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UNIVERSITY OF CALGARY

Individual Therapy With Sexual Abuse Survivors In Rural Alberta

by

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A THESIS

SUBMITTED TO THE FACULTY OF GRADUATE STUDIES

IN PARTIAL FULFILMENT OF THE REQUIREMENTS FOR THE

DEGREE OF MASTER OF SOCIAL WORK

FACULTY OF SOCIAL WORK

CALGARY, ALBERTA

AUGUST, 1999

ABSTRACT

This study evaluated long-term, individual treatment on adult survivors of sexual abuse from rural areas serviced by the East Central Communities Association For Sexual Abuse Treatment (ECCASAT). The 11 female participants had histories of sexual abuse consisting mainly of incest involving multiple perpetrators and intrusive sexual acts. Data was collected at intake, 3 months, and 6 months of therapy. Few statistically significant changes in symptomatology were found at either 3 or 6 months of treatment. However, visual inspection of the data revealed a trend towards improvement. Conversely, interpersonal relationships deteriorated during treatment. Although friendship networks remained stable, support from immediate family decreased over time. Marital discord, as perceived by partners, increased as therapy progressed. Implications for social work practice including the need for long-term treatment, the combination of individual and group therapy, and the utilization of couple counselling are discussed as possibly beneficial in the treatment of adult survivors.

ACKNOWLEDGEMENTS

First, and foremost, I am indebted to the courageous women who shared their lives and their paths to recovery with me. Without them this thesis would never have been written. I would also like to thank my family, Ammi, Brian, Anjitha, and Uncle Thusitha for their love and unfailing belief in me. Thank you, as well, to Cindy Ogden for her friendship, her humour, and, most of all, her many, kind words of encouragement. Finally, I would like to extend a very special thank you to my supervisor, Dr. Leslie Tutty, whose support and guidance from beginning to end was invaluable to me.

FOR MY MOTHER

Who inspires me always

In both word and deed

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CHAPTER ONE

LONG-TERM EFFECTS OF CHILD SEXUAL ABUSE

This chapter focuses primarily on the long-term consequences of child sexual abuse on adult survivors. An overview of the scope of the problem is presented through an examination of the prevalence rates of sexual abuse and the theoretical formulations that have been advanced in an attempt to explain how childhood trauma may manifest itself in adult dysfunctions. The chapter concludes with a review of some the more common difficulties found among adult survivors of sexual abuse.

Prevalence of Child Sexual Abuse

Child sexual abuse has attained public recognition as a serious social issue and this interest has lead researchers to try to determine the extent of the problem. However, authors such as Finkelhor (1984) and Wyatt and Peters (1986) have noted considerable disparity in the reported statistics on sexual abuse. They note that estimates of the prevalence of sexual abuse vary depending on how sexual abuse is defined, the number and type of questions asked regarding the abuse, the method employed in obtaining responses, and the sampling population. Much of the available information in the literature is derived from retrospective studies of adults in both community and clinical settings. Community studies utilize samples drawn from the community and thus may be more representative of the general population. Clinical research, alternatively, employs participants from clinical settings, often women who have sought treatment for their difficulties. These studies are limited in terms of external validity and may not be generalized to the entire population of sexual abuse survivors.

The Badgley Report (1984), a Canadian national survey of 2,008 people, found that approximately one in two adult females (54%, N=1006) and one in three adult males (31%, N=1002) had experienced some form of sexual victimization in childhood. The majority of these incidents occurred when the victims were between the ages of 12 and 18. The abusive experiences ranged from unwanted exposure and unwanted touching to attempted and completed sexual intercourse. Of the reported offenders, 24% were family members, 58% friends or acquaintances, and 18% were strangers.

Finkelhor, Hotaling, Lewis and Smith (1990) conducted a national incidence study in the United States. In this survey of 2,626 adult men and women, 27% of the women (N=1481) and 16% of the men (N=1145) reported a history of child sexual abuse. Most of the perpetrators were identified as older men who were perceived to be authority figures by the victims. Males were more likely to be abused by strangers whereas females were more often abused by a member of their family.

Prevalence rates have also been measured at the community level. One investigation conducted in the city of Calgary examined the prevalence of past sexual abuse in a sample of 750 women aged 18 to 27 (Bagley, 1991). Thirty-two percent of the participants reported sexual abuse experiences that included genital fondling and attempted or achieved penetration. Two other studies conducted in Calgary also found evidence of childhood victimization in their samples. Bagley and Young (1990) indicated that 32% of the 620 women they interviewed reported that they had experienced episodes of sexual abuse involving genital touching before the age of 17. Bagley and Ramsey (1986) reported a rate of 22% among their sample of 377 women.

Similar results have been reported in American community studies. In his study of 796 college students from New England, Finkelhor (1979) found that 16% had experienced some form of sexual abuse in childhood. When broken down by gender, 19% of women (N=530) and 9% of men (N=266) reported histories of sexual abuse. Eighty-one percent of the abusive activity experienced by the students included sexual behaviours that involved physical contact between the perpetrator and victim. In another study, using a sample of Boston area parents, Finkelhor (1984) found an overall rate of 12%. Of these 521 parents, 15% of the women (N=334) and 6 % of the men (N=187) reported childhood sexual victimization. Physical contact, in the form of sexual touching, oral-genital contact, and penetration, was present in 80% of these incidents while 20% involved exhibitionism and sexual propositions. Russell's (1983) randomized study of 930 women in San Francisco revealed that 38% of the participants had experienced sexual abuse before the age of 18. Thirty-one percent of the women also reported extrafamilial sexual abuse was reported by 31% of the women while 16% experienced incest.

These retrospective studies have shed some light on the prevalence of sexual abuse in society. An examination of the rates of sexual abuse amongst different populations has indicated that histories of childhood victimization may be found among both men and women. The majority of the cases reported, however, involve female victims. The abuse often involves physical contact ranging from touching to penetration of the child's body. Although the exact rates of child sexual abuse may never be computed, the research available at present suggests that it is a problem of some

magnitude.

Theoretical Models

Child sexual abuse, by definition, occurs in the early years of an individual's life and it often produces immediate difficulties for the young victim. The empirical evidence also suggests that these initial effects may expand and elaborate over time, increasing in severity and evolving into secondary dysfuntions (Courtois, 1988; Gelinas, 1983). The recognition of these long-term consequences has lead to hypotheses regarding their development. Two of the most commonly cited theoretical models found in the literature are posttraumatic stress disorder and the traumagenic dynamics model. These models provide conceptual frameworks for the understanding of the mechanism by which childhood traumatization leads into adult psychopathology. Both will be discussed in greater detail in the following section.

Posttraumatic Stress Disorder (PTSD)

The posttraumatic stress disorder (PTSD) model has been used to explain the observed physiological and psychological aftereffects of child sexual abuse. These aftereffects have been conceptualized as resembling those of other traumatic life events such as war, natural disasters, acts of terrorism, and rape in adulthood (Courtois, 1988; Herman, 1992; Lindberg & Distad, 1985; Sanderson, 1990). However, unlike traumatic events such as rape and terrorist attacks, child sexual abuse may continue for years and span several developmental stages (Courtois, 1988). Sexual abuse is a traumatic event whose effects often endure into adulthood (Beitchman, Zucker, Hood, Da Costa, Akman and Cassavia, 1992; Blume, 1990; Briere, 1989; Courtois, 1988; Browne & Finkelhor,

1986). The experience of a sexually abused child has been compared to the experiences of concentration camp internees in that the victim is not only assaulted but is reduced to complete physical and emotional dependency on the abuser (Courtois, 1988). Though the child is usually overwhelmed by fear and has no control over the situation, she may feel responsible for the abuse. Thus, child sexual abuse is both a physical and emotional assault.

PTSD provides a theoretical framework by which the consequences of sexual victimization may be understood. The symptoms of trauma are not seen as pathological but rather as a normal and healthy reaction to a terrifying experience (Courtois, 1988; Dolan, 1991; Herman, 1992). These symptoms are a form of adaptive behaviour that is assumed in order to survive the abuse.

PTSD reactions are defined as "a set of conscious and unconscious behaviours and emotions associated with dealing with the memories of the stressors of the catastrophe and immediately afterwards" (Figley, cited in Courtois, 1988, p.120). In some cases the symptoms emerge soon after the traumatic event, and may persist over time and become chronic (Courtois, 1988; Valentine & Feinauer, 1993). In other cases, the symptoms may emerge in a delayed fashion and not be manifested until long after the abuse has ended (Courtois, 1988; Courtois, 1996). The aftereffects of sexual abuse meet the Diagnostic and Statistical Manual of Mental Disorders (DSM IV, APA, 1994) criteria for both acute and chronic and delayed posttraumatic stress disorder (American Psychological Association, 1994). PTSD criteria include the experience of a traumatic event; a persistent re-living of this event; chronic avoidance of the elements associated

with the trauma; and continual symptoms of increased arousal (DSM IV, APA, 1994; Herman, 1992; Linberg & Distad, 1985; Rowan, Foy, Rodriguez & Ryan, 1994; Sanderson, 1990). Symptoms may vary in intensity and degree frequently alternating between emotional numbness and constricted affect, and recurrent and intrusive types of effects (Courtois, 1988; Lindberg & Distad, 1985; Sanderson, 1990). Recurrent and intrusive symptoms are ways in which the survivor relives the traumatic event. They include reactions such as nightmares and other sleep disturbances, recurrent and intrusive memories of the abuse, flashbacks, and distress when exposed to situations that resemble the original traumatic incident (Courtois, 1988; Herman, 1992; Lindberg & Distad, 1985; Sanderson, 1990). Other long-term effects of sexual abuse associated with PTSD include depression; anxiety; suicide and suicide ideation; self-mutilation; and substance abuse (Courtois, 1988; Herman, 1992; Lindberg & Distad, 1985; Sanderson, 1990).

Clinical studies have demonstrated some support for this theoretical model. Lindberg and Distad (1985) found that all of the 17 incest survivors in their clinical sample met the criteria for PTSD as determined by the DSM-III. The symptoms noted were intrusive memories, flashbacks, nightmares, hypervigilence, dissociation, depression, suicidal ideation and attempts, substance abuse, and sexual problems. Rowan, et al. (1994) conducted another investigation involving adult survivors in treatment finding that 64-69% exhibited symptoms that fulfilled DSM III-R diagnostic criteria for PTSD while 19% met criteria for partial PTSD. Duration and frequency of the abuse significantly contributed to a PTSD diagnosis.

A community-based study involving 391 female survivors found that the most

severe PTSD symptomatology was associated with sexual abuse experiences involving physical contact including penetration (Saunders, Villeponteaux, Lipovsky & Kilpatrick, 1992). Kilpatrick, et al. (1986, as cited in Sanderson, 1990), however, found PTSD symptoms to be currently present in only 10% of the sample of 126 female survivors. Lifetime prevalence of PTSD was found to be 36%.

The application of the PTSD model to sexual abuse survivors has come under criticism for several reasons. One of the faults noted is that the PTSD model does not account for all of the symptoms observed in victims of sexual abuse. In fact, many survivors do not have any PTSD symptoms but exhibit other problems stemming from their abuse experiences (Briere & Runtz, 1988; Finkelhor, 1990; Valentine & Feinauer, 1993). This model tends to be limited to affective symptomatology, ignoring cognitive aftereffects such as distorted beliefs and misinformation (Finkelhor, 1990; Sanderson, 1990). Additionally, the PTSD framework has been criticized because it does not lend itself to abusive experiences that occur without the presence or threat of violence. Factors such as the meaning ascribed to the abusive experience may have as much impact on psychological functioning as the possibility of physical violence (Finkelhor, 1990).

Traumagenic Dynamics

The traumagenic dynamics model proposed by Finkelhor and Browne (1985) is another descriptive framework that attempts to provide an explanation of the long-term effects of child sexual abuse. Like the PTSD model, it incorporates the idea that sexual abuse causes trauma by distorting a child's orientation to the world. However, it expands on this conceptualization to include both affective and cognitive distortions.

Finkelhor and Browne propose four trauma-inducing factors called traumagenic dynamics. Each of these dynamics correspond to a different area of a child's development that may be affected by the trauma of sexual abuse which are then thought to lead to the development of corresponding coping mechanisms that the child uses to survive the traumatic experience (Finkelhor & Browne, 1985). According to this model, these coping strategies are highly adaptive and effective during childhood, but become dysfunctional when the child becomes an adult and is no longer subjected to the abuse. The observed long-term effects of childhood sexual abuse are seen as a reflection of these maladaptive beliefs and behaviours.

The four traumagenic dynamics are traumatic sexualization, betrayal, stigmatization, and powerlessness. Traumatic sexualization focuses on how an abused child develops inappropriate and dysfunctional sexual behaviours. The child may learn that she can receive rewards or have normal developmental needs met in exchange for sexual activity. This confusion over sexuality may result in the later difficulties with sex and intimacy in adult relationships often seen in survivors. These difficulties may range from aversion to sex and sexual dysfunctions to promiscuity and prostitution (Finkelhor, 1987; Finkelhor & Browne, 1985; Sanderson, 1990; Watchel & Scott, 1991).

Betrayal is the dynamic that is activated when a child becomes aware that an adult who she has trusted and depended upon has caused her harm. This may include the abuser or any other individual who the child feels has failed to protect her (Finkelhor & Browne, 1985; Sanderson, 1990). This feeling of betrayal does not necessarily depend only on the closeness of the relationship but also on the nature of the bond (Finkelhor,

1987; Sanderson, 1990). For example, the betrayal may be perceived as much worse if the relationship began as one of nurturance and affection. This dynamic is associated with such aftereffects as depression, grief, overdependence, anger, hostility, lack of trust, and vulnerability to revictimization (Finkelhor, 1987; Finkelhor & Browne, 1985; Sanderson, 1990; Watchel & Scott, 1991).

The third dynamic, stigmatization, deals with the many negative images that a child receives during the abuse. These messages may be transmitted covertly through the secrecy surrounding the sexual abuse, or overtly by the abuser's blaming or labeling the child (Finkelhor & Browne, 1985; Sanderson, 1990). This can result in the child beginning to label herself which, in turn, leads to a more negative self-image and the eventual isolation and alienation that plagues many adult survivors (Finkelhor, 1987; Watchel & Scott, 1991). This dynamic is related to symptoms such as low self-esteem, feelings of worthlessness, and self-destructive behaviours including self-mutilation, and drug and alcohol abuse (Finkelhor & Browne, 1985; Sanderson, 1990; Watchel & Scott, 1991).

The final traumagenic dynamic of powerlessness refers to the child's reduced feelings of efficacy and empowerment that results from constantly having her body violated through violence or coercion, resulting in feelings of fear, frustration, anxiety, and despair (Finkelhor, 1987; Finkelhor & Browne, 1985; Sanderson, 1990). These feelings may increase at disclosure when the child is again in a vulnerable position (Sanderson, 1990). The fear and anxiety associated with powerlessness may lead to symptoms such as nightmares, phobias, somatic complaints, emotional numbing,

dissociation, and sleep disorders. The lack of control and impaired coping skills that are also associated with powerlessness may lead to long-term symptoms such as depression, suicidal behaviour, and vulnerability to revictimization (Finkelhor & Browne, 1985; Sanderson, 1990; Watchel & Scott, 1991). This dynamic may also be expressed in a need to dominate and control others as manifested in aggressive behaviours. These behaviours are often seen in male sexual abuse survivors (Groth as cited in Sanderson, 1990).

One empirical study has provided some support for the traumagenic dynamics model. Drauker (1993), in a qualitative study, interviewed 166 adult survivors in treatment in order to identify potential sources of their trauma. She found that the themes that emerged from the women's responses could be organized under the four dynamics of traumatic sexualization, betrayal, stigmatization, and powerlessness proposed by Finkelhor and Browne.

The traumagenic dynamics framework provides a fairly comprehensive explanation for the long-term consequences of child sexual abuse. The model accounts for the wide variety of symptoms exhibited by sexual abuse survivors and recognizes the differential effects of this trauma on different individuals. Finkelhor and Browne (1985) suggest that these differences are due to the extent to which each of the four dynamics may be operating within each individual survivor. Thus, the presence of each dynamic and their interaction determines the type of symptoms manifested as well as the severity of the abuse symptoms.

Both the PTSD formulation and traumagenics dynamics model have been proposed as possible explanations for the persisting negative consequences of child

sexual abuse. Each of the models advance rationales for the existence of these after-effects with PTSD accounting for some of the affective effects while the traumagenic dynamics model also incorporates the cognitive distortions present in many survivors. The traumagenic dynamics model also defines sexual abuse as a process rather than an event and, thus, provides a description of the dynamics of sexual abuse and how these processes contribute to the long-term dysfunction of adult survivors (Sanderson, 1990). Taken together, both of these models go far in explaining the myriad of negative symptoms that accompany child sexual abuse and provide a guiding framework for determining the best treatment strategy for each individual survivor.

The Long-Term Effects

Sexual abuse in childhood not only produces immediate distress and difficulties for the child victim but also often has serious repercussions for the adult that the child eventually becomes. Current interest in child sexual abuse has prompted researchers to investigate its long-term aftereffects on adult health and functioning. The results of these empirical investigations have uncovered a multitude of negative consequences that may manifest themselves in various spheres in the life of the adult survivor. These psychosocial problems often have a severe impact on the survivor's mental and physical well-being.

The long-term consequences of sexual abuse range from relatively mild and benign reactions to those that are life-threatening and extremely debilitating (Courtois, 1996; Valentine & Feinauer, 1993). The range and severity vary with each individual and her particular experience of sexual victimization. Browne and Finkelhor (1986) estimate that almost half of all victims of abuse seek psychotherapy in their adult years.

Research has also shown that 50-70% of inpatients in psychiatric facilities have histories of child sexual abuse while 40-50% of outpatients have similar backgrounds (Briere, 1984; Carmen, Rieker, & Mills, 1984; Goodwin, Attias, McCarty, Chandler & Romanik, 1988, cited in Courtois, 1988).

Christine Courtois (1996), a clinician with considerable experience working with survivors, suggests that negative outcomes may be especially salient for those children who did not receive validation or treatment at the time of their victimization. Courtois also hypothesizes that today's adult survivors may also suffer from more heightened symptomatology due to the historical social milieu in which their abuse took place since child sexual abuse has only recently become recognized by both the helping professionals and the general population as a pervasive and serious mental health problem with far-reaching and traumatic effects on its victims. Thus, the adult survivors of the present day grew up in a society in which their victimization and its consequences on their development were largely unacknowledged due to the societal repression and denial that existed during that time period.

The empirical evidence regarding the contribution of additional experiential factors on the traumatic impact of sexual abuse remains less clear than that collected on the presence of these aftereffects. There is, as yet, no consensus regarding the actual influence of these abuse-specific factors on the severity of subsequent adult psychopathology, but trends do appear in the literature. The factors that are most commonly cited are severity of the abuse, which encompasses the nature of the sexual activity and its duration and frequency; the use of force or threats; the relationship of the

perpetrator to the child victim; and the environmental context in which the abuse took place.

Studies on the nature of the sexual activity and its influence on the aftermath of abuse have indicated that the more intrusive sexual behaviours, those involving penetration of the child's anus, vagina, or mouth, are associated with greater subsequent trauma (Beitchman, et al., 1992; Classen, 1996; Courtois, 1988; Herman, Russell & Trick, 1986; Russell, 1986). Those involving less intrusive physical contact are accordingly associated with less serious consequences. The duration and frequency of the abusive incidents may also contribute to poor adult adjustment. The empirical evidence in this area is still equivocal but, in general, abuse of longer duration and greater frequency appears to result in more serious symptomatology (Beitchman, et al., 1992; Classen, 1996; Courtois, 1988; Herman et al., 1986; Russell, 1986). Another component of the sexual victimization experience, the use of force or threats during the commission of the abuse, also seems to contribute to the severity of future psychopathology. Some researchers have found that sexually abusive activity which includes force or violence tends to cause more long-term harm to victims (Beitchman, et al., 1992; Briere, 1989; Classen, 1996; Herman et al., 1986).

The child victim's relationship to the perpetrator the abuse has also been examined as a possible link to the negative consequences observed in adult survivors. Research has revealed that incestuous abuse involving biological fathers or stepfathers tends to be associated with more trauma than any other type of sexual offender (Bagley & King, 1990; Beitchman, et al., 1992; Classen, 1996; Herman et al., 1986; Russell, 1986).

This may be due to the closeness of a parent-child relationship and the subsequent level of betrayal and loss of trust that this form of victimization entails (Beitchman, et al., 1992; Classen, 1996). In addition, access to the child may result in longer and more intrusive abuse (Courtois, 1988). Aside from this particular type of victim-offender relationship, there does not appear to be a difference in impact on functioning between abuse perpetrated by relatives or individuals outside the immediate or extended family.

One final factor that has received more attention recently as a possible contributor to both the occurrence and subsequent aftermath of child sexual abuse is the victim's family environment. Some of the family characteristics that have been linked to poor adult adjustment are marital discord, poor parenting characterized by low care and high control, lack of parental support, and negative parental attitudes towards the child and the child's role in the abuse dynamics (Beitchman, et al.; Classen, 1996; Courtois, 1988; Fromuth, 1986; Jackson, Calhoun, Amick, Maddever & Habif, 1990; Mullen, Martin, Anderson, Romans & Herbison, 1993; Parker & Parker, 1991; Romans, Martin, Anderson, Herbison & Mullen, 1995; Yama, Tovey, & Fegas, 1993).

Much of the research into child sexual abuse in the past two decades has established that this type of victimization gives rise to a range of serious long-term effects in adulthood. A number of components related to the experience of abuse have also been identified as possible contributors to the severity of long-term symptomatology causing a certain amount of disparity in the observed symptomatology of different groups of survivors. The following sections will elaborate on those aftereffects most commonly cited in the literature on adult survivors of sexual abuse. These are depression, anxiety,

somatization, negative self-perceptions, self-destructive behaviours, substance abuse, social and interpersonal functioning, sexual functioning, revictimization, dissociation, and memory disturbances.

Depression

In their review of the research, Browne and Finkelhor (1986) concluded that one of the most common emotional reactions of sexual abuse survivors is depression. In this population, children may initially present with depression as an immediate, short-term response to sexual abuse but it often becomes a chronic, long-term condition in the adult survivor (Courtois, 1988). A number of studies provide evidence that this particular reaction is indeed a frequent problem that affects a large number of individuals.

Bagley and Ramsay (1986) examined the mental health status of a random sample of women in Calgary (N=387). They found that those who had past experiences of child sexual abuse had higher scores than their non-abused counterparts on two measures of depression. On the Centre for Environmental Studies Depression Scale (CES-D), 17% of abused women exhibited clinical symptoms of depression whereas only 9% of the control group showed these same symptoms. The second measure, the Middlesex Hospital Questionnaire, produced a ratio of 15% to 7% respectively, indicating that women with abuse histories were twice as likely to be clinically depressed.

Yama, Tovey and Fegas (1993) also demonstrated that depression is a prominent long-term reaction to sexual victimization in childhood. Using a sample of 139 female volunteers from an undergraduate American university class, these researchers determined that women who had experienced sexual abuse were more likely to be

depressed than those who had no such experiences. Levels of depression, as measured by the Beck Depression Inventory (BDI), were found to be significantly higher in the 46 abused students than in the 93 non-abused women who made up the control group. No differences were found between women who had suffered incestuous abuse and those whose perpetrators were non-family members. Further analysis indicated that sexual abuse and high levels of depression were correlated with negative family environment. Specifically, high scores on the BDI were associated with a family environment characterized by high conflict and less cohesiveness. Survivors who were raised in families in which there was a high level of control also had higher depression scores.

A British study conducted by Bifulco, Brown and Adler (1991) also uncovered an association between early sexual abuse and clinical depression in adulthood. This long-term research project was completed over a period of two years and involved a sample of 286 women from the London area. Of this group of subjects, 25 (9%) reported abuse experiences that involved physical contact. Their data analysis revealed that 64% of the abused subsample had clinical depression as compared to only 26% of the nonabused women, a significant difference. Furthermore, 36% of the sexually abused women had chronic and clinical levels of depression as compared to 10% of the nonvictimized group. These researchers found that the most severe cases of depression were correlated with more serious types of sexual abuse including those involving sexual intercourse and repeated incidences of victimization.

The clinical research regarding the association between depressive disorders and sexual abuse is not as clear as that found in the community studies. In some studies,

although differences between survivors and other women were found, these did not reach statistical significance. Herman (1981), for example, found that 60% of adult incest victims exhibited symptoms of major depression. However, 55% of the comparison group who had no history of sexual abuse but had what she termed "seductive" fathers also reported these same difficulties. Similarly, Meiselman (1978), who reviewed psychiatric records, found that while 35% of women who reported intrafamilial sexual abuse had been diagnosed with depression, an additional 23% of those in the comparison group had evidenced depressive symptomatology as well.

A more recent study employing a clinical sample found a high prevalence of depressive disorders amongst women with a history of child sexual abuse (Murrey, Bolen, Miller, Simensted, Robbins & Truskowski, 1993). Murrey, et al. studied 119 female outpatients who attended a mental health clinic in Seattle. All of the women in the sample had been diagnosed with a DSM III-R depressive disorder, either major depression, dysthymia, or depressive disorder, not otherwise specified (NOS). Of this sample, 43.7% reported a history of childhood sexual abuse. Using only these women in further analyses, Murrey et al. found that 83% had a diagnosis of depressive disorder NOS while 49% suffered from major depression. A limitation of this study was the lack of a control group of nonabused women with which more significant comparisons could have been made.

Overall, these studies, using both clinical and community samples, suggest that depressive symptomatology is a common aftereffect of sexual victimization and is linked to the onset of chronic depression in adult survivors.

Anxiety

Sexual abuse in childhood is an overwhelmingly traumatic and often terrifying experience for the child victim. The anxiety provoked by such an assault may linger long past the original experience and become a chronic condition negatively affecting adult functioning. Anxiety may manifest itself in a myriad of ways within the population of adult survivors. Researchers and clinicians have noted symptoms such as nervousness and extreme tension; nightmares and other sleep disturbances; anxiety attacks; fears and phobias; hypervigilence; and clinical disorders (DSM IV, APA, 1994) including panic disorder, agoraphobia, social phobia, obsessive-compulsive disorder, and generalized anxiety disorder (Beitchman, et al., 1992; Blume, 1990; Briere, 1989; Courtois, 1988).

Two recent Canadian studies have demonstrated a link between sexual abuse in childhood and later onset of anxiety disorders. Stein, Walker, Anderson, Hazen, Ross, Eldridge, and Forde (1996) compared 125 female patients from a Winnipeg hospital, all of whom had received a diagnosis of one DSM-IV anxiety disorder, with a matched comparison group from the community. The comparison group had been sampled from a large community survey of abuse experiences and dissociative symptoms. The anxiety disorders suffered by the experimental group included panic disorder, social phobia, and obsessive-compulsive disorder. The results suggested that the women patients with anxiety disorders were more likely to have a history of sexual abuse than the women in the comparison community sample (45.1% vs. 15.4%). The more severe forms of abuse, those involving penetration and/or oral-genital contact, were reported by 13.5% of the anxiety-disordered women compared to 1.9% of the women in the community sample. In

addition, the rate of childhood sexual abuse was significantly higher in women with panic disorder than in any of the other anxiety disorders (60% vs. 30.8%).

In the second Canadian study, Mancini, Van Ameringern and McMillan (1995) investigated the incidence of child maltreatment in a sample of patients from two anxiety disorders clinics in Hamilton. The anxiety disorders found amongst the 124 female and 81 male subjects included panic disorder-agoraphobia, social and simple phobias, obsessive-compulsive disorder, generalized anxiety disorder, hypochondriasis, posttraumatic stress disorder, and trichotillomania. Of this sample, 23.4% reported experiencing sexual abuse as children and a further 22% described a history of severe sexual abuse which included the use of threats or force as well as genital contact or actual penetration. These patients also had higher state and trait anxiety scores, as measured by the State-Trait Anxiety Inventory, than those without prior experiences of childhood sexual abuse. A final analysis indicated that the sexually abused group also tended to report poorer global functioning as well as more difficulties with family relationships and home responsibilities.

Other research has produced similar findings. In another clinical investigation, Briere (as cited in Finkelhor & Browne, 1986) found that victims of child sexual abuse were more likely to report a variety of anxiety-related symptoms in contrast to non-abused controls including anxiety attacks (54% of abused women vs. 23% of nonabused controls), nightmares (54% vs. 23%), and sleep difficulties (72% vs. 55%). Sedney and Brooks (1984), using a sample of 301 female college students, reported that survivors of sexual abuse were more nervous and anxious than controls (59% vs. 41%), felt more

extreme tension (41% vs. 29%), and had more sleep disturbances (51% vs. 29%). Another study of college students also found significantly higher anxiety scores amongst adult survivors (Yama, et al., 1993).

Finally, results from a large community study in Los Angeles indicated that 28% of female sexual abuse survivors (N=51) suffered from an anxiety disorder as compared to 9% of women in the nonabused control group (N=1307). Furthermore, the lifetime prevalence rate for this type of disorder was 37% for abused women and 14% for the other nonabused group (Stein, Golding, Burnam & Sorenson, 1988).

These studies appear to support the contention that childhood sexual victimization is often associated with chronic anxiety. Abuse victims from both clinical and community populations report higher incidences of both anxiety-related symptomatology and clinical anxiety disorders than their nonabused counterparts.

Somatization

One particular manifestation of anxiety that appears to be fairly prominent amongst adult survivors of sexual abuse is somatization. The somatization process is defined as "distress arising from perceptions of bodily dysfunction" and includes "the somatic equivalents of anxiety" (Derogatis, Lipman, Rickels, Unlenhuth & Covi, as cited in Briere, 1989, p.16). Physical complaints in the form of ulcers, severe or migraine headaches, menstrual disorders, gastrointestinal problems, dizziness and fainting, respiratory distress, and chronic pelvic pain have all been reported by former victims of sexual abuse (Briere, 1989; Courtois, 1988; Hume & Grove, 1994; Maynes & Feinauer, 1994; Rew, 1989). Maynes and Feinauer (1994) sampled a group of 226 individuals

from a community in Utah to examine the incidence of somatization in survivors of child sexual abuse. Using the Trauma Symptom Checklist (TSC-33), these researchers found that those subjects who had histories of sexual abuse were more likely to also have symptoms of somatization including dizziness, fainting, stomach problems, insomnia, respiratory difficulties, and headaches. Further, they noted that the severity of the abusive activity accounted for 13% of the variance of the somatized anxiety responses. However, severity of the abuse experiences was not found to significantly affect levels of somatization.

Hulme and Grove (1994) studied the long-term somatic effects of sexual abuse in a group of 22 female college students in the American southwest. Adverse physical symptoms were found in 50% of this sample. The symptoms recorded were severe headaches, ulcers, miscarriage, major surgeries, and hospitalizations. Brunngraber (1986) found similar patterns of symptomatology in her study of the long-term effects of incest. Bodily complaints reported by the abused women in this sample included migraine headaches, menstrual difficulties, and gastrointestinal disorders.

In a community study conducted in Calgary, 19% of the 82 adult survivors in the sample were found to have scores on the Middlesex Hospital Questionnaire indicating the presence of somatic anxiety. This was in comparison to 9% of the 285 nonabused subjects in the comparison group (Bagley & Ramsey, as cited in Browne & Finkelhor, 1986). Briere and Runtz (1988a) also found a relationship between both chronic and acute somatization in adult women who had been sexually victimized in childhood. Chronic somatization was positively correlated with abuse experiences that involved

older perpetrators, parental incest, and long duration. Acute somatization was associated with the use of threats or force during the course of victimization.

As with the other forms of anxiety, somatization appears to be related to childhood sexual abuse. It has been hypothesized that this preoccupation with physical symptoms may be the result of the key aspects of this type of abuse such as the physical invasion of the child's body and the sense of vulnerability that accompanies such an assault. The abuse, thus, may heighten feelings of unease about bodily functioning and may also result in a state of chronic autonomic arousal giving rise to many physical symptoms (Briere & Runtz, 1988a). Maynes and Feinauer (1994) also suggest that adult survivors may also use somatic complaints and concerns as a way of distracting themselves from the traumatic memories of their abuse experiences and the resulting negative emotions that such recall often engenders.

Negative Self-Perceptions

Another consequence of sexual abuse in childhood is the development of negative self-perceptions. Briere (1989) cites a number of authors who report that such victimization can adversely affect the way in which the victim perceives and understands the world and herself, others, and the future (Jehu, Klassen & Gazen, 1985-86; McCann, Pearlman, Sackheim & Abrahamson, 1988; McCord, 1985). These altered beliefs and perceptions are predominantly negative in nature and reflect some of the distressing aspects of the abuse experiences. Courtois (1988) notes that many survivors have "incorporated a marked sense of badness and shame, with a sense that something is wrong with them, making them inherently unlovable" (p. 105).

Poor self-esteem in adult survivors has been found in a number of empirical investigations. Bagley and Ramsey (1986) reported that 19% of women with abuse histories in their sample scored in the 'very poor' range on the Coopersmith self-esteem inventory compared to 5% of nonabused women. Another community study indicated that 73% of incest survivors reported moderate to severe feelings of alienation and isolation while 87% felt that their incest histories had moderately to severely affected their sense of self (Courtois, 1979).

Parker and Parker (1991) found that social self-esteem was poorer in college students who had childhood experiences of sexual abuse as compared to their nonabused peers. These researchers reported a steady significant increase in maladjustment across groups of students. Those with no abuse histories had the least impairment of self-esteem followed by students who had suffered extrafamilial abuse. The most dysfunction was found in those who had been incestuously abused.

Physical self-esteem has also been found to be correlated with a history of childhood sexual victimization. Brayden, Dietrich-MacLean, Deitrich, Sherrod and Altemeier (1995) found that negative physical self-esteem, as indicated by higher scores on the Physical Self subscale of the Tennessee Self-Concept Scale, were more likely to be present in women who had been sexually abused. This subscale gauges self-perceptions of body image, health, physical appearance, skills, and sexuality. The association between overall self-concept and sexual abuse disappeared when demographic and family variables were controlled. In addition, no differences were found in levels of impairment between women who had suffered extrafamilial or

incestuous abuse. Jackson, et al., (1990) also reported a relationship between poor social and physical self-esteem and sexual abuse. The 22 female college students who had been incestuously abused in childhood were found to have lower scores on the Rosenberg Self-Esteem Scale than the 18 women in the comparison group. The abused women also had poorer body images but did not have a greater external locus of control.

One clinical study revealed even more severe difficulties for abuse survivors in this area. Herman (1981) reported that while 60% of the incest survivors in her study had a negative self-image, only 10% of the comparison group felt this way. Further, all of these survivors felt that they had been branded, marked, or stigmatized by their childhood abuse experiences.

Not all studies have supported a correlation between negative self-perceptions and sexual abuse. Two studies of college students demonstrated no significant differences between abused and nonabused women in terms of negative self-concept (Briere & Runtz, 1988b; Fromuth, 1986). These results may be due to a sampling bias. Both researchers used college students as subjects for their studies. As Runtz and Briere (1988b) note, "the university screening process may require a certain minimal level of general functioning" (p.54). College students may thus be healthier than those in the general population and may not exhibit severe psychological symptomatology.

The bulk of the empirical literature appears to support the concept that adult sexual abuse survivors have very negative perceptions of themselves. Feelings of shame, self-hatred, and self-blame are of concern to clinicians because these invalidating self-evaluations may become more negative and encompassing over time and may result in

even more dysfunction.

Self-destructive Behaviours

Negative emotions and beliefs may lead to self-destructive behaviours in adult survivors of sexual abuse. Two of the most serious of these destructive behaviours are self-mutilation and suicidal ideation and attempts. Self-mutilation is defined as "deliberate, non-life-threatening, self-effected bodily harm or disfigurement of a socially unacceptable nature" (Walsh & Rosen, as cited in Briere & Runtz, 1993). These self-inflicted injuries include cutting or carving the limbs or torso with knives or razor blades; burning the skin with matches or cigarettes; biting of the fingers often until blood is drawn; tearing out hair; beating the head or fists against hard surfaces such as a wall; or cutting of the genitalia (Blume, 1990; Briere, 1989).

Briere and Runtz (1988a) studied psychosocial functioning in a sample of walk-in clients at a crisis counselling centre in Winnipeg. Of those women with a history of childhood sexual abuse, 31% reported the desire to hurt herself whereas 19% of the never abused group reported this type of compulsion. In another clinical investigation, Briere and Zaidi (1989) examined the records of 100 female psychiatric inpatients. They found that, while 17% of the sexually victimized women self-mutilated, none of the nonabused group exhibited this behaviour.

A New Zealand community-based study revealed that self-mutilation is not limited to clinical populations (Romans, et al., 1995). Of the 23 women who reported self-injurious behaviours, 22 had a history of child sexual abuse. These behaviours were more strongly associated with severe cases of sexual abuse, those involving higher

frequency of occurrence, the use of force, parental incest, and invasive sexual activities. Women who self-mutilated were also found to have poor family relationships and to suffer from depression, anxiety, and alcohol dependence. Another community study, involving college students, produced similar results (Boudewyn & Liem, 1995). Both male and female students with sexual abuse backgrounds reported self-harm ideation and attempts more often than their nonabused peers. Female survivors were more likely than males to injure themselves. Self-destructive behaviours were also associated with a history of serious illness and experiences of emotional abuse in adulthood. Partial correlations were found between direct and life-threatening types of self-mutilation and severity of abuse experiences. However, this was not found to be true in cases of chronic self-destructiveness which encompasses thrill-seeking and risk-taking behaviours or failures in self-care.

Blume (1990) and Briere (1989) have speculated that self-mutilation may serve a number of functions for the survivor. They hypothesize that such destructive behaviour may reduce the stress of negative emotions; end periods of dissociation; provide a distraction from traumatic memories; help to make the survivor feel more present and grounded in reality; or make her feel more alive by eliminating feelings of inner emptiness.

Suicidal thoughts and actions are another way in which adult victims may act self-destructively. However, unlike self-mutilators who are attempting to cope with the negative affect associated with their victimization, suicidal survivors are hoping to escape altogether ultimately through their deaths (Briere, 1989). Through her work with sexual

abuse survivors, Blume (1990) has noted that many of these women are often preoccupied with thoughts of death and dying. This type of ideation may lead to action as borne out by empirical studies that report that survivors tend to have a history of past suicide attempts (Briere & Runtz, 1988a; Briere & Zaidi, 1989; Sedney & Brooks, 1984). Some survivors may consider suicide due to their negative self-perceptions, especially feelings of shame, guilt, and self-hatred, seeing it as a way to punish themselves or the perpetrators of their abuse (Courtois, 1988). Suicide may also be viewed as a way of taking control of their lives and, thus, away from their abusers (Blume, 1990; Courtois, 1988).

Suicidality as a form of self-destructiveness in adult survivors has been examined in a number of empirical studies. Briere and Runtz (1988a) found that 51% of the sexually abused walk-in clients to a crisis counselling centre had attempted suicide at least once in the past. In comparison, 34% of the women with no history of abuse had tried to take their own lives, a significant difference. Briere and Zaidi's (1989) investigation of female inpatients in an emergency psychiatric room also yielded statistically significant results indicating that sexually victimized women were more likely than non-victimized women to have both current and past suicide ideation (77% vs. 33%) as well as a history of past suicide attempts (66% vs. 33%).

Suicidality is a problem with sexual abuse survivors in the general population as well as those in clinical settings. Sedney and Brooks (1984) reported that 16% of the abused college students in their study had made a previous suicide attempt while 6% of controls had attempted such a course of action. Boudewyn and Liem (1995) also using a

college sample, found that suicide ideation was more common amongst both male and female participants with abuse histories than those without an without an abuse history. Greater incidences of self-destructive thoughts and behaviours were associated with increased severity of abuse experiences. A final investigation of suicidality among sexually abused students found that those with abuse experiences involving genital contact exhibited significantly more suicidal behaviours than either controls or students whose abuse consisted of non-contact sexual activities (Peters & Range, 1995). These researchers found no differences between those whose abuse had been perpetrated by adults and those who had been victimized by their peers nor were gender differences found with respect to suicidality. However, women were more likely to have more survival and coping beliefs and also had more fear of suicide than men.

Another component of the community study by Romans et al. (1995) revealed that abused women more inclined to suicide ideation than those without abuse experiences (74.3% vs. 48.8%). Suicide attempts were also prominent in this group, with overdoses the most common method used. As with self-mutilation, suicidality was associated with the more severe forms of childhood sexual abuse. A community study involving a longitudinal research design conducted by Silverman, Reinherz and Giaconia (1996) investigated the relationship between childhood abuse and later psychosocial functioning. In early adulthood, the sexually abused group (N=23) were found to be significantly more suicidal than the comparison group (N=164). More than one-fifth of the abuse survivors had greater suicide ideation in the past year than the nonabused women (22% vs. 7%). Lifetime suicide attempts were also more prevalent amongst the

victimized women with more than a quarter of the sample having made at least one attempt (26% vs. 2%).

Adult survivors of child sexual abuse appear to take up where their perpetrators left off; further victimizing themselves long after the abuse has ended. Self-mutilation and suicidal thoughts and behaviours have been identified in the empirical literature as a chronic and dangerous aftereffect of sexual abuse. These self-destructive behaviours afflict survivors in both clinical and community populations.

Substance Abuse

Another form of self-destructive behaviour found to be prevalent among adult survivors is substance abuse. Drug and alcohol problems, like self-mutilation, may be used by survivors as a coping mechanism to help them deal with their pasts and the trauma associated with childhood memories. Briere and Runtz (1993) note that "drug and alcohol abuse serves as a form of chemically induced dissociation wherein the abuse survivor can separate from the environment, painful internal states, and disturbing memories through the use of psychoactive substances" (p. 320).

Research into this after-effect of sexual abuse has uncovered a relationship between childhood victimization and subsequent substance abuse in adulthood. In the Los Angeles Epidemiologic Catchment Area study, Stein et al. (1988) found that drug and alcohol abuse was a problem for the individuals with histories of childhood sexual abuse. Of the 82 participants who reported past sexual abuse, 26% were had drug addictions, while 27% were dependent on alcohol. The percentages reported for those with no history of abuse were 6% and 14% respectively; these differences were only

significant for drug use. When examining sex differences, further analysis indicated that abused men were found to be more prone to substance abuse problems than abused women. While 45% of the men used drugs, only 14% of the women reported doing so. Alcoholism was also more prevalent for abused men than women with the ratio at 36% to 21%. Significant differences were found for alcohol dependence only between abused and nonabused women. Drug use, however, was significantly higher amongst both male and female survivors as compared to their nonabused counterparts.

A community-based research project in New Zealand studied rates of drug and alcohol abuse in women survivors as compared to a control group (Mullen et al., 1993). Of the 248 women who reported histories of child sexual abuse, 13% used alcohol excessively in comparison to 9% of the 244 women in the control group, a result that did not reach statistical significance. Significant differences were unveiled when the comparison was made between women who had histories of severe abuse involving sexual intercourse and those who had no experience of sexual abuse. In this case, the results indicated that 34% of the severely abused group had alcohol addictions in contrast to 9% of the nonabused women. A significant difference was also found in drug use with 9% of abuse survivors having drug addictions compared to 4% of controls.

Clinical studies have supported the community research findings. Briere and Runtz (1988a) investigated substance abuse among women clients of a walk-in crisis counselling centre, indicating that clients with childhood victimization experiences were twice as prone to alcohol addiction than those with no sexual abuse history (27% vs. 11%), and ten times more likely to be dependent on drugs (21% vs. 2%). Teets (1995)

investigated the childhood histories of 60 recovering chemically dependent women from a long-term treatment centre in a Midwestern American state. These women had been addicted for an average of 14 years. Of the total sample, 68% had been sexually abused as children or adolescents. Of these, 43% had suffered incestuous abuse and 52% had extrafamilial abuse experiences. A range of abusive sexual activities were reported including fondling, oral-genital contact, and intercourse. Force was used by perpetrators of both incestual and extrafamilial abuse. The abused women were more likely to have started using alcohol and drugs at an earlier age than their nonabused counterparts (13 years vs. 18 years of age) and also had been using substances for a longer period of time (15 years vs. 11 years).

The empirical literature appears to substantiate the high incidence of drug and alcohol abuse amongst adult survivors of sexual abuse. Some authors have hypothesized that alcohol and drugs are used to numb pain and to overcome feelings of emptiness (Blume, 1990; Briere & Runtz, 1993). Substance abuse in this population may be especially serious due to the possibility of relapse after treatment for addictions. Wadsworth, Spampneto and Halbrook (1995) note that the cessation of drug and alcohol abuse may cause survivors to face their sexual abuse trauma for the first time. This retraumatization may then lead the way to a resumption of their former self-destructive lifestyles.

Social And Interpersonal Functioning

Another area of dysfunction in the aftermath of child sexual abuse is impaired social functioning and disturbed relatedness. Early studies of incest survivors have

revealed that many of these individuals experience difficulties in interpersonal relationships (Courtois, 1979; Herman, 1981). Courtois reported that 73% of her community sample indicated moderate to severe feelings of isolation and alienation while all of the paternally abused women in Herman's clinical sample reported feelings of stigmatization. Briere (as cited in Browne & Finkelhor, 1986) found that 64% of the abused women in his study felt isolated as compared to 49% of the control group. This pattern of alienation and estrangement from others is common to some survivors. These women may find it difficult to trust both men and women and their sense of betrayal may cause them to react to others with fear or hostility (Browne & Finkelhor, 1986; Briere, 1989; Courtois, 1988). They may also feel stigmatized by their abuse experiences and the accompanying feelings of unworthiness and shame may cause them to withdraw from others or be rejected by them (Briere, 1989).

Gold (1986) investigated social functioning in 103 sexually abused women recruited from an urban American university community. When compared to a nonvictimized control group (N=88), these women tended to have had fewer friends in childhood and reported feeling less emotionally close to their parents. Mullen, Martin, Anderson, Romans and Herbison (1994) reported that child sexual abuse victims had poorer relationships with their families and partners. These women did not perceive their partners as a source of emotional support and also indicated that these partners were controlling and domineering. No differences were found with regard to emotional closeness with friends or siblings. However, abused women were less likely to feel close to their parents.

Harter, Alexander and Neimeyer (1988) investigated social functioning in a community group of 85 female survivors of both incest and extrafamilial sexual abuse. When compared to the nonabused control group, these women were found to have a greater perception of social isolation and poorer social adjustment. Jackson et al., (1990) also found that their sample of sexually victimized women had significantly more difficulties in general social adjustment as measured by the Social Adjustment Scale. Incest survivors reported having more problems in the area of dating and social activities. The authors found no significant differences between abused and nonabused women on work and school functioning or relationships with family members.

Clinical observations have lead Courtois (1988) to propose that sexual abuse survivors may demonstrate different styles of social functioning. Not all survivors have difficulties in the social/interpersonal realm. For example, some former victims are often very successful in their communities and may use the survivor skills acquired as a result of their childhood experiences in ways that enable them to achieve in the social world. Courtois suggests that skills such as perceptiveness about other people's needs and behaviour; caretaking of these needs; pleasing behaviours towards others; and the ability to handle many responsibilities and stresses simultaneously and competently may enhance their social functioning. However, despite their apparent success, many of these women are unable to experience satisfaction from their accomplishments and may feel a sense of detachment from them. They also tend to suffer from stress and burnout as a result of their attempts to overachieve. Another subgroup of survivors, identified by Courtois, fit neither a pattern of underfunctioning or overfunctioning. Rather, these

women may enjoy a moderate level of success alternating between periods of competency and impairment as traumatic and delayed symptoms emerge to derail their efforts to overcome their traumatic childhood experiences.

Thus, like many of the other long-term effects of sexual abuse, levels of social functioning vary with each survivor and her individual circumstances. Nevertheless, much of the empirical research appears to indicate that childhood sexual victimization is associated with some impairment in social and interpersonal functioning.

Sexual Functioning

Intimate relationships are one aspect of interpersonal relating that appear to represent particular difficulty for survivors of sexual abuse. Two patterns of sexual behaviour that are common to survivors are withdrawal and sexual overactivity (Blume, 1990; Courtois, 1988). Withdrawal is characterized by social isolation and sexual abstinence. This behaviour may be a way of avoiding sexual feelings and an attempt to compensate for what may be perceived as bad or shameful sexual behaviour in childhood. It may also reflect fears about intimate relationships, sexual feelings, and sexual activity (Courtois, 1988; Jehu, 1989a; Hall& Lloyd, 1993). At the other end of the spectrum is sexual compulsivity in which the survivor may engage in frequent and indiscriminate sexual activity. Courtois (1988) suggests that this style of behaviour may "allow the survivor to own herself, to continue to feel special power over men and use them sexually, or to get back at the abuser" (p.107). Other reasons that have been advanced for such indiscriminate sexual activity include a need for closeness, distraction, excitement, avoidance of the sense of emptiness many survivors experience, or as means of avoiding

painful emotions related to the abuse (Blume, 1990; Briere & Runtz, 1993). It has been hypothesized that the survivor may feel that the only way to get the intimacy and nurturance of a relationship is to offer herself sexually, a belief that may been reinforced in childhood by her abuser (Blume, 1990; Briere & Runtz, 1993; Dolan, 1991). Some survivors may exhibit both of these styles of behaviour alternating at different times in their lives (Courtois, 1988; Herman, 1981).

A variety of sexual dysfunctions have been identified within this population. Desire disorders may take two forms, low sexual desire or aversion to sexual activity. Survivors, thus, may have inhibited desire or may avoid sex because it arouses negative emotions such as fear, anxiety, shame, or disgust (Courtois, 1988; Jehu, 1989a Hall & Lloyd, 1993). Arousal disorders pertain to difficulties in becoming sexually aroused and performing the sexual act. As with feeling desire, a state of arousal may serve to remind the survivor of her victimization and thus awakening the negative affect associated with the abuse (Courtois, 1988; Jehu, 1989a; Hall & Lloyd, 1993). Orgasmic disorders prevent the survivor from experiencing sexual pleasure. This problem reflects a fear of being out of control or may also be a method of suppressing feelings of guilt that often accompanies such feelings of pleasure (Courtois, 1988; Jehu, 1989a; Lloyd & Hall, 1993). A final problem is coital pain which may take the form of dyspareunia, vaginismus, or other pain that interferes with sexual activity (Courtois, 1988; Jehu, 1989a; Hall & Lloyd, 1993). Coital pain is also associated with emergence of negative memories although it may also be the result of actual physical injury incurred during the childhood victimization (Courtois, 1988; Hall & Lloyd, 1993).

Many of the early studies on the relationship of sexual dysfunction and child sexual abuse have focused on clinical samples. The results of these investigations have tended to support the existence of a link between sexual problems and early sexual victimization. Herman (1981) found that 55% of the incest survivors in her sample reported sexual problems. However, this result was not significantly different from that of the comparison group of women with seductive fathers. In another clinically-based study of incest victims, Langmade (as cited in Browne & Finkelhor, 1986) found that the victimized women reported being more sexually anxious, felt more sexual guilt, and were more dissatisfied with their sexual relationships than the matched control group of nonabused women. Briere and Runtz (1988a) reported similar findings in their study of women at a walk-in health clinic, noting that significantly more abused women had sexual difficulties than women with no such histories (45% vs. 15%). The abuse survivors were also more likely to have a decreased sex drive (42% vs. 29%) although this difference did not reach statistical significance.

The results of the community-based studies are less consistent. Kinzl, Traweger and Biebl (1995) studied sexual dysfunctions in 202 female college students. Dividing the sample into those with multiple experiences of abuse, those with a single episode of abuse, and those with no history of abuse, they discovered a number of differences in sexual functioning between the three groups. The women with multiple abuse experiences had more desire, arousal, and orgasm disorders than either of the other two groups. Additionally, these women reported more intimacy disturbances including feelings of shame, guilt, disgust, and anxiety. No significant differences were found in

sexual pain disorders among the three different groups of students. Jackson, et al. (1990) obtained similar results in another study of sexual disturbance in college students. Of the women with histories of sexual abuse, 65% met DSM-III criteria for sexual dysfunction as measured by the Derogatis Sexual Functioning Inventory. Fifty percent of the survivors reported inhibited sexual desire, 45% inhibited orgasm, 38% inhibited sexual excitement, 25% dyspareunia, and 10% vaginismus.

Two other community studies did not find significant levels of dysfunction in sexually abused women. Fromuth (1986) found no evidence of impaired sexuality in her sample of college students. This finding was supported by Greenwald, Leitenberg, Cado and Tarran (1990) who similarly found no differences in current sexual functioning between abused and nonabused women. In both of these studies, the lack of significant differences may be due to the previously described biases towards a higher functioning sample as well as the possibility of less serious abuse experiences (Fromuth, 1986; Greenwald, et al., 1990).

Mixed results were also found in the area of indiscriminate sexual behaviours. Sexual compulsiveness was apparent in Herman's (1981) sample of incest survivors of whom 35% reported promiscuous behaviour. Fromuth (1986), conversely, found that although abused women described themselves as promiscuous, the actual number of sexual partners reported did not confirm this belief. Furthermore, two other studies of college students did not find greater sexual activity among abuse survivors (Jackson, et al., 1990; Kinzl, et al., 1995).

Much like the other types of interpersonal functioning, survivors of sexual abuse

appear to experience difficulty with intimate relationships. Sexual activity is the defining event in child sexual abuse and, thus, it would seem reasonable to assume that such early and traumatic experiences would adversely affect adult sexuality. The research at this time supports this contention. Sexual dysfunction, in terms of avoidance due to negative emotional reactions, and physiological distress seem to be the most common form of difficulty encountered by this population.

Revictimization

Childhood sexual exploitation may leave women more vulnerable to sexual or physical abuse in adulthood. This phenomenon, known as revictimization, appears to be the result of beliefs and perceptions acquired from the early abuse experiences. For example, while survivors may fear and distrust men, they may at the same time show a tendency to idolize and overvalue them (Courtois, 1988; Herman, 1981), a tendency that could lead them into abusive relationships. Briere (1989) suggests that adult survivors may become involved with men who rape or batter them because, unlike nonabused women, they may not have the ability to recognize or, alternatively, may overlook danger cues such as aggressiveness or extremely sexist attitudes and behaviour. Survivors may also continue a pattern learned in childhood and dismiss abusive behaviour by 'forgetting' the distressing event (Briere, 1989). Revictimization may also occur because the abuse survivor harbours the hope that her present abuser, unlike her childhood abuse perpetrator, will somehow redeem himself (Briere, 1989).

Some researchers have investigated the revictimization of adult survivors of child sexual abuse. In her survey of 482 female college students, Fromuth (1986), found a

significant relationship between childhood victimization and rape in adulthood. Abused students were also more often victims of what Fromuth describes as nonconsensual sexual activity, sexual acts paired with the use of threats or force. This was especially likely for women whose childhood victimization took place before they were 13 years of age. Russell (1986) investigated the incidence of sexual revictimization in a sample of 930 women in San Francisco. She found that 65% of incest survivors had been victims of rape or attempted rape while the same was true of 61% of women who had suffered extrafamilial sexual abuse. In comparison, 35% of the nonabused women in the sample had been through the same experience. Russell also found evidence of marital rape. Of the incest victims, 27% reported having been sexually assaulted by their current spouse and a further 19% had been raped by a former spouse. The percentages reported for the nonvictimized women were 11% and 7% respectively.

Another community study examined revictimization rates within a sample of 248 women in Los Angeles (Wyatt, Guthrie & Notgrass, 1992). These researchers found that 40% of the women who reported sexual abuse in childhood had also been sexually victimized in adulthood. In addition, revictimization was more likely to occur to those women who had experiences of childhood abuse involving sexual body contact. Mayall and Gold (1995), using a college sample of 654 female undergraduates, obtained similar results. The students with histories of sexual abuse were found to have suffered further sexual assaults as adults at twice the rate of their non-abused peers.

One research project that did not support the relationship between childhood abuse and later sexual revictimization was a clinical study of clients of a counselling

centre (Briere & Runtz, 1988a). The results indicated that 18% of the abused women had a history of rape in contrast with 8% of the nonabused group, a difference that did not reach statistical significance. Briere and Runtz (1988a) did, however, find a significant positive correlation between sexual abuse and physical battering. Of their sample of 152 women clients, 49% reported being battered as opposed to 18% of the control group. Similarly, Russell (1986) found that 38% of the currently married incest victims in her study were physically battered by their husbands. Of the nonvictims, 18% suffered spousal abuse. Of those incest survivors who were not married at the time of the study, 27% indicated having had a physically abusive partner at some point in their lives. In comparison, 12% of the women without abuse histories also had had a partner who battered them.

The research on revictimization appear to uphold the hypothesis that child victims of sexual abuse become adult victims of sexual or physical assaults more often than those not victimized in childhood. The majority of studies seem to suggest that survivors are more vulnerable to sexual assault than physical battering in adulthood. Revictimization is a serious after-effect of sexual abuse since survivors appear to be repeating the pattern of violence from their childhood which often not only intensifies existing problems but also results in further psychological difficulties (Messman & Long, 1996).

Dissociation

A form of psychological withdrawal, dissociation is a common phenomenon among adult survivors of child sexual abuse. It is a type of psychological escape in which the individual experiences a loss of reactivity, detachment from others, and/or

constricted emotionality (Briere, 1989). Other symptoms of dissociation include depersonalization (the feeling of not being in one's body); derealization (the sense that the things in the immediate environment are not real); out of body experiences (the sensation of floating above one's physical body and travelling about); cognitive disengagement from one's surroundings into a dreamlike state ('spacing out'); and finally, temporary lapses in memory (Briere, 1989). Dissociation, as a coping mechanism, may enable the survivor to avoid memories and feelings associated with her childhood abuse experiences.

Much of the research on dissociation has been conducted in clinical settings. Chu and Dill (1990) studied dissociative disorders in a sample of female psychiatric inpatients. After examining the childhood histories of these patients using the Life Experiences Questionnaire and levels of dissociation with the Dissociative Experience Questionnaire, these researchers determined that women with either physical or sexual abuse experiences had significantly higher levels of dissociation than a nonabused control group. Those women with both physical and sexual abuse histories had the greatest amount of dissociative symptomatology. In a parallel study, Zlotnick, Begin, Shea, Pearlstein, Simpson and Costello (1994) studied a sample of women in a psychiatric treatment unit with histories of sexual and physical abuse with respect to dissociative tendencies. A subsample of women who reported histories of severe sexual abuse, that which included anal or vaginal penetration, were administered the Dissociative Experience Questionnaire. The results indicated a significant positive correlation between high dissociation scores and the number of perpetrators involved in each

woman's abuse experiences. When the number of perpetrators were removed form the analysis, age at onset of abuse also contributed to high levels of dissociation. Waldinger, Swelt, Frank and Miller (1994) also found higher levels of dissociation in their sample of female psychiatric patients with past sexual victimization experiences. Higher dissociation scores on the Dissociative Experience Questionnaire were associated with childhood sexual abuse and younger age at first reported incident of victimization.

Briere and Runtz (1988b) studied dissociation in the general community with a sample of 278 college students, finding that both acute and chronic dissociation were problems for college students with histories of sexual abuse. Higher levels of symptomatology were found in students whose victimization experiences included parental incest, older perpetrators, and longer duration of abuse.

Dissociation may start out as an adaptive response to an untenable situation in which a child is subjected to an extremely traumatic assault. However, this response to victimization appears to remain a part of the adult survivor's repertoire of behaviours. It may become a pervasive and automatic generalized response to any distressing situation and, thus, becomes ultimately maladaptive and an impediment to normal functioning in adulthood (Briere, 1989; Courtois, 1988)

Memory Disturbances

Related to dissociative disorders are memory disturbances, another long-term consequence of child sexual abuse that is present in some adult survivors. These memory problems may take the form of intrusive memories, such as flashbacks, or lapses in memory which may involve partial or complete amnesia for the childhood abuse

experiences.

Flashbacks are considered to be complete or fragmented memories of unprocessed traumatic events (Chandler, McGee, van der Kolk, as cited in Musicar & Josefowitz, 1996). Briere (1989) describes flashbacks as "classically conditioned associations to the original abuse event(s) which are triggered by stimuli in the survivor's current environment" (p.7). Intrusive memories may occur as vivid dreams or break into the survivor's working hours as sensory intrusions, emotional reliving, or behavioural enactments of the abuse (van der Kolk, Blank, as cited in Musicar & Josefowitz, 1996). They may include some or all of the senses including sight, sound, smell, taste, and touch. In many cases, the sensory perceptions are associated with the actual abusive experiences such as the sight of a penis, the taste of semen, or the sensation of the perpetrator's hands on the victim's genitalia (Briere, 1989; Courtois, 1988). Flashbacks vary in duration and frequency of occurrence. They may last from a few seconds to days and can occur many times over a day or only once a year (Chandler, Putnam, Mellman & Davis, as cited in Musicar & Josefowitz, 1996). These intrusive memories may be "so sudden and so compelling as to produce a temporary break with the current environment, resulting in what may appear to be hallucinations or psychosis" (Gelinas, as cited in Briere, 1989, p. 8).

Hulme and Grove (1994) found evidence of flashbacks in a sample of 22 sexually abused individuals recruited from three American universities. These researchers reported that 82% of the sexually abused women indicated that they suffered from flashbacks stemming from their childhood victimization experiences.

Amnesia is the second type of memory disturbance that is common to adult survivors . This may involve partial memory loss wherein only some aspects of the abuse experiences may be remembered or it may take the form of complete amnesia for the sexual victimization. In severe cases, the survivor may not be able to recall extended periods of her childhood (Courtois, 1996). The reasons for this amnesia are still unclear but hypotheses have been advanced that point to the trauma of the abuse experience as a possible factor in its development. Like the other long-term effects of sexual abuse, memory loss may be the result of severe traumatization occurring in childhood for which the child victim may not of received support, help, or validation (Courtois, 1996). Specifically, the survivor may have learned to avoid memories of victimization in order to escape the negative affect, such as horror, fear, or disgust, that often accompanies such recall (Elliott & Briere, 1995). Moreover, the propensity of abuse survivors to dissociate when stressed may encourage this process (Briere, 1992; Courtois, 1996; Lowenstein, van der Kolk, as cited in Elliott & Briere, 1995).

Amnesia and delayed recall of abuse memories have become increasing interests of both researchers and clinicians. In a clinical study, Briere and Conte (1993) studied 450 adult sexual abuse survivors who had indicated recent recollections of their childhood abuse. Of the total sample, 267 individuals reported amnesia for their abusive experiences at some time in their lives prior to the age of 18. This type of abuse-related memory disturbance was correlated with a number of variables associated with the victimization experience. These variables were early onset of abuse and severity of the abuse which included long duration, multiple perpetrators, physical injury, and verbal

threats. Poor current adult adjustment was also associated with memory loss.

Herman and Schatzow (1987), using a clinical sample of outpatients from a Boston clinic, obtained similar results. The 53 women participants were being treated in short-term incest survivor therapy groups. The survivors either had remembered their abuse histories or strongly suspected that they had experienced victimization in childhood. Sixty-four percent of the women reported some degree of amnesia while 28% evidenced severe memory deficits with very little recall of their childhood. The treatment modality proved to be an effective catalyst for the recovery of memories of sexual abuse for these survivors as almost all of the women with some form of amnesia reported retrieving their memories of childhood abuse. Greater amnesia for the sexual victimization was associated with early age of onset, shorter duration, and the use of force or violence. Seventy-four percent of the women who recovered memories later had them corroborated by outside sources including the perpetrator, family members, or physical evidence such as diaries or photographs.

Williams (1994) also investigated delayed recall of sexual abuse in adult survivors. A sample or 129 women who had documented histories of sexual abuse in childhood were contacted by the researcher and reinterviewed. When questioned about their sexual abuse histories, 38% had no recollection of their childhood sexual victimization, the details of which had been recorded in hospital and medical records up to 17 years earlier. This amnesia was correlated with experiences of abuse that involved a perpetrator who was a family member, friend of the family, or peer. Unlike the clinical studies, this research did not uncover a significant relationship between recall of abuse

and the use of physical force, genital trauma, or sexual penetration. The data also suggested that multiple experiences of victimization with the same perpetrator might not influence patterns of recall of abuse.

Williams investigated several possible explanations for the lack of recall found among the women in the study. These included embarrassment over disclosing personal matters; reluctance to discuss multiple incidents of abuse; traumatic life experiences; substance abuse; false allegations; and young age at onset of abuse. All of these hypotheses were rejected on the strength of the evidence produced after analysis of the data. This analysis did not find significant differences between women who did not recall abuse and those who did with respect to these variables.

Another general population study by Elliott and Briere (1995) researched delayed recall of child sexual abuse experiences in a national sample of 505 individuals. The 49 participants who reported a history of sexual abuse were further investigated as to the possibility of partial or complete amnesia for their abusive experiences at any time prior to data collection. Of this subsample, 42% reported partial amnesia for their abuse while 20% indicated a time when they had complete amnesia for these events. Individuals who had delayed recall were more likely to have been threatened with harm by their perpetrators and to have perceived their victimization as more distressing than those with continuous recall.

The only abuse-related variable that significantly differentiated between participants with partial amnesia and those with total amnesia was age at onset of abuse with those who were younger being more prone to have had complete amnesia. No

significant differences were found between these groups on measures of psychological distress or trauma symptomatology. However, differences were found between those whose recall was recent (within the last two years) as compared to those whose recollections were more distant. Those with recent recall had higher scores on measures of posttraumatic intrusion, avoidance, dissociation, and stress. They also demonstrated impaired self-functioning.

In summary, it would appear that some of the research conducted supports the existence of memory disturbance in sexual abuse survivors. Intrusive memories, in the form of flashbacks, are often a consequence of severe trauma including child sexual abuse (Burstein, 1985). Amnesia and delayed recall have recently come under more scrutiny by researchers and clinicians. There is some empirical evidence that both partial and complete amnesia may result after victimization and that this is more prevalent in clinical samples. This area has become one of increasing controversy and has produced an extensive literature outlining the differing opinions on the issue. The debate over whether or not victims of sexual abuse can forget their traumatic experiences is far beyond the scope of this thesis. The only purpose in including it in this paper was to present the issue of memory disturbance as a long-term effect of sexual abuse in order to provide as complete an understanding as possible of the problems encountered by adult survivors.

Summary

Investigations into the long-term effect of child sexual abuse have revealed that these are numerous and far-reaching, often interfering with the survivor's ability to

function competently in adulthood. The research has identified disturbances in the affective, cognitive, and behavioural domains of the survivor's life and being. Many of the after-effects of sexual victimization are interrelated and the presence or severity of one may affect that of another (Briere, 1989; Courtois, 1988). Affective disorders such as depression and anxiety disorders appear to be a common symptom for former victims. Identity problems, usually centred on negative self-evaluations, also seem to result from childhood abuse. These impairments in the emotional and cognitive realms seem to exist alongside and may exacerbate the behavioural and social dysfunctions also identified in the literature. Disturbed interpersonal relationships, sexual functioning, self-destructiveness, substance abuse, and later revictimization are all possible long-term consequences of sexual abuse. The areas of dissociation and memory disturbance and their relationship to child sexual victimization have come under further investigation. These problems and vulnerabilities have been observed in adult survivors in both the clinical and general population.

Overall, the research and clinical literature reveal an overwhelmingly negative picture of the long-term effects of child sexual abuse. These symptoms are described in the PTSD and Traumagenic Dynamics frameworks. Both of these models attempt to provide an account of the dynamics of child sexual abuse and an explanation for the existence of the long-term effects. They also contribute to the formulation of effective treatment strategies.

The long list of negative consequences identified with early sexual abuse is not a guaranteed outcome. A bleak future is not an inevitable event in the life of every child

victim. Not all survivors will exhibit every symptom described in the literature and the severity of dysfunction may also vary with the individual (Bagley & King, 1990; Briere, 1989; Courtois, 1988). Despite this, the range of symptomatology identified in the studies on the aftermath of sexual abuse is cause for concern. It is evident that sexual victimization at a young age can lead to serious maladjustment in adulthood. The impact of child sexual abuse may remain a source of psychological disturbance throughout a lifetime.

CHAPTER TWO

TREATMENT OF ADULT SURVIVORS OF SEXUAL ABUSE

The increasing realization of the impact of child sexual abuse on adult survivors has lead to the subsequent development of various treatment programs. There are a number of different approaches used in the treatment of adult survivors including individual, couple, and group therapy. Individual psychotherapy focuses on alleviating some of the intrapsychic difficulties that many survivors face as part of their own unique response to trauma (Cahill, Llewelyn & Pearson, 1991). Couple and group therapy are often employed as conjoints to individual therapy although both may be used as independent treatment programs (Bolen, 1993; Courtois, 1988; Sanderson, 1990). Couple therapy is predominantly used to address issues around sexuality and intimate relationships (Bolen, 1993; Sanderson, 1990). Group therapy may take the form of psychotherapy, psychoeducational, or self-group groups and is useful in treating interpersonal problems (Briere, 1989; Cahill et al., 1991; Hazzard, Rogers, & Angert, 1993).

The focus of the following chapter is the treatment of adult survivors of sexual abuse. The first section provides an outline of some of the common treatment modalities used with this population including individual and group therapy. Special emphasis is placed on trauma-focused therapy as it is the approach utilized by the treatment program under investigation in the current study. The final section of the chapter is an examination of the empirical evidence that has been collected thus far on the efficacy of both individual and group therapy in treating the long-term effects of child sexual abuse.

Models of Treatment For Sexual Abuse Survivors

Trauma-Focused Therapy

As noted earlier, treatment of adult survivors of child sexual abuse may take many forms ranging from individual to dyadic and group formats. One broad categorization of individual therapy approaches described by clinicians and researchers in the field is one in which the main focus of treatment centres on the early sexual abuse experience and the long-term trauma symptomatology associated with such a history. Although known by a number of different appellations including trauma-focused therapy (Herman, 1992), abuse-focused therapy (Briere, 1989), retrospective therapy (Courtois, 1988), and reintegration therapy (Meiselman, 1990), each of these has its core the same philosophy and guiding principles. To facilitate ease of reading, this treatment strategy will henceforth be referred to as trauma-focused therapy.

The critical theme of trauma-focused therapy is the close examination of the childhood sexual abuse experience and its traumagenic impact on the adult survivor's current psychological functioning (Briere, 1989; Courtois, 1988; Herman, 1992; Meiselman, 1990; Sanderson, 1990). The past abuse is not considered irrelevant or too remote an incident to warrant therapeutic interest. Rather, it is believed that such a clinical examination may produce favourable changes in the survivor's functioning (Briere, 1989). The survivor's presenting concerns are linked to the early trauma and her symptoms are organized within the PTSD formulation (Courtois, 1988; Herman, 1992; Meiselman, 1990).

Another component of this treatment model is the inclusion of an ecological

perspective on the experience of childhood abuse and the assessment of current functioning. The experience of sexual abuse is examined in the context of the social, cultural, historical, economic, and political milieu in which it occurred. These variables as well as individual characteristics, specific aspects of the abusive activity, the immediate environment, and their interactions all influence the survivor's idiosyncratic response and adaptation to the trauma as well as her process of recovery (Courtois, 1988; Harvey & Harney, 1995).

The ecological perspective stresses the uniqueness of each survivor's experience of sexual abuse and subsequent posttraumatic response. Proponents of trauma-focused therapy thus suggest that the treatment process be individualized to reflect each survivor's specific circumstances and requirements (Briere, 1989; Courtois, 1988; Sanderson, 1990). By matching the treatment plan to the individual survivor's particular needs, control over the content and pace of the recovery process is given to the survivor (Briere, 1989; Herman, 1992; Meiselman, 1990). This generates a more egalitarian relationship between the therapist and the sexually abused client which serves to reverse the power dynamics that existed during the sexual abuse. This, in turn, increases the feeling of a personal sense of power and helps the survivor assert some of her independence in a safe and supportive environment (Briere, 1989).

Incorporating the PTSD framework as part of assessment and treatment planning into therapy also lessens feelings of stigmatization and isolation in that it provides a level of normalization of the abuse survivor's original experiences and current difficulties. The emphasis is placed on presenting symptomatology as a normal, adaptive response to

victimization rather than as a form of pathology or mental illness (Briere, 1989; Courtois, 1988; Sanderson, 1990). This manner of approaching symptoms helps the survivor to abandon the role of victim and fosters a healthier sense of self (Courtois, 1988; Herman, 1992; Sanderson, 1990). The emphasis in therapy is on the survivor's strengths rather than her weaknesses. Her strength in surviving the trauma of sexual abuse is stressed and the coping methods adopted as a child are shown to have been creative and useful at that time (Courtois, 1988; Herman, 1992; Sanderson, 1990). She is also encouraged to see that these same childhood defense mechanisms are no longer helpful and that they may be contributing to her current distress (Sanderson, 1990).

Another important aspect of the abuse history that is addressed is the issue of truth and responsibility. The survivor's disclosure of past sexual abuse is accepted as a true childhood event and not a fantasy or wish (Courtois, 1988). Briere (1989) suggests that considerably more harm is done when a therapist discounts a truthful disclosure than when one that is distorted or technically false is accepted. The survivor is also encouraged to acknowledge and accept the verity of her childhood abuse history. The disclosure and its validation by the therapist aids the survivor to believe in her own memories and perceptions (Courtois, 1988). Recounting the details of the sexual victimization also allows repressed affect to come to the surface making it easier to work with the underlying trauma and its effects (Herman, 1992).

Following on the theme of disclosure and acknowledgment is the assumption of responsibility. Trauma-focused therapy acknowledges the power differentials that are inherent in sexual abuse situations and one of the main principles of this approach is the

shifting of blame and responsibility for the abuse from the victim to the perpetrator (Briere, 1989; Courtois, 1988; Sanderson, 1990). This shift in perspective provides the survivor with a new, more realistic and empathetic view of herself, her sexual abuse experience, and her role in that experience (Courtois, 1988).

Treatment for the effects of sexual abuse has been described as a process of recovery that involves breaking the secret, catharsis, and reevaluation of the incest, its circumstances, and its effects (Courtois, 1988). It also encourages awareness, growth and a sense of autonomy (Briere, 1989; Sanderson, 1990). The goal of trauma-focused therapy is to rework the trauma in order to integrate the various aspects of the abuse experience into the self (Briere, 1989; Courtois, 1988; Herman, 1992; Meiselman, 1990). This goal is accomplished by addressing three areas of the survivor's current psychological functioning: affect, cognitions, and behaviours (Courtois, 1988; Sanderson, 1990).

A necessary component of trauma-focused therapy is the discharge of painful emotion. Survivors may have and still continue the use of defense mechanisms such as denial, dissociation, and minimalization to keep painful affect at bay. This approach to therapy facilitates the recognition, labeling and expression of such feelings and memories associated with the sexual abuse (Briere, 1989; Courtois, 1988; Sanderson, 1990). This process allows for the cathartic release of repressed emotion and allows for the dismantling of dysfunctional coping mechanisms as the survivor learns to work through her feelings and integrate the abuse trauma in her adult self (Courtois, 1988; Sanderson, 1990).

Child sexual abuse involves a multitude of losses: the loss of the abusive parent or trusted adult, loss of childhood, loss of trust, loss of normal sexuality, and loss of an assumptive world (Courtois, 1988; Sanderson, 1990). Part of the process of trauma-focused therapy is acknowledgment and grieving for these many losses (Courtois, 1988; Herman, 1992; Sanderson, 1990).

Alongside numbed affect, negative cognitions and faulty belief systems are also addressed in therapy. Distorted beliefs that may have been internalized by the survivor are identified, reexamined, and reframed (Briere, 1989; Courtois, 1988; Sanderson, 1990). This cognitive restructuring allows the survivor to replace these dysfunctional cognitions with more realistic perceptions about herself, others, and the world. This shift in beliefs may lead to changes in behaviour as conditioned, maladaptive responses give way to alternative, new, more useful coping strategies and adaptive patterns of behaviour (Courtois, 1988; Sanderson, 1990).

A final treatment strategy employed in trauma-focused therapy involves education and skill development. Survivors often lack basic life skills that children learn as they grow up (Courtois, 1988; Sanderson, 1990). The therapist may assist the survivor in acquiring these skills and adapting them to situations outside the therapeutic domain. Thus, the therapist may impart information on areas such as communication, decision-making, problem-solving, stress management, conflict resolution, self-nurture, parenting, intimacy, and sexuality (Courtois, 1988; Sanderson, 1990). This helps to empower the survivor and facilitates the termination of the therapeutic relationship. The treatment process is one that fosters the eventual separation and individuation of the survivor from

the therapist (Courtois, 1988; Herman, 1992).

Trauma-focused therapists employ an eclectic approach when applying interventions to clients with sexual abuse backgrounds. A diverse array of techniques from a number of different theoretical and clinical orientations are borrowed and, in some instances, specifically adapted to this population. Gestalt and Transactional Analysis techniques, psychodrama, and art, music, and dance/movement therapies, all taken from the expressive and experiential domain have been incorporated into this treatment modality (Briere, 1989; Courtois, 1988; Meiselman, 1990; Sanderson, 1990). These interventions are useful in breaking through defenses such as denial in order to access painful affect. Expression of these emotions may eventually lead to catharsis and abreaction of the trauma (Courtois, 1988; Sanderson, 1990). Additionally, the exploration of both conscious and unconscious material related to the childhood sexual trauma has been effected through the use of psychodynamic and explorative strategies such as dream analysis, guided imagery and hypnosis, and examination of transference and countertransference issues (Meiselman, 1990).

Two other theoretical perspectives that have provided useful interventions are the cognitive and behavioural therapies. Cognitive techniques such as logical analysis, decatastrophizing, reattribution, and information provision help in the identification and modification of destructive belief systems (Courtois, 1988; Sanderson, 1990). Similarly, behavioural modification may be accomplished using techniques such as relaxation, desensitization, stress management, modeling, and assertiveness-training (Courtois, 1988; Sanderson, 1990).

These techniques are all available to the trauma-focused therapist. However, care must be taken when determining which to use with the individual client. One of the core principles of trauma-focused therapy is that the treatment plan be tailored to fit the needs of each particular survivor. Additionally, as many trauma-focused therapists maintain, therapeutic techniques are secondary to the establishment of a strong, positive therapeutic alliance (Briere, 1989; Courtois, 1988; Herman, 1992) .

Resolving the traumagenic impact of childhood sexual abuse using the trauma-focused approach is considered to be a long, and complex process. Recovery may take from nine months to up to three years depending on the individual survivor and the treatment pace that she can tolerate (Sanderson, 1990). The therapeutic process may be conceptualized as one that proceeds in a stepwise fashion wherein each phase targets specific goals and interventions. Completion of each phase prepares the survivor for the work to follow in the next stage of therapy (Harvey & Harney, 1995; Herman, 1992).

Herman (1992) has proposed one such model of therapy based on the trauma-focused approach. This framework outlines a course of healing from sexual abuse composed of three different stages that address the goals of trauma-focused therapy. The first stage is concerned with the establishment of safety, the second with remembrance and mourning, and the focus of the third stage is reconnection with ordinary life (Herman, 1992; Lebowitz, Harvey & Herman, 1993). Establishing safety provides the survivor with a sense of control over herself and her environment. This is accomplished through the acquisition of self-care techniques and the establishment of safe relationships. At this time, trust and safety are built up in between the therapist and survivor (Harvey &

Harney, 1995; Herman, 1992; Lebowitz, Harvey & Herman, 1993). Remembrance and mourning is the stage in which the traumatic memories of the sexual abuse and its effects are examined, grieved over, and eventually integrated into the self (Harvey & Harney, 1995; Herman, 1992; Lebowitz, Harvey & Herman, 1993). The final stage, reconnection, is the point at which the survivor begins to actively rebuild her life through self-empowerment and the renewal of relationships with those around her (Harvey & Harney, 1995; Herman, 1992; Lebowitz, Harvey & Herman, 1993).

In actual practice, the survivor may not proceed through the three stages of therapy in a straightforward, linear fashion but may, instead, oscillate between stages as she undergoes the process of recovery. Sgroi (1988) describes the journey of healing from sexual abuse as "a spiral, in which earlier issues are continually revisited on a higher level of integration" (as cited in Herman, 1992, p. 155). Briere (1989) also notes that resolving the trauma of sexual abuse does not erase these painful experiences from the survivor's personal history. Rather, the aim of therapy is to integrate this childhood trauma and aid the survivor to live a full and more contented life in the present.

In summary, trauma-focused therapy is a form of individual treatment with adult sexual abuse survivors that specifically addresses the issue of child sexual abuse and the PTSD symptomatology associated with such a history. The survivor is not pathologized but rather treatment is viewed as a process of healing in which the past abuse is reexamined and integrated into the adult self. Recovery from sexual abuse involves the eventual resolution of the trauma through the integration of these experiences and the validation of new, adaptive behaviours that the survivor may take on during treatment.

As her confidence increases, the goal is that the survivor will be able to leave therapy and gain an independence whereby she is more capable of dealing with the challenges that come her way.

Group Therapy

Group therapy is another treatment modality that may be employed to help resolve some of the trauma of child sexual abuse. Group therapy is an approach to counselling that provides opportunities that individual therapy may not. Corey and Corey (1992) have detailed a number of advantages of group treatment. For example, group therapy may enable clients to learn more about themselves and others who are in similar situations. It may also provide an opportunity to clarify the changes that they need to make and gives them the tools to make these changes. The essential component of group therapy is the interaction of group members. These exchanges provide empathy, support, and caring confrontations, all of which may facilitate the change process (Corey & Corey, 1992). Group process may also include interventions that promote the development of better problem-solving and decision-making skills. The group setting is a safe environment in which group members may practice newly acquired behaviours and skills, and receive feedback from others regarding their progress in therapy (Corey & Corey, 1992).

Group treatment is recommended for sexual abuse survivors because it provides a forum in which group members may learn to recognize, explore, manage, and resolve some of the traumatic symptomatology associated with the abuse (Briere, 1989; Courtois, 1988; Sanderson, 1990). However, unlike individual therapy, the group provides a

supportive setting in which these women can address their difficulties with others who have had similar experiences (Briere, 1989; Courtois, 1988; Sanderson, 1990). The group itself may become a social support network that, for many survivors, may not have been available to them previously (Richter, Snider & Gorey, 1997). Group therapy has also been conceived as a corrective recapitulation of the family of origin, counteracting the typical denial and lack of structure with the acknowledgment of the abuse and the establishment of clear boundaries (Goodman & Nowak-Scibelli, 1985; Hazzard et al., 1993).

Group therapy is often used as an adjunct to individual therapy but may be employed as the sole method of treatment with abuse survivors (Courtois, 1988). Group therapy has been perceived as having certain advantages over individual therapy alone. For example, group participation and interaction between members may reduce the isolation, alienation, secrecy, shame, and stigma often associated with childhood sexual abuse (Carver, Slatler, Stewart & Abraham, 1989; Deighton & McPeek, 1985; Hazzard et al., 1993). It also generally allows for the resolution of these issues in less time than would be achieved through individual therapy (Sgroi, 1989). However, a number of clinicians and researchers have indicated that the most appropriate program for the healing of trauma of sexual abuse incorporates both individual and group therapy (Bass & Davis, 1988; Briere, 1989; Carver, et al., 1989; Hazzard, et al., 1993; Richter, et al., 1997; Roberts & Lie, 1989; Courtois, 1988; Sgroi, 1989). In some cases, individual therapy may be used initially in the healing process followed by a course of group treatment. In other sexual abuse programs, group therapy may run concurrently with

individual psychotherapy (Courtois, 1988).

Individual therapy is recommended as an adjunct to group treatment as it may increase the survivor's knowledge of sexual abuse and her own response to her victimization. This, in turn, may enable her to participate more fully in the group process and thus gain more therapeutic benefits from treatment (Hazzard et al., 1993). The group process may also generate certain individual reactions for different group members that may have an impact on their relationships with significant others (Roberts & Lie, 1989). Finally, individual therapy may help resolve some of the issues brought out for particular survivors during group treatment. Some of the problems that may require more extensive, long-term intervention include those involving trust and behavioural difficulties (Carver, et al., 1989).

The group process provides the survivor with validation and normalization of life experiences that she may feel are deviant and unique only to her. This is accomplished by allowing each group member to ventilate and share feelings and experiences with other women with whom they share a common bond (Briere, 1989; Cahill, et al., 1991; Courtois, 1988; Sanderson, 1990). After the establishment of safety in the group, members may disclose their sexual abuse experiences and learn new coping mechanisms (Courtois, 1988; Sanderson, 1990). Group members are also given the opportunity to help and support others as well as receiving help and encouragement from the group facilitator (Hazzard, et al., 1993; Turner, 1993). This process may increase self-esteem and allow the survivor to become a more active participant in her recovery (Briere, 1989). Furthermore, the group provides its members with a number of positive role models such

as the facilitators and other group members. Hearing how other survivors have dealt with particularly painful issues may inspire hope and optimism in individual survivors and encourage them to continue on their own journey of healing (Sanderson, 1990).

Group treatment with adult sexual abuse survivors address a number of themes and goals including safety, trust, anger, denial, fear, guilt, grief, assertiveness, and interpersonal and intrafamilial difficulties (Courtois, 1988; Deighton & McPeek, 1985; Goodman & Nowak-Scibelli, 1985; Roberts & Lie, 1989; Sanderson, 1990; Turner, 1993). The initial stages of the group process usually involve creating safety and cohesiveness among group members (Courtois, 1988; Roberts & Lie, 1989; Sanderson, 1990). During this early phase, group members get to know and trust each other. This cohesiveness and trust is established through the stability of group membership, consistent attendance by members, and individual reliability (Courtois, 1988). At this time, it is important to impart information about child sexual abuse, to recognize the universality of abuse experiences among group members, and instill hope for eventual recovery (Courtois, 1988; Hazzard, et al., 1993; Roberts & Lie, 1989; Sanderson, 1990).

The group process may then shift to address the trauma of sexual abuse and its aftereffects. The survivors' responses to the trauma are normalized so that they may be able to understand their symptoms from a different perspective. Problems such as shame, guilt, self-blame, low self-esteem, addictive and self-harm behaviours, and problems with intimacy and sexuality are reframed so that they seem less deviant (Briere, 1989; Courtois, 1988; Sanderson, 1990; Turner, 1993).

Another issue that is addressed within the group setting is the breaking of secrecy

that often shrouds the sexual abuse experiences of most survivors. Each group member is encouraged to disclose and share with the others their own personal experiences of sexual abuse (Courtois, 1988; Hazzard et al., 1993; Turner, 1993). This helps to counter the denial, minimization, and repression that often accompanies memories of childhood abuse (Courtois, 1988; Hazzard, et al., 1993; Sanderson, 1990). The group also provides an opportunity for members to explore ambivalent feelings, express rage and anger, and grieve for the losses associated with the experience of child sexual abuse (Courtois, 1988; Roberts & Lie, 1989; Sanderson, 1990; Turner, 1993). Finally, the group context provides a safe environment in which to explore alternative behaviours, practice self-nurturing, and develop interpersonal skills (Courtois, 1988; Deighton & McPeek, 1985; Sanderson, 1990).

Group therapy with adult sexual abuse survivors may incorporate a variety of techniques. The interventions most often used are borrowed from a number of theoretical frameworks including cognitive-behavioural, gestalt, and, occasionally, psychodrama (Courtois, 1988). Interventions that may be introduced to the group include written exercises, journaling, relaxation techniques, assertiveness training, anger management, guided imagery, role-playing, and social networking (Courtois, 1988; Hazzard et al., 1993).

To summarize, group therapy is a treatment modality that provides a forum in which adult survivors may interact with others who share similar sexual abuse experiences. This interaction can be very beneficial in that it may reduce some of the lingering aftereffects of childhood victimization such as isolation, stigmatization,

alienation, shame, and secrecy. The group also provides a source of social support and a safe environment to engage in new interpersonal skills and behaviours. Thus, group therapy offers another method of combating some of the traumatic consequences of sexual abuse.

Evaluation of Individual and Group Therapy With Sexual Abuse Survivors

Research On Individual Therapy

Although the treatment of adult survivors has been extensively written about, the efficacy of individual therapy in resolving the long-term sequelae of child sexual abuse has not been well researched. Most of the literature in this area consists of brief case studies, anecdotal narratives, and clinical descriptions by clinicians who work with survivors. Research studies appear to be the exception. A very small number of published studies in this area are empirical investigations.

Treatment approaches with adult sexual abuse survivors have been investigated by Feinauer (1989) who used a sample of 57 women with abuse histories to study the efficacy of different therapeutic modalities in resolving the trauma of childhood victimization. The treatment approaches investigated included individual, marital, and family therapy. Through the use of questionnaires and interviews, Feinauer examined each woman's subjective perceptions of her therapeutic experiences. Data analysis revealed that over 36% of the survivors believed that they had adjusted to the abuse experiences without therapy while another 36% felt they had improved as a result of therapy. The remaining 28% did not perceive any difference in themselves after therapy. In addition, 89% of the women reported that they still needed help in resolving issues that

they believed to be related to their victimization. There was no indication that any of the three types of therapy were more effective than the others. The important variable appeared to be the focus of the therapeutic approach. Those that focused primarily of addressing the underlying sexual abuse trauma as a possible factor in the presenting difficulties appeared to be more successful in reducing the distress experienced by the survivors.

In explaining these results, Feinhauer hypothesized that adjustment and resolution of sexual abuse trauma may be different concepts. In addition, the quality of the participant's social support system affected the perception of adjustment. She noted that the well-adjusted women who had not sought out therapy had a strong support network with at least one person in whom they could confide. Finally, the author suggested that none of the women who had participated in the study had experienced severe sexual abuse and thus may not have had trouble functioning adequately in their community.

One clinical research program conducted at the University of Manitoba investigated the effectiveness of individual therapy in reducing mood disturbances in adult sexual abuse survivors (Jehu, 1989b). The study sample consisted of 36 female survivors who had experienced severe, long-term sexual abuse. These women underwent an average of 21 weeks of individual therapy designed to correct the distorted beliefs that many survivors hold about themselves and their experiences of abuse. This intervention was based on the assumption that a change in these beliefs would tend to reduce the occurrence of mood disturbances such as depression, low self-esteem, and feelings of guilt.

The treatment procedure consisted of the establishment of a supportive therapeutic relationship followed by the application of a variety of cognitive-behavioural techniques including cognitive restructuring, role play, induced imagery, and confrontation. Several instruments were used to analyze the effectiveness of individual therapy with this sample. These included the Belief Inventory, the Beck Depression Inventory (BDI), and the Hudson Index of Self-Esteem. The Belief Inventory was used to measure some of the common distorted beliefs associated with sexual abuse survivors, the Beck Depression Inventory to measure mood disturbance, and the Hudson Index of Self-Esteem to gauge each woman's level of self-esteem. The results of the study showed that the survivors had a clinically and statistically significant change in distorted beliefs which was accompanied by similar improvement in mood disturbance. All of the participants' scores improved on the Belief Inventory and the Beck Depression Inventory. On the Hudson Index of Self-Esteem, only the scores of 15 of the women could be analyzed. However, all of the survivors in this group reported a significant improvement in self-esteem.

Another component of this research concerned the treatment of sexual dysfunction in sexual abuse survivors. Gazan (1986) evaluated this treatment program using a sample of 5 women and their partners. Like the study on mood disorders, the interventions used were based primarily on cognitive-behavioural techniques.

The treatment package consisted of three components: relaxation training, cognitive restructuring, and treatment of the identified sexual dysfunctions. Relaxation training was utilized in order to decrease anxiety and facilitate the introduction of

therapeutic interventions related to the past sexual abuse trauma and the current sexual difficulties. Following this, cognitive restructuring assisted participants to correct their erroneous beliefs about their roles and responsibility in the sexually abusive activity. The final component of therapy addressed the women's abuse-related sexual dysfunctions. Interventions included the provision of information, skill-building, and stress reduction exercises. The weekly therapy sessions ranged from 15 to 33 weeks.

Gazan reported that, based on information gathered from a consumer evaluation form and personal interviews, all the women experienced a modification of their distorted beliefs about the sexual abuse. This change was manifested in a decrease in feelings of guilt, shame, and alienation. There was also an accompanying increase in self-esteem, assertiveness, and optimism about the future. The changes in sexual functioning were measured by the Hudson Index of Sexual Satisfaction. The results indicated that the treatment was only partially successful in improving sexual functioning. All of the women reported moderate to significant improvement in individual sexual responsiveness. However, therapy had only a limited positive effect on the couple relationships with four couples expressing some dissatisfaction with their sexual relationship. The author hypothesized that this result may be due to lack of support and a general lack of knowledge about the impact of sexual abuse on the part of the women's sexual partners.

Research on Group Therapy

As is the case with individual treatment, the research regarding the efficacy of group therapy with adult survivors has been somewhat scarce. Much of the literature in

this area consists of descriptive articles that expound upon group composition and process, or procedurals aimed at providing instruction in group therapy techniques. Nevertheless, more outcome studies have been published in this area than are found in the research literature concerned with individual therapy (Alexander, Neimeyer, Follette, Moore & Harter, 1989; Carver, et al., 1989; Fisher, Winne & Ley, 1993; Hazzard et al., 1993; Richter et al., 1997; Roberts & Lie, 1989; Sultan & Long, 1988; Threadcraft & Wilcoxin, 1993; Westbury & Tutty, 1999). These studies examined the efficacy of group treatment with adult survivors of both intrafamilial and extrafamilial sexual abuse. The majority of the groups investigated were short-term, closed membership groups. The variables most commonly examined were depression, self-esteem, self-concept, social adjustment, psychiatric and trauma symptomatology.

One study that employed an experimental research design was conducted by Alexander et al. (1989) who studied two types of short-term groups consisting of a total of 65 female, incest survivors. The participants were randomly assigned to either a 10 week process group, a 10 week interpersonal transaction group, or a waitlist comparison group. The results of the study indicated that there was a statistically significant improvement in levels of depression, fearlessness, and psychiatric symptomatology for the women in both treatment groups as compared to those in the waitlist comparison group. The measures used to evaluate these changes were the Beck Depression Inventory (BDI), the Symptom Checklist-Revised (SCL-90-R), and the Modified Fear Survey. A statistically significant improvement is social adjustment as measured by the Social Adjustment Scale was also noted for the survivors in the process group. A follow-up of

the participants indicated that these therapeutic gains were maintained at a six month interval after termination of the treatment groups.

Westbury and Tutty (1999) also utilized a waitlist comparison group in an evaluation of group therapy with adult sexual abuse survivors. Thirty-two women participated in the research study conducted at a community counselling centre in Calgary, Alberta. The outcome variables of interest were depression, trauma symptomatology and self-esteem. The measures used were the Beck Depression Inventory (BDI), the Trauma Symptom Checklist (TSC-33), and the Coopersmith Self-Esteem Inventory (CSEI). Participants in the treatment group showed a statistically significant decrease in levels of depression and anxiety while positive changes in self-esteem approached significance.

A final, more recent controlled quantitative study of group therapy was conducted by Richter et al. (1997). A sample of 115 adult female survivors were placed in either a treatment group or a nonrandomized waitlist comparison group. The group intervention consisted of 13 closed process therapy groups that met weekly for 15 weeks. The outcome variables evaluated were depression and self-esteem as measured by the Beck Depression Inventory (BDI), the Generalized Contentment Scale, and the Hudson Index of Self-Esteem. A posttest comparison of the participants indicated that those who had completed the group treatment had significantly lower levels of depression and higher self-esteem scores than those in the waitlist condition. A follow-up study indicated that these results were not only maintained but also tended to be even greater after six months.

The remaining studies on group therapy have been less controlled, lacking either a

comparison or wait-list group. Carver et al. (1989) investigated the effectiveness of time-limited groups on reducing depression and psychiatric symptoms and improving social behaviour. A sample of 29 women from a Canadian outpatient psychiatric clinic participated in either a 10 week or a 15 week group for sexual abuse survivors. A pretest/posttest design was used to evaluate group effectiveness. These researchers found a statistically significant change in psychiatric symptomatology, with the exception of paranoid ideation. There was no significant improvement found in either depression or social behaviour after termination of the group. Carver et al. hypothesized that paranoid ideation did not improve due to the severe impact of childhood sexual victimization on survivors' ability to trust others.

In another Canadian study, Fisher et al. (1993) examined the efficacy of group treatment with a sample of 32 sexual abuse survivors who participated in a weekly six month group therapy program run out of a mental health clinic in Maple Ridge, British Columbia. They found that this long-term group resulted in a statistically significant improvement in psychiatric symptomatology as determined by the Millon Clinical Multiaxial Inventory (MCMI). These researchers did not make a follow-up of these therapeutic gains.

Roberts and Lie (1989) examined another group therapy program for adult sexual abuse survivors. A sample of 53 women at a rape crisis centre participated in a total of nine therapy groups that met for 10 weeks. The researchers collected both process and outcome data using a client satisfaction questionnaire, a self-administered self-assessment scale and the Beck Depression Inventory (BDI). The results of the study indicated that

the participants found the group therapy to be an overall positive experience. In terms of outcome data, statistically significant improvement was found in levels of depression and overall psychosocial, physical, and sexual functioning. These changes were maintained for at least six months after the end of the group.

In a study on the efficacy of group treatment on survivors of both sexual and physical abuse, Sultan and Long (1988) investigated a short-term program at an American penal institution. A total of 15 female inmates who had histories of either or both sexual and physical abuse participated in two survivor groups that met weekly for a period of 16 weeks. Statistical significant improvement was found in self-esteem, alienation, and trust. Measures of these variables were taken prior to initiation of the group and then again every four weeks for a total of five administrations. No improvement was found for locus of control. The researchers attributed this result to an external prison-related event that reinforced for group members the extent to which they lacked any control of their environment. Interviews conducted at a two month follow-up indicated that these changes had been maintained after termination of the group.

Threadcraft and Wilcoxan (1993) studied the effects of group therapy on the affect and self-concept of adult survivors. With a small sample of seven women, these researchers evaluated a structured 10 session group therapy program for sexual abuse survivors. Pretest and posttest measures were taken with the Beck Depression Inventory (BDI) and the Adult Self-Perception Profile (ASPP). The results showed statistically improvement in both depression and self-concept.

Lastly, Hazzard et al. (1993) examined the process and outcome effects of a

number of year-long psychotherapy groups run by an American non-profit agency. A total of 102 female sexual abuse survivors took part in 22 weekly process-oriented therapy groups. The variables studied were locus of control, sexual difficulties, trauma-related symptomatology, and general psychological distress. The measures used were the Locus of Control Scale (LOC), the Sexual Symptom Checklist (SSC), the Index of Self-Esteem (ISE), the Trauma Symptom Checklist (TSC-33) and the Symptom Checklist -90-Revised (SCL-90-R). Changes between pretest and posttest scores indicated significant differences in locus of control, self-esteem, psychiatric and trauma symptomatology with the exception of dissociation. Mixed results were found for sexual problems with improvement found in sexual avoidance but not in sexual problems.

Summary

In summary, although much information is available regarding the treatment of adult sexual abuse survivors, little of the work published consists of evaluative studies. Some research has been conducted in the area of individual therapy but the majority of the empirical studies have investigated the efficacy of group treatment with this population. The research into individual therapy has evaluated the efficacy of this approach in treating depression, low self-esteem, distorted beliefs , and sexual dysfunction in sexual abuse survivors. The results of these studies indicate that individual psychotherapy does help alleviate some of these lasting after-effects.

Research into group treatment, like individual therapy, is fairly limited but more outcome studies have been published in this area. The variables most commonly examined were depression, self-esteem, self-concept, social adjustment, and psychiatric

and trauma symptomatology. Again, as with individual therapy, these studies indicate that survivor groups are effective in reducing depression and trauma symptomatology and in increasing self-esteem. Overall, the research into both individual and group therapy indicates that treatment that is specifically designed to address the trauma of child sexual abuse is effective in ameliorating long-term symptomatology.

Rationale For Current Study

The long-term consequences of child sexual abuse may have a devastating effect on many areas of an adult survivor's life including psychological functioning and interpersonal relationships. In seeking help from professionals such as social workers, the survivor is looking for solutions to these problems. Therapists working with this population need to be knowledgeable about both the needs of sexual abuse survivors and the appropriate treatment strategies available to them. The appropriateness of the treatment programmes cannot be determined if evaluation of clinical practice is not undertaken. In order to ensure that the work done by therapists is indeed helping and not harming clients, it is essential that this work is critically evaluated through sound research procedure. The present study will address these important issues and, thus, will be able to help determine whether the treatment programme under study is effective in fulfilling the objective of alleviating the distress felt by sexual abuse survivors. The study will attempt to ensure that the treatment offered by the programme is one that meets the needs of the clients that it serves.

In addition to increasing accountability in clinical practice, the research plan proposed in the present study will help to alleviate the gap in the professional literature

regarding the efficacy of individual treatment with adult survivors of sexual abuse. This increase in knowledge adds to the base on which social work practice rests. It is also hoped that in providing answers in some areas, this study will also generate other important, unanswered questions relevant to the problem. Thus, further research will be conducted and more knowledge will be acquired about child sexual abuse for both the survivors and those who want to help them.

CHAPTER THREE

METHODOLOGY

The focus of this chapter is a discussion of the methodology used in the present study of treatment for adult survivors of childhood sexual abuse. An overview of the treatment programme will be provided as well as a description of the study participants. This is followed by an in-depth examination of the evaluation instruments used to measure therapy outcome for each participant. The next section details the overall research design and procedure used in this study. The hypothesis regarding the effects of treatment will also be summarized. The chapter concludes with a discussion of the ethical issues that were addressed prior to the initialization of the research study.

The Treatment Programme

The East Central Communities Association for Sexual Abuse Treatment project (ECCASAT) is a community organization based in Stettler, Alberta. The Association provides service to a population base of 93,000 people who reside in eight rural communities in the East Central region of Alberta. ECCASAT provides assessment and both immediate and long-term treatment of the effects of sexual abuse. Clients of the treatment programmes include child survivors and their families, as well as adult survivors who experienced sexual victimization in childhood. ECCASAT also provides programmes for the assessment and treatment of the perpetrators of child sexual abuse. In addition, the organization offers public and professional education and encourages community involvement and support. The evaluation of the ECCASAT treatment programme was designed by Tutty (1994) and funded by the Family Violence Prevention

Division, Health Canada.

The treatment model used at ECCASAT is trauma-focused therapy. As described in the previous chapter, this model views the physiological and psychological consequences of sexual abuse as being related to post-traumatic stress disorder (Briere, 1992). The survivor's symptomatology is not perceived as individual pathology but rather as a normal reaction to an abnormal situation (Courtois, 1988). Thus, these symptoms are reframed as learned coping strategies and defense mechanisms rather than mental illness (Briere, 1992; Courtois, 1988). In addition, the survivor's difficulties are seen in the larger environmental and social system, both in the past and the present (Courtois, 1988).

Trauma-focused therapists use techniques that facilitate the establishment of safety and the resolution of traumatic memories. This is accomplished through interventions such as normalizing the therapy process; letting the survivor set the pace in which therapy progresses; teaching self-care; allowing the survivor to tell her story; helping her express emotions appropriately; and cognitive restructuring (Briere, 1992). A close, supportive therapeutic relationship is considered an essential component of the healing process and each survivor and her sexual abuse history is seen as unique.

The ECCASAT programme identifies a number of client objectives for survivors of sexual abuse. They include the following:

1. Creating a safe environment for therapy.
2. Building self-esteem.
3. Developing a strong support system.

4. Developing healthy coping and stress management strategies.
5. Awareness of past coping mechanisms.
6. Awareness of effect of abuse to current functioning and work toward healthy changes.
7. Recall of traumatic memories.
8. Integrating affect relating to the abuse with memory of abusive events.
9. Confronting current and past forms of victimization.
10. Developing healthy interpersonal relationships both within and outside of the family unit.

These treatment goals are incorporated into the treatment plan after a thorough assessment of the client's needs and current functioning. The overall aim of the sexual abuse treatment programme at ECCASAT is to "help survivors and their families express acceptance of a full range of emotional responses, put the abusive experience into a historical and emotional perspective, and empower the former victims to rebuild their own self-esteem and confidence." (Ploner & Hutchinson, 1995, p. 5).

Participants

The sample for this research study was made up of 27 adult women who had experienced either intrafamilial or extrafamilial sexual abuse in childhood. All of the participants were clients of the ECCASAT sexual abuse treatment programme for adult survivors. Although the ECCASAT programme provides treatment for both men and women, this study was limited to an investigation of treatment outcome for female survivors only. Thus, the sample of participants consisted of all the female clients of the

ECCASAT programme who volunteered to join in the study from October 1994 until completion of the project. The number of participants available for the study was restricted due to a decision in 1998 by Health Canada to withdraw their funding for any programme that focused on treatment rather than prevention.

Research Design and Procedure

The purpose of the current study was to investigate changes in the symptomatology and functioning of adult survivors as they progressed through the treatment programme offered by ECCASAT. The current study used a quasi-experimental research design with repeated measures. Though considered advantageous procedures, a control group and random assignment were not feasible. The ECCASAT sexual abuse programme operates in a rural area and, thus, has a small population base making it difficult to obtain large numbers of participants to assess treatment efficacy. The recruitment of a second set of participants as a comparison group was simply not possible in such a locality. This lack of a comparison group limits the interpretation of the results in that any changes noted in the symptomatology of the survivors cannot be unequivocally attributed to the treatment process as other factors independent of the therapy process may have contributed to differences in functioning.

The evaluation of treatment of adult survivors of sexual abuse was established through the collection of outcome data from those clients of the ECCASAT programme who were willing to take part in the study. Each client in the treatment programme had an individual therapist with whom she worked through her healing process.

The instruments used to gather information on the clients' symptomatology and

functioning were sent as a complete package to each participant's therapist at ECCASAT. The pretest measures of each client's symptomatology and functioning were assessed before the third session of therapy. Each therapist then continued to administer the scales to their individual clients at three month intervals. A measure of dyadic relationship was administered to the client's partner, if applicable, at the same points in time. In addition, the therapist also completed those instruments that were oriented towards clinical observations of each client. Thus, outcome data was collected at prettest, 3 months, and 6 months of treatment intervention. Having clear intervals at which information is collected establishes a routine and makes it easier for data to be gathered over a long period of evaluation.

Instruments

A number of instruments were used to evaluate the changes in client symtomatology and functioning as they progressed through the treatment programme offered by ECCASAT. The evaluation team that developed the proposal for this research study assembled this measurement package. The measures, both standardized and nonstandardized, were chosen to reflect the current theoretical and clinical issues associated with the treatment of adult survivors of child sexual abuse (Tutty, 1994). These instruments collected information from three different sources: the individual survivor, the therapist, and, if applicable, the survivor's current partner. Measures completed by the survivor were the Trauma Symptom Checklist, the Beck Depression Inventory, the Perceived Support From Family and Friends scales, and the Client Satisfaction Questionnaire. The therapist provided additional information through the

Therapist Rating Scales, the Problem Oriented Record, and a demographic questionnaire. Partners of survivors completed the Dyadic Relationships Scale of the Family Assessment Measure. Each of these measures will be discussed in more detail in the following section.

Trauma Symptom Checklist (TSC-40)

The Trauma Symptom Checklist was designed to measure the traumatic impact of the lasting consequences of child abuse. Briere and Runtz (1989) developed the instrument from their work on the Crisis Symptom Checklist (Briere & Runtz, 1987) and through the use of reports of other researchers investigating the long-term sequelae of child sexual abuse. The instrument, originally named the Trauma Symptom Checklist-33 (TSC-33), was intended to redress the lack of abuse-specific measures available for use in research with survivors of childhood sexual abuse. The TSC-33 was later amended to include seven new items in order to increase the power of the checklist as a research tool (Briere & Runtz, 1989; Elliott & Briere, 1992). This revised instrument, the TSC-40, contains 40 items that measure post-traumatic and other long-term symptoms associated with sexual abuse. Respondents rate, on a four point Likert scale, how often in the past two months they have experienced each symptom. The items in the checklist are grouped into six subscales: Dissociation, Anxiety, Depression, Sexual Abuse Trauma Index, Sexual Problems, and Sleep Disturbance. Each subscale is scored individually and a total score for the entire checklist may be obtained as well. Eight items are excluded from the subscales and simply added to the total score. Scores may range from 0 to 120 with higher scores indicating greater trauma symptomatology. Norms have also been

developed for the checklist using a sample of 2963 professional women (Elliott & Briere, 1992).

The TSC-40 has been found to be a reliable instrument. Elliott and Briere (1992) tested the TSC-40 using a sample of professional women and found that the total TSC-40 score is highly reliable with a coefficient alpha of .90. The subscale scores were also internally consistent with coefficient alphas that ranged from .62 to .77.

There is also evidence for the validity of the TSC-40 with regard to sexual abuse survivors. Elliott and Briere (1992), using a large sample of professional women, found that the total TSC-40 as well as all six of the subscales differentiated between women with histories of sexual abuse and their peers who had no such histories. Women who reported having been victimized in childhood scored significantly higher than those who had not been abused. The subscales that were most strongly associated with sexual abuse were the Sexual Abuse Trauma Index (SATI) and the Sexual Problems scale. Support for the validity of the TSC-40 has also come from studies utilizing clinical samples. Whiffen, Benazon and Bradshaw (1997) reported that the TSC-40 was able to discriminate between abused and non-abused Canadian outpatients (N=182). The strongest indicator of early sexual abuse experience was the SATI subscale. Similarly, in a study of psychiatric patients (N=130), Zlotnick, Shea, Begin, Pearlstein, Simpson, and Costello (1996) found that the total TSC-40 and all of the subscales with the exception of Depression were associated with backgrounds of childhood sexual abuse. As with the previous study, SATI was the most powerful discriminator of prior sexual victimization. The apparent ability of the TSC-40 to differentiate between sexually abused and

nonabused individuals in both clinical and nonclinical populations indicates that this measure has good criterion validity.

The construct validity of the TSC-40 has also been investigated. Zlotnick et al. (1996) reported the subscales of the TSC-40 correlated with different instruments that measure the same constructs. For example, the Dissociation subscale of the TSC-40 correlates significantly (r=.78) with the Dissociative Experiences Scale (DES; Bernstein & Putnam, 1986). Significant correlations were also found between the Depression (r=.64) and Anxiety (r=.60) subscales of the TSC-40 and the Depression and Anxiety subscales of the Symptom Checklist 90-R (SCL-90-R; Derogatis, 1977). Finally, a significant association was found between the SATI scale and the frequency of PTSD symptoms (r=.56) on the Self-Rating Traumatic Stress Scale measure (SR-TSS; Davidson, 1995).

The TSC-40 is a reliable and valid measure of trauma symptomatology in adult survivors of sexual abuse. It has been used by other researchers who have investigated treatment outcome with sexual abuse survivors (Hazzard et al., 1993; Westbury and Tutty, 1999). In addition, it is an abuse-related instrument that specifically targets the long-term effects of sexual abuse as identified in the literature and, therefore, is an appropriate measure to utilize in a study of treatment outcome with adult survivors.

Beck Depression Inventory (BDI)

The Beck Depression Inventory (BDI) is a self-administered instrument that measures the presence and intensity of depression experienced by the respondent during the previous week. It is composed of 21 items designed to assess the "affective,

cognitive, motivational, vegetative, and psychomotor components of depression" (Beck & Steer, 1987). The respondent rates the level of present symptomatology on a four point Likert scale. The instrument is scored by simply summing the individual items. The score may range from 0 to 63 with higher scores indicating greater levels of depression. Norms for the BDI were developed from studies on both in-patient and non-clinical groups (Beck & Steer, 1987).

The BDI has good to excellent reliability. Average alpha coefficients of .86 for psychiatric populations and .81 for non-psychiatric populations have been reported, indicating very good internal consistency (Beck, Steer, & Garbin, 1988). Split-half reliabilities range from .78 to .93, again showing the BDI to be highly consistent (Beck & Steer, 1987). The stability of the instrument has also been tested. Test-retest correlations ranging from .48 to .86 have been reported for psychiatric patients and .60 to .90 for non-psychiatric patients (Beck & Steer, 1987). Two studies with undergraduates reported differing test-retest correlations with one finding a .90 correlation (N=204) after two weeks (Lightfoot & Oliver, 1985) and the other a correlation of .64 (N=139) after a one week interval (Zimmerman, as cited in Beck & Steer, 1987). These studies suggest that more stable scores may be found amongst the nonclinical population.

The validity of the BDI has also been investigated. The concurrent validity is good. The BDI compares favourably with a variety of other measures of depression. Strong positive correlations were found between the BDI and the Hamilton Psychiatric Rating Scale for Depression (HRSD) with .61 to .86 for the five psychiatric samples and .73 to .80 for the two non-psychiatric samples (Beck et al., 1988). Similar correlations

were reported between the Zung Self-rating Depression Scale and the BDI with an average of .76 for the eight clinical studies and .71 for the five non-clinical samples (Beck et al., 1988). Finally, the MMPI-D scale also demonstrated a strong relationship with BDI scores with an average of .76 for psychiatric samples and .60 for non-psychiatric groups (Beck et al., 1988).

The content validity of the BDI does not appear to be as strong. The BDI measures only six of the nine criteria found in the DSM-III-R (Beck & Steer, 1987). Two of these symptoms, changes in appetite and in sleep, are only partially addressed and another, psychomotor agitation, is completely excluded from the instrument. However, these apparent deficits in the BDI were a deliberate and considered action in the construction of the inventory. Increases in appetite and sleep are not measured in order to reduce the occurrence of false positives as these symptoms also occur frequently in the normal population (Beck, Steer, & Garbin, 1988). Agitation was not included as a symptom to be rated as it was thought to be inappropriate for a self-report measure (Beck, et al., 1988). Thus, though the content of the BDI does not meet all of the DSM-III-R criteria, it would appear that these exclusions are warranted.

The BDI is a well-known measure of depression and has been utilized extensively in research. A number of studies of treatment efficacy on sexual abuse survivors have incorporated the BDI as an outcome measure (Alexander et al., 1989; Jehu, 1989b; Richter, 1997; Roberts & Lie, 1989; Sultan & Long, 1988; Threadcraft & Wilcoxin, 1993; Westbury & Tutty, 1999). It was, thus, considered to be a suitable addition to the package of instruments used in the current evaluation.

Perceived Social Support From Friends and From Family (PSS-Fr/Pss-Fa)

The Perceived Social Support From Friends (PSS-Fr) and From Family (PSS-Fa) scales were developed to measure the "extent to which an individual believes that his/her needs for support, information, and feedback are fulfilled by friends and by family" (Procidano & Heller, 1983, p. 2). The perception of social support may influence the individual's ability to assess and cope with stressful events (Heller & Swindle as cited in Procidano & Heller, 1983).

The PSS-Fr and PSS-Fa each consist of 20 items in the form of declarative statements. The individual responds to each statement in one of three ways: "Yes", "No", or "Don't Know". Scores may range from 0 to 120 with higher scores indicating greater perceived social support. Two of the items on the scales were slightly altered for use in this study. Item 19 of the PSS-Fr and the corresponding item 18 of the PSS-Fa were awkwardly constructed and difficult to understand. To prevent confusion on the part of the participants, these items were adjusted so that they no longer contained double negatives. The changes in the wording necessitated a slight change in how the scales were scored, with scoring for these items now proceeding in the opposite direction than in the original version of the instrument.

Both the PSS-Fr and the PSS-Fa scales are internally consistent. The reported coefficient alphas for the measures are .88 and .90 respectively. Test-retest reliability is available only for the preliminary version of the instrument, the Perceived Social Support scale (PSS). The reported correlation is r=.83 over a one month interval indicating that the measure is stable over time. The validity of this instrument has not as yet been

established.

The PSS-Fr and the PSS-Fa were used in the present study in order to obtain a broader view of the survivor as she proceeded through the treatment programme. These measures reveal not only changes in individual symptomatology, but also how therapy affects the survivor's interactions with others in her environment.

Client Satisfaction Scale (CSQ-8)

The Client Satisfaction Questionnaire (CSQ-8, Larsen, Attkisson, Hargreaves, & Nguyen, 1979) assesses client/patient satisfaction with health and human service programmes. The initial instrument was constructed after a review of the available literature on client satisfaction . It consisted of 31 items organized into nine categories. This preliminary questionnaire was further refined to produce a much briefer scale for assessing consumer satisfaction with human service programmes. This final version of the Client Satisfaction Scale, the CSQ-8, is composed of 8 items on which indicate satisfaction on a number of programme dimensions such as type of service, quantity and quality of service, and outcome of service. The client rates each of the eight items on a four point, anchored scale with no neutral position. The questionnaire also includes an open-ended question in which clients may add any additional comments.

Internal consistency estimates for the CSQ-8 range from coefficient alphas of .90 to .93. Some evidence of concurrent validity has also been reported. In a study of therapy outcome with a sample of 49 outpatient clients at a mental health centre, Larsen (as cited in Larsen et al., 1979) found that therapist estimates of client satisfaction significantly correlated ($r=.56$) with CSQ ratings.

The CSQ was utilized in this study in order to assess the client's perception of therapy. It gave each survivor the opportunity to rate the ECCASAT programme and indicate whether the programme was successful in meeting her individual needs.

Demographic Questionnaire

Background information was collected on each participant through the use of a demographic questionnaire (Tutty, 1994). The questionnaire consists of 18 items with both precoded and open-ended answers. In addition to such demographic variables such as age, marital status, and education, the questionnaire also attempts to collect information about the sexual abuse history of the individual survivor. The abuse variables investigated were those identified in the literature as having a potential influence on the long-term symptomatology of adult survivors. These factors include duration, frequency, and severity of the abuse experience. The demographic questionnaire is completed by the therapist and the information is collected throughout the course of therapy as it becomes available though client disclosures.

Therapist Rating Scale

The Therapist Rating Scale was developed by Tutty (1994) in her research proposal for the current study. The therapeutic relationship is an important aspect of the treatment process for adult survivors of child sexual abuse (Briere, 1989; Courtois, 1988; Olio & Cornell, 1993; Seigal & Romig, 1988). Thus, the 11 items in this scale measure aspects of the therapeutic relationship such as safety and containment, as well as eliciting information on the therapist's clinical opinion of the individual client's current functioning. Issues such as client dissociation or an inability to connect with the therapist

may interfere with the process of therapy and, thereby, reduce the efficacy of the treatment programme. The scale allows the therapist to rate the magnitude of such difficulties on a four point Likert scale. Similarly, the therapist may assess the client's symptomatology before and during the course of therapy through the use of the Likert scales on this instrument.

The Therapist Rating Scale provided another perspective on each survivor's progress through treatment. Assessment of the therapeutic relationship offers more insight into the survivor's pattern of symptomatology and recovery from sexual abuse and provides a further point of reference in evaluating the efficacy of treatment.

Problem Oriented Record

The Problem Oriented Record is a non-standardized instrument that was constructed for use in an evaluation of a child sexual abuse treatment programme (Bander, Fein & Bishop, 1982). This checklist provides information on the broader familial, social, and environmental context of each survivor's difficulties as presented prior to the treatment process. It is completed by the therapist who is thus provided with the opportunity to identify such problem areas as marital and family functioning, employment and educational difficulties, and criminal justice involvement. The Problem Oriented Checklist provides a broader ecological perspective on the problem of sexual abuse and the effects of treatment.

Family Assessment Measure (FAM-DR)

The Family Assessment Measure (FAM III, Skinner, Steinhauer, & Santa Barbara, 1983) is a self-report instrument that measures family functioning. It is based

on the Process Model of Family Functioning and assesses family strengths and weaknesses on several subscales measuring different theoretical constructs of the model. The FAM III consists of three measures that evaluate the family from three different perspectives. The first, a General Scale, focuses on the family as a system, the second, the Dyadic Relationships Scale examines relationships between family dyads, and the last, the Self-Rating Scale, examines the functioning of individuals within the family unit.

The Dyadic Relationships Scale was utilized in the present study to investigate the intimate relationships of adult women with histories of sexual abuse. The literature has identified disturbed relatedness as a consequence of early sexual abuse (Courtois, 1988; Herman, 1981). The measure is completed by the survivor's partner and, thus, may provide another perspective on the process and outcome of the therapy provided by the ECCASAT programme.

The Dyadic Relationship Scale is composed of 42 items that measure the key components identified by the Process Model of Family Functioning. These seven concepts are Task Accomplishment, Role Performance, Communication, Affective Expression, Affective Involvement, Control, and Values and Norms. Each construct is measured on a different subscale providing seven subscale scores as well as an overall rating of functioning within the marital dyad. Task Accomplishment refers to the "successful achievement of a variety of basic, developmental and crisis tasks" (Skinner, et al., 1983, p. 93) that each family encounters. The Role Performance subscale measures the extent to which various roles are differentiated and enacted. The Communication subscale determines how well information is exchanged between the members of the

dyad. The expression of feelings between the marital partners is measured by the items in the Affective Expression scale while the Affective Involvement scale refers to the degree and quality of interest that the couple have in each other. The Control subscale examines the process by which each individual in the dyad influence each other and the final construct, Norms and Values, refers to the values and norms of the larger society as well as that of the marital dyad.

The FAM III is a reliable instrument. The internal consistency of the Dyadic Relationships Scale is excellent with alphas of .95 for adults and .94 for children. The subscales of the Dyadic Relationships Scale exhibit a range of internal consistency coefficients with the lowest at .59 (Affective Expression) and the highest at .82 (Role Performance). These alphas are based on the scores of adult respondents. Most of the subscales exhibit reasonably good reliability. The test-retest reliability of the FAM III measure has not as yet been established.

The criterion validity of the FAM III was investigated in a study utilizing a sample of 475 families who were designated as either "problem" or "nonproblem" families. The results indicated that the FAM III had the power to significantly differentiate between clinical and nonclinical families. The concurrent validity of this measure has not been firmly established. However, the work of Bloom (as cited in Tutty, 1995) suggests that the FAM III and two other family functioning instruments, the Family Environment Scale (FES, Moos & Moos, 1981) and the Family Adaptability and Cohesion Evaluation Scale (FACES III, Olsen, Sprenkle, & Russell, 1979), all appear to assess similar constructs.

Like the Therapist Rating Scale, the FAM III provides a source of information outside of the survivor with which to evaluate the effects of sexual abuse treatment. It also provides a context, outside of the therapeutic relationship, in which to assess survivor functioning during treatment.

Hypotheses

It is predicted that the female adult survivors of child sexual abuse will undergo some change in their symptomatology and functioning as they progress through the sexual abuse treatment programme offered by ECCASAT. Specifically, it is hypothesized that this group of survivors will improve in trauma symptomatology as indicated by lower scores on the TSC-40. It is further hypothesized that levels of depression will also improve as indicated by lower scores on the BDI. Due to the exploratory nature of these instruments and the lack of prior research on which to draw upon, no predictions about the direction of change on the PSS-Fr, PSS-Fa, FAM-DR, or the Therapist Rating Scale will be made.

Ethical Considerations

The ethics procedures for this research study were examined and approved by the Joint Faculties Research Ethics Committee of the University of Calgary. Every attempt was made to treat potential participants for this study in an ethical manner. Clients of the ECCASAT programme who were invited to take part in the evaluation were assured that any such participation was strictly voluntary and that any decision not to participate would be respected and in no way would affect their relationship with the ECCASAT counselling agency personnel. Those clients that did accept the invitation to join in the

study were reassured that, if they had reservations at any point, they could withdraw from further participation.

Informed consent was obtained through the use of a letter and a consent form. These documents outlined the purpose of the study, the format of the research, and the approximate length of time required to complete the package of standardized measures. Participants were also provided with information about the precautions taken to ensure confidentiality. These included the use of coded answer sheets rather than participant names to identify the completed package of outcome measures. This allowed for the comparison of individual responses over time without compromising confidentiality. Furthermore, these answer sheets were kept in a secure office at the University of Calgary and are to be destroyed upon completion of the study.

An additional issue that was taken into consideration was the possibility of negative reactions on the part of participants to the content of the measures. To prevent such an occurrence, the measures were administered before or during the initial phase of the therapy session thereby giving the therapist an opportunity to debrief the participant on any issues that may be of concern. Therapists who feared that their clients would be negatively affected by completing the questionnaires were given permission to withhold the outcome measures.

Summary

The current study was developed to assess any changes in symptomatology and functioning in a group of adult women who had histories of childhood sexual abuse as they progressed through the ECCASAT treatment programme. Examining the efficacy of

individual treatment is a new research interest in the field of sexual abuse and few studies have been conducted in this area. Although the current study is limited by the lack of randomization and the use of a comparison group, a number of instruments are utilized to provide a variety of information about several different areas of symptomatology and functioning. In addition, three different perspectives, that of the survivor, her therapist, and her partner, are included to provide a more balanced view of the changes that are predicted to occur in the survivors as they proceed through their treatment.

CHAPTER FOUR

RESULTS

The results of the current research study concerning the efficacy of treatment on adult sexual abuse survivors are presented in this chapter. First, background information on the participants including demographic characteristics and sexual abuse histories are presented to provide a general picture of the personal attributes and environmental influences of the women who attended the ECCASAT treatment program and participated in the study.

The second part of the chapter focuses on the treatment process and its effect on the participants. This is accomplished through an examination of the statistical analyses performed on the data gathered from the measures used in the study. The results of the study of treatment effectiveness is presented in three different sections with each section dealing with a different aspect of the data collected and its subsequent analysis. The first section provides an overview of the survivor's initial level of symptomatology and functioning through a presentation of group scores on each of the measures at intake. The following section examines the progress made through treatment by analyzing scores at different points in the therapeutic process. The final section of the chapter is given over to an examination of patterns in recovery of the women in the treatment program.

The Participants

A total of 27 women participated in the evaluation study of the ECCASAT sexual abuse treatment program for adult survivors. Demographic data and sexual abuse histories were collected from 25 of the 27 participants.

The average age of the women in the study was 31 with the youngest participant being 18 years of age and the oldest being 48 years old. The majority of the women (44.4%) were married or in a long-term partner relationship. Of the remaining participants, 18.5% were divorced, 11.1% separated, and 11.1% single. Approximately 33% of the women had completed a high school education while 26% had gone on to attend a post-secondary educational institution.

Information collected on the sexual abuse histories of the study participants indicated that they had, on average, experienced severe acts of sexual victimization in childhood. The mean age at onset of the abuse was approximately 8 years of age. The earliest age at onset was infancy, whereas the oldest was 12 years of age. The duration of the sexual abuse was, on average, 4.4 years. The shortest duration recorded was 8 months while the longest was 16 years. In 26% of the cases, the abusive incidents occurred less than one time per month. However, in 19% of the cases the abusive activity occurred more than one time per week.

The average number of perpetrators in each woman's abuse history was 2.3 (s.d.=1.7). Six women (27%) reported one perpetrator, ten (46%) reported two and the final eleven (44%) reported from three to nine perpetrators. The perpetrators ranged from family members such as fathers, grandfathers, siblings, uncles, and cousins to family friends and finally to strangers. In most of the cases (71%), the perpetrator was a family member. Nine of the women (38%) identified their fathers as one of the perpetrators of their abuse. Only one woman identified a female perpetrator. Vaginal and/or anal penetration was the most common form of abuse occurring in 40.7% of the cases with

oral sex and digital penetration without intercourse occurring in 25.9% of the cases. Fondling as the sole form of abuse was reported in only 7.4% of the case histories. Force accompanied the abusive activity in approximately 56% or the cases while threats of harm were used about 45% of the time.

After disclosing the abuse, slightly more of the women (33.3%) were disbelieved rather than believed and only 18.5% were supported by their non-offending parent(s). Only one of the women was removed from the home after reporting the abuse and in 63% of the cases, no other family disruption ensued as a result of the abuse. However, 40.7% of the participants reported a high level of parental conflict in the home. The survivors expressed a large number of varying personal reactions to the abuse. These ranged from intrapersonal problems such as feelings of guilt, shame, fear, anger, and poor self-esteem to interpersonal difficulties such as social withdrawal, substance abuse, sexual promiscuity, and failed personal relationships. Almost half of the study participants (48%) had not sought previous counselling for these problems.

The Problem Oriented Record (Bander, et al., 1982) was used to identify problems that this group of survivors were experiencing prior to treatment. The most frequently reported difficulties at intake were financial problems (52%), marital difficulties (45%), and communication problems (37%).

Symptomatology At Intake

Group scores on both the standardized and non-standardized measures were analyzed at intake to assess the survivors' level of symptomatology and interpersonal functioning prior to the introduction of treatment (see Table1). The average total TSC-40

score was 56.49. However, there was a great deal of variability in the scores with lowest at 13 and the highest at 104. The TSC-40 does not have a clinical cutoff score. Scores on this instrument can range from 0 to 120. The TSC-40 subscales with the highest average intake scores were Depression, Sleep Disturbance, and Anxiety. The average initial BDI score the study participants was in the clinical range indicating a moderate level of depression.

The PSS-Fr and PSS-Fa scales were used to assess the survivors' perception of social support. These scales are not necessarily meant for clinical use and are not normed. However, higher scores indicate higher levels of perceived social support. The study participants reported fairly low levels of support from both friends and family upon entry into the ECCASAT programme.

Thirteen partners completed the FAM Dyadic Relationship Scale (FAM-DR). The average scores collected on each of the seven subscales that make up the instrument were in the poor to average range indicating some discord in the marital relationships of the ECCASAT clients at intake as perceived by their partners (see Table 2). Three of the seven subscales had average scores that came close to the clinical cutoff of 60 indicating poor functioning. These were Involvement, Experience, and Communication. The remaining four subscales had scores that indicated adequate functioning within the marital dyad.

Using the Therapist Rating Scale, each ECCASAT client's therapist could identify and rate the extent to which their clients were experiencing a number of problems associated with a history of child sexual abuse. At intake, symptoms that were rated as

being somewhat of a problem to this group of survivors were hypervigilence (65%), flashbacks (55%), distress over family disruption (55%), difficulties with relating to important people (50%), and avoidance of close relationships (40%). Sexual difficulties were identified as affecting 40% of the survivors a great deal. On the positive side, 65% of the participants were rated as being somewhat connected to their therapist and 50% were managing school or work somewhat successfully. Items that were rated as not being a problem at all for the majority of the women were dissociation (50%) and self-harm (50%).

TABLE 1
Client Scores At Intake

	Mean Score	Standard Deviation	Range
Trauma Symptom Checklist (TSC-40) N=26			
Total Score	56.5	21.2	13 - 104
Anxiety	10.8	4.7	0 – 21
Depression	14.6	5.7	4 – 27
Dissociation	7.8	3.4	1 – 15
Sexual Abuse Trauma	8.0	3.8	2 –17
Sleep Disturbance	11.3	3.8	5 – 18
Sexual Problems	8.6	5.8	0 - 20
Beck Depression Index (BDI) N=22	22.2	12.8	4 –54
Perceived Support from Friends (PSS-Fr) N=23	11.5	5.7	1 – 20
Perceived Support from Family (PSS-Fa) N=23	11.3	7.3	0 – 20

TABLE 2
Partner Scores At Intake

	Mean Score	Standard Deviation	Range
Family Assessment Measure (FAM-DR) N=13			
Task Accomplishment	48.5	9.0	30 – 62
Role	48.9	9.0	36 – 64
Communication	50.5	8.4	36 – 64
Affective Involvement	53.1	10.4	36 – 66
Affective Expression	51.2	11.4	24 – 64
Control	48.5	8.3	34 – 60
Values and Norms	49.2	9.5	34 - 64

Treatment Programme Completers Versus Non-Completers

The rate of attrition in this study was quite high, with 14 of the initial group of 27 (52 %) participants dropping out of the treatment programme after three months and another 2 leaving after six months. The reasons for not completing the treatment programme were not ascertained. Analyses of the data were conducted in order to determine if there were any differences between those women who left therapy and those who completed at least six months of treatment. Chi-square and t-test analyses on the demographic data, the sexual abuse histories, and the standardized measures did not reveal any significant differences between these two groups.

Symptomatology During Treatment

The primary focus of the data analysis was to determine what changes, if any, occurred in the symptomatology and functioning of the sexual abuse survivors as they received treatment offered by the ECCASAT programme. This was accomplished by comparing mean scores on the various measures at different points during therapy.

Two different analyses are presented to illustrate the effects of treatment on the study participants. The main analysis concerned changes in symptomatology and functioning that occurred between intake, three months and six months of therapy. A second analysis of changes between intake and three months is also presented.

Analysis of variance (ANOVA) for repeated measures was utilized to compare group means on the standardized instruments. The single non-standardized measure, the Therapist Rating Scale, did not fulfill the requirements for the ANOVA due to the ordinal level of measurement of the data collected. Thus, the nonparametric Friedman's Test was used to compare group means on this instrument.

Symptomatology At Six Months of Treatment

The statistical analyses were conducted on a total of 11 women. The remaining 16 participants did not complete the treatment programme and six month data was, therefore, not available from them. It is not known why these women did not continue their therapy.

The repeated measures ANOVAs conducted on the data for the primary period of interest, intake, three months, and six months, revealed no significant changes in the TSC-40, BDI, PSS-Fr/PSS-Fa, or the FAM-DR scores at the 0.05 level of significance (see Tables 3 and 4). The only exception was a deterioration found on the FAM-DR subscale of Affective Expression ($p=0.03$) as reported by the women's partners.

Despite the lack of statistical significance on most of the standardized measures, an examination of the means on the TSC-40 and BDI at the three data collection points, intake, three, and six months, indicates a general movement towards improvement in

symptomatology at the end of six months in therapy. In some cases, symptomatology worsened very slightly after six months but remained better than that specified by the survivors at intake. The exception to this positive trend was found on the FAM-DR measure completed by the women's partners. On all of the seven subscales of the FAM-DR, the average scores recorded at six months in therapy suggest that the marital relationship was more dysfunctional than at intake. The PSS-Fr and PSS-Fa scales, also revealed patterns such that support from family decreased slightly, on average, over the course of treatment. In comparison, support from friends increased at first and then remained stable after six months.

TABLE 3

Client Scores At Intake, Three Months, And Six Months

	Mean Score At Intake	Mean Score At 3 Months	Mean Score At 6 Months	Level of Significance
Trauma Symptom Checklist (TSC-40) N=11				
Total Score	50.6 s.d.=19.0	44.5 s.d.=20.1	45.3 s.d.=15.9	p=.32
Anxiety	9.6 s.d.=4.3	7.9 s.d.=4.5	8.1 s.d.=3.9	p=.20
Depression	13.8 s.d.=5.1	12.0 s.d.=5.4	11.9 s.d.=4.1	p=.30
Dissociation	6.6 s.d.=3.2	5.8 s.d.=3.9	6.3 s.d.=3.8	p=.59
Sexual Abuse Trauma	7.4 s.d.=4.0	6.6 s.d.=4.2	6.8 s.d.=2.9	p=.56
Sleep Disturbance	10.7 s.d.=3.6	9.6 s.d.=4.0	10.4 s.d.=3.7	p=.39
Sexual Problems	9.2 s.d.=6.9	7.8 s.d.=5.9	8.4 s.d.=5.5	p=.47
Beck Depression Index (BDI) N=11	25.3 s.d.=12.6	21.0 s.d.=13.4	16.9 s.d.=7.2	p=.15
Perceived Support From Friends (PSS-Fr) N=11	10.6 s.d.=4.9	12.1 s.d.=4.3	11.5 s.d.=3.8	p=.46
Perceived Support From Family (PSS-Fa) N=11	12.0 s.d.=8.0	10.0 s.d.=6.8	9.8 s.d.=6.4	p=.29

***p<.05**

TABLE 4
Partner Scores At Intake, Three Months, And Six Months

	Mean Score At Intake	Mean Score At 3 Months	Mean Score At 6 Months	Level of Significance
Family Assessment Measure (FAM-DR) N=13				
Task Accomplishment	49.3 s.d.=12.2	52.0 s.d.=10.4	53.3 s.d.=8.9	p=.51
Role	45.0 s.d.=8.3	50.7 s.d.=10.6	50.3 s.d.=8.7	p=.29
Communication	48.0 s.d.=8.0	54.3 s.d.=12.2	54.0 s.d.=7.5	p=.29
Affective Involvement	50.0 s.d.=12.8	47.7 s.d.=6.7	57.0 s.d.=10.6	p=.17
Affective Expression	46.0 s.d.=14.3	48.7 s.d.=7.6	58.7 s.d.=9.8	p=.03*
Control	47.0 s.d.=10.7	50.7 s.d.=10.9	51.3 s.d.=6.9	p=.63
Values And Norms	47.7 s.d.=8.7	50.0 s.d.=13.3	52.3 s.d.=7.6	p=.48

***p<.05**

An analysis of the Therapist Rating Scale using the nonparametric Friedman's Test yielded no significant changes between intake and six months of treatment. However, one item did approach significance: the therapists' rating of the client group's risk of continued sexual or physical abuse which produced a significance level of p=0.09. Thus, from the therapists' perspective, the survivors appeared to approach being less at risk for further abuse.

The final measure administered to the participants was a Client Satisfaction Questionnaire. Analysis of this questionnaire revealed that most of the women (80%) were overall very satisfied with the ECCASAT sexual abuse treatment programme. Eighty percent of the survivors indicated that most of their needs had been met and 60%

reported that their therapists had helped them somewhat in dealing with their problems. Finally, 70% were very satisfied with the help they received and 90% indicated that they would come back and also recommend the programme to others.

Symptomatology At Three Months of Treatment

The lack of significant results in the first analysis lead to a re-examination of the data in a secondary analysis. Although such a re-analysis is not considered correct research procedure, it was felt that the uniqueness of the study and the small sample size warranted a further examination of the results for exploratory purposes. It was believed that the addition of more data, in this case two more participants, might make a difference. The results bore out this prediction (see Table 5).

The analysis consisted of repeating ANOVA tests on the data collected at intake and three months in order to determine if their were any significant differences in scores during this time period. Again, no statistically significant changes were found on the BDI, PSS-Fr/PSS-Fa, or the FAM-DR scores (see Tables 5 and 6). However, the total TSC-40 score did approach significance at $p=0.07$. In addition, two of the TSC-40 subscales were statistically significantly different after three months of therapy. Scores on both the Depression ($p=0.04$) and Anxiety ($p=0.04$) subscales improved to a statistically significant level after three months of therapy. Another subscale, Sexual Problems, approached statistical significance at $p=0.08$.

As was the case at six months, the Friedman's Test revealed no significant differences between therapist ratings on the Therapist Rating Scale at intake and three months into treatment. Reductions on two items, the possibility of self-harm and

difficulties relating to important people both approached statistical significance with a level of p=0.08 each.

TABLE 5
Client Scores At Intake And Three Months

	Mean Score At Intake	Mean Score At 3 Months	Level of Significance
Trauma Symptom Checklist (TSC-40) N= 13			
Total Score	52.1 s.d.=18.4	44.0 s.d.=17.9	p=.07
Anxiety	10.1 s.d.=4.3	7.9 s.d=4.2	p=.04*
Depression	14.0 s.d.=4.9	11.8 s.d.=5.2	p=.04*
Dissociation	6.6 s.d.=2.8	5.8 s.d.=3.5	p=.39
Sexual Abuse Trauma	7.7 s.d.=3.8	6.3 s.d.=3.8	p=.16
Sleep Disturbance	10.9 s.d.=3.8	9.6 s.d.=4.3	p=.15
Sexual Problems	9.1 s.d.=6.4	7.2 s.d.=5.3	p=.08
Beck Depression Index (BDI) N= 13	23.6 s.d.=11.6	19.0 s.d.=12.4	p=.24
Perceived Support from Friends (PSS-Fr) N=13	11.7 s.d.=4.8	12.7 s.d.=4.2	p=.37
Perceived Support from Family (PSS-Fa) N= 13	12.9 s.d.=7.2	11.5 s.d.=6.7	p=.33

***p<.05**

TABLE 6
Partner Scores At Intake And Three Months

	Mean Score At Intake	Mean Score At 3 Months	Level of Significance
Family Assessment Measure (FAM-DR) N= 7			
Task Accomplishment	48.3 s.d.=11.5	51.1 s.d.=9.7	p=.18
Role	46.3 s.d.=8.3	51.1 s.d.=9.7	p=.12
Communication	48.0 s.d.=7.3	53.4 s.d.=11.4	p=.24
Affective Involvement	51.1 s.d.=12.1	48.0 s.d.=6.2	p=.45
Affective Expression	46.9 s.d.=13.3	48.3 s.d.=6.9	p=.72
Control	47.7 s.d.=9.9	51.4 s.d.=10.2	p=.53
Values and Norms	48.9 s.d.=8.6	50.9 s.d.=12.4	p=.63

***p<.05**

Patterns In Recovery

As an adjunct to the statistical analysis, a further examination of the data was conducted involving a visual inspection of the data on a case by case basis. This type of analysis is similar to the one incorporated by Rubin (1991) in his study on the efficacy of group counselling with battered women. It was adopted in an attempt to explore the study findings with respect to patterns of recovery in sexual abuse treatment.

Rubin presented a collection of six single case studies using an AB design which were aggregated to get an overall picture of treatment effects. Baseline data was collected while the women were waiting to join the group. The intervention phase consisted of 11 weeks during which time measurements were taken on a daily basis. For

the current study, the baseline data consisted of only one measurement, the intake score on two standardized instruments, the TSC-40 and the BDI. The intervention period consisted of scores on these instruments at three months and six months of treatment. Complete information was available for a total of 11 participants.

Examination of the scores showed two predominant patterns in the recovery process. The first is one of decreasing scores on both standardized measures of symptomatology at three and six months of therapy. This pattern was found in 45% (5 of 11) of the survivors. The second trend was one in which symptomatology increased between intake and three months of treatment and then decreased at the six month point. This pattern was evidenced in the scores on at least one of the standardized measures in 36% of the study sample (4 of 11). Of these four women, two had an increase and subsequent decrease in BDI scores, one in TSC-40 scores, and the remaining survivor exhibited this pattern of scores on both measures. Thus, the two main trends found in the recovery process were one in which steady improvement in symptomatology was evident over the course of six months in therapy and one in which the participant's situation became worse before becoming better. Two of the eleven women in this subsample of survivors did not conform to either pattern. In each of these cases, symptoms improved at three months of treatment and then worsened at six months. Both women experienced a fairly substantial rise in symptomatology at six months as revealed by higher scores on both the TSC-40 and BDI.

Case Studies

The following four case studies are presented to illustrate the principal patterns of

recovery noted through individual analysis of each participant's journey through the treatment programme. The case studies were constructed using the data compiled from the demographic questionnaire, the Problem Oriented Record, the standardized measures (TSC-40, BDI, PSS-Fa/PSS-Fr, and FAM-DR) and finally the Therapist Rating Scale.

The first case study, Jane, is one in which the survivor shows a trend towards a healthier level of functioning as evidenced by decreasing scores on both the TSC-40 and the BDI.

Case 1: Jane

Jane is a 32 year old woman who was in the ECCASAT sexual abuse treatment programme for six months. She is divorced and has completed a high school education. Data was gathered on Jane at intake, three months, and six months after joining the programme.

Jane's recollections of her sexual abuse are vague because the abuse started when she was an infant. It is unknown how long the abuse persisted or how frequently the abusive incidents occurred. The abuse consisted of acts including fondling, oral sex, and digital penetration. There were possibly two perpetrators involved whom Jane identified as her grandfather and maternal uncle. Threats of harm accompanied the abuse but it is unknown whether force was used against her.

Jane disclosed the abuse when she was an adult and was believed and supported by her parents. She was not removed from her home and the family was not disrupted in any other way. However, Jane reported that there was a very high level of parental conflict in her family of origin. Jane responded to the sexual abuse by becoming very withdrawn and began to have difficulties in her interpersonal relationships with a special emphasis on trust issues.

Therapist Reports

Before treatment was initiated, the therapist noted that Jane was dealing with quite a few problems as described by the Problem Oriented Record. In the area of intrafamilial interpersonal problems, she was experiencing communication, marital, and parenting difficulties. She was also struggling with feelings of helplessness and low self-esteem and adult sexual problems. Finally, financial difficulties were also troubling Jane at intake.

The Therapist Rating Scale was completed at intake and three months by Jane's therapist at ECCASAT. The therapist noted that Jane was exhibiting some extreme symptomatology at intake. The most severe problems appeared to be hypervigilence,

sexual difficulties, and possible further risk of abuse. She was also having difficulties relating to important people in her life and was having trouble managing her school/work duties. The therapist also had concerns about Jane's safety with respect to self-harm.

After three months of therapy, the majority of these difficulties were still present with the addition of a few others. The new problems included the onset of flashbacks and the inability to maintain close relationships. The hypervigilence, however, had abated to some extent and Jane's ability to connect with her therapist had improved.

Client Self-Reports

At intake, Jane's total TSC-40 score was quite high at 78. This score decreased regularly during the course of treatment both at three months (73) and at six months (66) but remained fairly high. The scores on the subscales of the TSC-40 exhibited a similar trend in two of the subscales, the Depression and Sexual Problem scales. Though all the scores were fairly high, the highest were found on Anxiety, Depression, and Sleep Disturbance.

The BDI scores followed a similar trend, decreasing throughout the treatment phase. The initial score, at 38, was much higher than the clinical cutoff. At three months, the score was still beyond the clinical level at 36. After six months, as with the TSC-40, the final score was still high but, at 22, was no longer near the clinical level of 30.

On the PSS-Fr measure, Jane's scores were very low. The score at intake was 2 out of 20 and this remained the case during the entire course of treatment. A reverse trend was seen in the PSS-Fa which also started low at 6 then decreased even further to 4 at three months. This score did not change after six months of therapy had been reached. These low scores suggest that Jane's support network is not strong in terms of friends or family.

Partner Reports

The information on the FAM-DR measure, as completed by Jane's partner, was available only at the six month period of treatment. At this time the scores on all seven of the scales were either approaching or well beyond the clinical cutoff of 60. The highest score was found on the Role scale (68) with the Control (64) and Values and Norms (64) scale scores close behind. These subscales along with Communication (60) were all at or beyond the clinical level.

Summary

In summary, the information gathered over the six months in which Jane has been in the ECCASAT programme suggests that some positive changes have occurred. Jane's symptomatology has decreased over the course of therapy as indicated by both the TSC-40 and BDI scores which still remained fairly high at the end of six months. It is not possible to ascertain whether any changes occurred in the FAM-DR scores as they are

only available for one time period. The therapist ratings also indicate that there were changes in Jane's symptomatology but that the problems she was dealing with were still severe at the last data collection point. Finally it is apparent that Jane was not getting a lot of social support from either her friends or her family.

The second case, Sarah, provides an illustration of the second pattern of recovery, that of worsening symptoms at three months followed by an improvement at six months of treatment.

Case 2: Sarah

Sarah is a 24 year old woman who was in the ECCASAT sexual abuse treatment programme for approximately one year. Sarah is divorced and has completed her high school education. Data was collected about her at intake, three months, and six months of treatment.

Sarah was 8 years old when the sexual abuse began and the abuse continued for three months. She reported that there were three perpetrators against her but also indicated the possibility that there may have been more. These perpetrators were all friends of her family. The types of sexual abuse that Sarah was subjected to included fondling, oral sex, digital penetration, and sexual and/or anal intercourse. Neither threats of harm nor force was used in the course of the abusive activity.

After reporting the abuse, Sarah was not removed from her home. She stated that the abuse did not result in any other disruption to her family but indicated that there had existed a high level of parental conflict within the family prior to her disclosure of abuse. In general, Sarah's own reaction to her abuse consisted of feelings of low self-esteem and self-destructive behaviours including drug and alcohol abuse and sexual promiscuity. She had sought professional help for these problems at another agency one year before joining the ECCASAT treatment programme.

Therapist Reports

At the beginning of her therapy, Sarah had a number of difficulties in various domains of her life as recorded by the Problem Oriented Record. She was experiencing intrapersonal problems characterized by feelings of guilt and depression as well as feelings of helplessness and low self-esteem . It was also noted that Sarah had difficulties in the area of adult sexuality and, as mentioned earlier, drug and alcohol addiction problems. Intrafamilial relationships were also posing problems for her at this time. She was experiencing both communication difficulties and marital problems. Finally, Sarah indicated that she was also having educational and employment problems as well as financial difficulties.

The Therapist Rating Scale indicated that Sarah had a number of symptoms ranging from dissociation, hypervigilence, and flashbacks to problems relating to

important people in her life. Sexuality was the only notably severe problem reported by the therapist at both intake and in the early stages of therapy. After six months these difficulties with sexual relationships were no longer present. However, this appears to be the only significant change. The therapist reported little or no improvement in other symptomatology.

Client Self-Reports

During the course of treatment, a pattern emerged in terms of her scores on this instrument. The TSC-40 scores began moderately at 58 and increased considerably at the three month point. The score at this point in treatment was 81. At six months, there was a decrease in symptomatology as evidenced by a score of 63.6 on the TSC-40. The subscales of the TSC-40 were also investigated and Sarah's scores on each subscale appeared to reflect those of her total TSC-40 scores. On each subscale, the scores generally increased until the six month mark, at which point, the scores dropped to just above their pretreatment level. The only exceptions to this pattern were found on the Sexual Abuse Trauma and Sexual Problems scales in which the final score was lower than at intake. In all the subscales, the scores were fairly high throughout the study period.

A similar trend was found in the BDI scores. Before the treatment process was initiated, Sarah's BDI score was just under the clinical cut-off at 28. After three months of therapy, her score increased substantially to 48 and then dropped to 31, just above the clinical level after six months. This pattern of increasing and decreasing scores were very similar to those found on the TSC-40 measure.

As with the other instruments, a trend was easily observed in her PSS-Fr scores. Sarah indicated a moderate level of support from her friends before entering therapy. Her score at this time was 10 out of a possible 20. During the course of treatment, this score dropped at three months to 8 and remained there at the six month point. A reverse trend was shown in the PSS-Fa scores. At intake, Sarah indicated from her score of 0, that she did not receive any support from her family at all. This score improved slightly as the treatment process continued. At three months, she had a score of 2 which increased one more point after six months of treatment.

Summary

In summary, Sarah's scores appear to follow the general trend of increasing at the beginning of therapy and decreasing to just above the pretreatment levels at the end of six months. The exception to this pattern was found in the PSS-Fa scores which increased slightly throughout the course of therapy. The scores that reflect sexual abuse symptomatology are all fairly high with BDI scores well in the clinical range during the middle phases of treatment. Sarah was in the ECCASAT programme for approximately twelve months. Her assessment of the programme, as recorded by the Client Satisfaction Questionnaire, indicates that she found her therapy to be a favourable experience.

The third case study, Lucy, is one of the women whose level of symptomatology decreased at three months only to increase after six months.

Case 3: Lucy

Lucy is a 35 year old woman who has been in the ECCASAT sexual abuse treatment programme for six months. She is single and has a post-secondary education. Data on Lucy's progress was collected at intake, three months, and six months into treatment.

Lucy reported that her sexual abuse began when she was six years old and continued for the next three and a half years. The abusive incidents occurred fairly frequently at more than one time a month but less than one time per week. Lucy indicated that there were two perpetrators involved in her abuse, her brother and a neighbour. She was subjected to fondling, oral sex, digital penetration and vaginal and/or anal penetration. Both threats of harm and use of force accompanied the sexual abuse.

Disclosure of the abuse resulted in Lucy not being believed and she was not supported by either of her parents. She was not removed from the home as a consequence of the disclosure and the family was not disrupted in any other way. Lucy reported that little conflict was expressed in her family of origin. Lucy's personal reaction to the sexual abuse consisted of poor self-esteem, unsuccessful personal relationships, and problems with sexuality.

Therapist Reports

The information from the Problem Oriented Record indicated that Lucy was dealing with a great deal of adversity when she first joined the treatment programme. This included intrapersonal problems such as feelings of helplessness and low self-esteem, and intrafamilial problems such as marital, parental, and communication difficulties. In addition, Lucy was struggling with financial and employment problems. Other difficulties centred around her children. Her eldest son was placed in a group home by child welfare authorities and a court case was in progress.

The therapist reported on the Therapist Rating Scale that Lucy was exhibiting a great deal of symptomatology at intake including flashbacks, hypervigilence, risk of self-harm, and distress over family disruption. Other problems centred around interpersonal issues as Lucy was experiencing difficulties relating to important people in her life and was also avoiding close relationships with others. She was not managing her employment situation very successfully either. The therapist was unable to comment on Lucy's sexual relationships but did indicate that she considered her to be still at high risk for further sexual and physical abuse.

At three months, most of these problems seemed to improve but then deteriorated back to their original levels at six months. The most important concerns seemed to be her risk of continued abuse and her inability to relate to significant others. Sexual difficulties also had begun to become apparent at this time.

Client Self-Reports

The total TSC-40 scores first decreased and then increased as Lucy's treatment at ECCASAT progressed. At intake, the score was moderate at 63 indicating a fair amount of trauma symptomatology. After three months of therapy, this score decreased quite a bit to 47 but at six months, the score increased again to 64, one point greater than that recorded at intake. The scores on the subscales of TSC-40 presented a similar trend to that found on the total scores. The highest scores were found on the Depression and Sexual Problems scales.

The BDI scores revealed a similar pattern. Before the treatment process was initiated, Lucy had a score of 27 which is just below that of the clinical cutoff of 30. At three months this score decreased to 15 indicating a moderate level of depression. After six months of treatment, the BDI score increased to 24 coming close to her initial level of depression.

The PSS-Fr scores increased during the course of therapy. The initial PSS-Fr score was 7 out of a possible 20. This increased slightly to 8 after three months and then increased again to 12 at six months in treatment. Lucy appeared to gain more support from her friends as she continued her therapy. The PSS-Fa score at intake was very low at 4 out of 20. This increased very slightly to 5 at three months into treatment and remained at this level after six months at ECCASAT. Lucy did not appear to receive a lot of support from her family either before or during her treatment.

Summary

In summary, Lucy seems to have not made a great deal of positive change in the six months of therapy while at ECCASAT. Although her symptomology as assessed by the TSC-40 and the BDI seem very minor, the therapist and partner measures indicate that there are still some serious issues that she must yet address. Lucy has only been in the program for six months and has not ended her course of treatment at ECCASAT. Her responses on the Client Satisfaction Questionnaire indicate that she is happy with the program and is finding that her most of her needs are being met.

The final case, Anna, is presented to provide an example of a survivor whose partner's increasing FAM-DR scores indicate an increasing level of dysfunction in the marital relationship.

Case 4: Anna

Anna is a 22 year old woman who was in the ECCASAT sexual abuse treatment programme for one year. She is married and has completed her high school education. Data was collected on Anna at intake, three months, and six months into the program.

Beginning at the age of 5, Anna was subjected to a number of sexually abusive acts including fondling, oral sex, and digital penetration. This abuse continued for approximately seven years and occurred less than once a month. Anna identified one perpetrator, her maternal aunt's husband. She also indicated that neither threats of harm nor force was used against her during the abusive episodes.

Anna was believed when she disclosed the abuse and she was not removed from her home as a result. The family was not disrupted in any other way and the level of parental conflict, as reported by Anna, was insignificant. Anna's personal reaction to the sexual abuse began initially as simple denial which began to diminish when she realized that her experiences had affected her self-esteem and prevented her from initiating close relationships because of lack of trust and fear of intimacy.

Therapist Reports

The therapist indicated that Anna had few problems as elicited by the Problem Oriented Record. Those she had included marital problems and adult sexual problems.

The Therapist Rating Scale revealed that Anna was having some difficulties both with intrapersonal and interpersonal issues before treatment was initiated. These included distress over family disruption related to the abuse, hypervigilence, flashbacks, and problems with sexuality. Anna was also having difficulties in her relationships with the important people in her life and was unable to form close relationships with others. She was also having trouble managing her school/work affairs.

The majority of these problems remained at the same level throughout the period in which she was in therapy. There were, however, some exceptions. At the beginning of treatment, the therapist indicated that Anna was not in danger of further sexual or physical abuse but by the end of six months, the risk of this happening had increased to a moderate amount. In addition, the sexual problems had decreased in the first three months, but in the later phases of treatment, these difficulties again became much more severe. In terms of positive change, Anna was able to increase her effectiveness in managing her school/work affairs. She also developed a better connection with her therapist.

Client Self-Reports

The TSC-40 total score at intake is quite high at 70. At three months there was a fairly dramatic decrease to 46 and then at six months a negligible rise to 48. The subscales scores of the TSC-40 displayed a generally decreasing trend with the exception found on the three month scores, which were generally higher than those found at intake. After this point, all the scores dropped to values that were substantially lower than those at pretreatment. The highest scores were found on the Depression and Sleep Disturbance scales respectively.

The BDI scores, similar to the TSC-40 began at a high level and steadily decreased throughout the course of therapy. At intake, Anna's score was 30, the clinical

cut-off for this instrument. At six months, her score had decreased by almost half to 16. Like the TSC-40 the final score was much lower than that at intake.

The PSS-Fr score at intake was high at 15. It remained at this level until the six month mark at which time it decreased to 9. Thus, it appears that Anna lost much of her friends' support at the six month point in treatment. The PSS-Fa scores followed a reverse trend. Before treatment commenced, the score was the highest possible at 20. At three months there was a very significant decrease in the score. The score at this point was a mere 3 out of 20. At six months there was a slight increase to 6. As with friends, Anna, lost a considerable amount of support from her family as she continued with her treatment.

Partner Reports

As with the other measures, the FAM-DR scores revealed a distinct pattern. Initially, on all the scales, the scores were moderately low and none were near the clinical cutoff of 60. After three months nearly all of the scores increased with the greatest increases seen in the Control scale which went from 36 to 52. After six months of therapy, all of the scores increased with the exception of Control which didn't change. The biggest increases were seen in the Involvement (36 to 62) and Affective Expression (42 to 64) scales. Both of these scores were beyond the clinical level. The remaining scores were just below that of the clinical cutoff and ranged from 52 to 56.

Summary

In summary, the course of Anna's therapy did provide some change in her initial situation. Her symptomatology scores all decreased to well below clinical levels and though her family support system wore down, her relationship with her friends remained at a moderate level. Her relationship with her partner, as with her family, did not improve a great deal over the course of treatment. It would also appear that the therapist did not note any significant changes in Anna's problems.

Anna has been in the ECCASAT program for one year and appears to be continuing her treatment there. From the Client Satisfaction Questionnaire, it appears that she is finding that the program is satisfactorily meeting her needs at this time.

Summary Of Results

In summary, largely because of the small sample size, the results of this study do not provide strong evidence on the efficacy of treatment of the sexual abuse symptomatology present in this sample of female survivors. What is apparent is that as a group, these women presented with fairly severe histories of child sexual abuse. They

had experienced abusive activities of an intrusive nature often accompanied by force or the threat of harm. Furthermore, the abuse had commenced at a young age, occurred over a number of years, and frequently involved multiple perpetrators. Test scores at intake revealed, on average, a moderate level of dysfunction. In addition, low levels of social support were accompanied by high levels of marital discord. Analyses of the available data did not uncover any significant changes after either three or six months in the treatment programme. However, a generally positive trend towards an alleviation of symptomatology was noted over the course of therapy. An examination of the data on a case by case basis also revealed two distinct patterns of recovery. Both of these patterns indicated a trend towards a healthier level of functioning amongst this group of survivors at six months of treatment.

CHAPTER FIVE

DISCUSSION

This final chapter addresses the study findings and whether these results support the hypothesis generated prior to the initiation of this research project. The findings are also discussed with regard to previous empirical research in the area of sexual abuse treatment. This is followed by an exploration of the implications to social work practice which may be inferred from this study. Three aspects of social work practice with adult sexual abuse survivors are discussed. These are long-term treatment, group therapy, and partner or couple counselling. The chapter concludes with an examination of the methodological strengths and limitations of the current study and suggestions for future research in the area.

Results of the Study

The twenty-seven participants of this study on the effects of long-term treatment of child sexual abuse were all female clients of the ECCASAT treatment programme. They were, on average, in their early thirties and the majority of them were married or in a long-term partner relationship. This is in contrast to other studies on the efficacy of sexual abuse treatment. The vast majority of these studies involved an evaluation of group therapy. The women in these research studies tended to be single rather than married or living with partners (Alexander, et al., 1989; Carver, et al., 1989; Richter, et al., 1997; Roberts & Lie, 1989). Only Jehu (1989b), who assessed individual treatment using cognitive-behavioural techniques, reported that most of his sample consisted of married women (47%).

The level of education achieved by the survivors in this study was, on average, a high school diploma. This finding is in general agreement with the group outcome studies (Alexander, et al., 1989; Carver, et al., 1989; Richer et al., 1997; Roberts, et al., 1989; Westbury & Tutty, 1999). Carver, et al., reported that 25% of their sample had gone on to attend a post-secondary institution similar to the 26% in the present sample.

The women in the current study had moderate to severe sexual abuse histories. All of the women were victimized before adolescence with the average age of onset at 8 years of age. This is consistent with other studies which reported ages of onset ranging from 5 to 10 years of age (Alexander, et al, 1989; Carver, et al., 1989; Richter et al., 1997; Roberts & Lie, 1989; Westbury & Tutty, 1999). The average duration of the sexual abuse reported by the participants was 4.4 years. This is less than that found in outcome studies researching group therapy. Richter, et al. reported an average duration of 9 years, while Alexander, et al., Hazzard et al., and Westbury and Tutty an average of 7 to 8 years. Again, Jehu's (1989b) study of individual therapy on mood disorders in survivors comes closer to the findings of the present study with a reported duration of 1 to 3 years for the majority of his sample. The relatively short duration of abuse found in this study was accompanied by a high frequency of incidents. Many of the women in the ECCASAT sample indicated that they were subjected to abusive activity on a weekly basis. Furthermore, in this group of survivors, the severity of the abuse was compounded through the use of force and threats of harm in at least half the cases.

The type of abusive activities most frequently reported by the participants in the current study were vaginal and anal intercourse followed by oral sex and digital

penetration. This level of severity is comparable to other treatment studies (Alexander, et al., 1989; Carver et al., 1989; Hazzard, et al., 1993; Richter, et al., 1997: Roberts & Lie, 1989; Westbury & Tutty, 1999). Intrusive sexual behaviours such as penetration, appear to have been a common occurrence in the histories of these sexual abuse survivors.

Incest was more often reported in this sample of survivors than extrafamilial sexual abuse with 77% of the women having been victimized by a family member. Thirty-eight percent identified their father or stepfather as one of the perpetrators of their abuse. Similarly, Carver, et al. (1989), found that 40% of their participants had been abused by fathers. Multiple victimization was also common to the women who attended the ECCASAT programme. The average number of perpetrators reported was 2.3 with 44% of the women identifying three or more assailants. This finding is in line with two other studies that have uncovered similar incidences of multiple victimization amongst their samples (Carver, et al., 1989; Roberts & Lie, 1989).

At intake, the participants reported moderate levels of trauma symptomatology and depression as measured by the TSC-40 and BDI. Their initial mean TSC-40 score is very similar to that of the clinical sample used in the validation study conducted by Whiffen, et al. (1997) but much higher than the community sample of 761 abuse survivors in Elliot and Briere's (1992) large scale survey of professional women. Similarly, the mean BDI score was parallel to that found by Westbury and Tutty (1999) yet higher than that reported by other researchers who evaluated group therapy with survivors (Alexander, et al., 1989; Richter, 1997; Roberts & Lie, 1989).

The primary focus of this study was an evaluation of long-term, individual

therapy on sexual abuse survivors. It was hypothesized that the treatment provided by ECCASAT would produce positive changes in trauma symptomatology and mood disturbance in this group of adult survivors. Specifically, it was predicted that symptoms of trauma as measured by the TSC-40 would decrease as indicated by a decrease in scores. Similarly, it was hypothesized that levels of depression would also improve as indicated by a decrease in BDI scores. Although differences were expected, no predictions were made as to the direction of change in levels of support (PSS-Fa/PSS-Fr scores), marital functioning (FAM-DR scores), or therapist evaluations (Therapist Rating Scale scores). The analyses of the data do not provide support for these hypotheses.

Analyses of data collected during the treatment period revealed few, if any, statistically significant differences in scores after either three or six months of therapy. Although statistical analysis failed to uncover any significant changes in group scores, a visual examination of the data revealed that the women tended to improve as treatment continued from intake to six months. Thus, it would appear that, on average, the study participants tended to experience healthier functioning, with less trauma symptomatology and depression, as they progressed through the treatment programme. More evidence for this positive change was found in the period between intake and three months of treatment. ANOVAs revealed statistical significant differences between scores at intake and three months on two of the subscales of the TSC-40, Anxiety and Depression. In addition, the TSC-40 total score and the subscale Sexual Problems approached significance.

The statistically significant difference found on the Anxiety subscale of the TSC-

40 at three months parallels the results of two studies on group treatment. Westbury and Tutty (1999) investigated the efficacy of a structured time-limited therapeutic treatment group using a treatment and comparison wait-list group in an urban Alberta population. Using an earlier version of the TSC-40, the TSC-33, Westbury and Tutty reported a significant difference on the Anxiety subscale between the treatment and comparison groups. Hazzard et al. (1993), using a pretest-posttest measurement design in their study of a year-long group, found a significant improvement on the TSC-33 total score and all of the subscales except Dissociation. In both of these studies the statistical significance reported on the Anxiety subscale was greater than that found in the current study. However, it must be noted that much larger sample sizes were available to these researchers.

The significant changes noted on the Depression subscale of the TSC-40 was not replicated on the BDI measure. These results are in direct contradiction to those found by Westbury and Tutty (1999) who reported significant differences on the BDI but not the TSC-33 Depression subscale in their sample of group therapy participants. The results on the TSC-40 Depression subscale obtained may be spurious. The BDI is a powerful and psychometrically sound test of depression and the TSC-40 is still a new and relatively untested measure with only nine items on the Depression subscale. The BDI may also have more content validity, measuring depression in various domains while the TSC-40 subscale, having being designed for use with sexual abuse survivors, may only focus on depressive symptomatology relating to the abuse experiences. Thus, it may be that the differences in scores obtained on the Depression subscale may be erroneous, making it

inadvisable to draw any firm conclusions from such results.

The lack of significant results of the BDI is somewhat surprising. All of the researchers who measured levels of depression using this instrument reported significant improvement at the conclusion of the treatment programme. This included the four studies on group therapy (Alexander, et al., 1989; Roberts & Lie, 1989; Threadcraft & Wilcoxin, 1993; Westbury & Tutty, 1999) and the single study of individual treatment (Jehu, 1989b). This may be due to methodological limitations in the current study. Alternatively, the group structure may provide an additional element that is lacking in individual intervention. Yalom (1985) noted that one of the key characteristics of groups is the instillation of hope in its members. It may be that this feeling of hope exerts a powerful influence on depressive symptomatology in survivors who participate in group therapy.

Statistically significant changes during treatment were not found on the PSS-Fa or PSS-Fr scales after either three months or six months of therapy. Nevertheless, an examination of average scores revealed trends in the data. Scores on the PSS-Fa tended to decrease over the course of treatment indicating a loss of family support during this time. In contrast, support from friends increased slightly at three months and remained stable after six months. This group of survivors appeared to have received more support from their friendship network than their family as they dealt with their abuse-related problems in therapy.

The PSS-Fa defines family as the client's partner, children or other individuals with whom they maintained close ties. This definition does not include the woman's

family of origin. Thus, this group of women did not feel supported throughout their recovery process by those who made up their immediate family. This drop in support from family members appears to be common to abuse survivors who undergo therapy. Herman (1992) describes the latter stages of abuse therapy as one in which the survivor begins to rebuild her life through self-improvement. At this point, she may begin to take a more interactive approach towards other people in her life and may attempt to challenge their reactions to her and her situation. Herman notes that many survivors do not report improvement in all aspects of their lives. Rather, many find that their relationships with their families have deteriorated as their newly discovered sense of self does not allow them to "routinely disregard their own wishes and needs" (Herman 1992, p.231). Courtois (1988) also reports that survivors are more likely to receive more support form their friends and distant relatives than immediate family members.

The final standardized measure, the FAM-DR, which was completed by the survivors' partners did not produce many statistically significant differences over the course of therapy. At intake, the scores on all seven scales were in the mid-range area indicating average to good functioning in the marital relationship. However, as the women entered therapy, these variables worsened steadily until the mean scores were much closer to the level of problem functioning after six months. The greatest changes were found on Affective Expression and Affective Involvement, with the former scale producing a statistically significant difference over the course of six months. Both of these scales are concerned with the process of communication within the couple relationship. Affective Expression includes the "content, intensity, and timing of the

feelings involved" (Skinner et al., 1983, p.93). High scores on this scale indicate an inappropriate or insufficient expression of affect. Emotional expression may be inhibited or overly intense for the situation (Skinner et al., 1983). Affective Involvement refers to the kind of interaction that the couple has with each other. It is a measure of the degree to which each member of the marital dyad are interested in each other. Scores in the clinical area on this scale indicate an absence of involvement or a relationship lacking in any feeling. Each person may not be able to meet the emotional or security needs of his or her partner. They may also lack the flexibility to support autonomy of thought and function in each other (Skinner et al., 1983). Skinner et al. notes that problems in these two areas of marital functioning may lead to difficulties in other areas including task accomplishment and role performance. Thus, it would appear that the partners felt that the ability to communicate feelings and express marital interest as well as the desire to share in each other's lives deteriorated in their relationships with the survivors as the women progressed through treatment.

No specific changes were documented on the Therapist Rating Scale over the course of treatment. However, a number of items on the measure did approach significance after six months. The therapists indicated that the possibility of self-harm as well as the risk or continued physical and/or sexual abuse at the hands of others had lessened during therapy. Difficulties relating to important people had also abated somewhat. It would appear that treatment had helped these survivors to approach a sense of safety in their lives and to make a start on rebuilding personal relationships; two of the tasks that Herman (1992) states are a part of the process of recovery from sexual abuse

trauma.

Examining the healing journeys of this group of survivors on an individual basis yielded two predominant patterns of recovery, one of increasing health throughout the treatment period (N=5) and one of initial decline followed by improvement in symptomatology (N=4). The first pattern is one that, if not entirely expected, is a hoped for path for those entering therapy. However, the latter trend is one that has been identified as common to this population. Not all survivors will experience the treatment process as one of continuous improvement. Some, like the four women in the current study, will feel worse before they get better. This intensification of trauma symptomatology may be attributed to the dismantling of dissociative and avoidant defenses such as repression, numbing, denial, intellectualization, and other tension-reducing activities during therapy. With such defenses down, the survivor experiences, perhaps for the first time, a more direct awareness of her childhood victimization (Briere, 1989;1992). Having to confront and integrate traumatic memories and the associated painful affect can cause the survivor more distress and a corresponding increase in symptomatology (Beran & Tutty, 1993; Briere, 1989;1992). These adverse reactions are usually transitory and typically recede as treatment progresses and the survivor often emerges from this low phase with a higher level of functioning and improved skills (Beran & Tutty, 1993; Briere, 1989;1992).

To summarize, the analyses performed on the data gathered on the women in the ECCASAT sexual abuse treatment programme revealed little or no statistically significant changes in trauma symptomatology or mood disturbance during the treatment

process. This is in contrast to research studies that have assessed the efficacy of group therapy with this population. Almost all of the studies on group intervention that have measured the same treatment variables as the current study have reported statistically significant improvement in at least one area of symptomatology at the conclusion of therapy.

Despite the lack of statistical significance, it is apparent from the analysis of patterns in the recovery process that most of the survivors who undertook the treatment program at ECCASAT did benefit. An examination of the data on a case by case basis indicates that, on the whole, the participants who remained in the programme for six months showed improvement in symptomatology and interpersonal functioning. In almost all the cases, the final scores on the two measures of symptomatology showed an improvement over intake scores. Only one participant remained in some distress as indicated by a BDI score that was still in the clinical range after six months of therapy. By and large, it appears that participating in the treatment programme provided by ECCASAT was helpful in alleviating some of the long-term problems associated with early sexual abuse. These positive trends in the test results were supplemented by the survivors' own evaluation of the services provided. The majority of the women were very satisfied with the both the treatment programme and their therapists. They reported that most of their needs had been met and their problems dealt with effectively.

Implications For Social Work Practice

An examination of the results of the current study provides some evidence of the efficacy of the sexual abuse treatment program offered by ECCASAT and, thus, some

support for the use of long-term therapy with survivors of childhood sexual abuse. Indeed the evidence that some survivors develop more adverse symptomatology in the initial stages of therapy before gradually improving speaks to the importance of carrying treatment beyond the short-term. Many researchers and clinicians advocate the use of trauma-focused treatment in addressing the problems associated with early sexual victimization (Briere, 1989;1992; Courtois, 1988; Herman, 1992; Meiselman, 1990; Sanderson 1990). This type of therapy tends to be a long-term process that may last from one to several years depending on the client's needs and tolerance (Courtois, 1988; Sanderson, 1990).

In a study of client response to short-term treatment, Holmes (1995) found that a history of childhood abuse, physical or sexual, had a mediating influence on the treatment outcome. Short-term therapy, defined as three to six sessions, was not effective in reducing anxiety or depression in those participants with histories of abuse. In some cases, similar to the current study, symptomatology increased during this period. From the lack of favourable response in his sample, Holmes concluded that time-limited treatment might be inappropriate for abuse survivors. Courtois (1988) and Sanderson (1990) suggest that long-term treatment is better suited to survivors because of the nature of their experiences and the therapeutic tasks required in the resolution of such trauma. Overcoming the effects of sexual abuse involves a process of recovery during which the survivor is required to recollect and integrate many painful memories associated with the childhood victimization. The pace of therapy may be slowed down if it becomes too intense for the client to tolerate. Often the success of this treatment depends on the

strength of the alliance between the therapist and client and this therapeutic bond may take time to develop due to the survivor's difficulties in establishing close, personal relationships with others (Briere, 1989; Courtois, 1988; Sanderson, 1990). These issues and concerns may all contribute to length of time required by the survivor in coming to terms with her past abuse and present problems.

Support for duration of therapy is not the only aspect of treatment about which inferences from the results of this study may be drawn. Modality of treatment is another consideration that must be taken into account when examining the study findings. This research was limited to the study of individual therapy with sexual abuse survivors. Other empirical studies in this area, as mentioned previously, have examined the effects of group therapy on this population. Also as noted earlier, most of these researchers have found statistically significant improvement in the same symptomatology as assessed in the current study. It is important to note that in the vast majority of these studies, the participants had either completed a course of individual therapy prior to joining the group, or were in a concurrent individual treatment programme. In contrast, the abuse survivors in the present study participated in individual therapy only, as group therapy was not available due to the lack of participants in these rural communities. Furthermore, in 48% of the cases, the individual treatment offered by ECCASAT was the first experience of counselling for these survivors. Previous therapy may influence other variables that can affect treatment outcome such as client expectations, motivation, and readiness for change (Beutler & Hill, 1992).

The concept that group therapy is a valuable adjunct to individual treatment has

received much support in the literature (Briere, 1989; Courtois, 1988; Herman & Schatzow, 1984; Sanderson, 1990; Sgroi, 1989). While individual therapy may serve as a starting point at which to begin addressing some of the difficulties survivors experience, it may be necessary to eventually supplement it with group work in order to undertake other areas of dysfunction. Group therapy offers a number of opportunities not available through individual counselling alone. The most notable of these are normalization, universality, and the acquisition of interpersonal skills (Yalom, 1985). Based on this literature, it may be hypothesized that the most beneficial treatment program for sexual abuse survivors is one that combines the advantages of both individual and group therapy.

A final implication for social work practice that may be derived from this study originate from the results of the FAM-DR measure. The FAM-DR, completed by the survivors' partners, was the only scale used in the study in which no improvement was found over the course of treatment. After six months of therapy, the couple relationships of the study participants, as perceived by their partners, had deteriorated to the point that the FAM-DR scores were higher than those at intake indicating an increase in marital dysfunction over the course of therapy. These results were reflected in the PSS-Fa scores in which the survivors expressed dissatisfaction with the level of support they received from their immediate family members including partners. These difficulties in intimate relationships may be due to the partners' negative reactions to the therapy process. Partners may not understand what treatment entails and consequently may feel threatened by it. Problems may arise because the partner is unprepared for the length of time

required for recovery, the changes, either positive or negative, that may occur in the survivor, or his or her own reactions to the survivor's disclosure of childhood victimization. Furthermore, the partner may not be able to cope with the changes in his or her relationship with the survivor and may also become resentful of the client-therapist bond.

In order to address these problems, it is often helpful to include partners in the treatment process. This may take the form of consultations with the therapist or group therapy with other partners of survivors (Courtois, 1979; Sanderson,1990). Through this type of involvement, the partner may increase his or her knowledge of sexual abuse and its long-term consequences as well as learn about therapy and its impact on the survivor. Partners may also be encouraged to become more supportive of the survivors and to learn how to interact and respond more positively to the survivors' needs during this time. Finally, couple counselling is often the best forum in which to deal with issues such as communication, intimacy and sexuality, and partner abuse (Follette & Pistorello, 1995). Including partners in the treatment program may, thus, benefit the survivors as they continue through their journey of healing.

Directions For Future Research

Child sexual abuse is still a relatively new area of research in the social work field. Much of the empirical research in this area is concentrated on determining what effect this type of early trauma has on both child victims and adult survivors. In addition, although the empirical research of the efficacy of group therapy is extensive, the literature with regard to individual treatment of the long-term problems associated with

abuse has consisted mainly of clinical anecdotes and advice. There is a definite need for future research endeavors in the field of treatment efficacy with individual therapy.

Methodological Issues in the Current Study

The current research was conducted to examine the efficacy of long-term, trauma-focused therapy on adult survivors of sexual abuse. A quasi-experimental research design was used in this study that sought to add to the still sparse knowledge base in this area of social work practice. As such, it does have a number of limitations that affect the interpretation of the results. Threats to internal validity of the research design including history, maturation, and testing are endemic to long-term studies using repeated measures and are to be expected to a certain degree. The participants in this study were evaluated at intake, three months, and six months of treatment. They attended therapy once a week. Changes in their symptomatology may have been effected through random events that occurred in their lives outside of the therapy sessions (history); through the simple passage of time (maturation); or because the test instruments were applied three times over the course of treatment (testing).

Attrition was also a problem in this study and may be due to the length of the treatment process. Of the original 27 participants, a total of 16 left the programme before six months had elapsed. Finally, the lack of a comparison group with which to compare the treatment group also restricted the interpretation of the study results (Pilkonis, 1993). Without such a group, it is difficult to state with any sense of certainty that the observed changes in symptomatology were due to the effects of the treatment. Factors outside of the therapy process, including those mentioned earlier, may have

contributed to the changes in symptomatology in the survivors. The inclusion of a comparison or wait-list group was, unfortunately, impractical due to the very small sample that was available for this study.

The limited number of individuals who participated in this evaluation led to the foremost threat to the study's external validity. The small sample size may be due to two factors. The first of these was that funding for the ECCASAT programme was discontinued during the research process, limiting the number of participants available for the study. The second reason for the limited sample may be due to the setting of the research study. The ECCASAT treatment programme is rural-based and thus serves a smaller population base than that found in large, urban centres. In addition, the treatment programme is administered through only one location in each of the eight rural communities, making it less accessible to survivors who live in more isolated areas. Accessibility is not the only impediment to service for survivors in rural areas. Issues such as confidentiality and anonymity may make it more difficult to seek help for problems related to sexual abuse (Hall & Lloyd, 1993). In rural communities, the smaller population often means that people are more inter-connected and that information is shared more readily among community members. This makes it difficult for the individual survivor to attend weekly therapy sessions with the sense of relative anonymity that is often taken for granted by those in larger, urban centres. Trust issues are often very salient to women who have been sexually abused and many find it difficult, initially, to trust their therapist. This difficulty may be compounded for women in tightly woven rural communities who may not believe that their therapist will observe

rules of confidentiality and that news of their problems may spread throughout the community. Thus, fear of exposure may keep some rural survivors from accessing even readily available treatment services (Ploner & Hutchinson, 1995). Additionally, the potential client may have to consider the possibility that her identification as a survivor of childhood abuse may cause divisions both in her family and the small community in which her abuser may still reside (Hall & Lloyd, 1993). If the abuser is a powerful and influential member of the community, disclosure may lead to a polarization in the community or collusion to protect the abuser at the expense of the survivor (Ploner & Hutchinson, 1995).

In spite of these limitations, this study has some strengths associated with it. Pilkonis (1993) states that there is a need for more long-term studies on the effectiveness of individual therapy on abuse survivors. The current research project is one such study. It evaluated the efficacy of individual treatment over the course of six months and measured changes in symptomatology at three points in the therapeutic process. The study period may have been extended and included more participants if the funding had not been withdrawn. Furthermore, unlike the two prior published studies on individual treatment, this study evaluated more than one treatment variable. A broad range of symptoms associated with a history of sexual abuse was investigated using at least one measure that was specifically designed for use with sexual abuse survivors. Beutler (1993) recommends this methodological strategy when designing outcome studies. A final strength of this study was the inclusion of three different sources of information on the efficacy of the treatment. These different perspectives, that of the survivor, the

partner, and the therapist, provided a richer, more complete portrayal of the survivors' process of recovery.

Recommendations for Future Research

The literature in the field of individual treatment of sexual abuse symptomatology so far has been limited to case histories, anecdotal evidence, and treatment manuals. At present there are only two studies on the effects of individual therapy in the literature. Both had small sample sizes and evaluated limited treatment variables. There is such a lack of empirical research into the efficacy of individual therapy with abuse survivors that any new studies would be a welcome addition. However, there are some methodological issues that need to be taken into consideration before such an undertaking may be initiated. Beutler (1993) suggests a number of factors that need to be addressed when conducting outcome studies that deal with the treatment of sexual abuse survivors. Some of these have been incorporated in the present study including the use of a within-subjects research design along with a variety of test measures to increase statistical power. He also suggests that dropouts from the program be monitored and that follow-up procedures be introduced in order to determine what factors are important to consider in the implementation of a treatment program. Potential sources for bias in the research must also be controlled in outcome studies. One method of reducing bias and increasing validity is through the utilization of a large group of therapists to provide treatment. The principal researcher should not be included in the study as a therapist. Additionally, the process of therapy may be made as uniform as possible through the use of structured treatment manuals (Beutler, 1993).

With these methodological considerations in mind, there are some areas that future researchers might consider exploring. The current study is one of only a handful investigating the treatment efficacy of individual therapy. Individual counselling is often the first experience of treatment that the survivor may encounter and the quality of this experience may influence her subsequent recovery in terms of her readiness and determination to affect change and explore other treatment modalities. As such, it is important that more research is conducted in this field.

A replication of this study might be more successful in an urban setting where a larger sample may be obtained. Such a study would also provide valuable information on both the similarities and differences between urban and rural abuse survivors. With respect to survivors in rural areas, it must be noted that more research needs to be conducted to provide a better understanding of this special population. Although at least one study has evaluated rural sexual abuse programs directed towards child victims, little research attention has been paid to adult survivors (Trute, Adkins, & MacDonald, 1994). It may be that this particular group has special needs, including those already outlined, that should be addressed within treatment programmes.

One final suggestion for possible future research lies in the need for more investigations into the different types of individual therapy available for sexual abuse survivors. The literature on group therapy has included research on a variety of group structures. The current study on individual treatment evaluated the use of trauma-focused interventions with survivors. Although, as mentioned earlier, replication of this study may provide valuable information, it may be prudent to also look into other forms of

individual therapy. One such form of intervention is solution-focused therapy which has been adapted for use with sexual abuse survivors by Dolen (1991). Evaluating different types of individual treatment can only generate more effective methods of helping survivors as well as broadening the knowledge base in this field of social work practice.

All of these recommendations are directed at improving the current state of the literature regarding treatment efficacy. At this point in time, it is an area that has been almost ignored by researchers. Only through the creation and utilization of sound empirical research can the quality of clinical practice be improved. Such information benefits both social workers and the clients they serve.

Conclusion

Child sexual abuse is a serious social issue that that has existed since the beginnings of civilization. Although abhorred and proscribed by all human society, the sexual victimization of children has continued to occur and been tolerated, if not tacitly accepted, as an inevitable societal evil. Early research in this field reflected this attitude of unspoken compliance. The prevailing clinical opinion declared that child sexual abuse was a rare phenomenon that, when it occurred at all, caused little if any harm to the children involved. It is only in recent history that sexual abuse has been recognized as a significant problem that affects individuals, families, and society as a whole. The increasing awareness of this problem, especially by clinicians and researchers, has fueled interest in the consequences and treatment of child sexual abuse.

Social workers and other members of the helping professions have devoted much of their professional attention to the young victims of sexual abuse. The needs of

children in crisis and the issue of protection from further abuse are, of necessity, immediate concerns that must be addressed. Nevertheless, child victims are not the only ones who are affected by this type of abuse. Adult women and men often continue to be victimized by their experiences of child sexual abuse long after the abuse has ended.

Most of today's adult survivors grew up in an environment in which their abuse was unacknowledged and their pain discounted. The present social climate has partially lifted the veil of secrecy that has surrounded the issue of sexual abuse and forbidden the discussion and disclosure of such experiences for so long. Amid this more receptive atmosphere, more and more adult survivors are coming forward to tell their stories and ask for help in resolving their difficulties. The first experience of therapy for many survivors takes place in an individual setting with a clinician with whom they are able to share their first steps on the path to recovery. Although there is an abundance of information regarding individual treatment of abuse survivors, the empirical research into the efficacy of such intervention is still in its infancy. The knowledge that may generated through increased endeavors by researchers in this field can only help the women and men who so courageously come forward seeking help. It is apparent that the road to recovery from the deleterious effects of child sexual abuse is long and hard. Hopefully, the rewards gained along the way make the journey worthwhile.

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APPENDIX A

Letter of Consent (Client)

Dear Client,

We are requesting your participation in an evaluation of the East Central Communities Association for Sexual Abuse Treatment (ECCASAT) funded by the Family Violence Prevention Division, Health Canada. The research is designed to study how helpful the program is for clients such as yourself. The information gathered from the research will be utilized to make any necessary changes in the program and to justify continued funding.

You will be asked to complete questionnaires at intervals of three months. The questions take approximately 20-30 minutes to answer.

Your responses to the questionnaires will be kept strictly confidential and individual responses will not be shared with ECCASAT personnel. Only members of the research team will see the questionnaires, however, the answer sheets will be coded so that your name does not appear. Completed questionnaires will be kept in a locked office at the University of Calgary campus. The answer sheets will be destroyed at the completion of the research or after a minimum of three years. No identifying information will be utilized in any subsequent publication of the research findings.

You have the right to withdraw from the research at any time. Your decision to participate in the research will not affect your participation in ECCASAT in any way.

If you are willing to participate, please read and sign the attached consent form. Thank you for your assistance. Your help in this research is important and will be greatly appreciated.

You may keep this letter as a reminder about the details of the research. If you have any questions and wish to contact me, I can be phoned at (403) 220-5040 during working hours.

Sincerely,

Leslie M. Tutty
Associate Professor
Faculty of Social Work
University of Calgary

APPENDIX B

Letter of Consent (Partner)

Dear Sir/Madame:

We are requesting your participation in an evaluation of the East Central Communities Association for Sexual Abuse Treatment (ECCASAT) funded by the Family Violence Prevention Division, Health Canada. The research is designed to study how helpful the program is for clients such as your partner. The information gathered from the research will be utilized to make any necessary changes in the program and to justify continued funding.

You will be asked to complete questionnaires at intervals of three months. The questions will take approximately 10 minutes to answer.

Your responses to the questionnaires will be kept strictly confidential and individual responses will not be shared with your partner nor with ECCASAT personnel. Only members of the research team will see the questionnaires, however, the answer sheets will be coded so that your name does not appear. Completed questionnaires will be kept in a locked office at the University of Calgary campus. The answer sheets will be destroyed at the completion of the research or after a maximum of three years. No identifying information will be utilized in any subsequent publication of the research findings.

You have the right to withdraw from the research at any time. Your decision to participate in the research or not will not affect your partner's participation in ECCASAT in any way.

If you are willing to participate, please complete the attached form, replace it in the envelope and seal it. Your partner will return it to ECCASAT.

Thank you for your assistance. Your help in this research is important and will be greatly appreciated.

You may keep this letter as a reminder about the details of the research. If you have any questions and wish to contact me, I can be phoned at (403) 220-5040 during working hours.

Sincerely,

Leslie M. Tutty
Associate Professor
Faculy of Social Work
University of Calgary

APPENDIX C

Consent Form

CONSENT FORM

I agree to participate in the evaluation of the ECCASAT Child Sexual Abuse Program, funded by the Family Violence Prevention Division, Health Canada. The analysis will be conducted by Leslie Tutty of the Faculty of Social Work, University of Calgary.

I understand that all responses will be kept completely confidential and that I may withdraw from the research at any time, without affecting my participation in the ECCASAT program in any way.

Signature: _____

Date: _____