EMPATHY: A POSSIBLE FACTOR IN TREATING MALE VICTIMS OF CHILD SEXUAL ABUSE

BY

LINDA MADELEINE PRAYER

A dissertation submitted in partial fulfillment of the requirements for the degree of

Doctor of Psychology in Clinical Psychology

Alliant International University

California School of Professional Psychology

Sacramento Campus

2012

UMI Number: 1571691

All rights reserved

INFORMATION TO ALL USERS
The quality of this reproduction is dependent upon the quality of the copy submitted.

In the unlikely event that the author did not send a complete manuscript
and there are missing pages, these will be noted. Also, if material had to be removed,
a note will indicate the deletion.

UMI 1571691

Published by ProQuest LLC (2014). Copyright in the Dissertation held by the Author.

Microform Edition © ProQuest LLC.
All rights reserved. This work is protected against
unauthorized copying under Title 17, United States Code

ProQuest LLC.
789 East Eisenhower Parkway
P.O. Box 1346
Ann Arbor, MI 48106 - 1346

CALIFORNIA SCHOOL OF PROFESSIONAL PSYCHOLOGY

SACRAMENTO CAMPUS

The dissertation of Linda Prayer, "Empathy: A Possible Factor in Treating Male Victims of Child Sexual Abuse," approved by her Committee, has been accepted and approved by the Faculty of the California School of Professional Psychology, Sacramento Campus, in partial fulfillment of the requirements for the degree of Doctor of Psychology in Clinical Psychology.

Dissertation Chair Person:

_____

Suni Petersen, PhD

December 5, 2013

_____

Beth Limberg, PhD
Program Director, Clinical PsyD Program

DEDICATION

To the children who suffered sexual abuse and who have to carry the pain and fears through their life. My heart goes to these innocent victims who are too often silenced by their aggressor. I sincerely hope to convey the message that someone hears their lamentations and is dedicated to making a difference to end the cycle of suffering.

To my late maternal and paternal grandmothers who have been an inspiration in my life. Both were strong and kind women, I will always be grateful to have known them.

To my father, a man of ethics and generosity, who taught me that I could achieve anything I wish in life. Merci Papa, I love you tremendously.

To Matt, my dear husband, who never doubted my dedication, even in the toughest times during my doctoral program. I admire your character and your kindness. Your unconditional love and support made an incommensurable difference in this journey and in my life, thank you.

As this final chapter of my doctoral program closes up, I am excited to discover the fantastic opportunities my career as a psychologist holds for me.

ACKOWLEGEMENTS

In my journey from France to the United States, I have been extremely fortunate to meet exceptional people who inspired me each day. Some I met briefly in life, others who I have been fortunate to know much more and who have been part of my progress through my doctoral program. I wish to express my deepest gratitude to those who provided me with the guidance and support I needed to complete this dissertation. Thank you to my friends, Emma and Gayle, who I know I can always count on for love, support, and advice. Thank you for always being there for me when I needed you, and I am so grateful to have friends like you.

A very special thank you to Dr. Suni Petersen, my chairperson, for her continued availability, guidance and support throughout this process. Your support and guidance will never be forgotten.

ABSTRACT OF THE DISSERTATION

Empathy: A Possible Factor in Treating Male Victims of Child Sexual Abuse

by

Linda Madeleine Prayer

California School of Professional Psychology, Sacramento Campus

Suni Petersen, PhD

Dissertation Chairperson

2012

This study investigated the variability in empathy amongst clinicians toward males and females who were the victims of child sexual abuse. Empathy has been clearly established as a crucial component of the direction and outcome of the psychotherapeutic care of a patient. Research shows that typically males who were the victims of sexual abuse during childhood often receive less empathy from their support system than females do. Empathy is pivotal to the treatment of males who were sexually abused because it is one of the main key-components addressing the psychopathology and perpetration risk-level of the patient. This study gathered clinicians' reports of empathic feelings utilizing the Interpersonal Reactivity Index (IRI). The research design was correlational. The findings showed that the group of therapists who read the male vignette demonstrated less empathy overall than the group of therapists who read the female vignette. This study highlights the importance of empathy within the treatment of sexually abused males and the goal of reducing the risk of perpetration.

TABLE OF CONTENTS

LIST OF TABLES

Chapter 1

INTRODUCTION

Prevalence of Child Sexual Abuse

Each year in America, nearly 10% of our children become the victims of sexual abuse (Administration for Children and Families, 2010). In spite of all the efforts put into place by the government and independent organizations to increase public awareness and prevention, the persistent statistics of 1 in 4 girls and 1 in 6 boys sexually abused before reaching the age of 18 emerges each year in every national report on child sexual abuse (The National Center for Victims of Crime, 2010). Although couples may sexually abuse children, the majority of sexual abuse cases are committed by lone sexual predators (pedophilic, hebephilic sex offenders and child molesters). A landmark study conducted by Rudin, Zalewski and Bodmer-Turner (1995) supports that females are most often the victims of child sexual abuse by revealing that "lone male perpetrators abuse more girls (76%) than boys (24%)" (p. 968) and that "lone female perpetrators also abuse more girls (62%) than boys (38%)" (p. 968). Behl, Conyngham and May (2003) also supported this concept in their study-review on child maltreatment by reporting that females have a significantly higher rate of child sexual abuse victimization than males. Fergusson and Meehan (2005) found similar data through their research on child sexual abuse by demonstrating that sixty percent of female sexual offenders engaged in sexual abuse toward their daughters and forty percent engaged in sexual abuse toward their sons.

Effects of Child Sexual Abuse

The traumatic effects of child sexual abuse are reflected in the child's behavior and emotional state during the abuse period and/or during the post-abuse period. As Wohab and Akhter (2010) explained, childhood sexual abuse is considered to be a central issue of mental and physical problems, which may carry on up to adult life of men and women.

Friedrich (1994) conducted a cluster analytic study of symptoms on 384 children victims of sexual abuse using the Child Behavior Checklist: 8.6% were categorized as sexualized, 6% as aggressive and sexualized, and 4.9% as anxious-sexualized. It has been observed that sexually abused children may immediately after reenact the sexual abuse with peers and/or adults (Webster, 2001). However, in some cases, children victims of sexual abuse may take up to a year to gradually display some signs of trauma, and they may be mislabeled as "no effects" children (Webster, 2001). Yet the accurate title for this group of children is "sleeper effect." "A sleeper effect refers to the situation in which the abused child shows no obviously significant or discernible emotional problems immediately subsequent to child sexual abuse. As time passes, the child survivor slowly begins to manifest increasingly more serious emotional and/or behavioral problems" (Webster, 2001, p. 437).

Among the multiple negative impacts of sexual abuse, "guilt and shame often are apparent, which can affect the child's capacity to develop meaningful present and future relationships with peers and other adults" (Webster, 2001, p. 438). A fundamental finding for the child sexual abuse literature was presented by Friedrich (1994); via the concept

that the victims of childhood sexual abuse encounter disturbances in at least three areas of functioning: attachment, dysregulation, and issues of self.

Perpetration Trends of Child Sexual Abuse

Although many more females than males are the victims of sexual abuse during childhood, only a very small percentage of females become a perpetrator (Behl et al., 2003). While attempting to explain the discrepancy between the number of male and female perpetrators of child sexual abuse, some researchers suggest that this discrepancy may be linked to the concept that victims less often report female perpetrators than males. It is often hypothesized that females are less violent or perceived as less violent than males while coercing a child into sexual acts. This is essentially based on the fact that females often fit the profile of the only caregiver or one of the primary caregivers for the child, which gives them access to the child very easily, as well as physical contact with him/her in a less suspicious fashion than males. "Women are permitted a much greater range of physical contact with children than are men, therefore the boundary that would indicate a shift from non-abusive to abusive behavior is much more difficult to discern" (Hetherton, 1999, p. 163). Most of the child sexual abuse instances committed by females take place during care-giving situations; Kelly (2002) stated that in the context of mother-son incest, the assault was likely to be subtle, involving behaviors that may be difficult to distinguish from normal care-giving patterns.

It has also been reported in child sexual abuse literature that female sexual abusers are less likely than males to be profiled and prosecuted as child molesters, pedophiles or hebephiles by society in spite of accusations. Society is still barely accepting the idea that females do also abuse children sexually. For instance, Hetherton

(1999) stated in her research that "while sexual abuse is widely acknowledged as a social problem perpetrated by men against children, its perpetration by women has not been so readily identified or addressed." Saradjian (1996) suggests that child sexual abuse perpetrated by males is more "acceptable" socially speaking because the "schemata of maleness includes aggression and sexual initiation, and lacks of expectation of care and nurturance. The schemata concerning females; however, predict that women are nurturing, caring, non-aggressive, and responsive to, rather than initiators of, sexual activity with others" (p. 5). Since sexual abuse by females falls outside the range of behaviors predicted by the schemata, psychological discomfort or "cognitive dissonance" (Festinger, 1957) arises, which in turn explains why female child sexual abuse is referred to as "misguided extensions of love" or "inappropriate affection" (Saradjian, 1996, p. 31). Essentially, the consequence of such refusal on society's part to recognize that females are also capable of sexually abusing children leads to a minimization of the phenomenon (Hetherton, 1999).

Another explanation offered by researchers concerning the discrepancy between the reported number of male and female sexual abusers is that "nearly 70% of [male] child sex offenders have between 1 and 9 victims" and "20% have 10 to 40 victims" per year each (Elliott & Kilcoyne, 1995, p. 584). To this date, data on female sex offenders are very scarce; more research needs to be done in order to better understand their profile and estimate accurately the number of victims they produce each year. At best, "government statistics suggest that women account for approximately 2-5% of sexual offenses in the U.S. according to the United States Department of Justice, which

represents approximately 10,000 separate offenses each year" (Ferguson & Meehan, 2005, p. 76).

Although the majority of the victims of childhood sexual abuse do not become perpetrators in adulthood, childhood sexual abuse carries substantial risk factors for the victim to become a perpetrator. Moreover, childhood sexual abuse may have an impact on one's psychosexual development which may increase the risk of becoming a sex offender in adolescence and/or adulthood (Jespersen, Lalumière & Seto, 2009). Glasser, Kolvin, Campbell, Glasser, Leitch and Farrelly (2001) demonstrated via their recent study that "the risk of being a perpetrator was positively correlated with reported sexual abuse victim experiences" as a child. In that study, out of 843 males and females, 35% of the males who were sexually abused as a child became perpetrators, and only 11% of the males who committed incest and/or an act of pedophilia were not sexually abused as a child. This finding is corroborated by a noteworthy research conducted by David Lisak (1994), in which out of 26 adult male survivors of childhood sexual abuse, "almost a third of the men (31%) had victimized others at some point in their lives" (p. 530). In contrast, 43% of the total subjects in Glasser et al. (2001) study were females who had been sexually abused as a child, but only one of them was a perpetrator. A recent study conducted by Peter (2009) that compared male and female perpetrated child sexual abuse, found only 10.7% of females perpetrated sexual abuse as opposed to 89.3% males. Rudin et al. (1995) also suggests via her research on male and female perpetrators of child sexual abuse that females sexually abuse children as well but "to a lesser degree than male perpetrators" (p. 968).

Although female sexual offenses against children remain rare, they share a striking similarity with their male counterparts; they too were often the victims of childhood sexual abuse (Kaplan & Green, 1995).

Empathy

As Hojat (2007) explained in his book, *Empathy in Patient Care. Antecedents, Development, Measurement, and Outcomes*, the word empathy comes from the Greek word empatheia, which means appreciation of another person's feelings. The English term empathy was coined in 1909 by psychologist Edward Bradner Titchener as a translation of the German word einfühlung, used for the first time in 1873 by Robert Vischer, an art historian and philosopher who used this word to describe an observer's feeling elicited by works of art. In 1915, Titchener used the term empathy to convey understanding of other human beings, but not until 1918 did Southard describe the significance of empathy in the relationship between a clinician and a patient for facilitating diagnostic outcomes.

Feller and Cottone (2012) also stated in their work on empathy in therapy, that many theorists, such as Kohut, Rogers and Freud, supported the view that empathy was an essential part of therapy. For instance, Kohut (1957), the founder of self-psychology, supported that the therapist's empathic response to his/her patient was more helpful than the interpretation of the client's behavior.

Rogers (1957) defined the therapist's empathy as being in touch with the "client's private world as if it were your own, but without ever losing the "as if" (p.85). Rogers (1980) further elaborated his definition of empathy as "the therapist's sensitive ability and willingness to understand the client's thoughts, feelings and struggles from the

client's point of view (p.85). [It is] this ability to see completely through the client's eyes, to adopt his frame of reference." Rogers (1980) also added that this "means entering the private perceptual world of the other […] being sensitive, moment by moment, to the changing felt meanings which flow in this other person. It means sensing meanings of which he or she is scarcely aware" (p.142).

Within the arena of neuroscience, empathy is defined according to three major neuroanatomically based subprocesses (Eisenberg & Eggum, 2009): (a) an *emotional simulation* process that mirrors the emotional elements of the other's bodily experience with brain activation centering in the limbic system and elsewhere (Decety & Lamm, 2009); (b) a conceptual, *perspective-taking* process, localized in parts of prefrontal and temporal cortex (Shamay-Tsoory, 2009); and (c) an *emotion-regulation* process used to soothe personal distress at the other's pain or discomfort, making it possible to mobilize compassion and helping behavior for the other, probably based in parts of the orbitofrontal, prefrontal, and right parietal cortex (Decety et al., 2009).

In their meta-analysis on empathy and its impact in psychotherapy, Elliott, Bohart, Watson and Greenberg (2011) made one of the following recommendations based on their findings: "an empathic stance on the part of the therapist is an essential goal of all psychotherapists, regardless of theoretical orientation, treatment format, and severity of patient psychopathology" (p. 47). Taking into consideration that "disclosure is a prominent variable in child sexual abuse research, particularly in descriptions of male victims" (Sorsoli, Kia-Keating & Grossman, 2008, p. 333) and that males are more likely than females to encounter negative reactions from their interlocutor(s) (Ullman & Filipas,

2005), it becomes clear that empathy is worth further investigation and attention as a compelling factor in the treatment of male victims of child sexual abuse.

Most importantly, empathy should be regarded as an important factor within the circle of professionals who have the responsibility to treat the males who were the victims of child sexual abuse. Davies and Rogers (2006) concluded that male victims most often are attributed more blame than are female victims in spite of the public education campaigns about child sexual abuse and a greater encouragement from society and the authorities for males to disclose the sexual abuse and seek help. This increased blame attribution for male victims is due to societal stereotypes that cast females as sexually passive and males as physically capable of resisting an assault. Davies and Rogers (2006) further explain that the attributions of victim blame are typically influenced by a myriad of ancestral social and cultural norms that place females in sexually passive roles while casting males in sexually aggressive roles. Dube, Anda, Whitfield, Felitti, Dong and Giles (2005), Dhaliwal, Gauzas, Antonowicz and Ross (1996) and Maikovich-Fonga and Jaffe (2010) emphasize that males and females both employ external and internal coping mechanisms in order to overcome their trauma of childhood sexual abuse. They also explain that the arousal and pleasure experienced by the child-victim during sexual abuse acts create a tremendous amount of confusion which often gives room to shame in the victim's psychological profile. According to Maikovich-Fonga and Jaffe (2010) this feeling of shame is shown to be much more persistent in the psychological profile of the male victims than in the females'. This is essentially explained by the incongruence between the societal description of the male's sex role identity and the actual traumatic sexual experience of the male victims of sexual

abuse. In favor of this concept, Davies and Rogers (2006) explained that only recently have researchers begun to focus on describing male victims of sexual assault, and much of this focus has been on the concept of victim blame.

In addition, Dube et al. (2005), Dhaliwal et al. (1996) and Maikovich-Fonga and Jaffe (2010) explained via their research that the discrepancy that exists between the amount of shame between male and female victims could be explained principally by the fact that female survivors of sexual abuse often have access to more support from professional services than males do. O'Leary and Gould (2009) and Lab, Feigenbaum and De Silva (2000) also explained that despite the high statistics of male sexual abuse, it is still currently viewed by society and handled by researchers and mental health professionals as a new discovery.

In conjunction with this previous observation, researchers have demonstrated that males who were the victims of sexual abuse during childhood often receive less empathy from their support group (e.g. family, friends, medical and/or mental health professionals) than females do. Neumann, Bensing, Mercer, Ernstmann, Ommen and Plaff (2009) who recently conducted a study on the effectiveness of empathy in clinical settings concluded that a therapist who is empathetic will display clinical objectivity and professional effectiveness. They further explained that clinical empathy is a fundamental determinant in the quality and accuracy of care provided by the clinician to the client which ultimately leads to enhanced health outcomes. While discussing empathy within the frame of psychotherapy, Harkins and Beech (2007) also explained that although a therapist's experience and attitudes are not traditionally discussed as therapist characteristics, they usually play a role in influencing treatment effectiveness. Bylunda

and Makoul (2002) highlighted in their study that general research on communication and gender has shown differences in the ways women and men interact. They found further support in their findings that females are more likely to disclose emotions than males, which may in turn reinforce a gender-specific type of communication between a therapist and his/her client.

The impact of the child sexual abuse survivor's gender onto the therapist's empathy has not been clearly established in clinical literature. This study will attempt to elucidate this topic while employing an experimental design. The independent variable is gender and the dependent variable is empathy. The hypotheses that will be tested are:

H_1: Therapists will demonstrate greater empathy when reading the vignette of the female client who experienced sexual abuse than reading the vignette of the male client who experienced sexual abuse. A t-test for independent means will be used to test this hypothesis.

H_2: There will be no significant difference between male and female therapists in empathy in response to vignette of sexually abused male client. A t-test for independent means will be used to test this hypothesis.

H_3: There will be no significant difference between male and female therapists in empathy in response to vignette of sexually abused female client. A t-test for independent means will be used to test this hypothesis.

Definition of Terms

Child sexual abuse is the "contacts or interactions between a child and an adult when the child is being used for sexual stimulation of the perpetrator or another person when the perpetrator or another person is in a position of power or control over the victim" (*The National Center on Child Abuse and Neglect, 2010).*

Among the pool of sexual predators against children three principal subcategories exist: the pedophile, the hebephile and the child molester:

The *pedophilic sex offender* targets children who are prepubescent (age 13 or younger).

The *hebephilic sex offender* targets children who are pubescent (age 14 or older). Beside a specific age range, pedophiles and hebephiles also favor some specific characteristics in their victims' profile such as their gender, race, hair color, etc.

The *child molesters* have a less restrictive type of victimology and are also more likely than pedophiles and hebephiles to be violent offenders. Child molesters do not present a strict preference to children, but rather will use children for sexual gratification due to their social inaptitude and/or when they do not have access to a mate of appropriate age of consent.

Empathy is defined within the general psychological literature as an intellectual capacity to comprehend and identify another's perspective or experience (Pithers, 1999).

Chapter 2

REVIEW OF LITERATURE

This literature review section will present the short-term and long-term effects that child sexual abuse produces on its victims, how societal gender-roles play into the coping mechanism of female and male victims of child sexual abuse, the impact child sexual abuse has on males specifically, the rate of disclosure for male and female survivors of child sexual abuse, and the perpetration trends of child sexual abuse. This section will also specifically discuss the most commonly used forms of therapy to treat male survivors or child sexual abuse as well as how empathy may be an essential part of the therapeutic process for the victims of child sexual abuse.

Psychopathological Outcomes of Childhood Sexual Abuse

When a child is sexually abused, an array of pervasive psychological and behavioral issues shows in his/her personality. He/she typically displays a wide range of behavior problems, mental health disorders, and adjustment difficulties, including anxiety, fear, depression, somatic complaints, aggressive behavior, inappropriate sexual behavior, and problems with learning and behavior immediately after the sexual abuse occurred (Wohab & Akhter, 2010). On a long-term scale, these children continue to face some serious difficulties as adults such as increased depression, anxiety disorders, antisocial behavior, substance abuse, eating disorders, suicidal behavior, posttraumatic stress disorder (PTSD), and sexual adjustment difficulties (Marx, Heidt & Gold, 2005; Messman-Moore & Long, 2003; Risser, Hetzel-Riggin, Thomsen & McCanne, 2006).

Maniglio (2009) produced a review of a large body of research conducted on child sexual abuse and its short- and long-term effects. After a thorough triage according to specific inclusion and exclusion criteria, his meta-analysis reviewed the outcomes of 14 studies. This meta-analysis confirmed that survivors of childhood sexual abuse are at greater risk to present with medical, psychological, behavioral and sexual disorders. Although the goal of this meta-analysis is most helpful in revealing the outcomes of childhood sexual abuse, the main criticism would be that it used in studies conducted on females exclusively; therefore a fair comparison of data between the two genders is lacking.

Research by Ackard and Neumark-Sztainer (2003) on 9th and 12th grade students, the findings show that girls and boys who experienced either a single form or more than one form of sexual abuse reported significantly higher rates of suicide attempts than their non-abused peers. In addition, Takkhar and her colleagues (2000) explained that their findings support the concept that women who were sexually abused as a child were at greater risk of suicide ideation and attempts than the victims of other forms of abuse. Also, Webster (2001) explained that more and more studies show now that child sexual abuse survivors infallibly develop many of the symptoms associated with posttraumatic stress disorder due to their traumatic experiences. Up to 50% of sexually abused children may display either partial or full criteria for PTSD (Paolucci, 2001).

Colton, Roberts and Vanstone (2009) explain in their study that over the past quarter of a century, there has been a growing body of work on the damaging short- and long-term effects of child sexual abuse (e.g., Chen, Dunne, & Ping, 2006; Curtis, 2006; Denov, 2004; Feerick & Snow, 2005; Finkelhor, 1986; Gill & Tutty, 1999; Johnson,

2001; Kahan, 1997; Liang, Williams, & Siegel, 2006; Rush, 1980; Spring, 1987; Tyler & Johnson, 2006; van Loon & Kralik, 2006) and the link between sexual victimization and subsequent offending among males (Briggs, 1995; Campbell, 1997; Howitt, 1995; Waterhouse, Dobash, & Carnie, 1994). Colton et al. (2009) explained that punishment is an important aspect of the criminal justice response to sexual crimes against children. Sentence lengths for sexual offenses have increased worldwide and in many countries, sexual offenders are mandated to register as such. Evidently, society's goal through these measures is to protect its children and reduce the number of future victims. However, Colton et al. (2009) cautioned society by explaining that the lifespan of these measures often come to expiration since most sex offenders will at some time be released and that most of them might fail to register as sexual offenders. Ultimately, any society addressing the issue of child sexual abuse should focus not only onto prevention by treating male victims of child sexual abuse but equally onto rehabilitation by treating male perpetrators of sexual offenses against children prior to their release. A logical response to prevention and rehabilitation is undeniably psychotherapy. Unfortunately, research focusing specifically on the effects of child sexual abuse on males and identifying the efficacy of therapies designed to treat male victims are still scarce to this day (Homma, Wang, Saewyc & Kishor, 2012).

When Childhood Sexual Abuse Shatters Gender Roles

Gender role is undeniably one of the most crucial elements in how one processes an event. As Putman (2003) explained, when child sexual abuse occurs it is always within a "gendered" social context in which males have noticeably more power than females. Moreover, "gender role orientation represents the extent to which a person conforms to

masculine or feminine norms associated with the respective gender by demonstrating socially prescribed attitudes, beliefs, and behavior congruent with being “masculine” or “feminine”” (Reidy, Sloan, & Zeichner, 2009). In the frame of child sexual abuse, gender role should be perceived as one of the most relevant factors in the outcomes of the traumatic event, in the sense that gender role provides a platform for how the sexual act is translated by the victim, the offender, and society. For instance Dollar, Perry, Fromuth, and Holt (2004) established via their research that child sexual abuse of a “homosexual” nature was perceived as more serious than heterosexual abuse, especially when the victim was male.

Bornstein, Kaplan and Perry (2007) conducted a study exploring the social perception of child sexual abuse in relation to the gender of the victim and offender. Their findings highlighted that the risk for sexual abuse to occur and reoccur at the hands of a male was perceived as more likely and believable than at the hands of a female. And similarly to the two studies cited above, Bornstein et al. (2007) found that the outcome of child sexual abuse was perceived as more “traumatic, severe, and repressible” when it was homosexual abuse rather than heterosexual abuse. More importantly and in support to the present research, they suggest that females and males process the same evidence differently. Additionally, Banyard, Williams and Siegel (2004) suggested as well that “prescribed gender roles may also play a role in differences in how symptoms are expressed.” Ullman and Filipas (2005) also supported this gendered approach to trauma processing and coping abilities by explaining that “the social context of abuse including men’s and women’s gender role beliefs should be examined to understand further both

men's and women's own responses to child sexual abuse as well as their social networks responses."

In sum, the impact of a traumatic event such as childhood sexual abuse may be different for a male and a female based upon the social attributions to each gender role. For instance, Unger, Norton and De Luca (2009) explained that the "traditional gender roles for women are associated with being a sexual object and submitting to the sexual advances of men," whereas Spiegel (2003) explained in his book, *Sexual abuse of males: The SAM model of theory and practice*, that the experience of being the victim of sexual abuse for males is in direct opposition with what society describes and expects their gender characteristics to be, such as "powerful, independent, courageous, masterful, aggressive, dominant, and competent." Anderson's (1999), Clear and Cole's (2000) research supported the fact that males do not feel comfortable expressing their pain as it may transmit and may be received as a sign of weakness simply based on their gender.

Gender Differences in Impact of Child Sexual Abuse

Many scholars have demonstrated that in most cases females have more severe and detrimental psychological effects due to the trauma of their childhood sexual abuse than males. Arriola, Louden, Doldren, and Fortenberry (2005) explained that girls are socialized to make more stable and internal attributions about negative experiences generally, thus leading to a greater likelihood of self-blame for abuse. Arriola et al. further explained that female survivors of sexual abuse tend to experience a greater level of depression or substance abuse disorders than men. They also explained that females face greater risks than males for negative adjustment related to childhood sexual abuse, and are therefore at greater risk for depression because of the way girls are raised.

Feiring, Taska, and Lewis (2002) later found meaningful gender effects in their research between boys and girls who were sexually abused. They explained through their findings that girls tend to experience more severe types of sexual abuse essentially because the assault committed against them often entails penetration and is often incestuous. Feiring et al. (2002) further explained that "girls persisted in showing higher levels of PTSD and depressive symptoms" than boys and the "greater abuse severity and shame at discovery may make them more vulnerable to internalizing problems over time."

In order to identify the severity of the impact of child sexual abuse in females, Katerndahl, Burge, and Kellogg (2005) conducted research on the comorbidity of disorders in women with a history of child sexual abuse. The cluster of disorders reported in their study was composed of Borderline Personality Disorder (BPD), Suicidal Attempts/Ideation, Bulimia, Depression, Substance Use, Panic Disorder, Agarophobia and Posttraumatic Stress Disorder (PTSD). The most frequent disorders reported by the participants were Suicidal Attempts/Ideation (47.3%), Substance Use (36%), PTSD (32%), Panic Disorder (31.3%), BPD (29.3%), and Depression (21.8%). Agoraphobia and Bulimia were the lowest diagnoses reported, 12.2% and 7.7% respectively. In a recent research conducted by Owens and Chard (2003), it was established that 89% of the female survivors of child sexual abuse met criteria for PTSD at the time of the study. Ultimately, Katerndhal's et al. (2005) results confirmed a clear incidence of comorbidity in their participants: 13% of the females who were sexually abused as a child had two disorders, 16% had three and 15% had more than three. Although the focus of their

research was on the comorbidity of diagnoses, it is worth noting that 69% of their participants had at least one diagnosis and 24% had only one diagnosis.

Similar findings concerning the impact of child sexual abuse on females is offered by Little and Hamby (1999) who explained that females report "more problems with self-esteem, interpersonal relationships, sexual intimacy, and work roles than male survivors of sexual abuse." Dimitrova, Pierrehumbert, Glatz, Torrisi, Heinrichs, Halfon and Chouchena (2009) also found that females who endured childhood sexual abuse "presented symptoms of moderate intensity (such as affective problems, episodic panic attacks) or some difficulties in social or professional functioning (such as having few friends, or frequent conflicts with colleagues)."

Many studies confirmed that child sexual abuse is related to personality disorders in females (Christopher, Lutz-Zois, and Reinhardt, 2007; Trull, 2001). Vick, McRoy, and Mathews (2002) found that the most common diagnoses in female sex-offenders were PTSD, Conduct Disorder, and Dissociative Disorders, along with Antisocial or Borderline Personality Disorder characteristics. Dimitrova's et al. (2009) findings supported the interpersonal difficulties that female survivors of child sexual abuse often encounter by stating that "abused women reported feeling less comfortable with closeness and intimacy in relationships [and] being more anxious in relationships, feared not being loved or being abandoned" in comparison with females who have not been sexually abused during childhood.

One of the most distinctive symptoms found in females who were the victims of childhood sexual abuse in comparison to males is dissociation. "Dissociation is defined as a disruption in the usually integrated functions of consciousness, memory, identity, or

perception of the environment, which may be sudden or gradual, transient or chronic" (*Diagnostic and Statistical Manual of Mental Disorders* [4th ed., text rev.]; American Psychiatric Association, 2000). Van Den Bosch, Verheul, Langwland, and Van Den Brink (2003) identified that approximately 80% of female adult survivors of childhood sexual abuse suffer from dissociative disorders. Also, in an attempt to demonstrate a relationship between dissociative symptoms and PTSD, Twaite et al. (2004) stated that their findings were "consistent with the theory that insecure adult attachment and dissociation are sequellae of childhood abuse and have a mediating role in the relationship between childhood abuse and adult PTSD." This concept was supported by Butzel et al. (2000) and Draijer et al. (1999) stating that "women with child sexual abuse histories also report significantly greater number of dissociative experiences during their adulthood than nonabused matched peers." Bremner (1999) suggested that "there may be two types of PTSD differentiated by the prominence of dissociative symptoms." Ginzburg, Koopman, Butler, Palesh, Kraemer, and Classen (2006) also identified a dissociative subtype of PTSD while surveying a sample of help-seeking childhood sexual abuse female survivors.

Presently, data on male survivors of child sexual abuse is slowly making its appearance in our literature. The amount of data on male survivors of child sexual abuse remains; however, to this day much scarcer than the amount of data on females. Dube et al. (2005) compared two large groups of males (n=4015) and females (n=4693) in their research on the long-term consequences of childhood sexual abuse. While comparing the two groups, they identified that most symptoms (e.g. drug abuse, suicide attempts, depression, interpersonal problems) were rather equivalent for each gender. It is worth

noting that this finding goes against the conclusion found by Arriola et al. (2005) which noted that female survivors of child sexual abuse have in general a higher level of substance abuse than male survivors. However, Dube and colleagues (2005) suggested that the rate of alcoholism in males was nearly double the rate in females, or 12.6%.

Kia-Keating, Sorsoli, and Grossman (2010) conducted research on the outcomes of child sexual abuse on males specifically with regard to their interpersonal difficulties. This research is particularly important as it stands out from most literature on male survivors of childhood sexual abuse that typically focuses on males' sexual dysfunction, child sexual abuse perpetration, violence and criminality (Ahmad, 2006; Loh & Gidyez, 2006; Simons, Wurtele & Heil, 2002; Johnson, Ross, Taylor, Williams, Carvajal & Peters, 2006). Kia-Keating and her colleagues' (2010) research shed more light on the understanding of the progression of childhood sexual abuse into adulthood, and offered insights that may be useful when considering treatment curriculums for males who were sexually victimized. In their results, they explained that the majority of their male participants felt extremely isolated and unsupported while growing up. The male survivors expressed that often their main goal once adult was to try to connect with someone who could love them with no judgment toward the sexual abuse they endured during childhood. Another key element emerged from this study was the quality of relational management or interpersonal skills for these surveyed male survivors. The male participants expressed having difficulty with boundaries, anger, trust and intimacy.

Although this study by Kia-Keatin et al. (2010) is extremely useful, one main criticism is that this study was a qualitative study. It shed light on concepts that emanated from the victims themselves, but it lacked of quantification; therefore, the degree to

which these concepts apply to the male population who endured child sexual abuse during childhood is unknown. Nonetheless, Kia-Keatin et al. (2010) introduced a relevant concept to this research topic, and in general to the professionals concerned with treating males who were the victims of child sexual abuse: Empathy.

It is undeniable that therapeutic processes that facilitate empathy toward the victim will prove to be effective. Ross, Polaschek, and Ward (2008); Marshall, Serran, Fernandez, Mulloy, Mann and Thornton (2003) supported through their research that the therapeutic alliance (which warrants in part the highest level of healing and change in the client) mandates empathy as a chore characteristic in the therapist's approach. Precisely, Marshall et al. (2003) and Serran, Fernandez, Marshall, and Mann (2003) who investigated therapists' characteristics deemed to be efficient and necessary for a successful therapeutic process, have identified several personal and professional qualities to be required including empathy.

Additionally, Ross et al. (2008) highlighted in their research that although a therapist plays a crucial role in therapy, a client is not a blank slate or passive receiver of therapeutic processes. They further explained that clients also bring distinctive personalities, experiences, capacities, goals, and expectations to their role. This comment becomes a natural invitation for taking in high consideration the client's trauma history and gender as affirmative and directive components of the therapeutic process.

The Effects of Childhood Sexual Abuse on Males

In many instances, the victims of childhood sexual abuse become excessively concerned with masturbation. Studies show that male sex offenders who were sexually abused during childhood reported an earlier onset of masturbation than other adult sex

offenders (Cortoni & Marshall, 2001; Smallbone & McCabe, 2003; Brown, Cohen, Chen, Smailes & Johnson, 2004). When the traumatic effects of sexual abuse remain so pervasive in the child's development, it may be observed that the child adopts an off-norm sexualized behavior and may replicate the assault onto others, often younger and smaller targets. Tyler (2002) conducted a meta-analysis in attempt to present the main social and emotional outcomes of childhood sexual abuse. In her review, she identified that children 12 and under displayed "inappropriate sexual behaviors" and children age 13 up to 17 displayed "risky sexual behaviors." In a noteworthy study by Pithers and Gray (1998), the findings highlight that nearly 40% of reported child sexual victimization is perpetrated by individuals under 20 years of age, and that 13–18% of all substantiated cases of child sexual abuse were committed by children age 6 to 12. Hall, Mathews and Pearce (1998) established that children who experienced sexual arousal are 15 times more likely to engage in aberrant interpersonal sexual behavior than their peers who had not experienced sexual arousal. When this previous scenario remains persistent, the victim is most likely to adopt deviant sexual behaviors during adolescence and/or adulthood. In some instances, the child may also be at greater risk of future revictimization. Sexually abused children also tend to demonstrate "poor boundaries and indiscriminate friendliness" which may put them highly at greater risk to fall into the hands of a pedophilic or non-pedophilic child molester (Pearce, 2003; Silovsky & Niec, 2002).

Although both males and females who were sexually abused during childhood are likely to adopt aberrant sexual behaviors during childhood, there seems to be a clear demarcation in the adopted type of sexualized behaviors between the two genders during adolescence and adulthood. For instance, Chandy, Blum and Resnick (1996) and Homma

et al. (2012) explained that young adult males who were the victims of child sexual abuse demonstrate a greater propensity to engage in sexual risk taking behaviors such as multiple partners, little use of contraception, and early onset for sexual activity than their female counter-parts.

The explanation of the gap between the male and female victims' sexuality may reside in the fact that girls' sexual abuse is often orchestrated in a violent fashion, and they also carry a heavy burden of internalized guilt and shame. Most often, girls are assaulted by a parental figure in comparison to males, 41% of girls versus 20% of boys were the victims of intrafamilial sexual abuse (Feiring, Taska & Lewis, 1999; Levesque, 1994). Girls are most often the victims of threats and physical injuries by the perpetrator than boys are (Levesque, 1994). This could explain why girls tend to "experience more personal vulnerability and perceive the world as a more dangerous place than boys" (Feiring et al., 1999).

Fergusson and Meehan (2005) demonstrated that although women may sometimes react to their feelings of anger, rage or jealousy with violence, it is not common for women to sexualize violence in comparison to males. Cortoni and Marshall (2001) further explained that most male sexual offenders make use of sexual activities extensively as a coping strategy in the face of difficult, stressful, or upsetting situations. Glasser et al. (2001) also reported in their study that male perpetrators had a more compulsive use of pornography than non-perpetrators, 4.4 % vs. 1.5% respectively. This conclusion may be explained by the idea that females as opposed to males display in general more caution and reservation toward sexuality (Fergusson and Meehan, 2005).

A study by Feiring et al. (1999) surveyed adolescents who were sexually abused during childhood revealed that females were more elevated than males on sexual anxiety, which is defined as the "feeling that sex is dirty, frightening, and to be avoided," conversely males were more elevated than females on eroticism. In research on male child molesters, a high frequency of sexual fantasies with sadomasochistic themes during adolescence was recorded (Cortoni and Marshall, 2001). Dorais (2009) also explained in his book, *Don't Tell – The Sexual Abuse of Boys*, that males who were sexually abused during childhood have a tendency to build up revengeful sexual fantasies. Additionally, Spiegel (2003) explained that males tend to adopt a hypermasculine role in order to counter-balance the stigmas that childhood sexual abuse generates. This hypermasculine role is often characterized by greater levels of anger, irritation, mood changes, and social alienation. Shumba (2004) also reported that society fosters the belief that male victims should be able to cope better than female victims because they are stronger emotionally. Clearly, males tend to receive less support than females from society when attempting to cope with childhood sexual abuse. This fact may, in turn, accentuate males' natural tendency to remain silent for many years, avoid seeking therapy, and unfortunately engage in deviant sexual behaviors involving children.

Disclosure of Child Sexual Abuse

Not all child sexual abuse is systematically reported by the child and/or the family. Several corroborating researchers (e.g., Schaeffer, Leventhal & Gottesegen-Asnes, 2011; Alaggia, 2005; Crisma, Bascelli, Paci & Romito, 2004; Goodman-Brown, Edelstein, Goodman, Jones & Gordon, 2003; Kogan, 2004; Smith, Letourneau, Saunders, Kilpatrick, Resnick & Best, 2000) supported the concept that children who were the

victims of sexual abuse often do not disclose. In most cases, it is not until adulthood that they denounce their aggressor (Berliner & Conte, 1995; Lamb & Edgar-Smith, 1994; Roesler & Wind, 1994; Goodman-Brown et al., 2003; Alaggia, 2005). The relation of the child to the sexual abuser plays a large part in that type of outcome. For instance, children are least likely to disclose the sexual abuse when the perpetrator is a biological parent. Sas (1993) also supported this concept by explaining that "89% of intrafamilial abuse victims, compared to 54% of victims of extrafamilial abuse, either delayed disclosing the abuse or did not disclose at all." Goodman-Brown's et al. (2003) findings were consistent with other previous researches while demonstrating that the victims of intrafamilial childhood sexual abuse may take longer to disclose the assault than the victims of extrafamilial child sexual abuse. But it also seems that the gender of the victim contributes greatly to the decision of disclosure (Alaggia, 2005; O'Leary & Barber, 2008). Most often girls are the victims of intrafamilial sexual abuse compared to boys (Feiring et al., 1999; Levesque, 1994), yet female survivors of child sexual abuse tend to disclose their childhood assault earlier and more often than males (Kimerling, Rellini, Kelly, Judson & Learman, 2002).

There are many studies that support the findings that male victims of sexual abuse disclose their trauma later than their female counterparts. Homma et al., (2012) and Alaggia (2005) identified that males report their victimization several years later from the sexual abuse incident(s). King and Woollett (1997) and O'Leary and Barber (2008) also reported that men may take up to 20 years to talk about their childhood sexual abuse. In their meta-analysis, Homma et al. (2012) supported that males delay disclosure because of cultural norms of masculinity and social stigma, especially when the sexual abuse was

produced by a male onto a male. Same-gender sexual abuse often generates greater shame in male victims because the act is perceived as homosexual and hypo-masculine.

In addition, for both genders, fear of retaliation is often a key decision factor in their non- or delayed-reporting of childhood sexual abuse. As Goodman-Brown et al. (2003) explained, 37% of the sexually abused children who reported the assault feared negative consequences to themselves, 11% feared negative consequences to others, and 8% feared negative consequences to the defendant. Because not every boy and girl discloses their sexual abuse, especially when the abuser is closely related to the child as previously discussed, it is reasonable to deduce that the numbers presented in most reports about child sexual abuse are lower than what the true picture of child sexual abuse is. It is also reasonable to conclude that, in spite of that fact, the discrepancy between the number of male and female sexual offenders against children is still most likely accurate. This concept is supported by the fact that in many instances, children who did not report their sexual abuse during childhood often end up sharing this burdening secret later in adulthood to their therapist, in surveys, to loved ones, friends, etc. This type of post-episode reporting is also very valuable to researchers who try to depict an accurate profile of child molesters, hebephiles and pedophiles because it provides additional information about their gender, background, modus operandi, and victim's profile. It also provides insights about the internal process employed by the victims to cope with the trauma as a child and later as an adult.

Post-episode reporting takes place when the child becomes a teenager or an adult, often because the degree of fear, guilt, shame, and pressure that initially prevented the child victim from reporting the abuse during his/her childhood tends to be less

predominant in the victim's mind as a teenager or adult. It is worth noting that similarly to when the sexual abuse is reported by the child victim, the number of female victims is greater than the number of male victims, and the assaults were principally committed by a male. In a study by Ullman and Filipas (2005), out of 733 college students, 55.2% disclosed their sexual abuse during adulthood, overall, 28.2% of the females had been the victims of childhood sexual abuse, and 13.3% were males. Similarly, Krug et al. (2002) presented a report on the prevalence of childhood sexual abuse among adults, 20% of females and 5-10% of males had been the victims of sexual abuse during childhood.

Concerned with understanding the taxonomy of disclosure of child sexual abuse early on, Schaeffer et al. (2011) interviewed 191 boys and girls who were the victims of child sexual abuse. The children's ages ranged from three to eighteen. Their goal was to identify: (a) the first person the child told, (b) why the child told, (c) why the child delayed, and (d) what made the child decide to tell after the delay. Their results reflected that of the 191 children interviewed, 105 (55.0%) identified the first person they told about sexual abuse as well as offered details about how they came to tell; 36 children (18.8%) identified the first person, but did not offer additional information about how they came to tell; 35 children (18.3%) described how they came to tell, but not the first person they told; and 15 children (7.9%) talked of neither the first person they told nor how they came to tell about the sexual abuse. Children 11–18 years old were significantly more likely to tell a peer about abuse (48.3%) than children 3–10 years old who were more likely (91.4%) to report their abuse to an adult x^2 (1) = 28.56, $p < .01$. Most of the children told one or both parents (68.6%), and of these, most told their mother (81.9%).

Schaeffer et al. (2011) concluded that younger children are more likely to disclose to a close relative whereas older children are most likely to disclose to peers.

In addition, Schaeffer et al. (2011) offered some corroborative information to previous studies (e.g., Alaggia, 2005; Crisma et al., 2004; Goodman-Brown et al., 2003; Kogan, 2004; Smith et al., 2000) with regard to delayed disclosure and non-disclosure. They categorized their findings into five domains which usually prevent children from disclosing their sexual trauma: threats, fears, lack of understanding, the child's relationship with the perpetrator, and a lack of opportunity to discuss difficult topics with adults.

Most Commonly Used Therapies to Treat Child Sexual Abuse Victims

To this day, more research has been produced in the identification and investigation of childhood sexual abuse short- and long-term negative effects than on assessment and treatment modalities designed to treat sexually abused children (Risser et al., 2006; Lev-Wiesel, 2008). As discussed previously, sexually abused children are more likely than others to demonstrate sexual behavior problems (Friedrich, Fisher, Dittner, Acton, Berliner & Butler, 2001). Out of the total of sexual offenses committed by those who were victims of sexual abuse, 30% of the perpetrations are generated by children (Bentovim, 2002). Juvenile courts and child protective services face a growing number of caseloads of children 12 and under who have been sexually aggressive (Araji, 1997). This is why it is essential that a therapeutic intervention takes place as soon as the abuse is discovered (Rasmussen, 2000). Therapy for children needs to address three major issues: the child’s initial victimization by an adult or older child, the child’s risk of perpetration,

and the child's risk of future revictimization. These three issues systematically encompass the array of psychological problems described in the previous sections.

The most commonly used therapeutic treatments for sexually abused victims are play therapy (especially with children) and cognitive-behavioral therapy in the format of individual therapy, group therapy, and/or family therapy (Macdonald, Higgins & Ramchandani, 2006; Trask, Walsh & DiLillo, 2011). Each type of therapy tends to target very specific problematic areas concerning the child's trauma and struggles.

Play therapy in its individual or group format is widely recognized as a very effective type of therapy for children who experienced trauma. Play therapy evolved from specific frame of schools of psychology which gave it a more defined title such as: Psychoanalytic play therapy (Anna Freud and Melanie Klein), Jungian play therapy (Carl Jung), Adlerian play therapy (Alfred Adler) and Child-centered play therapy (Carl Rogers). Play therapy presents a principal advantage over other forms of therapy for children because it addresses "the trauma symbolically without having to verbalize frightening experiences and feelings" (Homeyer, 1999). Group play therapy is a common treatment modality for children who have been sexually abused, the benefit of this format is that it highlights some of the problems that may not be obvious during individual therapy such as "conflict, boundary problems, and sexualized behaviors" (Jones, 2002). As reinforced by the results of a meta-analytic investigation of therapy modality outcomes conducted by Hetzel-Riggin, Brausch and Montgomery (2007), play therapy appeared to be "the most effective treatment for social functioning."

Concerning cognitive-behavioral therapy, noticeable accounts of efficacy have been reported as well. For instance, in a 10-year follow-up study by Bonner, Walker and

Berliner (1999) comparing groups of sexually abused children who displayed sexual behavior problems, only 2% of the children who had cognitive-behavioral therapy committed some sex offenses compared to 10% of those who were in the play therapy program. Within different formats, cognitive-behavioral, family, and individual therapy was reported to the most effective at addressing and treating psychological distress and abuse-specific issues in sexually abused children population. Under the format of cognitive-behavioral group therapy, low self-concept was successfully addressed and resolved as well (Hetzel-Riggin et al., 2007).

Cognitive-behavioral therapy is also widely used with adult female survivors of childhood sexual abuse due to its confirmed efficacy. Cohen, Mannarino and Knudsen (2005) conducted a study designed to compare the effectiveness short- and long-term of trauma-focused cognitive-behavioral therapy (TF-CBT) versus non-directive supportive therapy (NST) for victims of childhood sexual abuse. Their findings strongly suggest that TF-CBT was more effective than NST overall. More specifically, the improvements were strongly reflected on the scales of depression, anxiety, and sexual problems. At first follow-up, six months after the end of the treatment, the participants still demonstrated some improvement on the anxiety, depression, sexual problems and dissociation scales. At second follow-up, 12 months after the end of the treatment, the participants' improvements were still noticeable on the PTSD and dissociation scales. Additionally, group therapy is also widely used when treating childhood sexual abuse female survivors.

Macdonald et al. (2006) conducted a meta-analysis review of 10 studies with a total participant sample size of n = 847 designed to examine the impact of cognitive-behavioral treatment on children who were sexually abused. The results revealed that

cognitive-behavioral therapy interventions significantly reduced children's PTSD symptoms and anxiety. Trask and her colleagues (2011) found similar efficacy in cognitive-behavioral therapy in their recent meta-analysis. Their findings were based on the review of 16 studies, or 852 participants. The results showed that the treatment effects were significantly larger for cognitive-behavioral therapy treatments ($p < .01$).

In terms of treatment for adolescent and adult female survivors of childhood sexual abuse, a plethora of services is accessible to them. Most often the therapeutic techniques used to treat these groups of victims are psychodynamic therapy, individual and group cognitive-behavioral therapies.

Psychodynamic therapy is often used with adolescent and adult survivors of childhood sexual abuse because it naturally invites them to explore their object relation etiology and maintenance of psychological disturbances (Blagys & Hilsenroth, 2000). Price, Hilsenroth, Callahan, Petretic-Jackson and Bonge (2004) conducted research in order to test the efficacy of individual short-term, psychodynamic therapy with adult survivors of childhood sexual abuse. One of the core elements to the success of this study was that the participants were able to develop early on and maintain throughout the program positive therapeutic alliances with their therapist. The survivors of childhood sexual abuse also demonstrated significant improvement in "symptomatic distress, level of functioning, feelings about the self and dynamic personality variables according to self-report measures and clinical rating scales." They further conclude that psychodynamic therapy may be useful in addressing and treating depressive symptoms and interpersonal difficulties in the childhood sexual abuse victims. Alas, Price et al. (2004) were not able to conduct a follow-up assessment on their participants in order to

eventually attest to the efficacy of psychodynamic therapy on a long-term scale. Nonetheless, scholars who investigate the outcomes of psychodynamic therapy tend generally to provide many valuable reports on the short-term success with the participants.

On the other hand, Peleikis, Mykletun and Dahl (2005) maintained that long-term efficacy of psychodynamic therapy in the context of childhood sexual abuse survivors' treatment is highly questionable. They explained that when psychotherapy follows a frame of treatment guided by psychodynamically oriented therapy, it is less effective in dealing with the long-term consequences of traumatic childhood factors as compared to structured trauma-focused group psychotherapies.

A recent comparative study conducted by Higgins Kessler, White and Nelson (2003) on group treatment for child sexual abuse survivors offered a review on 13 group treatment programs. Their findings showed that overall group therapy helps reduce symptomatology of the female victims of childhood sexual abuse short-term and long-term. Another study by Tourigny, Hebert, Daigneault and Simoneau (2005) on group therapy identified a significant improvement among their female subjects. The improvement was noted on the measures of post-traumatic stress, internalizing and externalizing behavior problems, coping strategies, relationship with the mother, and sense of empowerment.

Identifying and analyzing psychotherapeutic treatments for survivors of childhood sexual abuse is vital in order to replicate or better develop these programs in order to better assist the victims. However, Lev-Wiesel (2008) reminded her audience that although there is a growing body of literature on the effects of childhood sexual abuse,

follow-up studies focusing on assessment and treatment modalities addressing the issue of childhood sexual abuse are scarce.

Current Issues with Therapy for Male Survivors of Child Sexual Abuse

Generally the same therapeutic techniques and approaches used to treat adult female survivors of childhood sexual abuse are used to treat male survivors of childhood sexual abuse (Ganon & Rose, 2008). Consequently, it would be wise to advise therapists that the use of these techniques should be altered in order to respond better to the unique gender and socialization issues of male survivors of childhood sexual abuse, such as a greater amount of anger, sexual identity issues and confusion surrounding homophobia.

With regard to anger Asgeirsdottir, Sigfusdottir, Gudjonsson, and Sigurdsson (2011) conducted a study on the correlation between child sexual abuse depressed mood and anger in the victims. Their sample was comprised of 4,652 (51%) females and 4,433 (49%) males students for which the average age was 17.2 years (SD=1.1). The study included five latent variables (parental education, depressed mood, anger, substance use, and self-injurious behavior) and four observed variables (sexual abuse, family conflict/violence, age, and family structure). The results of their study indicated that being exposed to sexual abuse was positively related to both depressed mood (females, beta=.20, t>1.96; males, beta=.08, t>1.96) and anger (females, beta=.17, t>1.96; males, beta=.13, t>1.96). With regard to gender differences, the results found were in line with prior findings and showed that sexual abuse had a significantly stronger positive effect on depressed mood among females than among males. Also, their findings supported that females are more likely than males to respond to stressful life events, including sexual abuse, with internalizing symptoms while males are more likely to exhibit externalizing

symptoms in reaction to certain stressful events. In general, their results indicated that males and females may react differently to particular stressors.

With regard to sexual identity issues and homophobia, Priebea and Svedin (2008) explained that males who were sexually abused often avoid or delay disclosing the abuse because they fear their peers' negative reactions, both real and expected. This fear strongly influences their decision not to tell about the sexual abuse they had experienced. Moreover, theories about masculinity and males sexualities offer the concept of hegemonic masculinity – the norm that "real men" are heterosexual and powerful. Males who were sexually abused often feel that being a victim of sexual abuse is not compatible with appropriate masculinity.

Priebea et al. (2008) surveyed 2,324 girls and 2,015 boys in a school setting. Of that sample, 65% of the girls and 23% of the boys reported some form of sexual abuse experience. Male completers had significantly more often not disclosed to anyone and fewer of them had talked to their mother or a friend but had instead more often talked to someone in the category "another" compared to girls. Moreover, the results of this research confirmed the concept that heterosexual males who were sexually abused often feared being perceived as homosexual. Priebea and her colleague (2008) found that boys who have been sexually abused by men do often report confusion over their sexual identity, fear of being regarded as homosexual by others and concern for being a potential offender or being regarded by others as a potential offender.

Although society tends to associate the child sexual abuse of males by males to a homosexual act, researchers and society need to recognize that the sequel of child sexual assault is as profound and detrimental among homosexual males as it is for heterosexual

males. Epidemiological studies have suggested that at least 30% of gay men experience childhood, adolescent, and/or adult sexual assault (Balsam, Rothblum, & Beauchaine, 2005; Heidt, Marx, & Gold, 2005). Gold, Marx and Lexington conducted a study in 2007 in order to demonstrate and measure the degree of internalized homophobia in gay males who were the victims of sexual abuse. Internalized homophobia is a culturally relevant factor for the LGBT population. It has been defined as "a set of negative attitudes and affects toward homosexuality in other persons and toward homosexual features in oneself [which] stem from the acceptance of negative stereotypes and myths about homosexuality that permeate mainstream culture" (Shidlo, 1994, p. 178). Balsam (2003) explained that some of the widespread myths about homosexuality are related to child sexual assault; specifically, these myths include the notion that sexual assault causes homosexuality and that LGBT individuals deserve to be sexually assaulted because they are immoral and deviant.

Gold et al. (2007) surveyed 342 adults who identified themselves as being part of the LGBT community. Their findings reflected that no significant differences were found between those who survived adult sexual abuse only, child sexual abuse only, and those who experienced both adult sexual abuse and child sexual abuse based on age, F (2, 68) = 1.35, p>.05, or ethnicity x^2 = (6, N = 65) = 10.55, p>.05. In addition, internalized homophobia proved to be a significant predictor of the severity of depression, β = .24, p = .05. The results of this study enhanced the understanding of the experiences and reactions of gay male sexual assault survivors, and confirmed that the findings of previous studies of a strong relation between internalized homophobia and both PTSD and depressive symptom severity among gay male survivors. This suggests that when treating LGBT

clients who have been the victims of child sexual abuse, internalized homophobia may be an important construct to consider in psychotherapy treatment.

The psychotherapeutic process of male survivors of childhood sexual abuse faces two major obstacles. First, very few adult males seek therapy concerning their past sexual abuse or the fact that their childhood sexual abuse is at the root of their current presenting problem(s). For instance, a study conducted by Gill and Tutty (1999) on males who sought out therapy for relationship issues such as being excessively controlling, physically, sexually, and verbally abusive towards their partners revealed that a very large number of their participants, 8 out of 10 males, suffered childhood sexual abuse. Clearly, their trauma was in part at the root of their presenting concerns; however; the males survivors did not recognize and/or acknowledge early on that their presenting concerns stemmed from their childhood trauma. Also, Blain, Muench, Morgenstern and Parsons (2012) conducted a study on 182 gay and bisexual men who presented with a compulsive sexual behavior problem in therapeutic settings. The findings of their research established a correlation between their presenting problem and a history of childhood sexual abuse for 39% of their participants.

The second major obstacle the psychotherapeutic process of male survivors of childhood sexual abuse faces is that inquiry about a history of child sexual abuse from professionals toward their male patients is too often rare. A study by Lab et al. (2000) showed that two-thirds of mental health professionals failed to inquire about history of sexual abuse in their male patients; although, when asked professionals recognize that in average about 25% of their male patients have histories of child sexual abuse. Day, Thurlow and Woolliscroft (2003) surveyed 54 male and female mental health

professionals. Most of their respondents (72%) reported having over 10 years of experience working in mental health, working in both in-patient and out-patient settings. The results showed that the majority of their participants (56%) felt that between 30% and 50% of mental health clients had experienced childhood sexual abuse. This finding calls once again for a more cognizant and supportive structure in mental health organizations in order to address a potential history of child sexual abuse in patients.

The necessity and urgency for more research and treatment development concerning males who were the victims of child sexual abuse is evident. Unfortunately, to this date, there is very limited empirical evidence on the effectiveness of the programs available for male survivors of childhood sexual abuse (Romano & Lucas, 2005). The ramifications of child sexual abuse are worrisome. For instance, several studies found that child sexual abuse is a salient risk factor for later suicide attempts among adolescent and adult males and females (Dube et al., 2005; Bedi, Nelson, Lynskey, McCutcheon, Heath, Madden & Martin, 2011; Martin, Bergen, Richardson, Roeger & Allison, 2004). Child sexual abuse of males is an especially alarming topic because men are more likely to complete suicide than women (Easton, Renner, & O'Leary, 2013). Moreover, Molnar, Berkman and Buka (2001) urged their audience to recognize that men with a history of child sexual abuse were 4–11x at higher risk to attempt suicide than men without a history of child sexual abuse.

The Role of Empathy in Treatment and its Effectiveness

In the field of clinical psychology, empathy is a required tool for understanding and better helping a client who suffered child sexual abuse. Theorists such as Truax,

Bergin, Garfield and Rogers, have long identified the important role that empathy plays in clinical settings.

In recent research on the effectiveness of empathy, Neumann and her colleagues (2009) developed a schematic model in order to describe the different therapeutic steps generated by the therapist's empathy. In the description of their model, the clinician's empathy will create a therapeutic environment in which the client will provide more data on his/her symptoms and concerns. This, in turn, will help the clinician collecting more information which leads to a more accurate diagnosis, and results in better treatment and outcomes. Continuing the dialogue on the necessity and effectiveness of a clinical model fostering empathy, Neumann et al. (2009) emphasized the concept that clinical empathy creates parallel affective-oriented effects. This means that the client internalizes the therapist's empathy, and feels heard, understood, and valued, which results greater level of compliance, involvement in the process, and trust in the therapist. Greenberg, Elliott, Watson and Bohart (2001) proposed that empathy contributes to a positive psychotherapy outcome as it helps clients feel understood, and improves the therapist–client relationship. They also proposed that it helps clients feel safer and more comfortable self-disclosing and working on difficult topics, reduces premature termination, provides a corrective emotional experience, promotes cognitive–affective processing, and supports clients' self-healing efforts.

As established previously, in order for empathy to play its crucial role in therapeutic settings designed to assist patients who were the victim of child sexual abuse, mental health professionals need first and foremost to inquire systematically about a potential history of child sexual abuse in their patients. Lab et al. (2000) explain that only

50% of mental health staff receives any specialist training in working with sexual abuse, and that knowledge of this area is likely to vary greatly.

Day et al. (2003) explained that although clients with a history of childhood sexual abuse present frequently to psychiatric services, there has been comparatively little research investigating the views of staff working within these settings. Staff views are important in so far as they are likely to play a significant role in how difficulties are understood which, consequently, affects the quality of treatment that individuals receive. Day et al. (2003) found that most of the surveyed staff generally felt under-equipped to meet the needs of survivors of child sexual abuse. In comparison, respondents who had received on average, 1- to 3-day workshops on child sexual abuse rated themselves as significantly more comfortable, competent and supported in their work than those who did not. This statement becomes extremely useful and powerful, as it highlights once again the need for better training and understanding of child sexual abuse among mental health professionals.

Better training and understanding of child sexual abuse among mental health professionals may lead to greater empathy while treating child sexual abuse survivors. This statement takes a greater importance when it is applied to male survivors of child sexual abuse as some gender-based differences between males and females do exist in the process of the trauma of child sexual abuse. The first difference is supported by Davies and Rogers (2006) who explained that males, in general, are blamed for the sexual assault they endured in comparison with female victims, because social norms define males as aggressive and strong, therefore able to defend themselves when assaulted, whereas females are considered sexually passive and unable to defend themselves. The second

difference resides specifically in the case of male against male child sexual assault. It is reasoned that the homosexual nature of male rape inspires homophobic attributions that result in victim blame and other negative attributions towards male victims (Davies & Rogers, 2006). Davies and Rogers (2006) further explained that heterosexual men, on average, are more homophobic than women. It becomes evident that male victims of child sexual abuse do not receive the appropriate form and level of empathy as they should from society and perhaps in a more dismaying fashion, from health care providers. The third difference is that males tend to disclose their child sexual abuse several years after the assault; and disclose to a mental health professional as opposed to a close relative. When the male disclosing his sexual childhood trauma is gay, his audience often endorses stereotypical and damaging attitudes fostering the concept of victim-blame. Mitchell, Hirschman, and Nagayama-Hall (1999) explain that a gay victim could be perceived as having suffered less trauma than a heterosexual victim because of his sexual orientation. In conclusion, when addressing males who suffered the trauma of child sexual abuse, therapists need be aware of the differences between males and females as explained previously, and ensure that empathy is demonstrated in order to facilitate the healing process of the male clients.

The Key Role of Empathy in Treating Male Victims of Child Sexual Abuse

Psychotherapist empathy has had a long and sometimes controversial history in psychotherapy. Proposed and codified by Carl Rogers and his followers in the 1940s and 1950s, it was put forward as the foundation of helping skills training popularized in the 1960s and early 1970s. Claims concerning its universal effectiveness were treated with skepticism and came under intense scrutiny by psychotherapy researchers in the late

1970s and early 1980s. After that, research on empathy went into relative eclipse, resulting in a dearth of research between 1975 and 1995 (Watson, 2011; Elliot et al., 2011).

Since the mid-1990s; however, empathy has once again become a topic of scientific interest in developmental and social psychology (e.g., Bohart & Greenberg, 1997; Ickes, 1997). In addition, the past 10 years has seen the emergence of active scientific research on the biological basis of empathy, as part of the new field of social neuroscience (Decety & Ickes, 2009; Elliot et al., 2011).

As supported by Elliott et al. (2011) regardless of the theoretical orientation of the psychotherapist, empathy is essential to the therapeutic process provided to victims of sexual abuse, especially when considering that a victim of child sexual abuse has to surmount a mountain of internal and external challenges in order to disclose his/her abuse to another and seek help.

While addressing the treatment of male victims of child sexual abuse a few issues arise.

1) The low level of disclosure by male victims of childhood sexual abuse:

Studies discussing child sexual abuse demonstrate that women are twice as likely as men to have a history of childhood sexual abuse. If all else were equal, one could conclude that this pattern of prevalence rates should be reflected among males who come to professional attention. A projected rate of 30% of males would disclose having been the victim of child sexual abuse; however, a low rate of 9% of referrals is most often reported in literature about males disclosing their sexual abuse (Holmes, Offen & Waller, 1997). Males are faced with a great challenge when considering freeing themselves from

the burden of their sexual victimization. Disclosure for males comes at a high price. Their disclosure is received very differently than the disclosure of female victims. The imposition of strict masculine stereotypes can leave males who were victims of child sexual abuse trapped and at risk of not receiving the help they need and deserve (Pollack, 1998; Sorsoli et al., 2008; Struve 1990; Way, 2001)

2) The lack of training and investigation about male childhood sexual abuse:

Mental health professionals are most likely to suspect child sexual abuse when treating a female than a male for behavioral or psychological problems (Finkelhor, 1984; Lab et al., 2000; Pierce & Pierce, 1985; Ramsey-Klawsnik, 1990). One main explanation for that is that research literature has concentrated its efforts in past few decades mostly in discussing female sexual abuse and the training of most professionals is based on this body of research. Most of the literature has successfully demonstrated that girls are in most cases the victims of incestuous sexual abuse in comparison with boys who are most often the victim of extrafamilial sexual abuse (Feiring et al., 1999; Holmes et al., 1997; Levesque, 1994). This trend has created a striking detrimental pattern amongst mental health professionals of failing to systematically investigate the occurrence of male childhood sexual abuse. However, it is the hope that the increasing effort to understand the alarming problem of child sexual abuse perpetration will lead to a much needed change. Seto amd Lalumière (2010) demonstrated in their meta-analysis that therapists were most likely to inquire and/or suspect child sexual abuse in younger male patients who presented with psychological and behavioral disturbances than in adult male patients.

3) An empathic approach toward male childhood sexual abuse:

It has been clearly established in past and current research that, on average, 30% of males who were the victims of childhood sexual abuse become perpetrators against children (Glasser, et al., 2001; Kaplan et al., 1995; Lisak, 1994; Jespersen et al., 2009; Rudin et al., 1995). Therefore, an empathic approach toward the male survivors of childhood sexual abuse is crucial in order to facilitate disclosure and recovery. Unfortunately, when males who were abused become perpetrators, they encounter a greater level of resistance from the field of mental health in terms of support and understanding. Due to the nature of their offenses, therapists often have some difficulty in developing and sustaining empathic relationships with these clients (Colton et al., 2009; Day, 1999; Mitchell & Melikian, 1995).

Heesacker, Wester, Vogel, Wentzel, Mejia-Millan, and Goodholm (1999) investigated the perception of general public and mental health counselors about the emotionality of males and females. They found that males are mostly perceived by society and counselors as hypoemotional and females as hyperemotional. They further explained that males and females often share similar emotions given a certain context; however, given the societal confinements, males and females are expected to react differently. Therefore they do react outwardly differently and thus reinforce typical social constructs. Because working with males who were the victims of child sexual abuse often means delayed disclosure, it becomes clear that empathy is an essential component of the therapeutic process while addressing the male population who suffered childhood sexual abuse. As Elliott et al. (2011) supported, the therapist's empathy is a mediating process facilitates the client's change.

This chapter discussed in detail the short- and long-term negative effects of childhood sexual abuse. Researchers agree on the core diagnoses that often emerge from child sexual abuse: posttraumatic stress disorder, dissociative identity disorder, sexual adjustment difficulties, depression, substance abuse, anxiety and eating disorders. This section also discussed two additional detrimental aspects of childhood sexual abuse: revictimization and perpetration. More precisely, this section discussed the higher rate of perpetration of sexual abuse by males as opposed to females, although the rate of female victims is traditionally greater than for males. This puzzling statistical discrepancy calls for a closer look onto the understanding and treatment that are required for male victims of childhood sexual abuse.

In terms of treatment, psychotherapy has proven to be the most efficient program employed to help the victims of childhood sexual abuse. However, this requires two essential components: disclosure from the victim and empathy from the therapist. To this day, it has been clearly established that females disclose the abuse sooner and more often than males do. As discussed previously, males may take 17 years or more to disclose the abuse. Often the presenting concerns of the male patients and the lack of inquiry from the treating body may lead to an extended period of recognition of the symptomology (e.g., depression, substance abuse) as a by-product of a history of childhood sexual abuse. The urgency in investigating sooner and more thoroughly the causation of such presenting concerns is highly needed due to the unfortunate propensity for males to replicate the abuse onto children. However, this requires a crucial component in the therapeutic setting: empathy. Empathy has been clearly established as a necessary element that not

only allows the client to feel comfortable to disclose, but also for the clinician to diagnose efficiently and therefore, treat adequately his/her client.

The key topics presented in this section are leading toward the obvious need for more research on empathy when treating males who have been the victim of childhood sexual abuse. Hence, the purpose of this research which was designed to identify the potential variability in the levels of empathy amongst therapists when treating male and female survivors of child sexual abuse.

Chapter 3

METHODOLOGY

This study intended to measure the differential levels of empathy among therapists when treating male and female survivors of child sexual abuse. This study used an experimental research design. The independent variable was gender. The dependent variable was empathy. The study tested the following hypotheses:

H_1: Therapists will demonstrate greater empathy when reading the vignette of the female client who experienced sexual abuse than reading the vignette of the male client who experienced sexual abuse. A *t*-test for independent means will be used to test this hypothesis.

H_2: There will be no significant difference between male and female therapists in empathy in response to vignette of sexually abused male client. A *t*-test for independent means will be used to test this hypothesis.

H_3: There will be no significant difference between male and female therapists in empathy in response to vignette of sexually abused female client. A *t*-test for independent means will be used to test this hypothesis.

Participants

Therapists were specifically used as participants in this research because of their level of education and experience in the field of psychology. The participants of this study provided a better understanding of whether or not there is a difference in perception of the severity of childhood sexual abuse experienced by a male or a female.

Participants were randomly assigned to two groups, stratified according to gender:

Group 1: Therapists who read the vignette of a female client who was the victim of child sexual abuse.

Group 2: Therapists who read the vignette of a male client who was the victim of child sexual abuse.

The following criteria were used to select the therapists participating in the study:

Inclusion criteria.

- Ph.D. or Psy.D. in Clinical or Forensic Psychology
- (M.D.) Psychiatrists in Clinical or Forensic Psychology
- LCSW
- M.A. graduate in Clinical or Forensic Psychology
- M.F.T. graduate in Clinical or Forensic Psychology
- Working in private practice, private or public mental health organization
- Retired
- Male or Female
- Practicing or has practiced in the U.S.
- No limitation on race
- No limitation on religious affiliation/spirituality
- No limitation on sexual orientation
- Willing to sign written informed consent prior to participate in this study

Exclusion criteria.

- Practicing or practiced outside the U.S. exclusively
- Masters' level therapists who are not licensed to practice
- M.F.T. with less than 1 year experience

- Psychiatrists who do not provide therapy

Sample size.

According to Cohen's (1992) guidelines designed to determine an effective sample size, the minimum number of participants per group needed for a moderate effect size is of 64 participants. An alpha level of .05 and a confidence level of .80 was used.

Recruitment.

A prescreening process took place when contacting therapists online or in person to participate to this study. The prescreening consisted in selecting therapists with the following title after their name: Ph.D., Psy.D., M.D., LCSW, M.A. or M.F.T. in Clinical or Forensic Psychology.

Therapists who practice or have practiced in the U.S. will be recruited via the Internet and professional contacts of this author. The selection of participants was made based on the inclusion and exclusion criteria, which were integrated into the Brief Demographic Form (Appendix A). If the potential participants met the desired inclusion criteria, the participants were invited to participate in the study. The participants were then presented in person or online the consent form to participate (Appendix B).

The researcher of this study emphasized that the participant's privacy and confidentiality rights were respected according to APA guidelines for research. This means that the information collected during this research was anonymous; therefore no identifiable information was tied to the data collected. An equal number of male and female participants were recruited.

The voluntary nature of this study and the right to withdraw from this study at any time was explained. This information was included in the consent form (Appendix B).

Whether the participants were contacted in person or online, this author ensured that the consent form was read prior to allowing any participant to move forward with the interviewing process.

Procedure.

The therapists who were selected by this author to take part in this survey were asked to respond to the Brief Demographic Form (Appendix A), which covered the inclusion and exclusion criteria.

The participants read the consent form (Appendix B) to participate in order to establish their understanding and agreement to its guidelines. The study was anonymous and the completion of the questionnaires constituted consent without signing.

The participants were randomly assigned to either the male or the female vignette. Efforts were made to ensure an equal number of male therapists and female therapists were assigned to each group.

Next, the participants were asked to read a brief clinical vignette of a male or a female client (Appendix C) recollecting their childhood sexual abuse. The vignette content for the male and the female survivor of child sexual abuse was identical in order to eliminate any potential source of bias in the procedural section of this study.

After reading the vignette, the participants were asked to respond to the Interpersonal Reactivity Index (Appendix D).

The completed forms were collected online and in-person. Once the data were collected, this author screened valid input by reviewing whether the all of the forms were fully completed. Were any of the forms be missing any information, the data was

considered invalid and not retained for data analysis. This screening process took place each time a new entry was made by a participant online or in person.

Protection of confidentiality.

When the data was collected by this author in person or online, it was kept in a locked cabinet in a locked office accessible only to this author. Each of the participants' questionnaires was anonymous. Access to the data was limited to this author and dissertation committee. The demographic form and questionnaire was stored separately in a locked file cabinet to which only this author had access. Research results were kept on a password protected computer.

Measures

Brief demographic form.

Background information was collected using a Brief Demographic Form (Appendix A), which was designed by this author. The Brief Demographic Form collected the following information: Gender, Level of Education, Licensed or not, Practicing or Retired, Practicing or Practiced in the U.S., and Number of years of practice.

Interpersonal Reactivity Index (IRI).

The Interpersonal Reactivity Index (IRI) (Appendix D) was used in order to measure the dependent variable: therapists' level of empathy toward a male or a female who was the victim of childhood sexual abuse.

The Interpersonal Reactivity Index was designed by Dr. M. H. Davis in order to measure both cognitive and emotional components of empathy in an individual toward another. Davis (1983) defined empathy as the "reactions of one individual to the observed

experiences of another." The Interpersonal Reactivity Index is a 28-self-report items questionnaire answered on a 5-point Likert scale ranging from "Does not describe me well" to "Describes me very well." The measure has 4 subscales, each made up of 7 different items. These subscales are (Davis, 1983):

1) Perspective Taking – the tendency to spontaneously adopt the psychological point of view of others.

2) Fantasy – taps respondents' tendencies to transpose themselves imaginatively into the feelings and actions of fictitious characters in books, movies, and plays.

3) Empathic Concern – assesses "other-oriented" feelings of sympathy and concern for unfortunate others.

4) Personal Distress – measures "self-oriented" feelings of personal anxiety and unease in tense interpersonal settings.

The first version of the Interpersonal Reactivity Index contained 50 items; some of the items were borrowed or adapted from other measures. New items were designed to measure either cognitive aspects of empathy or any other emotional responses to the observed emotional experiences of others. The factor analysis of these data revealed that there are four major factors (Davis, 1980).

The second version of the test had 45 items; some items were from the previous questionnaire and some were new, written to conform to one of the four empathy factors. A separate factor analysis was performed and a 4-factor solution was specified (Davis, 1980).

The Interpersonal Reactivity Index was revised for the third time and the items loading highest on a factor were selected for inclusion on the corresponding subscale. This procedure resulted in an instrument with four subscales; each consisting of seven

items (Davis, 1980). The items are measured on a 5-point Likert-type scale that ranges from 1-5 (Appendix D). Respondents indicated the degree to which each statement described them by circling choices 1 ("Does not describe me well") through 5 ("Describes me very well"). The total possible IRI scores on each subscale ranged from 7 to 35 points, with a higher score indicating a higher level of empathy (Davis, 1980).

The four subscales of the Interpersonal Reactivity Index have satisfactory internal and test/retest reliabilities (Davis, 1980). Through his numerous researches on empathy, Davis identified that the Interpersonal Reactivity Index has a test/retest reliability ranging from .62 to .81 for females and .61 to .79 for males. The scales have also adequate internal reliability with coefficient alphas ranging from .70 to .78 for females and .72 to .78 for males. The construct validity of the scales has been supported through correlations with other empathy measures and with measures of other theoretically related variables (Davis, 1983).

Data Analysis

Permission to conduct this research was granted by Alliant International University's Human Subjects' Committee. Permission to use the Interpersonal Reactivity Index in this study was obtained directly from Dr. M. H. Davis via E-mail (Appendix E).

Demographic information was analyzed in order to obtain the means and standard deviation of Number of years of practice. The categorical variables of Level of Education, Gender, Currently practicing or Retired were calculated using frequencies. Cronbach's alpha was used to determine the reliability of the instruments used in this study for this sample.

This study attempted to determine whether therapists demonstrate greater empathy toward a female who was the victim of child sexual abuse as opposed to a male who was the victim of child sexual abuse. Means and standard deviations for the groups of therapists who read the story of a female and a male victim were calculated for each variable. The following is a description of how the hypothesis was tested in this study.

H_1: Therapists will demonstrate greater empathy when reading the vignette of the female client who experienced sexual abuse than reading the vignette of the male client who experienced sexual abuse. A *t*-test for independent means will be used to test this hypothesis.

H_2: There will be no significant difference between male and female therapists in empathy in response to vignette of sexually abused male client. A *t*-test for independent means will be used to test this hypothesis.

H_3: There will be no significant difference between male and female therapists in empathy in response to vignette of sexually abused female client. A *t*-test for independent means will be used to test this hypothesis.

The correlation was tested using a Pearson *r* correlation model. The level of empathy expressed by the clinicians was measured using the Interpersonal Reactivity Index. Significance in the findings was set at a value of $p \leq .05$.

Summary

The purpose of this research study was to gain a better understanding of how empathy in psychotherapeutic settings may affect the treatment process of males who were the victims of child sexual abuse. The design of this research was a correlational design. It was estimated that the total number of participants per group was of 64

participants each for a moderate effect size based on the alpha level of .05. This research study required two groups, one constituted of therapists who read the vignette of the male who was the victim of child sexual abuse and a second constituted of therapists who read the vignette the female who was the victim of child sexual abuse. Participants were screened based on the inclusive and exclusive factors described in the participants' section. The procedures and methodology of this study were explained to the participants prior to them reading the consent form.

Chapter 4

RESULTS

This study sought to measure the differential levels of empathy among therapists when treating male and female survivors of child sexual abuse. Hypothesis 1 stated that therapists would demonstrate greater empathy when reading the vignette of the female client who experienced sexual abuse than reading the vignette of the male client who experienced sexual abuse. Hypothesis 2 stated that there will be no significant difference between male and female therapists in empathy in response to vignette of sexually abused male client. Hypothesis 3 stated that there will be no significant difference between male and female therapists in empathy in response to vignette of sexually abused female client.

The participants (N = 128) in this study were psychotherapists across the U.S. who fit the inclusion criteria. Each participant was sent a survey that contained a consent form, a demographic questionnaire, a vignette and an Interpersonal Reactivity Index (IRI) questionnaire. The participants completed the survey and submitted it online directly to the researcher.

Preliminary Analyses

Power analysis.

A power analysis determined that an adequate sample size for the variables in this study would require 64 participants per group to obtain a statistical significance of an alpha level of .05 for a moderate effect size. A power analysis was conducted to determine if 64 participants per group was a sufficient quantity to meet the moderate effect size for this study design based on Cohen's (1992) suggestions. The power analysis

revealed that having 64 participants per group was sufficient. Participants were recruited online via email solely by this researcher across the United States. This researcher had access to a professional database that contained psychotherapists' contact information and approved of being contacted for marketing or research purposes. The data were collected over a period of 4 months. A total of 1072 surveys were sent via the internet and 141 were completed in total. Of the 141 completed surveys 13 were rejected because they did not match the inclusion criteria.

Invalid surveys.

No missing data within the completed form was sent to the researcher because the program used for the survey did not allow the participants to submit their form with any unanswered sections. 13 surveys were rejected in the course of the data collection process were because they met the following exclusion criteria: Masters' level therapists who are not licensed to practice and M.F.T. with less than 1 year experience.

Test of normality.

Equivalent nonparametric tests were used where assumptions were not met (as identified by the Kolmogorav-Smirnov test of normality and the Levene test for homogeneity of variance). Data from the outcome measure was checked against the normal distribution using the Kolmogorav-Smirnov test for normality. Data from the outcome measure approximated a normal distribution. Results of the Levene's test for homogeneity of variances did not indicate a violation of homogeneity assumption required for male and female scores.

Descriptive Statistics

Participants.

Demographics. Of the 128 participants in the study, there was an even number of males and females (see Table 1). The highest level of education of the total of participants was for 1.6% L.M.F.T., 2.3% M.F.T., 7.0% L.C.S.W., 28.1% M.A., 26.6% PsyD. and 34.4% Ph.D (see Table 2). Of the total of participants, 71.1% of them were licensed and 28.9% were not (see Table 3). All of the participants in this study currently practice or have practiced in the U.S (see Table 4). In this study participants were asked what their length of experience was, none of the participant had less than 1 year of experience, 22.7% had between 1 and 5 years of experience, 20.3% had more than 5 years of experience, 26.6% had more than 10 years of experience, 14.1% had more than 20 years of experience and 16.4% had more than 30 years of experience (see Table 5).

Table 1.

Gender Demographics of Participants

Variable	*N*	Percentages
Gender		
Male	64	50.0
Female	64	50.0

Note. There was a total of 128 participants in this study.

Table 2.

Highest Level of Education Demographics of Participants

Variable	*N*	Percentages
Education		
L.M.F.T	2	1.6%
M.F.T.	3	2.3%
L.C.S.W.	9	7.0%
M.A.	36	28.1%
PsyD.	34	26.6%
Ph.D	44	34.4%

Note. There was a total of 128 participants in this study.

Table 3.

Licensure Demographics of Participants

Variable	*N*	Percentages
Licensed		
No	37	28.9
Yes	91	71.1

Note. There was a total of 128 participants in this study.

Table 4.

Practicing or Practice in U.S. Demographics of Participants

Variable	*N*	Percentages
Practice U.S.		
No	0	00.0
Yes	128	100.0

Note. There was a total of 128 participants in this study

Table 5.

Length of Experience Demographics of Participants

Variable	*N*	Percentages
Experience		
Less than 1 year	0	00.0
Between 1 and 5 years	29	22.7
More than 5 years	26	20.3
More than 10 years	34	26.6
More than 20 years	18	14.1
More than 30 years	21	16.4

Note. There was a total of 128 participants in this study

Measures

Participants completed the Interpersonal Reactivity Index (IRI).

Interpersonal Reactivity Index (IRI).

IRI measured empathy in this sample of male and female therapists. The mean for the total IRI scale for the group of female therapists was 64.39, SD = 11.10, and scores ranged from 44 to 88 (see Table 6).

The mean for the total IRI scale for the group of male therapists was 67.39, SD = 7.97, and scores ranged from 39 to 80 (see Table 6).

Of the four subscales of IRI, a difference was found with the perspective taking scale in which the female therapists scored higher than the male therapists with a mean of 19.84 and 18.78 respectively. The other subscales of the IRI: fantasy scale, empathic concern scale and personal distress scale did not reflect a significant difference between female and male therapists.

Also, through this statistical analysis significant linear relationships were observed. Empathic concern showed a positive correlation with perspective taking and fantasy, whereas personal distress showed a positive correlation with fantasy scale. No other correlations were significant (see Table 7).

Table 6.

Combined Descriptive Statistics and Internal Consistency of Dependent and Independent Variables

Variable	Therapist Gender	Mean	SD
Total Scale	Female	64.39	11.10
	Male	67.38	7.97
Perspective Taking*	Female	19.84	3.36
	Male	18.78	2.79
Fantasy	Female	15.31	6.02
	Male	17.63	4.61
Empathic Concern	Female	20.86	3.86
	Male	21.06	2.01
Personal Distress	Female	8.38	3.64
	Male	9.91	2.93

*Note. *=female and male scores differ significantly at $p \leq .05$*

Table 7.

Correlations

Scale	Fantasy	Empathic Concern	Personal Distress
Perspective Taking	.092	.232**	-.169
Fantasy		.353**	.467**
Empathic Concern			.057

*Note.***significant at $p \leq .05$*

Hypothesis Testing.

Hypothesis 1.

Hypothesis 1 stated that therapists would demonstrate greater empathy when reading the vignette of the female client who experienced sexual abuse than reading the vignette of the male client who experienced sexual abuse.

Results. The mean for the total IRI scale for the group of therapists who read the male vignette was 65.11, SD = 7.96 (see Table 8). The mean for the total IRI scale for the group of therapists who read the female vignette was 66.66, SD = 11.25 (see Table 8).

Specifically, the mean score in perspective taking for the therapists who read the female vignette was 20.19 and for those who read the male vignette was 18.44. The other scales were relatively close and therefore did not show a significant difference. The mean score in fantasy for the therapists who read the female vignette was 16.03 and for those who read the male vignette was 16.91. The mean score in empathic concern for the therapists who read the female vignette was 21.05 and for those who read the male vignette was 20.88. The mean score in personal distress for the therapists who read the female vignette was 9.39 and for those who read the male vignette was 8.89 (see Table 8). Perspective taking scale showed a significant difference between the vignettes t(-3.29, 126) = .001, the total scale or other scales did not show a significant difference (see Table 9).

Table 8.

Vignette Specific Descriptive Statistics and Internal Consistency of Dependent and Independent Variables

Scale/Group	N	Mean	SD	t	d*f*	Sig.
Total Scale						
Male Vignette	64	65.11	7.96	-.90	113	.37
Female Vignette	64	66.66	11.25			
Perspective Taking Scale						
Male Vignette	64	18.44**	3.03	-3.29**	126	.00
Female Vignette	64	20.19**	2.98			
Fantasy Scale						
Male Vignette	64	16.91	3.71	.90	98	.37
Female Vignette	64	16.03	6.79			
Empathic Concern Scale						
Male Vignette	64	20.88	3.34	-.32	122	.75
Female Vignette	64	21.05	2.98			
Personal Distress Scale						
Male Vignette	64	8.89	3.45	-.84	126	.40
Female Vignette	64	9.39	3.31			

*Note.**significant at $p \leq .05$*

Hypothesis 2.

Hypothesis 2 stated that there would be no significant difference between male and female therapists in empathy in response to vignette of sexually abused male client.

Results. The mean for the total IRI scale for the group of female therapists who read the male vignette was 63.16, SD = 9.47 (see Table 10). The mean for the total IRI scale for the group of male therapists who read the male vignette was 67.06, SD = 5.58 (see Table 10).

Specifically, the mean score in perspective taking for the female therapists was 19.03 (SD = 3.47) and for the male therapists 17.84 (SD = 2.42). The mean score in fantasy for the female therapists was 15.75 (SD = 4.10) and for the male therapists 18.06 (SD = 2.91). The mean score in empathic concern for the female therapists was 20.91 (SD = 4.33) and for the male therapists 20.84 (SD = 1.99). The mean score in personal distress for the female therapists was 7.47 (SD = 2.94) and for the male therapists 10.31 (SD = 3.38) (Table 10). Fantasy scale t(-2.065, 65) = .011 and Personal distress scale t(-3.589, 62) = .001 showed significant differences between male and female therapists. Perspective taking and empathic concern did not show a significant difference between male and female therapists (see Table 11).

Table 9.

Therapists Gender & Male Vignette Descriptive Statistics and Internal Consistency of Dependent and Independent Variables

Scale/Group	N	Mean	SD	t	d*f*	Sig.
Total Scale						
Female	32	63.16**	9.47	-2.01**	50	.05
Male	32	67.06**	5.58			
Perspective Taking Scale						
Female	32	19.03	3.47	1.59	55	.12
Male	32	17.84	2.42			
Fantasy Scale						
Female	32	15.75**	4.10	-2.06**	65	.01
Male	32	18.06**	2.91			
Empathic Concern Scale						
Female	32	20.91	4.33	.07	43	.94
Male	32	20.84	1.99			
Personal Distress Scale						
Female	32	7.47**	2.94	-3.59**	62	.00
Male	32	10.31**	3.84			

*Note.**significant at $p \leq .05$*

Hypothesis 3.

Hypothesis 3 stated that there would be no significant difference between male and female therapists in empathy in response to vignette of sexually abused female client. *Results.* The mean for the total IRI scale for the group of female therapists who read the female vignette was 65.63, SD = 12.54 (see Table 12). The mean for the total IRI scale for the group of male therapists who read the female vignette was 67.69, SD = 9.88 (see Table 12).

Specifically, the mean score in perspective taking for the female therapists was 20.66 (SD = 3.09) and for the male therapists 19.72 (SD = 2.84). The mean score in fantasy for the female therapists was 14.88 (SD = 7.52) and for the male therapists 17.19 (SD = 5.87). The mean score in empathic concern for the female therapists was 20.81 (SD = 3.40) and for the male therapists 21.28 (SD = 2.05). The mean score in personal distress for the female therapists was 9.28 (SD = 4.07) and for the male therapists 9.50 (SD = 2.37) (Table 12). None of the scale showed a significant different between their mean scores of the male and female therapists (see Table 13).

Table 10.

Therapists Gender & Female Vignette Descriptive Statistics and Internal Consistency of Dependent and Independent Variables

Scale/Group	N	Mean	SD	t	d*f*	Sig.
Total Scale						
Female	32	65.63	12.54	-.73	62	.47
Male	32	67.69	9.88			
Perspective Taking Scale						
Female	32	20.66	3.09	1.26	62	.21
Male	32	19.72	2.84			
Fantasy Scale						
Female	32	14.88	7.52	-1.37	59	.18
Male	32	17.19	5.87			
Empathic Concern Scale						
Female	32	20.81	3.40	-.67	51	.51
Male	32	21.82	2.05			
Personal Distress Scale						
Female	32	9.28	4.07	-.26	50	.79
Male	32	9.50	2.37			

*Note.**significant at $p \leq .05$*

Summary of Findings

The focus of this study was to identify the differential levels of empathy among therapists when treating male and female survivors of child sexual abuse. In addition to lending empirical evidence that female therapists do employ perspective taking much more commonly than male therapists while working with victims of child sexual abuse, it was also discovered that there was a significant positive correlation between empathic concern and perspective taking and fantasy as well as between personal distress and fantasy.

The study findings did not support that therapists would demonstrate greater empathy when reading the vignette of the female client who experienced sexual abuse than reading the vignette of the male client who experienced sexual abuse. However, it is worth noting that the perspective taking scale showed a significant difference between the vignettes among male and female therapists.

The results of this research did not support the null hypothesis that there would be no significant difference between male and female therapists' level of empathy in response to the vignette of sexually abused male client. There was a significant difference between male therapists and female therapists who read the male vignette. Additionally, significant differences were observed in the subscales of fantasy and personal distress between male and female therapists who read the male vignette.

Lastly, the results of this study supported the null hypothesis that there would be no significant difference between male and female therapists' level of empathy in response to vignette of sexually abused female client.

Chapter 5

DISCUSSION

Introduction

The purpose of this study was to examine the differential levels of empathy among male and female therapists who read a gender specific vignette depicting the reminiscing of a male or female survivor of child sexual abuse. Child sexual abuse is a form of severe trauma that has long-term negative ramifications in one's life. Therapists working with these victims have to ensure that empathy is one of the core elements of the therapeutic treatment in order to create a safe and productive environment for the client. Empathy is one of the main variables associated with clinical competence and patient outcome while working with survivors of traumatic events –such as child sexual abuse- (Crumpeia & Dafinoiu, 2012).

Although former research on clinical work has clearly established that empathy is an essential component to treatment process and outcomes (e.g., Greenberg, Elliott, Watson & Bohart, 2001), no other study has to this day focused specifically on the level of empathy therapists demonstrate toward victims of child sexual abuse comparing gender of the victim. The current research was the first to investigate empathy amongst therapists based on both the therapists' gender and that of the victim.

Findings

The differential levels of empathy among male and/or female therapists who read the vignette of a male or female victim of child sexual abuse were analyzed in this study. The results for the first hypothesis of this study indicated that aggregated data from all

therapists (both males and females) demonstrated non-significant differences in empathic feelings on the IRI full scale toward a female victim of child sexual abuse or toward a male victim of child sexual abuse. Also, when reviewing the scales of the IRI, all therapists also showed greater levels of perspective taking, empathic concern, and personal distress toward a female survivor of child sexual abuse than for a male survivor of child sexual abuse. All findings were non-significant except for the ones reflected on the perspective taking scale. The fantasy scale reflected a quasi-similar score for all therapists toward a female and a male survivor of child sexual abuse. This indicates that in general the body of clinicians tends to have more empathic feelings toward a female client than a male which was also supported by Sorsoli, Kia-Keating and Grossman (2008).

For the second hypothesis of this study, the differential levels of empathy between male and female therapists who only read the male victim of child sexual abuse vignette were analyzed. On the overall scale of the IRI, the results indicated that male therapists showed significantly greater empathy toward a male survivor of child sexual abuse than did female therapists. And in comparison with the female therapists of this study, the male therapists demonstrated significant higher levels of fantasy and personal distress toward a male survivor of child sexual abuse. However, female therapists demonstrated a non-significant trend of greater perspective taking than male therapists. The level of empathic concern for both male and female therapists toward the male survivor of child sexual abuse was similar and deemed statistically non-significant. The greater levels of empathic feelings expressed by the male therapists in this study are contrary to the general consensus found in literature supporting the concept that typically females

display greater empathic responses than males (Carlo & Randall, 2002; Paciello, Fida, Tramontano, Lupinetti & Caprara, 2008).

Finally, the findings for the third hypothesis of this study indicated that male therapists had greater empathy toward a female survivor of child sexual abuse than female therapists did. However, the results were statistically non-significant, meaning the results could have happened by chance. The level of perspective taking was greater, although statistically non-significant, amongst female therapists than male therapists in the context of the female victim of child sexual abuse vignette. Also, the fantasy and empathic concern scales reflected greater means amongst male therapists toward a female survivor of child sexual abuse than female therapists. In this context; however, the results were not statistically significant. Finally, for male and female therapists who read the vignette of the female survivor of child sexual abuse demonstrate an equal level of personal distress; however, the results were not statistically significant.

Contrary to the suggested hypothesis, the results of this study showed surprisingly higher means (67.69 vs. 65.63) on the overall scale of empathy for the male therapists who read the female survivor of child sexual abuse vignette in comparison with the female therapists who read the same vignette. This finding is surprising because the general consensus as established via research is that females usually display more empathic feelings toward others than males do. As Tennfjord (20006) explains, men have a higher rape-myth acceptance than women. Also, previous research conducted by Davis (1980), surveyed a large sample of males (N = 579) and females (N = 582) found that females displayed higher scores than males on the empathic scales. Similarly to Davis (1980), Berthoz, Wessa, Kedia, Wicker, and Grȇzes (2008) found that females score

higher on the IRI scales than males. However, similarly to Davis (1980), Berthoz et al. (2008) recruited students for their study and covered a wide range of educational interests within these student participants from several disciplines with very few in psychology. Except for two responders who had a low level of education (that is, less than a high school diploma), the other participants had an intermediate to high level of education 35.2% with a high school diploma; 22.5% with up to 2 years of college; 41.8% with more than 2 years of college. The participants recruited for the current study were clinicians with more education and more than 1 year of psychology practice experience. These variables could explain in part the differences noted in the outcomes of this study in comparison with Davis (1980) and Berthoz et al. (2008) findings.

For this research, in addition to testing the formerly proposed hypotheses, two additional statistical analyses were done in order to identify whether or not a correlation possibly existed between the male and female therapists' level of education and their level of empathy on the global scale of the IRI toward a male and a female victim of child sexual abuse, and whether or not a correlation possibly existed between the male and female therapists' length of experience and their level of empathy on the global scale of the IRI toward a male and a female victim of child sexual abuse. Findings show that therapists who had a higher level of education, Doctorate and above, demonstrated greater empathy toward a male and a female victim of child sexual abuse than the therapists who only had a Master's level and below of education in psychology. And, therapists who had a greater length of experience (10 years of more) in the field also show greater empathy toward a male and a female victim of child sexual abuse than the therapists who had less experience (less than 10 years). Although not a part of the

original hypotheses, these findings add important information to help explain what factors related to the level of empathy in a clinician toward a victim of child sexual abuse were affected and could have contributed to the increase in their empathic feelings.

Limitations of Study

There are several limitations to the results of this this research study. One major limitation is that the data collected in this study used a self-report questionnaire. The challenge with self-report measures is that researchers cannot identify whether participants are providing the most accurate data due to social desirability or inadvertently misrepresenting themselves because they are not adequately in touch with their emotions. Participants could have responded to questions with some reservation resulting in possible bias in the results as identified by Zhou, Valiente and Eisenberg (2003). In their study measuring empathy in students by using several instruments, Berthoz et al. (2008) tested the extent to which the responses on the IRI scales displayed desirability. The IRI scales scores were entered in to a Pearson's Product Moment Correlation Analysis along with the Social Desirability Scale scores. A positive correlation above 0.3 was taken as an indicator of a socially desirable responding. However, due to the nature of this research setting, it was justified to use a self-report instrument that has been long established for evaluating the level of empathy in an individual. As established by Davis (1996) and Bartholow, Sestir and Davis (2005) the IRI has good internal and convergent validity, and test-retest reliability.

Another limitation was the fact that the instrument used in this study was not normed on this specific population of experienced clinicians. Although, the initial participants used to norm this instrument were first year students in the field of

psychology (Davis, 1980), the limitation of this study was reinforced by the fact that this study excluded clinical students who had less than a year of experience. In a study conducted by Thomson, Hassenkam and Mansbridge (1997) measuring the level of empathy in a clinical setting and a non-clinical setting, the findings showed a positive correlation between practitioners' levels of education and clinical experience and empathic feelings. In future research, re-norming of the IRI to include the representation of the mental health field with greater experience (more than 1 year) would greatly enhance its validity.

A third limitation to this study was that the demographic questionnaire did not ask the clinicians who participated in this study whether or not they received any specialized training with regard to child sexual abuse treatment. This limitation was not addressed in this study because it was assumed that clinicians had a natural predisposition for greater empathy given their vocational choice. More specifically, it possible that the surprisingly higher means on the empathic scales of the IRI for the male therapists of this study not only reflected their dispositional qualities (innate empathy) but as well the benefits from greater knowledge with regard to child sexual abuse. Supporting this concept is a recent study by Gleichgerrcht and Decety (2013) surveying 7,584 board-certified practicing physicians employing the IRI in order to measure empathy revealed that the participants who had more experience in medical practice demonstrated significant differences in empathic feelings from those who had less experience. Although specific to the medical field, these findings are relevant to this context as they highlight the potential variability in empathy created by the length of training in a practitioner. In addition, Gleichgerrch and Decety (2013) noted that the participants who had longer experience in the field were

much more immune to compassion fatigue. This finding establishes the positive impact of increased training and length of experience in a field of healthcare practice onto the outcome of treatment and wellbeing of the patients. Future research dedicated to measuring the level of empathy in therapists toward a male or female survivor of child sexual abuse will shed more light on the topic by investigating to the extent to which the amount of training in child sexual abuse treatment may account for a greater level of empathic feelings toward a male or a female victim. This point would be of particular importance because generally therapists choose to become experts in a specific clinical issue (e.g., eating disorders, depression, anxiety, child sexual abuse, etc.), and within the context of this pioneer study, male therapists' answers reflected greater means on empathy scales in comparison with female therapists. It could be speculated that the greater means reported by the male therapists in this study differ greatly with the means reported by the males who were originally surveyed within the general population because male therapists are predisposed by the choice of their profession, prevention to vicarious trauma, and their continuous training throughout their career to foster possibly greater dispositional and situational empathy toward others.

The final limitation to this study was that the participants were not asked whether or not they had a history of child sexual abuse themselves. This limitation was not addressed because this study was designed to offer a preliminary question to whether or not a difference existed between male and female clinicians in response to a male or female survivor of child sexual abuse. Future research would certainly benefit from identifying whether or not its participants suffered from child sexual abuse because the personal trauma histories can have a severe negative effects on the therapeutic process

such as an increase of vicarious trauma, greater countertransference, and lower display of empathy (Sabin-Farrell & Turpin, 2003). The secondary trauma resulting from personal history of trauma combined with exposure to patients' trauma history also leads to a reduction in the capacity or interest in being empathic towards a client (Elwood, Mott, Lohr & Galovski, 2011). Other studies (e.g., Bride, Jones & MacMaster, 2007; Bride, Radey & Figley, 2007; Cunningham, 2003; Deighton et al., 2007; Dunkley & Whelan, 2006) measuring vicarious trauma amongst clinicians also found that a personal history of trauma in the clinician may greatly hinder his/her clinical skills and therefore the outcomes of treatment. It would further benefit future research to identify the impact of personal history of child sexual abuse in the clinician participants because it would not only identify its impact on empathic feelings toward the clients who were victims of child sexual abuse, but also reinforce the necessity for continuous training and prevention in order to minimize the challenges a mental health practitioner might face and help reduce the negative effects onto the treatment outcomes, the wellbeing of the client, and clinician.

The inclusion criteria of this study made this a homogeneous sample. Having stringent standards helps increase the internal validity of this research. However, this study would have been stronger if the limitations would have been addressed in order to control for additional variables (e.g., training in child sexual abuse or personal history of child sexual abuse) and lead to greater generalizability.

Implications for Research and Practice

Empathy is a fundamental dispositional trait (Covell & Scalora, 2002) and a valuable training area developed by clinicians. It is one of the most impactful components

of the therapeutic relationship between a clinician and a patient. As Davis (2009) emphasized, the concept of intentionality is of particular importance in the communication of empathy, and it is interpreted by the patient on both conscious and subconscious levels. It is clear that the practitioners who choose to enter the world of healthcare (e.g., psychology, psychiatry, medicine, etc.) have an innate ability to demonstrate empathy toward their patients.

However, such an innate ability can be worn out unless training is conducted to help prevent empathy fatigue (Brown, Ryan & Creswell, 2007; Rosenzweig, Reibel, Greeson, Brainard & Hojat, 2003; Shapiro, Astin, Bishop & Cordova, 2005). This observation opens the door on the idea that empathy may be cultivated within humans in order to promote a preventive approach to harmful activities, such as perpetration of child sexual abuse. This concept is of particular interest when considering the population of sex offenders, more precisely, child molesters, because the lack of empathy in sex offenders plays an important role in their repeated offenses since their aggressive tendencies are inversely related to empathic response (Covell et al., 2002; Geer, Estupinan & Manguno-Mire, 2000). With the attempt to study the mechanisms behind sex offenses and to propose a solution to reduce this problem, some researchers have investigated to what extent the integration of empathy-teaching in sex offenders' recovery programs may be helpful. Hudson, Wales, Bakker and Ward (2002) findings showed that with programs promoting awareness and empathy in sex offenders, their scores pre-treatment and post-treatment were encouraging. They also found amongst the clinicians' traits that were most effective with sex offenders and treatment outcomes were: empathy, warmth, rewarding and directive. Covell and Scalora (2002) also found that empathy-building

interventions also enhance child molesters' cognitive and affective awareness of the harmfulness of their assaults, and effectively counter the previously self-perceived rewards of sexual violence.

In terms of implications for clinical practice, the study of empathy in clinicians toward victims of child sexual abuse is extremely relevant and crucial as it can identify what factors in a clinician's career will promote empathy. Empathy is essential for the healing process of a victim of any type of trauma (Sabin-Farrell et al., 2003). This is most relevant when considering the population of child sexual abuse victims, and even more so toward male victims (Paivio & Laurent, 2001). As discussed previously, male victims are more likely to perpetuate the sexual violation they endured as a child onto young children. The risk level of perpetration was the greatest among male adults who were the victims of child sexual abuse, as many as 35% of the males become perpetrators (Glasser et al., 2001). Another study found a similar statistic, 31% of sexually abused males during childhood became adult perpetrators (Lisak, 1994).

Empathy becomes central in terms of treatment of the victims of child sexual abuse when considering that often these victims, especially males, do not always receive the empathy they deserve from their living-environment (e.g., caregivers, peers, healthcare providers). Men with a history of child sexual abuse are often internally conflicted and struggle with issues of self-blame, anger, and shame. They also tend to endorse extremely rigid gender norms which in turn predispose them to restrict their emotional expression and refuse to discuss their feelings with others (Easton, Renner & O'Leary, 2013). Furthermore, the perception of male survivors of child sexual abuse with regard to help-seeking is greatly challenged by their justified fears of not being believed,

being blamed, or being labeled as a homosexual (O'Leary & Gould, 2009; Spataro, Moss & Wells, 2001). Rogers (1998) long established that research, help, and support for male victims of child sexual abuse are still more than 20 years behind that for female victims. In addition, Walker, Archer and Davies (2005) found that very few male rapes or sexual assaults appear on police files or other official records because of the low report-rate from the male victims. In their findings, Walker et al. (2005) explained that only five out of the 40 male rape victims contacted the police after their rape, and only one out of these five cases resulted in a criminal conviction.

O'Leary (2009) urges psychology to provide mental healthcare to men with a history of child sexual abuse by highlighting that male victims were up to 10 times more likely to be classified as meeting clinical thresholds for psychiatric complaints in comparison with non-abused males. Easton et al. (2013) recommend that public health initiatives focused on men's mental health include a history-taking-process of child sexual abuse (and any other form of abuse) and offer educational programs designed to promote community awareness of the occurrence of child sexual abuse amongst males and its negative impact on mental health for adult survivors. Toledo and Seymour (2013) also emphasize on the importance of psychoeducational and therapeutic interventions for caregivers who had a history of child sexual abuse as this type of interventions train caregivers to show acceptance and empathy to their children with the aim of improving the parent–child relationship. Furthermore, research shows that those interventions produced an increased acceptance of the child from the caregiver, greater empathy, positive behavioral changes, and some improvement in the child's psychological well-being.

As discussed previously, the necessity for increased public awareness toward male sexual abuse, proper screening of males of a potential history of child sexual abuse, and greater empathy toward these victims will promote greater disclosure and adequate healing of these male victims. It could also be posited that a secondary crucial benefit may emerge from adequate and empathic clinical interventions: the internalization of empathy from the therapist toward the male victim. This internalized empathy may in turn invite the male survivor of child sexual abuse to increase his level of empathy toward his potential and/or past victims, in other words, this demonstration of empathy may become a critical factor in the potential and necessary eradication of perpetuation of child sexual abuse amongst males.

The treatment of sex offenders needs to include theories and models that emphasize individual strengths (e.g., protective factors and resilience), values, faith, morality, and positive attitudes and emotions (e.g., hope and optimism), and interventions that highlight humanistic strengths (e.g., compassion, love, forgiveness, social acceptance, human kindness, gratitude, and altruism) (Elisha, Idisis & Ronel, 2012; Ronel & Elisha, 2010). An emerging treatment modality for sex offenders called -positive criminology- demonstrates promoting positive qualities in offenders can lower the recidivism rate. Clinicians who demonstrated positive human strengths such as warmth, acceptance, empathy, respect, humor and encouragement were most successful at promoting these positive qualities in sex offenders (Marshall, Serran, Moulden, Mulloy, Fernandez, Mann &Thornton, 2002; Marshall, Ward, Mann, Moulden, Fernandez, Serran & Marshall, 2005; Moulden & Marshall (2005); Wormith, Althouse, Simpson, Reitzel, Fagan & Morgan, 2007).

When therapists face an adult who was sexually abused as a child, their level of empathy will not only promote the healing of the trauma but also become a learning experience allowing the victim, now grown to divulge empathy toward his/her past victims –in the case of perpetration- and/or promote a mechanism of resistance when facing the opportunity to perpetuate the sexual violation. As pioneer research on empathy haa established, empathy is a moderating variable in the display of aggression (Feshbach, 1964; Feshbach & Feshbach, 1969; Feshbach, Feshbach, Fauvre, & Ballard-Campbell, 1983; Mehrabian & Epstein, 1972; Wiehe, 1997). This concept is not only defended by clinicians, but by sex offenders as well. Recent studies on sex offenders showed that the offenders themselves often see victim-empathy work as one of the most important and influential components of their treatment (Levenson, Macgowan, Morin & Cotter, 2009; Wakeling, Levenson & Prescott, 2009; Webster & Mann, 2005). A meta-analysis conducted by Hanson and Morton-Bourgon (2005) uncovered that attitudes tolerant of sexual assault, such as demonstrating a lack of empathy toward the victim, were significantly related to sexual recidivism.

Future Research

This research study has opened the door to several future related research directions. Future research should look further into this clinical topic in order to identify precisely the relationship between clinicians' years of experience, specialized training in child sexual abuse, level of education and personal history of child sexual abuse, and their level of empathy toward male and female survivors of child sexual abuse.

Of further interest also, and with the intent of addressing the pressing issue of a greater rate of perpetration among males who were the victims of child sexual abuse as opposed to females, future research should also investigate the level of empathy expressed in clinical settings (e.g., individual and/or group therapy sessions) toward the male victims of child sexual abuse and its potential correlation with a decrease and/or complete prevention of perpetration.

Possibly, future research could also review the IRI validity within the field of clinical and forensic psychology amongst clinicians with extended levels of practice experience and training. As discussed previously, the IRI was validated with entry-level university students in psychology who could have been motivated to respond to the questionnaire in a socially acceptable manner. This calls into question the IRI means validity while assessing specifically the male clinicians' level of empathy, because they typically have undergone more training and applied experience in assessing and treating trauma, hence the suffering of others, than first year students in psychology.

Conclusion

The purpose of this study was to investigate the differential level of empathy amongst male and female therapists toward male and female victims of child sexual abuse. This study proposed a unique perspective as it focused on genders with regard to expressed empathy. Clinicians with more than one year of clinical experience were asked to answer a brief demographic profile questionnaire as well as the Interpersonal Reactivity Index (IRI), which measure empathic feelings.

This study included a total of 128 participants, composed of 64 male clinicians and 64 female clinicians located across the United States. Using the IRI, it was

hypothesized that therapists would demonstrate greater empathy when reading the vignette of the female client who experienced sexual abuse than reading the vignette of the male client who experienced sexual abuse. Findings showed that the group of therapists who read the male vignette demonstrated less empathy overall than the group of therapists who read the female vignette.

It was also hypothesized that there would be no significant difference between male and female therapists in empathy in response to vignette of sexually abused male client. Findings showed that the group of male therapists who read the male vignette demonstrated greater empathy overall than the group of female therapists.

Finally, it was hypothesized that there would be no significant difference between male and female therapists in empathy in response to vignette of sexually abused female client. Findings showed that the group of male therapists who read the female vignette demonstrated greater empathy overall than the group of female therapists.

This study revealed surprising findings in the sense that the predicted outcomes speculated that male therapists would demonstrate less empathy than female therapists on the basis of their gender. It was also speculated that a female victim might elicit greater compassion from the therapist based on her gender as well. However, given the speficity of the population survey in this study (experienced therapists as opposed to general population or entry-level students in psychology), it is difficult to pinpoint which factor(s) might have produced higher scores among male therapists in term of empathy toward a victim of sexual abuse. This incertitude certainly opens a door on future research in the clinical and forensic field as this research is unique in its genre and deserves further investigation. Furthermore, because empathy has been long established

as a crucial factor in clinical work as strongly correlated with promoting better outcomes for the client, and as discussed previously, a proven tool for prevention against sexual offenses perpetration and/or recidivism, it is important that more research be done in this arena. Additional research on the impact of empathy toward the victims of child sexual abuse could potentially become a valuable platform while promoting its healing properties amongst clinicians and other healthcare providers' training, but also become a valuable and necessary social value to implement in the public because it may in turn promote the reduction and prevention of child sexual abuse perpetration.

REFERENCES

References

Ackard, D. M., & Neumark-Sztainer, D. (2003). Multiple sexual victimizations among adolescent boys and girls: Prevalence and associations with eating behaviors and psychological health. *Journal of Child Sexual Abuse, 12*(1), 17-37. doi:10.1300/J070v12n01_02

Ahmad, S. (2006). Adult psychosexual dysfunction as a sequela of child sexual abuse. *Sexual and Relationship Therapy, 21*(4), 405-418. doi:10.1080/14681990600615206

Alaggia, R. (2005). Disclosing the trauma of child sexual abuse: A gender analysis. *Journal of Loss Trauma, 10*, 453–70. doi:10.1080/15325020500193895

American Psychiatric Association (2000). *Diagnostic and statistical manual of mental disorders* 4th - Text Revised. Washington, DC: Author.

Anderson, E. (1999). *Code of the street: Decency, violence, and the moral life of the inner city.* New York, NY: Norton.

Araji, S. K. (1997). *Sexually aggressive children: Coming to understand them*. Thousand Oaks, CA: Sage.

Arriola, K.R.J., Louden,T., Doldren,M.A., & Fortenberry, R.M.(2005). A meta-analysis of the relationship of child sexual abuse to HIV risk behavior among women. *Child Abuse and Neglect, 29*, 725−746. doi:10.1016/j.chiabu.2004.10.014

Asgeirsdottir, B. B., Sigfusdottir, I. D., Gudjonsson, G. H., & Sigurdsson, J. F. (2011). Associations between sexual abuse and family conflict/violence, self-injurious behavior, and substance use: The mediating role of depressed mood and anger. *Child Abuse & Neglect, 35*(3), 210-219. doi:10.1016/j.chiabu.2010.12.003

Balsam, K. F. (2003). Traumatic victimization in the lives of lesbian and bisexual women: A contextual approach. Journal of Lesbian Studies, *7*, 1–14.

Balsam, K. F., Rothblum, E. D., & Beauchaine, T. P. (2005). Victimization over the lifespan: A comparison of lesbian, gay, bisexual, and heterosexual siblings. Journal of Consulting and Clinical Psychology, *73*, 477–487. doi 10.1037/0022-006X.73.3.477

Banyard, V. L., Williams, L. M., & Siegel, J. A. (2004). Childhood Sexual Abuse: A Gender Perspective on Context and Consequences. *Child Maltreatment, 9*(3), 223-238. doi:10.1177/107755904266914

Bedi, S., Nelson, E. C., Lynskey, M. T., McCutcheon, V. V., Heath, A. C., Madden, P. A. F., & Martin, N. G. (2011). Risk for suicidal thoughts and behavior after childhood sexual abuse in women and men. *Suicide and Life-Threatening Behavior, 41*(4), 406–415. doi:10.1111/j.1943-278X.2011.00040.x

Behl, L. E., Conyngham, H. A., & May, P. F. (2003). Trends in child maltreatment literature. *Child Abuse & Neglect 27*(2), 215–229. doi:10.1016/S0145-2134(02)00535-5

Bentovim, A. (2002). Preventing sexually abused young people from becoming abusers, and treating the victimization experiences of young people who offend sexually. *Child Abuse & Neglect*, *26*(6-7), 661-678. doi:10.1016/S0145-2134(02)00340-X

Berliner, L., & Conte, J.R. (1995). The effects of disclosure and intervention on sexually abused children. *Child Abuse & Neglect* 19, 371-384. doi:10.1016/S0145-2134(94)00138-3

Bartholow, B. D., Sestir, M.A., & Davis, E.B. (2005). Correlates and consequences of exposure to video game violence: hostile personality, empathy, and aggressive behavior. Personality & Social Psychology, 31, 1573–1586. doi:10.1177/0146167205277205

Berthoz, S., Wessa, M., Kedia, G., Wicker, B., & Grèzes, J. (2008). Cross-cultural validation of the empathy quotient in a French-speaking sample. *Canadian Journal of Psychiatry, 53*, 469–477. pmid:18674405

Besel, L. D. S., & Yuille, J. C. (2010). Individual differences in empathy: The role of facial expression recognition. *Personality and Individual Differences, 49*, 107–112. doi:10.1016/j.paid.2010.03.013

Blagys, M. D., & Hilsenroth, M. J., 2000. Distinctive features of short-term psychodynamic–interpersonal psychotherapy: a review of the comparative psychotherapy process literature. *Clinical Psychology: Science and Practice, 7*(2), 167-188. doi:10.1093/clipsy.7.2.167

Blain, L. M., Muench, F., Morgenstern, J., & Parsons, J. T. (2012). Exploring the role of child sexual abuse and posttraumatic stress disorder symptoms in gay and bisexual men reporting compulsive sexual behavior. *Child Abuse & Neglect*, *36*(5), 413-422. doi:10.1016/j.chiabu.2012.03.003

Bonner, B. L., Walker, C. E., & Berliner, L. (1999). Children with sexual behavior problems: Assessment and treatment. Final Report, Grant No. 90-CA-1469. Washington DC: Administration of Children, Youth, and Families, DHHS.

Bornstein, B. H., Kaplan, D. L., & Perry, A. R. (2007). Child abuse in the eyes of the beholder: Lay perceptions of child sexual and physical abuse. *Child Abuse & Neglect*, 3*1(*4*), 375-391.* doi:10.1016/j.chiabu.2006.09.007

Bremner, J. D. (1999). Acute and chronic responses to psychological trauma: Where do we go from here? *American Journal of Psychiatry, 156*, 349-351. pmid: 10080546

Bride, B. E., Jones, J. L., & MacMaster, S. A. (2007). Correlates of secondary traumatic stress in child protective services workers. *Journal of Evidence Based Social Work, 4*, 69−80. doi:10.1300/J394v04n03_05

Bride, B. E., Radey, M., & Figley, C. R. (2007). Measuring compassion fatigue. *Clinical Social Work Journal, 35*, 155−163. doi:10.1007/s10615-007-0091-7

Brown, P., Cohen, H., Chen, E., Smailes, E. & Johnson, J. G. (2004). Sexual trajectories of abused and neglected youths, *Journal of Developmental and Behavioral Pediatrics, 25*(2), 77-82. doi:10.1097/00004703-200404000-00001

Butzel, J.S., Talbot, N.L., Duberstein, P.R., Houghtalen, R.P., Cox, C., & Giles, D.E. (2000). The relationship between traumatic events and dissociation among women with histories of childhood sexual abuse. *The Journal of Nervous and Mental Disease, 188*(8), 547-549. doi:10.1097/00005053-200008000-00012

Bylunda, C. L. & Makoul, G. (2002). Empathic communication and gender in the physician–patient encounter. *Patient Education and Counseling 48*, 207–216. doi:10.1016/S0738-3991(02)00173-8

Carlo, G., & Randall, B. A. (2002). The development of a measure of prosocial behaviors for late adolescents. *Journal of Youth and Adolescence, 31*, 31–44. doi 10.1023/A:1014033032440

Chandy, J. M., Blum, R. W., & Resnick, M. D., 1996. Gender-specific outcomes for sexually abused adolescents. *Child Abuse and Neglect 20*, 1219-1231. doi:10.1016/S0145-2134(96)00117-2

Christopher, K., Lutz-Zois, C. J., & Reinhardt, A. R. (2007). Female sexual-offenders: Personality pathology as a mediator of the relationship between childhood sexual abuse history and sexual abuse perpetration against others. *Child Abuse & Neglect*, *31*(8), 871-883. doi:10.1016/j.chiabu.2007.02.006

Clear, T. R., & Cole, G. F. (2000*). American corrections* (5th Eds.) (p. 250). Belmont, CA: Wadsworth.

Cohen, J. (1992). Quantitative methods in psychology: A power primer. *Psychological Bulletin, 112*(1), 155-159. Retrieved from http://web.mit.edu/hackl/www/lab/turkshop/readings/cohen1992.pdf

Cohen, J. A., Mannarino, P. A., & Knudsen, K. (2005). Treating sexually abused children: 1 year follow-up of a randomized controlled trial. *Child Abuse & Neglect, 29,* 135-145. doi:10.1016/j.chiabu.2004.12.005

Colton, M., Roberts, S., & Vanstone, M. (2009). Child Sexual Abusers' Views on Treatment: A Study of Convicted and Imprisoned Adult Male Offenders. *Journal of Child Sexual Abuse, 18,* 320–338. doi:10.1080/10538710902918170

Cook, E. P. (1998). Gender and psychological distress. In D. L. Anselmi & A. L. Law (Eds.), Questions of gender: Perspectives and paradoxes (pp. 740-747). Boston: McGraw-Hill.

Cortoni, F., & Marshall, W.L. (2001). Sex as a coping strategy and its relationship to juvenile sexual history and intimacy in sexual offenders. *Sexual Abuse: A Journal of Research and Treatment, 13*, 27-43. doi:10.1177/107906320101300104

Crisma, M., Bascelli, E., Paci, D., & Romito, P. (2004). Adolescents who experienced sexual abuse: Fears, needs and impediments to disclosure. *Child Abuse & Neglect, 28*(10), 1035–1048. doi:10.1016/j.chiabu.2004.03.015

Crouch, J. L., Smith, D. W., Ezzell, C. E., & Saunders, B. E. (1999). Measuring reactions to sexual trauma among children: comparing the children's impact of traumatic events scale and the trauma symptom checklist for children. *Child Maltreatment, 4,* 255-263. doi:10.1177/1077559599004003006

Crumpei, I., & Dafinoiu, I. (2012). The relation of clinical empathy to secondary traumatic stress. *Social and Behavioral Sciences, 33*, 438-442. doi:10.1016/j.sbspro.2012.01.159

Cunningham, M. (2003). Impact of trauma work on social work clinicians: Empirical findings. *Social Work, 48*, 45−459.

Davies, M., & Rogers, P. (2006). Perceptions of male victims in depicted sexual assaults: A review of the literature. *Aggression and Violent Behavior, 11*(4), 367-377. doi:10.1016/j.avb.2006.01.002

Davis, M. H. (1983). Measuring individual differences in empathy: Evidence for a multidimensional approach. *Journal of Personality and Social Psychology, 44*, 113–126. doi:10.1037//0022-3514.44.1.113

Davis, M. H. (1980). A Multidimensional approach to individual differences in empathy. *JSAS Catalog of Selected Documents in Psychology, 10*, 85-104.

Davis, M.H., Conklin, L., Smith, A., & Luce, C. (1996). Effect of perspective taking on the cognitive representation of persons: A merging of self and other. *Journal of Personality and Social Psychology, 70*(4), 713-726. Retrieved from http://www.eckerd.edu/academics/psychology/files/Davis_1980.pdf

Day, A. (1999). Sexual offender views about treatment: A client survey. *Journal of Child Sexual Abuse, 8*(2), 93–103. doi:10.1300/J070v08n02_06

Day, A., Thurlow, K., & Woolliscroft, J. (2003). Working with childhood sexual abuse: a survey of mental health professionals. *Child abuse & Neglect,* 27(2), 191-198. doi:10.1016/S0145-2134(02)00540-9

Decety, J., & Jackson, P. L. (2006). A social neuroscience perspective on empathy. *Current Directions in Psychological Science, 15*, 54–58. doi:10.1111/j.0963-7214.2006.00406.x

Decety, J., & Lamm, C. (2009). Empathy versus personal distress: Recent evidence from social neuroscience. In J. Decety & W. Ickes (Eds.), *The social neuroscience of empathy* (pp. 199–213). Cambridge, MA: MIT Press.

Deighton, R. M., Gurris, N., & Traue, H. (2007). Factors affecting burnout and compassion fatigue in therapists treating torture survivors: Is the therapist's attitude to working through trauma relevant? *Journal of Traumatic Stress, 20*, 63−75. doi:10.1002/jts.20180

Dhaliwal, G. K., Gauzas, L., Antonowicz, D. H., & Ross, R. R. (1996). Adult male survivors of childhood sexual abuse: prevalence, sexual abuse characteristics, and long-term effects. *Clinical Psychology Review, 16*(7), 619-639. doi:10.1016/S0272-7358(96)00018-9

Dimitrova N., Pierrehumbert B., Glatz N., Torrisi R., Heinrichs M., Halfon O., & Chouchena O. (2009). Closeness in relationships as a mediator between sexual abuse in childhood or adolescence and psychopathological outcome in adulthood. *Clinical Psychology and Psychotherapy. doi:10.1002/cpp.650*

Dollar, K. M., Perry, A. R., Fromuth, M. E., & Holt, A. R. (2004). Influence of gender roles on perceptions of teacher/adolescent student sexual relations. *Sex Roles, 50*, 91-101. doi:10.1023/B:SERS.0000011075.91908.98

Dorais, M. (2009). Don't Tell – The sexual abuse of boys, Second edition (p. 143). Montreal: McGill-Queen's University Press.

Draijer, N., & Langeland, W. (1999). Childhood trauma and perceived parental dysfunction in the etiology of dissociative symptoms in psychiatric inpatients. *American Journal of Psychiatry, 156*, 379-385. pmid: 10080552

Dube, S. R., Anda, R. F., Whitfield, C. L., Brown, D. W., Felitti, V. J., Dong, M., & Giles, W. H. (2005). Long-term consequences of childhood sexual abuse by gender of victim. *American Journal of preventative medicine, 28*(5) 430-439. doi:10.1016/j.amepre.2005.01.015

Dunkley, J., & Whelan, T. A. (2006). Vicarious traumatization in telephone counselors: Internal and external influences. *British Journal of Guidance & Counseling, 34*, 451−469. doi:10.1080/03069880600942574

Eisenberg, N., Fabes, R. A., Murphy, B., Karbon, M., Maszk, P., Smith, M. Suh, K., & O'Boyle, C. (1994). The relations of emotionality and regulation to dispositional and situational empathy-related responding. *Journal of Personality and Social Psychology, 66*, 776-797. doi:10.1037//0022-3514.66.4.776

Eisenberg, N., & Eggum, N. D. (2009). Empathic responding: Sympathy and personal distress. In J. Decety & W. Ickes (Eds.), *The social neuroscience of empathy* (pp. 71–83). Cambridge, MA: MIT Press.

Easton, S. D., Renner, L. M., & O'Leary, P. (2013). Suicide attempts among men with histories of child sexual abuse: Examining abuse severity, mental health, and masculine norms. *Child Abuse & Neglect, 37,* 380– 387. doi:10.1016/j.chiabu.2012.11.007

Elisha, E., Idisis, Y., & Ronel, N. (2012). Window of opportunity: Social acceptance and life transformation in the rehabilitation of imprisoned sex offenders. *Aggression and Violent Behavior, 17*(4). 323-332. doi:10.1016/j.avb.2012.03.004

Elliott, M., Browne, K., & Kilcoyne, J. (1995). Child sexual abuse prevention: What offenders tell us. *Child Abuse & Neglect, 5*, 579-594. doi:10.1016/0145-2134(95)00017-3

Elliott, R., Bohart, J. C., Watson, A. C., & Greenberg, L. S. (2011). Empathy. *Psychotherapy, 48*(1), 43–49. doi:10.1037/a0022187

Elwood, L. S., Mott, J., Lohr, J. M., & Galovski, T. E. (2011). Secondary trauma symptoms in clinicians: A critical review of the construct, specificity, and implications for trauma-focused treatment. *Clinical Psychology Review, 31*(1), 25-36. doi:10.1016/j.cpr.2010.09.004

Feiring, C., Taska, L., & Lewis, M. (1999). Age and gender differences in children's and adolescents' adaptation to sexual abuse. *Child Abuse & Neglect, 23*, 115-128. doi:10.1016/S0145-2134(98)00116-1

Feiring, C., Taska, L., & Lewis, M. (2002). Adjustment following sexual abuse discovery: The role of shame and attributional style. *Developmental Psychology. 38*(1), 79-92. doi:10.1037//0012-1649.38.1.79

Feller, C. P., & Cottone, R. R. (2012). The importance of empathy in the therapeutic alliance. *The Journal of Humanistic Counseling, Education and Development, 42(*1*)*. doi:10.1002/j.2164-490X.2003.tb00168.x

Fergusson, D. M., & Mullen, P. E. (1999). *Childhood sexual abuse: An evidence based perspective.* Thousand Oaks, California: Sage Publications.

Ferguson, J. C., & Meehan, D. C. (2005). An analysis of females convicted of sex crimes in the state of Florida. *Journal of Child Sexual Abuse, 14*(1), 75-89. doi:10.1300/J070v14n01_05

Festinger, L. (1957). *A theory of cognitive dissonance* Row, Peterson, Evanston, IL: Row Peterson & Co.

Finkelhor, D. (1984). Child sexual abuse: New theory and research. New York, NY: Free Press.

Fitzgibbon, B. M., Giummarra, M. J., Georgiou-Karistianis, N., Enticott, P. G., & Bradshaw, J. L. (2010). Shared pain: From empathy to synaesthesia. *Neuroscience & Biobehavioral Reviews, 34*(4), 500-512. doi:10.1016/j.neubiorev.2009.10.007

Friedrich, W. N., Fisher, J., Dittner, C., Acton, R., Berliner, L., & Butler, J. (2001). Child sexual behavior inventory: Normative, psychiatric, and sexual abuse comparisons. *Child Maltreatment, 6,* 37-49. doi:10.1177/1077559501006001004

Friedrich, W. N. (1994). Assessing children for the effects of sexual victimization. *New Directions for Mental Health Services, 64,* 17-27. doi:10.1002/yd.23319946404

Gannon, T. A., & Mariamne, R. R. (2008). Female child sexual offenders: Towards integrating theory and practice. *Aggression & Violent Behavior, 13*(6), 442-461. doi:10.1016/j.avb.2008.07.002

Gill, M., & Tutty, L. M. (1999). Male survivors of childhood sexual abuse: A qualitative study and issues for clinical consideration. *Journal of Child Sexual Abuse, 7*(3), 19-33. doi:10.1300/J070v07n03_02

Ginzburg, K., Koopman, C., Butler, L. D., Palesh, O., Kraemer, H. C., & Classen, C. C. (2006). Evidence for a Dissociative Subtype of Post-Traumatic Stress Disorder Among Help-Seeking Childhood Sexual Abuse Survivors. *Journal of Trauma & Dissociation*, *7*(2), 7-27. doi:10.1300/J229v07n02_02

Glasser, M., Kolvin, I., Campbell, D., Glasser, A., Leitch, I., & Farrelly, S. (2009). Cycle of child sexual abuse: links between being a victim and becoming a perpetrator. *The British Journal of Psychiatry*, *179*(6), 482-494. doi:10.1192/bjp.179.6.482

Gleichgerrcht E., & Decety, J. (2013) Empathy in Clinical Practice: How Individual Dispositions, Gender, and Experience Moderate Empathic Concern, Burnout, and Emotional Distress in Physicians. *PLoS ONE 8*(4), e61526. doi:10.1371/journal.pone.0061526

Gold, S. D., Marx, B. P., & Lexington, J. M. (2007). Gay male sexual assault survivors: The relations among internalized homophobia, experiential avoidance, and psychological symptom severity. *Behaviour Research and Therapy*, *45*(3), 549-562. doi:10.1016/j.brat.2006.05.006

Goodman-Brown, T. B., Edelstein, R. S., Goodman, G. S., Jones, D. P. H., & Gordon, D. S. (2003). Why children tell: a model of children's disclosure of sexual abuse. *Child Abuse & Neglect*, *27*(5), 525-540. doi:10.1016/S0145-2134(03)00037-1

Goodwin, J., & DiVasto, P. (1982). Female homosexuality: A sequel to mother-daughter incest. In: Goodwin, J. Editor, 1982. *Sexual abuse: Incest victims and their families (pp. 117-123)*. Boston, MA: John Wright.

Greenberg, L. S., Elliott, R., Watson, J. C., & Bohart, A. C. (2001). Empathy. *Psychotherapy: Theory, Research, Practice, Training, 38*, 380−384. doi:10.1037//0033-3204.38.4.380

Hall, D. K., Mathews, F., & Pearce, J. (1998). Factors associated with sexual behavior problems in young sexually abused children. *Child Abuse & Neglect, 22,* 1045-1063. doi: 10.1016/S0145-2134(98)00078-7

Hanson, R. K., & Morton-Bourgon, K. E. (2005). The characteristics of persistent sexual offenders: A meta-analysis of recidivism studies. *Journal of Consulting and Clinical Psychology, 73*, 1154–1163. doi:10.1037/0022-006X.73.6.1154

Harkins, L., & Beech, A. R. (2007). A review of the factors that can influence the effectiveness of sexual offender treatment: Risk, need, responsivity, and process issues. *Aggression and Violent Behavior, 12*, 615–627. doi:10.1016/j.avb.2006.10.006

Heesacker, M., Wester, S. R., Vogel, D. L., Wentzel, J. T., Mejia-Millan, C. M., & Goodholm, C. R. Jr. (1999). Gender-Based Emotional Stereotyping. *Journal of Counseling Psychology, 46*(4), 483-495. doi:10.1037//0022-0167.46.4.483

Heidt, J. M., Marx, B. P., & Gold, S. D. (2005). Sexual revictimization among sexual minorities: A preliminary study. *Journal of Traumatic Stress, 18*, 533–540. doi:10.1002/jts.20061

Hetherton J. (1999). The idealization of women: its role in the minimization of child sexual abuse by females. *Child Abuse & Neglect, 23*(2), 161-74. doi:10.1016/S0145-2134(98)00119-7

Hetzel-Riggin, M. D., Brausch, A. M., & Montgomery, B. S. (2007). A meta-analytic investigation of therapy modality outcomes for sexually abused children and adolescents: An exploratory study. *Child Abuse & Neglect, 31*, 125-141. doi: 10.1016/j.chiabu.2006.10.007

Higgins Kessler, M. R., White, M. B., & Nelson, B. S. (2003). Group treatments for women sexually abused as children: a review of the literature and recommendations for future outcome research. *Child Abuse & Neglect*, *27* (9), 1045-1061. doi: 10.1016/S0145-2134(03)00165-0

Hojat M. (2007). Empathy in Patient Care. Antecedents, Development, Measurement, and Outcomes (p. 4). New York, NY: Springer.

Holmes, G. R., Offen, L., & Waller, G (1997). See No Evil, Hear No Evil, Speak No Evil: Why Do Relatively Few Male Victims of Childhood Sexual Abuse Receive Help for Abuse-Related Issues in Adulthood? *Clinical Psychology Review, 17*(1). 60-88. doi:10.1016/S0272-7358(96)00047-5

Holmes, W. C. (2008). Men's self-definitions of abusive childhood sexual experiences, and potentially related risky behavioral and psychiatric outcomes. *Child Abuse & Neglect*, *32*(1), 83-97. doi:10.1016/j.chiabu.2007.09.005

Homeyer, L. E. (1999). Group play therapy. In D. S. Sweeney & L. E. Homeyer (Eds.), *The handbook of group play therapy: How to do it, how it works, whom it's best for* (pp. 3-14). San Francisco, CA: Jossey-Bass.

Homma, Y., Wang, N., Saewyc, E. & Kishor, N. (2012). The Relationship Between Sexual Abuse and Risky Sexual Behavior Among Adolescent Boys: A Meta-Analysis. *Journal of Adolescent Health, 51*, 18–24. doi:10.1016/j.jadohealth.2011.12.032

Jennings, K. (1994). Female child molesters: A review of the literature. In *Female sexual abuse of children*. M. Elliott (Eds.). New York, NY: Guilford Press.

Jespersen, A. F., Lalumière, M. L., & Seto, M. C. (2009). Sexual abuse history among adult sex offenders and non-sex offenders: A meta-analysis. *Child Abuse & Neglect, 33*(3), 179-192. doi: 10.1016/j.chiabu.2008.07.004

Johnson, R. J., Ross, M. W., Taylor, W. C., Williams, M. L., Carvajal, R. I., & Peters, R. J. (2006). Prevalence of childhood sexual abuse among incarcerated males in county jail. *Child Abuse & Neglect, 30*(1), 75-86. doi:10.1016/j.chiabu.2005.08.013

Jones, K. D. (2002). Group play therapy with sexually abused preschool children: Group behaviors and interventions. *Journal for Specialists in Group Work, 27*(4), 377-389. doi:10.1080/714860200

Kaplan, M., & Green, A. (1995). Incarcerated female sexual offenders: A comparison of sexual histories with eleven female nonsexual offenders. *Sexual Abuse: A Journal of Research and Treatment 7*, 287-300. doi:10.1007/BF02256833

Katerndahl, D. A, Burge S., & Kellogg N. (2005). Psychiatric comorbidity in women with a history of childhood sexual abuse. *Journal of Child Sex Abuse, 14*(3), 91-105. doi: 10.1300/J070v14n03_05

Kelly, R. J., Wood, J. J., Gonzalez, L. S., MacDonald, V., & Waterman J. (2002). Effects of mother-son incest and positive perceptions of sexual abuse experiences on the psychosocial adjustment of clinic-referred men. *Child Abuse & Neglect, 26*(4), 425-441. doi:10.1016/S0145-2134(02)00317-4

Kia-Keating, M., Sorsoli, L., & Grossman, F. K. (2010). Relational Challenges and Recovery Processes in Male Survivors of Childhood Sexual Abuse. *Journal of Interpersonal Violence 25*(4), 666-683. doi: 10.1177/0886260509334411

Kimerling, R., Rellini, A., Kelly, V., Judson, P. L., & Learman, L. A. (2002). Gender Differences in Victim and Crime Characteristics of Sexual Assaults. *Journal of Interpersonal Violence, 17*(5), 526-532. doi:10.1177/0886260502017005003

King, M., & Woollett, E. (1997). Sexually assaulted males: 115 men consulting a counseling service. *Archives of Sexual Behavior, 26*(6), 579-580. doi: 10.1023/A:1024520225196

Kogan, S. (2004). Disclosing unwanted sexual experiences: Results from a national sample of adolescent women. *Child Abuse & Neglect, 28*(2), 147–165. doi:10.1016/j.chiabu.2003.09.014

Kohut, H. (1977). The restoration of the seven. New York, NY: International Universities Press.

Krista, A. (1994). *Deadlier than the male. Violence and aggression in women.* London, England: Harper Collins.

Krug, E. G., Dahlberg, L. L., Mercy, J. A., Zwi, A. B., & Lozano, R. (2002). World report on violence and health. *World Health Organization, Geneva, 360*(9339), 1083. doi:10.1016/S0140-6736(02)11133-0

Lisak, D. (1994). The psychological impact of sexual abuse: Content analysis of interviews with male survivors. *Journal of Traumatic Stress*, *7*(4), 525-548. doi:10.1007/BF02103005

Lab, D. D., Feigenbaum, J. D., & De Silva, D. (2000). Mental health professionals' attitude and practices towards male childhood sexual abuse. *Child Abuse & Neglect, 24*(3), 391-409. doi:10.1016/S0145-2134(99)00152-0

Lamb, S., & Edgar-Smith, S. (1994). Aspects of disclosure: Mediators of outcome of childhood sexual abuse. *Journal of Interpersonal Violence, 9*, 307-326. doi:10.1177/088626094009003002

Lev-Wiesel, R. (2008). Child sexual abuse: A critical review of intervention and treatment modalities. *Children and Youth Services Review, 30*(6), 665-673. doi:10.1016/j.childyouth.2008.01.008

Levenson, J. S., Macgowan, M. J., Morin, J. W., & Cotter, L. P. (2009). Perceptions of sex offenders about treatment: Satisfaction and engagement in group therapy. *Sexual Abuse: A Journal of Research and Treatment, 21*, 35–56. doi:10.1177/1079063208326072

Levenson, J. S., & Prescott, D. (2009). Treatment experiences of civilly committed sex offenders: A consumer satisfaction survey. *Sexual Abuse: A Journal of Research and Treatment, 21*, 6–20. doi:10.1177/1079063208325205

Levesque, R. (1994). Sex differences in the experience of child sexual victimization. *Journal of Family Violence, 9*, 357-369. doi:10.1007/BF01531945

Little, L., & Hamby, S. L. (1999). Gender differences in sexual abuse outcomes and recovery experiences: A survey of therapist-survivors. *Professional Psychology: Research and Practice*, *30*(4), 378-385. doi:10.1037//0735-7028.30.4.378

Loh, C., & Gidycz, C. A. (2006). A prospective analysis of the relationship between childhood sexual victimization and perpetration of dating violence and sexual assault in adulthood. *Journal of Interpersonal Violence, 21*(6), 732-749. doi:10.1177/0886260506287313

Macdonald, G., Higgins, J. P., & Ramchandani, P. (2006). Cognitive-behavioural interventions for children who have been sexually abused. Cochrane Database Syst Rev; (4):CD001930. doi: 10.1002/14651858

Maikovich-Fonga, A. K., & Jaffee, S. R. (2010). Sex differences in childhood sexual abuse characteristics and victims' emotional and behavioural problems: Findings from a national sample of youth. *Child Abuse & Neglect 34*(6), 429–437. doi: 10.1016/j.chiabu.2009.10.006

Marshall, W. L., Serran, G., Moulden, H., Mulloy, R., Fernandez, Y. M., Mann, R., &Thornton, D. (2002). Therapist features in sexual offender treatment: Their reliable identification and influence on behavior change. *Clinical Psychology and Psychotherapy, 9*, 395–405. doi:10.1002/cpp.335

Marshall, W.L., Serran, G.A., Fernandez, Y.M., Mulloy, R.., Mann, R. E., & Thornton, D. (2003). Therapist characteristics in the treatment of sexual offenders: Tentative data on their relationship with indices of behavior change. *Journal of Sexual Aggression, 9*, 25–30. doi:10.1080/355260031000137940

Marshall, W. L., Ward, T., Mann, R. E., Moulden, H., Fernandez, Y. M., Serran, G., & Marshall, L. E. (2005). Working positively with sexual offenders: Maximizing the effectiveness of treatment. *Journal of Interpersonal Violence, 20*(9), 1096–1114. doi: 10.1177/0886260505278514

Martin, G., Bergen, H. A., Richardson, A. S., Roeger, L., & Allison, S. (2004). Sexual abuse and suicidality: Gender differences in a large community sample of adolescents. *Child Abuse & Neglect, 28*, 491–503. doi:10.1016/j.chiabu.2003.08.006

Marx, B. P., Calhoun, K. S., Wilson, A. E., & Meyerson, L. A. (2001). Sexual revictimization prevention: An outcome evaluation. *Journal of Consulting and Clinical Psychology, 69*, 25–32. doi:10.1037//0022-006X.69.1.25

McLeer, S.V., Deblinger, E., Henry, D., & Orvaschel, H. (1992). Sexually abused children at high risk for PTSD. *Journal of the American Academy of Child and Adolescent Psychiatry, 31*, 875-879. doi: 10.1097/00004583-199209000-00015

Messman-Moore, T. L., & Long, P. J. (2003). The role of childhood sexual abuse sequelae in sexual revictimization: An empirical review and theoretical reformulation. *Clinical Psychology Review, 23*(4), 537–571. doi: 10.1016/S0272-7358(02)00203-9

Mitchell, C., & Melikian, K. (1995). The treatment of male sexual offenders: Countertransference reactions. *Journal of Child Sexual Abuse, 4*(1), 87–93. doi:10.1300/J070v04n01_06

Mitchell, D., Hirschman, R., & Nagayama-Hall, G. (1999). Attributions of victim responsibility, pleasure and trauma in male rape. *Journal of Sex Research, 36*, 369−373. doi:10.1080/00224499909552009

Molnar, B. E., Berkman, L. F., & Buka, S. L. (2001). Psychopathology, childhood sexual abuse and other childhood adversities: Relative links to subsequent suicidal behavior in the US. *Psychological Medicine, 31*, 965–977. doi:10.1017/S0033291701004329

Moulden, H. M., & Marshall, W. L. (2005). Hope in the treatment of sexual offenders: The potential application of hope theory. *Psychology, Crime & Low, 11*(3), 329–342. doi:10.1080/10683160512331316361

Nalavany, B. A., Ryan, S. D., & Hinterlong, J. (2009). Externalizing behavior among adopted boys with preadoptive histories of child sexual abuse. *Journal of Child Sexual Abuse, 18*(5), 553-573. doi:10.1080/10538710903183337

Neumann, M., Bensing, J., Mercer, S., Ernstmann, N., Ommen, O., & Plaff, H. (2009). Analyzing the "nature" and "specific effectiveness" of clinical empathy: A theoretical overview and contribution towards a theory-based research agenda. *Journal of Patient Education and Counseling, 74*(3), 339–346. doi:10.1016/j.pec.2008.11.013

O'Leary. (2009). Men who were sexually abused in childhood: Coping strategies and comparisons in psychological functioning. *Child Abuse & Neglect, 33*, 471–479. doi:10.1016/j.chiabu.2009.02.004

O'Leary, P., & Barber, J. (2008). Gender Differences in Silencing Following Childhood Sexual Abuse. *Journal of Child Sexual Abuse*, *17*(2), 133-143. doi: 10.1080/10538710801916416

O'Leary, P., & Gould, N. (2009). Men who were sexually abused in childhood and subsequent suicidal ideation: Community comparison, explanations and practice implications. *British Journal of Social Work, 39*, 950–968. doi:10.1093/bjsw/bcn130

Owens, G. P., & Chard, K. M. (2003). Comorbidity and psychiatric diagnoses among women reporting child sexual abuse. *Child Abuse & Neglect, 27*(9), 1075-1082. doi:10.1016/S0145-2134(03)00168-6

Paciello, M., Fida, R., Tramontano, C., Lupinetti, C., & Caprara, G. V. (2008). Stability and change of moral disengagement and its impact on aggression and violence in late adolescence. *Child Development, 79*(5), 1288–1309. doi:10.1111/j.1467-8624.2008.01189.x

Paolucci, E. O., Genuis, M. L., & Violato, C. (2001). A meta-analysis of the published research on the effects of child sexual abuse. *Journal of Psychology, 135*, 17−36. doi:10.1080/00223980109603677

Paivio, S. C., & Laurent, C. (2001). Empathy and emotion regulation: reprocessing memories of childhood abuse. *Journal of Clinical Psychology, 57*, 213–226. doi:10.1002/1097-4679(200102)57:2<213::AID-JCLP7>3.3.CO;2-2

Pearce, J. (2003). Working with maltreated children: Guidance from attachment theory and research. Paper presented at the Oklahoma Conference on Child Abuse and Neglect, Oklahoma City, OK.

Peleikis, D. E., Mykletun, A., & Dahl, A. A. (2005). Current mental health in women with childhood sexual abuse who had outpatient psychotherapy. *European Psychiatry, 20*(3), 260-267. doi:10.1016/j.eurpsy.2005.01.004

Pierce, R., & Pierce, L. H. (1985). The sexually abused child. A comparison of male and female victims. *Child Abuse and Neglect, 9*, 191-199. doi:10.1016/0145-2134(85)90011-0

Pithers,W.D., & Gray, A. (1998). The other half of the story: Children with sexual behavior problems. *Psychology, Public Policy, and Law, 4*, 200-217. doi:10.1037//1076-8971.4.1-2.200

Pithers, W. D. (1999). Empathy**:** Definition, Enhancement, and Relevance to the Treatment of Sexual Abusers. *Journal of Interpersonal Violence, 14*(3), pp. 257-284. doi:10.1177/088626099014003004

Pollack, W. S. (1998). *Real boys: Rescuing our sons from the myths of boyhood.* New York, NY: Random House.

Priebe, G., & Svedin, C. G. (2008). Child sexual abuse is largely hidden from the adult society: An epidemiological study of adolescents' disclosures. *Child Abuse & Neglect, 32*(12), 1095-1108. doi: 10.1016/j.chiabu.2008.04.001

Price, J. L., Hilsenroth, M. J., Callahan, K. L., Petretic-Jackson, P. A., & Bonge, D. (2004). A pilot study of psychodynamic psychotherapy for adult survivors of childhood sexual abuse. *Clinical Psychology & Psychotherapy, 11*(6), 378-391. doi:10.1002/cpp.421

Putnam, F. (2003). Ten-year research update review: Child sexual abuse. *Journal of the American Academy of Child and Adolescent Psychiatry 42*, 269-278. doi:10.1097/00004583-200303000-00006

Ramsey-Klawsnik, H. (1990). Sexually abused boys: Indicators, abusers and impact of trauma. Paper presented at the Third National Conference on the Male Survivor, Tucson. doi: 10.1016/S0272-7358(96)00047-5

Rasmussen, L. A. (2000). The Trauma Outcome Process: An Integrated Model for Guiding Clinical Practice with Children with Sexually Abusive Behavior Problems. *Journal of Child Sexual Abuse*, *8*(4), 3-33. doi:10.1300/J070v08n04_02

Reidy, D. E., Sloan, C. E., & Zeichner, A. (2009). Gender role conformity and aggression: Influence of perpetrator and victim conformity on direct physical aggression in women. *Personality and Individual Differences*, *46*(2), 231-235. doi:10.1016/j.paid.2008.10.008

Risser, H. J., Hetzel Riggin, M.D., Thomsen, C. J., & McCanne, T. R. (2006). PTSD as a mediator of sexual revictimization: The role of re-experiencing, avoidance, and arousal symptoms. *Journal of Traumatic Stress, 19*, 687–698. doi: 10.1002/jts.20156

Rogers, C. R. (1980). *A way of being.* Boston, MA: Houghton Mifflin.

Rogers, C. R. (1957). The necessary and sufficient conditions of therapeutic personality change. *Journal of Consulting Psychology, 21*, 95-103. doi:10.1037//0022-006X.60.6.827

Roesler, T.A., & Wind, T.W. (1994). Telling the secret: Adult women describe their disclosures of incest. *Journal of Interpersonal Violence 9*, 327-338. doi:10.1177/088626094009003003

Romano, E., & De Luca, R. V. (2005). An individual treatment programme for sexually abused adult males: description and preliminary findings. *Child Abuse Review, 14*(1), 40-56. doi:10.1002/car.880

Ross, E. C., Polaschek, D. L.L. & Ward, T. (2008). The therapeutic alliance: A theoretical revision for offender rehabilitation. *Aggression and Violent Behavior*, *13*(6), 462-480. doi:10.1016/j.avb.2008.07.003

Rudin, M. M., Zalewski, C., & Bodmer-Turner, J. (1995). Characteristics of child sexual abuse victims according to perpetrator gender. *Child Abuse & Neglect, 19*(8), 963-73. doi:10.1016/0145-2134(95)00058-G

Sabin-Farrell, R., & Turpin G. (2003). Vicarious traumatization: implications for the mental health of health workers? *Clinical Psychology Review, 23*(3), 449-480. doi:10.1016/S0272-7358(03)00030-8

Sadowski, C. M., & Friedrich,W. N. (2000). Psychometric properties of the Trauma Symptom Checklist for Children (TSCC) with psychiatrically hospitalized adolescents. *Child Maltreatment*, *5*, 364-372. doi:10.1177/1077559500005004008

Saradjian, J. (1996). *Women who sexually abuse children. From research to clinical practice* (p. 5 & 31). Sussex, England: John Wiley & Sons.

Sas, L. (1993). *Three years after the verdict*. London, Ont., Canada: London Family Court Clinic Inc.

Schwartz, B., & Cellini, H. (1995). Female sex offenders. In *The Sex offender: Corrections, treatment and legal practice*. B. Schwartz & H. Cellini (Eds.). Kingston, NJ: Civil Research Institute.

Serran, G.A., Fernandez, Y. M., Marshall, W.L., & Mann, R.E. (2003). Process issues in treatment: Application to sexual offender programs. *Professional Psychology: Research and Practice, 34*, 368–374. doi:10.1037/0735-7028.34.4.368

Seto, M. C., & Lalumière, M. L. (2010). What Is So Special About Male Adolescent Sexual Offending? A Review and Test of Explanations Through Meta-Analysis. *Psychological Bulletin, 136*(4), 526–575. doi:10.1037/a0019700

Schaeffer, P., Leventhal, J., & Gottesegen-Asnes, A. (2011). Children's disclosures of sexual abuse: Learning from direct inquiry. *Child Abuse & Neglect, 35*(5), 343–352. doi:10.1016/j.chiabu.2011.01.014

Shamay-Tsoory, S. (2009). Empathic processing: Its cognitive and affective dimensions and neuroanatomical basis. In J. Decety & W. Ickes (Eds.) (2009). *The social neuroscience of empathy* (pp. 215–232). Cambridge, MA: MIT Press.

Shumba, A. (2004). Male sexual abuse by female and male perpetrators in Zimbabwean schools. *Child Abuse Review 13,* 353-359. doi:10.1002/car.865

Silovsky, J. F., & Niec, L. (2002). Characteristics of young children with sexual behavior problems: A pilot study. *Child Maltreatment, 7,* 187-197. doi:10.1177/1077559502007003002

Simons, D., Wurtele, S. K., & Heil, P. (2002). Childhood victimization and lack of empathy as predictors of sexual offending against women and children. *Journal of Interpersonal Violence, 17*(12), 1291-1307. doi:10.1177/088626002237857

Smallbone, S., & McCabe, B. (2003). Childhood Attachment, Childhood Sexual Abuse, and Onset of Masturbation Among Adult Sexual Offenders. *Sexual Abuse: A Journal of Research and Treatment*, *15*(1), 1-9. doi:10.1177/107906320301500101

Smith, D., Letourneau, E., Saunders, B., Kilpatrick, D., Resnick, H., & Best, C. (2000). Delay in disclosure of childhood rape: Results from a national survey. *Child Abuse & Neglect, 24*(2), 273–287. doi:10.1016/S0145-2134(99)00130-1

Sorsoli, L., Kia-Keating, M. & Grossman, F. K. (2008). "I Keep That Hush-Hush": Male Survivors of Sexual Abuse and the Challenges of Disclosure. *Journal of Counseling Psychology, 55*(3), 333-345. doi:10.1037/0022-0167.55.3.333

Spataro, J., Moss, S. A., & Wells, D. L. (2001). Child sexual abuse: A reality for both sexes. *Australian Psychologist, 36*(3), 177–183. doi:10.1080/00050060108259653

Spiegel, J. (2003). *Sexual abuse of males: The SAM model of theory and practice* (p. 131). New York, NY: Brunner-Routledge.

Struve, J. (1990). Dancing with the patriarchy: The politics of sexual abuse. In M. Hunter (Ed.), *The sexually abused male, Vol. 1: Prevalence, impact, and treatment* (pp. 3–46). Lanham, MD: Lexington Books.

Tennfjord, O. S. (20006). Prediction of attitudes toward child sexual abuse among three different Norwegian samples. *Journal of Sexual Aggression, 12*(3), 245-263. doi: 10.1080/13552600601090196

Thakkar, R. R., Gutierrez, P. M., Kuczen, C.L., & McCanne, T. R. (2000). History of physical and/or sexual abuse and current suicidality in college women. *Child Abuse & Neglect, 24(*10), 1345-54. doi:10.1016/S0145-2134(00)00187-3

Thomson, D., Hassenkamp, A. M., & Mansbridge, C. (1997). The Measurement of Empathy in a Clinical and a Non-clinical Setting: Does Empathy Increase with Clinical Experience? *Original Research Article Physiotherapy, 83*(4), 173-180. doi: 10.1016/S0031-9406(05)66074-9

Toledo, A., & Seymour, F. (2013). Interventions for caregivers of children who disclose sexual abuse: A review. *Clinical Psychology Review, 33*(6), 772-781. doi: 10.1016/j.cpr.2013.05.006

Tourigny, M., Hebert, M., Daigneault, I., & Simoneau, A. C. (2005). Efficacy of a Group Therapy for Sexually Abused Adolescent Girls. *Journal of Child Sexual Abuse, 14*(4), 71-93. doi:10.1300/J070v14n04_04

Trask, E. V., Walsh, K., & DiLillo, D. (2011). Treatment effects for common outcomes of child sexual abuse: A current meta-analysis. *Journal of Aggression and Violent Behavior, 16*(1), 6–19. doi:10.1016/j.avb.2010.10.001

Trull, T. J. (2001). Structural relations between borderline personality disorder features and putative etiological correlates. *Journal of Abnormal Psychology, 110,* 471-481. doi:10.1037//0021-843X.110.3.471

Twaite, J. A,. & Rodriguez-Srednicki, O. (2004). Childhood Sexual and Physical Abuse and Adult Vulnerability to PTSD: The Mediating Effects of Attachment and Dissociation. *Journal of Child Sexual Abuse*, *13*(1), 17-38. doi:10.1300/J070v13n01_02

Tyler, K. A. (2002). Social and emotional outcomes of childhood sexual abuse: A review of recent research. *Aggression and Violent Behavior*, *7*(6), 567-589. doi 10.1016/S1359-1789(01)00047-7

Ullman, S. E., & Filipas, H. H. (2005). Gender differences in social reactions to abuse disclosures, post-abuse coping, and PTSD of child sexual abuse survivors. *Child Abuse & Neglect*, *29*(7), 767-782. doi:10.1016/j.chiabu.2005.01.005

Unger, J. A., Norton, G. R., & De Luca, R. V. (2009). The relationship between a history of childhood sexual abuse and gender roles attitudes. *Journal of Child Sexual Abuse, 18*(6), 641-654. doi:10.1080/10538710903308207

Van Den Bosch, L.M.C., Verheul, R., Langwland W. & Van Den Brink, W. (2003). Trauma, dissociation, and posttraumatic stress disorder in female borderline patients with and without substance abuse problems. *Australian and New Zealand Journal of Psychiatry 37*(5), 549-555. doi:10.1046/j.1440-1614.2003.01199.x

Vick, J., McRoy, R., & Mathews, B. M. (2002). Young female sex offenders: Assessment and treatment issues. *Journal of Child Sexual Abuse 11*, 1–23. doi:10.1300/J070v11n02_01

Walker, J., Archer, J., & Davies, M. (2005). Effects of rape on male survivors: A descriptive analysis. *Archives of Sexual Behavior, 34*, 69−80. doi: 10.1007/s10508-005-1001-0

Wakeling, H. C., Webster, S. D., & Mann, R. E. (2005). Sexual offenders' treatment experience: A qualitative and quantitative investigation. *Journal of Sexual Aggression, 11*, 171–186. doi:10.1080/13552600412331321323

Way, N. (2001). Using feminist methods to explore boys' relationships. In D. L. Tolman & M. Brydon-Miller (Eds.), *From subjects to subjectivities: A handbook of interpretive and participatory methods* (pp. 111– 129). New York, NY: University Press.

Webster, R. E. (2001). Symptoms and Long-Term Outcomes for Children Who Have Been Sexually Assaulted. *Psychology in the Schools*, *38*(6), 533-47. doi:10.1002/pits.1041.abs

Wiehe, V. R. (1997). Approaching child abuse treatment from the perspective of empathy. *Child Abuse & Neglect, 21*(12), 1191-1204. doi:10.1016/S0145-2134(97)00094-X

Wohab, A., & Akhter, S. (2010). The effects of childhood sexual abuse on children's psychology and employment. *Social and Behavioral Sciences*, *5*, *144-149. doi:10.1016/j.sbspro.2010.07.063*

Wormith, J. S., Althouse, R., Simpson, M., Reitzel, L. R., Fagan, T. J., & Morgan, R. D. (2007). The rehabilitation and reintegration of offenders. *Criminal Justice and Behavior, 34*(7), 879–892. doi: 10.1177/0093854807301552

Zhou, Q., Valiente, C., & Eisenberg, N. (2003). Empathy and its measurement. In S. Lopez & C. R. Snyder (Eds.), Positive psychological assessment: A handbook of models and measures (pp. 269-284). Washington DC: American Psychological Association.

APPENDICES

APPENDIX A:

BRIEF DEMOGRAPHIC PROFILE

Appendix A

BRIEF DEMOGRAPHIC PROFILE

Please answer the following questions:

Gender: ☐ Male ☐ Female

Please select your highest Level of Education *(Most recent degree obtained)***:**

☐ Ph.D.
☐ Psy.D.
☐ M.D. (*Psychiatry*)
☐ LCSW
☐ M.A.
☐ M.F.T.

Are you currently licensed? ☐ Yes ☐ No

Are you currently: ☐ Practicing ☐ Retired

Do you or did you practice the U.S. during your career? ☐Yes ☐No

Years of experience providing therapy:

☐ Less than 1 year
☐ Between 1 and 5 years
☐ More than 5 years
☐ More than 10 years
☐ More than 20 years
☐ More than 30 years

APPENDIX B:

INFORMED CONSENT TO PARTICIPATE

Appendix B

INFORMED CONSENT TO PARTICIPATE

Alliant International University
California School of Professional Psychology-Sacramento
2030 West El Camino Avenue, Ste 200 Sacramento, CA 95833
Telephone: (916) 561-3209

This consent form is an agreement on your part to participate in research about Empathy in psychotherapy settings. You were selected as a possible participant because you are a therapist. Please read this form and ask questions before you agree to participate.

This study is being conducted by doctoral candidate, Linda Prayer, for dissertation research under the supervision of Suni Petersen, Ph.D. The purpose of this study is to determine the differential levels of empathy among therapists when treating male and female survivors of child sexual abuse. If you agree to participate in the study, you will be asked to provide demographic information, read one vignette and complete one questionnaire. This process will take approximately 15 to 20 minutes.

By filling out the following questionnaires you are giving me permission to collect psychological data from you as a participant in this research project. Please be aware that this information will be kept confidential and I will follow the American Psychological Association Ethical Standards including those for Research with Human Participants. Any information obtained during the interview that could identify you will be kept confidential. In the written reports, I will use summary data so that no one can identify you. During the study, the information obtained will be kept on a password-

protected computer and all information will be stored in a locked cabinet that is accessible only to the researcher involved in this project. All data will be kept in a locked file separate from the consent form; the data will only have a number, no names. This data will be destroyed three years after completion of the study.

Please be aware that you may participate or withdraw from the study at any time. You will suffer no penalty of any kind should you choose to withdraw.

There are minimal risks from taking part in this study. If you feel uncomfortable and this concerns you, let the researcher know so that you can get some help. If needed, the researcher can refer you to an appropriate agency. Neither the researcher, nor Alliant International University will be responsible for the cost of these services if needed.

If you have any questions about this research, you may reach me at (916) 955-6466.

Thank you for agreeing to take part in this research study.

By signing this paper with your initials, you are making a decision to participate voluntarily in this study. Your signature indicates that you have been told about this research and understand what is expected of you. You are free to stop at any time. You may keep a copy of this form for your record.

_____ _____

Signature of Researcher **Date**

APPENDIX C :

VIGNETTES

Appendix C

VIGNETTES

Vignette #1: Ana's story

This is the story of Ana who was sexually abused by her father: When I was 12, my father started coming into my room at night. At first, I did not understand what he was doing. I thought he was just trying to cuddle with me, but I realized something was not right. He started touching me and soon he forced himself onto me. I was confused. We rarely had family or friends visiting. I did not have any close friends from school. We lived in a remote area. My mother was a nurse, and she often worked at night and weekends. My father told me that I should not tell anyone about our secret. I did not know what to do… So I never told my mother what he did to me.

Vignette #2: John's story

This is the story of John who was sexually abused by his father: When I was 12, my father started coming into my room at night. At first, I did not understand what he was doing. I thought he was just trying to cuddle with me, but I realized something was not right. He started touching me and soon he forced himself onto me. I was confused. We rarely had family or friends visiting. I did not have any close friends from school. We lived in a remote area. My mother was a nurse, and she often worked at night and weekends. My father told me that I should not tell anyone about our secret. I did not know what to do… So I never told my mother what he did to me.

APPENDIX D:

INTERPERSONAL REACTIVITY INDEX

Appendix D

INTERPERSONAL REACTIVITY INDEX

The following statements ask about your thoughts and feelings in a variety of situations. For each item, show how well it describes you by choosing the appropriate number on the scale at the top of the page: 1, 2, 3, 4, or 5; when you have decided on your answer, fill in the letter in the blank next to the item. **READ EACH ITEM CAREFULLY BEFORE RESPONDING.** Answer as honestly and as accurately as you can. Thank you.

ANSWER SCALE:

1	2	3	4	5
DOES NOT DESCRIBE ME WELL				**DESCRIBES ME VERY WELL**

1. I daydream and fantasize, with some regularity, about things that might happen to me.	
2. I often have tender, concerned feelings for people less fortunate than me.	
3. I sometimes find it difficult to see things from the "other guy's" point of view.	
4. Sometimes I don't feel very sorry for other people when they are having problems.	
5. I really get involved with the feelings of the characters in a novel.	
6. In emergency situations, I feel apprehensive and ill-at-ease.	
7. I am usually objective when I watch a movie or play, and I don't often get completely caught up in it.	
8. I try to look at everybody's side of a disagreement before I make a decision.	
9. When I see someone being taken advantage of, I feel kind of protective towards them.	
10. I sometimes feel helpless when I am in the middle of a very emotional situation.	
11. I sometimes try to understand my friends better by imagining how things look from their perspective.	
12. Becoming extremely involved in a good book or movie is somewhat rare for me.	

13. When I see someone get hurt, I tend to remain calm.	
14. Other people's misfortunes do not usually disturb me a great deal.	
15. If I'm sure I'm right about something, I don't waste much time listening to other people's arguments.	
16. After seeing a play or movie, I have felt as though I were one of the characters.	
17. Being in a tense emotional situation scares me.	
18. When I see someone being treated unfairly, I sometimes don't feel very much pity for them.	
19. I am usually pretty effective in dealing with emergencies.	
20. I am often quite touched by things that I see happen.	
21. I believe that there are two sides to every question and try to look at them both.	
22. I would describe myself as a pretty soft-hearted person.	
23. When I watch a good movie, I can very easily put myself in the place of a leading character.	
24. I tend to lose control during emergencies.	
25. When I'm upset at someone, I usually try to "put myself in his shoes" for a while.	
26. When I am reading an interesting story or novel, I imagine how I would feel if the events in the story were happening to me.	
27. When I see someone who badly needs help in an emergency, I go to pieces.	
28. Before criticizing somebody, I try to imagine how I would feel if I were in their place.	

APPENDIX E:

PERMISSION FROM PUBLISHER

Appendix E

PERMISSION FROM PUBLISHER

Dear Linda:

Thanks for your interest in the IRI. You have my full permission to use the instrument in your dissertation, and to reproduce it in any way necessary for that purpose. I am attaching a few items that may prove of use to you. Please let me know if I can be of any further assistance, and best of luck with your project!

Regards,
Mark

On 12/11/2012 2:22 AM, www@eckerd.edu wrote:

Sent From: http://www.eckerd.edu/academics/psychology/faculty/davis.php#davismh

Contact Form

From: Linda Prayer <linda_prayer@yahoo.com>
Subject: Permission to use the IRI for dissertation
Message:
Dear Dr. Davis,

My name is Linda Prayer, I am a student with Alliant International University in Sacramento, CA. I am currently preparing my dissertation and its title is Empathy: A Possible Factor in Treating Male Victims of Child Sexual Abuse. I would like to ask for your permission to use the Interpersonal Reactivity Index as a measure.

Please let me know if there are any specific steps I need to take in order to obtain your permission to use the IRI.

Thank you very much for the time and interest you will dedicate to my request.

Respectfully,

Linda Prayer