresponding mean group scores.

TABLE 12: Client B' Scores for the B.D.I. & the Rosenberg Self-Esteem Scale

	B.D.I.	Rosenberg Self-Esteem
PRETEST	11 (19.5)	23 (25.37)
POSTTEST	8 (14.37)	16 (21.12)

Based on the posttest score for the Rosenberg self-esteem scale, client B was feeling more positive about himself at the end of group. This appeared evident in involvement at group. He was always one of the first to arrive and began to spend some time interacting with other members prior to the session. His B.D.I. posttest score was within the cutoff range of normal feelings of depression.

TABLE 11: Client B's Rating Scales

SELF-ANCHORED SCALES

January 19, 1993	**5***	**5****	**3*****
February 2, 1993	**4***	**7****	**6*****
February 23, 1993	**5***	**3****	**5*****
March 16, 1993	**7***	**7****	**5*****
April 13, 1993	**9***	**8****	**8*****

*Extent of feeling positive about self **Relationships ***Extent feelings shared

THERAPIST RATING SCALES

January 19, 1993	**2***	**2****
January 26, 1993	**3***	**3****
February 2, 1993	**4***	**4****
February 9, 1993	**4***	**5****
February 16, 1993	**5***	**4****
February 23, 1993	**5***	**5****
March 2, 1993	**5***	**4****
March 9, 1993	**6***	**4****
March 16, 1993	**6***	**7****
March 23, 1993	**4***	**6****
March 30, 1993	**5***	**6****
April 13, 1993	**7***	**7****

*Extent to which client shares feelings **Extent to which client makes positive self statement

Client B's STAXI pretest and posttest scores were not consistent with the mean scores of the group. His pretest scores fell within the normative range for four scales and posttest scores for five scales were within the normative range. Table 13 represents Client B's scores for the STAXI scales. The results are given as percentages and the table includes the percentile rank for the mean scores for the group.

Client B's high posttest score for the S-Anger scale suggests he is experiencing relatively intense angry feelings. This is the only scale where client B's posttest score was greater than the normative range. His posttest scores for the T-Anger scale and its subscale T-Anger/R were the only ones to fall below the normative range. A conclusion from the scores on the STAXI is that while client B may experience intense angry feelings from time to time (elevated S-Anger posttest score), anger is not a factor causing much difficulty for him. His T-Anger/R scores are significantly different from the mean scores of group. This subscale of T-Anger measures the degree of sensitivity of an individual. A high score would be interpreted as the individual experiencing intense angry feelings to perceived affronts or negative criticisms from others (Spielberger, 1988). There is a broad range between Client B's scores and the group mean scores for this subscale. Client B's scores were 18% at pretest and posttest and the group mean scores were <99%. It is surprising that client B's scores are so low. It was observed and he identified for himself, that he was a very shy and sensitive individual.

Speculation on the T-Anger/R subscale would be that client B does not feel criticism is undeserved. Perhaps he has come to not expect anything more from people. Client B did not identify any significant peer relationships and described himself as a

loner. He is self-employed and the work does not involve interacting with others. There is the question that client B may be denying many of his feelings.

TABLE 13: Client B's STAXI Scores

	PRETEST	POSTTEST
S-Anger	88% (93%)	88% (98%)
T-Anger	19% (>1%)	11% (1%)
T-Anger/T	29% (<99%)	29% (<99%)
T-Anger/R	18% (<99%)	18% (<99%)
AX/In	46% (46%)	66% (92%)
AX/Out	19% (<1%)	43% (19%)
AX/Con	26% (12%)	26% (2%)
AX/EX	51% (65%)	70% (95%)

Client B did not present as being angry or depressed during group although at different points he shared that he had experienced these feelings. He was disappointed

that group had ended and was one of the most vocal supporters of the suggestion by another member that they form a self-help group. He did say that group became his social activity for the week and between sessions he had experienced difficulties managing his emotions.

Summary

The undertaking of this practicum has been very rewarding. As a student it has been an opportunity to research the available information on male sexual victimization and the result of this has been an increased understanding on the effects for the adult male. To implement this practicum with the support of such skilled individuals has also contributed to my learning. There are some specific things that I have become aware of as a result of my exploration of short-term group therapy with this specific population. The succeeding paragraphs will elaborate on each of these.

I had not anticipated the quick establishment of group cohesion nor did I expect it to develop to such a level. The members did feel connected to one another and I sense this occurred early on in the group process. Several men reported on the Client Satisfaction Questionnaire and Klinic's evaluation form that one of the most significant things about the group was the comradery they experienced with other members. The time limit of the group did, indeed, focus the group and created a sense of urgency amongst members to *get to the business at hand.* There is likely merit in engaging the members in longer term therapy but perhaps it would be most effective to offer therapy in cycles. One could space out group treatment over short blocks of time, say four cycles of twelve week sessions. A couple of members did identify at the end of group the realization that a focus on only spirituality and sexual abuse or sexuality and sexual abuse would be important for them.

This was the first adult survivors group that I had led. I am cognizant that one

of the most beneficial aspects of group treatment for male children and adolescent survivors is being with other individuals and listening to them share their experiences. I had not thought it would be as significant for adults but I recall that at the first group session more than one member commented the relief at seeing other men in the room. Some comments that were made were "I thought the room would be empty" or "I didn't think there were that many people in the world who were abused". Being with men and sharing feelings and experiences seemed to be very effective in restructuring their belief that they were not normal. Group was very effective in alleviating the isolation and alienation these men felt.

The treatment theme that I had anticipated being similar to that experienced in group work with adolescents did emerge. A great deal of time was spent on sexuality and relationships with this group. The issue of gender confusion was not the same for the men as for adolescents but a variation to the issue did surface. The men were concerned with being evaluated as being not a "Real Man" based on their sexual performance. I doubt that this issue is unique to just men who were sexually assaulted. The connection between masculinity and sexuality in our society would suggest it is a pervasive issue amongst men. What became apparent though was that members believed their sexual prowess would disguise or guard their secret of having been sexually abused.

I have also become aware of the value of co-facilitating a male survivors group with a female therapist. The literature addresses the importance of the gender of the therapist and the female survivor and stresses the value of female survivors groups being co-facilitated by females. I had always assumed that the same must be the case for male

survivors groups. However, this does not seem to be true. Comments from the men in this particular group suggest that a female therapist can be critical to feeling safe for male survivors. There was one session when the co-facilitator was not present. At this particular session there were obvious dynamics that were not present at other meetings. The vocabulary of some members changed to that more commonly associated with "locker room talk". Some members also attempted to direct the discussion that night. While there may be several explanations as to why this occurred I speculate it was related to members feeling vulnerable without a female leader.

I had not expected the victim/offender conundrum to be present. However, four members disclosed that they had been sexually inappropriate as youths with other children. During the course of group one member was physically abusive with his partner. Another had allegations of physical assault made against him although these allegations were dropped. A premise I hold is that attention must be given to emotions when working with male victims. Males need to know what it is that they are feeling and the appropriateness of the feelings to the situations. Otherwise, males have a proclivity to aggress their hurt and not realize that is what they are doing. The literature review in this practicum report highlights some detrimental societal beliefs that become internalized by males.

A final note is that two members of the group were sexually victimized by their mothers. This is an unusually high ratio according to statistics of male sexual abuse victims. A third member of the group also thought he may have been sexually assaulted by his mother.

To conclude, this practicum has shown that group is an effective intervention for male adult survivors. Group treatment can swiftly address issues of isolation and stigmatization and is an ideal treatment forum to experience safe relationships with others of the same sex. The merit of this last point is something that can not be overstated.

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APPENDIX A

SUGGESTED QUESTIONS FOR SCREENING POTENTIAL GROUP MEMBERS

* What are your reasons for wanting to join this group? What do you want to get out of the group?
* How did you hear about the group? Have you ever had a group experience of this sort or do you know of anyone who has? How was it?
* How do you feel being here today?
* Tell us about yourself, your current life - family, school, work, friends. How are things going in your life at the present time?
* What was it like to grow up in your family? Are you in contact with your family at present? How do you feel about your family?
* How do you think it will be for you to disclose your abuse experience in a group and to hear others discuss theirs?
* Have you ever discussed the abuse with anyone before? What happened? What were the reactions? How did you react?
* Tell us, in general, about your experience. Who abused you? How did the abuse begin and end? How old were you? What kinds of activities were involved? What were you told by the perpetrator? Was forced used? How did you cope? Did you ever tell anyone or did anyone find out about the sexual abuse? Their reactions? Your reactions?
* How has it been to have us ask about these things and to be talking to us about them?
* How do you think the abuse affected you at the time it occurred and since then?
* How do you think it affects you today?
* What are your feelings about being in a group with other abuse survivors? What are your fears/concerns about dealing with the sexual abuse?
* Have you been in or are you currently in individual or group therapy? Tell us about the therapy - what is/was worked on, the therapy relationship, how you feel/felt about the therapy and the relationship, etc.
* Tell us about your medical history and any substance abuse problems. Are you currently in treatment for any medical/addiction problems and are you currently on any medications?

(Courtois, 1988, p. 257)

* Do you feel like you have control over some things in your life or does everything seem overwhelming? Tell us more about this?
* What do you look forward to in your day? What makes these things pleasurable or enjoyable?
* Have you ever thought of killing yourself? How old were you? Have you ever tried to? When? Tell us what happened.
* Did you tell anyone about you joining this group?
* How do you take care of yourself?
* Do you have anybody that you can share things with? How long have you known them? What do you do together?
* How do feel about us talking with your therapist about your progress with them?

APPENDIX B

INFORMED CONSENT

I _____, while engaged in group counselling at Klinic Community Health Centre, will also be participating in the educational study of David Sullivan, a graduate student of the Faculty of Social Work, University of Manitoba. As a client, I understand:

1. That I will attend 12 group sessions held once weekly, and that each session will be two hours in duration.

2. That I will be asked to complete Standardized measures and/or other pencil and paper instruments to assist in evaluating the effectiveness of such a group. Results of these measures will appear as non-identifying information in the practicum report to be compiled at a later date. Those measures that will be useful for clinical purposes will be kept on file at Klinic.

3. That, as any other counselling client at Klinic, a confidential file regarding my sessions will be kept on the premises. This information, generated in my sessions at Klinic is available for my review upon request. All information, both verbal and written, will be kept under strict conditions of professional confidentiality.

4. That information from my file will not be released outside the agency except: a) with signed consent by myself, b) if there is concern that I may be a danger to myself or to others, c) as necessary if subpoenaed for court, and d) if a child is at risk and a report to Child And Family Services is deemed necessary.

5. That information may be shared within the agency only as such information is required by individuals who have an identified need to know for the purpose of assisting me.

6. That in addition to my file maintained at Klinic, I understand that David Sullivan will keep non-identifying notes regarding the process of counselling sessions. These notes shall be part of a practicum report to be compiled at a later date. These notes may also be the basis for supervision by a member of the Faculty of Social Work, University of Manitoba.

7. That videotaping of group sessions will occur. The purpose of these tapes is to provide supervision to David Sullivan by one of Klinic's staff and by his Practicum Advisor from the Faculty of Social Work, University of Manitoba.

Read and agreed to:

_____ _____

Signature of client Signature of witness

Date:

APPENDIX C

1. What rules were there in your family about keeping secrets? Were there any rules on keeping the sexual abuse a secret?

2. What did you have to do or say to keep the abuse a secret? Did you make any deals with yourself? Did you make any deals with others?

3. What will happen, or do you fear happening, if you share your secrets in group?

4. How would your life have been different if you had not had to keep secrets? Or were you believed when you told somebody about the abuse?

5. If some body wise and protective was there for you as a child, what would they have said or done for you? If there was some body wise or protective right now with you, what would they say or do for you?

APPENDIX D

1. Why did I go along?

2. What really happened to me?

3 Why did I keep the secret?

4. Am I damaged for life?

5. Why is it so hard for me to stay connected to others?

APPENDIX E

THE CLIENT SATISFACTION QUESTIONNAIRE

Please help us improve our program by answering some questions about the service you have received. 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.

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?

4	3	2	1
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?

4	3	2	1
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?

4	3	2	1
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 have helped a great deal	*Yes they have 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 services you received?

4	3	2	1
Very satisfied	*Mostly satisfied*	*indifferently or mildly dissatisfied*	*Quite dissatisfied*

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

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

9. Do you think having a male and a female as co-therapists was beneficial for you?

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

10. Based on your experience with this group, if you were to be given the option of either individual or group counselling for a similar problem would you choose group?

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

(PLEASE FEEL FREE TO ADD COMMENTS ON SUPPLEMENTARY SHEET)

APPENDIX F

EVALUATION OF GROUP

1. What changes do you feel have taken place for you in the process of this group?

2. What were the most helpful parts of the group for you? Which parts would you keep the same?

3. What would you change about the group? Were there parts that were not helpful?

4. What were the strengths and weaknesses of the facilitators of the group?

5. Any other comments?

APPENDIX G

NAME_____

DATE_____

RELATIONSHIPS

1	2	3	4	5	6	7	8	9
no close relationships; I can't risk with those close to me				I can share some things with others				have close relationships; I can be open with those close to me

NAME_____

DATE_____

EXTENT FEELINGS SHARED

1	2	3	4	5	6	7	8	9
can't put words to my feelings				moderately anxious talking about my feelings				comfortably talk about my feelings

NAME:_____

DATE_____

EXTENT OF FEELING POSITIVE ABOUT SELF

1	2	3	4	5	6	7	8	9
can't identify anything positive about self				neutral				there are many positive things me

APPENDIX H

CLIENT_____

DATE _____SESSION #_____

EXTENT TO WHICH CLIENT SHARES FEELINGS

1	2	3	4	5	6	7	8	9
never shares feelings		sometimes shares feelings		shares feelings half the time		shares feelings most of the time		always shares feelings

EXTENT TO WHICH CLIENT MAKES POSITIVE SELF STATEMENTS

1	2	3	4	5	6	7	8	9
never says a positive self statements		says the occasional positive self statement		will say positive self statements		most self statements are positive		always says positive self statements