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Cognitive Behavioural Therapy for Women with a History of Childhood Sexual Abuse

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ABSTRACT

Many studies have suggested a link between child sexual abuse (CSA) and adult psychopathology. Despite this apparent association and the high prevalence of CSA, there are few controlled studies in the CSA treatment outcome literature. The present investigation involved two single-case design studies which examined the effectiveness of cognitive behavioural treatments created to help adult women who experienced intrafamilial, contact sexual abuse as children. In Study One, three women with general CSA sequelae took part in a standard cognitive-behavioural treatment programme. Severity of CSA sequelae was measured by a weekly diary (Child Sexual Abuse Attitudes Scale - CSAAS) and monitored in a multiple baseline design. All three subjects evidenced a reduction in negative attitudes during the intervention phase. Two out of three women reported high end-state functioning on a battery of outcome measures. These gains were maintained at three month follow-up.

In Study Two, three women with specific CSA-related problems took part in individualised cognitive behavioural treatment packages. Problems included a touch phobia, negative sexual attitude, and negative view of self. Treatment progress was monitored using a Target Complaint Scale in AB single case designs with follow-up. All three women improved to clinically significant levels at post-intervention and this gain was maintained at follow-up. Implications of the present studies and ramifications for future research are discussed. These findings provide preliminary support for the usefulness of cognitive behavioural therapy in the treatment of CSA sequelae.
PREFACE

This thesis contains sensitive information and reader discretion is advised. There are many people who have contributed to this thesis and deserve acknowledgement. I would like to sincerely thank my supervisor, Dr. Hamish Godfrey for his efforts. His clarity of scientific thought enabled this study to progress in the desired direction. Much appreciation is also felt towards Barbara Chisholm and Adrian Green whose involvement in the early planning stages of this project was invaluable. In addition, I am tremendously indebted to the women who took part in this study and gave so much of themselves for the benefit of all. Their courage and tenacity was beyond doubt.

Besides the practical help, there were others who helped me enormously via other means. Firstly, I would like to thank Phil Clark for his unwavering love, encouragement and patience. Also, I was privileged to have the support of many friends who were each my tower of strength while I was working in such a harrowing field. Finally, I would like to make reference to my parents who taught me a rare skill known as positivity. Without that, this project would have been blown out of the water several hundred times over. Thank you.
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INTRODUCTION

It was once thought that incest was a phenomenon of great rarity (Stone, 1989). It was widely regarded as taboo and reported to occur in only the most deviant of families. In some of the earliest incest literature, Weinberg (1955) estimated that there was one case of incest per million persons per year in English speaking countries. The reality was that up until the 1980s, the actual incidence and prevalence of childhood sexual abuse (CSA), in the family and outside of it, was unknown (Russell, 1983).

It has been argued by Russell (1986) that the feminist political movement of the 1970s, provided the overdue catalyst for large scale research on CSA. As a political movement concerned with the status of women, feminism provided female incest victims not only with an open and empathic ear but with a strong and energetic mouthpiece. During the late 1970s and early 1980s, American feminists such as Sandra Butler, Judith Herman and Diana Russell were amongst the earliest authors to promote the idea that incest prevalence had been grossly underestimated. They argued that the true rate of incest was much higher than Weinberg's estimate and that incest was largely a damaging experience for its victims. In addition, Butler (1978) stated that for all intents and purposes, incest was not taboo in American society but instead there had been a 'conspiracy of silence' which meant talking about the incest was prohibited. The aim of many of these feminist authors was to break this 'conspiracy of silence' and direct public attention and concern to the victims of incest. This was done through the publication of articles and books, evidenced by the proliferation of literature on CSA during the 1980s.

As a result of the increase in public awareness of CSA, large scale epidemiological studies were provided with funding in the 1980s (e.g., in San
Francisco, Los Angeles, Otago). With the publication of each new study it became clear that incest and indeed, CSA in general, was disturbingly common. In addition, the epidemiological studies suggested that CSA contributed to a wide range of adult psychopathology (Russell, 1983; Wyatt & Peters, 1986). The results of these early studies on CSA have highlighted the importance of continued investigations in this area. The fact that CSA is not a rarity and has such damaging effects on those on the receiving end would suggest that research on CSA, its effects, treatment and prevention is of vital importance.

**Definition of Childhood Sexual Abuse**

After familiarising oneself with the psychological literature it becomes clear that there has been little consensus regarding how to define CSA. This can, in part, be attributed to the many diverse behaviours which fit under the 'umbrella' of abuse. For example, behaviours as diverse as adult-child verbal solicitation and anal rape can be included within a CSA definition. While there is little doubt that these are both forms of sexual abuse, the severity is an important distinction.

The complexity of defining CSA is reflected by the variety of definitions in the literature. Since there is no standard definition of abuse, individual researchers are forced to make arbitrary decisions about whether an experience was abusive or not. Factors which have been considered in psychological definitions of CSA include the extent of the sexual contact, the age and development of the child, the degree of relatedness between the child and perpetrator, the affective nature of the relationship, age difference between the child and perpetrator, the consensual nature of the contact and the duration of the abuse (Clymer, 1987). A major disadvantage of the proliferation of definitions is that few cross-study comparisons can be made (Scott, 1989). A second disadvantage is that the prevalence and incidence rates deviate according to the
definition used (Wyatt & Peters, 1986) with rates varying from 6% to 62% depending on the interpretation of CSA (Finkelhor, 1993).

A CSA definition by Russell (1986) is becoming more widely accepted in the literature. She differentiated between two types of CSA - extrafamilial and intrafamilial. Russell (1986) defined extrafamilial child sexual abuse as:

involv[ing] unwanted sexual experiences with persons unrelated by blood or marriage, ranging from petting (touching of breasts or genitals or attempts at such touching) to rape, before the victim turned 14 years, and completed or attempted forcible rape experiences from the ages 13 to 17 years (inclusive). (p.61)

As is apparent, extrafamilial CSA was defined quite narrowly, using an age criterion, to avoid including the common experience of unwanted petting and intercourse in dating situations. As Russell adds this does not mean that these experiences are necessarily nonabusive but that her focus was on more severe cases of extrafamilial CSA. In contrast, in the definition of intrafamilial CSA, Russell decided to include the experiences of unwanted petting and intercourse with relatives for all age groups, since sexual contact between relatives is regarded as less acceptable in this culture. In addition, she restricted intrafamilial CSA to physical contact thereby excluding experiences such as verbal propositioning or exhibitionism to focus on the more severe cases of intrafamilial CSA. Therefore Russell's (1986) definition of intrafamilial child sexual abuse was "any kind of exploitative sexual contact or attempted sexual contact that occurred between relatives, no matter how distant the relationship, before the victim turned 18 years old" (p.59). Within Russell's definition, experiences involving sexual contact with a relative that were wanted and with a peer were regarded as non-exploitative, for example, sex play between cousins or siblings of approximately the same age. An age difference of less that five years was the criterion for a peer relationship.
By law, incest is generally defined as sexual intercourse between individuals who are too closely related to marry. Alternatively, psychological and psychiatric definitions of incest have been developed because sexual activity with relatives who are not too closely related to marry, or even with surrogate or quasi-relatives, can have psychological effects that may be considered incestuous (Courtois & Watts, 1982). Therefore Russell's definition departs from the traditional legal definition of incest.

In the present study which focused on incestuous abuse, a definition based on Russell's narrow definition of intrafamilial CSA (incest) was decided upon. The CSA definition included criteria of age, physical contact and non-consensual nature. The definition was purposefully narrow to enhance the possibility of generalisation of results. Therefore CSA was defined as unwanted genital contact between the victim and a relative before the victim turned eighteen years of age. The perpetrator must be a close male relative at least five years older than the victim at the time of the abuse episode(s) and the victim must have been under the age of eighteen.

Types of genital contact include penetration, attempted penetration, or stimulation of the vaginal or rectal area by a penis, finger, tongue or any other part of the perpetrator's body, or by an object used by the perpetrator; and also includes any type of genital or anal contact of the perpetrator by the victim, such as fellatio, masturbation, and intromission of any kind (Patton, 1991). The inclusion of quasi-relatives (e.g., step-relatives or adopted parents) in this definition of incestuous abuse was based on the belief that sexual activity between quasi-relatives can have a similar psychological impact to that between blood relatives (Courtois & Watts, 1982). The crucial psychosocial dynamic is the familial relationship between the child and perpetrator and Sgroi (1982) argues that for children, the kinship role is far more important than the blood tie.
Prevalence of Childhood Sexual Abuse

The true prevalence of CSA has proved difficult to assess, evidenced by the large variation in prevalence rates between studies. Three factors have been commonly associated with these discrepancies. Firstly, as mentioned earlier, prevalence rates vary widely depending on the definition (Wyatt & Peters, 1986). Secondly, rates of CSA differ according to population characteristics (Haugaard & Emery, 1989). For example, psychiatric populations report a higher rate of CSA than do general population samples (Coons, Bowman, Pellow & Schneider, 1989). Thirdly, methodological variations between studies may contribute to differing prevalence rates, for example, a postal questionnaire may produce different results from a face-to-face interview (Martin, Anderson, Romans, Mullen & O'Shea, 1993).

Another factor which may contribute to differing prevalence rates but is less commonly mentioned is under-reporting. Russell (1983) found only eight percent of abuse was reported to police or social welfare agencies. Studies such as that by the National Centre on Child Abuse and Neglect (1981), which relied on the annual number of public reports of child abuse to make its estimate of CSA prevalence, run the risk of seriously underestimating the problem. In addition, it is possible that a large proportion of CSA victims, when faced with a questionnaire regarding CSA choose not to respond. In most large scale studies the refusal rate was approximately 30-40% therefore a large proportion of the population remain unsampled. CSA victims may choose not to respond for a multitude of reasons (e.g., memories are too painful, fear of disclosure, maintenance of privacy) thereby contributing to an underestimation of CSA prevalence.

Despite these difficulties in obtaining true prevalence rates, it is well established that given even the narrowest of definitions, the occurrence of CSA is not rare. Prevalence estimates in community samples range from 6-62% for
females and 3-16% for males with the more comprehensive studies generally finding higher rates (Finkelhor, 1993). Finkelhor (1993) adds that "a rough expectation that at least one in four girls, and one in ten boys will suffer victimization, gives the order of magnitude that professionals ought to expect" (p.67).

The question of risk is often raised in regard to CSA - are some communities of children at more risk of abuse than others? Finkelhor (1993) reported several factors to be associated with greater risk including being a girl, preadolescent or early adolescent, having a stepfather, living without a natural parent, having an impaired mother, poor parenting and witnessing family conflict. Factors unassociated with CSA prevalence included class and ethnicity (Finkelhor, 1993). Finkelhor (1993) asserted that "the prevalence of sexual abuse is widespread enough and in no subgroup is it clearly absent or rare" (p. 67).

A large scale epidemiological study was completed in Dunedin, New Zealand known as the Otago Women's Health Survey (Anderson, Martin, Mullen, Romans & Herbison, 1993). In the process of this study over 3000 women were randomly selected from the Otago/Southland electoral rolls and sent a postal questionnaire, which identified those reporting a history of CSA before the age of 16. The results indicated that over 25% of women in the general population had experienced contact CSA before the age of 16. The rate of CSA rose to almost 32% when contact and non-contact abuse were combined. Over seven percent of the women had experienced unwanted genital contact before the age of 16 and nearly four percent had experienced unwanted intercourse before age 16. Intrafamilial CSA (contact and non-contact) was experienced by 12% of the sample. Unfortunately, there was no break-down of types of abuse (contact or non-contact) reported for victims of intrafamilial CSA. In addition, cross-study comparisons of prevalence rates are hindered by the different age criterions used.
For example, Russell (1983) and Wyatt and Peters (1986) both collected data on CSA occurring before 18 years whereas the Otago Women's Health Survey collected data on CSA occurring before 16 years.

Within the literature, there has been some debate as to whether the rate of CSA is increasing. Russell (1986) theorised that there had been an increase in CSA during the twentieth century, and presented prevalence estimates based on the incidence of CSA reported by 182 women, of a wide age range, in her sample. Her statistics suggested that incest which occurred prior to 18 years of age had quadrupled between 1900 and 1973. This finding was based on the fact that older women were reporting less CSA than younger women. In the Otago Women's Health Survey however, results do not support the rising incidence theory as there was no significant difference between the numbers of women reporting CSA by decade of age (Anderson et al., 1993). It is possible that this discrepancy relates to attitude change between the decade of each study. Russell's samples were interviewed in 1978 and the Otago women were interviewed in 1989 and 1990. It is possible that in 1978, the older sample of women felt less comfortable about discussing their sexual experiences than the older sample of women in 1990, a full twelve years later.

The Effects of Childhood Sexual Abuse

Based on the early literature on incest, Lukianowicz (1972) reported that there was little empirical evidence of psychiatric sequelae of CSA. With regard to a group of women with histories of CSA he stated that "the personality, intelligence and social class of the participants showed no marked deviations from what might have been expected of a random population" (p.312).

Around one decade later the literature on CSA had grown considerably but the majority of the published work revolved around clinical impression rather than empirical data. Despite this, Gelinas (1983) summarised clinician's impressions of
CSA sequelae and identified the following common clinical symptoms in adult victims of CSA - depression, guilt, low self-esteem, substance abuse, anxiety, somatic complaints and learning difficulties. She defined these as secondary symptoms of CSA as opposed to primary symptoms such as flashbacks of the abuse which can be directly attributed to the abusive episode(s). In addition, Gelinas mentioned a growing awareness that the effects of CSA often emerge latently. She cites examples of adults recalling memories of their abuse only when their children reached the same age at which their abuse began. She suggested that the latency of such responses may have reinforced the historical view that CSA is not harmful.

In addition to the sequelae noted by clinicians, many victims readily admit to CSA-related behavioural problems (Stone, 1989), for example, some victims linked their substance abuse with a history of CSA. In the last few years, empirical studies have provided confirmatory evidence that links CSA with psychopathological sequelae (Browne & Finkelhor, 1986; Cahill, Llewelyn & Pearson, 1991; Gelinas, 1983; Leitenberg, Greenwald & Cado, 1992; Mullen, Martin, Anderson, Romans & Herbison, 1993; Romans, Martin, Anderson, O'Shea & Mullen, in press; Russell, 1986). Symptoms such as depression, self-destructive behaviour, anxiety, feelings of anger, isolation and stigma, alienation and distrust, transient or negative relationships, sexual dysfunction, negative self-image, revictimisation and substance abuse have been found to have a positive correlation with a history of CSA (Browne & Finkelhor, 1986).

In their review, Browne and Finkelhor (1986) summarised the sparse empirical literature on the short and long term effects of CSA. They concluded that the immediate effects of CSA were "sketchy" but empirical studies with adults confirmed the elevated risk of adult psychopathology after such an event. Adult women sexually victimised as children were more likely to manifest depression,
self-destructive behaviour, anxiety, feelings of isolation and stigma, poor self-esteem, a tendency toward revictimisation and substance abuse.

While it may be true that there is a strong correlation between CSA and later psychological problems, up until very recently no controlled study had adequately separated out confounding influences, such as family dysfunction or personality variables (Fromuth, 1986) both of which could contribute to adult psychopathology. The desperate need for scientific research in this area contributed to Canadian psychiatrist James Henderson (1983) to write over a decade ago:

the absence of well-controlled studies makes it difficult or impossible to separate the effect of incest from that of other variables highly correlated with developmental trauma, such as low level of parental education.....poor child-rearing practices and high degree of family disorganisation (p.38).

In answer to Henderson, the most recent research suggests that CSA is an independent risk factor in the development of adult psychopathology (Mullen et al., 1993). A New Zealand study by Mullens and colleagues (1993) attempted to investigate the relationship between CSA and mental health in adult life. Using logistic regression, they found there was a positive correlation between reporting abuse and greater levels of psychopathology on a range of measures. Abuse emerged from logistic regression as a direct and independent contributor to adult psychopathology.

**Theories of CSA Sequelae**

There is an abundance of theories regarding the process by which CSA contributes to adult psychopathology. For the sake of clarity, only theories which are designed to be testable will be reviewed in the following section.
Learning Theory:

It has been theorised that two types of learning are involved in the development of CSA symptoms - classical and operant conditioning. The classical conditioning mechanism proposes that a neutral stimulus becomes associated with an unconditioned stimulus (UCS), the identified trauma. The neutral stimulus then acquires aversive properties that elicit anxiety and the stimulus becomes a conditioned stimulus (CS) which can then evoke a fear response. Higher order conditioning or the generalisation of these emotional responses results when the CS is paired with further neutral stimuli (Deblinger, McLeer, & Henry, 1990). For example, if a child experienced abuse (UCS) by a man with a long nose (a neutral stimulus) then men with long noses may become associated with the abusive event and may elicit anxious symptoms in the future (CS). Furthermore, by pairing long-nosed men with other neutral stimuli (e.g., elderly men), higher order conditioning of fear may result.

Operant conditioning mechanisms propose that CSA sequelae are a result of reinforcement. For example, the victim of CSA may attempt to reduce anxiety by avoiding anxiety-provoking stimuli. Such behaviour, results in temporary relief, but in doing so, reinforces the strength of the CS to elicit an anxiety response (Deblinger et al., 1990). In the abusive environment these symptoms may be adaptive in that survival chances are increased but in the post-abuse environment, previously adaptive coping behaviours such as avoidance may become archaic and dysfunctional (Briere & Runtz, 1988).

Learning theory has been used to explain the development of Post Traumatic Stress Disorder (PTSD) symptoms in CSA victims. PTSD formulations have been applied to numerous types of traumatic events (e.g., rape, war) and more recently applied to CSA with increasing frequency (Oles, 1991). To meet the criteria for PTSD, the person must have been exposed to a traumatic event in
which there was a threat to the physical integrity of self or other and the person's response involved intense fear, helplessness, or horror (American Psychiatric Association, 1994). Treatment is based on the theory that victims of traumatic events continue to re-experience aspects of the trauma until the event is totally integrated into the victim's life experience (van der Kolk, 1987). Optimal treatment includes exposure which involves repeatedly 'replaying' the aversive memories and anxiety management training, in which victims are taught a variety of skills to control anxiety in daily situations (Foa, Rothbaum, Riggs & Murdock, 1991). Despite its popularity, PTSD has been criticised as an inaccurate diagnosis (Finkelhor, 1987) for many victims of CSA since it does not account for some of the common CSA sequelae. For example, a PTSD formulation does not explain the development of depression (Spaccarelli, 1994) in many people who have experienced sexual abuse. Another problem for PTSD models is how it could account for the diversity of individual's responses to CSA. Other variables such as personality, coping style or temperament which may moderate the effect of CSA have not been incorporated into these models (Spaccarelli, 1994). Finally, it has also been criticised for its overuse (Finkelhor, 1987) as it was originally applied to rape victims (Rothbaum, Foa, Murdock, Riggs & Walsh, 1990) and war veterans (Keane, Fairbank, Caddell & Zimering, 1989) and its application to CSA appears ad hoc.

**Traumagenic Dynamic Model:**

Finkelhor (1988) proposed a traumagenic dynamic model and postulated that there are four main types of sexual abuse experiences that alter a child's cognitive or emotional orientation to the world. These include (a) traumatic sexualisation, (b) powerlessness, (c) stigmatisation, and (d) betrayal. Each of these four experiences contributes to a particular set of psychological impacts and behavioural manifestations, for example, betrayal is thought to cause feelings such
as grief, heightened dependency and mistrust (Spaccarelli, 1994). While this theory can explain the development of broad CSA sequelae (e.g., depression is a consequence of feelings of betrayal) it fails to take individual mediating variables into account. For example, the possibility that certain coping styles may mitigate the effects of each of the four key experiences (Spaccarelli, 1994) remains unacknowledged. Lastly, the theory is difficult to verify empirically (Spaccarelli, 1994).

Developmental Models:

Developmental theorists argue that CSA alters ongoing development in areas of social and self-functioning (Cole & Putnam, 1992). The degree and nature of this disruption is dependent on the developmental stage at which the child was abused. For example, if abuse occurs during a child's preschool years, their coping skills may be limited and children must rely on denial and dissociative strategies since other options (e.g., avoidance of perpetrator) may not be available to them. In school-age years, when children are developing social rules and are increasingly aware of feelings such as guilt and shame, CSA may reduce their positive self-concept or feelings of competence. During the adolescent period, the abused may cope through denial or other maladaptive coping strategies such as acting out which may lead to misconduct.

A second developmental theory has been proffered by Alexander (1992). She proposed that attachment theory can be useful in understanding CSA sequelae. This developmental theory is based on three assumptions. Firstly, that the occurrence of CSA necessitates a disorganised attachment with at least one caregiver. This assumption does not acknowledge that a large proportion of CSA perpetrators are extrafamilial and therefore the perpetrator is unlikely to be a primary attachment figure (Spaccarelli, 1994). The second assumption is that the wide range of adult symptomatology in CSA victims reflects these disturbed
relationships and thirdly, that the manifestation of symptoms in adulthood depends on the attachment type (e.g., avoidant, resistant). Accordingly, she suggests that an avoidant attachment during early childhood would predispose the victim to use denial strategies whereas a resistant attachment would predispose the victim to an approach-oriented style (e.g., overidealising her partner). This advantages of this model are that it is well-founded in theory and can be empirically tested (Spaccarelli, 1994) but as mentioned, it assumes that the occurrence of sexual abuse necessitates at least one disorganised primary attachment relationship which may not be the case in many incidents of extrafamilial CSA.

**Cognitive Model:**

A cognitive model assumes that cognitive activity affects behaviour and that cognitions can be monitored and altered by the individual (Fallon & Coffman, 1991). It also assumes that behaviour change is effected through cognitive change. This theory is derived from Beck and his associates' (Jehu, Klassen & Gazan, 1986) cognitive theories on mood disorders (Beck & Emery, 1985; Beck, Rush, Shaw & Emery, 1979). When applied to CSA, cognitive theory postulates that a person's beliefs about themselves and the world are at risk of distortion through the experience of CSA (Janoff-Bulman, 1985). This cognitive alteration can have a major impact on the victim's consequent behaviour, for example, if a child is abused and generates the cognition that people are not trustworthy then they may avoid further social contact. It is hypothesised that distorted or unrealistic beliefs are important sources of mood disturbances and related problems (Briere, 1989; Jehu, 1988).

Since mood disturbance is believed to be a function of distorted beliefs then it follows that their therapeutic correction is likely to be associated with an alleviation of the disturbances. To do this, one of the goals of cognitive behavioural therapy is to help clients become aware of the underlying assumptions
they hold about themselves and the world (Beck et al., 1979; Fallon & Coffman, 1991). If these assumptions are untrue or dysfunctional then the therapist works with the client to modify or change these ideas to become more accurate, flexible and functional. In addition, in order for treatment to be effective, it must redress any dysfunctional cognitions through restructuring. Cognitive restructuring is 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 order to correct distorted cognitions victims must firstly become aware of their thoughts, secondly, they must recognise the distortions in their thinking and finally substitute more accurate cognitions (Fallon & Coffman, 1991).

**Attributional Model:**

This model proposes that the victim's attributional style mediates the long term effects of sexual victimisation (Gold, 1986). Attributions are categorised according to three dimensions: internal/external, stable/unstable, and global/specific. The theory postulates that a person's causal attributions and expectancies mediate the individual's response to uncontrollable situations. If CSA is conceptualised as an uncontrollable event, then learned helplessness theory would suggest that the symptoms observed in many victims may result from internal, stable, global attributions for negative events and from expectations of having no control over the environment. Specifically, an internal, stable, global attribution for negative events is expected to correlate with poor functioning in victims (Gold, 1986). It follows then, that treatment focuses on cognitive techniques to help the victim explore their attributional style, to identify, and modify self-defeating thoughts. This is consistent with cognitive theories of CSA.
Transactional Model:

This model was proposed by Spaccarelli (1994) and is based on Sameroff and Fiese's (1990) transactional theory which proposes that development is a function of multiple transactions between the person and their environment (see Figure a). The transactional model of CSA predicts that risk of psychopathological sequelae is related to the total abuse stress (TAS). TAS is regarded as a function of three categories of stressful events: abuse events (e.g., degree of sexual exposure, coercion, denigrating messages, trust violation), abuse-related events (e.g., family dysfunction, non-support of disclosure), and disclosure-related events (e.g., insensitive/repeated interviewing, poor adjudication outcomes, stressful testimony). The higher the cumulative stress levels or TAS, the higher the risk for maladaptive outcomes. In addition, it is recognised that cognitive appraisal and coping responses mediate the effects of these three events as do developmental and environmental factors.

Figure a. Transactional theory of the effects of childhood sexual abuse (Spaccarelli, 1994).
Transactional theory postulates that any development is a function of multiple transactions between the person and the environment and that there may be reciprocal causal effects between variables. This conceptualisation helps to explain the wide diversity of individual responses to sexual abuse since no two people are ever likely to experience the same combination of events.

The theory is supported by recent empirical findings. For example, there is considerable research evidence that cognitive appraisal is an important mediator of the effects of stress (Lazarus & Folkman, 1984). It follows then that the short and long term impact of CSA may be mediated by the extent to which the victim perceives the experiences as threatening or causing emotional or physical harm (Spaccarelli, 1994). Numerous studies have found results which support the idea that variability in social support (Lazarus & Folkman, 1984) and coping responses can mediate the mental health outcome of CSA victims (Finkelhor, 1979; Leitenberg et al., 1992; Silver, Boon & Stones, 1983). These ideas are consistent with the transactional model described here because they also imply that support systems, appraisal and coping responses are important proximal determinants of mental health outcomes.

**Justification for the Transactional Model**

A review of the major empirical theories outlined above indicates there is no shortage of aetiological theories of CSA sequelae. The most comprehensive theory is the transactional model. It subsumes components of many of the strongest, testable theories. For example, it includes developmental, learning, attributional, traumagenic, and cognitive models within its conceptualisation. It is a complex and sophisticated conceptualisation of CSA which takes into account the recent empirical advances in the study of CSA. It has a strong scientific basis because of its solid theoretical underpinnings and its ability to account for the findings of recent empirical research. Finally, given the transactional model's
flexibility in accounting for individual difference in response to CSA it has many practical ramifications.

**Literature Review on Treatment**

There is a dearth of outcome studies on the treatments of CSA. There are even fewer studies which are well-controlled. These studies are briefly reviewed below:

**Uncontrolled Studies:**

One of the earliest treatment outcome studies was that reported by Tsai and Wagner (1978). In this study, ten groups of women, each comprising four to six members (n = 50) underwent four sessions of group therapy for incest. Clinical findings from a six month follow-up study showed that the most helpful component of the therapy was sharing experiences with other survivors of CSA. The women reported a reduction in guilt, an increase in self-acceptance, and improved intimate relationships. Unfortunately, there was no control group, a poor description of treatment and outcome was provided, and there were no objective independent measures. In addition, feedback from the women involved indicated that they felt four sessions was insufficient therapeutic time. Despite these criticisms, this study was important in that it was the first of its kind to attempt to report the clinical findings from a short-term therapy.

In 1984, Rychtarik and colleagues (Rychtarik, Silverman, Landingham, & Prue, 1984) reported a case study of implosive therapy for an incest victim. Self-report, physiological and behavioural measures all demonstrated notable decrease by the follow-up implosive therapy session and at six months follow-up. There was, however, considerable negative life change in this subject as she had resumed alcohol abuse and her marital relationship had deteriorated.

Herman and Schatzow (1984) provided a qualitative description of their short-term intervention for women with a history of incest. Again, the intervention
was poorly described but included ten sessions of group therapy. They reported increased self-esteem, reduced shame, guilt and isolation and increased ability to protect oneself. There was no control group and no follow-up. The results were descriptive only.

With regard to the descriptive nature of the majority of the literature on the treatment of CSA, Jehu (1988) stated that "the literature on the treatment of these problems in this client group is extremely sparse and most of the reports that are available do not include any systematic evaluation of the intervention" (p. xi).

In 1991, Herder and Redner (1991) reported their findings from a group therapy programme for incest victims. This programme involved 20 sessions of one and a half hours duration (n = 15). This study systematically followed the progress of these women during therapy and reported that all clients, with the exception of one, showed increased self-esteem scores between pre- and post-intervention on the Coopersmith Self Esteem Inventory. Unfortunately, their systematic evaluation ended here as there was no use of a control group, such as a wait-list control. The paucity of outcome research, contributed to Wheeler and Berliner's (1988) comments that "to date, no clinical outcome studies have demonstrated the efficacy of any treatments of the effects of sexual abuse on children, much less their differential efficacy or which treatments are effective for what problems" (p.245).

Controlled Studies:

A study reported by Alexander and colleagues several years ago (Alexander, Neimeyer, Follette, Moore, & Harter, 1989) represents the only empirical study to date comparing the effectiveness of different formats of short term group therapy to a control condition in which women did not receive these services. Sixty five women took part in the 10 week treatment (1 1/2 hour sessions) and were followed up six months post-intervention. This study
compared Interpersonal Process (IP) to Interpersonal Transaction (IT) group format in the treatment of adult women who experienced intrafamilial CSA. Their theoretical model guiding treatment was a Family Systems Approach. For a full description of the Interpersonal Process format and Interpersonal Transaction format, articles by Yalom (1975) and Neimeyer (1988) respectively, are recommended. Results from this study showed that both IP and IT increased adjustment (as measured by the Beck Depression Inventory, Modified Fear Survey, SCL-90-R and Social Adjustment Scale) and this was maintained at six month follow-up. A lower level of education was predictive of less improvement, as was being married, and the severity of abuse. Overall, the women reduced their levels of depression, reduced stress, and increased their social adjustment (Alexander, Neimeyer, & Follette, 1991). In conclusion, they reported that short-term group therapy was effective in reducing specific areas of difficulty as outlined above but added that women with more severe abuse experiences may need concurrent individual or marital therapy (Alexander et al., 1991).

One other controlled study was reported by Deblinger and colleagues (1990). The effectiveness of a twelve-session, individual, cognitive behavioural treatment programme for nineteen girls (age range = 3-16 years) with a history of intrafamilial CSA and current PTSD was evaluated. The treatment approach also included a nonoffending parent intervention consisting of teaching several cognitive behavioural family management strategies. Therapy was based on learning theory (classical and instrumental learning paradigms) and the intervention was aimed at reducing PTSD symptoms. On measures of PTSD symptoms, the results revealed significant improvements. Subjects showed a reduction between baseline and post-treatment in reexperiencing phenomena, avoidance behaviour, and arousal symptoms such that no subject met the criteria for PTSD following the intervention. On the Child Behavior Checklist (CBL), the
Children's Depression Inventory (CDI) and State-Trait Anxiety Inventory for Children (STAIC) there were significant changes in the desired direction between baseline and intervention. Unfortunately, no follow-up was reported so the long term efficacy of the intervention remains unclear.

Methodology

The majority of CSA treatment studies use inadequate measures, fail to describe their assessment measures and methods fully, provide anecdotal accounts of treatment outcome, use small sample sizes and fail to include control groups. They tend to be retrospective in nature and lack adequate follow-up data (Edwards & Donaldson, 1989). There have been few carefully designed and controlled treatment outcome studies using standardised measures and/or behavioural observations.

There have been only two controlled studies reported in the literature to date. The first of these by Alexander and colleagues (1989) compared the effectiveness of two short-term group therapy formats to a waitlist control condition for 65 adult women who were incestuously abused as children. Both group formats proved to be effective relative to the waitlist condition in improving adjustment, and the treatment gains were maintained at a 6-month follow-up. They concluded that short-term group therapy was a viable and effective means of intervention in reducing depression and distress and in promoting social adjustment but warned of the need for a multisystemic approach with certain individuals (Alexander et al., 1991).

The second study by Deblinger and colleagues examined the effectiveness of a cognitive behavioural treatment programme designed for female children who had experienced intrafamilial CSA. Nineteen children who met the criteria for PTSD and one care-taker took part in twelve individual treatment sessions. Immediately post-intervention, no subjects met the criteria for PTSD and on all
measures there were significant improvements. There was, however, no follow-up.

In conclusion, there has been no controlled study which has systematically evaluated treatment outcome, both short and long term, after adult women have undergone individual therapy for CSA. This situation has contributed to Patton's (1991) conclusion that "treatment effectiveness was, and continues to be, one of the major unknown variables in this field. Everyone involved wants to know what works, for whom, and for how long" (p.32).

The present studies were designed to help clarify the issue of CSA treatment efficacy. It was hypothesised in Study One, that a standard cognitive behavioural programme based on the transactional formulation of CSA, presented via individual therapy sessions, would be effective in reducing the chronic CSA sequelae present in women with a history of intrafamilial CSA. It was hypothesised in Study Two, that individual cognitive behavioural interventions based on the transactional formulation would also be effective in reducing specific, chronic CSA-related problems present in women with a history of intrafamilial CSA.
STUDY ONE

METHOD

Subjects

Three women (C, W and M) who had a history of intrafamilial sexual abuse by an older male relative commenced the programme. Two women completed the intervention while one woman (C) withdrew from the study due to increased work commitments. A brief background history of each subject follows with all identifying information removed:

Subject C:

C was a forty year-old woman of Caucasian and Polynesian descent. Her income included the Domestic Purposes Benefit which was supplemented by part-time cleaning work. C had two children, had married once and was currently separated.

C was born the fourth child in a large family. She was raised in a small New Zealand city, where her father was self-employed and her mother was a homemaker. C described her parents as very hard-working but the family were quite poor. The relationship between her parents was fraught at times especially when her father drank heavily. C reported that her mother had numerous extramarital affairs which prompted violent rages from her father. Physical affection between family members was rare. C denied any physical abuse and stated that discipline was limited to her mother smacking them occasionally with a three-foot ruler.

The sexual abuse of C occurred on two occasions when she was five years old. The offences are reported to have taken place in her uncle's home on two succeeding days when C had gone there after school had finished early. She was
told to wait with her uncle until some other family member could come and pick her up. On two of these occasions, her middle-aged uncle made C sit on a bench and then showed her pornographic pictures. Following this, the offender used her legs to masturbate between. The offender made her touch his penis and also made comments regarding future sexual experiences (e.g., "your vagina will be big enough when you're older"). The second offence was of a similar nature and was interrupted by another uncle. There was an angry altercation between brothers and the offender was directed to take C home. No mention of the abuse was made. She remembered her mother telling her off for being late home, being made to eat her cold dinner and then being sent to bed.

As a child, C did not disclose the abuse. She had assumed, from her relatives' reactions, that she had done something wrong and blamed herself for the abuse. In 1993, C disclosed the abuse to her mother who did not react with surprise. C did not make any further disclosures for fear of blame or judgement by others.

C reported enjoying attending both primary and secondary school but she failed School Certificate. Her mother encouraged her to leave school and her first job was as a factory-hand. Throughout her career, C has been employed in blue-collar work. She reported feeling unable to maintain a healthy relationship as she found herself particularly attracted to 'bad' men (e.g., physically violent or alcoholics) and she had been involved in tens of heterosexual relationships. At present, C lives with her youngest child in a rented house. C is involved in a steady, non-violent relationship. Her income includes the Domestic Purposes Benefit ($525 per fortnight) and wages from three, part-time jobs. She reported the following problems in her life: heavy alcohol use, promiscuity, anxiety regarding the CSA, general anxiety, lack of assertive behaviour and ineffective parenting skills.
Subject W:

W was a 26 year-old woman of Caucasian descent. She had one child of primary school age and had been living with her current partner for over two years. She was a full-time mother on a low income which included the Sickness Benefit and Family Support.

W was born the youngest child in a large family. She reported vague memories of her childhood. The family lived in a large New Zealand city. Her mother was a largely built woman who did full-time blue-collar work and her father was a semi-skilled labourer. She described both parents as physically and emotionally distant with little communication. In fact, she reported that family members were rather isolated with there being little communication between family members and little affection displayed. Physical discipline was rare and W could recall being smacked by her mother only once. Her parents lived largely separate lives, sleeping in separate beds, and spending little leisure time together. Her father spent most of his time in the garage fixing cars or in his vegetable garden. W believed that he experienced chronic depression and received treatment for this during her late childhood.

The sexual abuse occurred on one occasion when W was about nine years old. The offender was her father. W remembered the offence occurring on a stormy night when she had felt scared and gone to her parent's room for comfort. Initially, W climbed into bed with her mother but the single bed could not fit them both comfortably and her mother told her to get into her father's bed which she did. During the night, W experienced digital penetration by her father. She reported feeling very frightened and confused but pretended to be asleep. W was unable to recall the duration of abuse. She reported feeling rejected by her father and chose never to sleep in her father's bed again. W did not immediately disclose the abuse due to her feelings of emotional isolation.
The offender died in a work accident, when W was aged eleven. W described this episode as shocking. As was typical, there was little communication between family members about this event but W can remember her mother crying. W attended the local primary, intermediate and high schools. She reported enjoying school and being "quite good at it". During her first few years at high school, W started 'acting out' (e.g., engaging in truancy and frequent sex). She attributed this change in behaviour to a desire for attention from teachers and her mother. This behaviour prompted a change of schools. Around this time, W also noted an increase in ruminations about the sexual abuse. At this point, W decided to disclose the abuse to her mother who told W not to talk about it as "I don't want to remember him like that". W stated that after this reaction she felt doubly rejected by her parents. In addition, W was not enjoying her new school. She became chronically depressed and felt unable to sit School Certificate because of her low mood. W left school at age 16. She eventually found short term blue collar work and was flatting communally. She found it difficult to trust people and she believed that this contributed to her lack of emotionally close friends. W became involved in many short term sexual relationships including working for a short time as a prostitute. She made several suicide attempts during this time, including taking an overdose and cutting her wrists. W stated that she had meant to kill herself. Later she was prescribed anti-depressants and placed on the Sickness Benefit.

At the age of 19, W began her first long term relationship which lasted for several years. She engaged in heavy drinking while in this relationship as her partner was an alcoholic. She admitted alcohol tolerance but denied any alcohol dependence. Violence often developed after both her and her partner had been drinking. Following the birth of their child, W and her partner decided to move cities as house prices were cheaper elsewhere. Once there, they successfully
obtained a mortgage and bought a house. This relationship ended several years ago but the father's weekend access to his child has continued. In the period following this relationship's termination, W found full-time employment and described feeling happiest and having increased self-esteem during this period.

At the time of the assessment, W was living in her own mortgaged home with her child and partner of two years. Her new partner abused alcohol and drugs but she denied any violence. She reported feeling depressed over the last month due to relationship and financial difficulties as well as a recent miscarriage. W reported drinking about twice a month but admitted a recent binge episode during which she drank two hip flasks of spirits. This had been precipitated by relationship problems. She reported the following problems in her life: anxiety, depression, low self-esteem, loneliness and relationship difficulties.

**Subject M:**

M was a 33 year-old woman of Caucasian descent. She was employed as a health professional. M was currently separated and she and her ex-husband shared the care of their children. She rented a house in a large New Zealand city.

M was born the middle of three children in a large New Zealand city. She has no memories of her father as he disappeared when she was a preschooler. Her mother remarried when she was in primary school and M disliked her step-father. She had stepsiblings who she reported were more kindly treated than was she and her siblings (e.g., bought better toys, emotionally supported). She stated that her mother aligned herself with the new step-family and neglected her own children, emotionally and physically.

The sexual abuse occurred on multiple occasions when M was ten years old. The perpetrator was her step-father. M and her older sister shared a room opposite her parent's room and near the bathroom. On multiple occasions, her step-father asked one of the girls to "come and test the water" when he was having
a bath. She experienced digital penetration outside of the bath on these occasions. Despite feeling very unsafe in the house, M did not disclose the abuse as she suspected that she would have been called a liar or disbelieved. M reported that the abuse was "worse" for her elder sister and both dealt with the abuse in differing ways. She reported that her sister acted out whereas she became more withdrawn.

M was a successful student, being placed top in many classes. She passed four school certificate subjects despite denying any study. M left school at age 16 to go flatting and quickly found work. In her late teens, M became pregnant and felt obligated to marry. Soon after she left the marriage, taking her child with her. In her mid-twenties, she remarried but admitted that she married for a sense of security. Together, they had several other children but the pressures of full-time work, motherhood and study put the marriage under considerable strain. During this marriage, M reported being raped by an acquaintance and became pregnant. She agreed to have an abortion but only under considerable pressure from her husband. M became depressed and was hospitalised for a short time. At this point, she separated from her husband and he gained access to their joint children. M did not fight this decision, stating "I didn't deserve my children - I killed one, I don't deserve the others".

During the baseline phase of the intervention, M was made redundant from her position in the health system. She was, however, offered lower paid work by her employer so she continued to work full time. She had one close female friend and was involved in a long term heterosexual relationship. She reported the following problems in her life: anxiety, depression, low self-esteem, anger management problems and relationship difficulties.
Recruitment and Selection Criteria

An advertisement was placed in the local community newspaper of a large New Zealand city (see Appendix a). Interested potential subjects (volunteers) were instructed to ring the study research centre and leave their names and phone numbers. The primary researcher then contacted them by phone, conducted an initial screening (see Appendix b), provided information about the study, and answered any remaining questions. Unsuitable volunteers were informed of alternative resources available in the community, involving both emergency and counseling services.

An appointment was made with each volunteer who met the phone screening criteria. At this appointment the volunteer met the researcher, read an information sheet (see Appendix c) and consent form (see Appendix d). In addition, the Structured Clinical Interview for DSM III-R (SCID) was administered. These interviews were performed by trained post-graduate, clinical psychology students who screened for the following:

(1) those with a current major psychiatric disorder (e.g., obsessive-compulsive disorder, schizophrenia, alcohol dependency and abuse, bipolar disorder, organic disorders).

(2) persons with a history of any major psychiatric disorder (listed above)

In addition, all volunteers were screened for the following:

(3) persons who score more than 29 on the Beck Depression Inventory (within the range of severe depression)

(4) persons who are currently receiving assistance for their sexual abuse sequelae from other sources (including medications)

(5) persons who have had cognitive behavioural therapy for sexual abuse within the last two years
(6) persons who are currently using psychotropic drugs (prescription or non-prescription)

(7) persons who had retrieved memories of sexual abuse through hypnosis only

Within a week of screening, all volunteers were informed by telephone whether they were suitable for the study. The first seven volunteers who met the selection criteria were invited to be subjects. Each signed the consent form which was countersigned by the researcher. Volunteers who did not meet the selection criteria were informed of alternative community resources.

At the second appointment all seven subjects were given a battery of questionnaires to complete at home (see Appendix e) which monitored general emotional adjustment. In addition, they were given multiple copies of a diary known as the Childhood Sexual Abuse Attitudes Scales (CSAAS - see Appendix f). Subjects were asked to return one completed diary during each week of baseline. Any further questions about the study were answered during this appointment. An appointment for the initial therapy session was organised at this meeting.

**Intervention**

Subjects received 14 one-hour, individual counseling sessions. All subjects had the same therapist who was an advanced graduate student, in her final year of Clinical Psychology training. Sessions were held twice weekly for the first three weeks and once weekly in the final eight weeks of the programme. A description of the treatment programme and objectives is given in the treatment manual (see Appendix g).

In brief, during the first two sessions subjects were asked to talk about their personal history including the abusive episodes as a form of flooding. Education sessions followed which aimed to correct any misperceptions regarding CSA. Subjects received training in the recognition of anxiety and tension and were
taught to use them as cues for anxiety management strategies (e.g., relaxation techniques, thought-stopping, calming breath, distraction) to help them cope more effectively in anxiety-provoking situations. Cognitive restructuring was introduced after providing a rationale for this technique. Unrealistic or dysfunctional thoughts were identified, challenged, and modified and guided self-dialogue was introduced with the aim of improving mood control. Assertiveness and social skills training were incorporated as additional coping skills. To help reinforce and generalise these skills, homework assignments were assigned. Throughout the session, social reinforcement by the therapist was encouraged to reward the subjects. In addition, the subject was encouraged to verbally reinforce her own successful coping. The subject was also urged to practice using the coping skills when anxiety-provoking situations arose at home. Goal-setting and relapse prevention were covered in the final sessions to maintain progress.

The therapy was conducted through the Clinical Psychology Research and Training Centre at the University of Otago, Dunedin.

Experimental Design

The study employed a single-case research design which has been well validated and widely used in cognitive behavioural treatment research (Barlow & Hersen, 1984). The specific design employed was a multiple baseline across subjects. Providing each baseline changes when and only when the intervention is introduced, the effects can be attributed to the intervention rather than to extraneous events. The multiple baseline design has the advantage of showing greater treatment generalisability when applied across multiple subjects. In the case of a single case AB design, one could argue that extraneous factors might have influenced performance (e.g., some event at home coincided with the onset of the intervention and altered behaviour) but one would not expect a coincidence of this sort across two or more subjects in a multiple baseline study (Kazdin, 1982).
The pattern of results illustrates that whenever the intervention is applied, the baseline is changing. This repeated demonstration reduces the likelihood of the influence of extraneous factors.

Treatment was initiated after baseline assessment periods of four, five and eight weeks. Subjects were assigned to baselines of differing length according to their individual needs (e.g., work demands or urgency). Subjects served as their own controls, in that individual repeated measures collected before the intervention were compared to that collected after the intervention. CSA symptom severity, as measured by the Childhood Sexual Abuse Attitudes Scale (CSAAS - see section below), was monitored weekly throughout the baseline and intervention and once at follow-up as a progress monitor. The battery of measures was completed at pre-intervention, post-intervention and again at follow-up to monitor subject's general emotional adjustment.

Data from the CSAAS was graphed and analysed visually to determine whether the intervention was associated with any change in symptom severity. Statistics were not applied to the CSAAS as "the use of statistical analysis for single case data has been suggested primarily to supplement rather than to replace visual inspection" (Kazdin, 1982, p.242). With single case research, interest is focused on the individual's outcome and the clinical significance of that change. Clinical significance is not statistically computed but refers to a comparison between behaviour change that has been accomplished and the level of change required for the client's adequate functioning in society (Kazdin, 1982). It was decided that for the present CSAAS results to be clinically significant and indicate important change, subject's reports of negative CSA-related attitudes required a reduction to minimal levels (scores of five and under) at the termination of treatment.
Dependent Measures

The Childhood Sexual Abuse Attitudes Scale (CSAAS):

The CSA Attitudes Scale (CSAAS - see Appendix f) was constructed by the researcher with help from several community clinicians who had experience working with women who had been sexually abused. It was necessary to construct an original diary measure, with unknown reliability and validity, due to the scarcity of available measures on CSA sequelae. There are no published measures of CSA sequelae that have good reliability and validity, and provide normative data. Research shows that the reliability and validity of diary measures in general is good. The acceptability of self-monitoring diaries is reflected in their wide use in single-case design, treatment outcome research.

The construction of the present diary was based on the style of the Belief Inventory (Jehu, 1988) but the questionnaire was deliberately lengthened to increase the sensitivity of the weekly measure. In brief, the CSAAS was designed to survey negative attitudes which are reported to be a common sequelae of CSA. Items were identified from three sources; the CSA research literature, other publications on sexual abuse, and the advice of community clinicians experienced in working with women who report a history of CSA. Those items which were agreed upon by all sources were included in the CSAAS. Items lacking total agreement were precluded. Forty-three items were agreed upon by all sources. Once identified, it became clear that all 43 items appeared to fall into one of three subscales - self-destructive feelings, self-critical beliefs or maladaptive coping behaviours. Fourteen items were included in the self-destructive feelings subscale, 17 items under self-critical beliefs and 12 items included in the maladaptive coping behaviours subscale. Each of these subscales will be discussed in more detail.
Self-destructive Feelings Subscale:

Items included in the self-destructive feelings subscale were those CSA-related feelings commonly reported by women who were sexually abused as children. They included such items as "I felt ashamed about the sexual abuse" or "I felt different from others because I had been sexually abused". They were termed 'self-destructive feelings' as they were considered to be a negative psychological consequence of CSA.

Self-critical Beliefs Subscale:

Items included in the self-critical beliefs subscale were those beliefs reportedly commonly held by women who have been sexually abused. Most of these were unhelpful assumptions for the women to hold as they are thought to mediate negative affect. These items were termed 'self-critical beliefs' and included such things as "I am dirty" or "It was something about me that made the offender sexually abuse me".

Maladaptive Coping Behaviour Subscale:

Items included in the maladaptive coping behaviour subscale included behaviours which were commonly reported as coping mechanisms used by women who have experienced sexual abuse. In the short term, these behaviours may be adaptive (e.g., self-medicating anxiety through the use of alcohol) but in the long term, these behaviours may maintain a sub-optimal level of functioning. For this reason, they were termed 'maladaptive coping behaviours'. Other items in this subscale included such behaviours as avoiding sex, using alcohol, or other drugs to cope.

Negative Emotional State Subscale:

In addition, each subject's negative emotional state was monitored for interest only. It was not hypothesised that subject's mood would improve at the point of intervention as clinical experience suggests that initially many client's can
experience an increase in negative emotions during therapy. So while monitoring each subject's range of emotions from week to week allowed close observation of subject's mood, it was not pivotal for the study.

Prior to introducing the CSAAS to women involved in the study, psychologists and adult women who had experienced CSA were asked to provide feedback regarding the CSAAS. Both groups were positive regarding its face validity.

**Battery of Questionnaire Measures (pre/post/follow-up):**

A battery of measures was completed by each subject. This occurred prior to the intervention, at the termination of the intervention and at three month follow-up. These seven questionnaires monitored PTSD symptoms and more general emotional adjustment (e.g., depression, depressive thinking, anxiety, self-esteem, loneliness and anger). It was hypothesised that PTSD symptoms and emotional adjustment would show an improvement during the intervention. Each of the questionnaires is briefly described below.

The *Beck Depression Inventory* (BDI, Beck, Rush, Shaw & Emery, 1979) is a 21-item questionnaire which is purported to measure a general syndrome of depression. It is a widely used and standardised measure. A review of the major research studies involving the BDI showed that it has high reliability, high concurrent and discriminant validity and good correlation with the Hamilton Psychiatric Rating Scale for Depression (Beck, Steer & Garbin, 1988).

The *Crandell Cognitions Inventory* (CCI, Crandell & Chambless, 1986) is a 45-item questionnaire of self-reported frequency of depressive thoughts. It has been shown to have good construct and predictive validity, and high internal reliability (Crandell & Chambless, 1986). Normative data are available for this measure.
The Revised UCLA Loneliness Scale (Russell, Peplau, & Cutrona, 1980) is a 20-item scale which is reported to measure loneliness. Half of the items are positive and half of them are negative. New Zealand norms are available (Knight, Chisholm, Marsh, & Godfrey, 1988). It has been shown to have high reliability, and to have good convergent and discriminant validity (Russell et al., 1980).

The State-Trait Anxiety Inventory (STAI, Spielberger, Gorsuch, & Lushene, 1970) is one of the most widely used self-report measures of subjective anxiety in both clinical and research contexts (Hersen & Bellack, 1988). It is comprised of two 20-item scales measuring two distinct but related anxiety concepts. It has been found to have excellent psychometric properties with relatively high internal consistency, good retest reliability on the trait scale, good concurrent validity with other anxiety scales, and good construct validity (Hersen & Bellack, 1988).

The State-Trait Anger Expression Inventory (STAXI; Spielberger, 1988) is purported to provide a relatively brief, objectively scored measures of the experience, expression, and control of anger (Spielberger, 1988). The STAXI consists of 44 items, which form five primary scales and two subscales. The STAXI has been shown to have high internal consistency, good test-retest reliability of the T-Anger scale and it has moderately high levels of concurrent, discriminant, predictive and construct validity (Spielberger & Sydeman, 1994). Normative data is available for this measure.

The Rosenberg Self Esteem Scale (Rosenberg, 1965) is a 10-item scale consisting of questions concerned with subject's personal feelings about themselves in regard to their self-concept. The scale used a four-point ranking procedure (ranging from 1=strongly disagree to 4=strongly agree) which measured the amount of agreement the subject held for each item. Acceptable reliability and validity has been demonstrated for this scale of self-esteem (Rosenberg, 1965).
The PTSD Symptom Scale - Self- Report (PSS-SR) is a 17-item scale (Foa, Riggs, Dancu & Rothbaum, 1993) which has three subscales representing all criteria of the Diagnostic and Statistical Manual of Mental Disorders (3rd ed., rev) (American Psychiatric Association, 1987) for PTSD, including reexperiencing, avoidance and numbing, and high arousal. Foa and colleagues have reported a Cronbach's alpha of 0.91 for the total score and a one-month test-retest correlation of 0.74 for rape victims who were less than 4 months post-crime. They also reported good concurrent validity with a number of other scales including the Impact of Event Scale (Horowitz, Wilner, & Alvarez, 1979), and the Beck Depression Inventory (Beck et al., 1979) and the Structured Clinical Interview for DSM-III-R.

It was hypothesised that at post-intervention all three subjects would have high end-state functioning on all seven measures. High end-state functioning was defined in the following way. With the exception of the PSS-SR, scores were interpreted normatively. For the UCLA-LS, STAI, and STAXI percentile norms were used and a subject was considered to have high end-state functioning if their score was below the 75th percentile. For the BDI, classification was provided by Beck (no depression 0-9, mild depression 10-18, moderate depression 19-28, and severe depression 29-63) and high end-state functioning was evident if the subject was placed within the non-depressed range. For the CCI, total scores ranged from 34-170 and high end-state functioning was determined as a score lying within one standard deviation (8.3) of the mean (44.6) for normal controls. For the RSES, high end-state functioning was arbitrarily chosen as a score over 25 (range 10-40) since this score or higher is only obtained by endorsing the positive end of the scale on average. Finally, high end-state functioning for the PSS-SR was identified as the subject not meeting the criteria for PTSD (American Psychiatric Association, 1994).
RESULTS

Sub-scales of the CSAAS

Self-destructive Feelings Subscale:

All three subjects (C, W and M) reported self-destructive feelings during baseline (see Figure 1). For all three subjects, the self-destructive feelings declined over the intervention period, C experienced a rapid decline and a gradual reduction was evident in W's and M's cases. This decline in self-destructive feelings was maintained at a three-month post-intervention follow up for all three subjects.

Self-critical Beliefs Subscale:

All three subjects (C, W and M) identified self-critical beliefs during baseline (see Figure 2). These beliefs were reduced across all three subjects during the intervention. C evidenced the largest decrease in self-critical beliefs, followed by W. M reported a less significant decrease in self-critical beliefs. All improvements in self-critical beliefs were maintained at follow-up.

Maladaptive Coping Behaviour Subscale:

During baseline, all three subjects (C, W and M) reported some maladaptive coping behaviours (see Figure 3). Two subjects (C and W), reported a reduction in maladaptive coping behaviours during the intervention and this was maintained at a three month post-intervention follow-up. One subject (M), reported a consistent level of maladaptive coping behaviours throughout baseline and intervention. At follow-up, M's levels of maladaptive coping behaviours had evidenced a mild reduction from both baseline and intervention phases.

Negative Emotional State Subscale (monitored for interest only):

All three subjects reported some degree of negative emotional state in the baseline period (see Figure 4). For two subjects (C and W), average phases scores
Figure 1. Scores on CSAAS for Self-Destructive Feelings across three subjects
Figure 2. Scores on CSAAS for self-critical beliefs across three subjects
Figure 3. Scores on CSAAS for Maladaptive Coping Behaviours across three subjects
Figure 4. Scores on CSAAS for negative emotional state across three subjects
for negative emotional state was reduced from baseline to intervention period. This reduction was further improved at a three month follow-up. The large increase in negative emotional state in W's data during weeks 11 and 12 can be attributed to W ending a four-year relationship at this time. For one subject (M), average phase scores for negative emotional state remained high and unstable throughout the intervention period. At follow-up, there was little change.

Summary of Results from the CSAAS:

For all subjects there was a general trend towards improvement on the CSAAS during intervention. This included a reduction in self-destructive feelings and self-critical beliefs for all three subjects (C, W and M) and a reduction in maladaptive coping behaviours and negative emotional state for two out of three subjects (C and W). For two out of three subjects (C and W), this reached a clinically significant level (scores less than five at post-intervention and follow-up) on all subscales. Across all subjects, self-critical beliefs evidenced the largest mean change from pre-intervention to post-intervention, followed by self-destructive feelings. Maladaptive coping behaviours evidenced the least mean change from pre-intervention to post-intervention.

Baseline measures indicated a generally stable level of symptoms as measured by the CSAAS prior to the intervention. The duration of baseline ranged from four weeks to eight weeks. Both clinical and baseline data suggest that all three subjects had a chronic history of self-destructive feelings, self-critical beliefs, and maladaptive coping behaviours related to their CSA. In otherwords, these three women seem to have had long-standing problems which were unlikely to improve by chance.

On all the CSAAS measures, there were differing rates of change for each subject. C improved rapidly after two sessions of education regarding CSA and its effects. This improvement continued throughout the rest of therapy and had been
maintained and even strengthened at the three month follow-up. W improved gradually over the entire course of intervention with particular progress after cognitive restructuring sessions were begun in week nine. These gains were maintained at the three month follow-up. During the intervention period, M's symptomatology was slightly improved but this followed a very slow, gradual downward trend. This mild improvement in her symptomatology was only weakly maintained at the three-month follow-up.

In conclusion, prior to the intervention all four baselines across subjects were generally stable. Variability of symptoms between subjects during baseline was high and this did not appear to predict response in these three cases. During the intervention there were differing rates of change for each subject, although an analysis of trend lines suggests a reduction on all subscales for all subjects with the exception of maladaptive coping behaviour and negative emotional state for subject M.

Overall, there seems to have been strong levels of improvement in two cases (C and W) and moderate levels of improvement in the third case (M). At a three-month follow up, a reduction in the symptomatology had been maintained in two of the three cases.

Results from the Battery of Questionnaire Measures:

Table 1 shows each subject's scores on the battery of standardised questionnaires used to assess PTSD symptoms and more general emotional adjustment during pre-intervention, post-intervention and three month follow-up. As shown, all subject's reported high levels of PTSD symptoms and emotional maladjustment before the intervention was begun. After engaging in the programme, C achieved high end-state functioning on five out of seven measures. She continued to manifest further improvement at follow-up. W achieved high end-state functioning on six out of seven measures at the termination of
At follow-up she reported high end-state functioning on all seven measures. M reported a slight improvement on six out of seven measures after completing the intervention. Her reports of loneliness worsened by one percentile mark during the intervention. Despite this improvement, only two out of seven measures reached high end-state functioning (anger and self-esteem). Very similar scores were reported at follow-up.

Table 1

<table>
<thead>
<tr>
<th>Subject's State Functioning and Scores on Questionnaire Measures at Pre-Intervention, Post-Intervention and Follow-Up</th>
</tr>
</thead>
<tbody>
<tr>
<td>Measure</td>
</tr>
<tr>
<td>--------------------------------</td>
</tr>
<tr>
<td>PTSD (PSS-SR)</td>
</tr>
<tr>
<td>19 8* 2*</td>
</tr>
<tr>
<td>Depression (BDI)</td>
</tr>
<tr>
<td>22 7* 4*</td>
</tr>
<tr>
<td>Depn. Cognitions (CCI)</td>
</tr>
<tr>
<td>117 75 37*</td>
</tr>
<tr>
<td>Loneliness(UCLA-LS)</td>
</tr>
<tr>
<td>99% 47%* 47%*</td>
</tr>
<tr>
<td>Self-esteem (RSES**)</td>
</tr>
<tr>
<td>14 33* 39*</td>
</tr>
<tr>
<td>Anxiety (STAI)</td>
</tr>
<tr>
<td>100% 65%* 7%*</td>
</tr>
<tr>
<td>Anger (STAXI)</td>
</tr>
<tr>
<td>99% 95% 25%*</td>
</tr>
</tbody>
</table>

Notes:

PSS-SR = Post-Traumatic Stress Disorder Symptoms Scale - Self Report, BDI = Beck Depression Inventory, CCI = Crandall Cognitions Inventory, UCLA-LS = University of California Loneliness Scale, RSES = Rosenberg Self Esteem Scale, STAI = State-Trait Anxiety Inventory (Trait Score), STAXI = State-Trait Anger Expression Inventory (Trait Score).

* subject meets criteria for high end-state functioning.

** improvement is shown by an increase (versus a decrease on all other measures).
Overall, the effects of the intervention on state functioning were positive. Two of the women reported high end-state functioning while one improved somewhat from pre-intervention to post-intervention.

More specifically, for all women, BDI scores evidenced a decrease from pre to post-intervention (see Table 1). Two out of three (C and W) subject's gains were substantial enough to bring their mood levels within the criterion non-depressed range. Depressive thinking, as measured by the CCI, was reduced for all three women and at follow-up, two out of three women (C and W) had levels of depressive thinking within the criterion normal range. Feelings of loneliness at pre-intervention decreased to within a normal range for two women at post-intervention and was maintained at follow-up. Ratings of self-esteem increased for all women. C's score on the RSES evidenced an increase from a pre-treatment level within the "low" range to post-treatment and follow-up scores within a "high" self-esteem range. W and M experienced a moderate increase in self-esteem at post-intervention and follow-up. All self-esteem improvements were within the criterion range. Levels of trait anxiety were improved following the intervention. All women were placed on the 100th percentile for trait anxiety at pre-intervention and a post-intervention decreases ranged from 23-35 percentile marks. In two out of three cases, gains were substantial enough to reduce anxiety levels to within normal limits. At follow-up, further improvements were noted for two women (C and W) but M had returned to her pre-morbid levels of anxiety. Trait anger was reduced in all three women. Two out of three women (W and M) reported a criterion reduction in trait anger. At follow-up, all women scored within the criterion normal range.

Symptoms of post-traumatic stress disorder were improved for all women. For two women scores were halved and they no longer met the criteria for PTSD.
One woman continued to meet the PTSD criteria at post-intervention and follow-up but she reported a 20% reduction in symptoms.

Interestingly, there seems to be some consistency between the global outcomes on the CSAAS and the questionnaire measures. Two out of three women experienced substantial improvement and one woman experienced modest improvements.
DISCUSSION

Outcome on Diary Measure

Three women took part in a cognitive behavioural treatment programme designed for use with women who had experienced CSA. The major aim of the intervention was to alter negative attitudes which are commonly reported as sequelae of CSA. This was done using well-validated cognitive-behavioural techniques. A diary measure of negative attitudes after CSA (CSAAS) was used as the primary outcome measure. Three subscales of the CSAAS measured self-critical beliefs (e.g., "I am dirty"), self-destructive feelings (e.g., "I feel ashamed") and maladaptive behaviours (e.g., avoiding sex).

Overall, all three subjects evidenced a reduction in CSAAS scores during the cognitive-behavioural intervention with most improvements being maintained at three month follow-up. The self-critical beliefs subscale evidenced the largest mean change between phases of treatment. In other words, women who took part in this programme consistently reported fewer beliefs such as "It was partly my fault", "I should have done something else to stop the abuse" and "I am bad" as the intervention progressed. As expected given the long-standing nature of these beliefs and the educative approach, scores on the self-critical beliefs subscale decreased gradually across time. The maintenance of intervention gains at follow-up suggests that the change in self-critical beliefs was durable and not simply a function of therapist contact.

Scores on the self-destructive sub-scale also evidenced a reduction during intervention. In other words, women who took part in this programme reported less feelings of shame or guilt after the intervention. This change in feelings did not become apparent until the latter half of the intervention period and was strongly evident only after a reduction in self-critical beliefs. This order of change is
consistent with the Beckian hypothesis that cognitions mediate affect. It is plausible that self-destructive feelings responded once there was a change in self-critical beliefs. Again, the maintenance of this change at follow-up suggests that the reduction in self-destructive feelings is independent of therapist contact and that the improvement is not temporary.

Intervention was not associated with a consistent change across subjects on the maladaptive coping behaviour subscale. Data collected during the experimental phases indicated an irregular pattern of reporting across individuals. It was predicted that following the acquisition of novel coping behaviours during the intervention, maladaptive coping behaviour such as avoiding being alone or avoiding sex would be reduced. In fact, two subjects reported reductions in maladaptive coping behaviours as predicted but one subject reported an increase. There are several possible reasons for this. Firstly, this particular subject remained moderately depressed throughout the intervention and this may have prevented her from learning or utilising new coping skills offered during the treatment programme. Secondly, therapy can be stressful and increase the demand on coping strategies. If the only available strategies for coping are maladaptive, then the subject is likely to resort to them. Of all the subscales measured, maladaptive coping behaviour evidenced the least mean change between phases of treatment. There may be two reasons for this lack of effect. Firstly, as none of the three women reported high rates of maladaptive coping behaviours during the baseline phase it may be due to a floor effect. Secondly, altering styles of coping can take practice and the relatively short length of intervention and follow-up may be inadequate to detect any therapeutic change. Finally, it is possible that the present cognitive behavioural programme had little effect on changing maladaptive coping behaviours.
Negative emotional state was monitored in order to observe the effect of this programme on subject's affective state. It is recognised that entering therapy can be an emotional and disturbing period for a client so subjects were asked to report the severity of negative emotional reaction on a weekly basis. In all three cases, subjects reported a gradual increase in the frequency of negative emotions during the first four weeks of the programme. This suggests that negative affect was a common response to the initial stages of the programme. In two out of three cases, this negative affect reduced in the latter half of the programme and low levels were reported at follow-up.

In conclusion, baseline data from the CSAAS indicated generally stable and high level of CSA sequelae present in the three women who took part. This is consistent with each woman's report of long-standing problems which they related to having been sexually abused. For all three subjects, a considerable length of time had passed since the CSA, ranging from 18 to 35 years. Given the length of time since the CSA and the chronic nature of the problems, it seems unlikely that the change evident over the experimental phases is simply due to chance.

**Individual Differences in Response to Intervention**

Clinical and empirical data suggest there were differing rates of change across each of the three subjects. While C's improvement on the CSAAS was rather rapid and dramatic, W's was more gradual, as was expected of subjects, and M's improvement was small. Subjects reported that different aspects of the cognitive behavioural programme had varying efficacy. For example, C felt much improved in terms of blame and self-respect, after as little as two sessions of education whereas W improved at a much more gradual rate. This can be seen in Figures 1 and 2. W noted during the sessions that she felt the most helpful aspect of the treatment programme was the cognitive restructuring which occurred in sessions seven and eight. W was eager to learn this technique once the rationale
was explained. She enthusiastically practiced this technique between sessions and noted an improvement in her mood which encouraged her to continue. She began to use this consistently and was so impressed, she added "why don't our parents teach us this?". These results suggest that the complete cognitive behavioural programme may not be necessary for all people and different components of the present package may be combined for the optimal individual treatment package. Further research looking at this question is warranted.

The relatively small improvements made by M require comment. M's level of CSA sequelae remained at relatively high levels after 14 sessions of treatment and at three month follow-up. There are several possible reasons for this lack of effect. Firstly, M remained moderately depressed throughout the intervention. A strong depressogenic cognition consistent with Beck's notion of the negative cognitive triad was evident and possibly reduced her motivation levels. For example, after hearing the rationale for cognitive restructuring, M perceived herself as even less worthy since she had been thinking in an unhelpful way. Reassurance that change was possible was not successful in changing her perception of hopelessness. In addition to her high levels of depression, M was socially isolated which may have added to her low rate of social reinforcement. This is supported by Lewinsohn's model of depression which asserts that a low rate of social reinforcement can contribute to the development and maintenance of low mood. Finally, it is common for subjects, such as M, with comorbid problems (e.g., social isolation, depression) to experience a reduced treatment effect. This raises some concerns about this programme's utility given the high prevalence of comorbid problems, such as depression and social isolation in sexual abuse victims.
Outcome on Questionnaire Measures

Data which monitored subject's PTSD symptoms and more general psychosocial functioning throughout the phases of treatment indicated overall improvement. PTSD was eliminated in two out of three women. All told, levels of depression, loneliness, negative thinking, self-esteem, trait anxiety, and trait anger all improved during treatment. Two out of three women reported high end-state functioning on at least five measures at post-intervention and one woman showed high end-state functioning on two measures. These improvements were maintained and, in most cases, improved at follow-up.

Limitations of Study One

Measurement:

No theoretically validated diary measure has been reported in the literature which necessitated devising a novel, unvalidated measure. As an original measure, the CSAAS lacks strong scientific credibility. Having said that, there appeared to be consistency between the outcomes on the CSAAS and the battery of questionnaires with two out of three women reporting substantial improvement and one woman modest improvements. This provides some support for the validity of the CSAAS as there appears to be a positive correlation between the CSAAS and the other measures used in this study, such as the Beck Depression Inventory. Further research is needed on the CSAAS to provide psychometric data regarding its validity and reliability.

Sample Selection:

It is possible that population bias may explain the treatment success. The rate of alcohol and drug abuse in women with a history of CSA is much higher than the general population. As subjects involved in this study were screened for current alcohol and drug abuse, the population in the study may be a 'healthier'
sample than the general population of women who have experienced intrafamilial CSA. This may have biased the present sample of women.

**Treatment Response:**

In addition, the differing rates of response to the intervention, and the lack of response in one subject (M) raises implications regarding the generalisability of these results. It would seem that the present study suggests only the moderate utility of this particular cognitive behavioural intervention.

**Design:**

A final criticism can be levelled at the studies relatively weak experimental design. The small number of subjects reduces the treatment outcome reliability. Further replication of these results, either through group studies or larger multiple baseline designs are needed.

In sum, the data suggest that the cognitive behavioural programme was associated with some positive psychological symptom change results when used with three women who have a history of intrafamilial CSA. The lesser success with subject M raises the issue of the need to address comorbidity problems. A treatment programme with cognitive behavioural therapy for depression as an adjunct to the standard programme may have more utility for subjects who are experiencing moderately high levels of depression. Future research in the tailoring of intervention programmes to the client population is warranted. In conclusion, the present study is an encouraging preliminary investigation. Results suggest that further study of cognitive behavioural interventions in the treatment of CSA sequelae are warranted, employing larger sample sizes.
STUDY TWO

METHOD

Subjects

Four women (Y, G, L, and B) who had a history of intrafamilial, contact sexual abuse by an older male relative completed the intervention. One subject (B) did not return the questionnaires at the end of the intervention. The results appeared invalid (i.e., as if they were all completed in the one day) and in addition, B was unable to provide follow-up data due to a change of address. For this reason B was excluded from the analysis.

The three remaining women who took part in Study Two reported very few generalised symptoms of CSA. Instead, each woman described a very specific difficulty which they related to CSA. These included a touch phobia, negative sexual attitude and negative view of self. In other words, while the women in Study One reported a high number of self-destructive feelings, self-critical beliefs and maladaptive coping behaviours, these symptoms were reported much less frequently by the women in Study Two. As the data was graphed frequently it became clear that the cognitive behavioural programme used in Study One would not be the most appropriate intervention. Single case research should be a dynamic, interactive enterprise in which the design is always tentative and always ready to change if significant questions arise in the process (Hayes, 1981). With this in mind, after discussion with each of these women it was agreed that a more useful intervention target would involve targeting each woman's specific problem.

A brief background history of the three subjects (L, Y, and G) follows. Identifying information has been removed.
Subject Y:

Y was an artist in her forties. She lived in her own home in a small New Zealand city. Y’s income included the Unemployment Benefit and wages from part-time work.

Y was born the eldest of three children in the rural outskirts of a large New Zealand city. Her family were underprivileged and lived in temporary accommodation when Y was a toddler. Y’s father left his family during this time and her mother began full-time blue-collar work. Y believed her mother resented having to look after the children, making comments such as "I have to work so hard because of you bloody kids". Y reported feeling unimportant and rejected by both parents. Their difficult financial situation was not helped by her father’s refusal to pay child maintenance.

When her father left, Y’s family moved from their temporary accommodation and lived for several years with her grandmother. Her grandmother’s ‘shack’ was in an isolated area but was crowded with relatives, as her grandmother had many children. It was here that the CSA occurred when Y was five years old. The offender was a fourteen year old uncle who was boarding in another domicile on the grandmother’s property at this time. Y was found of her young uncle. She enjoyed his company and would like to visit him before he went to school. On one occasion, he placed Y down on the bed and digitally penetrated her vagina. At the time, she thought this was strange behaviour but was sufficiently trusting of her uncle to assume this was acceptable. For this reason, in addition to the fact that she like her uncle’s attention and did not feel abused at the time, she did not disclose the abuse. In addition to this experience, Y reported an unsuitable air of adult sexuality pervading most of her childhood. Y could cite numerous examples of inappropriate sexual conduct by adults in her overcrowded domicile. For example, on many occasions, Y observed "dirty looks from seedy
male uncles". Y recalled one episode when her stepfather placed her on a bed in an attempt to molest her but was prevented from doing so by the unforeseen entrance of another relative. She was also warned by female relatives not to sit on certain male relative’s knees or alternatively "avoid him if he’s in the bushes". In addition, she was asked by one uncle to sleep with him and his partner. She believed her 13 year-old brother may have had a sexual relationship with a 30 year old woman. This atmosphere of 'boundariless sex' was so pervasive that on one occasion, her mother checked Y’s genitals for physical signs of CSA.

Y described herself as the "good" child in her family whereas her siblings were more rebellious. She reported being quite shy and socially anxious. She attended local primary and secondary schools but despite having average to high average grades throughout school she did not pass School Certificate. After school, Y was keen to pursue a university career but there was familial pressure to go to work, so Y went back to high school and learned to type. Her first job involved working in a typing pool.

After leaving home, Y began more frequent socialising. She recalled feeling self-conscious in social situations which precipitated the use of alcohol. This was used to self-medicate her anxiety which precipitated weekly blackout periods (i.e., amnesic for two hours). Heavy drinking continued until her late teens when she stopped drinking due to its negative side effects. On one occasion, in her late teens, Y was anally raped at a party when she was very intoxicated. She did not disclose this abuse to anyone.

Y began having sex at age 15. Her first serious relationship lasted from her mid-teens to her mid-twenties but, in retrospect, Y did not feel that this had been a healthy relationship for her. She described feeling powerless and lacking in self-esteem while involved with this man. The relationship ended when Y became pregnant. Y moved away to raise her child. Several years ago, she moved to a
small New Zealand city to pursue a tertiary qualification, whereupon, she bought her own home and has rekindle her interest in art.

During the assessment, it became clear that Y's primary concern was her lack of self-esteem. She displayed a negative attitude toward herself, including disliking the majority of her physical attributes, detracting her artwork, a lack of social confidence, and unassertiveness. She experienced high levels of anxiety relating to the above issues which she considered restricted her lifestyle (e.g., felt guilty when she put herself first, limited her socialising, did not hold an exhibition of her artwork).

**Subject G:**

G was a 22 year old female tertiary student who lived in a small New Zealand city. She lived in a flat with her boyfriend of several years. Her income included Student Allowances.

G was born the youngest of two children. She was brought up, by their mother, in a large New Zealand city after their parents divorced when G was a preschooler. G's mother was an alcoholic who has been 'in recovery' for the last eleven years. From infancy to eleven years of age, G experienced considerable neglect due to her mother's alcohol problem, for example, her mother was often sick in bed. Her father had little to do with his daughters after the divorce but G remembered him as "moody and unpredictable", for example, on one occasion, he kicked her with no explanation. In addition, she described her relationship with her sister as "strange" and added that it was as if "she's not really my sister". She reported that they fought for their mother's attention and hated each other as children. G reported that they had led very separate lives due to a large age gap and her sister moving out of the family home quite early. G had vague unhappy memories of her childhood and described herself as a generally unhappy child.
After her divorce, G's mother became involved in many relationships. It was normal for the family to move in with her mother's current boyfriend whom G felt secondary to. She disliked many of them and typecast them as domineering, authoritarian perfectionists. G readily admitted rebelling against authority and regarded her mother as "weak, unloyal and pathetic" for accepting dominating treatment from her boyfriends.

Soon after G began primary school, G's family moved in with a new boyfriend. He was an alcoholic and his behaviour was unpredictable resulting in G being scared of him. In spite of this, he used to take the family on day trips and was physically affectionate towards the children. This amount of attention was very novel for the children and within a few months, G began to regard him as her 'stepfather'. The sexual abuse took place in this household when G was approximately seven years old. Her 'stepfather' was the offender. The abuse took place on many different occasions and involved many different types of behaviours - "lots of little things". He would walk around in his underpants in front of her and her friends, he would kiss intimately at bed time, and he would ask her to touch his penis during bathtimes together. On one occasion, while G was in the lounge her performed cunnilingus on her. This abuse took place when her mother was absent, either at work or sleeping in bed. Her stepfather threatened her, "don't tell mum cos you'll hurt her, it's our secret". To protect her mother, she did not disclose the abuse.

G began drinking around the age of eight. She would drink three to four handles of beer in the weekend at a friend's house. From the aged of 10-14, she would drink spirits with a friend and her friend's mother and get drunk once per weekend. Except for one short episode, G denied drinking alcohol from the aged of fourteen. She stated that she could never be an alcoholic because she hated losing control and she abhorred her mother's alcoholism. G had attended a Family
Members Programme at Hamner Springs while her mother was in recovery during which she was counselled for the CSA. This involved cathartic work (e.g., expressing feelings, hitting pillows), resolution work (e.g., forgiving the abuser), and some self-esteem work (e.g., self-affirmations). She reported that this was of limited use due to her inability to focus on herself at the particular time. Her current boyfriend is an alcoholic.

According to G, she did not think much of the abuse during her childhood but in her early teens she recognised that she had been abused. At this point, she felt much anger and resentment towards the offender. At age 14, G told her mother about the abuse. She was believed but G was disappointed in her mother's nonplused reaction.

Socially, G had struggled to trust people. She thought primary school was manageable and successfully made several friends. She remained very loyal to her friends (e.g., protecting them in aggressive school situations) which antagonised many people and made her a target for bullies in both intermediate and high schools. This bullying exacerbated her basic mistrust of people. G began to hate school and was attending only about half the time due to a combination of avoidance and mild ailments. G attended several different high schools as her mother moved often. She passed two subjects in School Certificate and two subject in Sixth Form Certificate. Upon leaving school, G worked as a waitress, followed by a period of unemployment and later joined a formal training programme. In the last year, she has been working towards a tertiary qualification.

G had her first sexual experience at the age of fourteen. She agreed to sex so that a boy would like her - "I wanted someone to love me but I ended up in more pain". The experience was physically painful. From the age of 16 to 18, G had approximately 20 one night stands and described herself as confused between sex and affection. She described men as "arseholes, dorks, pigs - all they want is
sex". She noted that she was lucky not to get pregnant or contract any sexually transmitted diseases. G did experience recurrent thrust which made some sexual activity particularly painful. A recent medical check precluded any other physical cause.

G expressed her desire for a positive attitude towards sex and her body in general. She reported very negative feelings towards sex and her body, including hating her legs, genitals and breasts. She was repulsed by sex. This was related to the pain she experienced during sexual activity, and the disgust she had towards her own body's sexual response, and her partner's sexual fantasies. For example, immediately after sex, G would wash her genitals. At the time of the assessment, G was engaging in sexual activity approximately once per month in the week before her menstrual cycle. She admitted that her current partner was not pressuring her for sex. She made it clear that she wanted to reduce her negative feelings about sex for herself as well as her current partner.

**Subject L:**

L was a woman in her late fifties, employed part-time as a care-giver. She was not married and had no dependents. She lived in her own home in a small New Zealand city.

L was born in a small rural community and lived on a farm. She was the youngest child in a large family. As a child, L had a good relationship with all her siblings except her youngest brother who she described as "strange". As her parents worked long hours on the farm, L was largely cared for by her eldest sister. She described her family as rather private and physically unaffectionate. There were not open discussions amongst family members about personal affairs (e.g., no sex education). She attended the local primary and high school in which she reported having "quite a few friends". She performed at an average level academically but was particularly good at sports. L left school at age 15 and
became involved in care-giving which she has continued, in both a voluntary and paid capacity since that time.

The sexual abuse took place on one occasion when L was aged approximately eight years old. The offender was the sibling closest in her aged to her, her "strange" 13 year old brother. On this occasion, he asked her to walk with him to the bridge on the family farm. Once under the bridge, he forced L to remove all her clothes and lie down on the stream bank. He then covered her face with the clothes and raped her. L recalled the rape as very frightening and incredibly painful - "I hated it to death". Immediately following the rape, he threatened her with more physical violence if she ever told. She could not recall his actual comments but believed they were some form of death threat. This intimidation was repeated on several other occasions. For example, while L was in the bath, he let himself in and "danced around" making more threats. According to L, she did not tell anyone about the rape firstly, as she believed her brother's threats, secondly, as she was concerned that no one would believe her, and thirdly, as she did not know the words to describe the sexual abuse. She maintained that she was unaware of memories for these events until a few years ago.

L was vividly reminded of the abuse when she returned to the family farm several years ago. She experienced flashbacks of the rape when she passed the bridge and saw the bank "naked and bare". Her memory for these events became clearer over the following months which L found to be a horrifying period of her life. Despite not being conscious of the events for over forty years, she did not feel surprised when these images surfaced and stated "they [the memories] weren't fresh". She reported feeling as though unconscious memories of the event had always been with her. For many months L chose not to tell anyone of her memories but later disclosed to her eldest sister. This sister was shocked but
believed L. In addition, L was informed by her sister that her brother had recently been prevented from working with children because of the risk of sexual abuse.

As a child, L immediately coped with the abuse by avoiding her brother where possible. It is likely that she also developed her fear of physical touch following this abuse. This fear remained despite her brother soon after leaving the farm to work elsewhere. For example, L would avoid hugging relations at Christmas or refused to go on dates with boys. When exposed to touch, she showed phobic anxiety indeed, she met the DSM-IV criteria for a specific phobia. It seemed likely that the onset of this disorder was precipitated by the rape in combination with the more general familial discomfort with physical affection. Her anxiety had been maintained, in part, by the avoidance of touch. Indeed, L's phobia had followed a chronic and unremitting course and it had impacted her life considerably. L had never married or had a sexual relationship due to her fear of touch and she regretted the loss of opportunity to have children. Despite the severity of her anxiety, there were several important modulators of her fear. These included variables such as the age and sex of the person, the nature of the touch (e.g., sexual or unexpected), and her control over the touch. When L presented at assessment, her phobia of touch was the main concern and it was agreed that this would be the focus of our intervention.

**Recruitment and Selection Criteria**

As for Study One.

**Intervention**

A summary of the cognitive behavioural interventions used with these women is contained in appendix h. A brief outline is explained below for convenience.
Subject Y:

Six cognitive behavioural modules were completed over fourteen sessions in which the goal was to reduce the subject's negative view of self. This involved assessment, exposure, education, cognitive restructuring, anxiety management, self-esteem work, goal-setting, and relapse prevention.

Subject G:

Six cognitive behavioural modules were completed over fourteen sessions in which the goal was to reduce G's negative sexual attitude. This included assessment, exposure, education regarding the role of CSA in the aetiology of sexual aversion, cognitive restructuring, sexual anxiety management techniques (e.g., body image exercises and affirmations), goal-setting, and relapse prevention.

Subject L:

Seven modules were completed over fourteen sessions of cognitive behavioural treatment of a touch phobia. This included assessment, exposure, education on the aetiology of touch phobia, and it's relations to CSA, constructing a hierarchy of phobic situations, anxiety management training, imaginal and in vivo systematic desensitisation, progress review, goal-setting, and relapse prevention.

Experimental Design

The design used in Study Two involved the use of non-replicative AB designs. Single case experiments such as these, attempt to answer the question - what is the effectiveness of a specific treatment for a specific individual? (Hilliard, 1993). Single case designs also attempt to isolate the mechanism of change in the therapeutic process and actively search for the possible sources of variability such as a failure to improve with treatment, spontaneous improvement without treatment, cyclical patterns, and improvement due to treatment (Barlow & Hersen, 1984). Given the novelty of individualised cognitive behavioural programmes for
CSA-related problems, single case designs seem more ethical than large scale group studies. Another advantage of the present design over group designs is that single case designs avoid averaging results and therefore allow intersubject variability to surface. In addition, they are the only way to evaluate low incidence problem treatments.

AB designs have been criticised for having a weak scientific design. Lack of both direct and systematic replication is one of the most common criticisms of most single case studies within psychotherapy research (Hilliard, 1993). With such weak experimental control in an AB design, there is a high possibility that the subject improved by chance alone. In addition, the AB design does not have the advantage of the multiple baseline design which offers greater external validity when applied across subjects. In spite of this criticism, the AB design is considered to be a natural design in applied research and allows for the possibility of an alternative method of establishing generality through the replication of single case experiments (Barlow & Hersen, 1984). AB studies should be viewed as more of an explorative clinical enterprise rather than a hardline research evaluation. According to Jones (1993), "single-case designs are more closely linked to traditional means of clinical inquiry, teaching, and learning than are large-sample studies, and they are likely to have more immediate relevance for how intervention is conducted" (p.371).

**Dependent Measures**

**Target Complaint Scales:**

Since the CSAAS was largely inappropriate for this group of women it was not used as a progress monitor in Study Two. Instead, individualised Target Complaint Scales were constructed for each of the women (see Appendix i) which were derived from scales used in earlier CSA research (Jehu, 1988) and are described below.
Prior to treatment commencing, a target complaint was identified after discussion between the subject and therapist. The target complaint was identified as one specific problem which the subject chose to work on during therapy. The following target complaints were identified by each subject. Y chose her negative view of self as her target complaint, G identified a negative sexual attitude as her major problem, and L chose to work primarily on her touch phobia. Following this, Target Complaint Scales were generated for each subject. These were 13-point scales on which the subject rated the severity of their target complaint (13=problem is at its very worst, 1=problem is vastly improved). To aid the subject in their ratings, each point was anchored to the scale by a behavioural definition required in order to make that particular rating. Prior to beginning the intervention, subjects agreed that a score of four or less indicated the problem was "much improved" and that this would be regarded as a clinically significant change.

Battery of Questionnaire Measures:

These were identical to those described in Study One, however, in Study Two the measures were monitored for interest only. It was not clear whether or not general emotional adjustment would be affected by such problem specific interventions. To achieve high end-state functioning, all seven questionnaires had to meet identical criteria to those described in Study One.
RESULTS

An AB design with follow-up was implemented for three subjects (L, Y and G). All three subjects' specific problems were monitored weekly, over varying baselines and during a problem-oriented intervention. One final data point was collected at a three month follow-up.

As all subjects in Study Two were involved in independent cognitive behavioural programmes, the data will be presented separately for each subject. Briefly, all three subjects reported stable Target Complaint Scale scores during baseline. All subjects improved on their problem specific hierarchy. Two out of three subjects reached levels of clinical significance at post-intervention and at follow-up all three subjects reported a clinically significant improvement.

Subject Y

The goal for Y was to decrease her negative view of self (see Appendix i(1)). Again, with an individualised cognitive behavioural programme (see Figure 5) Y responded quickly to the intervention.

![Graph showing Y's Target Complaint Scale Scores for Negative View of Self](image)

**Figure 5.** Y's Target Complaint Scale Scores for Negative View of Self
Within four weeks of beginning the intervention, Y reported "much improvement" on the hierarchy. This is manifest in the rapid decline of symptoms within the first four weeks of intervention. This level was maintained for the final seven weeks of treatment and maintained at follow-up. This change reached a level of clinical significance. Although Y improved, she appeared to reach a plateau around the score of three or four. In retrospect, it is possible that the criteria for reporting scores lower than three or four were possibly unrealistically difficult in Y's case. Alternatively, the rapid improvement between weeks three and seven may reflect subject-therapist contact and not improvement due to the intervention. This seems unlikely, however, given the maintenance of improvement at three months without subject-therapist contact.

Subject G

G's goal was to decrease her negative attitude towards sex and her sexuality (see Appendix i(2)). Initially, G (see Figure 6) responded slowly to the intervention but at around week 10, G made a decision to implement some of the cognitive behavioural techniques and it was at this point that changes in symptomatology were reported.

Figure 6. G's Target Complaint Scale Scores for Negative Sexual Attitude
Prior to this point, G had neglected all home exercises and had taken a rather non-committal approach to therapy. An underlying belief in her own ineffectiveness may well have contributed to this cognitive set and only after therapeutic confrontation regarding this issue was there any significant improvement in scores. The gains on her hierarchy were maintained and improved at follow-up. Three months post-intervention, clinically significant changes were reported.

**Subject L**

L's goals for therapy involved eliminating her phobia of human touch (see Appendix i(3)). L responded quickly and improved gradually to the intervention (see Figure 7). She made steady improvements in her touch phobia from week to week. This weekly stepwise reduction reflects the typical outcome data for phobias treated through graded exposure. By the end of the intervention, L was asymptomatic and these gains were maintained at follow up. These changes reached clinically significant levels.

![Figure 7. L's Target Complaint Scale Scores for Touch Phobia](image-url)
Table 2
Subject's State Functioning and Scores on Questionnaire Measures at Pre-Intervention, Post-Intervention and Follow-Up

<table>
<thead>
<tr>
<th>Measure</th>
<th>Pre</th>
<th>Post</th>
<th>FU</th>
<th>Pre</th>
<th>Post</th>
<th>FU</th>
<th>Pre</th>
<th>Post</th>
<th>FU</th>
</tr>
</thead>
<tbody>
<tr>
<td>PTSD (PSS-SR)</td>
<td>3</td>
<td>2*</td>
<td>0*</td>
<td>19</td>
<td>7*</td>
<td>5*</td>
<td>10</td>
<td>2*</td>
<td>1*</td>
</tr>
<tr>
<td>Depression (BDI)</td>
<td>16</td>
<td>2*</td>
<td>1*</td>
<td>18</td>
<td>11</td>
<td>5*</td>
<td>5</td>
<td>1*</td>
<td>0*</td>
</tr>
<tr>
<td>Depn. Cognitions (CCI)</td>
<td>67</td>
<td>59</td>
<td>44*</td>
<td>99</td>
<td>83</td>
<td>66</td>
<td>85</td>
<td>51</td>
<td>37*</td>
</tr>
<tr>
<td>Loneliness (UCLA-LS)</td>
<td>50%</td>
<td>28%*</td>
<td>40%*</td>
<td>99%</td>
<td>95%</td>
<td>86%</td>
<td>74%</td>
<td>35%*</td>
<td>30%*</td>
</tr>
<tr>
<td>Self-Esteem (RSES**)</td>
<td>26</td>
<td>40*</td>
<td>33*</td>
<td>25</td>
<td>27*</td>
<td>38*</td>
<td>26</td>
<td>36*</td>
<td>38*</td>
</tr>
<tr>
<td>Anxiety (STAI)</td>
<td>94%</td>
<td>89%</td>
<td>92%</td>
<td>95%</td>
<td>94%</td>
<td>59%*</td>
<td>92%</td>
<td>47%*</td>
<td>8%*</td>
</tr>
<tr>
<td>Anger (STAXI)</td>
<td>46%</td>
<td>25%*</td>
<td>33%*</td>
<td>96%</td>
<td>71%*</td>
<td>33%*</td>
<td>55%</td>
<td>39%*</td>
<td>9%*</td>
</tr>
</tbody>
</table>

Notes:
PSS-SR = Post-Traumatic Stress Disorder Symptom Scale - Self-Report, BDI = Beck Depression Inventory, CCI = Crandall Cognitions Inventory, UCLA-LS = University of California Loneliness Scale, RSES = Rosenberg Self-Esteem Scale, STAI = State-Trait Anxiety Inventory (Trait Score), STAXI = State-Trait Anger Expression Inventory (Trait Score).

* subject meets criteria for high end-state functioning

** improvement is shown by an increase (versus a decrease on all other measures).

Table 2 shows each subject's scores on standardised questionnaires measuring emotional adjustment at three points in time, pre-intervention, post-intervention and at three month follow-up. Although all subjects received individual forms of therapy, the results are grouped together in the table for convenience.
individual forms of therapy, the results are grouped together in the table for convenience.

Subject Y

At the termination of treatment, Y had improved on all seven measures of PTSD symptoms and general emotional adjustment. High end-state functioning was reported on measures of depression, depressive cognitions, loneliness, PTSD, and self-esteem with levels of depression and self-esteem showing the greatest change. Three months after the termination of treatment, further improvements were evident in levels of depression, depressive thinking, and PTSD symptoms. Levels of self-esteem, loneliness, trait anger, and trait anxiety had shown slight levels of deterioration in the three month follow-up period but were still improved from pre-intervention scores.

Subject G

G made positive gains on all seven measures of PTSD and more general emotional adjustment. In other words, her levels of depression, self-esteem, depressive thinking, PTSD symptoms, loneliness, trait anxiety and trait anger had all improved by the end of the intervention. G reached high end-state functioning on three out of seven measures (self-esteem, PTSD, and anger). These gains were maintained at follow-up and with the exception of loneliness and depressive thinking, all gains were significant and reached high end-state functioning levels.

Subject L

L reported high end-state functioning on all seven measures of PTSD and more general of emotional adjustment. These results were maintained and further improvement was noted at follow-up. In other words, immediately following the treatment and three months following the termination of the intervention, L reported significantly improved levels of depression, depressive thinking, PTSD symptoms, self-esteem, loneliness, trait anxiety and trait anger.
DISCUSSION

Three women took part in individualised cognitive behavioural interventions evaluated using AB design with follow-up. The problems were relatively diverse and included a touch phobia, sexual phobia and low self-esteem. In all three cases, there were impressive changes associated with the intervention. These results provide some preliminary support for the efficacy of individualised treatment programmes using cognitive behavioural techniques for women who had a history of intrafamilial CSA. All three women meet the specific clinical criteria for successful outcome and these gains were maintained at the three month follow-up. The present success of cognitive behavioural techniques used in treating these diverse problems bodes well for the generalisation of cognitive behavioural techniques to quite varied sequelae of CSA.

In all three cases, individualised graded hierarchies were utilised. Target goals were made explicit and defined in clear, behavioural terms. Progress toward the end goals was monitored on a weekly basis which appeared to be beneficial. This goal-setting format may help to explain the success of this intervention. Research has shown that goals are more likely to be achieved if they are subdivided into sub-goals and it is hypothesised that motivation levels are maintained if the subject witnesses themselves making progress towards the end goal. This process was ensured as all subjects were instructed to report back on their progress each week.

Results from the more general measures of psychosocial functioning indicate positive results. All subjects improved in levels of depression, anxiety, loneliness, self-esteem, anger and post-traumatic stress symptoms. High end-state functioning was reported for the majority of measures. These gains were largely maintained at three month follow-up.
It is interesting that despite focusing the intervention on a specific target complaint, substantial improvements were reported in PTSD symptoms and more general emotional adjustment. One possibility is that each woman's specific problem contributed to the development and maintenance of other psychopathology (e.g., anxiety, depression, low self-esteem). It follows that once their specific problem was alleviated other psychopathology improved. A second possibility is that each intervention had a generalised treatment effect. In other words, the benefits of the intervention were not specific to one problem and skills acquired during the programme were useful in other areas of the woman's life.

The present results are reasonably encouraging, however, further research is warranted. Replication of cognitive behavioural therapies for CSA-related problems is necessary. This can be done via further AB single case designs or alternatively, in a multiple baseline study across subjects with similar problems, such as a sexual aversion disorder.
GENERAL DISCUSSION

Cognitive behavioural techniques appear to have some benefit in assisting women who have experienced intrafamilial CSA. The present investigation suggests that cognitive-behavioural interventions are appropriate in the treatment of both specific and more generalised problems related to CSA. Each of the women who took part in the study was given the opportunity to provide feedback regarding the utility and appropriateness of the intervention. Their responses can be seen in Appendix j.

Results from Study One suggest that the presence of comorbid problems in subjects may reduce the efficacy of the treatment. This raises some concerns given the higher rate of comorbid psychopathology in sexually abused populations (Browne & Finkelhor, 1986). It is possible that before attempting cognitive behavioural therapy with a person who has been sexually abused, comorbid problems, such as severe depression or substance abuse, should be monitored and addressed if necessary. Additional treatment sessions may be useful as an adjunct to the CSA treatment package.

The positive results of the present study are consistent with the results of Deblinger and colleagues (1990). They reported a reduction in PTSD symptomatology in girls with a history of sexual abuse after a short-term, cognitive behavioural intervention via individual therapy. Together, both Deblinger's and the present study suggest that cognitive behavioural techniques have some utility in both child and adult populations. Future research involving well-controlled, group studies sampling a wider age-range of populations would provide further clarification as to the generalisation of the present results. Moreover, studies investigating the efficacy of cognitive behavioural therapy with male survivors of CSA are required. There is an obvious lack of controlled
research which uses a male population and this is a substantial oversight given the estimate of one in ten males experiencing CSA (Finkelhor, 1993).

The present results also support Alexander and colleagues (1991) findings regarding the utility of short-term therapy. Time-limited interventions appear to be useful in reducing depression, other emotional distress, and promoting social adjustment in women who have experienced CSA. Historically, concerns have been raised about short term therapy when working with clients who have been sexually abused (Stran, 1988; Tsai & Wagner, 1978). Those who advocate short term therapy (i.e., therapy which is time-limited and as brief as possible) are criticised for not recognising the depth or severity of trauma in cases of CSA. There is little evidence that long term therapy of CSA is any more effective than short term therapy, however, and given the added benefits of short term therapy, such as reduced cost to the client and client independence, then there seems little reason to implement long term therapy at present. In addition, because cognitive behavioural therapy is skills-based and aims to teach clients self-management techniques, then the termination of therapist-client contact does not necessarily mean the termination of 'therapy'. Cognitive behavioural therapy aims to provide clients with the necessary skills for 'self-therapy'. Results from Studies One and Two support the idea of 'therapy' continuing beyond the fourteen sessions of therapist-client contact as most subjects continued to improve up for up to three months without therapist communication.

Context for Research

In researching this topic, it became clear that there are numerous articles published in the literature and many therapists on talk-shows or talk-back who are willing to espouse their beliefs on the treatment of CSA. Voluminous accounts are available on how to help those men and women who have been sexually abused as
children. What is not available is scientific evidence that these interventions are helpful, or at the very least not harmful.

Publications on CSA and therapists working with those who have been sexually abused are coming under considerable scrutiny. For example, the popular self-help book for sexual abuse victims known as 'The Courage to Heal' has been both praised as the 'bible' for people with a history of CSA and castigated for inciting familial destruction (Oprah Winfrey Show, TV3, November 7, 1993). There is also much debate regarding therapists who work with victims to recover repressed memories. Recently, several American hypnotherapists who engage in recovered memory therapy have been found guilty in U.S. courts of implanting false memories into their clients (Guardian, 5.2.95). In such a volatile arena, there is a need for controlled research to determine valid and reliable interventions when working with clients who have a history of CSA.

In the wider context, the question of responsibility for CSA sequelae deserves discussion. Is CSA sequelae a psychological problem or a social problem? Who should take responsibility for the effects of CSA - the individual or society? Most people would readily agree that CSA should be tackled as a societal problem but the contemporary reality is far different. Russell (1986) found that it was the victims who actually ended the incestuous abuse in the greatest percentage of cases. The horrifying reality is that in the majority of cases young female children are burdened with the responsibility of stopping older males from perpetrating abuse. Under these circumstances, the child is forced to take responsibility for the actions of an adult. This suggests that in reality, the individual victim is shouldering the responsibility, even if CSA is asserted to be a wider social problem. This is an outlandish situation which should not be allowed to persist and every conceivable effort should be made to prevent this continuing.
The transactional model asserts that the sequelae of CSA are a function of the child's support resources, their coping strategies, and cognitive appraisals which suggests that the problem is both the individual's and society's. According to Spaccarelli (1994), the effect of CSA may be reduced given strong support resources, effective coping strategies and healthy cognitive appraisals (e.g., "The sexual abuse was not my fault - I was only a child"). To equip each child with these three resources may require a multi-level psychosocial input including state intervention (e.g., obligatory child abuse reporting), additional community interventions (e.g., Child and Family Mental Health Centres, school education programmes), and increased support for families and individuals who have experienced abuse or are at risk (e.g., parent management training programmes, family communication skills training, counselling).

Finally, the ultimate responsibility for the CSA sequelae must be placed squarely at the foot of the abuser. If there were no abuse, there would be no sequelae. It follows then, that the prevention of CSA is paramount. Programmes for convicted sex offenders (e.g., Kia Marama Unit, Christchurch, New Zealand) are vital. In addition, agencies offering assistance to those in the community who are at high risk of offending (e.g., Justice Department (Psychological Services) or Child and Adolescent, Family Mental Health Services) should be provided with increased funding to assist in preventing this crime. Whatever the individual components, it is clear that a multiple strategy approach is necessary if we are to combat the complex causes and effects of CSA in New Zealand society.
REFERENCES


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Appendix a:

Newspaper Advertisement Recruitment
Volunteers needed for sexual abuse treatment study

Tara Cathie, a postgraduate clinical psychology student in the psychology department at the University of Otago, is seeking volunteers for a research study on the psychological treatment of female adults who were sexually abused as children.

Many adults sexually abused as children have never had an opportunity to talk about their experiences and how it may have affected their lives. A lot of adult survivors believe that the sexual abuse which occurred in childhood still has a profound effect on their day-to-day lives. Some of the effects of sexual abuse which survivors often describe include low self-esteem, guilt, fear, emotional turmoil, constant intrusive memories of the abusive episodes, sexual problems and relationship difficulties.

The psychological treatment to be used in this study involves two components: First, it includes acknowledging the abuse experience and what impact it has had, and secondly, it involves recovery-moving through different stages of treatment which include building up social support, increasing self-esteem, relaxation, dealing with grief and finally “moving on”.

The treatment involves approximately 11 sessions, lasting about one hour. Initially these sessions will be twice-weekly but will occur weekly thereafter. These sessions will be conducted at the Clinical Psychology Research and Training Centre, and will be supervised by a qualified clinical psychologist. There is no charge for treatment. All information gathered is treated confidentially. This study has been approved by the Southern Regional Health Authority ethics committee.

Researchers are seeking volunteers who are experiencing difficulties in coping emotionally because of sexual abuse in their childhood. In particular, they are seeking women who experienced unwanted sexual contact before the age of 18 with an older male relative. Volunteers must be female and aged over 18 years. They should not be currently receiving assistance elsewhere (e.g. other forms of therapy) and should be able to attend regular weekly treatment sessions over a three-month period.

Anyone wishing to volunteer, or requiring further information, should direct inquiries to Ms Tara Cathie, Clinical Psychology Research and Training Centre, Department of Psychology, University of Otago, PO Box 56, Dunedin. Any inquiries about this study will be treated confidentially.

March 3, 1994

Good response on abuse study

Postgraduate clinical psychology student in the psychology department at the University of Otago Tara Cathie is “quite pleased” with the response she has received in relation to a study run in the Wrecc抢救or in March.

Ms Cathie is seeking volunteers for a research study on the psychological treatment of female adults who were sexually abused as children.

Although Ms Cathie already has five volunteers, more volunteers are needed.

The research will begin in April and treatment involves approximately 11 sessions, lasting about one hour. Initially these sessions will be twice-weekly, but will occur weekly thereafter.

These sessions will be conducted at the Clinical Psychology Research and Training Centre, and will be supervised by a qualified clinical psychologist.

There is no charge for treatment and all information gathered is treated confidentially. This study has been approved by the Southern Regional Health Authority ethics committee.

Researchers are seeking volunteers who are experiencing difficulties in coping emotionally because of sexual abuse in their childhood. In particular, they are seeking women who experienced unwanted sexual contact before the age of 18 with an older male relative. Volunteers must be female and aged over 18 years. They should not be currently receiving assistance elsewhere (e.g. other forms of therapy) and should be able to attend regular weekly treatment sessions over a three-month period.

Anyone wishing to volunteer, or requiring further information, should direct inquiries to Ms Tara Cathie, Clinical Psychology Research and Training Centre, Department of Psychology, University of Otago, PO Box 56, Dunedin. Any inquiries about this study will be treated confidentially.

March 3, 1994
Appendix b:

Initial Phone Screening Sheet
Screening Sheet

Name: ___________________  Address: ___________________

D.O.B: ___________________  Ph.no.: ___________________

Sexual Abuse History:
Subject is female  
Abuser was a close male relative? (grandfather, father, stepfather, brother, stepbrother, uncle, cousin)  
Subject under age 18 at time of abuse?  
Abuser at least 5 years older than subject?  
Subject suffered unwanted genital contact  
Last abusive episode at least 3 months previously

Treatment History:
Ever diagnosed with a psychiatric condition?  
Currently on psychotropic medication?  
Undergone any psychological therapy in the last two years?  
Seeking treatment for sexual abuse sequelae in response to this research?  
Currently receiving assistance elsewhere?

Suitable for Study:
Yes  No

Informed of study conditions?  Y / N  Reason
Wait period (up to 10 wks) ( )
Weekly diary recording ( )  Advice
Half day assessment ( )
1st 3 weeks (2x1hr sessions/week) ( )
Last 9 weeks (1x1hr session/week) ( )

Accepts conditions ( )  Referred to:
Given written consent ( )

Suggest half day assessment.
Place in study depends on results

Appointment made ( )
Will contact ( )
Appendix c:

Subject Information Sheet
Information Sheet for Subjects

This study is designed to examine how people respond when they have psychological treatment for familial child sexual abuse. It is concerned with investigating the changes which occur as a person participates in therapy.

The aim of this research is to refine and improve the existing therapies for adult survivors of child sexual abuse. All subjects will be informed of the research findings at the completion of the study.

If you agree to participate in this study you will be asked to record any symptoms you experience. Some individuals may be asked to monitor their symptoms for up to ten weeks before treatment begins. All persons will receive approximately 14 sessions of therapy over a period of approximately 12 weeks. Participants will go through a cognitive behavioural therapy for sexual abuse survivors. The cognitive therapy aims to change any unhelpful thoughts and beliefs associated with the sexual abuse and the behaviour therapy aims to change any maladaptive behaviours. At approximately three months after the completion of the treatment, your progress will be reassessed to determine whether any further therapy sessions are necessary.

This study is being conducted as part of a masters thesis in psychology and is supervised by Dr. Hamish Godfrey, a qualified clinical psychologist. Although individual results will form part of the thesis, identifying information will be removed. The information you supply will be treated as strictly confidential and your participation is completely voluntary. You may withdraw from the study at any time without any effect on the psychological treatment you receive.

If you have any questions regarding this research please do not hesitate to contact me or Dr. Godfrey.

Contact Address: Tara Cathie
Department of Psychology
University of Otago
P.O. Box 56
Dunedin

Phone: Tara Cathie (03) 4797-647
Dr. Hamish Godfrey (03) 4797-625
Leanne Turner (administrative assistant) (03) 4797-627
Appendix d:

Consent Form
Consent Form

I, ___________________________ (full name) agree to take part in this treatment outcome study.

* I have read the introduction sheet provided and have had the opportunity to discuss this study and to ask questions which have been answered to my satisfaction.

* I understand that the purpose of this study is to investigate changes in my behaviour which may occur as I participate in sexual abuse therapy.

* I understand that I will receive approximately 14 sessions of psychological counselling over a period of about 12 weeks.

* I understand that I will be contacted at three months after therapy to be reassessed. This will involve answering some of the same questionnaires completed at the beginning of the study.

* I understand that any information I supply will be treated as confidential and that no material which could identify me will be used in any reports on this study.

* I understand that my participation in this research is completely voluntary and that I may withdraw at any time without affecting the psychological treatment I am receiving.

* I have had sufficient time to read and understand this information in the absence of the researcher.

Signature ___________________________

Date _______________________________

Researcher __________________________

Date _______________________________
Appendix e:

Battery of Questionnaires
QUESTIONNAIRE 1:

1. Write your name and today's date on the top of the questionnaire.
2. Read the questionnaire instructions completely and carefully.
3. Complete the instructions for questions 1-20.
4. When finished take a short break and then go on to Questionnaire 2.
**UCLA - Loneliness Scale**

**Self-Evaluation Questionnaire**

**Instructions:** Below are a number of statements which ask about how much contact you have with other people. Indicate how often you feel the way described by circling a number for each one of the following statements.

<table>
<thead>
<tr>
<th>Statement</th>
<th>Never</th>
<th>Rarely</th>
<th>Sometimes</th>
<th>Often</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. I feel in tune with the people around me</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>2. I lack companionship</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>3. I feel there is no-one I can turn to</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>4. I feel alone</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>5. I feel part of a group</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>6. I have a lot in common with the people around me</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>7. I feel I am no longer close to anyone</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>8. My interests and ideas are shared by those around me</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>9. I am an outgoing person</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>10. There are people I feel close to</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>11. I feel left out</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>12. My social relationships are superficial</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>13. I feel no-one really knows me well</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>14. I feel isolated from others</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>15. I can find companionship when I want it</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>16. I feel there are people who really understand me</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>17. I am unhappy being so withdrawn</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>18. People are around me but not with me</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>19. There are people I can talk to</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>20. There are people I can turn to</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>
QUESTIONNAIRE 2:

1. Fill in the details on the top of the questionnaire (name, date, marital status, age, sex, occupation, education).

2. Read the questionnaire instructions completely and carefully.


4. Do not worry about adding up any scores. Researchers will do that.

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

|   | 1 0 | I do not feel sad.                  | 8 0 | I don't feel I am any worse than anybody else. |
|   | 1 1 | I feel sad.                        | 1 0 | I am critical of myself for my weaknesses or mistakes. |
|   | 2 2 | I am sad all the time and I can't snap out of it. | 2 0 | I blame myself all the time for my faults. |
|   | 3 3 | I am so sad or unhappy that I can't stand it. | 3 0 | I blame myself for everything bad that happens. |
|   |   |                                   | 9 0 | I don't have any thoughts of killing myself. |
|   | 2 0 | I am not particularly discouraged about the future. | 1 0 | I have thoughts of killing myself, but I would not carry them out. |
|   |   |                                   | 2 0 | I would like to kill myself. |
|   |   |                                   | 3 0 | I would kill myself if I had the chance. |
|   | 3 0 | I do not feel like a failure.      | 10 0 | I don't cry any more than usual. |
|   | 1 1 | I feel I have failed more than the average person. | 1 0 | I cry more now than I used to. |
|   | 2 2 | As I look back on my life, all I can see is a lot of failures. | 2 0 | I cry all the time now. |
|   | 3 3 | I feel I am a complete failure as a person. | 3 0 | I used to be able to cry, but now I can't cry even though I want to. |
|   |   |                                   | 11 0 | I am no more irritated now than I ever am. |
|   | 4 0 | I get as much satisfaction out of things as I used to. | 1 0 | I get annoyed or irritated more easily than I used to. |
|   | 1 1 | I don't enjoy things the way I used to. | 2 0 | I feel irritated all the time now. |
|   | 2 2 | I don't get real satisfaction out of anything anymore. | 3 0 | I don't get irritated at all by the things that used to irritate me. |
|   | 3 3 | I am dissatisfied or bored with everything. | 12 0 | I have not lost interest in other people. |
|   |   |                                   | I am less interested in other people than I used to be. |
|   | 5 0 | I don't feel particularly guilty.  | 2 0 | I have lost most of my interest in other people. |
|   | 1 1 | I feel guilty a good part of the time. | 3 0 | I have lost all of my interest in other people. |
|   | 2 2 | I feel quite guilty most of the time. |   |   |
|   | 3 3 | I feel guilty all of the time.     |   |   |
|   | 6 0 | I don't feel I am being punished.  | 13 0 | I make decisions about as well as I ever could. |
|   | 1 1 | I feel I may be punished.          | 1 0 | I put off making decisions more than I used to. |
|   | 2 2 | I expect to be punished.           | 2 0 | I have greater difficulty in making decisions than before. |
|   | 3 3 | I feel I am being punished.        | 3 0 | I can't make decisions at all anymore. |
| 14 | 0 | I don't feel I look any worse than I used to. |
|    | 1 | I am worried that I am looking old or unattractive. |
|    | 2 | I feel that there are permanent changes in my appearance that make me look unattractive. |
|    | 3 | I believe that I look ugly. |
| 15 | 0 | I can work about as well as before. |
|    | 1 | It takes an extra effort to get started at doing something. |
|    | 2 | I have to push myself very hard to do anything. |
|    | 3 | I can't do any work at all. |
| 16 | 0 | I can sleep as well as usual. |
|    | 1 | I don't sleep as well as I used to. |
|    | 2 | I wake up 1-2 hours earlier than usual and find it hard to get back to sleep. |
|    | 3 | I wake up several hours earlier than I used to and cannot get back to sleep. |
| 17 | 0 | I don't get more tired than usual. |
|    | 1 | I get tired more easily than I used to. |
|    | 2 | I get tired from doing almost anything. |
|    | 3 | I am too tired to do anything. |
| 18 | 0 | My appetite is no worse than usual. |
|    | 1 | My appetite is not as good as it used to be. |
|    | 2 | My appetite is much worse now. |
|    | 3 | I have no appetite at all anymore. |
| 19 | 0 | I haven't lost much weight, if any, lately. |
|    | 1 | I have lost more than 5 pounds. |
|    | 2 | I have lost more than 10 pounds. |
|    | 3 | I have lost more than 15 pounds. |
|    |     | I am purposely trying to lose weight by eating less. Yes ______ No ______ |
| 20 | 0 | I am no more worried about my health than usual. |
|    | 1 | I am worried about physical problems such as aches and pains; or upset stomach; or constipation. |
|    | 2 | I am very worried about physical problems and it's hard to think of much else. |
|    | 3 | I am so worried about my physical problems that I cannot think about anything else. |
| 21 | 0 | I have not noticed any recent change in my interest in sex. |
|    | 1 | I am less interested in sex than I used to be. |
|    | 2 | I am much less interested in sex now. |
|    | 3 | I have lost interest in sex completely. |

---

**Subtotal Page 2**

**Subtotal Page 1**

**Total Score**
QUESTIONNAIRE 3:

1. Write your name and today's date at the top of the questionnaire.

2. Read the questionnaire instructions completely and carefully.

3. Complete questions 1-10.

4. Again do not worry about adding up any scores. Researchers will do that.

5. When finished take a short break and then go on to Questionnaire 4.
ROSENBERG SELF ESTEEM SCALE

Instructions: Indicate how much you feel each statement applies to you by circling the appropriate number.

<table>
<thead>
<tr>
<th></th>
<th>Strongly agree</th>
<th>Agree</th>
<th>Disagree</th>
<th>Strongly disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. I feel that I'm a person of worth, at least on an equal plane with others</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>2. I feel that I have a number of good qualities</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>3. All in all, I am inclined to feel that I'm a failure</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>4. I am able to do things as well as most other people</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>5. I feel I do not have much to be proud of</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>6. I take a positive attitude towards myself</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>7. On the whole, I am satisfied with myself</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>8. I wish I could have more respect for myself</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>9. I certainly feel useless at times</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>10. At times I think I am no good at all</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>

SCORE =
QUESTIONNAIRE 4:

1. Fill in the details on the top of the red and grey booklet (name, sex, date highest level of education, occupation, marital status).

2. You should have a red and white sheet enclosed in this questionnaire. Fill in the details on the top of this sheet as well (name, sex, etc.).

3. Read the instructions on the grey and red booklet’s front page completely and carefully.

4. Carefully read the directions for Part 1 on page 2 of the grey and red booklet. Mark your answers on Part 1 of the red and white rating sheet.

5. Carefully read the directions for Part 2 on page 2 of the grey and red booklet. Mark your answers on Part 2 of the red and white rating sheet.

6. Carefully read the directions for Part 3 on page 3 of the grey and red booklet. Mark your answers on Part 3 of the red and white rating sheet.

7. Now you have finished this questionnaire. Ignore the back page of the red and grey booklet as this is for the researchers’ use only.

8. Please take a short break and when you are ready, continue with questionnaire 5.
Self-Rating Questionnaire
STAXI Item Booklet (Form HS)

Name ___________________________ Sex _______ Age _______ Date ____________
Education ___________________________ Occupation ___________________________ Marital Status _______

Instructions

In addition to this Item Booklet you should have a STAXI Rating Sheet. Before beginning, enter your name, sex, age, the date, your education and occupation, and your marital status in the spaces provided on this booklet and at the top of the Rating Sheet.

This booklet is divided into three Parts. Each Part contains a number of statements that people use to describe their feelings and behavior. Please note that each Part has different directions. Carefully read the directions for each Part before recording your responses on the Rating Sheet.

There are no right or wrong answers. In responding to each statement, give the answer that describes you best. DO NOT ERASE! If you need to change your answer, make an "X" through the incorrect response and then fill in the correct one.

Examples

1. ( )  ( )  (X) ( ) ( )
2. ( )  ( )  ( )  ( )
Part 1 Directions

A number of statements that people use to describe themselves are given below. Read each statement and then fill in the circle with the number which indicates how you feel right now. Remember that there are no right or wrong answers. Do not spend too much time on any one statement, but give the answer which seems to best describe your present feelings.

| Fill in 1 for Not at all | Fill in 5 for Moderately so |
| Fill in 2 for Somewhat | Fill in 6 for Very, much so |

How I Feel Right Now

1. I am furious.
2. I feel irritated.
3. I feel angry.
4. I feel like yelling at someone.
5. I feel like breaking things.
6. I am mad.
7. I feel like banging on the table.
8. I feel like hitting someone.
9. I am burned up.
10. I feel like swearing.

Part 2 Directions

A number of statements that people use to describe themselves are given below. Read each statement and then fill in the circle with the number which indicates how you generally feel. Remember that there are no right or wrong answers. Do not spend too much time on any one statement, but give the answer which seems to best describe how you generally feel.

| Fill in 1 for Almost never | Fill in 5 for Often |
| Fill in 2 for Sometimes | Fill in 6 for Almost always |

How I Generally Feel

11. I am quick tempered.
12. I have a fiery temper.
13. I am a hotheaded person.
14. I get angry when I'm slowed down by others' mistakes.
15. I feel annoyed when I am not given recognition for doing good work.
16. I fly off the handle.
17. When I get mad, I say nasty things.
18. It makes me furious when I am criticized in front of others.
19. When I get frustrated, I feel like hitting someone.
20. I feel infuriated when I do a good job and get a poor evaluation.

Continued ➔
Part 3 Directions

Everyone feels angry or furious from time to time, but people differ in the ways that they react when they are angry. A number of statements are listed below which people use to describe their reactions when they feel angry or furious. Read each statement and then fill in the circle with the number which indicates how often you generally react or behave in the manner described when you are feeling angry or furious. Remember that there are no right or wrong answers. Do not spend too much time on any one statement.

Fill in 0 for Almost never  Fill in 3 for Often
Fill in 2 for Sometimes  Fill in 6 for Almost always

When Angry or Furious...

21. I control my temper.
22. I express my anger.
23. I keep things in.
24. I am patient with others.
25. I pout or sulk.
26. I withdraw from people.
27. I make sarcastic remarks to others.
28. I keep my cool.
29. I do things like slam doors.
30. I boil inside, but I don't show it.
31. I control my behavior.
32. I argue with others.
33. I tend to harbor grudges that I don't tell anyone about.
34. I strike out at whatever infuriates me.
35. I can slap myself from losing my temper.
36. I am secretly quite critical of others.
37. I am angrier than I am willing to admit.
38. I calm down faster than most other people.
39. I say nasty things.
40. I try to be tolerant and understanding.
41. I'm irritated a great deal more than people are aware of.
42. I lose my temper.
43. If someone annoys me, I'm apt to tell him or her how I feel.
44. I control my angry feelings.
QUESTIONNAIRE 5:

1. Write your name and today's date on top of the questionnaire.
2. Read the questionnaire instructions completely and carefully.
3. Indicate how often you think the thoughts 1-45.
4. When you have finished take a short break and then continue with questionnaire 6.
Crandell Cognitions Inventory

In the list of statements below, you may find some statements which almost always come into your mind and other statements which almost never occur to you. Read each statement carefully and try to decide how often you think this thought or a thought similar to it. Some of the statements may not be your exact thought but may be very similar to your thought. Also try to answer the question, "How frequently do I think this thought or a thought similar to it?" NOT "Is this statement true for me?"

When you have decided how frequently you think a certain thought, put a mark in the appropriate space next to the thought to indicate how often you think that thought:
(a) Almost Never (b) Seldom (c) Sometimes (d) Frequently (e) Almost Always

For example, if you almost always think the thought, place a mark in the space under the column labeled Almost Always next to that thought. If you almost never think the thought, place a mark in the space under the column labeled Almost Never next to that thought.

Remember to indicate how frequently you think this thought or a thought similar to it, NOT to indicate if the statement is true for you.

<table>
<thead>
<tr>
<th>Statement</th>
<th>Almost Never</th>
<th>Seldom</th>
<th>Sometimes</th>
<th>Frequently</th>
<th>Almost Always</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. I'm just a nobody.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. I feel so full of energy.</td>
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<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. I'll never feel good again.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. I sure have wasted the opportunities in my life.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. I don't know what I should do.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. I'm always letting myself down.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Some people really care about me.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. I've made such a mess of my life.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. What a great day to be alive.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10. Nothing ever works out for me anymore.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11. Things really look hopeless.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12. Why can't I be happy?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Crandell Cognitions Inventory

Remember to indicate how frequently you think this thought or a thought similar to it, NOT to indicate if the statement is true for you.

<table>
<thead>
<tr>
<th></th>
<th>Almost Never</th>
<th>Seldom</th>
<th>Sometimes</th>
<th>Frequently</th>
<th>Almost Always</th>
</tr>
</thead>
<tbody>
<tr>
<td>13.</td>
<td>It all seems so useless.</td>
<td>( )</td>
<td>( )</td>
<td>( )</td>
<td>( )</td>
</tr>
<tr>
<td>14.</td>
<td>There's so much to live for.</td>
<td>( )</td>
<td>( )</td>
<td>( )</td>
<td>( )</td>
</tr>
<tr>
<td>15.</td>
<td>I just don't cut it.</td>
<td>( )</td>
<td>( )</td>
<td>( )</td>
<td>( )</td>
</tr>
<tr>
<td>16.</td>
<td>I sure am bored.</td>
<td>( )</td>
<td>( )</td>
<td>( )</td>
<td>( )</td>
</tr>
<tr>
<td>17.</td>
<td>My life is so confused, I'll never straighten it out.</td>
<td>( )</td>
<td>( )</td>
<td>( )</td>
<td>( )</td>
</tr>
<tr>
<td>18.</td>
<td>I'm a burden to my family.</td>
<td>( )</td>
<td>( )</td>
<td>( )</td>
<td>( )</td>
</tr>
<tr>
<td>19.</td>
<td>People like me when they get to know me.</td>
<td>( )</td>
<td>( )</td>
<td>( )</td>
<td>( )</td>
</tr>
<tr>
<td>20.</td>
<td>I'll never be happy with myself.</td>
<td>( )</td>
<td>( )</td>
<td>( )</td>
<td>( )</td>
</tr>
<tr>
<td>21.</td>
<td>I'm glad I was born.</td>
<td>( )</td>
<td>( )</td>
<td>( )</td>
<td>( )</td>
</tr>
<tr>
<td>22.</td>
<td>There's no way out of this mess.</td>
<td>( )</td>
<td>( )</td>
<td>( )</td>
<td>( )</td>
</tr>
<tr>
<td>23.</td>
<td>I don't seem to have the energy to get through the day.</td>
<td>( )</td>
<td>( )</td>
<td>( )</td>
<td>( )</td>
</tr>
<tr>
<td>24.</td>
<td>I really can't do what's expected of me.</td>
<td>( )</td>
<td>( )</td>
<td>( )</td>
<td>( )</td>
</tr>
<tr>
<td>25.</td>
<td>I have such good friends.</td>
<td>( )</td>
<td>( )</td>
<td>( )</td>
<td>( )</td>
</tr>
<tr>
<td>26.</td>
<td>No one can know how alone I feel.</td>
<td>( )</td>
<td>( )</td>
<td>( )</td>
<td>( )</td>
</tr>
<tr>
<td>27.</td>
<td>I'll never do as well as others.</td>
<td>( )</td>
<td>( )</td>
<td>( )</td>
<td>( )</td>
</tr>
<tr>
<td>28.</td>
<td>Everything I do is a failure.</td>
<td>( )</td>
<td>( )</td>
<td>( )</td>
<td>( )</td>
</tr>
<tr>
<td>29.</td>
<td>I don't even feel like going out of the house.</td>
<td>( )</td>
<td>( )</td>
<td>( )</td>
<td>( )</td>
</tr>
<tr>
<td>30.</td>
<td>I'm a real disappointment to my family.</td>
<td>( )</td>
<td>( )</td>
<td>( )</td>
<td>( )</td>
</tr>
</tbody>
</table>
Crandell Cognitions Inventory

Remember to indicate how frequently you think this thought or a thought similar to it, NOT to indicate if the statement is true for you.

<table>
<thead>
<tr>
<th>Number</th>
<th>Statement</th>
<th>Almost Never</th>
<th>Seldom</th>
<th>Sometimes</th>
<th>Frequently</th>
<th>Almost Always</th>
</tr>
</thead>
<tbody>
<tr>
<td>31</td>
<td>I'm somebody special.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>32</td>
<td>I feel so detached; I just can't communicate.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>33</td>
<td>I mess everything up.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>34</td>
<td>I'm happy with myself.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>35</td>
<td>I know what I should do, but I just can't do it.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>36</td>
<td>Nothing's ever going to work out for me.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>37</td>
<td>I feel trapped.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>38</td>
<td>Daytimes are bad, but nighttimes are terrible.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>39</td>
<td>I just wish it would be all over.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>40</td>
<td>I know people enjoy being with me.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>41</td>
<td>Nothing seems exciting anymore.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>42</td>
<td>I'm really a good person.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>43</td>
<td>I wish people would just leave me alone.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>44</td>
<td>Nobody cares about me.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>45</td>
<td>I feel so helpless.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

####

SAMPLE ENTRY

```markdown
<table>
<thead>
<tr>
<th>33</th>
<th>I mess everything up.</th>
<th>( )</th>
<th>( )</th>
<th>( )</th>
<th>( )</th>
<th>( )</th>
</tr>
</thead>
<tbody>
<tr>
<td>36</td>
<td>Nothing's ever going to work out for me.</td>
<td>( )</td>
<td>( )</td>
<td>( )</td>
<td>( )</td>
<td>( )</td>
</tr>
<tr>
<td>43</td>
<td>I wish people would just leave me alone.</td>
<td>( )</td>
<td>( )</td>
<td>( )</td>
<td>( )</td>
<td>( )</td>
</tr>
</tbody>
</table>
```
QUESTIONNAIRE 6:

1. Write your name, age, sex and today's date on the top of the questionnaire.

2. Read the questionnaire instructions completely and carefully.

3. Complete the instructions for questions 1-20.

4. Turn the page.

5. Read the instructions over the page completely and carefully.

6. Complete the instructions for questions 21-40.

7. When finished take a short break and then go on to Questionnaire 7.
SELF-EVALUATION QUESTIONNAIRE

STAI Form Y-1

Name _______________________________ Date __________ S __
Age __________ Sex: M __ F __

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

1. I feel calm .................................................. 
2. I feel secure ...........................................
3. I am tense .................................................. 
4. I feel strained .................................................
5. I feel at ease ................................................
6. I feel upset .................................................
7. I am presently worrying over possible misfortunes
8. I feel satisfied ...........................................
9. I feel frightened ...........................................
10. I feel comfortable ....................................... 
11. I feel self-confident ....................................
12. I feel nervous ...........................................
13. I am jittery ...................................................
14. I feel indecisive...........................................
15. I am relaxed .............................................
16. I feel content ...........................................
17. I am worried ............................................
18. I feel confused .........................................
19. I feel steady ............................................
20. I feel pleasant ...........................................
**SELF-EVALUATION QUESTIONNAIRE**  
**STAI Form Y-2**

Name ___________________________ Date ________________

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

<table>
<thead>
<tr>
<th>Statement</th>
<th>ALMOST NEVER</th>
<th>ALMOST ALWAYS</th>
</tr>
</thead>
<tbody>
<tr>
<td>21. I feel pleasant</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>22. I feel nervous and restless</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>23. I feel satisfied with myself</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>24. I wish I could be as happy as others seem to be</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>25. I feel like a failure</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>26. I feel rested</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>27. I am “calm, cool, and collected”</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>28. I feel that difficulties are piling up so that I cannot overcome them</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>29. I worry too much over something that really doesn’t matter</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>30. I am happy</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>31. I have disturbing thoughts</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>32. I lack self-confidence</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>33. I feel secure</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>34. I make decisions easily</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>35. I feel inadequate</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>36. I am content</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>37. Some unimportant thought runs through my mind and bothers me</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>38. I take disappointments so keenly that I can’t put them out of my mind</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>39. I am a steady person</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>40. I get in a state of tension or turmoil as I think over my recent concerns and interests</td>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>
QUESTIONNAIRE 7:

1. Write your name and today's date on top of the questionnaire.

2. Read the questionnaire directions completely and carefully.

3. Answer questions 1-17.

4. When you have finished this questionnaire, all questionnaires should have been answered - Thank you very much.

5. Please place all seven questionnaires and any answer sheets in the stamped, envelope addressed to Tara Cathie. Post the questionnaires back to Tara Cathie as soon as possible. After receiving the returned questionnaires a researcher will contact you by phone.

Thank you again.
PSS-SR

Name _______________________
Date _______________________

Directions: Please answer the following questions according to what has happened during the past two weeks using the 0-3 scale below. By "assault" we mean the sexual abuse that occurred during your childhood by a close male relative.

0 = Not at all
1 = Once per week or less/a little bit/once in a while
2 = 2 to 4 times per week/somewhat/half the time
3 = 5 or more times per week/very much/almost always

1. In the past 2 weeks, have you had upsetting thoughts or images about the assault that came into your head when you didn’t want them to?

2. In the past 2 weeks, have you been having bad dreams or nightmares about the assault?

3. In the past 2 weeks, have you had the experience of reliving the assault, acting or feeling as if it were happening again?

4. In the past 2 weeks, have you been very EMOTIONALLY upset when reminded of the assault (includes becoming very scared, angry, sad, etc.)?

5. In the past 2 weeks, have you been having PHYSICAL reactions (for example, break out in a sweat, heart beats fast) when reminded of the assault?

6. In the past 2 weeks, have you been trying not to think about or have feelings associated with the assault?

7. In the past 2 weeks, have you been making efforts to avoid activities, situations, or places that remind you of the assault?
8. In the past 2 weeks, are there any important parts about the assault that you still cannot remember?

9. In the past 2 weeks, have you found that you are not interested in things you used to enjoy doing?

10. In the past 2 weeks, have you felt distant or cut off from others around?

11. In the past 2 weeks, have you felt emotionally numb (for example, feel sad but can't cry, unable to have loving feelings)?

12. In the past 2 weeks, have you felt that any future plans or hopes have changed because of the assault (for example, will have no career, marriage, children, or long life)? DO NOT INCLUDE MOVING.

13. In the past 2 weeks, have you been having problems falling or staying asleep?

14. In the past 2 weeks, have you been more irritable or having outbursts of anger?

15. In the past 2 weeks, have you been having difficulty concentrating (for example, drift in and out of conversations, lose track of story on television, difficulty remembering what you have read)?

16. In the past 2 weeks, have you been overly alert (for example, checking to see who is around you, uncomfortable with your back to a door, etc.)?

17. In the past 2 weeks, have you been jumpier, more easily startled (for example, when some walks up behind you)?
Appendix f:

Childhood Sexual Abuse Attitudes Scale
Weekly Questionnaire
Attitudes Scale

Name ____________________________
Date ____________________________

Below are a number of statements which describe how some people feel when they think about their sexual abuse. Rate the extent to which you were disturbed by these feelings during the past week. Circle the number which best describes how much these feelings have disturbed you. Circling 0 represents "not at all disturbed" and 4 represents "very much disturbed".

<table>
<thead>
<tr>
<th>Feelings</th>
<th>Not at all disturbed</th>
<th>Just noticeably disturbed</th>
<th>A little disturbed</th>
<th>Quite a lot disturbed</th>
<th>Very much disturbed</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. I felt anxious when I thought about the sexual abuse</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>2. I felt different from other people because I had been sexually abused</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>3. I felt guilty about the sexual abuse</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>4. I felt angry at others because of the sexual abuse</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>5. I felt ashamed about the sexual abuse</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>6. I felt very confused when I thought about the abuse</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>7. I felt I would be better off dead</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>8. I felt people would not like me if they knew I had been sexually abused</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>9. I felt inferior to other people</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>10. I felt like a bad person because I had been sexually abused</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>11. I felt out of control when I thought about the sexual abuse</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>12. I felt dirty because of the sexual abuse</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>13. I felt I was unlovable because of the sexual abuse</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>14. I felt scared to be alone</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>
Below are a number of statements which describe beliefs some people have after being sexually abused. Please rate the extent to which you agree with the following statements. Circle the number which best describes how much you agree with these statements. Circling 0 represents "do not agree at all" and circling 4 represents "completely agree".

<table>
<thead>
<tr>
<th>Beliefs</th>
<th>do not agree</th>
<th>agree a little bit</th>
<th>half disagree</th>
<th>mostly agree</th>
<th>completely agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>15. It is extremely rare for a child to have any sexual experiences with an older person</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>16. Nobody can be trusted.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>17. The sexual abuse was my fault</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>18. The abuser thought he was just teaching me about sex</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>19. I do not deserve to be treated well</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>20. Only 'bad' guys would be interested in me</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>21. Because of the sexual abuse my life is ruined</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>22. It must be something about me that made them sexually abuse me.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>23. I think sex is disgusting</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>24. People only use you</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>25. My life is worthless</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>26. I should have done something else to stop the abuse</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>27. I am partly to blame since sometimes I became sexually aroused</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>28. I am a lesser person because of the abuse</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>29. Sometimes I enjoyed the attention and affection so I am partly to blame</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>30. The abuser showed me sex to give me physical pleasure</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>31. I don't think much of myself</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>
Below are a number of statements describing behaviours which some people engage in following sexual abuse. Please rate how often you engaged in the following behaviours during the past week. Circle the number which best describes how often you engaged in these behaviours. Circling 0 represents "I did this none of the time" and circling 4 represents "I did this all of the time". If there was no opportunity this week to engage in some of these behaviours (e.g. for question 37, you did not have any opportunity for sex during the last week) then please circle N/A which represents "not applicable".

<table>
<thead>
<tr>
<th>Behaviours</th>
<th>None of the Time</th>
<th>Once or Twice</th>
<th>A Number of Times</th>
<th>Many Times</th>
<th>All of the Time</th>
<th>Not Applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td>32. I had flashbacks (sudden, vivid distracting memories) about the abuse</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>33. I couldn't concentrate</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>34. I thought about the sexual abuse</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>35. I avoided being alone</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>36. I had bad dreams or nightmares about the sexual abuse</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>37. I tried to avoid sex</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>N/A</td>
</tr>
<tr>
<td>38. I used alcohol or drugs to cope with memories of the abuse</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>N/A</td>
</tr>
<tr>
<td>39. I was violent towards objects or people</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>40. I could not relax</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>41. I could not stop thinking about sex</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>42. I felt scared of men</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>43. I tried to physically hurt myself</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td></td>
</tr>
</tbody>
</table>

44. Please rate the overall intensity of the behaviours that you experience. How badly did they affect you?

<table>
<thead>
<tr>
<th></th>
<th>Not at all</th>
<th>Just Noticeably</th>
<th>A Little</th>
<th>Quite a Bit</th>
<th>A Lot</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>

45. Please rate the overall extent to which the behaviours you experienced interfered with the activity you were doing at the time. How much of a nuisance were they?

<table>
<thead>
<tr>
<th></th>
<th>Not at all</th>
<th>Just Noticeably</th>
<th>A Little</th>
<th>Quite a Bit</th>
<th>A Lot</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>
### WEEKLY DIARY
#### ADJECTIVE CHECKLIST

Below are a number of feelings which some survivors of sexual abuse report experiencing. Please rate how you have felt over the past week. Do this by circling a number from 0 through 4. Circling 0 represents "have not experienced that feeling at all" and circling 4 represents "have experienced that feeling frequently".

<table>
<thead>
<tr>
<th></th>
<th>Not at all</th>
<th>just noticeable</th>
<th>a little</th>
<th>quite a lot</th>
<th>frequently</th>
</tr>
</thead>
<tbody>
<tr>
<td>In the past week have you been feeling:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>sad</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>afraid</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>restless</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>aggressive</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>terrified</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>lonely</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>unsupported</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>desperate</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>worthless</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>unlovable</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>nervous</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>hopeless</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>worried</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>alienated</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>depressed</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>anxious</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>like a failure</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>inferior</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>frightened</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>panicky</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>angry</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>tense</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>irritable</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>hot tempered</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>dizzy</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>

Please rate the overall intensity of those feelings that you experienced, over the past week. How strong were these feelings?

**not at all** | **only slightly** | **somewhat** | **moderately** | **extremely**
---|---|---|---|---
0 | 1 | 2 | 3 | 4

Please rate the overall extent to which these feelings interfered with the activity you were doing at the time. How much of a nuisance were these feelings?

**not at all** | **only slightly** | **somewhat** | **moderately** | **extremely**
---|---|---|---|---
0 | 1 | 2 | 3 | 4
Appendix g:

Childhood Sexual Abuse Treatment Programme
CHILD SEXUAL ABUSE TREATMENT MANUAL

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Preface: 1. This manual has been designed as a tool for clinical psychologists. This includes those in training under supervision. It is not intended for more general use. 2. Although possibly applicable to both men and women, the following treatment programme has only undergone controlled research with female subjects.
**Transactional Theory of Childhood Sexual Abuse Sequelae**

The following treatment programme is based on a transactional theory of Childhood Sexual Abuse (CSA) sequelae (Spaccarelli, 1994). This model predicts that risk of developing psychopathological sequelae is related to the total abuse stress. Total abuse stress is regarded as a function of three categories of stressful events: abuse events (e.g., degree of sexual exposure, coercion, denigrating messages, trust violation), abuse-related events (e.g., family dysfunction, non-support of disclosure), and disclosure-related events (e.g., insensitive/repeated interviewing, poor adjudication outcomes, stressful testimony). The higher the cumulative stress levels, the higher the risk for maladaptive outcomes. In addition, it is recognised that cognitive appraisal and coping responses mediate the effects of these three events as do developmental and environmental factors. This model can be seen in Figure 1.

**Figure 1. Transactional theory of the effects of childhood sexual abuse (Spaccarelli, 1994)**

[Diagram showing the transactional theory of the effects of childhood sexual abuse]

There is no shortage of aetiological theories of CSA sequelae (e.g., developmental, attributional theories). The transactional model has the benefit over most other models however, in that it is an inclusive model which has incorporated previous sound and testable theories. For example, it takes into account developmental, learning, attributional, traumagenic, and cognitive models within its conceptualisation. These are all theories supported by the literature, well-founded in a scientific approach and their validity is supported widely in the literature.

It is apparent from Figure 1, that the transactional model of CSA sequelae allows a flexible approach to treating individuals because of its multifactorial nature. In
addition, the bidirectional nature of the arrows indicates a reciprocal causal effect between factors and provides the necessary flexibility for working with a wide range of individuals.

Briefly, it is possible to work with clients on several key issues according to this model. For example, according to Spaccarelli’s model, building up support resources (e.g., quality of parent-child relationship), encouraging adaptive cognitive appraisals of the abusive events (e.g., reducing self-blame), and teaching coping skills (e.g., anxiety management techniques) in therapy will mediate the psychological effects of the abuse. Given Spaccarelli’s formulation of the effects of CSA, cognitive behavioural techniques can be useful in the treatment. The following manual outlines a 14 session cognitive behavioural intervention for women who have experienced CSA and are seeking help because of it.

According to Fallon and Coffman (1991), CBT should be brief, time-limited, educational, structured, directive, problem-oriented approach, and use socratic questioning. The following programme has been designed with this in mind.

It is not intended that the therapist and client attend rigidly to the 14 session programme. Some flexibility in the scheduling of sessions is needed, since skills are acquired at different rates by different individuals; it may take one individual only a few minutes to acquire a skill which it takes another several hours to learn. In addition, each individual client will bring their unique needs to the therapy situation. Additional sessions may be required which address their unique needs, when and where it is appropriate. Extra sessions may include parent management training, communication skills, specific problem-solving or goal-setting, etc. Each session is organised to take one hour.

Before treatment is commenced, each client can complete the Structured Clinical Interview for DSM-IIIR (SCID) (non-patient version), thereby providing a complete psychiatric history and a screen for comorbid problems which may require more urgent assessment and treatment (e.g., severe depression, substance abuse). The taking of this history also provides an opportunity for a therapeutic relationship to begin forming prior to the initial treatment sessions commencing. Demographic data such as name, date of birth, occupation, marital history, children (names, sexes and ages), education, ethnic background and religion can also be obtained at this time. The pre-treatment use of the SCID is not necessary for most clients who present with a history of sexual abuse but may be of some use with clients who present with multiple complex problems.
List of Assessment and Treatment Sessions

Session 1: Assessment
Session 2: Assessment
Session 3: Treatment Outline, Formulation Presentation and Goal-setting
Session 4: Education I
Session 5: Education II
Session 6: Coping Skills: Progressive Muscle Relaxation
Session 7: Coping Skills: Calming Breath, Thought-stopping, Distraction
Session 8: Cognitive Restructuring I
Session 9: Cognitive Restructuring II
Session 10: Cognitive Restructuring III
Session 11: Assertiveness Training
Session 12: Social Skills Training
Session 13: Goal-setting for the Future
Session 14: Progress Evaluation and Relapse Prevention
SESSION 1:

Goal:

1. Gain rapport
2. Assess for demographic data

Procedure:

Interview for demographic data. During the first session it is recommended that
the therapist collect demographic data as the client's initial nervousness may be
quelled by such non-threatening topics. For some clients, asking about the sexual
victimisation during the first session may be too anxiety-provoking. It is advisable
to attain the following information during the assessment procedure (Jehu, 1988):

- **Demographics (if unknown)**
  a) Client’s age
  b) Ethnic Background
  c) Occupation
  d) Religion
  e) Children
  f) Marital Status and history
  g) Partner’s name, age, occupation, marital status and history, children,
     education, ethnic background and religion.

- **Family of Origin**
  a) Father figure (relationship with client, dead/alive, age, occupation, ethnic
     background, religion, client’s description of father figure and their
     relationship, problems exhibited by father figure).
  b) Mother figure (relationship with client, dead/alive, age now, occupation, 
     ethnic background, religion, client’s description of mother figure and their
     relationship, problems exhibited by mother figure).
  c) Siblings (relationship with client, names, sex, ages, client's relationship 
     with siblings, was sibling sexually victimised, did sibling sexually victimise 
     others?).

- **Family Functioning**
  a) Verbal Communication
  b) Forms of Behaviour Control
  c) Physical Affection
  d) Social Isolation
  e) Role Confusion
  f) Milieu of Abandonment
  g) Marital Conflict
h) Oversexualisation
i) Poor Supervision
j) Male Supremacy
k) Intergenerational Sexual Victimisation
l) Other Domiciles

- Current Circumstances
  a) Domicile
  b) Financial Situation

- Interests
- Occupational History
- Relationship History
- Educational History

NB/ The therapist should respond to the emotional tone presented by the woman in probing these areas. If a particular topic appears to provoke discomfort the therapist should decide whether to focus on this area at greater length or to postpone the questioning until a later time. This decision should take into account the expressed needs and wishes of the client at the time of the interview.

Before the client leaves, acknowledge to the client that the discussions in session 1 about family background can sometimes arouse strong emotions. How are they feeling at present? Advise times that therapist is available during the week and other resources (e.g. Emergency Psychiatric Services).
SESSION 2:

Goal:

1. Interview for additional demographic data
2. Interview for details of the CSA (exposure)

Procedure:

Check how the client is feeling after the session 1 and discuss if necessary. Any additional demographic data which was not covered in the initial session, can be a good starting point for session 2. This can be followed by an attempt to cover the following information:

NB/ With regard to purposeful disclosure of the abuse, initial data suggest that it may be stressful and anxiety-provoking in the short term but adaptive in the long run (Gomes-Schwartz, Horowitz, & Cardarelli, 1990; Wyatt & Newcomb, 1990). Current studies on CSA provide accumulating evidence of an association between cognitive avoidance coping and negative psychological symptoms, even when controlling for important abuse characteristics such as severity and duration of abuse (Leitenberg et al., 1992). It is suggested that exposure therapy involving gentle encouragement and discussion of the abuse experience with an appropriate response modeled by therapist (Wheeler & Berliner, 1988) can reduce the risk of negative psychological symptoms. Summit (1989) suggests that the therapist's non-judgmental approach provides a role model for the parental acceptance and validation that may have been lost in the original trauma. Gradual exposure appears to disconnect the classically conditioned association made between anxiety and abuse-related stimuli (Deblinger, McLeer & Henry, 1991). In addition to this process of extinction, it is thought that improved well-being may result from increased support seeking after disclosure, cognitive reappraisals that occur while thinking about the trauma, or a cathartic effect of disclosure (Spaccarelli, 1994).

According to van der Kolk (1989), traumatised people need to learn to understand that acknowledging feelings related to the trauma does not bring back the trauma itself, it's accompanying violence and helplessness. Through a process of talking about abuse-related material in a regular matter-of-fact way, the memories eventually lose the capacity to elicit arousal (Wheeler & Berliner, 1988).

- Victimisation
  a) Age of client at commencement of victimisation
  b) Duration of victimisation
c) Approximate number of occasions on which victimisation occurred
d) Sexual activities that occurred between victim and offender (for a complete list of these, see Jehu, 1988, p. 311)
e) Relationship of offender to victim and age of offender at time he began offending against the victim
f) Methods of inducement
g) Victim's reaction to victimisation
h) Secrecy and modulators of secrecy
i) Disclosure - reactions of others to disclosure, consequences of disclosure
j) Current partner's awareness of victimisation, reactions of partner

- Psychosocial Adjustment of Client
  a) Emotional
  b) Interpersonal
  c) Sexual
  d) Parenting
  e) Health
  f) Social development

- Prior Treatment

- Partner's Family of Origin

- Psychosocial Adjustment of Partner
Session 3:

Goal:

1. Present Formulation to Client
2. Present Treatment Outline
3. Discuss Goals

Procedure:

- *Present Formulation to Client*
  
  The transactional model (Spaccarelli, 1994) can be useful in formulating the effects of CSA. A diagram of the model with examples from the individual's history can be a useful method of educating the client about the therapeutic process. Ask the client for feedback, be prepared to alter formulation. Allow plenty of time for discussion. Make a list of goals from the formulation, allow the client to prioritise their goals. Make a copy of the list of goals and give this to the client.

- *Set up expectation of treatment programme*
  
  a) brief (14 sessions)
  b) time-limited (60 minutes sessions)
  c) educational focus
  d) structured goal-setting for each session
  e) problem-oriented (define problems, goals and possible solutions)
  f) skills-based
  g) skills to be practiced in homework exercises

- *State 'ground-rules' for treatment programme*
  
  a) confidentiality
  b) free to take breaks at any time
  c) free to call a support person at any time (discuss who this might be)
  d) free to express any emotions
  e) no interruptions
  f) no forced participation
  g) based on humanist principles (mutual trust and respect)
  h) no touch
  i) attendance is flexible (contract to ring and leave a message if unable to attend)
  j) each session is the client's time not the therapist's
  k) work at client's pace, not the therapist's (reiterate that the number of sessions and timing is flexible)

- *Provide Treatment Outline*

- *Issues of Safety*
a) Make a phone list of emergency contact numbers to ring for help during times of possible crisis.
b) Make a suicidal contract if necessary.
Session 4:

Goal:

1. Education: Effects of CSA

Education is an important component of any cognitive-behavioural intervention. In the case of CSA, education is a particularly vital component. There are many myths surrounding CSA which can be very damaging for clients who have been sexually abused, for example, that sexually abused children are more coy and 'sexy' than non-abused children and therefore caused the abuse to occur. Education which is based on the available CSA literature is a key to altering client's maladaptive attributions of responsibility (Wheeler & Berliner, 1988).

Procedure:

- Give client handout entitled "Understanding it Wasn't Your Fault" (Bass & Davis, 1992, pp. 104-110). Read with client and use the following questions as a guide for discussion:
  a) in what ways do you blame yourself for the abuse (if any)?
  b) what explanations can you come up with why you behaved that way as a child? Introduce the idea of coping mechanisms. What coping mechanisms did you use?
  c) what pleasurable activities became associated with negative activities (e.g. affection associated with feelings of shame)
  d) whose fault was the abuse?

- Give client handout entitled "Effects - Recognising the Damage" (Bass & Davis, 1992, pp. 33-39). Read with the client and use the following questions as discussion points:
  a) how can CSA affect people's self-esteem. How do you think it may have affected yours? Therapist to provide social reinforcement for positive self-talk.
  b) how can CSA affect people's emotional state. How do you think it may have affected yours?
  c) how can CSA affect people's feelings about their body? How do you think it may have affected yours?
  d) how can CSA affect intimacy? How do you think it may have affected your ability to be intimate with people?
  e) how can CSA affect people's sexuality? How do you think it may have affected yours?
  f) how can CSA affect people's parenting abilities? How do you think it may have affected yours?
g) how can CSA affect a family’s relationships? How do you think it may have affected yours?

Some people can be sexually abused and not suffer from some of these effects. What protects them? It seems that if children disclose the abuse in a safe environment (i.e. are believed, not blamed and protected from future CSA) then the long term effects on psychological outcome can be ameliorated. In what ways was your childhood environment safe and unsafe?

**Homework:** Observe children the same age as you when you were abused. Write down your observations. The goal of this homework exercise is to help the client recognise how vulnerable she was as a young child.
Session 5:

Goal:

1. Review Previous Session and Homework
2. Education: Prevalence and Nature of CSA

Procedure:

- Review previous session plus homework. Discuss client's observation of children.
- Give client handout entitled "Prevalence of Child Sexual Abuse" (Jehu, 1988, pp. 3-7). Read with client and make the following observations as discussion points:
  a) most studies show about 1/5 girls experience some unwanted sexual contact by a family member before the age of 17
  b) most studies show about 2/5 girls experience some unwanted sexual contact by any adult before the age of 17.
  c) when other non-contact abuse behaviours are included such as 'flashing', most studies show about 1/2 girls experience some unwanted sexual experience by any adult before the age of 17.
  d) a recent NZ study (Anderson et al., 1993) found 1/3 Otago women had experienced some unwanted sexual experience (contact and non-contact abuse) before the age of 17 and 1/5 had experienced the more severe unwanted genital contact. The rate was the same for young and old women suggesting that the rate of sexual abuse had not increased over the years.

- Give client the handout entitled "Nature of Child Sexual Abuse" by Jehu (1988), pp. 8-15. (NB/ this research is based on 51 women who were included in a sexual abuse treatment programme in the USA. Because these women sought to be included and were accepted for this treatment programme, they may be a different group (e.g. have more severe difficulties, have experienced more severe abuse, be more assertive) than women who have experienced CSA in the general population. This limits its generalisability to the population at large but it also suggests that these 51 women may be a good comparison group for women who have sought counselling). Read together and make the following points:
  a) 45% of victims were first abused before age 6
     86% of victims were first abused before age 10
     100% of victims were first abused before age 15
  b) 7.8% of victims were abused for up to one year
     21.5% of victims were abused for up to three years
     41.1% of victims were abused for up to six years
     86.2% of victims were abused for up to twelve years
c) 17.7% of victims were between 5-8 years when the abuse stopped
29.4% of victims were between 9-13 years when the abuse stopped
50.9% of victims were between 14-17 years when the abuse stopped
d) Almost all victims experienced manual stimulation of their genitals
e) Most of the offenders were father-figures (either natural or step fathers) or brothers (either natural, step or adoptive) and male acquaintances.
f) Most offenders used adult authority or threats to induce the victims. Physical force and misrepresenting activities as 'games' were also common.
g) Victim's most common reactions to the abuse were guilt/shame/disgust, fear, feelings of helplessness, passive compliance. Other common reactions included anger/resentment/hostility, avoidance of the offender and denial of the abuse. Some positive reactions to the offender were also common (e.g. loving/protective/compassionate feelings towards the offender and emotional pleasure).

NB/ The goal of presenting this information is to normalise the woman's experience. Additionally, caution should be taken not to minimise her experience either. Make it clear that whatever her feelings (e.g. loving feelings or sympathy) and behaviours towards the abuser (e.g. staying in the abusive situation or seeking out his company), they were childlike attempts to deal with a confusing situation. Recognise that her coping mechanisms (e.g. denial, using abuse to obtain affection or other rewards) helped her to survive the abuse at the time.
Session 6

Goal:

1. Teach client coping skills for dealing with anxiety

Some behavioural symptoms of CSA, hyper-vigilance or high tension levels are thought to come about through classical conditioning and as a result of social learning processes. Although different mechanism of acquisition are implied by these two types of learning, the adverse effects each produces are considered to have originated as attempts to cope with traumatic stress. It is hypothesised that treatments that are directed at altering the conditioned and socially acquired responses to the victimisation will alleviate initial symptoms and will reduce the likelihood of long-term or more serious disruptions in development (Wheeler & Berliner, 1988). Therefore mastering anxiety is a major goal for treatment. This can be done through increasing anxiety management which may include the teaching of coping skills, decreasing avoidance, graduated exposure and desensitisation, participated modeling, cognitive restructuring, desensitisation, relaxation training, and stress inoculation training (Wheeler & Berliner, 1988).

Procedure:

- *Education about anxiety*
  a) physical, behavioural, cognitive and emotional symptoms
  b) autonomic changes
  c) side effects of anxiety
  d) rationale for relaxation
  e) theories about the role of CSA in precipitating and maintaining anxiety
- *Following the education phase, a rationale for the coping skills is given.*
  a) Progressive muscle relaxation and breathing control manage physical symptoms
  b) Thought-stopping, distraction and guided self-dialogue are used to counter negative anxiety-provoking cognitions
- *Give client handout entitled "Advantages of Deep Relaxation". Read and discuss. Explain to client the behaviour, reactions and symptoms of anxiety will be relieved or aided by this new coping skill. The Jacobsonian (1938) tension-relaxation contrast training is used to teach muscle relaxation of all muscle groups. Verbatim transcripts of this technique are provided in Goldfried & Watson (1976).*
- *Commence PMR*
  a) introduce client to self-monitoring of tension levels and self-monitoring sheet
b) take present tension level and complete sheet
c) ask client to explain what she understands to be the rationale for learning PMR
d) prepare client and environment for relaxation (e.g. dim lights, take off shoes, etc)
e) therapist read through Jacobson's tension-induction relaxation with client following instructions
f) when finished, complete post-relaxation tension levels on self-monitoring sheet
g) give client tape of PMR and handout entitled "Relaxation Practice"
h) explain homework to client - attempt to practice PMR once per day between sessions

HOMEWORK: Practice daily tension-induction relaxation and self-monitor tension levels
Session 7

Goal:

1. Review PMR
2. Breathing exercises
3. Thought-stopping
4. Distraction
5. Introduce thought-monitoring

Procedure:

- Breathing exercises
  a) provide rationale for breathing exercises
  b) review how the client can utilise the breathing retraining and how the coping skill can be used daily to reduce tension in day-to-day stress and abuse-related situations (e.g. allow time for adrenalin to be reabsorbed into the adrenal glands meanwhile relaxing).
  c) give client handout entitled "Abdominal Breathing" from Bourne (1990), pp. 66-70.
  d) model the two different breathing techniques from Bourne
  e) client to practice both this week for five minutes per day and choose the breathing technique they prefer. Practice in session.
- Thought Stopping
  a) This technique is utilised to counter ruminative or obsessive thinking. Thought-stopping is taught by having the client deliberately think of troublesome thoughts. After she has continued for 35-45 seconds, the therapist says "STOP" in a loud, commanding voice (while clapping hands or hitting desk) and asks the client what happened. The client typically replies that the thought stopped. This process is repeated several times. The next step is to have the client stop their thinking with silent verbalisations of the work "STOP". Finally, the client will be instructed to imagine a pleasant scene after the silent verbalisation of the word "STOP".
  b) client is requested to apply this procedure first to moderately disturbing thoughts and then to quite upsetting ones. (Explain thought-stopping in accordance with psychological model of emotion).
- Distraction
  a) give rationale for distraction using psychological model of emotion
  b) list common distraction techniques
- Explain thought monitoring
a) introduce automatic thoughts log
b) fill out one example in session

Homework: Daily practice of PMR plus self-monitoring.
Practice deep breathing five minutes per day.
Monitor automatic thoughts.
Use thought-stopping and distraction where appropriate (focus on abuse-related negative thoughts).
Session 8

Goal

1. Cognitive Restructuring:

A cognitive model assumes that cognitive activity affects behaviour and that it can be monitored and altered by the individual (Fallon & Coffman, 1991). It also assumes that behaviour change is effected through cognitive change. This theory is derived from Beck and his associates cognitive theories on mood disorders (Beck & Emery, 1985; Beck, Rush, Shaw & Emery, 1979). When applied to CSA, it is postulated that a person's beliefs about themselves and the world are at risk of distortion through the experience of CSA (Janoff-Bulman, 1985). This cognitive alteration can have a major impact on the victim's consequent behaviour, for example, if a child is abused and generates the cognition that people are not trustworthy then they may avoid further social contact. It is hypothesised that distorted or unrealistic beliefs are important sources of mood disturbances and related problems (Briere, 1989; Jehu, 1988). Accordingly, since mood disturbance is believed to be a function of these beliefs then it follows that their therapeutic correction is likely to be associated with an alleviation of disturbances. To do this, one of the goals of cognitive behavioural therapy is to help clients become aware of the underlying assumptions they hold about themselves and the world (Beck et al., 1979; Fallon & Coffman, 1991). If these assumptions are untrue or dysfunctional then the therapist works with the client to modify or change these ideas to become more accurate, flexible and functional. In addition, in order for treatment to be effective, it must redress the cognitions so deeply affected by the CSA, through cognitive restructuring. Cognitive restructuring is 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 order to correct distorted cognitions victims must firstly become aware of their thoughts, secondly, they must recognise the distortions in their thinking and finally substitute more accurate cognitions (Fallon & Coffman, 1991).

Procedure:

- **Review PMR**
  Check PMR and self-monitoring. Problem-solve any difficulties.
- **Review use of distraction**
- **Review thought-stopping**
- **Review automatic thoughts log and provide rationale for cognitive restructuring**
Therapist first presents A-B-C (a = antecedent, b = belief, c = consequence) paradigm for automatic irrational thoughts (Beck, Rush, Shaw & Emery, 1979) focusing on how our thoughts affect our reactions. An example is given demonstrating how the same event (e.g. hearing a loud noise from the next room during the night) can lead to totally different responses depending on the interpretation ("There's a prowler in there - I'm in danger" leads to intense fear and leaving the house versus thinking "What did the darn cat get into now?" leading to mild annoyance and checking the room to see what happened).

- Give client handout entitled "How to Handle Negative Thoughts" from Fennell, 1991, pp. 218-234.

Read and discuss together. Firstly, help the client to recognise her distortions in thinking. Use automatic thoughts which are not related to the CSA (e.g., annoyance with children) as examples to work through. Generate helpful responses by challenging the evidence, etc. and then re-rate emotion and belief in automatic thoughts. The therapist assists the client in assessing the rationality of the beliefs that underlie the cognitions and consequently challenges them and replaces them with more rational self-statements. Do further examples on the automatic thoughts log.

Homework: Daily practice of PMR plus self-monitoring.
Practice deep breathing.
Monitor any automatic thoughts and generate helpful responses.
Session 9

Goal

1. Cognitive Restructuring

Procedure:

- Review relaxation and self-monitoring.
  If consistently post-tape tension levels are below 20 and client feels ready, encourage them to try 'letting-go' relaxation (Jacobsonian technique) using other side of tape.

- Review deep breathing

- Review automatic thoughts log.
  Generate solutions for an difficulties. Provide social reinforcement for any and all attempts to self-monitor.

- Cognitive Restructuring
  The process used in session 8 is repeated but using CSA related cognitions. Identify one or two strong negative beliefs which the client has regarding the CSA (e.g. I should have done something else to stop the abuse) and complete the automatic thoughts log using that statement as the automatic thought. Together generate alternative explanations for their childhood actions (reviewing some of the Education session and talking about the reading from Jehu, pp. 67-81 may be helpful at this point) and generate helpful responses (e.g., at the time, I did not think anyone would believe me, my brother threatened to kill me if I ever told anyone.) Now re-rate belief in the original automatic thought.

Homework: Monitor negative automatic thoughts regarding the client's CSA. Continue practicing 'letting go' relaxation and self-monitor tension levels.
Session 10:

Goal:

1. Cognitive Restructuring

Procedure:

- Review 'letting go' relaxation and self-monitoring
  Problem solve any difficulties.
- Review automatic thoughts log.
  Continue to cognitively restructure unhelpful beliefs about CSA as was done in Session 9.
- Guided self-dialogue
  The therapist teaches the client to focus on their internal dialogue, or on what they "are saying" to themselves. Irrational, faulty, or negative dialogue is labeled and rational, facilitative or task-enhancing dialogue is substituted.

Homework: Practice 'letting go' relaxation and self-monitor tension levels.
Identify two CSA beliefs and cognitively restructure as homework
Practice guided self-dialogue.
Session 11:

Goal:

1. Assertiveness training

Procedure:

- Review 'letting go' relaxation.
  If client wishes introduce 'differential' relaxation (Jacobsonian technique). Practice in session. Suggest practicing in situations during the week at home (e.g. relax while eating dinner).

- Review cognitive restructuring homework exercise.
  Problem solve any difficulties. Provide social reinforcement for any effort.

- Review guided self-dialogue.
  Problem solve any difficulties. Provide social reinforcement for any effort.

- Assertiveness Training

Homework: Encourage client to keep a self-monitoring sheet of situations in which they were assertive. Give client Chapter 1 of the book "Making Friends - A Guide to Getting Along with People" by Matthews (1990) as reading material for discussion in Session 12.
Session 12:

Goal:

1. Social Skills Training

Social isolation is very common in people with a history of sexual abuse. Often their lack of self-esteem and loss of trust prevent them from feeling able to approach others. This can contribute to low rates of social reinforcement and lowered mood. Teaching social skills and communication training is one method of increasing a client's confidence.

Procedure:

- **Review homework**
  Discuss situations in which client was assertive. How successful was the interaction? What did they do well? What needs improvement?

- **Social Skills Training**
  Discuss "Making Friends" article. What did the client get from the article? What have they discovered about meeting people? Who does the client trust? Why? Discuss the risks of trusting people (e.g. could be hurt) and the benefits (e.g. not lonely). Role play meeting someone new in several common situations - use role reversal. Client to decide the situations. Discuss.

NB/ Social learning theory assumes that people can learn by observing the behaviour of others. The therapist is situated in a very powerful position in enabling the client to learn to trust others again. The therapist's non-judgmental, accepting, honest stance can help the client to learn that not every person is untrustworthy. When working with clients who have trouble trusting, which is common in sexually abused clients, the therapist should endeavour to be particularly reliable (e.g. finish the session on time if you say you are going to, do what you say you will do).

Homework:  
Start one conversation with someone the client knows
Start one conversation with a stranger
Session 13:

Goal:

1. Goal-setting for the future

Procedure:

- Review attempts at socialising
  

- Goal-Setting
  
  Clients are asked to think about their goals for the future and sub-goals which are written down. Goals may include meeting one new person and inviting them over for coffee, joining a new community club, starting a new hobby, phoning an old friend. Practical steps are generated for reaching these goals. A positive approach is emphasised. Clients are also asked to think about the progress they have made during therapy and asked to offer feedback regarding the programme.

Homework: Complete questionnaire
Session 14:

Goal

1. Progress Evaluation and Relapse Prevention

Procedure:

- *Review work towards goals*
  What has client done in previous week? Problem solve any difficulties. Change goals if necessary.

- *Review questionnaire*
  Discuss answers

- *Review progress*
  At the end of the final session, the therapist and client will review the progress made during treatment specifically focusing on the major problems areas identified and addressed during treatment.

- *Resource identification*
  Solicit information about the skills the client felt they acquired, used successfully and intends to use in the future. If some abuse-related or other problems are identified, arrangements for continued sessions or referral to more appropriate resources (e.g. Marriage Guidance) for help should be made.
REFERENCES


Appendix h:

Individual Treatment Programmes
(1) Y: Negative View of Self
(2) G: Negative Sexual Attitude
(3) L: Touch Phobia
1. **Intervention Outline for Subject Y**

**Negative View of Self**

*Module I* (assessment/exposure; two sessions). Throughout the assessment and the course of treatment, the therapist responds calmly to abuse-related disclosures and models positive coping behaviours. In a structured, directive manner, the therapist consistently introduces abuse-related issues, thereby encouraging full and clear disclosures.

*Module II* (education; three sessions). Sexual abuse education is provided to help the client make more sense of their abuse experience. Basic facts about child sexual abuse are taught using discussion and bibliotherapy. Issues covered included the theoretical aetiology of sexual abuse sequelae, the effects of sexual abuse and the prevalence and nature of child sexual abuse.

*Module III* (cognitive restructuring; three sessions). The rationale for cognitive restructuring is provided to the client and she is taught to identify and self-monitor her cognitions and mood. Training in challenging maladaptive cognitions then ensues, initially with non-sexual abuse related cognitions and later sexual abuse related cognitions.

*Module IV* (anxiety management; two sessions). Anxiety education is followed by training in Progressive Muscle Relaxation (Jacobsonian), breathing techniques, stress inoculation training.

*Module V* (self-esteem work; three sessions). The client is trained to identify and cognitively restructure self-talk which damages her self-esteem, use guided self-dialogue, positive affirmations, assertiveness training. A progress review highlights her efforts.
Module VI (goal-setting/relapse prevention; one session). Future goals for the client are discussed and contracted. Resource identification and a skills review are performed for relapse prevention.
2. Intervention Outline for Subject G

Negative Attitude Towards Sexual Intercourse

*Module I* (assessment/exposure; two sessions). Throughout the assessment and the course of treatment, the therapist responds calmly to abuse-related disclosures and models positive coping behaviours. In a structured, directive manner, the therapist consistently introduces abuse-related issues, thereby encouraging full and clear disclosures.

*Module II* (education; four sessions). Sexual abuse and sex education is provided to help the client make more sense of their abuse experience. Basic facts about child sexual abuse and human sexuality are taught using discussion and bibliotherapy. Issues covered included the theoretical aetiology of sexual abuse sequelae, the effects of sexual abuse and the prevalence and nature of child sexual abuse, female and male sexual response, effect of sexual abuse on sexuality, sexual assertiveness.

*Module III* (cognitive restructuring; five sessions). The rationale for cognitive restructuring is provided to the client and she is taught to identify and self-monitor her cognitions and mood. Training in challenging maladaptive cognitions then ensues, initially with non-sexual abuse related cognitions and later sexual abuse/sexuality/body image related cognitions.

*Module IV* (sexual anxiety management; two sessions). The client is trained in muscular relaxation, calming breath exercises, positive self-talk, positive affirmations, sexual behavioural experiments, grounding exercises.

*Module VI* (goal-setting/relapse prevention; one session). Future goals for the client are discussed and contracted. Resource identification and a skills review are performed for relapse prevention.
3. Intervention Outline for Subject L

Touch Phobia

Module I (assessment/exposure; two sessions). Throughout the assessment and the course of treatment, the therapist responds calmly to abuse-related disclosures and models positive coping behaviours. In a structured, directive manner, the therapist consistently introduces abuse-related issues, thereby encouraging full and clear disclosures.

Module II (education; one session). Sexual abuse and sex education is provided to help the client make more sense of their abuse experience. Basic facts about child sexual abuse are taught using discussion and bibliotherapy. Issues covered included the theoretical aetiology of sexual abuse sequelae, the effects of sexual abuse and the prevalence and nature of child sexual abuse.

Module III (phobia/exposure education/graded hierarchy; one session). Education about phobias and exposure technique is followed by the generation of an extensive graded hierarchy for client's touch phobia.

Module IV (anxiety management; three sessions). Education regarding anxiety is followed by training in Progressive Muscle Relaxation (PMR), abdominal breathing, distraction techniques, stress inoculation training.

Module V (imaginal and in vivo exposure; two sessions). The client is exposed imaginally and in vivo to steps 1-7 on the graded hierarchy for touch phobia.

Module VI (in vivo exposure; three sessions). The client is exposed in vivo to steps 8-26 on the graded hierarchy for touch phobia. Generalisation with male stimuli is also included.

Module VII (progress review/goal-setting/relapse prevention; two sessions). The client's progress is identified and future goals for the client are discussed and
contracted. Resource identification and a skills review are performed to enhance relapse prevention.
Appendix i:

Target Complaint Scales
(1) Y: Negative View of Self
(2) G: Negative Sexual Attitude
(3) L: Touch Phobia
<table>
<thead>
<tr>
<th>PROBLEM: I HAVE A NEGATIVE VIEW OF MYSELF</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>13 THE PROBLEM IS AT ITS WORST</td>
<td>TALKING NEGATIVELY TO SELF, DWELLING ON MY 'MISTAKES', DOUBTING OWN ABILITY, FEELING UNATTRACTIVE</td>
</tr>
<tr>
<td>12 I AM MORE CONFIDENT ABOUT WHAT I SAY (NOT APOLOGISING, NOT MAKING STATEMENTS INTO QUESTIONS)</td>
<td></td>
</tr>
<tr>
<td>11 I AM ABLE TO DO THINGS FOR MYSELF WITHOUT FEELING SO MUCH GUILT</td>
<td></td>
</tr>
<tr>
<td>10 THE PROBLEM IS SLIGHTLY IMPROVED</td>
<td>I AM STARTING TO FEEL CONFIDENT THAT MY BELIEFS, OPINIONS &amp; VALUES ARE IMPORTANT</td>
</tr>
<tr>
<td>9 I AM LESS CRITICAL OF 'MISTAKES'</td>
<td></td>
</tr>
<tr>
<td>8 I AM LESS CRITICAL OF MY LOOKS</td>
<td></td>
</tr>
<tr>
<td>7 THE PROBLEM IS IMPROVED</td>
<td>I HAVE INCREASED CONFIDENCE IN MY OWN ABILITY (I DON'T FEEL I HAVE TO HAVE EVERYONE'S APPROVAL)</td>
</tr>
<tr>
<td>6 I AM USING LESS NEGATIVE SELF-TALK</td>
<td></td>
</tr>
<tr>
<td>5 I AM LEARNING TO ENJOY DOING THINGS FOR MYSELF WITHOUT SO MUCH GUILT</td>
<td></td>
</tr>
<tr>
<td>4 THE PROBLEM IS MUCH IMPROVED</td>
<td>I AM USING POSITIVE SELF-TALK</td>
</tr>
<tr>
<td>3 I AM NOT REGURGITATING PAST EVENTS WHICH I CAN DO NOTHING ABOUT</td>
<td></td>
</tr>
<tr>
<td>2 I HAVE CONSISTENT CONFIDENCE IN MY OWN ABILITY</td>
<td></td>
</tr>
<tr>
<td>1 THE PROBLEM IS VASTLY IMPROVED</td>
<td>I AM COMFORTABLE BEING MYSELF AND LESS SELF-CONSCIOUS</td>
</tr>
</tbody>
</table>
**PROBLEM: I HAVE A NEGATIVE ATTITUDE TOWARDS SEX**

<table>
<thead>
<tr>
<th>13</th>
<th>THE PROBLEM IS AT ITS WORST</th>
<th>I HAVE A NEGATIVE ATTITUDE TOWARDS SEX. I EXPERIENCE PAIN DURING SEX, AVOID SEX, DISLIKE SEX AND MY GENITALS &amp; RELATE SEX TO ABUSE.</th>
</tr>
</thead>
<tbody>
<tr>
<td>12</td>
<td></td>
<td>I CAN ACCEPT MY BREASTS (part of me and part of being a woman)</td>
</tr>
<tr>
<td>11</td>
<td></td>
<td>I CAN ACCEPT MY LEGS (part of me and part of being a woman)</td>
</tr>
<tr>
<td>10</td>
<td>THE PROBLEM IS SLIGHTLY IMPROVED</td>
<td>I CAN ACCEPT MY GENITALS (part of me, part of being a woman and not only associated with sexual abuse)</td>
</tr>
<tr>
<td>9</td>
<td></td>
<td>I INITIATE SEX ONCE PER MONTH</td>
</tr>
<tr>
<td>8</td>
<td></td>
<td>I INITIATE SEX ONCE PER FORTNIGHT</td>
</tr>
<tr>
<td>7</td>
<td>THE PROBLEM IS IMPROVED</td>
<td>I AM NOT THINKING ABOUT THE ABUSE DURING SEX</td>
</tr>
<tr>
<td>6</td>
<td></td>
<td>I CAN SAY 'NO' TO SEX BEFORE KISSING AND CUDDLING WITHOUT FEELING GUILTY</td>
</tr>
<tr>
<td>5</td>
<td></td>
<td>I CAN SAY 'NO' TO SEX AFTER KISSING AND CUDDLING WITHOUT FEELING GUILTY</td>
</tr>
<tr>
<td>4</td>
<td>THE PROBLEM IS MUCH IMPROVED</td>
<td>I AM EXPERIENCING LESS PAIN DURING SEX</td>
</tr>
<tr>
<td>3</td>
<td></td>
<td>I AM EXPERIENCING NO PAIN DURING SEX</td>
</tr>
<tr>
<td>2</td>
<td></td>
<td>I AM HAVING SEX AT OTHER TIMES BESIDES POST-MENSTRUATION</td>
</tr>
<tr>
<td>1</td>
<td>THE PROBLEM IS VASTLY IMPROVED</td>
<td>I HAVE A POSITIVE VIEW OF SEX. I ENJOY SEX, CAN ACCEPT MY BODY, INITIATE SEX SOMETIMES, DO NOT MAKE UP EXCUSES, EXPERIENCE MINIMAL PAIN, ASSOCIATE SEX WITH LOVE</td>
</tr>
</tbody>
</table>
PROBLEM: I DISLIKE TOUCH

<table>
<thead>
<tr>
<th></th>
<th>THE PROBLEM IS AT ITS WORST</th>
<th>I AVOID ALL TOUCH</th>
</tr>
</thead>
<tbody>
<tr>
<td>13</td>
<td></td>
<td></td>
</tr>
<tr>
<td>12</td>
<td></td>
<td>I CAN STAND WITHIN 1 METRE OF A PERSON*</td>
</tr>
<tr>
<td>11</td>
<td></td>
<td>I CAN TOUCH A PERSON’S HAND WHEN PASSING A PEN FROM ONE PERSON TO ANOTHER*</td>
</tr>
<tr>
<td>10</td>
<td>THE PROBLEM IS SLIGHTLY IMPROVED</td>
<td>I CAN SHAKE SOMEONE’S HAND WHEN THEY OFFER*</td>
</tr>
<tr>
<td>9</td>
<td></td>
<td>I CAN TOUCH AN OLDER PERSON ON THE SHOULDER*</td>
</tr>
<tr>
<td>8</td>
<td></td>
<td>I CAN TOUCH A YOUNGER PERSON ON THE SHOULDER*</td>
</tr>
<tr>
<td>7</td>
<td>THE PROBLEM IS IMPROVED</td>
<td>I CAN LET AN OLDER PERSON HUG ME*</td>
</tr>
<tr>
<td>6</td>
<td></td>
<td>I CAN OFFER TO SHAKE SOMEONE’S HAND*</td>
</tr>
<tr>
<td>5</td>
<td></td>
<td>I CAN HANDLE BEING TOUCHED ON THE SHOULDER*</td>
</tr>
<tr>
<td>4</td>
<td>THE PROBLEM IS MUCH IMPROVED</td>
<td>I CAN HANDLE BEING HUGGED BY A FRIEND*</td>
</tr>
<tr>
<td>3</td>
<td></td>
<td>I CAN DO THE DISHES WITH SOMEONE*</td>
</tr>
<tr>
<td>2</td>
<td></td>
<td>I CAN OFFER TO HUG SOMEONE*</td>
</tr>
<tr>
<td>1</td>
<td>THE PROBLEM IS VASTLY IMPROVED</td>
<td>I CAN HANDLE SOMEONE BRUSHING PAST ME*</td>
</tr>
</tbody>
</table>

*without feeling anxious
Appendix j:

Feedback from Subjects involved in Studies One and Two
FEEDBACK FROM SUBJECTS REGARDING
THE TREATMENT PROGRAMMES

1. WHY I DID THIS PROGRAMME.....

M: Because at the time I saw Tara's advertisement I was looking for something to help me as I had been aware for a while that there were many problems linked to my childhood that I hadn't dealt with and needed to. It seemed opportune.

Y: I was at the stage in my self improvement where feedback and input would benefit me. My self-esteem was still needing to be worked on and I thought the project would help me, as I thought - and I still do - that most of my ego/esteem problems had to do with the slimy men and lack of father figures in my childhood.

G: Because I was sick and tired of feeling depressed and so different because someone else had done something to me to make me feel so bad.

L: Because for some time I had been wanting to do something about my problem but didn't know how to go about it as didn't want to explain to anyone.

2. WHAT I HAVE ACHIEVED.....

C: I have more confidence in myself.

M: Whilst in many ways I have a long way to go I can now share the pain of the child within and not blame her in any way for what happened and grow from here!
Y: I have become more vulnerable in that I am more open to people (my cupboard of inner self has been unlocked, and sometimes the door is opened) and I think this is a good thing. I am becoming less vulnerable in that I can shrug off some things - comments, criticism, ability to say something directly to people knowing that they may 'dis-like' me for it - and not brood. I know that I need to work on ego and self esteem, but I am more consciously aware of my inner criticism. My 'face' is still a worry, but I love my body now. I have new feelings about the sexuality of my own body (very positive).

G: I feel better about myself and sex. I can change my negative thoughts to positive thoughts and my bad moods don't last as long.

L: I can now put the past behind me. I feel delighted, like a huge weight has been lifted off my shoulders. I couldn't believed at the beginning that I'd be doing these things. I can get on with my life - put it all in the past now - start afresh.

3. WHAT I AM REALLY PROUD OF.....

M: That I stuck it out and kept coming back and that I have finally begun to face my abusive childhood.

Y: Saying how I feel much more often. Trusting one or two people absolutely with innermost feelings. Learning that I love my body. Being 'at home' in places other than my house, e.g. being myself and not being what I think I should be with other people.
G: Is being strong enough to look at all my problems and be able to analyse them objectively and not let them drag me down further.

L: That I completed the course and that I am now able to do things that I never thought I could.

4. WHAT I WOULD LIKE TO CONTINUE WORKING ON.....

M: I need to work on my self-esteem and achieve relationships (healthy ones) with people around me and that I've only looked at the tip of the iceberg and need to learn from others how they have coped and get on with life. I have planted a little seed and it's up to me to water and care for it.

Y: Self-esteem. ego. I'd like to get to the point where people may dislike me (because I do what I want) and feel that it is a positive thing that I am being disliked (this means that I am putting myself first, and expressing myself and because of this I have people disagreeing with me). Opening to men - being my SELF and not being self-conscious - spontaneity. Being able to argue - stand up for myself! Learning to play. Practising doing things in step emotionally - that comparative thing with learning to ride my bike. Not to feel guilty about stuff because its for ME.

G: Is improving my self confidence, assertiveness, my self worth, believing that I am a good person and deserve to be treated well. I need to learn that not all people are going to hurt me, and not all people are horrible. I need to learn how to express my anger in ways that can help and not hurt me. I need to learn not to
react to what other people say or feel, and to remain confident about myself and not let other's moods affect me.

L: I realise this is only the beginning and that I must continue to put into practice what I have learnt.

4. I CAN LOOK AFTER MYSELF USING THE FOLLOWING.....

M: I can look at my negative thoughts and try to change them. With time and practice, I'm sure I can achieve this. Know that I no longer need to be a victim and have rights which help me to cope. I know that some of my coping skills - withdrawal etc, are OK.

Y: Confronting problems directly (physical/mental/verbal action) and moving forward step by step - initial action, e.g. verbalising; then re-action, etc., PAUSE - relax - review situation - centring.

G: Positive affirmations. Changing negative thoughts into positive ones.

L: Using the relaxing tape, deep breathing, telling myself to keep calm, to relax, no one is going to hurt me, using the distraction technique.

5. I HAVE DISCOVERED.....

C: I understand that I was not to blame, I don't hate anyone for it and I don't even think about unless I want to and I only did that once so I could put it all into perspective. Now I don't think of it anymore.
M: That my anger is directed at the right people not myself. That it is OK to feel angry and sad about the past but that hanging onto it (the past) is unproductive. That I have let people walk all over me and that I have a lot of growing to do.

Y: That I am a cautious individual - this is learned but also one of my personal traits. However I am discovering that I need to jump in at the deep end sometimes, because when I am always cautious I regret my caution but the moment has passed and its too late to gain insight/new experience. That if I act egoistically a little more often I will begin to believe I have one (an ego I mean). That I don't like my face because it expressed the worry/anxiety that has been part of my personality and the bags/lines in my skin are a sign of negative attributes. I also can't come to terms with accepting these outward signs when I look in the mirror.

G: That I am a good person and I do deserve to be happy. The abuse was not my fault and I do not need to go through the rest of my life in pain. I can enjoy life if I decide to.

L: Life is much more enjoyable! Anything is possible: That the things in life that should have been simple are now becoming simple.

ADDITIONAL COMMENTS.....

C: I would like to take this opportunity to thank you for all your hard work, if it wasn't for you I would not be as strong as I am today.
W: Thanks heaps for all your help. It seems that I am now able to put problems more into perspective and leave some where they belong (in the past)! So I decided that I don't need any more counselling. Time to go forward not back. Thanks again for helping me put things back on track.

G: I feel that these questionnaires (referring to battery of questionnaires) are not really accurate enough to determine my feelings. It doesn't take into account everyday events that are happening and any other events that could disrupt my normal activities.

L: A friend had suffered a big shock so I thought I'd phone her and then I thought I better go and see her and when I did she just hugged and hugged me! At the time it never entered my head that I don't like this. Have also been to X and greeted many friends with no problems. So as you see I'm much improved! Thanks again.