

FACTORS ASSOCIATED WITH THE SEVERITY OF LONG-TERM
REACTIONS TO A CHILDHOOD SEXUAL EXPERIENCE

by
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DECLARATION OF ORIGINALITY

I hereby declare that this thesis, unless specifically indicated to the contrary in the text, is my own original work and that it has not been submitted for any degree at another university.

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ABSTRACT

Factors associated with the severity of long-term reactions to childhood sexual abuse were investigated using a conceptual framework developed around the experiences of sexually abused children.

Phase I was given over to the development of a methodology for studying the long-term effects of child sexual abuse which controlled for, or minimized, threats to internal validity and which minimized the potential for secondary victimization. Pretesting of the proposed methodology on a target sample of 163 university women students yielded a participation rate of 92% and a prevalence rate for child sexual abuse of 39,9%. An analysis of respondents' evaluations of the research indicated that the proposed methodology has a potential for secondary victimization that does not exceed levels observed in carefully and sensitively designed studies conducted in the United States.

Phase II: The methodology developed during Phase I was applied to a sample of 640 university women students in an attempt to identify and explore different patterns of psychological adjustment and to identify and evaluate risk factors associated with differential adjustment. The results from Phase II revealed that the entire distribution of adjustment scores for the victimized sample was shifted significantly in the direction of more pathological levels of adjustment, with 17,5% of victimized subjects reporting levels of adjustment which effectively placed them at the "clinical pathology" end of the continuum of adjustment. Path analyses revealed that victim's personal appraisals of their abuse were more predictive of the severity of long-term outcomes than were more objective abuse related events; that objective abuse related events had a significant direct effect on abuse related appraisals; and that different constellations of variables were associated with risk and resilience to the long-term effects of abuse.

Phase III of the research attempted to cross-validate the findings obtained for the student sample (Phase II) using a volunteer sample of 246 women drawn from the general population of adult women. The findings from this phase of the research were consistent with findings obtained for the student sample (Phase II) across all research hypotheses.

The results of the three phases of the research are discussed in terms of their implications for theory, research, and practice.

<u>SHORT CONTENTS</u>		<u>Page</u>
ACKNOWLEDGEMENTS		(iii)
ABSTRACT		(iv)
CONTENTS		(vii)
LIST OF TABLES		(xviii)
LIST OF FIGURES		(xxii)
CHAPTER 1	INTRODUCTION	1
CHAPTER 2	THE TRAUMAGENIC POTENTIAL OF CHILDHOOD SEXUAL EXPERIENCES	7
CHAPTER 3	THE LONG-TERM EFFECTS OF CHILD SEXUAL ABUSE	33
CHAPTER 4	THEORETICAL ISSUES IN CHILD SEXUAL ABUSE RESEARCH	50
CHAPTER 5	METHODOLOGICAL AND ETHICAL ISSUES IN CHILD SEXUAL ABUSE RESEARCH	70
CHAPTER 6	RECAPITULATION	97
CHAPTER 7	PHASE I : DEVELOPING AN APPROPRIATE METHODOLOGY	99
CHAPTER 8	PHASE II : THE STUDENT SURVEY	141
CHAPTER 9	PHASE III : THE MEDIA SURVEY	197
CHAPTER 10	SUMMARY AND CONCLUSIONS	224
APPENDICES		237
BIBLIOGRAPHY		258

<u>CONTENTS</u>		<u>Page</u>
DECLARATION OF ORIGINALITY		(ii)
ACKNOWLEDGEMENTS		(iii)
ABSTRACT		(iv)
SHORT CONTENTS		(vi)
LIST OF TABLES		(xviii)
LIST OF FIGURES		(xxii)
CHAPTER 1	<u>INTRODUCTION</u>	
1.1	STATEMENT OF THE PROBLEM	1
1.1.1	The First Subproblem	1
1.1.2	The Second Subproblem	1
1.1.3	The Third Subproblem	1
1.1.4	The Fourth Subproblem	2
1.1.5	The Fifth Subproblem	2
1.2	NATURE OF THE RESEARCH	2
1.3	RATIONALE	2
1.4	DELIMITATIONS	3
1.5	RESEARCH PLAN	4
1.6	ORGANIZATION OF THE THESIS	4

	<u>Page</u>	
CHAPTER 2	<u>THE TRAUMAGENIC POTENTIAL OF CHILDHOOD SEXUAL EXPERIENCES</u>	7
2.1	INTRODUCTION	7
2.2	FIRST GENERATION RESEARCH (1896 - 1930)	8
2.3	SECOND GENERATION RESEARCH (1930 - 1970)	10
2.3.1	Studies Reporting Few or No Harmful Effects	12
2.3.2	Studies Reporting Harmful Effects	18
2.3.3	Conclusions	20
2.4	THIRD GENERATION RESEARCH (1970 TO DATE)	21
2.4.1	Studies of Initial Effects	22
2.4.2	Studies of Long-Term Effects	24
2.4.2.1	Clinical Studies	24
2.4.2.2	Studies of College Students	26
2.4.2.3	General Population Studies	29
2.4.3	Conclusions	31
CHAPTER 3	<u>THE LONG-TERM EFFECTS OF CHILD SEXUAL ABUSE</u>	33
3.1	INTRODUCTION	33
3.2	THE LONG-TERM EFFECTS OF CHILD SEXUAL ABUSE	33
3.2.1	Somatic Functioning	34
3.2.2	Intrapersonal Functioning	35
3.2.2.1	Impaired Self-Concept	35
3.2.2.2	Disturbances of Affect	36
3.2.2.3	Dissociative Experiences/Disorders	37
3.2.3	Behavioural Functioning	38
3.2.3.1	Self-Destructive Behaviour	38
3.2.3.2	Self-Mutilation	39
3.2.3.3	Substance Abuse	40

	<u>Page</u>	
3.2.3.4	Eating Disorders	40
3.2.4	Interpersonal Functioning	41
3.2.4.1	Psychosexual Adjustment	41
3.2.4.2	Interpersonal Relationships	41
3.2.5	General Social Functioning	43
3.2.6	Conclusions	43
3.3	FACTORS INFLUENCING THE IMPACT OF ABUSE	44
3.3.1	Abuse Characteristics	44
3.3.2	Family Background Variables	47
3.3.3	The Victim's Post-Assault Experiences	48
3.3.4	Conclusions	48
CHAPTER 4	<u>THEORETICAL ISSUES IN CHILD SEXUAL ABUSE RESEARCH</u>	50
4.1	INTRODUCTION	50
4.2	THE POST-TRAUMATIC STRESS DISORDER MODEL	50
4.2.1	Overview of the PTSD model	50
4.2.2	PTSD Theory	51
4.2.2.1	General Formulations of PTSD	51
4.2.2.2	The Stress Response Syndrome Model	51
4.2.2.3	Janoff-Bulman's Extension of the SRS Model	56
4.3	THE FOUR TRAUMAGENIC DYNAMIC (FTD) MODEL	57
4.3.1	Overview of the FTD Model	57
4.3.2	Evaluation of the FTD model	59
4.4	A PROPOSED SYNTHESIS OF THE 'FTD' AND 'SRS' MODELS	62
4.5	CONCLUSIONS	67

	<u>Page</u>
CHAPTER 5	<u>METHODOLOGICAL AND ETHICAL ISSUES IN CHILD SEXUAL ABUSE RESEARCH</u> 70
5.1	INTRODUCTION 70
5.2	METHODOLOGICAL ISSUES 70
5.2.1	The Definition of Abuse 70
5.2.1.1	Defining a Child 72
5.2.1.2	Defining Sexual Acts 73
5.2.1.3	Defining Abusiveness 73
5.2.1.4	Defining Abusive Relationships 73
5.2.1.5	Consequences of Definitional Decisions 73
5.2.1.6	Implications for Research 75
5.2.2	Samples 75
5.2.2.1	Clinical Samples 76
5.2.2.2	Volunteer Samples 76
5.2.2.3	Samples from Special Populations 76
5.2.2.4	Random Community Samples 78
5.2.2.5	Conclusions 79
5.2.3	Research Design 79
5.2.3.1	Methodologies of Design 80
5.2.3.2	Measurement and Instrumentation 81
5.2.3.2.1	Measures of Abuse Experiences 82
5.2.3.2.2	Mode of Administration 83
5.2.3.2.3	Outcome Measures 86
5.2.4	Data Analysis 87
5.3	ETHICAL ISSUES 89
5.3.1	Ethical Principals 89
5.3.1.1	Autonomy 89
5.3.1.2	Non-Maleficence 91
5.3.1.3	Beneficence 94
5.3.2	Ethical Dilemmas 94
5.4	CONCLUSIONS 96

	<u>Page</u>
CHAPTER 6 <u>RECAPITULATION</u>	97
CHAPTER 7 <u>PHASE I : DEVELOPING AN</u> <u>APPROPRIATE METHODOLOGY</u>	99
7.1 ISSUES IN RESEARCH DESIGN	99
7.1.1 A Conceptual Framework	99
7.1.2 Defining Child Sexual Abuse	99
7.1.2.1 Definitional Decisions	99
7.1.2.1.1 Child	99
7.1.2.1.2 Sexual	100
7.1.2.1.3 Abuse	101
7.1.2.1.4 Child Sexual Abuse	102
7.1.2.1.5 Perpetrator	102
7.1.2.1.6 Victim	102
7.1.2.2 Rationale for Definitional Choices	103
7.1.2.3 Consequences of Definitional Choices	103
7.1.3 The Study Sample	104
7.1.3.1 The Student Sample	105
7.1.3.2 The Volunteer Community Sample	107
7.1.4 Methodology of Design	107
7.1.5 Measurement and Instrumentation	108
7.1.5.1 Mode of Data Collection	108
7.1.5.2 Assessing for a History of Abuse	109
7.1.5.3 Independent Measures	111
7.1.5.3.1 Abuse Related Appraisals	111
7.1.5.3.2 Maturity	113
7.1.5.3.3 Formal Characteristics of Abuse	113
7.1.5.3.4 Family Background Variables	114
7.1.5.3.5 Post-Abuse Experiences	114
7.1.5.4 Dependent Measures	115
7.1.6 Control of Threats to Internal Validity	118
7.1.6.1 Selection	118
7.1.6.2 Instrumentation	118
7.1.6.3 Instability	118

	<u>Page</u>	
7.1.6.4	Statistical Regression	119
7.1.6.5	Experimental Mortality	119
7.1.7	Ethical Considerations	119
7.1.7.1	The Principal of Autonomy	119
7.1.7.2	The Principal of Non-Maleficence	120
7.1.7.3	The Principle of Beneficence	121
7.2	COMPILING THE RESEARCH QUESTIONNAIRE	121
7.2.1	The Introduction	121
7.2.2	The Body of the Questionnaire	122
7.2.3	The Pretest Questionnaire	123
7.3	THE PILOT SURVEY	124
7.3.1	Aims of the Pilot Survey	124
7.3.2	Method	124
7.3.2.1	Subjects	124
7.3.2.2	Materials	125
7.3.2.3	Procedure	125
7.3.3	Results	126
7.3.3.1	Participation Rate	126
7.3.3.2	Prevalence Rate	126
7.3.3.3	Exploratory Data Analysis	127
7.3.3.4	Selection Threats to Internal Validity	127
7.3.3.5	Abuse Effects	129
7.3.3.6	Validity of the Data	131
7.3.3.7	The Impact of the Pilot Survey	132
7.3.4	Discussion	133
7.3.4.1	Participation Rate	133
7.3.4.2	Prevalence Rate	133
7.3.4.3	Threats to Internal Validity	135
7.3.4.4	Abuse Effects	136
7.3.4.5	Validity of the Data	136
7.3.4.5.1	Willingness to Disclose	136
7.3.4.5.2	Capacity to Disclose	137
7.3.4.6	Impact of the Pilot Survey	138
7.3.5	Conclusions	139

CHAPTER 8	<u>PHASE II : THE STUDENT SURVEY</u>	141
8.1	INTRODUCTION	141
8.2	THE RESEARCH HYPOTHESES	141
8.2.1	Hypothesis 1	141
8.2.2	Hypothesis 2	142
8.2.3	Hypothesis 3	142
8.3	METHOD	143
8.3.1	Subjects	143
8.3.2	Materials	143
8.3.3	Procedure	144
8.4	RESULTS	144
8.4.1	Participation Rate	144
8.4.2	Respondents' Evaluation of the Survey	144
8.4.3	Prevalence and Abuse Characteristics	146
8.4.3.1	Prevalence	146
8.4.3.2	Abuse Characteristics	146
8.4.4	Between-Group Analysis	148
8.4.4.1	Demographic and Family Background Variables	148
8.4.4.2	Psychological Adjustment	149
8.4.4.3	Severity of Adjustment Problems	150
8.4.4.3.1	An Index of Symptom Severity (ISS)	150
8.4.4.3.2	ISS Scores: A Comparison of Abused and Nonabused Subjects	151
8.4.4.3.3	Convergent Validity of the ISS	152
8.4.5	Within-Group Analysis: Abused Subjects	158
8.4.5.1	Factors Associated with the Severity of Adjustment Problems	158
8.4.5.1.1	Factors Associated with an Increased Risk of Long-Term Effects	158
8.4.5.1.1.1	Univariate Analysis	159
8.4.5.1.1.2	Discriminant Analysis	162
8.4.5.1.1.3	Analysis of Significant Discriminant Variables	163
8.4.5.1.1.3.1	Recent Life Events	163

	<u>Page</u>	
8.4.5.1.1.3.2	Appraisals of Negativity	164
8.4.5.1.2	Factors Associated with a Reduced Risk of Long-Term Effects	165
8.4.5.1.2.1	Univariate Analysis	166
8.4.5.1.2.2	Discriminant Analysis	166
8.4.5.1.2.3	Analysis of Significant Discriminant Variables	169
8.4.5.1.2.3.1	Recent Life Events	169
8.4.5.1.2.3.2	Appraisals of Betrayal	170
8.4.5.1.2.3.3	Social Support (Helpfulness)	171
8.4.5.1.2.4	Path Analyses	172
8.4.6	Within-Group Analysis: Non-Abused Controls	175
8.4.6.1	Risk Factors for Clinical Pathology	175
8.4.6.1.1	Univariate Analysis	176
8.4.6.1.2	Discriminant Analysis	176
8.4.6.2	Factors Associated with Superior Adjustment	177
8.4.6.2.1	Univariate Analysis	178
8.4.6.2.2	Discriminant Analysis	178
8.4.7	Discriminant Analysis of Risk Factors	179
8.4.7.1	Discriminant Analysis for Clinical Pathology	179
8.4.7.2	Discriminant Analysis for Superior Adjustment	180
8.5	DISCUSSION	180
8.5.1	Limitations of the present research	180
8.5.2	The Research Hypotheses	181
8.5.2.1	Hypothesis 1	181
8.5.2.2	Hypothesis 2	184
8.5.2.3	Hypothesis 3	189
8.5.2.3.1	Risk Factors	189
8.5.2.3.2	Protective Factors	192
8.6	CONCLUSIONS	194

	<u>Page</u>
CHAPTER 9	197
	<u>PHASE III : THE MEDIA SURVEY</u>
9.1	197
9.2	197
9.3	197
9.3.1	197
9.3.2	197
9.3.3	198
9.4	198
9.4.1	198
9.4.2	199
9.4.3	199
9.4.4	199
9.4.4.1	199
9.4.4.2	200
9.4.5	200
9.4.5.1	200
9.4.5.2	202
9.4.5.3	203
9.4.6	206
9.4.6.1	206
9.4.6.1.1	206
9.4.6.1.1.1	207
9.4.6.1.1.2	207
9.4.6.1.1.3	210
9.4.6.1.1.3.1	210
9.4.6.1.1.3.2	210
9.4.6.1.2	211
9.4.6.1.2.1	212
9.4.6.1.2.2	212
9.4.6.1.2.3	215

		<u>Page</u>
9.4.6.1.2.3.1	Recent Life Events	215
9.4.6.1.2.3.2	Appraisals of Betrayal	215
9.4.6.1.2.4	Path Analyses	217
9.5	DISCUSSION	220
9.5.1	Limitations	220
9.5.2	The Research Hypotheses	221
9.5.2.1	Hypothesis 1	221
9.5.2.2	Hypothesis 2	221
9.5.2.3	Hypothesis 3	222
9.6	CONCLUSIONS	222
CHAPTER 10	<u>SUMMARY AND CONCLUSIONS</u>	224
10.1	AIMS OF THE STUDY	224
10.2	LIMITATIONS OF THE RESEARCH	224
10.3	RESULTS	225
10.3.1	Phase I	225
10.3.2	Phase II	226
10.3.3	Phase III	227
10.4	GENERAL CONCLUSIONS	227
10.4.1	The Prevalence of Child Sexual Abuse	227
10.4.2	Ethical Issues	228
10.4.3	Theory	229
10.4.4	The Long-Term Effects of Abuse	231
10.4.4.1	The Traumatic Potential of Abuse	231
10.4.4.2	Factors Associated with the Severity of Long-Term Reactions	232
10.5	RECOMMENDATIONS FOR FUTURE RESEARCH	234

APPENDICES

237

BIBLIOGRAPHY

258

LIST OF TABLESPage

TABLE NUMBER

1	Phases of the Research Process	4
2	Psychosexual Problems Observed in Adult Survivors of Child Sexual Abuse	42
3	Abuse Characteristics as Predictors of Long-Term Reactions to Child Sexual Abuse	44
4	Effects Associated with each Traumagenic Dynamic (Adapted from Finkelhor, 1988, pp. 73-74)	60
5	Factors Impacting on the Evaluation Phase of the Sexual Abuse Response Syndrome Model	65
6	Operational Definitions of Child Sexual Abuse in Recent Outcome Research	71
7	Prevalence Rates for Women by Number of Screen Questions Used	83
8	Prevalence Rates for Women by Mode of Administration	84
9	Prevalence Rates obtained by Russell (1983) Compared to Rates Obtained in Other Major Studies Which Have Employed FFI's (Controlling for Definitional Variation)	85
10	Readership Profile Provided by the Editor of the Magazine in Which the Media Appeal was Published	108
11	Abuse Related Appraisals Surveyed in the Present Research	112
12	Stress Response Themes, Psychological Impact, and Associated Outcome Measures	116
13	Nature of Child Sexual Abuse Reported by Pilot Survey Subjects	127
14	Scores Obtained by Non Victimized Controls on Outcome Measures During Phase I of the Research: Test for Normalacy of Distribution	128
15	Scores Obtained by Abused Subjects on Outcome Measures During Phase I of the Research: Test for Normalacy of Distribution	128
16	Zero Order and Multiple Correlations of the Dependent Measures with Selected Demographic and Family Background Variables	130

TABLE NUMBER		<u>Page</u>
17	Responses to Dependent Measures in the Pilot Survey	130
18	Semipartial Correlations of the Dependent Measures with a History of Sexual Abuse from which the Victim's Age, Parental Punitiveness, and Parental Supportiveness had been Partialled	131
19	Factors which Posed a Threat to the Validity of the Data	132
20	The Impact of the Pilot Survey	133
21	Participation Rates Obtained in American Studies of Child Sexual Abuse	134
22	The Prevalence of Incestuous and Extrafamilial Child Sexual Abuse: The Pilot Survey, Russell, and Wyatt Findings Compared	134
23	Type of Sexual Experiences Reported: The Pilot Survey and Levett Findings Compared	135
24	Nature of Child Sexual Abuse Reported by Student Sample	146
25	Characteristics of Sexual Abuse Experiences Reported by the Student Sample: Victims and Perpetrators	147
26	Characteristics of Sexual Abuse Experiences Reported by the Student Sample: Dynamics	148
27	Responses to Dependent Measures in the Student Survey	149
28	Severity of Adjustment Problems in the Student Sample: A Comparison of Abused and Nonabused Subjects	152
29	Factors Associated with an Increased Risk of Long-Term Effects among Abused Subjects in the Student Sample	159
30	Discriminant Analysis for Clinical Pathology: Analysis of Variable Discriminating Power	163
31	Negative Life Events: The Clinical and Non-Clinical Outcome Groups Compared	165
32	Factors Associated with a Reduced Risk of Long-Term Effects among Abused Subjects in the Student Sample	166
33	Discriminant Analysis for Superior Adjustment: Analysis of Variable Discriminating Power	169

		<u>Page</u>
TABLE NUMBER		
34	Negative Life Events: The "Superior Adjustment" Group Compared to Other Victims	171
35	Path Analysis: Factors Associated With an Increased Risk of Long-Term Effects in the Student Sample	172
36	Path Analysis: Factors Associated With a Decreased Risk of Long-Term Effects in the Student Sample	175
37	Non-Victimized Controls: Risk Factors for Clinical Pathology	176
38	Discriminant Analysis for Clinical Pathology: Analysis of Variable Discriminating Power for the Non-Victimized Sample	177
39	Non-Victimized Controls: Factors Associated with Superior Levels of Adjustment	178
40	Discriminant Analysis for Superior Adjustment: Analysis of Variable Discriminating Power	179
41	Nature of Child Sexual Abuse Reported by the Media Sample	200
42	Characteristics of Sexual Abuse Experiences: Victims and Perpetrators	201
43	Characteristics of Sexual Abuse Experiences: Dynamics	202
44	Responses to Dependent Measures in the Media Survey	203
45	Severity of Adjustment Problems Reported by the Media Sample: A Comparison of Abused and Nonabused Subjects	204
46	Factors Associated With an Increased Risk of Long-Term Effects Among Abused Subjects in the Media Sample	207
47	Discriminant Analysis for Clinical Pathology: Analysis of Variable Discriminating Power	209
48	Negative Life Events: The Clinical and Non-Clinical Outcome Groups Compared	211
49	Factors Associated with a Reduced Risk of Long-Term Effects Among Abused Subjects in the Media Sample	213
50	Discriminant Analysis for Superior Adjustment: Analysis of Variable Discriminating Power	213

		<u>Page</u>
TABLE NUMBER		
51	Negative Life Events: The "Superior Adjustment" Group Compared to Other Victims	216
52	Path Analysis: Factors Associated with an Increased Risk of Long-Term Effects in the Media Sample	217
53	Path Analysis: Factors Associated with a Decreased Risk of Long-Term Effects in the Media Sample	220

	<u>LIST OF FIGURES</u>	<u>Page</u>
FIGURE NUMBER		
1	Basic components of the Sexual Abuse Response Syndrome (SARS) Model	63
2	Different Patterns of Adjustment to a Childhood Sexual Experience	68
3	Severity of Adjustment Problems: Abused and Non-abused Controls Compared	153
4	Level of Adjustment X Mean Self-Esteem Scores	156
5	Level of Adjustment X Mean Locus of Control Scores	156
6	Level of Adjustment X Mean Suicidal Feelings Scores	157
7	Level of Adjustment X Mean Sexual Conflict Scores	157
8	Level of Adjustment X Mean Negativity Appraisal	160
9	Level of Adjustment X Mean Life Stressors	160
10	Level of Adjustment X Mean Social Support	161
11	Level of Adjustment X Mean Parental Punitiveness	161
12	Level of Adjustment X Mean Parental Supportiveness	162
13	Level of Adjustment X Mean Life Stressors	167
14	Level of Adjustment X Mean Betrayal Appraisal	167
15	Level of Adjustment X Mean Social Support	168
16	Level of Adjustment X Mean Parental Punitiveness	168
17	Proposed Model of Significant Relations Between Abuse, Abuse Appraisals, Life Stressors, and Increased Risk of Long-Term Effects with Variable Correlations and Path Coefficients (in Parentheses)	173
18	Proposed Model of Significant Relations Between Family Background, Sexual Abuse, Life Stressors, Social Support, and Decreased Risk of Long-Term Effects with Variable Correlations and Path Coefficients (in Parentheses)	174

		<u>Page</u>
FIGURE NUMBER		
19	Severity of Adjustment Problems: Abused and Non-abused Controls Compared	205
20	The Media Sample: Level of Adjustment X Mean Life Stressors	208
21	The Media Sample: Level of Adjustment X Mean Appraisal of Ambivalence	208
22	The Media Sample: Level of Adjustment X Mean Verbal Coercion	209
23	The Media Sample: Level of Adjustment X Mean Life Stressors	214
24	The Media Sample: Level of Adjustment X Mean Appraisal of Betrayal	214
25	The Media Sample: Level of Adjustment X Mean Verbal Coercion	215
26	The Media Sample: Proposed Model of Significant Relations Between Abuse, Abuse Appraisals, Life Stressors, and Increased Risk of Long-Term Effects with Variable Correlations and Path Coefficients (in Parentheses)	218
27	The Media Sample: Proposed Model of Significant Relations Between Abuse, Abuse Appraisals, Life Stressors, and Decreased Risk of Long-Term Effects with Variable Correlations and Path Coefficients (in Parentheses)	219

CHAPTER 1

INTRODUCTION

1.1 STATEMENT OF THE PROBLEM

The present research explored the long-term psychological effects of child sexual abuse using a conceptual framework developed around the experiences of sexually abused children [i.e., the Sexual Abuse Response Syndrome Model (SARS), cf., Chapter 4]. More specifically, the research aimed: (a) to identify and to describe different patterns of adjustment to a childhood sexual experience; and (b) to identify and to evaluate factors associated with differential outcomes.

The research problem outlined above translates into a number of specific subproblems:

1.1.1 The First Subproblem

To develop a methodology for studying the impact of childhood sexual abuse which controlled for, or minimized, threats to the internal validity of research findings, and which minimized the potential for secondary victimization that is inherent in this sensitive area of research.

1.1.2 The Second Subproblem

To obtain a measure of psychological adjustment in a sample of adults who reported a childhood sexual experience.

1.1.3 The Third Subproblem

To identify and to explore patterns of psychological adjustment in the study sample.

1.1.4 The Fourth Subproblem

To identify and to evaluate factors associated with different patterns of adjustment to a childhood sexual experience.

1.1.5 The Fifth Subproblem

To cross-validate the study findings using a sample drawn from a different population.

1.2 NATURE OF THE RESEARCH

The research problems investigated in the research were essentially propositional (rather than hypothetical) in nature. The general research strategy employed in the study was accordingly "exploratory" rather than "hypothetical"; with the research being directed towards the identification of important variables (and the relations between such variables) rather than towards a rigorous attempt to test hypotheses derived from the literature.

1.3 RATIONALE

There are a number of reasons for investigating differential reactions to a childhood sexual experience:

- (i) To explore the validity, and relative merits, of competing conceptual frameworks that have been put forward in an attempt to account for differential reactions to childhood sexual experiences.
- (ii) To identify and to evaluate factors that mediate or moderate the traumatic effects of abuse and thereby provide a rational basis for the development of appropriate secondary prevention programmes.
- (iii) To identify and to describe different patterns of adjustment to abuse and thereby provide a rational

basis for the development of appropriate tertiary prevention programmes.

1.4 DELIMITATIONS

The study was limited to an investigation of the long-term effects of childhood sexual abuse, with "long-term effects" being defined as psychological effects which persist for a period of at least two years following the termination of abuse. The decision not to include victims who were currently experiencing, or who had recently experienced, abuse was based on a desire to evaluate the impact of post-abuse experiences - such as the reaction of significant others to disclosure, and social and institutional responses to disclosure - which are likely to be relevant to the victim's adjustment (Finkelhor & Browne, 1986) but which are unlikely to form part of the experience of children whose abuse is ongoing or only recently terminated.

The study was restricted to female victims of child sexual abuse. This decision does not in any way imply that males are not victims of child sexual abuse, nor that the sequelae of such abuse are not worthy of study. It is simply a reflection of the fact that child sexual abuse is far more prevalent among females, with such victimization consequently constituting a more widespread social problem.

The definition of psychological adjustment used in the study was restricted to encompass only those areas of adjustment that previous studies have found to be affected by a history of abuse.

The use of an ex post facto design, combined with a reliance on largely correlational methods of analysis, restricted the confidence with which causal statements could be made. The present research was therefore limited to identifying statistically significant relations between variables, with

causality being inferred on the basis of logic and theory (rather than on the basis of data substantiation).

1.5 RESEARCH PLAN

The research involved three separate, although related, stages. The rationale for, and objectives of, each of these phases of the research process is summarized in Table 1.

TABLE 1 : Phases of the Research Process

Phase	Subproblem Addressed ^a	Objective
I	1	To develop a methodology for studying the long-term impact of child sexual abuse which controlled for, or minimized, threats to internal validity and which minimized the potential for secondary victimization.
II	2,3,4	To apply the methodology developed in Study 1 to a sample of university women (subproblem 2) in an attempt: (a) to identify and explore different patterns of psychological adjustment (subproblem 3) and (b) to identify and evaluate risk factors associated with differential adjustment (subproblem 4).
III	5	To cross-validate the findings obtained in Study 2 using a sample of women drawn from the general population.

^aThe subproblems described in sections 1.1.1 to 1.1.5 (p. 1)

1.6 ORGANIZATION OF THE THESIS

Chapter 2 reviews literature pertaining to the traumagenic potential of child sexual abuse.

Chapter 3 reviews the psychological effects of child sexual abuse that have been observed in both clinical and non-clinical samples, and examines factors that have been found to be associated with the severity of long-term effects.

Chapter 4 examines conceptual frameworks that have been put forward in an attempt to explain how and why child sexual abuse results in undesirable initial and long-term effects. The advantages and limitations of prevailing perspectives are considered in the context of empirical findings relating to child sexual abuse, and a modified conceptual framework - based on a synthesis of two dominant perspectives - is proposed.

Chapter 5 discusses methodological and ethical issues that are relevant to child sexual abuse outcome research.

Chapter 6 provides a summary of the main issues raised in Chapters 2 to 5, and considers the implications of these issues for the present research.

Chapter 7 elucidates the research design developed for Phase I of the research (i.e., the pilot survey). Thereafter, the results of the pilot survey are presented and discussed.

Chapter 8 focuses on Phase II of the research (i.e., the student survey). The design and objectives of the research are described and the results of the survey are presented and discussed.

Chapter 9 deals with Phase III of the research (i.e., the media sample). The design and objectives of the research are described and the results of the survey are presented and discussed.

Chapter 10 synthesizes material from all three phases of the research and provides a summary of, and conclusions about the

study as a whole. Limitations of the study are discussed and implications of the findings for future research and clinical practice are considered.

CHAPTER 2THE TRAUMAGENIC POTENTIAL OF CHILDHOOD SEXUAL EXPERIENCES

2.1 INTRODUCTION

Research on the traumagenic potential of childhood sexual experiences has evolved through a number of "generations" of growth. The first generation, which centred largely around the early formulations of Freud and other psychoanalytic theorists, reported on the psychological sequelae of abuse using detailed summaries of individual case studies.

Second generation studies attempted to extend these clinical impressions using larger, and more representative, samples. Although these studies represent an advance over previous efforts, they were, to the large part, flawed by methodological problems - including biased sampling, the absence of appropriate control groups, and/or a failure to employ objective outcome measures - which could invalidate their findings.

The last two decades has seen the emergence of a third generation of research which has attempted to estimate the psychological impact of childhood sexual abuse among large and representative samples using well designed studies and careful multivariate analysis.

Although it is tempting to view these three generations of research as discrete stages, it is, I believe, more accurate to construe them as three overlapping waves of endeavour, each of which occupied the leading edge of research activity at a particular point in time: first generation research predominating from 1896 to 1930; second generation research from 1930 to 1970; and third generation research from 1970 to date.

2.2 FIRST GENERATION RESEARCH: (1896 - 1930)¹

Freud was the first clinician to state categorically that child sexual abuse played an important aetiological role in the development of adult psychopathology. In a series of articles published in 1896 (Freud, 1896/1962a, 1896/1962b, 1896/1962c) Freud reported on his analysis of 13 cases of hysteria and concluded that, in each case, the specific (i.e., necessary and sufficient) cause of the neurosis had been:

A precocious experience of sexual relations with actual excitement of the genitals, resulting from sexual abuse committed by another person;² and the period of life at which this fatal event takes place is earliest youth - the years up to the age of eight to ten (Freud, 1896/1962a, p. 152).

At the time that Freud wrote his second paper on the neuropsychoses of defence (1896/1962b) it is clear that he believed that childhood sexual abuse also played an important aetiological role in the development of a number of other disorders including neurasthenia, anxiety neurosis, obsessional neurosis, and chronic paranoia (cf., Freud, 1896/1962b, pp. 168-185).

¹ The review which follows does not attempt to provide a comprehensive history of early psychoanalytic contributions to the field of childhood sexual abuse but is restricted to those contributions which: (a) most directly address the issue of the traumagenic potential of childhood sexual experiences; and/or (b) which were influential in terms of subsequent perceptions of the traumagenic potential of childhood sexual experiences.

² Although Freud initially maintained that the perpetrators were servants, teachers, or other children (cf., Freud, 1896/1962a, p.152) it is clear from a letter to Fleiss, dated September 21, 1897 (Standard Edition, 1, 259-260), that it was in fact the father who was the perpetrator in every case.

Within two years, however, Freud's growing realisation that the unconscious had no indications of reality led him to initially doubt (cf., Freud, 1906/1953, pp. 259-260) and subsequently to revise his views (Freud, 1906/1953). In the revised theory, memories of childhood sexual traumas - particularly memories of father-daughter incest - were no longer taken as evidence of 'actual' abuse but were interpreted rather as hysterical fantasies which had little, if any, basis in reality. As Freud later wrote:

I was at last obliged to recognise that these scenes of seduction had never taken place, and that they were only fantasies which my patients had made up (Freud, 1925/1959, p. 34).

Although Freud continued to acknowledge that child sexual abuse did occur, and that such abuse may have lasting consequences (see, e.g., Freud, 1917/1963, 1931/1961, 1940/1964), it is clear from his later writings (e.g., Freud, 1931/1961) that he no longer believed that such consequences were as inevitable, or as psychologically debilitating, as he had originally proposed.

Freud's retraction of his neurotica (traumatic theory of the neuroses) was enthusiastically endorsed by Abraham (1907/1949, 1907/1955) who maintained that infantile sexual traumas played no aetiological role in the development of neurotic or psychotic disorders. In line with the view held by most leading authorities at the time (e.g., Janet, 1907; Krafft-Ebing, 1905), Abraham argued that mental disorders were exclusively a function of an abnormal constitutional predisposition.

According to Abraham (1907/1949), children who were disposed to mental illness in later life showed "an abnormal desire for obtaining sexual pleasure" (p. 54) and an associated unconscious wish for such experiences. Abraham believed that it was this abnormal desire for sexual fulfilment that led such children to unconsciously seek out, to overly comply with, or to not adequately resist premature sexual contacts,

and which accounted for the high incidence of childhood sexual abuse among neurotic and psychotic populations.

Abraham was thus able to discount the traumagenic potential of childhood sexual traumas by presenting such experiences as little more than an indication that the child already had a disposition to mental illness. In the process, however, Abraham also managed to effectively discount the image of the sexually abused child as a "passive victim of adult sexual aggressions". In Abraham's formulation, the sexually abused child is portrayed rather as a somewhat less than innocent seducer/seductress, who unconsciously desires sexual contacts, and who plays an active role in initiating or maintaining such contacts.

To summarize: Freud and Abraham were able to de-emphasize the psychiatric significance of childhood sexual experiences by subjecting such experiences to a three-part interpretive transformation: recollections of childhood sexual experiences were transformed from historical fact to hysterical fantasy, abuse experiences were transformed from childhood stressor to childhood sexual activity, and the child was transformed from innocent victim to sexual delinquent. These reinterpretations not only constituted an effective denial of Freud's neurotica - thus clearing the way for the development of Freud's theory of the Oedipus complex - but also provided an interpretive framework which was to play a central role in the perceptions and interpretations of clinicians and researchers who followed in Freud and Abraham's footsteps.

2.3 SECOND GENERATION RESEARCH (1930 - 1970)

The retraction of Freud's neurotica shifted the focus of psychoanalytic concern from the pathogenic effects of childhood sexual experiences to the pathogenic effects of fantasy seduction. "Actual" memories of childhood sexual traumas were no longer regarded as real, relevant, or even

respectable topics for psychoanalytic investigation and as a result few articles relating to the psychological effects of childhood sexual experiences appeared in the professional (psychoanalytic and psychiatric) literature in the period 1910 to 1930.

The early 1930's witnessed a renewed interest in the experiences of sexually abused children; a development that can be attributed to a number of factors:

- (i) One member of Freud's psychoanalytic circle, Sandor Ferenczi, failed to 'respect the death' of Freud's neurotica. In a paper presented to the International Psychoanalytic Congress in Wiesbaden in September 1932 Ferenczi (1932/1984) argued that childhood sexual abuse was a lot more common than was generally suspected and that such abuse had a devastating effect on the child's emotional development.
- (ii) The English school of psychoanalysis, led by Melanie Klein (see, e.g., Klein, 1932), recognized that childhood sexual experiences may have serious effects upon the child's psychic development.
- (iii) The results of a German study, published in 1932 (Moses, 1932; cited in Burton, 1968, p. 102), provided empirical support for the view that childhood sexual experiences may seriously effect the child's subsequent emotional development. Moses' study traced the development, several years later, of 60 children who had been sexually abused by adults. At the time of the study, 37 children (62%) were found to be exhibiting deviant behaviours (neuroses, promiscuity, or a preoccupation with 'sexual things') and Moses concluded that these problem behaviours were the result of the earlier sexual trauma.

These developments posed a clear challenge to the notion that childhood sexual experiences had few, if any, harmful effects and prompted a new wave of research into the psychological effects of early sexual traumas.

2.3.1 Studies Reporting Few or No Harmful Effects³

A survey conducted by Rasmussen (1934) provided little support for the view that childhood sexual experiences were detrimental to the child's psychic development. Rasmussen examined the mental health and social development, 20 to 30 years later, of 54 girls who had been sexually abused before their fourteenth birthday. At the time of the study 46 respondents (85%) seemed none the worse for the experience while the status of 8 (15%) respondents was judged to be unsatisfactory (3 had become psychotic, 3 had become prostitutes, 1 was extremely anxious, and 1 was considered hysterical). In most cases characterized by negative outcomes Rasmussen believed that she found evidence of an independent constitutional predisposition to mental imbalance and this led her to conclude that it was constitutional factors, and not sexual abuse per se, that was the crucial factor in determining long-term reactions to childhood sexual experiences.

Rasmussen's allegiance to the views of Abraham (1907/1949) are apparent not only in her conclusions regarding the traumagenic potential of childhood sexual experiences but also in her emphasis on what she regarded as the consensual nature of many of the sexual assaults. Rasmussen pointed out that 39 girls (72%) had responded in what appeared to be a passive or accepting manner while 4 girls (7%) appeared to have actively

³ "Small sample" studies ($N < 5$) which reported few or no harmful effects of childhood sexual experiences (e.g., Yorukoglu & Kempf, 1966) are not included in the following review.

precipitated the attack. Although Rasmussen's findings are presented in a manner that suggests collusion or victim consent it is apparent from her discussion that what is really being referred to is compliance; a notion that is clearly distinct from, and which does not necessarily imply, acceptance, victim participation or victim consent (cf., Collings & Payne, 1991; Summit, 1983).

The issue of consensuality was also stressed by Bender and Blau (1937) in their study of 16 children (11 females and 5 males aged 5 to 12 years) who were admitted to New York's Bellevue Hospital following sexual experiences with adults. In most cases the authors believed that they found evidence that the child had cooperated or played an initiatory role in establishing the relationship and they therefore concluded that the "children undoubtedly do not deserve completely the cloak of innocence with which they have been endowed by moralists, social reformers and legislators" (Bender & Blau, 1937, p. 514).

With respect to the traumagenic potential of the sexual experiences Bender and Blau concluded that the children showed "less evidence of fear, anxiety, or psychic trauma than might be expected" (p. 510) with seven of the children showing "no apparent acute emotional or behaviour reactions to their sex experiences" (p. 512). In cases where adverse reactions were noted these were regarded by the authors as being due to disruptive experiences in the aftermath of abuse (e.g., the child's exposure to censure from parents or authorities) rather than to the effects of the abuse per se.

In a follow-up study, conducted 14 years later, Bender and Grugett (1952) examined the subsequent development of 14 of these children and found that nine (64%) had made satisfactory adjustments. Of the remaining children, three had become psychotic and two (who had "displayed as children more severe limitations in native endowment" [p. 828]) had achieved little

progress in personal adjustment.⁴ Bender and Grugett concluded that these less favourable outcomes could be attributed to deficiencies in intellectual competence or to a constitutional predisposition to psychotic behaviour that served to:

...limit their potential and frustrate normal maturation. Their sexual behaviour in childhood, rather than predisposing to a psychotic adjustment, had more likely been but one aspect of their generally confused reaction to the beginnings of a fundamentally disrupting process (Bender & Grugett, 1952, p. 829).

The view that childhood sexual experiences constitute a secondary process, derived from the child's predisposition to psychotic behaviour, is also reflected in the work of Rascovsky and Rascovsky (1950). On the basis of prolonged clinical observation of adult victims of father-daughter incest,⁵ Rascovsky and her colleague concluded that the 'typical' incest victim was predisposed towards incestuous relations by a combination of depressive traits and an extremely frustrated relation with the mother. In terms of the author's formulation, children operating from a basic depressive situation tended to overcompensate for primary maternal frustration by attempting to possess the father's penis. Such overcompensation placed the child at greater risk for, and created increased tolerance in the child of, incestuous approaches by the father. In the context of this formulation the authors believed that "the actual consummation

⁴ The findings from this follow-up study are also discussed in a subsequent article by the senior author (cf., Bender, 1965).

⁵ Rascovsky and Rascovsky provide no indication of the number of cases studied. They do, however, introduce their paper by pointing out that their paper represents a partial synthesis of "a wider study based on the psycho-analytic investigation of cases of consummated incest... We say a 'partial synthesis' since, of the incestuous relations we have studied, we refer only to conclusions derived from the father-daughter relation" (1950, p. 42).

of the incestuous relation ... diminishes (italics added) the subject's chance of psychosis and allows better adjustment to the external world" (1950, p. 45).

Rascovsky and Rascovsky's study was followed by Kinsey, Pomeroy, Martin and Gebhard's (1953) survey of female sexuality. Kinsey and his associates found that 24% of their sample had been "approached while they were adolescent by adult males who appeared to be making sexual advances, or who had made sexual contacts with the child" (1953, p. 117). Although Kinsey and his associates came to no definite conclusions regarding the psychological impact of such experiences - females in the sample reported that they had been "variously interested, curious, pleased, embarrassed, frightened, terrified, or disturbed with feelings of guilt" (p. 120) - their impression was that only a small proportion of the victimized sample appeared to have been seriously disturbed by the experience. The authors observed that "in most instances the reported fright was nearer the level that children will show when they see insects, spiders, or other objects against which they have been adversely conditioned" (p. 121).

Consistent with the views of earlier researchers, Kinsey et al. emphasized the consensual nature of many of the experiences. They noted that:

In many instances, the experiences were repeated because the child had become interested in the sexual activity and had more or less actively sought repetitions of the experience (p. 118) ... The adult contacts are a source of pleasure to some children (p. 120) ... and some of the older females in the sample felt that their pre-adolescent experience had contributed favourably to their later socio-sexual development (Kinsey et al., 1953, p. 121).

The consensual nature of childhood sexual experiences is also emphasized in the work of Weiss, Rogers, Dutton, and Darwin (1955). Weiss et al. studied 73 girls (aged 4 to 16 years) who had been the victims of adult sexual offenders and concluded

that 44 (60%) of the children had played an active role in initiating and maintaining the sexual relationship. According to the authors, 'participant victims' could be distinguished from 'accidental victims' on the basis of:

- (i) Personality traits. Participant victims tending to be more seductive, masochistic, and affection seeking.
- (ii) Abuse experiences. Participant victims being more likely to have experienced repeated abuse by a person who was known to them.
- (iii) Family dynamics. Participant victims being more likely to have experienced maternal deprivation or rejection.
- (iv) Emotional adjustment. Participant victims being more likely to exhibit behaviour indicative of profound emotional disturbance (e.g., promiscuity, anti-social behaviour, mood fluctuations, and self-damaging behaviour).

From their discussion of individual case studies it is clear that Weiss and his associates believed that the emotional problems experienced by participant victims were due to disruptive experiences that preceded the abuse (including "deprivation and rejection of the child by the mother" [p.27]) rather than to the effects of the abuse per se.

The distinction between 'participant' and 'accidental' victims was also emphasized by Landis (1956) in his survey of American college students. In a series of studies conducted between 1951 and 1954, Landis surveyed 1,800 students and found that 30% of the men and 35% of the women had been subjected to one or more experiences with an "adult sexual deviate". Landis judged that 47% of the victimized women "had had experiences which could possibly be of a type in which the child might have cooperated or might have initiated the situation" (p.

105).⁶ When compared to 'accidental' victims, 'possible participant' victims tended to have a poorer relationship with their mothers and were more likely to have come from homes characterized by an unhappy parental relationship.

With respect to the emotional effects of abuse, Landis concluded that "the great majority of the victims seem to recover rather soon and to acquire few permanently wrong attitudes" (p. 108). Of the women, 3% felt that permanent emotional damage had resulted, 30% reported temporary damage, and 66% said no damage had resulted. Of the men, 19% reported temporary damage and 81% no damage. In addition, 70% of the women and 80% of the men indicated that their "attitudes and ideas about sex were not undesirably affected by their experiences" (p. 101).

Similar findings regarding long-term outcomes were reported by Gagnon (1965) in his reanalysis of the Kinsey data. Gagnon examined the adult adjustment of 333 women who reported a childhood sexual experience and found that 73% had no apparent adult adjustment problems, 12% had only "slight difficulties", 10% "some difficulty", and 5% "serious difficulty".⁷ Gagnon also examined orgasm rates in marital coitus and found that

⁶ Landis provides no comparative figures for male subjects and no clear indication of the criteria used to classify subjects as 'possible participant' victims.

⁷ These percentages have been calculated from figures provided by Gagnon (1965, p. 188, Table 7). In terms of Gagnon's classification "slight difficulties" included lack of orgasm in coitus, moderately unhappy marriages, or records of short psychotherapy; "some difficulties" included divorce or very unhappy marriages, psychotherapy or psychoanalysis of one year or longer; and "serious difficulties" included three or more divorces, a history of institutionalization for crime or mental illness, or a history of prostitution.

orgasm rates for victimized subjects were not significantly different from those obtained for general populations of adult women in the United States.

Gagnon's study was followed by Burton's (1968) controlled study of the initial to medium-term effects of childhood sexual experiences. Burton assessed the psychological adjustment of 39 victims of child sexual abuse - four and a half months to seven and a half years post-assault - using the Bristol Social Adjustment Guides (BSAG) and the Thematic Apperception Test (TAT). When compared to non-victimized controls ($N = 136$), the victimized sample demonstrated little evidence of traumatic effects, with victimized subjects scoring higher than controls on only one syndrome of the BSAG (i.e., "Affection Seeking"). On the TAT, victimized children told significantly more stories indicative of a need for affiliation but did not differ significantly from controls on indications of personal distress, anxiety, and guilt.

Consistent with the views of earlier researchers (e.g., Bender & Grugett, 1952; Rasmussen, 1934), Burton concluded that "sexual assault of children by adults does not have particularly detrimental effects on the child's subsequent personality development" (p. 169), and that the victimized children's greater need for affiliation probably reflected a constitutional predisposition which "may well have predisposed the child to...sexual acting out" (p. 169).

2.3.2 Studies Reporting Harmful Effects

In the period 1930 to 1970 there were three studies which concluded that child sexual abuse was associated with harmful effects in a significant number of cases.

The earliest of these studies (Sloane & Karpinski, 1942) involved five cases of incestuous abuse that had been seen at a child welfare agency. All of the victims were adolescent

girls, with the perpetrator being a father (three cases) or a brother (two cases). With respect to the psychological impact of abuse the authors concluded that:

Incest in the post-adolescent period leads to serious repercussions in the girl, even in an environment in which the moral standards are relaxed ... Only one of the five girls could be said to have worked out a satisfactory adjustment, while the others manifested various degrees of distortion of the personality (Sloane & Karpinski, 1942, p. 673).

The authors note that these conclusions contrast with findings obtained for pre-adolescent samples (Bender & Blau, 1937; Rasmussen, 1934); a discrepancy which they felt could be attributed to "increased strength of the super-ego in the post-pubital period" (1942, p. 673) and an associated increase in feelings of guilt and self-recrimination among older victims.

Sloane and Karpinski's study was followed by Kaufman, Peck, and Tagiuri's (1954) study of 11 girls, aged 10 to 17 years, who had been involved in an incestuous relationship with a father or father substitute.⁸ On the basis of their investigations Kaufman et al. concluded that "depression and guilt were universal as clinical findings in these girls" (1954, p. 266). Other problems included somatic complaints (four subjects), learning difficulties (three subjects) bossiness (two subjects), sexual promiscuity (one subject), and running away (one subject). The authors clinical impressions were substantiated by the findings from projective tests (Rorschach and Thematic Apperception Test) which provided evidence of "depression, anxiety, confusion over sexual identity, fear of sexuality, oral deprivation and oral sadism" (1954, p. 268). Whilst nowhere specified, it would appear that the authors regarded these adjustment problems as

⁸ Kaufman et al. use the term "father substitute" to describe perpetrators who were either stepfathers, grandfathers, foster fathers, or brothers.

being largely a consequence of the abuse rather than a reflection of emotional stress prior to the abuse.⁹

Finally, in De Francis' (1969) study of 250 child sexual abuse victims - 217 females and 33 males mainly from low-income, multi-problem families - only 24% of the children were judged to be "emotionally stable" following the abuse. Over half of the children (52%) were judged to be "mildly to moderately" disturbed while 14% were judged to be "seriously disturbed" by the abuse.

2.3.3 Conclusions

Early studies of the traumatic effects of child sexual abuse are, to the large part, flawed by methodological problems such as biased sampling, the use of inadequate outcome measures, and the absence of appropriate control groups. The conclusions reached must therefore be regarded as extremely tentative.

Notwithstanding these limitations, an enormous amount of agreement was reached by researchers. First, the "myth" of childhood innocence was generally rejected, with some degree of victim precipitation or victim participation being accepted by most authors. Second, with a couple of notable exceptions (DeFrancis, 1969; Kaufman, Peck & Tagiuri, 1954; Sloane & Karpinski, 1942), all studies concluded that childhood sexual experiences were associated with few, if any, harmful effects.

⁹ Thus, for example, with respect to learning difficulties the authors note that although learning difficulty was a presenting problem in three cases, and one of these girls had had difficulties with school work prior to the detection of the incest "it became apparent during the course of treatment that following its detection (emphasis added) all but one experienced specific or general learning disabilities" (Kaufman *et al.*, 1954, p. 266).

The image of the abused child suggested by such conclusions is complex, containing as it does elements of "the child as rebel" (violating the adult world's expectations regarding sexual desires and conduct), "the child as adult" (desiring and experiencing sexual contact in an adult manner), and "the child as sick" (driven by preexisting psychopathology or unresolved Oedipal conflicts). What is, however, clearly missing is the image of "the child as victim"; a perspective on the abused child which is both consistent with, and confirmatory of, the views expressed by Freud and Abraham in their early psychoanalytic formulations.

2.4 THIRD GENERATION RESEARCH (1970 TO DATE)¹⁰

During the 1970's child sexual abuse began receiving a larger share of public attention. In the United States child abuse emerged as an important social problem¹¹ and the image of the "child-victim" became a more dominant theme¹² in the writings

¹⁰ This review is restricted to studies which included matched control samples and/or employed standardized outcome measures (i.e., studies which employed research designs that permit reasonable causal inference).

¹¹ This is not to suggest that child sexual abuse did not previously constitute an important problem; but rather that during the 1970's concern was directed towards the problem in a manner that made it an object of public concern and thus a social problem in the sense defined by constructionist sociologists such as Schneider (1985).

¹² This concern for "child-victims" came from several quarters, including: (a) the activities of physicians and other professionals (e.g., Sgroi, 1975) who brought the issue of child-victims to the attention of other professionals, the popular media, and legislators, and (b) the efforts of social activists (e.g., the woman's movement, the New Right) whose concern for child-victims emerged from broader social agendas (cf., Best, 1990).

and public statements of those concerned with the welfare of sexually abused children.

This concern with child-victims was reflected in a new wave of research activity, much of which was designed to examine the traumagenic potential of childhood sexual experiences using research designs that permit reasonable causal inference.

2.4.1 Studies of Initial Effects

Recent clinical studies suggest that a significant proportion of sexually victimised children develop clinically significant psychopathology in the immediate aftermath of abuse.

In what is probably the best designed of these studies, Tufts [1984; see also Gomes-Schwartz, Horowitz and Sauzier (1985)] examined the initial effects of child sexual abuse in a sample of 156 children (122 females and 34 males) who had been victimized, or had reported their abuse, within the preceding six months. Subjects' ages ranged from infancy to 18 years with emotional distress in the children being assessed using a battery of standardised outcome measures.¹³

The Tufts researchers found differences in the amount of pathology reported by children of different ages; with clinically significant pathology (i.e., a mean score of 0.5 SD higher than the general population sample) being reported by 17% of the 4- to 6-year olds and by 40% of the 7- to 13-year olds. The findings for the adolescent sample are less clear cut as the norms for Louisville version E-3 (the major outcome measure used in the study) are based on a clinical sample. The index of 'clinically significant pathology' for the adolescent sample (i.e., a mean score of 0.5 SD higher than that of a

¹³ The Louisville Behaviour Checklist, the Piers-Harris Self-Concept Scale, the Purdue Self-Concept Scale, and the Gottschalk Glesser Content Analysis Scales.

clinical sample) was thus more rigorous than that used for the two younger groups.

Despite the use of a more rigorous index of pathology, 24% of the adolescent sample showed clinically significant pathology on the Neuroticism scale (a measure of anxiety, depression, and obsessive concerns), 21% on the Dependent-Inhibited scale, 16% on the Neurological or Psychotic Abnormality scale, and 12% on the General Pathology scale.

Another study which used the Louisville Behaviour Checklist to assess the initial effects of child sexual abuse was conducted by Adams-Tucker (1982). Adams-Tucker evaluated 28 children (22 girls and 6 boys) who had experienced 'recent sexual abuse' and found that "all of the 28 sexually exploited youngsters needed psychiatric care. All children were symptomatic and all but 1 boy suffered appreciably" (1982, p. 1255).

In Friedrich, Urquiza and Beilke's (1986) study, 85 children (61 girls and 24 males), aged 3 to 12 years old, and sexually abused within the previous 12 months, were evaluated using the Child Behaviour Checklist (CBCL, Achenbach & Edelbrock, 1983). Friedrich et al. found differences in the amount of pathology reported by girls and boys; with 46% of the girls and 35% of the boys recording significantly elevated scores (i.e., $T > 70$) on the Internalizing Scale and 39% of the girls and 36% of the boys recording elevated scores on the Externalizing Scale.

Sex related differences in initial adjustment to sexual abuse are also suggested by the findings of a study conducted by Kiser et al. (1988). Kiser and his associates used the CBCL to assess the adjustment of 10 sexually abused children (5 girls and 5 boys) who were referred for evaluation at a psychiatric treatment unit. Analysis of the CBCL profiles revealed that the victimized boys scored significantly higher than the normative sample on the Social Withdrawal and Aggressiveness subscales, the girls significantly higher on the Schizoid-

Anxious subscale, and both girls and boys significantly higher on a measure of sexual problems.

The CBCL was also used by McCleer et al. (1988) to examine the initial impact of sexual abuse in a sample of 31 children (25 girls and 6 males) referred for psychiatric evaluation. On the Internalizing Scale of the CBCL, 33% of these victimized children had a T score above 70, whereas on the Externalizing Scale, 23% scored above 70. In addition, clinical interviews with the children revealed that 48% met DSM-III-R criteria for Post-Traumatic Stress Disorder (PTSD), with many children exhibiting partial PTSD symptoms (81% exhibiting one or more symptoms of re-experiencing behaviour, 48% demonstrating three or more avoidant behaviours, and 65% demonstrating two or more symptoms of autonomic hyperarousal).

2.4.2 Studies of Long-Term Effects

2.4.2.1 Clinical Studies

Clinical studies of the long-term effects of child sexual abuse have examined the psychological adjustment of adult female psychiatric or psychotherapy patients in an attempt to determine whether the adjustment of abused patients differs significantly from levels of adjustment demonstrated by demographically similar, but nonabused, clinical controls.

Thus, for example, Meiselman (1978) examined the psychological adjustment of 26 adult female psychotherapy patients who reported a childhood incestuous experience. When compared to non-victimized controls (N = 50), victimized subjects were found to have entered therapy with more presenting problems (an average of 3.4 vs. 2.5 problems), and were more likely to be experiencing problems in sexual adjustment (current sexual problems being reported by 87% of the abused sample and by 20% of nonvictimized controls).

Tsai, Feldman-Summers and Edgar's (1979) study of the long-term effects of childhood sexual abuse involved three groups of women: (a) a clinical group of 30 women seeking psychotherapy for problems associated with child molestation; (b) a non-clinical group of 30 women who had been sexually abused in childhood but who had never sought therapy and who considered themselves to be well adjusted; and (c) a control group of 30 women who had not been molested during childhood. The results of the study indicate that the clinical group were significantly less well adjusted than either the nonclinical group or the control group on measures of psychosexual adjustment. In addition, the clinical group scored significantly higher than the other two groups on seven subscales (i.e., Hypochondriasis, Depression, Psychotic Deviate, Paranoia, Psychoasthenia, Schizophrenia, and Social Introversion) of the Minnesota Multiphasic Personality Inventory (MMPI).

Two other studies have used the MMPI to assess the psychological status of adult women who were sexually abused during childhood. Meiselman (1980) reported that female psychotherapy patients with a history of child sexual abuse had elevated scores on the Psychopathic Deviate, Schizophrenia, and Depression subscales of the MMPI. These scores did not, however, differ significantly from those obtained for non-victimized controls. On the other hand, Roland, Zelhart, Cochran, and Funderburk (1985) found that sexually abused women scored significantly higher than controls on the Hysteria, Masculinity/Femininity, Hypochondriasis, and Psychopathic Deviate subscales of the MMPI. When these four subscales were entered in a multivariate discriminant analysis they produced a linear function that correctly classified 73% of abused subjects and 72% of non-abused controls.

In a study conducted by Bryer, Nelson, Miller & Krol (1987), the psychological adjustment of a sample of adult female

psychiatric patients who reported a history of childhood sexual abuse ($N = 36$) was compared to levels of adjustment exhibited by demographically similar but nonabused inpatients ($N = 30$). The authors found that patients with a history of abuse reported higher levels of distress (scoring significantly higher than nonabused controls on the Global severity index, and on seven out of nine subscales, of the SCL-90-R), were more likely to report a history of parasuicide, were more likely to have been given an Axis II diagnosis of Borderline Personality Disorder, and were more likely to have received pharmacological treatment.

In Briere and Runtz's (1988) study of 152 women requesting appointments at a Canadian crisis clinic, 67 (44%) were found to have a history of childhood sexual abuse. When compared to non-victimized controls:

Former sexual abuse victims were significantly more likely...to be currently taking psychoactive medication, to have a history of substance addiction, to have been victimized in an adult relationship, and to have made at least one suicide attempt in the past. Abuse victims were also more likely to report a variety of dissociative experiences, sleep problems, feelings of isolation, anxiety and fearfulness, problems with anger, sexual difficulties, and self-destructiveness (Briere & Runtz, 1988, p. 88).

2.4.2.2 Studies of College Students

A number of studies have examined the traumagenic potential of childhood sexual experiences using samples of college students.

In Finkelhor's (1979, 1984) study of 806 college students (536 women and 260 men) a history of child sexual abuse was reported by 121 respondents (104 women and 17 men). When compared to non-victimized controls, subjects with a history of sexual abuse reported significantly lower sexual self-esteem; with this finding holding for both male and female

subjects even after controlling for a range of demographic and family background variables (including class, ethnic background, family size, and parents' education).¹⁴

In a classroom survey of 301 college students, Sedney and Brook's (1984) found that 51 subjects (17%) reported a history of childhood sexual abuse. When compared to non-victimized controls, these 51 women reported significantly more symptoms indicative of anxiety, depression, and self-injurious behaviour.

In another study Fromuth (1986) examined the psychological adjustment of 106 college women who reported one or more sexually abusive experiences during childhood. When compared to non-victimized controls ($N = 277$), victimized subjects reported higher levels of personal distress (scoring significantly higher on the Global Severity Index, and on four of the nine subscales, of the SCL-90). The scores for victimized subjects did not, however, differ from those obtained by non-victimized controls on a range of other outcome measures including the Beck Depression Inventory, Rosenberg's Self-Esteem Scale, the Locus of Control Scale, a self-rating of adjustment, a self-rating of sexual adjustment, and Finkelhor's Sexual Self-Esteem Scale.

Identical procedures, and identical outcome measures, were used by Fromuth and her associate in a later study (Fromuth & Burkhart, 1989) to examine the traumagenic potential of childhood sexual abuse in two samples of college men (253 men from a midwestern university and 329 men from a southeastern university). For the midwestern sample a number of small but significant correlations emerged between a history of child sexual abuse and psychological adjustment as measured by the SCL-90. The southeastern sample did not, however, differ from

¹⁴ Sexual self-esteem was assessed using a six-item scale developed by the author (cf., Finkelhor, 1984, p. 192).

non-victimized controls on any of the scales of the SCL-90, and neither the midwestern nor the southeastern samples differed significantly from non-victimized controls on any of the other outcome measures.

In Harter, Alexander, and Neimeyer's (1988) study of 85 college women (29 with a history of intrafamilial child sexual abuse and 56 non-victimized controls) it was found that abused subjects reported an increased perception of social isolation and poorer social adjustment (as measured by the Social Adjustment Scale; Weissman & Paykel, 1974). When path analysis was used to simplify the contributors to social adjustment, family background and increased perceptions of social isolation were found to be more predictive of social adjustment than abuse per se. However, when the definition of sexual abuse was restricted to include only abuse by a paternal figure, abuse was found to be significantly related to social maladjustment even after controlling for significant family background and social-cognitive variables.

Haugaard and Emery's (1989) study of the long-term effects of childhood sexual abuse involved three groups of victimized college students: (a) a "broadly defined" group of 101 subjects (80 women and 21 men) who had experienced child sexual abuse involving "wanted or unwanted physical or nonphysical contact between a child of 16 years or younger and a perpetrator who was at least 16 years old and at least 5 years older than the victim" (p. 93); (b) a "narrowly defined" subgroup ($N = 77$) which comprised subjects from the broadly defined group but which excluded subjects who rated their sexual experience as very positive and/or who had only contact experience with an exhibitionist; and (c) a "clinical" subgroup ($N = 18$), comprising subjects from the narrowly defined subgroup but excluding those who had not experienced oral, anal, or vaginal intercourse.

These three victimized groups were compared separately to a

randomly selected group of 85 non-victimized subjects on measures of current peer relationships, self-perceived social skill, and current levels of trust and emotional stability. The comparisons involving the "broadly" and the "narrowly" defined groups produced few clear-cut distinctions (other than on measures of current emotional stability and relations with other women). However, for the "clinical" subgroup several significant differences emerged, with victimized subjects giving significantly lower ratings of peer and sexual relationships and showing significantly lower levels of trust, emotional stability, and self-perceived social skills.

2.4.2.3 General Population Studies

In Russell's (1986) probability sample of 930 women residents of San Francisco, 152 respondents (16%) reported a total of 187 childhood incestuous experiences. The victims rated 25% of these experiences to have had "great long-term effects", 26% to have had "some effect", 27% to have had "a little effect", and 22% to have had "no long-term effect". A comparison of the scores obtained by victimized women with those obtained by non-victimized controls on a scale designed to measure negative life experiences,¹⁵ indicated a highly significant and positive relationship between incest victimization and reports of subsequent negative life experiences.

In a Canadian community mental health survey involving 377 women (Bagley and Ramsey, 1986), 21,7% reported a history of sexual abuse before the age of 16. When compared to controls,

¹⁵ Negative life experiences were measured using a nine-item scale developed by the author (cf., Russell, 1986, p. 200). This scale included three measures of repeated victimization, three measures of instability in marital and reproductive life, two measures of downward social mobility, and one measure of poverty at the time of the interview.

sexually abused respondents were twice as likely to report poor mental health (scoring significantly higher on the depression, anxiety, and general psychoneurosis scales of the Middlesex Hospital Questionnaire). Abused respondents also gave significantly lower ratings of self-esteem (Tennessee Self-Concept Scale) and were more likely to report one or more acts of deliberate self-harm in the past year.

In Peters' (1988) community survey of 119 women in Los Angeles County, a history of child sexual abuse (reported by 60% of respondents) was found to be associated with a range of later psychological problems. Women with a history of abuse were more likely to experience problems with depression and substance abuse and reported a greater number of depressive episodes. This relationship between sexual abuse and psychological adjustment remaining significant even after controlling for an absence of maternal warmth [the family characteristic which has been found to be most strongly associated with the occurrence and severity of contact child sexual abuse (cf., Peters, 1984)].

In Stein, Golding, Siegel, Burnam, and Sorenson's (1988) probability sample of 3,132 adult residents of Los Angeles, a history of child sexual abuse (reported by 6,8% of women and 3,8% of men) was found to be associated with a higher prevalence of current (i.e., prior six months) depressive and anxiety disorders. Abused respondents were also more likely to report at least one lifetime diagnosis of mental disorder and demonstrated a higher lifetime prevalence of a number of mental disorders (including substance abuse, affective disorder, major depression, anxiety disorder, phobia, panic disorder, and antisocial personality disorder).¹⁶

¹⁶ Stein *et al.* assessed psychiatric disorders using the Diagnostic Interview Schedule which generates DSM - III diagnoses from computer algorithms based on self-report signs and symptoms.

In Bushnell, Wells, and Oakley-Browne's (1992) probability sample of 347 women drawn from the city of Christchurch (New Zealand), a history of intrafamilial child sexual abuse was found to be associated with an increase in a number of adult mental health symptoms including depression, bulimia, generalized anxiety, substance abuse, and somatic disorders.

2.4.3 Conclusions

In contrast to the findings of early (pre-1970) researchers, recent studies suggest that sexually abused children are at risk for developing a range of psychological problems both in the immediate aftermath of abuse and in the long-term.

There are a number characteristics of recent studies that make these findings particularly compelling. First, all studies reviewed employed research designs that permit reasonable causal inference. Second, a significant proportion of recent studies are based on nonclinical samples (including five probability community samples). And third, in those studies that employed multivariate analyses (e.g., Bagley & Ramsey, 1986; Finkelhor, 1984; Peters, 1988), differences between abused and non-abused subjects remained after controlling for a range of demographic and family background variables.

Although recent studies suggest that sexually abused children are at risk for developing psychological problems they are less informative about the extent of this risk. This is particularly true for studies of initial effects, in which the proportion of children manifesting psychological problems varies both across studies [from a low of 17% (Tufts, 1984) to a high of 100% (Adams-Tucker, 1982)] and within studies [with intra-study variation relating to factors such as the victim's age (Tufts, 1984) and the child's sex (Friedrich et al., 1986; Kiser et al., 1988)].

The extent of risk for long-term effects has only been

examined in two studies. In terms of simple self-assessment, Russell's (1986) found that 25% of subjects who reported an incestuous childhood sexual experience rated the experience as having had "a great effect" on their lives; 54% rated the experience as having "some" or "little effect", and 22% provided reports of "no long-term effects". A more objective assessment of risk for long-term effects was obtained by Bagley and Ramsey (1986) in their random community survey. Using standardised outcome measures, Bagley and his associate found that between 17% and 18% of abused subjects demonstrated clinically significant pathology on measures of depression and psychoneurosis.

To summarise: Recent studies suggest that sexually abused children are at risk for developing a range of psychological problems both in the immediate aftermath of abuse and in the long-term. Available findings would suggest, however, that extreme initial and long-term effects are not inevitable. In the immediate aftermath of abuse at least 17% of sexually abused children manifest some evidence of psychological disturbance. When studied as adults, approximately 17% of victims evidence clinically significant pathology, a further 50% to 60% report "some" or "few" long-term effects, and the remaining 20% to 30% report no long-term effects. As Finkelhor (1986) has commented:

These findings give reassurance to victims that extreme effects are not inevitable. Nonetheless, they also suggest that the risk of initial and long-term mental health impairment for victims of child sexual abuse should be taken very seriously (Finkelhor, 1986, p. 164).

CHAPTER 3THE LONG-TERM EFFECTS OF CHILD SEXUAL ABUSE

3.1 INTRODUCTION

The previous chapter concentrated on evaluating the traumagenic potential of child sexual abuse. This chapter reviews the psychological effects that have been observed to date in both clinical and non-clinical samples, and examines factors that have been found to be associated with the severity of long-term effects.

A number of areas of the literature are not included in the review. First, and in line with the focus of the present research, the review is restricted to studies of long-term effects (for reviews of initial effects see, Beitchman, Zucker, Hood, daCosta, & Akman, 1991; Browne & Finkelhor, 1986). Second, the review is restricted to female victims. As Browne and Finkelhor (1986) have pointed out "few clinical, and even fewer empirical, studies have been done on boys...and it seems premature to draw conclusions at this point" (p. 144). Third, the review is restricted to long-term effects that are likely to be distressing for the individual. Thus, for example, the adult sexual orientation of sexual abuse victims, a factor which is frequently included in discussions of the long-term effects of child sexual abuse (see, e.g., Finkelhor, 1984; Sanderson, 1990), will not be covered here.

Following Finkelhor (1986) the long-term effects of child sexual abuse will be defined as those reactions occurring two years after the termination of abuse.

3.2 THE LONG-TERM EFFECTS OF CHILD SEXUAL ABUSE

Systems theorists (e.g., Jasnowski, 1984) provide a useful

long term effects
= 2 yrs after
termination of
abuse.

framework of sexual abuse that can be functioning levels) these levels of functioning; 2) intrapersonal functioning; 4) interpersonal functioning; and 5) general social functioning.¹

Systems Theory explanation of long term effects

Somatic (intrapersonal, behavioural, interpersonal, general)

the effects of sexual abuse on the functioning level of distal somatic behavioural and social functioning.

3.2.1 Somatic Functioning

Women who have been sexually abused as children are more likely to report a variety of health or physical problems, These problems commonly include migraine headaches, stomach ailments, cramps, bladder infections, vaginal infections, sore throats, and skin disorders (Gil, 1988; Anderson, 1990).

A history of child sexual abuse has also been found to be associated with elevated scores on general measures of somatic distress. Thus, for example, in Briere and Runtz's (1988a) student sample, sexually abused students scored significantly higher than non-victimized controls on the somatization scale of the Hopkins Symptom Checklist. This finding is supported by the results of Bagley and Ramsay's (1986) community survey, in which child sexual abuse was found to be significantly, and positively, associated with somatic anxiety scores on the Middlesex Hospital Questionnaire. Similarly, in Evans (1989) study of 662 postpartum women, sexual abuse was found to be associated with the severity of psychosomatic symptoms even after controlling for the effects of race, marital status, income, and history of child physical abuse.

¹ Although these different levels of functioning will be discussed separately, it should be borne in mind that they are more accurately construed as complexly interrelated systems which function together to maintain a state of dynamic equilibrium (cf., Jasnoski, 1984, pp. 43-48).

Another somatic outcome connected with sexual abuse in the literature is muscular tension. In Sedney and Brooks (1984) college sample, extreme tension was reported by 41% of abused students (compared to 29% of non-victimized controls). Anderson (1990) speculates that such tension may be a reflection of the fact that many sexual abuse survivors are hypervigilant, which prevents them from relaxing, even during sleep.

Finally, a number of authors have observed that sleep disturbances can be associated with a history of child sexual abuse. Such problems include disturbed sleep patterns (Jehu, Gazan, & Klassen, 1985; Sedney & Brooks, 1984) and recurring nightmares (Ellenson, 1985; Jehu, Gazan, & Klassen, 1985).

3.2.2 Intrapersonal Functioning

Intrapersonal effects that have been found to be associated with a history of child sexual abuse include impaired self-concept, disturbances of affect, and dissociative experiences/disorders.

3.2.2.1 Impaired Self-Concept

One of the most commonly reported long-term effects of child sexual abuse is low self-esteem, with survivors reporting feelings of inferiority, stigmatisation, and low self-worth. In Herman's (1981) study, 60% of incest victims in psychotherapy reported a predominantly negative self-image (compared to 10% of the comparison group with seductive but not incestuous fathers). Similarly, in Jehu *et al*'s (1985) clinical sample, 86% of sexually abused women obtained scores indicating low self-esteem on the Battle Self-Esteem Questionnaire.

These clinical findings are supported by results from both college (Sedney & Brooks, 1984) and community studies (e.g.,

Bailey & McDonald, 1984; Bagley & Ramsay, 1986; Courtois, 1979; Evans, 1989; Gold, 1986) all of which suggest an association between poor self-concept and a history of child sexual abuse.

Associated with low self-esteem are feelings of guilt and self-blame (Ferguson, 1986; Jehu et al., 1985; Justice & Justice, 1979; Tsai & Wagner, 1978) Thus, for example, in Jehu et al.'s (1985) clinical sample, 82% of survivors indicated that they blamed themselves for the abuse; an attribution that was invariably associated with feelings of guilt and low self-worth. Similarly, in Ferguson's (1986) community survey, a high incidence of self-blame was reported by adult incest survivors, with subjects who acknowledged more self-blame (in response to a direct question) tending to be more psychologically distressed on a number of the clinical scales of the SCL-90.

3.2.2.2 Disturbances of Affect

A common finding in the literature has been that there is an association between affective disturbance and a history of child sexual abuse; with the most frequently reported affective disturbance being that of depression. Research with nonclinical samples has found that sexual abuse survivors report a higher incidence of depressive symptoms (Bagley & McDonald, 1984; Bagley & Ramsay, 1986; Briere & Runtz, 1985; Evans, 1989; Gold, 1986; S. Peters, 1988; Sedney & Brooks, 1984; Stein et al., 1988), and a greater likelihood of previous hospitalization for a depressive disorder (Peters, 1984; Sedney & Brooks, 1984).

Studies based on clinical populations (e.g., Herman, 1981; Meiselman, 1978) have tended to reflect similar, although less clear cut, distinctions in depression between victims and nonvictims. Thus, for example in Meiselman's (1978) study, 35% of the incest group reported depressive symptoms (compared to

23% of nonvictimized controls) and in Herman's (1981) study 60% of incest survivors reported depression (compared to 55% of controls).

Anxiety disorders are another frequently reported long-term effect of child sexual abuse. Such disorders take a number of forms, including generalized anxiety disorders (Briere & Runtz, 1988a; Jehu, et al., 1985; Sedney & Brooks, 1984; Stein et al., 1988), specific fears and phobias (Becker, Skinner, & Abel, 1983; Fromuth, 1986; Jehu et al., 1985; Peretti & Banks, 1984), obsessive compulsive tendencies (Fromuth, 1986), and post-traumatic stress disorders (Donaldson & Gardner, 1985; Frederick, 1986; Goodwin, 1985; Lindberg & Distad, 1985). Although the proportion of sexual abuse victims reporting one or other anxiety disorder varies markedly from study to study [from a low of 19% (Bagley & Ramsay, 1986) to a high of 59% (Jehu et al., 1985)] the modal incidence, for both clinical and non-clinical samples, is in the region of 50% to 59% (cf., Browne & Finkelhor, 1986, p. 155; Sanderson, 1990, p. 52)

3.2.2.3 Dissociative Experiences/Disorders

Recent studies (e.g., Blake-White & Kline, 1984; Briere & Runtz, 1988a, 1988b; Jehu, 1989) indicate a high incidence of dissociative experiences among adult survivors of child sexual abuse. In Briere and Runtz's (1988a) clinical sample, 21% of the women who had been sexually abused during childhood reported feelings of depersonalization (compared to 8% of controls), 33% feelings of derealization (compared to 11% of controls), and 42% feelings of estrangement (compared to 22% of controls).

A number of studies (Bliss, 1980; Boor, 1982; Coons & Milstein, 1984, 1986; Greaves, 1980; Putnam, 1985; Saltman & Soloman, 1982; Stern, 1984; Wilbur, 1984) also indicate a strong correlation between childhood sexual abuse, particularly incest, and the development of multiple

personality disorders (MPD). The fact that as many as 97% of MPD patients have been found to have sexual abuse histories (Putnam, 1985) has led some writers (e.g., Wilbur, 1985) to assert that without child sexual abuse there would be few, if any, cases of MPD.

The fact that MPD's are extremely rare, while the prevalence rate for child sexual abuse is relatively high, suggests, however, that the vast majority of sexual abuse survivors are not at risk for developing MPD; with the current state of knowledge indicating that MPD is a more probable outcome in cases where the abuse is incestuous and where "the abuse is frequent, unpredictable, inconsistent, sadistic, bizarre, or aggressive" (Sanderson, 1990, p. 64).

3.2.3 Behavioural Functioning

It has been noted that many survivors of child sexual abuse experience negative effects on their adult behaviour. These effects relate particularly to self-destructive behaviours (suicide, parasuicide, or suicidal ideation) and to self-injurious behaviours which may become life threatening (e.g., self-mutilation, substance abuse, and eating disorders).

3.2.3.1 Self-Destructive Behaviour

A number of clinical studies (Adams-Tucker, 1982; Anderson & Shafer, 1979; Briere, Evans, Runtz, & Wall, 1988; Briere & Runtz, 1986; Bryer et al., 1987; Harrison, Lumry, & Claypatch, 1984; Herman, 1981; Perlmutter, Engel, & Sager, 1982; Peters, 1988) have found that child sexual abuse victims demonstrate high levels of suicidal ideation or suicide attempts both at the time of victimization and much later in adulthood. The most compelling evidence for an association between child sexual abuse and self-destructive behaviour has emerged from a controlled study conducted by Briere et al. (1988). In a well designed study, Briere and his associates examined suicidality

in a sample of 40 women (20 with a history of child sexual abuse and 20 non-victimized controls) presenting at a crisis counselling programme of a community health centre. Among child sexual abuse survivors the authors found a high incidence (55%) of previous suicide attempts (compared to 25% for non-victimized controls).²

An association between child sexual abuse and self-destructive behaviour has also emerged from studies of nonclinical samples of adult women. Thus, for example, in Sedney and Brooks' (1984) study of American college students it was found that 16% of women with a history of child sexual abuse had made at least one suicide attempt, compared to only 6% of non-victimized controls. Similarly, in Bagley and Ramsay's (1986) community survey, a recent (i.e., past year) suicide attempt or act of deliberate self-harm was reported by 5% of adult sexual abuse survivors (with no recent self-destructive acts being reported by non-victimized controls).

3.2.3.2 Self-Mutilation

An association between child sexual abuse and self-mutilation - typically involving scratching, biting, cutting, or piercing parts of the body - has been noted by a number of authors (Briere, 1984; Briere & Runtz, 1988a; Gil, 1988; Sanderson, 1990; Sedney & Brooks, 1984; Shapiro, 1987). In Briere's (1984) community sample, 31% of child sexual abuse survivors reported a desire to hurt themselves compared to only 19% of the non-victimized controls. Similarly, in Sedney & Brooks (1984) student sample 39% of the sexually abused subjects

² In the same study Briere *et al.* examined suicidality in a sample of 40 men (20 with a history of child sexual abuse and 20 non-victimized controls) and found that 55% of sexually abused males reported a history of one or more suicide attempts (compared to 20% of non-victimized controls).

expressed thoughts of hurting themselves (versus 16% of non-victimized controls).

3.2.3.3 Substance Abuse

Self-injurious addictions have been observed among adult survivors of child sexual abuse (Briere & Runtz, 1988a; Herman, 1981; Peters, 1984, 1988). Thus, for example, in Briere and Runtz's (1988a) clinical sample, a history of alcoholism was reported by 27% of sexually abused subjects (versus 11% of non-victimized controls) and a history of drug addiction by 21% of abused women (compared to 2% of controls). These findings are supported by the results of Peters' (1988) community survey, in which 18% of sexually victimized women reported a history of alcohol abuse (compared to 6% of non-victimized controls) and 27% reported that they had abused at least one type of drug (versus 12% of non-victimized controls).³

3.2.3.4 Eating Disorders

There is limited evidence to suggest an association between eating disorders (anorexia nervosa and bulimia) and a history of child sexual abuse. In a British clinical programme for women suffering from eating disorders (Oppenheimer, Howells, Palmer, & Chaloner, 1986; Oppenheimer, Palmer, & Brandon, 1984), 34% of clients were found to have a history of child sexual abuse. Although this finding is suggestive, the figure of 34% is in fact lower than prevalence rates obtained for probability community samples in the United States (cf., Russell, 1986; Wyatt, 1985). Further research is thus clearly required before an association between eating disorders and a history of child sexual abuse can be claimed to have been demonstrated with any confidence.

³ These figures have been calculated from data provided by Peters (1988, p. 108).

3.2.4 Interpersonal Functioning

There is considerable evidence that survivors of child sexual abuse experience a variety of interpersonal effects. These effects relate to problems in psychosexual adjustment and functioning as well as to more general problems in interpersonal relating.

3.2.4.1 Psychosexual Adjustment

An association between childhood sexual abuse and later problems in sexual adjustment has been noted by a number of authors. These problems (which encompass sexual dissatisfaction, psychosexual dysfunction, and sexual phobia/aversion) are summarized in Table 2 (p. 42).

An indication of the prevalence of sexual dysfunction among sexual abuse survivors is provided by Jehu (1989). In a clinical study, involving 51 previously sexually abused women, Jehu found that 40 clients (78%) complained of at least one sexual dysfunction at initial assessment. A further eight clients were ascertained to be sexually dysfunctional during therapy, giving a total prevalence rate of 94%. The specific dysfunctions reported by these women included: dissatisfaction (58,8%), phobia/aversion (58,8%), impaired motivation (56,9%), impaired arousal (49%), impaired orgasm (45,1%), dyspareunia 27,4%), and vaginismus (7,8%).

3.2.4.2 Interpersonal Relationships

Women who have been sexually abused as children report a variety of interpersonal problems, including: fear of men (Briere & Runtz, 1988a; Levett, 1989); difficulty in relating to men (Bagley & Ramsay, 1986; Briere, 1984; Courtois, 1979; Jehu et al., 1985; Silbert & Pines, 1983); difficulty in relating to women (Briere, 1984; Herman, 1981); and conflict with parents (de Young, 1982; Herman, 1981; Meiselman, 1978).

TABLE 2 : Psychosexual Problems Observed in Adult Survivors of Child Sexual Abuse

Dysfunction	Study
Dissatisfaction	Bagley & McDonald (1984); Becker, Skinner, & Abel (1983); Briere (1984); Gold (1986); Jehu (1989); Jehu et al. (1985); Langmade (1984); Levett (1989); Tsai et al. (1979)
Impaired motivation	Becker, Skinner, Abel, & Treacy (1982); Briere (1984); Jehu et al. (1985)
Impaired arousal	Becker et al., (1982); Jehu et al. (1985); Peretti & Banks (1984); Jehu (1989); Tsai et al. (1979)
Impaired orgasm	Becker et al. (1982); Jehu (1989); Jehu et al. (1985); McGuire & Wagner (1978); Meiselman (1978); Tsai & Wagner, (1978)
Phobia/aversion	Becker et al. (1982); Jehu (1989); Jehu et al. (1985)
Dyspareunia	Becker, Skinner, Abel, Axelrod, & Cichon (1984); Jehu (1989)
Vaginismus	Becker et al. (1984); Jehu (1989)

In Briere's (1984) clinical sample, 48% of victimized women reported fear of men (compared to 15% of non-victimized controls) and 12% reported difficulties in relating to women (compared to 4% of non-victimized controls). Meiselman (1978) noted that 64% of incestuously abused women (versus 40% of controls) reported conflict with or fear of their husband or sex partner, and that 64% had predominantly hostile feeling towards their mother, with 40% continuing to harbour negative feeling towards their father. These results are supported by findings from de Young's (1982) sample, in which 79% of incest victims reported hostility toward the mother and 52% hostility toward the abuser.

Survivors of child sexual abuse have also been found to be more likely to be the victims of interpersonal violence later in life. This vulnerability to revictimization takes a number of forms including: an increased risk of being raped (Fromuth, 1986; Russell, 1986), an increased likelihood of experiencing repeated rape (Miller et al., 1978), and an increased incidence of battering by husbands or other adult partners (Briere, 1984; Briere & Runtz, 1988a; Herman, 1981; Russell, 1986).

3.2.5 General Social Functioning

A number of clinical studies suggest that adult survivors of child sexual abuse report a sense of isolation and/or alienation that affects their functioning in general social relationships. In her clinical sample, Courtois (1979) found that 73% of women who had been incestuously abused reported feelings of isolation, alienation and a general sense of being different from other people. In Herman's (1981) study of incest survivors, all respondents reported a sense of being branded, stigmatised, or in some way cut off from ordinary human interaction. Similarly, in Briere's (1984) study, feelings of isolation were reported by 64% of sexually victimized women (compared to 49% of non-victimized controls).

Although these clinical findings are suggestive, there has to date been no systematic attempt to examine the incidence of isolation, alienation, and stigmatisation in non-clinical samples of child sexual abuse survivors.

3.2.6 Conclusions

The forgoing review suggests that women who are sexually abused as children are at greater risk for developing a range of psychological/adjustment problems that impact on a broad range of human functioning (somatic, intrapersonal, behavioural, interpersonal, and social).

The review also suggests - regardless of the specific outcome measure examined - that undesirable outcomes are not inevitable, with some individuals appearing to be more vulnerable than others to negative effects.

3.3 FACTORS INFLUENCING THE IMPACT OF CHILD SEXUAL ABUSE

A number of studies have attempted to identify factors associated with the severity of long-term reactions to child sexual abuse. These studies have examined the impact of three classes of variables: (1) abuse characteristics, (2) family background variables, and (3) the victim's experiences in the immediate aftermath of abuse.

3.3.1 Abuse Characteristics

Attempts to examine the relationship between abuse characteristics and the severity of reactions to child sexual abuse have been contradictory and largely inconclusive. As can be seen from Table 3, there is no abuse characteristic that all studies agree upon as being consistently associated with a worse prognosis.

TABLE 3 : Abuse Characteristics as Predictors of Long-Term Reactions to Child Sexual Abuse

Abuse Characteristic	Finding (Study)
Victim's age	Older victims at greater risk (Bagley & Ramsay, 1985; Briere & Runtz, 1988b; Peters, 1985)
	Younger victims at greater risk (Courtois, 1979; Meiselman, 1978; Nelson, 1981)
	No significant trend (Finkelhor, 1979; Ferguson, 1986; Langmade, 1984; Russell, 1986)

(Table continues)

TABLE 3 : (Continued)

Abuse Characteristic	Finding (Study)
Duration	Longer duration associated with greater trauma (Bagley & Ramsay, 1985; Briere & Runtz, 1988b; Peters, 1988; Russell, 1986; Tsai et al., 1979)
	Longer duration associated with less trauma (Courtois, 1979; Seidner & Calhoun, 1984)
	No significant trend (Ferguson, 1986; Finkelhor, 1979; Langmade, 1984)
Sexual acts performed	More intimate contact associated with greater trauma (Bagley & Ramsay, 1985; Ferguson, 1986; Nelson, 1981; Peters, 1985; Russell, 1986)
	No significant trend (Anderson, Bach, & Griffith, 1981; Finkelhor, 1979; Fromuth, 1986)
Relationship to offender	Greater trauma where the abuser was closely related (Anderson et al., 1981; Bagley & Ramsay, 1985; Finkelhor, 1979)
	No significant trend (Peters, 1985; Seidner & Calhoun, 1984)
Coercion	More coercive abuse associated with greater trauma (Briere & Runtz, 1988b; Finkelhor, 1979; Fromuth, 1986; Russell, 1986)
	No significant trend (Anderson et al., 1981; Bagley & Ramsay, 1985)
Abuser's age	Greater trauma where the abuser was older (Finkelhor, 1979; Fromuth, 1986)
	No significant trend (Russell, 1986)

Studies which have used multiple regression procedures to identify combinations of abuse related variables which best predict long-term reactions (e.g., Finkelhor, 1979; Russell, 1986) have also produced few consistent findings.

Finkelhor (1979) used seven variables (coercion, abuser's age, disclosure, victim's age, relatedness, abuser's sex, and seriousness of sexual act) in a regression analysis for trauma in his student sample. The only two factors that emerged as significant predictors of long-term reactions were coercion and partner's age (multiple $R^2 = 0,34$).

In Russell's (1986) community sample the nine factors entered into the regression analysis were the frequency and duration of abuse, severity of abuse, coercion, victim's age, abuser's age, victim-abuser age disparity, number of abuser's, and whether the abuser was a father or some other relative. In marked contrast to Finkelhor's (1979) findings - where severity of abuse did not even approach significance at the 0,05 level - Russell found that severity of abuse was the abuse characteristic which was most strongly predictive of long-term reactions ($p < 0,001$). Conversely, the abuser's age - which was strongly predictive of reactions in Finkelhor's study - failed to reach significance in Russell's study.⁴

The picture is further complicated by the findings from Peter's (1988) community survey in which three variables (frequency of abuse, duration of abuse, and victim's age) emerged as significant predictors of long-term reactions (multiple $R^2 = 0,27$). In contrast to Russell's (1986) findings, Peters found no significant relationship between the seriousness of abuse and psychological effects.

Thus, while abuse characteristics appear to play some role in psychological outcome and the severity of symptoms, the specific contribution of individual factors awaits further clarification.

⁴ Other variables which were significantly predictive of long-term reactions in Russell's analysis were abuse by father, coercion, victim-abuser age disparity, and duration (multiple $R^2 = 0,31$)

3.3.2 Family Background Variables

In their discussion of the long-term effects of child sexual abuse, Steele and Alexander (1981) suggest that:

The family setting in which sexual abuse occurs is of crucial importance... It is the emotional climate in which the sexual abuse occurred that is the most potent instigator of long-lasting effects. It is our impression that less severe sexual abuse occurring in the bosom of a disturbed family is much more traumatic than the sexual abuse of a child perpetrated with greater aggression by a stranger, completely outside the family (Steele & Alexander, 1981, p. 224).

The empirical literature provides some support for Steele and Alexander's hypothesis. Family background variables have not only been found to constitute a significant risk factor for child sexual abuse (Bagley & Ramsay, 1986; Finkelhor, 1984; Fromuth, 1986) but have also emerged as significant predictors of long-term reactions. In Gold's (1986) community sample, "closeness to mother at age 12" was found to be significantly related to measures of adult sexual adjustment. Similarly, in Harter et al's. (1988) student sample, victim reports of "less cohesive and adaptable families of origin" were significantly predictive of scores on a measure of social adjustment.

In Peters' (1985, 1988) community survey, the severity of long-term reactions to child sexual abuse were most strongly related to family characteristics (i.e., poor relationship with mother, lack of closeness to siblings, and not being raised by biological parents), with a lack of maternal warmth emerging as the strongest predictor of long-term reactions ($R^2 = 0,25$).⁵ Two abuse characteristics (frequency and duration) also contributed significantly to the explained variance.

⁵ Maternal warmth was measured using an 8-item scale, developed by Peters (1984), which assessed aspects of the mother-daughter relationship during childhood and adolescence.

3.3.3 The Victim's Post-Assault Experiences

Although the victims experiences in the immediate aftermath of abuse - e.g., the decision to report or not, supportive versus nonsupportive disclosure, institutional reactions - have been found to be associated with the severity of initial effects (Anderson et al., 1981; Tufts, 1984), there has, to date, been no systematic attempt to examine the extent to which such experiences are predictive of long-term reactions.

The two studies which have examined the impact of reporting versus non-reporting on long-term reactions have produced no clear trends. In Bagley & Ramsay's (1985) community survey, the decision to report was found to be significantly related to psychological adjustment. However, this relationship fell away in multivariate analysis when other factors were controlled for. In contrast, Finkelhor's (1979) found no significant relationship between the decision to report and long-term reactions to abuse in his student sample.

3.3.4 Conclusions

As Browne and Finkelhor (1986) have cautioned, conclusions from the forgoing review must be tempered by the fact that:

...they are based on a body of research that is still in its infancy. Most of the available studies have sample, design, and measurement problems that could invalidate their findings (Browne & Finkelhor, 1986, pp. 175-176).

In the context of such limitations it is hardly surprising that attempts to account for differential reactions to child sexual abuse have been largely contradictory and inconclusive. However there are some trends in the findings.

First, it would appear that abuse characteristics do play some role in psychological outcome and severity of trauma, although the specific contribution of individual factors awaits further clarification.

Second, there is evidence to suggest that:

Some of the apparent effects of sexual abuse may be due to premorbid conditions, such as family conflict and emotional neglect, that actually contributed to a vulnerability to abuse and exacerbated later trauma (Browne & Finkelhor, 1986, p. 177).

Third, although it is generally assumed that the victim's post-assault experiences influence long-term reactions, there is to date little empirical evidence in support of this contention. Further research is clearly required on this issue.

CHAPTER 4

THEORETICAL ISSUES IN CHILD SEXUAL ABUSE RESEARCH

4.1 INTRODUCTION

The previous chapter focussed on the range of long-term effects that have been found to be associated with a history of child sexual abuse. This chapter examines and evaluates two explanatory models that have been put forward in an attempt to explain how and why child sexual abuse results in such undesirable outcomes.

The two models to be examined are: 1) The Post-Traumatic Stress Disorder (PTSD) Model, and 2) the Four Traumagenic Dynamic Model.

4.2 THE POST-TRAUMATIC STRESS DISORDER MODEL

4.2.1 Overview of the PTSD Model

The PTSD model was originally formulated to account for the trauma of war and its effects on veterans (Figley, 1978). More recently, a number of clinicians have noted that PTSD has applicability to the evaluation and treatment of traumatized children (see e.g., Benedek, 1985; Eth & Pynoos, 1985; Terr, 1983) and to the understanding of the impact of child sexual abuse (Courtois, 1986; Donaldson & Gardner, 1985; Edwards & Donaldson, 1989; Frederick, 1986; Goodwin, 1985; Kiser et al., 1988; Lindberg & Distad, 1985; McLeer et al., 1988).

According to the third revised edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-III-R; American Psychiatric Association, 1987), the essential feature of PTSD is "the development of characteristic symptoms (for a period of at least one month) following a psychologically distressing

event that is outside the range of usual human experience" and that "would be markedly distressing to almost anyone" (p. 247). The characteristic symptoms involve: 1) reexperiencing the traumatic event, commonly through recurrent and intrusive thoughts, feelings, or dreams relating to the event; 2) persistent avoidance of stimuli associated with the trauma or numbing of general responsiveness; and 3) persistent feelings of increased arousal, commonly evidenced by sleep disturbances, anger or irritability, and hypervigilance.

4.2.2 PTSD theory

4.2.2.1 General Formulations of PTSD

General formulations of PTSD (e.g., Pynoos & Eth, 1985) maintain that PTSD symptoms result from "an overwhelming event resulting in helplessness in the face of intolerable danger, anxiety, and instinctual arousal" (Pynoos & Eth, 1985, p. 38).

Although such explanations are consistent with the experiences around which the PTSD syndrome was developed (i.e., natural disasters, war combat, etc.) they suffer from a clear lack of "fit" when applied to child sexual abuse. As Finkelhor (1988) has pointed out, many cases of child sexual abuse do not occur under conditions of threat or danger but are nevertheless deeply distressing for the individual concerned.

General formulations of PTSD are also limited to the extent that they provide no adequate explanation for the persistence and periodicity of the traumatic effects of child sexual abuse. In addition, they provide no clear indication of the traumagenic dynamics of child sexual abuse and no adequate explanation for differential reactions to abuse.

4.2.2.2 The Stress Response Syndrome Model

The Stress Response Syndrome (SRS) model was formulated by

Horowitz (1978, 1986) in an attempt to explain the dynamics, the persistence, and the periodicity of stress-induced reactions. Although the SRS model provides an explanation for the characteristic symptoms of PTSD it is not restricted to PTSD reactions but also encompasses reactions to events which are conventionally regarded as being within the range of usual human experience. As Horowitz (1986) points out, some life events (e.g., simple bereavement, chronic illness, business loss, or marital conflict) which are clearly not outside the range of usual human experience, are nevertheless capable - depending on individual predisposition and situational circumstances - of producing stress induced reactions similar to those observed in PTSD.

The basic assumptions of the SRS model (cf., Horowitz, 1986, pp. 85-110) can be summarized under the following points:

- (i) In the normal course of events persons maintain a variety of inner working models (cognitive maps, or schemata) relating to the self, to significant others in the world, and to the world in general.
- (ii) An event - regardless of whether it is "inside" or "outside" the range of usual human experience - will be experienced as stressful when: (a) it is appraised as posing a threat to the notion of reality suggested by available inner models, and when (b) it cannot be dismissed as being unimportant or irrelevant to the individual's well-being.
- (iii) The discrepancy between inner schemata and the information conveyed by stressful events has two main consequences:
 - (a) It evokes a sense of subjective distress; with serious life events being "so different from one's inner models of oneself, one's attachment to others, and one's inner world view that very

painful emotional responses develop" (Horowitz, 1986, p. 100). This explains the emotional arousal experienced by individuals in the aftermath of stressful life events.

- (b) It activates a completion tendency [i.e., "the human mind's intrinsic ability to process new information in order to bring up to date the inner schemata of the self and the world" (Horowitz, 1986, p. 93)] in terms of which information conveyed by stressful events "must be reappraised so that it either conforms to internal models...or else inner schemata must be revised so that they match the changed circumstances" (p. 94).

- (iv) Cognitive processing of important life events involves "considerable cognitive change and extended time for the necessary information processing" (p. 94). This explains the persistence of post-traumatic reactions to stressful life events.

- (v) Until the information conveyed by stressful life events is integrated into the individuals inner schemata, the memories of the event remain active and have a tendency to interrupt other functioning. This explains the intrusive and repetitive thoughts and feelings reported by individuals who have experienced stressful life events.

- (vi) If the emotional reactions (fear, guilt, anxiety, etc.) associated with cognitive processing of stressful life events threaten to overwhelm the individual, various controls or defence mechanisms are activated to interrupt or inhibit cognitive processing. This explains the denial or numbing phase of post-traumatic reactions.

- (vii) Resolution of stress response syndromes occurs when the information conveyed by stressful events is incorporated into inner schemata. This explains how and when symptoms of compulsive repetition, denial, and emotional arousal may be terminated.

The explanation provided by the SRS model is clearly more comprehensive than that offered by more generalized formulations of PTSD. In contrast to more generalized formulations, the SRS model provides an explanation for the persistence, periodicity, and remittance of stress response syndromes while at the same time embracing a sophisticated (transactional) definition of stress and stress reactions which is consistent with contemporary theories of stress and coping (e.g., Lazarus & Folkman, 1984).

Despite these advantages, three main criticisms have been levelled at the SRS model in its application to childhood sexual experiences. The first of these criticisms relates to the extent to which the SRS model adequately accounts for the full range of symptoms observed in the aftermath of sexual abuse. Finkelhor (1988), for example, maintains that the SRS model accounts for only some of the symptoms observed in sexually abused children (e.g., nightmares, flashbacks, reenacting the abuse situation) while providing no adequate explanation for other effects (e.g., feelings of worthlessness, self-blame, and anger).

Although this particular criticism has been endorsed by a number of other authors (e.g., Sanderson, 1990), it is one which I believe cannot be sustained in the face of a more careful reading of Horowitz's work. In his review of stress response syndromes, Horowitz (1986, pp.17-21) identifies nine common stress related themes which have been found to emerge as common problems in the process of working through stressful life events. In the SRS model, these themes - which include sadness (at loss); fear (of repetition, of loss of control, or

of merger with the victim); rage (over vulnerability, at the source of stress, or at those exempted); and guilt (over surviving, at aggressive impulses, or at vulnerability) - are assumed to constitute core traumagenic dynamics which may characterize both the "denial" and "intrusion" phases of stress reactions. Such dynamics would clearly provide an adequate explanation for the feelings of worthlessness, self-blame, and anger observed in many sexually abused children.

A second criticism of the SRS model relates to the fact that:

For some sexual abuse victims (the problem) is not failure to integrate the experience, but what might be called an "overintegration" of the experience, that is, they take the behaviour learned in an abusive situation and apply it indiscriminately to other situations where it is inappropriate (Finkelhor, 1988, p. 67).

Although Finkelhor is correct in maintaining that some sexually abused children manifest oversexualized or inappropriate sexual behaviour, such behaviours can, I believe, be adequately accounted for by the SRS model.

In his explication of the SRS model Horowitz (1986) maintains that factors such as individual predisposition and situational circumstances may result in a pathological intensification of common responses to serious life events. In the case of intrusive experiences such pathological intensification is likely to involve "flooded and impulsive states, despair, impaired work and social functions, (and/or) compulsive reenactments" (Horowitz, 1986, p. 27); with 'compulsive reenactments' being defined as:

Any behaviour that repeats any aspects of the serious life event, from minor tic-like movements and gestures to acting out in major movements and sequences, including retelling the event. Repeated enactments of personal responses to the life event, whether or not they actually occurred at the time of the event (Horowitz, 1986, p. 32).

This definition is clearly broad enough to embrace the oversexualized and inappropriate sexual behaviours that have been observed in the aftermath of child sexual abuse.

Thus, while oversexualized and/or inappropriate sexual behaviours clearly constitute an "overintegration" of the experience (in the sense suggested by Finkelhor, 1986), such overintegration can be understood in the context of the SRS model as a pathological intensification of intrusion phase experiences.

A final criticism of the SRS model is that it fails to provide any clear indication of the specific traumagenic dynamics operating in cases of childhood sexual abuse. "Why, for example, should child sexual abuse (particularly abuse that is not overtly violent or coercive) constitute a threat to the child's assumptive world?" and "What aspects of the child's assumptive world are most likely to be threatened by such abuse?" The answers to these, and related, questions are not contained in the SRS model.

4.2.2.3 Janoff-Bulman's Extension of the SRS Model

An intriguing explanation of post-traumatic reactions to victimization is provided by Janoff-Bulman (1985). Using the core assumptions of the SRS model (see section 4.2.2.2, pp. 52-54) as her starting point, Janoff-Bulman attempts to provide a more 'fine-grained' analysis of the ways in which a victimization experience may challenge (threaten, or shatter) an individual's assumptive world.

Janoff-Bulman proposes that victimization experiences have the potential to challenge three basic assumptions that most people make about themselves and about the world in which they live. These assumptions involve:

- (i) The assumption of invulnerability. i.e., an underestimation of the likelihood of experiencing negative events, as reflected in beliefs such as "It can't happen to me".

- (ii) The world as a meaningful place. An assumption which is threatened by the unpredictability and apparent senselessness of many victimization experiences - with the victim's loss of meaning often focussing on questions such as "Why did this happen?" or, more specifically, "Why did this happen to me?"
- (iii) The victim's positive self-perceptions. The negative self-images evoked by victimization experiences (e.g., "I am weak, powerless, unable to cope, etc.") are contrary to, and are thus likely to bring into question, the positive self-perceptions that people generally hold about themselves.

While Janoff-Bulman's extension of Horowitz's SRS model provides some useful insights into the traumagenic dynamics that are likely to operate in cases of serious crime, accidents, and disease, one has to question the extent to which the assumptions made by victimized adults - adult victims being the primary focus of Janoff-Bulman's analysis - are likely to correspond to those made by victimized children.

Further, some of the dynamics of childhood sexual abuse (e.g., traumatic sexualization) are not adequately accounted for by Janoff-Bulman's formulation. As Finkelhor (1988) has pointed out:

Because of some of the unique characteristics of responses to (child) sexual abuse, particularly some of the sexual trauma, it seems preferable to delineate a separate syndrome relating to it. This syndrome could use some of the concepts and dynamics described in PTSD, but remain specific to sexual abuse in its particulars (Finkelhor, 1988, p. 68).

4.3 THE FOUR TRAUMAGENIC DYNAMIC (FTD) MODEL

4.3.1 Overview of the FTD Model

The Four Traumagenic Dynamic (FTD) model, developed by Finkelhor and Browne (1985), represents an attempt to identify

traumagenic dynamics which uniquely characterize an abusive childhood sexual experience. Although each of the four dynamics identified by Finkelhor and his colleague are generalized dynamics (i.e., not unique to sexual abuse), the authors maintain that it is:

The conjunction of these four dynamics in one set of circumstances...(which) makes the trauma of sexual abuse unique, different from such childhood traumas as the divorce of a child's parent or even being the victim of physical child abuse (Finkelhor & Browne, 1985, p. 530).

Although the FTD model is often contrasted with the PTSD model (e.g., Sanderson, 1990), it is clear - both from the description of the model itself (Finkelhor & Browne, 1985) and from Finkelhor's subsequent elaboration of the model (Finkelhor, 1988, pp. 68-69) - that many of the core concepts of PTSD, especially those contained in Horowitz's (1986) SRS model, are incorporated into the FTD model. What distinguishes the FTD model, then, is not an attempt to provide a new or novel conceptualization of stress or stress reactions, but rather an attempt to more precisely delineate the traumagenic dynamics unique to childhood sexual abuse.

The four traumagenic dynamics outlined by Finkelhor and Browne (1985) are:

- (i) Traumatic Sexualization. i.e., "The conditions in sexual abuse under which a child's sexuality is shaped in developmentally inappropriate and interpersonally dysfunctional ways" (Finkelhor, 1988, p. 69). Processes contributing to traumatic sexualization include: (a) the child being rewarded for developmentally inappropriate sexual behaviours, (b) the offender exchanging attention and affection for sexual contact, (c) fetishism of sexual parts of the child, (d) offender transmitted misconceptions about sexual behaviour and sexual morality, and (d) conditioning of sexual activity with negative emotions and memories.

- (ii) Betrayal. Processes in sexual abuse which contribute to a sense of betrayal include attempts to manipulate the child's trust and vulnerability, as well as acts (of either commission or omission), on the part of the abuser or significant others, which violate the child's expectations of care, support, or protection.
- (iii) Stigmatization. i.e., negative messages about the self - blame, shame, worthlessness, guilt - that are communicated to the child around the abuse experience.
- (iv) Powerlessness. i.e., a sense of disempowerment that occurs when "a child's will, wishes and sense of efficacy are repeatedly overruled and frustrated" or when "a child experiences the threat of injury or annihilation" (Finkelhor, 1988, p. 71).

Finkelhor and Browne (1985) stress that these four traumagenic dynamics do not apply solely to the abuse event. Each dynamic also needs to be understood in relation to the child's pre- and post-abuse experiences. The dynamic of 'powerlessness', for example, is likely to be potentiated by disempowering experiences (e.g., previous physical or emotional abuse) that occurred prior to the abuse. Similarly, and again by way of example, the dynamic of 'stigmatization' may be seriously affected if the child is later rejected or blamed by significant others.

4.3.2 Evaluation of the FTD model

The FTD model has a number of advantages. First, it provides an explanation for the broad range of symptomatology observed in the aftermath of child sexual abuse (see Chapter 3). Most of the effects that have been noted in the literature can be explained by reference to one or more of Finkelhor and Browne's dynamics (see Table 4).

TABLE 4 : Effects Associated with each Traumagenic Dynamic
(Adapted from Finkelhor, 1988, pp. 73-74)

Traumagenic Dynamic	Psychological Impact	Behavioural Manifestation
Traumatic Sexualization	Increased salience of sexual issues. Confusion about sexual norms/identity. Confusion of sex with love/care-getting/arousal sensations. Sexual aversion.	Sexual preoccupation. Sexual aversion. Sexual dysfunction. Sexual acting-out. Sexual aggression.
Stigmatization	Guilt and shame. Lowered self-esteem. Feeling different from others.	Isolation. Self-injurious behaviour/addictions. Criminal behaviour.
Betrayal	Grief, depression. Mistrust of others. Dependency. Anger, hostility. Problems with trust.	Dependency/isolation. Vulnerability to abuse/abusiveness. Problems in interpersonal relations.
Powerlessness	Anxiety, fear. Lowered sense of self-efficacy. Need to control. Identification with the abuser.	Anxiety disorders. Somatic disorders. Depression. Aggressive/abusive behaviour. Behavioural problems. Dissociation.

A second advantage of the FTD model is that it more accurately conceptualizes child sexual abuse as a process (rather than an event) in which pre-, peri-, and post-abuse factors may combine to potentiate or ameliorate operant traumagenic dynamics. Such a conceptualisation is consistent with empirical findings (see Chapter 3, section 3.3, pp. 44-48) which suggest that the impact of childhood sexual experiences may be influenced by both pre- and post-abuse experiences.

A final advantage of the FTD model is that it allows for individual differences in reactions to a childhood sexual experience. Thus, for example, in a situation where

predisposing, precipitating, and perpetuating factors combine to ameliorate a particular dynamic one might expect a reduction, or even an absence of, associated effects. Conversely, in a situation where one (or more) traumagenic dynamics is/are strongly potentiated, one might expect an increase in associated symptomatology.

Although the FTD model provides the most comprehensive explanation to date of the traumagenic dynamics associated with child sexual abuse, it nevertheless constitutes a less than complete explanation of child sexual abuse response syndromes. For one thing, Finkelhor and Browne fail to provide any adequate explanation for the persistence and periodicity of sexual abuse response syndromes. The persistence of psychological symptoms in the aftermath of child sexual abuse has been demonstrated in numerous studies of long-term effects (see Chapter 3), while a periodicity, or paroxysmal recurrence, of symptoms has been noted in studies which have involved repeated measures of psychological effects (e.g., Krener, 1985; Friedrich & Reams, 1987). In Friedrich and Reams (1987) longitudinal study, for example, the course of psychological symptoms was found to be characterised by:

A pattern of scattered improvement and shifting symptoms...Improvement was never linear; some children showed improvement followed by regression or improvement in some areas and not in others (Friedrich & Reams, 1987, p. 169).

Such a pattern of 'scattered improvement and shifting symptoms', which finds no explanation in the FTD model, is however consistent with the predictions of Horowitz's (1986) SRS model. In other words, the very strength of the SRS model (i.e., an explanation of the persistence and periodicity of stress response syndromes) would appear to constitute a limitation for the FTD model. At the same time of course, it needs to be stressed that the main focus of the FTD model (i.e., a description of the traumagenic dynamics specific to child sexual abuse) receives only cursory attention in Horowitz's formulation.

What is in fact suggested by such complementariness is the need for some form of synthesis between the FTD and the SRS models; a synthesis which I believe can be achieved without compromising either perspective.

4.4 A PROPOSED SYNTHESIS OF THE 'FTD' AND 'SRS' MODELS

If Finkelhor and Browne's four traumagenic dynamics are incorporated into Horowitz's SRS model as specific stress response themes associated with child sexual abuse one arrives at an explanatory model which is, I believe: (a) consistent with empirical findings relating to child sexual abuse response syndromes, (b) faithful to the assumptions of both the SRS and FTD models, and (c) more comprehensive, in terms of explanatory value, than either the SRS or FTD models alone.

The basic components of such an expanded model - which I will refer to as the Sexual Abuse Response Syndrome (SARS) model - are presented in Figure 1 (p. 63).

The starting point of the proposed model is the assumption that abusive childhood sexual experiences are most accurately construed as incentive events. Following Kagan (1983) the term "incentive event" is used to describe "a stimulus complex which might or might not provoke an affective reaction and, therefore, might or might not be a stressor" (p. 195).

The view that childhood sexual abuse constitutes an incentive events is consistent with: (a) empirical findings which suggest that undesirable affective reactions to childhood sexual experiences (both initial and long-term) are not inevitable (Browne & Finkelhor, 1986); (b) the assumptions of Horowitz's (1986) SRS model, in terms of which life event may or may not be associated with stressful effects (depending on the extent to which they are appraised as posing a threat to the notion of reality suggested by available inner models); and (c) the predictions of Finkelhor and Browne's (1985) FTD

model, in terms of which traumatic reactions to child sexual abuse are not regarded as being inevitable but are assumed to be dependent on the extent to which injurious dynamics are present.

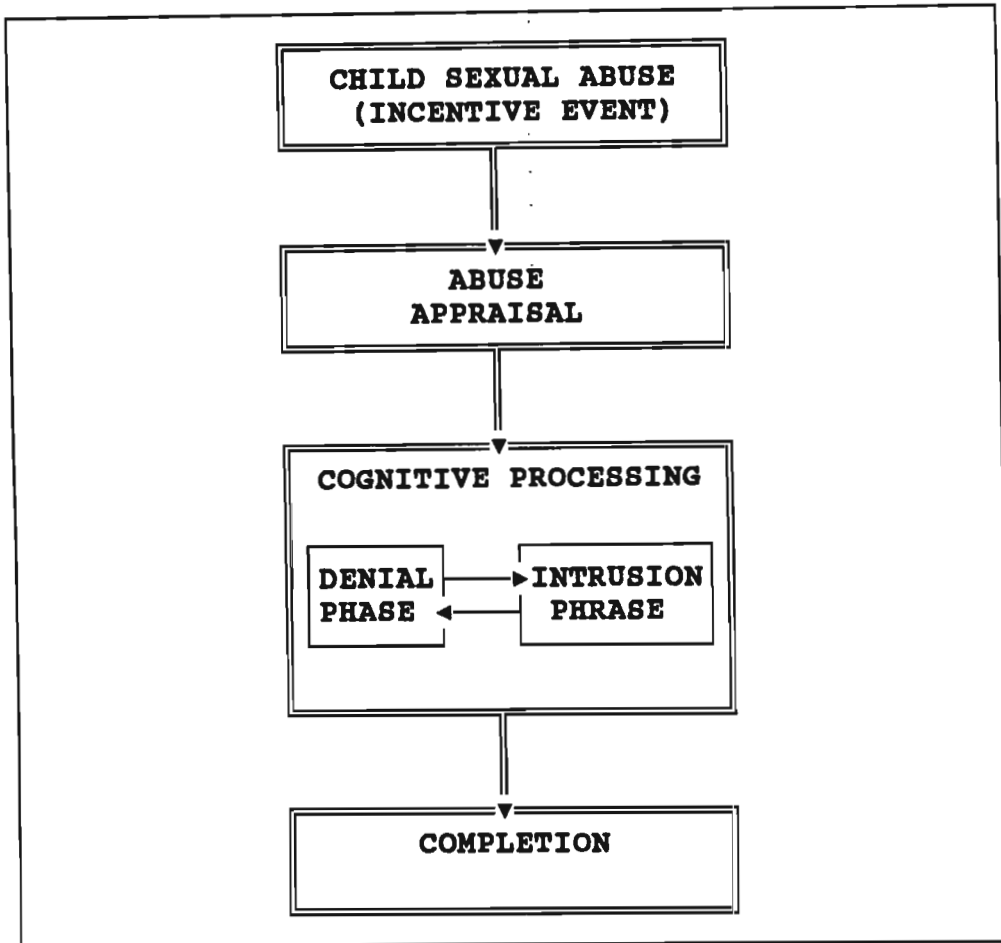


FIGURE 1 : Basic Components of the Sexual Abuse Response Syndrome (SARS) Model

The second phase of the proposed model is concerned with the individual's evaluation of an incentive event; and here it is assumed that abuse events will be associated with traumatic or undesirable effects to the extent that they are appraised as constituting a threat to the child's continued well-being and/or to the extent that they are interpreted in ways that constitute a threat to the child's developmental integrity. Available evidence (cf., Chapter 3, Section 3.3, p. 44) would

suggest that such appraisals are likely to be influenced by a number of factors, including the circumstances of the abuse, the child's age/developmental level, the child's experiences prior to the abuse (with specific reference to the nature and quality of parenting behaviours), and the child's experiences in the aftermath of abuse.

Specific threats to the child's well-being and developmental integrity that are likely to be posed by a childhood sexual experience, together with associated traumagenic dynamics are summarized in Table 5 (p. 65).¹

In the SARS model, the child's initial (or primary) evaluations of abuse events are not assumed to be fixed or final, but are rather assumed to be open to revision (or secondary appraisal), with such revision being influenced by a number of factors, including:

- (i) The Reactions of Significant Others. The response of significant others (parent's, therapists, police officers, court officials, etc.) to the abuse, or to the child, are likely to modify the child's initial appraisal of abuse events. Thus, for example, a child who is relatively unstigmatised by abuse may experience massive stigmatisation if blamed by family members. Similarly, the child's sense of powerlessness is likely to be greatly increased in the context of repeated assessment procedures or if the child is separated against his or her will from family members.

¹ The reasons why a childhood sexual experience should constitute a threat to a child's well-being and developmental integrity in the ways suggested in Table 5, and the specific aspects of abuse experiences which are likely to enhance or ameliorate such threats have been discussed in detail elsewhere (Finkelhor, 1988, pp. 61-82) and will not be dealt with here.

TABLE 5 : Factors Impacting on the Evaluation Phase of the Sexual Abuse Response Syndrome Model

Form of Threat	Locus of Threat	Associated Traumagenic Dynamic
Child's well-being	Self-esteem	Stigmatization
	Continued relationship with significant others	Betrayal
	Self-efficacy	Powerlessness
Developmental Integrity	Sexuality	Sexual traumatization

- (ii) Maturation. Children's initial and secondary appraisals of abuse events are likely to both reflect and be influenced by developmental considerations. Studies of emotional development (e.g., Harris, 1989) have, for example, shown that children's attributions of shame and guilt (i.e., the "emotional constituents" of stigmatization) are influenced by different considerations at different ages; with pre-schoolers tending to base their moral judgments largely on outcome (i.e., "was the outcome good or bad for me or for others") and older children increasingly acknowledging the relevance of additional factors such as personal responsibility and normative standards. As attributions of one or other description are likely to play an important role in the child's evaluation of each of Finkelhor's traumagenic dynamics, such developmental shifts would appear to have the following implications for children's abuse related appraisals: (a) abuse experiences which are initially appraised as being "non-threatening" by a young child may subsequently be reappraised as being "threatening" by

the same child when that child attains a level of development where "new" considerations (e.g., personal responsibility or normative standards) become relevant to the evaluation process;² (b) the fact that abuse related appraisals are likely to be influenced by different factors for children of different ages suggests that different constellations of risk factors are likely to be predictive of psychological adjustment in children who are at different levels of development.

- (iii) Coping Strategies Employed. The coping strategies employed by the child can, in themselves, contribute towards a reappraisal of the abuse event. Thus, for example, a child who successfully terminates a pattern of ongoing abuse (through disclosure, withdrawal of compliance, etc.) may in the process achieve a sense of self-efficacy and self-worth which could counteract (or reduce) feelings of powerless and/or stigmatization induced by the abuse.

The third stage of the SARS model involves cognitive processing of stressful abuse experiences. Consistent with the assumptions of the SRS model, and for the reasons suggested by Horowitz (1986; see also section 4.2.2.2, pp. 51-56), cognitive processing of abuse events is assumed to involve alternating cycles of denial and intrusion, with each of these cycles being characterized by a distinctive pattern of symptomatology.

The pattern of 'scattered improvement and shifting symptoms' which has been observed in longitudinal studies of the initial

² One would also predict that in some cases the converse situation may apply, i.e., that initial appraisals of "threat" may be reappraised as "non-threatening" on the basis of new understandings linked to developmental attainment.

effects of child sexual abuse (Krener, 1985; Friedrich & Reams, 1987) is clearly consistent with such an assumption. In addition, the psychological effects that have been observed in the aftermath of child sexual abuse (see Chapter 3) would appear to fall quite naturally into two broad categories; i.e., those suggestive of a denial or withdrawal phase (e.g., dissociation, withdrawal, isolation, sexual aversion, sexual avoidance) and those suggestive of an intrusive phase (e.g., fears, phobic behaviour, anxiety disorders, increased salience of sexual issues, sexual acting out).

The final stage of the proposed model (i.e., "Completion") involves the resolution of the stress response syndrome. Following Horowitz (1986), resolution is assumed to occur when, and if, the information conveyed by abuse experiences is successfully incorporated into the individual's inner schemata. It is assumed that such resolution is not inevitable,³ with resolution failure reflecting an inability/failure to successfully negotiate one or more of the stages of the SARS model (see Figure 1, p. 63).

4.5 CONCLUSIONS

The SARS model has implications for studies of the effects of child sexual abuse. First, the SARS model would predict that outcomes can take a number of forms (see Figure 2, p. 68).

³ This assumption is consistent with empirical findings reviewed in Chapter 2 (see particularly section 2.4.3, p. 31) which suggest that when studied as adults, approximately 17% of sexual abuse victims continue to evidence clinically significant pathology, a further 50% to 60% continue to report "some" or "few" long-term effects, and the remaining 20% to 30% report no lasting effects.

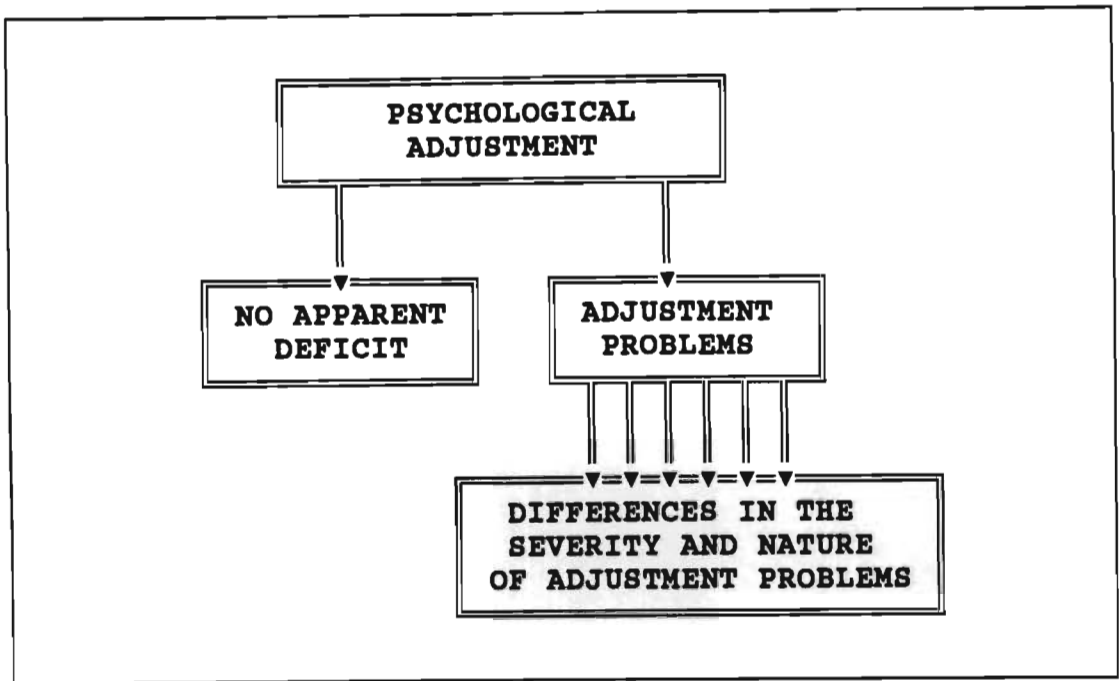


FIGURE 2 : Different Patterns of Adjustment to a Childhood Sexual Experience

The primary distinction made in Figure 2 is between individuals who are not currently experiencing adjustment problems (either because their abuse was never [or has not as yet] been appraised as being stressful, because an initial stressful appraisal was subsequently reappraised as non-stressful, or because successful resolution has been achieved) and those who continue to evidence symptoms of a stress response syndrome. A further distinction is made in Figure 2 among individuals who continue to evidence stress response syndromes. Here, it is assumed that undesirable outcomes are likely to take a number of forms, with different patterns of adjustment reflecting the impact of different traumagenic dynamics.

A second implication of the SARS model is that different patterns of adjustment to a childhood sexual experience are likely to reflect differences in current appraisals of abuse events and/or of the circumstances surrounding the abuse; with current appraisals, in turn, being influenced by a range of factors including: (a) the circumstances of the abuse; (b) the

individuals initial appraisal of the abuse; (c) the individuals experiences in the aftermath of abuse; (d) the individual's coping strategies in the aftermath of abuse; (e) the individuals level of development (both at the time of the abuse and current), and (f) the individual's pre-abuse experiences (with particular reference to the quality and adequacy of parent-child relationships).

The above implications translate into some specific recommendations for researchers who are interested in exploring the effects (both initial and long-term) of childhood sexual experiences. Researchers need, for example, to be aware that a simple division of victimized samples into two groups (i.e., subjects showing no apparent effects and subjects manifesting psychological/adjustment problems) fails to capture the full complexity of sexual abuse response syndromes. A more fine-grained analysis is clearly required if researchers hope to adequately address the full range of reactions to a childhood sexual experience. Researchers also need to view sexual abuse response syndromes "in terms of a transaction between the individual and the environment with the meaning and appraisal of the event intrinsic to its definition" (Rutter, 1983, p. 9). Finally, in their attempt to account for differential reactions to abuse, researchers need to focus on a broad range of pre-, peri-, and post-abuse factors, including the individual's level of development (both current and at the time of the abuse).

CHAPTER 5

METHODOLOGICAL AND ETHICAL ISSUES IN CHILD SEXUAL ABUSE RESEARCH

5.1 INTRODUCTION

This chapter outlines some important methodological and ethical issues that need to be considered by researchers working in the field of child sexual abuse.

As the present research is directed at an understanding of the long-term effects of child sexual abuse, the methodological and ethical issues to be discussed will be those that are likely to be most relevant to outcome research (i.e., specific methodological and ethical problems that may arise in studies of sexual offenders or in studies of treatment effects will not be addressed here).

5.2 METHODOLOGICAL ISSUES

There are a number of methodological concerns that need to be addressed by child sexual abuse researchers. These include issues relating to: (a) the definition of abuse; (b) sample selection and sampling procedures; (c) research design; and (d) data analysis.

5.2.1 The Definition of Abuse

Studies of the impact of child sexual abuse have not been characterized by a uniform definition of abuse. Table 6 (p. 71) provides some indication of the variety of definitions that have been employed in recent studies.

From Table 6 it can be seen that abuse definitions vary across a number of dimensions, including: (a) the age range that is

used to define childhood; (b) the range of behaviours that are regarded as being sexual; and (c) the criteria for defining behaviours as abusive. Although it is not apparent from Table 6, abuse definitions also vary in terms of the victim-perpetrator relationships that are regarded as being potentially abusive.

TABLE 6 : Operational Definitions of Child Sexual Abuse in Recent Outcome Research

Study	Upper Age Limit	Range of Sexual Acts	Definition of Abusiveness
Bagley & McDonald (1984)	14	At least manual genital contact	Partner at least 19 years old
Bagley & Ramsay (1986)	15	At least manual genital contact	Age discrepancy of 3 yrs. or use of force/threat
Briere & Runtz (1988a)	14	All forms of sexual contact	Age discrepancy of 5 years
Bryer et al. (1987)	15	All forms of sexual contact	Unwanted/coercive experiences
Edwards & Donaldson (1989)	16	All forms of sexual contact	Partner was a family member
Finkelhor (1984)	16	All contact and non-contact experiences	Partner 5 yrs. older and child considered the experience to be abusive
Fromuth (1986)	16	All forms of sexual abuse plus exposure and invitations	If child <13: partner at least 16 and 5 years older. If child 13-16: partner 10 years older
Gold (1986)	16	All forms of sexual contact	If child <13: partner 5 years older and post-pubital. If child 13-16: partner 10 years older or evidence of force

(Table Continues)

TABLE 6 : (Continued)

Study	Upper Age Limit	Range of Sexual Acts	Definition of Abusiveness
Harter et al. (1988)	17	All forms of sexual contact	Partner 5 years older
Peters (1988)	17	All forms of sexual contact plus exposure	Partner 5 years older or use of coercion
Russell (1986)	17	All forms of sexual contact	Partner 5 years older or evidence that experience was unwanted
Seidner & Calhoun (1984)	17	All contact and non-contact experiences	Partner 5 years older
Stein et al. (1988)	15	All forms of sexual contact	Use of force or pressure
Wyatt (1985)	17	All contact and non-contact experiences	Partner 5 years older or evidence that abuse was unwanted/coercive

Note: Studies which have failed to provide precise operational definitions of abuse (e.g., Fritz et al., 1981; Sedney & Brooks, 1984) are not included in the above Table.

5.2.1.1 Defining a Child

Researchers have shown little consistency in the upper-age used to delimit the concept of "childhood". While some researchers have restricted their definition of childhood to preadolescent children (Bagley & McDonald, 1984; Briere & Runtz, 1988a), others have used the age of 16 years - conventionally regarded in law as the age of consent for females - as a cut-off point (Edwards & Donaldson, 1989; Finkelhor, 1984; Fromuth, 1986; Gold, 1986), while still others have followed the convention of most child welfare legislation and set the upper-age limit for childhood at 17 years (Harter et al., 1988; Peters, 1988; Russell, 1986;

Seidner & Calhoun, 1984; Wyatt,, 1985).

5.2.1.2 Defining Sexual Acts

Most researchers agree that sexual abuse includes acts such as sexual intercourse, attempted intercourse, and manual or oral contact with the genitals of the child and/or the abuser. Some researchers have, however, extended the definition of sexual abuse to include extragenital forms of sexual contact (touching or fondling of breasts and thighs) and various "non-contact" forms of abuse such as exhibitionism, sexual requests, obscene phone calls, voyeurism, and exposure to (or involvement in) pornography.

5.2.1.3 Defining Abusiveness

Criteria which have been used to define sexual acts as abusive include the age disparity between the child and the perpetrator, evidence of coercion, and/or evidence that the experience was unwanted. As can be seen from Table 6, there has been little agreement between researchers as to which of these criteria (or which combination of criteria) should be used to define abusiveness.

5.2.1.4 Defining Abusive Relationships

While all studies include incestuous abuse in their definition of abuse, some studies have extended their definition to include: (a) extrafamilial forms of abuse, (b) abuse by older children, and (c) abuse by peers.

5.2.1.5 Consequences of Definitional Decisions

There are a number of ways in which definitional decisions can influence the findings of child sexual abuse research.

First, estimates of the prevalence and incidence of abuse are

likely to be influenced by the restrictiveness or inclusiveness of abuse definitions.¹ If, for example, Russell (1986) in her community study had decided to use 14 years rather than 17 years as an upper age limit for abuse she would have reduced the number of individuals identified as abused by 28%. Similarly, Wyatt and Peters (1986) have shown that the use of restrictive definitions can reduce prevalence rates for abuse by as much as 14%.

Second, definitional decisions are likely to impact on estimates of the psychological impact of abuse. Studies of the long-term effects of abuse (Haugaard & Emery, 1989; Peters, 1988) suggest that when compared to contact forms of abuse, a history of non-contact abuse is significantly less likely to be associated with lasting effects. The decision to use an inclusive definition of abuse - which includes both contact and non-contact experiences - may thus serve to attenuate differences between abused and non-abused groups, and thereby minimize estimates of psychological harm among subjects who have experienced more intrusive forms of abuse.

Third, definitional decisions are likely to impact on estimates of risk factors for abuse. For example, the finding that preadolescent (10 to 14 year old) girls tend to be at greater risk for abuse than either younger or older children (Finkelhor & Baron, 1986) could only have been obtained using an inclusive definition of abuse. The use of a more restrictive definition (e.g., one in which 14 years was set as the upper age limit for childhood) would have produced a different pattern of findings (i.e., increased risk with increased age) and different conclusions as regards risk factors (i.e., increased risk with increased age versus

¹ Restrictive definitions (as opposed to inclusive definitions) involve a lower upper age limits for abuse, a more restricted range of sexual acts, and/or a more restricted definition of abusiveness.

increased risk among preadolescent children).

5.2.1.6 Implications for Research

The fact that definitional decisions are likely to influence the findings of sexual abuse research raises the question of which definition is most appropriate for sexual abuse research. There is no simple answer to this question.

The specific definition adopted by a researcher is likely to reflect the interests and needs of that researcher as well as the particular focus and goals of the study. Rather than searching for an "ideal" definition of abuse, what would appear to be required is that researchers commit themselves to providing a reasoned and clear operational definition of abuse together with some comment on the effect that particular definitional decisions may have on research findings.

With respect to exploratory research, inclusive rather than restrictive definitions would appear to be indicated. As Finkelhor (1986) has pointed out:

If researchers are too restrictive in their definitions of abuse, they may never be able to test their own assumptions. Thus if encounters with exhibitionists are excluded on the grounds that this is not serious abuse, then the question of how serious such encounters are is never answered...It is always possible to redo analyses with a more restrictive definition, but it is not possible to recover cases that were initially screened out. To deal with possible objections to too liberal definitions, investigators may wish to present analyses based on several definitions (Finkelhor, 1986, pp. 202-203).

5.2.2 Samples

Researchers have used a number of different kinds of samples to explore the prevalence and impact of childhood sexual experiences.

5.2.2.1 Clinical Samples

The most common kind of sample used in child sexual abuse research has been the clinical sample. Clinical samples have been drawn from a number of sources including psychiatric inpatients (e.g., Bernard & Hirsch, 1985; Meiselman, 1978); psychiatric outpatients (e.g. Becker, 1988; Hartman et al., 1987); persons presenting at crisis intervention clinics (e.g., Anderson et al., 1981; Briere & Runtz, 1986); and clients in psychotherapy (e.g., Forward & Buck, 1978; Herman, 1981; Walsh, 1986).

Although clinical samples constitute an ideal group for assessing the effects of treatment (clinical samples being the target of most intervention programmes), such samples tend to be characterized by an overinclusion of persons with serious effects (Finkelhor, 1986) and can therefore not be regarded as being representative of sexual abuse victims in general.

5.2.2.2 Volunteer Samples

A number of researchers (e.g., Baker, 1983; Bernard, 1981; Ferguson, 1986; Nelson, 1981; Symonds et al., 1981; Tsai et al., 1979) have recruited volunteer samples using strategies such as media appeals or notices placed in public places. Although such strategies are cost effective they are extremely problematic as the researcher can have no way of knowing what selection biases are brought into play.

One form of selection bias that may arise through the use of volunteer samples relates to the fact that volunteers tend to "recruit from among the healthy" (Finkelhor, 1986, p. 207); a bias that may underestimate the impact of abuse.

5.2.2.3 Sampling from Special Populations

Subjects for child sexual abuse research have been drawn from

a number of special populations including college students (e.g., Finkelhor, 1979; Fritz et al., 1981; Fromuth, 1986; Landis, 1956; Levett, 1989); cases seen by public agencies (e.g., Bagley & McDonald, 1984; Ellwell & Ephross, 1987); and "deviant" populations such as prostitutes and drug addicts (James & Meyering, 1978; Silbert & Pines, 1983).

Although such samples have provided useful information about the prevalence and impact of sexual abuse within prescribed groups, any extrapolation of findings to the broader population must be made with due caution. Such caution would appear to be particularly warranted in cases where samples are drawn from public agencies, from "deviant" populations, or in fact from any special population where group membership is likely to be associated with an increased risk of sexual victimization.

In addition, Painter (1986) has argued that samples of college students are likely to be unrepresentative because students are a relatively well-functioning population "who are least likely to have had disruptive experiences such as that of sexual abuse" (Painter, 1986, p. 327). Although Painter's views would appear to be borne out by the low prevalence rates obtained in most studies of American college women there are other explanations (i.e., other than the nature of the sample) that could account for differences in prevalence rates. In a recent study, for example, Levett (1989a) has shown that when sensitive and appropriate methods of data collection are employed, the prevalence rate obtained for sexual abuse among university women is as high as rates obtained for women in the general population. Although Levett's findings are suggestive, further research is clearly required to establish the extent to which prevalence figures for student samples compare to those obtained for community samples.

5.2.2.4 Random Community Samples

In recent years a number of researchers (e.g., Badgley et al., 1984; Bagley & Ramsay, 1986; Bushnell et al., 1992; Russell, 1986; Wyatt, 1985) have employed random sampling procedures among the general population in an attempt to recruit representative samples of sexual abuse victims.

Although random community sampling would appear to constitute an ideal strategy for sample selection, it is a strategy that gives rise to a number of practical problems. As Finkelhor (1986) has pointed out, a major drawback of random community surveys is their cost. Most researchers simply do not have the financial resources required to meet the additional costs (e.g., the training and remuneration of a team of interviewers) that are incurred in large-scale surveys.

A second problem with random community samples, relates to the relatively low participation rates obtained in most studies. For example, in Russell's (1986) community survey - generally regarded as being one of the better designed surveys - the participation rate was only 50%. As Russell neither attempts (nor provides data that would permit) a systematic comparison of respondents and non-respondents it is not possible to determine the form, or forms, of selection bias that may have been operative. Russell does, however, provide data which indicate that her study sample was not representative of the target population in terms of some important demographic variables. For example, when compared to census data for women in San Francisco (i.e., the target population) the study sample contained proportionately more white women and fewer Asian and Latina women and had an age distribution which was somewhat younger than women in the general population (cf., Russell, 1986, p. 27-30).

As most researchers fail to provide any indication of relevant population parameters, it is not possible to evaluate the

extent to which other community samples are representative of the populations from which they were drawn. However, the findings from Russell's study - probably the best designed study - suggest that some degree of unrepresentativeness is likely.

5.2.2.5 Conclusions

There would appear to be both advantages and limitations associated with the use of each of the sampling strategies available to sexual abuse researchers.

While random sampling would appear to constitute the ideal strategy, care needs to be taken to ensure that final samples are representative of the population from which they are drawn. In this respect, steps need to be taken to maximise response rates, e.g., through the use of carefully trained interviewers who are sensitive to the issues involved in sexual abuse and who are matched with respondents in terms of demographic variables such as age, sex, and social class.

Attempts to maximize response rates are, however, likely to further increase the already high costs of random sampling, effectively placing such forms of sampling beyond the financial means of most researchers.

In cases where financial, or other practical, constraints dictate alternative forms of sample recruitment, researchers need to be aware of the kinds of selection factors that are likely to be operative. These selection factors, together with their likely influence on research findings, can then be described and considered in the interpretation of research findings.

5.2.3 Research Design

There are a number of design issues which have been found to

influence the findings of sexual abuse research and which therefore need to be considered in the planning phase of research.

5.2.3.1 Methodologies of Design

Most studies of the prevalence and impact of child sexual abuse have employed either a One-Group Only Post-Test Design or a Post-Test Only Design with Non-Equivalent Groups.

Despite the fact that the One-Group Only Post-Test Design is characterized by two basic deficiencies (i.e., no pretest observations and no control group) and is therefore invariably uninterpretable (Cook & Campbell, 1979), it is the design that has been used in over 40% of outcome studies.²

In recent years a growing appreciation of the limitations of the One-Group Design has led to the introduction of a non-victimized comparison group in most child sexual abuse studies. In the absence of pre-test observations, however, these studies continue to suffer from a basic deficiency (i.e., failure to establish pre-abuse equivalence) that severely restricts the confidence with which causal inferences can be drawn from research findings.

What is clearly required, particularly in the case of outcome research, is the use of alternative designs which permit stronger causal inference. One possibility would be for researchers to make pre-test observations on a group of children prior to the age of greatest risk for abuse and then for the children to be reassessed years later to establish which children had been abused. Such prospective longitudinal research is not only feasible but also needed. However, as Finkelhor (1986) has pointed out, "because of the time and

² This total has been calculated from data provided by Finkelhor (1986, pp. 145-146).

expense involved, consideration should be given in the interim to alternatives that provide more immediate, if somewhat less reliable, results" (p. 210).

One such alternative involves the retrospective collection of baseline data. In other words, researchers could attempt to obtain retrospective reports on antecedent conditions which are likely to be associated with pre-abuse status (e.g., a history of parental punitiveness or a history of emotional neglect) and then attempt to control for these conditions through the use of careful matching procedures or by entering these conditions as covariates in multivariate analyses. Attempts to establish experimental-control group equivalence would also be enhanced if researchers collected information relating to post-abuse experiences that are likely to be predictive of subjects' post-abuse status (e.g., subsequent life stressors) and attempted to control for such factors in their analyses.

Although the retrospective collection of baseline data is preferable to an absence of baseline data, such an approach has substantial limitations which need to be recognized. As Finkelhor (1986) has pointed out:

It is possible that...retrospective reports about something as global and vague as parental support or closeness with mother are not very valid or reliable. Of most concern is the possibility that if children become victims of abuse, it may affect their retrospective accounts of their relationships with their parents or other background conditions. Every effort should be made to improve on the validity of such retrospective measures, for example, by getting confirmatory information from siblings, or by anchoring the accounts in very concrete behaviours (Finkelhor, 1986, p. 211).

5.2.3.2 Measurement and Instrumentation

Issues of measurement and instrumentation that are relevant to child sexual abuse research include: (a) the number and nature of probes used to assess for a history of abuse, (b) the mode of data collection employed, and (c) the specific outcome measure/s used to estimate the impact of abuse.

5.2.3.2.1 Measures of Abuse Experiences

Childhood sexual abuse surveys differ with respect to the number and the nature of probes or "screen" questions that have been used to assess for a history of abuse.

The number of probes used to assess for abuse has ranged from one (Bagley & Ramsay, 1986; Keckley Market Research, 1983; Kercher & McShane, 1984; Miller, 1977; Murphy, 1985) to 14 (Russell, 1986), with the majority of studies using less than four probes. An examination of prevalence rates in relation to the number of probes used (see Table 7, p. 83) reveals a positive, and highly significant, relationship between prevalence rates and the number of questions asked.

A further difference in screen questions relates to the specificity of questions asked. While some studies have assessed for a history of abuse using general questions - i.e., questions which contain general terms such as "sexual abuse" or "molestation" which are not clearly defined (e.g., "Were you ever sexually abused as a child?" or "Were you molested as a child?") - others have probed for abuse using more specific questions. As Peters and her associates (1986) have pointed out, there are two ways in which screen questions can be specific: (a) "relationship-specific" questions, which focus on aspects of the perpetrator (e.g., "Before your 18th birthday did your father ever attempt to have any kind of sexual contact with you?"); and (b) activity-specific questions, which focus on specific behaviours (e.g., "Before your 18th birthday did anyone ever expose themselves to you?").

As one might suspect, the specificity of screen questions has been found to be significantly related to prevalence rates, with general questions tending to yield the lowest prevalence rates, and activity-specific questions tending to yield higher rates than relationship-specific questions (cf., Peters et al., 1986, pp. 41-43).

TABLE 7 : Prevalence Rates for Women by Number of Screen Questions Used

Number of Screen Questions	Prevalence Rate (%)
<u>One Question</u>	
Bagley & Ramsay (1986)	22
Briere & Runtz (1990)	15
Bushnell et al. (1992)	13
Gagnon (1965)	24
Keckley Market Research (1983)	11
Kercher & McShane (1984)	11
Miller (1977)	14
Murphy (1985)	13
Stein et al. (1988)	6
<u>Two to Four Questions</u>	
Badgley et al. (1984)	34
Finkelhor (1979)	19
Finkelhor (1984)	15
Finkelhor et al. (1990)	27
Fromuth (1983)	22
Haugaard & Emery (1989)	12
Seidner & Calhoun (1984)	11
<u>More than four questions</u>	
Landis (1956)	34
Russell (1983)	54
Wyatt (1985)	62

Note: $F(2,16) = 21.47; p < 0.0001$

5.2.3.2.2 Mode of Administration

Self-administered questionnaires (SAQ's) have been the most frequently utilized method of data collection in child sexual research. SAQ's have been used in all studies of American college students and in a number of community surveys (e.g., Badgley et al., 1984; Kercher & McShane, 1984; Miller, 1976). Other modes of data collection, which have been employed in more recent studies, include face-to-face interviews (FFI's; e.g., Bushnell, 1992; Russell, 1986; Wyatt, 1985), telephone interviews (TI's; e.g., Finkelhor, Hotaling, Lewis & Smith, 1990; Keckley Market Research, 1983), and a combination of SAQ's and FFI's (Finkelhor, 1984).

An examination of the relationship between mode of data collection and prevalence rates reveals no significant trends (see Table 8).

TABLE 8 : Prevalence Rates for Women by Mode of Administration

Mode of Administration	Prevalence Rate (%)
<u>Self-Administered Questionnaire</u>	
Badgley et al. (1984)	34
Briere & Runtz (1990)	15
Finkelhor (1979)	19
Finkelhor (1984)	15
Fromuth (1983)	22
Gagnon (1965)	24
Haugaard & Emery (1989)	12
Kercher & McShane (1984)	11
Landis (1956)	34
Miller (1977)	14
Seidner & Calhoun (1984)	11
<u>Face-To-Face Interview</u>	
Bagley & Ramsay (1986)	22
Bushnell et al. (1992)	13
Russell (1983)	54
Stein et al. (1988)	6
Wyatt (1985)	62
<u>Telephone Interview</u>	
Keckley Market Research (1983)	11
Finkelhor et al. (1990)	27
Murphy (1985)	13

Note: $F(2,16) = 1.43$; NS.

Despite this lack of significant findings, the prevalence figures for FFI's are worthy of comment. FFI's have produced prevalence figures that rank amongst the highest (Russell, 1983; Wyatt, 1985) and also figures that rank amongst the lowest (Bushnell et al., 1992; Stein et al., 1988). These disparate findings - obtained using similar modes of data collection - suggest the possibility that factors other than mode of data collection may be responsible for the relatively high prevalence rates obtained in Russell and Wyatt's studies.

One possible alternative explanation relates to the inclusiveness/restrictiveness of abuse definitions used. Both Russell and Wyatt employed extremely broad definitions of abuse (a high upper-age limit, the inclusion of both incestuous and extrafamilial forms of abuse, and the inclusion of both contact and non-contact forms of abuse). If, for example, Russell's (1983) findings are adjusted to account for definitional variation (see Table 9) one obtains a completely different picture. First, one obtains prevalence rates which are more in line with those obtained in studies which have employed other modes of data collection (i.e., SAQ's or TI's). Second, one obtains prevalence rates which are similar to, although slightly (3% to 5%) higher than, those obtained in other studies which have used FFI's.

TABLE 9 : Prevalence Rates obtained by Russell (1983) Compared to Rates Obtained in Other Major Studies Which Have Employed FFI's (Controlling for Definitional Variation)

Study	Definition of Abuse	Prevalence Rate (%)	Russell's Study (%)
Bagley & Ramsay (1986)	Contact abuse, upper age-limit 16, use of force.	22	28
Stein et al. (1988)	Contact abuse, upper-age limit 15, use of force.	6	11
Bushnell et al. (1992)	Contact incestuous abuse.	13	16
Wyatt (1985)	Contact abuse, upper-age limit 17, extrafamilial abuse and incest	45	43

The relatively high prevalence rates obtained in the Wyatt (1985) and Russell (1983) studies may also reflect the fact that these authors made every effort to ensure that their interviewers were carefully selected, intensively trained, and

demographically matched with respondents. Thus, for example, in Russell's study, each interviewer received 65 hours of intensive training (including at least 10 hours of training about rape and incest) and, whenever possible, race and ethnicity of interviewer and respondent were matched. Such careful attention to interviewer training/characteristics, combined with other methodological factors such as extensive pre-testing of the research instrument (pre-testing took place over a period of 8 months in Russell's study), and the use of a large number of probe questions to assess for a history of abuse (14 questions in Russell's study and 8 in Wyatt's study) undoubtedly contributed to the high prevalence figures obtained in these studies.

To summarize: Available data do not support the view that FFI's are consistently associated with higher prevalence rates. FFI's have produced prevalence figures that rank amongst the highest and also figures that rank amongst the lowest. Studies which have yielded high prevalence rates using FFI's have also tended to employ inclusive definitions of abuse, have tended to pay careful attention to interviewer selection and training, and have tended to use a large number of screen questions to probe for a history of abuse - and it is these methodological factors (i.e., rather than the mode of data collection per se) which would appear to be the major determinant of the high prevalence rates reported by authors such as Russell (1983) and Wyatt (1985).

5.2.3.2.3 Outcome Measures

A number of different kinds of outcome measures have been used in child sexual abuse research. These measures include subjective global measures (e.g., "Looking back on it now, how much effect would you say this experience has had on your life?" [Russell, 1986, p.138]) as well as "objective" psychological measures of psychological adjustment (e.g., the

MMPI, the Hopkins Symptom Checklist, and the Beck Depression Scale) which have a proven record of validity and reliability in clinical research.

Although subjective global measures have been widely used in sexual abuse research they have a number of limitations. First, they presuppose a history of abuse and can therefore not be used to assess the psychological adjustment of non-victimized controls. Second, they provide only a global measurement of outcome and can therefore not be used (a) to identify the specific effects of abuse or (b) to examine the differential effects of different kinds of abuse experiences. There are also drawbacks associated with the use of so-called "objective" clinical measures in outcome research. Many of these measures (e.g., the MMPI) have not been designed with child sexual abuse in mind and as a result fail to provide a comprehensive assessment of the specific impairments that have been found to be associated with an abuse experience.

As Finkelhor (1986) has indicated, there is a need for researchers to develop outcome measures that are based on a sound theoretical understanding of the effects of sexual abuse. What is clearly required is:

...instruments that have specific utility in assessing the impact of sexual abuse. Until such measures are developed, refined, and validated, it is probably a good idea for investigators to use a mix of measures: perhaps one general assessment, together with others developed specifically to look at certain theoretically anticipated impacts of sexual abuse (Finkelhor, 1986, p. 216).

5.2.4 Data Analysis

The complexity of child sexual abuse research - frequently involving multiple predictor variables and multiple dependent measures - suggests that child sexual abuse research should be orientated towards multivariate analysis.

Such an orientation has not, however, tended to characterize most sexual abuse research. An examination of 40 studies of

the long-term effects of child sexual abuse,³ reveals that multivariate analyses were only employed in 40% of cases (univariate analyses in 10% of cases, and no form of statistical analysis in 50% of cases). This widespread failure to employ appropriate methods of data analysis has meant that many researchers have not been in a position to adequately and/or objectively test their research hypotheses.

A failure to employ multivariate procedures also places researchers at risk for drawing spurious conclusions. Thus, for example, in Russell's (1986) community survey, the results of a univariate analysis suggested a significant and positive relationship between the number of perpetrators involved and the severity of long-term effects. However, this relationship fell away in multivariate analysis when controlling for variables such as severity of sexual acts and the use of physical force.

³ The totals (percentages) reported here are derived from the following studies of long-term effects:

No Statistical Analysis: Bernard & Hirsch, 1985; Bernard, 1981; Benward & Densen-Gerber, 1975; Forward & Buck, 1978; Goodwin, Sims, & Bergman, 1979; Jehu, 1989; Katan, 1973; Kinsey, 1953; Levett, 1989; Lowery, 1987; Lukianowicz, 1972a, 1972b; Meiselman, 1978; Nelson, 1981; Schultz & Jones, 1983; Shapiro, 1987; Silbert & Pines, 1983; Sloane & Karpinski, 1942; Symonds et al., 1981; Yorukoglu & Kempf, 1966.

Univariate Analysis: Bagley & Ramsay, 1986; Burton, 1968; James & Meyerding, 1978; Tsai, Feldman-Summers & Edgar, 1979.

Multivariate Analysis: Bagley & McDonald, 1984; Briere & Runtz, 1986; Briere & Runtz, 1988a, 1988b; Bryer et al., 1987; Finkelhor, 1979, 1984; Finkelhor et al., 1990; Fromuth, 1986; Gold, 1986; Harter et al., 1988; Hartman et al., 1987; Peters, 1985; Roland et al., 1985; Stein et al., 1988; Walsh, 1986.

Clearly, appropriate (and where necessary multivariate) methods of data analysis are indicated if child sexual abuse researchers are to provide objective and unambiguous tests of their research hypotheses.

5.3 ETHICAL ISSUES

Ethical issues that are likely to be relevant to child sexual abuse research have not been adequately addressed in the professional literature. Although the literature contains occasional reference to ethical concerns (e.g., Finkelhor, 1986; Levett, 1989a; Russell, 1986) there has, to date, been no systematic attempt to organize these concerns into a coherent set of principals or rules that could serve as a guide for researchers.

5.3.1 Ethical Principals

Ethical issues which have been raised in the professional literature, or which would appear to be relevant to child sexual abuse research, can, I believe, be encompassed by three widely accepted ethical principals; i.e, the principals of Autonomy, Non-Maleficence, and Beneficence (cf., Beauchamp & Childress, 1983; Ross, 1930; Steere, 1984; Steininger, Newell, & Garcia, 1984).

5.3.1.1 Autonomy

The principal of Autonomy asserts that individuals should be free to act in terms of their own beliefs and principles (i.e., without pressure, coercion, or deception of any kind) providing that such actions do not impede the freedom of others to do likewise.

In the context of research, the principal of autonomy implies a need for informed consent from participants or, in the case

of minor children, from the parents or legal guardians of participants.

As Steininger and her associates (1984) have pointed out, "informed consent" is an extremely complex concept which, most fundamentally, refers to:

Carefully considered agreement, given without external coercion, to participate in particular information gathering procedures after having been informed about them and about the voluntary nature of the participation. More specifically, people are to be informed about the purpose or rationale of the study, the procedures, possible risks and benefits, safeguards to minimize possible harms, and the voluntary nature of the participation (Steininger et al., 1984, p. 98).

The above definition suggests a number of ways in which the principle of autonomy can be violated in sexual abuse research. First, the principle of autonomy will be violated if: (a) participants are not informed about the purpose of the study, (b) if participants are misinformed about the purpose of the study, or (c) if participants are presented with insufficient information to enable them to discern the true purpose of the study. With respect to this latter point, it is informative to examine the ways in which sexual abuse research has been presented to participants in a number of recent studies:

Students were invited to participate in a series of group discussions on gender socialization (Levett, 1989a, p. 125).

Prospective subjects were informed of the sexual and sensitive nature of some of the items. At no point were the men informed that the study dealt specifically with child sexual abuse (Fromuth & Burkhart, 1989, p. 534).

The study was presented to students as 'an investigation of early sexual experiences and their relationship to later psychological adjustment'. Subjects were not informed that the survey dealt specifically with child sexual abuse (Collings, 1991a, p. 155).

The above descriptions - which are typical of descriptions used in child sexual abuse research - have one thing in

common. In each case an attempt has been made to obscure or disguise the detailed purpose of the study through a careful avoidance of any reference to the term "child sexual abuse". Although there are sound methodological reasons for such avoidance (e.g., controlling for expectancy effects which could pose a threat to internal validity) one has to question whether issues of experimental design should take precedence over the research participant's right to be fully informed.

A second way in which the principle of autonomy can be violated in sexual abuse research is if respondents are not clearly informed of the possible risks associated with participation. A number of researchers (e.g., Collings, 1991a; Russell, 1986) have demonstrated that participation in child sexual abuse research can be experienced as "stressful" or "upsetting" by respondents; with stressful reactions being significantly more likely in cases where the respondent has a history of child sexual abuse. Respondents clearly need to be alerted to the possibility of such undesirable reactions if their consent is to be regarded as being "informed" in any meaningful sense of the word.

Finally, the principal of autonomy requires that participation in sexual abuse research is voluntary. This means, firstly, that rewards, inducements, or punishment should not be used to coerce subjects into participating and, secondly, that subjects should be free to discontinue their participation at any stage. As some subjects may be reluctant to publicly declare their non-participation (e.g., through concerns that non-participation might be construed as "evidence that they have something to hide") they should be provided with the opportunity to withhold consent anonymously.

5.3.1.2 Non-Maleficence

The principal of Non-Maleficence asserts that we should not

wilfully harm others nor deliberately place others at risk for harm; with the definition of "harm" encompassing a broad range of negative consequences including physical or mental suffering, loss of reputation, loss of freedom, and so on.

The potential for harm in child sexual abuse research emanates from two sources: first, from the experience of participating in child sexual abuse research, and second, from harmful ideas or assumptions that may inadvertently be transmitted to participants and/or members of the public by sexual abuse researchers.

The first of these threats relates to the fact that participation in child sexual abuse research has been found to constitute a stressful experience for a significant number of participants. In Russell's (1986) community survey, 17% of participants reported that they had felt "somewhat uncomfortable" about answering abuse related questions and 6% reported that they had felt "very uncomfortable". Similarly, in Collings (1991) student survey, 5% of respondents reported that they had been "a little upset" by their participation and 2% reported that they had been "very upset".

The implications of these findings for sexual abuse research would appear to be twofold: First, "the value of future research in this sensitive area needs to be carefully weighed against the potential that such research has for secondary abuse" (Collings, 1991, p. 157). In the absence of such a "detriment-benefit analysis" researchers may "justifiably be accused of violating the principle of non-maleficence through neglect" (Steere, 1884, p. 9). Second, if (and only if) a detriment-benefit analysis suggests that the research should proceed, potential subjects should be forewarned that their participation may be experienced as stressful. As Steininger et al. (1984) have pointed out, if subjects are clearly informed of possible harm but nevertheless agree to

participate in a study they are in effect consenting to a risk of harm and therefore no ethical principal is violated.

The second potential source of harm in sexual abuse research relates to harmful ideas and assumptions that may inadvertently be transmitted to participants and/or members of the public by sexual abuse researchers. One such assumption is contained in the view that childhood sexual experiences are inevitably associated with severe, chronic, and debilitating psychological effects. Although undesirable outcomes have not been found to be an inevitable consequence of sexual abuse (see Chapter 2), an hypothesis of "inevitable harm" is suggested by treatment models for child sexual abuse which are based on assumed and inevitable damage (cf., Elwell & Ephross, 1987) and by press and media coverage of sexual abuse which has tended to focus almost exclusively on the negative consequences of abuse.

With specific reference to child sexual abuse research, an hypothesis of "inevitable harm" has been implicit in: (a) an almost exclusive focus on negative outcomes and on risk factors associated with such negative outcomes, (b) in the wording of media (and other) appeals for research subjects (which invariably suggest or imply an association between abuse experiences and undesirable outcomes), and (c) in the selection of outcome measures which have tended to provide estimates of the degree of psychological impairment (i.e., rather than an indication of whether abuse related effects are present or not).

As a number of authors have pointed out (Elwell & Ephross, 1987; Levett, 1989b; Schultz, 1980), the hypothesis of "inevitable harm" represents more than just a perspective on the problem; it is an assumption that carries with it a potential for damaging effects. This danger has been well stated by Schultz (1980):

Since we are all expected to react severely to child-adult sexual encounters, such a reaction is bound to ensure the unlikelihood of victims escaping the difficulties produced by the definition and interpretation of the experience (Schultz, 1980, p. 41).

From an ethical perspective, sexual abuse researchers clearly need to be aware of the potentially harmful effects of abuse related assumptions and every attempt needs to be made to ensure that such assumptions are not inadvertently communicated to research participants or to members of the public in the process of systematic data collection.

5.3.1.3 Beneficence

The principle of Beneficence asserts that we should actively contribute to others' health and welfare.

At a general level this principle implies that sexual abuse researchers should use their research skills to extend knowledge for the sake of ultimate human betterment. At a more specific level, however, the principle of beneficence serves as an injunction to researchers to provide direct benefit to persons who participate in their research.

Strategies which have been employed in an attempt to provide such direct benefit include: (a) providing participants with an educational perspective which can be used by victims to cognitively restructure their understanding of abuse experiences (cf., Levett, 1989a); and (b) providing participants with an offer of free counselling/psychotherapy to assist them to deal with abuse related concerns/issues (cf., Collings, 1991).

5.3.2 Ethical Dilemmas

Ethical dilemmas in child sexual abuse research are likely to arise when there is a conflict of interests involving two (or

more) of the main parties involved: i.e., researchers, research participants, and the broader population of sexual abuse victims.

An instructive example of such a dilemma is described by Russell (1986). The source of Russell's dilemma was a refusal rate of 50% which posed a threat to the representativeness of her sample. From a research perspective such a high refusal rate is clearly undesirable and suggests that additional strategies need to be employed in an attempt to increase response rates (e.g., sending a second interviewer to the household in an attempt to persuade the respondent to participate). To the extent that unrepresentative samples are likely to restrict the external validity of research data, a high refusal rate is also undesirable from the perspective of the population of abuse victims.

However, from the perspective of research participants, any attempt to elicit consent through pressure or persuasion - no matter how sensitively such pressure is applied - could be construed as a violation of the principle of autonomy (as defined in Section 5.3.1.1, pp 89-91).

Russell resolved this dilemma by giving priority to the principle of autonomy (i.e., by accepting a low response rate and making no further effort to elicit consent); a decision which, if viewed in the context of the ethical principles outlined above, would appear to be the only ethical option available. At a more general level, Russell's decision reflects a priority of interests which, I believe, could usefully be adopted as a general principle in future research; i.e, in cases where sexual abuse researchers encounter an ethical dilemma, the interests of research participants should come first, the interests of the population of abuse victims second, and the interests of researchers third.

5.4 CONCLUSION

This chapter has explored methodological and ethical issues that are relevant to outcome research in child sexual abuse.

Both of these sets of issues need to be carefully considered in the design and planning of future research if we are to "have a sound foundation of knowledge from which to build social policy" (Finkelhor, 1986, p. 223) and if we are to minimize the potential for secondary victimization that is inherent in this sensitive area of research.

CHAPTER 6RECAPITULATION

The persistent controversy over the impact of childhood sexual abuse (cf., Chapter 2) would appear to have been largely resolved by recent studies which suggest that childhood sexual experiences are associated with undesirable psychological sequelae in a significant proportion of cases. In the immediate aftermath of abuse at least 17% of sexually abused children have been found to manifest some evidence of psychological disturbance. When studied as adults, approximately 17% of victims have been found to evidence clinically significant pathology, a further 50% to 60% "some" or "few" long-term effects, and the remaining 20% to 30% no long-term effects.

There are a number of factors which make these recent findings particularly compelling. First, they have been obtained using a wide range of samples (including clinical samples, samples drawn from special populations, and random community samples). Second, observed differences between victimized and control samples have been found to persist after controlling for a wide variety of family background and demographic variables. And third, recent studies have tended to incorporate elements into their design (e.g., random sampling procedures, the inclusion of non-victimized control groups, the use of standardized outcome measures, and/or the use of multivariate methods of data analysis) which allow for more objective and unambiguous tests of research hypotheses.

One can therefore be reasonably confident in concluding that childhood sexual abuse constitutes an incentive event - in the sense defined by Kagan (1983) - which has a potential for undesirable outcomes in a significant proportion of its victims. The important question that remains then for

childhood sexual abuse researchers is not so much whether sexual experiences have a potential for traumatic effects but rather how and why such experiences produce undesirable outcomes in some victims and not in others.

Research which has attempted to address the issue of differential reactions to childhood sexual abuse has not been informed by any systematic theory of stress and stress reactions, has been characterized by serious shortcomings in methodology and design, and has produced few consistent findings (see Chapter 3). Clearly some improvements, at the level of both theory and design, are required if researchers are to adequately address the issue of differential reactions to childhood sexual experiences.

At the level of theory, none of the explanatory models that have been used to account for traumatic reactions to abuse would appear to provide an adequate or complete explanation for the phenomena being studied (cf., Chapter 4, pp. 50-62). A synthesis of two leading perspectives (i.e., the Stress Response Syndrome and the Four Traumagenic Dynamics models) would, however, appear to hold promise as a useful interpretative framework for future research. The structure of such an extended model is outlined in Chapter 4 (Section 4.4) and the implications of the proposed model for research are discussed (Chapter 4, Section 4.5).

Attempts to empirically validate the proposed model need to pay careful attention to a range of methodological and ethical issues that have been found to be relevant to sexual abuse outcome research (Chapter 5). Both of these sets of issues need to be carefully considered in the design and planning of future research if we are to "have a sound foundation of knowledge from which to build social policy" (Finkelhor, 1986, p. 223) and if we are to minimize the potential for secondary victimization that is inherent in this sensitive area of research.

CHAPTER 7PHASE I : DEVELOPING AN APPROPRIATE METHODOLOGY

7.1 ISSUES IN RESEARCH DESIGN

Finkelhor (1986, pp. 199-223) outlines a number of issues that need to be addressed in the design of child sexual abuse research. These issues include: (a) the selection of an appropriate conceptual/interpretative framework; (b) the operational definition of child sexual abuse; (c) sampling procedures and sample selection; (d) methodologies of design, (e) measurement and instrumentation; (f) experimental control; and (g) ethical considerations.

7.1.1 A Conceptual Framework

The conceptual framework employed in the present research was the Sexual Abuse Response Syndrome (SARS) model. The rationale for this decision, together with a detailed discussion of the structure and core assumptions of the SARS model, is presented elsewhere (cf., Chapter 4).

7.1.2 Defining Child Sexual Abuse7.1.2.1 Definitional Decisions7.1.2.1.1 Child

A "child" was defined as a person under the age of 18 years. This particular definition was selected because: (a) it is consistent with the South African legal definition of a "child";¹ (b) it is consistent with the definition of a

¹ In terms of the South African Child Care Act (Act 74 of 1983) a "child" means any person under the age of 18.

"child" that has been used in most recent studies of child sexual abuse (cf., Chapter 5, Section 5.2.1, Table 6, p. 71); and (c) it falls at the inclusive end of the continuum of definitions used by child sexual abuse researchers and is therefore consistent with Finkelhor's (1986) injunction that inclusive rather than restrictive definitions should be used in exploratory research.

7.1.2.1.2 Sexual

The term "sexual" was used to describe the following activities:

- (i) vaginal intercourse.
- (ii) anal intercourse.
- (iii) attempted vaginal or anal intercourse.
- (iv) cunnilingus.
- (v) fellatio.
- (vi) manual genital contact.
- (vii) stroking or fondling of breasts, buttocks or thighs.
- (viii) sexual (open-mouthed) kissing.

This definition of sexual behaviour was selected for a number of reasons. First, it falls near the inclusive end of the continuum of definitions used by child sexual abuse researchers and is therefore consistent with the injunction that inclusive rather than restrictive definitions should be used in exploratory research. Second, it embraces - and is restricted to - activities which have a common defining characteristic; i.e., activities involving physical contact in which the victim (or passive partner) is directly confronted by the perpetrator (or initiating partner).² Third, it encompasses all sexual behaviours which are described in the

² Non-contact forms of sexual abuse (sexual suggestions, exhibitionism, etc.) were not included in the definition, as such forms of abuse have not been found to be associated with undesirable long-term effects (cf., Collings, 1994; Haugaard & Emery, 1989; Peters, 1988).

legal definitions of rape, attempted rape, and indecent assault.³

7.1.2.1.3 Abuse

The term "abuse" was used to describe sexual activities involving a child if there was evidence that the child did not, or was not in a position to, provide informed consent. In the present study an absence of informed consent was assumed if one or more of the following conditions applied:

- (i) The sexual activity was unwanted by the child.
- (ii) Implicit or explicit threat/coercion was employed to secure the child's cooperation.
- (iii) The sexual activity involved a child and a person or persons who was/were at least five years older than the child.
- (iv) The sexual activity involved a child and a person or persons who occupied a position of power or authority in relation to the child (e.g., a doctor, a teacher, a parent, a step-father, etc.).

This particular definition of "abuse" was used because: (a) it

³ In South African law, rape is defined as intentional, unlawful, sexual intercourse (involving penile-vaginal penetration, no matter how slight), with a women, without her consent. Attempted rape involves all the elements of rape but with the absence of penile penetration. Indecent assault is defined as any sexual contact - including sexual fondling, masturbation, penile-anal penetration of a women/girl, and other sexual acts which are not sodomy (i.e., anal intercourse between two male partners) or rape - with a person against their will.

is consistent with definitions of "abuse" that have been used in most recent studies of child sexual abuse (cf., Chapter 5, Section 5.2.1, Table 6, p 71); and (b) it is based on criteria which would be taken as evidence of a lack of consent, or which would lead to a presumption of coercion, in South African law.⁴

7.1.2.1.4 Child Sexual Abuse

The term "child sexual abuse" was used to describe any activity which contained the elements of "child", "sexual", and "abuse" (as defined above).

7.1.2.1.5 Perpetrator

The terms "perpetrator" was used to refer to any person who performed an abusive sexual act with a child.

7.1.2.1.6 Victim

The term "victim" was used to refer to any person who reported

⁴ In criminal law (cf., Burchell & Milton, 1991, pp. 182-183) consent must be given freely, i.e, voluntarily and without objection (criterion i.) and consent induced by force or threat is not "real consent" (criterion ii.). With respect to criterion iii., legal definitions of child sexual abuse emphasize "that the sexual encounter should involve a child...and a sexually mature person who is older than the child by between five and ten years" (Burchell & Milton, 1991, pp. 564). With respect to criterion iv., legal definitions of child sexual abuse emphasize that the abuser does, or is able to, abuse a relationship of power or authority over the child. This is a significant element since "it identifies the ethical factor that renders sexual child abuse abhorrent. It emphasizes that what is involved is an abuse of the trust and dependency that young children must place in adults" (Burchell & Milton, 1991, p. 564).

an abusive sexual experience during childhood.⁵

7.1.2.2 Rationale for Definitional Choices

The definition of child sexual abuse employed in the present study was designed to satisfy three broad requirements:

- (i) Coherence. The definition embraced, and was restricted to, activities which had a common defining characteristic (i.e., activities involving physical contact in which the victim was directly confronted by the perpetrator).
- (ii) Inclusiveness. The definition falls near the inclusive end of the continuum of definitions used by previous researchers and is therefore consistent with Finkelhor's (1986) injunction that inclusive rather than restrictive definitions should be used in exploratory research.
- (iii) Relevance. The definition is not only consistent with South African legal definitions of child sexual abuse but also embraces the full range of sexually abusive behaviours seen: (a) in South African child welfare settings (Collings, 1989, 1990, 1993) and (b) in local counselling and treatment units.

7.1.2.3 Consequences of Definitional Choices

As indicated previously (Chapter 5, section 5.2.1.5, p. 73) the use of an inclusive definition of sexual abuse is likely

⁵ The term "victim" rather than the more popular term "survivor" was used because it was felt that it more accurately conveyed: (a) the harmful potential of child sexual abuse, and (b) the fact that the responsibility for sexual abuse lies outside of the child (cf., Russell, 1986, pp. 14-15, for the same argument).

to be associated with an increased estimate of the prevalence of abuse and an attenuation of any differences in psychological adjustment that may be observed between abused and non-abused subjects.

To compensate for these influences prevalence rates and estimates of psychological adjustment in the present research were calculated using both inclusive and restrictive definitions of abuse.

7.1.3 The Study Sample

The sample for the present research was determined by two main considerations: (a) Feasibility - the study was constrained by a relatively small research budget, and (b) Representativeness - i.e., a desire to minimize selection bias.

Unfortunately it was not possible to maximally satisfy both of these requirements. The ideal sample, in terms of representativeness would, for example, be a national probability sample which was clearly not feasible given the financial constraints of the present research. Further, even if financial constraints were not a consideration, the use of a probability sample might not be ideal for purposes of the present research. As indicated previously (Chapter 5, section 5.2.2.4, p. 78) probability sampling tends to be associated with low participation rates and a consequent increase in the risk of response bias.

To accommodate the conflicting demands of "feasibility" and "representativeness" it was decided to conduct the research using two non-probability samples drawn from different populations. The logic for this decision is eloquently summarized by Shaughnessy and Zechmeister (1990):

When the same experiment is done (using subjects drawn from different populations) ... the subjects and the settings in the experiment are very different. When we obtain the same results in these two replications of the experiment, we can be confident that the findings are not peculiar to the particular types of subjects tested in each experiment or to the particular setting in which either experiment was performed. Notice that neither experiment alone has external validity; it is the findings that occur in both experiments that have external validity (Shaughnessy & Zechmeister, 1990, p. 169).

The two samples used in the present research were: (a) a total sample of students drawn from undergraduate classes at the University of Natal, Durban; and (b) a volunteer sample recruited through an appeal placed in the letter's page of a national woman's magazine.

7.1.3.1 The Student Sample

There are a number of advantages associated with the use of a student sample in sexual abuse research. According to Finkelhor (1979) such samples are likely to be "well motivated, not threatened by the subject matter, not inconvenienced by the research, and able to provide the needed information." In addition, students "are still fairly close in time to their childhood experiences" and are therefore likely to "suffer from less memory distortion than would an older person questioned about a comparable event" (p. 38).

However, student samples also present a number of distinct disadvantages which relate mainly to their homogeneity and lack of representativeness. These disadvantages include:

- (i) Homogeneity in Age. The vast majority of university students are either in their late teens or early twenties. Although homogeneity in age is unlikely to affect prevalence figures in the present research - by age 18 all respondents who will have childhood sexual experiences would already have had them - the use of a student sample means that older age cohorts (who may differ in terms of risk of abuse and/or pattern of abuse) were underrepresented in the present sample.

- (ii) Bias of Social Class. Persons from lower socioeconomic groups are likely to be under represented in samples drawn from college or university populations. The results obtained in probability surveys conducted in the United States (e.g., Russell, 1986) - which suggest that the risk of child sexual abuse is not significantly related to social class - would suggest, however, that this form of bias is unlikely to seriously impact on prevalence figures obtained in the present research.
- (iii) Bias of Race. Despite the changing political situation in South Africa, persons of colour continue to be under represented in local tertiary institutions. The fact that race has been found to constitute a risk factor for abuse in this country - with black students facing a significantly higher risk of abuse (Collings, 1991a) - suggests that prevalence figures for the present sample are likely to underestimate the true scope of the problem.
- (iv) Bias of Selection. University students have been described as a highly select, well-functioning population (Finkelhor, 1979; Painter, 1986) who are "least likely to have had disruptive experiences such as that of sexual abuse" (Painter, 1986, p. 327). Although students undoubtedly constitute a highly select group (in terms of motivation, social background, intellectual capabilities, etc.) there is no conclusive evidence to support the view that students also constitute a low risk population for abuse. On the contrary, the prevalence figures obtained for student samples in this country (Collings, 1991a, Levett, 1989a) are as high as prevalence figures obtained for the general population of adult men and women in the United States.

In summary, the use of a student sample:

Probably excludes some crucial segments of the relevant population for the phenomenon we are studying. However, it is a good sample from the point of view of motivation, recall, and confidentiality. It is easily a much more normal and representative group than...those that have been previously studied - court cases, therapy clients, and volunteers (Finkelhor, 1979, p. 40).

7.1.3.2 The Volunteer Community Sample

Although volunteer samples recruited through media appeals are relatively inexpensive to assemble "they can be extremely problematic because the investigator has little way of knowing what kind of selection bias is at work" (Finkelhor, 1986, p. 207). The fact that the present media sample was drawn from a population which is more heterogeneous - in terms of factors such as age and education - than one would expect in a student population (cf., Table 10, p. 108), suggests, however, that the two samples used in the present research are likely to be characterized by different forms of selection bias. This difference in forms of selection bias provided the justification/rationale for the use of replication as means of enhancing external validity in the present research (cf., section 7.1.3, p. 104).

It needs to be emphasized, however, that the inclusion of a media sample was designed to enhance, rather than to establish the external validity of the study findings. The fact that both student and media samples are likely to be unrepresentative of the general population of South African women - in terms of factors such as, for example, race and class - would suggest that issues relating to selection bias still need to be considered in the interpretation of the present findings.

7.1.4 Methodology of Design

The present research employed a posttest-only design with nonequivalent groups. In order to accommodate for the lack of

pretest measures, and to enhance the interpretability of the design, steps were taken to control for a range of proxy pretest variables (i.e., demographic and family background variables). In the case of proxy pretests that involved retrospective recall (e.g., parental support during childhood) an attempt was made to increase the validity of recollections by anchoring accounts in concrete behaviours.

The rationale for employing proxy pretests in posttest-only designs has been summarized by Cook and Campbell (1979):

The hope is that proxy pretests will be correlated with the posttest within each treatment group, thereby serving two purposes. First, statistical power will be increased if scores on the proxy pretest are related to posttest scores. Second, a preliminary indication will be evident of the way in which selection operates, for the proxy variables may suggest some of the specific initial differences between groups (Cook & Campbell, 1979, p. 113).

TABLE 10 : Readership Profile Provided by the Editor of the Magazine in which the Media Appeal was Published

Characteristic	Profile (%)
<u>Age</u>	
16 - 24	31,4
25 - 34	25,2
35 - 49	22,8
50+	20,6
<u>Education</u>	
Some Primary	3,8
Primary Complete	6,6
High Complete	45,4
Some University	7,6
University Complete	9,9
Other Post-Matric	26,7
<u>Household Income</u>	
R 0 - 1 399	24,7
R1 400 - 2 499	17,6
R2 500 - 3 999	15,1
R4 000 - 5 999	13,3
R6 000 - 7 999	10,6
R8 000+	18,6

7.1.5 Measurement and Instrumentation

7.1.5.1 Mode of Data Collection

The mode of data collection employed in the present research was the Self-Administered Questionnaire (SEQ). This decision was informed by a number of considerations: (a) SEQ's tend to be associated with "a high response rate, accurate sampling, and a minimum of interviewer bias" (Oppenheim, 1992, p. 103); (b) SEQ's constitute an efficient and cost-effective method of data collection; and (c) prevalence rates obtained for child sexual abuse obtained using SEQ's have not been found to differ significantly from those obtained using more costly/time consuming modes of data collection (cf., Chapter 5, section 5.2.3.2.2, p. 83).

7.1.5.2 Assessing for a History of Abuse

Multiple probes - involving both relationship-specific and activity specific questions - were used to assess for a history of child sexual abuse. The full text of these probes is presented below:

Before your FOURTEENTH birthday how many times did you have each of the following experiences?

- (i) Someone attempting to have sexual intercourse or anal sex with you (i.e., without penetration taking place).
- (ii) Someone having sexual intercourse or anal sex with you (involving penetration).
- (iii) Someone stimulating your genitals with their mouth.
- (iv) Someone getting you to stimulate their genitals with your mouth.

- (v) Someone trying or succeeding in touching your breasts or genitals in a sexual way.
- (vi) Someone trying or succeeding in getting you to touch their genitals.
- (vii) Someone feeling you, grabbing you, or kissing you in a way that you felt was sexual.
- (viii) Any other experiences that you have not mentioned yet, but which you felt were sexual.

At ANY time in your life, have you had any of the following experiences?

- (ix) Having an unwanted sexual experience with a girl or woman.
- (x) Being the victim of rape or attempted rape.
- (xi) Having any kind of sexual experience with someone who had authority over you (e.g., a doctor, teacher, employer, therapist, policeman, or much older person).
- (xii) Having any kind of sexual contact with an uncle, brother, father, grandfather, or female relative.
- (xiii) Having any kind of sexual contact with someone less closely related to you (e.g., a stepparent, stepbrother, in-law, or first-cousin).
- (xiv) Narrowly missed being sexually assaulted.
- (xv) Being in a situation where there was violence or threat of violence in which you were also afraid of being sexually assaulted.
- (xvi) Any other unwanted sexual experience that you haven't mentioned above.

The decision to use multiple relationship-specific and activity-specific probes was based on the fact that the number of probes and the specificity of questions has been found to be positively, and significantly, related to prevalence figures in previous research (cf., Chapter 5, section 5.2.3.2.1, p. 82). The specific probes used were either identical to, or similar to, those developed by Russell (1986) in her community survey.

7.1.5.3 Independent Measures

According to the SARS model (cf., Chapter 4, Section 4.4, p. 62), differential adjustment to a childhood sexual experience is likely to be influenced by a number of factors: (a) abuse related appraisals; (b) the child's developmental level; (c) the circumstances of the abuse; (d) the child's experiences prior to the abuse (with specific reference to the nature and quality of parenting behaviours); and (e) the child's experiences in the aftermath of abuse.

7.1.5.3.1 Abuse Related Appraisals

Victimized subjects were asked to provide information relating to a number of abuse related appraisals. These appraisals, together with associated probe questions, are presented in Table 11 (p. 112).

In addition, an appraisal of "ambivalence" was derived using a formula adapted from Heilbrun (1981):

$$\text{Ambivalence} = [(N + P) - |N - P|]/2$$

Where: N represents the score for appraisals of negativity; P represents the score for appraisals of pleasurable; the first term (sum of two scores) represents extensivity; and the second term (absolute difference between two scores) represents balance. A correction factor (/2) was included to provide ambivalence scores ranging from 1 (no ambivalence) to 5 (extreme ambivalence).

TABLE 11 : Abuse Related Appraisals Surveyed in the Present Research

Form of Appraisal	Probe Questions
Negativity	When the incident first occurred did you experience any feelings of fear or shock?
Pleasurableness	Any sexual experience, regardless of whether it is experienced as negative or positive, may be associated with feelings of sexual arousal or some other pleasurable feelings. Was this at all true for you at the time of the experience?
Self-Blame	At the time did you feel you were in any way responsible, or to blame, for what happened?
Betrayal	At the time did you feel that the other person had let you down, or betrayed your trust, in some way?
Desirability	At the time, did you want the experience to take place?
Changeability	Do you believe that there was anything you could have said or done that could have prevented what happened?

^aIn all cases responses were scored on a 5-point scale ranging from "Not at all" to "Very much so".

The appraisals surveyed in the present research were selected because: (a) they have emerged as significant predictors of abuse outcome in previous research [stressful reactions to childhood sexual abuse have been found to be associated with appraisals of negativity (Finkelhor, 1979), pleasurableness (Russell, 1986); ambivalence (Russell, 1986), self-blame (Haugaard & Repucci, 1988; Hoagwood, 1988), and betrayal (Finkelhor, 1987, 1988)]; and (b) there were strong theoretical grounds for assuming that the selected appraisals would be associated with undesirable outcomes in the present study (both the SARS model and the Four Traumagenic Dynamic model would predict an association between the theme of traumatic sexualization and appraisals of negativity, pleasurableness, and/or ambivalence; the theme of

stigmatization and appraisals of self-blame; the theme of powerlessness and appraisals of desirability and changeability; and the theme of betrayal and appraisals of betrayal).

7.1.5.3.2 Maturity

For reasons mentioned earlier (Chapter 4, Section 4.4, p. 62) the child's maturity was assessed using developmental stages rather than age. Three developmental stages were employed: (a) preoperational (under 7 years); (b) operational (7 to 11 years); and (c) post-operational (12 years and older).

The decision to employ Piagetian stages of development to reflect stages of affective development was based on the close parallel between the development of affectivity and that of intellectual functions that is (a) suggested by Piagetian theory (Cicchetti & Hesse, 1983, Piaget, 1952, 1968, 1972),⁶ and which (b) has emerged in empirical studies of emotional development (Harris, 1989).

7.1.5.3.3 Formal Characteristics of Abuse

Formal characteristics of abuse were assessed using questions from Finkelhor's (1979) questionnaire. The specific abuse characteristics surveyed were: (a) nature of abuse, (b) duration of abuse, (c) frequency of abuse, (d) coerciveness of abuse, (e) victim-perpetrator relationship, (f) age of perpetrator, and (g) sex of perpetrator.

These specific characteristics were selected because they have emerged as significant predictors of abuse outcome in previous

⁶ Piaget suggests two possible ways that the relationship between emotion and cognition can be conceived; parallelism and epiphenomenalism (cf., Cicchetti & Hesse, 1983, p. 158). A close association between cognitive and affective development would, of course, be predicted regardless of which of these perspectives one adopts.

research (see e.g., Bagley & Ramsay, 1985; Browne & Finkelhor, 1986; Finkelhor, 1979; Russell, 1986).

7.1.5.3.4 Family Background Variables

The family background variable which has most consistently been found to be associated with a history of abuse is the nature and quality of parental rearing behaviours (cf., Chapter 3, section 3.3.2, p. 47).

The measures of parental rearing behaviour used in the present study were the 'Abusive' and 'Rejecting' subscales of the English form of the EMBU ('EMBU' relates to the Swedish initials for 'own memories of child-rearing experience'; Ross, Campbell & Clayer, 1982). The English translation of the EMBU has been established as a valid and reliable measure (Ross *et al.*, 1982) and recollections of parental punitiveness and coldness, as measured by the EMBU, have been found to be strongly predictive of a history of child sexual abuse (Bagley & Ramsay, 1986) and of long-term reactions to abuse experiences (Collings, 1991a).

7.1.5.3.5 Post-Abuse Experiences

The present study surveyed post-abuse experiences that have been found to^{be} associated with traumatic effects in previous research (cf., Chapter 3, Section 3.3.3, p. 48). Respondents were asked to indicate: (a) if the abuse had been reported to family, friends, or significant others; (b) if the abuse had been reported to the police; (c) if disclosure had been supportive; and (d) if the victim had received professional counselling or psychotherapy following the experience.

More recent life events were surveyed using a measure of social support and a measure of recent life stressors:

- (i) The Social Relationship Scale (SRS): Developed by McFarlane, Neale, Norman, Roy, and Streiner (1981), the SRS is a measure of the extent, helpfulness, and

reciprocity of social support in six broad areas: work; money and finances; home and family; personal and social; personal health; and issues that relate to society in general. According to the authors the SRS: (a) has a median test-retest reliability for the different categories of life stressors of 0.91, and (b) a reasonable degree of content and criterion related validity (cf., McFarlane et al., 1981, pp. 92-97).

- (ii) The Life Experiences Survey (LES): Developed by Sarason, Johnson and Siegel (1978), the LES is a 57-item self-report measure of recent life stressors. According to the authors, the LES has reasonable reliability (test-retest reliability of between 0,56 and 0,88) and LES scores have been found to be significantly and positively correlated with measures of anxiety, academic performance, and personal maladjustment (cf., Johnson & Sarason, 1979, pp. 205-230).

7.1.5.4 Dependent Measures

According to Finkelhor (1986), outcome measures in child sexual abuse research should be based on a theoretical understanding of the impact of abuse. In the context of the Sexual Abuse Response Syndrome model this translates into a need for outcome measures which adequately address four specific stress response themes (traumatic sexualization, stigmatization, betrayal, and powerlessness).

According to Finkelhor (1987) each of these four stress response themes can be matched to specific psychological symptoms that have been noted in the literature. The psychological impact of each response theme, together with the associated outcome measure used in the present research, is presented in Table 12 (p. 116).

The outcome measures mentioned in Table 12 comprise, or constitute subscales of, the following assessment instruments:

TABLE 12 : Stress Response Themes, Psychological Impact, and Associated Outcome Measures

Stress Response Theme	Psychological Impact	Outcome Measure
Traumatic Sexualization	Sexual maladjustment	Sexual Adjustment Scale (Briere, 1989)
Stigmatization	Social isolation	Psychoticism (BSI)
	Suicidal ideation	The Suicidal Feelings Scale (Paykel et al., 1974)
	Low self-esteem	Rosenberg's Self-Esteem Scale (Rosenberg, 1965)
Betrayal	Fear of rejection	Interpersonal Sensitivity (BSI)
	Depression	Depression (BSI)
	Interpersonal hostility	Paranoid Ideation (BSI)
Powerlessness	Suicidal ideation	Hostility (BSI)
	Low self-esteem	The Suicidal Feelings Scale (Paykel et al., 1974)
	Anxiety disorders	Rosenberg's Self-Esteem Scale (Rosenberg, 1965)
Powerlessness	Phobias	Anxiety (BSI)
	Depression	Obsessive-Compulsive (BSI)
	Somatic complaints	Phobic Anxiety (BSI)
	Lowered sense of self-efficacy	Depression (BSI)
		Somatization (BSI)
	Personal Locus of Control Scale (Mirels, 1970)	

Note. BSI = Subscales of the Brief Symptom Inventory (Derogatis & Spencer, 1982).

- (i) The Brief Symptom Inventory (BSI): Developed by Derogatis & Spencer (1982), the BSI is a 53-item self-report symptom inventory designed to reflect the psychological symptom patterns of psychiatric and medical patients as well as non-patient populations.

Items on the BSI are rated on a 5-point scale of distress ranging from "not at all" to "extremely". The BSI is scored in terms of nine primary symptom dimensions (Somatization, Obsessive-Compulsive, Interpersonal Sensitivity, Depression, Anxiety, Hostility, Phobic Anxiety, Paranoid Ideation, and Psychoticism) and yields three global measures of distress: the Global Severity Index (GSI), the Positive Distress Index (PDI), and the Positive Symptom Total (PST). The authors report alpha coefficients for the nine symptom dimensions ranging from 0,84 to 0,87, test-retest reliability ranging from 0,75 to 0,84, and discriminant validity ranging from 0,65 to 0,70.

- (ii) Sexual Conflict Scale (SCS): Developed by Briere and Runtz (1989) the SCS is an 8-item self-report measure of sexual adjustment. In the present study, SCS items were scored on a 5-point scale (rather than the 7-point scale suggested by the author) with response options ranging from 1 (not at all) to 5 (very much so). According to the authors, the SCS has been found to be relatively reliable, with an alpha coefficient for the scale of 0,78.
- (iii) The Suicidal Feelings Rating Inventory (SFRI): Developed by Paykel, Myers, Lindenthal, and Tanner (1974), the SFRI is a 5-item self-report inventory designed to measure levels of suicidal ideation/intent. SFRI items are rated on a 4-point scale ranging from "often" to "never", and SFRI scores have been found to be significantly correlated with measures of social isolation and with the number of stressful life events reported in the last year.
- (iv) Personal Locus of Control Scale (PLCS): Developed by Mirels (1970), the PLCS is a 9-item adaptation of Rotter's (1966) Internal-External scale which focuses

specifically on personal (as opposed to political) locus of control. A modified version of Mirel's scale was used in the present study. Specifically, only five items from the scale were used, with items being selected on the basis of factor loadings (i.e., a factor loading of 0,30 or greater on personal control for female subjects).

- (v) Rosenberg's Self-Esteem Scale: Developed by Rosenberg (1965), this is a 10-item measure of self-esteem. In the present study the scale was modified to permit a 3-point (instead of a 4-point) response scale (i.e., "Not at all", "A little", "A lot").

7.1.6 Control of Threats to Internal Validity

7.1.6.1 Selection

In an attempt to minimize confounding due to selection, groups were carefully matched on a range of proxy pretest variables (cf., Section 7.1.4, p. 107).

7.1.6.2 Instrumentation

Threats to internal validity related to instrumentation were controlled by means of: (a) careful pretesting of the research questionnaire to ensure that items were clearly and unambiguously stated; (b) the use of standardized instructions and administration procedures; and (c) an assessment of psychological adjustment prior to an assessment of childhood sexual experiences (to avoid possible carry-over effects).

7.1.6.3 Instability

Instability as a threat to internal validity was controlled through the use of assessment procedures that have been found to be reliable and through the use of large samples.

7.1.6.4 Statistical Regression

As subjects were not selected on the basis of extreme scores, there was no reason to suspect that regression would pose a threat to internal validity.

7.1.6.5 Experimental Mortality

Questions relating to child sexual abuse were phrased in a non-evaluative and sensitive manner in an attempt to overcome the reluctance that respondents may have in recounting abuse experiences. Responses from victimized subjects were further encouraged by stressing to all subjects that they were not required to provide any identifying information and that all responses would be treated in the strictest of confidence.

7.1.7 Ethical Considerations

7.1.7.1 The Principal of Autonomy

A number of strategies were employed in an attempt to ensure that participation in the research was based on free and informed consent:

- (i) Persons under the age of 18 years were not permitted to participate in the survey.⁷
- (ii) The detailed purpose of the research was clearly described on the cover page of the research questionnaire.
- (iii) Subjects were informed (both verbally and by means of a

⁷ This ruling is consistent with the provisions of section 39(4) of the Children's Act (Act 74 of 1983), in terms of which a person under the age of 18 is assumed to be incapable of giving informed consent without the assistance of their parent or guardian.

note on the cover page of the questionnaire) that participation was voluntary.

- (iv) Subjects were encouraged to carefully read through all sections of the questionnaire before deciding whether they wished to participate.
- (v) No reward or inducement was offered to subjects in an attempt to encourage participation.
- (vi) Subjects were informed (both verbally and by means of a note on the cover page of the questionnaire) that they should feel free to discontinue their participation at any stage.
- (vii) Subjects were provided with the opportunity to withhold consent anonymously.

7.1.7.2 The Principal of Non-Maleficence

Subjects were forewarned (both verbally and by means of a note on the cover page of the questionnaire) that their participation may be experienced as stressful. In this respect, subjects were advised not to participate, or alternatively to discontinue their participation, if such participation (continued participation) was likely to be experienced as unduly stressful.

As indicated previously (Chapter 5, Section 5.3.1.2, p. 92) the principle of non-maleficence can also be threatened by harmful ideas or assumptions (e.g., the assumption that childhood sexual experiences are inevitably associated with severe and debilitating effects) that may inadvertently be transmitted to participants by sexual abuse researchers.

In an attempt to counter/mimimize assumptions of "harmful effects" in the present research, the following strategies were employed:

- (i) In formulating the probes designed to assess for a history of abuse, an attempt was made to avoid the use of value-laden words (such as "rape" and "sexual molestation") which tend to be associated with harmful effects or undesirable outcomes.
- (ii) All questions relating to abuse effects included a response option which allowed subjects to indicate an absence of negative effects.
- (iii) The questionnaire was not restricted to a survey of negative effects but also contained items which were designed to assess the positiveness and/or desirability of abuse experiences.

7.1.7.3 The Principle of Beneficence

Two strategies were employed in an attempt to provide direct benefit to persons who participated in the research:

- (i) All respondents were provided with feedback on the major findings of the research. This feedback - which took place in the context of a general discussion of the nature and dynamics of child sexual abuse - was designed to provide respondents with an educational perspective which could be used by victims (and non-victims) to cognitively restructure their understanding of abuse experiences.
- (ii) All participants were provided with an offer of free counselling/psychotherapy to assist them to deal with abuse related concerns/issues.

7.2 COMPILING THE RESEARCH QUESTIONNAIRE

7.2.1 The Introduction

The introduction to the questionnaire (see Appendix A, p. 238) was a modified version of the introduction used by Finkelhor

(1979) in his student survey. Specific modifications included:

- (i) The use of an introductory statement which more clearly described the detailed purpose of the study; i.e., the phrase "this study of the family and sexual behaviour" in the opening sentence of Finkelhor's introduction was replaced by the phrase "a study of childhood sexual experiences".
- (ii) The phrase "it may be embarrassing or painful to answer some of the questions" was underlined to emphasize the fact that participation may be associated with undesirable/traumatic effects.
- (iii) In a further attempt to ensure that respondent's consent was truly informed, the following sentence was added to the introduction: "In you own interests, we recommend that you carefully read through all sections of the questionnaire before deciding whether you wish to participate".

7.2.2 The Body of the Questionnaire

The body of the research questionnaire (See Appendix B, p. 240) was divided into two broad sections. The first section (Section A) contained items relating to demographic and family background variables, psychological adjustment, life stressors, and current levels of social support; while the second part of the questionnaire (Section B) comprised the child sexual abuse survey.

Demographic variables (age, sex, race, education, marital status) were assessed using questions from Finkelhor's (1979) questionnaire, with socioeconomic status being determined as per Watts (1976, p. 63) on the basis of occupation as follows:

- (i) Married woman - husband's highest previous or present occupation.

- (ii) Widow - husband's highest previous occupation.
- (iii) Divorced woman - own occupation unless husband's was higher.
- (iv) Unmarried dependent - father's previous or highest occupation.
- (v) Unmarried/independent - own occupation.

Four categories of socioeconomic status were delineated:

- (i) Upper white collar - executive, managerial, senior administrative and professional workers.
- (ii) Lower white collar - subordinate administrative, clerical, commercial, and non-manual technical workers.
- (iii) Upper blue collar - skilled and supervisory manual workers.
- (iv) Lower blue collar - semi-skilled and unskilled workers.

Consistent with Finkelhor's (1986) recommendations: (a) the abuse survey was presented in the final part of the questionnaire (i.e., after measures of psychological adjustment) in an attempt to minimize expectancy effects; and (b) the basic design of the survey was a funnel-type response protocol that required the subjects to first respond to broad questions and then branch into a more detailed evaluation of their experiences.

7.2.3 The Pretest Questionnaire

For purposes of pretesting, respondents were asked to complete a follow-up questionnaire (see Appendix C, p. 249) after they had completed the main research questionnaire. The follow-up

questionnaire was designed: (a) to identify any problems that respondents may have had in completing the questionnaire, and (b) to assess how respondents felt about/experienced their participation in the survey.

7.3 THE PILOT SURVEY

7.3.1 Aims of the Pilot Survey

The pilot survey had seven main aims:

- (i) To obtain an indication of the extent and nature of volunteer bias.
- (ii) To assess the effectiveness of the survey questionnaire as a means of eliciting personal information relating to childhood sexual experiences.
- (iii) To evaluate selection threats to internal validity.
- (iv) To determine if subjects' scores on the selected outcome measures were normally distributed (a requirement for the use of inferential statistics).
- (v) To obtain an indication of the utility of the selected outcome measures in assessing the impact of abuse.
- (vi) To obtain an indication of the validity of the data.
- (vii) To assess the extent to which participation in the survey constituted an upsetting or stressful experience for respondents.

7.3.2 Method

7.3.2.1 Subjects

The target sample for the pilot survey was all female students registered for second year psychology courses at the

University of Natal, Durban ($N = 163$). The average age of the target sample was 19,4 years, with a range of 18 to 42 years. Ninety-six (59%) of the sample were white, 39 (24%) were Asian, 21 (13%) were black, and 7 (4%) were coloured.⁸

7.3.2.2 Materials

Data were collected using the research questionnaire (see Appendices A and B) and the pretest questionnaire (see Appendix C). The three parts of the research questionnaire (blank cover page, introduction, and body of the questionnaire) were stapled together to form one document, while the pretest questionnaire was presented separately.

7.3.2.3 Procedure

Second-year psychology students were invited to participate in the research as an option for a course credit.

Research and pretest questionnaires were distributed to all students during normal lecture periods, with students being requested to carefully read the questionnaire before deciding if they wanted to participate in the research. Students who decided to participate were given a period of 10 days to complete the questionnaire, with questionnaires being completed anonymously outside of class.

A week after all questionnaires had been returned, the class involved in the survey was given feedback on the major findings of the research. This feedback was provided during normal lecture periods and was presented in the context of a

⁸ This information was obtained from student records. As Levett (1989a, p. 125) has pointed out the terms black, white, and coloured cannot be evaded in contemporary South African research because all South Africans are classified according to "race" and this affects all aspects of life experience.

general discussion of the nature and dynamics of child sexual abuse. In addition to a general educative function, it was hoped that the feedback session would provide abused respondents with the opportunity to appreciate that their abuse was not an isolated phenomenon but rather a fairly common experience shared by a significant number of their peers.

At the end of the feedback session students were informed that they should feel free to contact the researcher at any time to discuss any issues that might have been raised by the survey. Students were also informed that free professional counselling was available to any person who felt the need for such services.

7.3.3 Results

7.3.3.1 Participation Rate

Of 163 female students who were eligible to participate in the survey, 10 (6,13%) elected to complete an alternative practical assignment. An examination of returned questionnaires revealed that three subjects had failed to complete some, or all, of the questions relating to child sexual abuse. These three questionnaires were classified as refusals, giving a final participation rate of 150 students (92%).

7.3.3.2 Prevalence Rate

Of the 150 women who returned completed questionnaires, 59 (39,9%) reported at least one experience which met the definition of child sexual abuse used in the present study. The nature of abuse experiences reported by these women is presented in Table 13 (p. 127).

TABLE 13 : Nature of Child Sexual Abuse Reported by Pilot Survey Subjects^a

Nature of Experience	Abuse Experiences	
	<u>N</u>	(%)
<u>Form of Abuse</u>		
Genital intercourse	10	(13%)
Attempted intercourse	23	(31%)
Genital fondling	36	(48%)
Other ^b	6	(8%)

^aThe pilot survey findings are based on a total of 75 experiences reported by 59 respondents.

^bBreast fondling, open-mouthed kissing, and other contact experiences that were experienced as sexual.

7.3.3.3 Exploratory Data Analysis

Chi-Square Goodness-of-Fit Tests were used to determine if subjects' scores on the dependent measures were normally distributed (a requirement for the use of inferential statistics). The hypothesis tested in these analyses were:

H_0 : The data are normally distributed

H_A : The data are not normally distributed

($\alpha = 0,05$)

The results of these analyses, which are presented in Tables 14 and 15 (p. 128) for non victimized controls and abused subjects (respectively), indicate that scores on all outcome measures were normally distributed.

7.3.3.4 Selection Threats to Internal Validity

A comparison of victimized and control subjects on demographic and family background variables revealed a number of significant differences:

- (i) The mean age of victimized subjects ($\bar{M} = 19,85$) was significantly lower than the mean for nonvictimized controls ($\bar{M} = 21,54$; $F(1, 148) = 8,07, p < 0,01$);

TABLE 14 : Scores Obtained by Non Victimized Controls on Outcome Measures During Phase I of the Research: Test for Normalacy of Distribution

Dependent Measure	Chi ²	df	p	Conclusion
BSI Scales				
Somatization	13,46	9	0,13	Normal
Obsessive Compulsive	12,03	8	0,15	Normal
Interpersonal Sensitivity	12,76	11	0,33	Normal
Depression	12,61	7	0,08	Normal
Anxiety	10,71	8	0,23	Normal
Hostility	12,26	9	0,19	Normal
Phobic Anxiety	14,79	9	0,09	Normal
Paranoid Ideation	15,57	10	0,11	Normal
Psychoticism	15,63	9	0,08	Normal
Global Severity Index	13,72	8	0,09	Normal
Rosenberg Self-Esteem	13,28	9	0,15	Normal
Locus of Control	5,01	4	0,24	Normal
Suicide Feelings	12,18	8	0,13	Normal
Sexual Conflict	16,90	10	0,08	Normal

TABLE 15: Scores Obtained by Abused Subjects on Outcome Measures During Phase I of the Research: Test for Normalacy of Distribution

Variable	Chi ²	df	p	Conclusion
BSI Scales				
Somatization	11,02	8	0,20	Normal
Obsessive Compulsive	9,97	7	0,19	Normal
Interpersonal Sensitivity	11,15	7	0,12	Normal
Depression	10,47	6	0,11	Normal
Anxiety	9,81	7	0,20	Normal
Hostility	9,48	8	0,32	Normal
Phobic Anxiety	13,76	8	0,09	Normal
Paranoid Ideation	10,34	7	0,16	Normal
Psychoticism	12,83	7	0,08	Normal
Global Severity Index	14,57	9	0,11	Normal
Rosenberg Self-Esteem	7,10	6	0,32	Normal
Locus of Control	5,46	4	0,27	Normal
Suicide Feelings	13,37	8	0,10	Normal
Sexual Conflict	13,06	9	0,16	Normal

- (ii) Abused subjects reported that they had been exposed to significantly more punitive parenting styles ($F [1, 148] = 6,22, p < 0,05$);
- (iii) Abused subjects reported that they had experienced significantly less supportive parenting relationships ($F [1, 148] = 4,38, p < 0,05$).

The comparisons for socioeconomic status (Kruskal-Wallis $H [1 df] = 2,78, p = 0,14$); race ($\text{Chi}^2 [3 df] = 5,73, p = 0,13$), and marital status ($\text{Chi}^2 [3 df] = 4,58, p = 0,21$) revealed no significant differences.

To further explore "selection" as a threat to internal validity, multiple correlations were performed predicting scores on the selected dependent measures from subject's age, parental punitiveness, and parental supportiveness (i.e., variables which had been found to be significantly associated with a history of abuse). As can be seen from Table 16 (p. 130) subject's age was not a good predictor of adjustment, while punitive and supportive parenting styles were significantly predictive of scores on most outcome measures.

7.3.3.5 Abuse Effects

Abused and nonabused subjects' scores on the nine scales of the BSI were compared using a Multivariate Analysis of Variance (MANOVA), with univariate Analyses of Variance (ANOVA's) following significant MANOVA's. The effect of sexual abuse on all other outcome measures was assessed using univariate ANOVA's.

The MANOVA produced a significant main effect for group, $F (1, 140) = 1.95, p < 0,05$; while the univariate F tests indicated significant differences between groups on most outcome measures. The results of these analyses are presented in Table 17 (p. 130).

TABLE 16 : Zero Order and Multiple Correlations of the Dependent Measures with Selected Demographic and Family Background Variables

Adjustment Measure	Subject's Age	Parenting Style		Multiple Correlation
		Punit.	Supp.	
	<u>r</u>	<u>r</u>	<u>r</u>	<u>R</u>
Scales of the BSI				
Somatization	0,08	0,22**	-0,18*	0,23**
Obsessive-Compulsive	-0,02	0,30**	-0,21**	0,31**
Int. Sensitivity	-0,13	0,16*	-0,14	0,19*
Depression	-0,04	0,20*	-0,21*	0,20*
Anxiety	-0,03	0,15	-0,15	0,20*
Hostility	-0,07	0,15	-0,12	0,13
Phobic Anxiety	-0,09	0,09	-0,10	0,06
Paranoid Ideation	-0,02	0,19*	-0,18*	0,21*
Psychoticism	-0,05	0,18	-0,25**	0,24**
Global Severity Index	-0,05	0,23**	-0,22**	0,25**
Rosenberg Self-Esteem	0,14	-0,18*	0,18*	0,20*
Sexual Adjustment	-0,08	0,23**	-0,23**	0,29**
Locus of Control	0,05	-0,09	0,04	0,01
Suicidal Feelings	-0,06	0,19*	-0,24**	0,32**

Note. Punit. = Punitive. Supp. = Supportive.

* $p < 0,05$. ** $p < 0,01$.

TABLE 17 : Responses to Dependent Measures in the Pilot Survey

Adjustment Measure	Abused ($n = 59$)		Control ($n = 91$)		F Value
	Mean	(SD)	Mean	(SD)	
Scales of the BSI					
Somatization	0,57	(0,52)	0,30	(0,44)	1,95*
Obsessive-Compulsive	1,22	(0,84)	0,84	(0,77)	11,42***
Int. Sensitivity	1,26	(0,95)	0,97	(0,86)	8,70**
Depression	1,04	(0,83)	0,75	(0,70)	4,20*
Anxiety	0,95	(0,81)	0,77	(0,75)	5,27*
Hostility	1,09	(0,99)	0,76	(0,69)	1,86
Phobic Anxiety	0,65	(0,83)	0,50	(0,63)	5,83*
Paranoid Ideation	0,65	(0,83)	0,50	(0,63)	1,58
Psychoticism	1,15	(0,83)	0,77	(0,76)	8,41**
Global Severity Index	0,84	(0,76)	0,59	(0,67)	4,53*
Rosenberg Self-Esteem	0,97	(0,60)	0,68	(0,53)	9,95**
Sexual Conflict	23,18	(4,61)	25,26	(3,79)	9,20**
Locus of Control	34,34	(6,38)	31,86	(5,67)	6,32**
Suicidal Feelings	3,09	(1,60)	3,13	(1,39)	0,35
	8,23	(2,91)	7,56	(2,71)	0,14

* $p < 0,05$. ** $p < 0,01$. *** $p < 0,001$.

To further explore the nature of the relationship between abuse experiences and psychological adjustment, a series of semipartial correlations were calculated to determine whether a history of sexual abuse significantly increased the prediction of psychological adjustment over and above that predicted by demographic and family background variables. The results of this analysis (see Table 18) suggest that the significant relationships found between a history of abuse and the dependent measures was not due to confounding of sexual abuse with demographic and family background variables.

TABLE 18 : Semipartial Correlations of the Dependent Measures with a History of Sexual Abuse from which the Victim's Age, Parental Punitiveness, and Parental Supportiveness had been Partialled

Adjustment Measure	Semipartial Correlations	F
Scales of the BSI		
Somatization	0,2279	7,94**
Obsessive-Compulsive	0,1976	5,89*
Int. Sensitivity	0,1741	4,53*
Depression	0,1666	4,14*
Anxiety	0,0947	1,31
Hostility	0,1923	5,57*
Phobic Anxiety	0,1089	1,74
Paranoid Ideation	0,2132	6,90**
Psychoticism	0,1548	3,96*
Global Severity Index	0,2361	8,56**
Rosenberg Self-Esteem	-0,2545	10,04**
Sexual Adjustment	-0,1901	5,48*
Locus of Control	-0,1219	2,19
Suicidal Feelings	0,0132	0,03

*p < 0,05. **p < 0,01.

7.3.3.6 Validity of the Data

Factors which posed a threat to the validity of the data included: (a) the respondent's willingness to disclose abuse experiences (i.e., were they prepared to respond to all items on the questionnaire, were they prepared to do so honestly, and did they feel in any way coerced or pressurized), and (b)

the respondent's capacity to disclose (i.e., could they understand the questions, and were they able to accurately recall childhood sexual experiences).

Items on the pretest questionnaire which were designed to assess these threats to data validity, together with subject's responses, are presented in Table 19.

TABLE 19 : Factors which Posed a Threat to the Validity of the Data^a

Threat to Data Validity	Respondents	
	<u>N</u>	(%)
<u>WILLINGNESS TO DISCLOSE</u>		
Felt coerced or pressurized		
Not at all	149	(97)
A little	3	(2)
A lot	1	(1)
Regret participation		
No	152	(99)
Yes	1	(1)
Was completely truthful		
Yes	150	(98)
No	3	(2)
Answered all items		
Yes	150	(98)
No	3	(2)
<u>CAPACITY TO DISCLOSE</u>		
Difficulty understanding questions		
No	149	(97)
Yes	4	(3)
Difficulty recalling abuse		
No	148	(97)
Yes	5	(3)

^aN = 153 (i.e., all respondents who elected to complete the questionnaire).

7.3.3.7 The Impact of the Pilot Survey

In an attempt to assess the extent to which participation in the pilot study constituted a stressful experience, respondents were asked the following question: "Some people find it upsetting to complete a questionnaire that contains

personal questions. Was this at all true for you?". The answers to this question, for both abused and nonabused subjects, is presented in Table 20.

TABLE 20 : The Impact of the Pilot Survey

Respondent's evaluation	Abused Subjects		Control Subjects		Combined Sample	
	<u>N</u>	<u>(%)</u>	<u>N</u>	<u>(%)</u>	<u>N</u>	<u>(%)</u>
Not at all upsetting	42	(71)	81	(89)	123	(82)
A little upsetting	15	(26)	10	(11)	25	(17)
Very upsetting	2	(3)	0	(0)	2	(1)
	59	(100)	91	(100)	150	(100)

From Table 20 it can be seen that participation in the pilot survey was experienced as being "a little upsetting" by 17% of respondents and "very upsetting" by 1% of respondents; with abused subjects being significantly more likely to report some degree of upset, χ^2 (1 df) = 7.83; $p < 0.01$.

7.3.4 Discussion

7.3.4.1 Participation Rate

The participation rate obtained in the pilot survey (92%) is significantly higher than participation rates obtained in American surveys of child sexual abuse (see Table 21, p. 134) and was therefore regarded as being adequate for purposes of the present study.

7.3.4.2 Prevalence Rate

The prevalence rate for child sexual abuse obtained in the pilot study (39,9%) is consistent with figures obtained in probability studies of the general population of adult women in the United States (see Table 22, p. 134), and is significantly higher than the 7% to 21% prevalence rates

obtained in studies of American college women (Briere & Runtz, 1985; Finkelhor, 1979; Fromuth, 1986; Fritz, Stoll, & Wagner, 1981; Sedney & Brooks, 1984).

TABLE 21 : Participation Rates Obtained in American Studies of Child Sexual Abuse

Study	Population	Type of Sample	Participation Rate
Finkelhor (1979)	Student	Total	62%
Brickman & Briere (1984)	Community	Random	41%
Wyatt (1985)	Community	Random	53%
Russell (1986)	Community	Random	50%
Haugaard & Tilly (1988)	Student	Total	61%

TABLE 22 : The Prevalence of Incestuous and Extrafamilial Child Sexual Abuse: The Pilot Survey, Russell, and Wyatt Findings Compared

Form of Abuse	Pilot Survey	Russell*	Wyatt**
	%	%	%
Incestuous abuse of females involving sexual contact	19	19	21
Extrafamilial sexual abuse of females involving sexual contact	27	35	32
Extrafamilial and/or incestuous abuse of females (involving contact)	39	43	45

*Russell's (1986) random community sample of women in San Francisco ($N = 470$).

**Wyatt's (1985) random community sample of women in Los Angeles ($N = 248$).

The prevalence rate obtained in the pilot survey is also consistent with the 43,6% prevalence rate obtained by Levett (1989a, 1989b) in her study of childhood sexual experiences among women students at the university of Cape Town. There are, however, significant differences in the nature of the experiences reported by the two South African samples (see Table 23).

TABLE 23 : Type of Sexual Experiences Reported: The Pilot Survey and Levett Findings Compared^a

Nature of Experience	Pilot Survey		Levett Survey	
	N	(%)	N	(%)
<u>Form of Abuse</u>				
Genital intercourse	10	(13)	3	(5)
Attempted intercourse	23	(31)	4	(7)
Genital or breast contact	42	(56)	22	(36)
Noncontact experiences	0	(0)	32	(52)
<u>Victim-Abuser Relationship</u>				
Family member	24	(32)	8	(13)
Acquaintance/stranger	51	(68)	53	(87)

^aThe pilot survey findings are based on a total of 75 experiences reported by 59 respondents, and the Levett findings on a total of 61 experiences reported by 41 respondents.

Compared to the Levett findings the present findings contained a higher proportion of more intrusive sexual experiences, chi-square (3 df) = 54,51, $p < 0,001$; and a higher proportion of incestuous experiences, chi-square (1 df) = 5,65 , $p < 0,02$. The nature of sexual experiences reported in the pilot survey are, nevertheless, consistent with patterns of abuse obtained in probability samples of the general population of adult women in the United States (Russell, 1986).

7.3.4.3 Threats to Internal Validity

The pilot survey identified a number of demographic and family background variables (victim's age, parental punitiveness, and

parental supportiveness) which posed a threat to the internal validity of the study. The fact that these variables were not only predictive of an abuse history but were also predictive of current levels of psychological adjustment suggests that their effects need to be carefully controlled - either statistically or through the use of matching procedures - to ensure an uncontaminated estimate of abuse effects.

7.3.4.4 Abuse Effects

Scores obtained on the selected outcome measures by both non victimized controls and abused subjects were normally distributed and thus appropriate for use with inferential statistics.

The results of the pilot survey also suggest that the selected outcome measures have specific utility at assessing abuse related effects (see Table 17, p. 130). Differences between abused and nonabused subjects were in the predicted direction (i.e., in the direction of less adequate adjustment for abused subjects) in all cases, with these differences reaching statistical significance in most (nine out of 13) cases.

The fact that these differences persisted after controlling for the effects of demographic and family background variables (see Section 7.3.3.5, p. 129) indicates that the significant relationships found between child sexual abuse and measures of psychological adjustment were not due to confounding of sexual abuse with family background and demographic variables.

7.3.4.5 Validity of the Data

7.3.4.5.1 Willingness to Disclose

A number of factors suggest that the vast majority of respondents were willing to disclose a history of child sexual abuse. These factors include: (a) a high participation rate,

with 94% of female students choosing to complete the questionnaire and 92% submitting usable responses; (b) a prevalence rate of 39%, which is significantly higher than the mean prevalence rate of 19% obtained in studies of American college women (Finkelhor, 1979; Fritz *et al.*, 1981; Fromuth, 1986; Landis, 1956; Seidner & Calhoun, 1984); and (c) a profile of reported abuse which includes a high proportion of experiences involving more intimate/intrusive forms of sexual contact (i.e., experiences which one might imagine would be least likely to be reported by respondents who were unwilling to disclose abuse).

The above findings notwithstanding, it is possible that respondents felt coerced or pressurized in some way to participate in the survey and thus chose to "misinform or to 'tell it slant'" (Levett, 1989a, p. 124). Although it is not possible to determine the veracity of responses with any certainty - respondents who provided misinformation in the research questionnaire may also have been less than truthful when asked about the veracity of their responses - the results of the pilot survey would suggest that the vast majority of respondents did not feel coerced and that they felt comfortable enough to answer all questions honestly. Although three respondents (2%) did admit that they had been unwilling to disclose abuse experiences, no respondent admitted to fabricating or embellishing a sexual experience. As sexual abuse tends to be associated with stigmatizing effects (Levett, 1989a, 1989b), the motive for such fabrication is likely to be rare (Russell, 1986) and thus fabrication of sexual experiences is unlikely to have played a major role in the present research.

7.3.4.5.2 Capacity to Disclose

The capacity to disclose could have been affected by two factors: (a) respondents' ability to understand the questions being asked, and (b) respondents' recall of abuse experiences.

The results of the pilot survey suggest that the vast majority of respondents (97%) did not experience any difficulty in understanding the questions. Although 4 respondents (3%) indicated that they had experienced difficulties understanding some questions, no information was provided regarding the nature of these difficulties or of the specific questions involved.

Respondents were also asked if they had experienced any difficulty recalling information relating to childhood sexual experiences. One hundred and forty-eight respondents (96,7%) indicated that they had experienced "no difficulty" recalling details of abuse experiences, three (2%) indicated that they had experienced "some difficulty", and 2 (1,3%) indicated that they had experienced "great difficulty".

In all cases where recall difficulties had been experienced the respondent was attempting to recall an experience that had occurred when they were younger than six years old. This difficulty in recalling early abuse experiences is consistent with the findings of Herman and Schatzow (1985, cited in Russell, 1986), and suggests that the present findings probably underestimate both: (a) the incidence of sexual abuse among the very young, and (b) the overall prevalence of the problem.

7.3.4.6 Impact of the Pilot Survey

The present findings provide support for the view that systematic data collection can constitute an additional stress factor for sexual abuse victims (Levett, 1989a). Levels of distress reported by respondents in the pilot survey (see Table 19, Section 7.3.3.7, p. 133) do not, however, appear to differ significantly from those obtained by Russell (1986) in her probability study of American women. In a well designed study, which employed carefully trained and sympathetic interviewers, Russell found that only 51% of respondents felt

"very comfortable" about participating in the study, 43% indicated that they had experienced some discomfort, and 6% indicated that they had felt "very uncomfortable".

7.3.5 Conclusions

The results of the pilot survey can be summarized under the following points.

- (i) The participation rate obtained in the pilot survey (92%) was significantly higher than participation rates obtained in previous surveys of child sexual abuse and was therefore regarded as being adequate for purposes of the proposed research.
- (ii) The prevalence figures obtained in the pilot survey are consistent with figures obtained in probability samples of the general population of adult women in the United States, and are significantly higher than prevalence rates obtained in studies of American college women. This would suggest that the method of data collection used in the pilot survey constitutes an effective method of eliciting personal information relating to childhood sexual experiences.
- (iii) The pilot survey identified a number of extraneous variables (victim's age, parental punitiveness, and parental supportiveness) which pose a threat to the internal validity of the study and which therefore need to be controlled to ensure an uncontaminated estimate of abuse effects.
- (iv) Scores obtained on the selected outcome measures by both non victimized controls and abused subjects were normally distributed and thus appropriate for use with inferential statistics.

- (v) The outcome measures used in the survey would appear to have specific utility in assessing abuse related effects.
- (vi) Available evidence would suggest that the vast majority of respondents participated willingly and were prepared to give an honest and complete account of past sexual experiences.
- (vii) There is no reason to believe that the pilot survey suffers from the problem of women inventing or fabricating experiences of abuse. There was, however, evidence to suggest that, in a small proportion of cases, respondents had difficulty recalling abuse experiences or were reluctant to divulge such experiences. This would suggest that the present findings probably underestimate the true prevalence of the problem.
- (viii) Participation in the study would appear to have been an upsetting experience for a significant number of women. Levels of distress or discomfort reported by respondents did not, however, differ significantly from discomfort levels reported in carefully designed studies conducted in the United States.

CHAPTER 8

PHASE II : THE STUDENT SURVEY

8.1 INTRODUCTION

In Phase II of the research, the methodology developed in Phase I was applied to a sample of university women (subproblem 2; Chapter 1, Section 1.1.2, p. 1) in an attempt to: (a) identify and explore different patterns of psychological adjustment to abuse experiences (subproblem 3; Chapter 1, Section 1.1.3, p. 1) and (b) identify and evaluate risk factors associated with differential adjustment to an abuse experience (subproblem 4; Chapter 1, Section 1.1.4, p. 2).

8.2 THE RESEARCH HYPOTHESES

The study was informed by a number of hypotheses derived from the Sexual Abuse Response Syndrome Model (cf., Chapter 4, Sections 4.4 and 4.5, pp. 62-69). As the present research was essentially exploratory, the hypotheses which follow are accordingly propositional (rather than hypothetical) in nature.

8.2.1 Hypothesis 1

The starting point of the SARS model is the assumption that child sexual abuse constitutes an "incentive event" in the sense defined by Kagan (1983; cf., Chapter 4, Section 4.4, p. 62). Child sexual abuse is thus assumed to constitute a class of events which has a potential for provoking undesirable affective reactions in a significant proportion of its victims. This provides the rationale for Hypothesis 1.

HYPOTHESIS 1: When compared to nonvictimized controls, a sample of female university students who report a history of child sexual abuse will, as a group, demonstrate impairment in psychological adjustment.

8.2.2 Hypothesis 2

To propose that child sexual abuse constitutes an incentive event with a potential for harmful effects, is not however to suggest that such undesirable outcomes are inevitable. In terms of the assumptions of the SARS model (cf., Chapter 4, Section 4.5, p. 68) one would, in fact, predict an absence of stress response syndromes in some proportion of sexual abuse victims, and this provides the rationale for Hypothesis 2.

HYPOTHESIS 2: When compared to a normative sample, a sample of female university students who report a history of child sexual abuse will comprise: (2a) a group of subjects who report clinically significant levels of pathology, (2b) a group of subjects who report "normal" levels of adjustment, and (2c) a group of subjects who report "superior" levels of adjustment.¹

8.2.3 Hypothesis 3

The SARS model proposes that reactions to abuse are likely to be influenced by a range of pre-, peri, and post-abuse factors (cf., Chapter 4, Section 4.5). This provides the rationale for Hypothesis 3.

¹ Operational definitions of "clinical pathology", "normal adjustment", and "superior adjustment" are provided in section 8.4.4.3.1 (p. 150).

HYPOTHESIS 3: The severity of long-term adjustment problems reported by female university students who report a history of child sexual abuse will be significantly related to: (3a) victim appraisals of the abuse; (3b) formal characteristics of the abuse; (3c) victim experiences in the immediate aftermath of abuse; (3d) demographic and family background variables; (3e) a history of recent life stressors; and (3f) current levels of social support.

8.3 METHOD

8.3.1 Subjects

The target sample for the study was all female students registered for undergraduate psychology courses at the University of Natal, Durban ($N = 734$).² The average age of the target sample was 19,9 years, with a range of 17 to 50 years. Four hundred and seventy-one (64,2%) of the sample were white, 153 (20,8%) were Asian, 82 (11,2%) were black, and 28 (3,8%) were "coloured".³

8.3.2 Materials

Data were collected using the research questionnaire (see Appendices A, B, and C; pp. 238-249) developed during the pilot survey. As was the case in the pilot survey, the three

² This total included the 150 second year students surveyed in Study 1. As no retesting was required (i.e., no modifications were made to the research questionnaire during pretesting) stage-of-practice effects did not need to be considered as a potential threat to internal validity.

³ This information was obtained from student records.

parts of the research questionnaire (blank cover page, introduction, and body of the questionnaire) were stapled together to form one document, while the pretest questionnaire was presented separately.

8.3.3 Procedure

The procedure employed in the student survey was identical to that employed in the pilot survey (Phase I; cf., Chapter 7, Section 7.3.2.3).

8.4 RESULTS

8.4.1 Participation Rate

Of the 734 students who were eligible to participate in the survey 71 (9,67%) elected to complete an alternative practical assignment, and 13 (1,77%) indicated that they were under the age of 18 (and thus not eligible to participate). An examination of returned questionnaires revealed that 10 subjects had failed to complete some, or all, of the questions relating to child sexual abuse. These 10 questionnaires were classified as refusals, giving a final participation rate of 640 students (87,19%).

A comparison of participating students with students who were ineligible/chose not to participate, revealed that the two groups did not differ significantly in terms of age or race.

8.4.2 Respondents' Evaluation of the Survey

Respondents were asked to indicate the extent to which they felt pressurized into participating in the research. Ninety-two per cent of respondents answered "not at all pressurized" and 8% answered "a little pressurized". All respondents indicated that they would be prepared to participate in a similar study if asked to do so in the future.

Respondent's were also asked how upset they had been by their participation in the research. Eighty-nine percent of the sample circled the answer that read "not at all upset", 8% answered "a little upset", and 3% admitted that they had felt "very upset". All of the respondents who reported some degree of 'upset' had experienced an unwanted sexual interaction during childhood. This suggests that it was the act of recounting personal, and possibly painful, abuse experiences and not simply the sensitive nature of the survey questions that was the source of respondent discomfort. A comparison of victimized subjects who had felt upset with victimized subjects who reported no distress revealed that the two groups did not differ significantly in terms of abuse experiences or demographic/family background variables.

Thirty-six (50,7%) of the victimized subjects who had been upset by their participation in the survey requested, and were granted, confidential interviews with the researcher. In 21 cases these requests were occasioned by a desire to obtain more information about the study and in 15 cases by a desire to discuss/work through personal feelings relating to the abuse. Appropriate counselling and/or psychotherapy was provided by the researcher in all cases where such interventions were indicated.

Personal interviews were also requested by 27 subjects who had not reported a childhood sexual experience. In 19 cases these requests were motivated by a desire to obtain further information about the study and in eight cases by a desire to discuss treatment options for friends (five cases) or other family members (three cases) who had experienced childhood sexual abuse. Here again, appropriate intervention was provided, or professional referral made, in all cases where such services were indicated.

8.4.3 Prevalence and Abuse Characteristics

8.4.3.1 Prevalence

Of the 640 women who returned completed questionnaires, 223 (34,8%) reported a total of 270 experiences which met the definition of child sexual abuse used in the present study. The nature of abuse experiences reported by these women is presented in Table 24.

TABLE 24 : Nature of Child Sexual Abuse Reported by Student Sample

Form of Abuse	Abuse Experiences ^a
	(%)
Sexual intercourse	13,8
Attempted intercourse	7,6
Oral sex	5,4
Genital fondling	62,4
Other ^b	10,8

^aBased on a total of 270 experiences reported by 223 respondents.

^bBreast fondling, open-mouthed kissing, and other contact experiences that were experienced as sexual.

8.4.3.2 Abuse Characteristics

More information on the nature of these experiences is presented in Table 25 (p. 147) and Table 26 (p. 148).

Overall, the description of abuse obtained for the student sample conforms to findings from other surveys (see e.g., Finkelhor, 1979, 1986; Finkelhor et al., 1990; Fromuth, 1986; Russell, 1986) with two main exceptions. There was an unusually large number of offenders who were less than 11 years older than their victims (56,5% compared to 23% in

Finkelhor et al's [1990] national survey) and there were an unusually large number of victims in the 15 to 17 year age range (26% compared to only 8% in Finkelhor et al's [1990] national survey).

TABLE 25 : Characteristics of Sexual Abuse Experiences Reported by the Student Sample: Victims and Perpetrators

Characteristic	Abuse Experiences (%)
Age of Victim	
0 - 5 years	9,8
6 - 8 years	22,0
9 - 11 years	14,8
12 - 14 years	27,4
15 - 17 years	26,0
Age of perpetrator	
0 - 17 years	34,5
18 - 25 years	29,6
26 - 35 years	17,1
36 years or more	18,8
Age difference	
0 - 3 years	28,2
4 - 10 years	27,3
11 years or more	44,5
Victim-perpetrator relationship	
Stranger	28,7
Acquaintance	40,4
Biological parent	4,3
Step-parent	3,9
Other relative	22,7
Gender of perpetrator	
Male	93,3
Female	6,7
Number of perpetrators	
One	97,8
Two	1,8
Three or more	0,4

TABLE 26 : Characteristics of Sexual Abuse Experiences Reported by the Student Sample: Dynamics

Characteristic	Abuse Experiences
	(%)
Verbal threat used	
No verbal threat	76,3
Threat (not of bodily harm)	16,6
Bodily harm	5,8
Extreme bodily harm	1,3
Force used	
No force	60,7
Pushed or held down	37,4
Hit or slapped	1,4
Beat, punched, kicked	0,5
Duration	
1 time only	56,1
1 month or less	16,5
1 month to 6 months	9,7
6 months to 1 year	5,6
1 year or more	12,1
Frequency	
1 time only	56,1
2 to 5 times	29,6
6 to 10 times	7,0
10 times or more	7,3
Disclosure	
No, never	45,9
Told family member	27,1
Told friend	27,0

8.4.4 Between-Group Analysis

8.4.4.1 Demographic and Family Background Variables

A comparison of victimized and control subjects on demographic and family background variables revealed that abused subjects reported:

- (i) Significantly more punitive parenting styles ($F [1, 633] = 17,63, p < 0,0001$);
- (ii) Significantly less supportive parenting relationships ($F [1, 632] = 4,38, p < 0,05$).

The comparisons for socioeconomic status (Kruskal-Wallis H [1 df] = 1,66, p = 0,20); race (Chi^2 [3 df] = 3,25, p = 0,35); age (F [1,638] = 0,77, p = 0,39); and marital status (Chi^2 [3 df] = 5,55, p = 0,23) revealed no significant differences.

8.4.4.2 Psychological Adjustment

Abused and nonabused subjects' scores on the nine scales of the BSI were compared using a Multivariate Analysis of Covariance (MANCOVA) with univariate Analyses of Covariance (ANCOVA's) following significant MANCOVA's (cf., Table 27).

The covariates entered in these analysis were scores on the "Punitive" and "Supportive" subscales of the EMBU. The effect of sexual abuse on all other outcome measures was assessed using univariate ANCOVA's.

TABLE 27 : Responses to Dependent Measures in the Student Survey

Adjustment Measure	Covariates		Sexual Abuse
	Punitiveness	Supportiveness	
	<u>F</u>	<u>F</u>	<u>F</u>
Scales of the BSI	4,55*	5,16*	6,65**
Somatization	5,29*	0,37	15,40***
Obsessive-Compulsive	16,76***	2,96	13,04***
Int. Sensitivity	4,02*	9,65**	12,01***
Depression	1,15	16,83**	30,75***
Anxiety	2,43	4,53*	11,03***
Hostility	1,42	2,63	25,12***
Phobic Anxiety	6,83**	1,84	4,59*
Paranoid Ideation	7,30**	8,86**	20,30***
Psychoticism	1,76	19,51***	12,01***
Global Severity Index	6,66*	10,27**	26,47***
Rosenberg Self-Esteem	0,52	14,26***	11,10***
Sexual Adjustment	10,76**	11,85***	22,40***
Locus of Control	0,64	8,80**	0,40
Suicidal Feelings	1,02	23,13***	21,08***

Note. N = 640, $df.$ = (1, 622).

* p < 0,05. ** p < 0,01. *** p < 0,001.

The results of these analyses (see Table 27) indicate that after controlling for the effects of punitive and supportive parenting styles, a history of child sexual abuse was associated with significantly lower/poorer levels of adjustment on all outcome measures with the notable exception of "Locus of Control".

8.4.4.3 Severity of Adjustment Problems

8.4.4.3.1 An Index of Symptom Severity (ISS)

An Index of Symptom Severity (ISS) was devised to assess the extent of adjustment problems reported by respondents in the present study. The ISS was based on BSI scores, with respondents being placed into one of three mutually exclusive adjustment categories (i.e., clinical pathology, normal adjustment, and superior adjustment) on the basis of the following rules:

- (i) Clinical Pathology. The extent of clinical pathology for abused and nonabused subjects was determined using the operational definition of "clinical pathology" developed by the authors of the Brief Symptom Inventory (Derogatis & Spencer, 1982):

$$\text{Positive } D_x = T_{\text{GSI}} \geq T_{63} \text{ or } T_{2\text{DIM}} \geq T_{63}$$

Simply given, this rule states that if a respondent has a Global Severity Index score greater than or equal to T-score 63 (i.e., 1,3 standard deviations above the mean), or any two primary dimension scores greater than or equal to T-score 63 (i.e., 1,3 standard deviations above the mean) then the individual shall be considered a positive diagnosis or a case.

- (ii) Superior Adjustment. "Superior adjustment" was operationally defined using a similar, although inverse rule:

$$\text{Superior } A_x = T_{\text{GSI}} \leq T_{37} \text{ and } T_{9\text{DIM}} < T_{63}$$

Simply given, this rule states that if a respondent has a Global Severity Index score less than or equal to T-score 37 (i.e., 1,3 standard deviations below the mean), and all nine primary dimension scores less than T-score 63 (i.e., less than 1,3 standard deviations above the mean) then the individual shall be considered "superior" in their adjustment.

- (iii) Normal Adjustment. "Normal adjustment" was a residual category which comprised all individuals who did not meet the criteria for clinical pathology or for superior adjustment as defined above.

8.4.4.3.2 ISS Scores: A Comparison of Abused and Nonabused Subjects

As Derogatis and Spencer (1982) do not provide BSI norms for university women, the level of adjustment of respondents in the present study was determined using norms developed by the author (see Appendix D, p. 251).

When the BSI scores obtained by respondents in the present study were transformed to normative T-scores (using the norms presented in Appendix E, pp. 252-253) and when levels of adjustment were defined in the manner specified in section 7.4.4.3.1 (above), a significant relationship emerged between a history of abuse and level of adjustment, with abused subjects being significantly more likely to report more severe adjustment problems (see Table 28, p. 152).

A more detailed comparison of ISS scores obtained by abused and non-abused subjects is presented in Figure 3 (p. 153). From Figure 3 it can be seen that, when compared to non-victimized controls, the entire distribution of ISS scores for abused subjects was shifted approximately 0,5 standard deviations in the direction of more pathological levels of adjustment; with the mean ISS score for abused subjects ($\bar{T} = 53$) being significantly higher than the mean for non-abused controls ($\bar{T} = 47$; $F [1,638] = 25,42$, $p < 0,001$).

TABLE 28 : Severity of Adjustment Problems in the Student Sample: A Comparison of Abused and Nonabused Subjects

Level of adjustment	Group	
	Sexually Abused (<u>n</u> = 223)	Nonabused Control (<u>n</u> = 417)
	<u>n</u> (%)	<u>n</u> (%)
Superior	14 (6,3)	68 (16,3)
Normal	170 (76,2)	317 (76,0)
Clinical Pathology	39 (17,5)	32 (7,7)

Chi² (2 df) = 24,02, p < 0,001

To further explore the relationship between ISS scores and abuse history, Chi-Square Goodness-of-Fit tests were used to determine if the proportion of victimized and non-victimized subjects in each T-score class interval (cf., Table 3, p. 153) deviated significantly from the proportion that would be expected under the normal curve. These analyses revealed that non-victimized controls were significantly over represented in the 0-30 T-score class interval (chi-square [1 df] = 3,96, p <0,05); while victimized subjects were significantly under represented in the 30-39 T-score class interval (chi-square [1 df] = 11,84, p <0,001) and significantly over represented in the 70-100 T-score class interval (chi-square [1 df] = 8,00, p <0,01).

8.4.4.3.3 Convergent Validity of the ISS

A series of two way analyses of variance - in which history of abuse and ISS categories of adjustment were entered as factors - were conducted to determine whether ISS categories of adjustment were associated with scores on other outcome measures.

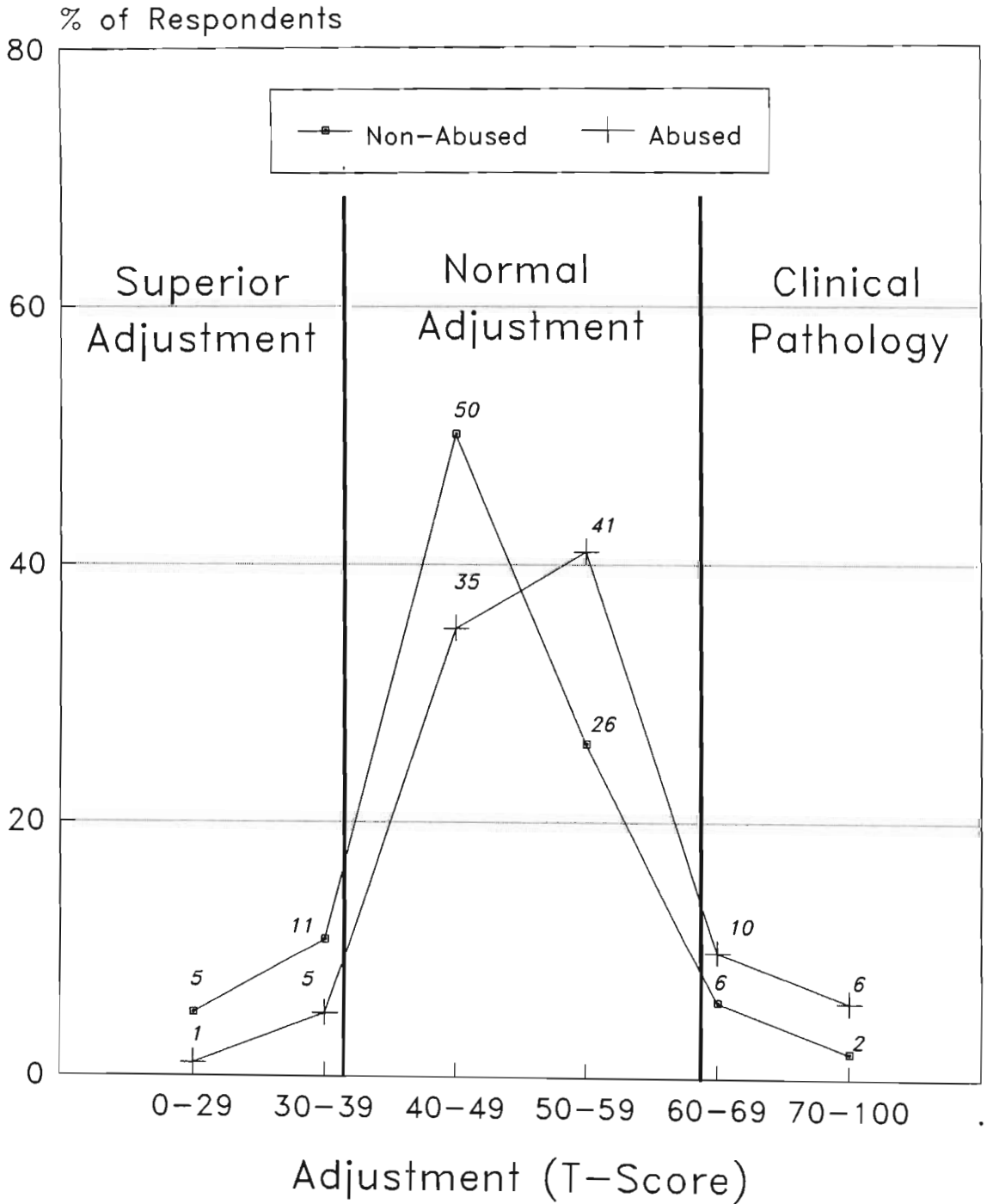


Figure 3 : Severity of Adjustment Problems: Abused and Non-Abused Controls Compared

When scores on Rosenberg's (1965) Self-Esteem Scale were entered as the criterion variable, the analysis produced a significant main effect for Abuse ($F [1, 634] = 7,33, p < 0,01$) and a significant main effect for Level of Adjustment ($F [2, 634] = 35,20, p < 0,001$). The Abuse X Level of Adjustment interaction did not reach significance ($F [2, 634] = 1,17, p = 0,30$). Post hoc analysis of the significant main effect for Level of Adjustment (illustrated in Figure 4, p. 156) revealed: (a) that the mean self-esteem score for the "superior" adjustment group ($M = 26,65$) was significantly higher than the mean for the "normal" adjustment group ($M = 23,95; F [1, 567] = 36,64, p < 0,000$); (b) that the mean self-esteem score for the "normal" adjustment group ($M = 23,95$) was significantly higher than the mean for the "clinical pathology" group ($M = 20,48; F [1, 556] = 51,38, p < 0,001$); and (c) that the mean self-esteem score for the "superior adjustment" group ($M = 26,65$) was significantly higher than the mean for the "clinical pathology" group ($M = 20,48, F [1, 151] = 105,45, p < 0,001$).

When scores on Mirels' (1970) Personal Locus of Control Scale were entered as the criterion variable, the analysis produced a significant main effect for Level of Adjustment ($F [2, 634] = 6,33, p < 0,01$). There was no significant main effect for Abuse ($F [1, 634] = 0,39, p = 0,850$) and no significant Abuse X Level of Adjustment interaction ($F [2, 634] = 1,18, p = 0,31$). Post hoc analysis of the significant main effect for Level of Adjustment (illustrated in Figure 5, p. 156) revealed: (a) that the mean Locus of Control score for the "superior" adjustment group ($M = 3,64$) was significantly higher than the mean for the "normal" adjustment group ($M = 2,91; F [1, 567] = 10,13, p < 0,01$); (b) that the mean Locus of Control score for the "normal" adjustment group ($M = 2,91$) did not differ significantly from the mean for the "clinical pathology" group ($M = 2,66; F [1, 556] = 2,13, p = 0,144$); and (c) that the mean Locus of Control score for the "superior adjustment" group ($M = 3,64$) was significantly higher than the mean for the "clinical pathology" group ($M = 2,66, F [1, 151] = 13,40, p < 0,001$).

When scores on Paykel et al's (1974) Suicidal Feelings Inventory were entered as the criterion variable, the analysis produced a significant main effect for Abuse ($F [1, 634] = 5,07, p < 0,05$) and a significant main effect for Level of Adjustment ($F [2, 634] = 56,72, p < 0,001$). The Abuse X Level of Adjustment interaction did not reach significance ($F [2, 634] = 0,41, p = 0,66$). Post hoc analysis of the significant main effect for Level of Adjustment (illustrated in Figure 6, p. 157) revealed: (a) that the mean suicidal feelings score for the "superior" adjustment group ($M = 6,35$) was significantly lower than the mean for the "normal" adjustment group ($M = 8,04; F [1, 567] = 22,39, p < 0,001$); (b) that the mean suicidal feelings score for the "normal" adjustment group ($M = 8,04$) was significantly lower than the mean for the "clinical pathology" group ($M = 11,64; F [1, 556] = 94,82, p < 0,001$); and (c) that the mean suicidal feelings score for the "superior adjustment" group ($M = 6,35$) was significantly lower than the mean for the "clinical pathology" group ($M = 11,64, F [1, 151] = 113,72, p < 0,001$).

Finally, when scores on Briere and Runtz's (1989) Sexual Conflict Scale were entered as the criterion variable, the analysis produced a significant main effect for Abuse ($F [1, 634] = 15,68, p < 0,001$) and a significant main effect for Level of Adjustment ($F [2, 634] = 27,90, p < 0,001$). The Abuse X Level of Adjustment interaction did not reach significance ($F [2, 634] = 1,43, p = 0,24$). Post hoc analysis of the significant main effect for Level of Adjustment (illustrated in Figure 7, p. 157) revealed: (a) that the mean Sexual Conflict score for the "superior" adjustment group ($M = 29,00$) was significantly lower than the mean for the "normal" adjustment group ($M = 33,71; F [1, 567] = 21,29, p < 0,001$); (b) that the mean Sexual Conflict score for the "normal" adjustment group ($M = 33,71$) was significantly lower than the mean for the "clinical pathology" group ($M = 36,50; F [1, 556] = 47,81, p < 0,001$); and (c) that the mean Sexual Conflict score for the "superior adjustment" group ($M = 29,00$) was significantly lower than the mean for the "clinical pathology" group ($M = 36,50, F [1, 151] = 72,45, p < 0,001$).

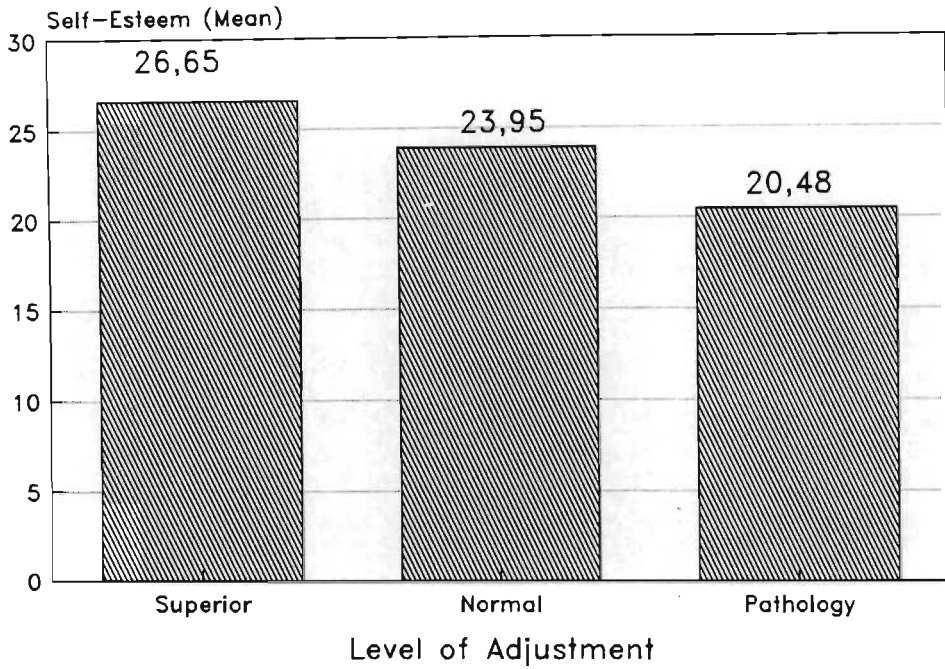


Figure 4 : Level of Adjustment X Mean Self-Esteem Score

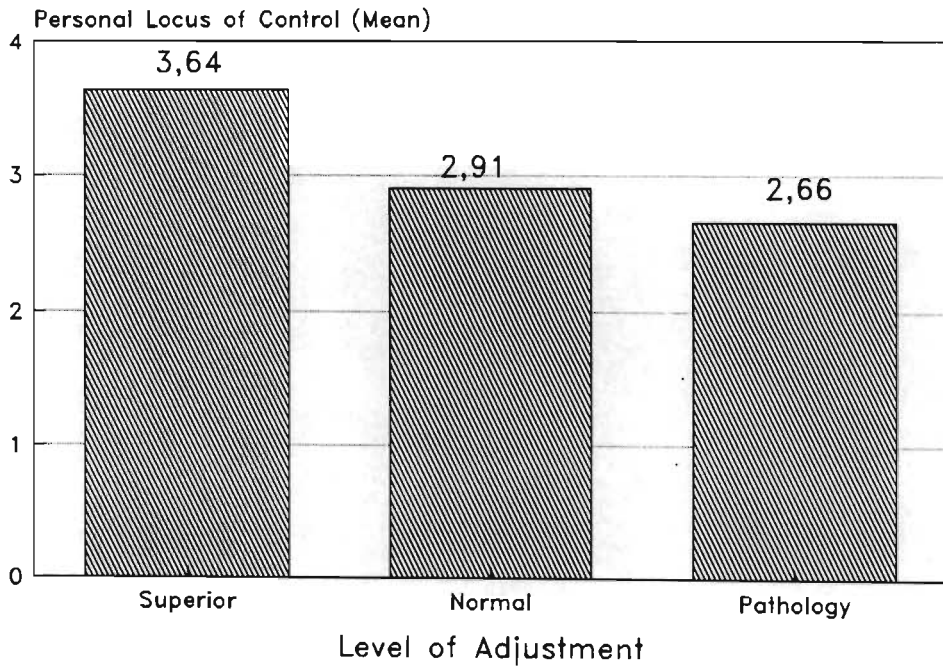


Figure 5 : Level of Adjustment X Mean Locus of Control Score

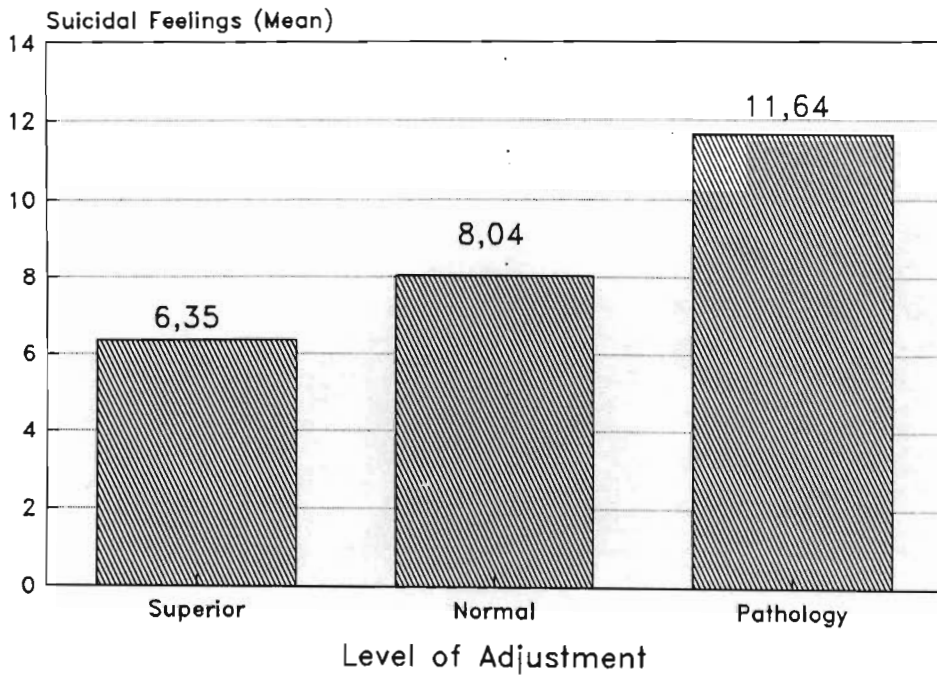


Figure 6 : Level of Adjustment X Mean Suicidal Feelings Score

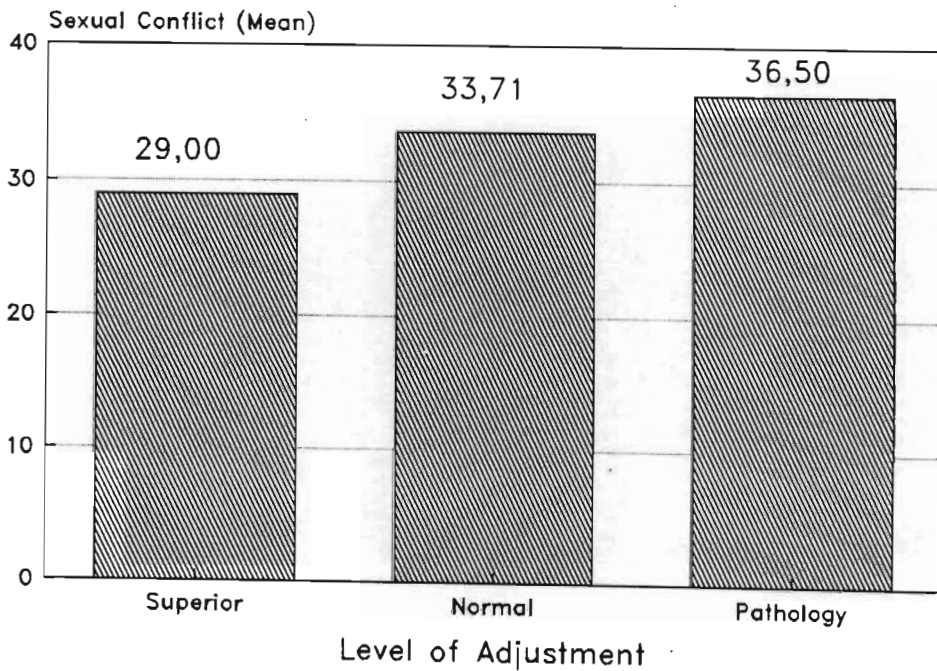


Figure 7 : Level of Adjustment X Mean Sexual Conflict Score

8.4.5 Within-Group Analysis: Abused Subjects

The findings from the between-group analysis are not consistent with the prediction (Hypothesis 2) that the victimized sample would comprise three discrete outcome groups characterized by "superior", "normal", and "clinical" levels of adjustment. The distribution of ISS scores for the victimized sample (see Figure 3, p. 153) suggests rather that the victimized sample constitutes a single normally distributed population; with the entire distribution of ISS scores for this population being shifted significantly in the direction of more pathological levels of development.

Although the present findings are not consistent with an hypothesis of differential effects (i.e., with the view that some victims are affected by abuse while others remain unaffected) there are, nevertheless, compelling reasons for exploring the factors associated with an increased or reduced risk of long-term effects (i.e., with placement towards one or other tail of the continuum of adjustment). As Rutter (1987) has argued the psychological processes involved in "risk" and "protection" are likely to differ in important respects, and it is these differences in the processes underlying adjustment which need to be systematically explored if: (a) we are to achieve a comprehensive theoretical understanding of stress and stress reactions and if (b) we are to develop rational and effective secondary and tertiary intervention programmes.

8.4.5.1 Factors Associated with the Severity of Adjustment Problems

8.4.5.1.1 Factors Associated with an Increased Risk of Long-Term Effects

Using a series of univariate analyses, victims who reported clinical levels of pathology were compared to victims who reported less severe adjustment problems (i.e., either

"normal" or "superior" adjustment) on a range of demographic, family background, abuse descriptive, and current life event variables.⁴ A discriminant function analysis was then performed including all variables that were significantly related to the adjustment categories at the univariate level.

8.4.5.1.1.1 Univariate Analysis

The univariate analyses indicated that five factors were significantly related to a risk of clinical pathology. From Table 29 (see also Figures 8 to 12, pp. 160-162) it can be seen that the clinical pathology group reported more negative abuse appraisals, had experienced a greater number of recent life stressors, reported less helpful social support networks, and had experienced more punitive and less supportive parenting styles.

TABLE 29 : Factors Associated with an Increased Risk of Long-Term Effects among Abused Subjects in the Student Sample

Factor	Clinical Pathology (<u>n</u> = 39)	Normal or Superior Adjustment (<u>n</u> = 184)	F (1,221)
	Mean	Mean	
Appraisal (negativity)	4,26	3,75	8,07**
Recent life stressors	7,69	4,55	22,32***
Support (helpfulness)	1,21	1,42	5,09*
Parental punitiveness	15,44	13,66	5,27*
Parental supportiveness	27,21	30,31	7,15**

*p < 0,05. **p < 0,01. ***p < 0,001.

⁴ The 32 independent variables considered in these analyses related to: victim demographics, family background, formal characteristics of the abuse, abuse related appraisals, post-abuse experiences, recent life stressors; and current levels of social support.

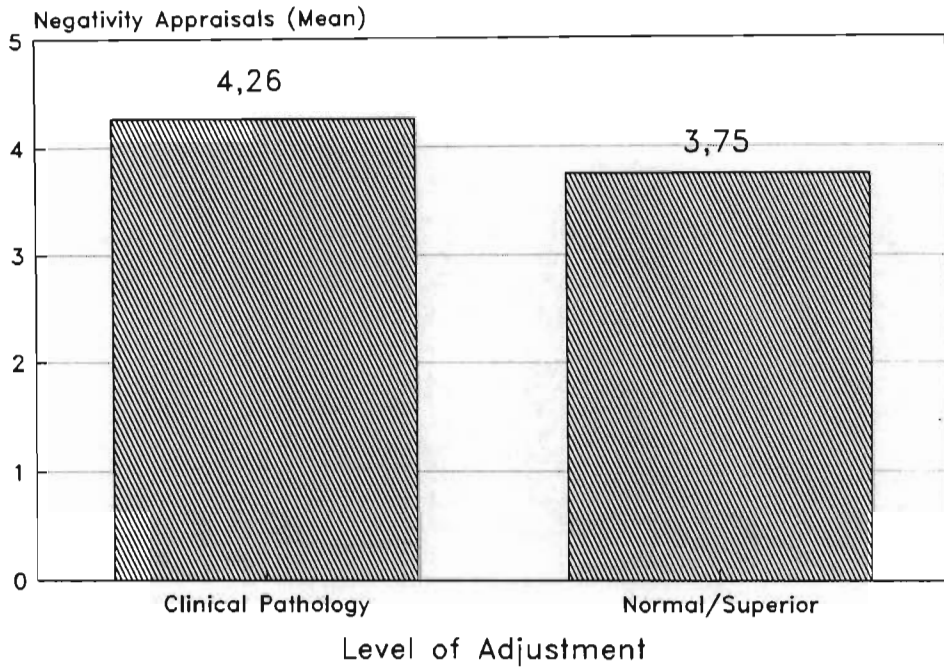


Figure 8 : Level of Adjustment X Mean Negativity Appraisal

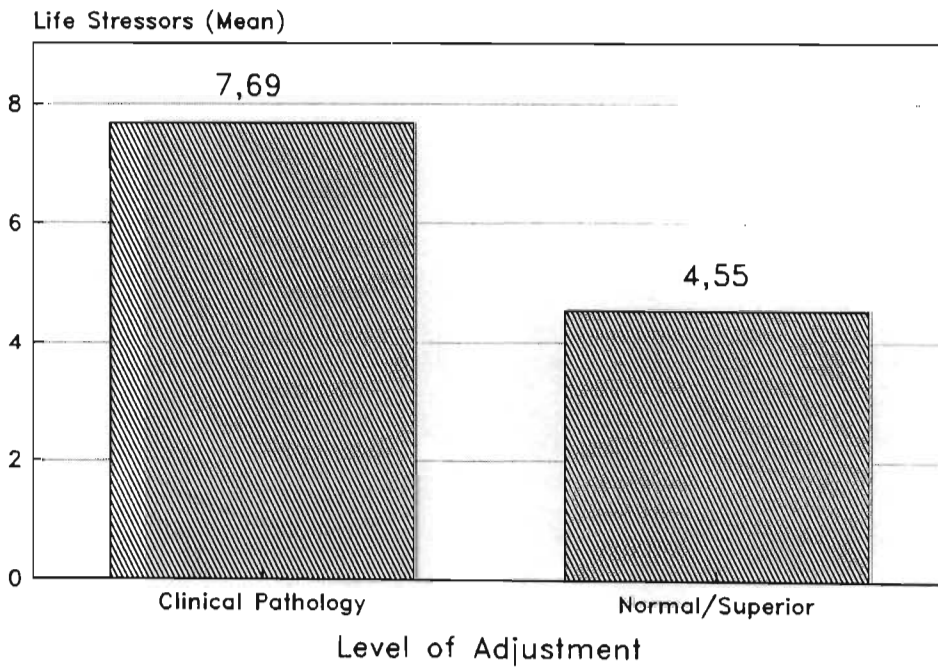


Figure 9 : Level of Adjustment X Mean Life Stressors

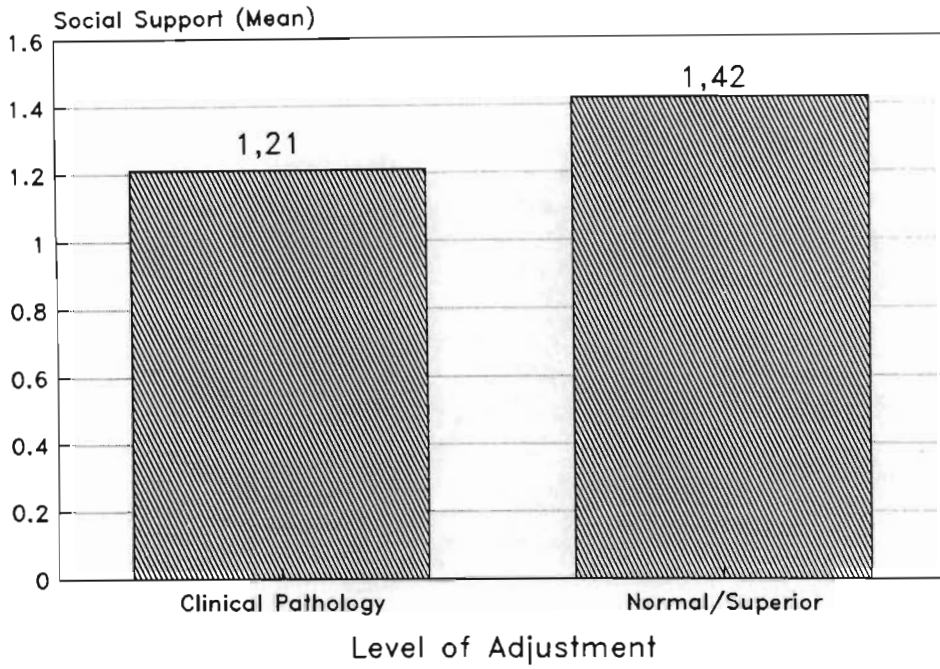


Figure 10 : Level of Adjustment X Mean Social Support

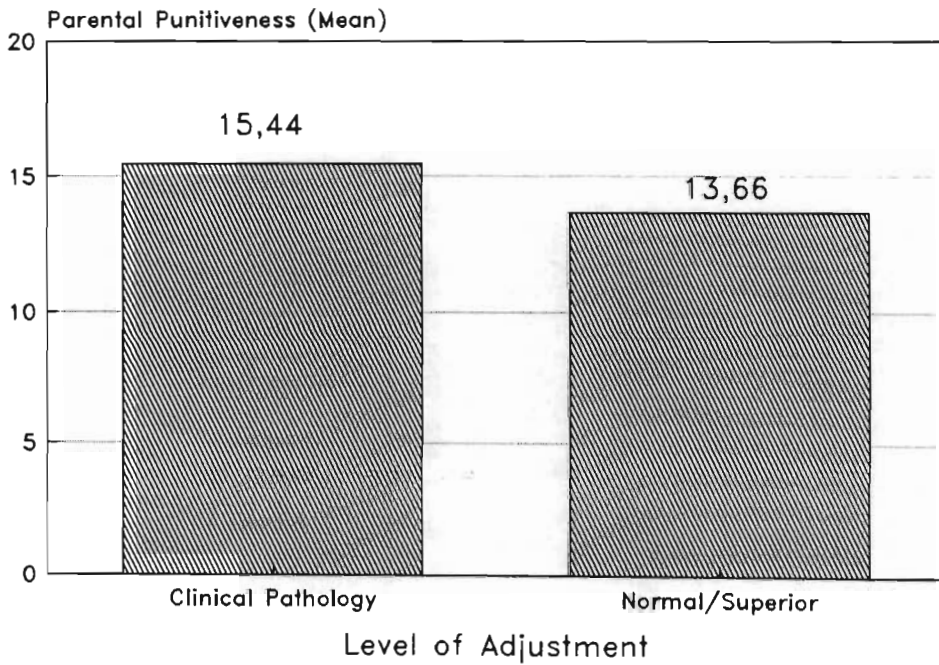


Figure 11 : Level of Adjustment X Mean Parental Punitiveness

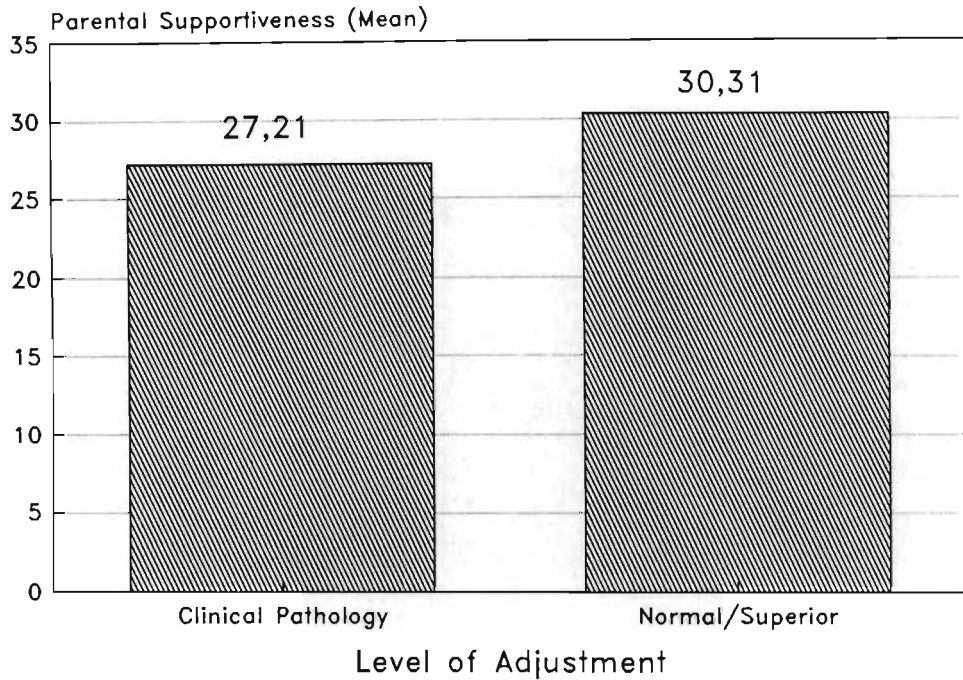


Figure 12 : Level of Adjustment X Mean Parental Supportiveness

8.4.5.1.1.2 Discriminant Analysis

Using the five risk factors identified at the univariate level (section 8.4.5.1.1.1, p. 158) as the discriminant variables, the discriminant analysis was able to differentiate reliably (as expressed by the canonical discriminant function) between the groups defined by the presence or absence of clinical pathology.

The best discriminant function yielded a chi-square (5 df) value of 33,29 ($p < 0,001$), a canonical correlation of 0,387, and a coefficient of determinism of 0,167. This indicates that approximately 17% of the variance can be accounted for by the best linear combination of the predictor variables selected for comparison.

An analysis of variable discriminating power revealed that the

risk factors selected for comparison were not equally powerful discriminators between the groups. As can be seen from Table 30, only two variables (recent life stressors and appraisals of negativity) emerged as significant discriminant variables, with recent life stressors being the most powerful discriminating variable.

TABLE 30 : Discriminant Analysis for Clinical Pathology: Analysis of Variable Discriminating Power

Variable	Wilk's Lambda	F (5,217)	Significance
Recent life events	0,469	23,04	p < 0,001
Support (helpfulness)	0,900	2,70	NS
Punitive parenting	0,989	1,42	NS
Supportive parenting	0,912	2,45	NS
Appraisal of negativity	0,889	5,64	p < 0,05

8.4.5.1.1.3 Analysis of Significant Discriminant Variables

8.4.5.1.1.3.1 Recent Life Events

The measure of recent life events used in the discriminant analysis was based on the number of negative life events reported by respondents. To determine if the higher LES scores obtained by subjects in the "clinical pathology" category also reflected an increased risk of exposure to potentially stressful life events, the "clinical" outcome group was compared to all other victims with respect to the number of recent life events experienced and the proportion of life events which were rated as negative.

These comparisons revealed: (a) that the mean number of life events reported by victims in the "clinical pathology" category ($\bar{M} = 7,24$) was significantly higher than the mean number of events reported by all other victims ($\bar{M} = 4,77$; $F(1,221) = 22,39$, $p < 0,001$), and (b) that there was no significant difference in the proportion of negative ratings

made by the two outcome groups (Chi-square {1 df} = 0,70, NS).

These two findings, taken together, suggest that the higher LES scores obtained by victims in the "clinical pathology" category reflect a greater risk of exposure to negative life events, and not merely a tendency on the part of victims with more serious adjustment problems to make more negative appraisals of potentially stressful life events.

In order to further explore LES scores, an item analysis was conducted to identify specific life events that discriminated victims in the "clinical pathology" category from other victims. This analysis identified seven life events which were significantly more likely to be reported by victims in the clinical outcome group. From Table 31 (p. 165) it can be seen that these seven items related mainly to social/interpersonal issues and to major changes in the individuals life circumstances.

8.4.5.1.1.3.2 Appraisals of Negativity

A stepwise multiple regression analyses was conducted to explore the relative predictive contribution of family background, abuse descriptive, and life event variables to abuse related appraisals of negativity.

This analysis revealed that abuse characterized by greater verbal coercion ($R = 0,28, p < 0,001$), abuse of longer duration ($R = 0,22, p < 0,001$), and abuse that first occurred when the victim was at a pre-operational level of development ($R = 0.22, p < 0,01$) was significantly predictive of appraisals of negativity. No further variables reached significance at the 0,05 level. The resulting regression equation, $F(3,219) = 12,01, p < 0,001$, accounted for 15,2% of the variation in appraisals of negativity.

TABLE 31 : Negative Life Events: The Clinical and Non-Clinical Outcome Groups Compared

Negative Life Event	Clinical Pathology (<u>n</u> = 39)	Normal or Superior Adjustment (<u>n</u> = 184)	p
	<u>N</u> (%)	<u>N</u> (%)	
<u>Social/Interpersonal</u>			
Change in social activities	15 (38)	33 (18)	< 0,01
Change (closeness to family)	20 (51)	44 (24)	< 0,02
Illness or injury (friend)	11 (28)	21 (11)	< 0,02
Break up with boyfriend	13 (33)	56 (30)	NS
Engagement	1 (3)	2 (1)	NS
Marriage	1 (3)	1 (1)	NS
Pregnancy	2 (5)	6 (3)	NS
Death (family member)	8 (21)	26 (14)	NS
Illness (family member)	9 (23)	43 (23)	NS
<u>Changed Life Circumstances</u>			
Leaving home	8 (21)	10 (5)	< 0,01
Losing a job	7 (18)	10 (5)	< 0,02
Major change in recreation	11 (28)	24 (13)	< 0,05
Change of residence	8 (21)	26 (14)	NS
<u>Medical</u>			
Personal injury/illness	8 (21)	12 (6)	< 0,02
Abortion	0 (0)	2 (1)	NS
<u>Financial</u>			
Borrowing > R10 000.	1 (3)	16 (9)	NS
Borrowing < R10,000.	6 (15)	24 (13)	NS
Financial problems	18 (46)	61 (33)	NS
<u>Victimization</u>			
Victim (political unrest)	2 (5)	10 (5)	NS
Teargassed/assaulted/shot	7 (18)	27 (15)	NS
<u>Criminal/Legal</u>			
Being arrested/detained	1 (3)	2 (1)	NS
Minor law violation	4 (10)	6 (3)	NS
<u>Other</u>			
Failing an exam	11 (28)	52 (28)	NS
Transport problems	19 (49)	76 (41)	NS

Note. Comparisons were made using Chi- Square Tests (1 df).

8.4.5.1.2 Factors Associated with a Reduced Risk of Long-Term Effects

A series of univariate analyses were used to compare victims who reported "superior adjustment" with victims who reported either "normal adjustment" or "clinical pathology" on a range

of demographic, family background, abuse descriptive, and current life event variables. A discriminant function analysis was then performed including all variables that were significantly related to the adjustment categories at the univariate level.

8.4.5.1.2.1 Univariate Analysis

The univariate analyses indicated that four factors were significantly related to "superior" levels of adjustment. From Table 32 (see also Figures 13-16, pp. 167-168) it can be seen that the "superior adjustment" group were less likely to appraise their abuse as a betrayal, had experienced fewer recent life stressors, reported more helpful social support networks, and had experienced less punitive parenting styles.

TABLE 32 : Factors Associated with a Reduced Risk of Long-Term Effects among Abused Subjects in the Student Sample

Factor	Superior Adjustment ($n = 14$)	Normal or Clinical Adjustment ($n = 209$)	F (1,221)
	Mean	Mean	
Recent life stressors	2,00	5,31	9,60**
Appraisal (betrayal)	2,71	3,64	5,23*
Support (helpfulness)	1,67	1,37	4,82*
Parental punitiveness	12,00	14,11	4,61*

* $p < 0,05$. ** $p < 0,01$. *** $p < 0,001$.

8.4.5.1.2.2 Discriminant Analysis

Using the four risk factors identified at the univariate level as the discriminant variables, the discriminant analysis was able to differentiate reliably (as expressed by the canonical discriminant function) between the groups defined by the presence or absence of "superior" outcomes.

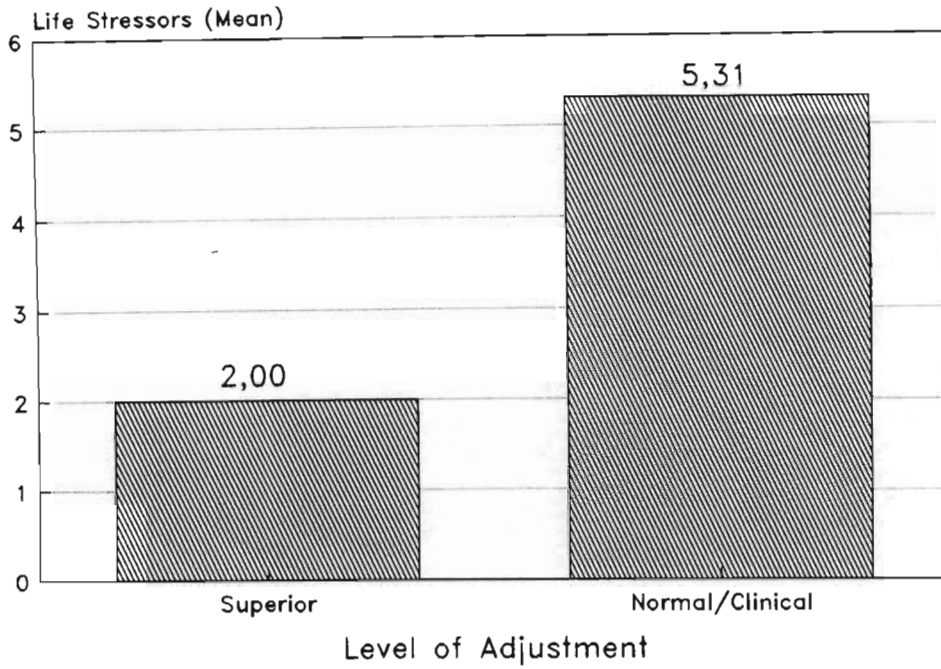


Figure 13 : Level of Adjustment X Mean Life Stressors

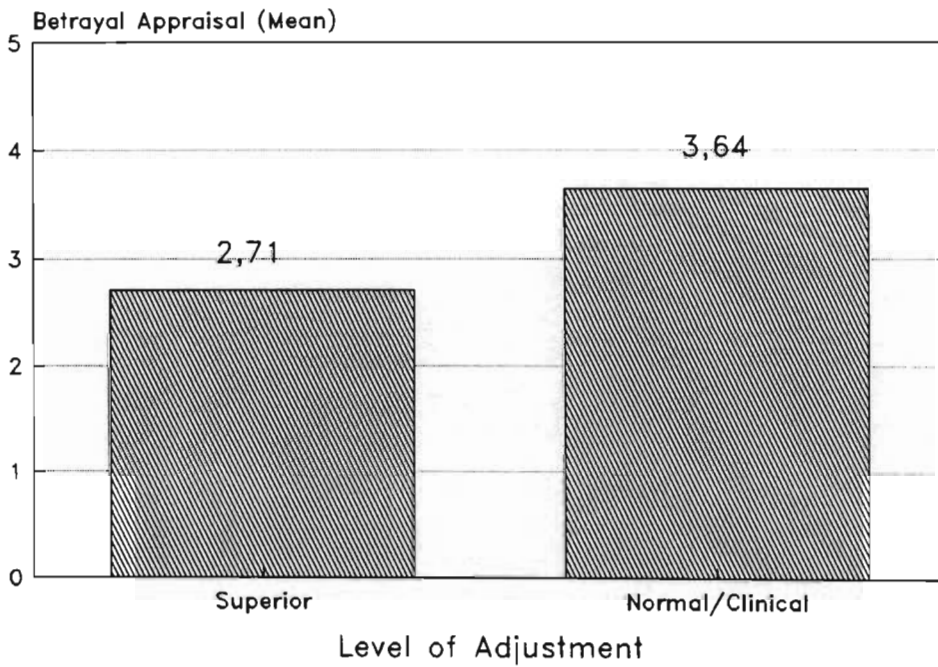


Figure 14 : Level of Adjustment X Mean Betrayal Appraisal

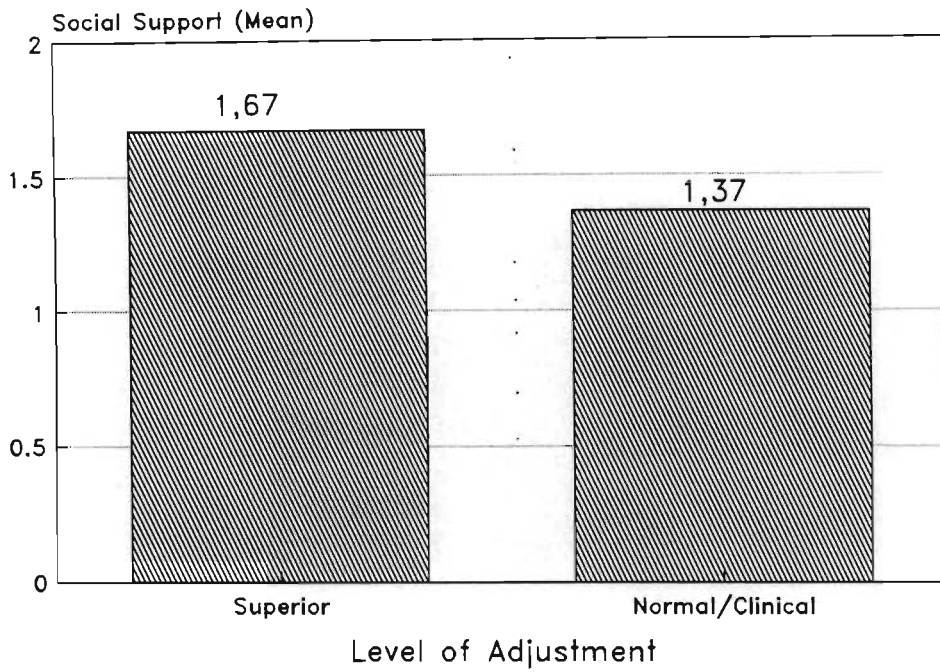


Figure 15 : Level of Adjustment X Mean Social Support

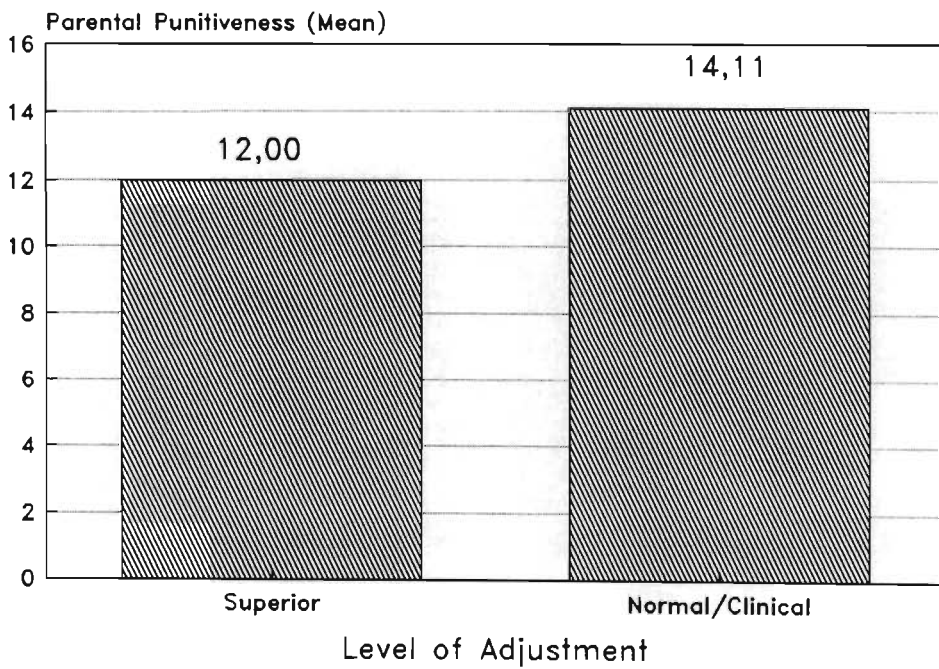


Figure 16 : Level of Adjustment X Mean Parental Punitiveness

The best discriminant function yielded a chi-square (4 df) value of 20,03 ($p < 0,001$), a canonical correlation of 0,298, and a coefficient of determinism of 0,087. This indicates that approximately 9% of the variance can be accounted for by the best linear combination of the predictor variables selected for comparison.

An analysis of variable discriminating power revealed that the risk factors selected for comparison were not equally powerful discriminators between the groups. As can be seen from Table 33, only three variables (recent life stressors, helpfulness of social support, and appraisals of betrayal) emerged as significant discriminant variables, with recent life stressors being the most powerful discriminating variable.

TABLE 33 : Discriminant Analysis for Superior Adjustment: Analysis of Variable Discriminating Power

Variable	Wilk's Lambda	F (4,218)	Significance
Recent life stressors	0,707	9,94	p < 0,01
Appraisal of betrayal	0,857	5,19	p < 0,05
Support (helpfulness)	0,869	4,46	p < 0,05
Punitive parenting	0,947	1,30	NS

8.4.5.1.2.3 Analysis of Significant Discriminant Variables

8.4.5.1.2.3.1 Recent Life Events

The measure of recent life events used in the discriminant analysis was based on the number of negative life events reported by respondents. To determine if the lower LES scores obtained by subjects in the "superior adjustment" category also reflected a decreased risk of exposure to potentially stressful life events, the "superior" outcome group was compared to all other victims with respect to the number of recent life events experienced and the proportion of life events which were rated as negative.

These comparisons revealed: (a) that the mean number of life events reported by victims in the "superior adjustment" category ($M = 2,93$) was significantly lower than the mean number of events reported by all other victims ($M = 5,28$; $F\{1,221\} = 9,37$, $p < 0,01$), and (b) that there was no significant difference in the proportion of negative ratings made by the two outcome groups (Chi-square $\{1\text{ df}\} = 1,02$, NS).

These two findings, taken together, suggest that the lower LES scores obtained by victims in the "superior adjustment" category reflect a decreased risk of exposure to negative life events, and not merely a tendency on the part of victims with less serious adjustment problems to make more positive appraisals of potentially stressful life events.

In order to further explore LES scores, an item analysis was conducted to identify specific life events that discriminated victims in the "superior adjustment" category from other victims. This analysis identified three life events which were significantly less likely to be reported by victims in the "superior adjustment" group (see Table 34, p. 171).

8.4.5.1.2.3.2 Appraisals of Betrayal

A stepwise multiple regression analyses was conducted to explore the relative predictive contribution of family background, abuse descriptive, and life event variables to abuse related appraisals of betrayal.

This analysis revealed that abuse characterized by greater physical coercion ($R = 0,24$, $p < 0,001$), nonsupportive disclosure ($R = -0,24$, $p < 0,001$), and older abusers ($R = 0,22$, $p < 0,01$) was significantly predictive of appraisals of betrayal. No further variables reached significance at the 0,05 level. The resulting regression equation, $F(3,219) = 11,04$, $p < 0,001$, accounted for 13,6% of the variation in appraisals of betrayal.

TABLE 34 : Negative Life Events: The "Superior Adjustment" Group Compared to Other Victims

Negative Life Event	Superior Adjustment (<u>n</u> = 14)	Normal or "Clinical" Adjustment (<u>n</u> = 209)	p
	<u>N</u> (%)	<u>N</u> (%)	
<u>Social/Interpersonal</u>			
Change in social activities	2 (14)	46 (22)	NS
Change (closeness to family)	2 (14)	62 (29)	NS
Illness or injury (friend)	1 (7)	31 (15)	NS
Break up with boyfriend	3 (21)	66 (32)	NS
Engagement	0 (0)	3 (1)	NS
Marriage	0 (0)	2 (1)	NS
Pregnancy	0 (0)	8 (4)	NS
Death (family member)	0 (0)	34 (16)	< 0,05
Illness (family member)	2 (14)	50 (24)	NS
<u>Changed Life Circumstances</u>			
Leaving home	0 (0)	18 (9)	NS
Losing a job	0 (0)	17 (8)	NS
Major change in recreation	0 (0)	35 (17)	< 0,05
Change of residence	2 (14)	32 (15)	NS
<u>Medical</u>			
Personal injury/illness	0 (0)	20 (10)	NS
Abortion	0 (0)	2 (1)	NS
<u>Financial</u>			
Borrowing > R10 000.	1 (7)	16 (8)	NS
Borrowing < R10,000.	2 (14)	28 (13)	NS
Financial problems	1 (7)	78 (37)	< 0,05
<u>Victimization</u>			
Victim (political unrest)	1 (7)	11 (5)	NS
Teargassed/assaulted/shot	1 (7)	33 (16)	NS
<u>Criminal/Legal</u>			
Being arrested/detained	0 (0)	3 (1)	NS
Minor law violation	0 (0)	10 (5)	NS
<u>Other</u>			
Failing an exam	2 (14)	61 (29)	NS
Transport problems	4 (29)	91 (44)	NS

8.4.5.1.2.3.3 Social Support (Helpfulness)

A stepwise multiple regression analyses was conducted to explore the relative predictive contribution of family background, abuse descriptive, and life event variables to victim ratings of social support.

This analysis revealed that exposure to punitive parenting styles ($R = 0,25$, $p < 0,001$) was significantly predictive of victim ratings of the helpfulness of social support. No further variables reached significance at the 0,05 level. The resulting regression equation, $F(1,221) = 11,07$, $p < 0,001$, accounted for 6,3% of the variation in ratings of the helpfulness of social support.

8.4.5.1.2.4 Path Analyses

Because of the high intercorrelations among the variables investigated in the discriminant analyses, path analyses were used as a heuristic device to simplify the interpretation of contributors to the severity of long-term effects.

Tentative models of the interrelations between contributors to an increased and to a reduced risk of long-term effects are presented in Figures 17 and 18 (pp 173 and 174) respectively. For ease of presentation, path coefficients which were not significant at the 0,05 level are not included in Figures 17 and 18. These coefficients do, however, appear in Appendix F and G (pp. 254-255).

Assuming correct specification of the model and accurate measurement, the total effects of the predictor variables on the severity of abuse effects are presented in Table 35 (below) and Table 36 (p. 175).

TABLE 35 : Path Analysis: Factors Associated with an Increased Risk of Long-Term Effects in the Student Sample

Variable	Direct	Indirect	Total
Coercion	0,091	0,077	0,168*
Pre-operational dev.	0,003	0,043	0,046
Duration	0,090	0,041	0,131*
Appraisal (negativity)	0,145*	0,027	0,172*
Life stress	0,301*		0,301*

$p < 0,05$

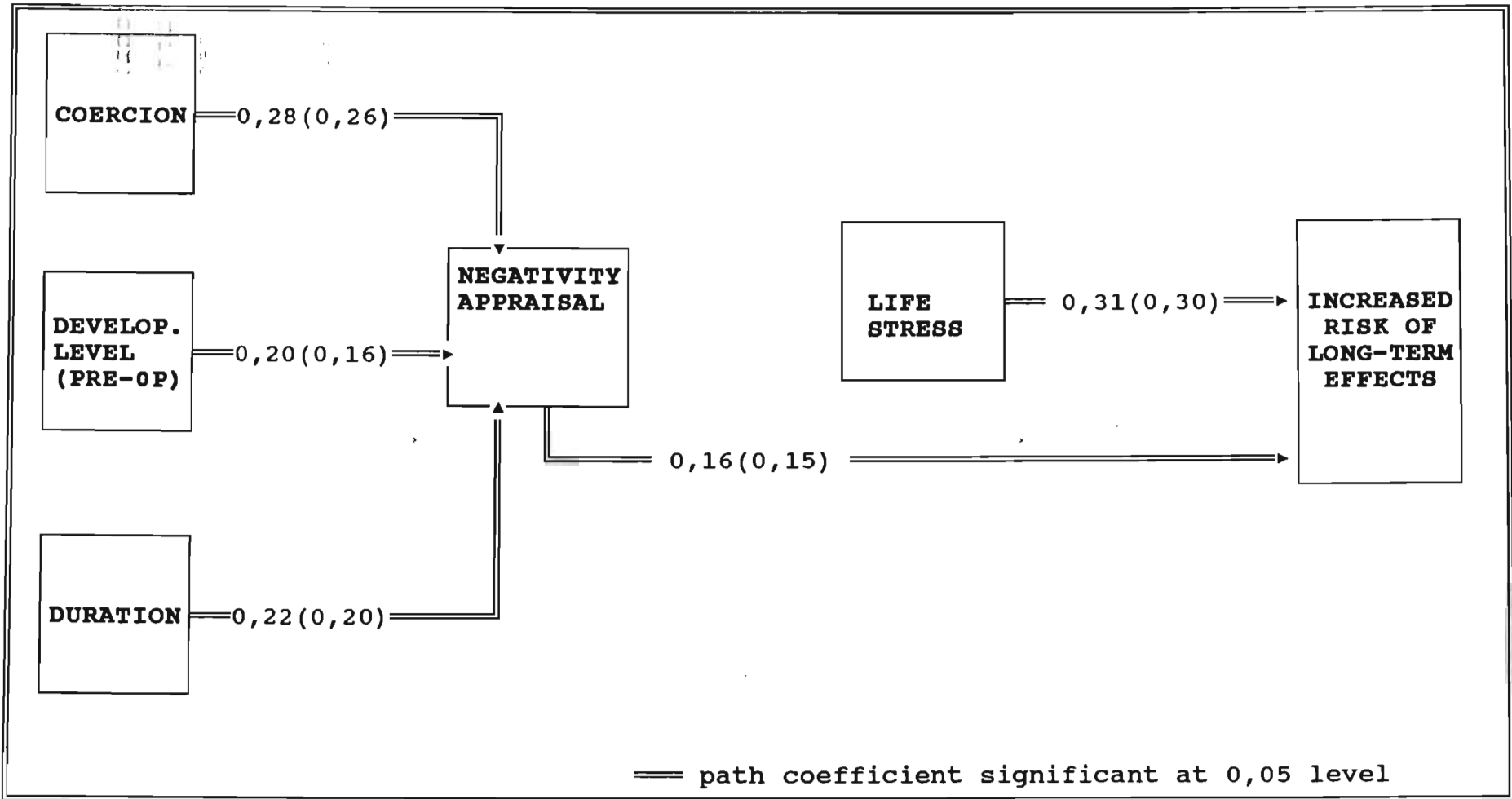


FIGURE 17 : Proposed Model of Significant Relations Between Abuse, Abuse Appraisals, Life Stressors, and Clinical Adjustment Among Victimized Subjects with Variable Correlations and Path Coefficients (in Parentheses)

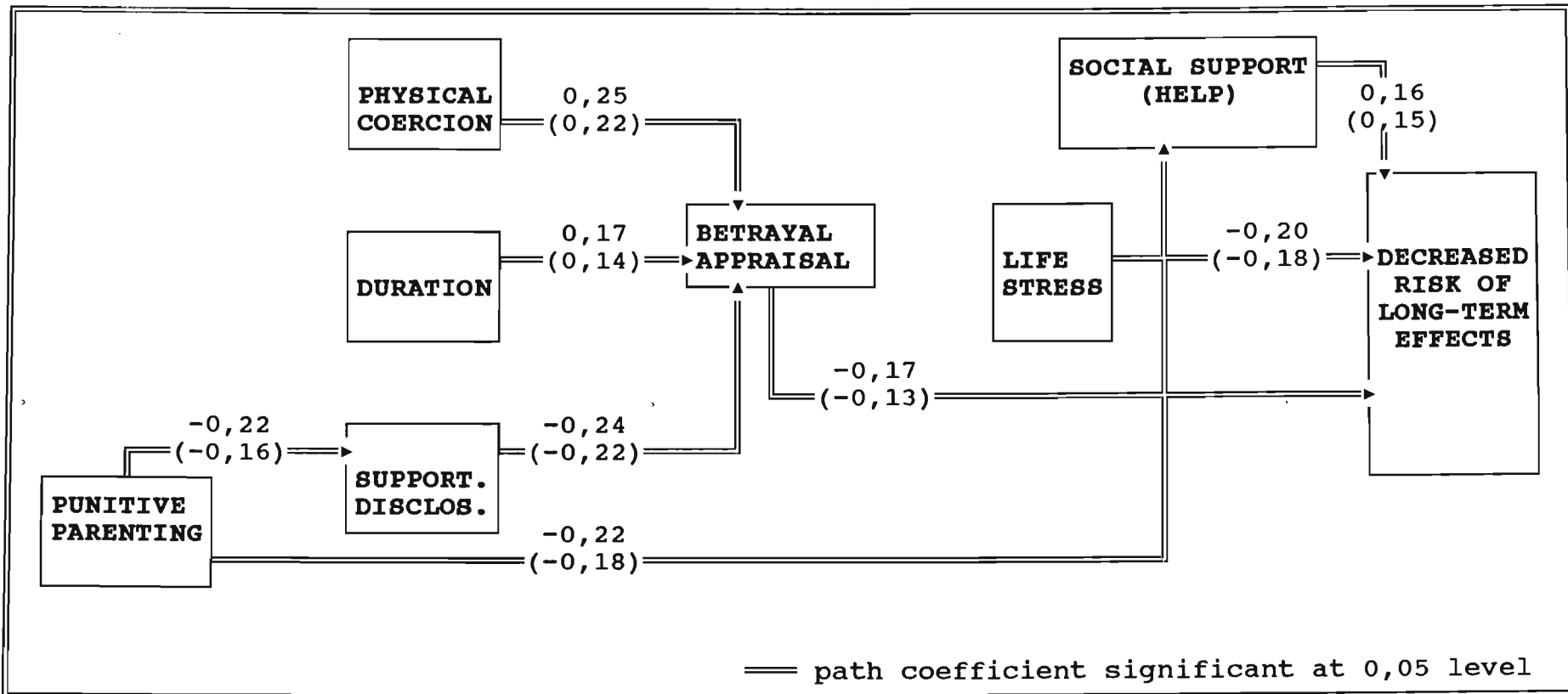


FIGURE 18 : Proposed Model of Significant Relations Between Family Background, Sexual Abuse, Life Stressors, Social Support, and Superior Adjustment among Victimized Subjects with Variable Correlations and Path Coefficients (in Parentheses)

From Table 35 (p. 172) it can be seen that appraisals of negativity and exposure to negative life events were directly related to an increased risk of long-term effects. Although other abuse descriptive variables did not have a significant direct effect on clinical outcomes when abuse appraisals and life stressors were controlled, the total (i.e., direct plus indirect) effect of two variables (coercion and abuse duration) reached significance at the 0,05 level.

TABLE 36 : Path Analysis: Factors Associated with a Decreased Risk of Long-Term Effects in the Student Sample

Variable	Direct	Indirect	Total
Punitive parenting	-0,102	-0,045	-0,147*
Physical coercion	-0,010	-0,020	-0,030
Duration	-0,011	-0,029	-0,040
Supportive disclosure	0,081	0,026	0,107
Appraisal (betrayal)	-0,132*	-0,002	-0,134*
Life stress	-0,180*	-0,001	-0,181*
Social support (help)	0,151*		0,151*

$p < 0,05$

From Table 36 it can be seen that appraisals of betrayal, exposure to negative life events, and perceived helpfulness of social support were directly related to a reduced risk of long-term effects. Although other predictor variables did not have a significant direct effect on "superior adjustment", the total effect of 'punitive parenting styles' reached significance at the 0,05 level.

8.4.6 Within-Group Analysis: Non-Abused Controls

The within-group analysis which focussed on non-abused controls attempted to identify factors associated with different patterns of adjustment.

8.4.6.1 Risk factors for Clinical Pathology

Using a series of univariate analyses, non-victimized controls

who reported clinical levels of pathology were compared to non-victimized controls who reported less severe adjustment problems (i.e., either "normal" or "superior" adjustment) on a range of demographic, family background, and current life event variables. The 32 independent variables considered in these analyses related to: victim demographics, family background, recent life stressors; and current levels of social support.

A discriminant function analysis was then performed including all variables that were significantly related to the adjustment categories at the univariate level.

8.4.6.1.1 Univariate Analysis

The univariate analyses indicated that two factors were significantly related to a risk of clinical pathology. From Table 37 it can be seen that the clinical pathology group reported less helpful social support networks and had experienced a greater number of recent life stressors.

TABLE 37 : Non-Victimized Controls: Risk Factors for Clinical Pathology

Factor	Clinical Pathology ($\underline{n} = 32$)	Normal or Superior Adjustment ($\underline{n} = 385$)	<u>F</u> (1,415)
	Mean	Mean	
Recent life stressors	5,42	3,85	7,23**
Support (helpfulness)	1,21	1,42	5,21*

* $p < 0,05$. ** $p < 0,01$.

8.4.6.1.2 Discriminant Analysis

Using the two risk factors identified at the univariate level as the discriminant variables, the discriminant analysis was

able to differentiate reliably (as expressed by the canonical discriminant function) between the groups defined by the presence or absence of clinical pathology.

The best discriminant function yielded a chi-square (2 df) value of 17,22 ($p < 0,001$), a canonical correlation of 0,297, and a coefficient of determinism of 0,167. This indicates that approximately 9% of the variance can be accounted for by the best linear combination of the predictor variables selected for comparison.

An analysis of variable discriminating power revealed that the risk factors selected for comparison were not equally powerful discriminators between the groups. As can be seen from Table 38 only one variables (recent life stressors) emerged as a significant discriminant variable.

TABLE 38 : Discriminant Analysis for Clinical Pathology: Analysis of Variable Discriminating Power for the Non-Victimized Sample

Variable	Wilk's Lambda	F (2,414)	Significance
Recent life events	0,464	26,71	p < 0,001
Support (helpfulness)	0,900	2,70	NS

8.4.6.2 Factors Associated with "Superior" Adjustment

A series of univariate analyses were used to compare non-victimized controls who reported "superior adjustment" with non-victimized controls who reported either "normal adjustment" or "clinical pathology" on a range of demographic, family background, and current life event variables. A discriminant function analysis was then performed including all variables that were significantly related to the adjustment categories at the univariate level.

8.4.6.2.1 Univariate Analysis

The univariate analyses indicated that two factors were significantly related to "superior" levels of adjustment. From Table 39 it can be seen that the superior adjustment group had experienced fewer recent life stressors and reported more helpful social support networks.

TABLE 39 : Non-Victimized Controls: Factors Associated with Superior Levels of Adjustment

Factor	Superior Adjustment ($n = 68$)	Normal or Clinical Adjustment ($n = 349$)	F (1,415)
	Mean	Mean	
Recent life stressors	1,97	3,84	9,60**
Support (helpfulness)	2,01	1,20	4,97*

* $p < 0,05$. ** $p < 0,01$.

8.4.6.2.2 Discriminant Analysis

Using the two risk factors identified at the univariate level as the discriminant variables, the discriminant analysis was able to differentiate reliably (as expressed by the canonical discriminant function) between the groups defined by the presence or absence of "superior" outcomes.

The best discriminant function yielded a chi-square (2 df) value of 24,98 ($p < 0,001$), a canonical correlation of 0,324, and a coefficient of determinism of 0,105. This indicates that approximately 10% of the variance can be accounted for by the best linear combination of the predictor variables selected for comparison.

An analysis of variable discriminating power revealed that the risk factors selected for comparison were not equally powerful

discriminators between the groups. As can be seen from Table 40, only one variables (recent life stressors) emerged as a significant discriminant variables.

TABLE 40 : Discriminant Analysis for Superior Adjustment: Analysis of Variable Discriminating Power

Variable	Wilk's Lambda	F (2,414)	Significance
Recent life stressors	0,712	9,94	p < 0,01
Support (helpfulness)	0,959	2,88	NS

8.4.7 Discriminant Analysis of Risk Factors

Step-wise multiple discriminant procedures were used to explore the independent role of abuse history and of selected non-abuse related risk variables - i.e., variables which emerged in the present study as being associated with current levels of adjustment and/or risk of abuse (i.e., number of recent life stressors, extent and helpfulness of social support networks, and parental punitiveness/supportiveness; cf., Chapter 8, sections 8.4.5 and 8.4.6) - in distinguishing between different levels of adjustment as measured by ISS adjustment categories.

8.4.7.1 Discriminant Analysis for Clinical Pathology

The analysis in which clinical versus non-clinical outcomes was entered as the criterion variable yielded an $F(2,637)$ ratio of 24,96 ($p < 0,001$), a canonical correlation of 0,630, and a coefficient of determinism of 0,397. This indicates that approximately 40% of the variance in adjustment scores (i.e., clinical versus non-clinical outcomes) could be accounted for by the best linear combination of the predictor variables selected for analysis.

The strongest predictor of clinical outcomes was the number of recent life stressors experienced by the respondent ($F[1,637]$

= 29,54, $p < 0,001$) with a history of abuse also accounting for a significant proportion of the explained variance ($F [1, 637] = 19,92, p < 0.001$). None of the other variables selected for comparison (i.e., extent and helpfulness of social support networks and parental punitiveness/supportiveness) made a significant independent contribution to the variance accounted for.

8.4.7.2 Discriminant Analysis for Superior Adjustment

The analysis in which superior versus normal/clinical outcomes was entered as the criterion variable yielded an $F (2,637)$ ratio of 27,12 ($p < 0,001$), a canonical correlation of 0,657, and a coefficient of determinism of 0,432. This indicates that approximately 43% of the variance in adjustment scores (i.e., clinical versus non-clinical outcomes) could be accounted for by the best linear combination of the predictor variables selected for analysis.

The strongest predictor of superior outcomes was the number of recent life stressors experienced by the respondent ($F [1,637] = 34,61, p < 0,001$) with a history of abuse also accounting for a significant proportion of the explained variance ($F [1, 637] = 21,03, p < 0.001$). None of the other variables selected for comparison (i.e., extent and helpfulness of social support networks and parental punitiveness/supportiveness) made a significant independent contribution to the variance accounted for.

8.5 DISCUSSION

8.5.1 Limitations of the Present Research

The present results were obtained using a student sample which is unlikely to be representative of the general population of adult women. Generalization of the present findings to the broader population therefore needs to be made with due

caution; with such caution being particularly warranted in the case of black women (who were under represented in the student sample) and in the case of men (who were not surveyed in the present research).

Additional limitations of the research include:

- (i) Necessary reliance on correlational data which restricts the confidence with which causal statements can be made.
- (ii) Retrospective evaluation of family background and abuse related variables which raises the possibility of distortion due to memory.
- (iii) The use of relatively small samples (particularly in the case of "superior" outcomes) which poses a threat to the stability of the findings.
- (iv) Simplification of the causal relations inherent in path analysis (although unidirectional causality was assumed in the proposed models, the relations between some of the variables investigated are likely to be multidirectional and systemic).

With these limitations in mind it is useful to examine the main findings that emerged from the research.

8.5.2 The Research Hypotheses

8.5.2.1 Hypothesis 1

The findings for the student sample confirmed hypothesized differences between abused and non-abused subjects in psychological adjustment (Hypothesis 1). After controlling for the effects of punitive and nonsupportive parenting styles - variables which emerged as significant risk factor for abuse,

and which were significantly associated with psychosocial adjustment, in the present study - a history of child sexual abuse was found to be associated with: (a) significantly elevated scores on the Global Severity Index, and on all nine symptom dimensions, of the Brief Symptom Inventory (Derogatis & Spencer, 1982); (b) significantly elevated scores on Briere and Runtz's (1989) Sexual Conflict Scale; (c) significantly elevated scores on Paykel et al's. (1974) Suicidal Feelings Rating Inventory; and (d) significantly lower scores on Rosenberg's (1965) Self-Esteem Scale.

A similar trend emerged when abused and non-abused controls were compared using the Index of Symptom Severity (ISS) developed during the present study. This analysis revealed that when compared to non-victimized controls the entire distribution of ISS scores for abused subjects was shifted approximately 0,5 standard deviations in the direction of more pathological levels of adjustment; with the mean ISS score for abused subjects being significantly higher than the mean for non-abused controls. The results of a discriminant analysis revealed that a history of abuse continued to make a significant independent contribution to the variation in ISS scores even after controlling for the effect of variables (i.e., number of recent life stressors, extent and helpfulness of social support networks, parental punitiveness, parental supportiveness) which were associated with current levels of adjustment and/or risk of abuse.

Although these results are consistent with findings obtained in most studies of American college women (Briere & Runtz, 1985; Finkelhor, 1979; Sedney & Brooks, 1984; Seidner & Calhoun, 1984), they contrast markedly with results obtained by Fromuth (1986). In her study of 482 college woman, Fromuth (1986) found that after controlling for family background variables, a history of child sexual abuse was not significantly predictive of scores on a range of adjustment measures (including the SCL-90, Beck's Depression Inventory, and Rosenberg's Self-Esteem Scale).

One possible reason for this discrepancy in findings relates to the fact that Fromuth employed an inclusive definition of abuse (i.e., a definition which encompassed both contact and non-contact forms of abuse). As the inclusiveness of abuse definitions has been found to be inversely related to estimates of long-term effects (Collings, 1994; Haugaard & Emery, 1989; Peters, 1988) it is possible that the less serious estimates of psychological harm obtained by Fromuth can be attributed to definitional issues.

The prediction that personal locus of control would be related to a history of abuse was not confirmed by the present findings. One possible reason for this negative finding relates to the fact that a global measure of personal control was used in the present research. Previous studies (e.g., Gold, 1986) which have employed more refined measures of personal control - i.e., measures which separately explore attributions of personal responsibility for "good" and "bad" events - have found that attributions of responsibility for good and bad events impact differently on measures of psychological distress; with internal attributions for bad events being associated with less desirable outcomes and internal attributions for good events being associated with more desirable outcomes. In this context it is possible that the negative findings obtained in the present research reflect an attenuation of "locus of control" effects due to the use of a combined measure of personal responsibility for good and bad events.

Finally, the finding that child sexual abuse and family background variables were each significantly associated with psychological adjustment needs to be considered in the context of a wider debate between those who maintain that the negative long-term effects of sexual abuse can be attributed primarily to family background variables (Alexander, 1985; Cohen, 1983; Fromuth, 1986; Steele & Alexander, 1981; Trepper & Barrett, 1986) and those who maintain that undesirable outcomes are

primarily a consequence of the degree of trauma incurred during the abuse (Bagley & Ramsay, 1985; Browne & Finkelhor, 1986; Finkelhor, 1979, 1984; Russell, 1986). Rather than providing support for either side of this debate, the present findings add to a growing body of evidence (cf., Edwards & Alexander, 1992) which suggests: (a) that child sexual abuse and family background variables are independently related to abuse outcome, and therefore (b) that both of these classes of factors need to be considered in any comprehensive aetiological formulation.

8.5.2.2 Hypothesis 2

The findings for the student sample did not provide support for the prediction (Hypothesis 2) that the victimized sample would comprise three discrete outcome groups characterized by "superior", "normal", and "clinical" levels of adjustment. The distribution of ISS scores for the victimized sample (see Figure 3, p. 153) suggests rather, that in terms of long-term adjustment, the victimized sample constitutes a single normally distributed population; with the entire distribution of ISS scores for this population being shifted significantly in the direction of more pathological levels of adjustment.

The present findings would thus suggest that the long-term impact of childhood sexual abuse is more extensive/pervasive than would be suggested by an index of adjustment which is restricted to the pathological/clinical end of the continuum of adjustment. The present findings suggest, further, that the important question which needs to be addressed by outcome research is not so much "Why do some victims of child sexual abuse manifest long-term effects of abuse and others not?" but rather "Why are some victims more (or less) successful at resisting the harmful effects of abuse?"

If vulnerability to the long-term effects of sexual abuse is operationally defined as an ISS score falling into the

"clinical pathology" category, then 17,5% of victims in the present study can be classified as "vulnerable" to the effects of abuse. This proportion is consistent with findings from Bagley and Ramsay's (1986) community survey in which 17% of sexual abuse victims were found to be clinically depressed and 18% were found to be seriously psychoneurotic. The present findings are also congruent with the conclusions drawn by Browne and Finkelhor (1986) following their extensive review of the literature, i.e., "when studied as adults...less than one-fifth (of child sexual abuse victims) evidence serious psychopathology" (Browne & Finkelhor, 1986, p. 164).

The finding that 82,5% of victims fell into the "normal" end of the continuum of adjustment, with 6,3% falling into the "superior" adjustment" category, warrants further comment. Previous studies of long-term effects have tended to be characterized by a clinical bias which has insured that the main thrust of inquiry has been directed towards the identification of clinical pathology in its various forms (cf., Browne & Finkelhor, 1986). As a result there has been no systematic attempt to explore the "normal end" of adjustment in adults who were sexually abused as children. The present findings strongly suggest the need for such an extended analysis, as well as suggesting the need for an extended theoretical understanding of sexual abuse reactions - such as that provided by the proposed SARS model (cf., Chapter 4) - which not only provides an explanation for the traumatic effects of child sexual abuse but which also acknowledges the possibility of, and accounts for, resilient/more desirable long-term outcomes.

The finding that 82,5% of victims fell into the "normal" end of the continuum of adjustment also has relevance to the ongoing debate regarding the damaging effects of child sexual abuse (Levett, 1990, 1992; Russell, 1991, 1993). The central issue in this debate has been the traumagenic potential of child sexual abuse; with Levett (1990, 1992) maintaining that

sexual abuse victims often suffer no severe long-term effects and Russell (1991, 1993) maintaining that victimization frequently results in serious initial and long-term effects.

Although the present findings would appear to be consistent with Levett's (1990, 1992) position, a word of caution is in order. The analysis which compared the distribution of ISS scores for abused and non-abused respondents indicated that the entire distribution of ISS scores for the abused group was shifted in the direction of more pathological levels of adjustment. In other words abused subjects were not only over represented in the "clinical pathology" category but were also: (a) over represented in the top half of the "normal" adjustment category (i.e., ISS T-score of 50-59); (b) under represented in the bottom half of the "normal" adjustment category (i.e., ISS T-score of 40-49); and (c) under represented in the "superior" adjustment category.

The present findings would thus suggest that the long-term impact of childhood sexual abuse is more extensive/pervasive than would be suggested by an index of adjustment which is restricted to the pathological/clinical end of the continuum of adjustment.

The view that apparently "resilient" or "stress resistant" individuals may also experience undesirable effects of abuse experiences is not novel but is consistent with findings which have emerged from related studies of children exposed to abusive or "high risk" life circumstances (e.g., Farber & Egeland, 1987; Anthony, 1987). Thus, for example, in Anthony's (1987) study of children raised by psychotic parents it was found that many "resilient" individuals paid a heavy price for their apparent immunity from psychiatric illness:

First, the mechanisms that they utilize - distancing, isolation of affect, suppression, externalization, rationalization, and intellectualization - make it difficult for them to maintain good object relations...Second, they often search for relationships with problematic objects and dedicate themselves to the life task of helping them...Third, some of them have joined various religious and social groups, diffusing and

diluting relationships although obtaining a good deal of ego support from the groups. Fourth, many relinquish objects for objectives and become involved in projects and life tasks that demand cooperation but not relationships. Finally, many of them seek treatment for reasons that they cannot specify, except that in the midst of all their successes and superachievements, they feel strangely unsatisfied (Anthony, 1987, p. 180-181).

From the perspective of Horowitz's (1978, 1986) SRS model - and by extension, from the perspective of the proposed SARS model - the maladaptive coping strategies described by Anthony (1987) could be interpreted as excessive or pathological controls against intrusion phase experiences which: (a) are designed to protect the individual from excessive levels of emotion (thus reducing levels of overt psychopathology) but which (b) (because of their excessive nature and habitual application) tend to permanently interrupt the completion tendency and thus prevent complete processing of the event.

In this context, it becomes problematic to equate an absence of clinical psychopathology (as measured by a psychiatric rating scale) with an absence of long-term effects. Clearly additional research, employing broader/more inclusive definitions of long-term effects, is required before any definitive conclusions can be drawn with respect to the issues raised in the Levett-Russell debate.

Finally, there are ethical issues to consider when discussing the notion of "resilience" or "stress resistance" in adults who were sexually abused as children. As Farber and Egeland (1987) have pointed out in their discussion of neglected and physically abused children, "social scientists have to be responsible in discussing invulnerability, lest policy makers come to harbor the idea that if children are only strong enough, they will survive" (p.286). There is, of course, also the risk that the present findings could be cited as evidence by those who would argue: (a) that "the anxiety over childhood sexual victims has been exaggerated" (Finkelhor, 1984, p. 198), (b) that child sexual abuse does not have detrimental effects (see e.g., Constantine, 1981, Ingram, 1981); or even

(c) that child sexual abuse has, or may have, beneficial effects (see e.g., Ingram, 1981; Robertson, 1989, pp. 14-15).

The fact that the present results are open to such (mis)interpretation makes it necessary to more clearly delineate the limits of the study findings. First - as I have indicated in my discussion of the Russell-Levett debate - the present study employed a restricted definition of adjustment (i.e., scores on a psychiatric rating scale) which does not adequately address a number of important areas of functioning (social, cognitive, occupational, intellectual etc.). The fact that different indices of competence have been found "to produce discrepant results when used singly or reduce sample size considerably when used in combination" (Fisher, Kokes, Cole, Perkins, & Wynne, 1987, p. 222) means that one cannot, with any confidence, equate adequate adjustment (as operationally defined in the present study) with an absence of long-term effects.

It is also necessary to emphasize that the present research was restricted to a study of long-term effects and that no attempt was made to assess initial/short-term effects. As the negative initial effects of sexual abuse are likely to attenuate with time (Finkelhor, 1984) the present findings probably provide an underestimation of the true traumagenic potential of abuse experiences.

There are, of course, always those who would argue that an absence of clinical pathology in some proportion of victims, regardless of whether or not there are initial traumatic effects, constitutes evidence that child sexual abuse is really a less traumatic experience than was previously thought. As Finkelhor (1984, 1986) has pointed out, however, such a way of thinking reflects a kind of ethnocentrism on the part of adults. Finkelhor (1986) elaborates as follows:

There is an unfortunate tendency in interpreting the effects of (child) sexual abuse...to overemphasize long-term impact as the ultimate criterion. Effects seem to be considered less "serious" if their impact is transient and disappears in the course of development. This tendency...betrays an "adultocentric" bias. Adult traumas such as rape are not assessed ultimately in terms of whether or not they will have an impact on old age: They are acknowledged to be painful and alarming events, whether their impact lasts one year or ten. Similarly, childhood traumas should not be dismissed because no "long-term effects" can be demonstrated. Child sexual abuse needs to be recognized as a serious problem of childhood, if only for the immediate pain, confusion, and upset that can ensue (Finkelhor, 1986, p. 178).

8.5.2.3 Hypothesis 3

8.5.2.3.1 Risk Factors

The present results are consistent with, and extend, previous findings (Gold, 1986; Harter et al., 1988) which suggest that a subject's personal construction of her sexual abuse would be more predictive of negative effects than would more objective abuse related events. After controlling for the effects of recent life stressors (the independent variable that was most strongly predictive of clinical outcomes: Hypothesis 3e) appraisals of negativity emerged in the discriminant analysis as the only significant predictor of clinical outcomes (Hypothesis 3a).

The extension to Gold (1986) and Harter et al.'s (1988) findings emerged from the path analysis which was used as a heuristic device to interpret significant relations between the variables investigated. This analysis revealed that three formal abuse characteristics (coerciveness, duration, and the child's developmental level) which, while not being directly related to clinical outcome, were significantly predictive of abuse related appraisals. This finding is consistent with one of the central assumptions of the SARS model, i.e., that the severity of long-term reactions to childhood sexual experiences are likely to reflect differences in appraisals of abuse events; with appraisals, in turn, being influenced by a range of factors including formal characteristics of the abuse

and the victim's developmental level (cf., Chapter 4, section 4.5).

Thus, although the hypothesized direct relation between formal abuse characteristics and negative outcomes (Hypothesis 3b) was not confirmed, the present findings are consistent with the predictions of the SARS model in suggesting that formal abuse characteristics make a significant (indirect) contribution to long-term outcomes through their impact on abuse related appraisals.

The findings relating to formal abuse characteristics are consistent with the results of previous studies which suggest that abuse duration (Bagley & Ramsay, 1985; Briere & Runtz, 1988b; Peters, 1988; Russell, 1986; Tsai et al., 1979) and degree of coercion (Briere & Runtz, 1988b; Finkelhor, 1979; Fromuth, 1986; Russell, 1986) are significantly related to abuse outcome. The findings relating to the child's developmental level are also congruent with previous findings (e.g., Harris, 1989) which suggest that children's initial and secondary appraisals of abuse events are likely to both reflect and be influenced by developmental considerations (cf., Chapter 4, Section 4.4).

Finally, as regards formal abuse characteristics, the present findings suggest a possible reason for the contradictory findings which have characterized previous outcome research (cf., Chapter 3, Section 3.3.1). With one or two notable exceptions (e.g., Harter et al., 1988) previous studies have tended to employ a simple linear model of causality which assumes a direct relationship between abuse related variables and long-term outcome and which fails to consider the role played by cognitive (and other) mediating variables in the adjustment process. The present findings would suggest that such simple notions of causality fail to adequately address the complexity of sexual abuse reactions and as a consequence place researchers at risk for drawing spurious, and thus

potentially conflicting/ contradictory , conclusions regarding the role played by abuse characteristics in long-term outcomes.

Hypothesized relations between clinical outcomes and family background (Hypothesis 3d), immediate post-abuse experiences (Hypothesis 3c), and current levels of social support (Hypothesis 3f) were not confirmed. Although parenting styles (punitive and supportive) and "helpfulness of social support" emerged as significant predictors of clinical outcome in univariate analysis, this relationship fell away in multivariate analysis after controlling for recent life stressors and abuse related appraisals.

The findings regarding "parenting styles" need to be interpreted with some caution. Previous studies - in which "family background" has been found to be strongly associated with the severity of long-term reactions to abuse (Gold, 1986; Harter et al's., 1988; Peters, 1985, 1988) - have employed operational definitions of "family background" (e.g., closeness to mother at age 12, family adaptability, maternal warmth, etc.) which differ from the definition used in the present study. The possibility can therefore not be ruled out that the negative findings obtained in the present research reflect the specific definition of family functioning used.

Clearly further research, employing different and/or more inclusive definitions of family functioning, is required before any definitive conclusions can be drawn with respect to the role of family background in clinical outcomes.

8.5.2.3.2 Protective Factors

The analysis of factors associated with "superior" outcomes provided additional support for Harter et al's (1988) view that a subject's personal construction of her sexual abuse would be more predictive of long-term outcomes than would more

objective abuse related events. After controlling for the effects of recent life stressors (Hypothesis 3f) and for the perceived helpfulness of social support (Hypothesis 3e) - independent variables which had a significant direct effect on "superior" outcomes - appraisals of betrayal emerged in the discriminant analysis as the only abuse related variable which was significantly related to superior outcomes (Hypothesis 3a).

Path analytic procedures revealed that abuse characterized by less physical coercion and shorter duration (Hypothesis 3b) and abuse in which there had been supportive disclosure (Hypothesis 3c), while not being directly related to superior outcomes, was significantly predictive of abuse related appraisals. This finding is once again consistent with the SARS model assumption that the severity of long-term reactions to childhood sexual experiences are likely to reflect differences in appraisals of abuse events; with appraisals, in turn, being influenced by a range of factors including formal characteristics of the abuse and the victim's experiences in the immediate aftermath of abuse (cf., Chapter 4, section 4.5).

Although previous studies have not explored the role of protective factors in the victim's adjustment process, the present results are nevertheless congruent with previous findings which suggest that less severe reactions to child sexual abuse are likely in cases where the abuse is of shorter duration (Bagley & Ramsay, 1985; Briere & Runtz, 1988b; Peters, 1988; Russell, 1986; Tsai et al., 1979), where lower levels of coercion are involved (Briere & Runtz, 1988b; Finkelhor, 1979; Fromuth, 1986; Russell, 1986), and where the victim experiences supportive disclosure (Gold, 1986). The present results extend these previous findings, however, by suggesting that formal abuse characteristics are indirectly related to "superior" outcomes through their significant direct effect on abuse related appraisals.

The results provide qualified support for hypothesized relations between family background variables and superior adjustment (Hypothesis 3d). Although punitive parenting styles emerged as a significant predictor of superior outcomes in univariate analysis, this relationship fell away in multivariate analysis after controlling for the effects of recent life stressors, current levels of social support, abuse related appraisals and abuse descriptive variables.

Further clarity on the nature of the relationship between parenting styles and superior outcomes is provided by the path analysis which suggests that punitive parenting styles are indirectly related to superior outcomes through their significant direct effect on supportive disclosure and through their significant direct effect on perceptions of the helpfulness of social support networks.

At a more general level, the present results are consistent with findings that have emerged in previous studies of protective factors in childhood development (see e.g., Antonovsky, 1987; Rutter, 1985, 1987; Werner, 1985, 1989; Werner & Smith, 1977, 1982). These studies have identified three relatively enduring constellations of protective factors that enhance resilience in "high-risk" children:

- (i) Affectional ties within the family that provide emotional support in times of stress;
- (ii) The nature and extent of extrafamilial support systems;
- (iii) Dispositional attributes of the individual, such as temperament, health, and intelligence.

The view that resilient outcomes can be related to factors in the individual's social environment - points (i) and (ii) above - is strongly confirmed by the present findings. First, victim perceptions of the helpfulness of social support were

found to be significantly related to "superior" outcomes. Second, appraisals of betrayal - the traumagenic dynamic which most clearly constitutes a threat to the individual's ongoing relationships with significant others - were found to mitigate against "resilient" outcomes. And third, exposure to punitive parenting styles was found to be indirectly related to resilient outcomes through a direct effect on supportive disclosure (as would be predicted from point (i) above) and through a direct effect on perceptions of current social support.

The view that resilient outcomes may also be a function of dispositional attributes of the individual (cf., p. 185) was not adequately addressed by the present research. The fact that dispositional factors have been found to constitute robust predictors of resilience in previous research (Antonovsky, 1987; Rutter, 1985, 1987; Werner, 1985, 1989; Werner & Smith, 1977, 1982) would suggest: (a) that dispositional factors are likely to be significantly predictive of reactions to child sexual abuse; and consequently (b) that dispositional factors need to be considered as important independent variables in the design of future outcome research.

8.6 CONCLUSIONS

The results of the student survey can be summarized under the following points:

- (i) The participation rate obtained in the student survey (87%) was significantly higher than participation rates obtained in previous surveys of child sexual abuse and was therefore regarded as being adequate for purposes of the present research.
- (ii) Participation in the study would appear to have been an upsetting experience for a significant number of women.

Levels of distress or discomfort reported by respondents did not, however, differ significantly from discomfort levels reported in carefully designed studies conducted in the United States.

- (iii) The profile of abuse obtained in the present study is similar to profiles obtained in previous studies of the general population of adult women in the United States. In addition, the prevalence figure obtained for the student sample (34,8%) is consistent with figures obtained in probability samples of the general population of adult women in the United States and is significantly higher than prevalence rates obtained in studies of American college women. These findings would suggest that the method of data collection used in the student survey constitutes an effective method of eliciting personal information relating to childhood sexual experiences.
- (iv) The proposed Index of Symptom Severity (ISS) was found to have adequate convergent and discriminant validity and would therefore appear to constitute a useful and valid index of the severity of long-term reactions to childhood sexual abuse.
- (v) The present findings confirmed hypothesized differences between abused subjects and nonabused controls in psychological adjustment (Hypothesis 1). A history of child sexual abuse was found to be associated with: (a) significantly elevated scores on all nine symptom dimensions of the BSI; (b) significantly elevated scores on measures of sexual conflict and suicidal feelings; (c) significantly lower scores on a measure of self-esteem; and (d) significantly elevated scores on the Index of Symptom Severity developed during the present study.

- (vi) The findings for the student sample did not provide support for the prediction (Hypothesis 2) that the victimized sample would comprise three discrete outcome groups characterized by "superior", "normal", and "clinical" levels of adjustment. The distribution of ISS scores for the victimized sample (see Figure 3, p. 153) suggests rather, that in terms of long-term adjustment, the victimized sample constitutes a single normally distributed population; with the entire distribution of ISS scores for this population being shifted significantly in the direction of more pathological levels of adjustment.
- (vii) The results of the within-group analysis:
- (a) Revealed that a significant proportion of the variance in long-term outcomes can be accounted for by the independent variables selected for comparison (Hypothesis 3).
 - (b) Provide support for two central assumptions of the SARS model: (a) that a victim's personal appraisal of their abuse would be more predictive of long-term outcomes than would more objective abuse related events; and (b) that objective abuse related events are likely to have a significant indirect effect on long-term outcomes through their direct effect on abuse related appraisals.
 - (c) Suggest that different constellations of variables are associated with vulnerability to and resistance to the long-term effects of abuse.

CHAPTER 9PHASE III : THE MEDIA SURVEY

9.1 INTRODUCTION

Phase III of the research explored the external validity of the findings obtained for the student survey (Phase II) using a volunteer sample of women drawn from the general population (subproblem 5; Chapter 1, section 1.1.2).

9.2 HYPOTHESES

The study was informed by the three research hypotheses developed during Phase II of the research (cf., Chapter 8, section 8.2).

9.3 METHOD

9.3.1 Subjects

The target sample for the study was the female readership of a national women's magazine.¹

9.3.2 Materials

Data were collected using the research questionnaire (see Appendices A and B, pp. 238-248) developed during the pilot survey. As was the case in the pilot survey, the three parts of the research questionnaire (blank cover page, introduction, and body of the questionnaire) were stapled together to form one document.

¹ The magazine in question is published bi-monthly in English.

9.3.3 Procedure

An appeal for research subjects was placed in the "Letters" column of a national women's magazine. The text of this appeal read as follows:

I am interested in hearing from readers who would like to participate in a survey of childhood sexual experiences and their effects on adult adjustment. If you are female, and at least 18 years old I would like to hear from you (regardless of whether you did or did not have early sexual experiences). Readers who want to participate in the survey can obtain a simple questionnaire by completing the following form and posting it to the address which appears below:

I would like to receive a survey questionnaire

Name: _____

Address _____

_____ Post Code _____

A copy of the research questionnaire, together with a stamped/addressed return envelope, was sent to all persons who responded to the initial appeal. An additional cover letter, which was included with the questionnaire, contained an address and telephone number for a "Survey Helpline". Respondents were invited to contact the helpline if they wanted further information about the study or if they felt they needed professional advice or counselling relating to any of the experiences covered by the survey.

9.4 RESULTS

9.4.1 Respondents

Two hundred and fifty-nine requests for survey questionnaires were received and 253 completed questionnaires were returned.

The average age of respondents was 31 years (range 18 to 65 years). Ninety-one per cent of respondents were white, 6%

Asian, and 3% coloured (no questionnaires were requested or returned by black respondents). The highest level of education was "some high school" in 8% of cases, matric in 50% of cases, tertiary degree or diploma in 41% of cases, and a post-graduate degree/diploma in 1% of cases. Fifty per cent of respondents were single, 40% married, 8% divorced, and 2% widowed. In terms of socioeconomic status (operationally defined in Chapter 7, Section 2.2), 18% of respondents were lower blue collar, 20% upper blue collar, 41% lower white collar, and 21% upper white collar.

In terms of age, educational level, and socio-economic status the study sample did not differ significantly from the profile of readers provided by the editor of the magazine (cf., Chapter 7, Table 10, p. 108).

9.4.2 Participation Rate

An examination of returned questionnaires revealed that seven respondents had failed to complete some, or all, of the questions relating to child sexual abuse. These seven questionnaires were classified as refusals, giving a final participation rate of 246 women.

9.4.3 Responses to the Survey Helpline

Twenty-eight respondents contacted the Survey Helpline to request further information relating to the study (17 cases), or to request counselling/psychotherapeutic services for themselves (six cases), friends (three case) or other family members (two cases). In all cases appropriate information/professional services were provided/arranged by the researcher.

9.4.4 Prevalence and Abuse Characteristics

9.4.4.1 Prevalence

Of the 246 women who returned completed questionnaires, 120

(48,8%) reported a total of 145 experiences which met the definition of child sexual abuse used in the present study. The nature of abuse experiences reported by these women is presented in Table 41.

TABLE 41 : Nature of Child Sexual Abuse Reported by the Media Sample

Form of Abuse	Abuse Experiences ^a
	(%)
Sexual intercourse	14,7
Attempted intercourse	9,1
Oral sex	5,8
Genital fondling	63,2
Other ^b	7,2

^aBased on a total of 145 experiences reported by 120 respondents.

^bBreast fondling, open-mouthed kissing, and other contact experiences that were experienced as sexual.

9.4.4.2 Abuse Characteristics

More information on the nature of these experiences is presented in Tables 42 (p. 201) and 43 (p. 202).

Overall, the description of abuse obtained for the media sample conforms to findings from other community surveys (see e.g., Finkelhor, 1979, 1986; Finkelhor et al., 1990; Russell, 1986) with one main exception. As was the case for the student sample (cf., Chapter 8), there was an unusually large number of offenders who were less than 11 years older than their victims (42,5% compared to 23% in Finkelhor et al.'s [1990] national survey).

9.4.5 Between-Group Analysis

9.4.5.1 Demographic and Family Background Variables

A comparison of victimized and control subjects on demographic and family background variables revealed that abused subjects

reported significantly more punitive parenting styles ($F [1, 244] = 13,94, p < 0,001$) and significantly less supportive parenting relationships ($F [1, 244] = 4,17, p < 0,05$). The comparisons for socioeconomic status (Kruskal-Wallis $H [1 \text{ df}] = 1,97, \text{NS.}$); race ($\text{Chi}^2 [3 \text{ df}] = 2,16, \text{NS.}$); age ($F [1,244] = 0,72, \text{NS.}$); and marital status ($\text{Chi}^2 [3 \text{ df}] = 3,73, \text{NS.}$) revealed no significant differences.

TABLE 42 : Characteristics of Sexual Abuse Experiences: Victims and Perpetrators

Characteristic	Abuse Experiences
	(%)
Age of Victim	
0 - 5 years	12,7
6 - 8 years	25,3
9 - 11 years	25,0
12 - 14 years	25,8
15 - 17 years	11,2
Age of perpetrator	
0 - 17 years	23,4
18 - 25 years	39,2
26 - 35 years	18,6
36 years or more	18,8
Age difference	
0 - 3 years	9,6
4 - 10 years	32,9
11 years or more	57,5
Victim-perpetrator relationship	
Stranger	36,4
Acquaintance	39,5
Biological parent	5,3
Step-parent	4,7
Other relative	14,1
Gender of perpetrator	
Male	95,7
Female	4,3
Number of perpetrators	
One	96,1
Two	3,3
Three or more	0,6

TABLE 43 : Characteristics of Sexual Abuse Experiences:
Dynamics

Characteristic	Abuse Experiences (%)
Verbal threat used	
No verbal threat	73,1
Threat (not of bodily harm)	19,2
Bodily harm	5,4
Extreme bodily harm	2,3
Force used	
No force	58,9
Pushed or held down	39,1
Hit or slapped	1,6
Beat, punched, kicked	0,4
Duration	
1 time only	61,2
1 month or less	12,6
1 month to 6 months	7,9
6 months to 1 year	8,0
1 year or more	10,3
Frequency	
1 time only	61,2
2 to 5 times	24,5
6 to 10 times	7,1
10 times or more	7,2
Disclosure	
No, never	51,4
Told family member	23,7
Told friend	24,9

9.4.5.2 Psychological Adjustment

Abused and nonabused subjects' scores on the nine scales of the BSI were compared using a Multivariate Analysis of Covariance (MANCOVA) with univariate Analyses of Covariance (ANCOVA's) following significant MANCOVA's. The covariates entered in these analysis were scores on the "Punitive" and "Supportive" subscales of the EMBU.

The effect of sexual abuse on all other outcome measures was assessed using univariate ANCOVA's.

The results of these analyses (see Table 44) indicated that after controlling for the effects of punitive and supportive parenting styles, a history of child sexual abuse was associated with significantly lower/poorer levels of adjustment on all outcome measures with the notable exception of "Locus of Control".

TABLE 44 : Responses to Dependent Measures in the Media Survey

Adjustment Measure	Covariates		Sexual Abuse
	Punitiveness	Supportiveness	
	F	F	F
Scales of the BSI	4,55*	1,97	4,98*
Somatization	4,83*	1,09	6,47*
Obsessive-Compulsive	5,78*	1,34	4,47*
Int. Sensitivity	5,35*	2,72	11,69***
Depression	4,71*	0,93	25,10***
Anxiety	7,60**	4,84*	4,94*
Hostility	8,95**	5,13*	12,11***
Phobic Anxiety	2,53	0,25	8,42**
Paranoid Ideation	6,99**	2,17	5,32*
Psychoticism	6,29*	4,37*	5,54*
Global Severity Index	9,95**	2,25	5,43*
Rosenberg Self-Esteem	4,25*	0,03	7,42**
Sexual Adjustment	12,68***	0,28	18,28***
Locus of Control	0,30	0,10	3,12
Suicidal Feelings	0,98	0,05	8,01**

*p < 0,05. **p < 0,01. ***p < 0,001.

9.4.5.3 Severity of Adjustment Problems

The Index of Symptom Severity (ISS) developed during Phase II of the research (cf., Chapter 8, Section 8.4.4.3) was used to assess the severity of adjustment problems reported by respondents; with levels of adjustment being determined using the norms for "Female Non-Patients" developed by Derogatis and Spencer (1982).

This analysis revealed a significant relationship between a history of abuse and levels of adjustment with abused subjects

being significantly more likely to report more severe adjustment problems (see Table 45).

TABLE 45 : Severity of Adjustment Problems Reported by the Media Sample: A Comparison of Abused and Nonabused Subjects

Level of adjustment	Group	
	Sexually Abused ($n = 120$)	Nonabused Control ($n = 126$)
	\underline{n} (%)	\underline{n} (%)
Superior	11 (9,2)	18 (14,3)
Normal	84 (70,0)	97 (77,0)
Clinical Pathology	25 (20,8)	11 (8,7)

Chi^2 (2 df) = 7,93, $p < 0,02$.

A more detailed comparison of ISS scores obtained by abused and non-abused subjects is presented in Figure 19 (p. 205). From Figure 19 it can be seen that, when compared to non-victimized controls, the entire distribution of ISS scores for abused subjects was shifted approximately 0,5 standard deviations in the direction of more pathological levels of adjustment; with the mean ISS score for abused subjects ($\bar{T} = 55$) being significantly higher than the mean for non-abused controls ($\bar{T} = 48$; $F [1,244] = 29,36$, $p < 0,001$).

To further explore the relationship between ISS scores and abuse history, Chi-Square Goodness-of-Fit tests were used to determine if the proportion of victimized and non-victimized subjects in each T-score class interval (cf., Table 19, p. 205) deviated significantly from the proportion that would be expected under the normal curve. These analyses revealed that non-victimized controls were significantly over represented in the 0-30 T-score class interval (chi-square [1 df] = 4,11, $p < 0,05$); while victimized subjects were significantly under represented in the 30-39 T-score class interval (chi-square [1 df] = 8,93, $p < 0,01$) and significantly over represented in the 70-100 T-score class interval (chi-square [1 df] = 10,47, $p < 0,01$).

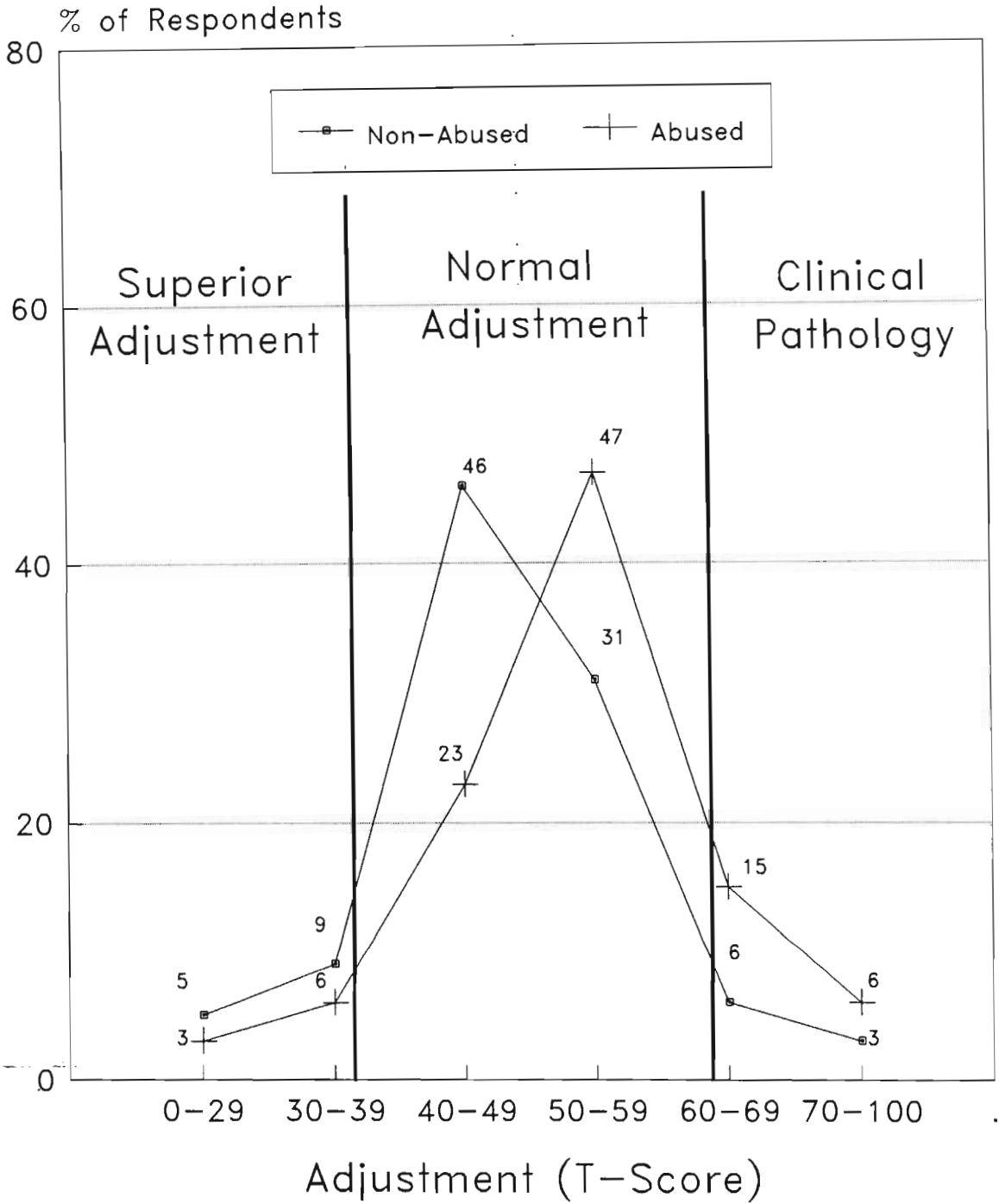


Figure 19 : Severity of Adjustment Problems: Abused and Non-Abused Controls Compared

9.4.6 Within-Group Analysis

The within-group analysis, which focussed on the sexually abused group, attempted to account for differences in the severity of adjustment problems reported by victimized subjects.

9.4.6.1 Factors Associated with the Severity of Adjustment Problems

9.4.6.1.1 Factors Associated with an Increased Risk of Long-Term Effects

Using a series of univariate analyses, victims who reported clinical levels of pathology were compared to victims who reported less severe adjustment problems (i.e., either "normal" or "superior" adjustment) on a range of demographic, family background, abuse descriptive, and current life event variables. A discriminant function analysis was then performed including all variables that were significantly related to the adjustment categories at the univariate level.²

² Independent variables considered in these analyses were: victim demographics (age, race, and marital status); family background (parents socioeconomic status, parental punitiveness, parental supportiveness); formal characteristics of the abuse (victim's age, victim's level of development, abuser's age, abuser's identity, abuser's sex, victim-abuser age difference, consanguinity, frequency and duration of abuse, nature of abuse, the extent of verbal and physical coercion, and the number of abusers); abuse related appraisals; post-abuse experiences (reporting, supportive disclosure, therapy received); recent life stressors; and current levels of social support (helpfulness and reciprocity).

9.4.6.1.1.1 Univariate Analysis

The univariate analyses indicated that three factors were significantly related to a risk of clinical pathology. From Table 46 (see also Figures 20-22, pp. 208-209) it can be seen that the clinical pathology group had experienced a greater number of recent life stressors, reported more ambivalent abuse related appraisals, and had experienced abuse characterized by greater verbal coercion.

TABLE 46 : Factors Associated with an Increased Risk of Long-Term Effects among Abused Subjects in the Media Sample

Factor	Clinical Pathology ($\underline{n} = 25$)	Normal or Superior Adjustment ($\underline{n} = 95$)	F (1,118)
	Mean	Mean	
Recent life stressors	6,90	3,64	19,74***
Appraisal (ambivalence)	4,89	3,69	9,46**
Coercion (verbal)	2,10	1,50	4,17*

* $p < 0,05$. ** $p < 0,01$. *** $p < 0,001$.

9.4.6.1.1.2 Discriminant Analysis

Using the three risk factors identified at the univariate level (section 9.4.6.1.1.1, above) as the discriminant variables, the discriminant analysis was able to differentiate reliably (as expressed by the canonical discriminant function) between the groups defined by the presence or absence of clinical pathology.

The best discriminant function yielded a chi-square (3 df) value of 37,76 ($p < 0,001$), a canonical correlation of 0,432, and a coefficient of determinism of 0,187. This indicates that approximately 19% of the variance can be accounted for by the best linear combination of the predictor variables selected for comparison.

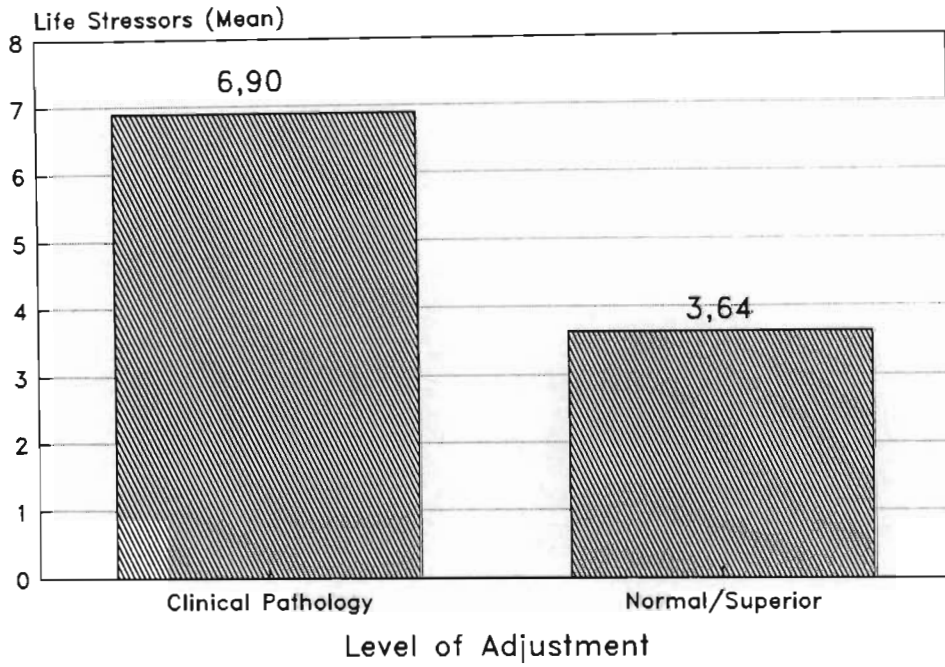


Figure 20 : The Media Sample: Level of Adjustment X Mean Life Stressors

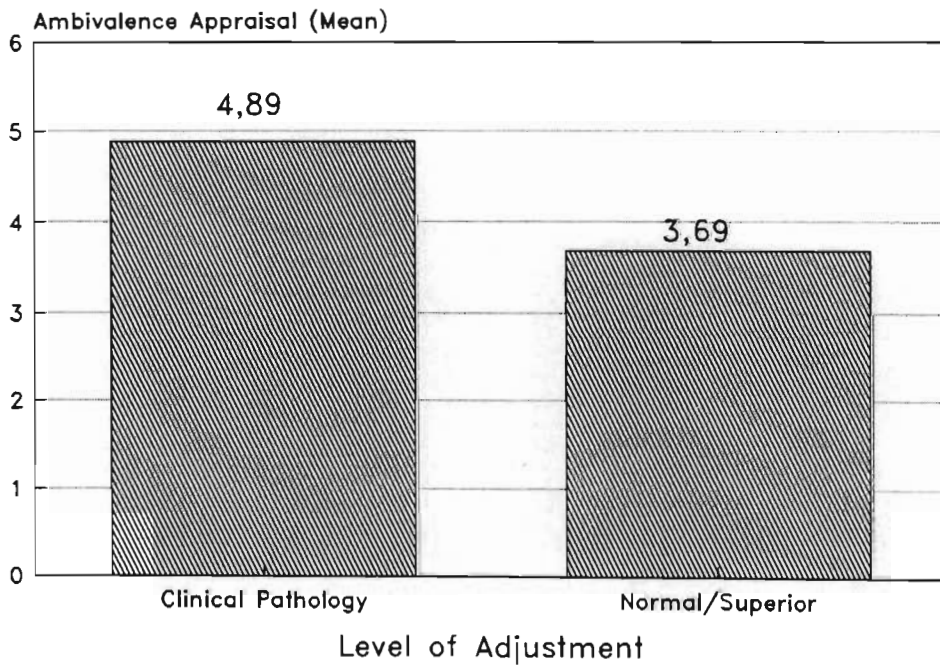


Figure 21 : The Media Sample: Level of Adjustment X Mean Appraisal of Ambivalence

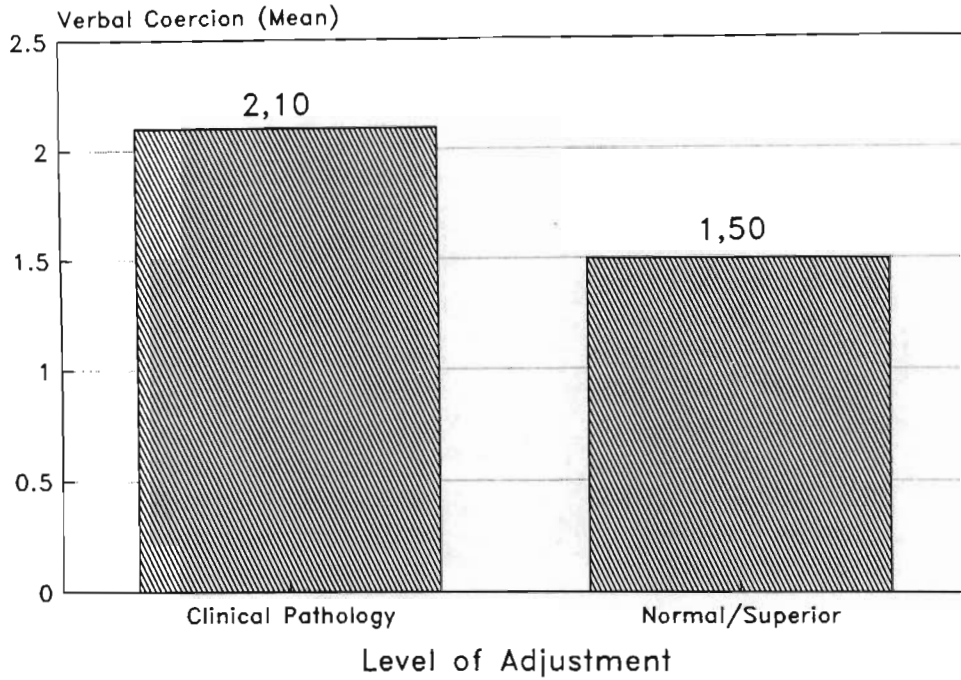


Figure 22 : The Media Sample: Level of Adjustment X Mean Verbal Coercion

An analysis of variable discriminating power revealed that the risk factors selected for comparison were not equally powerful discriminators between the groups. As can be seen from Table 47, only two variables (recent life stressors and appraisals of ambivalence) emerged as significant discriminant variables, with recent life stressors being the most powerful discriminating variable.

TABLE 47 : Discriminant Analysis for Clinical Pathology: Analysis of Variable Discriminating Power

Variable	Wilk's Lambda	F (3,116)	Significance
Recent life events	0,512	28,89	p < 0,001
Appraisal (ambivalence)	0,803	6,17	p < 0,05
Coercion (verbal)	0,921	2,43	NS

9.4.6.1.1.3 Analysis of Significant Discriminant Variables

9.4.6.1.1.3.1 Recent Life Events

An item analysis was conducted to identify specific life events that discriminated victims in the "clinical pathology" category from other victims. This analysis identified five life events which were significantly more likely to be reported by victims in the clinical outcome group. From Table 48 (p. 211) it can be seen that these items related mainly to social/interpersonal issues.

9.4.6.1.1.3.2 Appraisals of Ambivalence

A stepwise multiple regression analyses was conducted to explore the relative predictive contribution of family background, abuse descriptive, and life event variables to abuse related appraisals of ambivalence.

Independent variables considered in these analyses were: victim demographics (age, race, and marital status); family background (parents socioeconomic status, parental punitiveness, parental supportiveness); formal characteristics of the abuse (victim's age/level of development, abuser's age/identity/sex, victim-abuser age difference, consanguinity, frequency and duration of abuse, nature of abuse, the extent of verbal and physical coercion, and the number of abusers); post-abuse experiences (reporting, supportive disclosure, therapy received); recent life stressors; and current levels of social support (helpfulness and reciprocity).

This analysis revealed that abuse characterized by less verbal coercion ($R = 0,35$, $p < 0,01$) and abuse of longer duration ($R = 0.26$, $p < 0,01$) was significantly predictive of appraisals of ambivalence. No further variables reached significance at the 0,05 level. The resulting regression equation, $F(2,117) = 15,37$, $p < 0,001$, accounted for 17,4% of the variation in appraisals of ambivalence.

TABLE 48 : Negative Life Events: The Clinical and Non-Clinical Outcome Groups Compared

Negative Life Event	Clinical Pathology (n = 25)	Normal or Superior Adjustment (n = 95)	p
	<u>N</u> (%)	<u>N</u> (%)	
<u>Social/Interpersonal</u>			
Change in social activities	20 (80)	27 (28)	< 0,001
Change (closeness to family)	11 (44)	3 (3)	< 0,001
Illness or injury (friend)	8 (32)	8 (8)	< 0,01
Break up with boyfriend	5 (20)	18 (19)	NS
Engagement	1 (4)	3 (3)	NS
Marriage	2 (8)	5 (5)	NS
Pregnancy	1 (4)	3 (3)	NS
Death (family member)	9 (36)	10 (11)	< 0,01
Illness (family member)	16 (64)	29 (31)	< 0,01
<u>Changed Life Circumstances</u>			
Leaving home	1 (4)	3 (3)	NS
Losing a job	2 (8)	7 (7)	NS
Major change in recreation	5 (20)	18 (19)	NS
Change of residence	6 (24)	28 (29)	NS
<u>Medical</u>			
Personal injury/illness	6 (24)	7 (7)	NS
Abortion	0 (0)	0 (0)	NS
<u>Financial</u>			
Borrowing > R10 000.	3 (12)	9 (9)	NS
Borrowing < R10,000.	5 (20)	21 (22)	NS
Financial problems	10 (40)	41 (43)	NS
<u>Victimization</u>			
Victim (political unrest)	1 (4)	4 (4)	NS
Teargassed/assaulted/shot	0 (0)	1 (1)	NS
<u>Criminal/Legal</u>			
Being arrested/detained	0 (0)	0 (0)	NS
Minor law violation	1 (4)	6 (6)	NS
<u>Other</u>			
Failing an exam	2 (8)	4 (4)	NS
Transport problems	1 (4)	8 (8)	NS

Note. Comparisons were made using Chi- Square Tests (1 df).

9.4.6.1.2 Factors Associated with a Reduced Risk of Long-Term Effects

A series of univariate analyses were used to compare victims who reported "superior adjustment" with victims who reported either "normal adjustment" or "clinical pathology" on a range of demographic, family background, abuse descriptive, and

current life event variables.³ A discriminant function analysis was then performed including all variables that were significantly related to the adjustment categories at the univariate level.

9.4.6.1.2.1 Univariate Analysis

The univariate analyses indicated that three factors were significantly related to "superior" levels of adjustment. From Table 49 (p. 213; see also Figures 23-25, pp. 214-215) it can be seen that the superior adjustment group were less likely to appraise their abuse as a betrayal, had experienced abuse characterized by less verbal coercion, and had experienced fewer recent life stressors.

9.4.6.1.2.2 Discriminant Analysis

Using the three risk factors identified at the univariate level (section 9.4.6.1.2.1, above) as the discriminant variables, the discriminant analysis was able to differentiate reliably (as expressed by the canonical discriminant function) between the groups defined by the presence or absence of "superior" outcomes.

³ Independent variables considered in these analyses were: victim demographics (age, race, and marital status); family background (parents socioeconomic status, parental punitiveness, parental supportiveness); formal characteristics of the abuse (victim's age, victim's level of development, abuser's age, abuser's identity, abuser's sex, victim-abuser age difference, consanguinity, frequency and duration of abuse, nature of abuse, the extent of verbal and physical coercion, and the number of abusers); post-abuse experiences (reporting, supportive disclosure, therapy received); recent life stressors; and current levels of social support (helpfulness and reciprocity).

TABLE 49 : Factors Associated with a Reduced Risk of Long-Term Effects among Abused Subjects in the Media Sample

Factor	Superior Adjustment ($\underline{n} = 11$)	Normal or Clinical Adjustment ($\underline{n} = 109$)	\underline{F} (1,118)
	Mean	Mean	
Recent life stressors	1,97	5,12	10,37**
Appraisal (betrayal)	2,42	3,50	6,13**
Coercion (verbal)	1,31	2,17	4,02*

* $p < 0,05$. ** $p < 0,01$.

The best discriminant function yielded a chi-square (3 df) value of 22,16 ($p < 0,001$), a canonical correlation of 0,311, and a coefficient of determinism of 0,097. This indicates that approximately 10% of the variance can be accounted for by the best linear combination of the predictor variables selected for comparison.

An analysis of variable discriminating power revealed that the risk factors selected for comparison were not equally powerful discriminators between the groups. As can be seen from Table 50, only two variables (recent life stressors and appraisals of betrayal) emerged as significant discriminant variables, with recent life stressors being the most powerful discriminating variable.

TABLE 50 : Discriminant Analysis for Superior Adjustment: Analysis of Variable Discriminating Power

Variable	Wilk's Lambda	\underline{F} (2,117)	Significance
Recent life stressors	0,682	9,17	$p < 0,01$
Appraisal (betrayal)	0,857	4,39	$p < 0,05$
Coercion (verbal)	0,952	1,21	NS

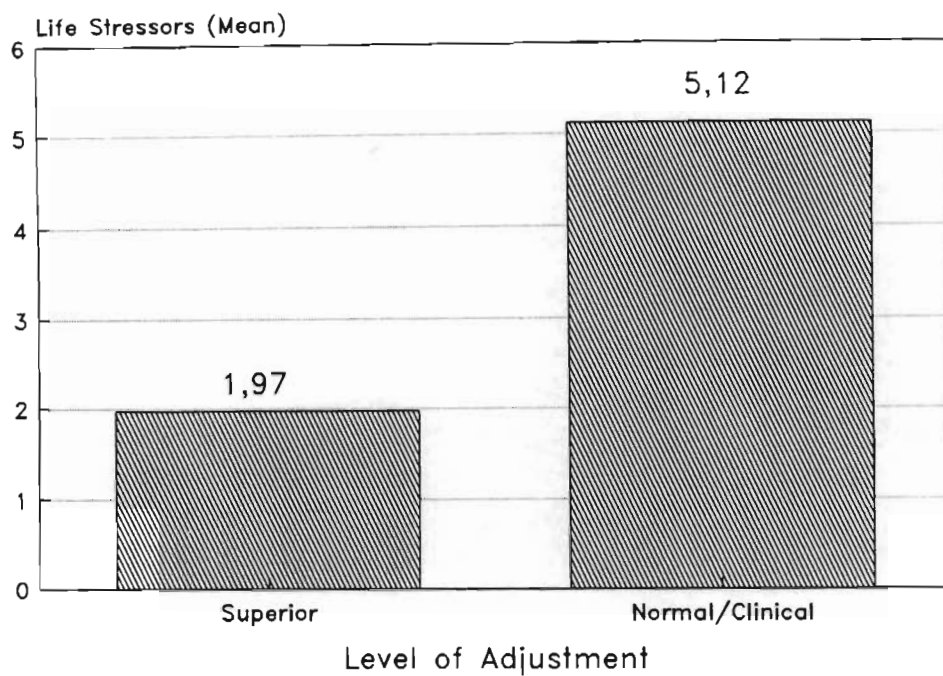


Figure 23 : The Media Sample: Level of Adjustment X Mean Life Stressors

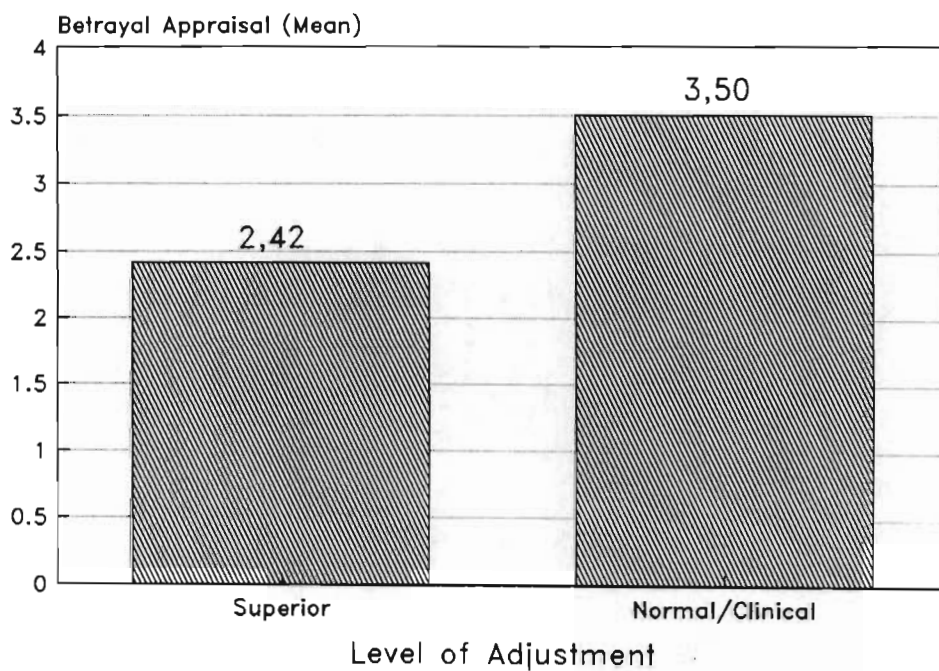


Figure 24 : The Media Sample: Level of Adjustment X Mean Appraisal of Betrayal

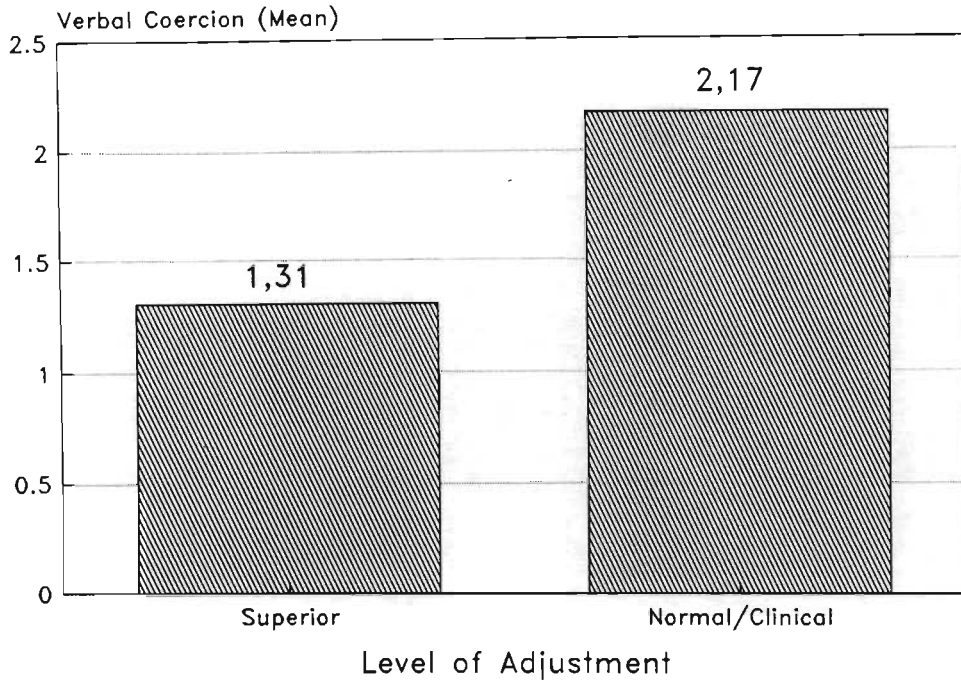


Figure 25 : The Media Sample: Level of Adjustment X Mean Verbal Coercion

9.4.6.1.2.3 Analysis of Significant Discriminant Variables

9.4.6.1.2.3.1 Recent Life Events

An item analysis was conducted in order to identify specific life events that discriminated victims in the "superior adjustment" category from other victims. This analysis identified two life events which were moderately related to "superior" outcomes (see Table 51, p. 216).

9.4.6.1.2.3.2 Appraisals of Betrayal

A stepwise multiple regression analysis was conducted to explore the relative predictive contribution of family background, abuse descriptive, and life event variables to abuse related appraisals of betrayal.

This analysis revealed that abuse characterized by greater verbal coercion ($R = 0,28$, $p < 0,001$) and abuse in which the perpetrator was older ($R = 0.22$, $p < 0,01$) was significantly predictive of appraisals of betrayal. No further variables reached significance at the 0,05 level. The resulting regression equation, $F(1,118) = 13,37$, $p < 0,001$, accounted for 14,7% of the variation in appraisals of betrayal.

TABLE 51 : Negative Life Events: The "Superior Adjustment" Group Compared to Other Victims

Negative Life Event	Superior Adjustment ($n = 11$)	Normal or "Clinical" Adjustment ($n = 109$)	p
	<u>N</u> (%)	<u>N</u> (%)	
<u>Social/Interpersonal</u>			
Change in social activities	1 (9)	46 (42)	< 0,07
Change (closeness to family)	1 (9)	13 (12)	NS
Illness or injury (friend)	2 (18)	14 (13)	NS
Break up with boyfriend	1 (9)	22 (20)	NS
Engagement	0 (0)	4 (4)	NS
Marriage	1 (9)	6 (6)	NS
Pregnancy	0 (0)	4 (4)	NS
Death (family member)	1 (0)	18 (17)	NS
Illness (family member)	1 (9)	44 (40)	< 0,08
<u>Changed Life Circumstances</u>			
Leaving home	0 (0)	4 (4)	NS
Losing a job	1 (9)	8 (7)	NS
Major change in recreation	1 (0)	22 (20)	NS
Change of residence	2 (18)	32 (29)	NS
<u>Medical</u>			
Personal injury/illness	1 (9)	12 (11)	NS
Abortion	0 (0)	0 (0)	NS
<u>Financial</u>			
Borrowing > R10 000.	1 (9)	11 (10)	NS
Borrowing < R10,000.	2 (18)	24 (22)	NS
Financial problems	3 (27)	48 (44)	NS
<u>Victimization</u>			
Victim (political unrest)	0 (0)	5 (5)	NS
Teargassed/assaulted/shot	0 (0)	1 (1)	NS
<u>Criminal/Legal</u>			
Being arrested/detained	0 (0)	0 (0)	NS
Minor law violation	0 (0)	7 (6)	NS
<u>Other</u>			
Failing an exam	1 (9)	5 (5)	NS
Transport problems	2 (18)	7 (6)	NS

9.4.6.1.2.4 Path Analyses

Because of the high intercorrelations among the variables investigated in the discriminant analysis, path analyses were used as a heuristic device to simplify the interpretation of contributors to the severity of long-term effects.

Tentative models of the interrelations between contributors to an increased and to a reduced risk of long-term effects are presented in Figures 26 and 27 (pp 218 and 219) respectively. For ease of presentation, path coefficients which were not significant at the 0,05 level are not included in Figures 26 and 27. These coefficients do, however, appear in Appendices H and I (pp. 256-257).

Assuming correct specification of the model and accurate measurement, the total effects of the predictor variables on the severity of adjustment problems are presented in Tables 52 and 53 (p. 220).

TABLE 52 : Path Analysis: Factors Associated with an Increased Risk of Long-Term Effects in the Media Sample

Variable	Direct	Indirect	Total
Coercion	0,062	0,053	0,115
Duration	0,052	0,039	0,091
Appraisal (ambivalence)	0,182*	0,008	0,190*
Life stress	0,204*		0,204*

$p < 0,05$

From Tables 52 (above) and 53 (p. 220) it can be seen that appraisals of ambivalence and exposure to negative life events were directly related to "clinical" outcomes; while appraisals of betrayal and exposure to negative life events were directly related to "superior" outcomes. None of the other variables considered in the analysis were significantly related (directly or indirectly) to abuse outcome.

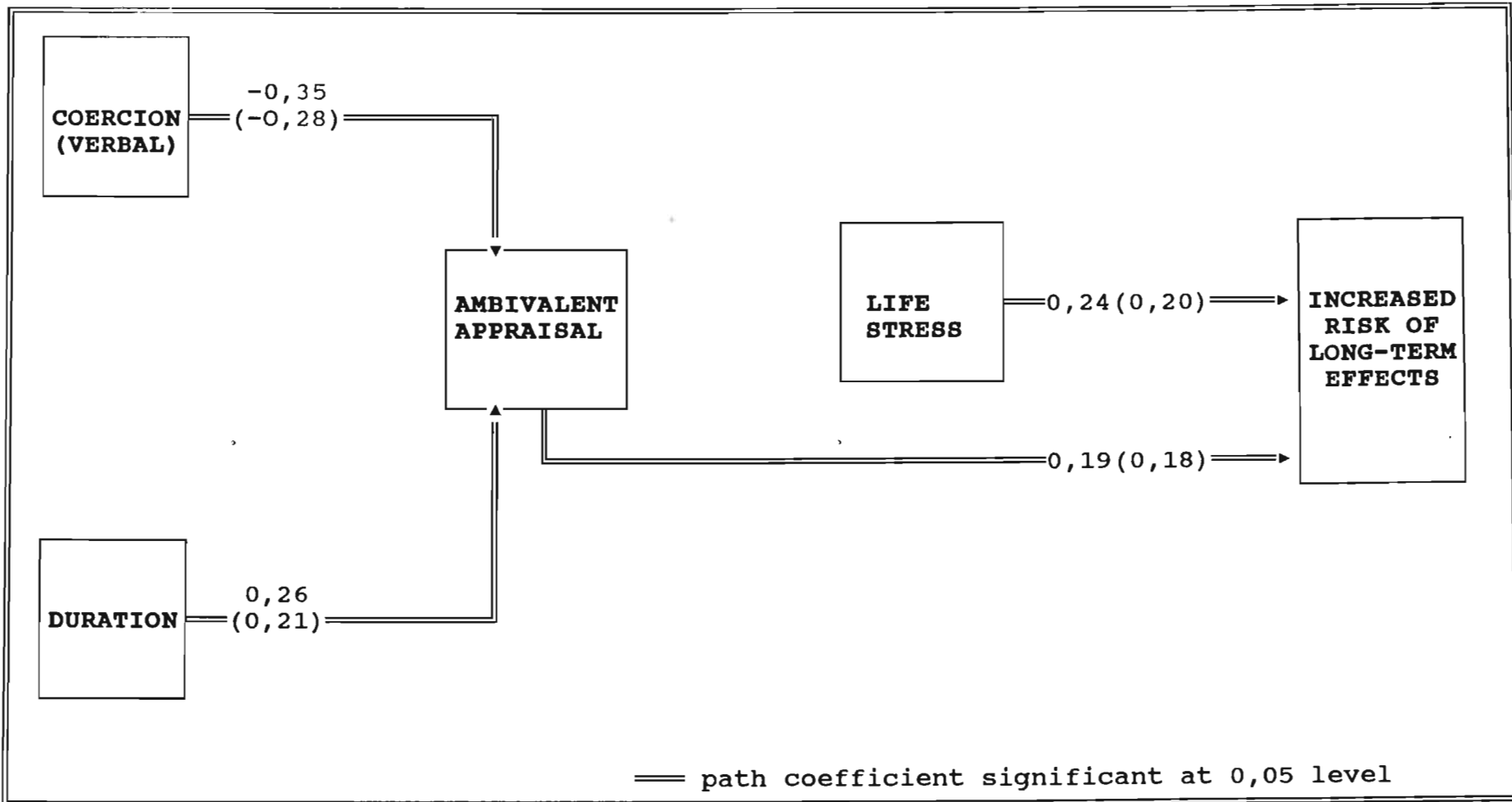


FIGURE 26 : The Media Sample: Proposed Model of Significant Relations Between Abuse, Abuse Appraisals, Life Stressors, and Clinical Adjustment among Victimized Subjects with Variable Correlations and Path Coefficients (in Parentheses)

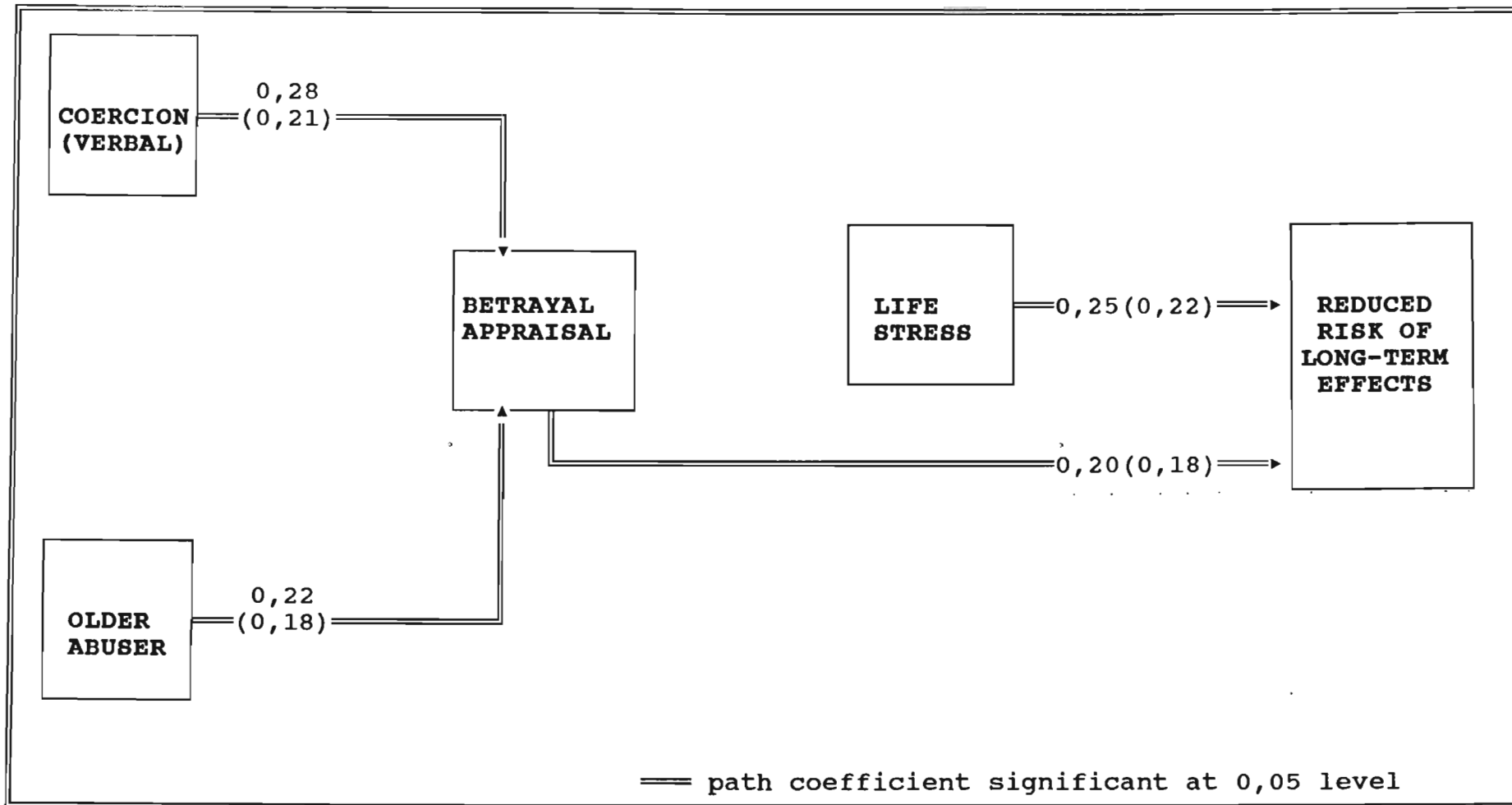


FIGURE 27 : The Media Sample: Proposed Model of Significant Relations Between Abuse, Abuse Appraisals, Life Stressors, and Superior Adjustment among Victimized Subjects with Variable Correlations and Path Coefficients (in Parentheses)

TABLE 53 : Path Analysis: Factors Associated with a Decreased Risk of Long-Term Effects in the Media Sample

Variable	Direct	Indirect	Total
Coercion (verbal)	-0,092	-0,038	-0.130
Abuser's age	-0,011	-0,009	-0,020
Appraisal (betrayal)	-0,181*	-0,002	-0,183*
Life stress	-0,220*		-0,220*

$p < 0,05$

9.5 DISCUSSION

9.5.1 Limitations

The present results were obtained using a volunteer sample which is unlikely to be representative of the general population of adult women. Generalization of the present findings to the broader population therefore needs to be made with due caution; with such caution being particularly warranted in the case of black women (who were not represented in the media sample) and in the case of men (who were not surveyed in the present research).

Additional limitations of the research include:

- (i) Necessary reliance on correlational data which restricts the confidence with which causal statements can be made.
- (ii) Retrospective evaluation of family background and abuse related variables which raises the possibility of distortion due to memory.
- (iii) The use of relatively small samples (particularly in the case of "superior" outcomes) which poses a threat to the stability of the findings.

- (iv) Simplification of the causal relations inherent in path analysis (although unidirectional causality was assumed in the proposed models, the relations between some of the variables investigated are likely to be multidirectional and systemic).

With these limitations in mind it is useful to examine the main findings that emerged from the research.

9.5.2 The Research Hypotheses

9.5.2.1 Hypothesis 1

The findings for the media sample confirmed hypothesized differences between abused and nonabused subjects in psychological adjustment (Hypothesis 1). After controlling for the effects of punitive and nonsupportive parenting styles, a history of child sexual abuse was found to be associated with: (a) significantly elevated scores on the Global Severity Index, and on all nine symptom dimensions, of the Brief Symptom Inventory (Derogatis & Spencer, 1982); (b) significantly elevated scores on Briere's (1989) Sexual Conflict Scale; (c) significantly elevated scores on Paykel et al's. (1974) Suicidal Feelings Rating Inventory; and (d) significantly lower scores on Rosenberg's (1965) Self-Esteem Scale.

These results are consistent with findings obtained for the student sample (cf., Chapter 8) and (b) with findings obtained in previous studies of the long-term effects of child sexual abuse (Bagley & Ramsay, 1985, 1986; Briere & Runtz, 1985; Finkelhor, 1979; Russell, 1986; Sedney & Brooks, 1984; Seidner & Brooks, 1983).

9.5.2.2 Hypothesis 2

The findings for the media sample did not provide support for the prediction (Hypothesis 2) that the victimized sample

would comprise three discrete outcome groups characterized by "superior", "normal", and "clinical" levels of adjustment. The distribution of ISS scores for the victimized sample (see Figure 19, p. 206) suggests rather, that in terms of long-term adjustment, the victimized sample constitutes a single normally distributed population; with the entire distribution of ISS scores for this population being shifted significantly in the direction of more pathological levels of adjustment.

These results are consistent with findings obtained for the student sample (cf., Chapter 8).

9.5.2.3 Hypothesis 3

The present results provide support for Harter et al.'s (1988) contention that a subject's personal construction of her sexual abuse would be more predictive of negative effects than would more objective abuse related events. After controlling for the effects of recent life stressors (the independent variable that was most strongly predictive of both "clinical" and "superior" outcomes: Hypothesis 3e) abuse related appraisals emerged as the only significant predictor of long-term outcomes (Hypothesis 3a).

The present results are: (a) consistent with results obtained for the student sample (cf., Chapter 8) and (b) consistent with one of the central assumptions of the SARS model, i.e., that the severity of long-term reactions to childhood sexual experiences are likely to reflect differences in appraisals of abuse events; with appraisals, in turn, being influenced by more objective abuse related events/circumstances (cf., Chapter 4, section 4.5).

9.6 CONCLUSIONS

The findings for the media sample were consistent with findings obtained for the student sample (across all three research hypotheses).

This consistency provides support for the validity of the present findings and increases the confidence with which generalizations can be made from the present research.

CHAPTER 10SUMMARY AND CONCLUSIONS

10.1 AIMS OF THE STUDY

Factors associated with the severity of long-term reactions to a childhood sexual abuse were investigated. Phase I of the research was given over to the development of a methodology for studying the long-term effects of child sexual abuse which controlled for, or minimized, threats to internal validity and which minimized the potential for secondary victimization. During Phase II (the main phase of the research) the methodology developed during Phase I was applied to a sample of 640 university women in an attempt: (a) to identify and explore different patterns of psychological adjustment and (b) to identify and evaluate risk factors associated with differential adjustment. Phase III of the research attempted to cross-validate the findings obtained for the student sample (Phase II) using a sample of 246 women drawn from the general population of adult women.

10.2 LIMITATIONS OF THE RESEARCH

The present results were obtained using nonprobability samples of adult women who are not necessarily representative of the general population of adult women. Although the consistency of findings across the student and media sample serves to enhance the external validity of the findings, such consistency falls short of establishing external validity. Generalization of the present findings to the broader population therefore needs to be made with due caution; with such caution being particularly warranted in the case of black women (who were under represented in the student sample and not represented in the media sample) and in the case of men (who were not surveyed in the present research).

Additional limitations of the research include:

- (i) Necessary reliance on correlational data which restricts the confidence with which causal statements can be made.
- (ii) Retrospective evaluation of family background and abuse related variables which raises the possibility of distortion due to memory.
- (iii) The use of relatively small samples (particularly in the case of "superior" outcomes) which poses a threat to the stability of the findings.
- (iv) Simplification of the causal relations inherent in path analysis (although unidirectional causality was assumed in the proposed models, the relations between some of the variables investigated are more likely to be multidirectional/systemic).

With these limitations in mind it is useful to examine the main findings that emerged from the present research.

10.3 RESULTS

10.3.1 Phase I

The results of the pilot survey (Phase I) suggest that the methodology developed for the research constitutes a useful and valid method of eliciting personal information relating to childhood sexual experiences. The validity of the proposed methodology is suggested by:

- (i) A participation rate of 92%, which is significantly higher than participation rates obtained in previous surveys of child sexual abuse.

- (ii) A prevalence rate (39,9%) which is: (a) consistent with prevalence rates obtained for probability samples of the general population of adult women in the United States, and (b) significantly higher than prevalence rates obtained in studies of American college women.
- (iii) A profile of abuse in which more intimate/ intrusive forms of abuse are represented in approximately the same proportion as has been observed in carefully designed and sensitively conducted studies in the United States.

An analysis of respondents' evaluations of the research indicated that the proposed methodology has a potential for secondary victimization that does not exceed levels observed in carefully and sensitively designed studies conducted in the United States.

10.3.2 Phase II

The results of the student survey (Phase II) can be summarized under the following points:

- (i) When compared to nonvictimized controls, victims of child sexual abuse (as a group) demonstrated impairment in psychological adjustment, with such impairment being evident across a broad range of outcome measures.
- (ii) The findings for the student sample did not provide support for the prediction (Hypothesis 2) that the victimized sample would comprise three discrete outcome groups characterized by "superior", "normal", and "clinical" levels of adjustment. The distribution of ISS scores for the victimized sample (see Figure 3, p. 153) suggests rather, that in terms of long-term adjustment, the victimized sample constitutes a single normally distributed population; with the entire

distribution of ISS scores for this population being shifted significantly in the direction of more pathological levels of adjustment.

- (iii) The within-group analysis revealed: (a) that victim's personal appraisals of their abuse were more predictive of the severity of long-term effects than were more objective abuse related events; (b) that objective abuse related events (e.g., the duration and coerciveness of abuse) had a significant direct effect on abuse related appraisals; and (c) that different constellations of variables were associated with risk and resilience to the long-term effects of abuse.

10.3.3 Phase III

The findings for the media sample (Phase III) were consistent with findings obtained for the student sample (Phase II) across all three research hypotheses. This consistency in findings provides support for the external validity of the study findings and increases the confidence with which generalizations can be made from the present research.

10.4 GENERAL CONCLUSIONS

10.4.1 The Prevalence of Child Sexual Abuse

Consistent with previous findings for South African student samples (Levett, 1989a) the prevalence rate obtained in Phase II of the research (34,8%) is significantly higher than prevalence rates obtained in studies of American college women. The fact that the present prevalent figure was obtained using a definition of sexual abuse which was more restrictive than definitions used in most American studies (e.g.,

Finkelhor, 1979; Fromuth, 1986) suggests that this discrepancy is unlikely to be a function of definitional issues. Further, the fact that the Levett (1989a) study and the present research used very different methodologies (i.e., different methods of sample recruitment, different methods of data collection, and different methods of data analysis) suggests that the relatively high prevalence figure obtained for South African samples is unlikely to reflect shared methodological variation.

A third possible explanation for the relatively high prevalence figure obtained in the present study is quite simply that there is a greater incidence of child sexual abuse among South African university (as opposed to American college) women. Although the present findings, and those of Levett (1989a), are consistent with such an explanation, further research - involving careful control of definitional and methodological issues, as well as large and more representative samples of South African women - is clearly required before any definitive conclusions can be drawn on this issue.

10.4.2 Ethical Issues

Consistent with previous findings for South African samples (Collings, 1991a; Levett, 1989a), the present results provide support for the contention that "systematic collection of data can be an additional stress factor in this area of human experience" (Levett, 1989a, p. 157). In Phase II of the research, 11 per cent of respondents (32% of victimized respondents) indicated that they had been upset by the experience. Although these levels of distress are not as high as those reported for American samples (Russell, 1986), they are nevertheless disquietingly high, and suggest that the value of future research in this sensitive area needs to be carefully weighed against the potential that such research has for secondary abuse.

10.4.3 Theory

The results from Phases II and III of the research provide support for a number of key assumptions of the SARS model. First, the present results are consistent with the view that childhood sexual abuse constitutes an incentive event with a potential for provoking undesirable long-term effects in a significant proportion of its victims. Second, the present results confirm the SARS model prediction that severe stress response syndromes (i.e., clinical pathology) are not an inevitable long-term consequence of abuse; with a significant proportion of victims in the present study - 82% of victims in the student sample and 79% of victims in the media sample - scoring in the "normal" range on the outcome measures selected for comparison. Third, the present results are consistent with the SARS model prediction that the severity of long-term reactions to childhood sexual experiences are likely to reflect differences in appraisals of abuse events; with appraisals, in turn, being influenced by more objective environmental events.

The present findings also provide empirical support for Finkelhor and Browne's (1985, 1986) contention that reactions to child sexual abuse are likely to be influenced by four traumagenic dynamics (i.e., Traumatic Sexualization, Betrayal, Stigmatization, and Powerlessness). The findings relevant to these four dynamics can be summarized under the following points:

- (i) Traumatic Sexualization. When compared to nonvictimized controls, victim's of child sexual abuse (as a group) scored significantly higher on measures of sexual conflict. In addition, aspects of the abuse experience (i.e., coerciveness, duration, and appraisals of negativity), which Finkelhor & Browne (1986) identify as central components of Traumatic Sexualization, were found to be significantly related to the severity of adjustment problems reported by victimized subjects.

- (ii) Betrayal. Abuse related appraisals of betrayal were found to be significantly related to the severity of adjustment problems reported by victimized subjects. Related feelings of interpersonal sensitivity and hostility were also found to be significantly more prevalent among victimized subjects.
- (iii) Stigmatization. When compared to nonvictimized controls, victim's of child sexual abuse (as a group) scored significantly lower on measures of self-esteem; with self-esteem scores for the victimized sample being significantly, and negatively, related to the severity of adjustment problems reported.
- (iv) Powerlessness. Aspects of the abuse experience (i.e., coercion, duration, nonsupportive disclosure) which Finkelhor & Browne (1986) identify as central components of Powerlessness, were found to be significantly related to the severity of adjustment problems reported by victimized subjects.

At a more general level, the present results have relevance to the ongoing debate between those who maintain that the effects of child sexual abuse are best understood in the context of a conceptual framework which is unique to child sexual abuse (Finkelhor, 1986, 1987; Finkelhor & Browne, 1985; 1986; Sanderson, 1990) and those who believe that general theories of stress and stress reaction (e.g., the PTSD model) constitute useful interpretative frameworks for child sexual abuse outcome research (Donaldson & Gardner, 1985; Frederick, 1986; Goodwin, 1985; Kiser et al., 1988; Lindberg & Distad, 1985; McCleer et al., 1988). Rather than providing support for either side of this debate, the present results point to the heuristic value of a more comprehensive formulation (i.e., the SARS model) which: (a) incorporates major elements of both prevailing perspectives (i.e., the traumagenic dynamics outlined in Finkelhor and Browne's (1985) FTD model as well as

a focus on the process of adjustment contained in Horowitz's (1978, 1986) SRS model); and which (b) is consistent with empirical findings (including the present findings) relating to child sexual abuse response syndromes.

10.4.4 The Long-Term Effects of Child Sexual Abuse

10.4.4.1 The Traumagenic Potential of Child Sexual Abuse

The present findings are consistent with, and extend, previous findings (e.g., Bagley & Ramsay, 1985, 1986; Briere & Runtz, 1988a, 1988b; Bryer *et al.*, 1987; Bushnell *et al.*, 1992; Finkelhor, 1979, 1986; Levett, 1989a; Russell, 1986) which suggest that:

When studied as adults, victims (of child sexual abuse) as a group demonstrate more impairment than their nonvictimized counterparts (about twice as much), but less than one-fifth evidence serious psychopathology (Browne & Finkelhor, 1986, p. 164).

The extension to previous findings emerged from the between-group analyses which revealed that, when compared to non-victimized controls, the entire distribution of ISS scores for victimized subjects was shifted significantly in the direction of more pathological levels of adjustment. In other words abused subjects were not only over represented in the "clinical pathology" category but were also: (a) over represented in the top half of the "normal" adjustment category (i.e., ISS T-score of 50-59); (b) under represented in the bottom half of the "normal" adjustment category (i.e., ISS T-score of 40-49); and (c) under represented in the "superior" adjustment category.

This finding suggests that the long-term impact of childhood sexual abuse is more extensive/pervasive than would be suggested by an index of adjustment which is restricted to the pathological/clinical end of the continuum of adjustment. The present findings suggest, further, that the important question which needs to be addressed by outcome research is not so much

"Why do some victims of child sexual abuse manifest long-term effects of abuse and others not?" but rather "Why are some victims more (or less) successful at resisting the harmful effects of abuse?"

Finally, the present findings suggest that future outcome research would benefit from a broader/extended conceptualization of sexual abuse reactions which incorporates notions of both "risk" and "resilience" and which directs researchers towards an exploration of both the "pathological" and "normal" ends of the continuum of adjustment.

10.4.4.2 Factors Associated with the Severity of Long-Term Reactions

The results from Phase II and III of the research are consistent with, and extend, previous findings (Gold, 1986; Harter et al., 1988) which suggest that a victim's personal constructions of their abuse are likely to be more predictive of long-term outcomes than are more objective abuse related events. The extension to previous results, lies in the present finding that objective environmental events - i.e., characteristics of the abuse, post-abuse experiences, and family background variables - emerged as significant predictors of abuse related appraisals.

These findings would appear to have implications for the ways in which child sexual abuse response syndromes are conceptualized and the ways in which child sexual abuse outcome research is conceived. First, the present findings suggest that child sexual abuse response syndromes need to be viewed "in terms of a transaction between the individual and the environment with the meaning and appraisal of the event intrinsic to its definition" (Rutter, 1983, p. 9). Second, the present findings suggest that future outcome research would benefit from the use of more complex transactional models of causality which: (a) are not restricted to linear and/or

unidirectional modes of explanation and which (b) consider the role played by cognitive (and other) mediating variables in the adjustment process.

The present findings would also appear to have important implications for clinical intervention. The association between abuse related appraisals and long-term outcomes which emerged in the present research suggests that abuse related appraisals are likely to constitute a useful (i.e., measurable and modifiable) focus for therapeutic intervention. Further research - directed both at attempts to replicate the present findings and at attempts to identify additional "cognitive variables" related to abuse outcome - would appear to hold promise for providing "a more sensitive and specific rationale to direct treatment and to evaluate clinical outcome" (Harter et al., 1988, p. 8).

Finally, the finding (from Phases II and III of the research) that different constellations of variables were associated with "clinical" and "superior" outcomes warrants further comment. This finding is consistent with Rutter's (1987) contention that "risk" and "resilience" are conceptually distinct concepts - as opposed to opposite ends of the same continuum - which are likely to be influenced by different processes or mechanisms and which therefore need to be examined/explored separately. In this context, there would appear to be a clear need for notions of both risk and resilience to feature prominently on the agenda's of future outcome researchers; with an important challenge for such research being the further exploration of factors associated with resilience as well as the explication of the protective processes or mechanisms involved in resilient outcomes. Such a focus on resilience and the mechanisms underlying resilience is not only likely to contribute towards a more balanced/comprehensive understanding of long-term reactions to child sexual abuse but also has a potential for providing information/understandings which can be used in the

development of innovative approaches to prevention and intervention. As Anthony (1987) has pointed out:

Were we to study the forces that move...children to survival and adaptation, the long-range benefits to our society may be far more significant than our many efforts to construct models of primary prevention deigned to curtail the incidence of vulnerability" (p. 46).

10.5 RECOMMENDATIONS FOR FUTURE RESEARCH

The present findings suggest some promising directions for future research.

Further research on "vulnerable" and "resilient" outcomes (both initial and long-term) to childhood sexual abuse would appear to be indicated. Important challenges for such research would appear to be:

- (i) The further exploration of factors associated with risk and resilience; with particular reference to dispositional attributes of the individual which: (a) were not adequately addressed in the present research, but which (b) have been found to constitute robust predictors of long-term outcomes in related studies of children raised in high risk life circumstances (Antonovsky, 1987; Rutter, 1985, 1987; Werner, 1985, 1989; Werner & Smith, 1977, 1982)
- (ii) The further explication of risk/protective processes or mechanisms involved in the realization or modification of risk trajectories. Rutter (1987) provides a preliminary typology of risk/protective mechanisms - including mechanisms such as "reduction of exposure to risk", "reduction of exposure to negative chain reactions stemming from the abuse encounter", and "enhancement of self-esteem" - which could serve as a useful starting point for such research.

- (iii) The exploration of abuse related effects using more comprehensive (inclusive) outcome measures. The fact that different indices of competence have been found "to produce discrepant results when used singly or reduce sample size considerably when used in combination" (Fisher et al., 1987, p. 222) suggests that the use of more inclusive dependent measures is likely to produce different estimates of abuse effects.

Further research, designed to validate assumptions of the SARS model, would also appear to be indicated. In particular, there is a need to validate the assumption that cognitive processing of abuse events involves alternating cycles of denial and intrusion, with each of these cycles being characterized by a distinctive pattern of symptomatology. The fact that changing patterns of symptomatology have been found to characterize victim adjustment in the first 12 months following the termination of abuse (Krener, 1985; Friedrich & Reams, 1987) would suggest that attempts to validate the Completion Tendency are likely to be most profitable if they involve repeated measures of initial effects.

Finally, there is a need for child sexual abuse outcome researchers to acknowledge the fact that "prospective studies of high-risk children are coming of age" (Werner, 1989, p. 157). The advantages of prospective designs (more accurate estimates of pre-abuse baselines, avoidance of distortion due to memory failure, the provision of a basis for more confident causal inference, etc.) suggests that prospective designs should be the design of choice in future child sexual abuse outcome research. The feasibility of prospective designs has been demonstrated in Farber and Egeland's (1987) recent study of risk and resilience among physically abused and neglected children, and Farber and Egeland's "at-risk approach" - involving early identification and longitudinal follow-up of children who are known (based on actuarial data) to be at high risk for abuse - would appear to hold promise as a useful

prospective strategy for future child sexual abuse outcome research.

Prospective approaches to outcome research are thus both desirable and feasible, with the application of such approaches to an understanding of sexual abuse response syndromes constituting a major challenge for future outcome research.

APPENDICES

1. Appendix A
2. Appendix B
3. Appendix C
4. Appendix D
5. Appendix E
6. Appendix F
7. Appendix G
8. Appendix H
9. Appendix I
10. Appendix J

APPENDIX A : THE INTRODUCTION TO THE QUESTIONNAIRE

Dear Respondent,

We would like you to participate in a study of childhood sexual experiences.

Because some of the questions are very personal, social scientists have been reluctant to investigate them in the past. However, if we are to obtain answers to important social issues like teen-age pregnancy, sex education, and child abuse, we need to know more about these personal things.

We hope with this in mind, and the knowledge that everything you answer here is completely anonymous, that you will decide to participate.

To help you to decide, we want to say a little more about the questionnaire. The questionnaire contains highly personal questions about sexual attitudes and experiences, as well as questions about your family. Some of the information you will be providing here is probably not information you would want others to know about. For one thing, it may be embarrassing or painful to answer some of the questions. For another thing, it may involve people besides yourself, who would not want information divulged. Finally, believe it or not, some of the the things you may be reporting in the questionnaire may be against the law. This gives you some idea of how sensitive an area this is. So carefully consider whether you really want to participate.

PLEASE CONSIDER THE FOLLOWING POINTS VERY CAREFULLY

1. You are under no obligation to participate. Much as we would like your cooperation, you should feel free not to fill out the questionnaire. In fact, if at any point while filling out the questionnaire you decide you no longer wish to participate, you may stop wherever you are and fill out no more. Moreover, if there are any particular questions which you want to skip, you may do so.
2. In you own interests, we recommend that you carefully read through all sections of the questionnaire before deciding whether you wish to participate.
3. If you decide not to participate you can do so without anyone knowing. All questionnaires have a blank cover sheet. If you decide not to fill out any part, just return the questionnaire along with everyone else, and no one will be aware that your questionnaire is incomplete.
4. All questionnaires are completely anonymous. Nowhere in the questionnaire do we ask for your name, and we have carefully avoided asking questions that might identify you directly.

5. Unfortunately, if you are not at least 18, and thus still legally a minor, we will not be able to use your questionnaire. According to law, minors need to obtain parental consent in order to participate in scientific research of this nature. If you are under 18, we are sorry to exclude you from the research, but unfortunately we have no other choice. So please just return a blank questionnaire.

6. Because of the sensitive nature of the research, it is important that we have your fully informed consent to use your questionnaire. If you choose to participate please make a cross in the box below to indicate your consent

Thank you for your cooperation.

I HAVE READ THE ABOVE AND AGREE TO PARTICIPATE []

I HAVE READ THE ABOVE AND DECIDED NOT TO PARTICIPATE []

I AM UNDER THE AGE OF 18 AND MAY NOT PARTICIPATE []

SECTION A

The following questions apply to your present and past life circumstances (where appropriate put a cross in one block)

1. Your age:
2. Your sex: 1 male
2 female
3. Race: 1 Asian
2 black
3 coloured
4 white
5 other
4. Highest level of education:
5. Occupation: self
partner
6. Marital status: 1 never married
2 married
3 divorced
4 separated
5 widowed

7. Indicate with a TICK which of the following events you have experienced in the LAST YEAR. For each item ticked indicate how negative or positive the experience was for you.

TICK	VERY NEGATIVE	SOMEWHAT NEGATIVE	NO IMPACT	SOMEWHAT POSITIVE	VERY POSITIVE
Being arrested or detained <input type="checkbox"/>					
Death of a close family member <input checked="" type="checkbox"/>					<input checked="" type="checkbox"/>
Being a victim of political unrest <input type="checkbox"/>					
Being teargassed, assaulted or shot at <input type="checkbox"/>					
Minor law violation <input type="checkbox"/>					
Pregnancy (self or partner) <input type="checkbox"/>					
Serious illness or injury to a close family member <input checked="" type="checkbox"/>					<input checked="" type="checkbox"/>
Major change in the closeness of family members <input type="checkbox"/>					
Change of residence <input type="checkbox"/>					
Major change in usual type or amount of recreation <input type="checkbox"/>					
Borrowing more than R10,000 <input type="checkbox"/>					
Borrowing less than R10,000 <input type="checkbox"/>					
Major personal injury or illness <input type="checkbox"/>					
You (or your partner) having an abortion <input type="checkbox"/>					
Marked increase or decrease in social activities <input type="checkbox"/>					
Serious illness or injury to a close friend <input type="checkbox"/>					
Engagement <input type="checkbox"/>					
Marriage <input type="checkbox"/>					
Retirement <input type="checkbox"/>					
You or your partner losing a job <input type="checkbox"/>					
Breaking up with a boyfriend/girlfriend <input type="checkbox"/>					
Leaving home for the first time <input type="checkbox"/>					
Failing an exam <input type="checkbox"/>					
Financial problems <input type="checkbox"/>					

How much have you been distressed or bothered by each of the following problems in the last 7 days including today (for each problem circle one number)?

	NOT AT ALL	A LITTLE BIT	MODERATELY	QUITE A BIT	EXTREMELY
1. Nervousness or shakiness inside	0	1	2	3	4
2. Faintness or dizziness	0	1	2	3	4
3. The idea that someone else can control your thoughts	0	1	2	3	4
4. Feeling others are to blame for most of your troubles	0	1	2	3	4
5. Trouble remembering things	0	1	2	3	4
6. Feeling easily annoyed or irritated	0	1	2	3	4
7. Pains in heart or chest	0	1	2	3	4
8. Feeling afraid in open spaces	0	1	2	3	4
9. Thoughts of ending your life	0	1	2	3	4
10. Feeling that most people cannot be trusted	0	1	2	3	4
11. Poor appetite	0	1	2	3	4
12. Suddenly scared for no reason	0	1	2	3	4
13. Temper outbursts that you could not control	0	1	2	3	4
14. Feeling lonely even when you are with people	0	1	2	3	4
15. Feeling blocked in getting things done	0	1	2	3	4
16. Feeling lonely	0	1	2	3	4
17. Feeling blue	0	1	2	3	4
18. Feeling no interest in things	0	1	2	3	4
19. Feeling fearful	0	1	2	3	4
20. Your feelings being easily hurt	0	1	2	3	4
21. Feeling that people are unfriendly or dislike you	0	1	2	3	4
22. Feeling inferior to others	0	1	2	3	4
23. Nausea or upset stomach	0	1	2	3	4
24. Feeling that you are watched or talked about by others	0	1	2	3	4
25. Trouble falling asleep	0	1	2	3	4
26. Having to check and double check what you do	0	1	2	3	4
27. Difficulty making decisions	0	1	2	3	4
28. Feeling afraid to travel on buses, subways, or trains	0	1	2	3	4
29. Trouble getting your breath	0	1	2	3	4
30. Hot or cold spells	0	1	2	3	4
31. Having to avoid certain things, places, or activities because they frighten you	0	1	2	3	4
32. Your mind going blank	0	1	2	3	4
33. Numbness or tingling in parts of your body	0	1	2	3	4
34. The idea that you should be punished for your sins	0	1	2	3	4
35. Feeling hopeless about the future	0	1	2	3	4
36. Trouble concentrating	0	1	2	3	4
37. Feeling weak in parts of your body	0	1	2	3	4
38. Feeling tense or keyed up	0	1	2	3	4
39. Thoughts of death or dying	0	1	2	3	4
40. Having urges to beat, injure, or harm someone	0	1	2	3	4
41. Having urges to break or smash things	0	1	2	3	4
42. Feeling very self-conscious with others	0	1	2	3	4
43. Feeling uneasy in crowds	0	1	2	3	4
44. Never feeling close to another person	0	1	2	3	4
45. Spells of terror or panic	0	1	2	3	4
46. Getting into frequent arguments	0	1	2	3	4
47. Feeling nervous when you are left alone	0	1	2	3	4
48. Others not giving you proper credit for your achievements	0	1	2	3	4
49. Feeling so restless you couldn't sit still	0	1	2	3	4
50. Feelings of worthlessness	0	1	2	3	4
51. Feeling that people will take advantage of you if you let them	0	1	2	3	4
52. Feelings of guilt	0	1	2	3	4
53. The idea that something is wrong with your mind	0	1	2	3	4

9. How characteristic are each of the following statements of you?

	not at all	a little	a lot
1. On the whole I am satisfied with myself.....			
2. At times I think I am no use at all.....			
3. I feel that I have a number of good qualities			
4. I am able to do things as well as most people			
5. I feel I do not have much to be proud of.....			
6. I certainly feel useless at times.....			
7. I feel that I am a person of worth, at least on an equal plane as others.....			
8. I wish I could have more respect for myself..			
9. All in all, I am inclined to believe that I am a failure.....			
10. I take a positive attitude to myself.....			

10. Below is a list of 5 pairs of statements. For each pair, circle either A or B to indicate the statement you agree with more.

1. A I have often found that what is going to happen will happen.
B Trusting to fate has never turned out as well for me as making a decision to take a definite course of action.
2. A When I make plans I am almost certain that I can make them work.
B It is not wise to plan too far ahead because many things turn out to be a matter of good or bad fortune anyhow.
3. A In my case getting what I want has little or nothing to do with luck.
B Many times we might just as well decide what to do by flipping a coin.
4. A Many times I feel that I have little influence over the things that happen to me.
B It is impossible for me to believe that chance or luck play an important role in my life.
5. A What happens to me is my own doing.
B Sometimes I feel that I don't have enough control over the direction my life is taking.

11. How often have you experienced each of the following in the last year?

	<u>often</u>	<u>sometimes</u>	<u>hardly ever</u>	<u>never</u>
1. Felt life was not worth living.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Wished you were dead.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Thought of taking your life (even though you knew you wouldn't do it..)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Seriously considered taking your life (e.g., made plans to do so)....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Made an attempt to take your life...	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

12. When you have personal problems (eg. problems relating to work, money, your family, or other personal matters:

a. How many people do you know that you generally discuss these problems with?

b. For each person that you indicated in 12a (above), indicate how helpful these discussions are and whether that person would come to you to discuss their problems

<u>Person</u>	<u>Helpfulness of discussion</u>				<u>Would this person come to you with their problems</u>	
	makes things a lot worse	makes things a bit worse	helps things a bit	helps things a lot	Yes	No
1						
2						
3						
4						
5						
6						
7						

[I DO NOT DISCUSS MY PROBLEMS WITH ANYONE]

13. When you were about 5 years old what were the occupations of the set of parents you had (regardless of whether they were biological, adoptive, foster or step parents)?

a. Mother

b. Father

14. When you were about 5 years old, how were you treated by the set of parents you had (regardless of whether they were biological, adoptive, foster, or step parents)? Answer separately for each parent.

SCORE AS FOLLOWS: 1 = never
 2 = sometimes
 3 = often
 4 = very often

	<u>Father</u>	<u>Mother</u>
1. Did it happen that you were punished by your parents without having done anything.....	<input type="checkbox"/>	<input type="checkbox"/>
2. Do you think your parents punished you justly.....	<input type="checkbox"/>	<input type="checkbox"/>
3. Did it happen that your parents beat you for no reason.....	<input type="checkbox"/>	<input type="checkbox"/>
4. Did your parents treat you in such a way that you felt ashamed.....	<input type="checkbox"/>	<input type="checkbox"/>
5. Did it happen that your parents gave you more corporal punishment than you deserved.....	<input type="checkbox"/>	<input type="checkbox"/>
6. Could you seek comfort from your parents if you were sad.....	<input type="checkbox"/>	<input type="checkbox"/>
7. Did you feel it was difficult to approach your parents.....	<input type="checkbox"/>	<input type="checkbox"/>
8. Did you feel that your parents liked you.....	<input type="checkbox"/>	<input type="checkbox"/>
9. If you had done something foolish, could you then go to your parents and make everything right by asking their forgiveness.....	<input type="checkbox"/>	<input type="checkbox"/>
10. Did you feel that warmth and tenderness existed between your parents.....	<input type="checkbox"/>	<input type="checkbox"/>

15. How true are each of the following statements for you?

	<u>not</u> <u>at all</u>	<u>a</u> <u>little</u>	<u>a fair</u> <u>amount</u>	<u>quite</u> <u>a lot</u>	<u>very</u> <u>much so</u>
a. Thoughts about sex disturb me more than they should.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. I have strong sex feelings but when I get a chance I can't seem to express myself...	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. My parent's influence has inhibited me sexually.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Something is lacking in my sex life.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Perverted thoughts have sometimes bothered me.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. I have felt deprived sexually.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. I have felt guilty about sex experiences.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. All in all I am satisfied with my sex life.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

SECTION B

It is now generally agreed that many people have sexual experiences as children and while they are growing up. We would like you to try to remember the sexual experiences that you had while growing up. In answering please remember that there is no way that you can be identified from your responses.

1. Before your FOURTEENTH BIRTHDAY, how many times did you have each of the following experiences (for each question circle one number)?

	Number of times				
1. Someone attempting to have sexual intercourse or anal sex with you (i.e., without penetration taking place)	0	1	2	3	+3
2. Someone having sexual intercourse or anal sex with you (involving penetration)	0	1	2	3	+3
3. Someone stimulating your genitals with their mouth	0	1	2	3	+3
4. Someone getting you to stimulate their genitals with your mouth	0	1	2	3	+3
5. Someone trying or succeeding in touching your breasts or genitals in a sexual way (besides someone you've already mentioned)	0	1	2	3	+3
6. Someone trying or succeeding in getting you to touch their genitals (besides anyone you've already mentioned)	0	1	2	3	+3
7. Someone feeling you, grabbing you, or kissing you in a way that you felt was sexual (besides someone you've already mentioned)	0	1	2	3	+3
8. Any other experience, that you have not mentioned yet, but which you felt was sexual					
_____ (briefly describe)	0	1	2	3	+3

2. At ANY time in your life, have you had any of the following experiences (for each question indicate number of times)?

	Number of times				
1. Having an unwanted sexual experience with a girl or woman	0	1	2	3	+3
2. Being the victim of rape or attempted rape	0	1	2	3	+3
3. Having <u>any</u> kind of unwanted sexual experience with someone who had authority over you (e.g., a doctor, teacher, employer, therapist, policeman, or much older person)	0	1	2	3	+3
4. Having <u>any</u> kind of sexual contact with an uncle, brother, father, grandfather, or female relative	0	1	2	3	+3
5. Having <u>any</u> kind of sexual experience with someone less closely related to you (eg. a stepparent, stepbrother, in-law, or first-cousin)	0	1	2	3	+3
6. <u>Narrowly missing</u> being sexually assaulted (other than by someone you've already mentioned)	0	1	2	3	+3
7. Being in a situation where there was violence or threat of violence in which you were also afraid of being <u>sexually</u> assaulted - again other than what you have mentioned already	0	1	2	3	+3
8. Have you had any (other) unwanted sexual experience (that you haven't mentioned above)					
_____	0	1	2	3	+3

If you checked one or more of the experiences listed on the previous page select the ONE experience that you believe was most important and answer the following questions about the FIRST time you had that experience.

NO SUCH EXPERIENCE GO TO QUESTION 24

With regard to the experience that you have selected:

3. About how old were you at the time?.... _____

4. About how old was the other person?.... _____

5. About how many times did you have a sexual experience with this person?.. _____

6. Over how long a time did this go on for (indicate number of days, months, or years)?..... _____

7. Which of the following best describes what happened?

- | | | |
|---|--------------------------|---|
| 1 | <input type="checkbox"/> | sexual or anal intercourse |
| 2 | <input type="checkbox"/> | attempted sexual or anal intercourse |
| 3 | <input type="checkbox"/> | someone stimulating your genitals with their mouth |
| 4 | <input type="checkbox"/> | you stimulating someone else's genitals with your mouth |
| 5 | <input type="checkbox"/> | someone stimulating your genitals with their hand |
| 6 | <input type="checkbox"/> | you stimulating someone else's genitals with your hand |
| 7 | <input type="checkbox"/> | Someone touching your unclothed breast |
| 8 | <input type="checkbox"/> | Someone feeling, kissing or hugging you in a sexual way |
| 9 | <input type="checkbox"/> | Other _____ |

_____ please indicate

8. Who was the other person?

- | | | | | | |
|---|--------------------------|----------------------|---|--------------------------|-----------------------|
| 1 | <input type="checkbox"/> | a stranger | 6 | <input type="checkbox"/> | a brother or sister |
| 2 | <input type="checkbox"/> | a friend of yours | 7 | <input type="checkbox"/> | a father or mother |
| 3 | <input type="checkbox"/> | your parent's friend | 8 | <input type="checkbox"/> | a step-parent |
| 4 | <input type="checkbox"/> | a cousin | 9 | <input type="checkbox"/> | other _____ |
| 5 | <input type="checkbox"/> | an uncle or aunt | | | _____ please indicate |

9. Was the other person male or female?

- 1 male 2 female

10. To what extent did the other person use verbal threats?

- | | | |
|---|--------------------------|--------------------------------------|
| 1 | <input type="checkbox"/> | no verbal threat |
| 2 | <input type="checkbox"/> | verbal threat (not of bodily harm) |
| 3 | <input type="checkbox"/> | verbal threat of bodily harm |
| 4 | <input type="checkbox"/> | extreme verbal threat of bodily harm |

APPENDIX C : THE PRE-TEST QUESTIONNAIRE

INSTRUCTIONS: Please answer the following questions AFTER you have completed the Survey Questionnaire.

1. Did you find any of the questions difficult to understand?

No

Yes (_____

 _____)

Please indicate which questions
and nature of difficulty

2. Do you feel that there are any changes or improvements that could (or should) be made to the questionnaire?

No

Yes (_____

 _____)

Please indicate

3. Did you feel at all pressurized or coerced into completing the questionnaire?

Not at all A little Very much

4. Do you have any regrets about your decision to complete the questionnaire?

No Yes

5. Were you completely truthful in all the answers you gave to the questionnaire?

No Yes

6. Some people find it upsetting to complete a questionnaire that contains personal information. Was this at all true for you?

Not at all A little Very much so

7. If you were given the option in the future to complete a similar questionnaire would you choose/agree to do so?

No Unsure Yes

8. I would welcome any further comments, criticisms, or suggestions relating to the survey questionnaire.

9. You have completed the questionnaire. Thank you for your cooperation. Please rest assured that all of your responses will be treated in the strictest of confidence.

APPENDIX D : DEVELOPING BSI NORMS FOR SOUTH AFRICAN UNIVERSITY
WOMEN STUDENTS

Procedure

Copies of the BSI were handed out in class to 786 female students who were: (a) registered for undergraduate psychology courses at the University of Natal (Durban), and who (b) had not participated in the sexual abuse survey. Students were requested to complete the BSI away from class and to return the questionnaires within 10 days. Completed questionnaires were returned by 726 students which represents a participation rate of (92,4%).

Characteristics of the Normative Sample

The average age of the normative sample was 19,7 years with a range of 17 to 43 years. Four hundred and thirty-five (60%) of the sample were white, 160 (22%) were Asian, 102 (14%) were black, and 29 (4%) were coloured.

BSI norms

Standard (T-score) norms were calculated for the normative sample on the nine symptom dimensions and Global Severity Index of the BSI. These norms are presented in Appendix E.

APPENDIX E : STANDARD (T-SCORE) NORMS FOR FEMALE UNIVERSITY STUDENTS (THE NORMATIVE SAMPLE) ON THE 9 SYMPTOM DIMENSIONS AND THE GLOBAL SEVERITY INDEX OF THE BSI (N = 726)

MEAN RAW SCORE	SOM	OBS	INS	DEP	ANX	HOS	PHO	PAR	PSY	GSI
0,00	40	37	37	38	39	39	42	38	39	36
0,04	41	38	38	39	39	39	43	39	40	36
0,08	42	38	38	39	40	40	43	39	40	37
0,12	43	39	39	40	40	40	44	40	41	38
0,16	44	39	39	40	41	41	45	40	42	39
0,20	45	40	40	41	41	41	45	41	42	40
0,24	46	40	40	41	42	42	46	41	43	41
0,28	46	41	40	42	42	42	46	42	43	41
0,32	47	42	41	42	43	43	47	42	44	41
0,36	48	42	41	43	43	43	47	43	45	42
0,40	49	43	42	43	44	44	48	43	45	43
0,44	50	43	42	44	44	44	49	44	46	43
0,48	50	44	43	44	45	45	49	44	46	44
0,52	51	44	43	45	45	45	50	45	47	45
0,56	52	45	43	45	46	46	50	45	48	45
0,60	53	45	44	46	46	46	51	46	48	46
0,64	53	46	44	46	47	47	52	46	49	47
0,68	54	46	45	47	47	47	52	47	49	47
0,72	55	47	45	47	48	48	53	47	50	48
0,76	55	47	45	47	48	48	53	48	51	49
0,80	56	48	46	48	49	49	54	48	51	49
0,84	57	48	46	48	49	49	54	49	52	50
0,88	58	49	47	49	50	50	55	49	52	51
0,92	59	49	47	49	50	50	56	50	53	51
0,96	60	50	48	50	51	50	56	50	54	52
1,00	60	51	48	51	51	51	57	51	54	53
1,04	61	51	49	51	52	51	57	51	55	53
1,08	62	52	49	51	52	52	58	52	55	54

MEAN										
RAW SCORE	SOM	OBS	INS	DEP	ANX	HOS	PHO	PAR	PSY	GSI
1,12	63	52	49	52	53	52	59	52	56	55
1,16		53	50	52	53	53	59	53	57	55
1,20		53	50	53	54	53	60	53	57	56
1,24		54	51	53	54	54	60	54	58	57
1,28		54	51	54	55	54	61	54	58	57
1,32		55	52	54	55	55	61	55	59	58
1,36		55	52	55	56	55	62	55	60	59
1,40		56	53	55	56	56	63	56	60	60
1,44		56	53	56	57	56		56	61	60
1,48		57	53	56	57	57		57	61	61
1,52		57	54	57	58	57		57	62	62
1,56		58	54	57	58	58		58	63	62
1,60		58	55	58	59	58		58		63
1,64		59	55	58	60	59		59		
1,68		59	55	59	60	59		59		
1,72		60	56	59	60	60		60		
1,76		61	57	60	61	60		60		
1,80		61	57	60	61	61		61		
1,84		62	57	61	62	61		61		
1,88		62	58	61	62	62		62		
1,92		63	58	61	63	62		62		
1,96			58	62		63		63		
2,00			59	62						
2,04			59	63						
2,08			60							
2,12			60							
2,16			61							
2,20			61							
2,24			61							
2,28			62							
2,32			62							
2,36			63							

APPENDIX F : VARIABLE CORRELATIONS (PATH CORRELATIONS) FOR
PREDICTORS OF CLINICAL PATHOLOGY IN PHASE II OF
THE RESEARCH

Variable	Variable				
	Coerc.	Pre-Op.	Durat.	Negat.	Stress
Pre-Op.	0,08 (0,04)				
Durat.	0,05 (0,01)	0,10 (0,07)			
Negat.	0,28 (0,26)	0,20 (0,16)	0,22 (0,20)		
Stress	0,11 (0,10)	0,05 (0,03)	0,04 (0,02)	0,11 (0,09)	
Clin.Pa.	0,09 (0,05)	0,02 (0,01)	0,09 (0,07)	0,16 (0,15)	0,31 (0,30)

Note. Coerc .= Physical coercion. Pre-Op. = Pre-operational level of development. Durat. = Duration of abuse. Negat. = Appraisals of negativity. Stress = Negative life stressors. Clin.Pa. = Clinical pathology.

APPENDIX G : VARIABLE CORRELATIONS (PATH CORRELATIONS) FOR
PREDICTORS OF SUPERIOR ADJUSTMENT IN PHASE II
OF THE RESEARCH

Variable	Variable						
	Punt.	Coer.	Dura.	Disc.	Betrl.	Stress	Help.
Coer.	0,09 (0,07)						
Dura.	0,10 (0,06)	0,06 (0,03)					
Disc.	-0,22 (-0,16)	0,11 (0,07)	0,03 (0,02)				
Betrl.	-0,05 (-0,03)	0,25 (0,22)	0,17 (0,14)	-0,24 (-0,22)			
Stress	0,10 (0,08)	0,10 (0,08)	0,02 (0,01)	-0,02 (-0,01)	-0,04 (-0,02)		
Help.	-0,22 (-0,18)	0,07 (0,05)	-0,04 (-0,01)	-0,10 (-0,06)	-0,11 (-0,09)	0,05 (0,02)	
Super.	-0,10 (-0,07)	-0,07 (-0,01)	-0,03 (-0,01)	0,11 (0,08)	-0,17 (-0,13)	-0,20 (-0,18)	0,16 (0,15)

Note. Punit. = Punitive parenting styles. Coer. = Physical coercion. Dura. = Duration of abuse. Disc. = Supportiveness of disclosure. Betrl. = Appraisals of betrayal. Stress = Negative life stressors. Help. = Helpfulness of social support. Super. = Superior Adjustment.

APPENDIX H : VARIABLE CORRELATIONS (PATH CORRELATIONS) FOR
PREDICTORS OF CLINICAL PATHOLOGY IN PHASE III
OF THE RESEARCH

Variable	Variable			
	Coerc.	Durat.	Ambiv.	Stress
Durat.	0,04 (0,01)			
Ambiv.	-0,35 (-0,28)	0,26 (0,21)		
Stress	0,02 (0,01)	0,03 (0,01)	0,06 (0,04)	
Clin.Pa.	0,10 (0,06)	0,09 (0,05)	0,19 (0,18)	0,24 (0,20)

Note. Coerc .= Verbal coercion. Durat. = Duration of abuse.
Ambiv. = Appraisals of ambivalence. Stress = Negative life
stressors. Clin.Pa. = Clinical pathology.

APPENDIX I : VARIABLE CORRELATIONS (PATH CORRELATIONS) FOR
PREDICTORS OF SUPERIOR ADJUSTMENT IN PHASE III
OF THE RESEARCH

Variable	Variable			
	Coer.	Ab.Age.	Betrl.	Stress
Ab.Age.	-0,04 (-0,02)			
Betrl.	-0,28 (-0,21)	0,22 (0,18)		
Stress.	-0,06 (-0,03)	0,03 (0,01)	0,01 (0,01)	
Super.	-0,09 (-0,05)	-0,04 (-0,01)	-0,20 (-0,18)	-0,25 (-0,22)

Note. Coer. = Physical coercion. Ab.Age. = Abuser's age.
Betrl. = Appraisals of betrayal. Stress = Negative life
stressors. Super. = Superior Adjustment.

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