THE UNIVERSITY OF CALGARY

IDENTIFICATION AND TREATMENT OF A SEXUALLY ABUSED CLINICAL POPULATION

by

GAYLE READ

A THESIS

SUBMITTED TO THE FACULTY OF GRADUATE STUDIES

IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE

DEGREE OF MASTER OF SOCIAL WORK

FACULTY OF SOCIAL WELFARE

CALGARY, ALBERTA

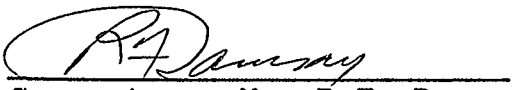
APRIL, 1987

ISBN Ø-315-35921-8

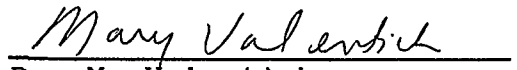
THE UNIVERSITY OF CALGARY

FACULTY OF GRADUATE STUDIES

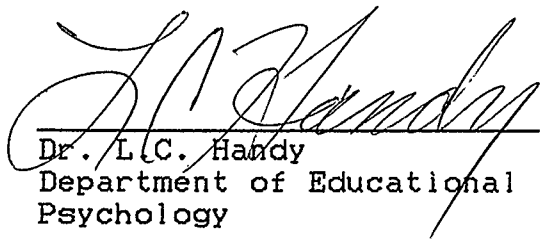
The undersigned certify that they have read, and recommend to the Faculty of Graduate Studies for acceptance, a thesis entitled, "Identification and Treatment of a Sexually Abused Clinical Population" submitted by Gayle Read in partial fulfillment of the requirements for the degree of Master of Social Work.



Supervisor, Mr. R.F. Ramsay
Faculty of Social Welfare



Dr. M. Valentich
Faculty of Social Welfare



Dr. L.C. Handy
Department of Educational Psychology

(DATE) May 1, 1987

ABSTRACT

The identification and treatment of female adult clients with histories of childhood sexual abuse were examined within a secondary data analysis. Numerous social and psychological characteristics, presenting problems, and diagnoses of sexually abused and non-abused client groups were compared. In contrast to earlier studies, treatment and therapist characteristics were also examined. Overall, the results revealed significant differences between the abused and non-abused client groups on miscellaneous background features, childhood characteristics and features of adult functioning. More specifically, moderate associations were found to exist between abuse history and the following variables: drug or alcohol use, assertiveness in speaking, sex life anxiety, number of presenting problems, childhood feelings of isolation, family alcohol history, and rated childhood quality. In spite of the therapists' considerable background training in sexual abuse, their pervasive beliefs that childhood sexual abuse negatively affects adult functioning and their reported levels of reasonable comfort with the topic of sexual abuse, the results revealed that the sexual abuse histories of the majority of abused clients were addressed in but one session of their treatment programmes and, for one-fifth of the clients, were never addressed at all.

ACKNOWLEDGEMENTS

The writer wishes to acknowledge the help and support of the following people. My thanks to Dick Ramsay, my supervisor, whose suggestions, comments, and helpful manner were very much appreciated. In addition, my thanks to Bev Shea for her warmth and guidance through the whole process of graduate school. Finally, and most importantly, I want to acknowledge the support, patience, and love of my friends and my family. My thanks to my friend and colleague Nan Ivison for proofreading my thesis. Special thanks to my husband, Don, for his encouragement, his input and editorial comments; and to my daughters Lara, and Alaina, for putting up with me when "I wasn't very nice".

TABLE OF CONTENTS

LIST OF TABLES

CHAPTER I

INTRODUCTION

Sexual abuse of children has received a great deal of attention over the past decade. Although this problem has been addressed previously, at no time in history has it commanded such wide attention by the media, researchers and clinicians. This attention has been welcomed by clinicians who have recognized in many of their clients a common history of childhood sexual abuse.

The writer's interest in this subject developed out of three years' experience as a clinical social worker in a mental health clinic, working predominantly with female adult clients. Many of these clients presenting with a wide variety of problems, admitted a history of childhood sexual abuse. Often, the abuse was not mentioned until the client was well into therapy. Frequently the disclosure was a pivotal point for the client and only after such revalations, did any real progress occur in therapy.

Although the central problem for many clients appeared to be a reaction to their early childhood experience of sexual abuse, they rarely identified past sexual abuse as the presenting problem. The writer's experience is consistent with others who found that clients sexually abused as children typically present with other problems such as depression, anxiety, parenting,

marital or other relationship problems (Bergert, 1986; Butler, 1978; Courtois, 1980; Faria & Beloklovek, 1984; Forward and Buck, 1978; Gelinas, 1983). Gelinas (1983) calls this reference to nonsexual abuse problems "disguised presentation". She believes these presenting problems dissipate only after the abuse experience comes to light and the experience itself and its aftermath are addressed in treatment. A diagnosis based on the symptoms of disguised presentation, often results in the labelling of victims of sexual abuse as neurotic, chronically depressed, or suffering from a histrionic, inadequate or borderline personality disorder (Briere, 1984). Treatment tends to be relatively unsuccessful until prior childhood sexual abuse is identified and available for treatment (Bagley and Ramsay, 1985). Once disclosure occurs, the therapist and client can decide whether the sexual abuse is relevant to the presenting problem. It may be that the past abuse becomes the focus of treatment; the abuse may be addressed in conjunction with the presenting problem; or the abuse may no longer be an issue that needs to be explored further. To the writer the most disturbing situations are those cases where the client discloses a history of sexual abuse, and the therapist chooses to not address the issue because of his or her own discomfort with the subject, lack of expertise, or else minimizes the potential harmfulness of the experience.

The study includes a secondary analysis of existing data from the clients' files and an exploratory survey of therapists' attitudes towards childhood sexual abuse. In this study, the concepts of childhood sexual abuse and sexual molestation are used interchangeably. These concepts are used in the broadest sense to include intra-familial abuse (involving members of the child's immediate and extended family, including members functioning in a familial role such as step-father or common law spouse), extra-familial abuse (involving persons known to the child and family as friends, babysitters, or acquaintances), and stranger abuse (involving persons unknown to the child or family). A standardized definition of the term sexual molestation was not possible because this definition was left up to the client.

This study approaches the issue of childhood sexual abuse from a feminist perspective. Sexual abuse is viewed as an outgrowth of the power differential that exists between men and women. This power differential is evidenced by the supremacy of males and the subordination and sexualization of women and children. Several authors have incorporated the feminist perspective along with other factors including family dynamics and the intra-psychic functioning (or dysfunctioning) of individual participants in the abuse (Anderson & Mayes,

1982; Brickman, 1984; Courtois, 1982; Deitz & Craft, 1980; Finkelhor, 1984; Giaretto, 1982; Groth, 1978a; Kaplan & Pelcovitz, 1982; Rush, 1974; Russell, 1986).

The central concern of this study is identification and treatment by mental health professionals of female adults with histories of childhood sexual abuse. The study addresses the following research questions:

1. What is the incidence of self-reported childhood sexual abuse/sexual molestation at the time of intake in an adult female clinical population?
2. How do the social and psychological variables of a childhood sexually abused client group compare with a control sample of non-abused clients in a mental health clinic?
3. How do the presenting problems and diagnoses in the childhood sexually abused group compare with a control sample in a mental health clinic?
4. Do therapists address the problem of childhood sexual abuse when identified by clients at intake and how much time do they spend addressing the problem of the abuse?
5. What are the differences in level of comfort and training between therapists who address the abuse and those who do not?

The writer expects to find prevalence levels similar to those found in studies conducted in Winnipeg, Manitoba (Briere, 1984; Jehu & Gazan, 1983) and other clinical

locations in the United States (Herman, 1981; Meiselman, 1978; Rosenfeld, 1979). These levels have been estimated to be between 23 and 44%. Social and psychological characteristics, presenting problems, and diagnoses are expected to indicate greater pathology in the sexual abuse group, than those of the control group. It is predicted that not all therapists will address the abuse problem when indicated by the client on the intake form. Those therapists with training in sexual abuse and a high degree of comfort in dealing with this topic, would be most likely to address the abuse.

This thesis is offered in an attempt to expand the knowledge base on the incidence and treatment of adults with a history of childhood sexual abuse. Research in Alberta on the incidence and characteristics of women with a history of childhood sexual abuse has been limited to university students and general population studies (Sorrenti-Little, Bagley, & Robertson, 1984; Bagley & Ramsay, 1985). Clinical population studies have been conducted in Winnipeg by Briere (1984) and Jehu and Gazan (1983). Courtois (1979) and Meiselman (1978) have conducted similar studies in the United States. Although Briere (1984) has addressed the diagnosis of Borderline Personality Disorder in sexually abused females, Meiselman (1978) is the only researcher who has investigated the incidence of presenting problems and diagnoses of clinical

sexually abused and control groups. How therapists address the abuse when identified by the client, and the therapists' training and levels of comfort in dealing with sexual abuse cases, have not, to the writer's knowledge, been investigated previously.

Childhood sexual abuse is an important social problem that affects virtually all clinical social workers. Prevalence levels in clinical populations of 23 - 44% mean that clients reporting a history of childhood sexual abuse are no longer a rare occurrence. The purpose of social work according to the National Association of Social Workers (NASW) is "to promote and restore a mutually beneficial interaction between individuals and society" (Minahan, 1981). In order to facilitate this purpose, clinical social workers must be aware that a history of childhood sexual abuse affects not only one's perception of oneself, but also one's interaction with other individuals and with society in general.

Chapter II provides a literature review of childhood sexual abuse. Chapter III presents the method by which the data were collected and analyzed. The results are presented in Chapter IV. In Chapter V the results are discussed.

CHAPTER II

LITERATURE REVIEW

The central concern of this study is childhood sexual abuse as reported by a female adult client group in a mental health clinic. This chapter, however, provides a broad examination of the literature on sexual abuse in order to comprehend the complex phenomenon of childhood sexual abuse.

Sexual abuse will be reviewed beginning with Sigmund Freud's retraction of his seduction theory through to current authors who have addressed the topic. Second, the incest taboo will be explored from biological, psychological and sociological perspectives. Third, the issue of why sexual abuse is committed more by males than females, will be addressed from a feminist perspective. Fourth, similarities and differences between intrafamilial and extrafamilial abuse will be explored by looking at personality characteristics of the perpetrator, mother, and child. Fifth, the question of harm is addressed from the point of view of people who do not believe it is harmful and those who do believe it is harmful. Negative effects of sexual abuse are further explored. Finally, literature on professionals' reactions to sexual abuse cases will be presented.

Recognition of Sexual Abuse

Perhaps the earliest recognized attempt to address childhood sexual abuse was made by Sigmund Freud. Several authors have addressed Freud's "cover-up" of his original seduction theory including Herman (1981), Masson, 1984), Rush (1977), and Russell (1986). These authors describe how Freud, in attempting to discover the etiology of hysteria, stumbled upon what appeared to be rampant sexual abuse of female children at the hands of their fathers, relatives, and trusted family friends. In 1896, Freud published "The Aetiology of Hysteria" and "Studies on Hysteria" in which he stated that the roots of hysteria lie in childhood sexual trauma. However, because of the serious implications of his findings for respectable family men, including himself, Freud was very uncomfortable about identifying fathers as the source of this abuse. Freud falsified his incest histories citing governesses, maids, and other children as the offenders (Herman, 1981). Only in two cases did he name an adult family member, an uncle, as being the perpetrator. He did admit, however, in private correspondence to his friend, Wilhelm Fliess, that the primary finding in his exploration of hysteria was seduction by the father. Within a year of the publication of his works on hysteria, Freud rejected the entire seduction theory. He concluded that his patients were lying and that the seductions were

fantasies based on the child's own incestuous desires, thus incriminating the children rather than their fathers. At this point, Freud abandoned his attempts to understand female psychology and focused his attention on the psychology of men (Herman, 1981). Freud's development of the Oedipus complex normalized incestuous wishes of children toward to the opposite sex parent, and took the focus away from parental responsibility for sexual abuse (Russell, 1986). Evidence of Freud's contribution in the denial of the reality of sexual abuse of children, has remained with us for many years with many laypeople and professions continuing to deny the existence of sexual abuse or minimize its harmful impact (Herman, 1981; Rush, 1977).

Prior to the mid 70s sexual abuse was seen as a fairly rare phenomenon that sometimes occurred at the hands of some deranged stranger. If it did occur intrafamilially, it was a subcultural phenomena which happened only in the backwoods hillbilly population, or in very dysfunctional, poor, uneducated, families who lived on the wrong side of the tracks (Finkelhor, 1984). Sexual abuse was certainly not seen as occurring across all cultural, racial, and economic lines, and possibly affecting one's neighbor, friends, or someone within one's own family. Largely due to the efforts of the women's and child protection movements, the extent of childhood sexual

abuse has come to public attention (Berliner & Stevens, 1982; Butler, 1978; Finkelhor, 1984; Finkelhor, & Browne, 1985; Herman, 1981; Meiselman, 1978; Sgroi, 1982). The number of reported cases has risen dramatically over the past ten years. Finkelhor (1984) quotes reported cases to the American Humane Association increasing from 1,974 in 1976, to 22,918 in 1982. Professionals working in the area considered these figures to grossly underrepresent actual incidents of sexual abuse. Student and general population studies conducted in the United Stated and Canada between the years 1979 and 1984 estimated that 18-30% of women had experienced serious, unwanted sexual asssault, involving at least manual interference with their genital area prior to age 18 (Finkelhor, 1979; Russell, 1983; Sorrenti-Little, Bagley, Robertson, 1984). Russell (1986) reports an even higher prevalence level of 38% overall, with incestuous abuse occurring in 16% of the cases and extra-familial abuse occurring in 31% of the cases. There is an overlap in some of the cases because some victims are abused both intra- and extra-familially. Prevalence levels among out-patient mental health clinics are slightly higher than general population figures, and have been estimated between 23 and 44% (Briere, 1984; Herman, 1981; Meiselman, 1978; Rosenfeld, 1979). Herman (1981) believes that part of the reason for fluctuations in estimates in clinic populations, has to do with the

awareness of the therapist and his or her familiarity with the indicators of sexual abuse. Increasingly more attention is being focused on empirical investigation of sexual abuse through prospective (Bagley & McDonald, 1984), retrospective (Butler, 1978; Forward & Buck, 1978; Gelinas, 1983; Meiselman, 1978), and epidemiological (Finkelhor, 1979; Greenberg, 1979; Russell, 1986) studies. These studies have attempted to increase the data base, validate or disprove past findings, and provide useful information for treatment and prevention (Bergert, 1986; Courtois, 1982; Faria & Belohlavek, 1984; Gordy, 1983; McFarlane & Korbin, 1983; Tsai & Wagner, 1978).

Origins of The Incest Taboo

Intra-familial sexual abuse or incest, is considered by many researchers to be the most common form of sexual abuse and the majority of research has focused on sexual abuse by family members (Finkelhor, 1984; Herman, 1981). However, in a recent study by Russell (1986), prevalence levels for extra-familial abuse were shown to be almost double the levels for incest. Incest is still, however, considered to be the most harmful and most complicated form of abuse because of the nature of sexual contact between relatives in a family and the dynamics this special relationship involves (Deitz & Craft, 1980; Giarretto, 1982; Hoorwitz, 1983). In order to understand

the dynamics of incest one must first of all look at the incest taboo which exists in virtually all societies (Forward & Buck, 1978).

Various explanations for the incest taboo have been postulated over the years including those that emphasized biological, psychological, and sociological factors (Forward & Buck, 1978; Herman, 1981; Meiselman, 1978). Herman (1981) addresses each of these three approaches which have achieved varied acceptance at different times. At the basis of the biological approach is the belief that the incest taboo serves the primary function of preventing inbreeding which is known to increase the incidence of stillbirths, genetic abnormalities, and mental retardation (Herman, 1981). Although this argument has certainly been overstated and the incidence of this occurrence probably highly exaggerated, the data supports the presence of such a connection between inbreeding and birth defects. Forward and Buck (1978) cite a 1967 American study in which eighteen babies of incestuous unions were compared to eighteen babies of non-incestuous unions with mothers matched for age, weight, stature, intelligence, and socio-eonomic status. In the incestuous group five babies died within six months, and only seven were free from pathology, compared to fifteen normal babies in the non-incestuous group. Similarly, in a Czechoslovakian study (cited in Forward and Buck, 1978), out of total of

161 incestuous union babies, more than forty percent suffered physical or mental defects compared to five percent in the control group. It is believed that inbreeding produces recessive traits in offspring. Although certain traits may be coded in the genes they may not manifest in offspring until two identical genes pair in an incestuous union. Herman (1981) points out that the biological explanation for the incest taboo falls short in that it addresses only intercourse with the possibility of pregnancy and does not take into account other forms of sexual contact. It also does not explain why mother-son incest is considered more detestable than father-daughter incest, both of which could produce offspring.

According to the psychological approach as presented by Herman (1981), the incest taboo is viewed as a rule governing not only intercourse but all forms of sexual expression within the family. The taboo serves the function of maintaining peaceful harmony within the family by eliminating sexual competition and jealousy, providing security and appropriate socialization, and preparing the children for leaving the nuclear family and forming a new family of their own. This view proposes a natural sexual attraction between family members with whom one lives and shares other intimate moments (Forward & Buck, 1978). A primary erotic attachment and the resultant frustration of genital sexuality between family members, supposedly aids

in the development of maturity and a sense of self that can survive frustration and disappointment, and ultimately prepares children to separate from the parents. Like the biological theory, this theory does not account for the incest taboo outside the nuclear family which would include grandfathers and uncles. Neither does this theory address the more accepting attitude found toward father-daughter incest than toward mother-son incest.

Finally Herman (1981) addresses the sociological theory which views the incest taboo as an attempt to prevent role confusion within the family. Socialization outside the family forces people to seek partners other than family members. This theory accounts for the popular view of isolated families such as hillbillies being incestuous, because of their limited options in outside contacts. Failure to develop outside commitments, results in retarded personal growth and prevents the development of a sense of community. Incestuous relationships make it very difficult to individuate and separate from the family both emotionally and physically. Family relationships are difficult enough as it is, and the development of a sense of autonomy is not an easy task. Again, this theory by itself does not explain the incest taboo, nor does it address the sex-differences in levels of acceptance of incest.

Herman (1981) points out that all three theories are

sex-biased in the observation of the incest taboo and reflect the nature of our patriarchal society. The incest taboo which governs the sexual use of females within the family, is made and enforced by men. It does not reflect the interests of the social group as a whole and reinforces the idea of ownership of females by males.

Gender Differences

It would be difficult to explore the area of sexual abuse without noting the differences in gender between those who abuse and those who are abused. Overwhelmingly, males are the abusers, and females the abused. Finkelhor (1984) states that men are the perpetrators in 95% of the abuse against females, and the perpetrators in 80% of the abuse against males. Several authors have addressed this sex difference from a feminist perspective and have offered an explanation of this sex difference in the rate of perpetration of abuse (Brickman, 1984; Courtois, 1982; Finkelhor, 1984; Herman, 1981; Rush, 1974; Russell, 1986).

Finkelhor (1984) describes four differences between men and women which make men more likely to abuse. First, men do not distinguish as well as women the difference between sexual and nonsexual forms of affection. Men, by virtue of their socialization, typically do not learn how to give and receive nurturing and affection in ways other than sexual expression. Second, men grow up with much

more ego involvement in heterosexual success. The masculine identity is very much tied to sexual prowess. Third, men's sexual interests are more likely to be focused on sexual acts which may be isolated from the intimacy of a relationship. Women focus much more on romantic encounters which include intimacy. Fourth, men typically see their sexual partners as being younger, smaller, and weaker than themselves. Women typically see their partners are older, larger, and stronger than themselves, which would make children as sexual partners seem more inappropriate. These four factors point to a difference in socialization between men and women.

Nancy Chodorow (1978), Carol Gilligan (1982), and Judith Herman (1981) have called attention to the differences in socialization between males and females. These feminist writers describe how the patriarchal family which is typical in Western society, places the father in a dominant role and mother and children in submissive roles. The father has unlimited powers ascribed to him including sexual access to his wife when he pleases (only very recently has sexual assault of one's wife been recognized as an indictable offence), and sexual control over his daughters (Herman, 1981). Traditionally, the father has been asked for the daughter's hand in marriage, thus handing sexual control over to the son-in-law. Given the power at the hands of the father, "sexual initiation

or education" of the daughter can be a distorted extension of his "rights" as a father, and is frequently cited as a rationalization for his incestuous behavior (Deitz & Craft, 1980; Hoorwitz, 1983). Females in the patriarchal family are primarily responsible for child care. Because of their central role in the rearing of children, mothers become the primary love object for both boys and girls. The realization of the power differential between men and women is handled quite differently by male and female children (Gilligan, 1982). Male children separate from their mothers who are seen as different from themselves and identify with the stronger masculine identity suppressing the nurturant, empathic side of their personality (Chodorow, 1978; Herman, 1981). Herman (1981) describes how boys realize in their love for their mothers, a rivalry with their powerful fathers. To violate this taboo would bring certain punishment and banishment from the world of adult males. Freud called this fear "castration anxiety". Boys suppress their incestuous wishes for their mothers in exchange for entry into the male world where, as adults, they too can have the same rights and privileges as their father. On the other hand, female children see their mother like themselves, and identify with the inferior role of being female. Girls through their identification with their mothers develop their nurturant, empathic side at the

expense of separation and individuation (Chodorow, 1978). Erotic interest in their fathers develops in girls as a result of males preferential treatment in society and the role model of mother serving father. Fathers are seen as having the power to make girls more superior like men. Freud coined this wish to be more like men, "penis envy". Girls' incestuous wishes toward their fathers are repressed because of fear of rejection and loss of their mothers love. This fear of loss is especially threatening to female children because their mothers remain their primary love object. Girls frustrated in their incestuous wishes toward their fathers, turn to fantasies of a relationship with other "safe" men, similar to their fathers, who will fulfill their need for attachment to a powerful figure (Herman, 1981). Although women's sense of independence and power are grossly underdeveloped, their sense of nurturance, empathy, and affection, are highly developed, and may explain why few women molest children (Herman, 1981; Gilligan 1982).

Intra-familial Sexual Abuse

In intra-familial abuse, recent attention has been focused on the family members and what commonalities, if any, exist in families in which incest has occurred. An incestuous family profile has emerged from several studies (Courtois, 1980; Deitz & Craft, 1980; Finkelhor, 1984;

Hoorwitz, 1983; Meiselman, 1978; Sgroi, 1982).

It is important to look at the mother's role in the incestuous family. From a feminist perspective, the mother is seen as also being a victim of male domination and manipulation (Brickman, 1984; Rush, 1974). It is very likely that the mother has also been a victim of childhood sexual abuse which has left her handicapped in her ability to properly nurture and care for her own children (Brickman, 1984; Finkelhor, 1984; James & Nasjletil, 1983; Meiselman, 1984; Russell, 1986). Her response to this victimization within the family may be to become "psychologically absent" (Sgroi, 1982). In most cases, the mother is a passive, dependent women unable to assert her own needs let alone her children's. Another possibility, though less common, is that she may become dominant in the family and very wrapped up in activities outside the home as a way of avoiding dealing with family dynamics. In either case the mother may be frequently absent from the home due to outside involvement, illness, or desertion (Deitz & Craft, 1980; Hoorwitz, 1983; Meiselman, 1978).

Finkelhor (1984) found that stepfathers are five times more likely than biological fathers to sexually abuse their daughters. The father or father-figure who commits incest, is unlikely to be psychotic or seriously disturbed in any psychiatric way (Kaplan & Pelcovitz,

1982; Meiselman, 1978; Rude, 1981; Sgroi, 1982). However, the abusive father may possess psychopathic or paranoid personality traits, even though these traits may not be to the degree to warrant a diagnosis of personality disorder. He may have experienced a disrupted childhood and have a distorted picture of family life based on his early experiences. It is fairly common for the perpetrator to have experienced physical or sexual abuse in his own childhood (Groth, 1978b; James & Nasjleti, 1983). His role in the family is most likely to be dominant with a patriarchal attitude toward his wife and children. Some abusive fathers have also been described as acting out their feelings of inadequacy and insecurity in a passive manner (Hoorwitz, 1983). A high level of sexual activity is frequently considered very important to his self-esteem and masculine identity (Meiselman, 1978).

The incestuous father most closely resembles the "regressed offender" as described by Groth (1978b). Up to the point of the offense, he has enjoyed normal, satisfactory peer social and sexual relationships. These offenders turn to children for sex when adult relationships become unsatisfying, stressful, or complicated. The offender when feeling cut off from others, turns to his daughter looking to her to meet his needs. The offender quite often feels remorse, shame and guilt over his behavior, but these feelings do not prevent

him from offending again. It is possible that during the sexual activity, the offender is in a state of depression in which he does not care or in a state of partial dissociation.

The onset of sexual abuse within the family often coincides with some stressful event such as unemploymment, illness, or birth of a new child (Herman, 1981; Hoorwitz, 1983). The father who was having difficulty coping to begin with, may be left in a state of anxiety which may lead to increases in alcohol consumption, impulsive behavior and sexual drive. He may also feel overwhelmed and retreat to the psychological safety of involvement with a child.

Meiselman (1978) believes that although the commonalities mentioned above may exist in father-daughter sexual abuse, no single personality factor or pattern of family dynamics is the cause of incest. Many families have similar circumstances and yet not all of these families end up in sexual abuse. Many men faced with these situations would turn to affairs, alcohol, illegal behavior, or fights. Other men turn to their daughters. It is likely, for whatever reason, that these men are pre-disposed to committing incest rather than to use more "socially accepted" ways of dealing with frustration, stress and feelings of inadequacy.

The daughter involved in incest may be a quiet,

submissive girl with low self-esteem. Her role in the family is likely to be as a substitute mother with housekeeping and childcaring responsibilities. She is likely to be seen as mature beyond her years (DeYoung, 1982; Gil, 1983; Herman, 1981; Meiselman, 1978). The ages of intrafamilial sexual abuse victims typically range between 4 and 17 years old, although victims as young as 4 months old have been identified (Gelinas, 1983; Russell, 1986). Russell (1986) reports the mean age for sexual abuse at 11 years, with girls between the ages of 10 and 13 being at the greatest risk. Cooperation of the child is gained quite easily by the abuser through various coercive techniques such as misrepresenting sex as affection or sex education, threats or bribes, and exploiting the child's need for affection, desire to please, sense of loyalty and trust of the parent (Gelinas, 1983; Courtois, 1982). Physical violence is rare in incest cases (Sgroi, 1982).

At the lower end of the age range, the sexual abuse usually consists of genital fondling, mutual masturbation, and oral-genital contact (Finkelhor, 1984; Sgroi, 1982). Incest rarely begins with intercourse. However, as the child approaches puberty around age 9 - 11, the abuse usually has progressed to intercourse (Gelinas, 1983). It is generally around this same period that the child gains an increasing awareness that the sexual activity is wrong,

but feels powerless to stop it (Kempe & Kempe, 1984). The child also feels a deepening sense of responsibility and guilt because it may have felt good at some level, and because she/he let it go on so long (Butler, 1978, Gelinas, 1983; Herman, 1981; Sgroi, 1982). These feelings, along with confusion, fear of punishment, abandonment, being blamed, or not being believed serve to keep the victim silent.

Duration of abuse varies from a single incident to multiple incidents over a 10 year period (Finkelhor, 1984; Gelinas, 1983; Russell, 1986). In Russell's 1986 study, 43% of the cases of incestuous abuse occurred only once, and in 35% of the cases it occurred over a period of less than 6 months. In only 10% of the cases did the abuse occur over a period of 10 years. Abuse is usually terminated by age 14 or 15 by the child's running away, purposeful disclosure or accidental disclosure as in the case of venereal disease or pregnancy (Sgroi, 1982). As victims approach mid-adolescence, they are more powerful, more involved with peers outside the home, and better able to terminate the abuse (Meiselman, 1978).

Disclosure can be almost as devastating and confusing for the incest victim as the actual abuse (Courtois, 1982; Herman, 1981). If the non-abusing parent fails to support and believe the child, the victim can be pushed even further into despair. Loyalties become

confused and the victim may end up feeling even more betrayed and isolated. It is much easier for a parent to be supportive when the abuser is a stranger than when the abuser is a friend or family member.

Extra-Familial and Stranger Abuse

Generally, sexual abuse by someone outside the family, even though there is increased risk of greater physical trauma to the child, is much easier for the victim and the family to deal with (Sgroi, 1978). Because there are no threats to family loyalties and integrity, it is easier for the parents to be understanding and supportive of the child, and to unite against a common enemy.

Mothers of victims of extra-familial and stranger abuse have many characteristics in common with mothers of incest victims. Feminists would see the mother as a victim whose response may be physical or emotional absence. In addition, role model theory suggests that daughters with mothers who are powerless, dependent, and obedient, may may take on similar characteristics to their mothers. Both of these factors may contribute to the child being more as risk (Finkelhor, 1984; Herman, 1981). Sgroi (1982) reported that the majority of mothers of victims of extra-familial abuse, are single parents who may directly or indirectly expose children to abuse

through male acquaintances and/or poor supervision. In addition, research suggests that mothers of victimized children are less likely to discuss sexuality with their children and more likely to be punitive about sexual matters, possibly because of their own victimization as a child (Sgroi, 1978).

Feminists would argue that it is much too easy to blame the mothers for failure to protect and nurture the children. It should be emphasized that fathers also have responsibilities to help meet the emotional needs of the children. Unfortunately, many fathers do not see this as part of their role, preferring instead to remain somewhat distant, and to leave the nurturing up to the mother. If both mothers and fathers are emotionally unavailable to their daughters, the situation can arise where daughters with unmet emotional needs, who feel isolated and unloved, may be more vulnerable and susceptible to attention and affection from strangers or acquaintances. Finkelhor (1984), believes that the physical and emotional presence of friends and family may act as a deterrent to potential abusers, and reduce the susceptability of the child to the abusers attempts at manipulation.

Meiselman (1978) stresses that although certain family factors may make children more at risk in relation to the manipulative tactics of the sexual offender, these factors can not be held responsible for the occurrence of

sexual abuse. Certainly, many children from good, solid, caring families also become victims of extra-familial or stranger abuse. A recent tragic case, reported in the newspapers, of a young Toronto teenager who was raped and murdered after being lured from her home by a bogus phone call from someone claiming to be a photographer, demonstrates the clever and manipulative tactics sometimes used by the extra-familial or stranger sexual offender.

Individuals who molest children previously unknown to them or only vaguely associated with them, are described by Groth (1978b) as "fixated offenders". These offenders are most like pedophiles or "lovers of children". Groth (1978b) found that 85% of the fixated offenders were either complete strangers or only casually acquainted with the children. With the fixated offender, the behavior is chronic rather than acute as it is in the regressed offender. The offender typically does not feel intense guilt or shame for his behavior because it seems normal to him. Sexual activity with children may become an obsession where thoughts of children occupy much of his time. The psychosocial development of the fixated offender has been arrested in childhood and the sexual interest in children has been present since adolescence. During adolescence the offender typically avoided usual socialization with peers, including dating. As an adult he does not initiate social or sexual activity with people

his own age, because of shyness, anxiety, fear of rejection and the absence of feelings of sexual stimulation. If others initiate the contact he may become temporarily involved but does not maintain the relationship because it does not feel comfortable to him (Geizer, 1979). The difficulty with normal adult relationships experienced by these offenders is supported in a study by Groth (1978b) in which he found that only 12% of fixated offenders had been married, as compared to 75% of the regressed offenders, who had been married (Geizer, 1979).

Children who become victims in extra-familial and stranger abuse are similar in many ways to incest victims. Both groups of children suffer from low self-esteem and lack of assertiveness. Perpetrators have stated that they select their victims according to how shy, alone, and vulnerable they appear (Groth, 1978b). These children are more likely to respond to a kind word and attention from strangers. The children may come from families where there is little affection or attention or where there are many family problems that leave the children feeling alone and unloved (Sgroi, 1978).

A Question of Harm

Over the past decade, the increased attention focused on sexual abuse, and apparent abuse of power on the part

of males, has created a serious challenge to traditional male dominance. This threat has, not surprisingly, resulted in a defensive response, which proposes that sexual abuse, in particular incest, is not as harmful as we are led to believe (Henderson, 1983; Herman, 1981; Russell, 1986). This movement has been termed 'the pro-incest lobby' by De Mott (1980). It is no surprise that men's sex magazines have promoted the idea that incest is harmless. Perhaps more surprisingly, however, is the promotion of this belief by well known and influential professionals including Sigmund Freud and Alfred Kinsey (Russell, 1986). Freud's suppression of his seduction theory has already been presented. The Kinsey Report was a well known piece of research on sexual behavior of males and females. It is interesting to note that although Kinsey saw evidence of sexual abuse of children in his study, he placed little significance on this finding (Herman, 1981; Russell, 1986). He believed that incest was more in the imagination of psychotherapists than it was an actual experience of the client. Kinsey also expressed surprise that a child should be upset at having his or her genitals fondled by a stranger (Finkelhor, 1979; Russell, 1986).

Several clinicians and authors argue that some incest experiences may actually be beneficial, and suggest that the guilt over breaking the incest taboo may be much more

harmful than the incest itself (Henderson, 1983). We are told that men who abuse, again in particular fathers or father figures, are not to blame and did not do any harm. Henderson (1983) quotes several studies claiming to support the belief that incest is not necessarily a harmful experience. In the Rasmussen study (1934, cited in Henderson, 1983), 46 out of 54 sexually abused children in a hospital setting, were believed to have made a normal adult adjustment. This conclusion was based on the subjects not being in difficulty with law enforcement agencies and showing satisfactory citizenship. Yorokoglu and Kemph (1966) concluded on the basis of 2 case studies that incest may not impair future functioning if the child at the point of abuse, has a reasonably healthy ego. This study suggests that incest is not so much the problem as the child's ego state prior to the incest. Herman (1981) quotes sociologist James Ramey's statement "that we are in the same position regarding incest today as we were a hundred years ago with respect to our fear of masturbation." Ramey claims that the reluctance of incest victims to testify in court against the offender supports his claims, and that social intervention is at the root of any negative consequences of incest. He believes that the great increase in women's accounts of the harmful effects of childhood sexual abuse are the result of women's suggestibility as well as their manipulation by the media.

Support for the sexual abuse of children has been couched in the argument of the "sexual liberation" of children. Larry Constantine (cited in Henderson, 1983), attacks society's prudishness and lack of respect for children's sexual rights based on his examination of thirty studies consisting of 2500 sexual abuse cases. In all but one of the studies some negative outcomes were found. Constantine, however, focused only on the six studies which claimed to show some positive or neutral effects. It is interesting to note that these cases consisted primarily of sibling incest rather than adult-child abuse. Further, he states that "legitimate sexual experiences are those in which the child is sexually knowledgeable and fully comprehends the activity, to which he or she freely consents ...". This argument fails to recognize that children are not developmentally mature enough to fully comprehend the sexual activity. Neither are they in a position, because of unequal power, to "give consent" (Russell, 1986).

Negative Effects of Sexual Abuse

Finkelhor (1984) suggests there are three arguments frequently made against adults having sex with children. First, sex is seen as "instrinsically wrong" between adults and children because of biological and

psychological reasons. The biological reason given is that a young girl's vagina is too small to accommodate an adult male's penis. Psychological reasons consist of the disgust most adults have for the idea of sexual relations with a child. This is supported by the incest taboo that exists in most societies. Finkelhor points out, however, that similar arguments of "intrinsic wrong" have been used against homosexuality and masturbation, which reduces its credibility as a viable argument. The second argument consists of opposition to the premature sexualization of the child. Childhood is viewed as a period that should be free from the complications of sexuality. Again, Finkelhor points out that this argument fails to recognize that children are naturally curious about sexuality and do explore their own sexuality through self-stimulation and sex play with peers. In fact, many professionals argue that sexual interest and play with peers during childhood is a necessary part of normal healthy adult sexual functioning. The third argument is simply that adult-child sexual activity is harmful. This argument is supported by increasing reports by clinicians of cases of dysfunctional adults who report a common history of child sexual abuse. As Meiselman (1978) points out, it is difficult to prove an absolute causal relationship between past sexual abuse, or any other past experience for that matter, and current functioning. However, if certain

characteristics are more frequently associated with a history of sexual abuse than with a history of no sexual abuse, there is certainly reason to believe that a causal relationship exists.

Finkelhor and Browne (1985) have identified four traumagenic dynamics that contribute to the consequences of child sexual abuse. These dynamics include traumatic sexualization, betrayal, stigmatization, and powerlessness. Considered individually, these dynamics are not unique to sexual abuse; however, the combination of the four dynamics make sexual abuse different from other childhood traumas. Finkelhor and Browne (1985) describe how the abuse victims' cognitive and emotional orientation to the world are distorted by these dynamics.

Traumatic sexualization refers to children's sexuality being shaped in a inappropriate manner. For example, children may be rewarded for sexual behavior through affection, attention, gifts, or privileges, thereby teaching children that sex can be used to manipulate others. The offender misrepresents sex and morality and children are left confused and uncertain about what is appropriate behavior. Sex may also take on very negative connotations because it is associated with painful events.

Betrayal refers to children being manipulated by someone whom they trusted and depended on for support and protection. Not only the offender, but other family

members who fail to support and believe the children, can contribute to feelings of betrayal. Powerlessness refers to children feeling trapped and being unable to protect themselves. Children's bodies are invaded against their will, and they are unable to stop the abuse. Stigmatization refers to the negative connotations associated with the abuse. The need to keep the activity secret and children's perceptions of the activity as deviant and taboo contribute to these negative connotations which are incorporated into the child's self-image.

The effects of childhood sexual abuse on current functioning as well as later functioning in adult life, have been well documented in the literature (Bagley, 1984; Bagley & Ramsay, 1985; Briere, 1984; Browne & Finkelhor, 1986; Courtois, 1979; Faria & Beloklavek, 1984; Finkelhor, 1984; Gelinas, 1983; Herman, 1981; Jehu and Gazan, 1983; Meiselman, 1978; and Tsai & Wagner, 1978). Bagley (1984) estimates that at least twenty-five percent of girls who are sexually abused within their families have long-term adjustment problems, while a further twenty-five percent have chronic personality problems. In a review of the research on childhood sexual abuse, Browne & Finkelhor (1986) identified the following long-term effects of earlier childhood abuse on current adult functioning: "depression and self destructive behavior, anxiety,

feelings of isolation and stigma, poor self-esteem, difficulty in trusting others, a tendency toward revictimization, substance abuse and sexual maladjustment". Gelinas (1983) also identified marital difficulties, increased risk of physical and emotional abuse of the children of sexual abuse victims, and increased intergenerational risk of incest of the victim's own children by her spouse or partner. Of the many possible consequences of earlier childhood sexual abuse, Jehu and Gazen (1983), believe the most likely emotional problems are those of guilt, depression, and low self-esteem.

Tsai and Wagner (1978), claim universality for guilt among women sexually abused as children, and believe this to be due to the victim's feelings of shame which helped keep the abuse secret, the possibility of the body physically responding and obtaining some pleasure from the abuse, vengeful angry feelings toward the parents, the victim blaming herself for allowing the abuse to continue so long, and disruption to the family resulting from disclosure. The guilt and feelings of helplessness, hopelessness, and despair contribute to depression.

Depression is the most common symptom reported by women who were sexually abused as children (Browne & Finkelhor, 1986). In a survey of college women, Sedney & Brooks (1984) found that 65% of the women who reported a

history of sexual abuse also reported symptoms of depression compared to 43% in a control group. Bagley & Ramsay (1985) in a community mental health survey, reported that the sexually abused group scored more depressed (17%) on the Center for Environmental Studies Depression Scale (CES-D) than did the group of nonabused subjects (9%). Clinical population studies report that 35% (Meiselman, 1978) and 60% (Herman, 1981) of the sexual abuse group suffer from problems with depression; however, no significant differences were found with the control groups. Comparisons of sexually abused clinical groups to control groups of non-abused clinical clients are less likely to yield significant differences because both groups are more likely to be experiencing depression than would members of the general population.

Bagley & Ramsay (1985) have provided evidence in their community mental health survey that supports the development of a negative self-concept in subjects who had been sexually abused as children. These authors found that women with poor self-esteem were four times more likely to report a history of childhood sexual abuse. Courtois (1979) found that 87% of the female sexual abuse victims in a research study reported their sense of self as being moderately to severely affected. Herman (1981) reported 60% of the incest sample had a negative self-image. Several authors have commented on the serious

effects of sexual abuse on normal adolescent developmental tasks such as the development of a sense of self and development of positive self-esteem (Brooks, 1985; Burgess & Holmstrom, 1985; Gaddini, 1983; Galambos, 1984; Lubell & Soong, 1982; Shen, 1982). Finkelhor (1984), comments not only on the detrimental effects of sexual abuse on a child's self-esteem, but also on his/her ability to form healthy sexual and intimate relationships. An individual's perception of him/herself not only affects how he/she feel about himself/herself but also influences his/her interactions with others (Anderson & Lauderdale, 1982; Gil, 1983). The sexual abuse victim's interpersonal relationships are characterized by feelings of being different from others, feelings of isolation, alienation, mistrust and insecurity (Bergert, 1986; Browne & Finkelhor, 1986; Jehu & Gazan, 1983). Branden (1969) states: "there is no value judgment more important to man (or woman), no factor more decisive in his (or her) psychological development and motivation, than the estimate he (or she) passes on himself (or herself)." He continues: "The nature of this self-evaluation has profound effects on man's (or woman's) thinking processes, emotions, values, and goals. Self-esteem is the single most significant key to his (or her) behavior." One of the most important factors contributing to the development of self-esteem is the nature of early family experiences

and the amount of respectful, accepting and concerned treatment an individual receives from significant others in his/her life (Clark, 1978; Coopersmith, 1967; Briggs, 1975; Felker, 1974). If early experiences are negative, as in the case of the sexual abuse victim, the child will likely have a very negative self-image and low self-esteem (Samuels, 1977). The person with low self-esteem lacks respect for him/herself and believes he/she is incapable, insignificant, unsuccessful, and unworthy (Adams, 1978; Coopersmith, 1967; Maslow, 1973). In addition, the person who has been victimized as a child may come to identify him/herself in a victim role, increasing the likelihood of further victimization (Meiselman, 1978; Sanford & Donovan, 1984). Victims often confuse guilt, sex, and love and end up being used as a sex object and exploited in future relationships in their search for acceptance and love, or become promiscuous or turn to prostitution as a form of self-punishment (James & Meyerding, 1977).

Meiselman (1978) reported that the most striking finding in her sample of 23 case histories of sexual abuse victims consisted of complaints of sexual difficulties. Serious sexual problems at some time since the abuse were reported in 87% of the cases compared to 20% in a control group. Courtois (1979), also reported that 80% of incest victims suffer from sexual difficulties. In only a minority of cases, sexual problems were the reason for

seeking treatment. It is more common for sexual complaints to be found in among other complaints of personal difficulties. The sexual complaints include frigidity, promiscuity, and confusion of sexual identity.

Forward and Buck (1978) believe that incest in particular, is "almost always a devastating experience for the victim because of our cultural reactions to incest, the child being thrust into an adult role they are not prepared for, and the perpetrator's betrayal of the child's trust and innocence." The effects of the incest experience can become even more incapacitating with the passage of time and lack of treatment (Bagley & Ramsay, 1985). Several factors contribute to the degree of traumatic effects of child sexual abuse (Adams & Tucker, 1982; Courtois & Watts, 1982; Geiser, 1979; Groth, 1978b; Sgroi, 1982). The traumatic effects are less if the attacker is a stranger rather than someone the child knows and trusts such as a family member, friend, or neighbor. The trauma is also less if it is a single incident rather than repeated incidents. If the incident did not involve force or injury, and if actual penetration or intercourse did not take place, the effect is often less damaging. The trauma is also reduced if the child is able to report the abuse to a supportive adult and if the child receives counselling. Trauma tends to be less if the child is not forced to go through prolonged police and court procedures

especially at the hands of untrained or insensitive staff members.

Professionals' Reactions

There is little doubt that the way cases are handled by various professionals can either negatively or positively effect the victims' adjustment (Alexander, 1980; Courtois & Watts, 1982). Professionals involved in sexual abuse cases include child welfare workers, police, crown prosecutors, judges, and mental health therapists. All of these professionals have important roles to play in the handling of sexual abuse cases. However, it is the mental health therapists' specific job to aid the victims of sexual abuse in their adjustment through the therapeutic process. The attitudes and level of comfort that therapists have with regard to sexual abuse in general and sexual abuse victims in particular, unquestionably effect not only the way the cases are handled but may also contribute to whether the abuse is addressed or not in therapy.

Little research to date, has been conducted on professional or lay attitudes toward sexual abuse, or professionals' level of comfort in dealing with sexual abuse cases. The majority of studies have been conducted on attitudes toward adult victims of rape (Alexander, 1980; Resick & Jackson, 1981; King, Rotter, Calhourn &

Selby, 1978; Feild, 1978). These studies indicate that professionals' attitudes appear to focus around the amount of responsibility for the assault to be attributed to the victim. Professionals have many conflicting views on victim responsibility in cases of adult sexual abuse. The amount of responsibility attributed to the victim is often judged according to several factors including the victim's marital status, manner of dress, time and place of assault, whether the perpetrator was known to the victim, and amount of victim resistance as indicated by extent of physical injury that occurred during the assault (Alexander, 1980). The possibility that many of these same attitudes exist with regard to childhood sexual abuse was demonstrated recently in a newspaper story in which a sexual assault case was dismissed in court because the judge believed that the five year old victim behaved in a seductive manner.

Summit & Kryso (1978) addressed the difficulty people have in general with accepting that children are sexually abused. Topper & Aldridge (1981), believe that we are all conflicted about sex and sexuality, especially where children are concerned. Sexuality in children is often denied and certainly any feelings of sexual attraction to children are not acknowledged to ourselves let alone anyone else. All of us, professional and lay people, feel uncomfortable and are angered and disgusted by reports of

sexual abuse, especially at the hands of those very people who are supposed to care, love and protect the child. Some individuals react to this extreme discomfort, with the denial of the existence of child sexual abuse, others minimize both its occurrence and its effects. In order to protect themselves and their families, many choose to view sexual abuse victims and perpetrators as very different from themselves and their families. They may even see the victims as seductive or at least not resisting the sexual activity (Weaver & McCarthy, 1981). This view somehow protects people from the frightening reality that it could happen to their children, and that someone close to them that they love and trust could offend against their children. The presence of these attitudes and discomfort can seriously affect the professional's ability to work effectively with victims of sexual abuse.

Finkelhor (1984) points out a difference between the way professionals handle cases of intra-familial abuse versus extra-familial abuse. There appears to be a greater emphasis on catching and punishing the offender in the case of extra-familial and stranger abuse. When family members are involved, there may be a greater concern with protection issues through child welfare and more of a reluctance to refer to police. Depending on the professional's view of sexual assault, the focus may be on punishment if sexual assault is viewed as a crime,

individual psychotherapy if viewed as mental illness, or family therapy if viewed as family dysfunction. The result of these differing opinions and focuses, are addressed by Berliner & Stevens (1982) and McFarlane & Bulky (1982) who cite cases of conflict among agencies involved, lack of consistency in handling cases, and inexperienced therapists handing cases. All of these concerns leave many professionals frustrated and worried.

Professionals must examine their own values and beliefs and resolve their own feelings of anger and ambivalence by coming to terms not only with their own history with regard to sexuality, but also with their fears with regard to children's sexuality and sexual abuse (Courtois, 1982; Gelinas, 1983; Meiselman, 1978). Certainly, not all professionals have an interest in working in the area of sexual abuse, nor are all professionals suitable for this work. Recognition on the part of the therapists of their own level of comfort and interest in working with these cases is an important awareness since almost all therapists will come in contact with such cases.

CHAPTER III

METHOD

Research Design

The research design was a comparative study of clinical records for two groups of adult female clients at a mental health clinic, one group who had a history of childhood sexual abuse and one who had not. The project had two components. One component was concerned with the determination of the differences between the social and psychological characteristics of a clinical group of adult females with a history of childhood sexual abuse with a group of non-abused adult females. The second component consisted of a determination of the treatment considerations for members in the abused group including their diagnoses, amount of time spent by therapists addressing the clients' abuse history, and characteristics of the therapists.

In the first component, the dependent variables selected were a number of social and psychological characteristics including miscellaneous background features (e.g. marital status, previous counselling, hospitalization for an emotional problem, use of prescription drugs, and alcohol or drug abuse), presenting problems, diagnoses, childhood characteristics, and characteristics of current adult functioning. To reduce

the researcher's subjectivity in the classification of these characteristics, information about these variables was limited to that which was readily available on the intake form and intake assessment. The independent variable reflected the characteristics of the two client groups, those who reported a history of childhood sexual abuse and those who did not.

In the second component, the independent variables selected were therapist characteristics reported by the therapists; specifically, years of therapeutic experience, amount of sexual abuse training, and degree of personal discomfort in dealing with sexual abuse issues. In all cases, the dependent variable was the amount of time spent by the therapist addressing the abuse.

Population and Sample

The sample frame was drawn from a client population at a government community mental health clinic in a medium size city in the province of Alberta. Clients at this clinic are seen on a referral basis through either self-referral or referral by their physician, probation officer, child welfare worker or other related professionals. Although this clinic serves men, women and children, only adult female clients were included in the sample frame. More specifically, the study population consisted of all new adult female intakes (N=156) of this

clinic assigned to four therapists on the adult team. It was necessary to eliminate 21 incomplete files, which reduced the total number of files (N=135). The intake period extended from September 1, 1985 to November 1, 1986. The experimental group (N=42) consisted of all adult female clients who recorded a history of childhood sexual abuse on the Clinical Intake Form, or reported such a history to the therapist in the Clinical Intake Assessment. The comparison group (N=93) consisted of the remaining female client files.

The therapist group was comprised of four therapists on the adult team. Two therapists were eliminated from the original adult team of six members because they carried specialized caseloads. Due to the small number (N=4) of therapists surveyed and the risk to anonymity, the therapists were not identified by age, sex, or professional discipline. However, both male and female therapists who represented the disciplines of psychology, social work and psychiatric nursing, were included in the study.

Materials and Procedures

A secondary analysis method was used for the first part of the study to collect data from an existing data base at the mental health clinic. Informed consent was obtained from the clinic director prior to consulting the

data base (Appendix 2). The data base contained information taken from the Clinical Intake Form completed by all adult clients who presented at the clinic. The form included questions about the clients' presenting problems, childhood history, and the goals they would like to accomplish through therapy. In addition, the data base included both the Clinical Intake Assessment and session-by-session progress notes that the therapists were required to complete on each of their clients. In these progress notes the therapists outlined briefly what topics had been addressed in each session. Social and psychological characteristics of the clients were taken directly from the Clinical Intake Form completed by the client and this information was transferred onto a data collection sheet (Appendix 3). The data collection sheet was tested in a pilot study of 15 files in order to rule out any obvious difficulties or omissions. Minor revisions were made following the pilot study to include two relevant questions which had been previously ommitted. Although neither the intake form nor the intake assessment procedures had been designed for research purposes and, therefore, were not assessed for reliability or validity, it is the case that these materials were completed in a consistent manner, according to clinic policies. In a few cases, however, the intake forms had not been completed because the clients either ignored the form completely or

did not respond to the questions about childhood history or about current goals. These files were eliminated from further analysis (N=21). Following the completion of the data sheets, the sheets were numbered and kept in a separate file for each therapist.

For the second part of the study, a Therapist Questionnaire was constructed by the writer. The Therapist Questionnaire contained questions about the levels of the therapists' training and discomfort in dealing with sexual abuse in situations ranging from the client presenting with the problem of past sexual abuse, to the client not presenting with the problem of past sexual abuse but the therapist having reason to believe that it may have occurred (Appendix 4). A pilot study was conducted to reduce any ambiguities in the understanding or interpretation of the Therapist Questionnaire. The questionnaire was individually administered to the therapists after obtaining informed consent (Appendix 5). The therapists were asked to complete the questionnaire, place it in an envelope and seal it. They were asked to put their name on the outside of the envelope to match the questionnaire with the file collection sheets for each therapist. The data were given to an assistant who removed the questionnaire from the sealed envelopes and assigned a code letter to each of the four sets of data. The data sheet codes consisted of the same letter added to

the already numbered data sheets. The envelopes with the initials were discarded. At this point the identities of the therapists and their clients' files were unretrievable.

Neither the data collection sheet nor the Therapist Questionnaire were assessed for reliability and validity, although both were considered to have face validity.

Limitations in Data Collection

Since the data were collected from existing file information, only the information recorded in the file was accessible to the researcher. As a result, there were constraints or limitations in data collection and interpretation. First, the definition of the term sexual molestation as contained on the clinical intake form was left up to the client and, no doubt, their definitions were quite variable. Second, there was no way to identify important variables about the childhood sexual abuse experience, for example, the identity of the perpetrator, type of abuse, duration of abuse, degree of coercion or force, and the way in which the abuse was handled by the family. All of these abuse variables contribute to the effects of childhood sexual abuse on later adjustment in adulthood. Therefore, the study population included people who may have been negatively affected by the abuse and others who may not have been negatively affected.

Similarly, of those who were negatively affected, some may have already worked through the abuse experience, and others may have been suffering from such negative effects at the time of referral to the clinic. Needless to say, no identification of these different subgroups could be made. Third, standardized, objective measures were not used, and the data were based on clients' subjective evaluation of outcome variables. Fourth, since information with regard to treatment was limited to the file progress notes, the researcher was forced to rely upon the therapists' recording skills and their thoroughness in completing the progress notes. For example, even when sexual abuse was discussed, some therapists may have recorded the discussion while others may not have. The writer had to assume, therefore, that if the discussion of sexual abuse was not noted in the file, its discussion did not take place.

The data collected through the therapist questionnaire was intended to be only exploratory in nature and was of limited utility, because of the extremely small sample size (N=4) from which definitive conclusions could not be drawn. In addition, in order to preserve anonymity of the therapists, it was necessary to eliminate possible identifying information. Whereas information about the therapists' age, sex, and discipline would have been interesting and relevant to the study, it

is hoped that future studies in which a larger sample of therapists is available will explore the relationship between these variables.

Finally, it should be noted that the descriptive and corelational results may only be generalized to other investigations of clinical populations. It is recognized that attempts to draw statistical comparisons between samples of adult women seeking treatment and general populations may give a biased view of the effects of sexual abuse. The fact that the clinical group as seeking psychiatric treatment indicates that they may have had greater pathology than members of the general population. At the same time, comparisons of sexually abused groups to other clinical non-abused clients may fail to show significant differences because of the overall pathology present in people who seek psychiatric treatment. In the Results and Discussion sections to follow, comparisons to other studies will be limited primarily to other studies which focused on clinical populations.

CHAPTER IV

RESULTS

A total of 156 files were examined. Twenty one files were eliminated because either the form was missing or the client had not responded to the questions with regard to childhood characteristics or current characteristics of adult functioning. Of the remaining 135 files, 42 clients or 31% of the total client group, reported a history of childhood sexual abuse as indicated by the Clinical Intake Form or the Clinical Intake Assessment. This figure falls within the range of reported sexual abuse in other studies which have found the incidence of sexually abused females in clinical populations to be between 23 and 44% (Briere, 1984; Herman, 1981; Jehu & Gazan, 1983; Meiselman, 1978; Rosenfeld, 1979). The comparison group consisted of the remaining 93 clients, or 69% of the total client population and who did not report a history of childhood sexual abuse.

The data were examined for differences in the frequencies of occurrence of the various characteristics between the sexual abuse and comparison groups by use of chi-square analyses. The criterion for all analyses and comparisons in this research was significance at the .05 level. Phi coefficients (for 2x2 tables) and Cramer's V statistics (for larger tables) were used to determine the magnitude of the relationship between the two variables

for which a significant chi-square was obtained. Scores of .30 and over were considered to be indicative of moderate association and possibly have predictive value. It should be noted that previous clinical studies have usually provided only percentage comparisons, in some cases chi-square analyses, but none have calculated the degree of relationship between the abuse variable and other client characteristics. Table 1 presents a listing of all of the characteristics for which significant chi-square values and phi/Cramers V were obtained. Although relative frequencies (percentages) are provided in the table, the chi-squares were calculated on the basis of the obtained frequencies. Tables 2 through 5 provide more detailed representations of certain characteristics.

In a few cases, presentation and discussion are provided for characteristics on which the two groups did not differ significantly. In these cases the reseacher felt this information was important regardless of the lack of statistical significance.

Social and psychological characteristics

As shown in Table 2, the age range for the clients was between 18 and 60 years old; the mean age for the total client group was 32.5 years with a standard deviation of 9.06. There was a significant difference by t-test between the sexual abuse and comparison groups,

TABLE 1
Client characteristics for clients in the sexually abused and comparison groups.

Client Characteristics	Group: Sexual Abuse %	Group: Comparison Group %	Chi-Square	df	p	Phi/ Cramer's V
Background features						
Separated/Divorced	52.4	29.0	8.31	3	.040	.25
Previous counselling	85.7	57.0	9.39	1	.002	.28
Previous hospitalization	33.3	14.0	5.62	1	.017	.22
Prescription medications	50.0	30.1	4.13	1	.042	.19
Drug/Alcohol abuse	47.6	12.9	17.41	1	.000	.38a
Presenting problems						
2 or more presenting problems	70.7	32.3	15.57	1	.000	.36a
Diagnoses						
2 or more assigned diagnoses	52.4	25.8	7.95	1	.005	.26
Depressive Disorder	40.5	23.7	3.21	1	.073	.17
Personality Disorder	47.6	23.7	6.67	1	.010	.24
Adjustment Disorder	28.6	58.1	8.93	1	.003	.27
Childhood Characteristics						
Isolation	14.3	0.0	10.74	1	.001	.32a
Alcoholism	47.6	16.1	13.35	1	.000	.33a
School failure	40.5	15.1	9.18	1	.002	.28
Parental Disinterest	35.7	16.1	5.34	1	.021	.22
Strict discipline	42.9	19.4	7.02	1	.008	.25
Poor Childhood Quality	50.0	8.6	32.75	2	.000	.49*a
Current Adult Functioning						
Depression	88.1	67.4	5.37	1	.020	.22
Anxiety/Guilt	83.3	58.7	6.78	1	.009	.24
Difficulty sleeping	64.3	44.6	3.73	1	.053	.18
Upset with criticism	59.5	38.0	4.54	1	.033	.20
Difficulty speaking up	71.4	35.9	13.24	1	.000	.33a
Anxious re: sex life	33.3	8.7	11.02	1	.001	.31a

* = Cramer's V
a = moderate strength of association

with the sexual abuse group being slightly younger with a mean age at 30.2 and the comparison group mean age at 33.5, t (df=133) = 2.01, p<.05. Briere (1984), Herman (1981) and Meiselman (1978) have reported slightly younger means for both group with no significant differences found.

Significant chi-square values were obtained for a number of miscellaneous background features indicated in Table 1. In what follows each of these significant outcomes will be described and, where appropriate, reference will be made to earlier work that provided comparative data. First, with regard to marital status, clients in the sexual abuse group were more likely to be separated or divorced than members of the comparison group (52.4% compared to 29.0%). However, the Cramers V value reflected only a modest relationship and indicates that, in spite of different patterns of frequencies in the two groups, knowledge of this information alone would not substantially enhance predictability as to an incoming client's background with respect to abuse. Previous studies have reported a much lower incidence of separation and divorce within clinical sexually abused groups, ranging from 27.5% (Herman, 1981) to 22.9% (Jehu, Gazan, & Klassen, 1985) to 18% (Meiselman, 1978). The distribution of clients with regard to marital status is shown in more detail in Table 3.

TABLE 2

Ages at intake for clients in the sexually abused and comparison groups.

	Group	
Ages	Sexual abuse	Comparison
	%	%
18 - 25	28.6	17.2
26 - 30	31.0	24.7
31 - 35	16.7	22.6
36 - 40	11.9	15.1
41 - 60	11.9	20.4
Total	100.0	100.0
Mean Age	30.5	33.5

TABLE 3

Marital status for clients in the sexually abused and comparison groups.

	Group	
Marital status	Sexual abuse	Comparison
	%	%
Never married	14.3	12.9
Married	33.3	55.9
Separated/divorced	52.4	29.0
Other	0.0	2.2
Total	100.0	100.0

Further with reference to Table 1, the abuse group was more likely to have received previous counselling (85.7% compared to 57%). Similarly, the abuse group was more likely to have been previously hospitalized for an emotional problem (33.3% compared to 14%). These figures are higher than those reported in previous studies which failed to show significant differences between abused and non-abused females (e.g. Briere, 1984; Meiselman, 1978). The members of the abused group were more likely to be taking prescription medication at the time of referral (50% compared to 30.1%) and reported significantly more incidence of alcohol and drug abuse (47.6% compared to 12.9%). Both of these results are similar to those obtained in earlier research (Briere, 1984). It should be noted that all of the above associations were fairly weak with the exception of alcohol and drug abuse which had a moderate association (.38). Finally, whereas Briere (1984) found that the sexual abuse group was more likely to report feeling suicidal, this study failed to support his finding. However, Briere (1984) did not test for the strength of this association, therefore, conclusions based on his data should be tentative.

As shown in Table 4, only 5 of the 42 clients, or 12 percent of the total abuse group, presented with sexual abuse as the problem. Briere (1984) reported a much larger percentage (39%). He, however, believes that this

TABLE 4

Percentages for presenting problems at intake for clients in sexually abused and comparison groups.

Problems	Group	
	Sexual Abuse	Comparison
	%	%
Depression	58.5	46.2
Anxiety	9.8	6.5
Relationship problems	56.1	43.0
Sexual abuse	12.2	0.0
Sexual dysfunction	2.4	0.0
Other	53.7	37.6

*totals do not equal 100% because clients may have 1 or more presenting problems

TABLE 5

Percentages for childhood quality for clients in sexually abused and comparison groups.

Quality	Group	
	Sexual Abuse	Comparison
	%	%
Good	7.1	35.5
Average	42.9	55.9
Bad	50.0	8.6
Total	100.0	100.0

finding may be due to a 'self-selection' factor since the clinic is well known in providing service to victimized women. The most frequent presenting problems in the abuse group were depression (57%), relationship problems (55%), and the "other" category (52%) which included low self-esteem, dealing with the past, difficulty with anger control, understanding self, difficulty coping, and sexual abuse of their own children. There were no significant differences in the frequencies of specific presenting problems of the sexual abuse and comparison groups, and earlier studies have also failed to show differences (Briere, 1984; Meiselman, 1978). However, as indicated in Table 1, there was a significant difference between the two groups when the numbers of presenting problems were compared (70.7% had 2 or more presenting problems compared to 32.3%). Moreover, a moderate association was found to exist (.36). Meiselman (1978) also found that the sexual abuse group reported more presenting problems (3.4 problems) than were reported in the comparison group (2.5 problems).

As shown in Table 1, the clients in the sexual abuse group were assigned significantly more diagnoses than were clients in the comparison group (52.4% had 2 or more diagnoses compared to 25.8%). The diagnoses for which significant differences were obtained were the depressive (40.5% compared to 23.7%), adjustment (28.6% compared to

58.1%), and personality disorders (47.6% compared to 23.7%). However, for none of the diagnoses were even moderate associations obtained. Whereas Jehu, Gazan, & Klassen (1985) and Meiselman (1978) supported the findings with regard to depressive and adjustment disorders, Meiselman (1984) obtained a much lower incidence of personality disorders (12%) among the abused clients. Luklanowicz (1972), however, reported similar findings to the present study (42%) with regard to personality disorders in the abuse group. It should be noted that in the present study as well as in Meiselman's (1978) study, an adjustment disorder was the only diagnosis for which the comparison group was more likely to be diagnosed than was the sexually abused group. Typically, a diagnosis of depression or personality disorder indicates greater pathology than does a diagnosis of adjustment reaction. In short, although the frequencies of particular diagnoses varied between the abuse and comparison groups, the relationships were relatively weak.

Table 1 also demonstrates that the frequencies of several childhood characteristics of the sexual abuse group were significantly different from those obtained for the comparison group. First, several clients (6) in the sexual abuse group reported feeling isolated in their childhood, whereas not one client in the comparison group reported a similar feeling (14.3 compared to 0%).

Interestingly, Briere (1984) reported the sexual abuse group as feeling significantly more isolated in adulthood than the control group. Jehu, Gazan, & Klassen (1985) also found that a majority of their clinical population of adult abused women felt isolated. Moreover, Herman (1981) reported a high incidence of feelings of isolation in a clinical population of women who had experienced father-daughter incest. These findings may suggest that feelings of isolation increase with age in the sexual abuse group. Second, the abuse group more frequently reported problems with alcoholism in their family (47.6% compared to 16.1%). Third, the sexual abuse group was more likely to have experienced school failure (40.5% compared to 15.1%). Fourth, parental disinterest (35.7% compared to 16.1%) and strict discipline (42.9% compared to 19.4%) were also reported at higher rates in the abused than were the comparison group. Finally, and not surprisingly, the abuse group was more likely to rate their childhoods as having been "bad" rather than "good" or "average" (50% compared to 8.6%). The strength of associations for the variables of feelings of isolation, alcoholism in family, and the rating of childhood quality were all at least moderate, with the latter being the strongest association (.49). Table 5 demonstrates in more detail how the sexual abuse and comparison groups viewed their childhoods. The writer is unaware of previous

clinical studies which have looked at these factors in childhood. However, studies conducted on general populations have indicated that sexual abuse victims tend to have greater difficulties in their childhoods and view their childhoods as having been more negative (Bagley & Ramsay, 1985). Taken together, this group of characteristics provides considerable promise for distinguishing between abused and non-abused females.

In addition to the determination of differing childhood characteristics, the writer was also interested in the possible differences in current adult functioning. Significant differences between the sexual abuse and comparison group were indeed found and are presented in Table 1. First, the abuse group was more likely to be experiencing difficulty with: depression (88.1% compared to 67.4%), anxiety/guilt (88.3% compared to 58.7%), sleeping disturbances (64.3% compared to 44.6%), feeling upset when criticized (59.5% compared to 38%), inability to speak up when they felt they were right (71.4% compared to 35.9%), and feeling anxious about their sex life (33.3% compared to 8.7%). Previous studies have reported similar findings (Briere, 1984; Meiselman, 1978). Of those characteristics listed in Table 1, only the inability to speak up when they felt they were right and feeling anxious about their sex life yielded moderate associations according to phi coefficient analyses.

Treatment of the sexual abuse group

The results obtained for the treatment component of the study will be presented descriptively rather than with regard to statistical significance. Overall, the childhood sexual abuse identified in the intake form was addressed by the therapists in 81% of the cases. In addition, the therapist addressed the abuse in the intake session in 81% of the cases. In other words, when the abuse was addressed by the therapist, it always occurred in the intake session. The discussion most frequently occurred within the context of psychosexual development, and usually consisted of only a few sentences. The identity of the perpetrator, age of client at the time of the abuse, and a brief description of the type of sexual activity involved were discussed. In only a very few cases did the discussion include the clients' feelings about the abuse or whether the clients felt the abuse was still an issue for them. In 61.9% of the cases there was no further discussion of the abuse, and in only 19.1% of the cases were 2 or more sessions spent on the abuse. Overall, only 59 sessions or 18% of the total 276 counselling sessions were spent dealing with the sexual abuse.

Whereas it was the writer's intention to consider therapist characteristics as independent variables such

that comparisons might be made about the likelihood of their addressing a client's sexual abuse history, a combination of small therapist sample size (N=4) and the lack of variability in their responses to the questionnaire items effectively ruled out this possibility. As with the previous treatment considerations, therapist characteristics will be presented in a descriptive manner.

The therapists had been working as therapists between 5 and 13 years. All four therapists had attended workshops on sexual abuse and believed that long term difficulties may arise as a result of a history of childhood sexual abuse. Further, in a quantitative assessment of these potential difficulties, the extent of negative effects on adult functioning were rated on a scale of 1 (minimum) to 5 (maximum). Three therapists rated the negative effects between 4 and 5 with one therapist rating 1 to 5 depending on various factors. The therapists rated their level of discomfort in dealing with sexually abused clients as being minimum (1) to moderate (3), with the most discomfort arising in situations where the client did not disclose sexual abuse but in which the therapist may have suspected that sexual abuse had occurred. Generally, the responses on the therapist questionnaire indicated that the therapists had some training in the area of sexual abused, believed that

childhood sexual abuse does cause difficulties, and that they felt reasonably comfortable dealing with the abuse. Given this finding, it is interesting to note that even though the therapists addressed the abuse in roughly 80% of the cases, it was given very brief attention and very few of the therapists spent more than the initial intake session talking about the abuse (only 19% spent 2 or more sessions). When one considers the number of areas in adult life documented in the present results for which the abused women seem to be at a disadvantage, the seemingly superficial manner in which the abuse history was discussed by the therapists, is all the more striking.

CHAPTER V

DISCUSSION

Overall, based on the chi-square values alone, it appears that these results support previous research which demonstrated the negative consequences of a history of childhood sexual abuse on adult functioning in a female clinical population. However, even though significant chi-squares were obtained, most of the characteristics were only weakly associated with abuse, as reflected in the phi coefficients and Cramer's V statistics, and therefore, the results are not quite so impressive and have limited predictive ability. In other words, the presence of any one factor alone does not indicate that a particular client is necessarily more likely to have had a history of childhood sexual abuse than a client for whom the factor is absent. Therefore, conclusions based on the presence of such social and psychological factors as separation or divorce, previous counselling, hospitalization for emotional problems, use of prescription drugs, and the therapists' assignment of more diagnoses, should be very tentative and do not necessarily suggest greater instability or pathology in the sexually abused group. As well, the existence in current adult functioning of depression, anxiety/guilt, sleeping disturbances, and feeling upset when criticized, individually have limited predictive value because of the

weak relationships obtained.

A history of drug and alcohol abuse and the presentation of 2 or more presenting problems yielded moderate associations. The only characteristics of current adult functioning for which moderate associations were obtained were: anxiousness about their sex life and difficulty speaking up when they felt they are right, which may be related to difficulties with assertiveness or low self-esteem. The strongest associations were obtained for the clients' subjective evaluations of their own childhoods. As adults looking back on their childhood experiences, the sexual abuse group rated their childhoods as being more negative than did members of the comparison group, and, accordingly, reported greater incidence of alcoholism in their families, and feelings of isolation. Based on this study and previous studies, it also appears that childhood feelings of isolation may actually increase in adulthood. It is also interesting to note that alcoholism in the family was present in childhood as well as being present in the clients' own adult functioning. The whole area of adults' perceptions of their childhoods as an indicator of past childhood sexual abuse warrants further investigation.

The exploratory investigation of treatment characteristics of cases where a history of childhood sexual abuse has been indicated by the client, provided a

starting point for further investigation. Based on these preliminary results, it appears that in the large majority of cases, the therapists did address the abuse even though it appears that this discussion may have been fairly superficial and brief. Given the small sample size of therapists and the lack of variability in their characteristics, correlations between therapist characteristics and amount of time spent addressing the abuse were not possible. However, considering the responses to the therapist questionnaire which indicated that the therapists have all received training in sexual abuse, that they felt that childhood sexual abuse has negative consequences for adult functioning, and that they felt reasonably comfortable addressing the abuse, it is surprising that so few of the therapists addressed the abuse in further sessions. This possible inconsistency in stated beliefs and actual therapeutic practice may point to a difficulty in putting into practice what one knows and believes about sexual abuse and may actually indicate greater discomfort and reluctance to address the abuse than therapists may be willing to admit. It is possible that the abuse was given only token attention in the intake session and not really explored in sufficient depth to make a decision as to its importance. This possibility warrants further investigation.

The present study undertook an examination of the

identification and treatment by mental health professionals of female adults with histories of childhood sexual abuse. It is important to keep in mind that the preliminary conclusions discussed above were reached in the absence of assessments of the levels of reliability and validity of the instruments, and, therefore, are tentative. Like previous research, this study can not claim that a history of childhood sexual abuse contributes to greater social and psychological instability in that individual, nor can it claim that the presence of certain factors increases the predictability of a particular client having had such a history. In addition, studies which rely on file data are restricted to information available on the files and do not lend themselves to more sophisticated statistical analyses because of the nature of nominal data. This study does, however, extend the attempt to improve methodology used in previous studies, especially with regard to statistical analyses and predictive ability. It is hoped that some of the moderate associations found in this study with regard to characteristics of adult functioning and perceptions of past childhood experiences, will be further investigated through interviews with sexual abuse and control groups of clients. Further analyses of types of individual factors differentiating the abused and non-abused clients, may yield greater utility for predictive purposes when

considered as groups of factors. Finally, it is hoped that this study will encourage further investigation into the area of clinical treatment of adult females sexually abused as children. Once the clinician identifies clients who have a history of childhood sexual abuse, the critical issue becomes what the therapist does with this information.

REFERENCES

Adam, B. (1978). Inferiorization and self-esteem. Social Psychology, 41, 47-53.

Adams-Tucker, C. (1982). Proximate effects of sexual abuse in childhood: A report on 28 children. American Journal of Psychiatry, 139, 1252-1256.

Alexander, C. (1980). The responsible victim: nurse's perception of victims of rape. Journal of Health and Social Behavior, 21, 23-33.

Anderson, S. & Lauderdale, M. (1982). Characteristics of abusive parents: a look at self-esteem. Child Abuse and Neglect, 6, 285-293.

Anderson, C. & Mayes, P. Treating family sexual abuse: The humanistic approach. Journal of Child Care, 1, 31-45.

Bagley, C. (1984). Mental health and the in-family sexual abuse of children and adolescents. Canada's Mental Health, 32, 17-23.

Bagley, C. & McDonald, M. (1984). Adult mental health sequels of child sexual abuse, physical abuse, and neglect in maternally separated children. Canadian Journal of Community Mental Health, 3, 15-26.

Bagley, C. & Ramsay, R. (1985). Sexual abuse in childhood, psychosocial outcomes and implications for social work practice. Journal of Social Work and Human Sexuality, 4, 33-47.

Bergert, A. (1986) Isolation to intimacy: Incest survivors in group therapy. Social Casework, 67, 266-275.

Berliner, L. & Stevens, D. (1982). Clinical issues in child sexual abuse. In J. R. Conte & D. Shore (Eds.) Social work and child abuse. New York: Haworth.

Branden, N. (1969). The psychology of self-esteem. Los Angelas: Nash Publishing Corporation.

Brickman, J. (1984). Feminist, non-sexist, and traditional models of therapy: implications for working with incest. Women and therapy. 3, 49-67.

Briere, J. (1984). The effects of childhood sexual abuse on later psychological functioning: defining a post-sexual abuse syndrome. Paper presented at the Third National

Conference on Sexual Victimization of Children, Children's Hospital National Medical Center, Washington, D.C. April.

Briggs, D. (1967). Your child's self-esteem. New York: Dolphin Books.

Brooks, B. (1985). Sexually abused children and adolescent identity development. American Journal of Psychotherapy, 39, 401-408.

Browne, A. & Finkelhoor, D. (1986). Impact of child sexual abuse: A review of the literature. Psychological Bulletin 99, 66-77.

Butler, S. (1978) Conspiracy of silence. San Fransisco: Volcano Press Company.

Burgess, A. & Holmstrom, L. (1985). Sexual trauma of children and adolescents. Nursing Clinics of North America, 10, 552-563.

Chodorow, N. (1978). The reproduction of mothering: Psychoanalysis and the sociology of gender. Berkley: University of California Press.

Clark, J. (1978). Self-esteem: A family affair. Minneapolis: Winston Press.

Coopersmith, S. (1967). Antecedents of self-esteem. San Fransisco: W.H. Freeman.

Courtois, C. (1979). The incest experience and it's aftermath. Victimology, 4, 337-347.

Courtois, C. (1982). Studying and counseling women with past incest experience. Victimology, 5, 322-334.

Courtois, C. & Watts, D. (1982). Counselling adult women who experienced incest in childhood or adolescence. Personnel & Guidance Journal, 60, 275-279.

DeYoung, M. (1982). Innocent seducer or innocently seduced? The role of the child incest victim. Journal of Clinical Child Psychiatry, 11, 56-60.

DeMott, B. (1980). The pro-incest lobby. Psychology Today, March, 11-16.

Deitz, C. & Craft, J. (1980). Family dynamics of incest: A new perspective. Social Casework, 61, 602-609.

Faria, G. & Belohlavek, N. (1984). Treating female adult survivors of childhood incest. Social Casework, 65, 465-471.

Feild, H. (1978). Attitudes toward rape: A comparitive analysis of police, rapists, counselors, and citizens. Journal of Personality and Social Psychology, 36, 156-179.

Felker, D. (1974). Building positive self-concepts. Minnesota: Burgess Publishing.

Finkelhor, D. (1979). Sexually victimized children. New York: Free Press.

Finkelhor, D. (1984). Child sexual abuse: New theory and research. New York: Collier MacMillan.

Finkelhor, D. & Browne, A. (1985). The traumatic impact of child sexual abuse: A conceptualization. American Journal Orthopsychiatry, 55, 530-541.

Frude, N. (1982). The sexual nature of sexual abuse. Child Abuse & Neglect, 6, 211-223.

Forward, S. & Buck, D. (1978). Betrayal of innocence. New York: Penguin Books.

Gaddini, R. (1983). Incest as a developmental failure. Child Abuse and Neglect, 7, 357-358.

Galambos, N. & Dixon, R. (1984). Adolescent abuse and the development of personal sense of control. Child Abuse and Neglect, 8, 258-293.

Geiser, R. (1979). Hidden Victims. Boston: Beacon Press.

Gelinas, D. (1983). Persisting negative effects of incest. Psychiatry, 46, 312-322.

Giaretto, H. (1982). A comprehensive child sexual abuse treatment program. Child Abuse and Neglect, 16, 263-278.

Gil, E. (1983). Outgrowing the pain . San Franscisco: Launch Press.

Gilligan, C. (1982). In a different voice. Massachusetts: Harvard University Press.

Gordy, P. (1983). Group work that supports adult victims of childhood incest. Social Casework, 64, 300-307.

Greenberg, N. (1979). The epidemiology of childhood sexual abuse. Pediatric Anals, 8, 16-28.

Groth, A. (1978a). Patterns of sexual abuse against children and adolescents. In A. Groth, L. Holmstrom & S. Sgroi (Eds.) Sexual assault of children and adolescents. Toronto: D.C. Heath Books.

Groth, A. (1978b). Guidelines for the assessment and management of the offender. In A. Groth, L. Holmstrom, & S. Sgroi (Eds.) Sexual assault of children and adolescents. Toronto: D.C. Heath Books.

Herbert, C. (1985). The sexually abused child: The hidden victim. Diagnosis, Aug, 18-27.

Herman, J. (1981). Father-Daughter Incest. Massachusetts: Harvard University Press.

Hoorwitz, A. (1983). Guidelines for treating father-daughter incest. Social Casework, 64, 515-524.

James, J. & Meyerding, J. (1977). Early sexual experiences as a factor in prostitution. Archives of Sexual Behavior, 7, 31-43.

James, B. & Nasjleti, M. (1983). Treating sexually abused children. Palo Alto: Psychologists Press Inc.

Jehu, D. (1985). Common therapeutic targets among women who were sexually abused in childhood. Journal of Social Work and Human Sexuality, 3, 25-46.

Jehu, D. & Gazan, M. (1983). Psychosocical adjustment of women who were sexually victimized in childhood or adolescence. Canadian Journal of Community Mental Health, 2, 71-82.

Jehu, D., Gazan, M., & Klassen, C. (1985). An intervention program for women who were sexually abused in childhood. Paper presented at Counselling the Sexual Abuse Survivor, Winnipeg, Manitoba, February.

Kaplan, S. & Pelcovitz, D. (1982). Child abuse and neglect and sexual abuse. Psychiatric Clinics of North America, 5, 321-332.

Kempe, R. & Kempe, C. (1984). The common secret: Sexual abuse of children and adolescents. New York: W.H. Freeman & Company.

King, H., Rotter, M., Calhoun, L., & Selby, J. (1978). Perceptions of the rape incident: Physicians and volunteer counselors. Journal of Community Psychology, 6, 74-77.

Krener, P. (1985). Clinical experience after incest: Secondary prevention. Journal of the American Academy of Child Psychiatry, 24, 231-234.

Lindberg, F. & Distad, L. (1985). Survival responses to incest: Adolescents in crisis. Child Abuse and Neglect, 9, 521-526.

Lubell, D. & Soong, W. (1982). Group therapy with sexually abused adolescents. Canadian Journal Psychiatry, 27, 311-315.

Luklanowicz, N. (1972). Incest. British Journal of Psychiatry, 120, 301-313.

Maslow, A. (1973). Dominance, self-esteem and self actualization. California: Brooks-Cole.

Masson, J. (1984). The assault on the truth: Freud's suppression of the seduction theory. Toronto: Farrar, Strauss & Giraux.

McFarlane K. & Bulkey, J. (1982). Treating child sexual abuse: an overview of current program models. In J.R. Conte & D. Shore (Eds.) Social Work and Child Sexual Abuse. New York: Haworth.

McFarlane, K. & Korkin, J. (1983). Confronting the incest secret long after the fact. Child Abuse & Neglect, 7, 225-237.

Meisselman, K. (1978). Incest: A psychological study of cause and effects. San Fransisco: Jossey-Bass.

Minahan, A. (1981). Purposes and objectives of social work revisted. Social Work, 62 .

Mrazek, P. & Kempe, C. (1981). Sexually abused children and their families. Toronto: Pergamon Press.

Nasjleti, J. (1983). Treating sexually abused children and their families. Palo Alto: Consulting Psychological Press.

Rawlings & Carter (1977). Psychotherapy for women: Treatment toward equality. Illinois: C.C. Thomas.

Resick, P. & Jackson, T. (1981). Attitudes toward rape among mental health professionals. American Journal of Community Psychology, 9, 481-491.

Rosenfeld, A. (1979). Incidence of a history of incest among eighteen female psychiatric patients. American Journal of Psychiatry, 6, 791-795.

Rush, F. (1974). The sexual abuse of children: A feminist point of view. In C. Wilson & N. Connell (Eds.) Rape: The first sourcebook for women. New York, New American Library.

Rush, F. (1977). The Freudian cover-up. Chrysalis, 1, 31-45.

Rush, F. (1980). The best kept secret: Sexual abuse of children. New Jersey: Prentice Hall Incorporated.

Russell, D. (1984). The prevalence and seriousness of incestuous abuse: Stepfathers vs. biological fathers. Child Abuse and Neglect, 8, 15-22.

Russell, D. (1986). The secret trauma: Incest in the lives of girls and women. New York: Basic Books.

Samuels, S. (1977). Enhancing self-concept in early childhood. New York: Human Sciences Press.

Sanford, L. & Donovan, M. (1984). Women and self-esteem. New York: Penguin Books.

Sedney, M. & Brooks, B. (1984). Factors associated with a history of childhood sexual experience in a non-clinical female population. Journal of the American Academy of Child Psychiatry, 23, 215-218.

Sgroi, S. (1982). Handbook of clinical intervention in child abuse. Toronto: Lexington Books.

Sgroi, S. (1978). Child sexual assault: Some guildelines for intervention and assessment. In A. Burgess, L. Holmstrom, & S. Sgroi, (Eds.) Sexual assault of children and adolescents. Toronto: D.C. Heath Books.

Shen, J. (1982). Sexual abuse of adolescents. Adolescent Sexuality, 71, 213-219.

Sorrenti-Little, L., Bagley, C., & Robertson, S. An operational definition of the long-term harmfulness of sexual relationships with peers and adults by young children. Canadian Children, 4, 46-57.

Summit, R. & Kryso, J. (1978). Sexual abuse of children: A clinical spectrum. American Journal of Orthopsychiatry, 48, 238-251

Topper, A. & Aldridge, D. (1981). Incest: Intake & investigation. In P. Mrazek & C. Kempe (Eds.) Sexually abused children & their families. Toronto: Pergamon Press.

Tsai, M. & Wagner, N. (1978). Therapy groups for women sexually molested as children. Archives of Sexual Behavior, 7, 417-427.

Weaver, B.& McCarthy, P. (1981). Sexual misuse of children: An emergency department nursing perspective. Emergency Nursing 7, 59-62.

Yorokoglu, A. & Kemph, J. (1966). Children not severely damaged by incest with a parent. Journal of American Academy of Child Psychiatry, 5, 111-124.

APPENDICES

THE UNIVERSITY OF CALGARY

CERTIFICATION OF INSTITUTIONAL ETHICS REVIEW

This is to certify that the Committee on the Ethics of Human Studies at The University Calgary has examined and approved the research proposal.

by: (Applicant): Gayle Read

of the Department of: Faculty of Social Welfare

to: (Agency): The University of Calgary

entitled: "Social and Psychological Characteristics of a Sexually Molested Clinical Population and Treatment in a Mental Health Setting."

(the above information to be completed by the applicant)

Chair, Committee on the Ethics of Human Study
J. P. Hornick

November 28, 1986
Date

THE UNIVERSITY OF CALGARY

Faculty of SOCIAL WELFARE

2500 University Drive N.W., Calgary, Alberta, Canada T2N 1N4

Telephone (403) 220-5942

Letter of Introduction and Consent of Alberta Mental Health Services

Title: Social and psychological characteristics of a sexually abused clinical population and treatment in a mental health setting.

Researcher: Gayle Read, Master of Social Work candidate, University of Calgary. This thesis project is being conducted under the supervision of Dick Ramsey, Associate Professor, Faculty of Social Welfare, University of Calgary.

I, , Area Manager of Alberta Mental Health Services, understand that I am being asked to allow a research project to be carried out in our clinic which will focus on the social and psychological characteristics of clients who were sexually abused in childhood and the treatment of these clients. If I agree to allow this project to be conducted in this clinic I will be agreeing to the following:

1. I understand that the data for this project will be derived directly from the client's clinic file. Information on the characteristics of the clients will be gathered from the clinic intake form. Data with regard to treatment, that is, number of sessions prior to dealing with the abuse and number of sessions actually dealing with the abuse, will be obtained from the progress notes.

2. I understand that information with regard to the therapist's feelings about dealing with sexual abuse will be obtained through an anonymous questionnaire. These therapists will be asked to sign an informed consent form as well. The therapists will not be identified by age, sex, or discipline.

3. I understand that anonymity of both clients and therapists will be carefully protected at all times, and they will be identified only by a code number.

4. I understand that I am giving my consent for Gayle Read to view the client files and approach the therapists to ask for their participation, and that I may withdraw this consent at any time.

5. This research project has been fully explained to me and I have been given the opportunity to ask any questions I may have.

Signed: Date:

DATA COLLECTION SHEET

Social and Psychological Characteristics

Group: (1) Sexually abused (2) Not sexually abused

Age at time of registration: _____

1. Diagnosis: (1) depressive disorder (2) anxiety disorder (3) personality disorder (4) adjustment reaction (5) sexual dysfunction (6) Post-traumatic stress disorder (7) other

2. Presenting problem: (1) depression (2) anxiety (3) relationship problems (4) sexual abuse (5) sexual dysfunction (6) other

Characteristics of childhood:

3. Feelings of isolation in childhood: (1) yes (2) no

4. Alcoholism in family in childhood: (1) yes (2) no

5. School failure in childhood: (1) yes (2) no

6. Strict discipline in childhood: (1) yes (2) no

7. Parental disinterest in childhood: (1) yes (2) no

8. Childhood is described as being: (1) good (2) bad (3) average

Characteristics of current adult functioning:

9. Current marital status: (1) never married (2) married (3) sep/divorced (4) other

10. Previously received counselling: (1) yes (2) no

11. Hospitalized for an emotional problem: (1) yes (2) no

12. Currently taking medication prescribed by a doctor: (1) yes (2) no

13. Currently taking medication not prescribed by a doctor:
(1) yes (2) no

14. Period of heavy alcohol or drug use, past or present:

(1) yes (2) no

15. Difficulties with eating: (1) yes (2) no

16. Difficulties with depression: (1) yes (2) no

17. Difficulties with anxiety and/or guilt:
(1) yes (2) no

18. Difficulties with hearing voices or seeing strange things:
(1) yes (2) no

19. Feeling people are against me or out to get me:
(1) yes (2) no

20. Difficulties with headaches: (1) yes (2) no

21. Difficultes with falling asleep at night:
(1) yes (2) no

22. Difficulty controlling unwanted impulses:
(1) yes (2) no

23. Difficulty controlling unwanted sexual impulses:
(1) yes (2) no

24. Difficulty controlling desire to hurt other people or be hurt:
(1) yes (2) no

25. Difficulty feeling comfortable carrying on a conversation with other people: (1) yes (2) no

26. Feeling upset when others criticize me:
(1) yes (2) no

27. Difficulty speaking up when I feel I'm right:
(1) yes (2) no

28. Difficulty making decisions: (1) yes (2) no

29. Feeling suicidal: (1) yes (2) no

30. Feeling anxious about my sex life: (1) yes (2) no

Treatment of cases in which sexual abuse is indicated

31. Sexual abuse was addressed by the therapist:
(1) yes (2) no

32. Abuse was addressed in 1st (intake) session:
(1) yes (2) no

33. Number of sessions prior to further discussion of abuse:
(1) 1-2 (2) 3-4 (3) 5-6 (4) 7-8 (5) more than 8
(6) no further discussion

34. Total number of sessions dealing with the abuse:
(1) 0 (2) 1 (3) 2-3 (4) 4-5 (5) 6-7 (6) 7-8
(7) more than 8

35. Total number of counselling sessions: (1) 1-3 (2) 4-6
(3) 7-9 (4) 10-12 (5) 13-15 (6) more than 15

THERAPIST QUESTIONNAIRE

Please circle the appropriate response:

1. How many years experience as a therapist do you have?

1 - 3 4 - 6 7 - 9 10 - 13 Over 13

2. How many workshops on sexual abuse have you attended?

0 1-2 3-4 5 or more

3. Generally, do you believe long-term adjustment difficulties can arise as a result of a history of childhood sexual abuse?

(1) yes (2) no

4. If you answer yes to #3, to what degree do you believe childhood sexual abuse negatively effects adult functioning?

(minimal) 1 2 3 4 5 (extreme)

5. Rating of personal level of discomfort in dealing with adult sexually abused clients if client presents past sexual abuse as the presenting problem.

(minimal) 1 2 3 4 5 (extreme)

6. Rating of personal level of discomfort in dealing with adult sexually abused clients if client does not present past sexual abuse as the presenting problem, but does indicate a history of sexual abuse on the clinic intake form.

(minimal) 1 2 3 4 5 (extreme)

7. Rating of personal level of discomfort in dealing with adult sexually abused clients if client does not present sexual abuse as the presenting problem, does not indicate a history of sexual abuse on the clinic intake form, but the therapist has reason to believe that sexual abuse may have occurred.

(minimal 1 2 3 4 5 (extreme)

THE UNIVERSITY OF CALGARY

Faculty of SOCIAL WELFARE

2500 University Drive N.W., Calgary, Alberta, Canada T2N 1N4

Telephone (403) 220-5942

Letter of Introduction and Consent of Therapist Participants

Title: Social and Psychological characteristics of a sexually abused clinical population and treatment in a mental health setting.

Researcher: Gayle Read, Master of Social Work candidate, University of Calgary. This thesis project is being conducted under the supervision of Dick Ramsey, Associate Professor, University of Calgary.

I, , understand that I am being asked to participate in a research project which will focus on the social and psychological characteristics of clients who were sexually abused in childhood and the treatment of these clients. If I agree to participate in this study, I will be agreeing to take part in the treatment section of this study, which will include the following:

1. I will be asked to complete a brief questionnaire regarding my professional background and my feelings about dealing with the topic of sexual abuse.

2. I understand that my anonymity will be carefully protected and I will be identified only by a code. I will not be identified by age, sex, or discipline.

3. I understand that my participation in this project is completely voluntary and I may withdraw my consent at any time.

4. This research project has been fully explained to me and I have been given the opportunity to ask any questions I may have.

Signed: Date: