

AN ABSTRACT OF THE THESIS OF

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James Firth, PhD

Research indicates that child sex abuse contributes to emotional and behavioral dysfunction in adult survivors. However, no one factor within the abuse experience has been found to independently affect adult functioning, and it is unclear if several factors acting together influence degree of dysfunction. This study compared the Global Assessment of Functioning (GAF) scores of 54 adult women survivors, who were clients of several counseling services, with their answers on a questionnaire about seven factors within the abuse experience. These factors were: the number of abusers, the relationship of abuser and abused, the age of the victim when first abused, the duration of the first abuse, the degree of coercion used by the first abuser, the degree of sexual intrusion during the first abuse, and if the child felt arousal during abuse by the first perpetrator. The results of this study tended to agree with the literature in that age of the victim and duration of the molestation experience affected adult functioning. Subjects who were very young (birth through age three) had lower scores, indicating

greater dysfunction, as did subjects who were abused for over five years by the first abuser. Disagreement with the literature was found in that whether or not a child felt arousal during the experiences was not found to be significant as to GAF scores. No significant differences were found as to: number of abusers, degree of coercion, type of sexual activity, or relationship of abuser and abused. Discriminate analysis of all seven variables indicated that further research into how these factors interact is needed, as when all seven variables were weighed, there was better than chance that GAF scores could be correctly predicted using the factors studied in this project.

The Effects of Childhood Molestation  
on the Functioning of Adult Survivors:  
Implications for the Disposition of Sex Abuse Cases.

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Mary Jane Dennis

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Redacted for Privacy

Chair of the Department of Counselor Education

Redacted for Privacy

Dean of the College of Education

Redacted for Privacy

Dean of the Graduate School

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Typed by Joyce Hibberts for

Mary Jane Dennis

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THE EFFECTS OF CHILDHOOD MOLESTATION  
ON THE FUNCTIONING OF ADULT SURVIVORS:  
IMPLICATIONS FOR THE DISPOSITION OF SEX ABUSE CASES

CHAPTER I

INTRODUCTION

This chapter presents a brief overview of the problem of childhood sexual abuse and explains the purpose of this research. It also outlines the questions which will be explored in the research presented in subsequent chapters. Definitions of terms in the text can be found in Appendix I.

The Problem

Even though the sexual use of children has historically been considered taboo, the taboo is frequently broken (Meiselman, 1979). When molestation does occur, victims often do not report it and it is inconsistently prosecuted and punished (Herman, 1986). Those who do reveal molestation as children often encounter additional trauma at the hands of the legal system (Hindman, 1989). Despite some victim's reluctance to report molestation, the number of reports steadily increases (Renvoize, 1982).

Childhood molestation is of concern to counselors, as research points to a connection between childhood sex abuse and mental, emotional, and behavioral dysfunction in survivors (Renvoize, 1982). Understanding the outcome of the molestation experience also seems problematic in the adjudication of molestation cases.

Legal authorities are often unsure as to how to determine which disposition is in the best interest of society and the victim of this crime (Renvoize, 1982).

Professional counselors are expected to make decisions about how best to help victims of childhood sexual abuse. They may be asked to act as witnesses during child abuse court cases. Counselors and court personnel may not be sophisticated about the effects of child abuse. Their decisions may be based on ignorance about how a complex group of factors may interrelate to cause mental and emotional distress in survivors of childhood molestation (Wald, 1976).

In order to aid counselors and court personnel in the decision making process, this research attempts to discover which, if any, of several previously researched variables are most predictive of the mental and emotional dysfunction found in survivors of molestation.

### The Outcome of Molestation

It is difficult to judge the effect of molestation on the majority of victims as most do not seek counseling. However, the literature does indicate that there is nearly always harm done (Renvoize, 1982). Due to differences in individuals and in the nature of childhood sexual abuse, long-term effects may vary (Shearer & Herbert, 1987). Evidence suggests that, as a group, molestation victims are vulnerable to a number of pathological developments in childhood and a considerable number may suffer lasting harm (Herman, 1981).

### The Child Victim

In some early studies, researchers doubted the negative results of child molestation. When Freud revised his original theory -- in which he considered incest as implemental in the pathological functioning of many of his patients -- he placed the blame for incest on the child victim's imagination (Herman & Herchman, 1977). He therefore minimized the child's view of the experience, as did Kinsey who later stated that incest was more in the minds of psychotherapists than in the real experiences of their clients. He wondered why a child would be disturbed by having her genitals fondled by an adult (Kinsey, 1948, 1953).

More recent work indicates that there are immediate negative reactions by child victims which include depression, anxiety, sexual acting out, and personality disturbance (Farina & Belohlavick, 1984; Mrazek, 1980). Other symptoms found in children survivors include: learning disabilities, somatic complaints, promiscuous behavior, masochistic-like search for punishment, and intense fear of abandonment (Kaufman, Peck & Taquiri, 1954; Mrazek & Kempe, 1981; Sgori, 1978). Teenage victims often act out with delinquency and by running away (Burgess & Holstrom, 1975; de Young, 1981; Sgori, 1975; van der Kolk, 1987), and women suffering from bulima often have histories of childhood sex abuse (Root & Fallon, 1988).

Presently there is little question that molestation can cause major trauma for the child victim (Gelinas, 1983). The effects are reported in emergency rooms of hospitals which regularly treat children suffering from the consequences of molestations and are described as being similar to those experienced by adult rape victims. The reported

results of sexual abuse in both groups are confusion, guilt, and an awareness of carrying a stigma (Burgess, Hartman, McCauland & Powers, 1984; Finkelhor, 1979). These children also feel psychological paralysis in that they feel overwhelmed and helpless (Gelinas, 1983).

There seems to be a progression of symptoms in children survivors as they go through developmental stages. In every developmental stage, sexually exploited children must deny reality in order to defend their sense of self. They project, interject, split, avoid, and distance so that the objective world is distorted. The understanding of the meaning of love, coercion, sex and aggression may become unclear to the victim (Klugman, 1987).

As molested children progress through developmental changes, their anger may push them toward acting out. In order to deal with their pain, they may become antisocial and self-destructive (Butler, 1978). This self-destruction may be due to children's tendency to split things into good or bad. In order to maintain the illusion of the "good parent" and, therefore, to feel psychologically safe and in control, they may embrace the "bad" persona as themselves (Courtois, 1988).

Molested children's internal self-view and their attempts to defend against the traumatic experiences may cause them to become emotionally disturbed. In a study of 250 abused children by de Francis (1968), 61% showed signs of emotional disturbance as a result of being molested, and 14% of these were judged to be severely disturbed. The greatest degree of disturbance was found in girls molested by a close relative. These children manifested disturbance by extreme guilt, feelings of inferiority and poor

self-esteem, anxiety, imitative ritualized sexual behavior, hostile aggression, and school phobia (de Francis, 1968). In another study of 65 children who were hospitalized for severe pathology, it was found that all of the children had been victims of molestation (Emslie & Rosenfeld, 1983).

If childhood pathology can be caused by molestation, is there a connection between a history of molestation and emotional problems in adult survivors? Some researchers question the connection. In one study, researchers found no evidence to show that prior reports of a specific relationship between a history of childhood molestation and adult psychosis existed; although a relationship between sex abuse and childhood psychosis was noted (Beck & van der Kolk, 1987). Confusion about the connection between molestation and psychosis can be explained by recent research which suggests that real psychotic disorders more than likely are caused by genetic factors rather than by the socialization process (DSM III-R, 1987). Additionally, what may appear to be psychotic symptoms in both children and adults may, in fact, be symptoms of Post-traumatic Stress Disorder (van der Kolk, 1987).

### The Adult Survivors

As with children, adult survivors of molestation who develop major mental illness may present confusing symptoms and are often classified among the most difficult to diagnose and treat (Bryer, Nelson, Miller, & Krol, 1987; Carmen, 1984; Gelinas, 1983; Herman & Herchman, 1981; Mills, Reiker & Carmen, 1984; Summit, 1981; Tiza, 1982). In a study by Bryer, et al (1987), it was found that symptoms and degree of dysfunction

can be used to aid in identifying patients who have histories of sex abuse as children. These findings may suggest that inpatient clients with a history of molestation differ as a group from non-abused patients. They are more often diagnosed as borderline psychotic, have more character disorder symptoms, are more suicidal, and are more often given psychotropic medication (Bryer, Nelson, Miller & Krol, 1987).

The most common group of psychotropic drugs given to adults is for the treatment of depression. Although it has been established that there is a genetic predisposition to depression (DSM III-R, 1987), a traumatic event may trigger or aggravate this underlying tendency. Fifty percent of depression in women may be triggered by the environmental effects of trauma (Brown & Harris, 1978). Due to childhood trauma, adult women survivors of incest may have been trained to be depressed in that they have learned to be helpless and selfless, to have no hope, and eventually to lose motivation for change and to suppress their emotions (Swink & Leveille, 1986). Thus, depression is a frequent symptom in adult molestation survivors (Briere & Runtz, 1985; Courtois, 1988). Indeed, studies have found that from 48% to 60% of incest survivors have been diagnosed as having a major depressive disorder (Brown & Harris, 1978; Herman, 1981; Meiselman, 1979).

Although depression may be the initial presentation of many survivors, it may be a secondary elaboration of untreated molestation. If the diagnostician looks past the original presentation and persists with in-depth assessment, the symptoms of Post-traumatic Stress Disorder may emerge. A closer look at the symptoms may present a similar pattern to the Viet Nam veteran and to victims of terrorism. As with war

veterans and terror victims, the survivors of incest also display a delayed presentation of symptoms which might explain why clinicians have found that these clients are often more difficult to diagnose and treat (Gclinas, 1983; van der Kolk, 1987).

Common to Post-traumatic Stress Disorder is a response to psychological injury by alternating between intrusive and numbing mechanisms. Intrusive responses include hyperactivity, aggression, startle response, pressing recollections and compulsive re-enactment of situations reminiscent of the trauma. The primary numbing defense most often is dissociation which may manifest by frequent and often unremembered nightmares or night terrors, amnesia (especially for childhood events), trance states, depersonalization, fainting spells, migraine headaches, non-organically caused seizures and multiple personalities (Briere & Runtz, 1985; Courtois, 1988; Ellenson, 1983).

Other dissociation related symptoms which may be frequently encountered are drug and alcohol abuse, anxiety attacks, feelings of fear or entrapment, phobic reactions to particular people and places, hyperventilation, and flashbacks (Briere & Runtz, 1985; Courtois, 1988; Ellenson, 1983). Also, survivors may desire to harm themselves and their children, have sudden sensations that their children are not their own, and that their own childhood happened to someone else (Ellenson, 1985). They also often experience problems with sexual functioning which may include intrusive re-experiences of molestation memories (or flashbacks) during their adult sex acts (Burgess, Hartman, & McCormack, 1987; Courtois, 1988).

### Research Focus

Such dysfunction in adults has been considered by some researchers to be caused by one or more factors which make up the incest experience. The most widely studied factors which have been thought to correlate with serious long-term effects are: the type of sexual activity engaged in, the length of time the activities occurred, the frequency of the acts, the occurrence of penetration, the degree of force used, the age of the child, the relationship of the participants, and the help or harm to the child of disclosure (Browne & Finkelhor, 1986; Hindman, 1989). The factors which have been found to independently contribute to victims' perceptions of long term effects are: the relationship between the offender and the victim, the severity of body violation, the degree of violence, the duration of the abuse, and the age difference between the participants (Herman, Russel & Trocki, 1986). However, in a recent literature review, no one of these factors was found to be consistently associated with worse outcome to the victim (Browne & Finkelhor, 1986).

A few studies suggest another area which might contribute to the knowledge about the molestation experience and how it may impact victims. This infrequently studied factor is whether the child victim felt any sexual arousal or pleasure during the molestation experiences. One study found that 87% of the severely disturbed girls felt pleasure or arousal during molestation in contrast to 31% who experienced violence, 42% who were penetrated, 60% who had more than five experiences, and 68% who were children under the age of eight years (Hindman, 1989). This is in contrast to an earlier study of non-clinical subjects of which only 8% reported feeling any pleasure

during childhood molestation experiences (Finkelhor, 1979). These two studies suggest that feeling sexual arousal or pleasure during molestation experiences may cause enough distress in victims to cause them to be referred to counseling services.

The research in this paper looks at some of the more often studied factors identified in the list of research questions below. Additionally, the possibility that the child's experience as to arousal or pleasure may also impact the adult functioning of survivors is assessed. It is hoped that the outcome of this research may help the courts, child protective services, and clinicians in understanding the impact of childhood sexual abuse experiences. The researcher compares molestation experience variables and the degree of dysfunction found in women clients of mental health program who have histories of childhood molestation.

#### Research Questions

1. Is the degree of dysfunction found in adult women survivors of childhood molestation, who are counseling clients, related to the number of persons who abused them?
2. Is the degree of dysfunction found in adult women survivors of childhood molestation, who are counseling clients, related to how closely child victims and perpetrators were related?

3. Is the degree of dysfunction found in adult women survivors of childhood molestation, who are counseling clients, related to the age child victims were when first abused?
  
4. Is the degree of dysfunction found in adult women survivors of childhood molestation, who are counseling clients, related to the length of time child victims endured sexual abuse?
  
5. Is the degree of dysfunction found in adult women survivors of childhood molestation, who are counseling clients, related to the degree of sexual intrusion experienced by child victims?
  
6. Is the degree of dysfunction found in adult women survivors of childhood molestation, who are counseling clients, related to how the child victim was convinced to participate in the sexual activity?
  
7. Is the degree of dysfunction found in adult women survivors of childhood molestation who are counseling clients, related to whether the child felt arousal during the sexual act/s?

## CHAPTER II

### REVIEW OF THE LITERATURE

#### The Taboo

Sexual activity with children has been forbidden in nearly every known culture. It has been banned by social tradition and authority, and there is an almost universal emotional aversion to the practice (Webster, 1949; American Heritage, 1982). The taboo forbids the sexual exploitation of children by persons who, by virtue of being older, have a great advantage over the child participant due to greater power and sexual knowledge (Finkelhor, 1979).

If incest was culturally allowed, it was usually restricted to certain group members at certain times for specific reasons. For example, in ancient Egypt brothers and sisters were encouraged to break the taboo in order to assure that the property and family lines of the elite remained intact. The same apologies for incest were given by the ruling families of old Hawaii and by the Inca society. In North American history, during the 1800s, the Mormons allowed incest in order to assure that children married into a religion with a small membership, and some African tribes allowed it within religious rituals (Meiselman, 1979).

Most of these incestuous events were between adults or between people considered to be adults by their societies. In more modern times, although incest seemed to frequently occur even between adults and children, it was rarely acknowledged (Meiselman, 1979). Child prostitution and incest were common in the Victorian era but were hidden under the stated taboo. Childhood is a new concept in most societies, and

children as a group have only recently been set apart in advanced societies. In the past, if a child was old enough to work -- around the age of eight -- she or he was considered to be an adult (Rush, 1977).

As late as the 1950s, the possibility that childhood molestation might cause the victim distress was minimized by Kinsey's studies of human sexuality. Although he found that the sexual use of children existed, he questioned its importance, perhaps due to a desire to protect the then prevailing social drive to reform sexual restrictions (Finkelhor, 1979).

Kinsey's attitude reflected Freud's famous change of mind. At first Freud accepted as true the complaints of his women clients that they had been sexually abused as children by adult relatives and concluded that there was a connection between incest and adult dysfunction (Rush, 1977). However, he later recanted this theory and stated that his client's allegations of incest were caused by their fantasies, not by their experiences (Rosenfeld, 1979).

Freud's later contention was challenged in the 1970s when the women's movement, and the growing child protection lobby, expressed their concerns about the prevalence of children reporting sexual abuse in the newly established rape crisis and battered women's shelters (Renvoize, 1982). Current feminist theory contends that incest is an outgrowth of a patriarchal power system which inflicts damage on all ages of females (Renvoize, 1982).

However, there are various theories from several disciplines which also attempt to understand the sexual use of children and of the taboo against the practice. For

instance, psychoanalytic theorists think that an innate, repressed desire for incest in children accounts for the intensity of the incest taboo as the ego's defense of reaction formation (Murdock, 1949). According to Renvoize (1982), who cites Murdock (1949), sociologists theorize that the incest taboo exists in order to prevent sexual jealousy and competition within the family in order to assure its primary role which is the socialization of children. They also suggest that the taboo may assure alliances between families through marriage and thereby spread customs and inventions throughout a culture, promoting cooperation and peaceful ties between groups (White, 1948). Even so, the taboo has frequently been broken. After all, early people's everyday lives were difficult and children's rights or emotional needs may not have been of great importance to their families (Renvoize, 1982).

Developmental theory sees the taboo as important in that the prohibition of sex with children may assure healthy personality formation and promotes the learning of interfamily roles which are vital to society (Parsons, 1954). There may be more primitive reasons for the banning of incest. Genetic theorists, according to Renvoize (1982), point out that children born of incest have higher rates of infant mortality and physical or mental handicaps than do children in the general population (Renvoize, 1982).

Biologists who study the natural selection processes, including adaptive physical and behavioral traits, determine that these processes are not dependent on awareness and are seldom mediated by insight (Segner & Collins, 1978). Due to primitive people's lack of understanding of how children were conceived, it might be questioned that genetic

considerations affected the early formation of the incest taboo (Renvoize, 1982). Indeed, incest avoidance may have been selected in the absence of awareness of the effects of inbreeding, but the effects of nuclear family inbreeding, although rare, are often dramatic and quickly recognized after birth. Some of these dramatic anomalies are albinism, dwarfism, and sensory loss (Segner & Collins, 1978).

Less dramatic results of incest, which may not have been consciously recognized by primitive people are increased infertility and less variable offspring. Variability in offspring increases the ability of a people to survive in changing environments and, along with increased fertility, may have assured the survival of groups who did not practice incest (Lindzey, 1967).

Whatever the reason, the taboo against incest seems to be very old and a deep abhorrence to it prevails in most societies (Meiselman, 1979). The truth about the taboo's function probably can be found in a combination of several explanations (Renvoize, 1982).

#### Intervention

Although frequently broken, the taboo against adults having sex with children remains in effect because all states in the United States legally recognizes that the molestation of children is a social problem and have designed intervention strategies to combat it, but there is no uniform reporting or intervention system between the states. Therefore, there are few national statistics on the extent of the problem. Each state differs as to the definition of incest and molestation and some do not differentiate child sexual or physical abuse or neglect in their figures (Renvoize, 1982).

In practice, most states recognize a spectrum of sexual offenses against children. Generally the most severe penalties for offenders are given for the violent sexual assault of very young children. Many states punish intercourse more harshly than other acts, even though there is conflicting research as to whether any type of sex act, or the age of the child, portends more damage to the victim (Herman, 1981; Hindman, 1989).

In child sexual abuse cases, the legal system tends to focus on punishing the offender, using a rather subjective criteria in determining the seriousness of the crime, rather than on the realities of the child's trauma and the resulting damage to the victim. If the offender is prosecuted, the punishment may vary radically (Herman, 1986).

For instance, in Alaska, the penetration of a child under the age of 13 years may bring a maximum sentence of 20 years while molestation without penetration may bring only a five year sentence. In Kentucky, intercourse with a child under the age of 12 years is considered first degree rape and carries a 10 to 20 year sentence, but in the same state, there is a one to five year sentence for third degree rape if the child is aged 13 to 16 years old. In Mississippi, if the victim is under 12 years old, and there is penetration, the offender may get a life sentence or even the death penalty, but, if the victim is a teenage there may be only a \$500 fine and six month jail sentence imposed. Mississippi is not the only state which can execute a child molester. Florida and Oklahoma also can impose this sentence, and 17 states can sentence a perpetrator to life imprisonment. Although these punishments can be imposed, in most states as late as 1986, it was rare that an incest perpetrator was either prosecuted or punished (Herman, 1986).

Many children fail to report molestation to authorities (DeFrancis, 1968; Giarretto, 1978; Herman, 1981). It has been estimated that as few as three in 27,000 cases of molestation are reported (Talaso, 1981). In a survey of 1,200 college students, 26% reported childhood molestation to the researcher. Only 5% of those reporting a history of molestation had ever told any person in authority prior to this study, and 21% had previously told no one (Finkelhor, 1979).

Those who did not tell may have made a healthy choice because disclosure can be traumatic to a child (Armstrong, 1978; Finkelhor, 1979). In a recent study, the researcher found that 100% of severely disturbed subjects with molestation histories reported disastrous results from revealing their incest experiences. Of the less severely disturbed subjects, 79% had never reported their experiences, and of those who did, 21% reported immediate traumatizing experiences after telling (Hindman, 1989).

Other studies have discovered similar disastrous outcomes due to the revelation of molestation (Butler, 1978; Renvoize, 1982; Summit, 1981). One reason that victims may feel exposure of the secret of molestation to be traumatic may be the revictimization some experience at the hands of the legal system. If the allegation is investigated at all, the victim most often faces repeated interrogation first by an investigating police officer or social worker; then, in many cases, the child is next questioned and examined by a physician. Later on, there is a preliminary hearing and discussions with lawyers. Finally, there is a court hearing which may be open to the public which involves cross-examination about the details of the sexual events and the truthfulness of the child's recollections (Butler, 1978; Herman, 1981; Renvoize, 1982).

Compounding the trauma of these events, the child is often removed from the home and may remain in foster care for a year or more. Therefore, the child's original confusion about what her or his role was in the sexual experiences is reinforced. The tendency to blame herself or himself for the molestation is compounded by what may be perceived to be punishment by the court system (Butler, 1978; Herman, 1981; Renvoize, 1982).

Yet, the reporting of molestation has risen greatly in the past 20 years. This may be due to better public education, stricter reporting laws, or an increase in the activity itself. Professionals are aware of the legal obligation to report and, due to better education about the subject of child abuse, are more apt to enquire about molestation when interviewing clients. Schools frequently offer lessons about molestation in the classroom while the media offers on-going information about the problem (Renvoize, 1982).

Some new research suggests that the rise in the reporting of molestation may reflect a real growth in the problem, and it is suspected that the rising divorce rate may be contributory, as incest may be more often perpetrated by stepfather figures than by natural fathers. Renvoize (1982) suggests that stepfathers abuse more often due to not having the inhibitions that the bonding process gives to most birth fathers (Renvoize, 1982).

More liberal divorce laws and available financial aid for single mothers and children may allow mothers to more easily leave abusing men and, therefore, to more safely report a perpetrator to the authorities (Renvoize, 1982). For whatever reason, the

estimates of the number of children who are victims of molestation has risen from one in one million in the 1950s (Hussain & Chapel, 1983; Rosenfeld, 1979), to anywhere from 9% to 40% of all girls in more recent research (Beck & van der Kolk, 1987; Finkelhor, 1979; Herman, Russell & Trocki, 1986; Shearer & Herbert, 1987; Swanson & Biaggio, 1985; Swink & Leveille, 1986).

Some researchers report that 50% to 80% of reported sex abuse is perpetrated by members of the child's immediate family, and 75% of these victim's report abuse by their fathers (Butler, 1978). Extensive research shows that 20% of all girls have had at least one molestation experience (Russell, 1986). These figures are of concern as research suggests that molestation experiences may often result in dysfunction in survivors. Some research suggest that between 20% and 44% of all psychiatric and counseling clients were victims of sex abuse as children (Briere, 1985; Emslie & Rosenfeld, 1983; Gelinas, 1983; Herman, 1981; Meiselman, 1979).

The indication that molestation experiences may engender the need for counseling is consistently found in studies of revictimization behavior in mental health clients. For instance, there are high incidents of incest histories in the childhood of battered women (Swanson & Biaggio, 1985) and in 35% of rape victims (Herman & Herchman, 1981). Also, studies of self-destructive behavior in psychiatric clients indicate that up to 44% of drug-addicted women have molestation histories (Benward & Densen-Geber, 1973; Emslie & Rosefeld, 1983) and 29% of bulimic women have been sexually abused as children (Root & Fallon, 1988). Additionally, runaway children report high rates of incest in their backgrounds (L.A. Institute, 1976; Courtois, 1988), and 51% to 75% of

prostitutes report such abuse (Emslie & Rosenfeld, 1983; Flugel, 1926).

### The Molestation Experience

Some researchers contend that victims of incest, in contrast to victims of stranger molestation, are captives in the family wherein they are trapped due to dependency and an inability to escape from their environment. Such abuse may be of longer duration and frequency than abuse in an extrafamilial situation and may involve closer relationships and a large age difference between the victim and the offender. Also, the sexual behavior experienced by incest victims may be more serious and may more often include intercourse. It may also include more force and more frequent involvement with multiple abusers. Additionally, victims of incest seem to be more vulnerable to subsequent abuse by persons not related to them (Herman, 1981; Russell, 1986).

These factors may be related to greater trauma experienced by the survivors of incest. For instance, Walsh (1986) found that the younger the child at the onset of the abuse, the more likely that he or she would be molested by others. Also, if the molestation experiences occurred more frequently and lasted longer and included more deviant acts, then, it was likely that there was more trauma experienced by the victim (Walsh, 1986). In another study, it was found that there was a correlation between high level of trauma and duration of the abuse and multiple abusers (Russell, 1986). These factors, addressed in the following research review, may be predictive of the molestation survivor's future emotional and mental functioning.

### Area One: Number of Abusers

A substantial proportion of incest survivors have been victimized by multiple members of their nuclear and/or extended family (Courtois, 1982; Russell, 1986; Walsh, 1986). It seems that children who are victims of incest may be more vulnerable to multiple molestation than children molested by extrafamily abusers because of their dependent relationships within the family (Russell, 1986). In 1984, Mills found that 41% of 181 psychiatric patients who had a history of molestation were abused by more than one person (Mills, Reiker, & Carmen, 1984), and Meiselman (1979) found that 30% of her subjects were sexually involved with more than one family member. She also found cases where teen-aged girls were molested by stepfathers years after being involved in incest with their natural fathers (Meiselman, 1979).

Recent studies support the above research. Gold (1986) discussed 103 women survivors' reports of 191 abuse experiences with different offenders. Fifty-two of these subjects reported abuse by family members. In this study, the number of offenders per victim ranged from one to five (Gold, 1986). Bryer (1987) reported that 29 subjects were abused by 37 perpetrators (Bryer, Nelson, Miller, & Krol, 1987).

However, revictimization is not exclusive within the family. Herman (1981) cited work at the Rape Crisis Center in Albuquerque, New Mexico, which reported that 18% of teen and adult rape victims who had been raped more than once were past victims of incest. She also cited work at the Rape Relief Group in Tacoma, Washington, where it was estimated that 35% of teen and adult rape victims were survivors of incest as well (Herman, 1981).

### Area Two: Relationship of Abuser and Abused

Research has found that 75% of all reported sexual abuse of children is committed by someone the victim knows and trusts. Often, that someone is a member of the victim's immediate family (Butler, 1978). A study of 103 women sexually victimized as children reported that 51.3% of the time the perpetrators were known to the victims, 36.3% of the time the offender was a family member, and 12.2% of the offenders were strangers (Gold, 1986). In a study of a non-clinical population, Finkelhor (1979) found that of the subjects reporting having been molested as children, 43% of the women were molested by a family member while 33% were molested by family friends. Strangers accounted for 24% of the molestations. Of the women reporting molestation by family members, 50% were abused by immediate family members, and 41.8% of them were molested by in-laws or close family friends. Only 1% of all of these victims were molested by a natural father while 29% were molested by a stepfather (Finkelhor, 1979).

In an earlier study by Mulvehill (1969), it was found that 30% of offenders were related to victims and 45% were family friends (Mulvehill, 1969). Other research results found that, especially for girls, the offender was most often a family member (Butler, 1978; Hussain & Chapel, 1983; Mills, Reiker & Carmen, 1984; Russell, 1986). In summary, most research suggests that the majority of sexual abuse of children occurs within the child's support system.

#### Fathers and Stepfathers as Abusers

Russell (1986) estimated that 28% of all girls may have been sexually exploited by

the age of 14 and that 4.50% of all girls have had incest relationships with their fathers or stepfathers (Russell, 1986). In that same year, Mills (1986) reported that 40% of all sexually assaulted girls are abused by a father or stepfather and that 34% of hospitalized psychiatric patients, who were women with a history of sexual abuse, were abused by a father or stepfather (Mills, Reiker & Carmen, 1984). Many studies of incest indicate that abuse by a father or stepfather has a more negative effect on a child than abuse by other perpetrators (Browne & Finkelhor, 1986).

The above studies do not differentiate between father and stepfather perpetrated molestation. However, some other researchers have separated natural father abuse from stepfather abuse. One such study by Meiselman (1979) found that stepfathers were less likely to molest than were natural fathers (Meiselman, 1979). However, most other studies contend that stepfathers are more likely to sexually use the children of their wives than are the children's natural fathers (Finkelhor, 1980; Renvoize, 1982).

Indeed, in a study by Finkelhor (1980), it was found that stepfathers were five times as likely to sexually abuse than were the children's natural fathers (Finkelhor, 1980). Russell (1986) suggested that stepfather-stepdaughter incest happens more often than does father-daughter incest because pedophiles often purposefully marry women with children in order to have ready access to sexual objects of the preferred age. She also suggested that pedophiles and other stepfathers are more apt to abuse stepchildren due to the lack of early bonding with children which may inhibit such behavior by natural fathers (Russell, 1986). In any event, whether by a natural father or a stepfather, abuse by a parental figure may be associated with more serious sequela than

abuse by other persons in or out of the family (Herman, Russell & Trocki, 1986).

### Siblings as Abusers

Although father-daughter (or stepfather-stepdaughter) incest is reported more often, brother-sister incest has in the past been considered the most common type of incestuous activity (Finkelhor, 1979). In Finkelhor's study of a non-clinical population, he found that sibling incest usually occurs between a young child, often between the ages of eight and eleven years, and a teen-aged sibling. His study suggests that most incest in the general population is between siblings, as he found that 37% of college women and 19.5% of college men reporting incest were abused by older brothers while 9.3% of women and 20.8% of men said they were abused by an older sister (Finkelhor, 1979).

Other studies suggest that sibling incest is rarer than adult perpetrated abuse. For instance, Mills found that only 16% of subjects reported sibling incest, and Tsai and Wagner reported only 8.5% of the 118 women survivors they studied were molested by a sibling (Mills, Reiker & Carmen, 1984; Tsai & Wagner, 1979). Meiselman also found sibling incest to not be as prevalent as father or stepfather incest in her study of childhood molestation (Meiselman, 1979).

The findings of Finkelhor's (1979) research may have been influenced by the population he studied, a non-clinical group of college students. Clinical subjects may show another pattern as perpetrators of sibling incest may be less disturbed than victims of father figure perpetrators who may be more often mentally, emotionally, or behaviorally disturbed (Kubo, 1979; Santiago, 1973; Weinberg, 1976). In contrast, the

teen-aged perpetrator may be simply acting out his or her inability to satisfy sexual needs with peers (Hussain & Chapel, 1983). In general, research indicates that children who are molested by their siblings seem to suffer less trauma than do children who are molested by parent figures (Meiselman, 1979).

#### Mothers as Abusers

Mother-perpetrated molestation of children seems to be quite rare (Renvoize, 1982). The highest incidence of molestation by a family member is by a father or a stepfather, then by a brother, then by other relatives, and lastly by a mother (Swink & Leveille, 1986). Mother-caused molestation is found so rarely in research that Herman placed it in the 'other relative' category which accounted for only 6% of all molestations in her extensive study of both clinical and community subjects (Herman & van der Kolk, 1987). In support of the contention that sexual abuse by a mother is rare in the general population, Tsai found that only 1.6% of her subjects were molested by a mother in contrast to 17.5% reporting molestation by a brother and 31.7% reporting molestation by a father (Tsai & Wagner, 1978).

In a study of non-clinical subjects, Finkelhor found that mothers were involved in only 5% of all cases of molestation reported by college students. All such reports involved girl victims only (Finkelhor, 1979). In contrast to the above study, Russell found that 20% of boys were molested by their mothers in contrast to 5% of girls (Russell, 1986). In a study of women psychiatric patients, 23% of the victims of molestation were sexually involved with their mothers (Mills, Reiker & Carmen, 1984).

One researcher has suggested that women who molest children cause less trauma

due to a shorter duration of abuse and less severe type of abuse (Russell, 1986). The rare woman who does molest a child has been found to be most often mentally, emotionally, or behaviorally disturbed. She also is most often the parent of an only male child (Goodwin & De Vasto, 1979). In one study, it was found that in mother and son incest a teen-aged son most often initiated the sexual relationship. These sons were found to be either psychotic or otherwise severely disturbed. Although the mothers were not psychotic in these cases, they did have a history of promiscuity and were without conventional sexual partners. In most cases, the mother and son had not lived together throughout his childhood, only meeting when he was an adolescent or adult (Meiselman, 1979).

It seems that most studies have found that mother-perpetrated molestation is a rare event when compared to molestation instigated by other family members. However, it is suggested that molestation by a mother may cause greater psychological difficulty for the survivor than other types of reported familial molestation.

#### Grandfathers as Abusers

Although more common than mother-child molestation, grandfather-perpetrated sex abuse may also be rare. In non-clinical subjects, it was found that of 194 women respondents, only one subject reported being molested by a grandfather while no male subject reported such abuse (Finkelhor, 1979). However, research of clinical subjects found that grandfather initiated incest comprised from 6% to 11% of all reported incest (Courtois & Hindley, 1981; Goodwin, Cormier & Owen, 1983; Herman, 1986; Meiselman, 1979; Russell, 1986; Tsai & Wagner, 1978).

### Uncles as Abusers

Non-clinical college student subjects reported a higher incidence of child abuse by uncles than by grandfathers in that 16 of 194 women respondents said that they were abused by their uncles (Finkelhor, 1979). However, other researchers found that subjects drawn from the community reported more incest with an uncle than with any other family member (Meiselman, 1979).

The above researcher theorized that these subjects were not disturbed enough by the molestation to seek treatment due to not being raised by the abusers (Meiselman, 1979). The research of clinical subjects shows that of those involved in psychotherapy, 11% reported being abused by an uncle (Herman, 1986; Tsai & Wagner, 1978).

It appears that uncle perpetrated molestation may not be as rare as mother or grandfather abuse and not as pervasive as abuse by other family members. Also, this incest relationship may not cause as much emotional damage due to lesser attachment between the victim and the abuser.

### Other Family Members as Abusers

Due to the apparent rarity of sex abuse by a relative other than a mother, father, stepfather, grandfather, sibling, or uncle, research often fails to differentiate as to which other relative may be an abuser. One study that did so was Finkelhor's (1979) research of college students' experiences with sexual abuse. He found that none of the 194 women respondents reported abuse by an aunt and only one of the 77 men respondents reported such abuse. Only five of the women, and none of the men, reported abuse by a brother-in-law. However, he found that 16 of the women and 33 of the men were

abused by an older female cousin, and 48 of the women and 9 of the men had been molested by a male cousin.

#### Friends, Strangers, and Others as Abusers

It has been suggested that the relationship between victims and perpetrators of childhood sex abuse may be related to the degree of emotional and mental harm to survivors. Strangers and friends who engage a child in sex acts are thought to cause less lasting harm than primary caretakers who instigate the same acts (Herman, 1986). In a clinical study, it was found that victims of sex abuse by a non-family member stayed in psychiatric hospital care for a shorter time than did incest victims. The average length of stay in the hospital was 54.3 days for victims of non-family members in contrast to 69.8 days for incest victims. Also, patient self-destructive behavior was 15% higher for incest victims than for victims of non-family molestation (Mills, Reiker & Carmen, 1984).

According to Butler (1978), 75% of all sex offenders are known to the victim or to their families, and 50% of these offenders are not family members. Forty-five percent of these offenders may be family friends or neighbors (Gebhard, 1965; Mulvehill, 1969). In Finkelhor's (1979) study of non-clinical subjects, it was found that 33% of women subjects reported being molested by family friends and 24% reported being abused by strangers. Other investigations of non-clinical subjects' molestation experiences found that from 25% to 57% related being abused by persons other than family members (Butler, 1978; Gebhard, 1965; Mulvehill, 1969).

Researchers who studied hospitalized populations found similar patterns in that

from 19% to 48% of their subjects reported abuse by strangers, family friends, and other non-family members (Bryer, Nelson, Miller & Krol, 1987; Emslie & Rosenfeld, 1983; Mills, Reiker & Carmen, 1984; Tsai & Wagner, 1978). The above research is unclear as to which population is most harmed by sex abuse by persons not related to them. It does, however, suggest that incest may be more debilitating than extra familial molestation.

### Area Three: The Age of the Victim

Sexual abuse of children can begin at any age. Victims as young as four months old have been recorded in clinical settings (Gelinas, 1983). However, most research shows that sex abuse usually begins between the ages of four and 12 years (Mac Farlane, 1978), and that a child is at greatest risk when she is between the ages of seven and 12 years old (Courtois, 1988). Usually by age 14 or 15, the abuse ends -- often when the child tells, threatens to tell, or runs away from home (Gelinas, 1983). Mac Farlane (1978) found the following:

It is easy to gain the compliance of a young child by misrepresenting sex as affection or training, by threats and bribes, and by exploiting the child's loyalty, need for affection, desire to please, and especially trust of the parent. Most children are not even aware of what the activity is that is demanded, and only gradually realize by age ten or eleven that things are not as they should be. (pp. 313-314)

Compliance is easily gained due to the children's innocence. At the age when sex abuse commonly starts, most children have very little idea of sexual anatomy and do not understand adult sexual behavior. Also, children, prior to the age of eight, may not be able to tell the difference between fact and fantasy so may not believe their own perceptions of what is happening. Between eight and 12 years, they can understand the

difference between fantasy and fact but may be unclear as to the meaning of the sexual activity expected or the words used to describe the acts (Renvoize, 1982).

They also cannot as yet comprehend the importance of the acts they are encouraged or forced to perform. They have no concept as to what their feelings will be about their experiences in the future. Due to lack of sophistication, they may not clearly understand the importance of the social pressures that they may have to endure if they let the secret be known. It is impossible for them to deny the adult. Even if the abuser is kind and does not use force, they are at risk for difficulty in adulthood due to interference with their normal developmental processes (Russell, 1986).

Research suggests that there is an impact on children's normal development depending on their ages when sexual abuse occurs. Bowlby (1984) thought that abused children had an heightened sense of vulnerability. This vulnerability may, according to Trankel (1958) be due to being new to the vocabulary and gestures of sex, so that the child may misinterpret sexual actions and intentions on the part of others. How can a four-year-old child who has just learned the habits of cleanliness accept the fact that an adult has just put his penis in her mouth (Renvoize, 1982)?

Events such as the above might profoundly affect the normal development of children. For instance, Gelinias (1983) thought that some parts of the survivor's personality could be over developed in that there might be an exaggeration of her or his care-taking function and sense of responsibility at the expense of other parts of him or herself such as personal esteem, social skills, and talents.

Such imbalances may result in emotional distress in many survivors. Bryer and Nelson (1987), who studied patients in a mental hospital, found a correlation between sexual abuse at a young age and severe mental disorder, as measured by the Global Assessment Scale (GAS). They also found that 82% of adult patients who had histories of sexual abuse as children required medication while only 52% of patients with no such history required medication for mental or emotional distress.

The severity of mental or emotional distress in psychiatric patients may be connected to the age a child was at the time she was sexually abused. Beck and van der Kolk (1987) in a study of 205 women psychiatric clients found that 46% of their subjects had a history of sexual abuse and that the worst outcome was for the patients who had been abused as young children.

Several studies have tabulated the age at which girls most commonly have their first experience with molestation. A British study found that pre-adolescents were more prone to abuse than girls of other ages (Queen's Bench Foundation, 1976). This finding was replicated by Russell (1986), who found that 11% of sexual abuse victims were first abused prior to age five, 19% between ages six and nine, 41% between ages 10 and 13, and 29% between ages 14 and 17. Other studies which show similar findings include one by Finkelhor (1979), who surveyed college students and found that of women students reporting sexual abuse as children, 14% were first abused from ages four to six years, 23% were first abused between ages seven and nine years, 47% between 10 and 12 years, and 16% between the ages of 13 and 16 years.

When the Harborview Hospital's sexual Assault Program reviewed the records of

their child clients, they found that 22% of the girls were abused for the first time prior to the age of six years, 40% from ages six to 12 years, and 38% between the ages of 13 and 16 years (Harborview, 1980). Another study found that 10% of the women subjects were first molested before the age of five years, 12.5% between the ages of five and six, 12% between the ages of seven and eight, 22.5% between ages nine and 10, 10% between 11 and 12 years, and 20% were 13 years and older. Five percent were unsure as to the age when the abuse began (Herman, 1986).

A 1985 paper citing both Finkelhor (1979) and Goodwin (1982) found in a literature search that sexual abuse most often begins between eight and 12 years of age (Swanson & Biaggio, 1985). In a study of 437 girls who were victims of sexual abuse, it was found that the mean age at onset of the abuse was 10.2 years (Hussain & Chapel, 1983).

Another study found that onset of abuse was most often from two to 16 years with the mean age being 9.4 years (Gold, 1986). And others discovered that the mean age of the onset of sexual abuse was 8.2 years in a clinical group and 11.2 years in a non-clinical group of women reporting childhood abuse (Herman, Russell & Trocki, 1986). This may indicate that abuse occurring at an early age may contribute to enough mental and emotional distress to cause survivors to seek counseling for their problems.

In summary, children can be sexually abused at any age, but they may be at greatest risk when they are between the ages of eight and twelve years. Some research suggests that the worst outcome for victims of sex abuse is connected to early childhood experiences. These experiences, which the child has difficulty understanding and

accommodating into normal development of the self, may traumatize the child so much that she grows into an adult with serious emotional and relational problems.

#### Area Four: Duration of Sexual Abuse

Most survivors of childhood sexual abuse have not been exposed to a single, overwhelming event; rather, they may have experienced many sexual acts over a long period of time which more than likely affected different developmental stages (Goodwin, 1985). The long duration of some incest is often interpreted as evidence of the child's cooperation with the sexual activity (Swanson & Biaggio, 1985).

This position fails to appreciate children's basic dependency which makes them highly vulnerable to persuasion, coercion, and intimidation (Swanson & Biaggio, 1985). Not only are children victimized by incest, they are also often reduced to emotional and physical dependency on the abusers (Herman & van der Kolk, 1987).

Such dependency may develop and intensify over time. In 1979, Meiselman found that 53% of her subjects had been abused for over one year, and Russell (1986) found that the average duration of incest for her subjects was for four years. In contrast, extrafamilial sexual abuse was usually of short duration and without progression in severity of sexuality. Other research has found that sex in incest occurs more often, lasts longer, includes more deviant acts, and is more traumatic than extra-family sexual abuse (Walsh, 1986).

There are exceptions to the above findings, as some types of extra-family molestations are also long term and cumulative in effect. In a longitudinal study of 34 children survivors of a child pornography ring, which compared duration of abuse to

later delinquency and drug abuse, it was found that cumulative trauma added to the psychological problems in child victims of extra-family abuse (Burgess, Hartman & McCormack, 1987). However, in most cases, abuse by a parent figure was more forceful and more prolonged with more serious repercussions than was abuse by a non-family member (Herman, 1981).

Sexual abuse seems to rob children of developmentally determined control over their own bodies and the right to their own preferences. This is so regardless of whether children have to deal with a single overt and perhaps violent act or with continuous intrusions which may last for years and may be tender, insidious, or coercive (Kempc, 1978).

In a 1978 study of 50 incest survivors, it was found that the average length of time a child was abused was from four to six years (Tsai & Wagner, 1978). In 1979, another study, at a sexual assault treatment center, it was found that in 17% of incest cases the child was abused only once, 24% for less than six months, 19% for six months to one year, 31% for one to five years, and 9% for more than five years (Gelinas, 1983).

In 1,100 cases of incest researched by Butler (1978), 41% of the child subjects were abused for at least seven years. In a study of university students' childhood molestation experiences it was found that 60% of the young women reported one isolated experience of abuse while 40% reported being abused more than one time. Of the group reporting more than one incidence of abuse, 40% reported abuse over a period

of more than one week with the average duration being 31 weeks (Finkelhor, 1979). Incest and extra-family molestation were not differentiated in these figures and the subjects, taken from a non-clinical population, can be assumed not to have been severely emotionally disturbed.

Meiselman (1979) found that the sexual molestation of 255 of her subject was of short duration. When these cases were withdrawn from the study, it was found that 75% of the remaining cases of abuse lasted on the average of three-and-one-half years. Other researchers substantiate that the length of time a child may endure sexual abuse can be from one time only to over seven years (Butler, 1978; Courtois, 1988; Finkelhor, 1979; Gebhard, 1965; Harborview, 1980; Herman, 1981; Summit, 1981; van der Kolk, 1987).

The results of long term sexual abuse may also be of long duration. Beck and van der Kolk (1987) found that in hospitalized survivors of such abuse, early, long-lasting, and violent sex abuse by a primary care giver caused the worst outcome. The client sample had experienced abuse for time periods lasting from one to nine years. Another study of 188 women hospitalized for emotional and mental problems found a correlation between length of hospital stay and the length of sexual abuse, type of abuse, and the relationship between the abused and the abuser. Survivors showed impairment in self-esteem as compared to matched controls, and if the abuse was prolonged or forced, the effects were especially noxious (Swanson & Biaggio, 1985).

#### Area Five: Type of Sexual Activity

Children who are sexually abused have been found to experience all of the sexual acts that are experienced by adults (Farina & Belohlavic, 1984; Gelinis, 1983; Meiselman, 1979). Incestuous abuse, in contrast to molestation by a non-family member, may be more serious and more likely include penetration and greater force, because the child is dependent on the abuser and is captive in the abusive situation (Russell, 1986).

The dependent child is likely to be young when the abuse begins and is more likely to be subject to frequent and more deviant sex acts for a longer period of time than other victims of molestation (Walsh, 1986). The first acts of abuse with a very young child are often covert in nature. A child of two years old may be touched or fondled so unobtrusively that she or he is not aware that anything special is happening (Renvoize, 1982). This young child is often the victim of progression through a series of acts due to her or his constant availability, compliant stance, and the misrepresentation of the sex acts as affection or training (Gelinis, 1983; Meiselman, 1979; Weinberg, 1976).

The common progression of molestation may include adult nudity and disrobing in front of the child, and adult exposing his or her genitals, observing the child in compromising situations, kissing the child in an erotic manner, fondling the child and forcing the child to fondle him or her, fellatio, cunnilingus, finger penetration of the child's anus or vagina, penile penetration of the child's anus or vagina, and may culminate in forced intercourse (Sgori, Brick & Porter, 1982). However, sexual intercourse with the child has been found to be rare in most sexual abuse cases

(Berlinger & Stevens, 1979; Finkelhor, 1979; Tsai, Feldmand-Summers & Edgar, 1979).

The above progression is often less gradual in the case of incest which begins when the child is pubescent and in the case of extra-family molestation of older children. In these cases, intercourse may be quickly instigated and may be more forceful than with a younger child (Courtois, 1988).

Perhaps due to a reluctance of victims to talk of the intimate details of sex abuse, the available research into the types of sexual acts children encounter when molested is limited. One study which has documented a variety of types of sexual behavior molestation victims experience found that of subjects molested outside of the family 59% reported oral-genital contact, 12% reported penetration, 10% were forced into masturbation activities, and 3% experienced several types of sexual behavior (Mills, Ricker & Carmen, 1984).

In contrast, when molestation occurred within a family, 8% of subjects reported purely oral-genital contact, 23% were forced into masturbation acts, and 31% experienced a variety of sex acts (Harborview, 1980). These findings seem to suggest that incest includes a greater variety of sex acts and a greater degree of intrusion by the abusers than does molestation by a person outside of the family. Several early researchers have documented oral-genital contact between adults and children. The rate of such contact among victims ranged from 40% to 20% according to findings of early research projects (Gebhard, 1965; Meiselman, 1979; Weiner, 1962).

In a study of incarcerated men who were sex offenders, 39% of the offenders reported having oral-genital sex with girls under the age of 12 years. The same men

reported that they had genital intercourse with young girls. Nine percent reported this act with children under 12 years old, 72% with girls aged 12 to 16 years old, and 91% reported having intercourse with girls 16 years and older (Gebhard, 1965).

There is some disagreement in the literature as to which type of sexual experience is most damaging to the victim of sexual abuse. For instance, some researchers contend that mutual genital contact of any kind seems to have more serious psychological consequence for the victim (Browne & Finkelhor, 1986; Courtois, 1988; Russell, 1986). However, another researcher contends that, "...intercourse is only half the story. Anyone working in this field will soon discover that any number of acts may be committed which are at least as traumatic to the victim as full intercourse" (Renvoize, 1982, p. 126).

The trauma inflicted on the victim is not necessarily related to the actual activity. Six episodes of cunnilingus do not equal one act of intercourse. On the contrary, a child who's father does nothing more than continuously expose himself to her in a deliberate sexual manner all through childhood may well be more damaged than an adolescent who experiences a brief period when forced intercourse takes place between her and her father (Renvoize, 1982, p. 126).

#### Area Six: Enticement to Participation

Most sex abuse does not involve violence but does involve coercion and misrepresentation of the relationship and the activity. Children involved sexually with adults may be said to be unable to give informed consent due to immaturity, dependency, powerlessness, and in the case of incest, being a captive in the family (Courtois, 1988; Peters, 1976; Russell, 1986). These children's basic dependence makes them highly vulnerable to persuasion, coercion, and intimidation. They may remain

passive due to fear (Herman & Herchman, 1977; Ricmer, 1979). They are in a double-bind as there is an enforcement rule and a paradox that cannot be openly discussed. The victims of familial sexual abuse are placed in the position of forced silence, which may intensify the trauma they experiences (Speigel, 1986).

These children, whether victims of incest or of other molestation, are afraid of the consequences of telling someone about their situations, as the perpetrators may often use threats to insure their silence (Maisch, 1972). They are also often victims of the abuse of power by trusted adults (Tsai, 1978). However, children of incest may be in more serious positions. they live in families which most often give the appearance of normalcy. Under these unremarkable appearances are typically rigid patriarchies with fathers who may maintain dominance through threats or violence (Herman & Herchman, 1977). There often is an aura of violence in these families which insures compliance by all family members (de Young, 1982). The fathers in these families are often authoritative and take what they want, no matter how gently (Renvoize, 1982). The amount of coercion and force used against the victim may be more traumatic than the choice of the sex act (Renvoize, 1982; Burgess, 1978), and as the child ages, force tends to be increasingly used to gain compliance (Gelinas, 1983).

The degree of trauma associated with all molestation seems to be partly dependent on the degree of coercion or force used by the abuser to insure compliance (Browne & Finkelhor, 1986; Courtois, 1981; Eth, 1985; Finkelhor, 1980; Herman, Russell & Trocki, 1986; Rosenfeld, 1979). The degree of emotional distress connected with forceful sexual abuse may be connected to the fear engendered in the child. Finkelhor (1979)

found that 58% of abused children experienced fear and 26% experienced shock. The greater the force used, the more profound was the emotional reaction.

The fear and shock experienced by the victims of sexual abuse might be said to be based on a realistic assessment of the situation. Although most children do not suffer physical trauma due to being molested, some do. The documented physical trauma to children of abuse include trauma to the mouth, genitals, urethral and rectal areas. Such traumas cited in reports are: lacerations, tears, bruises, abdominal swelling or dilation, objects inserted into body cavities, problems with urination or defecation, venereal disease, and pregnancy (Russell, 1986).

Psychosomatic illnesses observed in survivors of molestation include gastrointestinal disturbance or pain, gagging, nausea, eating disorders, stomach aches, headaches, sleep disturbances, and anxiety or panic attacks (Russell, 1986). However, a medical examination cannot detect sex abuse in the eyes of the court, unless there has been violent penetration. Therefore, many cases go untreated or undetected, and often uninvestigated, due to lack of legally acceptable physical evidence (Harborview, 1980).

#### Area Seven: Victim's Sexual Arousal or Pleasure

Variables associated with the molestation victim's arousal response to the abuse have rarely been investigated (Gold, 1986). In a study of non-clinical adult survivors who reported their immediate reaction to incest, only 8% reported feeling pleasure during the experience (Finkelhor, 1979). Even in research committed to gaining a positive view of child sexual molestation 85% of the subjects felt only negative effects and only three out of 100 subjects felt that the experience was positive (Nelson, 1979).

A recent study which looked at this factor in a more than cursory manner found that of subjects with severe emotional disturbance, 87% reported feeling arousal or pleasure during their childhood molestation experiences. These survivors were victims of incest (Hindman, 1989).

Molestation by strangers may be more easily assimilated by victims. Children molested by family members may experience a double bind in that there may be difficulty in understanding independent causation. These children may know that they wanted attention from the abusing relative but also may feel humiliation and may be unable to incorporate the resulting confusion (Courtois, 1988). Also, children may not understand that their physical pleasure is not under their control, as the second-most powerful predictor of sexual victimization of children has been found to be the lack of any sex education (Finkelhor, 1980).

Additionally, children's natural expression of affection may increase their guilt feelings regarding the abuse. They know they want some of the touches they receive, and although they may develop anger later on and begin to understand how they have been used, they may feel guilt and remorse due to believing they are partly responsible. The feeling of responsibility may be especially troublesome if they enjoyed some of the sexual activity, as some victims do (Renvoize, 1982).

Experiencing arousal during molestation may be an overwhelming source of trauma for survivors. For instance, orgasm experienced in the early stages of development may have a profound effect on children, and the use of objects such as vibrators may be perceived as weapons by them. Arousal, coupled with abuse may often carry over into

adulthood. Adult survivors often show signs of continued arousal toward their abusers or for the kind of activities the abuser instigated. Therefore, victims of molestation who felt pleasure during the sex acts may tend to seek repetition of the traumatic abuse in order to gain arousal as adults (Hindman, 1989).

## CHAPTER III

### METHODS

#### The Population

The subjects used in this research were drawn from the clientele of several counseling services in Kern and Los Angeles Counties, in California. In Kern County, the Desert Counseling Clinics serve eleven (11) county communities. Its head office in Ridgecrest offers counseling to that city of about 50,000 people as well as the small towns of Trona and Inyokern, the China Lake Naval Weapons Research Center, and people living isolated in the surrounding desert. The Lake Isabella office serves several small mountain resort areas. The Mojave office serves that community, Rosamond, California City, Edwards Air Force Base, Tehachapi, Boron, and a few other rural communities, all of which include about 60,000 people.

The private practice clinic site located in Ridgecrest primarily serves people from the military and scientific community of the China Lake Naval Weapons Research Center, and other more affluent clients. The private practitioner in Bakersfield offers service to a diverse population in a city of about 200,000 people and several near-by farming communities. The Lancaster clinic (Kaiser) is in Los Angeles County and serves a population of about 20,000 persons. The overall population base of this study represents a variety of income and educational levels, from the homeless to space science personnel.

### The Subjects

In an attempt to assure similarity of experiences, all of the subjects of this study were adult women survivors of childhood molestation. They were active clients at the above counseling settings. Men were not included in the study as the unique experiences within that population might complicate the findings. For instance, the effects of molestation on gender identity of boys molested by men might add an element of disturbance not encountered by girls abused by men.

### Research Design and Procedures

Questions which address the research factors were designed by the researcher. A preliminary questionnaire was administered to a group of four survivors of childhood molestation who were clients at the Desert Counseling Clinic at Mojave, California. The answers to the presented questions were understood and adequately answered by this group and the original questionnaire (Appendix II) was subsequently distributed to the participating sites for research.

The participating counselors were either visited in person or telephoned by the researcher in order to explain and discuss the procedures. The questionnaires were then mailed to the participating sites with written instructions, release of information forms, and requests for findings summary forms. The questionnaires were mailed back to the researcher. There were 175 forms distributed with the anticipation that 75 would be returned; 54 questionnaires were returned. The data was then compiled by the researcher and put into computer language.

### The Questionnaire

In the instructions, counselors were asked to request that their adult women clients (ages 18 and older), who had revealed histories of childhood sex abuse, answer several questions which explored molestation experiences. The clients' answers, as well as their entry GAF scores, were recorded on the questionnaires.

It was decided that the subjects would complete the questionnaires in the presence of their own counselors during a regular therapy session rather than the researcher. As the questions might engender distress for some subjects, it was assumed that they would best be served in a setting which could offer immediate intervention. To ensure confidentiality, the questionnaires did not include the usual demographics or the subjects' names. Instead, they were numbered according to the counseling setting (first digit), the counselor (second digit), and client (next three digits), so that if there are any questions about any subject's answers, the researcher could consult with the counselor interviewer. The clients' signed agreements to participate in the research were kept in their files at their counseling settings. Any subject could refuse to participate in the study or to answer any specific question.

### Instrument

The dependent variable in this study is the Global Assessment of Functioning Scale. This instrument measures the severity of mental, emotional, and behavioral dysfunction in individuals. In this case, it measures the dysfunction of women who have histories of childhood sexual abuse. The Global Assessment of Functioning Scale (GAF) is one

of five diagnostic tools used by most counselors who work in the field of mental health. These axes are found in the Diagnostic and Statistical Manual of Mental Disorders (DSM III R, 1987). Their use is required by all insurance companies, funding agencies, and courts of law.

### Diagnostic and Statistical Manual of Mental Disorders

The DSM I, published in 1952, was the first manual of mental disorders to contain a glossary which described the various psychiatric diagnostic categories. It was influenced by a psychological view which contended that all mental disorders represented reactions of the personality to psychological, social, and biological factors (DSM III-R, 1987). In 1968, the manual was revised in order to create a system more closely related to the system of classification of physical diseases. It viewed only the now out-of-use term 'neurosis' as a reaction of personality to the above factors. The DSM II, therefore, did not focus on a particular theoretical framework for understanding the nonorganic mental disorders (DSM III-R, 1987).

The DSM III, published in 1980, was prepared by a taskforce in order to reflect the most current state of knowledge about mental and emotional disorders. It attempted to create a multiaxial system for psychiatric evaluation wherein each individual would be evaluated by the following five diagnostic criteria.

Axis I of the DSM III classified psychiatric syndromes and other disorders such as schizophrenia or adjustment disorders, which may be successfully affected by treatment with medication or psychotherapy. Axis II classified the personality disorders and specific developmental disorders, such as antisocial personality disorder or autism, which

may not be effectively treated by these methods. Axis III described physical conditions which might be important to the understanding of the diagnosis or treatment possibilities of the individual. For instance, seizure disorders, pregnancy, or heart disease, might indicate caution in the use of medication. It also looks at other physical problems such as head injury or premenstrual syndrome which might indicate physical causes for presenting symptoms (DSM III-R, 1987).

For clinical, research, and teaching purposes, two other non-diagnostic axes were added in the DSM III. Axis IV asked the clinician to indicate the specific psychosocial stressors which they judged to be significant contributors to the development or exacerbation of the current disorder. This is a rating of the overall severity of stress which any average person with similar circumstances would experience (DSM III-R, 1987).

Axis V, the only axis used in this research, began in DSM III as the Global Assessment Scale (GAS). It was designed as a procedure for measuring overall severity of the individual's disturbance. It allowed for the combining of several elements into a single clinically meaningful index of severity of disorder by looking at the level of adaptive functioning of the person suffering from mental and emotional distress (Endicott, Spitzer, Fleiss & Cohen, 1976). According to McGlashan (1973) global ratings of status seem to be more sensitive to differential treatment effects than do measures of single dimensions of psychopathology, such as those measured on Axes I and II.

In the DSM III, the GAS was used as a single rating scale for evaluating the overall functioning of a subject during a specific time period on a continuum from psychological sickness to health. The scale values ranged from one, representing the hypothetically sickest person, to 100 which represented the hypothetically healthiest person. The scale was divided into intervals: 1 to 10, 11 to 20, and so on to 91 to 100. Most individuals seen in a clinical setting would be rated between 31 and 50, in psychiatric hospitals between 1 and 49 (Endicott, Spitzer, Fleiss & Cohen, 1976).

The GAS scale permitted the clinician to indicate a subjective judgement of the client's highest level of adaptive functioning during a few months of the previous year. Adaptation was measured by a composite of three areas; social relations, occupational functioning, and the use of leisure time. Social functioning was weighed most heavily, as it was considered to be of greater prognostic significance (DSM III-R, 1987).

Field trials of this system used 247 clinicians' assessments of 281 clients. The interclass reliability coefficients for this axis were .80 for joint assessments and .69 for individual assessments. These findings indicated that the reliability of clinicians' judgements about the highest level of adaptation was quite good on Axis V of the DSM III (Spitzer & Forman, 1979). Clinicians in a mental hospital setting were able to make accurate criterion based judgements regarding psychosocial stress and levels of social and occupational functioning as measured on Axis IV and Axis V with about the same frequency as they were able to make an accurate psychiatric diagnosis (Schrader, Gordon & Harcourt, 1986).

After the DSM III was introduced, few empirical studies were done to assess the

reliability of its multiaxial system. However, in 1985, Williams published a review of the available studies which did address the reliability and validity of the DSM system. She cited a presentation at the seventh world congress of psychiatry which discussed a survey of diagnostic experts on their views of multiaxial systems of assessments. Of 164 respondents, 51% said that they currently used the DSM III system. Of these, 46% reported that the multiaxial system was highly useful while 21% said that it was of low usefulness. The respondents also compared the usefulness of all the axes with 37% indicating that Axis V was essential in their diagnostic and prognostic assessment (Williams, 1985).

In another study, 745 patients of a walk-in clinic were examined for disposition of their cases. It was found that a rating of a patient's current adaptive functioning as measured by Axis V had the strongest correlation of all the DSM III axes with the decision to hospitalize a client. This indicated that Axis V may be an efficient indicator of severity of mental or emotional distress (Mezzich, Evanczuk & Mathias, 1984). However, there have been some researchers who have criticized the structure of this axis due to the subjective means of its determination (Spitzer & Forman, 1979).

The subjectivity of this measure was researched in a study which assessed interrater reliability and whether reliability was influenced by the client's diagnosis, gender, age, ethnic origin, or marital status. It was found that complete agreement occurred between pairs of raters with diverse disciplines at a 38% level, and 45% of the assessments differed by only one point. The greatest difference between any pair of ratings was three points, and that only occurred 3% of the time. The researchers concluded that

with an interclass correlation coefficient of .49, there was an indication of agreement better than chance but less than satisfactory as it was less than .60. However, as 83% of the paired ratings in this study showed complete agreement or differences of only one point, it can be implied that the DSM III, Axis V rating scale did have a reasonable degree of clinical usefulness (Thakshan, 1986).

#### Global Assessment of Functioning (GAF)

Prior to 1987, publication of the DSM III-R, (R=Revised), a committee revised Axis V to explicitly include symptoms as well as indicators of social, occupational, and leisure functioning. It also transformed the scale to include both the GAS and The Children's Global Assessment of Functioning Scale (CAF). It was renamed the Global Assessment of Functioning (Skodol, Link, Shrout & Horwath, 1988).

The ratings on the new GAF (Appendix A), in contrast to the GAS, are made for two time periods. The current level of the client's functioning at intake and the highest level of functioning for at least a few months during the past year are both now determined. For teenagers and children, these levels must include at least a month during the school year (DSM III-R, 1987).

This new scale helps the counselor assess the current need for treatment. It also rates the highest functioning of a client, which can have prognostic significance due to a person's return to previous level of functioning after an episode of dysfunction (DSM III-R, 1987). For instance, the client's highest functioning in the past year might be 80 while at the time of intake it might have been 45 and at the time of discharge, it might be 78. This information seems to indicate improvement toward baseline functioning.

The GAF differs from the GAS in another aspect. It is a 90 point scale rather than a 100 point scale. The highest interval in the GAS is 91 to 100 for unusually high-functioning persons. In the new scale, it is assumed that these people would not seek mental health care; therefore, the new scale ranges from one to 90 points, or from severely dysfunctional to absent or minimal symptoms (DSM III-R, 1987).

The Global assessment of Functioning Scale, as introduced in the DSM III-R, has been understandably scantily researched as it has been in publication only a few years (DSM III-R, 1987). One study which examined the relationship of psychological symptoms to clinicians' ratings on Axis V was published in 1988 by Skodol. In this study, the authors found that Axis I diagnosis explained 19% of the variance of Axis V, demographics explained 6.5% and symptoms explained 7%. The authors concluded that symptoms exhibited by clients tended to detract from the adaptive functioning of clients and wondered if the inclusion of symptoms in the GAF, in contrast to the GAS, was a mistake (Skodol, Link, Shrout & Horwath, 1988). However, a longitudinal study of 188 subjects, who had been followed over a 50 year time period, found that Axis V of the DSM III-R to be a valid measure of impairment when compared to five other assessment methods (Vaillant, 1988).

### Hypotheses

1. As measured by the GAF, there will be no significant difference between groups based on the number of perpetrators.

2. As measured by the GAF, there will be no significant difference between groups based on the relationship with the perpetrator.
3. As measured by the GAF, subjects who were molested early on (1 to 3 years old) will be more dysfunctional than subjects who were molested in later years.
4. As measured by the GAF, there will be a significant difference between groups based on the length of time subjects were first molested.
5. As measured by the GAF, there will be no significant difference between groups based on the degree of body intrusion experienced by victims when first abused.
6. As measured by the GAF, there will be no significant difference between groups based on the degree of coercion experience by victims during the first abuse experience.
7. As measured by the GAF, there will be significant difference between groups based on sexual arousal of the victim during abuse by the first perpetrator.

## CHAPTER IV

### FINDINGS

#### Analysis of Data

Seven variables found within the molestation experience were compared with subject's GAF scores to determine if significant differences existed within each variable. A frequency distribution of the GAF scores was compiled; N 54, highest score 75, lowest score 25, mean score 48.78, Sd 12.773.

Analysis of Variance was used to test hypotheses 1, 3, 5, 6, and 7. A "t" test was used to test hypothesis 2, and a Chi Square test was used to test hypothesis 4. Also, a Discriminant Analysis was run on all variable to determine the predictability of GAF scores by the variables studied. The variables studied were: the number of abusers, relationship of abuser and abused, age of abuse victim, duration of abuse, degree of sexual intrusion, degree of coercion, and, if the victim felt sexual arousal during abuse.

#### Findings

##### Hypothesis 1: Number of Abusers

Analysis of variance was used to test for differences between the GAF scores of subjects (N 54) who experienced sex abuse by one (38.9%), two (20.4%), three (13%), or four or more (27.8%) perpetrators. The following table illustrates the findings.

Table 1

Number of Abusers -- Analysis of Variance

Source	Df	Sum of Squares	Mean Squares	F ratio	F prob.
Between	3	841.1515	280.3838	1.7959	.1600
Within	50	7806.1818	156.1236		
Total	53	8647.3333			

Calculated F = 1.7959, Table F = 2.79,  $\alpha = .05$

With  $\alpha$  at .05 and F probability at .16 being more than .05 (Table F larger than Calculated F), then the null hypothesis was retained. There was no significant difference found between the GAF scores of subjects abused by one, two, three, or four and more molestation perpetrators.

Hypothesis 2: Relationship Between Abuser & Abused

"t" tests were used to test for differences between the GAF scores of subjects (N 54) who were either abused by a parent or a non-parent. One test assessed the first abuse experienced. The other test assessed all of the abuse experienced by subjects, whether they were abused only once or more than once. The following tables illustrate the findings.

Table 2

Relationship with First Abuser - "t" Test

Variable	Number Cases	GAF mean	Stand. Div.	Stand. Error
parent	23 (42.6%)	47.52	14.90	3.1
non-parent	31 (57.4%)	49.71	11.20	2.0

Variance Estimate

F	Pooled Variance				Separate Variance			
	2 tail var.	t val.	df	2 tail prb.	t val.	df	2 tail prb.	
2	.144	-.62	52	.539	-.59	38	.556	

With  $\alpha$  at .05 and 2 tail probability at .539, there is no significant difference found between GAF scores and if subjects were abused by a parent or non-parent during the first abuse experienced.

Table 3

Closest Relationship with All Abusers - "t" Test

Variable	Number Cases	GAF mean	Stand. Div.	Stand. Error
parent	25 (59%)	49.36	15.58	3.116
non-parent	29 (40.7%)	48.28	10.01	1.859

Variance Estimate

F	Pooled Variance				Separate Variance			
	2 tail Prb.	t val.	df		2 tail prb.	t val.	df	2 tail prb.
2	.026	.31	52		.759	.30	40	.767

With  $\alpha$  at .05 and 2 tail probability at .759, there was no significant difference between groups. Those who were abused by either a parent or non-parent during all abuse experiences had non-significant different GAF scores.

Hypothesis 3: Age the Child Was When First Abused

Analysis of variance and the Student-Newman-Keul Procedure were used to test for differences between the GAF scores of subjects and the age they were when they were first sexually abused (N 54). The age groups that were assessed were: birth to three years (27.8%), four to seven years (37.0%), and eight years and older (35.2%). The following tables summarize both statistical procedures used for analysis of the data.

Table 4.

Age of Victim at Onset of Abuse - Analysis of Variance

Source	Df	Sum of Squares	Mean Squares	F ratio	F prob.
Between	2	933.0105	466.5053	3.0841	.0544
Within	51	7714.3228	151.2612		
Total	53	8647.3333			

Calculated F 3.0841 Table F 3.18  $\alpha$  .05

F probability at .054 and  $\alpha$  at .05 (Table F was slightly larger than calculated F) indicated the possibility of a significant difference between groups, therefore a Multiple Range Test was run.

Table 5.

Age of Victim at Onset of Abuse - Student-Newman-Keul Procedure

Table Ranges: 2.85 3.41 Actual Value: 8.6966

Group	Mean Score	Group	0-3 yrs	4-7 yrs	8yrs+
0-3 yrs	42.4667		*		
4-7 yrs	49.6000				
8 +	52.8947		*		

\* = significant at  $\alpha$  .05.

There was a significant difference between group one (0 to 3 years of age) and group 3 (8 and more years). The youngest age group showed more disturbance, as measured by the GAF, than did the oldest group.

Hypothesis 4: Length of Time the First Abuse Lasted

The Chi Square test was used to assess any difference between subjects, N = 54, as to the length of time their first abuse lasted. Fifty-nine point three percent of

subjects were molested by the first abuser from one time only to up to five years; 40.7% were molested by the first abuser for over five years. The following tables illustrate the findings.

Table 6.

Duration of First Abuse - Chi Square Analysis

Chi Square Given

GAF	Less than 5 years	More than 5 years	Total
21-40	4	13	17
41-60	9	5	14
61-80	19	4	23
Total	32	22	54

Chi Square Expected

GAF	Less than 5 years	More than 5 years
21-40	10.07	6.39
41-60	8.30	5.70
61-80	13.63	9.37

df = 2, Calculated X<sup>2</sup> = 14.33, Table X<sup>2</sup> = 5.991,  $\alpha$  = .05

As df is 2, Tabulated Chi Square is 5.991, Calculated Chi Square is 14.33, and  $\alpha$  is at .05, the Null hypothesis was rejected. There is significant difference between

those subjects who were abused for less than five years and those molested for more than five years.

Hypothesis 5: Degree of Sexual Intrusion, First Abuse.

Analysis of Variance was used to test difference in GAF scores and the degree of sexual intrusion experienced during subject's (N 49) earliest molestation experience.

Three general types of sexuality were compared: non-touching sexuality through fondling (37%), oral genital contact (26%), and anal or genital penetration (37%). The following table illustrates the findings.

Table 7.

Degree of Sexual Intrusion, First Abuse - Analysis of Variance

Source	Df	Sum of Squares	Mean Squares	F ratio	F prob.
Between	2	299.8548	149.9274	.9160	.4066
Within	47	8347.4786	163.6761		
Total	48	8647.3333			
Calculated F	.9160	Table F	3.18	$\infty$	.05

As the Table F value is larger than the Calculated F value (.4066 larger than .05), there is no significant difference found between groups.

Hypothesis 6: Degree of Coercion, First Abuse.

Analysis of variance was used to test if the GAF scores of subjects (N = 49), according to degree of coercion used to gain compliance by their first abuser, were different. The two categories examined were: non-threatening or non-violent behavior (28.6%) and threatening or violent behavior (71.4%) on the part of the abuser. The following table illustrates the analysis of this factor.

Table 8.

Degree of Coercion, First Abuse - Analysis of Variance

Source	Df	Sum of Squares	Mean Squares	F ratio	F prob.
Between	1	29.8796	29.8796	.1690	.6829
Within	47	8309.9571	176.8076		
Total	48	8339.8367			
Calculated F	.1690	Table F	4.04	$\alpha$	.05

As Calculated F is smaller than Tabular F (F probability .6829 is larger than .05), the Null hypothesis was retained. There is no significant differences between groups.

Hypothesis 7: Sexual Arousal, First Abuse.

Analysis of Variance was used to assess if the GAF scores of subjects were significantly different according to whether they were aroused sexually (38.3%) or not aroused (61.2%) during their first abuse experience. The following table illustrates this

analysis.

Table 9.

Sexual Arousal, First Abuse - Analysis of Variance

Source	Df	Sum of Squares	Mean Squares	F ratio	F prob.
Between	1	425.9077	425.9077	2.5050	.1202
Within	47	7991.0719	170.0228		
Total	48	8416.9796			
Calculated F	2.5050	Table F	4.04	$\alpha$	.05

As Calculated F is smaller than Tabular F, the Null hypothesis is retained. There are no significant differences between groups.

### Other Findings

#### Discriminant Analysis:

Discriminant function analysis was done in order to determine if the GAF scores of subjects could be predicted when all seven independent variables were weighed. As seven subjects failed to include one or more variables in their responses, 47 cases were used in the analysis. Two groupings of GAF scores were analyzed: 50 and below and 51 and above. Scores of 50 and below are considered by funding agencies to be indicative of dysfunction serious enough to warrant mental health counseling paid for by public funding.

Table 10.

Discriminant Function Analysis of All FactorsClassification Results:

Group	Number of cases	Predicted group membership	
		50 and below	51 and above
50 and below	28	71.4% (20)	28.6% (8)
51 and above	19	21.1% (4)	78.9% (15)

Percent of "grouped" cases correctly classified 74.47%

By chance alone, it would be expected that scores could be correctly classified 50% of the time. With correct classification at 74.47%, it would seem that when looking at overall response some element is added which increases the probability of predicting whether subjects will be more or less seriously dysfunctional according to the GAF.

## CHAPTER V

### SUMMARY AND DISCUSSION

#### Summary

Sexual abuse of children is of concern to counselors as research points to a connection between childhood molestation and mental, emotional, and behavioral dysfunction in adults who survived the molestation experience (Renvoize, 1982). It seems important that the molestation experience and its outcome be understood by professionals so that they may make adequate decisions as to the proper treatment or disposition of child abuse cases, whether they are counselors, attorneys, or judges.

In order to address this problem, research into the actual experiences of adult survivors who are in counseling and who have experienced childhood molestation were surveyed. Their responses on a questionnaire were compared with their entry-level GAF scores. These scores measured clients' social, occupational, leisure, and mental functioning at the time they first presented themselves for counseling at their present counseling site. Their answers as to seven variables were compared with their GAF scores. These variables were: the number of people who abused them, the relationship they had with the first abuser, their age when first abused, the length of time the first abuse lasted, how sexually intrusive the first abuse was, how coercive the first abuser was, and if they were sexually aroused during their first abuse.

Statistical procedures were selected in order to analyze the seven variables. The analysis was aided by the use of the computer at California State University at Bakersfield's Computer Resource Center. The results were analyzed as to significance

and implications.

### Limitations

#### Sample

The sample size was smaller than expected and may not be generalizable to the population of outpatient survivors of childhood sexual abuse. Also, caution should be used in generalizing the findings as samples were drawn from a self-selected population of volunteer clinical clients, excluding less disturbed survivors in the general population and those who were so severely disturbed that they needed hospitalization.

#### Questionnaire

The questionnaire could have been more precisely designed and may not have adequately measured adult survivor's level of dysfunction. For instance, one question, "How was the abuser related to you?" was misunderstood by some subjects who assumed that "related" meant being a family member. Also, as only eight questions were asked and sample size was small, reliability decreased. If there is replication of the study, the Delphi technique might be used to better establish usability of the measure. Also, interrelationship of the seven variables may have been hard to separate when assessing dysfunction.

#### Demographics

In an attempt to assure subject confidentiality, some information which might have helped explain variability of scores were not included in the study. For instance, does it matter if the child victim was believed when she told of the abuse, if she was involved

in the foster placement system, the age the subject was at the time of the interview, or if she had received previous counseling as a child or adult? These and other variables might have affected the factors studied and the degree of dysfunction found in the GAF scores of the subjects.

### Measurement

The GAF scale was the dependent variable in this study. The GAF has been somewhat controversial in that it seems to some to be too subjective to be an accurate study of dysfunction. However, the GAF is the most widely used measure of dysfunction in the field of counseling and psychology, and some research contends that it is a useful measure of the social, occupational, and leisure functioning of mental health services clients.

## Discussion

### Hypothesis 1: Number of Abusers.

Some researchers suggest that as rape victims are often past victims of incest and that incest often includes more than one abuser, multiple abuse may suggest that molestation victims place themselves in harm's way. The indication is that dysfunction in survivors may be caused by more than one abuse experience (Herman, 1981). This research found no significant difference in adult dysfunction compared with whether a person was victimized by one or more perpetrators.

Although no significant difference was found as to dysfunction and the number of perpetrators, there is agreement with other researchers who relate that most sexual abuse

of children is perpetrated by more than one person (Meiselman, 1979; Mills, Reiker & Carmen, 1984; Russell, 1986). Of the subjects in this study, 61% were abused by two or more people while 39% were abused by only one person. Perhaps it is the first abuse, usually when a child is very young, that accounts for any dysfunction in survivors whether or not they are abused by subsequent perpetrators. This will be explored in more depth when considering Hypothesis 3.

Hypothesis 2: Relationship between abuser and abused.

No significant difference as to dysfunction of adult survivors and who their first abuser was was found in this research. It was noted, however, that the first abuser was most often a non-parent (57%), in contrast to other researcher's findings that most children are abused by a father (Butler, 1978; Finkelhor, 1976; Gold, 1986). However, if all abusers reported are considered, other research is born out in this research in that 59% of this study's subjects were abused by parents and most of these parents were fathers. Only three subjects reported abuse by a mother. Also of interest is that only one subject reported molestation by a stepfather in contrast to some other research which found that more parental molestation was perpetrated by a stepfather than by a father (Finkelhor, 1980; Renvoize, 1982). The cited research into relationship of abuser and abused disagree somewhat about just who most often molests children, but it seems that most children are abused within their family.

Hypothesis 3: Age of the Victim at First Abuse.

Review of the literature suggests a connection between the age children are when first abused and behavioral and psychological problems (Beck & van der Kolk, 1987;

Bryer & Nelson, 1987). This research is in agreement as dysfunction in adult survivors was found to significantly relate to being abused at an early age (from birth through age three).

Some researchers have explored possible reasons that early childhood sex abuse might cause dysfunction in survivors. According to Krystal (1984), a victim of any trauma is traumatized not so much by degree or duration of the traumatizing events as on the victim's ability to fit the experience into existing mental structures in order to make it meaningful. How a child does this may depend on the child's level of development.

This research indicates, more dysfunction is created from birth through age three years. During this time, children progress through two stages of development. From birth to age two, children are completely dependent on adults and have little differentiation between the self and others. They process information viscerally rather than cognitively. From ages two to four, the child perceives the self and others as having unbreakable boundaries and attributes "bad" events to the self (Piaget, 1970). If abuse occurs prior to the age of two, the child does not understand sexuality and may doubt its own feeling perceptions about the sex events as it is not intellectually equipped to assimilate this information into its present mental structures. It may feel that what is happening is under his or her control as self and other are the same. If abused from age two to four, the child may become confused as to boundaries and perceive the self as causing the "bad" events.

The inability to differentiate or trust one's feelings, to have difficulty setting

appropriate boundaries, to blame oneself for negative events, and to assume one is somehow "bad," in this researcher's clinical experience, are all attributes of adult survivors of sex abuse. These attributes seem similar to how very young children might perceive sexual abuse events and may partly account for adult dysfunction in survivors, as normal development in children seems to be interrupted when abuse occurs (Bowlby, 1984; Gelinias, 1983).

Hypothesis 4: Length of Time Child Experienced the First Abuse.

The length of time children are abused was found to be significantly related to adult functioning as measured by the GAF. This finding was expected as reviewed research pointed in this direction (Beck & van der Kolk, 1987; Swanson & Biaggio, 1985). Also, other researcher's contended that incest involves sex acts which last over longer periods of time than does extra family molestation (Courtois, 1988; Russell, 1986; van der Kolk, 1987). The above research is born out as 85% of subjects who were abused by a parent were abused for more than four years. In contrast, if abused by a non-family member, only 8% were abused for over four years.

These figures may be understood if developmental theory is considered. Normal psychological growth in children happens in stages. These stages require two functional variants of thinking: assimilation of new experiences into an existing view of the world and accommodation of these experiences in order to adjust and transform one's view of the world, thereby correcting discrepancies between fantasy about the world and reality (Piaget, 1970). The combination of these processes help balance the new and the known, allowing for building control and mastery over life and for aiding in problem

solving.

The developing child organizes new information according to increasingly complicated sets of mental relationships (van der Kolk, 1987). If, due to trauma, children's normal progress through developmental stages is constantly interrupted, they may not be able to fulfill the promise of progression toward healthy maturity (Krystal, 1984). If sexual abuse continues over a long period of time, the normal emotional, social, and intellectual functioning of the child may be damaged.

Hypothesis 5: Degree of Sexual Intrusion.

No significance was found on this variable, as adult functioning measured by the GAF was similar for those subjects who experienced fondling only, oral sex, or penile penetration of the genital area. A review of previous research tended to show disagreement as to what type of sexual experience is more damaging to the victim. Some researchers found mutual genital contact to be the most harmful of all molestation activity (Browne & Finkelhor, 1986; Courtois, 1988; Russell, 1986) while other researchers contend that incest experiences contain more genital area penetration than does non-family molestation (Finkelhor, 1979; Mills, Reiker & Carmen, 1984; Russell, 1986).

This research study tends to agree with other research's contention that there is a prevalence of more intrusive sexuality during incest as 59% of subjects reported penetration of the genital area during incest in contrast to 8% reporting such abuse during extrafamily molestation.

Developmental theory may shed light on why the degree of sexual intrusion may

not be directly related to the degree of victim dysfunction. Perhaps young children do not easily distinguish between different kinds of intrusion as more or less traumatic (e.g., finger into labia, tongue into mouth, penis into vagina, eye peeping into bathroom invading privacy). Boundary intrusion and confusion can be problematic for all ages of children. The small ones, birth to age two, do not clearly understand boundaries; those from the age of two to four have firm boundaries. From the age of four to seven children have more flexible boundaries and think they may cause events even though they know adults know more about life than they do. Children who are aged seven to eleven can recognize reciprocity in boundary settings and take the role of intruder themselves at times. At about the age of twelve, children can understand boundaries if normal development has progressed. They can think about boundaries and set them for themselves and for others (Piaget, 1970).

If sexual intrusion happens, in any manner, during any developmental-stage, abused children may develop into confused, guarded, or non-guarded adults who continue to struggle with physical, emotional, and intellectual integrity.

Hypothesis 6: Degree of Coercion.

Earlier research has found that the more force used to convince a child to comply with sex abuse, the more stress is engendered in the child (Finkelhor, 1980). In contrast, this research found no significant difference in GAF scores of subjects who experienced threats or force and those who did not. A review of the literature indicates that the greatest potential for violent coercion is within family-based abuse (de Young, 1982; Renvoize, 1982). At least within the first abuse experience, this research found

that force was used to gain the child victim's compliance for sexual activity by a family member 59% of the time in contrast to 64% of the time if the abuser was not a family member.

Perhaps children who are sexually abused within the family do not always have to be forced to comply. According to some researchers, most sex abuse of children does not involve violent or threatening coercion as the boundaries within the family may be misrepresented and the activity defined as affection or education to a child who is young enough to still define reality through the eyes of her or his caretakers (Courtois, 1986; Russell, 1986).

#### Hypothesis 7: Arousal of the Victim.

This research did not find the same amount of sexual arousal reported by adult survivors as Hindman (1989) did in her study of disturbed children in therapy. She reported that 87% of severely disturbed girls reported feeling sexual arousal during molestation. This study found no significant difference between dysfunction in adult survivors of molestation who either felt or did not feel arousal during sex abuse. More subjects (61%) felt no arousal than did subjects who felt arousal (38%).

Adult survivors of molestation, due to more experience with sexuality, may be more able to understand that sexual arousal is not completely within their control. Children must advance through several stages of development before arriving at this understanding. Perhaps if the girls in Hindman's study (1989) presented themselves for counseling at the age of 28 or 42, their life experiences would have allowed them to better understand that sexual arousal is often not voluntary (Hindman, 1989).

### Implications

A review of the findings of this research suggests that further study is needed into how the experiences of childhood sexual abuse are affected by, or affect, the development of children. If very young children are often severely disturbed due to sexual abuse, and the effects of abuse may be compounded over time, future research into the relationship between the normal stages of development and how normal developmental stages may be disrupted due to early sexual experience is strongly indicated.

Another area of research which might be an interesting follow up to this study would be exploration into just how all seven variables interacted when weighed together so that GAF scores could be predicted 75% of the time as they were in the Discriminant Analysis used in this work. Future research might use Step-Wise Multiple Regression Analysis to determine which factors are more or less predictive of dysfunction. If a pattern could be found as to degree of dysfunction from highest to lowest predictability, a checklist might be generated which could be used by professionals who must make decisions as to disposition of sex abuse cases in the court room and in the counseling office.

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## APPENDICES

## APPENDIX I

### DEFINITION OF TERMS

Accommodate	To mentally readjust and transform new information in order to correct discrepancies between fact and fantasy.
Albinism	The congenital absence of normal pigmentation in an organism.
Anxiety	An intense fear or dread, lacking a conscious cause or threat.
Assimilation	The process of taking new information into mental structures in order to correct differences between fact and fantasy.
Bonding	The formation of close humanizing relationships, such as between a parent and a child.
Clinical	Pertaining to the direct, objective, counseling of a client.
Coercion	The act of manipulating, dominating, restraining or controlling another person.
Compulsive	To have an irresistible impulse to act, regardless of rational motivation.
Counselor	A licensed or certified professional who gives advise or who helps a client solve problems.
Counseling	The act of helping a client solve problems.
Cunnilingus	Oral stimulation of the clitoris or vulva.
Depersonalization	The loss of the sense of individual identity.
Depression	A state of profound sadness wherein a person has problems with eating and sleeping, feels hopeless and helpless, cries often, feels no pleasure, and may think of suicide.
Diagnosis	Analyzing symptoms in order to determine the cause and proper treatment of a client's dysfunction.
Dissociation	The separation of aspects of the personality as a survival mechanism during stress.

Dwarfism	The condition of arrested physical growth.
Fellatio	Oral stimulation of the penis.
Flashback	The reliving of a past traumatic event as if it were happening again.
Hyperventilation	Abnormally fast or deep respiration which may cause ear buzzing, dizziness, and numbness in the extremities.
Incest	Sexual stimulation or activity with someone who is related genetically or who acts as a surrogate for a blood relative.
Masochistic	The tendency to seek out situations wherein one is punished or abused.
Molestation	The act of accosting sexually.
Multiple Personality	The state of having more than one distinct personality system, usually due to defending against trauma by dissociation.
Neglect	To fail to care for the needs or to give proper attention to another.
Neurotic	Having a disorder of the mind or emotions with no obvious organic cause.
Nightmare	A dream arousing feelings of intense, inescapable fear, horror, or distress which may or may not be clearly remembered.
Night Terror	The phenomenon of displaying extreme terror reaction during sleep with no remembered dream.
Offender	One who violates a rule or law, such as the prohibition against an adult having sex with a child.
Oral-genital Sex	The stimulation of a person's genital area with the mouth or tongue of another person.
Pathology	The anatomic or functional manifestation of a disease.
Patriarchy	The rule of a family, tribe, or society exclusively by men.
Pedophile	An adult who prefers children over adults as sexual objects.

Perpetrator	One who instigates an act, such as sex abuse.
Phobic	Having an intense fear of something.
Post-traumatic Stress	Stress related to an earlier trauma which is felt at a later date.
Primary Caretaker	A person a child considers to be a parent and expects to nurture and protect him or her.
Prognostic	Indicating the future course of a disease.
Projection	The attribution of one's own attitudes, feelings, or desires to others.
Promiscuous	Indiscriminate in sexual relations.
Psychiatric	The study, diagnosis, treatment, and prevention of mental and emotional problems.
Psychoanalytic	Counseling techniques developed by Freud using free association, dream work, and other methods to analyze mental processes.
Psychosis	Any mental disorder characterized by deterioration of normal intellectual and social functioning and by partial or complete withdrawal from reality, usually caused by genetic brain dysfunction or by long-term drug abuse.
Psychosocial	Involving aspects of both psychological and social behavior.
Psychosomatic	The experience of bodily symptoms as a result of mental conflict.
Psychotherapist	Anyone of several disciplines (Counselors, Psychologists, Social Workers, or Psychiatrists), who are licensed or certified to treat emotional, mental, and behavioral problems.
Psychotropic	That which has an altering effect on the functioning of the brain or mind.
Pubescent	Reaching, or having reached, adolescence.
Rape	Forcing another to submit to sexual activity.

Reaction Formation	Preventing fearful feelings or thoughts from being expressed by taking on opposed attitudes and types of behaviors and using them as barriers to acknowledgement of personal problems.
Retarded	Slow or backward in mental, emotional, developmental, or academic achievement.
Schizophrenic	One who has a psychologically caused psychotic disorder, characterized by gross distortion of reality, disorganization and fragmentation of perception, thought, emotion, and withdrawal from social life.
School Phobia	An unrealistic fear of going to school.
Socialization	The training of someone to fit into a social group such as a child into a family.
Sociopathic	Disregarding others' rights or being uncaring about others.
Somatic	Pertaining to the body.
Split	To separate the personality into parts.
Stepfather	A husband or paramate of one's mother who is not one's natural father.
Stigma	A mark of disgrace.
Survivor	One who lives and persists through adversity.
Taboo	A ban or inhibition attached to something by social custom or emotional aversion.
Trance State	A state of mental and emotional detachment from one's physical surroundings.
Trauma	An emotional shock which creates substantial and lasting damage to the psychological or physical development of an individual.
Treatment	The application of remedies with the object of affecting a change or cure.
Victim	A person who suffers injury or loss as a result of an act of another or by nature.

## APPENDIX II

### GLOBAL ASSESSMENT OF FUNCTIONING SCALE (GAF SCALE)

Code	
90	ABSENT OR MINIMAL SYMPTOMS (e.g., mild anxiety before an exam), GOOD FUNCTIONING IN ALL AREAS, INTERESTED AND INVOLVED IN A WIDE RANGE OF ACTIVITIES, SOCIALLY EFFECTIVE, GENERALLY SATISFIED WITH LIFE, NO MORE THAN EVERYDAY PROBLEMS OR CONCERNS (e.g., an occasional argument with family members).
81	
80	IF SYMPTOMS ARE PRESENT, THEY ARE TRANSIENT AND EXPECTABLE REACTIONS TO PSYCHOLOGICAL STRESSORS (e.g., difficulty concentrating after family argument); NO MORE THAN SLIGHT IMPAIRMENT IN SOCIAL, OCCUPATIONAL OR SCHOOL FUNCTIONING (e.g., temporarily falling behind in school work).
71	
70	SOME MILD SYMPTOMS (e.g., depressed mood and mild insomnia) OR SOME DIFFICULTY IN SOCIAL, OCCUPATIONAL, OR SCHOOL FUNCTIONING (e.g., occasional truancy, or theft within the household), BUT GENERALLY FUNCTIONING PRETTY WELL, HAS SOME MEANINGFUL INTERPERSONAL RELATIONSHIPS.
61	
60	MODERATE SYMPTOMS (e.g., flat affect and circumstantial speech, occasional panic attacks) OR MODERATE DIFFICULTY IN SOCIAL, OCCUPATIONAL, OR SCHOOL FUNCTIONING (e.g., few friends, conflicts with co-workers).
51	
50	SERIOUS SYMPTOMS (e.g., suicidal ideation, severe obsessional rituals, frequent shoplifting) OR MAJOR IMPAIRMENT IN SOCIAL, OCCUPATIONAL, OR SCHOOL FUNCTIONING (e.g., no friends, unable to keep a job).
41	

40 SOME IMPAIRMENT IN REALITY TESTING OR  
COMMUNICATION (E.G., speech is at times illogical, obscure, or  
irrelevant) OR MAJOR IMPAIRMENT IN SEVERAL AREAS,  
SUCH AS WORK OR SCHOOL, FAMILY RELATIONS,  
JUDGEMENT, THINKING OR MOOD (e.g., depressed man  
avoids friends, neglects family, and is unable to work; child  
frequently beats up younger children, is defiant at home, and is  
31 failing at school).

30 BEHAVIOR IS CONSIDERABLY INFLUENCED BY  
DELUSIONS OR HALLUCINATIONS OR SERIOUS  
IMPAIRMENT IN COMMUNICATION OR JUDGEMENT (e.g.,  
sometimes incoherent, acts grossly inappropriately, suicidal  
preoccupation) OR INABILITY TO FUNCTION IN ALMOST  
21 ALL AREAS (e.g., stays in bed all day, no job or friends).

20 SOME DANGER OF HURTING SELF OR OTHERS (e.g., suicide  
attempts without clear expectation of death, frequently violent,  
manic excitement) OR OCCASIONALLY FAILS TO MAINTAIN  
MINIMAL PERSONAL HYGIENE (e.g., smears feces) OR  
GROSS IMPAIRMENT IN COMMUNICATION (e.g., largely  
11 incoherent or mute).

10 PERSISTENT DANGER OF SEVERELY HURTING SELF OR  
OTHERS (e.g., recurrent violence) OR PERSISTENT INABILITY  
TO MAINTAIN MINIMAL PERSONAL HYGIENE OR SERIOUS  
1 SUICIDAL ACT WITH CLEAR EXPECTATION OF DEATH.

## APPENDIX III

### RESEARCH QUESTIONNAIRE

Therapist  
Introduction

I am engaged in research for my doctoral thesis which will explore the effects of several aspects of childhood sexual molestation on the functioning of adult women survivors.

During the next two weeks, please ask all of your women clients who have histories of childhood sex abuse if they would be willing to answer eight questions about the subject of childhood sexual abuse. If they agree to participate, have them sign the attached release of information and complete the attached questionnaire. Please do not help them formulate their answers. However, you may help them with understanding instructions and any words they may not know the meaning of.

You will notice that the questionnaire is numbered, and that the client's name is not requested. The first digit of this number is assigned to your work setting, the second to you, so that if there is any question about the client's answers, the researcher can contact you for clarification. The remaining numbers identify the client. This is to assure that your client will remain anonymous.

Please keep the signed releases in the client's file.

**IT IS IMPORTANT THAT YOU INCLUDE THE GAF SCORE (AXIS V) GIVEN TO THE CLIENT AT THE TIME OF INTAKE!!!!!!!! YOU WILL FIND A SPACE FOR THIS NOTATION ON THE FIRST PAGE OF THE QUESTIONNAIRE.**

I appreciate your help and will be glad to send you a copy of the research summary findings if you so request by signing your name and your work setting below.

If you need more forms, please do not use the leftovers of your co-workers! Please call me at 805/824-2260 for forms or copy them and bill me! Thanks!!

Jane Dennis

Send a summary to: \_\_\_\_\_ Setting \_\_\_\_\_

# \_\_\_\_\_

## Research Questionnaire

ENTRY GAF \_\_\_\_\_

Please answer the following questions about your experiences of sexual molestation as a child and/or a teenager.

If you do not know the exact answer, please guess or estimate. If you were molested by only one person, just answer the questions under "Abuser #1." If there was more than one abuser, please go on and answer the questions in order of abusers, from the second one who abused you through the last one who abused you (#2 to #6). If there were more than six abusers, check "Yes" to the last question.

## Abuser #1

1. How was this abuser related to you?  
(please tell me the sex of the person if it might be unclear, for instance: if the abuser was a cousin, was the cousin a girl or a boy?).  
\_\_\_\_\_
2. If this abuser wasn't a member of your natural family, did this abuser feel like a dad, mom, or sibling to you even if they really were not members of your natural family? (for instance: a grandparent who raised you, or a foster brother, etc.)  
Yes \_\_\_\_\_  
No \_\_\_\_\_
3. How much older than you was this abuser?  
(guess, or estimate, if you are not sure.) \_\_\_\_\_
4. How old were you when this abuse began? \_\_\_\_\_
5. How long did the abuse last?  
(for instance: once, 2 months, 4 years.)  
(guess, or estimate, if you are not sure.) \_\_\_\_\_

6. What was the worst sexual thing this abuser did to you, or made you do? (for instance: showed his penis, had me suck his penis, intercourse.)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

7. What was the worst way this abuser convinced you to go along with the sex acts? (for instance: attention, promises, bribes, force.)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

8. What (if any) type of physical pleasure did you feel during this abuse? (for instance: nice skin feelings, nice feelings in the private parts, orgasm.)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

If more than one abuser, please continue the questionnaire.

Abuser #2

1. How was this abuser related to you? (please tell me the sex of the person if it might be unclear, for instance: if the abuser was a cousin, was the cousin a girl or a boy?).

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

2. Did this abuser feel like a dad, mom or sibling to you even if they really were not members of your natural family? (for instance: a grandparent who raised you, or a foster brother, etc.)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

3. How much older than you was this abuser? (guess, or estimate, if you are not sure.)

\_\_\_\_\_

4. How old were you when this abuse began?

\_\_\_\_\_

5. How long did the abuse last?  
(for instance: once, 2 months, 4 years.)  
(guess, or estimate, if you are not sure.)
6. What was the worst sexual thing this abuser did to you, or made you do?
7. What was the worst way this abuser convinced you to go along with the sex acts?  
(for instance: attention, promises, bribes, force.)
8. What (if any) type of physical pleasure did you feel during this abuse? (for instance: nice skin feelings, nice feelings in the private parts, orgasm.)

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Abuser #3

1. How was this abuser related to you?
2. Did this abuser feel like a dad, mom or sibling to you even if they really were not?
3. How much older than you was this abuser?
4. How old were you when this abuse began?
5. How long did the abuse last?
6. What was the worst sexual thing this abuser did to you, or made you do?
7. What was the worst way this abuser convinced you to go along with the sex acts?
8. What (if any) type of physical pleasure did you feel during this abuse?

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Abuser #4

1. How was this abuser related to you? \_\_\_\_\_
2. Did this abuser feel like a dad, mom or sibling to you even if they really were not? \_\_\_\_\_
3. How much older than you was this abuser? \_\_\_\_\_
4. How old were you when this abuse began? \_\_\_\_\_
5. How long did the abuse last? \_\_\_\_\_
6. What was the worst sexual thing this abuser did to you, or made you do? \_\_\_\_\_
7. What was the worst way this abuser convinced you to go along with the sex acts? \_\_\_\_\_
8. What (if any) type of physical pleasure did you feel during this abuse? \_\_\_\_\_

Abuser #5

1. How was this abuser related to you? \_\_\_\_\_
2. Did this abuser feel like a dad, mom or sibling to you even if they really were not? \_\_\_\_\_
3. How much older than you was this abuser? \_\_\_\_\_
4. How old were you when this abuse began? \_\_\_\_\_
5. How long did the abuse last? \_\_\_\_\_
6. What was the worst sexual thing this abuser did to you, or made you do? \_\_\_\_\_
7. What was the worst way this abuser convinced you to go along with the sex acts? \_\_\_\_\_

8. What (if any) type of physical pleasure did you feel during this abuse?

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Abuser #6

1. How was this abuser related to you?
2. Did this abuser feel like a dad, mom or sibling to you even if they really were not?
3. How much older than you was this abuser?
4. How old were you when this abuse began?
5. How long did the abuse last?
6. What was the worst sexual thing this abuser did to you, or made you do?
7. What was the worst way this abuser convinced you to go along with the sex acts?
8. What (if any) type of physical pleasure did you feel during this abuse?

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