CHILD SEXUAL ABUSE: THE IMPACT ON PSYCHOLOGICAL ADJUSTMENT OF ADULT SURVIVORS

RITA L. SWENSON

CHILD SEXUAL ABUSE: THE IMPACT ON PSYCHOLOGICAL ADJUSTMENT OF ADULT SURVIVORS

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by

Rita L. Swenson

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To the Graduate and Research Council:

I am submitting herewith a Research Paper written by Rita L. Swenson entitled "Child Sexual Abuse: The Impact on Psychological Adjustment of Adult Survivors." I have examined the final copy of this paper for form and content, and I recommend that it be accepted in partial fulfillment of the requirements for the degree Master of Science, with a major in Guidance and Counseling.

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Dean of the Graduate School

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CHAPTER I

Introduction

Statement of the Problem

With the acknowledgement of child sexual abuse (CSA) over the past few years, a social ill has been recognized for which society frantically seeks a solution. The pressure for a social cure seems to stem from the increasing number of children choosing to disclose their victimization. Children of today are better educated concerning sexuality, pregnancy, sexually transmitted diseases, especially AIDS, and their personal rights to their own bodies. Preventative programs have been adopted by schools and churches and today's parents seem to be more open in discussing sexual issues with their children. The threat of AIDS in our society has had a tremendous effect on the implementation of preventative programs. Although our society has not cured this social ill, measures have certainly been taken to reduce the incidence and to deal with the consequences.

Much research has focused on the short term effects of child sexual abuse on children. Several common characteristics have been identified in sexually abused children including fear, helplessness, self-blame, depression, negative self-esteem, withdrawal, and guilt (Elliott & Tarnowski, 1990). Further research has examined criteria

for determining the credibility of children's allegations of CSA and has substantiated their use as valid predictors of whether or not abuse has occurred (Faller, 1988). Other researchers have focused on preventative programs, such as We Help Ourselves (WHO), which was implemented in Dallas, Texas by the Mental Health Association of Dallas County. After presentation of materials dealing with victimization to primary and secondary students, follow-up data indicated that students learned sensitive material and remembered it three months later (Middleton, 1989). Still other researchers have focused on treatment groups for mothers and children (Richards & Sealover, 1991).

Researchers have focused less on the adult population who have been sexually abused as children. Some adult research has focused on adult perpetrators and found that many were abused as children (Myers, 1989). Parents of perpetrators have been examined and those parents seem to lack appropriate sexual information and education, deny or cover-up the perpetration and exhibit a cycle of abuse (Becker, Cunningham-Rathner, & Kaplan, 1988). Still other researchers have specifically examined the effect that incest has on parenting skills and attitudes (Cole, Power, Smith, & Woolger, 1992).

A growing number of adults are disclosing their victimization as children (Bass & Davis, 1988) and are seeking therapy to move through the healing process. Research has

suggested that CSA may be the most damaging of childhood traumas (Burgess, Holstrom, & McCauseland, 1977), yet demographic estimates suggest that 10-20% of the general population has been exposed to CSA as children and have neither sought nor received treatment (Curtis, 1986). Ellen Bass and Laura Davis (1988) report that one out of three girls and one out of seven boys are sexually abused by the time they reach age 18 and that trauma does not stop when the abuse stops.

In the first national survey of adults concerning a history of CSA, 27% of the women and 16% of the men reported victimization (Finkelhor, Hotaling, Lewis, & Smith, 1990). Adults sexually abused as children generally experience long term effects that interfere with daily functioning and researchers are just beginning to address those consequences.

Purpose of the Study

The purpose of this study is to examine the long-term over-all impact of CSA on adults who were victimized as children, often referred to in the literature as adult survivors of CSA. In this study, CSA is defined as any inappropriate sexual conduct inflicted upon a child, 18 years old and younger, by someone at least five years older than the child. It includes forced and nonforced encounters as well as contact and noncontact incidents. Information reviewed will be evaluated and analyzed to determine

the needs of adult survivors during the healing process and the direction of future research.

CHAPTER II

Review of Related Literature

The long-term effects of child sexual abuse are so pervasive for some adult survivors that it may be difficult for them to recognize how the abuse has affected them. Bass and Davis (1988) contend that many survivors minimize, rationalize, deny, or forget the abuse that has occurred. As children, these mechanisms are essential for survival. Unfortunately, if CSA is not treated prior to adulthood, victims continue using these mechanisms and subsequently become confused as to the origins of their psychological difficulties. This "sleeper" effect emerges with dramatic impact in adulthood and it is important to recognize that long-term effects of CSA will manifest differently from short-term effects. Understanding the adult perspective is essential in weighing the impact of CSA since an adult has the capability to assess childhood events from a different psychological perspective than the child (Akman et al., 1992).

Researchers have begun to address the long-term psychological sequelae of CSA through studies with clinical and non-clinical samples. The bulk of the research addresses CSA in female samples rather than male samples. It seems that CSA among male children is significantly

under-reported (Sebold, 1987) and as adults, males are somewhat more likely than females (42% vs. 33%) never to have disclosed the abuse (Finkelhor et al., 1990).

In contrast to studies addressing the initial effects of CSA, more sophisticated research has determined long-term effects. At least seven surveys of sexually abused women in the general population have found significant identifiable mental impairments compared to non-victims in the same sample. Although none of the studies alone are definitive on negative mental health outcomes, they are collectively impressive (Finkelhor, 1987). Research suggests that CSA can be associated with a variety of psychological and social difficulties in adulthood. Depression, guilt, low self-esteem, sexual and relationship problems, substance abuse, suicidality and self-destructive behaviors, communication difficulties, anger or hostility, and increased likelihood of revictimization (Briere & Runtz, 1988; Donaldson & Edwards, 1989) are prevalent. Other effects include anxiety, fear, a greater evidence of homosexual experiences in adolescence and adulthood among women (Akman et al., 1992), and parenting difficulties (Cole et al., 1992). In a recent analysis examining the impact of CSA on the mental health status of a community, Los Angeles Epidemiologic Catchment Area (LAECA) data indicate that a history of CSA significantly increases an individual's

chance of developing specific psychiatric disorders in adulthood.

Through epidemiologic methods of measurements reflecting either causal risk or protective risk it is estimated that 74% of psychiatric cases with a history of CSA and 3.9% of all psychiatric cases within a community population can be attributed to CSA (Scott, 1992). However, multiple exposure categories such as CSA alone, CSA with physical abuse, and CSA with emotional neglect were not utilized to determine if CSA alone or multiple variables are associated with the onset of disorders.

Psychological and Social Difficulties

Unresolved feelings of anger and hostility are common among adults who have experienced CSA. Many of these adults have an inability to identify emotions and express feelings and may display incongruity between affect and behavior (Leehan & Wilson, 1985). In their work with women survivors of CSA, Bass and Davis (1988) found that victims have either repressed their anger, denied their anger or turned their anger toward others. Because of past experiences with anger, some victims are afraid of expressing their anger.

In a research review, Finkelhor (1987) notes that in studies which have compared sexual abuse victims to other mental health seekers, CSA victims were more isolated and had lower self-esteem. Bass and Davis (1988) believe that

in a culture that devalues women, feelings of inadequacy and self-doubt are often a struggle and become even more so for victims of CSA. Negative messages, either directly or indirectly, become internalized and victims suffer feelings of self-hate, powerlessness, and shame. Although CSA is cited as having an effect on self-esteem, this has not yet been established by empirical studies and current research indicates contradictory results (Browne & Finkelhor, 1986). A survey of 54 female nurses who had been sexually abused as children indicated no difference on a measure of self-esteem but did report more symptoms of distress on the Global Severity Index and on seven out of nine subscales of the Derogatis Brief Symptom Inventory. It is probable that this sample excluded survivors of CSA who were functioning poorly, since subjects were well educated and employed. It is also likely that due to the small sample size, differences between those subjects who were abused and those who were not abused were obscured (Cado, Greenwald, Leitenberg, & Tarran, 1990).

Interpersonal relations are affected by CSA. Parenting difficulties, continuing problems with parents, difficulty in relating to men and women (Browne & Finkelhor, 1986), and difficulty with intimacy (Bass & Davis, 1988) have been found to be associated with CSA. Using an Impact Interview Scale, Gorcey, McCall-Perez, and Santiago, (1986) found that sexually abused women reported more difficulty

in relating to males and females and in engaging in sexual intimacy. More than one half of the sample expressed anger, fear, and/or distrust of men while one fourth expressed anger and mistrust of women. Another study that examined clinical and non-clinical samples of adult women who were victims of incest reported negative feelings about men, sex, or themselves as well as distrust and difficulty in forming or maintaining intimate relationships (Herman, Russell, & Trocki, 1986). Upon examination of responses to a Childhood Incest Questionnaire, Donaldson and Edwards (1989) found that symptoms among adult female survivors of incest became intensified when exposed to events that resembled the abusive event. These studies are based on retrospective self-report and therefore, measure long-term effects that are recognized by the subjects themselves. Bass and Davis (1988) contend that as children, adult victims may not have learned how to give or receive nurturing and may threaten their own relationships by confusing the past with the present.

In a recent study that examined the quality of the parenting experience as well as the parenting practices, Cole et al., (1992) found that women with a history of incest between father and daughter reported less confidence and sense of control as non-incest parents. Feelings of loss of authority and inefficacy, inability to provide structure, and inconsistency were commonly reported.

Results suggest that their children may be less well behaved which may further contribute to the parents' feelings of inadequacy. In corroboration with an earlier study, findings suggest that incest victims desire autonomy in their children, but lack the knowledge of how to promote autonomy and/or lack the emotional energy or control to do so. The earlier study makes a further distinction between the attitudes of CSA survivors who were victimized by fathers or step-fathers and those victimized by men who were not family members indicating that incest has a greater impact (Cole & Woolger, 1989). Again, both studies are limited by maternal self-report and observational studies of mother-child interactions were not employed.

The association of homosexuality with CSA has had little empirical confirmation (Browne & Finkelhor, 1986). Although some women have been influenced to relate sexually and emotionally to women rather than men, according to Bass and Davis (1988), sexual preference is not determined by abuse. Leehan and Wilson (1985) contend that in the case of some women, fear of men has resulted in homosexuality. They further describe similar sexual identity confusion among men who have had abusive fathers and passive, but nurturing mothers. In a clinical study of 14 males with a history of CSA, Myers (1989) found that at the time of referral, nine were in conflict about their sexual orientation. Of the 14, eight identified themselves as

homosexual, one as asexual, one as bisexual and four as heterosexual. Six of the men described homophobic attitudes such as irrational loathing of homosexuality and homosexuals, although four of them also identified themselves as homosexual. Since males are less likely to disclose CSA, this clinical sample is not representative of those males who have never sought treatment.

Self-defeating behaviors seem prevalent in the lives of adults victims of CSA. Some survivors describe the feeling that something "bad" is going to happen when things are going smoothly. The pressure of waiting for the bad to come is sometimes so great that the victim will engage in self-defeating behaviors or manipulate situations to bring about negative consequences (Leehan & Wilson, 1985). In their work with college students who were physically and sexually abused as children, Leehan and Wilson (1985) found that anxiety levels and fear of failure related to course work often became debilitating. Even in cases of students with high achievement and intellect, the fear of failure and high anxiety sometimes resulted in the student dropping the course or performing poorly on tests. It is suggested that such self-defeating behaviors offer relief from the tension that builds while waiting for something bad to happen.

The majority of studies indicate an increased risk of revictimization among adult survivors of CSA (Akman et al.,

1992). Although only a few studies have examined the effects of revictimization, prevalence measures range from 6% to 68% (Guthrie, Notgrass, & Wyatt, 1992). In a study of 248 women, ages 18 to 36, Guthrie et al. (1992) found that among women who reported CSA before the age of 18 years, 44% experienced contact or non-contact abuse in adulthood and 30% experienced only contact abuse. In an earlier study of 41 female volunteers, Gorcey et al., (1986) found that 37% of women abused in childhood later experienced rape as teenagers or adults. Although there is considerable variation in prevalence estimates and only a few studies have examined the effects of revictimization, these findings indicate that a significant number of victims experience incidents of sexual revictimization. In addition to sexual victimization, adult survivors of CSA also seem more likely to be abused by husbands or other adult partners (Browne & Finkelhor, 1986). In a clinical sample, Briere (cited in Browne & Finkelhor, 1986) found that 49% of CSA victims reported being battered in an adult relationship compared to 18% of non-victims. In their work with adult victims of CSA, Leehan and Wilson (1985) reported similar findings of subsequent molestations, beatings, rapes or deep feelings of vulnerability and fear of revictimization. Research suggests that some battered women appear anxious, low in ego-strength and self-esteem, unable to cope and depressed (Gleberman, Margolin, &

Sibner, 1988), all of which are recognized as long-term effects of CSA.

Briere (1989) suggests that the phenomenon of revictimization may be due to the fact that some survivors overlook behaviors such as aggressiveness that non-abused women may see as danger signs. He contends that the survivor may be more prone to attracting abusive individuals because of their own low self-esteem, self-punitiveness and learned helplessness. Similarly, Bass and Davis (1988) believe that survivors of CSA have been trained to be victims are especially vulnerable to assault, rape, and battering. Leehan and Wilson (1985) noted a tendency for these women to either be flirtatious and encourage sexual overtures in search for male approval or to be anxious and withdrawn around men.

Research has suggested an association between CSA and promiscuity and prostitution (Briere, 1984; Guthrie et al., 1992). A study of 186 men and women enrolled in a counseling and testing program in southeastern New England revealed that survivors of CSA were four times more likely to report having worked as a prostitute during their lifetime than those who reported no history or CSA (Feingold et al., 1991). Male survivors were almost eight times more likely to report a history of prostitution than non-victims. Compared to those reporting no history of CSA, survivors were two times more likely to have multiple sexual partners

on an average yearly basis and a 40% increase in frequency of sexual relations with someone they did not know (Feingold et al., 1991). However, this sample appears somewhat biased due to exclusion of non-sexually active subjects and those who were at no risk of acquiring or transmitting the human immunodeficiency virus (HIV) infection. In later research, Cohen and Frazier (1992) note that incest survivors have higher rates of prostitution than the general population. Briere (1989) describes prostitution as a human interaction for many survivors since it involves the exchange of sex for money, similar to the exchange of sex in childhood for attention or escape from injury.

The risk-taking sexual behaviors of promiscuity and prostitution have health-related consequences. Women with a history of CSA are almost three times more likely to become pregnant before the age of 18. Men with a history of CSA are two times more likely to contact HIV infections (Feingold et al., 1991). In their community sample, Guthrie et al. (1992) reported high rates of unintended pregnancies and abortions as well as sexual behaviors that increase the risk of sexually transmitted diseases.

Sexual problems may include an avoidance of sex as well as an increased level of sexual behavior (Cohen & Frazier, 1992). In earlier findings, Leehan and Wilson (1985) reported that women's motivation in sexual relations

was toward satisfying the man's needs rather than their own while others expressed fear in developing relationships with men which might result in sexual contact.

Clinical Classifications

In the analysis of the LAECA data, Scott (1992) reported increased odds of experiencing one or more diagnoses in adulthood for respondents with a history of CSA. The study provided data for diagnoses of major depression, alcohol abuse or dependence, drug abuse or dependence, obsessive-compulsive disorder, panic disorder, and phobia. Other researchers have associated CSA with a variety of psychological disorders (e.g., Briere, 1989; Browne & Finkelhor, 1986).

According to Finkelhor (1987), one of the best studies addressing depression was a survey of women in Calgary which utilized such instruments as the Middlesex Hospital Health Survey and CES-D depression scale. Results indicated that sexually abused women were generally at twice the risk for depression, psychoneurosis, somatic anxiety, psychiatric hospitalization, and suicidal gestures even after controlling for other negative developmental and family background factors. On the positive side, severe levels of psychopathology appeared in less than 25% of the victims surveyed (Bagley & Ramsey, 1986). Another often cited study is a community survey of 248 Los Angeles County women who participated in interviews requiring personal and

family histories. Women with a history of CSA were significantly more likely than non-victims or non-contact victims to have experienced a major depressive episode and to have had more episodes (Peters, 1988). In yet a third study using The Beck Depression Inventory (BDI), the State-Trait Anxiety Inventory (STAI) and the Fear Survey Interview (FSI) to assess the long-term effects of CSA, abused women were found to be more depressed, anxious, and fearful than the controls (Gorcey et al., 1986).

Feelings of anxiety are experienced by a number of adult survivors of CSA and were often adaptive responses at the time of victimization (Briere, 1989). Some adult survivors experience panic or anxiety attacks, phobias (Bass & Davis, 1988), difficulty sleeping and nightmares (Browne & Finkelhor, 1986). In a clinical sample, Briere (1984) found that 54% of CSA victims experience anxiety attacks compared to 28% of non-victims, 54% reported nightmares compared to 23% of non-victims, and 72% had difficulty sleeping compared to 29% of non-victims (Briere, 1984).

An often addressed area in empirical literature on long-term effects of CSA is the impact of early sexual abuse on adult sexual functioning. Finkelhor (1987) and Browne and Finkelhor (1986) note that almost all clinically based studies indicate later sexual problems among CSA victims including frigidity, vaginismus, flashbacks, and emotional problems related to sex. However, clinical

samples represent only a small minority of CSA victims and those who do not seek treatment may not be represented. Cado et al. (1990) addressed this shortcoming in current research with their non-clinical sample of adult women and found that abused subjects did not differ from the control subjects of self-reported levels of sexual satisfaction and dysfunction. One study examined a mixed sample of clinical and non-clinical female volunteers obtained through public advertising and letters sent to mental health professionals. When comparing 41 women sexually abused in childhood to 56 women who had not been abused, sexual functioning and fear and distrust of men were the most cited long-term problems in those sexually abused (Gorcey et al., 1986). Such research inconsistencies exist because sexual disturbance has not been clearly defined and appropriately matched controls have not been utilized. The true proportion of sexual disturbance in the general population remains unknown (Akman, 1992). Akman et al. (1992) cite Anderson, Frank, and Rubenstein's 1978 study of sexual dissatisfaction in 100 "normal" couples which suggests that the general population suffers from a high base rate of sexual problems.

Addictions, including drug and alcohol, food, exercise, shopping, sex, television, gambling, work, and others are commonly associated with CSA and dysfunctional families (Friel & Friel, 1988). Bass and Davis (1988) view

addiction as a way to escape, to protect one's self or to gain control.

Substance abuse seems to be a common long-term consequence of CSA. A personal account of "Anna's" experiences with CSA reveals that she began drinking at the age of twelve years in order to get relief from pain and gain some control (Bass & Davis, 1988). Briere (1984), using a community health center sample, found that 27% of CSA victims compared to 11% of non-victims had a history of alcoholism and that 21% had a history of drug addiction versus 2% of non-victims (Browne & Finkelhor, 1986). Considering the results of a later study of university women in which CSA victims scored higher on acute and chronic dissociation and somatization as well as chronic anxiety and depression (Briere & Runtz, 1988), substance use and abuse seems a logical consequence of CSA. Scott's (1992) study of the LAECA data indicates that although alcohol abuse is more common to males, female CSA survivors appear to be more prone to alcohol abuse and dependence than male CSA survivors. Results showed no significant alcohol abuse and dependence increase among men with a CSA history. However, an increase in drug abuse and dependence was noted (Scott, 1992).

Anorexia, bulimia, compulsive eating, and dieting have been associated with CSA. In a study of female clients from a women's counseling center at a large Midwestern

university, Cohen and Frazier (1992) found that 22% reported eating disorders and 38% reported weight issues. Counselors classified most of the eating disorders as compulsive overeating rather than anorexia or bulimia. Females reporting histories of incest were more likely to report eating disorders. Clinical impressions rather than standardized measures were used to measure sexually abusive experiences and counselor subjectivity may have resulted in an overestimation of the frequency of victimization among clients.

Eating too much or too little are attempts to protect one's self or to assert control (Bass & Davis, 1988). In describing one patient's paradox, Young (1992) cited that only by destroying the body which keeps her in a physically dangerous world, could she survive. Other survivors feel that if they make themselves unattractive by becoming overweight, they will be less vulnerable to abuse (Bass and Davis, 1988).

Self-destructive behaviors and suicide have been associated with CSA. In a sample of clients attending a crisis counseling center, Briere & Runtz (1986) found that 56% of women with a history of CSA had previously attempted suicide compared to 23% of non-abused women. An earlier Briere study (1984) of 153 clients of a community health counseling center produced similar results. Previous suicide attempts were made by 51% of the CSA victims versus

34% of the non-abused clients. A desire to hurt themselves was expressed by 31% of the CSA victims compared with 19% of the non-victims. In yet another study, using a sample of college students reporting a history of CSA, Sedney & Brooks (1984) found that 39% of victims reported suicidal ideation compared to 16% of non-victims. Of the subjects in the sample, 16% made previous suicide attempts. Finally, in a community study, Bagley & Ramsey (1985) also found an association between CSA and suicide or attempts at self-harm. Adult survivors of CSA frequently struggle with suicidality and require continuous assessment during treatment (Briere, 1989).

Self-destructive behaviors may stem from the victim's perspective that he or she is bad, unworthy, or unlovable. The result may be attempts to punish, reduce stress, or decrease feelings of helplessness (Briere, 1989). One survivor describes carving her skin with a knife when she was a child and watching the blood drip so she would know she was alive. As an adult, she describes rubbing her body with poison oak during a suicidal episode and recalls the relief from the shame she had felt for so long (Bass & Davis, 1988).

Post-Traumatic Stress Disorder (PTSD) has been associated with CSA by several researchers (e.g., Donaldson & Edwards, 1989; Gorcey et al., 1986; Briere, 1989). In order to make a diagnosis of PTSD, the Diagnostic

Statistical Manual of Mental Disorders, third edition, revised (1987) (DSM IIIR) requires the presence of several symptoms. The client must reexperience the trauma through recurrent and intrusive thoughts and emotions pertaining to the event and exhibit a feeling of reoccurrence of the event when environmental stimuli is presented. A feeling of detachment and general numbing of responsiveness to the external world must be experienced. At least two of the following symptoms must be present: (a) feelings of guilt about survival; (b) avoidance of activities that arouse recollections of the event; or (c) an intensification of symptoms when exposed to events that resemble the traumatic event. In a self-report study assessing symptoms in adult survivors of incest, researchers found that symptoms fit the diagnostic criteria of PTSD (Donaldson & Edwards, 1989). Researchers adhere to severe post-sexual-abuse trauma as a specific form of PTSD (Briere, 1989).

Personality Disorders

Briere (1989) refers to the prevalence of a numbing of general responsiveness or a psychological withdrawal from the outside world among CSA survivors. This psychological escape from pain probably develops early in life as a coping strategy. Several researchers in the field report such dissociations in their work with survivors of CSA (e.g., Bass & Davis, 1988; Briere, 1989; Briere & Runtz, 1986). A dramatic example is that of multiple

personalities. Clinical reports support an association between Multiple Personality Disorder (MPD) and CSA, although according to Akman et al., (1992), there is insufficient evidence to establish a strong link between the two. They contend that in cases of MPD, severe physical abuse is a factor as well as CSA and that studies do not account for the former. Perhaps one of the most well-known cases, Sybil, involved severe sexual abuse coupled with physical abuse (Young, 1992). According to the DSM IIIR (1987), the disorder has often been preceded by severe abuse, including sexual abuse and is not as rare as it has commonly been thought to be.

Historically, the concept of hysteria has been linked to Freud and his theory of feminine psychosexual development (Briere, 1989), and current research seems to be lacking in the area. In his work with adult CSA survivors, Briere (1989) describes a "hysteria" closely related to the diagnosis of Histrionic Personality Disorder (HPD). Typical behaviors include focus on symptoms and illnesses, egocentricity, attention-seeking behaviors, craving for novelty, stimulation, over reactive behaviors, constant need for approval, etc. (Briere, 1989; DSM IIIR, 1987).

A more current phenomenon, Borderline Personality Disorder (BPD), is a common diagnosis among individuals who present with severe post-sexual-abuse trauma (Briere, 1989). Many of the symptoms of BPD listed in the DSM IIIR

(1987) are similar to problems seen in adults who have experienced severe and prolonged CSA. While recent research has suggested a high incidence of CSA among BPD patients, Paris and Zweig-Frank (1992) believe current studies have not weighted risk factors equally and propose a multivariate model for future research.

Major psychiatric disorders cannot be understood in terms of one specific pathogenic developmental factor, such as CSA (Paris & Zweig-Frank, 1992). The long-term effects of CSA are mediated by several factors such as the frequency of the abuse, the duration of the abuse, the relationship of the child to the perpetrator, the type of abuse, the relationship of the child to the perpetrator, the type of abuse, whether or not force was used, the age of the child at the time of the abuse, the age of the perpetrator, whether or not the abuse was disclosed, and the reaction of the parents to disclosure of the abuse (Browne & Finkelhor, 1986). To be workable, models of etiologies of psychiatric disorders must consider multiple factors.

CHAPTER III

Summary and Conclusions

Addressing the Needs of Adult Survivors of CSA

According to Briere (1989), the therapist's general orientation toward working with sexual victimization is more important than treatment techniques. In some cases of client disclosure, there is a tendency for the therapist to disbelieve the abuse. Bass and Davis (1988) and Briere (1989) advise the therapist to approach the problem from an "abuse perspective" and be willing to believe the unbelievable. Our society has a tendency to blame the victim, even when he or she is a child, and therapists are not immune to this bias. Most adult victims have at one time believed that the abuse was their fault. They are in need of a therapist who will not reinforce feelings of guilt and responsibility (Briere, 1989).

In working with adult survivors of CSA, countertransference is likely to occur at some point in the therapy relationship. Therapists must examine their own attitudes toward sexual abuse and realize the potential of past CSA experiences to influence therapeutic effectiveness (Beutler & Hill, 1992).

According to Beutler and Hill (1992) some adult survivors expect to be betrayed and abused as they were in past

abusive relationships and transfer this to the therapeutic relationship (Beutler & Hill, 1992). This relationship can be equally threatening for the survivor of CSA (Briere, 1989).

Adult survivors need to have their feelings of anger, rage, and hostility validated. They should be encouraged to identify and express these feelings (Bass & Davis, 1989). Outbursts of rage or hostility can be triggered by therapist behaviors that remind the victim of the abuser. Therapists must be able to respond to challenging behavior yet not react on a personal level (Briere, 1989).

Survivors need to understand the development of coping strategies as necessary and useful during victimization, but no longer appropriate in adulthood (Bass & Davis, 1988). Training in providing appropriate coping styles will be necessary during the healing process.

It is important in working with survivors, that the topic of sexual abuse not be ignored and symptoms of CSA be recognized (Bass & Davis, 1988; Briere, 1989). Many women have never talked about their abuse and may present other problems, such as eating disorders, depression, addictions, suicidal feelings, and sexual problems. Survivors need to be encouraged to talk about the abuse.

Adult survivors need support. A relatively egalitarian atmosphere in which the survivor is seen as an equal partner in treatment is most effective (Briere, 1989).

Teyber (1988) also stresses the importance of establishing a collaborative relationship early in the therapeutic process to help clients achieve a greater sense of their own mastery and competence.

It is helpful for survivors to work with several sources of support at once such as individual counseling and support groups. Interaction with other survivors is effective in debunking social myths regarding CSA and in providing a sense of normalcy (Briere, 1989). Since healing is a growth process during which the survivor will experience good times and bad times throughout (Bass & Davis, 1988), a support system is essential.

During the healing process, some survivors appear to regress. Confronting and integrating long repressed memories results in psychological discomfort and the survivor experiences increased anxiety and depression (Briere, 1989). The reality of suicide must be recognized and threats should never be discounted.

Since addictions are ways to numb feelings, suppress memories, and escape pain, they must be broken before healing can occur (Bass & Davis, 1988). Survivors need help in seeking appropriate resources that address addictions.

The term "survivor" suggests that healing from CSA is possible, and that the victim is not doomed to a lifetime of psychological distress. According to Bass and Davis

(1988), the cliche, "time heals all wounds", is true to a certain extent. Time dulls the pain, but deep healing or "thriving" doesn't occur unless the survivor commits to make lasting changes.

Future Research

A review of current literature indicates that the majority of studies of long term effects of CSA have several shortcomings. (Beutler & Hill, 1992; Briere & Runtz, 1988; Cado et al., 1990). First, more clinical theory than empirical research is available and results are sometimes contradictory. It is not clear whether findings in the clinical studies are applicable to the general non-clinical population (Briere & Runtz, 1988). With fewer control groups employed in clinical studies, it is difficult to account for the effect of variables such as family dysfunction, parent illness, alcoholism, and other variables which are commonly associated with psychopathologies present in this population (Akman, 1992). Cado et al. (1990) support the contention that clinical studies represent only a relatively small minority of adult female survivors of CSA. As noted earlier, there are a number of adult survivors who never disclose their abuse and never seek treatment.

Non-clinical studies are not without flaws. Biases in samples are likely since subjects are volunteers solicited from newspapers and advertisements or random, representative surveys from a particular locale or a specific group.

Finkelhor (1987) reports that even though all non-clinical community surveys report at least 5% of adults have experienced some sexual abuse in their childhood, the variation among studies is great, ranging from 6% to 62% for women and 3% to 31% for men.

University student samples employed in several studies can also lead to inaccurate interpretations. If victims of CSA choose courses dealing with sexuality because of their own abuse, the college population would erroneously yield a higher prevalence of CSA than the general public (Akman et al., 1992). Determining long-term effects on college samples may produce inaccurate interpretations since the subjects have not yet established sustained adult relationships and abuse may have ended only a few years earlier (Cado et al., 1990). In addressing the direction of future research, more empirical research employing non-biased samples and matched control groups is needed. Methods are needed for collecting data from silent victims of CSA, who, despite psychological distress, have not sought treatment.

Second, current research consists of variations in methodologies, definitions and findings so that assessment of factors affecting psychological and sexual adjustment of adult survivors is difficult (Guthrie et al., 1992). The definition of CSA is not consistent throughout research (Browne & Finkelhor, 1986). Studies are limited by methodological weaknesses such as inappropriate or no

control groups, questionable statistical analyses, non-standardized measures, and failure to probe causality of effects of abuse (Briere & Runtz, 1988). More sophisticated research methodology that employs standard measurements, definitions of CSA, and appropriate statistical analyses is needed.

Third, the majority of current research focuses on female victims of CSA. This seems logical since cases generally involve a male perpetrator and female victim (Sebold, 1987) and males are less likely to disclose CSA experiences (Finkelhor et al., 1990). Future research endeavors that include male CSA victims in their samples should examine gender differences, treatment modalities, and the potential for male victims to become perpetrators.

Finally, victimization issues have received little attention in the counseling literature, and this deficit is reflected in inadequate counselor training programs (Cohen & Frazier, 1992). Future research in this area is essential since uninformed mental health professionals can inadvertently "revictimize" those who seek help.

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